# A review of the use of therapeutic communities with sexual offenders

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Abstract

Sexual offender treatment programs are often facilitated in secure settings such as prisons or psychiatric hospitals, which are not ideal environments for such treatment. Arguably, however, when these environments are structured as therapeutic communities (TCs), opportunities are created to enhance the effectiveness of treatment. We describe the concept of a therapeutic community, its operating principles and rationale, as well as the benefits and rationale for establishing TCs in conjunction with cognitive behavioral treatment with sexual offenders. We discuss this in terms of the potential of TCs to improve targeting of treatment content; to enhance treatment process; to provide optimal environments for therapeutic gain; and to provide a broad therapeutic framework for treating sexual offenders. We review and summarize what evidence exists for the use of TCs with both non-sexual offenders and sexual offenders. Finally, we highlight the gaps in our knowledge of the use of TCs in order to inspire further empirical and conceptual consideration of these issues .

Key words: therapeutic community, sexual offenders, review, treatment

There is now considerable optimism for the effectiveness of sexual offender treatment programs (Hanson et al., 2002; Lösel & Schmucker, 2005). The content of these programs and the manner in which they are delivered is based on a large cumulative body of theoretical and empirical literature, which has evolved considerably over the past 40 years. This has led to the development of new etiological theories, better risk prediction procedures, new treatment targets and techniques (*what* is targeted within treatment), and a more recent focus on effective treatment methods and procedures (*how* we should deliver treatment content).

What has not received any significant attention is the broader context and environment in which treatment takes place. Sexual offender treatment programs are often facilitated in secure settings such as a prison or psychiatric hospital. This is not necessarily ideal from a therapeutic perspective. Clearly, the typical secure setting presents considerable drawbacks for those who would seek to address the typical habits and practices associated with sexual offending (e.g., secrecy and concealment). Prison environments, particularly, are often seen as contexts for the maintenance and reinforcement of antisocial attitudes and behaviour, and as inimical to attempts to change (see for example, Dhami, Ayton & Loewenstein, 2007). More especially, the identity and reputation of child sex offenders in prisons is seemingly even more marginal than it is in the outside community (see Akerstrom, 1986; Hogue, 1995). We argue, nevertheless, that secure environments (prisons, hospitals, youth units) also represent opportunities and potential benefits, particularly if they are set up with therapeutic and rehabilitative goals in mind. The concept of the therapeutic community (TC) has emerged from the recognition of these opportunities (Baker & Price, 1995). Broadly speaking, TCs are effectively a "living-learning situation" (Cullen, 1994, p. 239) where every event and any relationship within the environment is considered a learning opportunity, potentially maximizing therapeutic gain. In this sense, secure environments may actually offer benefits that less secure (i.e., community) treatment environments do not. In our view, these potential benefits are yet to be explored and understood fully.

Within this review we aim to summarize the evidence for sexual offender treatment programs and to establish that there is unexplored opportunity to increase their effectiveness, particularly for incarcerated high risk sexual offenders. We will describe the concept of a therapeutic community and its operating principles and rationale. Our principal goal is to describe the benefits and rationale for employing

TCs in conjunction with cognitive behavioral treatment with sexual offenders. We discuss this in terms of the use of TCs: to increase ability to target treatment content; to enhance treatment process; to provide optimal environments for therapeutic gain; and, to provide a broad therapeutic framework for treating sexual offenders. Aware that there is not yet sufficient evidence to demonstrate these benefits in the sexual offender treatment context, we firstly review and summarize what evidence exists for the use of TCs with non-sexual offenders and then sexual offenders. Finally, we aim to highlight the gaps in our knowledge of the use of TCs, with a view to inspiring empirical and conceptual consideration of these issues in the future.

How effective is sexual offender treatment?

A number of large scale meta-analyses have demonstrated that sexual offender treatment appears to be effective (e.g., Hanson et al., 2002; Lösel & Schmucker, 2005), although questions continue to be asked around inherent methodological problems and a lack of randomized control trials (with the notable exception of Marques, Wiederanders, Day, Nelson & van Ommeren, 2005). Lösel and Schmucker's (2005) meta-analysis contained 80 comparisons between treatment and control groups, containing a total of more than 22,000 individuals. They determined that the mean rate of sexual recidivism was 11.1% in treated groups and 17.5% in control groups. This is effectively a 6% difference, which is equivalent to a 37% reduction between the control and treatment groups. Thirty-five of the 80 studies involved some degree of prison based treatment whereas 10 used therapeutic communities as a mode of treatment. Prison-based treatment was found to be less effective than outpatient treatment. While this outcome was probably confounded by the fact that high risk sexual offenders were more likely to receive treatment in prison, it does raise the issue of whether prison-based treatment can be improved upon.

Importantly, it appears that approximately 1 of every 10 sexual offenders will re-offend after participating in sexual offender treatment (Hanson et al., 2002; Lösel & Schmucker, 2005). Also, not all treatment programs are effective. For example, the large-scale evaluation of a sexual offender treatment program by Marques et al. (2005), was one of three random allocation designs considered in the Hanson et al. (2002) meta-analysis . As one of only a few such methodologically rigorous treatment evaluations, it is cited extensively, often as evidence that sexual offender treatment does not work. Closer inspection of this study, however, reveals

considerable methodological weaknesses, such as significant differences in pre-treatment risk levels between the treatment and non-treatment groups and the large number of non-volunteers for the study (see Marshall & Marshall, 2007). Clearly, we have an obligation to continue to strive for enhanced treatment effectiveness in light of the potential cost to innocent victims when treated offenders re-offend.

Recent treatment programs are more effective than older programs (Hanson et al., 2002). This indicates the advances the field has made, notably in the content of programs and how they are delivered. We can now assume that treatment programs are accurately targeting a comprehensive range of offence-specific and offence-related factors, often referred to as criminogenic needs (Andrews & Bonta, 2003) or dynamic risk factors (Hanson & Harris, 2000). There is now an extensive body of research that demonstrates that these factors are reliably related to recidivism risk and, therefore, should be targeted within treatment (see Hanson & Morton-Bourgon, 2004). Similarly, it now appears that the *process* variables inherent in the group based treatment of sexual offenders are significantly related to treatment benefits (see Marshall et al., 2003 for review). Evidence now exists that therapist features , quality of therapeutic relationship, and models of group treatment delivery all contribute to the effectiveness of sex offender treatment (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Marshall et al., 2003).

Psychological treatment should differ in intensity and duration, depending on the assessed risk of recidivism for the offender (Andrews & Bonta, 2003). Sexual offenders assessed to be at a high risk of recidivism are usually matched to a high intensity of psychological treatment, which is most often facilitated in prison. In our view, there is limited evidence as to what "high intensity" should mean. It appears that programs described as "high intensity" are usually approximately eight months in duration (see Beech & Mann, 2002; Ware & Bright, 2008) and involve over 300 hours of face-to-face contact within a group setting. Although these figures appear somewhat arbitrary there is some supporting evidence for them. Beech, Fisher, and Beckett (1999) evaluated multi-site prison-based sex offender programs operating in England and Wales. They found that a 160-hour cognitive behavioral group-based program was effective for moderate risk sexual offenders but was *not* effective for offenders assessed as high risk (in terms of reduction of recidivism). They concluded that this was sufficient evidence that these high risk offenders required a higher

"dose" of treatment (see Harkins and Beech, 1997 for discussion). We will argue that the use of TCs increases treatment intensity.

## Therapeutic communities

### *Common features*

The term "therapeutic community" is often used broadly, and a wide variety of facilities describe themselves as such, even where there is limited knowledge of identified TC principles (Lipton, 1998). Although there is some conjecture as to what exactly constitutes a therapeutic community, it represents an opportunity in offender work to increase the "intensity" of treatment experience beyond the group therapy forum. In their systematic review of 181 therapeutic communities within 38 countries, Lees and colleagues (1999) used the following working definition:

> *A consciously designed social environment and program within a residential or day unit in which the social and group process is harnessed with therapeutic intent* (Lees, et al., 1999, p.1).

We will briefly review this clinical modality here and argue that it is perhaps most usefully considered as a therapeutic setting in which a program of treatment is delivered. The therapeutic community concept emerged from the recognition of the potential benefits gained in attending to the social-emotional climate of closed environments. It has historical foundations in attempts to intervene pro-actively in the social milieu of institutional rehabilitative contexts, such as psychiatric facilities and, later, prison settings. The TC became established initially in the UK, then North America and other countries as a systematic and purposeful method of psycho-social treatment both within formal institutions and without (for a detailed history and explanation, see Inciardi, 1996 or Lipton, 1998).

A therapeutic community describes the establishment of a social order that applies its entire organization to therapeutic outcomes. While the label describes a wide range of programs and practices, the ultimate goal of interventions based around this modality is the enhanced ability of clients to function appropriately in the "outside world" upon release or reintegration. This requires the development and maintenance of a temporary social environment in which residents' experiences occur

against a background of consistent and predictable values and principles designed to facilitate comprehensive re-socialization. Such an environment is characterized ideally by a positive and rehabilitative sub-culture, developed and maintained with the active participation of both staff and residents. The common elements then are the provision of a communal living experience, encouraging open communication and promoting psychological and social adjustment.

All relationships are considered potentially therapeutic, and attention is directed in all social experience, interaction and activity toward therapeutic goals . This arrangement generally requires the creation of a bounded and relatively autonomous environment. This is especially so in prison settings, where the mainstream environment is likely to be contrary to the goals and means of the TC. The TC aims to provide a balance between autonomy and dependence (i.e., interdependence) in order to stimulate residents' potential for personal growth. While residents are accorded the liberties and opportunities to act relatively freely, the environment must also be responsive, confronting actions that are inconsistent with therapeutic goals. In other words residents come to learn from "mistakes". In these ways responsibility is devolved to residents by various means. This ensures a context of intensive social interaction in which they can experiment with and practice newly-acquired personal and interpersonal skills.

There is a strong emphasis placed on teams: within and between staff and residents. Nevertheless, according to De Leon (1995), a good deal of self-responsibility is placed with the resident. He states as a clear principle that treatment is not provided as such, but is *made available* in the TC environment. It is, therefore, left to the individual to take up the offer and to "fully engage in the treatment regime" (De Leon, 1995, p. 1610).

*Democratic TCs*

Despite common principles there is a range of typical arrangements and procedures used by TCs to enact them. In general, contemporary TCs can be broadly classified by theoretical orientation as either "democratic" or "concept-based". Given the greater relevance and appropriateness for sex offender work of the democratic model over the more hierarchical concept-based variant, we will describe the former here.

The democratic TC model has evolved from a treatment modality for mental health clients but has more recently been applied to other populations, including offender groups. Typical sub-modalities and forums within this variant of TC are:

- Group psychotherapy
- Community meetings (involving staff and residents)
- Committees and subcommittees, mentoring programs, structured activity days
- Therapy-related employment opportunities
- Other arrangements where conduct and practices are openly raised and processed

A key aspect is the interpersonal-exploratory aspect of activities, where members challenge, confront or celebrate significant behaviour and events (Main, 1977; Norton, 1992).

Key social features of the classical "democratic" TC then are collaboration, democratization, permissiveness, confrontation, and a prospective orientation (Kennard, 1983; Lees, Manning, & Rawlings, 1999; Rapport, 1960). The TC might be seen as a therapeutic supra-system that subsumes and incorporates other modalities. Indeed, these sub-systems may be seen as integral, if not primary, to the overall enterprise. In prison-based treatment programs addressing substance abuse or sex offending issues, for instance, the primary therapy *group* is considered the "backbone" of the change process (Baker & Price, 1995). As such, it is understood to conform and contribute to the underlying culture and philosophy established in the milieu.

In summary, then, the democratic therapeutic community model represents a psycho-social treatment modality. Community is the method of change. Responsibility is devolved to residents and their total immersion in the community is desirable in order that they adopt its "culture". Applying this concept to a clinical setting involves the purposeful use of the institution's organization and community for therapeutic purposes.

How effective are TCs with *non-sexual* offenders?

Although we have suggested that the use of TCs can enhance treatment effectiveness for sexual offenders we are aware that there is not yet sufficient

evidence to demonstrate this and, therefore, we initially review and summarize what evidence exists for the use of TCs with *non-sexual* offenders.

Until relatively recently, research evaluating TCs (for all offender types) has primarily been descriptive and there has been little quantifiable data attesting to their effectiveness (Lees, Manning & Rawlings, 2004). It appears that few prison-based treatment programs have defined themselves as TCs or, if they have, they have not sought to evaluate the relative impact of using TC principles. Furthermore, any such research has been limited by methodological difficulties, such as small and heterogeneous research populations, difficulties conducting randomized or even incidental control group designs, and short follow-up periods (Lees et al., 2004). Finally, it is often difficult within such research to accurately account for other potential moderating influences, such as those cases where treatment precedes TC involvement.

Although initial research suggested that, at worst, TCs by themselves did not reduce reconviction rates (Gunn, Robertson & Dell, 1978); there is now an emerging foundation of evidence attesting to their efficacy. Lees et al. (1999) conducted a meta-analysis of TC treatment for people with personality disorders and mentally disordered offenders and found an effect size of .57 – indicating a significant reduction in re-offending. The study by Lees and colleagues (1999) is consistent with other recent research reviews of similar intent and approach in its conclusion that there is clear support for the effectiveness of the therapeutic community modality, especially in relation to substance abuse-related offending and personality disorder (see, for example, Lees et al.,, 2004; Pearson & Lipton, 1999; McMurran, 2007). In fact by 1997, Wexler, in conducting a review of treatment for drug addiction, had concluded that therapeutic communities should be the treatment of choice for those with drug addictions.

The time an offender spends in a TC has been demonstrated to be important, as longer stays result in greater reductions in re-offending (Marshall, 1997; McMurran, 2007; Newton, 2000; Taylor, 2000). Mode of release from the TC might be another salient factor. In a seven-year follow-up, of just over 700 men from HMP Grendon TC,, those who were released from custody into the community immediately following Grendon were less likely to re-offend than those who initially returned to the general prison population. ,It is possible, however, that risk level might actually account for this finding (Taylor, 2000). It is also suggested that offender age and

criminal history may impact on the successfulness of TCs. Research has suggested that in some groups of offenders (e.g., violent offenders), TCs may be more effective for those who are older and those with a more extensive criminal history (and thus a higher risk of recidivism) (Marshall, 1997; Taylor, 2000).

Another method for demonstrating the effectiveness of TCs has been to measure within-TC changes in order to demonstrate that goals are met. Research has demonstrated post-treatment improvements in self-reported positive change (Miller, Sees & Brown., 2006); personality change (e.g., decreased levels of hostility, neuroticism, and psychoticism) (Newton, 1998); increased employment and reductions in drug use (Messina, Wish & Nemes, 2000); decreased custodial disciplinary charges within and post TC (Cooke, 1989; Hodkin & Woodward, 1996); and reduced adherence to conventional prisoner attitudes (Genders & Player, 1995). Neville, Miller, and Fritzon (2007) conducted an interesting study involving the development and use of a check-list to evaluate behavioral change in 30 TC based offenders. A number of outcomes were reported including an increase in offenders' engagement in 'functional' behaviors, such as asking others for advice and being supportive of one another, and a decrease in dysfunctional behaviors, such as becoming angry or disruptive and being "anti-staff".

There appears to be research attesting to the effectiveness of TCs, both in terms of recidivism reduction and within-TC changes, in a wide range of offender types – including violent offenders, personality disordered individuals, adolescent offenders, and substance mis-users (Davies & Campling, 2003; Lees et al., 1999; Lipton, Pearson, Cleland & Yee, 2000; Jainchill, Hawke, De Leon & Yagelka, 2000; Jainchill, Hawke & Messina, 2005; Marshall, 1997; McMurran, 2007; Taylor, 2000). There are, however, incidences where TCs may not be effective, or in fact, potentially harmful. Opinion about their use with offenders assessed as psychopathic is more contentious and reflects the ongoing debate regarding the capacity of these individuals for psychological change (Hare, Clarke, Grann & Thornton, 2000; Looman, Abracen, Serin & Marques, 2005). It has been argued that that this group of offenders responds poorly to TCs, which, at worst, may result in increases in recidivism (Rice, Harris & Cormier, 1992; Harris, Rice & Cormier, 1994). Salekin (2002), in a comprehensive review of 42 treatment studies on psychopathy, found TCs to be the least effective treatment modality with an average success rate of 25%, a marginal increase on the 20% success rate experienced by the control group.

How effective are TCs with sexual offenders?

We have argued that there is considerable merit in facilitating treatment for sexual offenders, particularly those requiring a high intensity of treatment, within prison-based TCs. Although TCs for sexual offenders are intuitively appealing, in contrast with research involving non-sexual offenders, there is a relative lack of empirical evidence to support this notion. Existing research appears to be based on the notion of sexual offender TCs being defined as a therapeutic setting in which a program of treatment is delivered. It is our contention that, despite this paucity of research, there is already sufficient evidence to suggest that TCs are a worthwhile endeavor with sexual offenders.

Within Lösel and Schmucker's (2005) comprehensive meta-analysis of sex offender treatment effectiveness, the mean effect size for TCs (based on the use of odds ratios) was OR = 0.86. This does not reflect a positive effect of treatment and is significantly less than cognitive-behavioral treatments alone (OR = 1.45). However, it is not clear to what extent these 10 programs actually used therapeutic community principles and what particular sex offenders were treated in these. It is also possible that a number of the prison-based treatment programs reported to be effective within the Lösel and Schmucker meta-analysis do, in fact, use TC principles, but do not label themselves as such, or have simply not reported this if they did. As an example of this, the Kia Marama program of the New Zealand Department of Corrections incorporates TC principles extensively, yet this is not emphasized within its research (see Bakker, Hudson, Wales & Riley, 1998; Allan, Grace, Rutherford, & Hudson, 2007).

In a large scale evaluation of the sex offender TC at the Colorado Department of Corrections, participation in treatment was found to be significantly related to successful parole completion (Lowden et al., 2003). Those who completed the therapeutic community program were found to remain arrest-free for longer (15.8%) when compared with those who were un-treated (47.7%). Survival analyses demonstrated that this pattern was consistent over time (Lowden et al., 2003). Within his large-scale evaluation of over 700 high risk offenders Marshall (1997) assessed the effectiveness of TC for sex offenders who had been admitted to HMP Grendon. Looking at a four-year follow-up period, and using an untreated group as comparison, he found that 18% of treated offenders with two or more previous convictions for

sexual offences were reconvicted compared to 43% of untreated offenders. Thirty-one percent of treated offenders who had committed either sexual or violent offences were reconvicted, compared to 72% of untreated offenders.

There appears to be an absence of more specific research regarding within TC changes with sex offenders. Boswell and Wedge (2004), in their comparison of a group of TC-treated adolescent sex offenders with a matched control group, observed key lifestyle changes and reductions in general problems (e.g., self harm, depression and drug use) in those who received treatment when compared to the pre-TC baseline levels and the untreated group. Qualitative research has indicated that TC participants report aspects such as the mutual support of other residents, staff support, a safe and friendly environment (Boswell & Wedge, 2004), and the "out-of-group" environment as being important to their treatment success (Frost & Connolly, 2004).

Could the use of TCs enhance the effectiveness of sexual offender treatment?

We believe that there are compelling, albeit empirically untested, reasons why the use of therapeutic communities, particularly for high risk sexual offenders, might enhance the effectiveness of sex offender treatment. Firstly, we argue that a TC is an ideal environment to deliver the *content* of sex offender treatment, that is, the specific risk factors relevant to sexual offenders. Secondly, we have argued elsewhere that group therapy is ideally suited to the treatment needs of sexual offenders (see Frost, Ware, & Boer, in press; Ware, Mann, & Wakeling, in press) and we suggest here that TCs provide for an extension of the group therapy *process*.

We propose, firstly, that the content of sex offender programs be consistently and repeatedly targeted outside of formal therapy settings and that this is likely to enhance treatment effectiveness (Frost & Connolly, 2004). Secondly, we maintain that the concept of "high intensity treatment" is currently not sufficiently defined but, for the reasons outlined below, argue that TCs deliver improved treatment intensity. Thirdly, we believe TCs provide secure environments where treatment opportunities can be maximized and that these environments are likely to be attractive to sexual offenders ambivalent about treatment. Finally, we believe that TCs can provide a broad therapeutic "framework" whereby appropriate treatment can occur in a constructive manner, within a clear and transparent model, 24 hours a day, seven days a week.

*TCs are an ideal environment to deliver the content of sex offender treatment*

The content of sexual offender treatment programs will invariably reflect four broad categories of criminogenic needs (dynamic risk factors) – notably, sexual arousal factors, attitudes tolerant of sexual assault, interpersonal deficits, and self-regulation deficits (see Mann & Fernandez, 2006; Thornton, 2002). It is our contention that TCs are an ideal environment to deliver the content of sex offender treatment.

Treatment targets with respect to sexual arousal factors include decreasing deviant sexual arousal and fantasy, increasing arousal to appropriate consenting sexual activities with adults, and reducing the importance of (frequent) sexual behaviors. In non-TC environments, offenders may still be presented with opportunities to think or to act in sexually inappropriate ways – such as predating upon, or grooming, younger more vulnerable individuals. Inappropriate sexual discourse surrounding sexual matters is considered the norm amongst the general prison population. Such discourse is seen to reflect secretiveness, abusive themes, and disrespectful attitudes. Within a sex offender TC such discourse is considered worthy of attention and openness is encouraged. The appropriateness of sexual attitudes and conduct is readily distinguished and targeted either by way of concerted efforts by therapy and custodial staff, or by way of community intervention. As such, sexual arousal factors can be targeted frequently and consistently both within group therapy sessions and around the prison unit.

Attitudes tolerant of sexual assault targeted within sexual offender treatment include rape myths, the acceptability of sexual contact with children , sexual entitlement, negative views of women, indifference to victim harm, and lack of a sense of accountability for sexually abusive behaviors (see Marshall, Marshall, Serran & Fernandez, 2006). Within a TC, acceptance of responsibility for such attitudes is readily targeted at a community level. Negative attitudes such as those listed above when expressed within a TC are open to immediate and concerted challenge. This is neither available nor supported within non-TC prison units. There is even the possibility that these attitudes are implicitly endorsed by untrained custodial staff. Likewise, in contrast to non-TC prison units, it is argued that TCs provide greater opportunities for targeting empathy skills – such as perspective taking. This appears to be perceived by offenders as a critical part of their treatment (Wakeling, Webster, & Mann, 2005).

Sexual offending is interpersonal behaviour and sexual offenders tend to demonstrate pervasive deficits and distortions in interpersonal relationships (Marshall, Anderson, & Fernandez, 1999). TCs are likely to offer opportunities to explore interpersonal deficiencies and develop new skills such as resolving conflict, communicating emotions and learning about the impact of one's social behaviour . Ward, Vess, Collie, and Gannon (2006) noted that every aspect of treatment involves the opportunity for interpersonal skills training and, further, that the "therapy group is an external condition that can act as a catalyst for the development of a whole range of treatment related competencies" (p. 389). We argue that opportunities to target interpersonal deficits are likely to be even greater when treatment is provided within a TC.

Self-regulation deficits targeted within sexual offender treatment include impulsivity, poor problem solving, and coping with troublesome emotions. These deficits reflect general criminality and are targeted with non-sexual offenders. It is our contention that a TC environment is an optimal context to assist in the development of self-regulation skills. TCs provide for continuous modeling opportunities, behavioral rehearsal, positive and negative reinforcement . Within non-TC prison environments there are arguably limited opportunities to practice self-regulation skills other than in very circumscribed circumstances (Dhami, Ayton & Loewenstein, 2007).

*TCs provide for an extension of the group therapy process*

The literature addressing sex offender treatment has for some time emphasized the *content* of programs: the theories, modalities, models, and interventions. This emphasis has been moderated, more recently, by a tide of interest in the qualitative factors associated with success (Marshall et al., 2003; Serran, Fernandez, Marshall & Mann, 2003). Such interest has centered on the interpersonal qualities of program providers and, to a lesser extent, the therapeutic climate of treatment groups (Beech & Fordham, 1997).

However, there is still little that addresses the culture of the therapeutic setting – the broader context in which treatment takes place – and especially the *active* participation of those undertaking treatment. Given the particular propensity, identified in the literature, of these offenders to shift blame, deny responsibility, rationalize and minimize (e.g., Happel & Auffrey, 1995; Levenson, & MacGowan,

2004; Mann, 2000) it is arguable that the active engagement of sex offender clients in treatment is an especially important target of intervention. It is also possible, as clinicians will attest, for offenders to participate only minimally within therapy group sessions, and it must be considered that inevitably much of the offender's time is spent outside the therapeutic session or group room. This is where TC environments can maximise treatment effectiveness. Harnessing the usefulness of out-of-group time increases the potential benefits of treatment (Frost & Connolly, 2004). The positive and meaningful peer interactions within group therapy sessions are able to be built upon in a wider prison setting where this is encouraged. Take the instance of an offender who benefits significantly from a group therapy session where assertiveness and adaptive communication has been the topic. If he was to return after the session to a non-therapeutic community prison wing, his practice and rehearsal of these newly acquired knowledge and skills is likely to be severely limited. Indeed he is likely to experience a punishing response. In short, he is unlikely to use them again.

Further, Frost and Connolly (2004) found that men within their qualitative study of sexual offenders undergoing treatment in a TC environment would typically, following a group session, seek to discuss aspects of this with other residents of the wing. The authors concluded that these men, in light of their personal disclosures within session, primarily sought to determine and limit the "damage" to their selves or their relationships. They typically found, however, that their fears were unrealised, and this allowed them to re-invest in treatment in a more committed and hopeful fashion. In one sense, such behavior occurring out of session should, in our view, be seen as part of the overall treatment experience.

Group therapy, it is argued, has a number of advantages over individual therapy, including the opportunity to experience multiple sources of challenge, positive feedback and support, and extensive opportunities for vicarious learning (see Clark & Erooga, 1994; Sawyer, 2000; Schwartz, 1995; Ware, Mann, & Wakeling, in press). In our view, it is likely, albeit not yet empirically supported, that TCs can maximise and intensify these advantages. As an example, an offender may be challenged over his inappropriate comments made within a group therapy session. Within a TC, not only is he likely to be repeatedly challenged over any additional similar comments, but he may be specifically challenged with a community meeting and by custodial staff, and his employment or rewards within the prison wing may become contingent upon changes with respect to these comments. An important point

here is that in TCs custodial staff are actively involved in engaging the men in treatment. Within this context the custodial staff become increasingly important as they facilitate the congregation of the men and the facilitation of interactive peer processes. The role of custodial staff extends from the provision of humane, secure and safe containment, to actively promoting the change process.

The TC notion, therefore, holds promise for a deeper and more committed quality of involvement from those undertaking treatment and a more sensitive level of examination of progress (i.e., arguably a greater *intensity* of treatment). In a TC, the quality of relationships within and between teams of treatment providers, custodial staff, health providers, educators and, more especially, the offenders themselves becomes the subject of interest and attention. Given the high levels of intensity that they experience, the treatment milieu is the sum of all these interactions, and thus represents a therapeutic matrix. We hold that a "democratic" TC framework as an extension of a group CBT treatment represents a compelling treatment approach for work with sexual offenders, particularly those assessed as high risk, who require a higher intensity of treatment.

*TCs provide secure environments where treatment opportunities can be maximized*

A democratic TC is likely to be appealing to an incarcerated sexual offender for a number of reasons. In the first place a bounded, circumscribed setting can create a refuge – an oasis of safety – within the wider prison environment. Beyond that, a sufficiently evolved TC culture will teach that the "inmate code" (Cordilia, 1983) is not of benefit (as is normatively believed), but in fact contributes to their experience of abuse. While high levels of self disclosure are required of these clients within treatment, the social stigma associated with being identified as a sex offender are clearly an obstacle, and so a "safe" and trusting social climate is of critical importance. TC experience will support the principles and learning from the core treatment program: that, by breaking away from practices of domination and control, clients can progress toward meeting treatment goals, and in so doing are likely to be exposed to consistently satisfying and rewarding experiences that contradict their negative expectations or schema.

This notion is consistent with the more recently developed models of rehabilitation, such as the 'Good Lives Model' (GLM; Ward & Stewart, 2003), which direct attention toward consideration of the advantages of working in more

constructive ways with offenders using a humanistic philosophy (Marshall et al., 2005; Ward & Stewart, 2003). These approaches place less emphasis on individual pathology and more on a developmental and relational view of offenders and offending. This change in emphasis has been largely driven by a re-consideration of the offender as one who has used sexually exploitive means in order to meet universal human needs. By this argument then, improving the individual's capacity to identify appropriate goals and to satisfy them by developing functional interpersonal strategies is likely to erode the motivation to offend. This has prompted calls for a change in the emphasis of the treatment context to one that is accepting of the offender and that is conducive to helping him explore alternative, non-abusive, ways of meeting his needs and living a rewarding life. TCs can provide this context.

Furthermore, secure environments (prisons, hospitals, youth units) also represent features and opportunities consistent with personal transformation: a prescribed daily routine, a customized physical environment, and a bounded social environment with the potential for protracted intimacy. The benefits in creating such boundaries extend not just to the insulation of these clients from criminogenic "pollution", but also to the accommodation, the concentration and singleness of purpose necessary for therapeutic change (Hubble, Duncan & Miller, 1999; Mahoney, 1991). The secure setting provides a forum for reflection, reflexivity, "immersion learning" and a sufficient "workspace", factors that are often implicated as important ingredients in theories of change. Arguably, the processes of treatment generalization (behavior change outside of group room), response generalization (i.e., when an individual starts to use the content of treatment for issues not targeted within treatment), and response maintenance (i.e., using treatment content outside of group over time) are all optimized by the use of TCs (Cooper, Heron, & Heward, 1987).

In fact, such qualities may be much less available in non-secure environments, and even the outside community, where there are likely to be considerably more distractions, interruptions, temptations and fewer dedicated resources. In this way, we argue, individuals can move beyond a mere physical presence in the TC and become recruited into honoring and supporting its principles.

*TCs provide a therapeutic framework for the treatment of sex offenders*

The generic TC "hardware" components have been described elsewhere: the procedures, forums, components and arrangements, such as community meetings,

committees, team meetings, celebrations, community activities – the flesh and the bones. But the question remains of how to use these "tools of the trade" (Baker & Price, 1995) to enact the principles that underlie sex offender treatment. In order to put the "therapeutic" into the "community", the form and process need to support some sort of content.

The overarching therapeutic framework that we propose is derived by determining and defining key factors typically associated with sexual offending and reflecting on their opposites. In the all-day-every-day context of the prison this means not just "talking the talk" in the therapy group, but "walking the walk" in the prison compound. According to our approach, offenders are held accountable for their everyday behaviour; but then so are members of the therapy team and the custodial staff. All members of the community should be able to "expect respect" and this principle should be promoted in the various meetings and forums of the TC. The rationale for choosing to focus here on the "positive" side of the responsibility / irresponsibility divide follows the psychological arguments that the pursuit of "approach" goals is more productive than the pursuit of "avoidance" goals (Mann, Webster, Schofield, & Marshall, 2004) and that sexual offender treatment should adopt a broader focus on improving the quality of an offender's life (Ward & Stewart, 2003). In the interests of brevity we have chosen to reflect on five examples that represent this approach.

*Responsibility versus blame*

As we described earlier, personal responsibility is a hallmark of democratic TCs. Responsibility and accountability are also considered important factors in sex offender treatment. Related to responsibility and accountability is the construct of personal agency. Personal agency, in turn, marries the construct of "readiness" for treatment (Ward, Day, Howells, & Birdgen, 2004) to the energies that are put into active participation to achieve treatment outcomes (see Melnick, De Leon, Thomas, Kressel & Wexler, 2001). We, therefore, take the view that opportunities in the TC to promote and enhance a sense of personal agency within an anti-abusive, pro-social milieu should be a central theme for this work. The concept of "ownership" of offending is central to most sexual offender programs; that is, where sexual abuse has occurred, there is a requirement for the acceptance of full and sole responsibility by the perpetrator (cf., Maruna & Mann, 2006). According to this precept, there is no-

one and nothing else to blame; to think otherwise can contribute to a justification for offending. In terms of transferring this notion into the prison yard and other custodial settings, this requires that the individual takes on, as far as is practicable, personal responsibility for his daily life; for the inputs and outcomes. Building a sense of personal empowerment, we contend, engenders a sense of personal efficacy often missing from the qualities of those who sexually offend.

*Respect versus Abuse*

Failure to respect the rights and needs of the other as a human being is arguably an important component of sex offender treatment. Sexual victimization involves a wide range of power and control techniques and strategies, ranging from the subtle to the obvious. Therefore, acknowledging the contribution, the worth and the dignity of one another through one's everyday conduct is an expression and an expectation of the sex offender TC culture. Respect, of course, should be a bi-directional quality that is evident in, among other permutations, custodial officers' communication with offenders and from therapy team members to custodial staff.

*Openness versus concealment*

Glaser and Frosh (1993) suggested that group treatment was the most appropriate treatment method with sexual offenders as it breaks down the secrecy inherent in sexual offending. Sexually abusive behaviour thrives in a context of secrecy and silence. Where this is broken, even an enduring pattern of sexual abuse is likely to cease. In secure settings, fear, intimidation, and victimization thrive where deaf ears and blind eyes are turned. In any context, openness, through courage and a willingness to challenge, is poisonous to abuse. In the sex offender TC there is an expectation of openness, directness (incorporating assertiveness) and honesty, which might well be absent from the typical interpersonal dealings of offenders. Our combined clinical experience suggests that where this tide is turned, mainstream prisoner codes begin to unravel, as offenders refuse to remain silent about evidence of, for example, a physical or sexual assault.

*Collaboration versus collusion*

Collusion assists abuse by contributing to the acceptability of offence-process thinking: attitudes, beliefs that are tolerant of, say sexual contact between adults and

children. Collaboration and co-operation contribute to a sense of connectedness and attachment, defeating the alienation and isolation that are often the forerunner to sexually abusive behaviors. We note that collaboration in clinical work with sexual offenders is an area receiving increased attention for its relative importance (see Shingler & Mann, 2006).

*Support versus grooming*

Grooming is a component of the build-up to sexual offending (particularly so with offenders against children), typically presenting preparation for victimization as personal care and nurturance. In the secure setting, patterns of interpersonal conduct masquerading as altruism or friendship can turn out to be the forerunner to exploitation. A culture of genuine support is achieved through a willingness to challenge members to take on responsibility as well as a publicly-displayed attitude of care and concern for individuals and the institutional community.

A strong underlying social therapy model is also considered essential to the functioning of a TC. Consistent with interpersonal theory, Bell (1994), for example, construes the TC as intervening in the client's impaired ability to connect with others. With the potential of the TC environment to establish a climate of trust, residents are able to reactivate and reconstruct these connections. Bell describes how residents undergo the process of dynamic interpersonal learning (described by Leszcz (1992), Yalom (1985) and others). According to this description, initially the resident will typically experience threat from his immersion in the interpersonally demanding milieu, activating feelings of helplessness, related to early experiences of abandonment and victimization. He will then resort to habitual but exacerbating responses. As he is confronted with the impact of these responses in the carefully constructed environment, so he learns to face up to his vulnerability and to modify adaptively his interpersonal style. In this way, distorted perceptions of relationships between self and others are laid bare, and are disconfirmed within the social microcosm of the TC. This hypothesized process mirrors that hypothesized to occur in the microcosm of psychotherapeutic groupwork.

*Maintaining the wellbeing of community members*

We have argued here that the TC modality holds considerable promise to enhance the treatment of sex offenders by promoting anti-abusive and pro-social

principles. We have maintained this is achieved by a sustained attention to issues that arise in the natural life of the community. This involves sustained and active, sometimes contentious, challenges to matters, events, habits and practices related to an abusive lifestyle. We consider this process to contribute to the social wellbeing of those who undertake such programmes, and ultimately to the safety of the community.

In this process, the staffing components of the community – particularly professional treatment providers and custodial staff – become exposed to both distressing content and unpleasant interpersonal behaviour, often in protracted, intimate and invasive circumstances. Staff members also tend to experience the effects of social stigma by association with the sex offender population.

Some recent literature has taken an interest in the impact of working therapeutically with sex offenders (for a review, see Clarke & Roger, 2002). Shelby, Stoddart and Taylor (2001) in the US, and Clarke & Roger (2007) in the UK have, in the respective jurisdictions, explored and conceptualized factors surrounding this matter. They have uniformly concluded that, while this work confers unique satisfactions, it holds considerable risk, with implications for personal wellbeing (such as emotional depletion and depersonalization) as well as treatment effectiveness. Indeed, those working in a prison context are seen to be at particular risk (see Shelby, Stoddart & Taylor, 2001). In investigating this domain, authors have considered protective responses, with implications for the screening and training of staff and means by which the important factor of organisational support can be maximized.

With respect to the sex offender TC, there are clearly both elevated risks and enhanced protections against the insidious aspects of this work. The identification of common goals in the TC (such as the practice of respectful relationships) and the considerable team-based forums (community meetings, shared staff meetings) provide the basis of a cohesiveness and singleness of purpose that might be lacking where aspirations are less explicitly articulated.

From the practice and research experiences of the current authors, shared training can also enhance these functions, as well as providing a basis for countering experiences of disgust, fear, anger, alienation and frustration that tend to be generated in the work. Such forums also offer opportunities for the "public" recognition of therapeutic progress and teamwork. Of especial note with regard to individual and group wellbeing in the TC is the case of custodial staff. While occupying an interstitial position and multiple roles as both custodian and "community therapist",

the prison officer role is accorded an enhanced status by virtue of its multi-layered professionalism. This is more likely to happen of course if this role is supported and promoted by the organization, both hierarchically and collegially. For this reason, it is important that corrections organizations offer integral training, credence and recognition to the rehabilitative function of custodial their staff.

Summary & concluding comments

Sexual offender treatment programs, particularly for high risk offenders, are often facilitated in secure settings such as a prison or psychiatric hospitals. Although arguably not ideal from a therapeutic perspective, such environments when structured as TCs may in fact provide enhanced therapeutic opportunities. We have argued that the use of TCs with sexual offenders can enhance treatment effectiveness, although this is as yet empirical untested. We have reviewed the existing evidence as to the effectiveness of TCs with offenders in general and more specifically with sexual offenders, concluding that there is positive evidence for their use. In describing the benefits and rationale for employing TCs in conjunction with cognitive behavioral treatment with sexual offenders, we have suggested that there are a number of specific advantages of TCs that may add to the effectiveness of cognitive behavioral treatment programs. Specifically, we have argued that TCs are an ideal environment to deliver the content of sex offender treatment and that they provide for an extension of the important group therapy process. TCs provide secure environments where a broad range of treatment opportunities are exploited in a constructive therapeutic "framework", 24 hours a day, seven days a week.

We believe that the most obvious conclusion from this review is that more research is needed as important questions still remain. If the benefits of TCs for sexual offenders are as compelling as we have suggested why are they not used more extensively? More specifically, do these benefits actually exist? While intuitively attractive, supported by practice experience and based on sound psychological theory, they need to be rigorously evaluated. Ideally, the sexual offender field would produce studies whereby offenders are randomly allocated to TCs or non-TC units within which the same cognitive-behavioral treatment is delivered. Of course, we acknowledge that there are practical difficulties in and ethical obstacles to doing so. These, and other, TC-related research questions are important issues to explore as we

continue to strive for the enhancement of treatment effectiveness, and we hope that this review will stimulate research interest in the future.

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