Positive Psychology and the Good Lives Model: Translating Strengths Based Approaches to the Treatment and Assessment of Those who have Committed Sex Crimes
Overview

- A Brief History of Sex Offender Treatment
- Review Current Practices/Models
  - RNR
  - GLM
  - Strength-Based Approaches
- How are we applying these models in practice?
  - Challenges
- How to integrate Strengths Based Approaches into your work
A Brief History
Discussion of Sexual Deviancy started in mid 1800s

- Freud 1896 – Seduction Theory of Childhood Sexuality
  - Childhood sexual abuse product of imagination of alleged victims
  - Three essays on the Theory of Sexuality
    - Sexual deviations
    - Infantile sexuality
    - Sexuality in puberty
- 1869 - Homosexuality introduced as a term
- 1886 – von Krafft-Ebing published:
  - Psychopathia Sexualis
  - Most complete descriptions of unconventional sexual behavior
- 1893 - Moll – Perversions of the Genital Instinct
History - Treatment

- Earliest Published account to treat “sexual deviancy” in late 1800s
  - Masturbatory reconditioning (Charcot & Magnon 1882)
  - Moll (1911) reported 2 cases where he was able to shift sexual interest in boys to young women using this technique

- Rise of Behaviorism – early 20th century
  - Alfred Binet – learned responses
  - Watson – radical behaviorism
  - Behaviorist Manifesto

![Image of Behaviorism Manifesto](image-url)
History of Treatment – Theoretical Influences

- **Pavlov – Classical Conditioning**
  - Biologically potent stimulus paired with previously neutral stimulus

- **Skinner – Operant conditioning**
  - Learning through reward and punishment

- **Bandura – Social Learning Theory**
  - Behaviors learned through observing and imitating others

- **Kinsey – Sexuality in Human Male and Female**
  - Conducted research/gathered data on sexual behavior
History of Treatment

- Early behavior interventions
  - Aversion Therapy
    - Noxious stimulus (inducing vomiting) paired with images (CC) or enactment of deviant behavior (OC)
    - Electric aversion – shock therapy
    - Other aversive stimuli included:
      - foul odors
      - covert aversive images
      - Shame/embarrassment
  - Aversion therapy never demonstrated to produce permanent change in sexual behavior
    - Quinsey & Earls, 1990; Quinsey & Marshall, 1983
    - Based upon sexual preference hypothesis – not supported in research
    - PPG introduced by Kurt Freund in 1957
History of Treatment

- 1970s – Introduction of more comprehensive therapies
- Need to target more than just deviant arousal
- Psychological treatments that:
  - Targeted appropriate arousal
  - Development of social and communications skills
History – Change of Zeitgeist

- Report by Robert Martinson (1974) that was widely interpreted as showing that "nothing works" in offender rehabilitation

- Results of the research teams' assessment of 231 evaluations of treatment programs 1945-1967

- Concluded: "With few and isolated exceptions the rehabilitative efforts that have been reported so far have had no appreciable effect on recidivism"
The perception that “nothing works” became widespread throughout the U.S. → movement away from treatment.

Gave rise to a strong movement to change both the **philosophy and control of imprisonment policy** and this impact was felt throughout the 1980s.

- Mandatory sentencing
- Three strikes Laws
- Removal of certain recreational programs from prisons
- Start of creation of restrictive sex offender policies
Current Practices/Models

CBT
THOUGHTS
What we think affects how we feel and act
EMOTIONS
What we feel affects how we think and act
CHANGING PERCEPTIONS
BEHAVIORS
What we do affects how we think and feel

Risk
Need
Responsivity
Recidivism Reduction

GOOD LIVES MODEL
Effective intervention adheres to current standard practice and methods:

- Principles of **risk, need, responsivity** (RNR)
- Pre-treatment assessment (risk factors/criminogenic needs, other relevant factors)
- Cognitive-behavioral (CBT) and skills-based
- Targets identified risk factors/criminogenic needs
Effective intervention adheres to current standard practice and methods:

- Post-treatment maintenance/follow-up
- Adjunctive intervention as required (e.g., pharmacological, special needs)
- Effective clinical intervention methods (pro-social modeling, reinforcement, flexibility, directed/structured, supportive challenging, empathic, non-confrontational, motivational, etc.)
Treatment has standard components addressing raising awareness and building skills in key areas of risk:

- Deviant sexual interests
- Antisocial orientation
- General self-regulation
- Sexual self-regulation
- Offence-supportive attitudes/schemas
- Significant social influences
- Intimacy deficits
- Emotion regulation
Cognitive Behavioral Therapy

- Most widely accepted type of intervention with offenders “best practice”
- Research demonstrates that CBT interventions consistently reduce reoffending
- Thoughts, attitudes and beliefs about a situation influence behavior
Cognitive Behavioral Therapy

- To change behavior or emotion management, must explore thoughts/beliefs about the situation and then alter them.
- CBT uses a variety of techniques to help client examine these beliefs and change behavior.
Cognitive Behavioral Therapy

- Determining goals collaboratively
- Cognitive restructuring
  - Changing attitudes and beliefs by finding evidence to refute them (Albert Ellis; Aaron Beck)
- Modeling
  - Imitation
  - Observational learning
Cognitive Behavioral Therapy

- **Behavioral Rehearsal and Role Plays**
  - Rehearsal new prosocial behaviors
  - Major strategy used in programs
  - Can assess how well offender is progressing

- **Shaping**
  - When offenders demonstrate desired behavior they should immediately be reinforced
Cognitive Behavioral Therapy

- Overlearning
  - New skills need to be practiced over and over again so they become a regular part of behavioral repertoire

- Positive Reinforcement
  - Desired response followed immediately by reward (i.e. praise)
  - Needs to be immediate and consistent
Cognitive Behavior Therapy

- **Homework assignments**
  - Review and consolidate new information between sessions
  - Rehearsal and practicing new skills in “real life”
Targets of Treatment

- Cognitive Distortions
- Intimacy and Social Functioning Deficits
- Problems with Emotion Regulation
- Empathy and Victim Awareness
- Deviant Sexual Arousal
- Self Management/ Relapse Prevention
Cognitive Distortions

- learned assumptions, sets of beliefs and self-statements about deviant or aggressive sexual behaviors
- Underlying attitudes and beliefs lead to distorted thinking which supports sexual offending behavior
- Demonstrate how changing thoughts can change behavior
- Use ABC Model
Long believed that sex offenders lack social skills

More recent research indicates that social functioning deficits more specific:

- Intimacy and attachment difficulties
- Self esteem
- Loneliness

Improvement in self esteem after treatment directly related to changes in treatment targets
Emotion Management

- Affective dyscontrol linked to sexual offending behavior
- Both negative and positive affective states can increase the likelihood of offending
- High levels of stress can precipitate and offense
- Offenders need to identify the emotions that put them at risk
Empathy and Victim Awareness

- Demonstrated that many offenders lack empathy for their victims
- Although offenders generally have empathy deficits it doesn’t mean that they lack the capacity to feel empathy
- Mann and Barnett (2013) reviewed three meta-analytic studies and some individual studies that suggest victim empathy work is unnecessary, or even harmful
Deviant Sexual Arousal

- Deviant arousal per se doesn’t explain sex offending behavior – but it could contribute
- Not recommended for all offenders – but instead those for whom deviant arousal is a major contributor to sexual offending behavior
- Behavioral interventions currently have minimal data supporting effectiveness (Laws and Marshall, 1991)
Deviant Sexual Arousal

- Behavioral strategies for extinguishing deviant arousal have included:
  - Aversion therapy
  - Masturbatory satiation
  - Sexual arousal reconditioning

- Behavioral techniques have shown good results and have been found to decrease recidivism
Self Management/ Relapse Prevention

- Original relapse prevention model for substance abuse was applied to the treatment and maintenance of treatment gains in sexual offenders
- Current evidence suggests that sexual offending behavior is less similar to addictive behavior than had been previously believed (Marshall & Marshall, 1998)
- Outcome data of RP programs suggests minimal to no treatment benefits (Marques et al., 2005)
Relapse Prevention

Abstinence
(Sense of Control, Continued Success Expected)

Seemingly Unimportant Decision?
Yes

No: Prevention

High-Risk Situation
(Sense of control threatened)

Adequate Coping Response
No

Lapse
Abstinence Violation Effect (giving up)

Adequate Coping Response?
No

Relapse (Reoffense)

Yes: Prevention

Yes: Prevention

Development of Self-Management includes:

- Perceptions
- Cognitive distortions
- Planning of the offence
- Post-offence evaluation
- Influence of positive and negative emotions
Effective Treatment

- Most recent Treatment outcome data (Schmuker & Lösel):
  - 10.1% recidivism for treatment groups
  - 13.7% for comparison groups

- Issues with study design
  - Lack control groups
  - No random assignment

- Only replicable intervention is MST
  - Used with juveniles only
RNR Criticisms

- Risk as static versus dynamic
- Notion of risk → tied to subjective ideas of harms/benefits
- Underplays the contextual nature of human behavior
- Doesn’t focus on motivation
- Focus on traits vs. personal goals
- Radical behaviorist view of human nature
- Avoidance and approach goals
- One size fits all
The Good Lives Model
“Offenders want the possibility of better lives, not simply the promise of less harmful ones”
“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.”
Good Lives Model

- A rehabilitation framework
- Strengths-based, positive approach
- Collaborative, motivational approach
- Two goals:
  1. Attaining a fulfilling life, psychological well-being
  2. Managing risk
- Focuses on how treatment will benefit client/what client will gain from treatment
Good Lives Model

- Good life attained by understanding what is important to offender and helping offender to obtain these goals
- Risk managed by attaining what is important in offenders’ life
- Risk managed by changing and monitoring known risk factors, self-regulation
Primary Human Goods

- GLM proposes 10 primary human goods – things individuals seek to obtain for their own sake

- Value or importance placed on various goods determines good life plan

- Good life plan = individual roadmap to fulfilling, well-balanced life = Pro-social & offence-free!

- Goods may also be related to sexual offending (presence or absence)

- In treatment and supervision = attaining goods should assist to reduce or manage risk to re-offend
A ‘Good Life’

- **LIFE**: Healthy living and functioning
- **INNER PEACE**: Freedom from emotional turmoil and stress
- **RELATEDNESS**: Including intimate, romantic, and familial relationships
- **EXCELLENCE IN WORK**: Including mastery experiences
- **EXCELLENCE IN AGENCY**: Autonomy, power, self-directedness
- **COMMUNITY**: Connection to wider social groups
- **CREATIVITY**: Expressing oneself through alternative forms
- **KNOWLEDGE**: How well informed one feels
- **PLEASURE**: Feeling good in the here and now
- **EXCELLENCE IN PLAY**: Hobbies, interests
- **SPIRITUALITY**: In the broad sense of finding meaning and purpose in life
Secondary Goods

- Secondary goods \(\rightarrow\) provide concrete means of securing primary goods

- Secondary Goods can be achieved using CBT techniques
GLM Treatment Approach

- Motivational enhancement approach/techniques
- Skills-oriented (cognitive, behavioral, emotional)
- Alter problematic patterns of affect, cognition, behavior
- Development of pro-social/non-offending attitudes and beliefs
- Structured but individualized
- Develop a Good Lives Plan
GLM

- McGrath (2009) survey showed 33% of treatment programs in US and 50% in Canada use GLM model

- How many familiar with GLM?

- How many are currently using GLM?
  - Using GLM client workbooks?
  - Using GLM individually?
  - Using GLM in groups?
### Table 4. Examples of GLM Consistent and Inconsistent Practices.

<table>
<thead>
<tr>
<th>Program Domain</th>
<th>Consistent With the GLM</th>
<th>Inconsistent With the GLM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program aims and orientation</td>
<td>• Clear communication of the dual aims of risk reduction and well-being enhancement</td>
<td>• Avoidant-goal oriented treatment contracts</td>
</tr>
<tr>
<td>Assessment</td>
<td>• Comprehensive assessment practices canvassing a range of GLM primary goods</td>
<td>• Minimal assessing of clients’ prioritized goods</td>
</tr>
<tr>
<td>Intervention planning</td>
<td>• Individualized treatment/intervention plans for each client</td>
<td>• No routine structured assessment of dynamic risk factors</td>
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<tr>
<td>Program content</td>
<td>• Self management plans incorporating the GLM</td>
<td>• Generic treatment plans</td>
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<tr>
<td></td>
<td>• GLM-based assignments</td>
<td>• No formal treatment plans</td>
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<td></td>
<td>• Linking program modules to attainment of primary goods</td>
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<tr>
<td>Program delivery</td>
<td>• Positive therapist characteristics</td>
<td>• Overly heavy emphasis on accepting responsibility for offending</td>
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<td></td>
<td>• Collaboration with clients</td>
<td>• Overly heavy emphasis on RP</td>
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<td>• Attention to individual client goals</td>
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<td>• Rigid use of manuals</td>
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<td>• Classroom-style delivery</td>
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<td>• Displays of confrontation</td>
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GLM Criticisms

- No treatment outcome data
- Overly complex/Confusing
- Not Mutually Exclusive from RNR
- Ignores Risk Factors
- Doesn’t take into account US Sex Offenders Laws
<table>
<thead>
<tr>
<th><strong>RNR</strong></th>
<th><strong>GLM</strong></th>
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<tbody>
<tr>
<td>Most data</td>
<td>Increases motivation/clients like it</td>
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<tr>
<td>Important to assess risk</td>
<td>More in line with field in general → strengths based approaches</td>
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<tr>
<td>Identifies treatment targets</td>
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</table>
SO, WHERE DOES THAT LEAVE US?
New Frontiers – Strengths Based Approaches
Strengths Based Approaches
Look to the General Psychology Literature
- Positive Psychology
- Resilience
- Protective Factors
Positive Psychology

- The field of Positive psychology was introduced in 2000 by Martin Seligman and Mihaly Csikszentmihalyi.

- Shift away from the disease or deficit model of human functioning which has dominated the field of psychology since World War II.

- Instead of emphasizing psychopathology, positive psychology focuses on the human prospering and helping individuals live happier.
Positive Psychology

- Pathology
- Illness
- Neurosis
- Life Sucks
- What is Wrong with You?
- Is This All There Is...
- Life Satisfaction
- What is Right with You?
- Well-Being
- Positive Emotions
- Engagement
- Relationships
- Meaning
- Accomplishments

TRADITIONAL PSYCHOLOGY  →  POSITIVE PSYCHOLOGY

3x + 10
\[ \sqrt{5 - x} \]
Positive Psychology - Outcome

- **Meta-analysis:**
  - Interventions using strengths based approaches showed small to medium effect sizes for:
    - subjective well-being
    - psychological well-being
    - depression indicating

- These effects observed at follow-up (3-6 months) – suggesting gains are sustainable
Resilience

“Success is not final, failure is not fatal: it is the courage to continue that counts.”

Winston Churchill

When you bend with the wind but don’t break in the storm.
What is Resilience?

Dimensions of Resilience

- Physical
  - Physical flexibility
  - Endurance
  - Strength
  - Vitality

- Emotional
  - Emotional range and flexibility
  - Positive feelings
  - Self-regulation
  - Relationships
  - Ease instead of resistance

- Mental
  - Mental flexibility
  - Attention span
  - Optimistic world view
  - Incorporating multiple points of view

Coherence
Resilience - Outcomes

- **Meta-analyses**
  - Prevention
  - CBT
  - Decrease in mental health symptoms

- **At risk youth**
  - Decreases in delinquency
Protective Factors

- Used to estimate risk
- Build on protective factors to prevent reoffending
- Focus on strengths

**Risk Factors**
Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

**Protective Factors**
Protective factors are characteristics associated with a lower likelihood of negative outcomes or that reduce a risk factor's impact. Protective factors may be seen as positive countering events.
Proposed Protective Domains for Those who Sexually Offend (Vries Robbe et al., 2015)

1. Healthy Sexual Interests
2. Capacity for Emotional Intimacy
3. Constructive Social and Professional support network
4. Goal Directed Living
5. Good problem solving
6. Engaged in work or constructive leisure
7. Sobriety
8. Hopeful, optimistic and motivated attitude
Challenges

- How to integrate strengths based approaches?
  - In assessment
  - In treatment
  - In release planning

- How to make the clients understand?

- How to integrate with laws/legislation?
How are you Applying these Models in Practice?
Integrating Strengths Based Approaches into CBT with those who Sexually Offend

- Program Framework
- Therapist/client behaviors
- The Practical Part
  - Assessment
  - Treatment
  - Release Planning
Program Framework

- Communicate goals of program throughout treatment
  - Dual aim – reduce risk and promote well-being
  - Include in all written material/therapy workbooks/consent forms
  - Program materials focus on approach rather than avoidance goals i.e. coping versus avoiding

- Holistic Focus
  - Focus on both criminogenic and noncriminogenic needs
  - Living a “healthy life”
Program Framework

- Treatment targets linked to promotion of primary goods
  - i.e. problem solving, coping skills training, affect regulation, mindfulness
Therapist/Client Behaviors

- Therapists approach residents as fellow human beings ➔ equal intrinsic value

- Language conveys respect

- Focus on behaviors related to Therapeutic Alliance
  - Warmth
  - Empathy
  - Praise
  - Some directedness
  - No confrontation
Therapist/Client Behaviors

- **Language promotes change**
  - Approach versus avoidance language – “what could you do differently next time?” – versus – “what should you not do”.

- **Encourage positive reinforcement**

- **Be collaborative**
  - Clients involved in treatment planning

- **Be transparent**
  - Discuss assessments/test/risk assessments with residents
Assessment

- Static and Dynamic Factors Assessed
  - Static-99R/Stable-2007/ LSI-R

- Clients Primary Goods/Strengths are identified and assessed:
  - Semi-structured interview (Yates, Kingston & Ward, 2009)
  - Identify the Level of Importance for client of each primary good.
  - Checklist
    - Internal/External Strengths and Barriers
    - Relationship to Offending
  - Protective/Resilience Factors (Vries Robbe e al., 2015)
    - Structured Assessment of Protective Factors SAPROF-SO
Assessment

- Assessment should address a number of different issues with respect to each human good/strength:
  - What does the good mean to the individual?
  - How important is it to him?
  - Has his view of its importance changed over time (e.g., is it more important currently than previously)?
  - How has the individual tried to achieve this in his life? Which strategies have worked the best? Which have worked least well?
  - Would he like to have more of this in his life?
  - What has prevented him from achieving this in his life?
<table>
<thead>
<tr>
<th>Goods</th>
<th>Rank (1-11)</th>
<th>Inner Strength</th>
<th>Inner Barrier</th>
<th>External Strength</th>
<th>External Barrier</th>
<th>Means (appropriate or not)</th>
<th>Relationship to Offending</th>
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Treatment Planning

- Based upon assessment → Individualized treatment plans are developed:
  - Weighted on achievement of primary goods
    - Focus on prosocial attainment of clients primary goods
    - Building on strengths
    - Developing resiliency
    - Approach versus avoidance goals
  - Balanced Life Exercise
Balanced Life Exercise

1. ________________

8. ________________

7. ________________

6. ________________

5. ________________

4. ________________

3. ________________

2. ________________
Integrating Strengths Based Approaches into CBT
Strengths Based Approaches and CBT

- Treatment is seen as an activity that should *add to* an offenders’ skills

- **NOT** as an intervention that *removes* a problem or is devoted to *managing* problems

- A lifetime of restricting activity is **NOT** the only way to avoid offending.

- Thus standard CBT interventions are wrapped around pursuit of personal goals in way that promotes well-being and reduces risk
Strengths Based Approaches and CBT

- Treatment/intervention is therefore seen as an activity that should *add to* an offender’s repertoire of personal functioning,

- NOT an activity that simply *removes* a problem or is devoted to *managing* problems

- A lifetime of restricting one’s activity is the only way to avoid offending.

- Thus standard SO CBT interventions are wrapped around pursuit of personal goals in way that promotes well-being and reduces risk.
Integrating Evidence Based Practice

- Dialectical Behavior Therapy (DCT)
- Motivational Interviewing
- Mindfulness
- Trauma Informed Care
Goal: Life

- **Definition**
  - Healthy living and functioning
  - Basic needs

- **How to Achieve this:**
  - Acquiring income to meet basic needs
  - Physical activity
  - Healthy nutrition
  - Health care
  - Physical survival

- **Problem Solving/ Psychoeducation/ Pros & Cons**
Goal: Learning and Knowing

Definition
- Desire for information and understanding about oneself and the world

How to Achieve this:
- Attending school, training, vocational courses
- Self-study, informal activities
- Attending treatment, self-help activity

Psychoeducation, time-management, listing goals
Goal: Being Good at Play and Work

- **Definition**
  - Mastery in work and leisure

- **How to Achieve this:**
  - Participation in sports
  - Participation in other leisure/recreational activities, hobbies
  - Participation in training, certification, apprenticeships

- **Brainstorming, goal setting, time management**
Goal: Personal Choice and Independence

- **Definition**
  - Desire for independence, autonomy, choice
  - Desire to formulate own goals

- **How to Achieve this:**
  - Formulates and implements plans to achieve a specific end or objective
  - Engages in activities to ensure self-sufficiency
  - Asserts self and needs with others, communicates needs and desires to others

- **Goal setting, communication training, assertiveness training** ([Dear Man]), cognitive restructuring
Goal: Peace of Mind

• Definition
  ○ Emotion regulation, equilibrium
  ○ Freedom from emotional turmoil and stress

• How to Achieve this:
  ○ Strategies, specific activities to minimize emotional distress/achieve equilibrium (e.g., exercise, meditation)
  ○ Strategies to manage impulsivity
  ○ Manage Substance abuse/ Harmful sexual impulses

• Affective Regulation, Mindfulness, Pros & Cons
Goal: Relationships and Friendships

- **Definition**
  - Desire to establish bonds with others
  - Intimate, romantic, family relationships

- **How to Achieve this:**
  - Engages in social or other activities that facilitate meeting new people and maintaining relationships
  - Spends time with friends
  - Gives and receives support (e.g., emotional, practical)
  - Intimate relationships

- **Social Skills training, use of social support, communication training**
Goal: Finding Community

- **Definition**
  - Desire to be connected to similar social groups

- **How to Achieve this:**
  - Participates in community activities (e.g., social service groups, special interest groups)
  - Participates in volunteer activities, groups
  - Membership in groups sharing common interests, values, concerns
  - Provides practical assistance to others in times of need (e.g., neighbors)

- **Social Skills training, Use of Social Support, Brainstorming**
Goal: Spirituality/Having Meaning in Life

- **Definition:**
  - Desire for meaning and purpose in life
  - Sense that is part of larger whole

- **How to Achieve this:**
  - Attends formal religious/spiritual events (e.g., church)
  - Participates in activities such as meditation/prayer
  - Involved in spiritual community/group
  - Studies/reads spiritual materials

- **Self Reflection, Mindfulness, Psychoeducation**
Goal: Happiness

- **Definition**
  - State of being of overall experience of contentedness in one’s life
  - Pleasure in life

- **How to Achieve this:**
  - Activities that result in sense of satisfaction, contentment, fulfillment
  - Activities that result in sense of pleasure (e.g., leisure activities, sports, sex)
  - Activities intended to achieve sense of purpose, direction in life (e.g., work, friendships, family)
  - Attends treatment, self-help activities

- **Problem solving, Cognitive Restructuring, Activity Scheduling**
Integrating Strengths Based Approaches into CBT

- Includes standard treatment components and exercises
  - E.g., cognition, relationships, sexual interests, self-regulation, etc.
- Is motivational, positive, collaborative
- Builds on clients’ strengths
- Lots of rehearsal (not just insight!)
- Results in good life/self-regulation plan (risk management; alternative to RP plan)
Integrating Strengths Based Approaches into CBT

- Motivational enhancement approach/techniques
- Skills-oriented (cognitive, behavioral, emotional)
- Alter problematic patterns of affect, cognition, behavior
- Development of pro-social/non-offending attitudes and beliefs
- Structured but individualized
- Within GLM/SM framework = good lives and risk management
Integrating Strengths Based Approaches into CBT

- Treatment addresses raising awareness and building skills re: dynamic risk factors
- Deviant sexual interest/preference
- Antisocial orientation
- General self-regulation
- Sexual self-regulation
- Offence-supportive attitudes/schemas
- Significant social influences
- Intimacy deficits
- Emotion regulation
Integrating Strengths Based Approaches into CBT

- Reinforce important goods/goals
- Reinforce & develop positive approach goals
- Develop appropriate means to attain goods/goals
- Assist to overcome flaws/skills development
- Develop risk management skills
- Develop self-regulation skills
- Develop good life/self management plan
Integrating Strengths Based Approaches into CBT

- Start with clients’ goals – what do they want to get out of life? What goals did they have at different life stages that they would like to have again?
- Personal identity – how do they see themselves and how/who they would like to be?
- Frame treatment and supervision in approach goals rather than avoidance goals (positive goals)
- Address flaws in good life plan that lead to problems in life
- Address flaws in good life plan that lead to offending
Integrating Strengths Based Approaches into CBT

- Pre-/Post-Treatment Assessment
- Pre-Treatment Individual Sessions
- Comprehensive Case Formulation
- Introduction to Treatment & Good Lives
- Offence Progression
- Specific Treatment Targets Based on Assessed Risk Factors
- Integrated Good Life/Risk Management Plan
- Maintenance/Follow-up/Supervision
Pre-treatment

- Pre-/Post-Treatment Assessment:
  - Risk assessment
  - GLM assessment
  - (SRM assessment/offence pathway)

- Pre-Treatment Individual Sessions
  - Goals of treatment (good lives, risk management)
  - Individual mutual goal-setting
  - Begin work on motivational enhancement

- Development of comprehensive case conceptualization & treatment plan
Pre-treatment

- Comprehensive Case Formulation:
- Foundation of treatment and supervision/maintenance plans & activities
- Detection of clinical phenomena implicated in sexual offending
  - Responsivity characteristics/needs
  - Specific needs (e.g., intellectual functioning, mental health needs)
  - Strengths/capabilities
  - Understanding of social, personal, interpersonal, cultural, environmental contexts in which person will be living
- Function/purpose of offending for the individual
- Identification of context/environment in which individual will be living
Introduction to Treatment

- Purpose of treatment (good lives, risk management)
- What will be gained in treatment – benefits to participants
- Expectations, fears
- Collaborative setting of group rules
- Continue work on motivational enhancement
Introduction to Treatment

- Concept of good life plan (their roadmap)
- Concept of goods/common life goals (primary goods)
- Attaining primary goods (secondary/instrumental goods)
- Flaws attaining primary goods
- Introduce notion of links between goods, flaws and offending/risk factors
- Can use “homework assignments” if needed or discuss in group sessions
Good Lives Plan

- Replaces RP Plan
- Individual’s “plan for living”
- Also risk management plan
- What are my important goals?
  - Goals for living
- How will I get these (step-by-step)?
  - Approach activities
  - Specific secondary goods
  - Self-regulation
Good Lives Plan

- Includes all goods important to individual
  - Sufficient scope
- Includes non-offending, practical ways to attain goods/goals
- Includes strategies to address flaws
- Includes links between goods & offending, risk factors
Good Lives Plan

- Indicators that plan is being implemented
  - To self
  - To others

- Indicators of not attaining goods
  - What will I do if I don’t get these?
  - What is link to risk?
  - What is link to self-regulation failure?
  - Action plan

- Indicators that flaws in plan are re-emerging
  - What is link to risk?
  - Action plan

- Risk management plan
Integrating Treatment Targets

- Integration with standard treatment targets
- Reinforcement of learning and skills
- Rehearsal
- Approach goals vs. avoidance goals
- Frame all targets in approach goals (though include risk management/ avoidance goals where required)
  
  E.g., having healthy relationships vs. avoiding problematic/risky relationships
  
  E.g., having good (non-offending) sexual activity vs. controlling arousal
  
  E.g., achieving emotional balance vs. managing emotions in situation
Case Examples
Case Example: Scott

Scott is a 52-year-old offender convicted for downloading child pornography. Scott’s original victim was a 12-year-old girl who was Scott’s neighbor whose family Scott knew very well. At the time of the offence, Scott was participating in sex offender maintenance treatment and, up to that time, had been doing very well. Scott had learned to accept his sexual attraction to pubescent girls and to manage his risk and avoid children. However, to his most recent offense, Scott was rejected by a potential lover, was feeling lonely and depressed, and had not yet found a job following his conviction (he is trained and had worked as a physical therapist for 20 years). Scott was feeling worthless and disconnected from his family and friends as they all but abandoned him once they found out what he did. He used to coach softball and participated in church, but because of residence restrictions, Scott can’t do many of these activities. Because he felt hopeless he stopped caring about what happened to him and he succumbed to his urges and started looking at underage pornography.
Scott’s Plan – Relapse Prevention

- Develop coping skills (rejection, loneliness, etc.)
- Limit activities to restrict access to potential victims/internet
- Teach to get out of high risk situations
- Sexual arousal reconditioning/management
Scott’s Plan – Integrated GLM

- Reinforce goal to avoid offending
- Build identity that he is worthwhile
- Motivate to implement previous treatment plan
- Develop new means to achieve primary goods (peace of mind, relationships/intimacy, community)
- Build internal capacity:
  - Ongoing emotional equilibrium (peace of mind)
  - Self-regulation skills (problem-solving, emotion regulation, sexual self-regulation)
  - Skills to attain and maintain relationships
Scott’s Plan – Integrated GLM

- **Build external capacity:**
  - Assist to find acceptable employment
  - Assist to connect to community and social network (i.e. other released offenders)
  - Assist to re-connect safely to church community
  - Assist to re-connect with family (if desired)
  - Assist to find acceptable partner
Example - Frank

- Frank is a 35-year-old offender with a long history of sexual abuse of teenaged girls. Frank has worked as a lifeguard and has worked in community swimming pools since he was 16. Although he takes significant pride in his work, Frank admits that his work provided him with the opportunity to meet “lots of hot young girls” who, he said, were easy targets. He knew how to pick out the shy and insecure ones that would feel flattered by the attention of an older, more mature male. Frank made friends with these girls, pay them compliments, text them and bought them small pieces of jewellery. He reports that, in each instance, the girls engaged in “consensual” sexual activity with him as they viewed him as their boyfriend. Frank has never been married and isn’t interested in being weighed down by a “ball and chain” – he likes being with insecure young girls as they are not assertive and “demanding” like women his age can be.
Frank’s Plan - RP

- Limit activities to restrict access to potential victims
- Quit job?
- Teach to get out of high risk situations
- Change cognitive distortions
- Develop victim awareness/empathy
- Develop coping skills
Frank’s Plan – Integrated GLM

- Develop avoidance goal re: offending
- Expand scope of good life plan – what else would help him achieve autonomy, happiness – and develop skills/alternate means to get these
- Alternate means to establish satisfying relationships
- New job to continue to attain excellence/mastery in work
Frank’s Plan – Integrated GLM

- Understand source of cognitive schema and alter
- Risk management plan:
  - Plan to manage risk situations
- Supervision:
  - Monitoring stable and acute risk, victim access
  - Monitor implementation of good life plan (e.g., appropriate relationships, new activities in plan)
Questions/Comments

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