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# Book Review: Where Are We Now? Reflections on *The Good Lives Model for Adolescents* and How We Define "Models"

David S. Prescott, LICSW
Director of Professional Development and Quality Improvement
Becket Family of Services

## Introduction

Bobbie Print, CQSW, aided by numerous authors, has recently published *The Good Lives Model for Adolescents who Sexually Harm.* It chronicles the diligent and often courageous journey of the G-MAP program in the UK from an unspecified relapse prevention approach to adapting the good lives model for use with adolescent males. Ms. Print is clear that it is not the final word in applying the good lives model to adolescents, while contributors Helen Griffin and Laura Wylie further note that it is not a stand-alone model, but necessarily overlaps with others.

*The Good Lives Model for Adolescents who Sexually Harm* receives an excellent review on its own merits by Phil Rich in this issue of the *Forum*. The current article places this book project in the context of the broader good lives model (GLM) as well as the more general field of assessing and treating adolescents who have sexually abused. The following commentary further asks questions about the evolution of models and where they begin and end in daily practice.

## Background

The first *Evolution of Psychotherapy* conference in 1985 (often dubbed "Woodstock for therapists") focused on individual pioneers. Carl Rogers discussed therapy as he saw it, as did James Bugental, Virginia Satir, Murray Bowen, and many others. Sophie Freud and Margot Adler discussed the contributions of their forebears. The names of the actual methods, such as gestalt or psychodynamic approaches, appeared in the background. Aaron Beck described cognitive-behavioral therapy, although the research was only beginning.

Today's vast lexicon of therapeutic approaches contains more models, theories, principles, and techniques than it does names, even if some individuals have inspired entire movements (e.g., Miller & Rollnick's motivational interviewing). Theoreticians and researchers from Saul Rosenzweig (1936, 1937) to Bruce Wampold (2010) have noticed the commonalities between them. In fact, such researchers as Wampold, Michael Lambert, Scott Miller, Barry Duncan, and even Bill Miller have found that treatment techniques are far less important than their basic elements, like the therapeutic alliance. At a time when physical scientists discuss whether there is a "God particle," the comparable question in the helping professions might be whether there is a single element – or cluster of elements – that is essential to building healthier lives and safer communities, rather than the numerous, sometimes proprietary approaches in the current marketplace (Prescott, 2013).

When the good lives model first appeared, some practitioners complained that it resembled work

they were already trying to do, namely to help their clients build a better life. Others noted that it seemed to rest on an existing foundation, known as "old me/new me", established by Jim Haaven and his colleagues in Oregon. In others words, the GLM appeared to have a lot in common with other forms of good therapeutic practice, which is a valid observation. It is also a fair appraisal of other models and approaches. For example, the most unique characteristic of motivational interviewing is its concept of "change talk." The rest, such as open questions and reflective statements, did not originate with Miller and Rollnick (1991).

In the interest of full disclosure, having contributed to GLM's development and practical application, I admit I am not without some bias. Combining the idea of "approach goals" (objectives to work toward rather than avoid) with common life goals that may be linked to dynamic risk factors (Yates & Prescott, 2011) and taking into account the goals sought at various steps of an offense process have been novel in practice. To some degree, proper implementation of the GLM relies more on subtracting such practices as traditional cycle work than on adding elements like GLM approach goals into an existing mix of practices.

The GLM has evolved considerably during the past decade, and continues to do so. The question remains: In the area of treatment interventions, where precisely does the GLM fit in? Willis, Prescott, and Yates (2013) described it as, "The GLM is a strengths-based rehabilitation theory that augments the risk, need, and responsivity principles of effective correctional intervention through its focus on assisting clients to develop and implement meaningful life plans that are incompatible with future offending." Many treatment models claim to be strengths-based, while others claim to use approach goals, or focus on desired future states that people pursue for their own sake. Combining these with anchored theory about the nature of rehabilitation moves us closer to a genuine model, even as some details are still unclear. (For example, assuming that they do change, how is it that people actually change as a result of the GLM?)

**The Good Lives Model for Adolescents**

In the introduction of her new book, Bobbie Print (2013, p. 2) notes:

*The purpose of this book is to share our experience of adapting the good lives model for use with the adolescents with whom we work. In our view, the model has proved to be an exciting, positive, and helpful framework that we have enjoyed exploring, experimenting with, and employing.*

With this as its purpose, this book is clearly a success as well as a work in progress. The introductory points are important, as the book is not intended to be the final word or ultimate "how to" guide to the GLM with adolescents. Indeed, one has to admire the authors' humble approach, offering an inside view of their program's evolution. This appears particularly collegial in an era in which some curricula require massive expense, negotiation, and licensing fees in exchange for the privilege of administering them. Like any other worthwhile work-in-progress contribution to the literature, it inspires as many questions as it answers. As an admirer of both Ms. Print's G-MAP program and the GLM (and having recently published a chapter of G-MAP's work with the GLM and other approaches; see Fisher, Morgan, Print, & Leeson, 2012), I offer questions below that may streamline professionals' adaptation of the model for their own needs.

The book discusses the authors' disappointment with approaches that are based on the principles of risk, need, and responsivity (RNR) and that employed some variation of relapse prevention. However, there is no discussion of what these programs actually were. It begs the question of how adherent to the responsivity principle these programs could have been if they were so negative and unhelpful in nature. After all, motivation and engagement are central to the responsivity principle. The principles of risk, need, and responsivity are introduced at least five times throughout the book, but receive little discussion as to how the GLM actually works with and not against them. Indeed, there is a sizeable body of literature on the importance of these principles with youth. Adherence to the RNR will naturally be different

in juvenile programs than in adult programs (i.e. juveniles have different risks and risk levels, while criminogenic needs can change dramatically in a few short years, while responsivity considerations are much more likely to involve environmental factors). Practitioners considering the GLM in a way that adheres to the RNR principles will want to think carefully about how their use of GLM can best adhere to these principles.

Further, there is a case example involving an 11-year-old girl (Leanne). Given the many questions about exporting adult models into juvenile programs, the case of Leanne prompts similar questions. Can the good lives model for adolescents be used meaningfully with children?

It is also important to note that the authors approach risk very differently from other programs. From page 87: "The good lives model for adolescents enables 'risk' to be assessed in respect to whether the young people's present circumstances allow them to positively meet their needs that have been, or could be related to further inappropriate behavior." In other words, the authors say that there are many forms of risk in the lives of adolescents, including the risk that the youth might not reach his or her ultimate potential in life. Practitioners will therefore want to beware that the use of the word "risk" in the good lives model for adolescents can vary, and does not map out onto traditional notions of risk assessment and the risk principle of effective interventions. This may lead to interesting questions about treatment dosage, placement, etc.

Towards the end of their discussion of risk assessment, the authors advocate the use of their own measure, the AIM2, which "includes factors that do not necessarily have a strong and direct link to sexual recidivism but are nonetheless considered relevant" (p. 89). While there is no question that comprehensive assessments should consider more than just risk, practitioners should be wary of blending in factors not known to be related to risk into an instrument billed as a risk assessment instrument (p. 88). Further, the authors describes as "alternative" two instruments that actually have a more supportive research base (i.e. the JSOAP-II and ERASOR; see the meta-analysis of these instruments by Viljoen, Beneteau, & Mordell, 2012). This triggers a broader question: At what point does one abandon the use of
a more established measure in order to adhere to a larger model or theory that may have more appeal and less evidence behind it? Practitioners should consider their response carefully.

The broader GLM views people who sexually abuse, like all other human beings, as goal- directed and seeking certain experiences, outcomes, and states of being in their daily lives (Yates, Prescott, & Ward, 2010, p. 38). Historically, these have been called "primary goods." In response to the concerns of front-line professionals, Yates and Prescott (2011) suggested that practitioners can think of these as "common life goals". This change did not occur without considerable discussion within the GLM community. After all, the word "goal" can have many meanings beyond the concept of "goods" described above; hence the term "common life goals" (and its accompanying descriptors).

In the good lives model for adolescents, Print's team of authors has replaced the concept of goods/goals with "primary needs". Some practitioners will note that this use of "need" is at considerable variance with other uses, such as "treatment needs", "the need principle", etc. This raises several questions: Many people confuse wanting something with needing it. Does the good lives model for adolescents in its current state truly account for this
difference? Can we truly say that needs are the same as goals? Beyond that, whose needs are they anyway? Although the authors emphasize that these primary needs should be defined from the client's perspective, there is considerable discussion about how adults can assess these needs on behalf of the young person. In fact, there is no discussion of how adults can best uphold the viewpoint of the adolescent. If the GLM has thus far emphasized the shared understanding of a good life plan between the client and their therapist, much of the good lives model for adolescents appears vulnerable to adults assigning these "primary needs" to the youth in their care rather than developing them through a shared conversation and mutually developed goals. To be clear, adolescents are more dependent on the adults in
their life than adults are on each other, and adult treatment providers are often functioning *in loco parentis* with adolescents. As it stands, there are questions as to how "primary" the primary needs are to the adolescent when they are developed primarily through adult assessments. This

further raises questions as to where the dividing line is between fidelity to the model and fidelity to the individual client. Given the importance of self-direction to the broader GLM, perhaps there should be greater discussion about the subtle imposition of adult values onto adolescents in treatment.

Ultimately, the GLM (like motivational interviewing and other approaches) is something done*with* and *for* clients, not *to* and *on* them. When treatment programs also stand in the place of parents, what are all the subtle ways that they might compromise the emerging self-determination of their clients? Many programs rightly answer these questions on a case- by-case basis. For the purposes of developing models, however, one wonders where the boundaries are. How much collaboration and self-determination can professionals sacrifice before a model is no longer considered collaborative or strengths-based? Of course, the best answer may be to ask the clients themselves (Prescott & Miller, in press). As a work in progress and memoir of an agency's evolution, Print's book does not attempt to answer these questions; perhaps that can be part of the model's next steps. In order for professionals to best understand and advance the model, the above questions will doubtless require further discussion.

As examples of where the bounds of fidelity to model versus fidelity to client may clash, consider the following: The good lives model for adolescents book contains a fascinating discussion about the idea of physical and emotional safety as a primary need. Anyone who has ever raised or worked with teens recognizes their ongoing need for safety. However, for a variety of reasons, the authors elected not to list safety as a primary need. What would happen with an adolescent entering a program, as some have, saying "my number one priority is figuring out how I can best keep myself safe." Would the treatment providers then work with the young person to establish a different set of priorities, arguing that, as a concept safety, overlaps with many other primary needs? Likewise, the primary need called "sexual health" seems almost exclusively designed by adults. On its own, "sexual health" does not sound like a need that most youth would endorse, although many of its components (e.g., sexual pleasure) would likely have some appeal. Within my own career, I have never heard an adolescent in treatment say "I want more sexual health."

In fairness, Glaser (2011) offered a similar criticism of the adult GLM. He used as an example a client who stated at the start of treatment that his goal was to avoid offending in the future. Would that client be forced to re-establish the goal in an approach-based format? The available resources make it clear that the answer is no. However, these kinds of questions still require sorting out with a population for whom self-determinism is still emerging.

The book notes the importance of family involvement, trauma-sensitive treatment, and motivation, even as there is very little discussion about specific methods for treatment. Many programs and approaches already emphasize trauma, family involvement, and motivation; these areas fill entire conferences and book volumes. How is the good lives model for adolescents new or different in these respects? The lack of description as to how to put this into actual practice highlights the work yet to be done, and the fundamental questions that remain in determining when treatment is and isn't GLM. After all, many helpful discussions are not motivational interviewing, just as many discussions about thoughts and behavior are not cognitive-behavioral therapy.

Likewise, the book is quite clear that it is based on Haaven's old me/new me model, although it is here called "old life/new life" (p. 83). This further raises questions about model definition. If one approach completely subsumes an older one, can it claim to be its own model, or is it an extension of the older one?

It may be worth further exploration into integrating the good lives model for adolescents with additional models relating to the processes that result in sexual abuse. For example, in adult assessment and treatment, the GLM is fully integrated with the self-regulation model (SRM; Yates, Prescott, & Ward, 2010). In this way, exploring what the client's goals were at each step can

inform an understanding of how best to formulate a good life plan. No such linkage appears in the good lives model for adolescents, and the authors are understandably wary of applying the adult SRM to adolescents. There are legitimate questions about how much adolescents can recall or understand the chains of events that lead to abuse, particularly when they have experienced severe and/or complex trauma. However, the absence of detail in understanding the abuse process leads to potentially vague case conceptualizations. For example, in one case example a 15-year-old young man named "Joe" anally rapes his 11-year-old brother several times over the course of seven months. In the final case conceptualization on p. 100, the authors conclude that the "primary needs" met through his offending are emotional health, having people in his life, and a sense of achievement. Given the persistence of this behavior over time, one might wonder what other goals were met by this behavior, such as a sense of gratification, pleasure, and empowerment. Given that this form of sexual assault can cause considerable distress to the victim, this could be a significant concern. Although it is praiseworthy that the good lives model for adolescents lends itself to establishing approach goals, it might be more effective if there was a greater opportunity to unpack the decision process that led to Joe initiating and then repeating this behavior over several months.

On a broader level, however, practitioners will want to consider very strongly how they understand the positive "needs" underlying sometimes vicious behavior without also fully accounting for less desirable motivations behind a sex crime. If all one focuses on are the

positives, it can be easy to miss the negatives. Clearly, the harsher and more confrontational approaches of the past were appropriate neither for adults nor adolescents. Still, practitioners will want to take care that they don't allow the pendulum to swing too far in the other direction and forget to account for the whole person they are assessing and treating. Hopefully, future authors will discuss how practitioners can help adolescents
accept and acknowledge their actions in a GLM-adherent way.

Another area where practitioners will want to exercise caution is in the treatment planning process. In this adaptation of the GLM, the "primary needs" are listed together in case illustrations (e.g., on page 151) with a suite of interventions to address them. Frankly, the list of interventions may appear to many practitioners as something they have been doing in their programs without this adaptation of the GLM. For example, Joe's treatment interventions for the "needs" listed above includes trauma work, a focus on attachment and relationships, "understanding and managing harmful sexual behavior," and "problem solving". Because there is no apparent linkage demonstrating how each intervention addresses each need, the result is less clear than many practitioners will like or understand. In the end, there is a real question of what makes this array of interventions GLM-adherent and not simply a variation on what practitioners and researchers have been urging all along in literature (including works by Phil Rich, Gail Ryan, Rob Longo, and their colleagues) and conferences (ATSA, NAPN, NOTA, MASOC) during the past twenty years. It is reasonable to suspect that diligent efforts to tie these interventions to specific good-life approach goals that are, in turn, tied to dynamic risk factors will make this a more conceptually clear adaptation. As a work in progress, however, the book provides an interesting start in this direction.

A final area for practitioners to consider is the role of "flaws". In the original GLM, flaws (such as means, scope, capacity, and conflict; see Willis, Prescott, & Yates, 2013 for a review) in good life plans are viewed as contributing to sexual offending. In the current adaptation, "means" refers to the methods by which people attempt to satisfy their primary needs. Flaws are considered to be "obstacles" and are classified as internal or external impediments. According to the book, between an adolescent's old life and their new life is something described as a "muddle roundabout." The idea is that adolescents get caught in a circular muddle of internal and external obstacles to achieving a better life. Pages 82 and 83 contain diagrams to illustrate this circular process, in which adolescents either go on to their new life or back to their old life. Absent from the equation is that they might go in any number of other directions, for better or worse. An implicit assumption is that adolescents are somehow specialists who will return to old behavior if they are not working to build a better life for themselves. Research cited elsewhere in the book demonstrates that this isn't the case, and that adolescents may progress to many other kinds of

crimes or desist entirely on their own.

Likewise, figure 5.3 on page 82 shows a repeating cycle of harmful sexual behavior that many will understand to persist inevitably without intervention, via "maintenance/reinforcement." This, too, may not be the case, as research has shown; even without intervention the majority of youth who sexually abused are not known to re-offend. The book actually acknowledges this point elsewhere, and therefore it is puzzling that desistance does not appear in the diagrams. The sum total of these figures and descriptions is imagery that looks strikingly like the various assault cycles so common in latter-day relapse prevention programs, and from which the GLM originally tried to distance itself. If the "muddle roundabout" is a circular process of problems meeting needs, it is unclear how this is not also a variation on the more traditional programming for youth. Have we almost literally come close to re-inventing the wheel? How do we define the good lives model for adolescents, and how do we prevent the appearance of claiming other good interventions in the name of the GLM?

To place this further into context, Lucinda Rasmussen began describing multiple outcomes among young people with sexual behavior problems as early as 1989. These involve self- victimization, abuse, and recovery (Rasmussen, 1989). This was, in part, a response to assault cycles that seemed to regard sexual re-offense as an inevitable result of a series of events. She further developed this into an integrated model called the "trauma outcome process", noting that young people who abuse often have horrific backgrounds as well as internal and external obstacles to change (Rasmussen, 1999). Joann Schladale has further developed this model into practical applications and workbooks (Schladale, 2002, 2010). These and other authors have emphasized in diagrams and metaphors as well as their writings that there are many possible outcomes among adolescents who sexually abuse, and that our imagery should take care not to imply that cycles necessarily repeat themselves, as the imagery in the current book does. Schladale (2010), for example, uses the image of a
tree with many branches, each representing possible outcomes. This seems more in line with the original GLM/SRM, which describes many possible pathways to offense.

Nevertheless, without the current report on the thoughtful journey of G-MAP, these questions would not present themselves. The authors have been courageous and diligent in outlining the intensive level of internal discussions that have taken place to adapt a model that has been helpful elsewhere. As contributors Helen Griffin and Laura Wylie state, "(The GLM) does not constitute a stand-alone model, but is reliant on the use of other theories and approaches to realize its effectiveness and to operationalize the intervention process" (p.
51). This opens the door to further clarifying and refining the GLM for adolescents.

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