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A Therapeutic Community Approach to Address Harmful Sexual Behaviour in Older Teenagers

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A THERAPEUTIC COMMUNITY APPROACH TO ADDRESS HARMFUL SEXUAL BEHAVIOUR IN OLDER TEENAGERS

Karen Parish and Peter Clarke

Introduction

Glebe House is a specialist residential therapeutic community for adolescent males who display harmful sexual behaviour. This chapter provides an overview of the history and theoretical underpinnings of therapeutic communities, focusing on the Glebe House model. It then explores the impact of trauma and disrupted attachment on the development of harmful sexual behaviour. The therapeutic community model can be a useful approach to respond to complex trauma and associated behaviours. This chapter explores some of the key ways in which Glebe House addresses these issues, considering relationships, emotional regulation, power and control, learning normative social behaviour and considering development into adulthood and transition into the wider community. The chapter concludes by exploring the effectiveness of the Therapeutic Community approach.

Therapeutic Community Approach

Main (1946) coined the term *therapeutic community*, describing therapeutic communities as structured, psychologically informed environments where the social relationships, structure of the day, and activities are designed to help promote health and well-being. This approach is designed to provide a safe and containing environment where trauma can be explored and responded to.

For an organisation to move from a community that includes therapy to a therapeutic community, Main argued, requires a questioning approach which he identified...
as a *culture of enquiry*. A culture of enquiry encourages the questioning of fundamental beliefs and practices held by professionals, questioning the roles professionals play and the impact of their experiences on the work. Psychoanalysis supports the development of democratic therapeutic regimes as it offers ways of understanding and making sense of apparently irrational thoughts and behaviours. Three aspects of psychoanalytical thinking are particularly present in therapeutic communities: the use of psychoanalytic approaches to understand group dynamics; the use of theoretical structures to promote reflection and thinking; and the use of psychoanalytic thinking to understand relationship dynamics especially transference (directing feelings on to therapist), counter-transference (therapist directing feelings onto patient), projection (attributing undesired feelings onto others), and scapegoating (blaming others for own difficulties).

During the Second World War the therapeutic intervention at the Northfield Military Hospital led to a sophisticated model for understanding group dynamics. Bion (1961) identified that working collectively with war veterans now understood to be experiencing PTSD was beneficial. He identified that using the power and strength of the patients as *experts by experience* can drive treatment, and that the sharing of individuals’ lived experiences can help them and the group to understand the effects of trauma and can aid patient recovery. It was in the publication of *Experiences in Groups* in 1961 that the ideas came together and reached prominence.

In the late 1960s, Glebe House was established as a therapeutic community by three Quakers: Geoffrey Brogden, a probation officer; David Clark, a psychiatrist; and David Wills, an educationalist. The therapeutic community approach adopted at Glebe House is based on Rapoport’s *Four Cornerstones*. Rapoport (1960) published *Community as Doctor* which detailed his experiences and observations at the Social Rehabilitation Unit at Belmont Hospital. Rapoport identified four characteristics (or cornerstones) that he felt distinguished the unit as a therapeutic community and provided a structure to assist the individual and the group to make sense of their experiences:

- **Democracy**: the concept that each member of the community should share decision-making. At Glebe House the model is one of consensus which reflects both Quaker values and the decision-making described by Jones (1968). This gives opportunity to prolong discussion and increase reflection. There is a Director’s veto to prevent unsafe or illegal decision, which is rarely used.
- **Permissiveness**: renamed *Tolerance* due to the cultural meaning of permissiveness changing after Rapoport’s work was published, tolerance is the idea that community members might bring distressing behaviours into the community and these should be understood and tolerated as much as possible – with a feedback loop regarding the effect of behaviour on others.
- **Communalism**: the idea that the process of living together, solving the problems that this generates is itself a healing medium.
- **Reality-Confrontation**: this refers to the practice where the “patients” are continuously presented with interpretations of their behaviour to counteract processes of denial, distortion, or withdrawal. This encourages the verbalisation of thinking. It is
possible for different and apparently mutually exclusive interpretations to both be valid – in the way that at times any individual may hold conscious or unconscious core beliefs that are themselves mutually exclusive.

Kennard (1998) identifies two key principles of social psychiatry that can be applied to understand therapeutic communities: firstly, that an organisation fosters therapeutic relationships where safety, collaboration, and open communication are engrained in its structures to enhance recovery; and secondly, that treatment is more effective in organisations where genuine and appropriate responsibility and ownership for personal recovery is given to the patient. The terms Planned Environment Therapy and Living/Learning Environments have been coined to describe this structured therapeutic approach. The principles of therapeutic communities are echoed in the current thinking and principles of trauma-informed care, reaffirming the importance of the therapeutically informed environment and the need for safety, choice, collaboration, trustworthiness, and empowerment.

Although a snapshot of a therapeutic community can sometimes give the impression of a place with a degree of chaos and lack of boundaries, the framework requires a thinking approach that offers containment to those whose experience of persistent trauma has led to a world view where others cannot be trusted and emotions cannot be contained (Bath, 2008). The intervention to interrupt that process and “reset” the pattern requires persistent experiences of containment (the holding of anxiety) and reflection (the processing of thoughts and feelings). The striving to get to that functionality offers a sense of hope and improvement. The use of self and the concept of experts by experience provide a context that makes change achievable. Bloom (2010) highlights how the presence of trauma can impact on an organisation’s ability to create a healthy culture, with the staff group experiencing the impact of transferential trauma. Bion (1961) suggests that groups that experience high levels of anxiety caused by unprocessed trauma can oscillate between three different emotional states: dependency, pairing, and fight or flight. In order to work with trauma in such an intensive environment there need to be structures in place to allow all community members, staff, and young people, the space to reflect, to process what they are experiencing, and to recognise the emotional impact this can have. This links to the culture of enquiry referenced previously. It is important that behaviour is not just experienced but time is dedicated to exploring and understanding the meaning of behaviour through a nuanced theoretically informed lens.

It is helpful to understand behaviour through the lens of misdirected communication. The attempt to reflect and think about trauma and distress in the here and now can often be met with resistance and self-protective defences, such as challenging behaviour. “The children we work with will also attack our attempts to think about and understand them. This is linked to their overwhelming sense of mistrust” (Tominson, 2004; p.112).

The fundamental principles of the therapeutic community model encourage behaviour to be understood as a means of communication and help individuals to feel respected and valued through both positive and negative experiences. These are necessary for healthy development of the individual, the group, and the wider
community. This is achieved by providing healthy attachments and interdependence between people, recognising the importance of mutual need, and an understanding of wider social relationships. This helps create a safe, supportive, and containing environment that allows the individual to develop, grow, and change by actively being involved in decision-making, sharing responsibility, and ownership.

**Trauma and Harmful Sexual Behaviour**

Attachment theory (Bowlby, 1969) highlights the importance of the relationship between an infant and their primary caregiver. A secure attachment allows the infant the safety to explore the world knowing there is a secure base to which they can return. This learning process offers opportunity to develop emotional well-being and self-regulation, adaptability and resilience, and to form and maintain healthy relationships with others. Marshall (1993) highlights how those who offend sexually often do not form secure attachments in childhood. Marshall suggests that these attachment insecurities can result in young people experiencing developmental deficits in relation to interpersonal skills, self-esteem, and empathy. Zaniewski, Dallos, Stedmon, and Welbourne (2019) explored attachment strategies among young people who engage in harmful sexual behaviour, concluding that young people who display harmful sexual behaviour often hold complex insecure attachment strategies that have the intrusion of trauma and loss. They also found that there were intergenerational patterns of avoidant attachment with unresolved trauma and loss for these young people.

It is important to consider the impact of adverse childhood experiences on the development of harmful sexual behaviour. Felitti et al. (1998) highlight seven adverse childhood experiences (ACEs): psychological, physical, and sexual abuse; family members with mental illness or substance abuse problems; exposure to domestic violence; and a family member in prison. Felitti et al. highlight how these experiences increase the likelihood of young people experiencing difficulties in later life. Shonkoff et al. (2012) suggest that, if ACEs are continuous and unresolved, young people’s bodies can produce too much cortisol, affecting the nervous and immune systems. Longo (2008) further suggests that traumatic histories can cause neurological and developmental deficits, and that adolescents who display inappropriate and harmful sexual behaviours must be viewed holistically because of these developmental factors.

McMackin, Leisen, Cusack, LaFratta, and Litwin (2002) highlight how trauma-associated feelings can be triggers for harmful sexual behaviours in adolescents. They found that 95% of the adolescents who displayed harmful sexual behaviour in their study had experienced a traumatic event and 65% were assessed as meeting the criteria for PTSD. Braga, Goncalves, Basto-Pereira, and Maia (2016) highlight a link between experiencing trauma and ACEs and increased rates of antisocial behaviour and a strong link between childhood experiences of physical and sexual abuse and adolescent aggression.

The impact of ACEs is magnified during adolescence; adolescence is a time when independence and responsibility are striven for. However, young people may not have the skills or emotional capacity to manage the change in responsibility and
Therapeutic Community Approach

independence (Crittenden & Ainsworth, 1989). Ward and Siegert's (2002) Pathways Model posits that harmful sexual behaviours develop from difficulties with intimacy and social skills deficits, emotional dysregulation, distorted sexual scripts, antisocial cognition, or a combination of these factors that may affect the development of independence and responsibility. These deficits appear to originate from early ACEs and attachment difficulties. If left unresolved they can affect the individual's ability to regulate their emotions, manage relationships and trust, leading to maladaptive behaviours.

Gil and Cavanagh-Johnson (1993) highlight how adolescent sexual behaviour should be understood as a continuum between consensual behaviour at one end and sexual abuse at the other. The difficulty for professionals assessing harmful sexual behaviour is that once there has been an incident of sexual abuse, being able to distinguish between behaviours that are concerning and part of an abusive pattern and behaviours that are part of normal development can be extremely difficult. Many adolescents experiment with drugs and alcohol, risk taking behaviour, and egocentric behaviour. Often, however, these behaviours are viewed as factors that increase risk when seen through the lens of harmful sexual behaviour. If these behaviours in adolescence are considered a “normal” part of development, it could be argued that rather than being considered a risk factor they should be considered as a vulnerability that needs addressing.

Asmumssen, Fischer, Drayton, and McBride (2020) highlight how trauma-informed care can reduce the impact of ACEs if a young person is placed in an environment where there is safety, personal choice, and a degree of control, coupled with positive and trusting relationships. Elliot, Bjelajac, and Fallot (2005) highlight how recovery from trauma must be a primary goal and that this is best achieved through empowerment, personal control, and positive relationships. The therapeutic community approach provides a wide range of potential healing relationships and, as such, is an effective structure for responding to young people who have displayed harmful sexual behaviours and have a history of ACEs. The structure and containment of the therapeutic environment allows for some of the effects of these developmental deficits and childhood adversities to be addressed and responded to.

Therapeutic Community and the Importance of Relationship

Within psychotherapy there is clear reference to the importance of the therapeutic relationship/working alliance between professional and young person. It is considered to be one of the most significant factors in changing behaviour, even more important than the type of intervention model used. It is believed that a positive relationship is essential to achieve desired outcomes in treatment (Mallinckrodt, 2000). The importance of the therapeutic relationship for promoting positive outcomes is also highlighted by Horvath, Del Re, Fluckiger, and Symonds (2011). Rogers (1957) identifies conditions that are necessary for therapeutic change in clients; these are that the counsellor has congruence/genuineness in the therapeutic relationship, unconditional positive regard (warmth), and the ability to empathise and communicate empathy. Relational factors and the importance of family, peers, and intimate
relationships are highlighted within the literature in relation to harmful sexual behaviour (Smallbone, 2006; Altschuler & Brash, 2004).

Young people who display harmful sexual behaviour, who have experienced ACEs and insecure attachment relationships, need to be placed within therapeutic settings that can focus on providing specially adapted environments that offer nurturance, security, and safety so that recovery can take place. Young people who have experienced ACEs will often display psychological (heightened emotional arousal or controlling behaviour) and physical (fight or flight) defences, perceiving the environment and people around them as frightening, hostile, and unsafe. The lived therapeutic experience that a therapeutic community provides can aid a young person to build the confidence to try to form relationships (Lanyado, 2001). Whilst outpatient therapeutic support can also aid these developments, some young people with significant ACEs need their primary lived experience to be therapeutic (Dockard-Drysdale, 1990).

The primary lived experience needs to contain the young person both emotionally and physically. Within a therapeutic residential setting this occurs in a variety of ways. Young people can seek and be willing to receive positive physical contact in the form of hugs, but this can also be through the young person creating situations to have physical containment through restraint and physical intervention. Within therapeutic communities the meaning of behaviour is considered and reflected on, this allows there to be a thoughtful approach to responses, early intervention to redirect behaviour and the young people having consistency and containment in the responses they receive. It offers a platform for a young person to develop alternative working models concerning their identity, relationships, and behaviour options. In considering relationships one Glebe House young person stated:

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Young Person DK

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Young Person DK

Within the therapeutic community model there is a focus on the relationship between the staff and young people; these relationships are based in psychodynamic principles that highlight a two-way process, with both parties bringing conscious and unconscious dynamics. There will be expectations, assumptions, and agendas for those involved that need to be acknowledged and understood. This mutuality in the relationship is a strength of the therapeutic community model and aids the development of perspective taking and empathy.

In a therapeutic community initiating the relationship is key, being able to be with the person in the emotional place they are in, to not place significant demands or expectations on them. Within this relationship forming phase there is a focus on holding the young person in mind and providing unconditional positive regard. It is the security and trust that is developed from these relationships that allows the young person to develop relationships with peers and other community members. With secure relationships being formed there is a base from which the meaning of behaviour can be explored, understood, challenged, and redirected. The fundamental
principles of the therapeutic community model help to provide healthy attachments and interdependence between people, recognising the importance of mutual need, and an understanding of wider social relationships. They provide a safe, supportive, and containing environment to help the individual to develop, grow, and change by actively being involved in decision-making, sharing responsibility, and ownership. They encourage behaviour to be understood as a means of communication.

Another advantage of the therapeutic community model is the use of group process and peer challenge. The notion of the young people being experts by experience means that the feedback they provide to each other has significant power and impact. The sense that they understand and have commonality aids connection and attachments between the young people and a voice that can be heard in a different way to the professionals around them.

Therapeutic Community, Emotional Regulation, and the Development of Empathy

Primary attachment and early child development provide children with a schema for managing their emotions. Some abused adolescents may not have the skills to manage their emotions appropriately and therefore may displace these emotions into destructive or harmful sexual behaviours. Gillespie, Mitchell, Fisher, and Beech (2012) suggest that adolescents who display harmful sexual behaviours often display difficulties with appropriate regulation of their emotions. They highlight how developing the control of this maladaptive emotional arousal, originally developed as a survival strategy, needs to be part of intervention. Hunter, Figueredo, and Malamuth (2010) highlight how children growing up in environments where there is trauma and abuse can develop a sense of the world as being highly sexualised and/or hostile. These unsafe environments can lead to heightened emotions, poor emotional literacy, and self-regulation difficulties.

The therapeutic community’s emphasis on the community as container provides a safe space for emotions to be expressed and understood by the group. The slowing down of responses allows for consideration of what the meaning(s) of the behaviour exhibited is and what emotions may be driving the behaviour. Rapoport’s four cornerstones model gives a structure that reinforces the containment process and the need for taking a tolerant approach in responding to challenging and emotionally led behaviour. This tolerance allows the young person the opportunity to process their emotional experiences and undertake intervention around developing emotional literacy; they are able to share experiences with other young people within the community and receive feedback in relation to impact of their behaviour on others. These factors support and promote behavioural change. One Glebe House young person spoke about his experiences struggling with his emotions, describing:

Emotions are a bit like sticky mud, it feels like you get stuck in it and you keep falling down. Glebe is helping me to control my emotions, I have emotion cards to help me say how I am feeling when I can’t find the words, and I am also learning to talk to staff and to get support.

Young Person SP
Empathy is a crucial element of work with young people who display harmful sexual behaviour; being aware of their own emotions enables them to understand and respond to the emotions of others. An advantage of the therapeutic community model is the focus given to understanding meaning(s) of behaviour, attending to the emotional responses of the individual and the group, and reflecting the experiences of others.

**Therapeutic Community and Working with Power and Responsibility**

Adult sexual offending is often identified as having compensatory motives (Prentky, Cohen, & Seghorn, 1985). It can be motivated by anger and sadism (Knight, 1999), power and control issues (Robertillo & Terry, 2007), antisocial tendencies or high levels of impulsivity (Hazelwood, 1995; Knight, 1999). These drives can have origins in developmental deficits and trauma, such as those identified by Ward and Siegert’s (2002) Pathways Model. Trauma impacts on the young person’s sense of safety, choice, trust of others, and feelings of empowerment, as highlighted in the principles of trauma-informed care. When these key developmental needs are not attended to, this can lead to maladaptive behaviours forming where these needs are met inappropriately through the misuse of power and control.

Glebe House explores the use of power and control, understanding it as a key therapeutic tool – starting from a point of having a flattened hierarchy between young people and the staff, with all community members having an equal voice, sharing responsibility and control over the day-to-day running of the community. Democratic communities often use a sociological framework called Interaction Ritual Chain Theory (IR.CT: Collins, 2004), which suggests that people seek the emotional energy that others provide, creating ritual in mutually focused emotion and attention and that this creates a shared reality. This theory considers how community expectations are negotiated, challenged, and enforced and does so by observing and analysing the power dynamics within the lived experiences rather than the structured therapy spaces. This model looks at the fluidity of power and how it moves and changes with group dynamics. It also focuses on how power is experienced by group members, considering exclusion and inclusion within those dynamics.

Bloor, McKeganey, and Fonkert (1988) highlight how power is an inherent part of social interaction. Haigh (2013) describes how power within social interactions can be both creative and destructive. When an individual experiences positive power-related interactions (such as holding a position of responsibility) they can experience motivation to repeat the behaviour, however unsuccessful or negative power-related interactions (such as bullying, using power at the expense of others) can lead to feelings of alienation and despair. Using the group process inherent in the therapeutic community model, the group can reinforce positive interactions and provide feedback and challenge to unwanted power dynamics.

Understanding power and control is a key therapeutic aim in working with young people who display harmful sexual behaviour, with feelings of inadequacy and rejection from adverse childhood experiences fuelling anger and power and control issues. It is important that young people are given opportunities to receive feedback and
learn to differentiate between negative and positive power interactions, recognising that micro-aggressions in everyday life are important learning opportunities. However, macro-aggressions need to be responded to robustly. Other young people can help them to understand the difference between being feared and being respected; this is crucial and is an area that IRCT can help. It is also important that the young people experience the trust and respect that comes from having positive power interactions. There are roles within Glebe House that have status such as “chairman”, which provide opportunities for this to be achieved. A Glebe House young person described his experience of the chairman role, stating:

I have been a chairman twice, I was fired and had to work to get the role back. I lost the role for trying to manipulate a member of staff into giving me their keys. I lost the role for trying to manipulate a member of staff into giving me their keys. I learnt that this was not OK, I talked to the member of staff afterwards about this, I apologised and took responsibility for my actions and how it left her feeling. I wouldn’t have been able to have done this before; I would have just flounced about for a bit.

Young Person DK

The Glebe House therapeutic community model also provides opportunities to experience offence paralleling behaviour. Offence paralleling behaviour is behaviour that mirrors the offending behaviour cycle without an offence being committed. This could be behaviour that displays issues relating to power and control, spite and jealousy, or risk-taking behaviours. This type of behaviour is connected to individual experiences, often relating to the creation of certain stressors such as thoughts, situations, emotions, and reactions that mirrored those connected with their offending (Jones, 2004). The notion of offence paralleling behaviour raises significant issues in relation to relapse, or more importantly the difference between lapse and relapse. Pithers, Marques, Gibat, and Marlatt (1983) highlight that the experience of lapse is often beneficial for the offender, as they learn to manage struggles and grow in confidence and control. It is important to recognise that the offence paralleling behaviour is likely to be rooted within complex trauma paralleling behaviour, reactive enactments of past trauma (McMackin et al., 2002).

The living/learning experience of Glebe House allows for observation and comment on these paralleling behaviours. These behaviours provide opportunities to highlight both the offending and/or trauma pattern without the intense emotions and defences that are connected to the original events. For example, jealousy within relationships in the community may provide an opportunity to make links to primary relationships, past motivations to offend, maladaptive attachment behaviours, and the impact of ACEs.

Therapeutic Community and Understanding Normative Social Behaviour

In thinking about normative social behaviour, Bandura’s (1977) Social Learning Theory is key, with its notion that young people learn social behaviour through
observation and imitation of social interaction, experiencing reinforcement and punishment for behaviour.

In relation to sexual offending, the role of attachment and early child development are helpful in exploring how children develop working models of social relationships and intimacy, as well as cognitive skills and moral awareness (Craissati, 2009; Rich, 2003). For young people who display harmful sexual behaviour, their childhood experiences have often involved ACEs that have shaped their view of the world, with them perceiving the world as highly sexualised and/or dangerous. The difficulty with growing up in hostile and unsafe environments is that the young person is unlikely to have positive life or sexual experiences to compensate for the trauma, and this can result in a distorted understanding of social and sexual behaviours. Young people need to experience a social environment where there is security, safety, and containment. The therapeutic community model’s use of community helps the young person to understand normative social behaviour through role modelling and reinforcement.

Pearce & Haigh (2017) explore relational properties of reinforcement stating:

“This is a central mechanism in the way TCs operate. In a TC that is running well there are multiple feedbacks to members from other members and staff in every meeting, and therefore multiple opportunities for vicarious learning. This is likely to be more effective when a member identifies with the person being observed, as is common in the TC when there are personal similarities in problem type or demographics.”

Pearce & Haigh, 2017; p. 87

At Glebe House community meetings are used as a space to help think about how behaviour in the community affects others. One young person spoke about this stating:

“I am learning that if there is a problem it is helpful to talk. I can call a communications meeting; this is a special community meeting because things feel unsettled. This helps everyone to have a space to talk about what is happening; these meetings help me to feel heard.”

Young Person SC

Interaction Ritual Chain Theory aids the development of morals, values, and social rules, using the power of the group to explore the impact of behaviour on others and continuously negotiating group boundaries and expectations. IRCT is typically characterised when the young people come together, sharing experiences and emotions. This repetition generates feelings of belonging and has a longer-term impact in relation to positive emotion, and it encourages the shared values of the group to become morally charged (Collins, 2004). The process of modelling is crucial in changing behaviour through observing others undertake behaviour, being encouraged to undertake the behaviour and being provided with the opportunity to reflect and gain feedback on that behaviour. Summers-Effler (2002) highlights how not conforming to community values and expectations can lead to a lack of
emotional positivity and exclusion from the group. This is often a didactic process, with overt teaching; however, within the therapeutic community model this process is embedded in the culture.

Therapeutic Community, Independence, and Transition into the Wider Community

Adolescence is a time when independence and responsibility are striven for. However, young people may not have the skills or emotional capacity to manage these changes in responsibility and independence. It is widely recognised that adolescents who display harmful sexual behaviour experience deficits in the areas of intimacy and social skills which may affect the development of independence and responsibility. When left unresolved, these deficits can lead to difficulties in regulating emotions, resulting in trust issues and maladaptive relational behaviours. Maturation is a key part of developing these skills. However, individuals with harmful sexual behaviour also need to have intervention around their sexual offending and have positive aspirations about their future in order to make the necessary changes (Farmer, McAlinden, & Maruna, 2015). A Glebe House young person spoke about their journey through Glebe House:

I have been in care for 5 years because of my sexual behaviours, I have been at Glebe House for 2 years and 1 month and am due to leave soon. When I first came to Glebe, I was very scared about going out on my own without staff supervision because of my risks. Now I feel more confident that I can manage myself and not get into tricky situations. I have also found appropriate coping strategies. My future looks a lot brighter than it used to.

Young Person TS

Altschuler and Brash (2004) identify seven transition domains that need to be considered: family/living, employment, peer groups, substance misuse, mental health, education, and leisure. The therapeutic community model can respond to many of these identified domains. Uggen and Staff (2001) consider the importance of employment for offenders in helping them desist from offending, concluding that work programmes appear to be more useful for adults than for adolescents, and that the quality of this employment plays a significant role. Therapeutic communities provide within their structure opportunities for individuals to take roles and responsibilities. Within Glebe House there is a role of chairman, a mentoring role in which young people are given the opportunity to support others, be given greater responsibility and trust, and to take responsibility, and have input into the day-to-day running of Glebe House. This role is a paid role with a clear job description and accountabilities and is regularly reviewed and appraised. This gives young people the opportunity to develop a work ethic and a sense of achievement.

House therapeutic community approach. The research explored the experiences of young people in transitioning from Glebe House into adulthood and independence. Boswell et al. reported that young people often experience difficulties with physical and mental health issues, echoing the earlier research in relation to the impact of adverse childhood experiences. They also highlight how there is often a lack of support services for young people to aid them with this transition. In response to this deficit in transition support, Glebe House developed a transition service that provides support for young people for 18 months after leaving Glebe House. The Circles of Support and Accountability model (Nellis, 2009) was adopted as a framework to provide this support. Dominey and Boswell (2018) undertook an evaluation of the Glebe House Circles Project and highlighted how the Circles of Support and Accountability model is a useful model for young people to aid them transition from services.

Is the Therapeutic Community Model Effective?

In considering the treatment of harmful sexual behaviour, Silovsky et al. (2018) highlight how targeted intervention with young people can have a significant impact in reducing harmful sexual behaviour displayed by young people. It is important that any programme has a focus on sexual concerns, such as sexual deviance, victim profile, and the use of threat and harm (Seto and Lalumiere, 2010). In addition to sexual concerns, there also needs to be a focus on non-sexual antisocial behaviours such as aggression (Righthand et al., 2005), as well as on developmental factors, such as trauma and abuse experience, domestic violence, and mental health (Hackett et al., 2013). In order for young people to benefit from the therapeutic support available and to develop the skills necessary to lead an offence-free lifestyle, there needs to be a readiness for change. Glynn (2014) highlights in the New Moons Model how individuals need to build on social capital, having a network of relationships that aid the development of pro-social lifestyles. The therapeutic community model can provide a framework where these factors are addressed, both within a structured therapeutic space but also in a lived experience, as highlighted throughout this chapter.

Vanderplaschsen et al. (2013) describe how therapeutic communities come with a considerable history and a long research tradition, though research into their effectiveness is limited. Malivert, Fatséas, Denis, Langlois, and Auriacombe (2012) suggest that therapeutic communities are considered effective treatment methods. However, the research evidence for them is often derived from poorly controlled studies. Condelli and Hubbard (1994) highlight that therapeutic communities are effective for reducing criminal behaviour and suggest that the length of time spent in treatment is a clear predictor of outcomes.

Boswell et al. (2016) undertook a ten-year longitudinal evaluation of Glebe House. This study reported on the effectiveness of the Glebe House model; it found a notable reduction of some very serious problems identified by its residents on arrival. The research followed 43 young people from Glebe House over a period of ten years, together with a comparison group of 43 young people who were identified as having similar issues but who were not placed at Glebe House. Boswell et al. found that
84% of young people admitted to Glebe House were not subsequently re/convicted, compared to 56% of the comparison group. Of the Glebe House cohort only one person had re/offended sexually and one violently, compared with five each of the comparison group.

The therapeutic community model at Glebe House appears to be an effective approach to address harmful sexual behaviour in older teenagers, particularly where there are issues with attachment, emotional regulation, power, and control. However, the model is intensive and needs a commitment over time. For some young people the two- to three-year placement within an environment where the primary lived experience is therapeutic is necessary to rebuild relationships and address the impact of entrenched adverse childhood experiences. However, it is important to recognise that this level of intervention is not necessary or appropriate for all and that for some young people whose experiences are less entrenched, these needs can be addressed through a less intensive therapeutic approach. The assessment of suitability into a therapeutic community is crucial to ensure that young people are appropriately placed and able to make use of the therapeutic programme so to minimise the potential for further rejection and trauma if the placement was to be unsuccessful.

Further Reading


References


Karen Parish & Peter Clarke


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