Université de Montréal

Treatment Programs for Adolescents Who Sexually Harm and The Good Lives Model

École de Criminologie
Faculté des Arts et des Sciences

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Rapport de stage présenté
en vue de l'obtention du grade de Maitrise ès sciences (M.Sc)
en Criminologie
option intervention

Septembre, 2017

Résumé

Depuis les années 1980, les programmes de traitement pour les délinquants sexuels ont considérablement évolués. Par conséquent, de nombreuses études se sont focalisées sur l'évaluation de leur efficacité. Plus récemment, de nouvelles études empiriques ont été publiées sur les programmes de traitement pour les adolescents auteurs d'abus sexuels. Ce rapport offre un aperçu des programmes les plus courants pour cette population spécifique. Cependant, ce rapport porte plus particulièrement sur l'utilisation du Modèle de Vies Saines (Good Lives Model) avec les mineurs qui commettent des agressions sexuelles. Le Modèle de Vies Saines est basé sur le principe que tout être humain, les délinquants y compris, est motivé à atteindre des besoins primaires, mais il ne possède pas les stratégies adéquates (besoins secondaires) pour les réaliser. Les besoins primaires représentent des expériences, sentiments ou circonstances qui, si atteints, entrainent une augmentation du bien-être. D'autre part, les besoins secondaires ou besoins instrumentaux sont les moyens ou les actions utilisées pour sécuriser les besoins primaires. Le Modèle de Vies Saines a deux objectifs principaux : promouvoir les besoins primaires et la gestion du risque. Pour diminuer le risque de récidive, le Modèle de Vies Saines est axé sur la motivation, les valeurs et les aspirations des délinquants afin de susciter le changement. Ce modèle cherche également à éliminer les distorsions cognitives. Le Modèle de Vies Saines fut développé par Tony Ward en réponse aux critiques du modèle du risque et des besoins (RBR) d'Andrews & Bonta (2005). L'approche de Ward concernant le traitement de la délinquance sexuelle, peut être utilisée parallèlement ou conjointement au RBR. Ce projet du Modèle de Vies Saines a été effectué aux Services Externes de l'Institut Philippe Pinel de Montréal (IPPM) et inclut deux cas d'étude. L'analyse du matériel clinique met en avant les bénéfices et inconvénients de ce modèle. De plus, ce projet offre une compréhension globale du passage à l'acte sexuel chez les adolescents.

Mots-clés : Modèle de Vies Saines, délinquance sexuelle, adolescents, facteurs de risque, besoins fondamentaux, traitement

Abstract

Since the 1980s, treatment programs for sexual offenders have greatly evolved. Subsequently, many studies have focused on evaluating their efficiency. Most recently, new empirical research has arose on treatment programs for adolescents who sexually harm (AWSH). This report offers an overview of most prevalent treatment programs currently available for this specific population. The present report focuses more specifically on the application of the Good Lives Model (GLM) to ASWH. The GLM is based on the principle that all human beings, offenders included are motivated by reaching primary goods but they do not have healthy strategies (secondary goods) to do so. Primary goods are feelings, experiences or circumstances human beings seek to achieve well-being. On the other hand, secondary or instrumental goods are the means or actions used to secure primary goods. The GLM has two main objectives: promote goods and risk management. In order to reduce offending, the GLM focuses on the offender's motivation, values and aspirations to elicit the change process. It also seeks to get rid of cognitive distortions. The GLM was developed by Tony Ward as a response to the criticism of Andews & Bonta's (2005) Risk-Need-Responsivity (RNR) model. Ward's approach to sexual offending treatment can be either used as an alternative or complementary approach to the RNR model. This GLM project took place at the Services Externes of the Philippe Pinel Institute of Montréal (IPPM) and included two case studies. The analysis of the clinical material revealed the benefits and drawbacks of this model. Furthermore, it offered a more global understanding of the pathways to sexual offenses amongst the adolescent population.

Keywords : Good Lives Model, adolescent who sexually harm, treatment programs, risk factors, primary goods

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List of acronyms

ADD :	Attention Deficit Disorder
ADHD :	Attention Deficit Hyperactivity Disorder
AVE :	Abstinence Violation Effect
AWSH :	Adolescents Who Sexually Harm
BP :	Bipolar Disorder
BPD :	Borderline personality disorder
CBT :	Cognitive Behavioral Therapy
CPLM :	Centre de Psychiatrie Légale de Montréal
CSQ :	Correctional Services of Quebec
DASH-13 :	Desistence for Adolescents who Sexually Harm
DAT :	Differential Association Theory
DIY :	Do-it-yourself, handiwork
DMR :	Developmental Model of Recovery
DPJ :	Direction de la Protection de la Jeunesse
ERASOR :	Estimate of Risk of Adolescent Sexual Offense Recidivism
ERG :	Existence Relatedness Growth theory
GLM :	Good Lives Model
GPCSL :	General Personality and Cognitive Social Learning
GST :	General System Theory
IPPM :	Institut Philippe Pinel de Montréal
ITSO:	Integrated Theory of Sexual Offending
MDOs :	Mentally disordered offenders
MI :	Motivational Interviewing
MST :	Multisystemic Therapy
NB :	New-Brunswick
OJJDP :	Office of Juvenile Justice and Delinquency Prevention
RBR:	Risque-Besoin-Receptivité
RNR :	Risk-Need-Responsivity
RP :	Relapse Prevention

SE :	Services Externes de l'IPPM
SMART :	Specific, Measurable, Achievable, Realistic and with Timeframes
SRT :	Self-Regulation Theory
SRS 3.0 :	Session Rating Scale
STDs :	Sexual transmistted diseases
SUD :	Seemingly Unimportant Decision
TTM :	Transtheoretical change Model

Abbreviation list

Etc. :	et cætera
I.e. :	id est
E.g. :	exempli gratia
Et al. :	et alia, meaning « and others »

À Papuche.

Acknowledgments

To my internship supervisor, Geneviève Martel; thank you for your patience and for believing in my project. You have been a great teacher, a great mentor, and a good friend. Thank you for taking the time to teach me the skills in becoming a better practitioner. Thank you for always being available and supportive.

Thank you to Denis Lafortune for guiding me throughout my project and giving me advice.

To Papuche, thank you for always being there for me, for offering me the opportunity to pursue my dreams and for supporting me through the joys and difficulties of life. I could not have done it without you; I am forever grateful to you.

Thank you to my parents for teaching me to always reach for the stars and offering me the opportunity to keep studying when I should probably be getting a job. You have always believed in me and supported me unconditionally through thick and thin. I hope to make you proud. Thank you to my brother for your constant positive attitude and encouragements. Thank you to all my friends across the world, from India to Europe, to the United States, for being present when I needed you.

To Laura, thank you for this incredible friendship that first started on a cold Québécois day. Thank you for being there for me at indecent hours of the day. You have been a pillar a strength for me, and I am so happy to have found you.

To Michelle Côté, this Canadian adventure has been fantastic and greatly thanks to you. You have helped Sébastien, and I feel at home in this country. Thank you for being very supportive and constantly available. Thank you for all your great advice.

Introduction

All over the world, sex offenders generate intense negative responses from the general public including anxiety, disgust, moral outrage and fear. A sex offender can be defined as a person convicted of one or more sexual crimes "including rape, molestation, sexual harassment and pornography production or distribution" (Hill & Hill, 2005). According to The Office of Juvenile Justice and Delinquency Prevention (OJJDP) in the United States, juveniles account for 35.6 % of sexual offenses against minors (Finkelhor, Quenneville & Proulx, 2009). In Quebec, around 21% of all sexual offenders are between the ages of 12 and 17 years old (Tardif et al., 2013). In 2011/2012, Statistics Canada reported that three in 10 (30%) of those accused of sexual offenses against youth and children were under the age of 18. Probation was the most common sentencing (67%) and custody ordered in 9% of cases (Cotter & Beaupré, 2014). This implies that the majority of juveniles who commit sexual offenses will be released into the community. These non-negligible statistics highlight the importance of focusing on treatment and rehabilitation programs because most Legislature and laws do not take into account the empirical evidence of rehabilitation and focus solely on repression and incarceration.

Over the past couple of years, approaches to offender rehabilitation have greatly evolved. In 1974, authors Lipton, Martinson and Wilks, assessed all the evaluations of criminal rehabilitation programs between 1945 and 1967 using meta-analysis. They reached the following conclusion: "With few and isolated exceptions, the rehabilitative efforts that have been reported so far have had no appreciable effect on criminal recidivism" (Purpura, 1997). The results of this assessment convinced individuals that "Nothing Works" and that crime could only be reduced through social justice. However, in 1989, Gendreau and Cullen managed to shift this ideology by showing that positive outcomes did exist in offender rehabilitation programs. This was known as the "Nothing Works / What Works" debate (Wilson, 1980). From then on, many researchers have focused on finding and establishing efficient programs to reduce recidivism rates.

In the first part of this report, the main treatment strategies are described including Multisystemic Therapy, Relapse Prevention, the Risk-Need-Responsivity model and finally, the Good Lives Model (GLM). Using the GLM with adolescents who sexual harm (AWSH) has very little research. The current model of the GLM has proven to be promising with adult sex offenders but AWSH may not have the same needs and primary goods as adults, and there is no GLM made specifically for them. It is interesting to address how different the GLM is from

cognitive-behavioral models and how it can be put into practice. This is why the second part of this report will focus on the internship, its objectives and the implementation of GLM aspects when working with juveniles who sexual offend.

Recidivism

Recidivism is a complex concept that is defined as: 'the reversion of an individual to criminal behavior after he or she has been convicted of a prior offense, sentenced, and (presumably) corrected." (Maltz, 1984). In Pew's *State of Recidivism* report (2011), recidivism is defined as: "the act of re-engaging in criminal offending despite having been punished." Recidivism can be divided into two terms, specific recidivism and general recidivism. In the case of sexual offending, specific recidivism implies re-offending for any sexual offense. On the other hand, general recidivism refers to subsequent offending of non-sex related offenses. In regards to juveniles who commit sexual offenses, studies have shown that general recidivism is more common amongst this group than specific recidivism. Indeed, it is believed that between 10 to 20% of juveniles who sexually offend turn to specific recidivism while 30 to 40% turn to violent general recidivism (Tardif et al., 2013). This means that juvenile who engage in sexually abusive behaviors are more likely to commit non-sexual violent crimes following their initial conviction than sexual offenses.

In 2010, Caldwell described general recidivism as six times greater than specific recidivism over a three year period amongst juveniles. Juveniles who only commit sexually specific offenses do not engage or only mildly in conduct disorder behaviors. In contrast, for others, the sexual offense is only part of a broader pattern of versatile and general criminal behavior. However, it must be noted that those rates do not give an accurate statistical portrait of the re-offense rates. Most of the statistics are based on official criminal or juvenile justice records pertaining to an arrest or conviction and therefore underrepresents the true incidence rate. Many victims do not report sexual assaults, and many offenders are never arrested. Tjaden and Thoennes (2006) found that only 12.9% of men who were raped reported it to the police and only 19.1% of women. Moreover, Grotpeter and Elliot (2002) found that only 3 to 10% of juveniles reported committing a sex crime following their arrest. These statistics offer a descriptive portrait on how AWSH recidivate, and help understand which factors need to be targeted.

Adolescents who sexually harm (AWSH)

AWSH are mostly heterogeneous groups that have different beliefs, expectations, and values than adults; where the role of family is more critical. Adolescents are developmentally immature; their emotions, attitudes, behaviors and cognitive functioning are still developing. This implies that the moral significance of their actions is not the same as for adults. Moreover, the majority of AWSH will desist from the behavior by the time they reach adulthood. It is estimated that only 10% to 13% of AWSH will recidivate. Although there isn't one X risk factor responsible for explaining sexual offenses, some risk factors have been identified (Rich, 2011). Statistics show that adolescents who sexually offend are more likely to do so in groups than adult sexual offenders. Furthermore, sex offenses peak at age 12 and plateau after age 14. It is estimated that one out of 8 young sexual offenders is under the age of 12 years old (Department of Justice, 2009).

Research shows that the most common path of youth sex offending includes complex traumatic childhood experiences, family instability, attachment issues, neglect or abuse as well as social anxieties (Rich, 2011). Up to 10 risk factors have been identified in AWSH assessments: (1) poor sexual beliefs, attitudes and drives, (2) history of sexually abusive behavior, (3) history of personal victimization, (4) history of general antisocial behavior, (5) lack of social relationships and connection, (6) personal characteristics (e.g. motivation, deficits, etc.), (7) poor psychosocial functioning (self-regulation, impulse control, etc.), (8) stressful or unstable family relationships and functioning, (9) unstable environmental conditions, and (10) response to treatment. Also, young offenders, including AWSH have numerous deficiencies in problem-solving such as defining problems in hostile ways, adopting hostile goals, seeking few additional facts and generating few alternatives (Rich, 2011). Those risk factors all affect the normal course of development.

However, if there are risk factors, it also means that there are protective factors such as prosocial parental values, prosocial peer groups, positive adult models, etc. Some believe that there are some strengths that sexually abusive adolescents lack, that need to be built during therapy. This includes self-acceptance (healthy self-image), purpose (meaning to life), environmental mastery (manage everyday life), personal growth (accomplishment, continued development), positive relationships (peers and family), and autonomy (independence and self-determination (Rich, 2011). Community relatedness, as well as emotional health, were found as

strong protective factors. Some studies have looked at the needs of young offenders who sexually harm and what clinicians should focus on.

According to Ryan & Deci (2000) relatedness, competence and autonomy are the main needs young offenders seek. One study (Chu, Koh, Zeng & Teoh, 2015) was done in Singapore (important to note because of cultural differences) with a sample of 168 AWSH applied the GLM in combination to self-regulation models in treatment. In this context, authors found that relatedness, pleasure and inner peace were the more sought primary goods. Hoge, Andrews, and Leschied (1996) identified the following protective factors for young offenders: positive peer relations, good educational achievement, positive response to authority and effective use of leisure time. These studies confirm that it is innate to seek primary goods although it is essential to note that the cultural differences may have been an influencing factor (Chu, Koh, Zeng & Teoh, 2015). Furthermore, these studies offer guidelines as to what needs to be taken into account when admitting juvenile offenders into treatment.

The first part of this report is an overview of the most prominent treatment programs used in sexual offending; it focuses most specifically on the RNR model and the GLM. The second part of the report describes the internship location and clinical objectives sought. Next, is a description of the methodology used in applying the GLM to AWSH. Finally, two case studies are presented with a clinical review.

Chapter I

Theoretical context

In Europe and North America, treatment programs have evolved greatly. Up until the 1980s treatment programs were essentially based on simple behavioral concepts while since then, the focus has shifted to more cognitive-behavioral models. These more recent programs address a multitude of aspects of sexual offending and not only sexual deviance.

Several studies have tried to evaluate the efficacy of treatment programs for sexual offenders. These studies have mainly focused on recidivism rates. However, there were some methodological issues because programs vary greatly which has resulted in the absence of consensus. One meta-analysis by Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto (2002) has, nevertheless, brought some insight into the matter. According to the meta-analysis, treatment programs decrease sexual recidivism as well as general recidivism in comparison to control groups that receive no treatment. In addition, treatment programs that were implemented after 1980 and those implemented before 1980 were compared. Results showed that cognitive-behavioral therapy (CBT) programs established after 1980 reduced recidivism rates but behaviorist programs prior to 1980 did not.

In terms of offender rehabilitation, CBT programs are the most common and efficient. These programs seek to help offenders control their thought processes, emotions, behaviors, and attitudes. In cognitive-behavioral psychology, sexual offending is considered a learned behavior that is influenced by thought patterns, attitudes, and beliefs. Therefore, CBT programs try to modify such factors for offenders to act in a prosocial manner. Yates (2003) identifies the following goals of CBT: acquire social abilities, fulfill intimacy deficits, acquire healthy adaptation strategies, improve problem-solving competencies and develop empathy. This leads to cognitive restructuring and/or diminishes deviant sexual interests. This is why CBT targets criminogenic needs and dynamic risk factors. Also, treatment programs should be tailored to each individual based on their risk estimate.

Currently, Andrew and Bonta's Risk-Need-Responsivity (RNR) model remains the most prevalent as its efficiency has been proved numerous times. The GLM emerged has a critical reaction to RNR and is deeply rooted in positive psychology. Ward and his colleagues believed that the RNR was too negative of an approach, that it dehumanized offenders and did not take into account the context they lived in. Its ethical core is that of human rights, and it starts from the assumption that while offenders have obligations to respect other peoples' entitlements to wellbeing and freedom, they are also entitled to the same considerations.

Following are exposed some of the most prominent treatment programs currently available to juvenile sexual offenders and the GLM. It must be noted that to improve treatment programs; pharmacology treatments can be used in addition to the psychological treatment.

1.1 Multisystemic therapy

Multisystemic therapy (MST) is an ecologically-based model that was developed in the United States in the 1970s. It is a family and community-based treatment program. This model has proven to be effective with chronic and violent juvenile offenders. More recently, it has been used to treat juveniles who sexually harm.

1.1.1 Theories and empirical references

The social, ecological theories underlying the MST include Bronfenbrenner's Ecological Systems Theory (1979), the principle of ecological validity and the reciprocal nature of human interaction. As reported by Bronfenbrenner (1979), the development of a child must be studied within the context of his multiple environments. Bronfenbrenner defined these environments as ecosystems and identified five levels, going from the most intimate to the broadest: the microsystem (immediate environment), the mesosystem (connections), the exosystem (indirect environment), the macrosystem (social and cultural values) and the chronosystem (changes over time). Bronfenbrenner describes it as follows: "a set of nested structures, each inside the next, like a set of Russian dolls, At the innermost level is the immediate setting containing the developing person" (1979, p.3). According to him, all these ecosystems interact and influence the child's development. If adolescents develop conduct disorders, it is a result of the unhealthy interplay between the ecosystems. Therefore, there is a multitude of risk factors that can lead to criminal behavior and it varies from one individual to another. This theory offer guidelines for treatment program as it leads to not focus only on personality traits but also on the environment of the juvenile (Borduin, Henggeler, Blaske & Stein, 1990).

The principle of ecological validity is the assumption that behavior can only be fully understood if the natural environment is taken into account. In MST, this forces the clinician to understand how the adolescent functions in different spheres of his life. Finally, the principle of reciprocal nature of human interaction, which is similar to the coercion mechanism argues that children born in coercive environments are more likely to develop social deficits and will apply

it to other spheres of their lives. Reciprocity is the idea that individuals give to others what has been given to them. In MST, it helps understand why and how a juvenile offender has acquired certain reactions (Letourneau, Henggeler, Borduin, Schewe, McCart & Chapman, 2009).

1.1.2 Overview

The MST promotes targeting not only the risk factors but also focus on the family dynamic. It believes that the key to helping youths is through helping their families; it is a family preservation model. Interventions go beyond simply providing the necessary tools to the family members; it seeks to modify the adolescent's behavior by altering his/her natural contexts such as school, family or neighborhood. MST is usually applied to serious delinquents and offenders. Services should be available 24h a day and seven days a week but are time limited from one to five months. Family values, culture, and beliefs should be respected and taken into account during interventions (Borduin & Schaeffer, 2002).

1.1.3 Nine principles

The implementation and design of the MST are based on nine core principles (Henggeler, 1999). The first step consists of identifying the issues within their social context. To do so, therapists will obtain information from family members, teachers, friends and other relevant sources. This allows isolating the risk factors that lead to delinquent behavior. Because each individual is different, each assessment and treatment are specific.

The second principle is that therapeutic interactions between the family members, the therapist and the youth accentuate the positive aspects of the adolescent's life. Furthermore, these systemic strengths elicit change. Third, responsible behavior should be promoted through these interactions, and irresponsible behavior should be decreased in a similar manner. To do so, parental figures must teach discipline and provide structure to the youth, but also meet the youth's basic physical needs and provide nurturing and love. This means that family members play an essential role in this therapy model; they must change their behaviors to decrease the youth's problematic conduct. On the other hand, the adolescent is responsible for avoiding violent behavior, increasing school performance and actively participating in domestic chores.

The fourth principle postulate that MST should be solution-focused and rooted in the present rather than the past. Moreover, goals must be attainable, clearly articulated and all

members participating in the treatment therapy must work together towards the same goal. It is only once all the goals have been met that the MST program ends (Borduin & Schaeffer, 2002).

In the fifth principle, the therapist must address all the issues within each system. Also, the therapist must also address how the systems interact with each other. Sixth, interactions seek developmental maturity for the adolescent as well as for his family. Parenting skills and increasing the adolescent's competencies and skills are at the center of MST. Seventh, efforts must be made on a daily or weekly basis and interactions are intensive. Eight, the evaluation must be ongoing and outcomes viewed from multiple perspectives. It is the therapist's responsibility to ensure that the therapy fits the family, that the family gives in the effort required and that the interventions are viable to generate change. Finally, all treatment gains must be put into practice and maintained after the end of the MST program. Family members are given the necessary tools to solve their problems and are offered a community support network (Borduin & Schaeffer, 2002).

1.1.4 Evaluated efficacy and results

Letourneau et al., (2009) conducted a study that compared MST to other typical treatment programs used with AWSH. Their sample comprised of 127 AWSH. Outcomes were evaluated over the course of a 12 months period. The authors assessed problematic sexual behavior, delinquency, mental health functioning, out-of-home and substance use. Results showed that juveniles who received the MST program were less likely to present negative outcomes than those who received the other treatment program. This implies that the community and family aspects of MST are essential when dealing with such population. Moreover, Borduin & Schaeffer (2002) recount studies that have found similar promising results. Although the studies mentioned have small samples, results were still found to be significant. In one study, including 16 AWSH, a three year follow-up revealed that juveniles in the MST group were less likely to be rearrested for a sexual crime than juveniles in outpatient individual therapy. Furthermore, rearrests rates for non-sexual crimes were also significantly lower. A more recent study (Henggeler & Sheidow, 2013) found that MST decreased behavioral problems and criminal behavior, improved family and peer relations. Also, AWSH obtained better school grades, and it reduced parent's symptomatology.

One of the reasons MST may be so effective is that it takes into account the issues faced by young offenders based on empirical findings. These issues include social immaturity, low family warmth, and academic difficulties. Furthermore, this treatment program is flexible and adapted to the adolescent's natural environment. When used in sexual offending therapy, it addresses the risk factors correlated with inappropriate sexual behavior and takes into account the complex environment (Borduin & Schaeffer, 2002).

1.2 Relapse prevention model

Relapse prevention (RP) is a self-management treatment program that targets individuals who are trying to change their behaviors. It was first developed in 1985 by Marlatt and Gordon and initially targeted addictions (e.g. alcohol, substance abuse). In RP, offenders are taught how to cope and anticipate with the issue of relapse (Larimer, Palmer & Marlatt, 1999). Relapse can be defined as "a setback in a person's attempt to change or modify any particular behavior or class of behaviors" (Bromberg & O'Donohue, 2014, p.201). RP techniques are a combination of cognitive interventions, behavioral skills training, and lifestyle changes strategies. It can either be done on an individual basis or in group therapy. Usually, in cases of juveniles who engage in sexual harmful behaviors, group RP is preferred (Bromberg & O'Donohue, 2014).

1.2.1 Theories and empirical references

RP therapy is a cognitive-behavioral approach that targets addictions. RP is rooted in the literature of substance abuse and was initially used with alcoholic or drug addicts. Some of the theories underlying the RP include Bertalanffy's general system theory (GST), Bandura's self-efficacy theory, Prochaska's and DiClemente's transtheoretical change model (TTM) and Gorski's developmental model of recovery (DMR).

Bandura self-efficacy theory originated from social cognitive psychology. According to Bandura (1995), self-efficacy "refers to beliefs in one's capabilities to organize and execute the courses of action required to manage prospective situations" (Bandura, 1995, p. 2). Put simply; it is the person's own perceived ability to achieve a particular task. Self-efficacy is influenced by the environment, behaviors and cognitive/personality factors. In this theory, it is hypothesized that individuals are more likely to engage in tasks in which they have high self-efficacy rather than in activities where they have low-efficacy. How people perceive their

abilities directly influences motivation and performance. Individuals with high-efficacy tend to show better performance and motivation in comparison to low-efficacy individuals. In RP, it is believed that self-efficacy can determine relapse.

> In this view, people are self-organizing, proactive, self-regulating, and self-reflecting. They are contributors to their life circumstances, not just products of them (Bandura, 2005, p. 1).

Prochaska's and DiClemente's TTM is a biopsychosocial model that conceptualizes the stages of change individuals go through when modifying behavior. Prochaska and DiClementte identify six stages: precontemplation (Not Ready), contemplation (Getting Ready), preparation (Ready), action, maintenance, and termination. The authors also include relapse, but it is not considered a stage. They define it as follows: "return from Action or Maintenance to an earlier stage" (Prochaska, DiClemente & Norcross, 1992)

Gorski's developmental model of recovery (DMR) (Gorski, 2008) entails that recovery is complex and happens over time through different stages. There are six stages of recovery: transition (recognizing the addiction issue), stabilization (detoxification and recuperation), early recovery (changing addictive feelings, thoughts, and behaviors), middle recovery (lifestyle balance), late recovery (family of origin issues) and maintenance (growth and development). It is a flexible model that seeks to prioritize problems (Ziedonis & Stern, 2001).

The GST was influenced by the philosophy of science, biology, physics, ontology and engineering. It states that physical, psychological, cultural, social and biological systems are interrelated and interdependent. Systems must be perceived as a whole rather than individually; because of their dynamic nature, together they create a living system. Furthermore, addiction is considered a result of larger social systems interacting. In this mindset, groups surrounding an individual influence his/her actions (Chen & Stroup, 1993). These theories have contributed to the creation of the RP model.

1.2.2 Core principles

There are eight core assumptions to RP therapy: (1) the client's issues must be addressed in cognitive terms and his/her case formulation should always be evolving, (2) therapeutic alliance is central, (3) treatment should be problem focused and goal-oriented, (4) the present should be emphasized although the past may be useful when addressing issues that have

influenced the current problematic behavior, (5) therapy has to be educative and teach the client to be his/her own therapist, (6) treatment sessions should be structured, (7) RP should teach the client how to evaluate, identify and handle his/her beliefs and dysfunctional thoughts and (8) feelings, thoughts and behaviors can be modified using a variety of strategies (Bromberg & O'Donohue, 2014).

1.2.3 The re-offense chain

Marlatt's cognitive-behavioural model of RP makes a distinction between lapse and relapse. Lapse implies a brief episode of acting out on an unwanted behavior while relapse implies a complete return to the unhealthy behavior. Lapses can lead to relapse. The RP model classifies risk factors or situations that can contribute to relapse. These factors are split into two categories: covert antecedents (urges, cravings and lifestyle imbalances) and immediate determinants (a person's coping skills, high-risk situations, the abstinence violation effect (AVE) and outcome expectancies) (Larimer et al., 1999). To understand the RP model, the re-offense chain must first be explained. This chain is usually used with sexual offenders in RP. It involves five steps that lead individuals to relapse.

The first step is the Seemingly Unimportant Decision (SUD) and refers to a decision that may not appear as important but is. In this phase, offenders must recognize whether the decision seems important or is truly important. If the offender takes the wrong decision, it will lead to the second step: the Risky Situation. In a dangerous situation, re-offense or relapse becomes a possibility even if the individual has no intent on reoffending. In turn, this can lead to a lapse. In the context of sexual offending, a lapse would be described as inappropriate sexual fantasy or an inappropriate sexual action (Bromberg & O'Donohue, 2014). If the sexual offender experiences a lapse, the AVE will occur. The AVE refers to the offender's emotional state following the lapse and the causes the offender attributes to the lapse. If the offender considers personal failure as the leading cause of the lapse, he will experience negative emotions and possibly guilt. These emotions are more likely to lead to the final stage: the offense. This chain helps recognize the stages sexual offenders can go through. RP states that there are only two strategies to avoid being caught in the re-offense chain. These are avoidance or escape. Avoidance simply means that the offender should keep away from risky situations. For example, if a child molester needs to go grocery shopping, he could choose to go very early in the morning

or late in the evening to avoid coming across children. On the other hand, escape refers to getting out of a situation. This could be at any stages of the chain. This chain brings insight into the stages of offenses; but to avoid getting caught in this chain, some surrounding issues must be addressed (Bromberg & O'Donohue, 2014).

1.2.4 Issues addressed

A key element of RP is that this treatment is a choice. Clients must understand that all their choices have consequences and therefore must think before acting. Clients have to take responsibility for their actions, thoughts, and feelings. The therapist's role is to give the necessary tools to the client for him/her to make healthy rather than unhealthy choices. These strategies will prevent re-offense. However, consequences cannot be controlled. RP therapy simulates various situations where the client must make a choice and anticipate outcomes. The clients must understand that each action will have desirable and undesirable consequences. Nonetheless, positive outcomes should always outweigh negative ones (Bromberg & O'Donohue, 2014).

RP therapy seeks to correct thinking errors (cognitive distortions). Sexual offenders tend to have distorted perceptions of their victims and themselves. RP therapists use strategies to change these distorted thoughts such as writing letters, role-playing or even drawing. These exercises are linked to a word list of emotions. For AWSH, it allows them to understand better how emotions function and how they may be misplaced. Needs satisfaction and self-understanding are equally at the core of RP. Offenders, like others, have needs. Yet, they try to satisfy those using inappropriate needs. RP aims at creating self-awareness and finding healthy ways to meet one's needs (Bromberg & O'Donohue, 2014).

Another important step is that of identifying and diffusing risk factor. Triggers or what leads the risk factor to arise are identified. Triggers usually come from the environment. Once identified, sexual offenders must establish coping strategies to avoid re-offending. Tactics to diffuse risk factors can be activities such as drawing, going to the gym or talking to the therapist. Improving communication increases coping skills. Offenders are taught how to express their feelings, how to listen to others and follow assertiveness training. Communication can also increase awareness.

With AWSH, sexual education and appropriateness teach interpersonal boundaries and basic sexual functioning. Many juvenile offenders do not know this information and such courses enhance awareness. Moreover, building relationships can be a complicated task for adolescents. Many adolescents rush into relationships and can experience rejection or betrayal. By encouraging them to have relationships built slower (whether friendship or romantic), they can avoid problematic behavior (Bromberg & O'Donohue, 2014).

Ultimately, AWSH must learn to delay gratification and control urges. To do so, they must first recognize what urges are. Self-management skills can be employed to control dangerous fantasies or urges. AWSH can turn to other activities, avoid triggering situations or talk to someone about their feelings. Not all techniques work equally for each offender. Therefore, offenders should use the ones that best work for them (Bromberg & O'Donohue, 2014).

1.2.5 Evaluated efficacy and results

Over the years, RP therapy has been improved and modified. In sex offender treatment, it is generally used in combination with other treatment services such as anger management, victim empathy or sexual education. A study that looked at how effective RP is across different populations indicated that it seemed most effective with young offenders rather than adult offenders (Dowden, Antonowicz & Andrews, 2003). Overall, RP is associated with a moderate decrease in recidivism. Bromberg & O'Donohue (2014) state that "RP is effective for some of the adolescents some of the time. However, we do not know which adolescents are most likely to benefit from RP programs than others". According to Polaschek (2003), there are mixed opinions as to whether or not RP is truly effective. In regards to sexual offender treatments, there is too little if not any empirical evidence in reducing recidivism. Consequently, it cannot be concluded that RP is efficient.

There is one noteworthy issue with the RP model. As mentioned previously, participating in the RP program is a choice. This implies offender in RP want to change their behavior(s). There are many sexual offenders who do not wish to change their behaviors. When working with such offenders, the RP program becomes useless. Therefore, RP only targets a specific group of offenders. Also, although RP is a cognitive-behavioral approach, programs

that include the RP framework vary considerably, so it is difficult to know which aspect is responsible for reducing re-offenses (Polaschek, 2003).

1.3 Risk-Need-Responsivity model

Currently, the most influential assessment and treatment program of sexual offending is Andrews and Bonta's Risk-Need-Responsivity model (RNR) of rehabilitation and correctional assessment. The RNR was first developed in the 1980s but formalized in 1990. This treatment program can be applied to any types of offenders including those who suffer from mental disorders, juvenile offenders, sexual offenders and native offenders.

1.3.1 Theories and empirical references

The creation of RNR model was influenced by different psychological theories. Psychodynamic theory which is rooted in the Freudian psychoanalytic perspective has contributed to the understanding of criminal conduct. In Sigmund Freud's theory, personality is structured with the ego and the superego that both interact with the environment and the demands of the id. It states that psychological maturity can be reached if individuals have the ability to delay gratification to achieve long-term gain. According to Andrews and Bonta (2015), this theory has given a better understanding of how psychological immaturity and weak self-control in specific situations is linked to criminal behavior. It brought insight on impulsivity, weak superego and disturbed interpersonal relationship,

Other influential theories are the social location theories of crime. As reported, these theories suggest that social status is linked to criminal behavior. Social inequality, age/ethnicity, and gender may contribute to crime. Therefore, personal distress is linked to criminal behavior. This is partly related to Merton's strain theory that stipulates that social values and structures may pressure individuals to commit crimes. This theory has offered the RNR model some risk factors and a better understanding of the social context of crime (Paternoster & Mazerolle, 1994).

Differential association theory (DAT), similarly to the psychodynamic theory focuses on thinking processes: beliefs, attitudes, values, and rationalizations. These mental patterns can lead to procriminal or anticriminal paths. In DAT, learning is a central component and occurs in association with others. This follows the perspective of operant conditioning (Akers, 2012).

DAT supports the RNR's principle that reinforcement and punishment can deter or accentuate criminal behavior. Andrews and Bonta (2015) relate it to antisocial attitudes and antisocial associates.

Finally, the General Personality and Cognitive Social Learning (GPCSL) (Andrews & Bonta, 2015) perspective of criminal behavior also influenced the RNR model. It involves some theories based on behavioral and cognitive psychology. The GPCSL specifies that like any other behavior, criminal conduct is a learned process. Furthermore, a variety of factors must be taken into account to understand why certain individuals engage in such behavior; there is no single risk factor. Risk factors that were identified as relevant are part of the "Big Four"; which will be described further. All these theories have played a role in making the RNR model as they each offer a different perspective on the understanding of criminal conduct (Andrews & Bonta, 2015).

1.3.2 Concept of risk

In the RNR model, the concept of risk is central. The concept of risk can be defined as "the possibility of harmful consequences occurring" (Ward, Vess, Collie & Gannon, 2006) while risk assessment refers to the process of determining if an individual presents a potential for harmful behavior towards himself or others. Blackburn (2000) describes risk assessment as follows: "It entails consideration of a broad array of factors related to the person, the situation, and their interaction" (p. 179). Therefore, risk factors are variables that increase the likelihood of an individual committing harmful behavior. Risk factors can be identified as static or dynamic.

Dynamic risk factors are predictors associated with criminal behavior and recidivism, but that fluctuate over time. Dynamic risk factors can be stable or acute. Stable ones can change over the course of weeks, months or even years. On the other hand, acute ones can change almost instantaneously. In some cases, factors can be both acute and stable. Examples of dynamic risk factors include interpersonal relationships, substance abuse or emotional collapse. On the other hand, static risk factors are historical factors that have been demonstrated to relate to recidivism potential. Unlike dynamic risk factors, those factors cannot be changed. Criminal antecedents or family criminality are examples of static risk factors (Andrews & Bonta, 2003).

1.3.3 Overarching principles

Those principles offer a basis for the practice of the RNR model. In order to have effective interventions with offenders, services must first be offered in an ethical, legal, moral, decent, just and humane manner. Moreover, it must be based upon empirically valid theories that help fully understand the complexity of criminal conduct. Also, offering human services should be more important than relying on the severity of the penalty. Finally, this model should be used across the different justice systems and in other institutions to improve crime prevention (Andrews, Bonta & Wormith, 2011).

1.3.4 Core principles

This very specific model addresses three clinical issues related to its core principles: (a) who should receive more intensive treatment (risk principle), (b) what are the most appropriate intermediate targets of services for purposes of an ultimate reduction in criminal behavior (need principle) and (c) what strategies of service, modes and style are best employed (responsivity principle).

In 1990, the RNR only included three core principles: the risk principle, the need principle, and the responsivity principle. More recently, some other principles have been added to the model including the principle of human services, breadth, strength, structured assessment and professional discretion (Andrews & Bonta, 2015).

The risk principle or "who to target" has two aspects to it. First, criminal behavior can be predicted based on empirical evaluations. Second, the level of risk will determine the intensity of the intervention; treatment services and risk level need to match. Andrews, Zinger, Hoge, Bonta, Gendreau & Cullen, (1990) believe that higher risk offenders need more intensive services than low-risk offenders. Furthermore, the authors recommend little to no intervention for low-risk offenders. This is why the level of risk should be identified prior to any intervention.

The need principle or "what to target" refers to the offenders' needs whether criminogenic or noncriminogenic. Criminogenic needs are dynamic risk factors associated with recidivism whereas noncriminogenic needs are only weakly associated with recidivism. This is why the RNR model focuses on changing criminogenic needs to reduce recidivism. This is the primary focus of the model; although other needs can be addressed, they are not the primary

focus. Andrews and Bonta (2015) do not believe that addressing noncriminogenic needs will alter future recidivism significantly. The core principle of need seeks to move criminogenic needs to become strengths.

The responsivity principle or "how to intervene" refers to offering treatment programs in a mode or style that fits the ability and learning style of the offender. Responsivity is either general or specific. General responsivity stipulates that cognitive-behavioral and cognitive social learning strategies are the most efficient interventions. Because there is solid empirical evidence of its efficiency, it should be used to elicit change. This can be done using strategies such as modeling, reinforcement, skill building or cognitive restructuring. Specific responsivity seeks to adapt the mode and style of service according to characteristics specific to the offender such as gender, age, ethnicity, motivations, strengths, personality or preferences and takes into account the setting of the service. When working with weakly motivated offenders, the intervention should focus on reducing obstacles that affect participation, on building strengths, establishing good relationships and focusing on personal interests. Treatment should start where the person "is at." In the most recent version of the RNR, the authors have mentioned that focusing on non-criminogenic needs could also be part of the responsivity principle (Andrews & Bonta, 2015).

The last four core principles have been added later on. Breadth refers to targeting multiple criminogenic needs when working with high-risk offenders. Therefore, more than one or two criminogenic needs should be addressed in such cases. The strength principle seeks to assess the offenders' strengths to enhance specific responsivity and prediction. The 11th principle of structured assessment offers guidelines. All assessment should be done using validated and structured assessment instruments. Andrews and Bonta (2015) claim that such instruments are more reliable than clinical judgments. Finally, professional discretion refers to the fact that in certain specific cases, professional judgment may deviate from the instruments and can override instrumental decision-making.

1.3.5 Organizational principles

The setting, staffing, and management are essential parts of the RNR model. The RNR model recommends community-based services rather than institutional and residential settings. Moreover, to apply the RNR, the staff needs to be appropriately trained with high-quality

relationship skills and structuring skills. Therapists and staff need to show respect, care, personal autonomy, collaboration, and enthusiasm. Also, they must use cognitive behavioral and skill building strategies. Regarding the management aspect, staff cannot use the RNR model without the support of its organization. Furthermore, the authors recommend implementing training, supervision, monitoring and feedback. Care should be continuous and collaboration essential (Andrews & Bonta, 2015).

1.3.6 The central eight

As mentioned previously, the concept of risk is core to the RNR model. Andrews and Bonta (2015) have identified eight risk/need factors. These factors are divided into two groups: the Big Four and the Moderate Four. The Big Four factors are the ones most correlated with criminal behavior and recidivism while the Moderate Four are less associated to recidivism. The Big Four include (1) history of antisocial Behavior, (2) antisocial personality pattern, (3) antisocial cognition and (4) antisocial associates. The Moderate Four include (5) family/marital circumstances, (6) school/work, (7) leisure/recreation and (8) substance abuse.

The RNR model offers specific targets of change, and all risk/need factors are related to the core principles of the model. Furthermore, the authors define each risk/need factor in both extremes, as dynamic needs or strengths (Andrews & Bonta, 2015).

1.3.7 Critiques of the RNR model

The RNR model has proven to be efficient in numerous studies. Meta-analyses, as well as other studies, have shown that the RNR reduces recidivism. However, this model has also been criticized, mainly by Tony Ward and his colleagues. According to Ward, this model focuses solely on the management of risk rather than on establishing a more positive way of life for offenders. Furthermore, little attention is given to the primary goods/needs of the offenders. Ward and Brown (2003) also point out that in the RNR model, the offender is not perceived as a complex human being that seeks to make meaning of his life but rather as a set of risk factors. This approach, in turn, leads the correctional system to intervene in a negative way towards the offenders. The RNR focuses on what needs to be avoided or eliminated rather than on finding prosocial ways to adapt. Ward, Mann & Gannon (2007), qualify the RNR has to be a *"one size fits all"* model; all offenders are treated equally, and the model is applied similarly to everyone.

This goes against the core principles of the GLM which believes in an individually tailored approach.

It is important to note, however, that some changes have been made to the RNR model over the years and some of these critics may not be as valid as they used to be. Indeed, Andrews and Bonta (2015) have tried to incorporate more humanistic principles into their model

1.4 The Good Lives Model

1.4.1 Indications/contraindications

The GLM is a framework of offender rehabilitation. It is a strength-based approach that aims at reducing the offending behavior. According to the GLM, rehabilitation should have a twin focus: goods promotion (approach goals) and risk management (avoidance goals). This holistic approach targets offenders, usually when released from prison and living in the community. It is recommended that there has to be a minimum of motivation to change their behavior for the GLM framework to be efficient. So far, the GLM has been particularly used among adult sex offenders. However, it could be applied to any type of offending behavior, any gender as well as to individuals with mental disorders (Wylie & Griffin, 2013). It cannot be applied to pro-social individuals as they already use appropriate means to reach their primary goods.

1.4.2 Theories and empirical references

Initially, rehabilitation was sought solely through punitive means (e.g., prison). It eventually evolved from "nothing works" to believing that some treatment therapies may be efficient in decreasing recidivism rates. The GLM was created in contrast to the Risk-Need-Responsivity Model that focuses primarily on the dynamic risk factors (criminogenic needs). The GLM was greatly influenced by positive psychology and humanistic traditions (Abraham Maslow, Carl Rogers, Erich Fromm, etc.). Ward and Brown (2004) believe that offenders are like any other human being; all seek high levels of well-being. The authors define these goals as primary goods. Primary goods are defined as "actions, states of affairs, characteristics, experiences, and states of mind that are intrinsically beneficial to human beings and therefore sought for their own sake rather than as means to more fundamental ends." With the influence

of psychological and social theories, evolutionary theory, anthropology, and ethics, the authors identified 9 primary goods: (1) life (healthy living, sexual satisfaction), (2) knowledge (3) excellence in play and work (4) excellence in agency (autonomy), (5) inner peace (freedom from stress), (6) relatedness and community (romantic, intimate, family), (7) spirituality, (8) happiness and (9) creativity.

Ward and Brown (2004) managed to pick out nine primary goods by looking at different theories. Although it isn't clear as to which theories on goods influenced Ward and Brown, we can assume that Maslow's hierarchy of needs is probably one of them. Maslow believed that all human beings go through different stages of growth to achieve well-being. Although Ward and Brown's (2004) primary goods are more complex, some of the goals are similar to Maslow's hierarchy, such as belonging and relatedness. Maslow was a pioneer in establishing the pyramid of the human needs which he divided into five groups: physiological, safety, belonging, self-esteem and self-actualization. To reach a state of well-being, all individuals much fulfill these five stages (Lester, 1990).

Another humanistic theory on needs that may have influenced the creation of the GLM is Alderfer's ERG (Existence Relatedness Growth) theory of motivation. Alderfer regrouped Maslow's pyramid into three groups: existence, relatedness, and growth. He believes that these groups are a key to motivation. Unlike Maslow's theory and similarly to the GLM, Alderfer acknowledges that these needs are different for each individual and that some may have a higher value than others. Therefore, it is person specific. The ERG theory of motivation also mentions the "frustration-regression" element that goes about the fact that if a person is frustrated at one of the higher levels, he may regress to a lower one (Yang, Hwang & Chen, 2011). This goes hand in hand with the GLM and how primary goods when frustrated or not fulfilled become problematic and lead to maladaptive behavior.

To some extent, Rogers' humanistic theory is also a major source of influence. His theory of client-centered therapy is somewhat part of the GLM; like in MI, the therapist needs to show genuineness, nonpossessive warmth and accurate empathy. This means that the therapist should not use a conflictual attitude but rather a trustworthy one (Rogers, 1949).

These humanistic theories are all essential to the GLM because they all imply that human beings, whether offenders or not have needs that need to be fulfilled to reach a certain well-being. Furthermore, Roger's theory suggests that it isn't because an offender has committed a

crime or several that he should be treated in a judgmental way; not only is it counterproductive but it also goes against humanistic traditions.

The social theory of self-determination (SDT) states that all individuals have "inherent growth tendencies." This means that all human beings have psychological needs that lead to motivation. These needs include competence, relatedness, and autonomy. These elements are all considered innate. This echoes with the GLM and intrinsic motivation (Ryan & Deci, 2000).

Baumeister's self-regulation theory (SRT) is the capacity and willingness to control one's own actions or emotions to achieve better personal outcomes. People regulate themselves; they essentially force themselves not to do things that shouldn't be done. Self-regulation usually occurs when there are conflicting motivations and has four components: standards, motivation, monitoring, and willpower. For offenders, self-regulation is tiring, and it is why they often act on impulses. SRT can be developed in the GLM as it is a key to controlling offending behavior (Baumeister, Gailliot, DeWall & Oaten, 2006).

The GLM does not only include making "better lives" for offenders, but it also focuses on the management of dynamic risk factors. The concepts of risk factors and protective factors originated in medicine. In forensic psychology, risk factors are environmental conditions or personal characteristics that increase the likelihood of delinquent behavior (increase chances of recidivism). On the contrary, protective factors are personal characteristics or environmental conditions that decrease the likelihood of delinquent behavior (reduce chances of recidivism). It is crucial to understand these concepts as they are strongly linked to the GLM model (Ward & Brown, 2004).

Finally, cognitive distortion theory also plays an important role in the GLM framework. Cognitive distortions are irrational thoughts that individuals perceive as real. There are many different types of cognitive distortions such as overgeneralization (generalize without knowing everything), dichotomous thinking (all-or-nothing, black and white), disqualifying positive experiences (focusing solely on the negative aspects) or even filtering (choosing which information to take while leaving the rest out) (Beck, 1979). In the GLM is it important to identify the cognitive distortions of the offender to eliminate them as they are linked to criminal behavior (Ward & Brown, 2004).

1.4.3 Context

The GLM has mainly been applied to adult offenders; it is rarely applied to young offenders. Furthermore, the GLM can be used as a complementary framework to other models such as the Risk-Need-Responsivity Model (RNR) or Cognitive Behavioral Therapy (CBT). Treatment using the GLM is individual (therapist and offender only) as it needs to be tailored to a specific offender; not two offenders have the same good lives goals and criminogenic needs. It is not a "one-size fits all" framework. However, it has been used in group therapies. Moreover, the atmosphere needs to be respectful and collaborative (Ward & Brown, 2004).

1.4.4 Key issues formulation

The GLM is a positive rather than negative approach. It states that offenders seek primary goods in a maladaptive way. The GLM addresses any criminal behavior although a great focus has been placed on sexual offending. This framework tries to englobe how criminogenic needs, primary goods, and instrumental goods interact with each other.

Primary goods are what all human beings seek to achieve well-being. Primary goods are experiences, personal characteristics, life goals, outcomes or states of mind that all humans hope to have in their lives. Examples of primary goods include relationships, leisure or happiness. On the other hand, secondary or instrumental goods are the means or actions used to secure primary goods. Instrumental goods can be either antisocial or pro-social. Dynamic risk factors or criminogenic needs are perceived as cognitive distortions; they are internal (e.g. lack of skills or abilities) or external obstacles (e.g. no access to education, poor social support) that block the acquisition of primary goods. Often, these distortions result from conditioning or have been learned. This means that according to the GLM, issues are at the same time endogenous and exogenous. When offenders fail to achieve primary goods in a pro-social way it is generally because they face one or more of the following four difficulties: (1) lack of scope, (2) conflict between goals or incoherence, (3) lack of skills or capacities and (4) difficulty in securing goods. Lack of scope implies that the offender left out some major goods in his plan for living. For example, an offender might not include relatedness as an important good, and it may lead him to feel lonely or incomplete. The conflict between goals or incoherence is when an individual will seek a primary good through unhealthy behavior which in turn will affect another primary

good. For example, if an offender seeks intimacy and autonomy but that he/she uses control and domination to achieve autonomy, this could affect intimacy and make it unlikely to achieve healthy interpersonal relationships. This can generate stress and unhappiness. Lack of skills or capabilities indicates that the offender has difficulties adapting to his/her environment and to adjust depending on the circumstances. Finally, the difficulty of securing goods implies that the offender does not use appropriate secondary goods to reach its primary goals. For example, some child molesters may rather socialize with children than adults to reach his good of relatedness. The GLM helps identify these issues to design a better rehabilitation strategy (Ward & Brown, 2004).

The application of the GLM to sexual offenders is based upon the Integrated Theory of Sexual Offending (ITSO) (Ward & Beech, 2006). According to this theory, sexual offenders act out due to multiple variables interacting. Those variables are biological (genetic, brain development), ecological (personal, cultural and social circumstances) and psychological.

It is also important to note that it is argued that there are two primary routes to sexual offending: direct and indirect. The direct pathway is when a sexual offender seeks certain goods through sexual abuse or assault. The indirect pathway occurs when an individual seeks a number of goods which creates a ripple effect in the individual's personal circumstances which increases the chances of sexual offending, such as conflicts between goals or feelings of distress and loneliness (Lindsay, Ward, Morgan & Wilson, 2007).

1.4.5 Main objectives

The GLM has two main objectives: promote goods and risk management. To reduce offending, the GLM focuses on the offender's motivation, values, and aspirations to elicit the change process. It also seeks to get rid of cognitive distortions.

The GLM is based on the principle that all human beings, offenders included are motivated in reaching primary goods but they do not have healthy strategies to do so. This means that the offender is the one who defines his goals. Each primary good weights differently. For example, one offender may consider knowledge as more important than relatedness while another thinks otherwise. This holistic approach looks at what is the most important goal for the offender and finds ways to reach it while at the same time looking at ways to manage risk. The point of this

approach is to reduce recidivism rates and improve the rehabilitation process for offenders (Whitehead, Ward & Collie, 2007).

1.4.6 Motivation/work alliance

Like most humanistic approaches, the GLM is a client-centered process that focuses on the offender's strengths rather than on his problematic behaviors. This positive rather than negative approach to treatment tends to increase offender motivation. Therefore, offenders have better engagement and participation in treatment. The GLM also promotes client autonomy and positive attitudes from the therapist including, warmth, respect, empathy and honesty. Ward and Brown address the issue of motivation by using the term of readiness. They believe that treatment readiness depends on internal and external or contextual factors. Internal factors refer to intrinsic personal factors such as cognitive (beliefs or values, cognitive strategies), volitional (goals, desires), affective (emotions) and behavioral (competencies and skills) factors. On the other hand, contextual factors are linked to circumstances (imposed vs. voluntary, offender type), opportunities (availability of treatment programs), location (correctional facility or community), resources (program quality, qualified therapist) and interpersonal supports (people that seek to help the offender). Change occurs when offenders have all the necessary tools to do so. Moreover, offender motivation results from wanting to fulfill primary goods through secondary goods (Ward & Brown, 2004). According to Prochaska's and DiClemente's transtheoretical change model (1992), offenders within the stage of precontemplation can benefit from the GLM.

The work alliance in the GLM is collaborative; therapist and offender work together to find news, pro-social ways of achieving primary goods. It is a respectful relationship that needs to be based on trust. Ward and Brown (2004) highlight the importance of trust: if the offender does not have minimal trust in the therapist, chances are it won't work. The therapist must also openly mention to the offender that he/she is a trustworthy person. The ideas of trust and collaboration as crucial to treatment are, once more, inspired by positive psychology.

1.4.7 Intervention strategies

<u>Material aimed</u>

The GLM needs to address primary and secondary goods as well as dynamic risk factors when implementing a strategy. It can be divided into some steps.

The first step to the GLM framework is to assess the criminogenic needs to understand which primary goods are missing or problematic. Each primary good needs to be detailed in favor of understanding how secondary goods are either attaining or not attaining the desired goal. In this first phase, the importance the offender places on each primary good is indispensable and specific to him. This means establishing the offender's priorities in life and his goals. Treatment readiness must also be assessed. This initial stage is a goal-setting exercise that is future-focused rather than present-focused. It is crucial to note that these goals are not moral ones but prosocial personal ones; what would make the offender happy? (Ward & Brown, 2004).

The second phase consists in establishing a plan. Now that the offender has a better understanding of his personal identity, he needs to conceptualize the necessary steps to achieve a "better life." By understanding how his criminogenic needs influences his acquisition of primary goods, the offender can focus on how to reach his valued goals in prosocial ways. This is the stage where therapist address at the same time goods promotion and risk management (Ward & Mann, 2004).

The third phase is about developing a Good Lives case formulation. This implies that the offender should be aware of how his criminogenic needs and secondary goods frustrate human goods. Therefore, once awareness is reached, it is about finding alternative ways of obtaining a better life. The offender should be able to understand the conflict between his different goals and how to secure them in a better way.

Another crucial phase, stage four is about equipping the offender with the values, attitudes, resources and skills necessary to live his "ideal life" without harming others or themselves. The standard goal-setting techniques of SMART (specific, measurable, achievable, realistic and with time frames) should break down the goals into steps the offender can achieve.

Finally, the last stage focuses on implementing new skills to reach the primary goods monitor progress. This is done through regular supervision. This also means establishing a safety plan. The GLM is flexible in the sense that although it follows certain steps to change behavior, it can be adapted to different types of offenders, with particular needs or values. According to Barnett and Wood (2008), for sex offenders, the most neglected goods are agency, relatedness,

and inner peace. This is why the GLM identifies 13 specific areas that need to be specifically addressed with sex offenders (Ward & Mann, 2004).

Counselling attitudes

The GLM places emphasis on a respectful, trustworthy and non-judgmental attitude from the therapist. Research has shown that positive attitudes from therapists result in better treatment outcomes than negative attitudes. The therapist needs to have a positive approach; his/her opinions on the nature of human beings will greatly influence his/her way of interacting with the offender. This means, that if the therapist believes like Rousseau that "everyone is born naturally good" or that all individuals can be altruistic and selfish, he/she is more likely to be comprehensive and non-judgmental. On the other hand, if the therapist believes that offenders are naturally "bad," this is likely to create a hostile, confrontational situation. This implies that the offender needs to feel that he is entitled to be treated in a respectful manner (Ward & Brown, 2004).

Ward and Brown (2004) mention the terms of acceptance and forgiveness; in some way, the therapist must "forgive" the offender's acts to productively help. Implicit forgiveness plays a key role in the change process because it leads to respect, which in turn allows possible behavior change. This also helps establish trust between the offender and the therapist.

The therapist also needs to show empathy towards the offender. This does not mean agreeing but rather recognizing what the individual is feeling is understandable. Furthermore, the therapist should help the offender actively engage in therapy as well as facilitate change. Other therapist attitudes that are essential include open-mindedness, honesty, warmth, showing interest (in what the offender has to say or feels), encouragement and progress rewards. All the elements serve the purpose of increasing the offender's self-esteem to facilitate change (Ward & Laws, 2010).

Verbal skills

The therapist needs to question and explore what the offender aspires to. It is important to look at what the offender wants, what is meaningful to him and how his criminal behavior is an obstacle to these goals. Since the offender's engagement is crucial, it should not be confrontational but rather guiding. Suggestions and explanations can be given but never in a

condescending way; always by respecting the offender. Motivation has to come from the offender; he actively engages while the therapist only elicits ideas and gives information. Moreover, the therapist needs to help the offender understand his way of functioning as it will provoke change and ask detailed questions of the offender's commitments. Finally, language and terms used need to be changed and more positive, especially when working with sex offenders. Problems and deficits could be rephrased as approach goals, intimacy deficits as intimacy building and relapse prevention as self-management. Ward & Mann (2004) also recommend giving more positive names to treatment programs.

Factors of change

Factors that contribute to change in this model are both extrinsic and intrinsic. They are mostly driven by the desire to reach primary goods. The desire to reach optimal well-being is what motivates offenders to change. High self-esteem, self-efficacy, developing self-regulation and a solid, respectful therapeutic alliance also contribute to pro-social changes. According to Ward & Brown (2004), this model works because it is person tailored, it cannot be applied to all offenders in a uniform way. Moreover, it focuses on individual goals and respects offender autonomy. This model takes into account cultural context; not two individuals have the same cultural and social background; traditions may differ. On the other hand, cognitive distortions are an obstacle to change. This is why they need to be eliminated during therapy for change to occur. Moreover, prior research on sexual offending (Ward & Steward, 2003) has pointed out the importance of noncriminogenic needs in treatment. Increasing the self-esteem of sexual offenders plays a crucial role in the therapeutic process. Moreover, working collaboratively with offenders in developing treatment goals results in a stronger therapeutic alliance. The change process in sex offenders is also facilitated by therapists showing empathy, warmth and providing rewards for progress as well as encouragement. These non-negligible factors of change are at the heart of the GLM (Ward & Laws, 2010).

1.4.8 Evaluated efficacy and results

The GLM is a relatively new model that has mainly been used amongst adult sex offenders. It implies that we still do not know its full impact. Many studies have shown that the GLM is efficient in decreasing recidivism rate of sexual offenders.

One study by Ward & Willis (2011) looked at the application of the GLM with released child molesters. Although the sample was quite small (only 16 sex offenders), results were positive. The majority of offenders endorsed primary goods with high importance. Furthermore, participants reported partial fulfillment or goals relating to future fulfillment across each primary goods. The attainment ratings increased significantly across the follow-up period (6 months); this means that the offenders found increased satisfaction in their relationships outside of prison. Re-entry scores in the community (accommodation, employment, social support) were positively correlated with good lives ratings. An essential result is that none of the child-molesters in the six months follow-up committed another offense. There is a consensus that so far, treatment programs that have incorporated the GLM with sex offenders have found positive outcomes and a reduction in recidivism rates (Ward & Willis, 2011).

Whitehead, Ward & Collie (2007) showed that the GLM could be applied to violent offenders as well. It has to be complementary to risk management but helps provides a framework. The GLM's collaborative approach facilitates change. A twin-focus to treatment was shown to be highly effective. Lindsay et al., (2007) confirm these findings with sex offenders; the use of the Self-Regulation Model in addition to the GLM offers a robust, practical treatment procedure.

Willis, Ward & Levenson, (2013) looked at 13 North American treatment programs that had integrated the GLM. Although the application of the GLM was not consistent over all units, results showed that the GLM enhanced engagement in treatment at treatment completion. Another interesting fact is that even mentally disordered offenders completed their treatment because of the GLM framework, as it increased motivation. Gannon, King, Miles, Lockebie & Willis (2011) also found that this model promoted treatment engagement of offenders.

More recently, studies have shown that the GLM can be used in other areas such as case management and probation. This shows that the GLM is a flexible framework that can be applied in many different settings and to different populations, offering a wide range of opportunities (Purvis, Ward & Willis., 2011).

1.4.9 Consensus, debates and unknown

In the past 20 years, CBTs, including relapse prevention (RP) and RNR have been references in terms of reduction of sexual recidivism. The RP model mainly targets problematic

affect, cognitions, and behaviors associated with sexual offending. This allows sex offenders to understand their offense pattern and cope with psychological and situational factors that increase the risk of recidivism. This implies eliminating or reducing dynamic risk factors (usually clinical needs or problems) (Gannon et al., 2011). RNR, on the other hand, is a very strict set of therapeutic principles (risk-need-responsivity) that focuses on controlling risk factors that are proportional to the offender's risk to re-offend. It addresses criminogenic needs rather than non-criminogenic needs. CBT and RNR are evidence based and have proven their efficiency in many ways. This is partially why the GLM has generated some debates especially with Bonta and Andrews (2003) that argue that it is not empirically based and that it is only theoretical.

According to Bonta and Andrews (2003), the GLM is not based on empirical evidence. They believe that although the GLM has noble intentions, there is no research as to how the authors chose the primary goods and no evidence on the viability of the model. Bonta and Andrews (2003) also mention that Ward and Brown were strongly influenced by the self-determination theory and that this same theory was never applied empirically to delinquents or offenders. This means that it is impossible to know if this intrinsic motivation theory may be effective with offenders. Moreover, the authors state that interventions such as the GLM have not proven to reduce recidivism rates, unlike the RNR model.

Bonta and Andrew also argue that the treatment techniques and steps the GLM proposes are not new and already used in the RNR model. Overall, Bonta and Andrew's (2003) biggest critique of the GLM is that it is not backed up by empirical data; it is mostly theories and speculations. Also, the theories are influenced by philosophy, ethics or anthropology; none of them being grounded in the field of criminal behavior. Moreover, according to them, the GLM focuses on noncriminogenic needs instead of criminogenic ones and only the last ones mentioned help reduce recidivism rates. This is why Bonta & Andrews (2003) remain skeptical as to the efficiency of the GLM.

As explained: "treatment programs for sexual offenders are typically problem-focused and aim to eradicate or reduce the various psychological and behavioral difficulties associated with sexually abuse behavior" (Ward et al., 2007). This includes deviant sexual preferences, deficits in empathy and intimacy, cognitive distortions and difficulties managing emotional states.

One study looked at how the GLM and RNR could be used complementarily to reduce sex offending. Wilson & Yates (2009) argue that both programs can be used together. On the one hand, the RNR focuses mainly on risk while, on the other hand, the GLM focuses on protective factors. With sex offenders more specifically, there are some interactions between environmental factors, social factors, psychological and offender specific characteristics. Only focusing on containment issues and disregarding these offenders as whole beings could increase recidivism rates. Because sex offending is a multi-faceted problem, to address the totality of risk, some domains need to be addressed. Treatment programs must address RNR criteria such as lifestyle contributing to the offending, skill deficits, and psychological needs but also GLM criteria such as creating a strong therapeutic alliance and engaging the offenders to actively participate in treatment (motivation) and focus on their protective factors. Focusing on both difficulties and strengths could offer a more efficient treatment program and more promising results. Ward & Mann (2004) also argue that the RNR should be used but that to the risk, need, and responsivity, should be added the priorities/goals of the GLM.

So far, research has given some very encouraging results as to the outcome of offending using the GLM. The GLM seems to reduce offending rates on the short term and facilitate rehabilitation. Although the GLM does create debate because of its lack of empirical proof, the few studies (Barnao, Ward & Robertson, 2010) that have looked at its efficiency have found promising results (Langlands, Ward & Gilchrist, 2012). A solution to avoid debates on which treatment is more efficient, combining the GLM to pre-existing programs could be a solution. The GLM is a framework that offers guidelines and is not as strict as certain CBT therapies and the RNR. Therefore, it can be used as an addition rather than on its own.

1.4.10 Applying the GLM to juveniles who sexually harm

All the treatment programs mentioned above have proved their efficiency in reducing recidivism rates. However, the GLM remains relatively new and very little research has been done on its application to AWSH. Wylie & Griffin (2013), applied the GLM in combination to the G-map organization. The G-map model was established by first gathering feedback from young people. Young people were asked individually or within a group-work setting to give feedback on the GLM needs. The feedback was then linked to existing theories and frameworks. The G-map model took into account Maslow's Hierarchy of Needs (1969) and theories of child

and adolescent development (e.g. attachment theory, the Search Institute's developmental assets framework). Moreover, in the United Kingdom, Children's Services made a reform based upon the Every Child Matters (ECM) agenda. ECM was a government initiative launched in 2003 that sought to ensure that adolescents and children's services would achieve five aims: (1) be healthy, (2) stay safe, (3) enjoy and achieve, (4) make a positive contribution, (5) achieve economic well-being. Child and Adolescent Mental Health, Youth Offending Services, and Social Care teams used the GLM approach and created six primary needs. The G-map was piloted and revised over a six-year period through service-user feedback, clinical experience, and semi-structured interviews. They condensed and reclassified the primary goods of the GLM, creating a model comprising of eight primary needs: "having fun", "achieving", "having people in my life", "emotional health", "sexual health", "physical health", "being my own person" and "having a purpose and making a difference" (Wylie & Griffin, 2013).

This allowed the empowerment of young individuals rather than stigmatizing and labeling them. This study found that the GLM, because of its positive approach, reduced feelings of shame and increased motivation.

Youth sexual offending can decrease considerably if there is appropriate treatment that takes into account the complex emotional and developmental interactions of adolescents. The GLM for AWSH needs to focus on social awareness, self-identity, self-development and establish self-hope (Wainright & Nee, 2014). So far the research has targeted a number of protective and risk factors. Focusing on protective factors with youth offenders deters offending behavior (Carr &Vandiver, 2001). Research needs to expand in that domain to offer better guidelines for the treatment and rehabilitation of AWSH. The G-map adaptation of the GLM (Print, 2013) seems very promising and may offer the possibility to obtain empirical data on the efficacy of the GLM with this particular population. This project seeks to provide insight on the practical application of the GLM with juveniles who engaged in sexually abusive behavior.

Chapter II

The internship and clinical objectives

This present chapter gives an overview of the location of my internship, the values, mission, and mandates of the institution. It describes the program I worked in, its different programs and the clinical objectives of applying the GLM to AWSH.

2.1 The Philippe Pinel Institute of Montréal (IPPM)

The Philippe Pinel Institute of Montréal (IPPM) is a national psychiatric institution that was founded in 1970. The institute is mandated by the Ministry of Health and Social Services, the Ministry of Justice and the Ministry of Public Security. The IPPM is one of the additional (supplementary) health services provided by the provinces and territories. It is named after the French physician Philippe Pinel that advocated a more humane approach to the treatment and custody of mentally ill patients. The IPPM is affiliated with the University of Montreal since 1976. The hospital has 292 beds and offers a wide range of services. Services available seek to treat and rehabilitate psychiatric patients that are considered violent and difficult. Patients come from all over Quebec, either from penal institutions or other health care network establishments. On certain occasions, patients can come from other regions of Canada.

The values of the institute include excellence, initiative, respect, collaboration, recognition and equity. The mission of the IPPM seeks to prevent violence, offer treatment and risk evaluation of patients with a high risk of violence, research and understanding and teaching.

The IPPM prides itself in being open to the community (families, neighbors, etc.) and their partners and as being a national leader in its field. The institute's team is multidisciplinary that comprises of psychiatrists, psychologists, criminologists, probation officers, nurses, doctors, and sexologists. The 2015-2016 annual report stated that the Institute had a total of 624 admissions, of which 466 were evaluations and 158 were for treatment.

2.2 Services Externes de l'IPPM

The Services Externes de l'IPPM (SE), formerly named the Centre de Psychiatrie Légale de Montréal (CPLM), is an outpatient clinic affiliated to the IPPM that was founded in 1988 as a response to the growing needs of patients with a forensic psychiatry profile. The SE offers forensic psychiatry services that comprise of assessment (diagnostic and recommendations), treatment, remote consultation (videoconferencing), teaching and research. The outpatient clinic

I was interested in specializes in sexual offending. The team is multidisciplinary; there are psychologists, criminologists, psychiatrists, a probation officer, sexologists, nurses, security guards and sociotherapists.

2.2.1 Programs

The SE offers two programs in sexual offending: the program for adolescents who have committed sexual offenses and the program of treatment and evaluation for adults displaying a sexual deviance.

2.2.2 The program for adolescents who have committed sexual offenses

Requests for this program come from youth centers, youth prosecutors, and judges, general practitioners, pediatricians, child psychiatrists, psychosocial care workers or from self-referencing (adolescent or parent). To be eligible for this program, adolescents need to meet a certain number of criteria. Adolescents must be between the ages of 12 years old and 18 years old. Furthermore, adolescents must have a sexual deviance issue; either sexual abuse or a paraphilia. Finally, a minimal recognition of the sexual problem is required; adolescents in denial are not accepted to participate in this program.

The assessment process is divided into two preliminary interviews; the family interview and the clinical interview. The family interview establishes a first contact with the adolescent and the parent(s) or significant adult. During this first interview, the different steps of the evaluation process are explained as well as the intended objectives. The adolescent's recognition of the facts is also evaluated. If desired, all the care workers can be met. This first evaluation usually takes an hour and a half to complete.

The clinical interview is a multidisciplinary psychiatric evaluation that focuses on the sexual development and the sexual issue of the adolescent. Risk assessment is central in this interview and is evaluated at the end. Usually, the adolescent meets with two team members and without family members. In the end, conclusions and recommendations are shared with the adolescent and his/her family. This second evaluation usually takes two hours to complete. The assessment report is then routed to the referral source. After the evaluations, the team and the adolescent decide if treatment should be pursued. Treatment programs include group therapy,

individual therapy, family intervention, and pharmacotherapy. It is essential to note that each treatment option is specific to each adolescent.

Group therapy (prevention of re-offending)

This group is animated by two team members and lasts an hour and a half, once a week for about 25 weeks. The objectives are to address the underlying issues linked to the sexual problematic and to increase the adolescent's accountability for his/her actions. Moreover, it helps identify contributing factors and warning signs related to the sexual issue (relationship issues, self-confidence issues, aggression, etc.) and offers tools to control or diminish the risk of recidivism. Some exercises are offered such as reading fictional stories, writing a letter to the victim and genogram work. These exercises address cognitive distortions, the cycle of abuse, avoidance strategies, emotions and consequences.

Individual psychotherapy

Psychologists offer different therapies such as psychodynamic therapy, cognitive-behavioral therapy or a specialized follow-up adapted to autism or intellectual deficiency. Duration and length are determined according to the needs of the adolescent.

Family intervention

This intervention is available to help families better understand the issues related to the adolescent's sexual misconduct. It also brings support to the family and the adolescent in regards to recidivism risk management. The development is tailored specifically to the needs of the adolescent and his/her family.

Psychiatric care

Psychiatric care is available for the adolescents who need it. Pharmacology treatments are offered for comorbid pathologies, to diminish libido or impulsivity. Treatments vary, and the adolescent is informed of the different options and possible side effects of medication. It is used in addition to other therapies. At the end of treatment, a report is drafted, and a final review is done with the adolescent and his/her family members. In 2012-2013 there were 65 service

requests, 94 adolescents in active follow-up and 58 forensic expertise (evaluation and consultation) in the ADO program.

2.2.3 The program of treatment and evaluation for adults displaying a sexual deviance

Requests for this program come from general practitioners, psychiatrists, the Correctional Services of Quebec (CSQ), the Court of Quebec (Youth Division) and in rare cases from the Correctional Service of Canada. In order to be eligible for this program, the individual must recognize the presence of a sexual problem, and if the legal proceedings are underway, the individual must have pleaded guilty or have been found guilty.

The assessment process involves three initial interviews: the preliminary interview, the evaluation of sexual preferences and a multidisciplinary psychiatric evaluation. The preliminary interview is conducted by a criminologist or the probation officer and lasts an hour. It involves data gathering, an overview of the key issues and the completion of sexologic and psychological inventories. The evaluation of sexual preferences consists of a penile plethysmography performed by a technician at the Philippe Pinel Institute. Penile plethysmography is a tool that tests a man's level of sexual arousal. It "involves placing a pressure-sensitive device around a man's penis, presenting him with an array of sexually stimulating images, in determining his level of sexual attraction by measuring minute changes in his erectile responses" (Harlow & Scott, 2007). This procedure lasts between an hour and a half and two hours and a half.

2.3 Clinical objectives

My academic project targeted a number of clinical objectives, including:

- Operationalize the GLM to AWSH so that it could be used concomitantly to the other services provided at the SE.
- Identify the pathway to the sexual offense(s): as mentioned previously, according to the GLM, the route to the sexual offense(s) can be direct or indirect.
- Identify the commonalities between the GLM's risk evaluation and the evaluations used within the internship

- Identify GLM difficulties faced by AWSH
- Establish the link between the theoretical and practical aspects of the GLM
- Evaluate progress of the adolescents

Chapter III

Methodology

This chapter gives a detailed plan of the different stages in implementing the GLM to juveniles who sexually harm. The methodology is greatly based on the G-map model (Print, 2013). This section includes participant selection, data gathering, risk evaluations and the description of the interviews I conducted.

3.1 Participant selection

My case studies comprised of 4 youths between the ages of 15 years old and 18 years old who had committed sexual offenses. All participants were initially in psychotherapy, but their psychologist had to take a leave of absence for medical reasons. This led to her caseloads being prioritized and dispatched among the team. My four case studies were labeled as a high-priority, and the adolescents were offered the GLM awaiting a new psychotherapy. However, during the course of my project, two of the four adolescents (Ramsay and Jon) had to discontinue for reasons beyond our control. With these two adolescents, the GLM questionnaire could not be completed, and therefore, they were excluded from my case studies.

3.2 Data Gathering

Data was gathered through case files. Case files included multidisciplinary psychiatric evaluations (risk evaluations, anamnesis of family and developmental history, sexual development and offense(s)), police reports (victim and perpetrator testimonies), legal documents (court orders, legal conditions), medical reports (child psychiatrists, family physicians, hospital reports) and reports from the youth protection directorate (Direction de la Protection de la Jeunesse, DPJ).

3.3 Risk Evaluations

Risk evaluations had been done before my arrival and were included in the case files. The risk was evaluated using two tools, the ERASOR[1], and the DASH-13 [2].

[1] See appendix A

[2] See appendix B

3.3.1 Estimate of Risk of Adolescent Sexual Offense Recidivism (ERASOR)

The ERASOR (Worling & Curwen, 2001) is a sexual recidivism risk assessment tool that only targets juveniles between the ages of 12 and 18 years old who have previously committed a sexual offense.

It follows an empirically-guided clinical judgment methodology. This type of methodology is different from actuarial assessments and unstructured clinical judgments. Actuarial assessments are structured and objective based rating systems. Risk factors are scored, and the scores are then summed. The overall risk score is linked to a probabilistic statement of risk (algorithm). On the other hand, unstructured clinical judgment refers to the professional's perception of the risk based on their anecdotal experiences. Both these methodologies have strengths and drawbacks. Empirically-guided clinical judgment combines a list of fixed risk factors and clinical judgment. There are no fixed rules for tallying scores which allow better flexibility is terms of risk evaluation (Worling & Curwen, 2001). This instrument is designed to be used by evaluators directly following the clinical assessment. However, it can also be coded from archival data (Worling & Langstrom, 2006).

The ERASOR comprises of 25 risk factors (9 static and 16 dynamic) divided into 6 categories: sexual interests, attitudes and behaviors (e.g. deviant sexual interests), historical sexual assaults, psychosocial functioning (e.g. antisocial interpersonal orientation), family / environmental functioning (e.g. high-stress family environment, instability), treatment (e.g. sexual-offense specific treatment) and other factor (if not included in the list, can be added). The identified risk factors were selected from three sources of information: studies investigating recidivism risk factors (specific to adolescents), guidelines and checklists on risk assessment and protective factors and research on adult sexual recidivism.

Each risk factor is scored as either "present" if it can be readily observed in the adolescent, "possibly or partially present" if there is some evidence of the item being present, "not present" if the item does not apply to the adolescent or "unknown" when there isn't sufficient information available to determine the presence or absence of the risk factor (Worling & Curwen, 2001).

The overall level of risk can be predicted as "low," "moderate" or "high." There is no specific formula to calculate the risk as it relies on clinical judgment. Although it is anticipated

that there will be a general relationship between the rating of risk and the number of high-risk factors (e.g. more high-risk indicators implies higher risk), the final rating should rely primarily on the combination of risk factors rather than on the number of present risk factors. Moreover, a single high-risk factor (e.g. planning to reoffend) can indicate a high-risk estimate (Worling & Curwen, 2001).

3.3.2 Desistence for Adolescents who Sexually Harm (DASH-13)

The DASH-13 is a checklist that includes 13 protective factors that are rated as "yes" (present), "no" (absent) and "?" (unknown). Research has shown that focusing solely on risk-factors in risk assessment tools, increases biased judgments and inaccuracy (Worling, 2013). Seven factors are specifically related to future sexual health: prosocial sexual arousal, prosocial sexual attitudes, awareness of the consequences of sexual reoffending, hope for a healthy sexual future, successful completion of sexual offense treatment and environmental controls that match risk to reoffend sexually. The other six remaining factors focus on general and prosocial functioning: compassion for others, positive affect-regulation skills, positive problem-solving skills, close relationship with a supportive adult, emotional intimacy with peers and prosocial peer activity. Unlike the items on sexual health, the prosocial items are based on limited available research.

The DASH-13 seeks to highlight an individual's strengths and to focus on these when developing and delivering interventions. However, it is still unclear whether or not these items enhance predictive accuracy of existing risk assessment tools. This implies that the protective factors included in the DASH-13 are suggestive and may be linked to desistence of sexual reoffending (Worling, 2013). See Appendix B.

3.4 Applying the GLM

3.4.1 First interview: Introduction

The first interview sought to meet the youth and the most significant people in his life. This could include social workers, youth delegates, educators and family members. The GLM is an ecosystem approach that seeks to include as many people and resources as possible to bring support and help the adolescent achieve primary goods in a prosocial way. In this first interview,

the GLM was briefly described. I explained that the GLM focused on strengths and capacities rather than on difficulties and risk management. Furthermore, they were told that eight primary needs were identified amongst young people and that some individuals achieve these needs in inappropriate ways. Therefore, the goal of the GLM is to find prosocial ways (secondary goods) to fulfill these primary needs. They were told that attainable and realistic long-term and short-term goals would be identified. I mentioned that a Good Lives Plan would then be established and tailored specifically to the youth as it is not a "one-size fits all" model. The individual's environment, development, support network, and capacity are specific to each individual. The Good Lives Plan also had to take into account dynamic risk factors, and possible difficulties encountered.

After the GLM overview, patients and their accompanying members were told about the authorization forms that needed to be signed: one form allowing the exchange of useful information between myself and members of his close environment and a form allowing vocal recordings of the sessions (for my project). Moreover, I told the participants that the next interviews would be done with only the adolescent but that all pertinent information would be shared through phone calls and that active participation on their part was recommended. They were told about anonymity and confidentiality limits.

With the aim of better knowing the adolescents, they were asked about where they currently lived, how it was going (conflicts, difficulties, etc.), what activities they took part in and scholar level or internships. I asked the youth and the present members to target objectives that needed to be worked on. Ultimately, the adolescents were asked if they had any legal conditions to respect or recommended conditions, name them and explain what obstacles they presented in their daily lives. All interviews lasted an hour.

3.4.2 The GLM Questionnaire

These interviews consisted of using the GLM questionnaire [3] to understand the pathway to sexual offending (direct or indirect route) and identify which primary needs were most important for each adolescent at the moment of the sexual offenses. The adolescents were met alone and first asked to define in their own words, what each primary good meant to them. They

[3] See appendix C

were then asked a set of open-ended questions. For each primary good, the adolescents had to rate from 1 to 5 how important the good was to them (1 being not important at all and five being very important), and whether or not they believed it was linked to their sexual offense. The questionnaire was answered in two or three interviews, lasting an hour each. Initially, the questionnaire is in English, but I had to translate it to French as most of my case studies only spoke French.

3.4.3 Old Life/New Life

The fourth interview followed the concept of the Old Life / New Life. Once more, they were seen alone, and the interview lasted an hour.

In the first part, the adolescents were asked to draw the graph below (Figure 1). They had to describe their thoughts, emotions, and behaviors at the Old Life stage and Now stage. They also had to identify any conflicts, difficulties or needs at those specific moments of their lives. In the New Life stage, adolescent explained what primary needs they considered most important and what would qualify as "an ideal me."

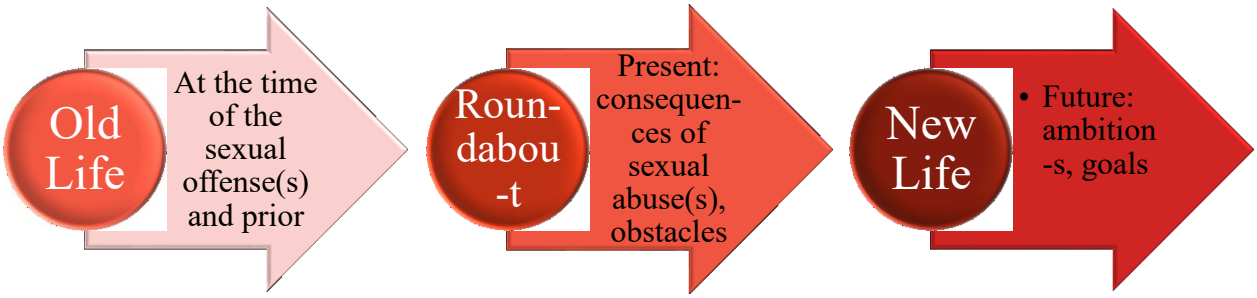

Figure 1. Old Life/New Life stages.

Secondly, each adolescent had to identify goals (whether long-term or short-term) that they wished to achieve using the graph below (Figure 2). All goals had to be achievable, attainable and prosocial. There was no specific number of goals. Afterwards, they were asked to recognize which need/needs their goals fulfilled.

Figure 2. An example of goals for the New Life and the needs they represent. Reprinted from *The Good Lives Model for Adolescents Who Sexually Harm*, by Bobbie Print, 2013.

3.4.4 The Good Lives Plan

In order to establish a Good Lives Plan, the adolescents were asked to answer a different set of questions including:

- What are my strengths to help myself? (internal capacity and resources)
- What people or things are around to help me? (external capacity and resources)
- What are my emotional difficulties? (e.g. anxiety, low self-esteem, etc.)
- What are my external difficulties (e.g. antisocial friends, family conflicts, etc.)
- How can I reach my goals in a more appropriate way?
- Which of my needs conflict?
- Which primary goods do I neglect?

These questions would lead the juveniles to increase self-awareness and work on introspection. They were told that they had to take into account their environment, development, capacities and social support while working on their short term and long term goals. Finally, they were asked to define appropriate and inappropriate before giving examples of prosocial and antisocial ways of achieving each primary good. The adolescents were also given a list of pleasant activities[4] from which they had to choose the ones they enjoyed most.

3.4.5 Follow-ups

The follow-up interviews were either done over the phone or face to face, depending on the patient's availabilities. These interviews sought to evaluate the youth's progress. This included whether or not the adolescents had replaced inappropriate needs by appropriate needs. Moreover, if some of the youths encountered difficulties in making positive changes, new strategies would be discussed. The follow-up interviews evaluated the juveniles' involvement and motivation. Unlike previous steps of the GLM, there was no specific number of follow-up interviews; it lasted as long as the internship.

3.4.6 Final interview

The final interview sought to get feedback, critics, suggested modifications and overall appreciation of the model. The juveniles were given the Session Rating Scale (SRS) V.3.0[5] which rates the therapeutic relationship, goals and topics, approach or method and overall. To facilitate rating of the SRS, the scale was rated from 1 to 10. The score of 10 meant great satisfaction while 1 meant low satisfaction.

[4] See appendix D

[5] See appendix E

Chapter IV

Case studies and clinical review

4.1 Case Study #1: Ramsay

Ramsay is an 18-year old that was referred to the SE by a youth delegate following reports of sexual abuse.

4.1.1 Personal background

Sexual development and offenses

In the sexual sphere, Ramsay's pornography consumption coincided with puberty, around age 14 years old. Ramsay would watch different kinds of pornography including violent and child pornography. In addition, Ramsay greatly questioned his sexual orientation; an element still present to this day.

At the age of 16, Ramsay was accused of two counts of sexual assault and four counts of sexual contact. The victims were family friends, two girls aged 6 and nine years old. There were three separate events of sexual assaults, involving sexual touching and fellatio.

Medical and psychiatric background

Ramsay has multiple psychiatric diagnoses. He first started consulting psychiatrists and psychologists at age nine years old. Ramsay was diagnosed with ADHD (with impulsivity), for which he was prescribed Adderall. His other diagnoses include a generalized anxiety disorder, a sleep disorder, Asperger's syndrome, dysorthography, cognitive rigidity, oppositional traits and poor social abilities.

Personal and family history

Ramsay has a brother that is three years younger than him. Ramsay always lived with his parents and brother until recently, when his mother left home. In his childhood, Ramsay is described as oppositional and would often fight with his peers. The family moved a lot around Canada due to his father's profession in the military. During his adolescence, Ramsay's behavioral issues persisted, particularly at home. Ramsay would refuse to do household chores when told to do so. However, his parents described him as a sensitive and affectionate adolescent. The year prior to the sexual offenses Ramsay committed, the family experienced a crisis due to his mother's loss of employment and lack of social support from the military

(retirement of his father). During that same period, Ramsay described the home environment as very conflictual; his father would often get angry at him and would break household objects. On the other hand, his mother would pressure him into succeeding academically, which would also lead to quarrels. At school, Ramsay was bullied, and rejected by his peers, making him frustrated and angry. The adolescent linked his social difficulties to his impulsivity and agitation (ADHD).

4.1.2 Risk evaluation

Static risk factors

Ramsay's risk of sexual recidivism was evaluated using the ERASOR. Ramsay's ERASOR results indicated that four out of nine factors were present regarding the history of sexual abuse. Ramsay reports three events (more than twice) of sexual transgression towards two children (2 victims or more). Following these events, Ramsay was sanctioned by an adult. However, Ramsay did not use violence or threats during the sexual offense, did not sexually assault a stranger, did not show lack of discrimination in his choice of victims, nor did he sexually assault a male victim or showed diverse sexual-assault behaviors.

Dynamic risk factors/criminogenic needs

In the sexual interests, attitudes and behaviors category, three out of four factors were retained of which, two were considered as potentially present. The deviant sexual interests (younger children, violence, or both) item was present while obsessive sexual interests/preoccupation with sexual thoughts and attitudes supportive of sexual offending were potentially present. These two factors were harder to evaluate because the adolescent gave only partial access to his sexual experience. Unwillingness to alter deviant sexual interests/attitudes was absent. Psychosocial functioning indicated that Ramsay potentially lacked intimate peer relationships (social isolation). Four other factors were absent including antisocial interpersonal orientation, negative peer associations and influences, interpersonal aggression and poor self-regulation of affect and behavior (impulsivity). The last factor, recent escalation in anger or negative affect was unknown as Ramsay did not reveal his emotions. In the family/environmental functioning, Ramsay did not score on problematic parent-offender relationships/parental rejection, parent(s) not supporting sexual-offense-specific

assessment/treatment and environment supporting opportunities to reoffend sexually. However, the high-stress family environment factor was retained.

In the treatment category, the two factors were present: no development or practice of realistic prevention plans/strategies and incomplete sexual-offense-specific treatment. Adolescents automatically score of these two items if these have never been evaluated or followed regarding problematic sexual behavior. Lastly, two other risk factors were added, poor management of anger and emotions.

Protective factors

Protective factors were rated using the DASH-13. Numerous protective factors were identified in Ramsay's case. Ramsay shows prosocial sexual attitudes (believes young children would be harmed by sexual activity), awareness of the consequences of sexual reoffending (short-term and long-term), compassion for others, close relationships with positive and supportive adults (his parents). Moreover, Ramsay is actively involved in prosocial structured activities with peers and hopes that he can enjoy a healthy sexual future that is free of sexual offending.

Based upon the combination of the ERASOR and the DASH-13, the overall risk rating for Ramsay was estimated as moderate if he remained in a controlled environment (parental supervision). If Ramsay were to be in an uncontrolled environment, the risk would be revised upwards, at high.

4.1.3 The Good Lives Model

First Interview

All interviews with Ramsay were done through video-conferencing. During the first interview, I met Ramsay with his social worker and his father. I presented to them the core principles of the GLM and how the following interviews would unfold. Initially, Ramsay mentioned that he did not need help and was satisfied with his current lifestyle. Ramsay's legal conditions included: not being allowed to own a computer or smartphone (internet access), not being allowed to be in parks with children below the age of 16 years old and not being able to work with vulnerable people (children, old population, etc.). His social worker and his father

mentioned that Ramsay needed to work on the following objectives: take responsibility for his actions and words, be more autonomous and prioritize his activities (mainly work).

The GLM questionnaire

The GLM questionnaire with Ramsay was done over a period of 3 interviews.

Having fun

Ramsay associates the primary good of *having fun* to friends and a feeling of security. He did not include his family as a source of fun.

> Int- « *Pour toi, ça veut dire quoi s'amuser ?* »
> T- « *Pour moi c'est tous les amis ...pis l'ambiance […] tu te sens en sécurité…*»

At the moment of sexual offenses, Ramsay enjoyed playing board games and video games with his brother. He reported considering his brother as his best friend and having similar interests.

> Int- « *Tu faisais quoi pour t'amuser?* »
> T- « B*ah je jouais avec mon frère… mon frère c'était mon meilleur ami dans l'temps [...] on jouait ensemble, on jouait à des jeux de société ensemble, on jouait aux jeux vidéos ensemble, on faisait presque toute ensemble.* »

However, Ramsay had few opportunities to have fun outside the home environment, Obstacles to this were that he did not have many peer associates with whom to engage in fun activities (socially isolated) and his parents did not promote recreational pursuits. His parents were more likely to emphasize the importance of work (*achieving*) rather than having fun. Moreover, at school, Ramsay was often bullied.

> T- « *Euh…bah j'étais beaucoup, beaucoup mis de côté, j'avais beaucoup d'intimidation, je me faisais battre à l'école, faque moi l'école c'était pas une place que j'aimais être. Je pochais beaucoup à l'école.* »

Ramsay attached little importance to this need and did not appear to focus on it to the exclusion of other needs. He believed that *having fun* was easy to achieve and present in his daily life. This somewhat contradicts his prior statements about not being able to have fun outside the home environment.

Int- « *Si je te demandais de noter s'amuser de 1 à 5 ?* »

T- « *Je mettrais 2.* »

Int- « *Pourquoi 2?* »

T- « *Parce que s'amuser c'est….. Pour moi, ça prend pas grand-chose… c'est que je suis tout le temps comme les gens diraient, heureux….fait que je priorise pas l'amusement parce que je suis tout le temps content, je m'amuse tout le temps quand je fais de quoi… sinon je le ferais pas […] je recherche pas trop l'amusement… tout ce que je fais, je trouve ça amusant.* »

Ramsay did not believe that this need was associated with the sexual offenses he committed. He stated that affection was most likely linked to the offenses, as well as curiosity. The way Ramsay attempted to meet his need for fun seemed appropriate.

Achieving

Ramsay could not dissociate the primary good of *achieving* from his parents and had difficulty defining it in his own terms.

Int- « *Le deuxième besoin c'est la réussite/réussir, comment tu le définirais ?*

T- « *Bah moi mes parents mettent un… m'ont toujours poussé à me dépasser... fait que pour moi réussir c'est euh… améliorer le résultat précédent… genre comme si à mon bulletin j'ai eu 75 en français, bah moi réussir c'est avoir 75 et plus, c'est toujours se dépasser.* »

Int- « *Ok … là tu me parle de tes parents mais, si supposons que tes parents te disaient pas ce que pour eux représente la réussite ; si c'était seulement toi, sans l'opinion de tes parents, ça serait quoi pour toi de réussir ? Est-ce que ça serait la même chose que tes parents ou est-ce que ça serait différent ?* »

T- « *Bah quand tu commences quelque chose et bah que tu l'accomplis, t'as réussi. Quand tu mets à terme ton projet... c'est réussir.* »

This primary good was largely due to his parents embedding this value throughout his upbringing. Yet, he insisted that status was of high importance (rated 5) to him. Ramsay also considered society as playing a huge role in imposing this value. Ramsay had a strong wish to achieve, particularly in school, to satisfy his parents.

Int- « *Pourquoi 5 ? Qu'est ce qui est si important dans la réussite?* »

T- « *Parce que la société d'aujourd'hui c'est une société de savoir, si tu réussis pas ton cours, bah tu recommences. Tant que t'as pas réussi, t'as pas les qualifications, t'a pas ce qui faut pour faire le travail et les gens oublient que faire des échecs c'est… on apprend de ça aussi [...] c'est ça que je trouve un peu triste de la société d'aujourd'hui.*»

Int- « *Tu donnes la note de 5, mais est-ce que c'est parce que la société te l'impose ou c'est pour toi ?* »

T- « *La société me l'impose fait que c'est inculqué dans nos valeurs maintenant.* »

Int- « *Mais si on imagine un monde où on n'impose pas la réussite, toi, est ce que tu le garderais a 5 ?* »

T- « *Ça serait à 3 là…*»

His motivation to achieve was a notable strength. Obstacles to attaining a sense of achievement included his lack of self-confidence and his incapacity to identify his strengths.

Int- « *Dans quoi est ce que t'es bon ? Quels sont tes talents ?* »

T- « *Pour de vrai, je sais pas [...] Tout ce que je sais c'est que je réussis bien à l'école, mieux qu'avant pis que j'ai un avenir devant moi… mais sinon je ne sais pas ce que j'ai accompli.* »

Ramsay often mentioned that school was a priority over having fun. According to him, succeeding at school meant you would succeed in life. He believed that this need was the most important and essential of all. Ramsay gave much importance about "being someone in life," getting a name for yourself and being able to provide financially for yourself. Ramsay indicated that the primary good of *achieving* was connected to the sexual abuses and the need for affection.

Int- « *Est-ce que tu penses que ce besoin est en lien avec les abus ?* »

T- « *Oui* »

Int- « *Dans quel sens?* »

T- « *Dans le sens que… de pas avoir eu… de pas réussir à avoir de l'affection…des affaires comme ça… plus je prends du recul de ce qui s'est passé, plus que c'était un échec qu'une réussite parce que c'est… ça a marqué à vie les deux petites filles…. C'était plutôt moi… c'était plutôt « selfish ». »*

Based on his statements, the way Ramsay attempted to meet his need for achieving seemed inappropriate. Moreover, Ramsay did appear to focus on achievement excessively and to the detriment of other needs.

Being my own person

Ramsay considered the good of *being my own person* as the most challenging. Ramsay was never capable of achieving a sense of identity.

> Int- « *Être moi-même ça veut dire quoi pour toi*?
> T- « *Euh... je n'ai jamais été moi-même... en fait j'ai tout le temps porté un masque pour plaire aux autres, à mes parents*. »
> Int- « *Mais être toi-même, c'est quoi derrière ce masque* ? »
> T- « *je sais plus en fait. Je sais plus ce que c'est être soit même. Je peux m'adapter à des différents groupes pis… je change complètement de personne [...] je change de personnalité, de personne.* »

Ramsay defined himself as naive and different from his pairs and other people. He stated never having a sense of belonging. Moreover, he recalls growing up in environments where individuality and being one's self was hardly achievable. Ramsay mentioned having a uniform at school and in the cadets, making everyone alike. When questioned about his different attitudes and personalities, Ramsay said he did not like himself when alone, leading him to seek constant company. Ramsay expressed that when alone, he would access illegal and violent pornography. For Ramsay, this need intertwined with the need of having people in his life.

> Int- « *Quand tu es tout seul, est ce que tu es différent qu'avec tes amis* ? »
> T- « *Oui, c'est pour ça que j'aime pas ça être tout seul.* »
> Int- « *Qu'est-ce que t'aime pas dans ce que t'es quand t'es tout seul ?* »
> T- « *Bah… j'ai des goûts déplacés… des affaires comme ça [...] comme… bah… j'aime ça quand j'attrape des animaux... et c'est empailler leurs cadavres, des affaires comme ça [...] et des choses un peu plus dégueulasses [...] avant quand je pouvais aller sur l'ordinateur bah quand j'étais tout seul, j'étais sur ce qui s'appelait des chambres rouges. Pis ce que je voyais là... bah c'est des gens qui se faisaient torturer ou des fois tuer. C'est ça. Ça c'est arrivé que 3 fois car c'est très difficile d'accéder à ça.* »

He associated the need of *being my own person* to his deviant sexual interests and dark humor, generating poor self-esteem. Ramsay attached no importance at all to the need of *being my own person*, as he linked it directly to his sexual offenses.

> Int- « *Tu le coterais à combien ?* »
> T- « *A 0.* »
> Int- « *Tu m'expliques un peu pourquoi tu l'a noté comme ça* ? »
> T- « *C'est juste ce qui m'a apporté à commettre les actes que j'ai fait*. »

The way Ramsay attempted to meet his need for achieving was inappropriate, but he did not focus unduly on it.

Having people in my life

At the time of the sexual abuse, Ramsay was socially isolated and had little to no people to confide in. He stated having only three friends and labeled an outcast.

> Int- «*Comment définirais tu 'avoir des gens dans ma vie' ?* »
> T- « *Des gens que tu peux compter dessus. Quand t'as des problèmes et qu'ils viennent d'aider... des gens que tu peux te confier à, que tu peux t'amuser avec.* »

Ramsay identified that his relationship with his brother was the only positive one within the family unit. He would constantly have conflicts with parents and could not recall any positive moments with them.

> Int- « *Au moment des abus comment ça se passait tes relations avec ta famille, tes amis?*
> T- « *Il y a avait beaucoup de conflits... si je pense le moment le plus proche avec ma famille c'était… j'ai de la misère à me rappeler des bons moments qu'on a eu ensemble, c'est tout le temps un milieu de conflit. Mais avec mon frère c'est un peu différent, c'était mon meilleur ami. Mais avec mes parents il y avait toujours de la chicane, tous les jours y étaient fâchés de quelque chose. [...] si j'avais fait mes devoirs ou pas, des affaires comme ça qui les rendent bin frustrés. Mon père a fait 35 ans dans l'armée donc pour lui la propreté c'est obligatoire. Pour ma mère c'était les bonnes notes ou les devoirs. Si j'avais en bas de 65 j'avais des conséquences. Où quand… euh… je faisais pas mes devoirs je pouvais pas aller dehors, des affaires comme ça.* »

Ramsay goes as far as describing his relationship with his parents as noxious and unhealthy. According to him, they had nothing in common. During that period, he would keep his emotions bottled up rather than sharing and communicating with family members. He always had to seek parental approval which led to low self-esteem. This led Ramsay to seek acceptance elsewhere. As mentioned previously, Ramsay closely relates this need to being his own person and achieving. He believes the parental pressure he experienced stopped his personal development.

> Int- « *Tu dirais que ta relation avec tes parents était comment ?* »
>
> T- « *Malsaine.* »
>
> Int- « *Pourquoi malsaine ?* »
>
> T- « *J'étais pas vraiment heureux où c'que j'étais. J'étais plus heureux ailleurs que chez les parents {..} j'étais tout le temps en conséquences pis j'avais… j'étais tout le temps contrôlé fais que je pouvais jamais me développer ...euh…. j'avais plus de confiance en soi…fallait tout le temps que je me fasse approuver par mes parents…fait que quand je faisais quelque chose à l'école j'essayais de me faire approuver par mon… par mes… par des gens [..] ça m'a stoppé dans mon développement personnel.* »

Ramsay also had poor social skills; he would make inappropriate jokes and crude comments to his peers. Because Ramsay had such difficulties building relationships, he resorted to the use of the internet to share his feelings. He believed that communication was easier through the internet. However, Ramsay attached high importance to this need. He rated it at five but stated that it only applied to friends; he did not attach any importance to parental relationships. Ramsay did not believe that this need was related to the sexual abuses. He did not appear to focus on it to the exclusion of other needs.

Having a purpose and making a difference

Ramsay evoked carrying out around 300 hours of volunteering for different associations. He volunteered at the armistice celebration, at biathlon competitions, with the cadets, at music concerts and in centers for the elderly.

> Int- « *Comment définirais-tu le besoin "avoir un but/faire une différence"?* »
>
> T- « *Bah euh… c'est très simple faire ça……euh… présentement ma vie……j'ai fait une différence dans la vie de deux personnes puis euh j'ai aidé à améliorer la société environ*

trois fois…. Avec les cadets… euh je me rappelle une activité des cadets, c'était de récolter des denrées non périssables puis aller les porter directement aux gens. Les réactions que ces gens-là ont, là… je me rappelle un moment donné, c'était proche du jour de l'an puis y'avait deux enfants d'environ 5 -12 ans, quand eux autres ont vu les boites, aye y étaient excités là… puis t'sais, ça te parle, ça te change quand tu vois ça. Faque un but ou faire une différence dans le monde c'est vraiment facile, ça prend pas grand-chose. »

Ramsay enjoyed giving and helping others. He considered himself an altruist and attached great importance to the values of loyalty, respect, and charity. He explained that his parents had taught him about charity, through religious upbringing. His father would often tell him that giving of your time was better than giving money. Yet, he also described himself as dishonest and disrespectful. Ramsay attached high importance to this need.

Int- « *Si tu notes ce besoin de 1 à 5 en fonction de l'importance ?* »

T- « *Bah en fait ça serait 5 parce que c'est… parce que pour moi j'avais pas besoin d'y penser… genre…je le fais naturellement … fait que pour moi c'est pas un effort à faire.* »

Ramsay did not believe that this need was associated with the sexual offenses he committed. There were no indications that Ramsay attempted to meet the need of *having a purpose and making a difference* through inappropriate means or that he focused on it to the detriment of other needs.

Emotional health

Ramsay recalls that he never managed to be emotionally healthy and that his moods would constantly fluctuate. He mostly felt negative emotions (i.e. sadness, anger, anxiety) rather than positive ones.

Int- « *Pour toi c'est quoi d'être en santé émotionnellement ?* »

D- « *Pour de vrai j'ai jamais été en santé émotionnellement, de ma vie.* »

Int- « *Déjà essaye de me le définir* »

T- « *Bah être au courant de ce que tu vis pis de…de soit améliorer ou essayer de garder le niveau d'émotions stable, positif. Moi ça a tout le temps été ça, toute ma vie, je suis*

pas capable de garder le cap. [..] J'ai jamais été capable de gérer mon stress, il y a tout le temps eu des choses qui me rendent triste. »

Prior to displaying the harmful sexual behavior towards his two victims, Ramsay recounted experiencing a high level of personal distress that he linked to his parent's pressure, his schoolwork and family conflicts.

Int- « *Au moment des abus, tu étais comment émotionnellement ?* »

T- « *Instable.* »

Int- « *Qu'est qui faisait que tu étais instable ?* »

T- « *Bah j'avais beaucoup de stress à cause des examens dans ce temps-là…. Beaucoup de pression des parents de réussir en haut de 70%-75%. J'avais aussi beaucoup de conflits intérieurs. Genre je suis qui dans la vie moi, je m'en va ou dans la vie. J'étais arraché sur mon identité… je n'avais aucune idée de qui j'étais. C'était 'ça allait être quoi mon but'.* »

When confronted with emotional challenges, such as family conflicts, Ramsay resorted to inappropriate and maladaptive strategies (i.e. juvenile pornography, violent pornography, alcohol/drug consumption, hurting animals, and insult people). Ramsay also recalls suffering from suicidal ideation in the past. Ramsay hoped to become emotionally healthy and attached great importance to this need, rating it at 5. He believed that his difficulty in controlling his negative emotions played a central part in the sexual offenses. There were indications that Ramsay attempted to meet the need of *emotional health* through inappropriate means. Nevertheless, he did not focus on it unduly.

Sexual health

Ramsay would make a lot of misplaced jokes, especially when sexuality was addressed. Ramsay automatically associated the primary good of *sexual health* to religion. He attended a Catholic school, and his parents would support religious values. For Ramsay's parents, any sexual contact before marriage was forbidden and poorly looked upon.

Int- « *Ça veut dire quoi pour toi la santé sexuelle ?* »

T- « *La chasteté, pis acheter souvent des ceintures de virginité, c'est la meilleure chose qu'on peut faire.* »

Int- « *Et plus sérieusement ?* »

T- « *Bah c'est ça que mes parents m'ont appris. La chasteté, tu touches pas à ça les femmes, des affaires comme ça. Jusqu'au mariage, pour des raisons religieuses.* »

During his adolescence, prior to the sexual offenses he committed, Ramsay questioned his sexual orientation. His first sexual relationship was with an 18year old man when he was aged 14 years old. Although he recalls being sexually satisfied, he mentions that he had to hide this relationship from his parents and the cadets to avoid rejection. Ramsay's parents did not promote homosexuality because of their Christian beliefs. According to Ramsay, sexuality was not a taboo in the household, but it was never spoken of. He rated the primary good of *sexual health* at 5 and linked it to the sexual abuses he committed. Ramsay believed that the consumption of child pornography created curiosity which then led to him wanting to try what he had seen.

Int- « *Ce besoin, a-t-il un lien avec les abus?* »

T- « *Oui parce que c'est la pornographie juvénile qui m'a …. Qui en grande partie m'a fait faire ça. Je voulais essayer ça. Une des raisons que j'ai fait les abus c'est que je voulais essayer ce que j'avais vu dans les pornos.* »

Ramsay recognized that the sexual behaviors towards his two victims were inappropriate. He did not believe that he focused on sexual health to the detriment of other goods.

Physical health

Although Ramsay attached great importance to physical health (rated 5), he acknowledged that he engaged in limited exercise. Moreover, he described a relatively healthy diet and very good personal hygiene. Ramsay recalled having body image issues and wishing to lose weight. He did not appear to recognize his physical attractiveness as a resource.

Int- « *Peux-tu me définir la santé physique ?* »

T- « *Hmmm. Que tu as toujours deux bras pis deux jambes... si t'as plus ça bah va voir un médecin….. Bref….euh, faire du sport, bien dormir, bien se nourrir. Je trouve que la santé physique c'est une des plus importantes. Juste parce que moi j'aime pas à quoi je ressemble, je trouve que je suis trop gros, des affaires comme ça …fais que… le problème c'est que je fais pas des choses pour régler la situation la [rit].* »

While Ramsay had little motivation to pursue physical health goals, the limited means he used to meet this need appeared to be appropriate. He did not believe that this need was linked to the sexual offenses.

Conflict among needs

The information gathered through this semi-structured questionnaire suggested that Ramsay's need of *having people in my life* would conflict with the need of *being my own person*. For example, Ramsay wished to have friends to confide in but would make inappropriate comments/jokes towards his peers. This behavior inadvertently resulted in his peers rejecting him. Moreover, emotional health needs such as negative emotions, family conflicts or suicidal ideology would equally conflict with *being my own person*. On the one hand, Ramsay sought a sense of identity, but on the other hand, he disliked his personality, especially when alone.

Scope

Ramsay had limited scope of primary needs, in that he placed emphasis on the needs of *achieving* and *having a purpose/making a difference* while neglecting the needs of *having fun* and *being my own person*.

Internal/external capabilities

Ramsay lacked affect regulation skills. He would easily get angry and frustrated and would lash out verbally at other people. Moreover, he would repress his emotions rather than express them. Ramsay also lacked social skills; he had difficulty making friends and would not take responsibility for his behavior.

Inappropriate or harmful needs

As mentioned in the questionnaire, Ramsay would use inappropriate and sometimes harmful needs to reach his primary goods. When faced with emotional difficulties, Ramsay would resort to animal cruelty or violent pornography. Furthermore, on some occasions, he would consume drugs to handle negative emotions. Moreover, his *sexual health* need was met through harmful sexual behavior.

Pathway to offense

The first stage of the GLM consists in classifying dynamic risk factors and examining the link between these factors and the sexual offense. At the time of the offenses, Ramsay relates having very conflictual relationships with his parents. He recalls that his father was very demanding and would often get angry. Ramsay was being pressured into succeeding by both his parents; work was always emphasized to the detriment of amusement. This led Ramsay to have low self-esteem and no sense of identity. Also, Ramsay's sense of belonging was eroded by his bullying and marginalization experiences by his peers. These circumstances were further exacerbated by his poor social skills and his lack of entertainment.

Ramsay faced some challenges on a personal level (e.g. family conflicts, pressure to achieve, negative emotions) and was not able to implement adequate strategies to resolve them. Indeed, Ramsay felt great anger and frustration from being in a controlling environment (parental). The sexually abusive behaviors were a mean to regain control of his life; he attempted to fulfill his need for power by exerting control over his victims. Moreover, the harmful sexual behavior became a mean to self-soothe his emotional instability and poor affect regulation. Therefore, Ramsay's sexual offenses provided a means through which he could meet his emotional health and belonging needs. The lack of resources and obstacles associated with these needs formed a direct route to Ramsay's harmful sexual behaviors.

Old Life/New Life

Ramsay was first asked to describe his thoughts, emotions, and behaviors prior to the sexual harmful behaviors and in the present. He also had to name the conflicts, difficulties and needs at those stages. This exercise allows youths to have an overview of their progression throughout time, and to visualize themselves in the future.

Figure 3. Old Life/New Life stages of Ramsay.

When addressing the Old Life topic, Ramsay remembered having strong sexual impulses and a wide range of sexual interests. Furthermore, he experienced high levels of stress associated with school work, the cadets, and parental pressure. Ramsay recalled often feeling angry and sad; he could not recall feeling any positive emotions. Ramsay mentioned that he would be oppositional towards his parents and would act impulsively. He acknowledged that he neglected the needs of *being my own person* and *having fun*. However, he had difficulty describing his thoughts and behaviors; he considered this period too far back to remember what he felt or how he acted.

Ramsay described the Roundabout or Now stage as slightly more positive. Although family conflicts were still present, he believed he faced fewer obstacles into achieving a more prosocial lifestyle. He stated that his emotional distress was mainly linked to his legal restrictions, which he characterized as an "emotional hell." During the GLM project, Ramsay was arrested for a breach of condition; he had kept his work cell phone on him while not allowed to do so. Ramsay feared the possible consequences of his violation. Moreover, Ramsay would regularly get burn-outs due to stress but said he was accustomed to it, as it had always occurred in his life. Also, Ramsay often felt exasperated by his present situation, saying he had little to no control over it. Yet, he qualified himself as mostly happy and less avoidant of his daily issues. Ramsay recognized that he excessively focused on *achieving* while neglecting other needs.

When addressing the New Life aspect of the GLM, Ramsay identified seven prosocial goals he wished to achieve and linked them to primary goods. His goals were either short-term or long-term[6].

[6] See Figure 4

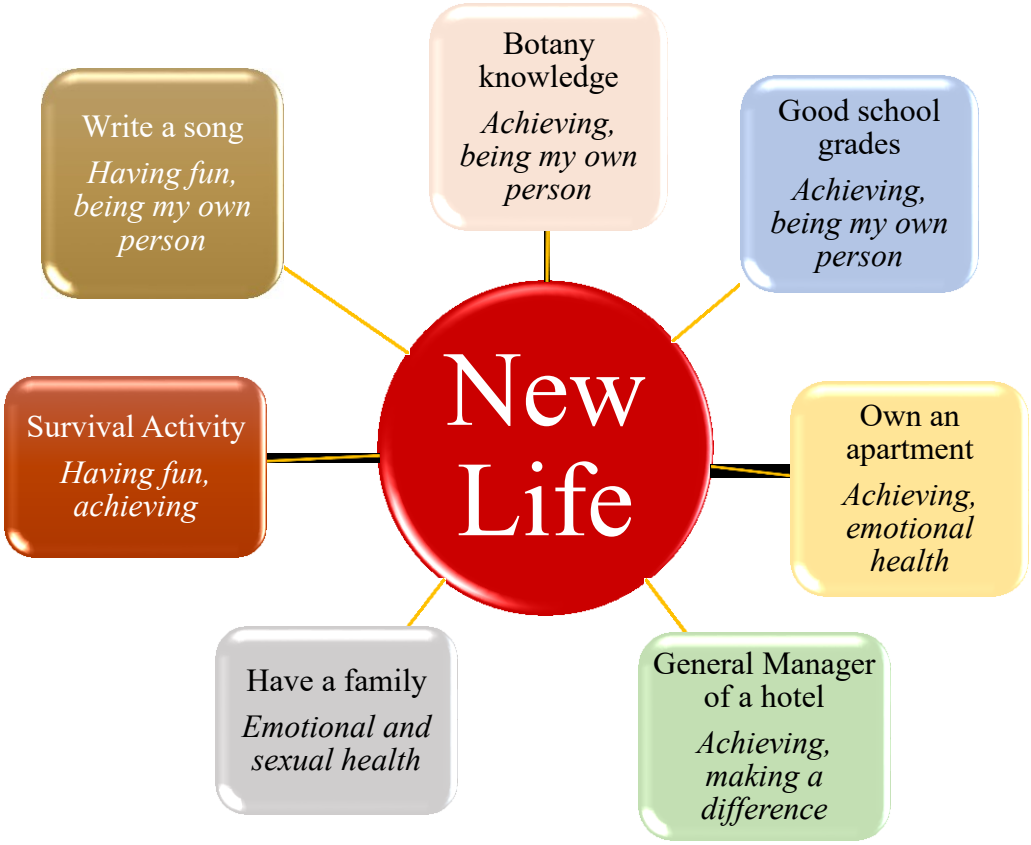

Figure 4. New Life Goals of Ramsay.

On the short-term, Ramsay identified the following goals:

- Planning a survival activity (either alone or with his brother) for a week's time where he would put to use his current knowledge about surviving in the wild. He associated this goal to the primary goods of *having fun* and *achieving*.
- His second goal focused on school grades; Ramsay wanted to obtain an average grade of 75% or more. He linked this goal to *achieving* and *being my own person*.
- Ramsay identified learning about botany as his third goal. This goal was part of his desire to organize a survival excursion. Ramsay named *achieving* and *having fun* as associated with this goal.
- His last short-term goal involved writing a song which was connected to *having fun* and *being my own person*.

His long-term goals included:

- Becoming the general manager of a hotel. Ramsay wished to obtain a master's degree in hotel management and work in a hotel in Switzerland.
- Owning his own apartment. One of Ramsay's most important goals was to leave the household and become financially independent. Because living with his father was a major source of stress, he hoped to feel emotionally healthier on his own.
- Having a family. Ramsay expressed his desire to have a family but specified that his work would always be a priority over this goal.

The goals and needs identified by Ramsay demonstrate his desire for independence, success and emotional stability.

The Good Lives Plan

Once Ramsay's goals were established, a Good Lives Plan could be designed. Firstly, Ramsay had to identify his internal and external capacities/resources. He also had to determine his emotional difficulties and external difficulties. Based on Ramsay's relationship with his parents, we did judge them as positive external resources; his mother was disinvested, and his father would seek to control the progress of the GLM follow-ups. Therefore, we focused on using his prosocial friends and his internal capacities to make positive changes. Ramsay was highly motivated and demonstrated a positive attitude. Moreover, he would invest himself in the GLM project. Therefore, we focused on these strengths. Ramsay was self-conscious about his emotional difficulties and the needs he neglected.

Using a table, Ramsay had to classify inappropriate means he would use to meet each primary good. Afterwards, he had to identify alternative, appropriate means to meet these same needs. (i.e. Table 1).

Table 1

Means to meet primary goods for Ramsay

NEEDS	**APPROPRIATE**	**INAPPROPRIATE**
Having fun	Boards games	Making fun of people
Achieving	Accomplish a school project	Cheating, lying

Being my own person	Tell my friends about my feelings, identify my values	Physical and mental isolation, wearing "masks" to please others, change my personality
Having people in my life	School friends, prosocial friends	Satan worshipper friends, drug addicts
Having a purpose and making a difference	Volunteering, cadets, president of the prom comity	Ø never did any
Emotional health	Listening to music, archery, reading a book, talk to friends, smoking cigarettes	Animal cruelty (killing), violent/illegal pornography
Sexual Health	Legal/consensual pornography, no violence	Juvenile pornography, violent pornography, sexual abuse
Physical Health	Sports: jogging, hiking, bicycle, healthy diet	Insomnia, drugs, cigarettes

Follow-ups

From the beginning of the GLM project, Ramsay was actively engaged. He was proactive and showed enthusiasm to reach the therapeutic objectives. He would follow recommendations and apply appropriate means to reach his primary goods.

In the social sphere, Ramsay managed to spend less time with antisocial friends and befriended a prosocial person at his school. This new friendship led him to engage in fun, prosocial activities. Instead of studying constantly and being socially isolated outside of school, he spent time with his new friend, playing board games, sharing similar interests and teaching him about survival techniques. Ramsay also succeeded in being more assertive with his parents.

Instead of being avoidant in conflictual relations, he would openly express his emotions, his thoughts, and feelings.

During the GLM follow-up, Ramsay achieved his short term goal of organizing a survival activity with his school. He also received a bronze medal for his school grades and engagement in the school's administration/organization. Ultimately, Ramsay was promoted at work for his increased sales. These events increased Ramsay's sense of achievement and his self-confidence.

Regarding his sense of identity, I encouraged Ramsay to participate in activities he considered enjoyable. Ramsay once mentioned that he never managed to choose his own clothes because his mother would do so for him. I recommended that he go shopping and buy himself something he had chosen rather than clothing his mother has chosen for him. Ramsay enjoyed participating in this activity as it gave him a feeling of empowerment. Ramsay expressed his longing desire for independence and being his own person. Unfortunately, due to lack of time, no other appropriate means could be implemented.

Ramsay's biggest challenge was to meet his emotional health needs in appropriate ways. During the course of the GLM, he experienced many family issues and conflicts. Not only did his parents separate, but his relationship with his mother deteriorated. In the past, when faced with such emotional difficulties, Ramsay would resort to violent pornography and animal cruelty. During the follow-ups, Ramsay managed to replace these means by more appropriate ones. Indeed, he fulfilled his need of *emotional health* by confiding in a friend when feeling sad or angry, by engaging in prosocial activities (e.g. listening to music, taking a walk, reading a book) and by smoking cigarettes. Although smoking cigarettes was not the most appropriate mean to use, it was still more appropriate than violent pornography and animal cruelty. However, it must be noted that these changes did not happen suddenly; he progressively decreased his illegal pornography consumption. By the end of the GLM project, he had managed to not consume any illegal pornography or be cruel towards animals for a month. When Ramsay would use appropriate means to achieve his needs, I would congratulate him and encourage him to pursue his efforts. This increased Ramsay's motivation.

While Ramsay did make numerous positive changes, his real motivation for change must be questioned as it appeared extrinsic. Ramsay seemed to want to please and meet my expectations rather than truly make positive changes in his life. Ramsay would always want to

show himself in the best possible light to obtain a positive review of his participation. Also, Ramsay would try to control the topics addressed and would avoid talking about his inappropriate means to meet his needs. Because his parents could not be used as valuable resources to confirm his progression, the implementation of appropriate means to meet his needs is solely based on his sayings. This implies that since Ramsay wishes to please practitioners, his statements may not always be accurate, as is prior psychologist confirmed.

Final interview

During the final phone interview, Ramsay was asked to fill out the SRS V.3.0. On a scale 1 to 10, Ramsay rated the therapeutic relationship at 8. Ramsay mentioned that he mostly felt respected and heard. However, he did mention that some of the topics he addressed (violent pornography and animal cruelty) seemed to generate frustration and disappointment on my end. Ramsay enjoyed talking about positive themes and not focusing on the negative aspects of his life. Therefore, he rated the goals and topics at 10. Regarding the approach and method, Ramsay gave it an 8, saying that the abrupt change of one practitioner to another was difficult to adapt to. The adolescent rated the overall at 9, once more bringing forward the positive perspective of the approach.

When asked what he retained from the GLM, Ramsay stated that he became more respectful of nature and more self-confident. Moreover, he considered himself more social, he had increased motivation and realized that primary needs can always be reached with appropriate secondary means. Ultimately, Ramsay was asked to make future recommendations about the GLM. The adolescent suggested that Visio conferences did not facilitate therapeutic alliance and made the schedule less convenient. Ramsay added that interviews should be on a weekly basis, at a more stable pace.

4.2 Case Study #2: Theon

Theon is a 16-year-old adolescent that was referred to the SE by a social worker following reports of sexual abuse, serious conduct disorder, and bestiality.

4.2.1 Personal background

Sexual development and offenses

In the sexual sphere, Theon's issues started at age 7-8 years old. Early on, he engaged in bestiality with dogs, would show pornography to children and would solicit sexual favors from children.

At the age of 11, Theon engaged in sexual harmful behavior (i.e. sexual touching and fellatio) towards a friend's brother; the victim was ten years old. When Theon was 13 years old, he sexually abused (i.e. sexual touching and fellatio) of one of his younger brothers (then aged 9). The events occurred on multiple occasions, over a period of 2 weeks.

Medical and psychiatric background

Theon was diagnosed with ADD at age nine years old, for which he was prescribed Concerta. However, because Theon suffered from negative side effects (i.e. suicidal ideation and depressed affect) from the medication, he discontinued its use. As a child, Theon also received the following diagnoses: dysorthography, dyslexia, and weaknesses of the working memory. More recently, the adolescent's psychiatrist stated that Theon presented borderline personality traits (BP), bipolar disorder (BD) and histrionic traits.

Personal and family history

Theon's parents separated shortly after his birth as a result of domestic violence. Theon had no contact with his biological father, until recently, when his father decided to reconnect with him. Theon and his mother would often move to avoid his biological father. When the adolescent was five years old, his mother a new partner with whom she had three sons. The family lived in New-Brunswick (NB) until Theon's bestiality was revealed and suffered from discrimination. Following these events, the family moved to Quebec. From a young age, Theon exhibited poor social skills with his peers; he would be aggressive and impulsive. Due to his conduct disorder, the adolescent had two repeat two grades.

As a teenager, Theon was a victim of bullying (verbal abuse), mainly due to his sexual orientation (homosexuality). Furthermore, he would often get into physical fights with his peers.

At school, he frequently got suspended. Within the family unit, Theon displayed similar behaviors; he had temper rages, would physically hurt his brothers, would not respect rules and would steal from his parents. In addition, Theon would use drugs (marijuana) on a regular basis and socialize with the wrong crowd. Following the reports of sexual abuse, Theon was placed in a rehabilitation center. His behavior considerably improved; Theon follows the rules and is respectful although he tends to test limits by asking for favors and attempts to negotiate rules.

4.2.2 Risk evaluation

Static risk factors

Theon's risk of sexual recidivism was evaluated using the ERASOR. Theon's ERASOR results indicated that four out of nine static factors were present: sexual assault of the same victim twice or more, sexual assault of a child, sexual assault of a male victim and diverse-sexual-assault behaviors (bestiality, fellatio, fondling). The following factors were absent: prior adult sanctions for sexual assault(s), threats of, or use of, violence/weapons during the sexual offense, ever sexually assaulted 2 or more victims (prior to age 12 years old), ever sexually assaulted a stranger and indiscriminate choice of victims.

Dynamic risk factors/criminogenic needs

According to the ERASOR criteria, Theon did not present any of the factors in the sexual interests, attitudes and behaviors category. Indeed, Theon did not show deviant sexual interests, preoccupation with sexual thoughts, attitudes supportive of sexual offending or an unwillingness to alter deviant sexual interests/attitudes. Psychosocial functioning indicated that Theon had negative peer associations and influences as well poor self-regulation of affect and behavior (impulsivity). Antisocial personal orientation and interpersonal aggression were partially present. Social isolation and recent escalation in anger or negative affect were not identified in Theon's case. In the family/environmental functioning, no factors were present. Theon did not live in a high-stress family environment or have problematic relationships with his parent(s)/parental rejection. Moreover, parents showed support of sexual-offense-specific assessment/treatment and Theon's environment did not support opportunities to reoffend sexually. Ultimately, in the treatment category, the two factors were present: no development or

practice of realistic prevention plans/strategies and incomplete sexual-offense-specific treatment.

Protective factors

In the case of Theon, no DASH-13 was used as some of the evaluators do not always include them. Based upon the ERASOR, the overall risk rating for Theon was estimated as low when in living in specific housing. Though, if Theon were to return home, the risk would increase to low-moderate.

4.2.3 The Good Lives Model

First Interview

At the first interview, Theon was accompanied by his mother, his stepfather, and his social worker. I presented to them the core principles of the GLM and how the following interviews would unfold. Theon's legal conditions included: not being allowed at children's playgrounds, not being left unattended with children and animals, not being allowed to watch pornography. His parents and social worker named the subsequent objectives: learn to know himself better, share his emotions, be less susceptible to suggestion and control his emotions. During this first meeting, Theon said that he did not want information to be shared with his parents as he did not get along with them.

The GLM Questionnaire

The GLM questionnaire with Theon was done over a period of 2 interviews. Theon would alternate between French and English.

Having fun

According to Theon, having fun was closely related to sexuality. Theon believed that sexuality was an inappropriate mean to achieve entertainment. During the interview, the adolescent was told that sexuality was an appropriate mean to achieve fun if it was consensual, non-violent and with age appropriate partners.

Int- « *Selon toi, ça veut dire quoi 's'amuser' ?* »

T- « *Je sais pas… genre jouer avec quelque chose… je sais pas… parce que moi s'amuser…. moi j'ai deux manières à le prendre. J'ai la manière croche plus j'ai la manière genre de jouer avec un jouet ou quelque chose.* »

Int- « T*u veux dire quoi par manière croche ?* »

T- « *Bah m'amuser sexuellement… genre je pense sexuellement souvent.* »

At the time of the abuse, Theon lived in a small town in New-Brunswick. He enjoyed fishing, spending time at the beach with his friends and playing video games. However, he stated only having fun outside of the household. At home, he considered rules to be too strict and had little opportunities to have fun. Theon mentioned being bored most of the time. Therefore, he would leave home as often as possible to find amusement elsewhere. Theon attached high importance (rated 4) to this need and did appear to focus on it to the exclusion of other needs. Often, Theon would focus so much on amusement that he would fail to do his chores. This failure to listen and respect rules would lead to family conflicts. Furthermore, Theon mentioned that without fun, life would be meaningless.

Int- « *Est ce que s'amuser c'est important pour toi?* »

T- « *Oui parce que des fois on a besoin de s'amuser dans la vie. On a pas… on veut pas toujours rester la a se tourner les pouces là.* »

Int- « *Est ce que tu penses que ça t'arrivait de trop focaliser sur le fait de t'amuser que tu négligeais tes autres besoins ?* »

T- « *Ouais. Ouais [...] ma mère m'avait demandé de faire quelque chose et j'ai complètement oublié, j'ai continué à faire autre chose.* »

Theon did not believe that this need was associated with the sexual offenses he committed. He stated that excessive and uncontrollable curiosity was the main cause for his sexually abusive behaviors.

Int- « *Penses-tu que ce besoin a eu un lien avec ta problématique sexuelle ? Avec les abus ?* »

T- « *Non... non je pense que de ce temps-là c'était plus de la curiosité que j'avais. C'était plutôt une grosse curiosité que j'avais que je pouvais pas contrôler.* »

Although Theon focused excessively on fun, the way, he attempted to meet this need for seemed appropriate. Moreover, he found it easy to achieve.

Achieving

Theon assumed that achievement was automatically linked to school and grades.

> Int- « *Pour toi ça veut dire quoi réussir ?* »
>
> T- « *Réussir… euh…. Pour moi réussir c'est réussir à l'école. Que moi je réussisse mon français.* »
>
> Int- « *Penses-tu que la réussite peut s'appliquer à d'autres aspects de ta vie ?* »
>
> T- « *Oui… je sais pas. Genre réussir… oh j'ai réussi mon dessin, oh j'ai réussi ma bouffe, oh j'ai réussi mon travail.* »

Initially, the adolescent had trouble identifying his strengths and qualities. At the time of the abuse, played musical instruments, would draw and cook. Yet, Theon did not believe he excelled in anything.

> Int- « *Quels étaient tes talents et tes qualités ?* »
>
> T- « *La musique, je jouais de la trompette, de la clarinette, du baryton. […] les dessins, euh la cuisine.* »

Theon attached moderate importance to the need of *achieving*, rating it at 3. He would easily get distracted by external stimuli and had concentration issues. Consequently, he would rarely achieve his goals.

> Int- « *Comment noterais-tu ce besoin ?* »
>
> T- « *3, parce que des fois je réussis pas des choses que je veux donc je le mets à la moitié.*»
>
> Int- « *Qu'est ce qui fait que tu n'arrives pas à réussir certaines choses ?* »
>
> T- « *Les distractions. Je suis souvent distrait dans la vie. Moi j'ai de la misère quand qu'y a beaucoup de choses qui bougent en même temps.* »

Theon indicated that the primary good of *achieving* was not connected to the sexual offenses.The way Theon attempted to meet his need for achieving was appropriate, and he did not focus unduly on it.

Being my own person

Theon had a very strong sense of identity. He associated this need specifically to his dressing style. The adolescent wanted to be different from his peers and stand out.

Int- « *C'est quoi pour toi être toi-même ?* »

T- « *Être moi-même…. Humm… je sais pas. Être moi-même genre ... je fais jamais les mêmes choses que les autres. [...] mon style est toujours différent que les autres.* »

Theon recalls suffering from uniforms at school and in the cadets, which made everyone alike. He did not want his peers to wear the same clothes as him or look similar. Moreover, the adolescent contemplated getting a sex change. He admired transgender individuals and hoped to follow a similar path.

Int- « *C'est important pour toi de te démarquer?* »

T- « *Faut toujours que je sois différent, je peux jamais être comme… être quelqu'un d'autre genre, faut toujours que ce soit moi. Faut toujours que ... comment dire ça… mmmh… je sais plus [...] Je déteste quand quelqu'un porte le même linge que moi. Je veux être unique.* »

Although he had suffered from discrimination due to his dressing style and his sexual orientation, *being my own person* was Theon's most important need. Theon's uniqueness considerably increased his self-esteem and his confidence.

Int- « *Quelle note mettrais-tu ?* »

T- « *Un bon 5. Un bon 5. 100%. C'est le truc le plus important dans ma vie, c'est être moi, être unique.* »

Theon did not link this need to his sexual harmful behaviors. Based on his statements, the way Theon attempted to meet his need for *being my own person* seemed appropriate. However, he did focus on this need excessively while neglecting other needs.

Having people in my life

The adolescent attached high importance to being surrounded by people, rating it at 5. If left alone, Theon would get bored and depressed, making him emotional dependent on others.

Int- « *C'est important pour toi d'avoir des gens dans ta vie?* »

T- « *Moi faut toujours que j'aie quelqu'un. Moi si j'irais en appartement je pourrais pas être tout seul. Je peux pas être tout seul sinon je m'ennuie puis je 'dépresse'. Non, moi faut que j'aie tout le temps quelqu'un avec moi. Tout le temps, tout le temps.* »

In New-Brunswick, Theon had very few friends. One of the main reason for his social isolation was his sexual orientation. Because Theon lived in a small, Catholic town, homosexuality was poorly looked upon. Moreover, his sexual orientation led him to a bullied by his peers. Nevertheless, the adolescent longed to have friends to confide in.

Int- « *Est ce que tu recherchais des amis au New Brunswick?* »
T- « *Oui mais je pouvais pas avoir… l'intimidation, l'homophobie.* »

The little friends Theon had, he could not confide in. He recalled that living in a small town implied that one's life was never kept secret and intimacy was absent. He knew that if he confided in one of his friends, it would be revealed publicly. Therefore, Theon kept his feelings and emotions to himself. Theon mentioned that he suffered from that social isolation.

Int- « *Est-ce que tu avais des gens à qui te confier ?* »
T- « *Oui pis non... parce que au NB tout le monde se connait donc si tu dis quelque chose ça va aller oreilles a oreilles, oreilles, oreilles, bouche oreille.* »

With his family, relationships were no better. Theon did not get along with his step-father and felt his mother would always go against him. Moreover, he expressed jealousy towards his brothers that, according to him, got preferential treatment.

T- « *My parents were never there for me [...] I wasn't really happy with my stepfather when my mother met him and stuff… even when I was five years old, I was like "you're disgusting, go away." When my mom got with him, he never had any kids, so he was really aggressive. Physically and verbally. My mom took my stepdad's side.* »

Theon also revealed that his stepfather worked a lot while his mother stayed at home. The adolescent would avoid staying home and would spend most of his time with his cousins, uncle, and grandmother. He had better relationships with them and would share many activities such as baking, going to the beach and DIY. Theon did not believe that this need was associated with his harmful sexual behavior. He did not appear to focus on it to the exclusion of other needs.

Having a purpose and making a difference

Theon associated this need to *being my own person*. Since he had suffered from being different than his peers, he believed that making a difference included tolerance, respect, and honesty.

> Int- « *How would you define having a purpose or making a difference?* »
> T- « *To make the world a better place for you to live in and not to be judged or anything, everybody is like equal so … everybody is different but equal.* »

Another aspect of this need Theon named, was volunteer work. At the time of the offenses, the adolescent was in the scouts and the cadets; he would participate in charity work. He enjoyed giving and helping others. The adolescent would often do household chores at his grandmother's house and help his aunt cook. Theon attached relatively high importance to pleasing others, rating it at 4.

> Int- « *How important is it to you to having goals, making a difference?* »
> T- « *It depends… sometimes you need to make life important, but sometimes you just need to go with it. It's a 4.* »

Theon did no associate this need to his sexual offenses. Furthermore, there were no indications that Theon attempted to meet the need of *having a purpose and making a difference* through inappropriate means or that he focused on it to the detriment of other needs.

Emotional health

Theon did not manage to define emotional health. Nonetheless, he was able to name the negative emotions he felt.

> T- « *So much anger, that I can't control my anger sometimes. Sadness a lot. Fear.* »
> Int- « *At the moment of the abuse, what was your more prevalent emotion?* »
> T- « *I don't know. Confused. Confused. I don't remember.* »

Theon recalls being angry at his parents, feeling lonely and left out by his peers. Moreover, he feared physical punishment from his stepfather.

> Int- « *What were you scared of?* »
> T- « *My stepdad. Physical violence and like… of him. A guy that's like 6 foot 2 that runs after you in the house.* »

Lacking peers to confide in, Theon was not able to regulate his emotions. It must be noted that his emotional health challenges are also linked to his psychiatric disorders (BPD and BD). When confronted with emotional challenges, Theon resorted to inappropriate and maladaptive strategies; the adolescent would self-harm and consume marijuana. Prior to displaying the harmful sexual behaviors towards his brother and other children, Theon recounted experiencing high levels of personal distress. Theon believed this need was related to the sexual harmful behaviors he engaged in but was not able to explain why. Theon considered emotional health as an important need, rating it 4. However, he remained ambivalent and hesitated in using more appropriate means to achieve this need.

> Int- « *How important is it for you to achieve emotional health?* »
>
> T- « *4 because I want to do it, but I don't want to do it.* »

Based on Theon's statements, the way he attempted to achieve emotional health was inappropriate (i.e. cutting, drugs). Yet, he did not seem to focus on this need to the detriment of others.

Sexual health

Sexuality was always a central part of Theon's life. He started questioning his sexual orientation at age 11 and eventually envisioned a sex change. Theon was never satisfied with his biological gender.

> Int- « *How would you define it?* »
>
> T- « *I don't know. But I know I want to change sex right now. Well… I don't know. I wasn't satisfied with what I had under, at the bottom.* »

His homosexuality was not well accepted amongst his friends. However, he did have a boyfriend with whom he would engage in sexual intercourse. Theon's sexual satisfaction with his boyfriend was very ambivalent. The adolescent relates being forced to engage in sexual intercourse, while at the same time, taking pleasure. Based on Theon's statements, it is difficult to identify whether or not he was a victim of rape; many of his sayings would contradict one another.

> T- « *He was forcing me. Like we are gonna do it, we are gonna do it and stuff, but at the same time, I had pleasure too.* »

Regarding bestiality, Theon recalled being introduced to animal pornography by his cousin when he was around six years old. Progressively, he started watching more bestiality pornography on his own. Theon blames pornography for his offenses against dogs. Moreover, he recalls wanting to try what he had seen.

> Int- « *Do you think there is a link?* »
>
> T- « *Yes. Because when I started at the start… I realized that curiosity brought me a lot to that. Plus porn.* »

Theon associated *sexual health* to the harmful sexual behaviors he engaged in. He stated that the combination of strong sexual impulses, pornography, and curiosity led him to commit the sexual offenses. The means Theon used to meet this need were inappropriate. Even if the adolescent only attached moderate importance to sexual health (rated a 3), the events mentioned above show that he focused excessively on it, to the detriment of other needs.

Physical Heath

Theon always attached very high importance to personal hygiene (rated 5). Furthermore, he paid great attention to his physical appearance.

> Int- « *Was it easy for you?* »
>
> T- « *Yeah. I always need to be clean.* »

At the time of the offenses, Theon would engage in sports but would occasionally skip meals by fear of gaining weight. However, he did not consider himself as physically attractive. On multiple occasions, Theon mentioned that although he believed physical health was important, he did not enjoy the hard work it required.

> Int- « *In NB, what would you do to keep healthy?* »
>
> T- « *I walked a lot, fishing, hunting and stuff. Sometimes I wouldn't eat, but we made our own garden. […] Soccer, karate, scouts, cadets.* »

Theon did not associate this need to his sexual offenses. There were no indications that Theon attempted to meet the need of *physical health* through inappropriate means or that he focused on it to the detriment of other needs.

Conflict among needs

The information gathered through this semi-structured questionnaire suggested that Theon's need of *having people in my life* would conflict with the need of *being my own person*. On the one hand, Theon wanted to differentiate himself from his peers and be unique. On the other hand, he sought acceptance from his peers, hoping for a sense of belonging. Yet, his desire to be unique bothered his peers, and they rejected him. In addition, his needs of *having people in my life* and *sexual health* conflicted. Theon wanted to have friends but engaged in sexually inappropriate behaviors with dogs. As a consequence, he was bullied and had to leave N.B.:

Scope

Theon had limited scope of primary needs, in that he placed emphasis on the needs of *having fun*, *being my own person*, *sexual health* and *having people in my life* to the detriment of *achieving*, *emotional health*, *physical health* and *having a purpose/making a difference*.

Internal/external capabilities

Theon's psychiatric diagnoses led to poor affect regulation skills. He would easily get angry or sad, especially towards family members and friends. Moreover, because of social isolation and lack of intimacy in a small town, Theon would not share his emotions. This resulted in poor emotional regulation. Ultimately, one of Theon's biggest challenge was taking responsibility for his behavior. The adolescent had a tendency to always blame others for his actions.

Inappropriate or harmful needs

As stated previously, Theon used harmful needs to achieve *emotional health*. The adolescent would self-harm and consume drugs. Moreover, his *sexual health* need was achieved through the sexual offenses and bestiality.

Pathway to offense

The first stage of the GLM consists in classifying dynamic risk factors and examining the link between these factors and the sexual offense. Theon's poor attachment history, more specifically his biological father abandoning him, adversely affected his senses of belonging. Moreover, Theon's sense of belonging was further eroded by his stepfather's rejection. He also felt unjustly treated by his mother who, he claims, would always take her husband's side against

him. In addition, Theon expressed great jealousy towards his half-brothers, whom he though benefited from preferable treatment from his parents. These circumstances were further exacerbated his desire to be unique which in turn led to peer rejection and bullying. In such an environment, Theon found it difficult to achieve a sense of closeness and intimacy, until he developed a relationship with a male peer.

When his boyfriend exploited their relationship and possibly sexually harmed him, Theon's feeling of rejection was amplified. Achieving a sense of connectedness and uniqueness became 'overarching needs' meaning the most important ones to Theon and reflective of his personal identity. The adolescent's feelings of isolation and his fragmented sense of belonging became detrimental to his emotional health. His existing tendency to use inappropriate coping skills (i.e. self-harm and drugs) as a means of managing emotional distress in combination to a distorted perception of intimacy and sex, resulted in Theon's harmful sexual behaviors. Therefore, Theon introduced sexual behaviors as a means of meeting his need belonging and emotional health. Theon's lack of resources and obstacles associated with these needs formed a direct route to his harmful sexual behaviors.

Old Life/New Life

Theon was first asked to describe his thoughts, emotions, and behaviors before the sexual harmful behaviors and in the present. He also had to name the conflicts, difficulties, and needs at those stages. This exercise allows youths to have an overview of their progression throughout time, and to visualize themselves in the future.

Figure 5. Old Life/New Life stages of Theon.

When addressing the Old Life focus, Theon recalled feeling many negative emotions including loneliness, anger (towards his parents), sadness (parental rejection), fear (of

stepfather) and hate (parents). During the interview, Theon did not mention any positive emotions related to that period. Furthermore, he mentioned his victimization by his peers and bullying as being key events of his past. He acknowledged that he neglected the needs of *emotional health* and *achieving*. Though, he had difficulty describing his thoughts and behaviors; he did not want to remember his past.

In the Now/ Roundabout phase, Theon still felt anger, but he believed he faced fewer obstacles into achieving a more prosocial lifestyle. The adolescent was still angry at his parents but also at the rehabilitation center. Theon did not like living in a place where there were rules to follow. Moreover, there were still some family conflicts. During the course of the GLM, Theon's biological father contacted him, hoping to reconnect. Initially, this created acute distress for Theon; he would exhibit rage fits, severe anxiety, and self-harm. However, Theon was able to regulate his emotions and called his father. The outcome was positive; the adolescent planned to visit his father in the summer. Also, Theon had many friends which he could confide in; he was no longer socially isolated. Overall, Theon considered himself mostly satisfied with his current situation.

When addressing the New Life aspect of the GLM, Theon identified seven prosocial goals he wished to achieve and linked them to primary goods. His goals were either short-term or long-term[7].

[7] See Figure 6

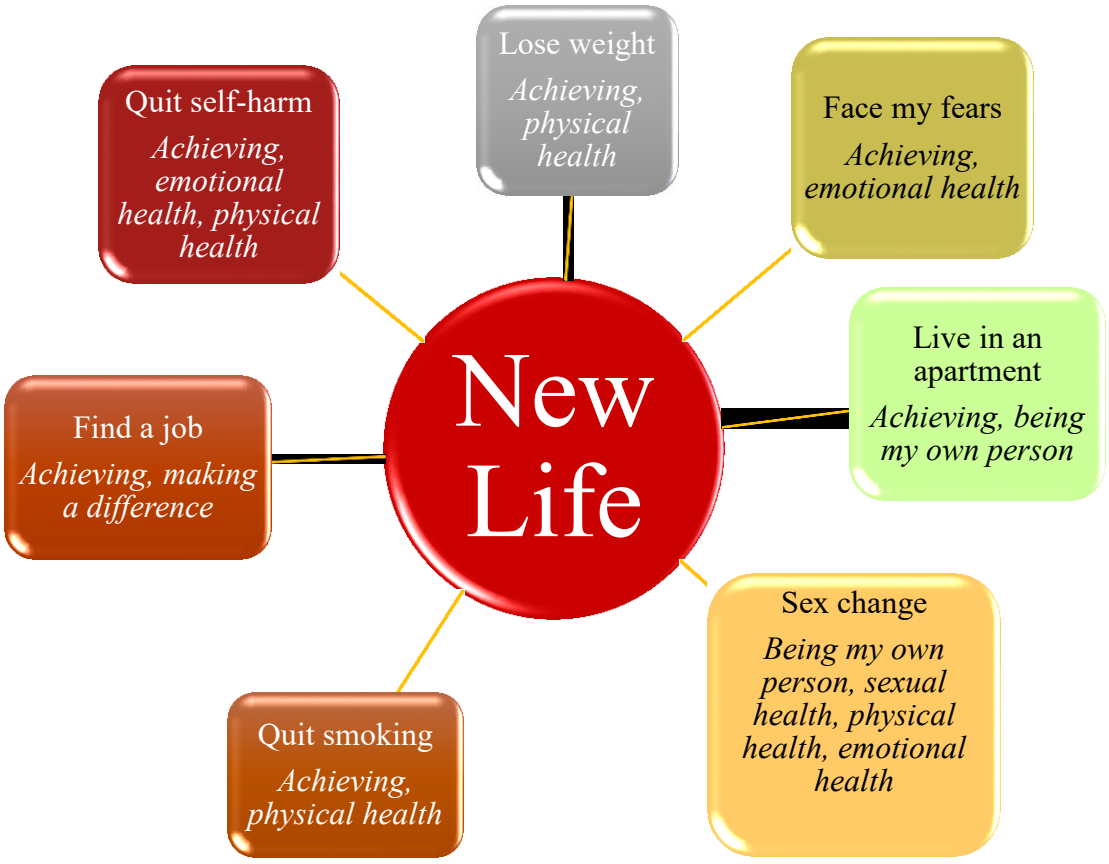

Figure 6. New Life Goals of Theon.

On the short-term, Theon identified the following goals:

- Quit smoking; Theon smoked 3 cigarettes a day. He believed it helped him reduce his stress levels. However, he hoped to quit. He associated this goal to the needs of *achieving* and *physical health*.
- Stop self-harm; when feeling sad, angry or stressed, Theon would resort to cutting. According to him, it helped relieve his negative emotions. He associated this goal to the needs of *achieving*, *emotional health* and *physical health*.
- Lose weight. Theon was not satisfied with his physical appearance; he believed he needed to follow a strict diet. He associated this goal to the primary goods *achieving* and *physical health*.

His long-term goals included:

- Find a job. Theon wanted to find a job in an artistic field such as the fashion industry. He associated that good to *achieving* and *making a difference*. He believed that designing clothes or having your own sense of style could improve people's self-esteem.
- Theon also wanted to live in an apartment. He wanted to be independent and longed to leave the rehabilitation center he was in. This goal was associated with *achieving* and *being my own person*.
- Theon had many fears which he wished to overcome. He feared firearms, heights, clowns and death. These fears generated a lot of anxiety for Theon. He connected this goal to *achieving* and *emotional health*.
- Ultimately, Theon wanted a sex change. The adolescent felt that he would be more comfortable in a woman's body rather than a man's body. However, this goal was not anchored yet, and he still hesitated. He associated the sex change to *being my own person*, *sexual health*, *emotional health* and *physical health*.

The goals and needs identified by Theon demonstrate his desire for independence, emotional stability and wanting to set himself apart from others.

The Good Lives Plan

Once Theon's goals were established, a Good Lives Plan could be designed. Firstly, Theon had to identify his internal and external capacities/resources. He also had to determine his emotional difficulties and external difficulties. Theon did not get along with his mother and step-father. Therefore, he chose not to select them as positive external resources. However, his social worker was actively invested, and Theon perceived her as an available external resource. Moreover, he considered his friends as being pillars of strength that needed to be included in this model. We also focused on Theon's internal capacities, including his constant positive attitude, his open-mindedness and his investment in the GLM project. Theon understood his emotional difficulties and was able to identify the needs he neglected.

Using a table, Theon had to classify inappropriate means he would use to meet each primary good Afterwards; he had to identify alternative, appropriate means to meet these same needs. (i.e. Table 2).

Table 2

Means to meet primary goods for Theon

NEEDS	APPROPRIATE	INAPPROPRIATE
Having fun	Shopping, fishing, dancing	Stealing, annoying/bothering people
Achieving	Looking for a job	Procrastinating, not looking for a job
Being my own person	Having your own fashion style, personality (empathic, helpful, generous)	Being hyperactive, annoying people, being too generous
Having people in my life	Boyfriend, prosocial friends, family, educators	Drug dealers, gangsters
Having a purpose and making a difference	Work, apartment, taking care of people	Being lazy, being in a bad mood
Emotional health	Music, meditation, cleaning (house), taking walks, spend time with friends	Self-harm (cutting), being mean to others
Sexual Health	Using protection, consensual sexual relationships	Insisting, sexual abuse
Physical Health	Losing weight, healthy diet	Smoking pot, drugs

Follow-ups

From the beginning of the GLM project, Theon's attitude was highly positive. The adolescent showed enthusiasm for the GLM and believed he would benefit from it. However, it took a lot of time for Theon to undertake the necessary steps to fulfill the GLM objectives. Moreover, Theon would get distracted easily; due to his diagnosis of ADD, he lacked the capacity to focus on a topic over a long period of time. Therefore, it was regularly necessary to rein him in. When establishing goals, Theon expressed great motivation. However, he initially did not implement initiatives. Most of Theon's positive changes occurred within the last two weeks of the project.

One of Theon's biggest challenge was to meet his emotional health needs in appropriate ways. During the GLM, his mood would often fluctuate; some days he seemed satisfied, while others he would get upset about everything. Nonetheless, it was the first goal Theon achieved. I recommended to Theon to use other means to regulate his negative emotions including listening to music, sharing his feelings with a friend or use meditation. The adolescent succeeded quitting self-harm for over a month. Whenever he felt like cutting, he would find new activities. By the end of GLM, Theon felt proud of reaching this goal.

Theon also took the necessary steps to find a job. I asked him to bring his resume so we could work on it together. After offering him some modifications, the adolescent had the responsibility to retype it and give his resumes to different shops. At first, Theon would find many excuses for which he had not done so. To mobilize Theon, he first had to be made accountable for his actions and consequences. Eventually, the adolescent asked his educators for help and made the necessary steps to find a job.

Finally, Theon also took the necessary measures to lose weight. Even if Theon did not like hard work and hoped that losing weight would be easy, he used appropriate external resources to achieve a healthy diet. Theon asked his doctor for diet advice. By the end of the GLM, he would eat healthily, smaller portions and planned on taking dance classes.

Although Theon did not achieve all his short term goals, he did succeed in using more appropriate needs to fulfill his primary goods. His social worker contacted me to confirm that Theon's motivation had considerably increased over the course of the GLM he was implementing positive changes in his life.

Final interview

During the final phone interview, Theon was asked to fill out the SRS V.3.0. On a scale 1 to 10, Theon rated the therapeutic relationship at 10. Theon mentioned that he always felt heard, respected and had much fun participating in this project. Theon rated the goals and topics at 9. He explained that the GLM helped him learn more about himself, he learned about his own goals and desires. However, Theon rated the method at 6, stating that he had a lot of difficulty answering the GLM questionnaire; he did not manage to make links between primary goods and his sexual offenses. Theon gave the overall a 10. According to him, the GLM increased his motivation, improved his relationships with his peers and parents, but also helped him make positive changes (e.g. stop self-harm, healthy diet). At the end of my internship, Theon's social worker contacted me to confirm that the GLM's outcome was fruitful and very useful to the adolescent. Apart from mentioning the questionnaire being difficult, Theon did not make any recommendations; he was very satisfied with the GLM.

Chapter V

Conclusion

5.1 Limitations

Overall, both case studies seems to have prospered according to this model. In regards to Theon, his social worker confirmed the benefits this model had in motivating him and increasing his positivity. Ramsay also mentioned that he benefited from this model. Though, his statements were self-reported and could not be confirmed by external sources.

However, applying the GLM to AWSH presents a number of issues and limitations. The first difficulty encountered was trying to get as much of the youth's entourage members to be present during the first interview. Juveniles evolve within a complex social context, where family plays an essential role. Research has shown that multisystemic treatment is more efficient than individual therapy (Johnides, Borduin, Wagner & Dopp, 2017). This implies that involving family members and other facilitators is essential to reduce recidivism. One of my initial participants, Ramsay, was seen alone during the first interview. His youth delegate did not have any flexible availabilities nor did his mother and educator. Although the GLM requires people's involvement, it cannot be imposed.

Another issue I faced was the lack of motivation from certain family members of youth delegates. In Ramsay's case, his father and his youth delegate did not deem the GLM pertinent and believed it should not be prioritized over psychological treatment. This led me to further justify the positive aspects and advantages of the GLM. Nevertheless, Ramsay did want to pursue and made the decision to participate in my project in parallel to sexual individual psychotherapy.

The biggest limitation was a lack of time. In order to properly implement the GLM and evaluate the long-term progress of the patients, a minimum of a yearlong period is necessary. The couple of months I had available allowed me to implement part of the GLM but did not permit me to evaluate long-term progress. Moreover, because of time constraints, I could not operationalize the GLM for it to be an asset to the present therapies at the Services Externes.

Visio conferencing can be a major asset to pursue therapy with a patient who lives far. However, it can also be an obstacle. Within the framework of my internship, I believed it made it more difficult to develop a therapeutic alliance and convey warmth. Moreover, video conferences require a special conference room reservations, limiting availabilities and time frames. Ramsay also mentioned it as an inconvenience.

Another major limitation is the evaluation of progress. There are no specific tools to evaluate how the patient evolves throughout the GLM. This implies that change evaluation is partly subjective and dependent on the adolescent's sayings or what his entourage notices. As stated previously, in the case of Ramsay, I could not have confirmation of his positive changes. However, in Theon's case, his social worker did contact me to tell me about the changes she had noticed. Furthermore, some adolescent may not want information to be shared outside of the therapeutic setting. For example, Theon did not want me to share pertinent information with his mother and father-in-law; he only authorized information exchange with his social worker.

Some juveniles did not relate to certain needs or weren't able to make links between their sexual offenses and the primary goods. The GLM is not a one-size fits all model, but outcomes of this study have shown me that some youths do not consider some of these needs relevant. Furthermore, some adolescents lacked introspection capacities.

In this present project, the juveniles were not selected according to motivation levels, as they were assigned based on priority levels; they did not participate on a voluntary basis. This implies that motivation could either be intrinsic, extrinsic or absent. The GLM states that patients must be minimally motivated to benefit from this model. One of the adolescents I started working with, Jon, was not motivated to participate in this project. This led him to cancel numerous appointments, or be completely passive during interviews. Therefore, because of lack of time and absent motivation, I had to end the follow-up. Also, unpredictable external factors can affect the GLM. As mentioned formerly, Jon's follow-up ended for numerous reasons. In Ramsay's case, at the beginning of the GLM project, he was arrested and incarcerated for possession of juvenile pornography and breach of conditions. Because Ramsay had just turned 18 years old, he was now considered an adult rather than a minor. Consequently, I could not pursue the GLM follow-ups.

Finally, the GLM must be used concomitantly with other therapeutic models in order for patients to work on social abilities, anger management, etc. The abilities adolescent acquire in other treatment programs become complementary to the GLM and offer them the tools to achieve primary goods in appropriate ways. During my project, some adolescents did not have any other therapeutic commitments. This meant that they were not always equipped with the internal resources to achieve their primary goods. Therefore, the GLM should unequivocally be used in a multi-disciplinary team.

5.2 Recommendations

Based on the limitations previously mentioned, some future recommendations can be made for purposes of improving the practical application of the GLM. Firstly, the GLM should not be limited by time constraints. The GLM is a framework that must be continuously reviewed over time. Reaching primary goods through appropriate means takes time and cannot be done over the course of a couple of months. In addition, this project has shown that to properly operationalize the GLM, practitioners must constantly be proactive, especially with adolescents. Teenager's lives tend to change a lot quicker and more often than adult's lives, which requires perpetual adaptation. Also, because the GLM is applied in a therapeutic setting, practitioners may not always be aware of the juvenile's life outside of that setting. Therefore, feedback and information should be sought from external support structures on a regular basis. Moreover, young people's objectives and goals may change over time, meaning that they should equally be reviewed on a regular basis.

Most research about the GLM has evaluated its efficacy when combined with CBTs. Motivation is an essential factor in the GLM. In order to allow less motivated patients to benefit from this approach, the GLM could be used concomitantly to motivational interviewing (MI). This could not only increase motivation, but it could also address any resistance patients could have. Furthermore, the GLM requires a variety of professionals to be involved in the youth's life. The multidisciplinary team could also discuss possible strategies to increase the youth's motivation.

Treatment programs for adolescents who engage in sexually abusive behavior have considerably improved over the past couple of years. However, most of the available treatment programs for AWSH focus on risk factors rather than protective factors. Andrews & Bonta's RNR (2015) remains the most prevalent one. Yet, it has often been criticized for its negative aspects; using derogatory terms and not taking into account the individual's strengths (Ward & Brown, 2003). Research suggests including strengths and resilience factors in clinical assessments of young individuals. Such factors can have a significant impact on the likelihood of general recidivism (Hoge, Andrews, & Leschied, 1996). Because youths have different beliefs, expectations, and values than adults, treatment programs for juvenile offenders need to take into account the complex emotional and developmental interactions of adolescents.

Adolescents are developmentally immature; their emotions, attitudes, behaviors and cognitive functioning are still developing. Consequently, positive attitudes would prove more beneficial in reducing recidivism rather than negative attitudes.

The GLM is a positive approach that focuses on the offenders' strengths, capacities, and skills (Ward & Stewart, 2003). This model's objectives include reducing the offenders' risk of recidivism while also increasing their well-being. Well-being is achieved when primary goods are fulfilled through appropriate means.

There is little to no articles written on the implementation of the GLM with juveniles who sexually offend. This project sought to observe the practical application of the GLM with this specific population. The GLM has proven useful in understanding the pathway to offense. Likewise, this model demonstrated that it could increase the adolescent's motivation and overall well-being. The GLM increased self-esteem and confidence. Conversely, the GLM is time-consuming and there is a lack of properly established guidelines on its practical application. Therefore, this project was greatly experimental and innovative. Hopefully, researchers will continue to evaluate the efficiency of the GLM with AWSH, as it proved very promising.

References

Akers, R. L. (2012). *Criminological theories: Introduction and evaluation* (2nd ed.). New York, NY: Routledge. (Original work published 1999)

Andrews, D. A., & Bonta, J. (2003). *The psychology of criminal conduct*. (3rd ed.). Cincinnati, OH: Anderson.

Andrews, D. A., & Bonta, J. (2015). *The psychology of criminal conduct* (5th ed.) (E. S. Boyne, Ed.). Abingdon: Routedge. (Original work published 1994)

Andrews, D. A., Bonta, J., & Wormith, J. S. (2011). The Risk-Need-Responsivity (RNR) Model does adding the Good Lives Model contribute to effective crime prevention? *Criminal Justice and Behavior*, *38*(7), 735-755. https://doi.org/10.1177/0093854811406356

Andrews, D. A., Zinger, I., Hoge, R. D., Bonta, J., Gendreau, P., & Cullen, F. T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28, 369−404.

Bandura, A. (1995). *Self efficacy in changing societies* (Cambridge University Press, Ed.). Retrieved from https://www.researchgate.net/profile/Barry_Zimmerman/publication/247480203_Self-efficacy_and_educational_development/links/549b67770cf2b80371371ad5/Self-efficacy-and-educational-development.pdf

Bandura, A. (2005). The evolution of social cognitive theory. In K. G. Smith & M. A. Hitt (Eds.), *Great minds in management: The process of theory development* (pp. 9-35). https://doi.org/10.5465/AMR.2007.23467624

Barnao, M., Ward, T., & Robertson, P. (2015). The Good Lives Model: A new paradigm for forensic mental health. *Psychiatry, Psychology and Law*. http://doi.org/10.1080/13218719.2015.1054923

Barnett, G., & Wood, J. L. (2008). Agency, relatedness, inner peace, and problem solving in sexual offending how sexual offenders prioritize and operationalize their Good Lives conceptions. *Sexual Abuse: A Journal of Research and Treatment*, *20*(4), 444-465. https://doi.org/10.1177/1079063208325202

Baumeister, R. F., Gailliot, M., DeWall, C. N., & Oaten, M. (2006). Self-regulation and personality: How interventions increase regulatory success, and how depletion moderates the effects of traits on behavior. *Journal of Personality*, *74*(6), 1773-1802. https://doi.org/10.1111/j.1467-6494.2006.00428.x

Beck, A. T. (1979). *Cognitive therapies and emotional disorders*. New York, NY: Penguin Group.

Blackburn, R. (2000). Risk assessment and prediction. In J. McGuire, T. Mason, & A. O'Kane (Eds.), *Behavior, crime and legal processes: A guide 672 for legal practitioners* (pp. 178−204). Chichester, UK: John Wiley & Sons.

Bonta, J., & Andrews, D. A. (2003). A commentary on Ward and Stewart's model of human needs. *Psychology, Crime & Law*, *9*(3), 215-218. http://doi.org/10.1080/10683/16031000112115

Borduin, C. M., Henggeler, S. W., Blaske, D. M., & Stein, R. J. (1990). Multisystemic treatment of adolescent sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, *34*(2), 105-113. https://doi.org/10.1177/0306624X9003400204

Borduin, C. M., & Schaeffer, C. M. (2002). Multisystemic treatment of juvenile sexual offenders: A progress report. *Journal of Psychology & Human Sexuality*, *13*(3-4), 25-42. https://doi.org/10.1300/J056v13n03_03

Bromberg, D. S., & O'Donohue, W. T. (2014). *Toolkit for working with juvenile sex offenders*. London, UK: Elsevier.

Bronfenbrenner U (1979). *The ecology of human development: Experiments by nature and design*. Harvard University Press; Cambridge, MA.

Butler, S. M., & Seto, M. C. (2002). Distinguishing two types of adolescent sex offenders. *American Academy of Child and Adolescent Psychiatry*, *41*(1), 83-90.

Caldwell, M.F. (2010). Study Characteristics and Recidivism Base Rates in Juvenile Sex Offender Recidivism. *International Journal of Offender Therapy and Comparative Criminology*, 54, 197-212.

Carr, M. B., & Vandiver, T. A. (2001). Risk and protective factors among youth offenders. *Adolescence*, *36*(143), 409-426.

Chen, D., & Stroup, W. (1993). General system theory: Toward a conceptual framework for science and technology education for all. *Journal of Science Education and Technology*, *2*(3), 447-459. https://doi.org/i059-0145/93/0900-0447507.00/0

Chu, C. M., Koh, L. L., Zeng, G., & Teoh, J. (2013). Youth who sexual offended: Primary human goods and offense pathways. *Sexual Abuse: A Journal of Research and Treatment*, *27*(2), 151-172. http://doi.org/10.1177/1079063213499188

Cotter, A., & Beaupré, P. (2014). Police-reported sexual offences against children and youth in Canada, 2012. *Juristat: Canadian Centre for Justice Statistics*, 1.

Department of Justice. (2009, December). *Juveniles who commit sex offenses against minors* (D. Finkelhor, R. Ormrod, & M. Chaffin, Authors).

Dowden, C., Antonowicz, D., & Andrews, D. A. (2003). The effectiveness of relapse prevention with offenders: A meta-analysis. *International Journal of Offender Therapy and Comparative Criminology*, *47*(5), 516-528. https://doi.org/10.1177/0306624X03253018

Gannon, T. A., King, T., Miles, H., Lockebie, L., & Willis, G. M. (2011). Good Lives sexual offender treatment for mentally disordered offenders. *The British Journal of Forensic Practice*, *13*(3), 153-168. http://doi.org/10.1108/14636641111157805

Gorski, T. T. (2008, May 5). Recovery – Gorski's developmental model [Blog post]. Retrieved from Terry Gorski's Blog: https://terrygorski.com/2012/04/28/125/

Grotpeter, J. K., & Elliott, D. S. (2002). *Violent Sexual Offending*. A report to the Sex Offenders Management Board, in the Colorado Division of Justice. Boulder, CO.

Hanson, R. K., Gordon, A., Harris, A. J. R., Marques, J. K., Murphy, W., Quinsey, V. L., & Seto, M. C. (2002). First report of the Collaborative Outcome Data Project on the effectiveness of psychological treatment for sexual offenders. *Sexual Abuse: A Journal of Research and Treatment, 14*(2), 169-194. http://doi.org/10.1177/107906320201400207

Harkins, L., Flak, V. E., Beech, A. R., & Woodhams, J. (2012). Evaluation of a community-based sex offender treatment program using a Good Lives Model approach. *Sexual Abuse: A Journal of Research and Treatment*, 1-25. http://doi.org/10.1177/1079063211429469

Henggeler, S. W. (1999). Multisystemic therapy: An overview of clinical procedures, outcomes, and policy implications. *Child and Adolescent Mental Health*, *4*(1), 2-10. http://doi.org/10.1111/1475-3588.00243

Henggeler, S. W., & Sheidow, A. J. (2012). Empirically supported family-based treatments for conduct disorder and delinquency in adolescents. *Journal of Marital and Family Therapy*, *38*(1), 30-58. https://doi.org/10.1111/j.1752-0606.2011.00244.x.

Hill, G., & Hill, K. "Sex Offender." Law.Com Dictionary. 17 Feb. 2009 http://dictionary.law.com/Default.aspx?typed=sex+offender

Hoge, R. D., Andrews, D. A., & Leschied, A. W. (1996). An investigation of risk and protective factors in a sample of youthful offenders. *Journal of Child Psychology and Psychiatry*, *37*(4), 419-424. https://doi.org/10.1111/j.1469-7610.1996.tb01422.x

Johnides, B. D., Borduin, C. M., Wagner, D. V., & Dopp, A. R. (2017). Effects of Multisystemic Therapy on caregivers of serious juvenile offenders: A 20-year follow-up to a randomized clinical trial. *Journal of Consulting and Clinical Psychology*, *85*(4), 323-334. http://doi.org/10.1037/ccp0000199

Johnson, L. D., Miller, S. D., & Duncan, B. L. (2000). *Session Rating Scale (SRS V.3.0)*.

Langlands, R. L., Ward, T., & Gilchrist, E. (2012). Applying the Good Lives Model to male perpetrators of domestic violence. *Behaviour Change*, *26*(2), 113-129. https://doi.org/10.1375/bech.26.2.113

Larimer, M. E., Palmer, R. S., & Marlatt, A. G. (1999). Relapse prevention An overview of Marlatt' s cognitive-behavioral model. *Alcohol Research & Health*, *23*(2), 151-160.

Lester, D. (1990). Maslow's hierarchy of needs and personality. *Personality and Individual Differences*, *11*(11), 1187-1188. https://doi.org/10.1016/0191-8869(90)90032-M

Letourneau, E. J., Henggeler, S. W., Borduin, C. M., Schewe, P. A., McCart, M. R., & Chapman, J. E. (2009). Multisystemic therapy for juvenile sexual offenders: 1-year results from a randomized effectiveness trial. *Journal of Family Psychology*, *23*(1), 89-102. https://doi.orf/10.1037/a0014352

Lindsay, W. R., Ward, T., Morgan, T., & Wilson, I. (2007). Self-regulation of sex offending, future pathways and the Good Lives Model: Applications and problems. *Journal Journal of Sexual Aggression*, *13*(1), 37-50. http://doi.org/10.1080/13552600701365613

Maltz, M.D. (1984). *Recidivism*. Orlando, FL: Academic Press, Inc.

Miner, M. H. (2002). Factors associated with recidivism in juveniles: An analysis of serious juvenile sex offenders. *Journal of Research in Crime and Delinquency*, *39*(4), 421-436. http://doi.org/10.1177/002242702237287

Paternoster, R., & Mazerolle, P. (1994). General strain theory and delinquency: A replication and extension. *Journal of Research in Crime and Delinquency*, *31*(3), 235-263. https://doi.org/10.1177/0022427894031003001

Pew Center on the States (2011), *State of Recidivism: The Revolving Door of America's Prisons.* Washington, DC: The Pew Charitable Trusts.

Polaschek, D. L. L. (2003). Relapse prevention, offense process models, and the treatment of sexual offenders. *Professional Psychology Research and Practice*, *34*(4), 361-367. https://doi.org/10.1037/0735-7028.34.4.361

Print, B. (2013). *The good lives model for adolescents who sexually harm* (T. Ward, Ed.). Brandon, VT: Safer Society Press.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist*, *47*(9), 1102-1114. http://doi.org/10.1037/0003-066X.47.9.1102

Purpura, P. P. (1997). *Criminal justice: an introduction*. Newton, MA: Butterworth-Heinemann.

Purvis, M., Ward, T., & Willis, G. (2011). The Good Lives Model in practice: Offence pathways and case management. *European Journal of Probation*, *3*(2), 4-28. https://doi.org/10.1177/206622031100300202

Rich, P. (2011). *Understanding, assessing, and rehabilitating juvenile sexual offenders* (2nd ed.). Hoboken, NJ: John Wiley & Sons.

Rogers, C. R. (1949). The attitude and orientation of the counselor in client-centered therapy. *Journal of Consulting and Clinical Psychology*, *13*(2), 82-94. http://doi.org/10.1037/h0059730

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, *55*(1), 68-78. https://doi.org/10.1037110003-066X.55.1.68

Stinson, J. D., & Becker, J. V. (2013). *Treating sex offenders: an evidence-based manual*. New York, NY: The Guilford Press.

Tardiff, M., Jacob, M., Quenneville, R., & Jean Proulx. (2012). *La delinquance sexuelles des mineurs*. Les Presses de l'Universite de Montreal.

Tjaden, P. G., Thoennes, N., National Institute of Justice (U.S.), & Centers for Disease Control and Prevention (U.S.). (2006). *Extent, nature, and consequences of rape victimization: Findings from the National Violence Against Women Survey*.

Washington, DC: U.S. Dept. of Justice, Office of Justice Programs, National Institute of Justice.

Tracey, D., & Hanham, J. (2015). Applying positive psychology to illuminate the needs of adolescent males transitioning out of juvenile detention. *International Journal of Offender Therapy and Comparative Criminology*, 1-16. http://doi.org/10.1177/0306624X15591242

Wainwright, L., & Nee, C. (2014). The Good Lives Model – new directions for preventative practice with children? *Psychology, Crime & Law*, *20*(2), 166-182. http://doi.org/10.1080/1068316X.2013.770851

Ward, T., & Beech, A. (2006). An integrated theory of sexual offending. *Aggression and Violent Behavior*, *11*, 44-63. https://doi.org/doi:10.1016/j.avb.2005.05.002

Ward, T., & Brown, M. (2003) The Risk-Need Model of Offender Rehabilitation: A Critical Analysis. In Ward, T., Laws, D. R., & Hudson, S. H. (Eds.), *Sexual deviance: Issues and controversies* (pp.338-353). Thousand Oaks, CA: Sage.

Ward, T., & Brown, M. (2004). The good lives model and conceptual issues in offender rehabilitation. *Psychology, Crime, and Law*, 10, 243−257.

Ward, T., & Gannon, T. A. (2006). Rehabilitation, etiology, and self-regulation: The comprehensive good lives model of treatment for sexual offenders. *Aggression and Violent Behavior*, *11*, 77-94.

Ward, T., & Laws, D. R. (2010). Desistance from sex offending: Motivating change, enriching practice. *International Journal of Forensic Mental Health*, *9*(1), 11-23. http://doi.org/10.1080/14999011003791598

Ward, T., & Mann, R. (2004). Good Lives and the rehabilitation of offenders: A positive approach to sex offender treatment. In A. P. Linley & S. Joseph (Eds.), *Positive Psychology in Practice* (pp. 298-616). Hoboken, NJ: John Wiley & Sons. https://doi.org/10.1002/9780470939338.ch36

Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, *12*, 87-107.

Ward, T., & Stewart, C. (2003). The treatment of sex offenders: Risk management and good lives. *Professional Psychology Research and Practice*, *34*(4), 353-360. https://doi.org/10.1037/0735-7028.34.4.353

Ward, T., & Stewart, C. A. (2003). The treatment of sex offenders: Risk management and good lives. *Professional Psychology: Research and Practice*, *34*(4), 353-360. http://doi.org/10.1037/0735-7028.34.4.353

Ward, T., Vess, J., Collie, R. M., & Gannon, T. A. (2006). Risk management or goods promotion: The relationship between approach and avoidance goals in treatment for sex offenders. *Aggression and Violent Behavior*, *11*(4), 378-393. https://doi.org/10.1016/j.avb.2006.01.001

Whitehead, P. R., Ward, T., & Collie, R. M. (2007). Time for a change: Applying the good lives model of rehabilitation to a high-risk violent offender. *International Journal of Offender Therapy and Comparative Criminology*, *51*(5), 578-598. https://doi.org/10.1177/0306624X06296236

Willis, G. M., & Ward, T. (2011). Striving for a good life: The good lives model applied to released child molesters. *Journal of Sexual Aggression*, *17*(3), 290-303. http://doi.org/10.1080/13552600.2010.505349

Willis, G. M., Ward, T., & Levenson, J. S. (2013). The Good Lives Model (GLM): An evaluation of GLM operationalization in north american treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, 1-24. http://doi.org/10.1177/1079063213478202

Wilson, J. Q. (1980, Fall). "What works?" Revisited: New findings on criminal rehabilitation. *The Public Interest*, (61).

Wilson, R. J., & Yates, P. M. (2009). Effective interventions and the Good Lives Model: Maximizing treatment gains for sexual offenders. *Aggression and Violent Behavior*, *14*, 157-161.

Worling, J. R. (2013). *Desistence for i* [Pamphlet].

Worling, J. R., & Curwen, T. (2001). *Estimate of Risk of Adolescent Sexual Offense Recidivism Version 2.0* [Pamphlet].

Worling, J. R., & Langstrom, N. (2006). Risk of sexual assault recidivism in adolescents who offend sexually: Correlates and assessment. In H. E. Barbaree & W. L. Marshall (Authors), *The juvenile sexual offender* (2nd ed., pp. 219-247).

Wylie, L. A., & Griffin, H. L. (2013). G-map's application of the Good Lives Model to adolescent males who sexually harm: A case study. *Journal of Sexual Aggression*, *19*(3), 345-356. http://doi.org/10.1080/13552600.2011.650715

Yang, C.-L., Hwang, M., & Chen, Y.-C. (2011). An empirical study of the existence, relatedness, and growth (ERG) theory in consumer's selection of mobile value-added services. *African Journal of Business Management*, *5*(9), 7885-7898. https://doi.org/10.5897/AJBM10.1586

Yates, P. M. 2003. Treatment of adult sexual offenders: A therapeutic cognitive-behavioral model of intervention. *Journal of Child Sexual Abuse.*, 12: 195–232. http://doi.org/10.1300/J070v12n03_08

Ziedonis, D. M., & Stern, R. (2001). Dual recovery therapy for schizophrenia and substance abuse. *Psychiatric Annals*, *31*(4), 255-264. http://doi.org/10.3928/0048-5713-20010401-0

Appendix A

ERASOR (Worling & Curwen, 2001)

This is a SUMMARY sheet ONLY.
VALID ONLY IF ratings have been transferred from Coding Form attached.
Name of Adolescent and Date of Assessment are noted on Page 1

High Risk Factors for Sexual Reoffense	Present	Partially/Possibly Present	Not Present	Unknown
Sexual Interests, Attitudes, and Behaviours				
1. Deviant sexual interests (younger children, violence, or both)				
2. Obsessive sexual interests/Preoccupation with sexual thoughts				
3. Attitudes supportive of sexual offending				
4. Unwillingness to alter deviant sexual interests/attitudes				
Historical Sexual Assaults				
5. Ever sexually assaulted 2 or more victims				
6. Ever sexually assaulted same victim 2 or more times				
7. Prior adult sanctions for sexual assault(s)				
8. Threats of, or use of, violence/weapons during sexual offense				
9. Ever sexually assaulted a child				
10. Ever sexually assaulted a stranger				
11. Indiscriminate choice of victims				
12. Ever sexually assaulted a male victim (***male offenders only***)				
13. Diverse sexual-assault behaviours				
Psychosocial Functioning				
14. Antisocial interpersonal orientation				
15. Lack of intimate peer relationships / Social isolation				
16. Negative peer associations and influences				
17. Interpersonal aggression				
18. Recent escalation in anger or negative affect				
19. Poor self-regulation of affect and behaviour (Impulsivity)				
Family/Environmental Functioning				
20. High-stress family environment				
21. Problematic parent-offender relationships/Parental rejection				
22. Parent(s) not supporting sexual-offense-specific assessment/treatment				
23. Environment supporting opportunities to reoffend sexually				
Treatment				
24. No development or practice of realistic prevention plans/strategies				
25. Incomplete sexual-offense-specific treatment				
Other Factor				

Overall Risk Rating ☐ Low ☐ Moderate ☐ High

Appendix B

DASH-13 (Worling, 2013)

DASA-13 **D**esistence for **A**dolescents who **S**exually **H**arm

Name of adolescent_____ Age_____ ID number_____

Name of evaluator _____ Date_____

1. Prosocial sexual interests Adolescent demonstrates exclusive sexual interest in consenting sexual activity with age-appropriate partner(s).	Yes ☐	No ☐	? ☐
2. Prosocial sexual attitudes Adolescent believes that young children would be harmed by sexual activity with teens/adults and that peers/adults would not "invite", enjoy, or fabricate accounts of forced sexual activity.	Yes ☐	No ☐	? ☐
3. Prosocial sexual environment Adolescent is typically in an environment where prosocial sexual attitudes and messages are routinely espoused, valued, and enacted.	Yes ☐	No ☐	? ☐
4. Awareness of the consequences of sexual reoffending Adolescent is aware of the short- and long-term harm to survivors caused by sexual offending and is aware of the negative personal consequences of reoffending sexually.	Yes ☐	No ☐	? ☐
5. Compassion for others The adolescent regularly demonstrates an awareness of, and sympathy for, the suffering of others and acts to alleviate suffering in others.	Yes ☐	No ☐	? ☐
6. Positive problem-solving skills The adolescent regularly demonstrates positive problem-solving skills (i.e., can identify the problem, generate possible solutions, evaluate possible solutions, reflect on choices made, and learn from consequences).	Yes ☐	No ☐	? ☐
7. Positive affect-regulation skills The adolescent regularly demonstrates the capacity to appropriately regulate and express various emotional states.	Yes ☐	No ☐	? ☐
8. Emotional intimacy with peers The adolescent is experiencing a close, warm, and trusting relationship with at least one peer in which private thoughts and feelings are mutually shared.	Yes ☐	No ☐	? ☐
9. Close relationship with a positive and supportive adult Adolescent enjoys a close relationship with a prosocial adult who is an advocate for the adolescent and is supportive of a healthy and productive future for the adolescent.	Yes ☐	No ☐	? ☐
10. Adequate environmental controls Adolescent is typically in an environment where adequate adult supervision and/or controls are in place to match the adolescent's current risk to reoffend sexually.	Yes ☐	No ☐	? ☐
11. Active involvement in prosocial structured activity with peers Adolescent is actively involved in one or more prosocial structured activities with peers outside of the regular school curriculum (e.g., clubs, teams, extra-curricular school activities, etc.).	Yes ☐	No ☐	? ☐
12. Hope Adolescent believes that they can make positive life changes and can enjoy a healthy sexual future that is free of sexual offending.	Yes ☐	No ☐	? ☐
13. Successful treatment completion Adolescent has successfully completed sexual offense-specific treatment.	Yes ☐	No ☐	? ☐

Total (Yes) _____

Appendix C

GLM Questionnaire (Print, 2013)

Having Fun

- ❖ *Having fun* might be defined as play, amusement, enjoyment, entertainment, and excitement. Examples of how this need could be attained might include: going to a theme park; playing sport; going to the theatre; reading a book.

- What did you do to have fun at this time?
- (The following can act as prompts: what did you do that gave you a sense of thrill and excitement? What were your favorite games/play activities? Did you enjoy doing new things, and if so, what?)
- How easy was it for you to have fun? (What helped?)
- What got in the way of you of you having fun? (What were the obstacles? How able were you to overcome these obstacles?)
- Was having fun important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was having fun to you?
- Do you think the things you did to have fun were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up anything that wasn't ok? If so, what helped of what got in the way?)
- Did you focus so much on having fun that it got in the ways of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Achieving

- ❖ *Achieving* may be defined as knowledge, learning, talents, fulfillment, competence, and status. Examples of how this need could be attained might include: passing an exam; learning to ride a bike; painting a picture; scoring a goal in sport; or being popular among friends.

- What were your achievements? (What were you good at? What were your talents? Were you popular? Were you respected by others?)
- How easy was it for you to achieve? (What skills, talents, and supports did you have to help?)
- What got in the way of you achieving? (What were the obstacles? How able were you to overcome these obstacles?)
- Was achieving important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was achieving to you?
- Do you think the things you did to achieving were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up anything that wasn't ok? If so, what helped of what got in the way?)
- Did you focus so much on achieving that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Being my own person

- ❖ *Being my own person* might be defined as independence, self-motivation, making decisions, self-reliance, expressing self-identity, empowerment, life skills, internal locus of control, and self-actualization. Examples of how this need could be attained might include: choosing to dress in a particular style; self-care skills; setting future goals; stubbornness; or financial independence.

- How easy was it for you to be your own person? (e.g., having goals, being independent)?
- What got in the way of being your own person? (What were the obstacles? How able were you to overcome these obstacles?)
- Was being your own person important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was being your own person to you?
- Do you think the things you did to be your own person were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up anything that wasn't ok? If so, what helped of what got in the way?)
- Did you focus so much on being your own person that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Having people in my life

- ❖ *Having people in my life* might be defined as relationships with family, peers, community, romantic, and intimate relationships. It can also refer to the young person availing of an emotional confidant. Examples of how this need could be met include: making friends; attending youth club; joining a football team; having a boyfriend/girlfriend; spending time with family; or talking to a trusted friend about a problem.

- What relationships did you have at this time? (Refer to relationships with family, friends, community, or a boyfriend/girlfriend).
- How would you describe these relationships? (Note to assessor: Attempt to gauge information on closeness/intimacy).
- Did you have someone that you could talk to about your feelings and get support from? (Was this person always available?)
- How easy was it for you to make and keep relationships? (What helped?)
- What got in the way of you having relationships? (What were the obstacles? How able were you to overcome these obstacles?)

- Was having people in your life important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was having relationships to you?
- Do you think all your relationships were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up any relationships that weren't ok? If so, what helped of what got in the way?)
- Did you focus so much on relationships that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Having a purpose and making a difference

❖ *Having a purpose and making a difference* might be defined as ascribing to positive social values and codes of behavior, conforming to societal norms, spirituality, and making a positive contribution are ways in which this need can be realized. Specific examples could include: donating money to charity; doing things for others without expecting reward; respecting others; lawful behavior; or having a belief in or an appreciation of something outside of oneself.

- What did you do to have a purpose and make a difference at this time? (What things did you do that were helpful, generous, or respectful? How able were you to follow rules? Were you spiritual or religious? What beliefs did you have which gave a sense of meaning to your life?)
- How easy was it for you to have a purpose and make a difference? (Was it easy for you to be helpful, generous, respectful, spiritual, or religious)? (What helped?)
- What got in the way of you having a purpose and making a difference? (What were the obstacles? How able were you to overcome these obstacles?)
- Was having a purpose and making a difference in your life important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was having a purpose and making a difference?
- Do you think the things you did to have a purpose and make a difference were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up any relationships that weren't ok? If so, what helped of what got in the way?)
- Did you focus do much on helping others, following rules, spirituality, or religion that got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Emotional health

- ❖ *Emotional health* includes emotional safety, emotional regulation, mental health, and well-being. Examples of how this can be achieved include: using calming self-talk; empathizing with another person; living in an environment that is free from conflict; seeking support to manage difficult feelings; or restoring a sense of well-being through exercise.

- What did you do to be emotionally healthy? (i.e., manage your feelings, feel safe, keep healthy in your mind)
- How easy was it for you to feel safe, keep a healthy mind, and manage your feelings?
- What got in the way of you feeling safe, keeping a healthy mind, and managing your feelings? (What were the obstacles? How able were you to overcome these obstacles?)
- Was feeling safe and being able to cope with difficulties important to you? On a scale of 1 (not important to me at all) to 5 (very important to me), how important was emotional health to you?
- Do you think the things you did to be emotionally healthy were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up any of the things that weren't ok? If so, what helped of what got in the way?)
- Did you focus too much on your emotional health that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Sexual Health

- ❖ *Sexual health* includes sexual competency and satisfaction. It may include sexual knowledge, sexuality, sexual development, sexual confidence, and sexual pleasure and fulfillment. This need might be attained through the following more specific examples: sexual education classes at school; having a positive sexual identity; having a positive experience of puberty; speaking to supportive others about sexual anxieties; use of masturbation; or sexual experiences.

- How did you meet your sexual health needs at this time? (How much sexual knowledge did you have? What sexual experiences did you have? How confident did you feel with sexual experiences and your sexual identity? How did you experience puberty? How satisfying were your sexual experiences?)
- How easy was it for you to meet your sexual health needs? (What helped?)
- What got in the way of you meeting your sexual health needs? (What were the obstacles? How able were you to overcome these obstacles?)
- Was meeting your sexual health needs important to you? On a scale of 1 (not good at all) to 5 (very good), how important was this to you?

- Do you think the things you did to meet your sexual health needs were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up anything that wasn't ok? If so, what helped of what got in the way?)
- Did you focus so much on your sexual health needs that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Physical Health

❖ *Physical health* includes sleep, diet, exercise, hygiene, physical safety, and physical functioning. Examples of how a young person might meet this need are: getting sufficient rest; eating fruit and vegetables; going to the gym; bathing regularly; or being free from physical harm.

- What did you do to meet you physical health needs at this time? (i.e., eat healthily, look good, keep fit, have a good sleeping pattern, manage any illness or physical disability, or keep safe from physical harm)
- How easy was it for you to meet your physical health needs? (What helped?)
- What got in the way of you meeting your physical health needs? (What were the obstacles? How able were you to overcome these obstacles?)
- Was meeting your physical health needs important to you? On a scale of 1 (not good at all) to 5 (very good), how important was this to you?
- Do you think the things you did to meet your physical health needs were appropriate? (If applicable: What was not appropriate and why? Did you try to change or give up anything that wasn't ok? If so, what helped of what got in the way?)
- Did you focus so much on your physical health needs that it got in the way of doing other things?
- Do you think that this need was relevant to your harmful sexual behavior? If so, how?

Appendix D

Pleasant activities list

- Partir en vacances
- Recycler de vieux objets
- Planifier l'avenir
- Relaxation, méditation
- Collectionner des choses (pièces de monnaie, timbres, etc.)
- Aller au cinéma
- Faire du jogging, marcher
- Écouter de la musique
- S'allonger au soleil
- Rigoler
- Lire des magazines ou journaux
- Passer du temps avec mes amis
- Planifier mes journées
- Regarder un beau paysage
- Économiser des sous
- Manger
- Faire des arts martiaux
- Faire du yoga
- Faire de la mécanique (voitures, bateaux, etc.)
- Passer des soirées seul
- M'occuper de mes plantes
- Aller se baigner
- Dessiner
- Faire du sport
- Monter à cheval
- Jouer au football
- Faire des dîners en famille
- Faire du camping
- Chanter
- Pratiquer ma religion (aller à l'église, prière de groupe, etc.)
- Aller à la plage
- Jardinage
- Passer une journée à ne rien faire
- Aller en cours
- Faire du bateau
- Voyager
- Peindre
- Faire quelque chose de spontané
- Dormir
- Conduire
- Jouer des instruments musicaux
- Acheter, télécharger de la musique
- Regarder un sport à la TV
- Cuisiner
- Faire des randonnées
- Écrire (poèmes)
- Coudre
- Faire du shopping
- Aller dîner au restaurant
- Faire du magasinage
- Travailler
- Travaux manuels
- Visiter de beaux bâtiments
- Boire du thé, café
- Aller au théâtre, concerts
- Rêvasser
- Regarder la télévision
- Marcher dans les bois
- Jouer au tennis
- Aller voir un évènement sportif
- Photographie
- Aller à la pêche
- Manger équilibré
- Jouer avec des animaux
- Être seul
- Faire du skateboard, du roller
- Danser
- Écrire dans son journal intime
- Faire un piquenique
- Se promener dans les montagnes
- Jouer au hockey
- Faire de la poterie
- Skier
- Bien s'habiller
- Repenser à mes réussites passées
- Parler au téléphone
- Joue au bowling
- Travailler le bois, menuiserie
- Penser à mon avenir
- Suivre des cours de danse
- Débattre de divers sujets
- Avoir un aquarium
- Jouer au piano, guitare
- Jouer au sudoku
- Penser à mes qualités
- Acheter des livres
- Résoudre des énigmes (mathématiques, etc.)
- Vistites historiques
- Visites de musées
- Prendre un bain
- Penser à des moments heureux de mon enfance
- Faire quelque chose de nouveau
- Faire un puzzle, un casse-tête
- Faire le ménage

- Jouer aux cartes
- Discuter / chatter avec mes amis
- Faire une sieste
- Envoyer des textos
- Mettre mes habits préférés
- Offrir des cadeaux aux gens
- Jouer aux jeux de société (Monopoly, Cluedo, etc.)
- Jouer aux jeux vidéo
- Aider les gens, leur rendre service
- Faire de la luge dans la neige
- Regarder un film
- Acheter un CD de musique
- Regarder le sport à la télévision
- M'occuper de mes animaux de compagnie
- Faire du bénévolat
- Regarder des films drôles
- Aller à la librairie
- Être dans un orchestre (musique)
- Apprendre à faire quelque chose de nouveau
- Aller à la pêche, à la chasse
- Observer les étoiles et la lune
- Travailler dehors (ferme, travailler le bois, etc.)
- Lire des bandes dessinées ou comics
- Parler une langue étrangère
- Rencontrer de nouvelles personnes
- Décorer ma chambre
- Faire un bonhomme de neige
- Faire du patin à glace
- Faire de l'informatique

Appendix E

Session Rating Scale (SRS) V.3.0 (Johnson, Miller & Duncan, 2000)

APPENDIX

Session Rating Scale (SRS V.3.0)

Name _____Age (Yrs):____
ID# _____ Sex: M / F
Session # ____ Date: _____

Please rate today's session by placing a hash mark on the line nearest to the description that best fits your experience.

I did not feel heard, understood, and respected.	Relationship I——————————I	I felt heard, understood, and respected.
We did not work on or talk about what I wanted to work on and talk about.	Goals and Topics I——————————I	We worked on and talked about what I wanted to work on and talk about.
The therapist's approach is not a good fit for me.	Approach or Method I——————————I	The therapist's approach is a good fit for me.
There was something missing in the session today.	Overall I——————————I	Overall, today's session was right for me.

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