THE GOOD LIVES MODEL WITH JUSTICE-INVOLVED WOMEN

Dawn Pflugradt, Bradley Allen, and David Prescott

Don’t Worry

- We won’t call on you for answers
- We won’t ask you to role play
- We won’t put too much research into each slide

  Maybe some lighthearted profanity, though…

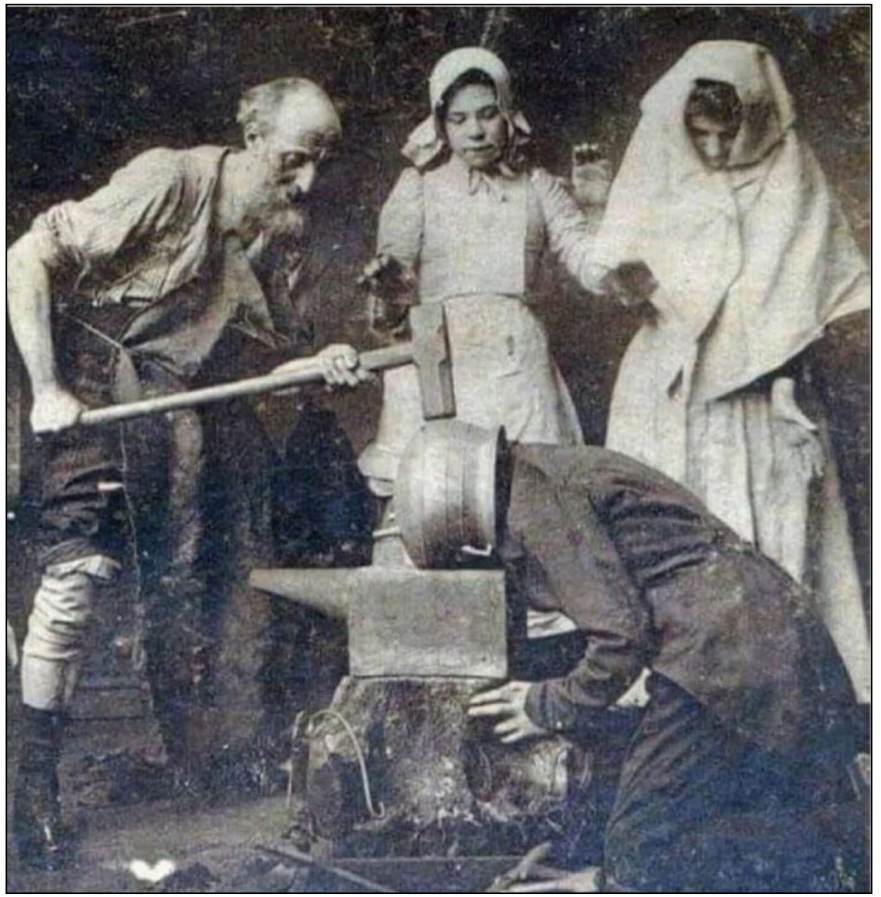
This natural masterpiece is cared for by the Auckland Regional Council

GRATITUDE!

GRATITUDE!

HISTORICAL
CONTEXT

1895-1985



CURRENTLY ON
EXIT 58A-B
95
1
Zoloft
9
Prozac
Paxil
LAST EXIT BEFORE TOLL
Buspar
Wellbutrin
Celexa
Xanax

It has been well established over the years that punishment temporarily suppresses behavior thereby appearing that it has changed. However, once the punishment is removed the behavior typically rebounds/reoccurs

Ultimately:

- By the most rigorous/conservative standards:
- Punishment doesn't reduce risk
- Punishment = punishment
- Treatment can work
- Treatment can be better with the right community supervision

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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

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?

Newsweek
THE U.S. EMBASSY BOMBINGS
Gay for Life?
Going Straight: The Uproar Over Sexual 'Conversion'

Questions

- Under what conditions is it acceptable to “change” any part of someone’s sexuality?
  - When do we know that treatment is with or against their will?

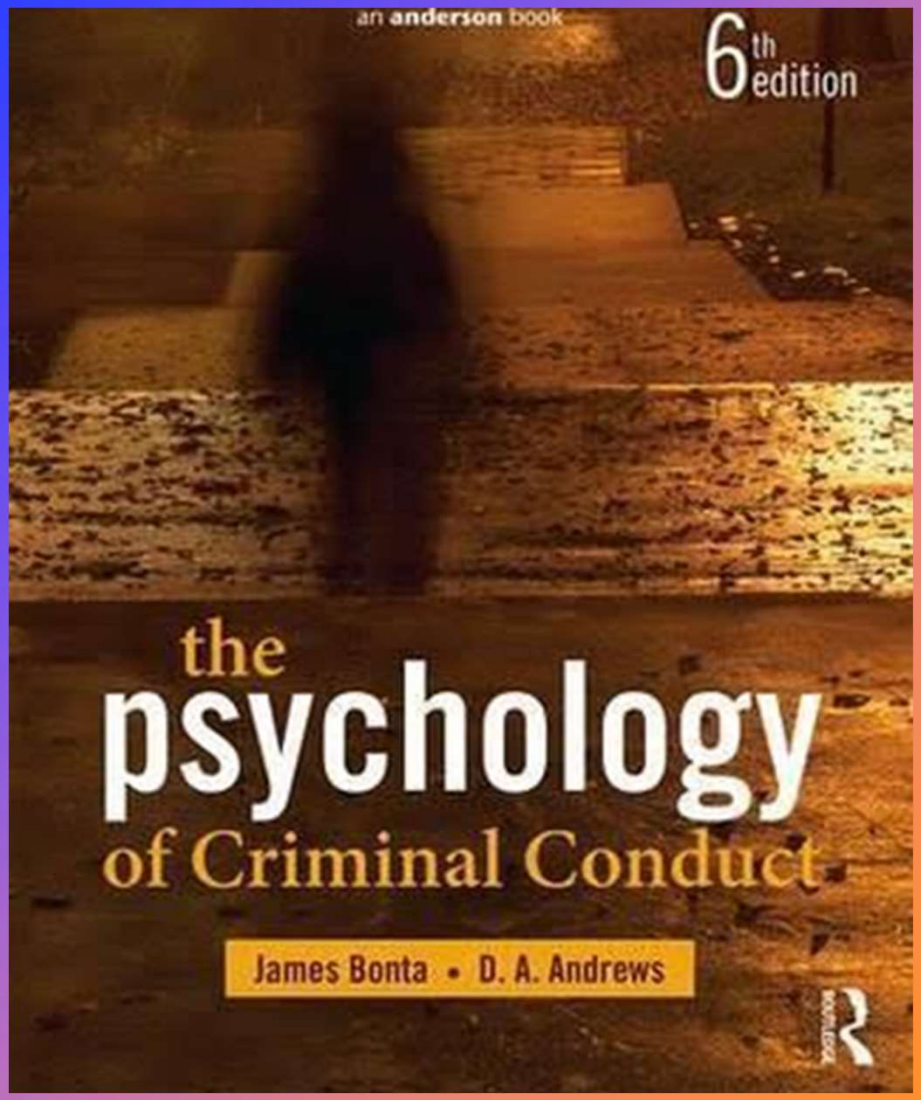
- We likely can’t change what someone wants
- We can change how someone behaves around what they want
- Collaboration and the therapeutic alliance are key
  - Service user voice is critical throughout treatment

1979: Edward S. Bordin

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

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

IDEALLY



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

01

Risk: Match level of services to level of risk

02

Need: Target dynamic risk factors/criminogenic needs

03

Responsivity: Use empirically supported approaches; also specific responsivity

RNR with Women Who Perpetrate Sexual Offenses

- The most current research on female perpetrated criminal offenses has shown that women are generally low risk to re-offend sexually but at higher risk to commit other offenses (e.g., violent offenses, property crimes) (Cortoni et al., 2010; Vandiver et al., 2018).
- That is, the basic premise of the RNR principles is that interventions should be matched with an individual's risk and needs; those who are at the highest risk of recidivism receive the most resources (Bonta & Andrews, 2017). Given that women who commit sexual offenses are at higher risk to commit other nonsexual offenses, they would likely benefit from treatment that addresses general criminogenic factors/characteristics. We must remember that we can take what we know about women who commit crimes and apply it to women who perpetrate sexual offenses.

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

- ASSESS AND CLASSIFY CLIENTS ACCORDING TO RISK
- ASSESS TREATMENT NEEDS
- ASSESS PROTECTIVE FACTORS
- CONDUCT COMPREHENSIVE ASSESSMENT TO DEVELOP UNDERSTANDING OF SPECIFIC RESPONSIVITY
- DEVELOP UNDERSTANDING OF THE NARRATIVE UNDERLYING RISKS, NEEDS, AND RESPONSIVITY FACTORS
- FORMULATE INITIAL HYPOTHESES ABOUT HOW RISK/NEED FACTORS MAP ONTO THE GOOD LIVES MODEL GOALS THAT WE WILL EXPLORE IN DEPTH

Gendered Theory

For women, we endorse programs that align with gendered theory.

Research shows us that gender responsive programs work better than gender neutral programs.

Women who perpetrate sexual offenses should be viewed from a gendered perspective (as opposed to a gender neutral or gender specific perspective).

As delineated by Steffensmeier and Allan (1996), the influence of gender on criminal behavior may be generally conceptualized from three main theoretical perspectives: gender-neutral; gender-specific; and gendered.

Gendered Approach

- ***Gender-neutral*** theories are derived from samples of male offenders that are then applied to females. Male and females who commit sexually motivated offenses share some common characteristics such as histories of adverse childhood experiences, difficulties with relationships, antisocial attitudes, antisocial associates and substance abuse (Cortoni, 2010; Cortoni & Gannon, 2011; Freeman & Sandler, 2008; Gannon et al., 2008; Van Voorhis et al., 2010)

Gendered Approach

Despite these similarities, however, there are important differences between male and females.

Some researchers have suggested that ***gender-specific*** models are more appropriate because they do not assume that the dynamic factors associated with female sex offending are the same as those that apply to males (Cortoni & Gannon, 2010; 2011).

The life experiences of women are unique and manifested differently compared to males (Cortoni & Gannon, 2010; 2011; Gannon et al., 2008).

Gendered Approach

Steffensmeier and Allan (1996) proposed a gendered theory of female offending behavior. Gendered theories do not assume that causal patterns for female criminality are either the same or distinct from those for identified for men. Rather, gendered theories consider how gender in combination with differing life experiences influence the behavioral manifestations of criminal behavior.

Thus, the gendered perspective considers the unique life experiences of women who commit sexual offenses, how these experiences influenced or were associated with dysfunctional relationships/ criminal behaviors, the association between offender's criminogenic/ relational characteristics and manifestation of sexually assaultive behaviors and the relevant social/contextual factors. *It also takes into consideration how the individual perceives their gender.

A Gendered Perspective Should:

- Explain how social norms, identities, arrangements, institutions and relationships transform gender into something physically and socially different;
- Account for gender differences in type and frequency of crime as well as differences in the context of offending;
- Consider the ways in which the pathways to crime for women differ from those of men;
- Explore the extent to which gender differences in crime derive not only from social, historical, and cultural factors but also from biological and reproductive differences.

A Gendered Perspective Considers:

- It is not possible to separate offense factors or behavioral manifestations from the social context (Pflugradt & Cortoni, 2014).
- Relational factors are a major component when looking at offending behaviors in females.

Gendered Approach

- As proposed by the presenters in various other forums, the most comprehensive and integrated treatment model for women who commit sexual offenses includes a gendered, strength-based approach that also considers social and contextual dynamics.

What Works to Reduce Re-offending?

- 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)

Note: Treatment Provider Characteristics

Given the highly contextual and relational nature of female offending, it is hypothesized that clinician characteristics will directly relate to treatment outcome.

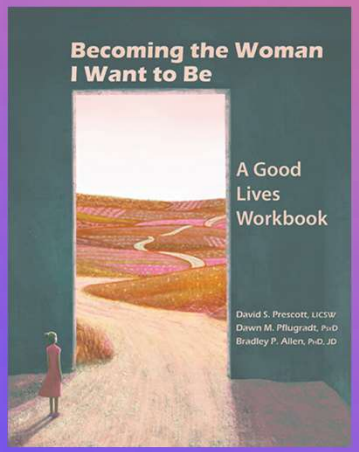
Clinicians providing treatment to women should display warmth, empathy, and be non-judgmental. They should also model pro-social behavior as well as display genuineness.

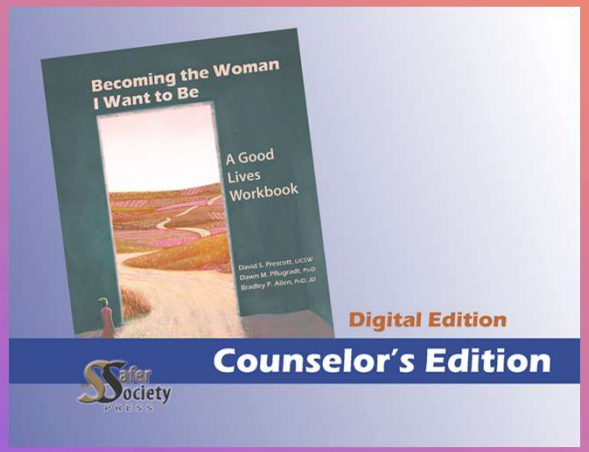
Many women have had negative experiences with men. We have found that by having male and female co-facilitators, a new experience with males can be provided within a safe context.

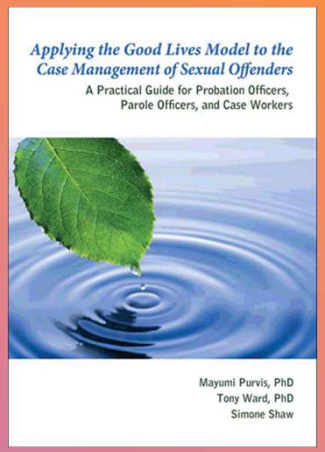
Treatment Provider Characteristics that Inhibit Effectiveness

- Confrontational
- Sarcastic/Rejecting/Not Genuine
- Angry/Aggressive and/or Dismissive
- Discomfort with Silence
- Problems with Boundaries

GOOD LIVES MODEL AND CORE PRINCIPLES







GOOD LIVES WITH ADULT WOMEN

The Good Lives Model (GLM)

- "…[our clients] want better lives, not simply the promise of less harmful ones" (Ward, Mann, & Gannon, 2006)

- “Because of how I was raised, 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 my counselor asked me what I wanted to be I had no idea.”
    - 23-year-old women recently released to the community after serving time for a sexually motivated offense

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

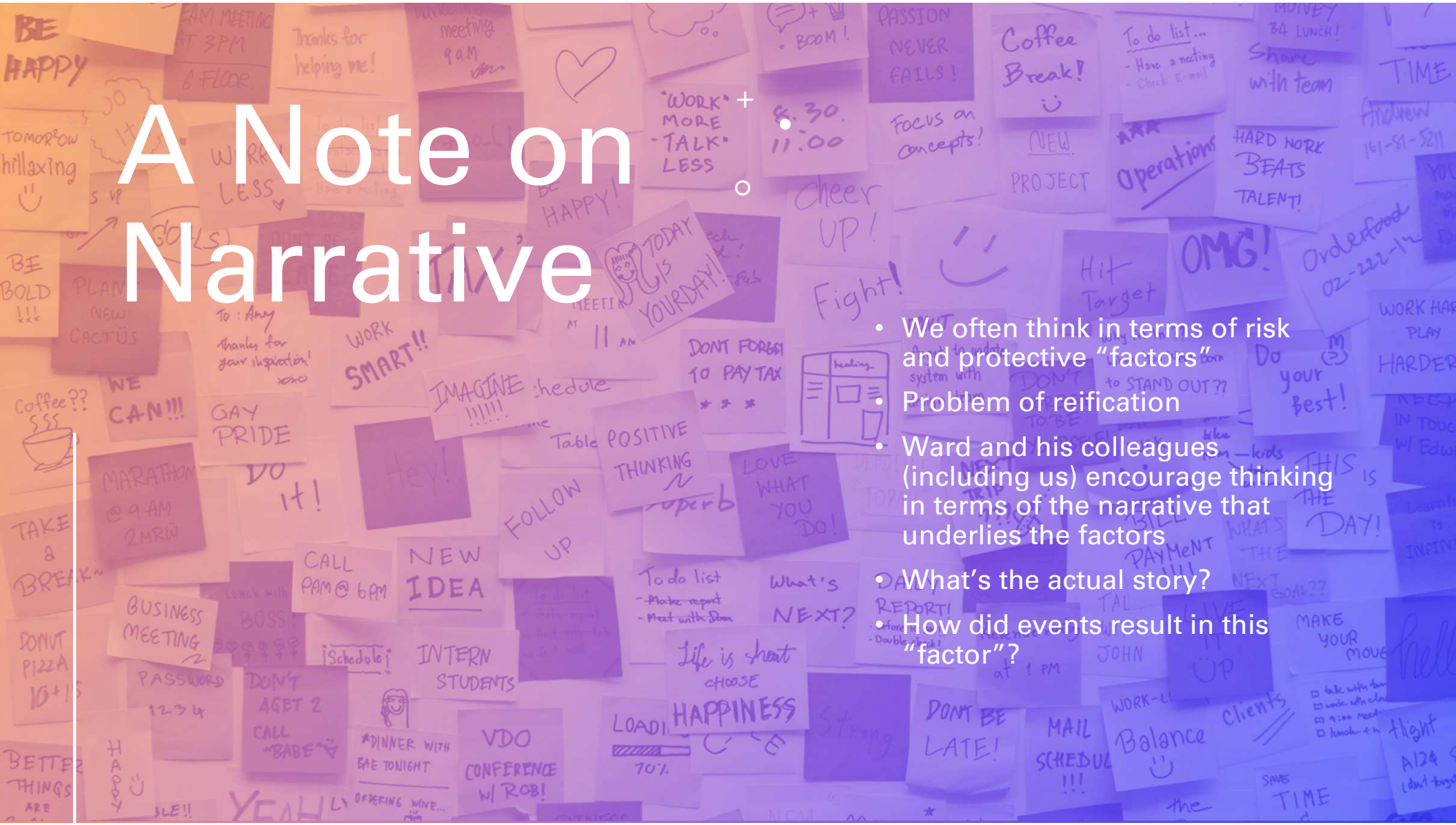
- Offending relates to the pursuit of legitimate goals via harmful, maladaptive means
- All human beings are goal-directed and predisposed to seek primary human goods
- Primary human goods = actions, experiences, circumstances, states of being, etc., that individuals seek to attain for their own sake

GLM Approach

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

- Dynamic risk factors (i.e., treatment need areas)= 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 as Common Life Goals

(Yates & Prescott, 2011)

Primary Good	→	**Common Life Goal**
Life	→	Life: Living and Surviving
Knowledge	→	Knowledge: Learning and Knowing
Excellence in Work & Play	→	Being Good at Work & Play
Excellence in Agency	→	Personal Choice and Independence
Inner Peace	→	Peace of Mind
Friendship/Relatedness	→	Relationships and Friendships
Community	→	Community: Being Part of a Group
Spirituality	→	Spirituality: Having Meaning in Life
Happiness	→	Happiness (Content, Fulfillment)
Creativity	→	Creativity

Primary Goods: Definitions

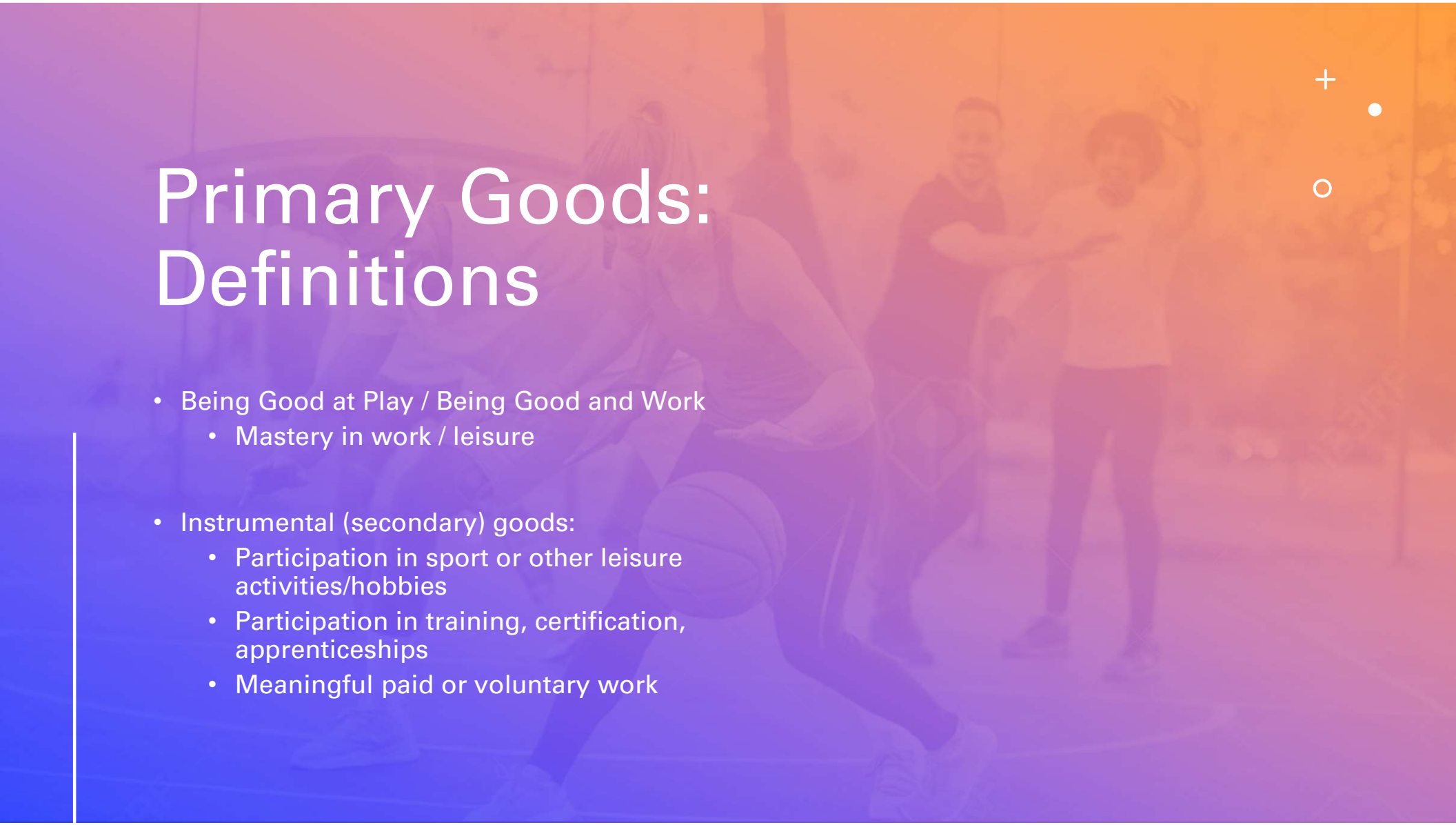
- Life: Living & Surviving
  - Healthy living and functioning
  - Basic survival needs

- 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

- Being Good at Play / Being Good and Work
  - Mastery in work / leisure

- Instrumental (secondary) goods:
  - Participation in sport or other leisure activities/hobbies
  - Participation in training, certification, apprenticeships
  - Meaningful paid or voluntary work

Primary Goods: Definitions

- 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 (Very Important for Women)

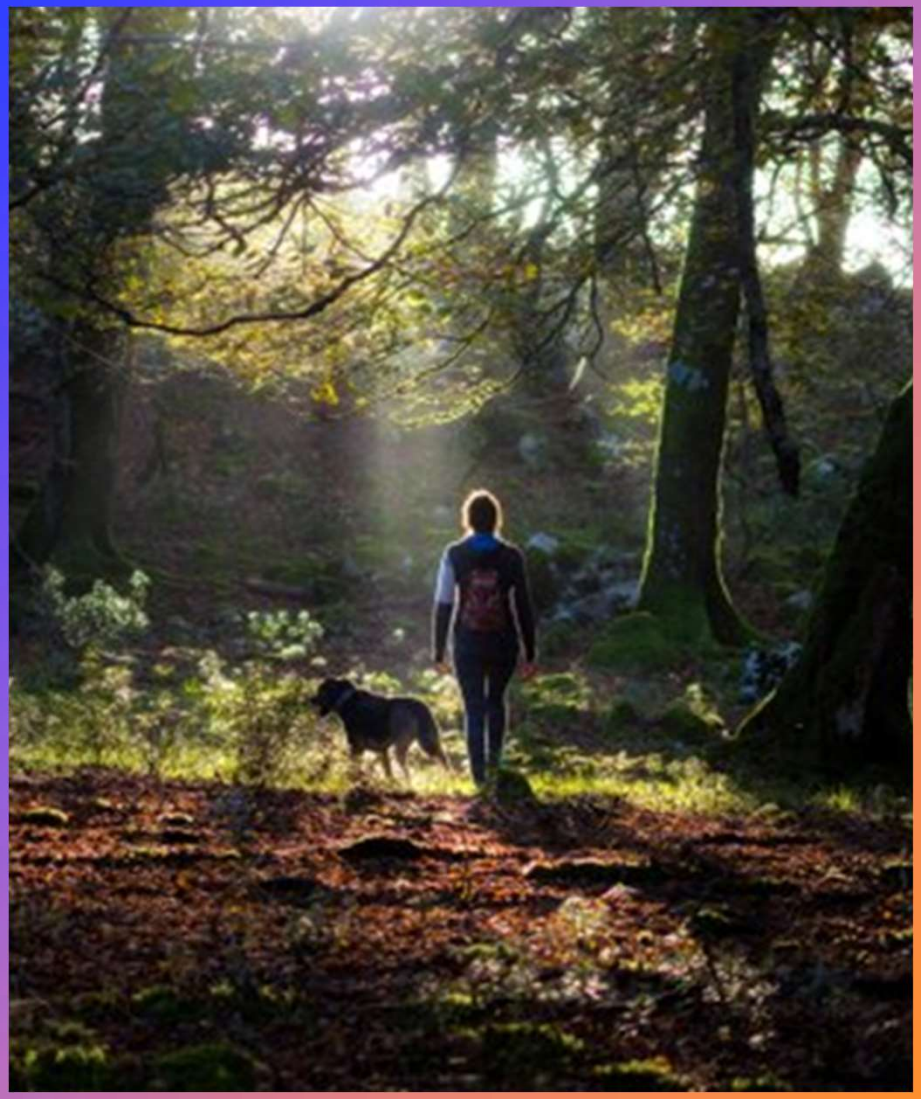
- Relationships and Friendships
  - Desire to establish bonds with others; includes intimate, romantic and family relationships

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

Primary Goods: Definitions (Very Important for Women)

- Community: Being Part of a Group
  - Desire to be connected to similar social groups

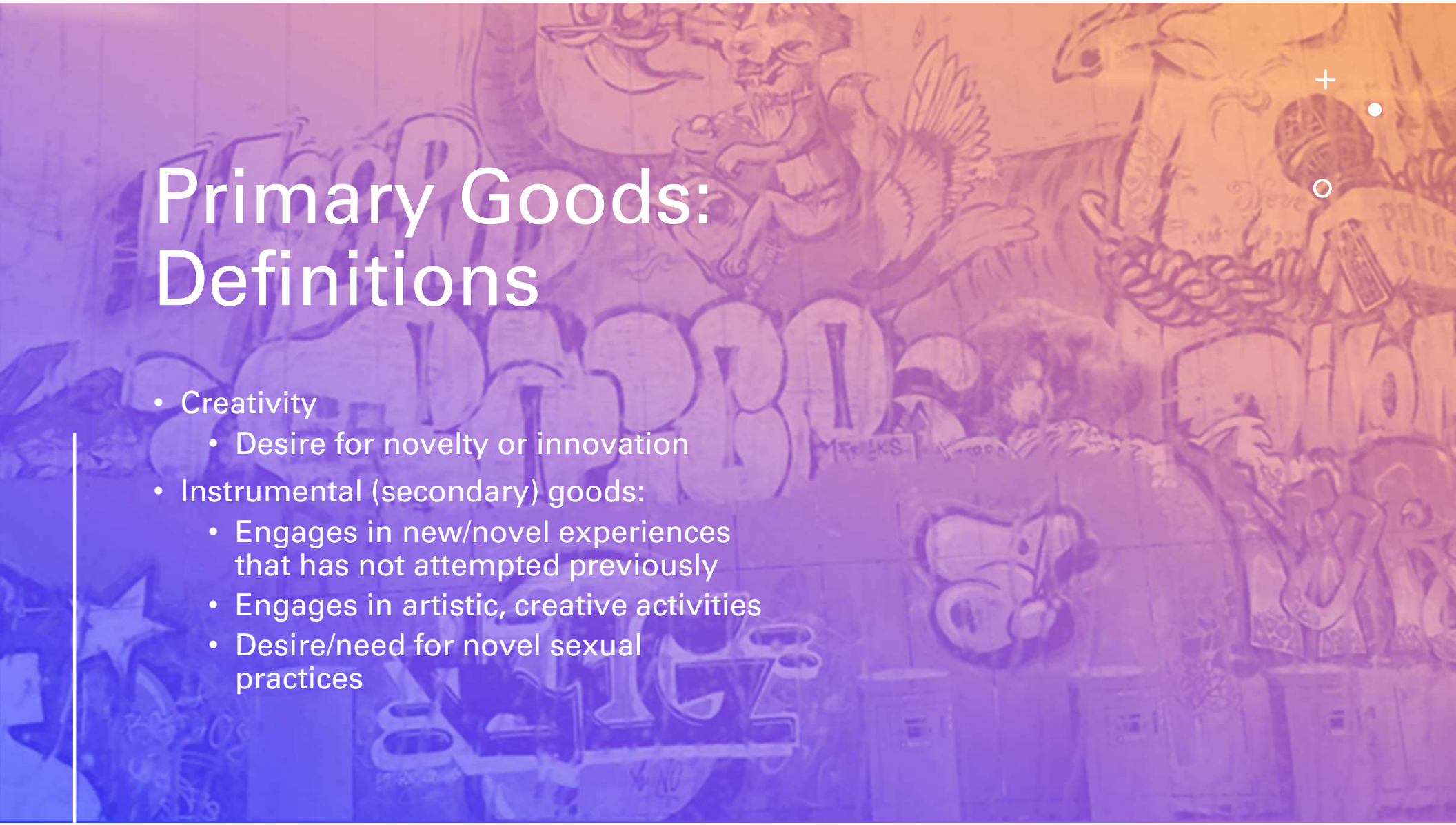
- Instrumental (secondary) goods:
  - Participate in community activities (e.g., social service groups, special interest groups)
  - Participate in volunteer activities, groups
  - Membership in groups sharing common interests, values, concerns
  - Provide practical assistance to others in times of need (e.g., neighbors)



Primary Goods: Definitions

- Spirituality: Having Meaning in Life
  - 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
  - Forest bathing



Primary Goods: Definitions

- Creativity
  - Desire for novelty or innovation
- Instrumental (secondary) goods:
  - Engages in new/novel experiences that has not attempted previously
  - Engages in artistic, creative activities
  - Desire/need for novel sexual practices

Primary Goods: Definitions

- Happiness
  - State of 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)
  - Activities intended to achieve sense of purpose, direction in life (e.g., work, friendships, family)

Primary Human Goods as Common Life Goals

(Yates & Prescott, 2011)

Primary Good	→	**Common Life Goal**
Life	→	Life: Living and Surviving
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Creativity	→	Creativity

Case Example

- Christina is a 28-year-old female imprisoned for taking sexually explicit photos of female children that she was babysitting. She took the photos at the request of her boyfriend, Shawn. In each instance, she was a trusted babysitter. She described her offending as a desire to please her boyfriend and as a way to keep him interested in their relationship. Other than her relationship with Shawn, she was fairly isolated and also enjoyed the company of the children she was babysitting. Babysitting was also a way for her to make money so she could save to take classes at the community college.

Christina's prioritized primary human goods

Primary goods Important to Christina:

- Relationships & Friendships
- Happiness
- Knowledge

Primary goods implicated in offending:

- Relationships & Friendships
- Other?

Question?

- What might have obstructed Christina from seeking valued primary goods in prosocial, adaptive ways?

Case Example

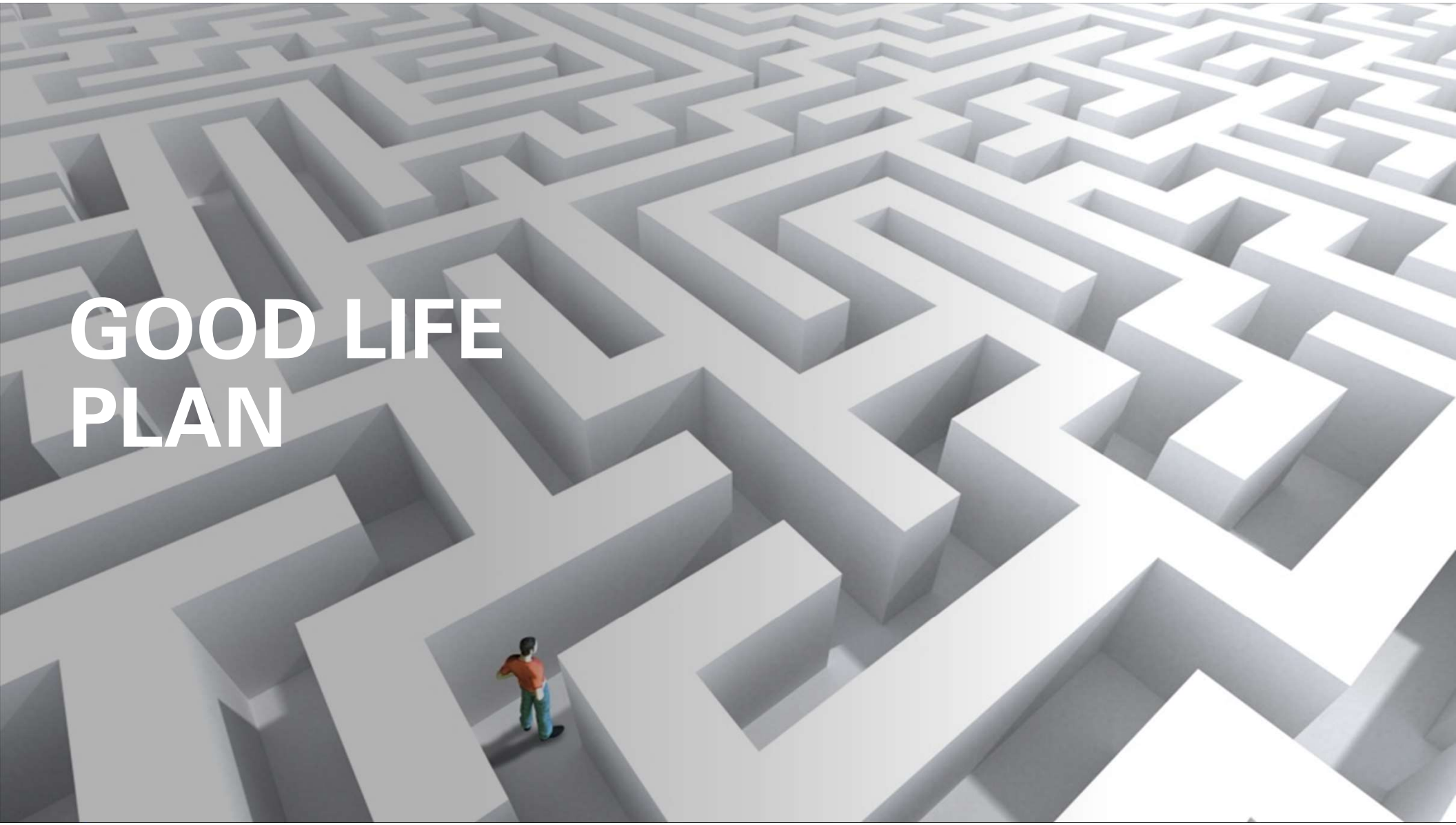
- Sarah is a 27-year-old high school teacher. Although she took significant pride in her work, Sarah admitted that it took up a majority of her time and she had not been able to hang out with her friends as much as she would have liked. Further, she stated that there were a lot of students that were in need of a supportive adult to talk to. Sarah ended up making friends with these students and on occasion the "friendships" would turn into sexual relationships. She found that as the "friendships" developed she was getting her emotional needs met as well.

Sarah's prioritized primary goods

- Primary Goods Important to Sarah:
  - Knowledge
  - Relationships
  - Excellence in Work and Play
  - Happiness
- Primary Goods Implicated in Offending:
  - Relationships
  - Happiness
  - Other?

Question?

- What might have obstructed Sarah from seeking valued primary goods in prosocial, adaptive ways?


GOOD LIFE
PLAN

When Things Go Wrong: Good Life Plan Obstacles

The GLM proposes that offending and life problems result when…

- Maladaptive/harmful means used to seek out primary goods
- A Good Life Plan lacks scope
- Conflict between goods and/or means
- Lack of capacity to attain goods in a prosocial/adaptive way (internal and external)

Conflict: the pursuit of one good interferes with pursuit of another good

Adverse Child Experiences (ACEs) in the Lives of Adult Women Who Have Committed Sexually Motivated Offenses

- 50.3% of community females report 1-3 ACEs
- ACEs have been shown to contribute to a variety of health & social problems
- In general, the more ACEs one has the poorer the outcome.
- Women who commit sexual offense have:
  - Three times the odds of child sexual abuse;
  - Four times the odds of verbal abuse;
  - Three times the odds of emotional neglect and having an incarcerated family member.
- Only 20% endorsed zero ACEs (compared with 35% of the general female population)
- 41% endorsed four or more ACEs
- Higher ACE scores were associated with having younger victims

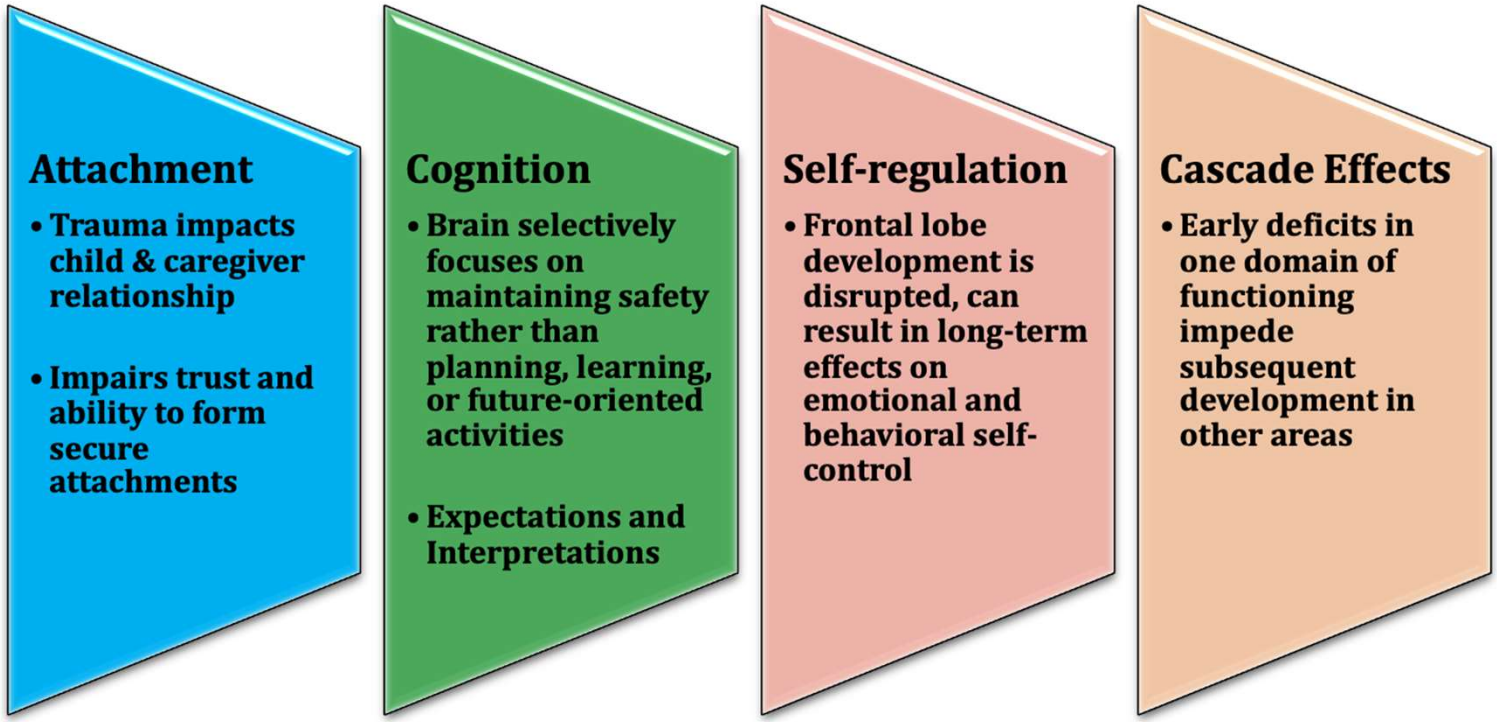
ACEs Continued

- Multiple maltreatments often co-occurred in households with other types of dysfunction, suggesting that many female sex offenders were raised within disordered social environments by adults with problems of their own who were ill-equipped to protect their daughters from harm.

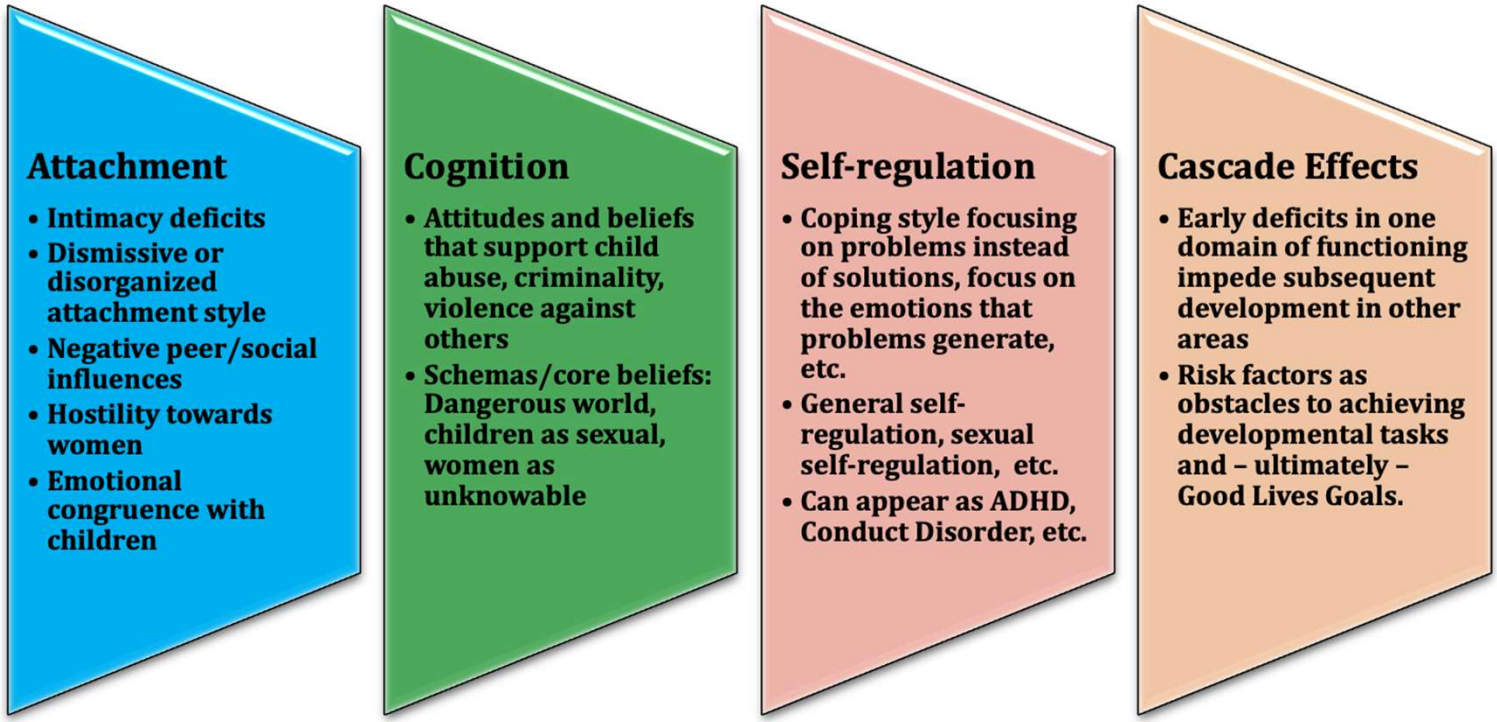
- As ACEs increased, level of violence also increased

(Levenson et al., 2014; Pflugradt, Allen, & Zintsmaster 2018)

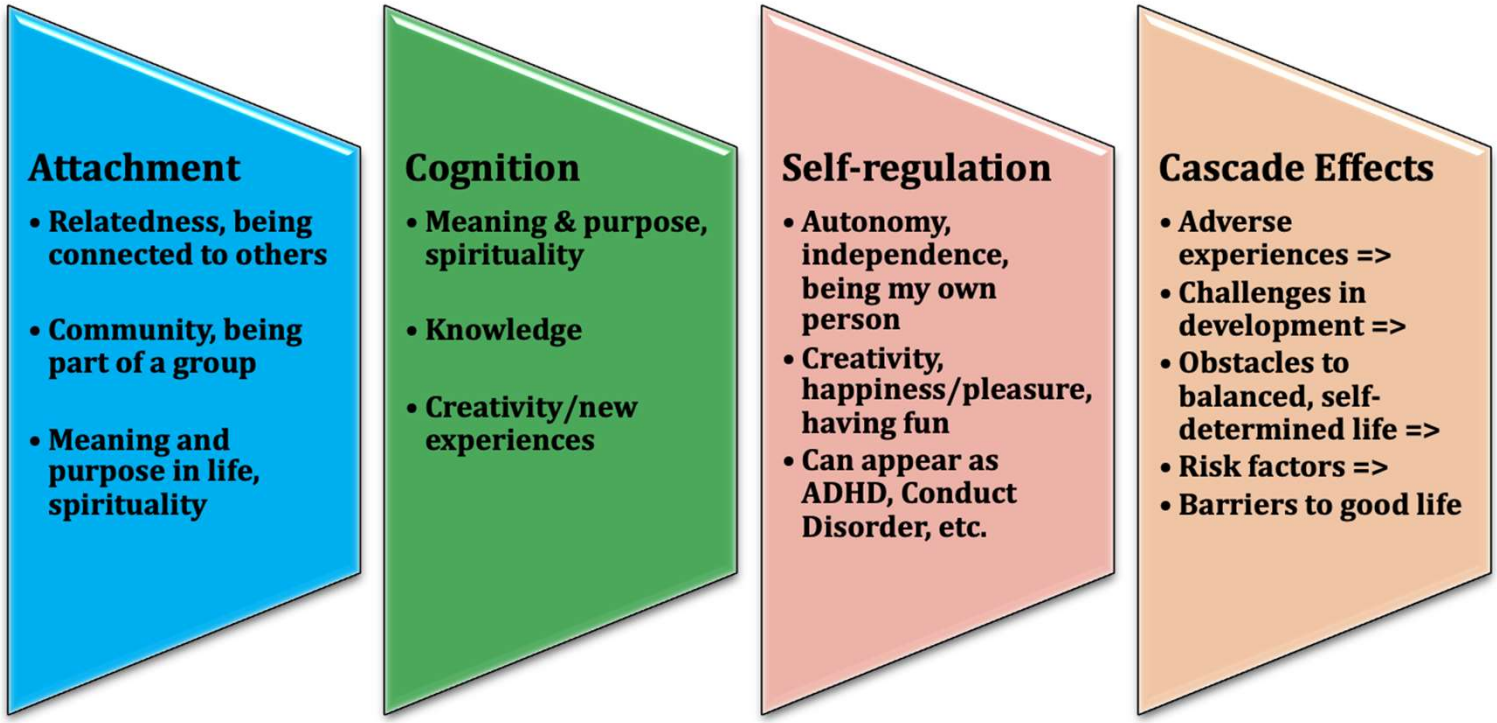
Developmental effects of childhood adversity



Developmental Effects of Childhood Adversity and Risk



Developmental effects of childhood adversity and Good Lives Goals



LACK OF CAPACITY: INTERNAL

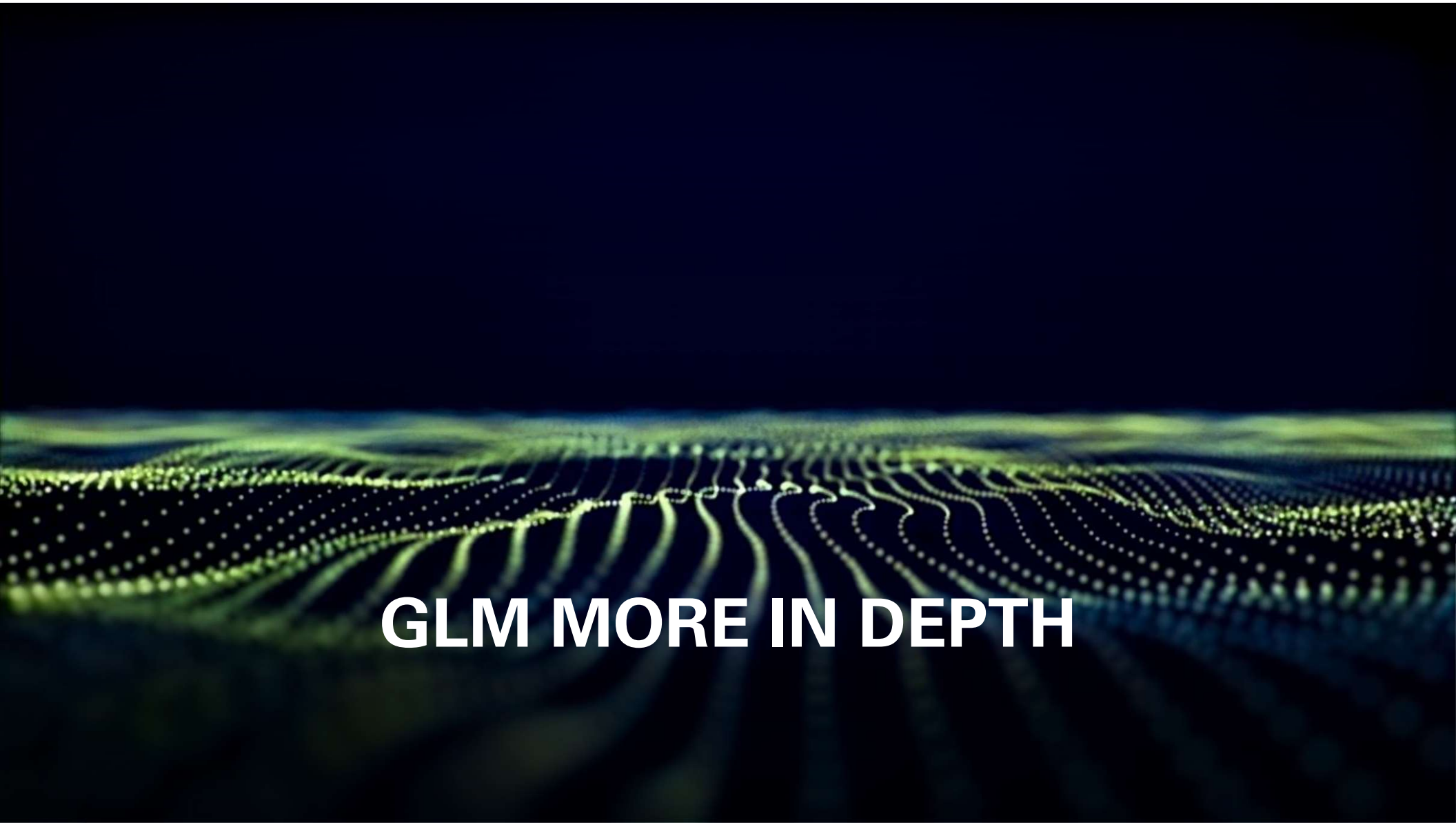
Lack of Internal Capacity

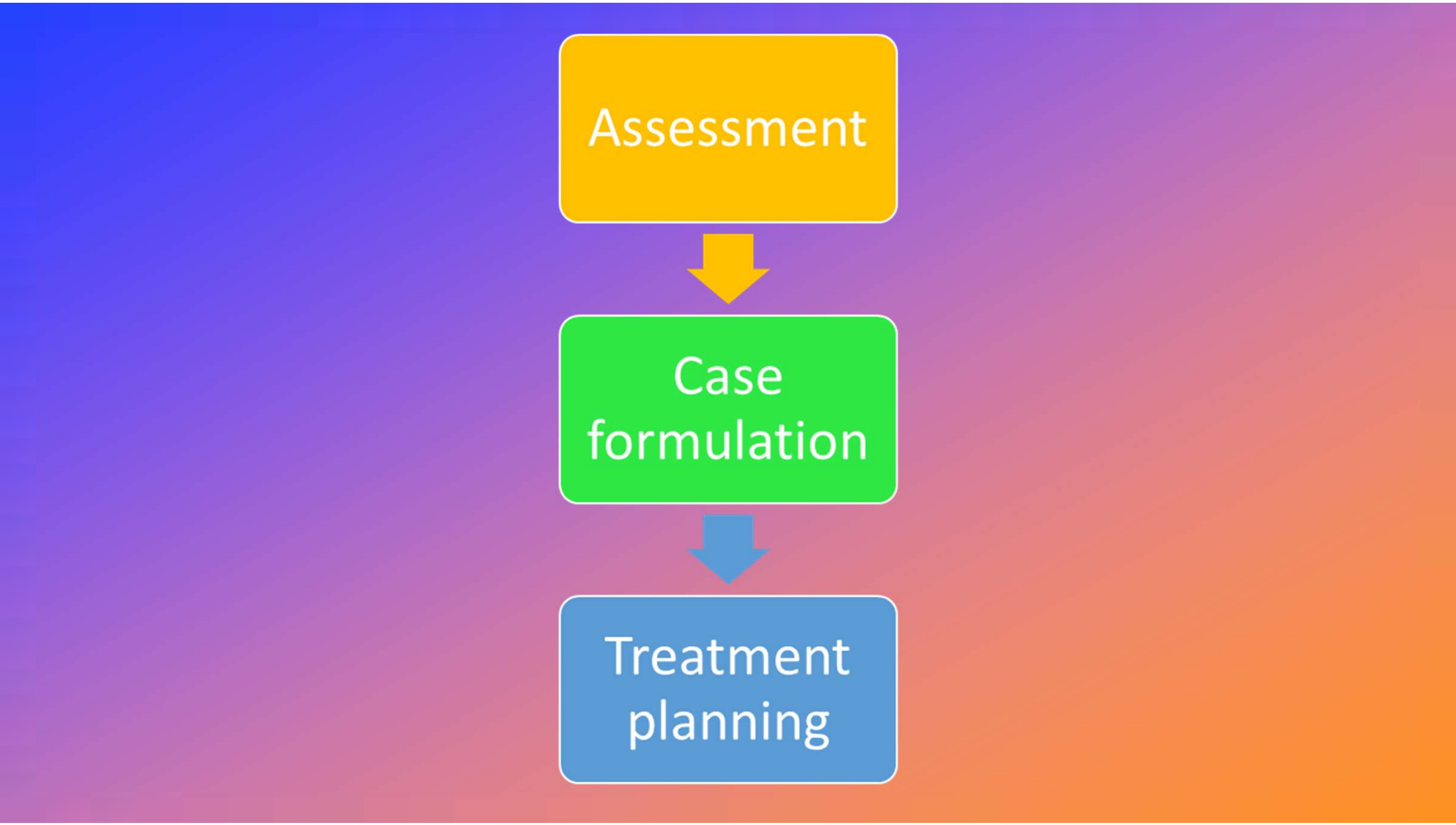
Maladaptive Schemas	Maladaptive Attachments	Maladaptive Coping
Other people will abuse/reject/abandon me	Relationship instability	Self-harm behavior
Dangerous World (men as dangerous)	Dependency (Co)	Sex as coping
Children less threatening		Substance abuse

Case Analysis: Christina

- Primary goods Important to Christina:
  - Relationships & Friendships
  - Happiness
  - Knowledge
- Primary goods implicated in offending:
  - Relationships & Friendships
  - Other?

- Obstacles in Good Life Plan:
- Maladaptive Schemas
  - Abandonment
- Maladaptive attachments/relational styles
  - Relationship instability, possible co-dependency


GLM MORE IN DEPTH


Assessment
Case formulation
Treatment planning

EXERCISE ON IDENTIFYING STRENGTHS

FIND THE
STRENGTH

FIND THE STRENGTHS

FIND THE STRENGTH

Consider

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

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

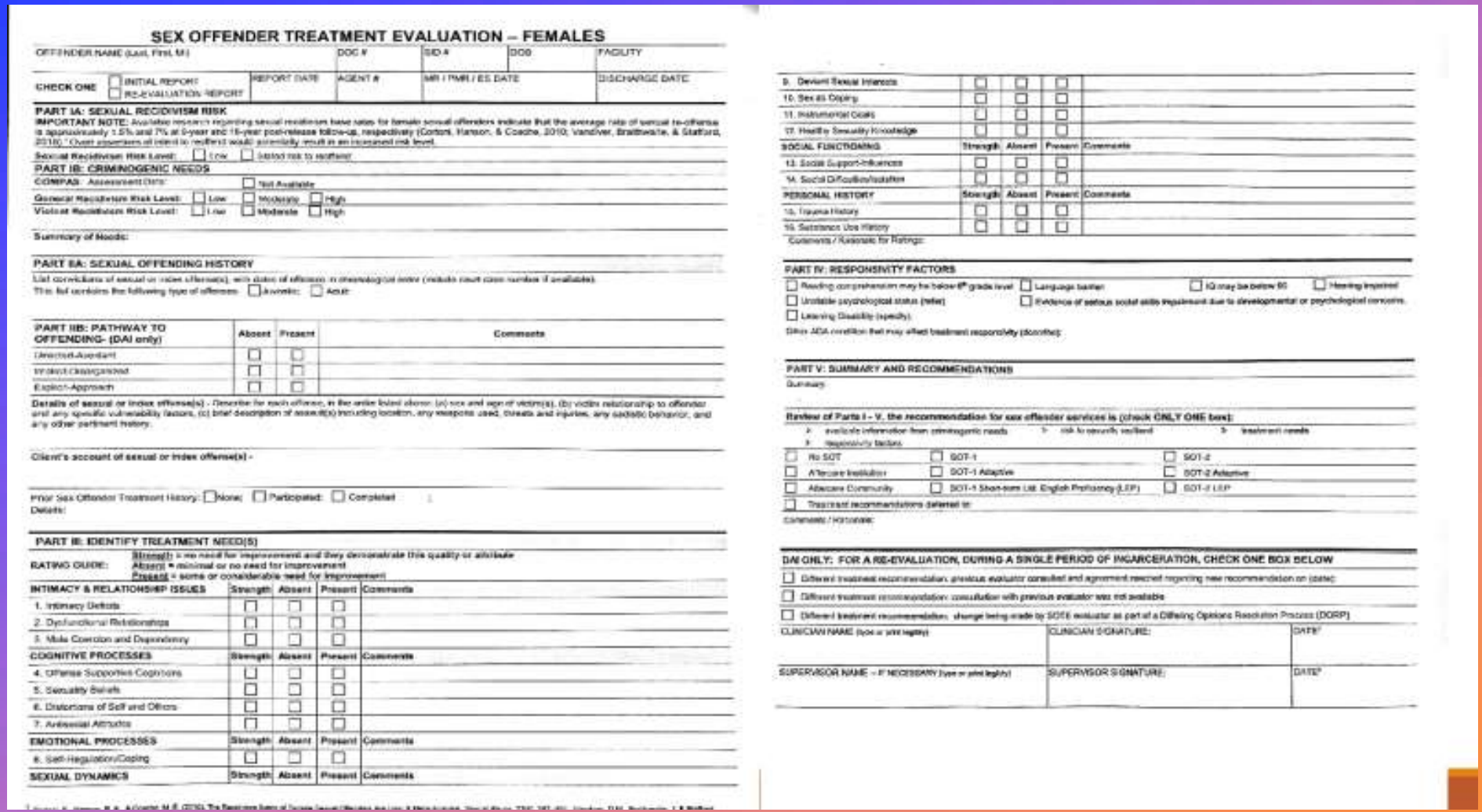
Consider

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

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

Assessment Tasks

RNR-based assessment	Exploration of good life plan (at time of offending and now)	Exploration of protective factors
• Includes static/dynamic risk and specific responsivity factors (use WRNA or LSI-R and then see Pflugradt, Allen, & Marshall, 2018 for details; Do Not Use Static-99R or Stable-2007).	• 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	



SEX OFFENDER TREATMENT EVALUATION – FEMALES

OFFENDER NAME (Last, First, M.I) | DOC # | SID # | DOB | FACILITY

CHECK ONE ☐ INITIAL REPORT ☐ RE-EVALUATION REPORT | REPORT DATE | AGENT # | MR / PMR / ES DATE | DISCHARGE DATE

PART IA: SEXUAL RECIDIVISM RISK

IMPORTANT NOTE: Available research regarding sexual recidivism base rates for female sexual offenders indicate that the average rate of sexual re-offense is approximately 1.5% and 7% at 5-year and 15-year post-release follow-up, respectively (Cortoni, Hanson, & Coache, 2010; Vandiver, Braithwaite, & Stafford, 2018). Overt assessment of intend to reoffend would potentially result in an increased risk level.

Sexual Recidivism Risk Level: ☐ Low ☐ Limited risk to reoffend

PART IB: CRIMINOGENIC NEEDS

COMPAS: Assessment Date: ☐ Not Available

General Recidivism Risk Level: ☐ Low ☐ Moderate ☐ High

Violent Recidivism Risk Level: ☐ Low ☐ Moderate ☐ High

Summary of Needs:

PART IIA: SEXUAL OFFENDING HISTORY

List convictions of sexual or violent offense(s), with dates of offenses, in chronological order (include court case number if available).

This list contains the following type of offenses: ☐ Juvenile ☐ Adult

PART IIB: PATHWAY TO OFFENDING- (DAI only)	Absent	Present	Comments
Directed-Avoidant	☐	☐	
Impulsive-Disorganized	☐	☐	
Explicit-Approach	☐	☐	

Details of sexual or index offense(s) - Describe for each offense, in the order listed above: (a) sex and age of victim(s), (b) victim relationship to offender and any specific vulnerability factors, (c) brief description of assault(s) including location, any weapons used, threats and injuries, any sadistic behavior, and any other pertinent history.

Client's account of sexual or index offense(s) -

Prior Sex Offender Treatment History: ☐ None ☐ Participated ☐ Completed

Details:

PART III: IDENTIFY TREATMENT NEED(S)

RATING GUIDE: Strength = no need for improvement and they demonstrate this quality or attribute
Absent = minimal or no need for improvement
Present = some or considerable need for improvement

INTIMACY & RELATIONSHIP ISSUES	Strength	Absent	Present	Comments
1. Intimacy Deficits	☐	☐	☐	
2. Dysfunctional Relationships	☐	☐	☐	
3. Male Coercion and Dependency	☐	☐	☐	
COGNITIVE PROCESSES	**Strength**	**Absent**	**Present**	**Comments**
4. Offense Supportive Cognitions	☐	☐	☐	
5. Sexuality Beliefs	☐	☐	☐	
6. Distortions of Self and Others	☐	☐	☐	
7. Antisocial Attitudes	☐	☐	☐	
EMOTIONAL PROCESSES	**Strength**	**Absent**	**Present**	**Comments**
8. Self-Regulation/Coping	☐	☐	☐	
SEXUAL DYNAMICS	**Strength**	**Absent**	**Present**	**Comments**
9. Deviant Sexual Interests	☐	☐	☐	
10. Sex as Coping	☐	☐	☐	
11. Instrumental Goals	☐	☐	☐	
12. Healthy Sexuality Knowledge	☐	☐	☐	
SOCIAL FUNCTIONING	**Strength**	**Absent**	**Present**	**Comments**
13. Social Support-Influences	☐	☐	☐	
14. Social Difficulties/Isolation	☐	☐	☐	
PERSONAL HISTORY	**Strength**	**Absent**	**Present**	**Comments**
15. Trauma History	☐	☐	☐	
16. Substance Use History	☐	☐	☐	

Comments / Rationale for Ratings:

PART IV: RESPONSIVITY FACTORS

☐ Reading comprehension may be below 6th grade level ☐ Language barrier ☐ IQ may be below 80 ☐ Hearing impaired
☐ Unstable psychological status (refer) ☐ Evidence of serious social skills impairment due to developmental or psychological concerns
☐ Learning Disability (specify):

Other ADA condition that may affect treatment responsivity (describe):

PART V: SUMMARY AND RECOMMENDATIONS

Summary

Review of Parts I – V, the recommendation for sex offender services is (check ONLY ONE box):

- Available information from criminogenic needs
- risk to sexually reoffend
- treatment needs
- responsivity factors

☐ No SOT	☐ SOT-1	☐ SOT-2
☐ Aftercare Institution	☐ SOT-1 Adaptive	☐ SOT-2 Adaptive
☐ Aftercare Community	☐ SOT-1 Short-term Ltd. English Proficiency (LEP)	☐ SOT-2 LEP

☐ Treatment recommendations deferred to:

Comments / Rationale:

DAI ONLY: FOR A RE-EVALUATION, DURING A SINGLE PERIOD OF INCARCERATION, CHECK ONE BOX BELOW

☐ Different treatment recommendation; previous evaluator consulted and agreement reached regarding new recommendation on (date):
☐ Different treatment recommendation; consultation with previous evaluator was not available
☐ Different treatment recommendation; change being made by SOTE evaluator as part of a Differing Opinions Resolution Process (DORP)

CLINICIAN NAME (type or print legibly)	CLINICIAN SIGNATURE:	DATE:
SUPERVISOR NAME – IF NECESSARY (type or print legibly)	SUPERVISOR SIGNATURE:	DATE:

Pflugradt, Allen, & Greene, 2019

Treatment Need Factors

- Generally grouped in five domains with a sixth domain used to identify unique individual characteristics. These overlap and cannot be separated out from a women's overall life

  - Intimacy & Relationship Issues
  - Cognitive Processes
  - Emotional Processes
  - Sexual Dynamics
  - Social Functioning
  - Assessment of Unique Characteristics

(Pflugradt & Cortoni, 2015)

Identifying Primary Goods/ Common Life Goals

1

Determine those things (i.e., activities, situations, experiences) that are important to the individual in her life

2

Infer common life goals

3

Detect goals evident in offense-related actions and general life functioning

4

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?
- 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?

Life: Health and Survival

- 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?

Relationships & Friendships

- 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?

For each of the Primary Human Goods

- Go through each primary human good with the client.
- 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?**
- We have found that relationships and connectedness are important for women. In addition, research has demonstrated that by attending to these goods, recidivism can be decreased

Tasks

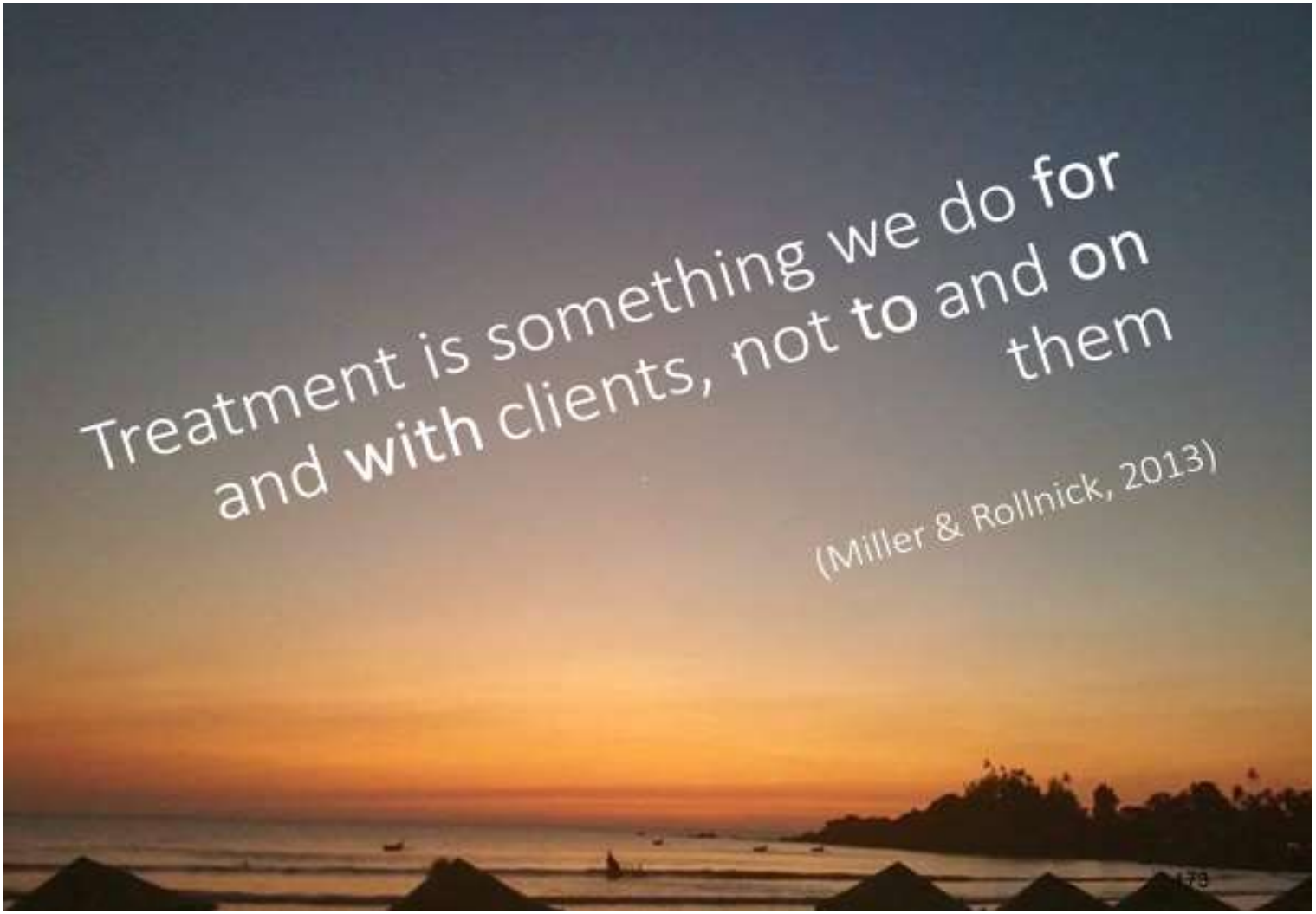
- Identify Common Life Goals valued overall
- Identify Common Life Goals implicated in offending
- Identify Good Life Plan obstacles
- Identify dynamic risk and protective factors

Planning for a Good Life

- Informed by case formulation
- Relationship between offending, dynamic risk factors, protective factors, pursuit of common life goals
- Intervention plans provide roadmap for working toward dual aims of treatment
- Enhanced well-being, reduced risk
- Intervention plans form basis of future-oriented good life plans
- Dynamic, refined as treatment progresses, clients build strengths, develop skills to achieve common life goals in pro-social ways

Planning for a Good Life

- Planning = collaborative
- Therapist links client goals with treatment goals
- Individualized plans constructed for each client
- Revolve around goal attainment, increasing protection, reducing risk
- Set out valued common life goals, how clients plan to attain them
- Attend to internal and external conditions necessary to attain goals
- This also targets risk factors
    - E.g., Pflugradt & Allen, 2019; Pflugradt, Allen, & Marshall, 2018; Willis et al., 2013; Yates et al., 2010


Treatment is something we do for and with clients, not to and on them
(Miller & Rollnick, 2013)

Current Psychiatry Reports (2019) 21:119
https://doi.org/10.1007/s11920-019-1115-z

SEXUAL DISORDERS (LE MARSHALL AND H MOULDEN, SECTION EDITORS)

The Application of the Good Lives Model to Women Who Commit Sexual Offenses

Dawn M. Pflugradt[1] · Bradley P. Allen[1]

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Abstract

Purpose of Review
Despite increased studies which have identified the treatment needs of women who commit sex offenses, there are no empirically derived treatment models based upon a comprehensive theoretical paradigm.

Recent Findings
Although current treatment models include similar goals and approaches, there are some important distinctions. The following article provides an overview of two treatment models, gender-responsive treatment and gendered strength-based treatment. These models were then examined to determine whether they could be integrated within a comprehensive theoretical rehabilitation framework such as the Good Lives Model.

Summary
The Good Lives Model provides a comprehensive theoretical framework that allows for integration of the gender-responsive and gendered strength-based treatment models. These treatment models utilize strength-based approaches, risk-need-responsivity principles, cognitive behavioral techniques, and relational processes to foster change.

Keywords Good lives model · Offender rehabilitation · Women sex offenses

Introduction

Despite recent advances in the identification of dynamic risk factors [1••, 2••, 3], there does not currently exist any empirically derived treatment models for women who commit sexual offenses based upon a cogent theoretical paradigm [1••]. The lack of a clearly delineated treatment paradigm based upon established theoretical constructs has been historically attributed to limited empirical information pertaining to female specific risk factors [4–10]. Moreover, the systematic study of risk factors associated with sexual offenses perpetrated by female offenders has been hampered by socio-cultural factors resulting in a lack of detection, prosecution, and/or legally mandated interventions [1••, 2••, 3]. As suggested by some studies, these cultural and systemic reactions to women who have committed sexual offenses are presumably a reflection of societal beliefs that women who perpetrate sexual crimes were influenced or coerced by extenuating or external causes (e.g., co-offender, substance abuse, mental disorders) [6, 11]. Consequently, a primary focus of treatment has often emphasized addressing the social influences (e.g., relationships, family support) associated with offense typologies or processes that led to the sexually offending behaviors [12, 13]. Moreover, this social perspective combined with low recidivism rates provided a persuasive argument for focusing on relational and social factors in individual treatment [14, 15]. Despite limited empirically derived information about the association between social integration or connections and recidivism risk, the focus on interpersonal dynamics and healthy relationships provided a reasonable

This article is part of the Topical Collection on *Sexual Disorders*

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Published online: 15 November 2019

Aggression and Violent Behavior 40 (2018) 12–18

Contents lists available at ScienceDirect

Aggression and Violent Behavior

journal homepage: www.elsevier.com/locate/aggviobeh

A gendered strength-based treatment model for female sexual offenders☆

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ARTICLE INFO

Keywords:
Gendered treatment
Strength-based treatment
Female sex offenders

ABSTRACT

Due to the relatively limited knowledge about female sexual offenders, treatment approaches and programs have been primarily based upon models developed for male perpetrators. Although male and female offenders share some common characteristics, there is increasing empirical evidence that many aspects of female sexual offending behaviors are separate and different from those of males. By integrating theoretical constructs from the current literature, this paper proposes a strength-based treatment approach utilizing a gendered paradigm of female sexual offending. In general, a gendered strength-based treatment model involves a collaborative process that builds upon positive skills and provides options to utilize those skills to fulfill unmet needs. This treatment process also considers the contextual nature of the female sexual offender's social functioning and the individual manifestations of her sexually assaultive behaviors.

1. Introduction

As research on female sexual offenders continues to grow and evolve, there is an increasing body of literature which identifies empirically validated factors associated with female sexual offending (Cortoni & Gannon, 2013). Despite these advances, however, the germane research methodologies used to identify factors associated with the sexually assaultive behaviors of women continue to have significant limitations. For example, the available empirically based information regarding female sex offenders is typically obtained from either large data bases or studies of very small nonrandom samples usually determined by availability or convenience (DeCou, Cole, Rowland, Kaplan, & Lynch, 2014; Gannon & Alleyne, 2013; Gannon, Rose, & Ward, 2008; Levenson, Willis, & Prescott, 2014; Pflugradt & Allen, 2010, 2013, 2014, 2015; Vandiver & Kercher, 2004; Williams & Bierie, 2015).

Although large scale data reviews provide some useful general information about offense characteristics (e.g., co-offenders, victim characteristics), the results are limited by variation in the data input/collection (Budd, Bierie, & Williams, 2015), assumptions that may or may not be valid, under/over-represented geographical areas and law enforcement agencies, incident level data and a limited number of variables which excludes information that may be of interest (Budd et al., 2015; Sandler & Freeman, 2009; Vandiver & Kercher, 2004; Wijkman, Bijleveld, & Hendriks, 2010; Williams & Bierie, 2015). Conversely, the available studies which examine the individual dynamics of female sexual offending are derived from very small samples which significantly impair any ability to generalize them to female sex offenders as a group. Additionally, small sample sizes preclude most multivariate research designs and analyses; as a result, empirically guided information is obtained from univariate group comparisons and/or nonparametric correlational procedures (Pflugradt & Allen, 2011, 2013, 2015). Whereas both macro- and micro-analytic approaches provide some constructive information, the consequent suggestions for any practical applications are constrained within narrow parameters beleaguered with caveats about limited generalizability. That is, even though current methodologies provide information from which to derive hypotheses for further studies, it is important to bear in mind the significant limitations of current research.

Another widely cited reason for the paucity of relevant empirical information about female sex offenders is socio-cultural barriers (Budd et al., 2015; Cortoni, 2010; Denov, 2004; Logan, 2008; Rousseau & Cortoni, 2010; Strickland, 2008). That is, there are several recognized social influences that affect the detection and identification of women who commit sexual assaults. For example, society often fails to recognize women as sex offenders and they are more likely than males to avoid detection, prosecution and legally mandated interventions such as monitoring, registration and treatment (McLeod, 2015; Vandiver &

☆ Author Note: The views expressed in this paper are that of the authors and do not necessarily represent the views of the Department of Corrections or the Department of Health Services. The authors would like to thank the staff at Taycheedah Correctional Institution for their assistance with this project.

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https://doi.org/10.1016/j.avb.2018.02.012
Received 10 April 2017; Received in revised form 16 December 2017; Accepted 28 February 2018
Available online 04 March 2018
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Good Lives

- A basic description of the Good Lives Model (GLM) is that it is "…a strength-based approach by virtue of its responsiveness to offenders' core aspirations and interests and its aim of providing them with the internal and external resources to live rewarding and offence-free lives" (Ward, 2010).

- Additionally, the GLM differs from other treatment approaches because its central focus is building upon client strengths instead of addressing deficits.

GLM

- The application is comprised of three sets of basic assumptions:

1. All persons strive to meet or acquire primary or basic goods (e.g., health, knowledge, work, happiness). The importance that individuals assign to their specific basic goods reflect their life values and life priorities. Their behaviors are the means to achieve/acquire their desired goods.
2. The second set of assumptions is that all persons organize or, in a sense, create their lives around core values and follow some type of good life plan.
3. It also assumes that the first two assumptions can be applied to direct or inform the treatment of offenders.
(Willis et al., 2013)

Treatment 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?
- 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?

Treatment Goals

- 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

Risk-based treatment components and related GLM constructs

Risk Based	GLM Constructs
Autobiography	→ Good Life Plan (past and present)
Offence Progression	→ Knowledge, Good Life Plan (past and present)
Cognition/Problem-Solving	→ Knowledge, Personal Choice & Independence, Peace of Mind, Relationships & Friendships
Relationships/ Intimacy Deficits	→ Relationships & Friendships, Community
Sexual Self-Regulation	→ Happiness, Peace of Mind, Relationships & Friendships, ++
General Self-Regulation	→ Peace of Mind, Personal Choice & Independence, ++
Emotion Regulation	→ Peace of Mind, Personal Choice & Independence, ++
Relapse Prevention Plan	→ Integrated Good Lives and Risk Management Plan (present and future-oriented)

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

Contrast: A relapse-prevention oriente lan

- Avoid beir (e.g., outside schools, p
- Avoid any depicting prepubesc
- Do not joi in which children are preser
- Avoid isol ow mood
- Constantly risk situations/
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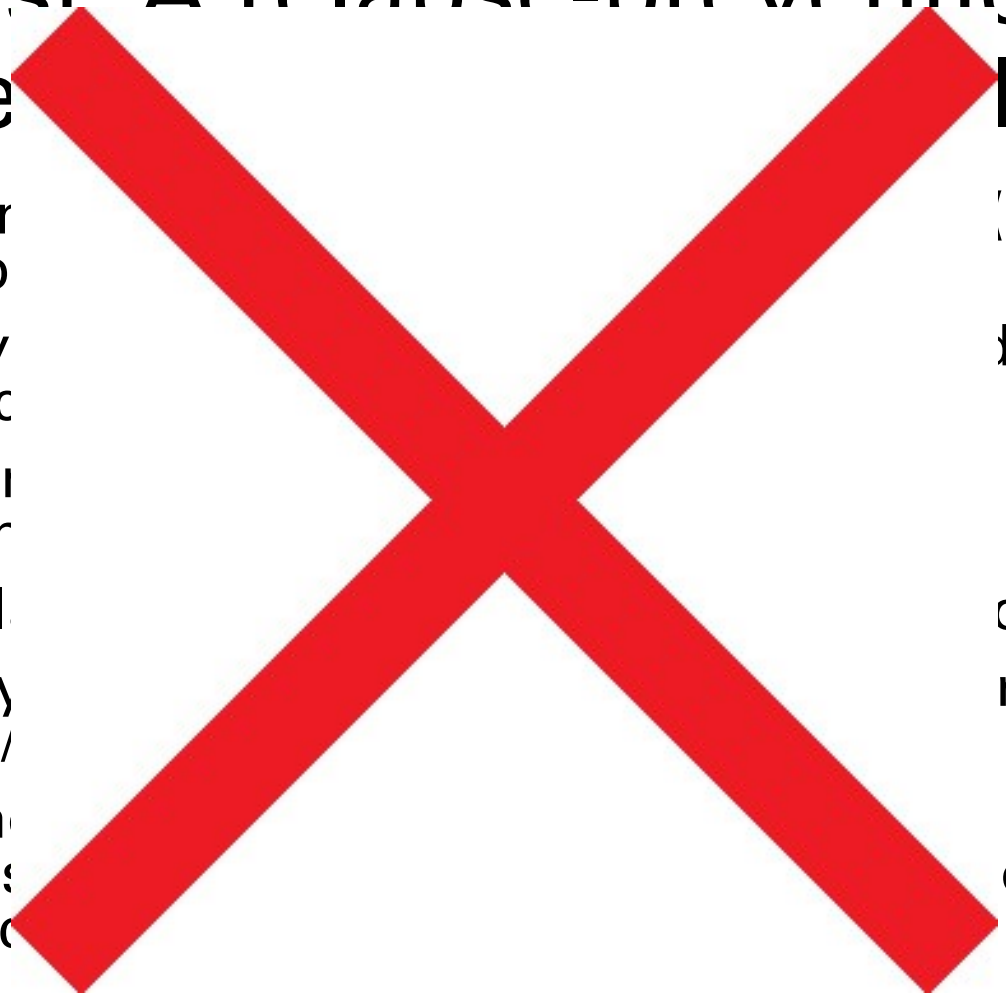
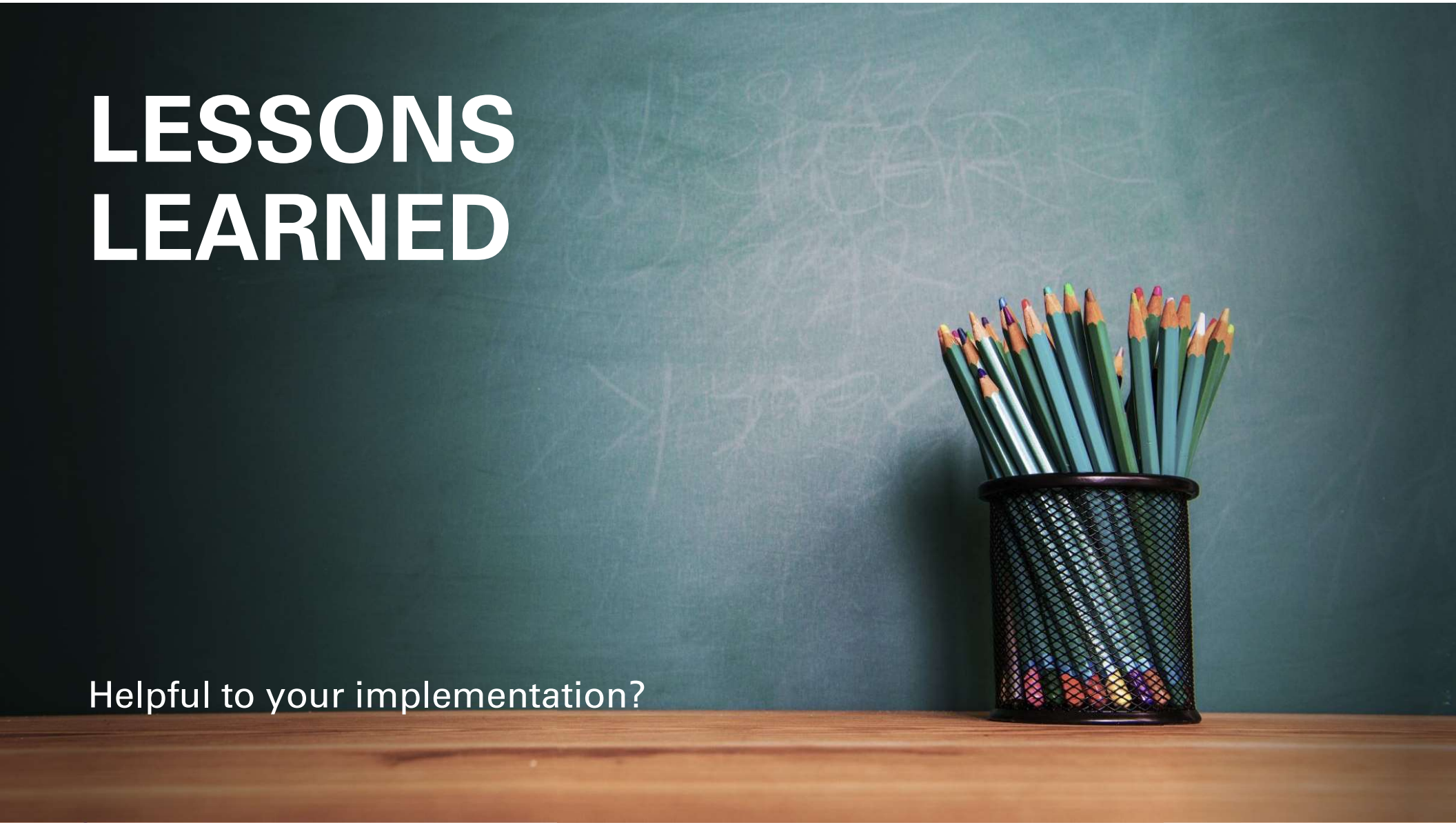


Integrated Good Lives Plan

- 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 strategies to manage needs/risk factors
- Strategies to attain a better life
- Includes all goods important to individual
- Sufficient scope
- Includes non-offending, practical ways to attain goods
- Build on client strengths
- Identifies threats/obstacles to goods attainment and strategies for managing
- Includes risk management plan

LESSONS LEARNED



Helpful to your implementation?

An Overarching Practical Framework for Rehabilitation

Implementation can result in push back from:

Colleagues: "'Treatment' is a confusing word to outside stakeholders; maybe we should call it 'management'"

Practitioners: "All this theory and background information isn't helpful. Just tell me what to do. Bullet points, please"

Community: "These people don't deserve to have a good life"

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
    - (See Prescott & Willis, 2021)

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

The GLM is about 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

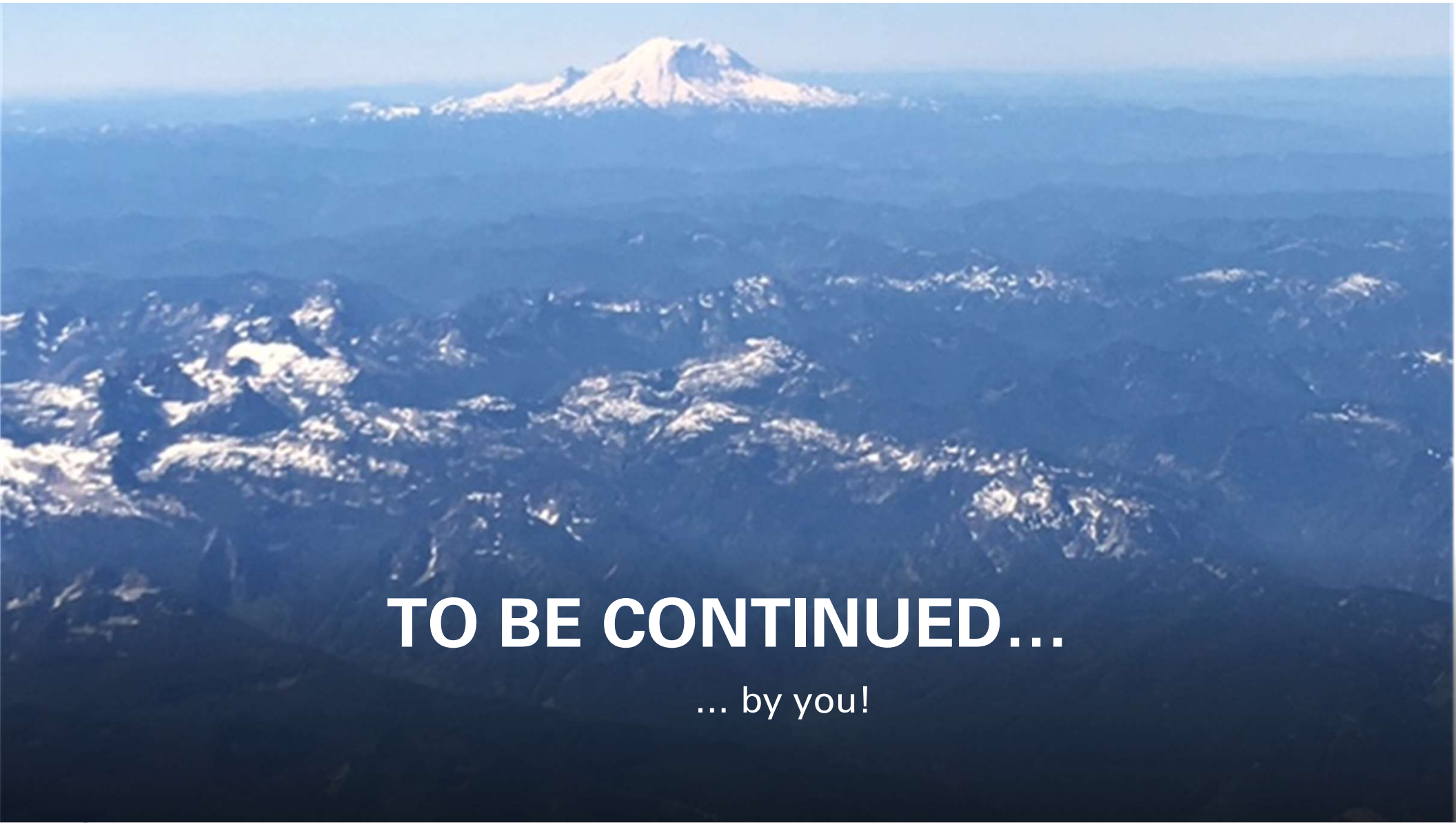
GLM Fidelity Monitoring Tool

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


TO BE CONTINUED…
… by you!