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Efficacy of Group Versus Individual Treatment of Sex Offenders

Jan Looman
Correctional Service of Canada.

Jeffrey Abracen
Correctional Service of Canada.

Roberto Di Fazio
Correctional Service of Canada.

Abstract

There is debate in the literature as to the relative efficacy of group versus individual treatment of sex offenders. Nonetheless, there has been relatively little empirical research on this topic to date. The current study examined the efficacy of the Regional Treatment Centre (Ontario) Sex Offender Program (RTCSOP), which consisted of group plus individual therapy (i.e., full treatment program), versus individual therapy alone (i.e., individual treatment program). The treated sample consisted of individuals deemed to be at high risk of recidivism based on actuarial assessment and/or as presenting with significant treatment needs (i.e., serious psychiatric disorder). A group of 76 sex offenders who were provided with both group and individual treatment was matched to a group of 76 sex offenders who were provided with an individual treatment program alone. Results indicated that treatment outcome, as measured by rates of sexual, violent and general recidivism, did not differ between the two treatment groups. Both the full treatment program as well as the individual treatment program used in this study appeared to be equally effective methods of treatment based on follow-up. Differences between the groups, which might help to explain these results, are discussed.

Until recently researchers have debated whether sex offender treatment is effective at reducing recidivism (e.g., Hall, 1995; Looman, Abracen, & Nicholaichuk, 2000; Marshall, Anderson & Fernandez, 1999; Quinsey, Harris, Rice, & Cormier, 1998). Although there appears to be an emerging consensus regarding the potential efficacy of sex offender treatment (see below for discussion) this debate has sidetracked discussion regarding a number of other important treatment issues. One such issue involves the relative merits of group versus individual treatment of sex offenders.

It seems clear that, based on the available research, cognitive-behavioral treatment using contemporary approaches can reduce recidivism relative to comparison groups (Hanson, Gordon, Harris, Marques, Murphy, Quinsey & Seto, 2002; Losel & Schumcker, 2005). Nonetheless, issues such as the relative efficacy of individual versus group treatment have received rather sparse attention as demonstrated by the above review of the literature. Ware, Mann & Wakeling (2009) recently reviewed the sex offender treatment literature regarding treatment modalities and found only one study comparing group to individual approaches (DiFazio, Abracen & Looman, 2001). However, this study was seen as inadequate to draw conclusions regarding the issue of the best modality due to methodological concerns (see discussion below). Overall, Ware et al. concluded that while further research is needed, group therapy approaches are probably superior to individual.

With reference to individual treatment several studies authored by Maletzky have reported (e.g., Maletzky, 1993; 1998) the relative efficacy of individual relative to group cognitive-behavioral treatment. Nonetheless, Maletzky himself (1999) has noted that these studies were retrospective, uncontrolled and geographically limited. Craissati and McClurg (1997) found that, with reference to certain outcome measures, those sex offenders treated in-group or individual treatment settings improve to similar degrees. Maletzky and Prueitt (1995; as cited in Maletzky, 1996) found that group treatment was more effective at reducing denial than was individual treatment. Although not specifically related to the issue of individual versus group treatment, Marshall (1994) also found that group treatment was effective at reducing denial.

It may be that group treatment is often chosen due to extrinsic factors such as therapist convenience, scheduling, and cost-effectiveness (Maletzky, 1999; Schwartz, 1995). Group therapy assists in the development and practice of social skills (Maletzky, 1999), and facilitates disclosure (Blackburn, 1993) which may allow group members to recognize their own criminogenic patterns. In addition, group therapy provides an avenue for peer confrontation of clients' attitudes and cognitions (Williams, 1995). Although not unimportant some of the above mentioned concerns

Correspondence: Dr. Jeffrey Abracen, Department of Psychology, Regional Treatment Centre (Ontario), 555 King Street West, P.O. Box 22, Kingston, Ontario, K7L 4V7, Canada. Email: AbracenJA@CSC-SCC.GC.CA

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(e.g., convenience) appear to be generated by pragmatic concerns and not treatment efficacy (Maletzky, 1999).

In spite of the many positive aspects associated with group treatment, these approaches are not beyond criticism. For example, Maletzky (1999) discusses the "tyranny of the group" (p. 179). That is, allowing the group to make important decisions regarding treatment-related issues (e.g., the adequacy of a disclosure). In extreme cases, such "tyranny" may impact upon whether an offender is permitted to remain in treatment. Individual treatment offers an opportunity to explore parameters of the crime cycle and relapse prevention in greater detail than traditional treatment programs. Additional treatment components which can be addressed include overcoming a client's initial reticence and anxiety, as well as circumventing certain issues when cognitive capacity is a concern (Schwartz, 1995). Further, individual therapy offers the advantages an enhanced sense of confidentiality and provides the therapist with the opportunity to continually reassess how each patient is progressing (Maletzky, 1999; Schwartz, 1995). At the same time, individual therapy is considered time-consuming, labor-intensive, expensive, and provides less opportunity to learn empathy or help others (Maletzky, 1999; Schwartz, 1995).

Given the idiosyncratic nature of sexual response it may be that individual treatment is at least as effective as traditional therapeutic approaches, particularly when dealing with clients who are perhaps more fragile than others (e.g., due to mental illness or intellectual handicap). This would certainly be in keeping with the responsivity principle as outlined by Andrews and Bonta (2010) in that it would allow therapists to provide the type of treatment which might be most effective for these groups of offenders, including flexibility with reference to the pace of therapy. This, as well as the way in which cognitive distortions and discrepancies between client version of events and official records are handled are of paramount importance when dealing with fragile clients.

Previous research by our team (Looman et al., 2000) found a greater than 2:1 ratio (51.7% vs. 23.6%) for sexual recidivism with reference to untreated and treated sexual offenders, respectively, for clients treated at the Regional Treatment Centre (Ontario) Sex Offender Program (RTCSOP). The RTCSOTP was an inpatient sexual offender treatment program housed within a residential psychiatric treatment facility located on the grounds of a maximum security Canadian federal penitentiary. Prior to its being discontinued in 2011, the RTCSOP was the oldest continuously run sex offender treatment program offered by the Correctional Service of Canada. From its inception in 1973, Dr. W.L. Marshall designed the program for offenders deemed to be at high-risk for sexual recidivism or who presented with significant treatment needs or both. Rather than treat offenders for an extended period of time (i.e., years) it was felt, from the outset, that a time-limited treatment program of relatively short duration would be the preferable mode of treatment delivery. Given the available resources it was felt that providing a larger group of offenders with treatment made more sense than providing in-depth treatment to a small number of clients (Dr. S. Williams, 2000; Personal Communication).

The RTCSOP included some of the essential features Andrews and Bonta (2010) include as components of effective forensic treatment programs: (1) treatment service is delivered to higher-risk individuals, (2) criminogenic needs are targeted for change, (3) treatment focuses on behavioral and social learning principles (e.g., modeling, role playing, detailed verbal guidance and explanation). Last, issues related to client responsivity need to be considered. That is, treatment programs should be delivered in a style that is consistent with the ability and learning mode of the offender.

The present research investigated the impact of a full treatment program versus an individual treatment program with high-risk/high-need sexual offenders. The full treatment program consisted of group plus individual therapy. The dependent measure, that is, treatment outcome, used in this study was offenders' rate of sexual recidivism. The RTCSOP meets the basic requirement of being sensitive to a client's level of treatment risk, need and responsivity.

In keeping with the responsivity principle, clients who were assessed as being unable to attend the full treatment program were offered the opportunity to attend individual therapy only (i.e., the individual treatment program). Typically, individuals were placed in the individual treatment program due to intellectual handicaps and/or psychiatric disabilities. In this study, the expectation, given the additional contact hours provided to the participants in the full treatment program, was that treatment outcome would be better for those participants relative to those individuals provided the individual treatment program only.

The current research was conducted in follow-up to a previous study (DiFazio, et al. 2001) in which a group of 143 men who completed the full RTCSOTP were compared to a group of 62 sex offenders who received only individual treatment. That study found that there were no differences between the groups in terms of recidivism. However, the subjects were not matched on risk to re-offend or offence type, and no data were presented regarding the reason for individual treatment. Men are provided individual treatment for a variety of reasons, including responsivity issues such intellectual disability, psychiatric impairment; but also practical reasons such as entering treatment too late to complete

the group program. These shortcomings make it difficult to draw conclusions from the results of the study.

Method

Participants

All offenders who participated in the present study were referred to the RTCSOP for treatment in the period between January 1, 1989 and January 1, 2010.

In total, 152 offenders were included in the sample, with 76 men in each of the individual and group samples. Men were matched on offence type (child molester vs. pubescent victims vs. adult rapist) and Static-99R score (Helmus, Thornton, Hanson & Babchishin, 2012). Men were included in the Individual Therapy group only if they were placed in that stream due to responsivity issues such as psychiatric difficulties or intellectual impairment.

Description of the Program

There are three primary components to the RTCSOP programs: group therapy, individual therapy, and milieu therapy.

Treatment Approaches

Full treatment program. Clients in the full sexual offender program received both individual and group treatment relating to a variety of topics including victim awareness, self-management skills, social skills and relationship skills. Treatment personnel at the RTCSOP consisted of both psychologists and nursing staff. The full treatment program lasted approximately 30 weeks. Deviant sexual arousal was targeted directly using cognitive-behavioral strategies including covert sensitization and arousal reconditioning. The group setting consisted of a maximum of 12 offenders. These individuals were provided two or three group sessions per week with a psychologist and two group sessions with nursing staff. The number of individual sessions a client attended was determined by an individual's respective needs. Each of the individual sessions lasted approximately one hour. Individual sessions with nursing staff were scheduled on an as needed basis. Sessions with the nurses typically dealt with issues in day to day living (interpersonal problems, coping with urges to use drugs, problem solving personal issues). The content of individual sessions varied. With lower functioning clients (i.e., cognitive impairment), a number of individual sessions may have been dedicated to discussing material presented in group and clarifying any issues about which the client was confused. In other cases, clients may have needed to confront issues associated with minimization and denial in more detail than could be discussed in group. Additionally, a number of sessions may have been dedicated to the discussion of thoughts and behaviours related to institutional maladjustment (e.g., impulsive or manipulative behaviours). This last issue was particularly true for individuals who met the criteria for psychopathy as measured by the Hare Psychopathy Checklist-Revised (Hare, 2003). Finally, all clients attending the full treatment program were provided the benefits associated with living in a therapeutic milieu (see details below).

Individual treatment program. As noted above, individuals who were not considered appropriate referrals for the full treatment program were screened into the individual treatment program. Clients assigned to the individual treatment program were provided two individual sessions a week with a psychologist, with each session being approximately one hour in length. In some cases sessions lasting only one-half hour were offered to clients considered unable to attend the full one hour treatment sessions. Sessions with nursing staff were scheduled on an as needed basis. As with the clients in the full treatment program, the individual treatment program emphasized a cognitive-behavioral approach. Typically, an attempt was made to discuss the same issues which were presented in the full treatment program. Nonetheless, the material may not have been covered with the same level of detail due to psychiatric and/or cognitive impairments. Basic information related to relationship skills and the relapse prevention component of the full treatment program was typically discussed with individual treatment clients.

The approach taken in the individual treatment program was most often concrete except when dealing with higher functioning clients. Due to the more didactic nature of the individual treatment program, the therapist may have spent more time than in the full treatment program on fostering rapport, discussing the fact that intimacy and sex are not equivalent, accepting one's physical/psychiatric limitations, and striving to increase a client's self-esteem. The issues associated with the therapeutic relationship were particularly important for the individual treatment program clients given the fragile nature of many of these individuals. Further, all clients attending the individual treatment program were provided the benefits associated with milieu therapy.

Milieu therapy. The residential nature of the program was considered to be an integral part of the treatment approach. In addition to the full and individual treatment components nursing staff spent at least two hours per shift on the unit. Interactions with clients were either formal or informal. Aside from reinforcing the behaviours discussed in group or individual therapy, nursing staff were able to monitor

the behaviour of clients when the clients were not engaged in therapy. Any inconsistencies between what clients said regarding their behaviour in group or individual sessions and their actual behaviour on the unit were discussed.

Procedure

Individual and full treatment groups were compared with reference to type of sexual offence. Participants were coded, based on their sexual offending histories, as adult rapists (victim 16 years or older), child molesters (victims 12 years or younger), pubescent victims (victims 13-15 years of age), and incest offenders (i.e., offending against a family member). Based on these classifications, 29 (38.7%) men from each group were adult rapists; 8 (10.7%) of the group subjects and 7 (9.2%) of the individual subjects had pubescent victims; 22 from each group (29.3%) were child molesters; 7 from each group (9.3%) were incest offenders; while the remainder had victims from multiple categories. None of the differences between groups reached acceptable levels of significance.

Results

Demographic Variables

Analyses were conducted to determine similarity between the two samples of participants. Groups were compared on age at first conviction, age at assessment for the program, pre-treatment number of sexual offences, pre-treatment number of violent offenses, pre-treatment number of non-violent offenses, age at time of release following treatment at the RTCSOP and the Static-99R score. As can be seen by reviewing Table 1, the groups did not differ on any of these variables.

Psychiatric Profiles

As noted above, men were selected for the Individual treatment group based on an inability to function effectively in a group setting due to some type of impairment. Groups were compared on psychiatric diagnoses and intellectual functioning (coded low, borderline or average), based on coding from a file review. The results are presented in Table 2. In terms of level of functioning, the Group treatment men were more likely to be of average functioning, while the Individual clients were more likely to be low functioning (χ^2 (2) = 33.23, p = .000). Regarding psychiatric diagnoses, the Individual therapy clients were much more likely to have Schizophrenia or a Severe Personality Disorder as their primary diagnosis, while the Group clients were more likely to have a Paraphilia or Antisocial Personality Disorder as their primary diagnosis (χ2 (8) = 78.07, p = .000). There were no differences in terms of rates of substance abuse.

Recidivism

Follow-up analyses were performed among those sex offenders released to the community. For the purpose of the present analyses, all offences not classified as sexual according to the Criminal Code of Canada were grouped under the headings of violent or non-violent offences. The follow-up periods in years were M = 6.7 (SD= 5.2) for the participants in the full treatment program and M = 6.5 (SD = 4.9) for those participants in the individual treatment program. Recidivism rates were compared via Chi-squared analyses. Of the men in the Group program, 5 (11.4%) sexually re-offended, while 15 (26.3%) of the Individual therapy clients re-offended (χ2 (1) = 3.50, p = .06). For violent, including sexual, recidivism 12 (27.3%) of the Group treatment men re-offended, while 18 (34.0%) of the Individual treatment men re-offended. This difference was not significant (χ2 (1) = 0.50, p = .478). For general (i.e., non-violent, non-sexual) recidivism, a similar result was found. Twenty (43.5%) of the Group clients re-offended in this manner, while 26 (46.4%) of the Individual therapy clients re-offended (χ2 (1) = 0.09, p = .766).

In order to control for the differing periods of follow-up, as well as to account for group differences in diagnoses and intellectual functioning, a Cox Regression analysis was conducted. For purposes of these analyses, low-frequency diagnoses were collapsed into an “Other” diagnosis group. Results indicated that there was no significant difference in the rates of recidivism for the two groups accounting for level of functioning and diagnosis (χ2 (8) = 12.13, p = .145). Results are displayed in Table 3.

The same analyses were conducted for violent, including sexual, recidivism as an outcome, with similar results obtained. There were no differences in the rates of recidivism for the two groups (χ2 (8) = 11.29, p = .186). Results of the analysis are displayed in Table 4.

Similar results were obtained for the general recidivism outcome (χ2 (8) = 7.81, p = .452), however for space reasons the results will not be displayed.

Discussion

The present study addressed the relative efficacy of group versus individual treatment with sexual offenders. A group of high-risk/high-need sex offenders who attended the full RTCSOP (i.e., group plus individual therapy) or an Individual treatment program were compared in order to examine this issue. Contrary to prediction, no group differences emerged with

Table 1
Demographic Variables by Group

	Full treatment			Individual treatment			
Demographic Characteristics	M	SD	n	M	SD	n	*t*
Age at first conviction	22.3	11.0	71	22.6	10.7	67	0.89
Age at assessment	41.8	11.3	71	42.2	11	67	-0.12
Pre-treatment number of sexual offences	4.1	5.8	71	3.4	3.0	67	0.89
Pre-treatment number of violent offences	1.9	2.0	71	1.9	2.3	67	-.14
Pre-treatment number of non-violent offences	11.2	13.0	71	17.1	23.3	67	-1.87
Age at time of release	40.7	10.3	67	43.3	10.1	67	-1.24
Static-99R	4.6	2.3	48	4.4	2.4	46	0.35

Table 2
Psychiatric Diagnoses by Group

	Group *N*(%)	Individual *N*(%)
Schizophrenia	1 (1.7)	10 (13.5)
Severe PD	2 (3.3)	28 (37.8)
Mood Disorder	0	5 (6.8)
Head Injury	0	5 (6.8)
Paraphilia	23 (38.3)	3 (4.1)
ASPD	20 (33.3)	0
No Diagnosis	14 (23.3)	21 (28.4)
Substance Use	47 (68.1%)	47 (75.8%)
Level of Functioning		
Low	0	39 (52.0)
Borderline	9 (23.7)	15 (20.0)
Average	29 (76.3)	21 (28.0)

Table 3
Cox Regression Analysis Examining Sexual Recidivism

	B	SE	Wald	df	*p*	Exp(B)
Individual vs Group Treatment	-.304	.438	.482	1	.488	.738
Level of Functioning			.050	2	.976	
Borderline	.049	.360	.019	1	.891	1.051
Average	.079	.381	.043	1	.836	1.082
Diagnosis			8.706	5	.121	
Severe PD	1.233	.504	5.987	1	.014	3.433
Other	.142	.377	.141	1	.707	1.152
Paraphilia	-.631	.555	1.293	1	.256	.532
Antisocial PD	.187	.443	.179	1	.673	1.206
No diagnosis	.168	.483	.121	1	.728	1.183

Table 4
Cox Regression Analysis Examining Violent, Including Sexual Recidivism

	B	SE	Wald	df	*p*	Exp(B)
Individual vs Group Treatment	-.626	.498	1.581	1	.209	.535
Level of Functioning			.348	2	.840	
Borderline	-.035	.401	.008	1	.930	.965
Average	.214	.439	.237	1	.627	1.238
Diagnosis			7.693	5	.174	
Severe PD	.604	.529	1.306	1	.253	1.830
Other	-.305	.420	.527	1	.468	.737
Paraphilia	-1.421	.677	4.408	1	.036	.241
Antisocial PD	.189	.491	.149	1	.699	1.209
No diagnosis	-.007	.580	.000	1	.990	.993

reference to rates of sexual, violent or general recidivism.

It is interesting to note that in the Cox Regression analysis for sexual recidivism, although the overall analysis did not reach significance, for the diagnosis variable, the E(B) value for Severe Personality disorder was 4.01, Wald = 7.14, p = .008. Again, this was an isolated finding in an overall non-significant analysis, however it suggests that those offenders with severe personality disorders are four time more likely to re-offend sexually than those diagnosed with schizophrenia. A similar trend was not noted for other outcomes.

As expected based on the selection criteria for men receiving Individual treatment, the Individual clients were more likely to suffer from major mental illnesses, especially schizophrenia, as well as more likely to be intellectually impaired and to have suffered a head injury. Men in the Group program were more likely to suffer from a Paraphilia and to have a diagnosis of Antisocial Personality Disorder. This is not to say that men in the Individual therapy stream did not suffer from paraphilias, only that it was not their primary diagnosis.

Of interest was the fact that no significant differences in rates of sexual recidivism between groups emerged even though the intensity of the treatments provided to the samples was substantially different. Overall, clients in the Individual treatment program received less total treatment (i.e., direct contact hours) than did those clients in the full treatment program. It has been our experience that many individuals who attend individual therapy are very deficient in social skills and appear to have significant difficulty achieving intimate relationships. Whether individual therapy clients are, in fact, more deficient in these domains is an empirical question which will be investigated in future studies by our team. Nonetheless, the present data are in keeping with this hypothesis. That is, for this group, the primary criminogenic needs may relate to social and relationship skills development. Although issues associated with more traditional criminogenic needs were addressed (e.g., offence supportive attitudes, deviant sexual arousal, antisocial associates) they were clearly not present in the same detail as with individuals attending the full treatment program. The focus of treatment (both in the individual and milieu components of the program) with these clients tended to be social and relationship skills.

Implications

The present data highlight the importance of responsivity issues. Some high-risk/high-need clients may indeed be sufficiently well served by a full treatment program. Nevertheless, in having group therapy as the sole treatment modality available for all types of sex offenders, we may not be meeting the responsivity needs of certain individual clients. We believe that those individuals who attended the individual therapy program would not have been able to function in the group environment. Further, these clients may have impeded the group process by requiring an unreasonable amount of therapist attention or being disruptive to the group process. It was our opinion that certain clients who attended the individual therapy component of the program would have been at increased risk of decompensating had they attended group. By allowing the clinician to moderate the amount or type of emotionally demanding material individual therapy offers clinicians an opportunity to titrate treatment to the needs of a given client.

In the end issues associated with responsivity and outcome need to be addressed. The present data indicate that when responsivity issues are addressed outcome may be unaffected and, in fact, treatment may be provided at a reduced cost. The reader should keep in mind that individuals in both programs received the same amount of individual treatment per week, but those receiving the individual treatment program did not receive any group treatment. It might be argued that if this is the case then why not offer individual therapy to all clients entering the RTCSOP. We believe that this would be an erroneous conclusion. The individuals attending the full treatment program tended to have greater criminogenic needs that those attending individual treatment. These treatment needs required the addition of certain modules that were not always discussed with individual therapy clients. Further, individual therapy may have extended beyond the 30 week period typically associated with the full RTCSOP. That is, individual therapy was catered to the needs of an individual client and followed a more idiosyncratic pattern including having a variable length. In some cases this resulted in less than 6 months of treatment whereas in others treatment extended beyond this time period.

Author Note

Roberto Di Fazio, Jeffrey Abracen, and Jan Looman, Correctional Service of Canada (CSC). Roberto Di Fazio (Ph.D., C. Psych.) is a psychologist associated with the Violence Prevention Maintenance Program with Regional Headquarters (Ontario). Jeffrey Abracen (Ph.D., C. Psych.) is a psychologist associated with the Research Branch of CSC located in Ottawa. Jan Looman (Ph.D.) is a psychologist and the program director of the RTCO sex offender program. All three authors have published in the area of sexual offender assessment and treatment. The opinions expresses in

this research do not necessarily reflect the views or policies of the Correctional Service of Canada.

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