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

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

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Abstract

Purpose of Review

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

Recent Findings

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

Summary

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

Keywords Good lives model · Offender rehabilitation · Women sex offenses

Introduction

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

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model for treating women who perpetrated sexual offenses either alone or with co-offender(s) [1••, 2••].

During the past few years, there have been significant advances in the research of women who commit sexual offenses especially in regard to the identification of individualized treatment needs [2••]. While the empirical identification and validation of these needs may be due to studies with larger samples or more innovative methodologies, there also appears to have been a paradigm shift of sorts. That is, society began to perceive women who committed sexual assaults as culpable for their behavior. With this shift in perspective a greater emphasis was placed not only on punishment but also on rehabilitation. Consequently, in order to provide efficacious treatment, the goals of research became more focused on identifying specific treatment needs associated with recidivism risk rather than social issues [4, 11].

While men and women who commit sexual offenses share some common offense and behavioral characteristics, the underlying psychological and contextual dynamics are often different [16–18]. For example, some studies have found that although some men and women who commit sex offenses fulfill the diagnostic criteria for paraphilic disorders, the associated psychological and social dynamics often differ [19, 20•, 21, 22]. This "similar" but "different" conceptualization of female offending and the need for treatment centered on gender was initially described by Steffensmeier and colleagues [23–25] and then applied to women who commit sex offenses by Pflugradt and Allen [1••]. In addition, Cortoni [2••] describes a treatment approach that includes addressing the unique needs of women.

Although still very much in the developmental stages, two models for treating women who have perpetrated sexual offenses have been proposed; although similar in many respects, they tend to emphasize slightly different treatment aspects. In general, both treatment approaches accentuate the multifactorial nature of female sexual offending and influence of relationships or social connections [1••, 2••]. Moreover, the models include aspects of trauma-informed care [2••] with an emphasis on enhancing self-esteem and self-reliance by building upon strengths and abilities [1••]. Whereas these treatment models are based upon the current established treatment principles for women who committed sexual offenses, the differences between paradigms tend to be related to the specific treatment processes.

The following paper provides an overview of the two treatment models, gender-responsive treatment and gendered strength-based treatment. These models will then be examined to determine whether or not they can be integrated within a comprehensive theoretical rehabilitation framework such as the Good Lives Model.

Gender-Responsive Treatment

A gendered-informed treatment model proposed by Cortoni is primarily cognitive-behaviorally based but also considers personality and learning styles of female sex offenders [2••]. In addition, a major premise of this model, derived from developmental psychology, is that relative to men, women require more social connections. As emphasized by Cortoni [2••], research has supported the assertion that women benefit from social relationships and support; as a result, treatment interventions based upon relational models have been shown to be effective. For example, a study by Rumgay [26] found that increased social support improves the general functioning and stress management of women reintegrating into the community. Moreover, interventions based upon a relational model offer women a safe and supportive environment to establish appropriate relational boundaries and practice healthy connections with others [2••].

In addition to addressing the relational and social dynamics of female sex offenders, Cortoni [2••] also stressed that gender-responsive treatment includes other gender-specific needs. That is, by conducting a thorough assessment, the gender-related issues that led to the offending behavior are identified so that individualized treatment goals or targets may be developed. Cortoni suggested that a comprehensive assessment should focus on the offender's life history, victimization history [13, 27], criminal history [13], the presence of a co-offender [28], offense supportive cognitions [13], socioeconomic status [29], mental health history/needs [9], substance abuse history [29], and coping strategies [2••].

In summary, Cortoni [2••] proposed a gender-specific treatment model based upon a multifactorial approach which she considered to be the best practice to address the needs of women who committed sexual offenses. In addition, the needs of women who have committed sexual offenses should be treated concurrently within an integrated approach due to the interrelationship between treatment domains. That is, ideally, all of the women's treatment needs would be integrated within the sexual offender treatment context. However, if any of her treatment needs cannot be addressed within the sex offender treatment context, her needs should be addressed in separate but parallel (occurring at the same time) services. If the latter, the treatment providers should work together on a shared treatment plan to best meet the women's needs. Additionally, Cortoni [2••] indicated that the risk, needs, and responsivity principles typically utilized for male offenders also apply to treatment interventions for women who committed sexual offenses [29]. As she emphasized, in some cases the offender's level of need may indicate a greater level of intervention even when the overall recidivism risk is low [15]. And lastly, the primary goal of treatment is to address the factors associated with a woman's sexually assaultive behavior in a way that makes sense to her and enables her to move forward with her life in a positive manner [2••].

Gendered Strength-Based Treatment

The gendered female sex offender treatment paradigm, proposed by Pflugradt and Allen [1••], combined the gendered theoretical perspective of Steffensmeier and colleagues [23–25] with the strength-based program created by Marshall et al. [30•]. While there are considerable similarities with Cortoni's [2••] model, there are also some important distinctions. The gendered theoretical perspective is unique insofar as it does not assume that the patterns of female criminality are either the same or completely distinct from those of males [23, 31, 32]. In addition, the gendered perspective considers how gender in combination with different life experiences impact the behavioral manifestations of offending [1••]. The gendered theoretical perspective proposed by Steffensmeier and Allan [23, 24] is based upon four fundamental elements. A gendered perspective should (1) explain how social norms, identities, arrangements, institutions, and relationships transform the manifestations of human sexuality into the social construct gender; (2) account for gender differences in type and frequency of crime as well as differences in the context of offending; (3) consider the ways in which the pathways to crime for women differ from those of men; and (4) explore the extent to which gender differences in crime also derive from biological and reproductive differences. Whereas Cortoni's [2••] treatment approach considers the second and third elements, her discussion of the other two is relatively more limited. As suggested by Pflugradt and Allen [1••], a gendered theoretical paradigm not only provides a coherent and integrated model but also is amenable to operationalization from a strength-based perspective.

Of the current strength-based treatment models, an adaptation of Marshall and colleagues' approach [30•] is best suited for women who commit sex offenses insofar as it addresses the primary elements of the gendered perspective operationalized via strength-based applications. That is, their treatment approach, similar to the Good Lives Model [33–37], is derived from the basic premise that sexually assaultive behaviors occur because offenders do not have "the full range of requisite skills" (p.25) [30•]. Not only do Marshall and colleagues [30•] emphasize the importance of strengthening already present skills and abilities to pursue desired goods, they also offer treatment recommendations to achieve them. Another important distinction is the emphasis that Marshall and colleagues [30•] place on the therapeutic process relative to treatment content [30•]. By focusing on these processes, they identify and incorporate important social and cultural considerations into treatment while including support from others, similar to the Circles of Support and Accountability model [38, 39].

In addition to the emphasis placed on therapeutic process, treatment should also consider the neurological and biological differences between males and females. The significance of social processes from a neurobiological perspective was described by Siegel [40] as the "mirror neuron system." This neurological system links the perception and motor areas in the brain during the creation of representations of internal states. As he further explained, this system along with other parts of the brain forms the "resonance circuity" which encodes intention and involves empathy, emotional resonance, and "attunement of minds" [40]. Siegel's neurobiological perspective is consistent with a gendered perspective; that is, female brain development "appears to involve more integration" than the development of male brains [40]. Because of this, neurobiological differences should be kept in mind when developing programs designed to meet the needs of women. For example, Siegel's work provides an explanation of certain treatment targets such as perspective taking and the ability to relate to others. As such, neurobiological development is facilitated by social and relational factors in the female brain. Consequently, specific treatment approaches should "stimulate neural activation and growth" to promote "neural integration, promote coherence of mind, and inspire empathy in relationships" [40; p.291–292].

Thus, on a conceptual level, the content of a strength-based treatment approach based upon a gendered perspective not only includes skill building or acquisition but also addresses social factors and behaviors that involve all aspects of the offender's life. In regard to treatment processes, a gendered strength-based treatment approach involves a collaborative process that builds upon already possessed skills and provides options to utilize those skills [1••]. It also considers the social and contextual nature of the offending behaviors as well as the participant's individual manifestations of those behaviors. That is, as articulated by Marshall and colleagues [30•], a strength-based process fosters both responsibility and autonomy while providing flexibility so that it can be adapted to meet individual needs. Moreover, such a treatment paradigm is consistent with other models which generally include the following components [1••, 2••, 20•]: (1) reducing or eliminating antisocial attitudes and behaviors while increasing prosocial skills; (2) empowering clients to overcome both past traumas and socio-cultural barriers to rehabilitation; (3) building and enhancing coping skills and abilities, especially emotional regulation; (4) and developing relational strengths (e.g., healthy relationships with intimate partners, peers, and other social supports).

To summarize, a gendered strength-based treatment approach provides women who commit sexual offenses with specific suggestions to achieve their treatment targets while also accommodating unique characteristic(s) which are often the result of varied social and/or relational factors. As suggested by Cortoni [2••], a need for "connection" or emotional bonding is a basic psychological component of growth for women. Perhaps the primary distinction between a strength-based model and other treatment approaches is the emphasis that it places upon processes rather than content. These

treatment processes should involve strengthening relational skills and abilities by improving the participant's ability to perceive, interpret, and respond to social and interpersonal cues and behaviors. Thus, gendered sex offender treatment should include the gender-responsive domains identified by other models [2••] within the context of cultural and social influences, which enhance the participants' ability to form and maintain positive relationships. As suggested by Covington [41], treatment providers should reflect (i.e., are trained and sensitive to) the women's needs in the areas of social background and language. They should also be positive role models and mentors, promote cultural awareness and sensitivity, and be skilled in the area of facilitating transitional programs which focus on building long-term community support.

The Good Lives Model

Ward described the Good Lives Model (GLM) as "…a strength based approach by virtue of its responsiveness to offenders' cores aspirations and interests and its aim of providing them with the internal and external resources to live rewarding and offence-free lives" [35]. In addition, he further described the GLM as closely aligned with positive psychology involving "practical reasoning" [35], or using judgments about the worthiness of a person's goals and how to achieve them through coordinated action. Although a complete description of the GLM and recent adaptations is beyond the scope of this paper, its applicability to sexual offender treatment was summarized by Willis et al. [42•]. As delineated by Willis and colleagues [42•], the GLM is a theoretical approach that differs from traditional paradigms because its central focus is building upon client strengths rather than only managing or reducing deficits. In addition, the application of the GLM to offender rehabilitation comprises three sets of basic assumptions.

The first category or general assumption assumes that to some degree, all persons strive to meet or acquire primary or basic goods (i.e., healthy living and functioning, knowledge, excellence in play, excellence in work, excellence in agency, inner peace, friendship, community, spirituality, happiness, and creativity) [42•]. The importance or degree of desirability that individuals assign to specific primary goods reflects or represents his or her life values and life priorities. The activities or behaviors that individuals engage in are a means to achieve their desired goods.

The second set of assumptions is "etiological" insofar as they are associated with or explain the onset and maintenance of offending behaviors. That is, the GLM assumes that all individuals organize or, in a sense, create their lives around core values and follow some type of good life plan (GLP). As Willis and colleagues explain [42•, p.125–126], offending relates to the pursuit of primary goods and is considered to result from "flaws" in an individual's GLP.

The third group of assumptions essentially assumes that the first two assumptions can direct or inform the practices used for the rehabilitation of offenders. Arguably, this category of assumptions is perhaps the most significant strength of the GLM; that is, the paradigm can be applied not only to offenders in general but also modified to address the unique needs of specific groups/individuals [43–47]. Whereas the framework offered by Willis and others [42•] is meant to be applied to programming for men who commit sexual offenses, the following applies the same conceptual framework to organize the currently identified components of treatment for women who have committed sexual offenses.

Integrating the GLM Into Sex Offender Treatment for Women

As found by numerous studies, an important component of sex offender programing involves motivating offenders to participate in treatment to meet needs and reduce recidivism risk [48]. Although there are various approaches to increase treatment motivation [48–50], the GLM proposes communicating the program aims so that participants derive a sense of purpose associated with the desire to attain a better life. That is, one of the central aims of the GLM is to assist the participants with identifying his or her primary goods and ways to achieve them without harming others. These objectives may be attained by working collaboratively with participants by orienting them to the treatment process, forming goals, building and maintaining prosocial influences, and mutually agreeing upon program guidelines and therapeutic processes.

These guidelines are also inherent in the current treatment models for women who have committed a sexual offense [1••, 2••]. For example, as suggested by Pflugradt and Allen [1••], during the early stages of gendered strength-based treatment, it is important to provide participants with an overview which includes establishing confidentiality requirements and discussing offense relevant background factors in a positive supportive setting that enhances self-esteem and reduces shame. Moreover, treatment preparation skills are reviewed to improve coping and mood management, and exercises are provided to broaden/improve perspective taking within the therapeutic setting to reduce treatment interfering factors. Whereas other treatment approaches have recommended similar aims and goals [23], the focus of a strength-based gendered perspective includes the following elements: (1) a collaborative process by which the participant may identify her abilities; (2) assisting participants with practicing their identified abilities/strengths within the applicable social and relational contexts; and (3) providing a sense of responsibility and autonomy [1••, 30•].

In their second set of guidelines, Willis and colleagues [42•] recommend utilizing the effective rehabilitation assessment procedures included in RNR-based programs [34]. As described by Bonta and others [51•, 52•], the assessment procedures of the RNR model involve matching level of program intensity to the offender risk level. For men who have perpetrated a sexual offense, the assessment process involves using empirically informed risk measures to determine risk levels [42•]. The assessment process also involves identifying treatment needs utilizing dynamic measures. Based on the assessment results, offenders are matched to services and interventions based on their level of risk and need [51•, 52•]. The last component of the RNR model is responsivity. One part of responsivity includes matching the intervention to the offenders' abilities and style of learning as well as addressing any other areas that may be a barrier to treatment participation.

As previously indicated, however, there are no empirically derived risk assessment measures for use with women who have committed a sexual offense [1••, 2••]. Despite this limitation, current female treatment models have identified empirically relevant domains to guide the assessment process [1••, 2••, 20•]. Assessment includes evaluating needs in the areas of intimacy/relationship issues, personality characteristics, cognitive processes, social functioning, sexual dynamics, and individual characteristics that relate to offending behavior [1••, 2••, 20•].

The assessment process for women who have committed a sexual offense is compatible with the treatment and intervention planning component proposed by Willis and colleagues [42•]. That is, the assessment not only obtains information about risk but also directs treatment planning so that the participants are able to identify primary goods and ways in which to achieve them. From the GLM perspective, assessment is an on-going individualized interactive process that identifies the weighted goods of the participants and the appropriate interventions to facilitate acquisition and/or realization of those goods.

Regarding their guidelines pertaining to intervention content, Willis and others [42•] emphasized that the GLM is an overarching rehabilitation framework that does not prescribe specific treatment approaches. Rather the focus of interventions is on individualized planning and consequently, the use of specific or structured treatment formats, such as treatment manuals, is generally not consistent with the GLM. As Willis and colleagues [42•] acknowledged however, some studies have suggested that structured or formatted treatment programs with comprehensive manuals ensure consistency in service delivery and adherence to the treatment goals. Whatever approach is utilized, most models emphasize the importance of flexibility to accommodate the individual needs of the participants. These general guidelines are also consistent with the current treatment models for women who have committed sexual offenses, which recognize the importance of consistent formats to address individualized needs [1••, 2••].

There are two important distinctions between male and female sex offender treatment programs, namely the emphasis placed on specific treatment domains and treatment processes. Differing intervention strategies relate to the differing significance or salience of the gendered factors relating to risk. For example, whereas sexually deviant arousal may be a primary focus of treatment for males who commit sexual offenses, it is a much less common treatment need for females [1••, 2••]. Rather, female offending may be related to relational issues or lack of information about healthy sexuality, and consequently these issues require significantly greater focus. In addition, many of the treatment intervention processes also vary across gender [1••, 2••]. Regarding this point, the current treatment models for women [1••, 2••] emphasize the importance of processing treatment content from a relational perspective. That is, within a relational context, treatment should focus on identifying and building upon strengths, not focusing on deficits or other approaches that may result in further traumatization, disempowerment, or social alienation [1••]. This approach is consistent with the framework proposed by Willis and associates [42•] stressing the importance of strength-building. That is, instead of addressing relationships deficits, the interventions should focus on the skills that the participants possess and build upon them.

The last set of guidelines proffered by Willis and colleagues [42•] pertains to how the interventions are provided or delivered. As they proposed, there are several factors to consider in the provision of treatment including therapist characteristics, language, cultural sensitivity, collaboration, transparency, and participant agency. While these factors are consistent with the current treatment models for women who commit sexual offenses, there are also additional important gendered considerations. Perhaps one of the most important differences in treatment delivery is the social and relational dynamics involved in the therapeutic process. That is, as the participants strive for connectedness and emotional intimacy, they may experience emotional vulnerability and/or dysregulation, often the result of past traumatic/abusive experiences. Consequently, it is important for the treatment process to provide participants with opportunities to learn about healthy relationships and practice forming/maintaining them within a safe and supportive environment. This is typically accomplished through the therapeutic relationship with the treatment facilitator and other treatment participants. Moreover, along with forming positive relationships, it is also important for participants to identify negative or destructive relationships and learn how to respond to them in a safe and healthy manner.

As further suggested by the current treatment models for women who commit sexual offenses [1••, 2••], the acquisition of skills needed to manage relational and social needs is best accomplished from a perspective of confidence and emotional resilience fostered from a gendered strength-based approach. As the participants' become more capable of managing

relationships and social influences, it is also important for them to learn how to generalize their skills and abilities beyond the treatment setting. To this end, involving a multidisciplinary team/support system is important. The GLM provides a useful framework from which input from all professionals can be integrated to provide a comprehensive treatment plan. This set of guidelines, similar to the previous recommendations, are also compatible with current treatment models for women which consider therapeutic rapport, the social and physical environment and generalizability of the interventions outside of the treatment setting.

Conclusions

As the research pertaining to women who commit sexual offenses continues to evolve, there are several treatment modalities that consistently emerge as applicable to the needs of women who engage in sexually assaultive behaviors. An interesting finding from these more recent studies is that despite the literature which has traditionally emphasized the different treatment needs of male and female offenders, on a theoretical level, there are also several similarities [16–19, 23, 32, 53–57]. For example, both male and female treatment methodologies, across paradigms, include components of strength-based approaches, elements of RNR, and specific treatment methods most notably cognitive behavioral therapy [1••, 2••].

Despite the similarities, the underlying psychological processes related to offending behavior are different between men and women, necessitating different treatment foci. Specifically, female sexual offending behavior appears most often related to relational factors and social context. As proposed by this paper, the GLM provides a comprehensive theoretical framework to organize and apply the elements of gendered-strength based treatment which includes elements of RNR and CBT, as well as biological and ecological factors. Moreover, the GLM as an over-arching rehabilitation principle provides the necessary flexibility to address the contextual factors and other individual influences that are integral dimensions of a gendered treatment model. To summarize, as treatment for women who have committed a sexual offense continues to evolve, it will become increasingly important for future empirical inquiry to be guided by sound theoretical tenets. The GLM provides a conceptual framework to integrate the substantive elements of a gender-responsive paradigm with a process-oriented gendered perspective such that empirically derived treatment needs are identified and effectively implemented.

Compliance with Ethical Standards

Conflict of Interest The authors declare that they have no conflicts of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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