Using the Good Lives Model with Adolescents and Young Men Who Have Harmed Others

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Healthy lives, Safe communities

Don’t worry!

- I won’t call on you for answers
- I won’t ask you to role play
- I won’t put too much research into each slide
    - Maybe some lighthearted profanity, though…

Flow

- Introduction
- Background Information
- Good Lives Model – core principles
- Obstacles to a Good Life Plan
- Identifying Strengths and Protective Factors
- Application
- Trauma
- Implementation

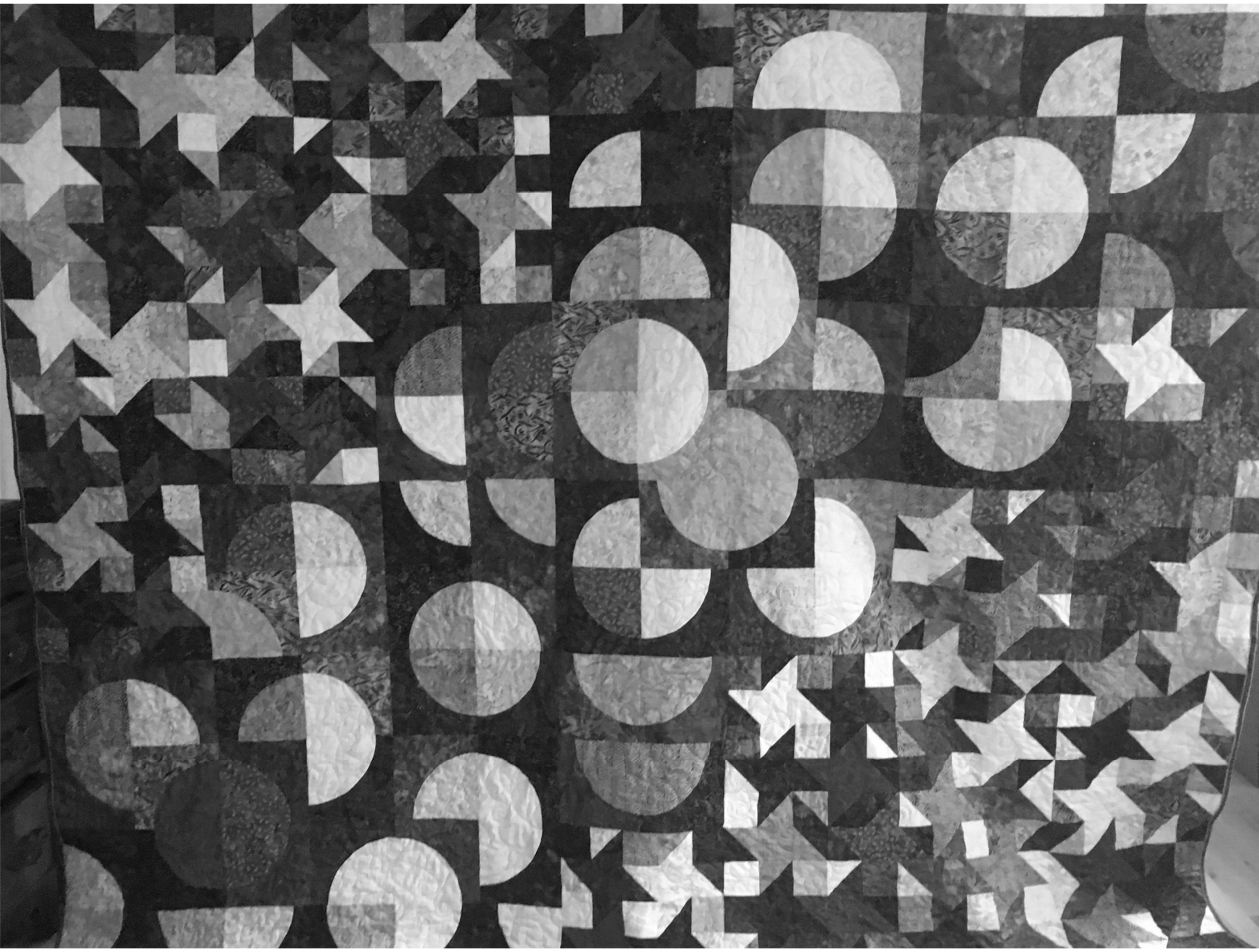
Please be patient with me

- We live in troubled times
- I am going to be very provocative
- I am going to be highly irreverent
- This is a training for professionals only
- I come in peace and believe in human dignity
- I mean no harm
- Please take everything I say in the spirit in which it is intended

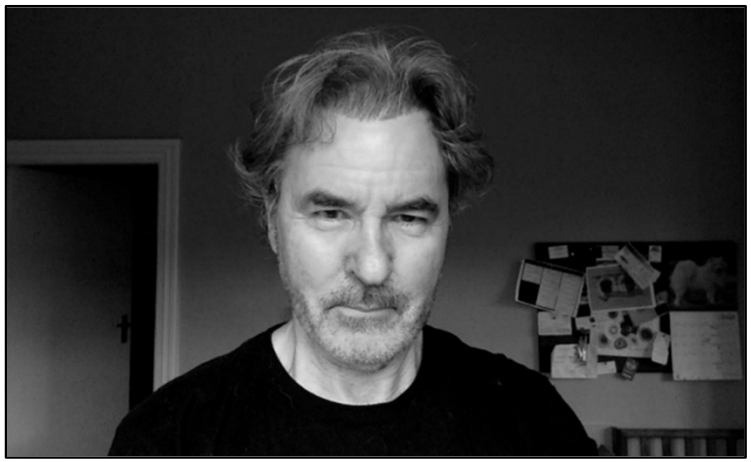
Please notice!

- I've included LOTS of extra slides
- If we can get to them we will
- They are intended as an added bonus; not the result of bad time management. ☺


ISCONSIN
HOCKEY



Gratitude





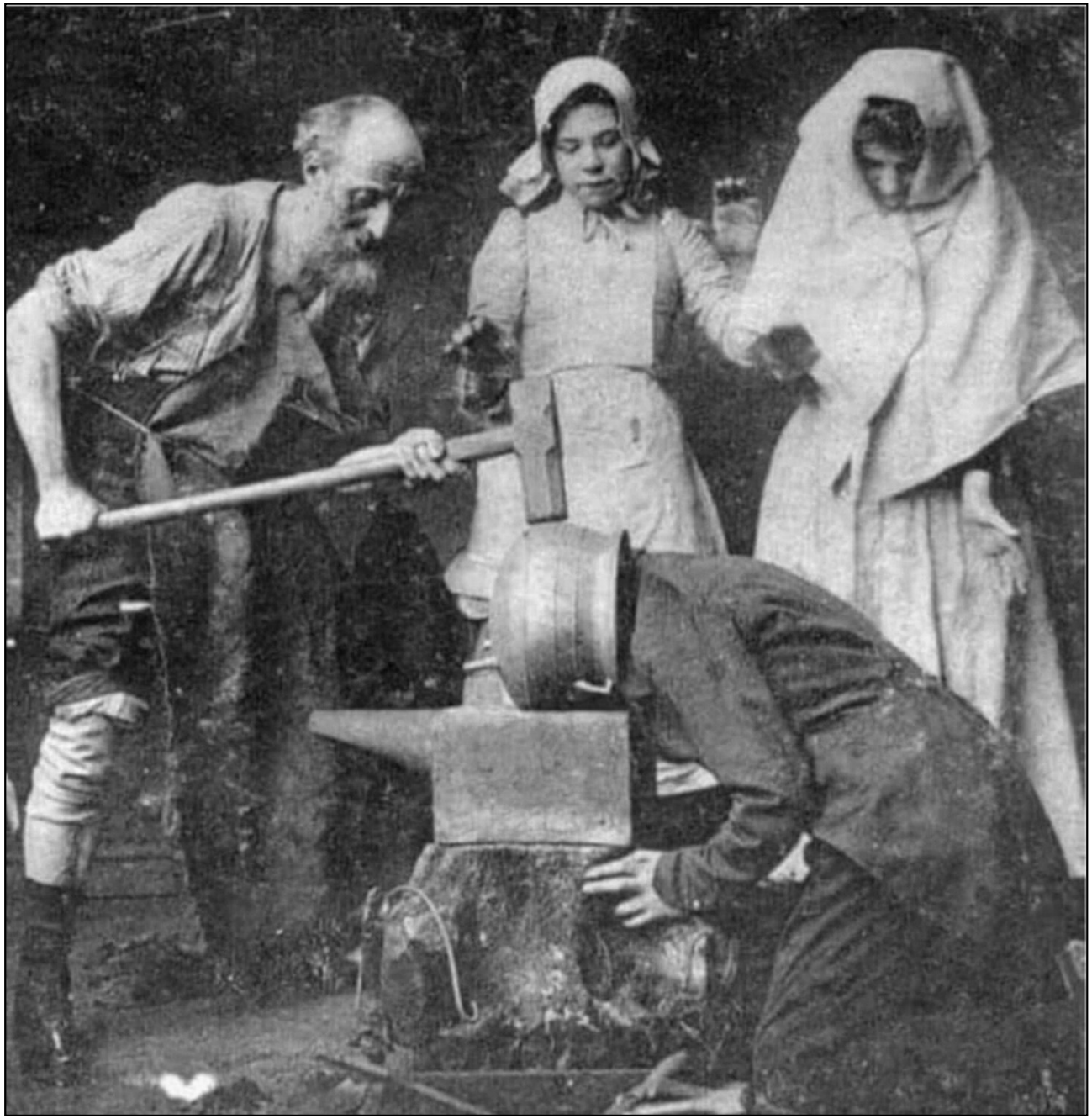


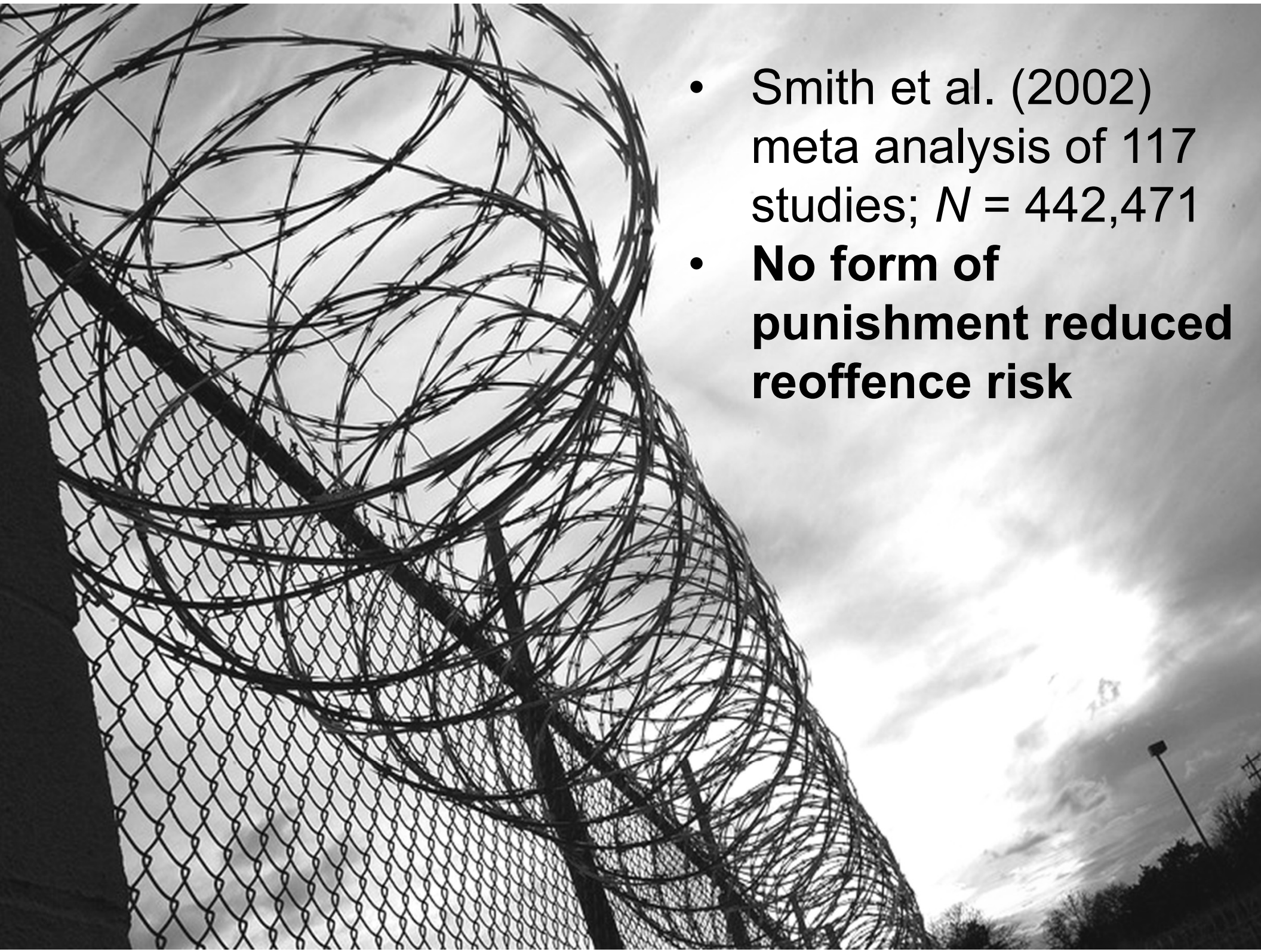



Historical Context

Overview

- 1895-1985





- Smith et al. (2002) meta analysis of 117 studies; *N* = 442,471
- **No form of punishment reduced reoffence risk**

- Petrich et al (2021) meta analysis of 116 studies; *N* = 4.5 million
- **Custodial sanctions had no effect on reoffending or slightly increased reoffending compared to noncustodial sanctions**

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

Ultimately

Female inmates sterilized in California prisons without approval

By Corey G. Johnson
The Center for Investigative Reporting

Published: Sunday, Jul. 7, 2013 - 12:00 am | Page 1A
Last Modified: Sunday, Jul. 7, 2013 - 8:24 am

Doctors under contract with the California Department of Corrections and Rehabilitation sterilized nearly 150 female inmates from 2006 to 2010 without required state approvals, the Center for Investigative Reporting has found.

At least 148 women received tubal ligations in violation of prison rules during those five years –

PHOTOS

Noah Berger For the Center for Investigative Reporting

Crystal Nguyen, a former inmate at Valley State Prison seen with son Neiko Nguyen, said she worked in the prison infirmary. She said she often heard the medical staff ask repeat offenders to agree to be sterilized. "I was like, 'Oh my God, that's not right.'" Nguyen recalls

MOST VIEWED

Third nude photo leak contains pics of Jennifer Lawrence, Anna Kendrick

Megachurch pastor plans to live on the streets of Sacramento to raise money for homeless

Championship might indicate MLS readiness for Republic FC

49ers game plan vs. Philadelphia: Pass, pass, pass

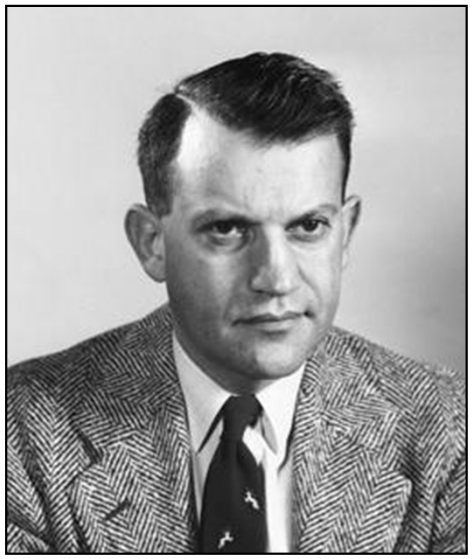
49ers' challenge: Slowing the Eagles' fast-and-furious offensive attack

Health benefits for those who stick to their knitting

Questions

- What are the forces that turn medical care into coercive action?
  - What attitudes?
  - What beliefs?
  - Where was the Hippocratic Oath of “do no harm?
  - Under what conditions do people acquiesce to those who have more power?
- Can the right policies, models, and frameworks prevent this kind of horror?
  - Collaborative treatment?
  - Methods for including the service user’s voice?

1979: Edward S. Bordin



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

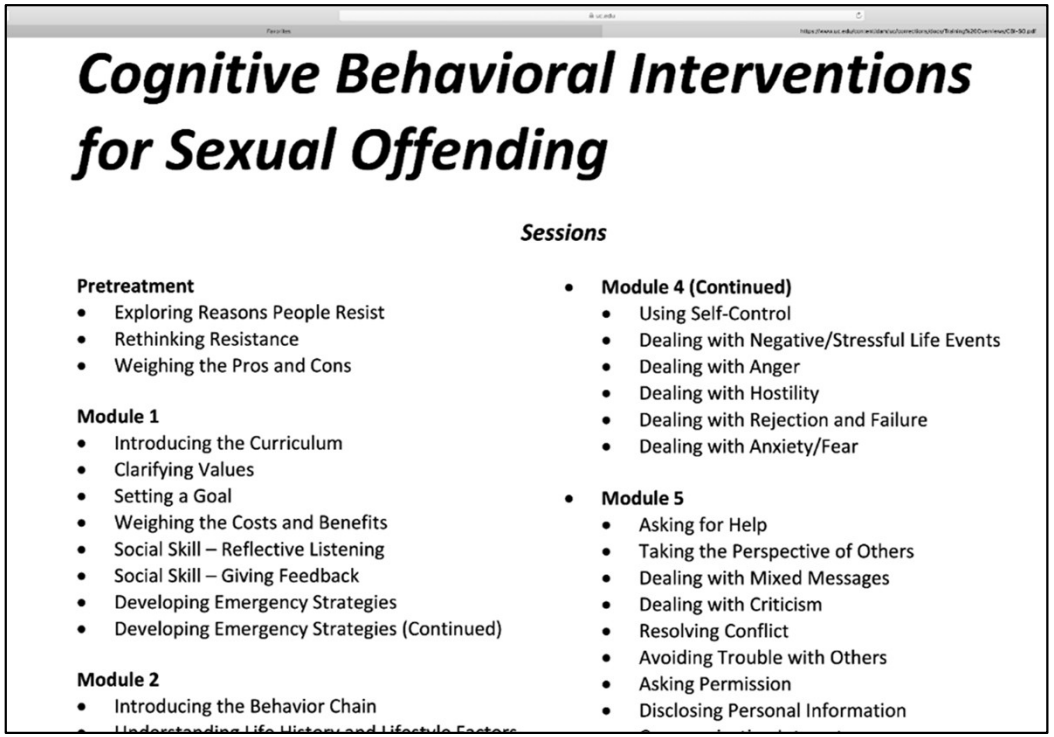
  - Over 1,100 studies have emphasized the importance of the alliance in psychotherapy since (Prescott et al., 2017)

Aebi et al., 2022

- *There is ongoing debate about whether specialized treatment is effective to reduce sexual recidivism in juveniles who have sexually offended. Although most treatment programs are based on cognitive behavioral therapy principles for preventing sexual offending, accordant scientific evidence is poor…*
- *Despite some methodological limitations, the current findings favor offending-specific skills-based therapy over general skills-based ones [i.e. general social-emotional skills] for preventing sexual reoffenses.*

Scripted Manualization:
Never the complete treatment program

- The map is not the territory
- The menu is not the meal



Cognitive Behavioral Interventions for Sexual Offending

Sessions

Pretreatment
- Exploring Reasons People Resist
- Rethinking Resistance
- Weighing the Pros and Cons

Module 1
- Introducing the Curriculum
- Clarifying Values
- Setting a Goal
- Weighing the Costs and Benefits
- Social Skill – Reflective Listening
- Social Skill – Giving Feedback
- Developing Emergency Strategies
- Developing Emergency Strategies (Continued)

Module 2
- Introducing the Behavior Chain

- **Module 4 (Continued)**
  - Using Self-Control
  - Dealing with Negative/Stressful Life Events
  - Dealing with Anger
  - Dealing with Hostility
  - Dealing with Rejection and Failure
  - Dealing with Anxiety/Fear

- **Module 5**
  - Asking for Help
  - Taking the Perspective of Others
  - Dealing with Mixed Messages
  - Dealing with Criticism
  - Resolving Conflict
  - Avoiding Trouble with Others
  - Asking Permission
  - Disclosing Personal Information

Ideally

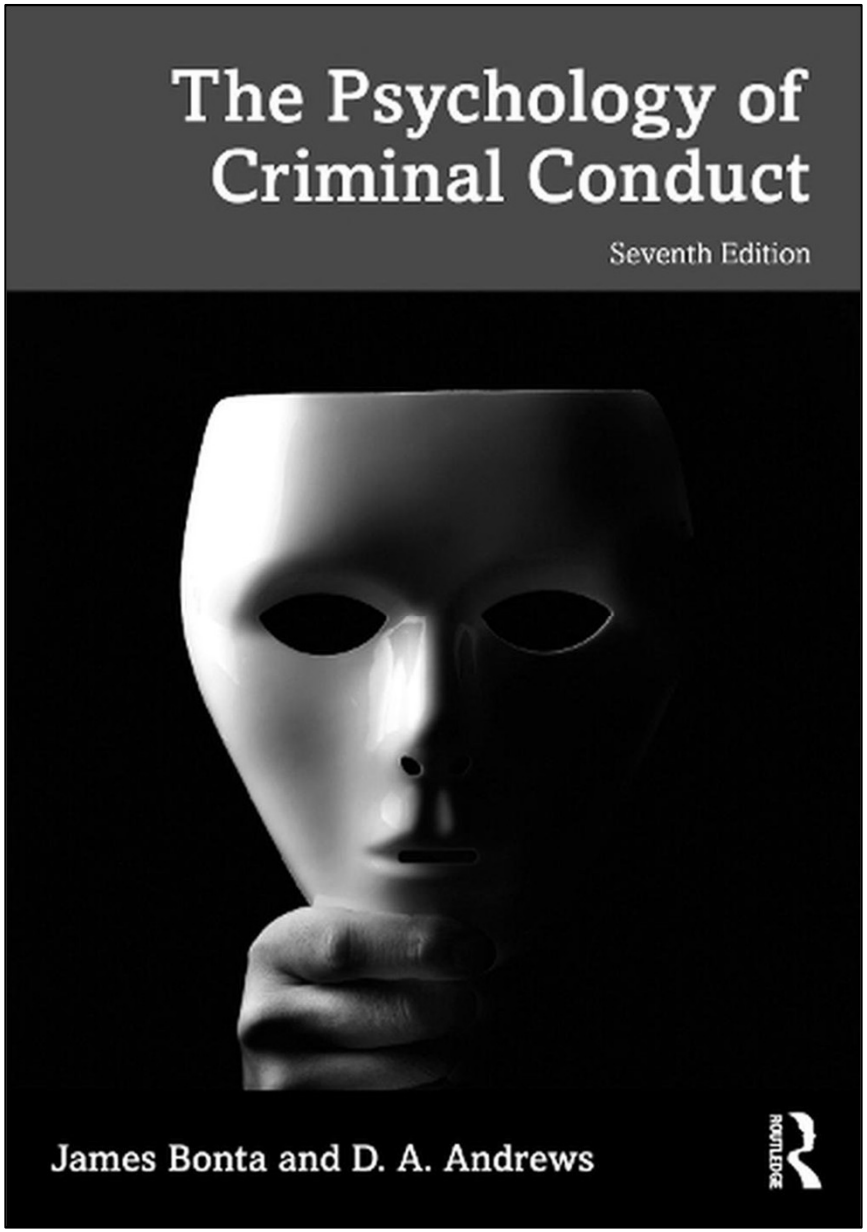

LOVE

The Power of People

> **The power of people in rehabilitative behaviour change is all too often neglected in favour of a bureaucratically streamlined, "doing more with less".**
>
> Theresa A. Gannon, DPhil, Professor of Forensic Psychology at University of Kent, UK & Director of the Centre of Research and Education in Forensic Psychology (CORE-FP)

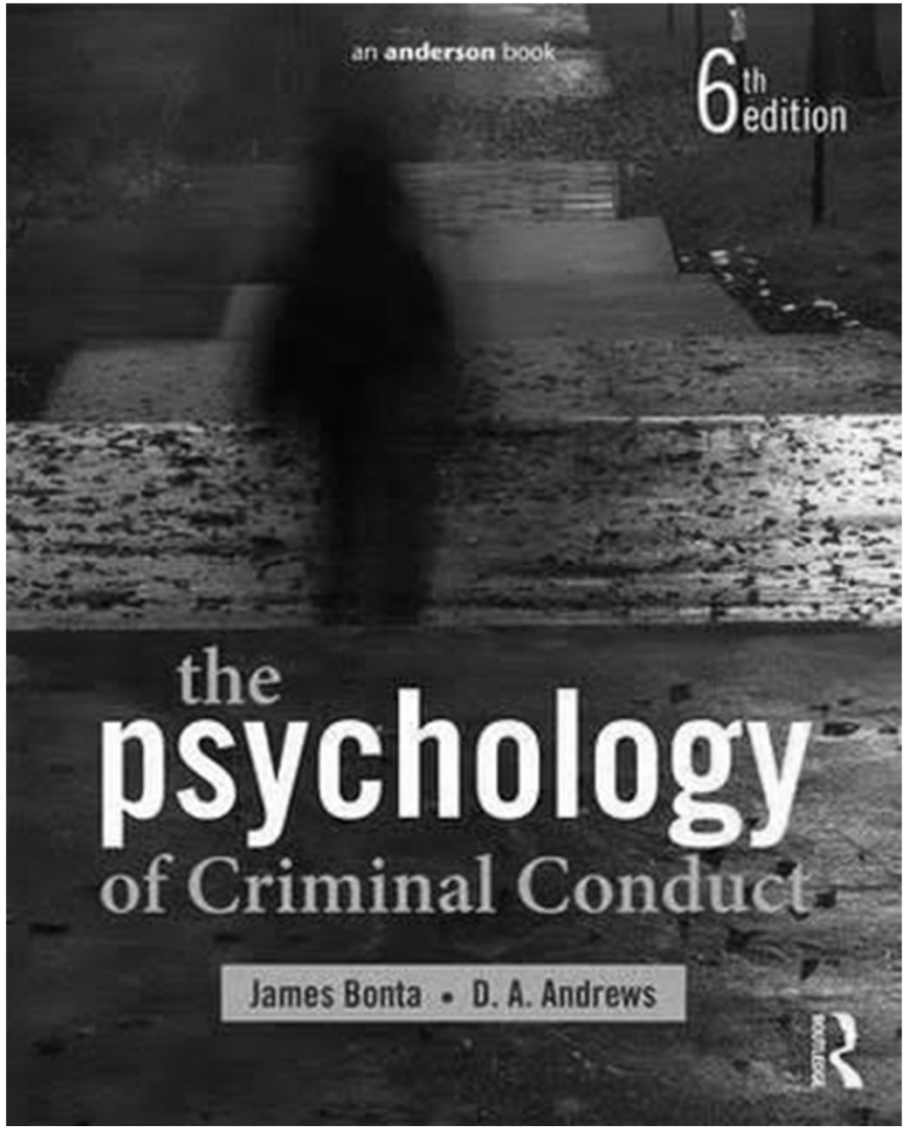
Justice Trends Magazine August 2025
https://justice-trends.press/rehabilitation-and-reintegration-lessons-from-the-frontlines-of-research-and-practice/

Treatment context: What works?



Treatment context: What works?

"I am bound to say that these data, involving over 200 studies and hundreds of thousands of individuals as they do, are the best available and give us very little reason to hope that we have in fact found a sure way of reducing recidivism through rehabilitation"
(Martinson, 1974, p. 49)



RNR: Core Aims and Assumptions

- Primary aim of correctional intervention is to reduce harm inflicted on community
- Most important treatment targets are those empirically associated with reduced recidivism rates
- Clients should be treated humanely, with research and treatment delivered in an ethically responsible manner
- Client rights trumped only by community needs

Bonta & Andrews (2017)

Treatment context: What works?

- **Risk:** Match level of services to level of risk
- **Need:** Target dynamic risk factors/criminogenic needs
- **Responsivity:** Use empirically supported approaches; also *specific* responsivity

Dynamic risk factors (criminogenic needs)

- Antisocial personality pattern
- Antisocial cognitions
- Antisocial (and/or lack of prosocial) social influences
- General self-regulation difficulties
- Emotional identification with children
- Poor sexual self-regulation
- Deviant sexual interest/preference

(e.g., Bonta & Andrews 2017))

Treatment context: What works?

- **Risk:** Match level of services to level of risk
- **Need:** Target dynamic risk factors/criminogenic needs
- **Responsivity:** Use empirically supported approaches; also *specific* responsivity

We can't ignore what *happened to them*

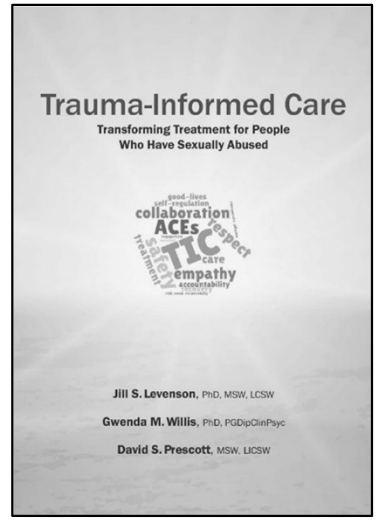
Article

Sexual Abuse
2022, Vol. 34(5) 597–619

DOI: 10.1177/10790632211051681
journals.sagepub.com/home/sax
SAGE

Exploring Risk for Sexual Recidivism and Treatment Responsivity Through the Lens of Early Trauma

Gwenda M. Willis, PhD[1] and Jill S. Levenson, PhD[2]



Turf Wars

Myths and Misunderstandings

- Academic arguments about RNR “versus” GLM
- RNR = principles; GLM = a rehabilitation model
- RNR has excellent research
  - Although in our experience, responsivity is often poorly defined
- GLM principles have an excellent underlying research base
- GLM applied properly adheres to the RNR principles
- GLM can be a way to “do” RNR; there are other ways
- In actual treatment, there is no “versus”

One Administrative Perspective

1. Assess and classify clients according to risk
2. Assess treatment needs
3. Assess protective factors
4. Conduct comprehensive assessment to develop understanding of specific responsivity
5. Develop understanding of the narrative underlying risks, needs, and responsivity factors
6. Formulate initial hypotheses about how risk/need factors map onto the Good Lives Model goals that we will explore in depth

Turf Wars

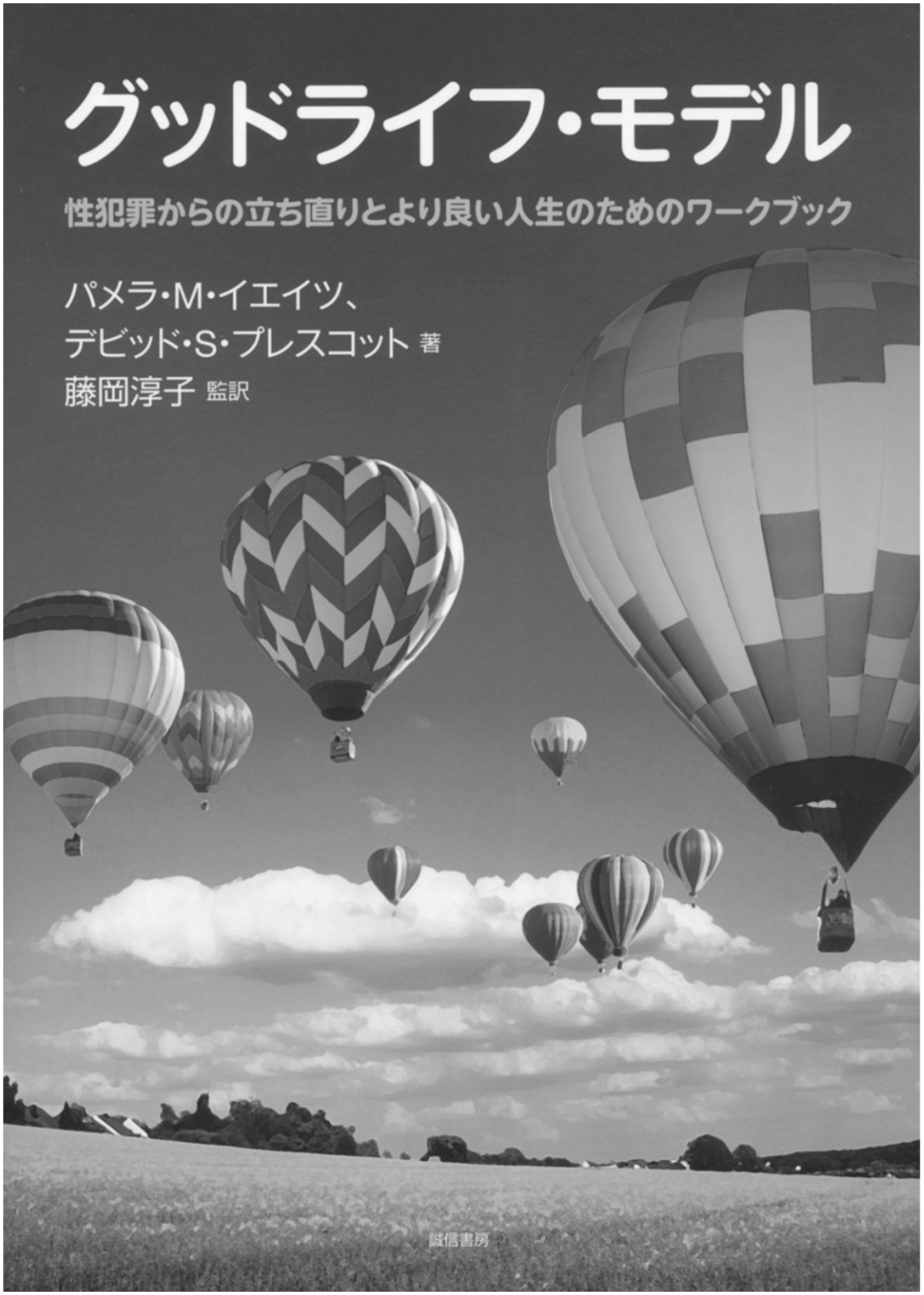
What *else* works to prevent reoffending?

- Common factors of effective psychotherapy
  (e.g., Marshall, 2005; Marshall et al., 2002)
- Comprehensive re-entry planning
  (e.g., Willis & Grace, 2008, 2009)
- Cognitive transformation
  (e.g., Maruna, 2001)
- Achieving informal social control
  (e.g., Sampson & Laub, 1993)

What works?

Who works?

GLM Approach and Core Principles


グッドライフ・モデル
性犯罪からの立ち直りとより良い人生のためのワークブック
パメラ・M・イエイツ、
デビッド・S・プレスコット 著
藤岡淳子 監訳
誠信書房

美好生命 (GLM)：人生共同需要 Primary Human Goods

(重要性及信心) Importance and Confidence

人類共同需要 **Primary Human Goods**	定義 **Definitions**	重要分 **Importance (0-10)**	信心分 **Confidence (0-10)**	備註： Remarks
人生：生活與求生 Life	能照顧個人健康與/或能維持個人生命及安全 Looking after physical health, and/or staying alive and safe.	9	4	
知識：學習與認知 Knowledge	追尋關於自己、他人、環境或特定範籌的知識 Seeking knowledge about oneself, other people, t environment, or specific subjects.	7	6	
於工作或休閒活動時有卓越表現 **Mastery at work or play**	在工作、進行休閒活動時追求卓越表現 Striving for excellence/mastery in work, hobbies or leisure activities.	5	5	

The Good Lives Model for Adolescents Who Sexually Harm

Edited by Bobbie Print, CQSW

Foreword by Tony Ward, PhD

Becoming Who I Want to Be

A Good Lives Workbook for Young Men

David S. Prescott, LICSW

Becoming Who I Want to Be

A Good Lives Workbook for Young Men

David S. Prescott, LICSW

BECOMING WHO I WANT TO BE

A Good Lives Workbook for Young Women

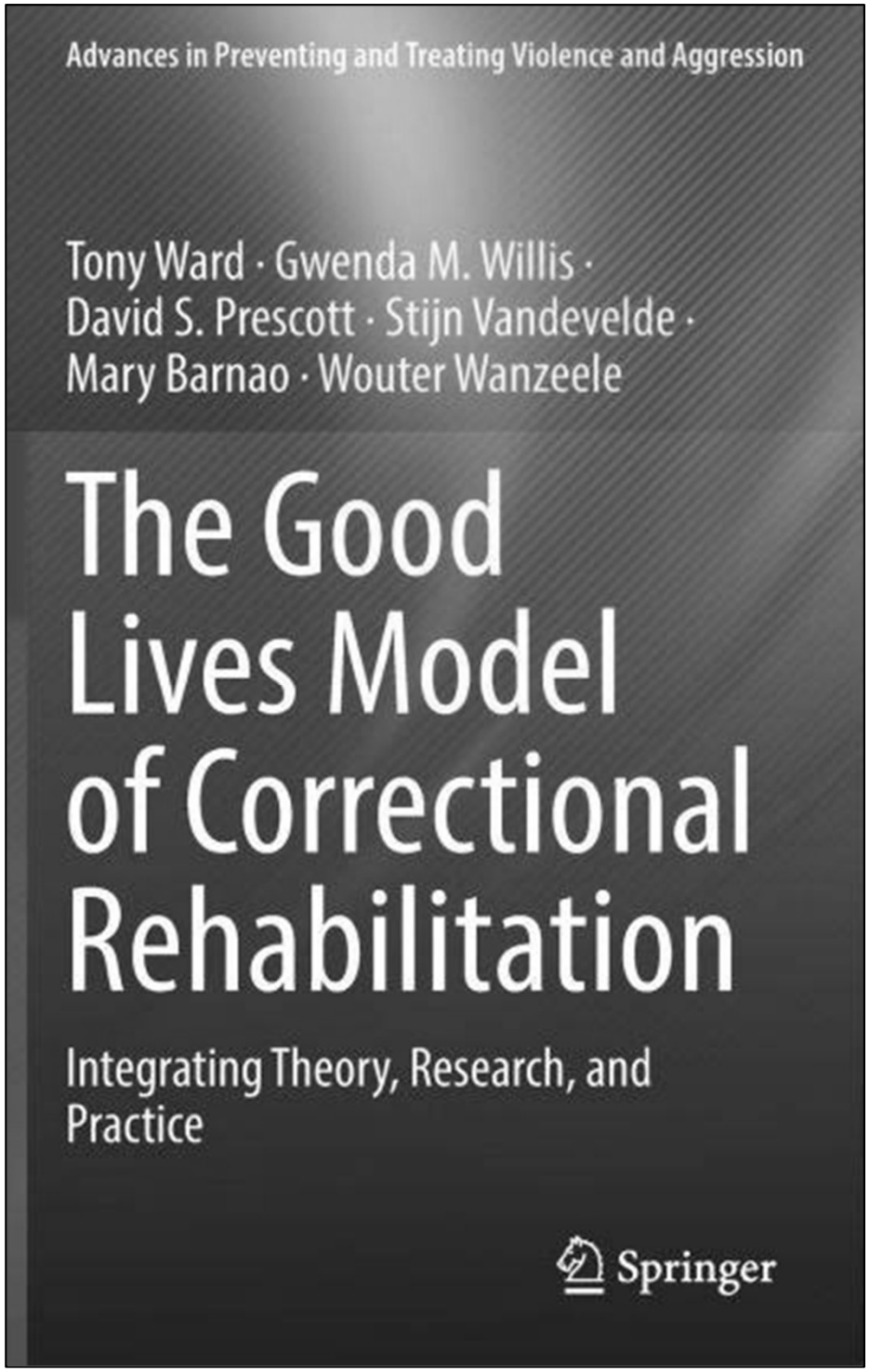
David S. Prescott, LICSW
Tyffani Dent, PsyD

A Note on Workbooks

- Intended as tools for treatment
  - Help make therapy multi-modal
  - Offer structure
  - Provide avenues for clinical dialogue

- They are *not* stand-alone programs
- The are not required

2025


Advances in Preventing and Treating Violence and Aggression
Tony Ward · Gwenda M. Willis · David S. Prescott · Stijn Vandevelde · Mary Barnao · Wouter Wanzeele
The Good Lives Model of Correctional Rehabilitation
Integrating Theory, Research, and Practice
Springer

GLM Foundations

(Ward et al., 2025)

Fundamentally

- The GLM has a naturalistic view of people and their functioning.
- It views people as continually evolving beings who act in the pursuit of a range of biological, psychological, and social goals within certain environments.
- These *natural desires* motivate people to act in ways that they believe will satisfy them.

Fundamentally

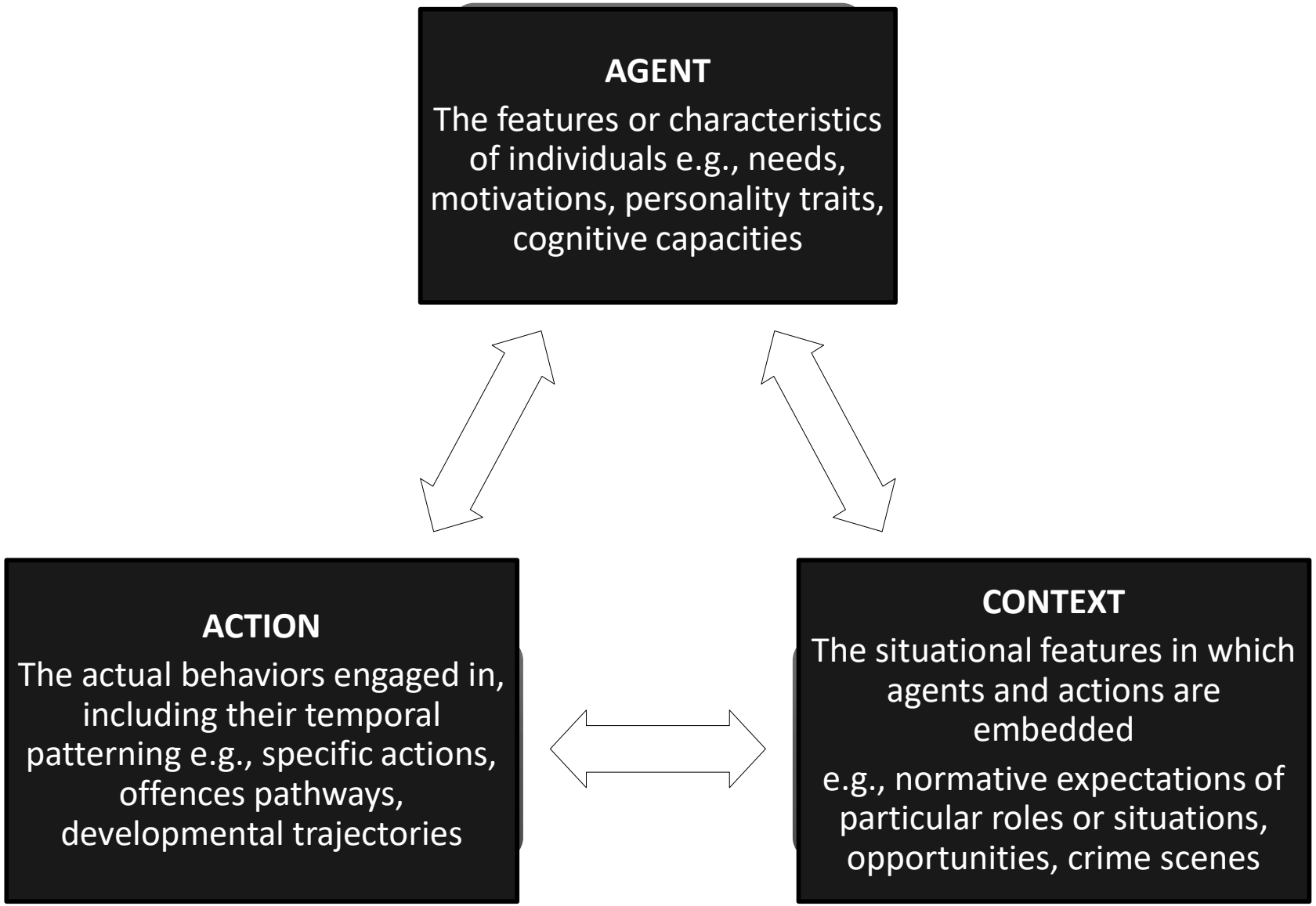
- To ignore individuals' core motivations is to run the risk of:
  - Not understanding the reasons why they committed crimes.
  - Constructing invalid case formulations and therapy plans and failing to persuade them to engage fully in intervention programs.
- Dynamic 'internal' risk factors such as impulsivity or aggressiveness are only meaningful in terms of the situational, social and cultural contexts in which they are expressed.

Fundamentally

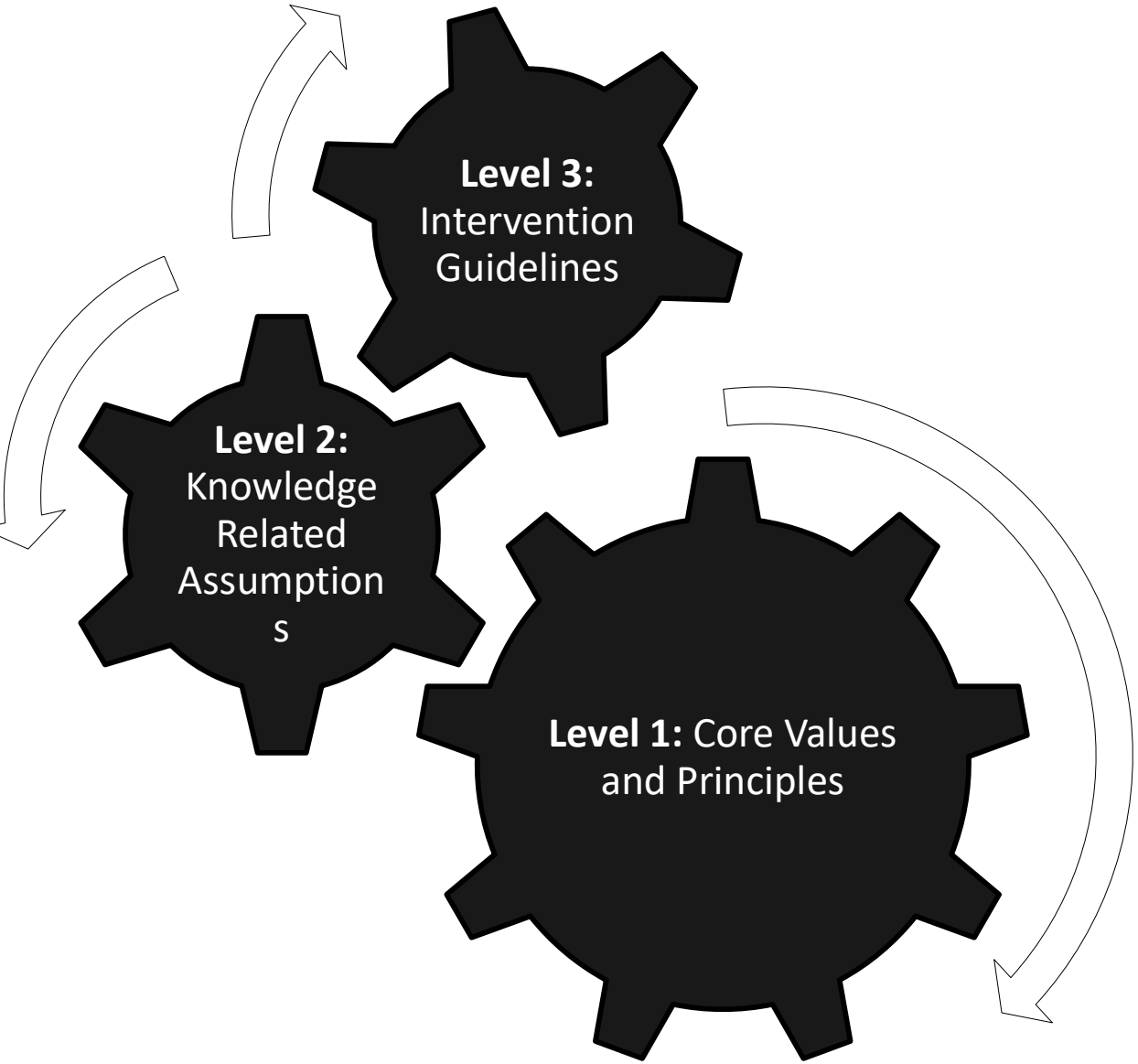
- Interventions should:
  - Take into account individuals' strengths, values, goals, relevant environments and contexts.
  - Specify precisely what competencies are required to secure valued outcomes in pro-social and personally meaningful ways.

Agent-Action-Context Schema

(Ward & Durrant, 2022)



Practice Frameworks in Correctional Psychology (Ward & Durrant, 2021; Ward et al., 2025)



- We've observed that many programs inspired by the GLM tend to operate at the third level focusing on techniques or additions (e.g., vocational training)
- Attending to the first levels is essential to ensure fidelity to the GLM

Level 1: Core values & principles

- Human dignity
- Universal human rights
- Strong emphasis on human agency
- Enhancing individuals' ability to formulate and select goals, to construct plans and to act freely in the implementation of these plans
- Viewing individuals as *fellow human beings* (or "fellow travellers") rather than as simply the bearers of risk, and because of this perspective, taking their core needs and concerns seriously.

Level 2: Knowledge related assumptions

- Humans are goal-directed
- We seek to enact agency:
  - Goal-directed
  - Intentional
  - Rational *(*reflecting on the reasons for and against specific plans and anticipate possible barriers and come up ways of countering them)
  - Normative *(*a uniquely human capacity to engage with normative social institutions and act in morally accountable ways)
- Behavior is rarely random and can typically be understood in terms of benefits, environmental constraints and internal resources and states.

Level 3: Intervention guidelines / practice commitments

- Balance promoting PHGs and reducing risk.
- View individuals who commit offenses as fellow travelers, not moral strangers.
- GLM interventions uses language that is future-oriented, optimistic, and approach-goal focused.
- Individuals should be viewed holistically and are more than the sum of their risk factors and criminal records.
- The principles of risk, need, and responsivity should be nested or embedded within a GLM framework.
- Take into account individuals' strengths, prioritized PHGs, relevant environments, and specify exactly what competencies and resources are required to achieve these goods.

What the GLM is *not*

- Not a specific treatment protocol
- Not time limited
- Not designed to be implemented in any one specific or inflexible way
- No official certification of GLM practitioners or programs (but fidelity monitoring is expected)
- Not a way of telling clients what is wrong or missing from their lives
- Not patronizing or paternalistic
- The GLM is not “done to” a client. The GLM is inherently collaborative.

The GLM Practitioner

- Is grounded in the mission of building internal and external capacities for clients.
- Pays equal attention to risk variables.
- Approaches 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.
- Strives 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 Good Lives Model (GLM)

"…[our clients] want better lives, not simply the promise of less harmful ones"
(Ward et al., 2007)

“As a kid I had lots of examples of what I didn't want to be. I spent my life trying not to be those things. Then when an aide asked me about 5 years ago what I wanted to be I had no idea.”

40 y/o male
in civil commitment (USA)

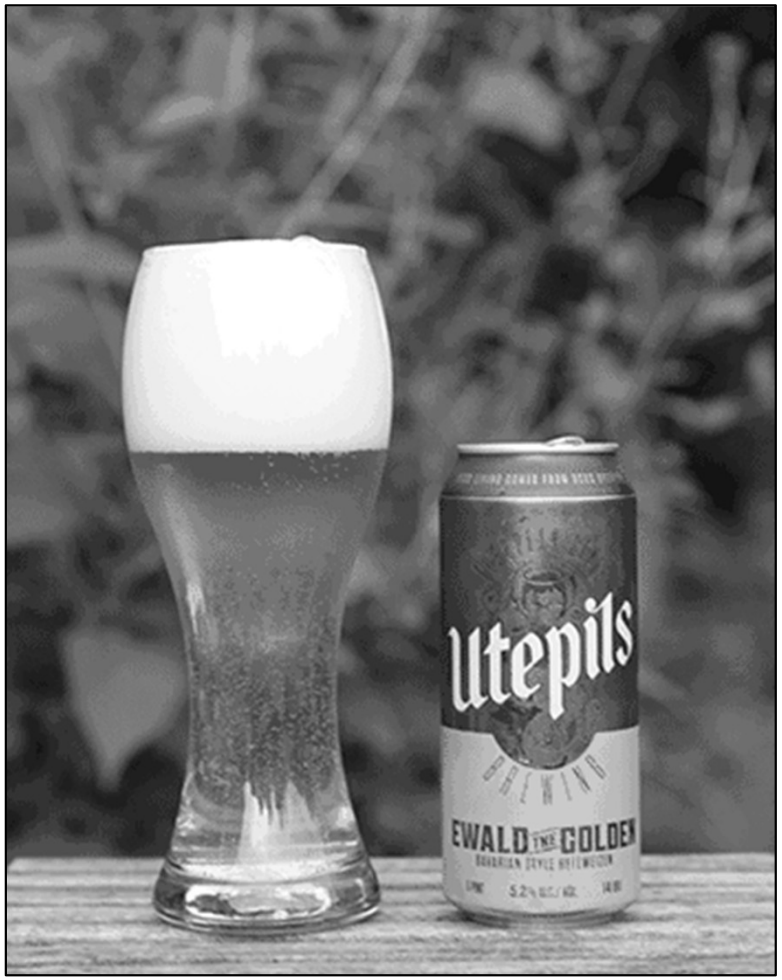
Going Upstream

- What is something (anything) that you would like right now?
  - Irish Coffee? World peace? A new cell phone?
  - If you had that, then what else would you have in your life?
  - And if you had that, what else would you have in your life?
  - And if you had that, what else would you have in your life?
  - Keep going until your answer is one word and you can’t go further
  - What have you learned?

Important Skill

- Going Upstream:
  - What's the larger goal behind the immediate goal or clinical presentation?
  - "I'm not gonna" and "you can't make me" reflect deeper goals around autonomy and relationships.
  - "I'm not the same person as I was then" reflects avenues for inquiry regarding identify.
  - Please note that one statement or action can reflect multiple goals!

What are all the needs that these meet?



Krakow

- Lord’s Ark Church
- Built by hand from ruins caused by Soviet invasion
- What needs was this meeting?

GLM Approach

- Strengths-based, positive approach
- Collaborative, motivational approach
- Focuses on how treatment/supervision/case management will benefit client
- Two goals:
  - Reducing/managing risk
  - Attaining fulfilling life, psychological well-being
- GLM integrated with RNR

GLM Approach

- Problematic behaviors/Offending relates to the pursuit of legitimate goals via harmful, maladaptive means
- All human beings are goal-directed and predisposed to seek *primary human goods*
- Primary human goods = actions, experiences, circumstances, states of being, etc., that individuals seek to attain for their own sake

GLM Approach

- Secondary goods = concrete ways (means) to secure primary goods (also called instrumental goods)

- Dynamic risk factors = markers for internal or external obstacles that block achieving primary goods in pro-social ways in addition to increasing risk

A note on narrative

- We often think in terms of risk and protective “factors”
- Problem of reification
- Ward and his colleagues (including us) encourage thinking in terms of the narrative that underlies the factors
- What’s the actual story?
- How did events result in this “factor”?

Primary Human Goods

- GLM proposes at least 10 primary human goods
- Value/importance placed on various goods determines individual's conceptualisation of a "good life"; reflected in good life plan (GLP)
- Assumption: Pro-social attainment of goods will help reduce or manage risk to re-offend (alongside targeting criminogenic needs)

Primary Human Goods

- Life
- Knowledge
- Excellence in work
- Excellence in play
- Agency
- Inner peace
- Relatedness
- States of happiness/pleasure
- Community
- Spirituality
- Creativity

Primary Human Goods operationalized

(Ward et al., 2025; Updated from Yates & Prescott, 2011)

Primary Good		Goal
Life	→	Life: Living and Surviving
Knowledge	→	Knowledge: Learning and Knowing
Excellence in work	→	Being Good at Work
Excellence in play	→	Being Good at Play
Agency	→	Personal Choice and Independence
Inner peace	→	Peace of Mind
Relatedness	→	Relationships and Friendships
Community	→	Community: Being Part of a Group
Spirituality	→	Spirituality: Having Meaning in Life
States of happiness/pleasure	→	States of happiness/pleasure
Creativity	→	Creativity

GLM vs. Andrews & Bonta Big 8
(possible comparison)

- GLM

- States of happiness and pleasure
- Creativity
- Knowledge
- Excellence at work
- Excellence at play
- Personal choice/independence
- Relationships and friendships
- Meaning and purpose in life
- Peace of mind
- Community
- Living and surviving

- Big 8

- 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

Good Life Goals
(Prescott, 2025; Print, 2013)

- Having fun
  - (states of happiness and pleasure; creativity)
- Being an achiever
  - (excellence at work and play)
- Being my own person
  - (independence and autonomy)
- Being connected to other people
  - (relatedness/community)
- Having a purpose in life
  - (spirituality)
- Meeting my emotional needs
  - (inner peace)
- Meeting my sexual needs
  - (relatedness/happiness/inner peace/knowledge)
- Being physically healthy
  - (living and surviving)

Primary Goods: Definitions

- Life: Living & Surviving
  - Healthy living and functioning
  - Basic survival needs

- Instrumental (secondary) goods:
  - Acquiring income for food/shelter
  - Physical activity
  - Healthy nutrition
  - Health care

Primary Goods: Definitions

- Knowledge: Learning & Knowing
  - Desire for information and understanding about oneself and the world

- Instrumental (secondary) goods:
  - Attending school, training, vocational courses
  - Self-study
  - Therapy and self-help activities

Primary Goods: Definitions

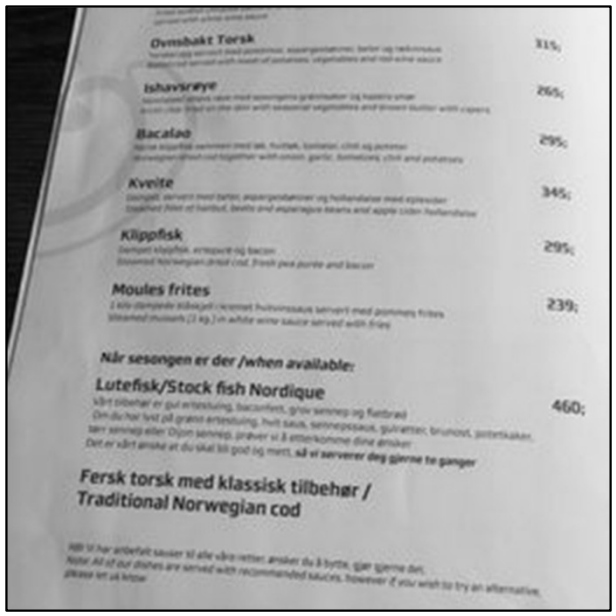
- Excellence in Play
  - The experience of mastery from leisure/recreational pursuits
- Instrumental (secondary) goods:
  - Participation in sport or other leisure activities/hobbies
  - Training for an event/competition
  - Any other activity associated with a drive for mastery in leisure

Primary Goods: Definitions

- Excellence in Work
  - The experience of mastery through work

- Instrumental (secondary) goods:
  - Participation in training, certification, apprenticeships
  - Meaningful paid or voluntary work

Primary Goods: Definitions



- Agency/Personal Choice and Independence
  - Desire for independence, autonomy, choice, self-directedness

- Instrumental (secondary) goods:
  - Formulate plans to achieve a specific end or objective
  - Engage in activities to ensure self-sufficiency
  - Assert self; communicate needs and desires with others
  - Control, dominate, abuse or manipulate others to establish personal control

Primary Goods: Definitions

- Peace of Mind
  - Emotion regulation, equilibrium
  - Freedom from emotional turmoil and stress

- Instrumental (secondary) goods:
  - Activities to minimize emotional distress/achieve equilibrium (e.g., exercise, meditation)
  - Substance use or sexual activity to regulate mood/cope

Primary Goods: Definitions

- Relationships and Friendships
  - Desire to establish bonds with others; includes intimate, romantic and family relationships

- Instrumental (secondary) goods:
  - Activities that facilitate meeting new people and maintaining relationships
  - Spending time with friends
  - Giving and receiving support
  - Intimate relationships

Primary Goods: Definitions

- Community: Being Part of a Group
  - Desire to be connected to groups that share one's values, concerns, interests
  - Experiencing a sense of belonging

- Instrumental (secondary) goods:
  - Participate in community activities/groups (e.g., social service groups, special interest groups, voluntary activities)
  - Provide practical assistance to others in times of need (e.g., neighbours)

Primary Goods: Definitions

- Spirituality
  - Desire for meaning and purpose in life
  - Sense that one is part of larger whole

- Instrumental (secondary) goods:
  - Attends formal religious/spiritual events (e.g., church)
  - Meditation/prayer
  - Involved in spiritual community/group
  - Mindfulness

Primary Goods: Definitions

- Creativity
  - Desire for novelty or innovation

- Instrumental (secondary) goods:
  - Engaging in new/novel experiences not attempted previously
  - Engaging in artistic, creative activities
  - Novel sexual practices

Primary Goods: Definitions

- States of happiness and pleasure
  - Being happy/content
  - Pleasure in life

- Instrumental (secondary) goods:
  - Activities that result in sense of satisfaction, contentment, fulfillment
  - Activities that result in sense of pleasure (e.g., leisure activities, sports, sex)

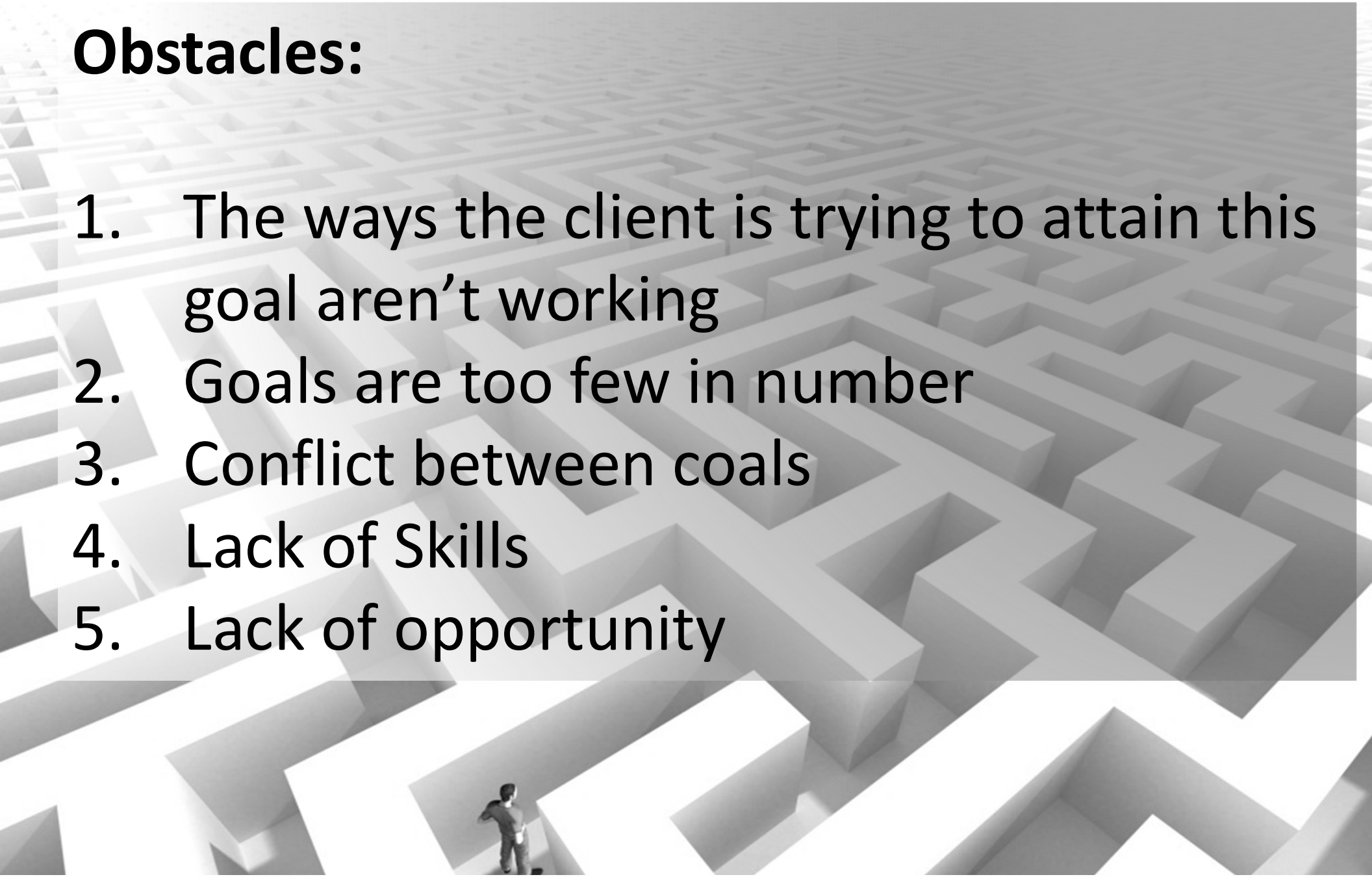
Good Life Goals

(Prescott, 2025; 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

What are your prioritised primary human goods?

Good Life Plan



Obstacles:

1. The ways the client is trying to attain this goal aren't working
2. Goals are too few in number
3. Conflict between coals
4. Lack of Skills
5. Lack of opportunity

The way the client is trying to meet this goal aren't working

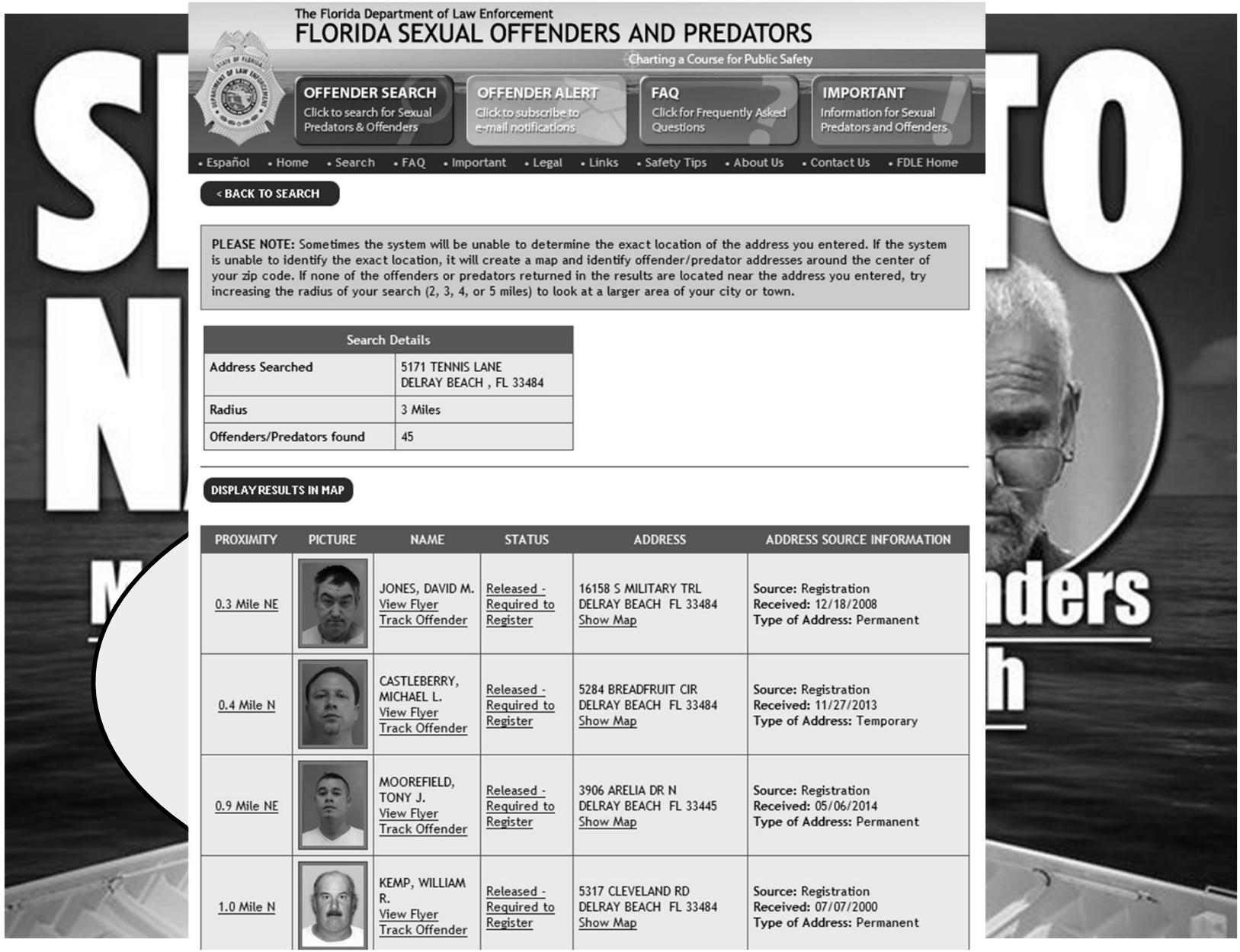
Goals are too few in number

(Putting all the eggs in one basket)

Lack of Skills

Maladaptive schemas	Offense-supportive beliefs	Maladaptive coping	Maladaptive attachments
other people will abuse/reject/ abandon me	*dangerous world, children as sexual objects, uncontrollability*	*substance abuse, sex as coping, aggression*	*relationship instability, hostility towards women, social rejection*

Lack of Opportunity



The Florida Department of Law Enforcement

FLORIDA SEXUAL OFFENDERS AND PREDATORS

Charting a Course for Public Safety

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PLEASE NOTE: Sometimes the system will be unable to determine the exact location of the address you entered. If the system is unable to identify the exact location, it will create a map and identify offender/predator addresses around the center of your zip code. If none of the offenders or predators returned in the results are located near the address you entered, try increasing the radius of your search (2, 3, 4, or 5 miles) to look at a larger area of your city or town.

Search Details	
Address Searched	5171 TENNIS LANE DELRAY BEACH , FL 33484
Radius	3 Miles
Offenders/Predators found	45

DISPLAY RESULTS IN MAP

PROXIMITY	PICTURE	NAME	STATUS	ADDRESS	ADDRESS SOURCE INFORMATION
0.3 Mile NE		JONES, DAVID M. View Flyer Track Offender	Released - Required to Register	16158 S MILITARY TRL DELRAY BEACH FL 33484 Show Map	**Source:** Registration **Received:** 12/18/2008 **Type of Address:** Permanent
0.4 Mile N		CASTLEBERRY, MICHAEL L. View Flyer Track Offender	Released - Required to Register	5284 BREADFRUIT CIR DELRAY BEACH FL 33484 Show Map	**Source:** Registration **Received:** 11/27/2013 **Type of Address:** Temporary
0.9 Mile NE		MOOREFIELD, TONY J. View Flyer Track Offender	Released - Required to Register	3906 ARELIA DR N DELRAY BEACH FL 33445 Show Map	**Source:** Registration **Received:** 05/06/2014 **Type of Address:** Permanent
1.0 Mile N		KEMP, WILLIAM R. View Flyer Track Offender	Released - Required to Register	5317 CLEVELAND RD DELRAY BEACH FL 33484 Show Map	**Source:** Registration **Received:** 07/07/2000 **Type of Address:** Permanent

Conflict between goals

Lack of Capacity: External

METRO (WMATA)

Metro police can now ban repeat violent or sexual offenders for up to a year

MTPD previously could only ban passengers for up to 24 hours

By **Joseph Olmo, News4 reporter** and Jordan Young • Published
June 2, 2025 • Updated on June 2, 2025 at 6:52 am

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Lack of Capacity: External

Wednesday, December 24, 2025 COURTHOUSE NEWS SERVICE Free Litigation Reports Find Judi

Alabama defends law limiting where sex offenders can go

The law's expanded definitions of "reside" and "overnight visit" have drawn scrutiny for turning everyday activities into potential criminal conduct.

GABRIEL TYNES / August 1, 2025

Lack of Capacity: External

PSYCHOLOGY, CRIME & LAW
2018, VOL. 24, NO. 7, 727–743
https://doi.org/10.1080/1068316X.2017.1421640

Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology

Gwenda M. Willis

School of Psychology, The University of Auckland, Auckland, New Zealand

The GLM

Application in practice

Protective Factors

Defined

- Factors associated with Desistance/low probability of offending
- Factors that:
  - Enhance personal competencies
  - Ameliorate the effects of specific risks directly or by interacting with them
  - Serve a stabilizing or enhancing function

(Langton & Worling, 2015)

Two kinds?

1) Factors on the other end of a continuum from risk (e.g., young versus older age; interpersonal competence versus isolation)

2) Factors with no corresponding risk (e.g., religiousness; sex education/knowledge)
   - Also known as “promotive factors”

de Vries Robbé et al. (2015)

- Medication
- Empathy
- Secure attachment in childhood
- Intimate relationship
- Motivation for treatment
- Attitude toward authority
- Self-control
- Coping skills
- Work and leisure interests

de Vries Robbé et al. (2015)

- Desistance factors:
  - Treatment as a turning point
  - Social network
  - Personal agency
  - Internal locus of control
  - Finds positive outcomes in negative events

de Vries Robbé et al. (2015)

- Best outcomes:
  - Goal-directed living
  - Good problem-solving
  - Constructive employment/leisure activities
  - Sobriety
  - Hopeful, optimistic, motivated attitude towards desistance

8. Strategies to Prevent Sexual Offending

☐ Protective	☐ Neutral	☐ Risk
Appropriate use of reasonable strategies to prevent sexual offending Uses reasonable strategies, when necessary, to prevent sexual offending. Strategies may or may not have been developed through formal counseling.		**Lack of use of reasonable strategies to prevent sexual offending** Does not use reasonable strategies, when necessary, to prevent sexual offending. May be the result of not having reasonable strategies or of not using them when they are necessary. Strategies may or may not have been developed through formal counseling.

9. Compassion for Others

☐ Protective	☐ Neutral	☐ Risk
Compassionate and caring towards others Typically demonstrates compassionate and caring behavior towards others. The individual recognizes the misfortune of others and is motivated to alleviate their suffering.		**Callous and/or uncaring towards others** Often demonstrates callous and/or uncaring behavior towards others. The individual is cruel towards others and/or is indifferent to the misfortune of others.

10. General Values and Attitudes

☐ Protective	☐ Neutral	☐ Risk
Prosocial values and attitudes Typically demonstrates respect, honesty, and integrity in relationships and values and respects the role of social rules, laws, and authority figures.		**Antisocial values and attitudes** Often demonstrates a lack of respect, and/or honesty, and/or integrity in relationships and/or does not value or respect the role of social rules, laws, and authority figures.

PROFESOR

11. Self-Regulation

☐ Protective	☐ Neutral	☐ Risk
Good self-regulation Typically demonstrates good emotional and behavioral self-regulation (i.e., able to delay gratification, consider consequences before acting, and express affect appropriately).		**Poor self-regulation** Often demonstrates poor emotional and/or behavioral self-regulation (i.e., unable to delay gratification and/or consider consequences before acting and/or express affect appropriately).

12. Problem Solving

☐ Protective	☐ Neutral	☐ Risk
Good problem-solving Typically demonstrates good problem-solving ability (i.e., can identify when there is problem; generate possible solutions; identify consequences of possible solutions; evaluate outcome of chosen solution).		**Poor problem-solving** Often demonstrates poor problem-solving ability (i.e., unable to identify when there is a problem; and/or has difficulty generating solutions; and/or has difficulty identifying consequences of possible solutions; and/or does not evaluate outcomes of chosen solutions).

13. Adaptation

☐ Protective	☐ Neutral	☐ Risk
Makes positive changes in behavior following consequences Typically makes positive changes in behavior following consequences.		**Failure to make positive changes in behavior following consequences** Often has difficulty making positive changes and/or refuses to make positive changes in behaviour following consequences.

14. Responsivity to Guidance and Support

☐ Protective	☐ Neutral	☐ Risk
Responsive to reasonable guidance and support Responsive to reasonable guidance and support that is provided. This could involve reasonable guidance and support provided by professionals, family, peers, or others.		**Rejecting of reasonable advice and support** Rejecting of reasonable advice and/or support that is provided. This could involve reasonable guidance and support provided by professionals, family, peers, or others.

15. Self-Esteem

☐ Protective	☐ Neutral	☐ Risk
Healthy self-esteem Healthy and positive sense of self and self-worth. And Individual sees that prior sexual offending behavior does not define who they are.		**Unhealthy self-esteem** Unhealthy and/or negative sense of self or self-worth Or an overly inflated level of self-esteem. And/Or Individual experiences significant shame related to past sexual offending behavior and sees that prior sexual offending behavior defines who they are.

PROFESOR

16. Intimacy and Friendship

☐ Protective	☐ Neutral	☐ Risk
Emotional intimacy and close friendship with prosocial peer(s) Has at least one close friendship with a peer that involves emotional intimacy (i.e., warmth, trust, and mutual support). For those aged 12-17, a peer is generally considered to be a nonfamilial individual who is not more than 3 years younger or older. For those aged 18-25, a peer is generally considered to be a nonfamilial individual who is not more than 4 years younger or older.		**Lack of emotional intimacy and/or close friendship with prosocial peer** Lacks close friendship and/or emotional intimacy (i.e., warmth, trust, and mutual support) with peers. For those aged 12-17, a peer is generally considered to be a nonfamilial individual who is not more than 3 years younger or older. For those aged 18-25, a peer is generally considered to be a nonfamilial individual who is not more than 4 years younger or older.

17. Relationship with Parent/Caregiver

☐ Protective	☐ Neutral	☐ Risk
Feels close to and supported by a parent/caregiver Feels a close relationship to, and supported by, at least one parent/caregiver.		**Feels distant from and/or rejected by parents/caregivers** Feels a distant relationship from, and/or rejected by, parents/caregivers. Consider only those parent/caregiver figures that have been important to the individual and involved in their lives. If there is *at least one* parent/caregiver figure with whom the individual feels a close and supportive relationship, do not mark as "Risk".

Exercise on Identifying Strengths

Start with Strengths

Strengths

- CASE SUMMARY C
- Dan, 16.5, entered residential treatment after he molested his two younger siblings, one male and one female. He also physically assaulted his mother, which has led to long-term concerns as to whether he can return home. Dan hates treatment and complains that he should have access to a grand piano, because his treatment is interfering with his future career as a musician. Dan has intense difficulty getting along with others and often views them as stupid.

Strengths

- CASE SUMMARY D
- Dan is almost 17. He is very serious about his future as a classical music composer. However, he has great difficulty getting along with others. He wants desperately to have friends. His growing up in a house where he was beaten by his father (before his father became incarcerated) has left him with a belief that he has to fight to get even. Curious about sex and wanting to feel like a man, he molested his younger brother and sister and physically assaulted his mother when he realized she was going to have him placed outside of her home. Dan wants nothing more than to find his way out of his circumstances, and that means getting a solid musical education and practicing piano.

Find the strength

Find the strength

Find the strength

Find the strength

Find the strength

Find the strength

Find the strength

LET’S GO DEEPER

Consider…

- Excellence
- Agency
- Connection
- Meaning and Purpose
- Happiness and Pleasure

- Can you see the ambivalence?
- The difference between where he is and where he wants to be?

Consider…

- Competence
- Agency
- Connection
- Meaning and Purpose
- Happiness and Pleasure

- Can you see the ambivalence?
- The difference between where he is and where he wants to be?

Meet your clients where they DREAM


Always Meet your Clients Where they Dream

LET’S GO WIDER

Find the Strength

Hint

Autonomy?
Connection?
Creativity?
Competence?

Find the Strength

Hint

- Autonomy?
- Connection?
- Creativity (in the sense of novelty seeking)?
- Happiness and Pleasure?

Find the Strength

Hint

Autonomy?
Connection?
Life?

What is the difference between where he is and where he wants to be?

Find the Strength

Hint

Autonomy?
Connection?
Life?
Happiness/Pleasure?

Find the Strength

Hint

Autonomy?
Connection?
Life?
Happiness/Pleasure?

What's the difference between where he is and where he wants to be?

Question

Am I the only one picking up themes of trauma and other adverse experiences?

David’s Cases

Shane

- Shane, 16, is ready to become violent at the slightest provocation. Shane recently assaulted a female staff member in his residential program. The assault was highly impulsive in nature and took place in the nurse's office of his community-based residential treatment program. She was passing medication at the time. She asked him to return to his room and he became angry and told her that no one can tell him what to do. When she continued to ask him to leave, he beat and choked her. Other staff, becoming concerned by sounds coming from the office (two floors below) intervened after several minutes.

- Shane had been placed in this program due to past violence towards family members and professional caretakers. Found not competent to stand trial, he was provided a legal guardian and committed to the custody of the state.

Shane

- Shane's IQ testing has been inconsistent, reflecting a presentation that can change rapidly.
- Shane presents with ADHD, high levels of anxiety, depression, and PTSD symptomatology. Shane's program staff have all been trained to view him through the lens of early trauma. This trauma interfered with his attachments, resulting in anxiety, depression, impulsivity, a tendency to focus on his physical safety and wellbeing, and a cognitive schema that the world is a dangerous place.

Shane

- Shane has been in treatment for several years, attempting to come to terms with issues from his family of origin. These include witnessing domestic violence and being sexually abused by his mother's boyfriends.
- Shane's parents were both heavily drug-involved. His mother used cocaine while pregnant with him. Shane's father was violent towards her throughout much of their relationship, controlling her access to friends and outside information. He frequently convinced her that she had serious mental health issues.

Shane

- Shane attended special education classes from Kindergarten onward. He was diagnosed with learning disabilities in the areas of math and language. Shane was happiest in classes that involved hands-on/manipulative activities, such as woodworking, and eventually became involved in auto mechanics classes as he entered adolescence.
- Shane was placed in residential treatment at the age of fourteen, and much of his education has taken place within these settings.

Shane

- Shane is known for his excellent sense of humor. He enjoys watching sports on television and talking about sporting events with others. He also loves action/adventure movies with outer-space themes, like Star Wars.
- Shane currently volunteers at an animal shelter in the community, where he is supervised by staff. Shane's interactive style is one of always wanting to please and form connections with the staff around him. He views the male staff as people he wants to form friendships with, the administrators as people who might have been his parents, and female staff as potential girlfriends. He is particularly angry and confused when they reject his friendly advances.

Shane's Risk Factors

- Significant history of violence
- Offense-supportive attitudes
- General Self-regulation Problems (impulsivity across all domains)
- Poor cognitive problem-solving
- Resistance to/noncompliance with rules and supervision
- Lack of emotionally intimate relationships with adults
- Childhood behavior problems
- Grievance/Hostility
- ? Sexualized Violence

Shane's protective factors

- A strong desire to do well!
- A strong desire to connect with others
- A strong desire to live autonomously
- Believes treatment is important
- Compliant with medications
- Periodic contact with mother
- Hates to let others down

Shane's responsivity factors

- IQ and changes in IQ
- Learning disabilities
  - Non-verbal
  - Verbal
- High levels of anxiety and depression; PTSD
- Cognitive Schema: The world is a dangerous place; you have to fight to get even; women are unknowable/deceptive

Shane's Risk/Good Lives Factors

- Offense-supportive attitudes
- General Self-regulation Problems (impulsivity across all domains)
- Poor cognitive problem-solving
- Resistance to/noncompliance with rules and supervision
- Lack of emotionally intimate relationships with adults
- Childhood behavior problems
- Grievance/Hostility
- ? Sexualized Violence

- Peace of Mind
- Happiness and Pleasure
- Learning and knowing
- Personal choice and independence
- Connection
- Spirituality?

Shane's Obstacles

- Lack of internal capacity: trauma-related symptoms
- Conflict between goals (independence vs. peace of mind)

Shane's Treatment

- Group Therapy
- Individual Therapy
- Vocational/Occupational assistance
- Program activities
- Meditation
- Journaling
- Affirmation

Shane's Treatment

- Group Therapy
- 90 seconds meditation
- 3 good things
- Let's examine a good life goal
  - How did you achieve this goal in the past
  - How can you work on this goal in the present?
  - How can you achieve this goal in the future?
  - What obstacles have you encountered in the past
  - What obstacles can you expect in the future?
  - How have "trauma echoes" acted as obstacles?

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?

Shane's Treatment

- Clinician listens with a goal of understanding
- Clinician offers summaries and reflections to make sure s/he is understanding
- Clinician offers advice only with permission
- Individual therapy address more personal issues, such as abuse history and discussing the details of incidents.

“Staff-Led Groups”

- Twice-weekly groups led by paraprofessional staff
- Open discussion of a single Good Life Goal
  - Sometimes involves artwork or story-telling about that goal
- Staff will also teach skills related to that goal
  - For example, muscle relaxation or DBT skills for the goal of “Peace of Mind”
  - Communication skills curriculum for the goal of relationships and friendships
  - Discussion of job skills for goal of excellence at work
  - Review of program activities for goal of excellence at play
  - Etc.

Jerry

Jerry, 18

- Significant history of brain injury resulting from a motorcycle crash
- Lives in a supervised home
- Significant substance abuse history
- Friendly and easily engaged, however,
    - Seriously invested in his smoking schedule
    - Drinks as much coffee as possible
    - Becomes angry at the slightest changes in his schedule
- Motivated by AA and enjoys meetings
- Requires considerable supervision to stay on track

Jerry

- “Mr. Motivation”
- After moving to a less-restrictive setting, Jerry got angry at a housemate who had brought drugs into the program and wouldn’t share them. Jerry physically assaulted him. The police had to intervene.
- Jerry returned to a higher level of care

Jerry's Good Life Plan

- Goals valued
  - Happiness and pleasure
  - Spirituality (meaning and purpose): feeling that he has something to offer the universe
  - Excellence at work
  - Peace of mind
  - Community
  - Independence/autonomy
- Goals implicated in offending
  - Happiness and pleasure
  - Peace of mind
  - Independence/autonomy

Jerry's Obstacles

- Lack of capacity – internal for managing addiction-related urges
- Conflict between goals as a result of a lack of capacity
- Narrow scope to his good life plan: He is focused either on not relapsing or on areas of his life that are addictive in nature.
- Lack of opportunities and lack of insight into developing new opportunities:

Jerry's Treatment

- Group Therapy
- Individual Therapy
- Vocational/Occupational assistance
- Program activities
- Meditation
- Journaling
- Affirmation

Jerry's Treatment

- Group Therapy
- 90 seconds meditation
- 3 good things
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  - Communication skills curriculum for the goal of relationships and friendships
  - Discussion of job skills for goal of excellence at work
  - Review of program activities for goal of excellence at play
  - Etc.

Assessment

Assessment tasks

- RNR-based assessment
  - Includes static/dynamic risk and specific responsivity factors (e.g., developmental disability, mental health, substance abuse, etc.)
- Exploration of good life plan (at time of offending and now)
  - Identify valued primary goods and goods implicated in offending
  - Identify past and current means used to attain valued primary goods
  - Identify any concerns re: scope, conflict and capacity
- Exploration of protective factors

E.g., Willis et al (2013); Yates et al (2010)

Identifying Primary Goods/ Common Life Goals

- Clinical exercise
- Determine those things (i.e., activities, situations, experiences) that are important to the individual in his or her life
  - Infer common life goals
- Detect goals evident in offense-related actions and general life functioning
  - Infer common life goals implicated in offending – what was client trying to gain?

Possible questions

- What are the most important things for you to achieve in your life?
- What drives you? Gets you out of bed in the morning?
- What do you do on a day to day or regular basis to achieve these goals?
- Are some goals more important to you than others? Which ones, and why?
- Where would you like to be with respect to these goals in one year's time? Five years' time? Ten years' time?

Deeper

- What's missing from your life that you wish were there?
- How many people deeply accept you for who you are?
  - Would you like more?
- What are you longing for in your life?
- Who are you longing for?

Mission Critical:

- In answering those questions, what external pressures did you feel?
- Do we answer these questions for our clients? On their behalf? For their “own good”?
- Or do we explore, collaborate, evoke what is important/meaningful for them?

Having Fun

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Being an Achiever
(being good at something)

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Being My Own Person

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Being Connected to others

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Having a Purpose in Life

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Meeting My Emotional Needs

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Meeting My Sexual Needs

Importance:

0 1 2 3 4 5 6 7 8 9 10

Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Being Physically Healthy

Importance:

0 1 2 3 4 5 6 7 8 9 10

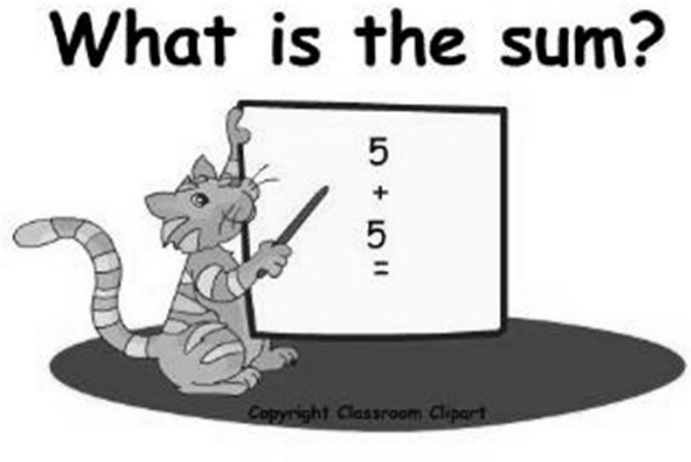
Confidence:

0 1 2 3 4 5 6 7 8 9 10

Why that number and not a lower one?
What would it take for you to score higher?

Case Formulation

- Integrates information collected during assessment to provide a comprehensive explanation (or set of hypotheses) for the client's presenting problems/offending
- Attempts to account for the client's current problems, how they developed and how they are maintained. Why these problems and why now?
- Adjusted as new information /understanding comes to light



Case Formulation

Other relevant theories, may include:

- Pathways model (Ward & Siegert, 2002)
- Self-Regulation model (Ward & Hudson, 1998)

Biopsychosocial explanation of predisposing, precipitating, perpetuating and protective factors

Treatment is
something we do
for and **with** clients,
not **to** and **on** them

(Miller & Rollnick, 2013)

Treatment Process

and Process Challenges

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?

Let’s talk some about trauma

What is trauma?

PTSD
Complex PTSD
DESNOS
Complex trauma
Developmental Trauma
Disorder

What is Trauma?

Trauma is the desperate hope that the past was somehow different.

— Jan Hindman


TRAUMA
.Relational issues
.Somatic challenges

What is Trauma?

The goal of (trauma) treatment is to help people live in the present, without feeling or behaving according to irrelevant demands belonging to the past.

— Bessel van der Kolk

Ultimately

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest.

— Judith Herman, M.D.

Reframe: Interventions that empower survivors foster recovery

What is Trauma-Informed Care?

"A program, organization, or system that is trauma-informed:

1. *Realizes* the widespread prevalence and impact of trauma;
2. *Recognizes* the signs and symptoms of trauma;
3. *Responds* by integrating knowledge about trauma into policies, procedures, and practices; and
4. Seeks to actively resist *re-traumatization*."

Substance Abuse and Mental Health Services Administration
SAMHSA

(Substance Abuse and Mental Health Services Administration, 2014)

Herman, 1992

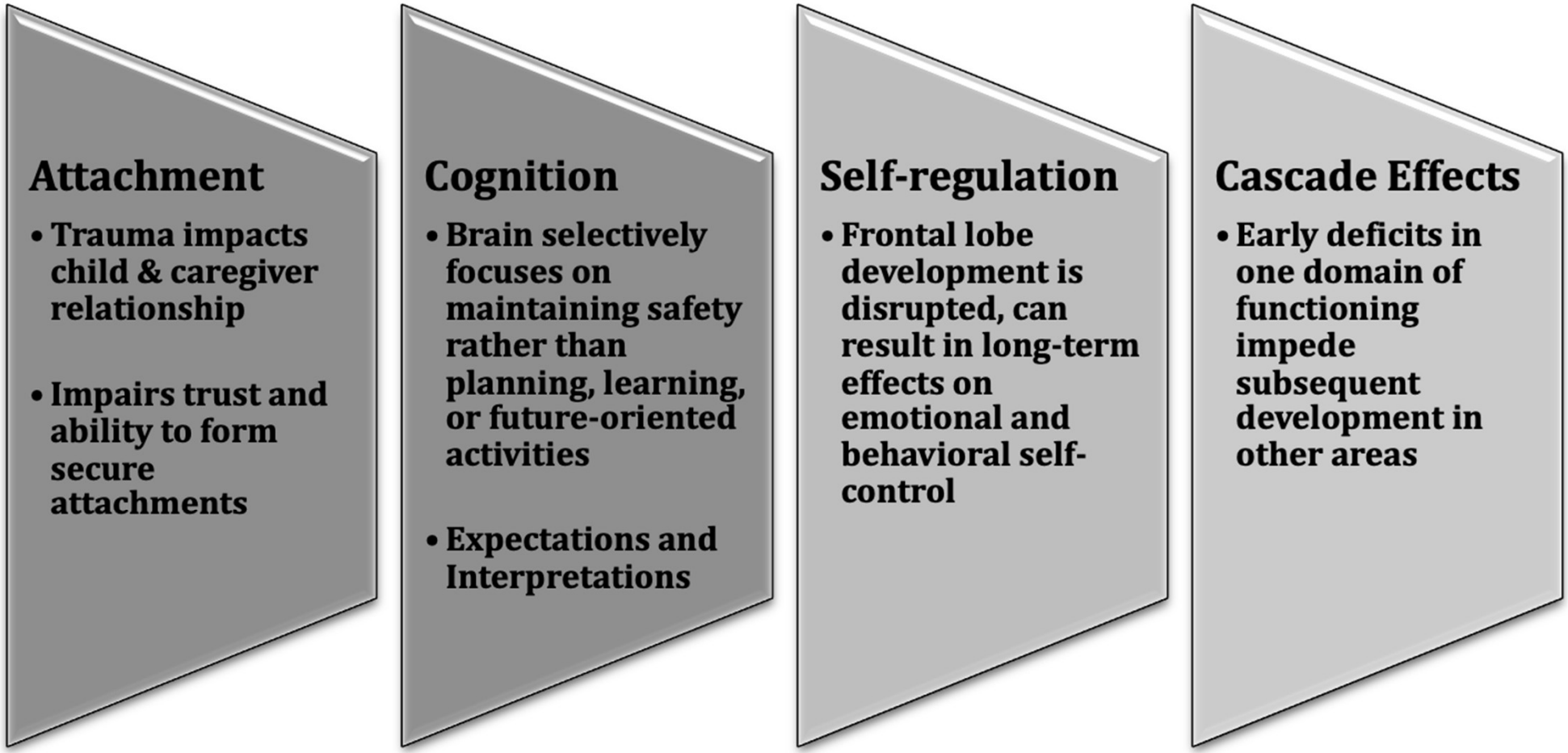
Type 1 Trauma: Isolated, simple trauma	Type 2 Trauma: Chronic & Complex
Usually a single incident or time-limited duration	Prolonged, repeated trauma
Acute Stress Disorder/PTSD	Increased risk for long-term PTSD symptoms
Response and effects may vary with many factors	Increased risk for related behavioral health syndromes

How do trauma and adversity affect development?

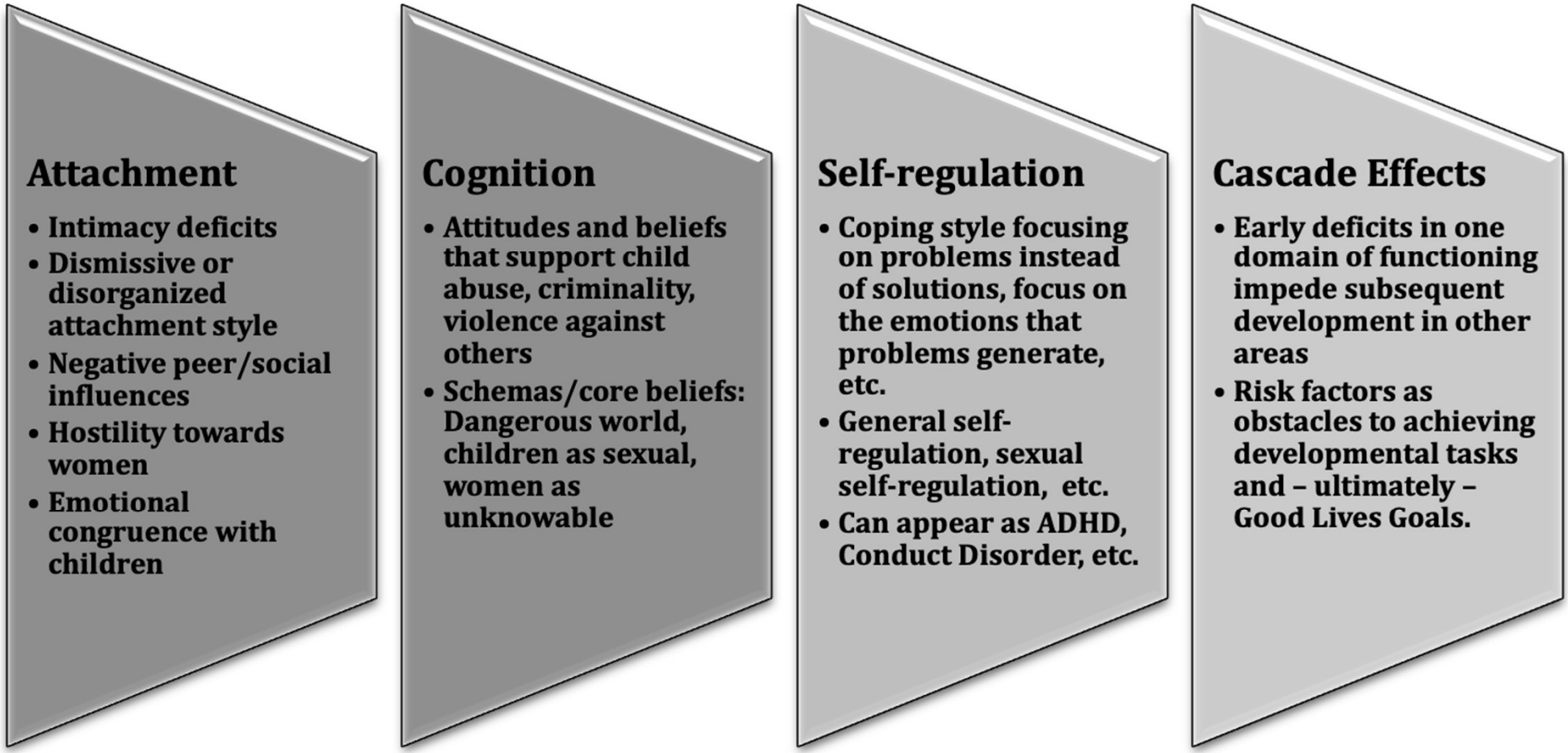
And Risk Factors?

And Good Lives Goals?

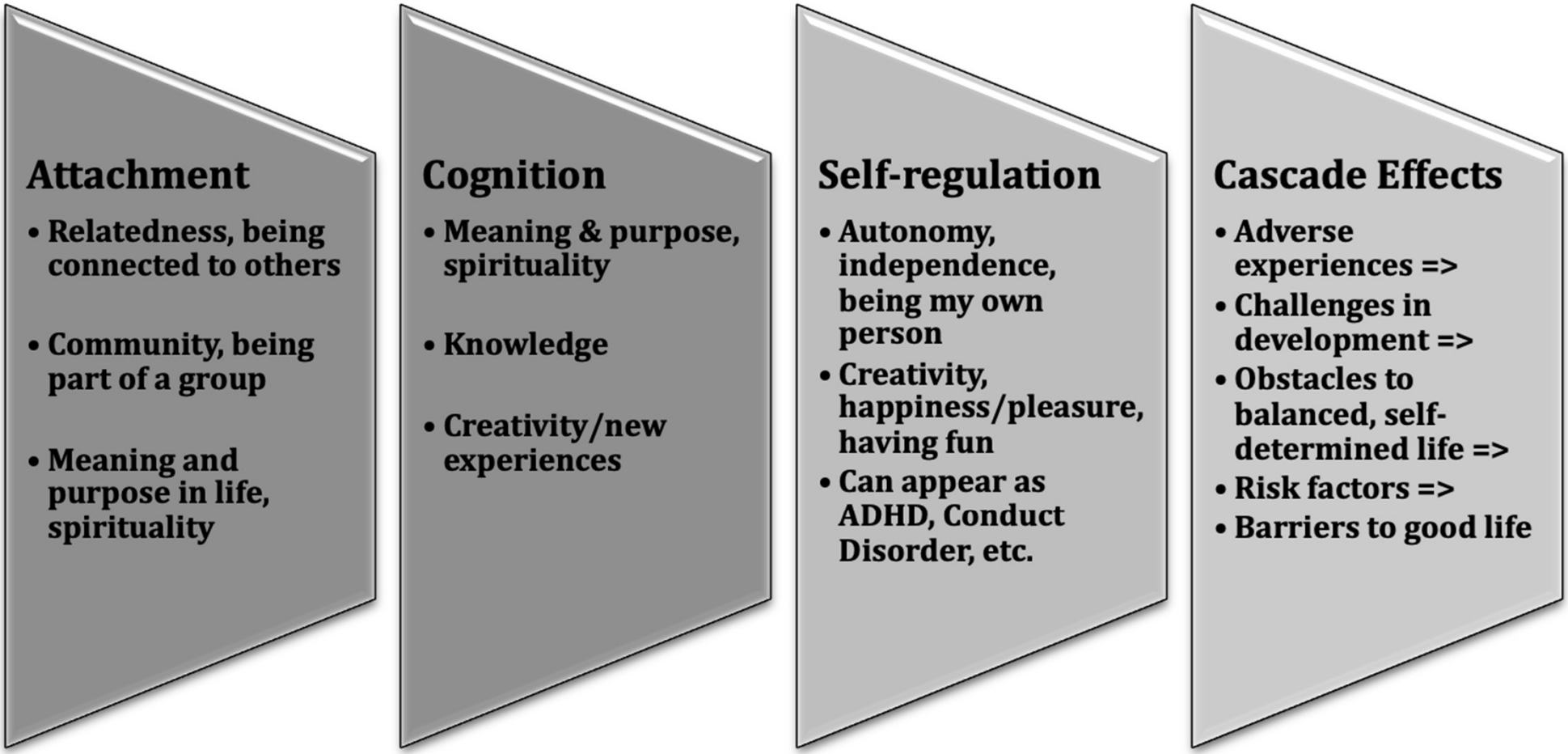
Developmental effects of childhood adversity



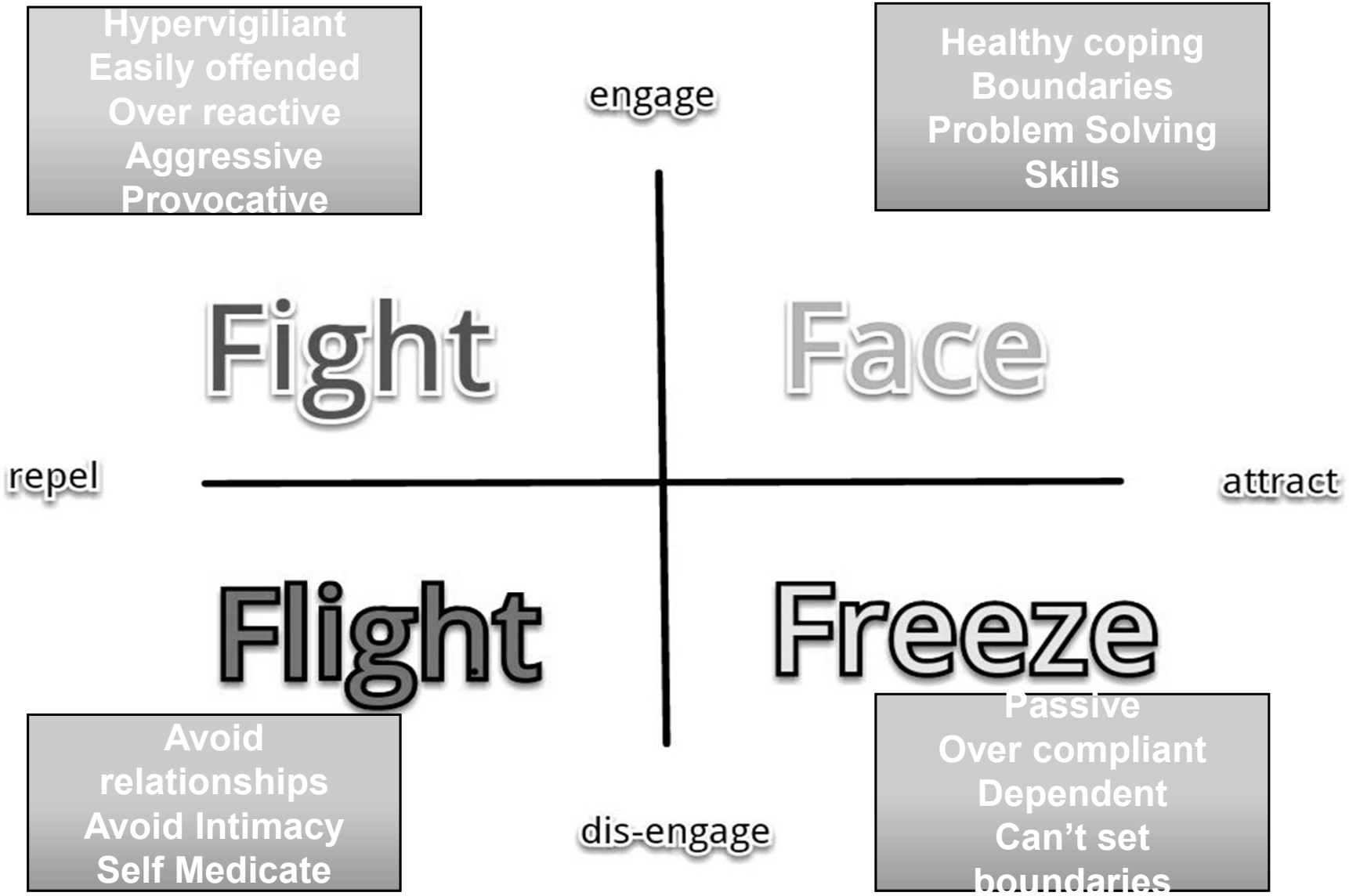
Developmental effects of childhood adversity and Risk

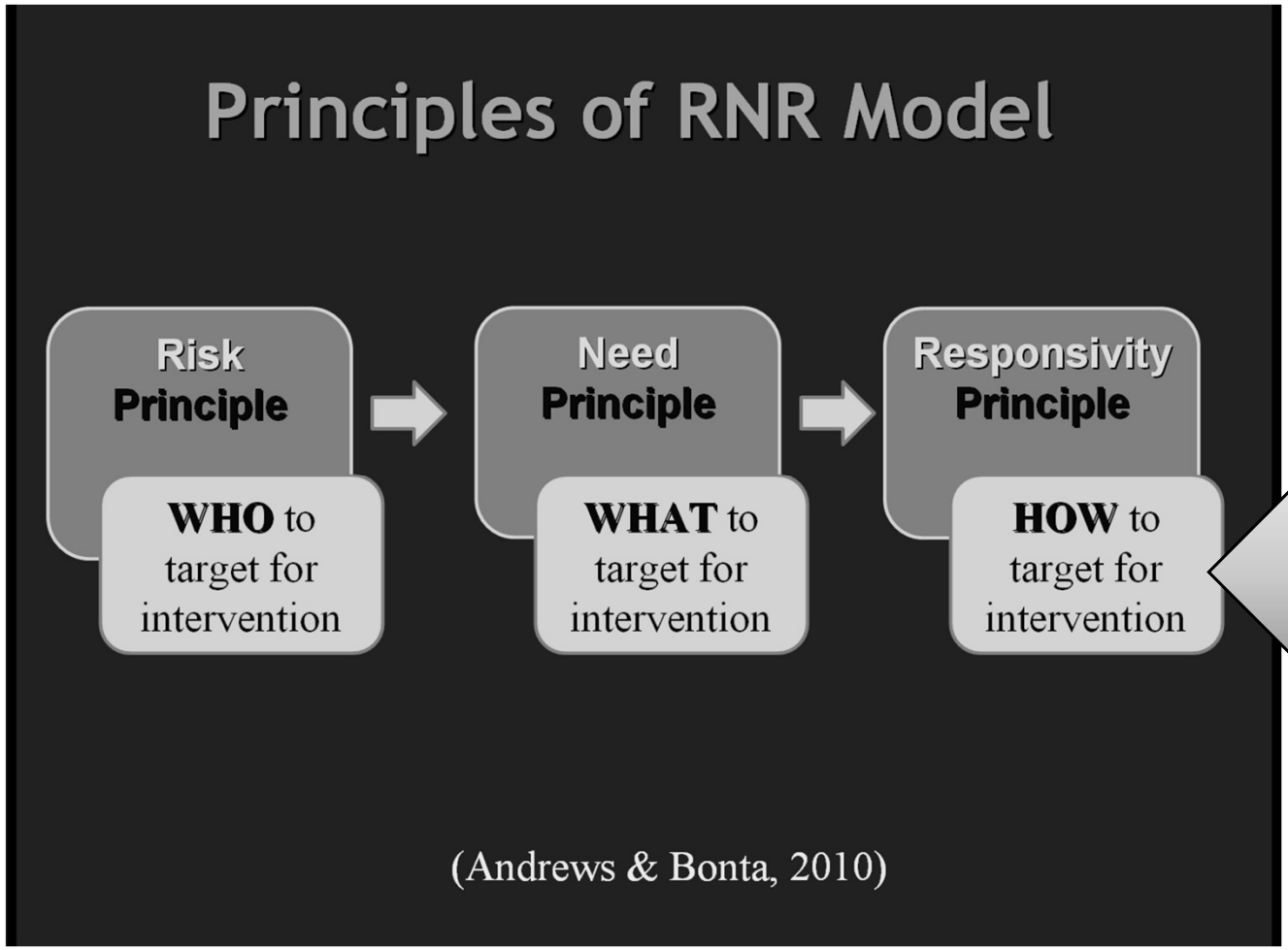


Developmental effects of childhood adversity and Good Lives Goals



Ways trauma may impact relational dynamics





Trauma-Informed Care in treatment

The Importance of Narrative

CONSIDER …

Among the tasks of the mind is to reduce the difference between the prediction and the sensation

Application

“I went to the grocery store, and for the first time ever I knew what I wanted.”

Analysis

- Trauma interferes with decision-making
- Trauma interferes with prediction of sensations
- Trauma interferes with prediction of happiness
- Trauma interferes with the belief that predictions and decisions are possible
- Trauma focuses on surviving threats in the moment
- Move beyond teaching how to make lists
- Move beyond decision-making skills

Reflection

1. *That's fantastic. There you were, able to focus on what you wanted and not on what others wanted from you.*
2. *Hey, that's great! In that moment, you were aware of the things that mattered most to you*
3. *Good for you. Staying focused on what matters to you in a busy place like a grocery store can be a real challenge.*

Application

“I can’t tell you what I’m thinking. It’s too confusing. I’m not sure you’d get it. Look, never mind.”

Translation

- “Other people have always told me what to do.
- I’ve had to hide to avoid being beaten
- Now you’re asking me to express my thoughts freely; that’s dangerous
- I’ve learned not to trust my thoughts and feelings
- Survival has meant focusing outside myself
- My capacities to observe my thoughts and feelings have atrophied.
- It’s safer to shut down.”

Reflection

1. *Describing your experience is really hard.*
2. *It's really hard to talk about these things when you don't know if I'll really get it.*
3. *There's a bigger piece of all of this that I may not be seeing.*
4. *If you were to really talk about these things, you'd need to know that others will understand and respect you.*

Cultural Trauma

- “What’s it like to be working with a white guy like me?”
- Activation of cultural trauma can happen at the epigenetic level
- We forget how much power we have over clients

Possible reflections

- *You might be wondering if someone like me – who comes from outside your culture – can understand you and you have every right to be suspicious about all of this.*
- *With everything going on for you, including having to talk with a counselor who's not from your same culture(s), it's probably better if you don't completely trust me.*
- *At some point, if you'd be willing to talk with me about our cultural differences, I would be honored to listen and respond as best I can.*

Treatment Content

- Treatment intensity and targets based on risk and needs
- Goals of each stage framed using approach (rather than avoidant) goals
- Programming linked to fulfilment of common life goals
  - Consider SMART-goal framework

Risk-based treatment components and related GLM constructs

Autobiography	→	Good Life Plan (past and present)
Offense Progression	→	Knowledge, Good Life Plan (past and present)
Cognition/Problem-Solving	→	Knowledge, Personal Choice & Independence, Peace of Mind, Relationships & Friendships
Relationships/	→	Relationships & Friendships, Community
Intimacy Deficits	→	Happiness, Peace of Mind, Relationships & Friendships, ++
Sexual Self-Regulation	→	Peace of Mind, Personal Choice & Independence, ++

Treatment Components

(Yates et al., 2010)

- Relevant personal history
  - Good life plan(s)
    - Valued common life goals, associated secondary goods
    - Problems attaining common life goals
    - NOT “autobiography”
  - Purpose:
    - Examine strengths
    - Examine/confirm GL goals
    - Examine/confirm risk and protective factors
    - Facilitate comfort with disclosure in treatment

Treatment Components

(Yates et al., 2010)

- Understanding the offense process
  - Understand role of common life goals, secondary goods (means), obstacles
  - Determine common life goals at all stages of offense process
  - Focus = what individual was trying to gain
    - Did pre-offense behavior and offending represent opportunities to meet, keep, or re-acquire common life goals?
    - After offending, were goals achieved?
    - How does offense fit into good life plan?

Integrated Good Lives and Risk Management Plan (Yates et al., 2010)

- Includes all goods important to individual
  - Sufficient scope
- Includes non-offending, practical ways to attain goods/goals
  - Consider environment in which client will be living
- Identifies threats/obstacles to goods attainment and strategies for managing
- Includes risk management plan
  - Strategies to manage dynamic risk factors
  - Strategies to attain a better life

Integrated Good Lives and Risk Management Plan (Yates et al., 2010)

- Includes all goods important to individual
  - Sufficient scope
- Includes non-offending, practical ways to attain goods
  - Build on client strengths
  - Approach-oriented SMART goals
- Identifies threats/obstacles to goods attainment and strategies for managing
- Includes risk management plan

Contrast: A relapse-prevention oriented risk management plan

- Avoid being in areas that children congregate (e.g., outside schools, parks)
- Avoid any media (e.g., magazines, television) depicting prepubescent girls
- Do not join church or other community groups in which children are present
- Avoid isolating especially when experiencing low mood
- Constantly monitor environment for new high risk situations/warning signs
- Phone a nominated support person in event of warning signs (loneliness, deviant arousal) or high risk situations which I cannot escape

Considerations for Special Populations

Intellectual disabilities

- Not just talk slower and louder
- Use visual imagery
- Use multi-modal methods, including role plays
- Use social stories
- Repeat key points often

Seek their perspective

- How seriously do we try to understand their understanding of treatment?
- When we do, in what ways are we patronizing?
  - “I’m the one with the letters after my name; you’re the messed up client”
- The “bobble-head effect”
- Don’t be afraid to modify practices
  - Curriculum
  - Empathic, attuned interventions

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?

Selfishness

- For people with very high levels of selfishness:
- Focus on what's in it for them
- What is the cost of offending to them?
- What is the price they pay?
- If offending continues, what will happen to them?
- What's missing from their life that they wish were there?

Key Points with Autism Spectrum

- Keep it individualized:
  - *“If you’ve met one person with an ASD, you’ve met one person with an ASD”*
- Keep it concrete: GLM concepts can be high-minded and difficult to grasp
- Keep it trauma-informed
- Keep your attitudes about sexuality in check
- Use functional behavior analysis

Autism Spectrum

- Depending on where they are on the spectrum 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.

ASD

- 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 taking care of ADLs or at time when he is getting agitated.

Considerations for Clinical Supervision

When supervising

- Begin with a case and consider:
- What are this clients goals?
- Who are you in this client's life, from his/her perspective?
  - (clarifying relationship)
- What things do and don't work for him/her in treatment
  - (clarifying tasks and approach of therapist)
- What cultural considerations exist?
  - Is the therapist taking these into account in constructing services?

Supervision

- Consider Good Life Goals
  - Including those implicated in offending
- Consider daily life functioning
- What Good Life Goals are implicated in his daily functioning?
  - How are they implicated?

- How can the therapist use their trained methods and approaches to enhance this client's understanding and implementation of the GLM?

Example

- The seemingly impossible case: Unmotivated, uninterested, has had enough of therapists
- Explore client goals
  - His desire for freedom and living in the community maps onto strong priority on personal choice and independence.
  - Set therapist goal of exploring other goals with interest and no agenda as part of a regular conversation; not overtly clinical
- Explore client relationship
  - Who is this therapist in the client's life? Just an innately annoying person? Define what the therapist can and can't do

Example

- Therapist approach
  - Open discussions about what is working for the client, what kind of approaches may be necessary, and why.
  - It may be as simple as “what’s in it for you”.

- Cultural considerations
  - What strongly held values assist or impede this case?
  - Client comes from a family in which receiving assistance of any kind is considered a sign of weakness.

Consideration

Supervision can:

- Proceed case by case
- Good life goal by good life goal
- Therapeutic skill by therapeutic skill

Implementation

Terms

Implementation:

- "to put into effect according to or by means of a definite plan or procedure."
- In treatment, refers to implementing a model or approach with fidelity
  - Usually top-down training and consult

Terms

Integration:

- “to bring together or incorporate (par ts) into a whole”
- “Our program uses the GLM, is informed by the GLM, etc.”

Terms

- Implegration (Carl Åke Farbring)
- The process of implementation and integration
- Using internal expertise to assist in implementation.
  - Including unique approaches to learning

Problems

- Implementation:
  - Top-down training and consult:
    - Can alienate staff
    - Benefits can disappear with staff turnover
    - Involves unlearning old habits as well as new
    - Does not always result in actual change of behavior at the front lines (Farbring, 2010)

Problems

Integration:

- “Our program uses the GLM, is informed by the GLM, etc.” is not necessarily faithful to the model or its guiding principles.

Integrated implementation (implegration) ≠ one size fits all

- Bottom-up perspective
- Balance between guidelines and mindlines
- Exploring-and-listening attitude
- Local ownership
- Adjusting implementation to local conditions
- Positive support trumps monitoring and control

Examples

- After motivational interviewing training:
  - Two agencies sought to have trainer come back to observe and re-train in order to “keep the spirit alive”
  - Two agencies set up the “MI Tip of the Week”
  - Two agencies grew their own internal trainers
  - Numerous practitioners selected specific skills to practice that week.
  - No agencies have taken an advantage of an offer of a free post-training consult

Ultimately

Successful GLM implementation may rely as much on subtracting old practices (cycle work and avoidance based goals and tasks) as on adding new ones (e.g., approach goals)

Implementation: Lessons Learned

Treatment is
something we do
for and **with** clients,
not **to** and **on** them

(Miller & Rollnick, 2013)

Challenges to Implementation

- "We tried the GLM, but we thought it was confusing. So we went back to what we were already doing."
  - Successful implementation of any approach takes two years or more (Fixsen et al., 2005)
  - Treatment effects can take well over two years to begin to improve (Brattland et al., 2018)

- "We got ourselves trained in the GLM and now we're doing it."
  - Consultation and continuous efforts at improvement matter.

Challenges to Implementation

- Cultural considerations
  - Surprisingly, most has been along individualistic/collectivistic cultural lines
  - The role of relationships and friendships
  - The role of independence
  - Ultimately, the answer is in how clients weight the importance of these PHGs
  - Cultural differences between client and their community

Challenges to Implementation

- The belief that “we already do this.”

- Is the practitioner using the actual PHGs as they are defined?
- Is the practitioner using the PHGs as they are defined?
- Can the practitioner identify the PHGs that are important to this client?
- 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?

Challenges to Implementation

- The belief that “we already do this.”

- Has the practitioner conducted a solid assessment of the client’s strengths (as they related 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?
- 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?

Challenges to Implementation

- "This is easy"
  - Therapist qualities
    (WERD; Marshall, 2005)
  - Underlying "Spirit" of delivery
    (PACE; Miller & Rollnick, 2013)
  - Prioritizing skills that promote change
  - Actively and explicitly seeking client feedback
    (Prescott, Maeschalck, & Miller, 2017)
  - Focus on PHGs, conceptualization of risk factors, and how each is implicated in offending, as above
  - Understanding obstacles to achieving a good life
    (Prescott & Willis, 2021a)

Challenges to Implementation

- "We've made a simplified GLM"
  - Combining PHGs can lead to one or more going unaddressed (e.g., spirituality)
  - Decisions about combining PHGs or abandoning them typically made by administrators without client feedback.
  - Clinical convenience can mean ignoring significant portions of clients' lives.
  - When you've implemented the GLM, simplification becomes very simple indeed.

Ultimately

- Effectively using the GLM involves effective therapeutic practice
- The therapist who delivers it is the most important variable
    - It's not just "what works," it's "who works"
- Instead of "nothing works" we can ask, "Has nothing been implemented?" (hat tip to Faye Taxman)

How Well Am I Implementing the GLM?

GLM Fidelity Monitoring

(Prescott & Willis, G.M., 2021b)

GLM Fidelity Monitoring Tool

Table 1

GLM Fidelity Monitoring Tool Overview

GLM Fidelity Monitoring Tool Section	Fidelity Indicator
1. Fundamental Considerations and Processes • Qualities of the therapist, as perceived by the client and others • Underlying "spirit" of treatment delivery • Prioritizing clinical skills that promote change • Actively and explicitly seeking client feedback	0 – 2 rating[a]
2. GLM-Specific Considerations and Processes • Focus on Good Life goals • Conceptualization of risk factors • Good Life goals implicated in offending • Obstacles to achieving one's Good Life plan	0 – 2 rating[a]
3. Client-Focused GLM Considerations • Ten questions exploring therapist's progress developing a GLM grounded case conceptualisation and therapy plan for individual clients	Extent to which each question can be answered

[a]0 = poor (or absent) fidelity, 1 = partial fidelity, 2 = fidelity

Looking Beyond

The New York Times

New Approach Advised to Treat Schizophrenia

By **BENEDICT CAREY** OCT. 20, 2015

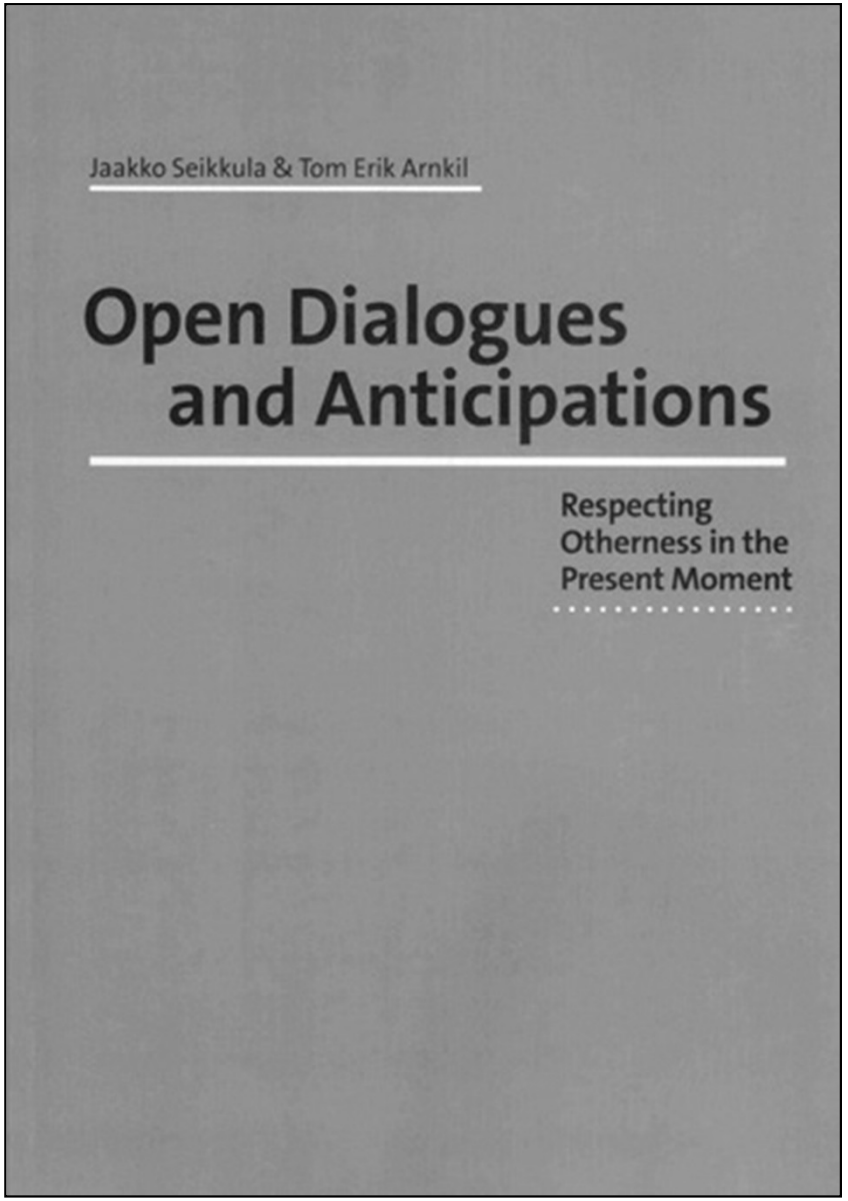
361 COMMENTS

More than two million people in the United States have a diagnosis of schizophrenia, and the treatment for most of them mainly involves strong doses of antipsychotic drugs that blunt hallucinations and delusions but can come with unbearable side effects, like severe weight gain or debilitating tremors.

Now, results of a landmark government-funded study call that approach into question. The findings, from by far the most rigorous trial to date conducted in the United States, concluded that schizophrenia patients who received a program intended to keep dosages of antipsychotic medication as low as possible and emphasize one-on-one talk therapy and family support made greater strides in recovery over the first two years of treatment than patients who got the usual drug-focused care.

John Kane, chairman of the psychiatry department at Hofstra North Shore-LIJ School of Medicine, who led a study on the treatment of schizophrenia. Uli Seit for The New York Times

Jakko Seikkula



To Be Continued…

… by you!