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Review of the Empirical and Clinical Support for Group Therapy Specific to Sexual Abusers

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Abstract

This review compiles 48 empirical studies and 55 clinical/practice articles specific to group therapy with sex offenders. Historically, group therapy has always been the predominant modality in sex offender–specific treatment. In the first decades of the field, treatment applied a psychoanalytic methodology that, although not empirically supported, fully appreciated the primary therapeutic importance of the group modality. Conversely, since the early 1980s, treatment has applied a cognitive behavioral method, but the field has largely neglected the therapeutic value of interpersonal group dynamics. The past decade has seen a growing re-appreciation of general therapeutic processes and more holistic approaches in sex offender treatment, and there is an emerging body of empirical research which, although often indirectly concerned with group, has yielded three definitive conclusions. First, the therapeutic qualities of the group therapist—specifically warmth, empathy, encouragement, and guidance—can strongly affect outcomes. Second, the quality of group cohesion can profoundly affect the effectiveness of treatment. Third, confrontational approaches in group therapy are ineffective, if not counter-therapeutic, and overwhelmingly rated as not helpful by sex offenders themselves. Additional conclusions are less strongly supported, but include compelling evidence that sex offenders generally prefer group therapy over individual therapy, that group therapy appears equally effective to individual therapy, and that mixing or separating groups by offense type is not important to therapeutic climate. Other group techniques and approaches specific to sexual abuse treatment are also summarized.

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Introduction

Although group therapy has been the predominant modality used in the treatment of sex offenders for over five decades, there has been little research dedicated specifically to sex offender–specific treatment (SOST) groups. The reason, first posed as a challenge to the field 15 years ago by Sawyer (2000), is that the field has failed to appreciate the unique therapeutic potential of the group modality itself. Three years later, Jennings and Sawyer (2003) appealed to clinical practicality to argue for the unrealized therapeutic value of the group modality, but they lacked empirical studies specific to sex offender group treatment to support their assertion. Since then, however, a surge of 26 new studies with empirical data related to SOST groups have been published. In combination with new trends in the field, which emphasize a more holistic, multimodal approach to treatment (and that deemphasize a narrow cognitive behavioral focus on offense behavior and relapse prevention), the time may be ripe to revisit the unique value of group therapy in sex offender treatment.

The present review compiles 43 empirical studies, five empirical reviews, and 55 clinical/practice articles specific to group therapy with sex offenders (see Table 1). Beginning with a brief historical review of early SOST groups, the review categorizes the areas with the strongest empirical support for aspects of group therapy with sex offenders.

History and Early Group Work With Sex Offenders

The first published study of group therapy with sex offenders appeared in 1952. Bromberg and Franklin (1952) used group psychodrama with a population of 75 male "sexual deviates" who had been committed to a state psychiatric hospital for a variety of sexual offenses. Their primary conclusion was that an "open rift developed between the homosexual and heterosexual patients." It is notable that psychodrama is still being used today, over 60 years later, particularly the use of role-play (e.g., Daniels, 2005; Schwartz & Bergman, 1997).

Around the same time, Albert Ellis, a pioneer in the development of cognitive therapy, was first developing a new psychotherapeutic method that focused directly on beliefs. What few people know, however, is that Ellis was *driven to develop cognitive therapy by his work with sex offenders*. When Ellis graduated from Columbia in 1947, he was indoctrinated in psychoanalysis and continued his advanced psychoanalytic training under Karen Horney. In 1950, Ellis was hired as a chief psychologist in the New Jersey correctional system, where he was responsible for evaluating and treating large numbers of sex offenders. Ellis very quickly realized the limits of psychoanalytic treatment and began to experiment with directly challenging the logical and rational basis for the sex offenders' denial and distorted beliefs. He initially called his new

Table 1. Sex Offender-Specific Group Therapy Citations.

Type	Citations	Clinical population	Content code								
C	Allam, Middleton, and Browne (1997)	Probationed sex offenders (SOs)					5		7		
C	Anderson (1969)	Practice							7		9
E	Aylwin (2010)	95 outpatient SOs	1	2							
C	Aubrey and Dougher (1990)	Overview				4		6			
C	Barnett, Corder, and Jehu (1990)	Female SOs							7		
C	Bauman and Kopp (2006)	Overview		2					7		
E	Beech and Fordham (1997)	8 probation, 4 prison residential groups	1								
E	Beech and Hamilton-Giachritsis (2005)	7 community-based groups	1				5				
C	Brancale, Vinocolo, and Prendergast (1972)	Prison SOs			3				7		9
C	Bromberg and Franklin (1952)	75 SOs in state hospital							7		9
C	Cabeen and Coleman (1961, 1962)	120 SOs civil commit state hospital							7		9
E	Carpentier, Silovsky, and Chaffin (2006)	135 children, 5-12, sex behaviors								8	
C	Clark and Erooga (1994)	Child molesters	1								
C	Clark and Liddle (2012)	Outpatient SOs							7	8	
E	Colton, Roberts, and Vanstone (2009)	35 prison child molesters									
E	Connor, Copes, and Tewksbury (2011)	24 prison SOs			3						
E	Cook, Fox, Weaver, and Rooth (1991)	63 probationed, non-physical SOs									
C	Costell and Yalom (1972a, 1972b)	Pedophiles in state hospital	1	2			5	6			9
C	Cowburn (1990)	Mixed rapists and child molesters					5				
C	Daniels (2005)	Practice							7		
E	Davis, Marshall, Bradford, and Marshall (2008)	Prison and mentally ill SO groups	1								
E	Di Fazio, Abracen, and Looman (2001)	205 prison-based SOs				4					
E	Drapeau (2005); Drapeau, Körner, Granger Brunet, and Caspar(2005)	24 child molesters in prison, CBT		2	3						
C	Ellis (1961)	Prison and outpatient SOs			3				7		9
C	Erooga, Clark, and Bentley (1990)	Child molesters				4					
C	Etgar and Prager (2009)	Adolescent gang rapists								8	

(continued)

Table 1. (continued)

Type	Citations	Clinical population	Content code							
C	Frey (1987)	Outpatient incest offenders					6	7		
C	Frost (2000)	Overview		2						
E	Frost (2004), Frost and Connolly (2004)	16 child molesters		2						
C	Frost, Ware, and Boer (2009)	Overview								
C	Ganzarain and Buchele (1990)	20 outpatient incest offenders					6	7		
E	Garbutt and Palmer (2016)	277 prison SOs		2						
E	Garbutt and Hocken (2014)	Prison SOs		2						
E	Garrett, Oliver, Wilcox, and Middleton (2003)	13 in prison and 29 probationers				4				
E	Grady and Swett (2014)	44 and 26 prison SOs		2						
C	Griffin, Williams, Hawkes, and Vizard (1997)	Young sexual abusers						7	8	
E	Haines, Herrman, Baker, and Graber (1986)	Juvenile SOs in detention center							8	
E	Halse et al. (2012)	12 adolescent intrafamilial SOs				4			8	
ER	Harkins and Beech (2007)	Review			3					
E	Harkins and Beech (2008)	73 SOs					5			
E	Harkins, Beech, and Thornton (2012)	Psychopathic SOs	1							
C	Hartman (1965a, 1965b)	7 "chronic pedophiles" outpatient				4				9
ER	Holdsworth, Bowen, and Brown (2014)	Review		2						
E	Houston, Wrench, and Hosking (1995)	2 groups of child molesters	1							
E	Hudson (2005)	Prison child molesters			3	4		7		
C	Jennings (2015)	Practice					6			
C	Jennings and Deming (2013)	Practice					6	7		
C	Jennings and Sawyer (2003)	Practice					6	7		
C	Johnson and Lokey (2007)	Practice					6	7		
E	Levenson and Macgowan (2004)	61 outpatient using CBT group		2						
E	Levenson, Macgowan, Morin, and Cotter (2009)	338 outpatient SOs		2	3	4				
E	Levenson and Prescott (2009)	44 Wisconsin SVPs			3	4				
E	Levenson, Prescott, and D'Amora (2010)	88 outpatient SOs	1	2	3					
E	Levenson, Prescott, and Jumper (2014)	113 Illinois SVPs			3	4				
C	Lindquist (2001)	Female adolescent SOs						7	8	
E	Lothstein (2001)	109 outpatient SOs						7		
E	Macgowan and Levenson (2003)	61 outpatient SOs		2						

(continued)

Table 1. (continued)

Type	Citations	Clinical population	Content code								
C	Maletzky (1999)	Practice				4					
C	Mamabolo (1996)	Juvenile SOs in secure detention								8	
C	Marcus (1971), Marcus and Conway (1971)	10 "dangerous" SOs in prison			3				7		9
E	Marshall (2005)	Prison SO groups		2	3						
ER	Marshall and Burton (2010)	Review		2	3						
C	Marshall, Burton, and Marshall (2013)	Overview	1	2	3	4					
E	Marshall et al. (2003)	Prison SO groups		2	3						
E	Marshall et al. (2002)	Prison SO groups		2	3						
E	Morgan, Ferrell, and Winterowd (1999)	159 group therapists, 78 prisons		2							
C	Nahum and Brewer (2004)	Adolescent SOs							7	8	
C	Newbauer and Blanks (2001)	Adolescent SOs							7	8	
C	O'Reilly, Morrison, Sheerin, and Carr (2001)	Adolescent sex abusers								8	
E	Peters and Roether (1972)	Probation, mostly exhibitionists	1								9
E	Peters, Pedigo, Steg, and McKenna (1968)	92 probationed SOs									9
C	Prendergast (1978)	Rapists in prison						6	7		9
C	Prescott (2008)	Civilly committed Wisconsin SVPs						6	7		
E	Quinsey (1977)	Review				4					
C	Reddon, Payne, and Starzyck (1999)	100 sex offenders, overview		2						8	
E	Reimer and Mathieu (2006)	34 prison SOs	1	2							
C	Resnik and Peters (1967)	25 child molesters outpatient					5				9
C	Rich (1994)	Overview						6			
E	Roether (1972)	Probationed SOs									9
E	Romero and Williams (1983)	231 probationed SOs							7		
C	Sawyer (2000, 2002)	Practice						6			
C	Sawyer and Jennings (2014)	Practice						6	7		
ER	Sawyer and Jennings (2016)	Empirical review and clinical practice	1	2	3	4	5	6			9

(continued)

Table 1. (continued)

Type	Citations	Clinical population	Content code
C	Sawyer and Prescott (2011)	Practice	6
C	Schwartz (1995)	Overview	
C	Schwartz and Bergman (1997)	Practice	7
C	Schwartz and Cellini (1988)	Overview	3 5 7 9
E	Sribney and Reddon (2009)	67 inpatient adolescent SOs	1 8
C	Steg, Wright, and Peters (1972)	Probationed SOs	7 9
E	Thornton, Mann, and Williams (2000)	Prison SO groups	2 3
E	Tregaskis (2000)	Adult sex abusers	4 5
C	Walker (2000)	Practice	7
C	Ward and Groener (2015)	High-risk antisocial outpatient SOs	6
C	Ward, Mann, and Gannon (2007)	Overview	7
ER	Ware, Mann, and Wakeling (2009)	Review	4
C	Whitford and Parr (1995)	Adolescent sex offenders	7 8

Key	Total	Key	Total
C = Clinical 55		1 = Group cohesion	15
E = Empirical 43		2 = Group therapeutic climate and therapeutic factors	27
ER = Empirical Review 5		3 = Confrontation contraindicated	21
		4 = Group preferred and advantages over individual	17
		5 = Mixed versus single offender type groups	10
		6 = Detailed guidelines for group practice	18
		7 = Alternative approaches/ techniques beyond CBT	34
		8 = Adolescent SOST groups	14
		9 = Published before 1972 or containing historical info.	20

Note. CBT = cognitive behavioral therapy; SVP = sexually violent predators.

approach "rational therapy" (later termed Rational Emotive Therapy in 1955, then Rational Emotive Behavior Therapy). At a time when the treatment of sex offenders was deemed useless, Ellis (1961) was one of the first to declare that "unusually good results can often be obtained if the therapist employs a *highly directive, rational psychotherapeutic approach*" (p. 953, emphasis added). In addition to his broader interest in sexuality and marriage, Ellis published seven articles and a book about the treatment of sex offenders between 1951 and 1961. He also experimented with his new cognitive methods with sex offender groups, but did not publish about it.

The important point is that the tradition of confronting denial is rooted in the earliest historic attempts to treat sex offenders and was the inspiration and impetus for the development of Ellis's prototype for cognitive therapy. In turn, Aaron Beck has acknowledged that he was specifically influenced by Ellis's focus on beliefs in the development of his own cognitive behavioral therapy (CBT) in the early 1960s. This helps to explain why CBT was so rapidly embraced by the SOST field in the early 1980s as its primary methodology of treatment—and remains predominant today.

The next published studies about group therapy with sex offenders do not appear until the early 1960s. Cabeen and Coleman (1961, 1962) published two studies of offenders committed to Metropolitan State Hospital in the late 1950s under the Sexual Psychopath Act in California. Cabeen and Coleman conducted psychoanalytic therapy groups within the context of the therapeutic community (TC) model, but acknowledged doubt that treatment had made any significant impact. During the same period, another group therapy TC program for sex offenders was instituted at Atascadero State Hospital (Schultz, 1965; Schwartz & Cellini, 1988).

By the mid-1960s, Hartman (1965a, 1965b) declared that "group psychotherapy may be regarded as the treatment of choice for certain types of personality disorders, pedophilia being one of them" (quoted in Quinsey, 1977, p. 213). In this 4-year group treatment of seven pedophiles, Hartman affirmed that the most powerful impetus to meaningful engagement and disclosure was the "peer influence" of other pedophiles, which was not possible in individual therapy.

Two years later, in Philadelphia, Resnik and Peters (1967) published a study of 24 child molesters treated with outpatient psychoanalytic group therapy. They described four stages of group development, beginning with mistrust of the therapist, followed by development of peer bonding, and then exploration of their relationships with women (all but one had female child victims). The last stage was described as improving attitudes toward authority and self-esteem. Encouraged by a decline in re-arrests after therapy, Peters and colleagues conducted a large study that compared 92 sex offenders receiving psychoanalytic group therapy and probation with 75 sex offenders receiving probation alone. Of the latter group, 27% committed crimes other than sex offenses, as compared to 3% of the group therapy clients (Peters, Pedigo, Steg, & McKenna, 1968). Four years later, however, they repeated the study and the treated group had a higher rate of re-offense (Peters & Roether, 1972).

Like Hartman (1965a), Peters and the Philadelphia group asserted that *peer influence was the essential therapeutic force in group therapy* of sex offenders because it counteracted their social isolation, pushed them toward prosocial conformity, and

reinforced their control of deviant (antisocial) impulses (Steg, Wright, & Peters, 1972). At this time in history, they still doubted whether sex offenders were treatable because of their denial of abuse, failure to cooperate, personality deficits, and lack of motivation for change (Peters & Roether, 1972; Roether, 1972). Nevertheless, they recognized that the peer influence of group therapy could do something that individual therapy could not: break through the denial and shame, while providing an opportunity to form meaningful relationships that promoted prosocial values over deviancy. They also observed that, like other therapy groups, sex offender groups progressed through a typical pattern of development: Starting in denial and hostility to authority, they moved to a middle phase of increasing prosocial values and respect, then a phase of challenging new members' denials and asserting positive role-modeling, and, finally, members were allowed to act as cotherapists by the end of their treatment.

Romero and Williams (1983) tested Peters's psychoanalytic group therapy in a 10-year follow-up study. A total of 148 sex offenders attended weekly 90-minute groups for 40 weeks and received probation, while 87 sex offenders received probation only. Those attending group recidivated at a higher rate (13.6% vs. 7.2%), but it was not statistically significant.

Meanwhile, Marcus and Conway (1971) explored group therapy for "dangerous sexual offenders" in the Canadian prison system. Despite their presumption that sex offenders would only participate for ulterior motives and would conceal their true thoughts, they concluded that group process provided a more accurate assessment than could be achieved through individual evaluations. Marcus (1971) and Anderson (1969) also replayed videotapes of group sessions to confront denial and create a cathartic emotional "crisis" to motivate change.

A similar "cathartic" approach was tried at the Adult Diagnostic and Treatment Center at Avenel, New Jersey (Brancale, Vinocolo, & Prendergast, 1972). Recognizing that 90% of the rapists in his program had been sexually abused during childhood, Prendergast (1978) combined videotaping with marathon group therapy to focus on the traumatic origins of their adult sex offending. In extended sessions that could go for hours over a weekend or longer, the group would relentlessly confront a given member until he exploded in rage and then the group would make physical contact. This was hypothesized to reenact the memory of the individual's own sexual trauma and yield a cathartic healing experience.

Perhaps the best work done in the early group therapy of sex offenders was conducted by the grand master of group therapy himself, Irving Yalom. Just 2 years after his landmark book on *The Theory and Practice of Group Psychotherapy* (Yalom, 1970), Yalom described group therapy with child molesters at Atascadero and Patuxent State Hospital in Maryland (Costell & Yalom, 1972a, 1972b). Like Hartman (1965a, 1965b), Yalom asserted that the group members would inevitably reveal themselves during therapy through peer influence. But Yalom regarded this disclosure as a natural and expected process of *any* therapy group, not something specific to breaking through the unique denial of sex offenders. In essence, Costell and Yalom simply conducted their sex offender groups as they would any group of patients, trusting to the universal "curative" factors of group therapy itself.

Presuming that it was "completely unrealistic for confirmed pedophiles" to learn genuine sexual attraction to adult women, they did, however, make one modification specific to sex offenders: The pedophiles were encouraged to modify their masturbatory fantasies and reduce frequency of deviant arousal and share strategies for dealing with deviant impulses. Yalom and Costell did observe some issues unique to this setting, such as the morale problems caused by extremely lengthy stays, and role conflicts for staff acting as both group therapists and ward members. Otherwise they noted that group helped to break isolation and loneliness by providing motivation and a sense of hope, cohesiveness and belonging, socialization, emotional release, and, interestingly, the opportunity to help others (altruism).

In a review of the treatment of child molesters up to that time, Quinsey (1977) stated that "group therapy remains the most widely used treatment," (p. 214) but complained that there was almost no data to show effectiveness and that the variations among programs prevented replication. A decade later, in their survey of sex offender programs, Schwartz and Cellini (1988) observed that group therapy was the one universal feature of every treatment program and was often the only treatment provided.

The conclusion of this historical review is that, for 20 years, the field of SOST was applying a theoretical approach (psychoanalytic) that was largely unsupported by research, but practitioners clearly appreciated the therapeutic importance of group dynamics. Then, in the 1980s, the field was revolutionized by cognitive behavioral treatment and relapse prevention, and the situation reversed. For the next 25 years, the field applied a theoretical approach (CBT) that had stronger empirical support but increasingly neglected the therapeutic benefits that can be gained through the interpersonal relations of group therapy. More recently, however, there has been a surge of interest and empirical research in sex offender–specific group therapy and therapeutic factors, which has precipitated this review.

Method

This review originated as an effort to create an annotated guide to research and practice specific to group therapy with sexual abusers. As *Sexual Abuse* is the official journal of Association for the Treatment of Sexual Abusers (ATSA), it began with a "shelf" search of 60 issues of the journal from 1998 to 2014. The surprising, and discouraging, result showed that only seven of 375 articles (only 1.8%) were focused on group therapy. Presuming, therefore, that the available literature would be small, the authors searched the Internet for publications containing "group therapy" and sex offender/abuse terms. This was followed by a search of group therapy journals for articles dealing with any types of sexual abuse. The citations within each article were searched for other group articles. Articles pertaining to group therapy with forensic and nonsex offender populations were excluded.

With a resulting selection of 93 books and articles, five dissertations, and five presentations, the authors wrote a brief "content analysis" of each. With an emphasis on *empirical* data, the authors subselected only those articles that presented any type of quantitative data pertinent to some aspect of SOST group therapy. With the pool

reduced by half, the authors then applied an "inductive thematic analysis" (Braun & Clarke, 2006), sorting studies by the primary topic of the research as it related to group (i.e., engagement, cohesion, therapeutic climate, therapist qualities). This yielded five "data-driven" themes by which to organize the findings.

The authors then sorted the clinical/practice articles into these five categories and added four "nondata" categories based on frequency of the subject matter: This created a category for articles specific to SOST group therapy with "adolescents" and one for "history" for any article published before 1972 or one that contains historical information about early SOST group work. "Alternative" is any article that offers an approach or technique that is atypical to traditional CBT groups, such as humanistic, role-plays, female-specific, and videotaping. Finally, the "practice" category is any article with detailed clinical, ethical, and/or practice guidelines for conducting SOST groups.

The articles in the review are summarized in Table 1 using the nine categories, along with the sample size and type of sexual abusers (if known). Empirical articles ("E") and empirical reviews ("ER") present or include quantitative data related to SOST groups. Clinical articles ("C") are related to practice and theory. Clinical articles that merely describe group programs, but lack detail on conducting groups, are identified as "overview" and not counted as "practice." (Note: This review does *not* include the extensive literature on general group therapy research, which also has much to offer to those conducting SOST groups; Sawyer & Jennings, 2016.)

Therapist Qualities and Therapeutic Climate

In 2001, Marshall et al. (2003) had the opportunity to assess videotapes of multiple therapists who were delivering a highly prescriptive, group-based, cognitive behavioral treatment program to sex offenders in various prisons in Britain. Correctional authorities expected the videotapes to verify that their group therapists were adhering to the manualized treatment program in the belief that greater compliance would maximize outcomes. In turn, the group therapists understood the expectation to "stick to the script" of the curriculum in conducting their therapy groups. Indeed, under such controlled conditions, the only factor that could vary was the style and way that the individual therapists delivered the set curriculum.

Interested in discerning the impact of specific process variables, Marshall et al. (2003) developed a set of 27 therapist behaviors and qualities, which could be reliably observed from the videotapes. Three experienced clinicians then independently rated the videotapes. Of the 27 factors, they discovered that four therapist features were very highly correlated with the measures of positive behavior change: warmth, empathy, rewardingness, and directiveness. (Subsequently, Marshall, Burton, and Marshall [2013, p. 165] have declared that "directive" is more accurately described as "guiding" and "rewarding" is more accurately described as "encouraging." These are the terms that will be used in this review.) In fact, they determined that these four therapist factors accounted for as much as 30% to 60% of the treatment effect, which was even higher than the strongest results reported in the general therapy effectiveness literature. (They

also discovered that confrontation was strongly negatively correlated with change, which will be discussed later.)

Impressed by the unexpected power of these findings, Marshall et al. (2002) planned a second study. First, they changed the treatment program and modified the training of group therapists in ways that would emphasize the four positive therapeutic variables and discourage the use of confrontation. Recognizing that flexibility is equivalent to the responsivity principle in the Risk, Need, Responsivity (RNR) Model (Andrews & Bonta, 1998/2006), they urged the correctional program designers to reduce prescriptive detail in the treatment manuals and allow greater individual flexibility for the group therapists. Independent raters evaluated five videotapes for each group therapist—one video at the beginning, three in the middle, and one near the end of treatment. This follow-up study replicated the findings of the first and, in fact, achieved even stronger outcomes, finding that the four therapist features accounted for 32% to 61% of variance in the six measures of treatment change: overall benefits, improved relationships, increased responsibility, decreased denial of planning, decreased victim blaming, and minimization of offense.

The outcomes from these two studies convinced the Marshall group that therapist characteristics are essential to effective sex offender treatment. Subsequently, Marshall (2005) sought empirical support for the four therapist features from the research literature from mainstream psychotherapy (but not mainstream *group* therapy). Marshall was unequivocal in concluding that "displays of empathy and warmth by the therapist and provision of rewards for progress and some degree of directiveness, maximize the benefits derived from the procedures employed in treating sexual offenders" (p. 109). Rewardingness was defined as "offering verbal encouragement to clients for small steps toward whatever goal was being sought." Directiveness was defined as "guidance from the therapist when necessary, such as 'Have you thought of trying . . . ?' and 'Did you consider . . . ?'"

Five years later, Marshall and Burton (2010) conducted another literature review that extended beyond the sex offender field to address the four process issues that promote treatment effectiveness: therapist characteristics, clients' perceptions of the therapist, the therapeutic alliance, and the group climate. They concluded that the four process features

> account for a greater proportion of the variance in the sought-after changes with treatment of offenders than do the procedures used to achieve these changes. This proportion of variance accounted for is significantly greater than is true in the treatment of nonoffending clients. (p. 141)

They also cited research showing that therapists who adhered most closely to manualized CBT group treatment for batterers were far less effective than those who emphasized the therapeutic alliance and flexibly adjusted the approach to individual needs. Jennings (1987, 1990) was early to recognize the shortcomings of overly manualized CBT group programs for batterers and pushed for less structured group therapy that could focus more flexibly on treatment goals.

As noted by Marshall and Burton (2010) and Marshall et al. (2013), the huge importance of empathy and warmth and therapist characteristics has been soundly established in general literature of psychotherapy effectiveness since the original landmark studies by humanistic psychologist Carl Rogers (1957). It is not surprising to find that an explicitly humanistic approach to SOST group therapy emphasizes therapist characteristics that improve therapeutic outcomes (Bauman & Kopp, 2006).

Three other studies support the Marshall findings. In an unpublished study of prison-based SOST groups, Thornton, Mann, and Williams (2000) found that groups that were led by warm and supportive therapists showed significant changes across all measures of treatment effectiveness, such as reductions in cognitive distortions, while the groups led by confrontational therapists showed improvement on fewer measures. Likewise, in their studies of child molesters, Drapeau (2005) and Drapeau, Körner, Granger, Brunet, and Caspar (2005) found that child molesters engaged more fully in treatment when the group therapists showed empathy, warmth, caring, respect, and nonjudgmental attitudes, and they disengaged from therapists that were confrontational and not supportive.

Cohesion and Therapeutic Climate

While the Marshall studies are compelling, they are perhaps limited by their primary focus on group therapist characteristics and only secondary or indirect concern with group process. Research by Beech and his colleagues has focused directly on group process variables with sex offenders, particularly cohesion, which is the therapeutic factor that has been most often studied in the field of group therapy research (Burlingame, McClendon, & Alonso, 2011).

In their first study, Beech and Fordham (1997) applied two key elements from the general group psychotherapy literature to SOST groups: the well-established Group Environment Scale (GES) (Moos, 1994) and the foundational group concepts of "therapeutic factors" by Yalom (1970). The GES is an objective behavioral measure of group cohesion, including eye contact, group interactions, positive verbalizations, disclosure, and ratings of trust and satisfaction. Beech and Fordham ranked four prison-based and eight outpatient probation groups and found that group therapy with strong cohesion showed superior outcomes on measures of cognitive distortion, denial, and admission of offense behaviors. The groups with lowest subscale scores for Cohesiveness (the degree to which group works together, supports and challenges one another) and Expressiveness (the degree to which members express themselves, enter discussions, and display emotions in group) showed least change. Therapeutic climate encouraged open expression of feelings and a sense of group responsibility, and instilled hope in its members. They also found that a confrontational style reduced treatment effectiveness.

Eight years later, Beech and Hamilton-Giachritsis (2005) repeated this study with seven community-based sex offender programs and again found that group cohesion and emotional expressiveness were significantly related to improvements in measures of dynamic risk, including victim empathy, cognitive distortions, and emotional

identification with children. Subsequently, Harkins, Beech, and Thornton (2012) put these strong outcomes to the "hardest test" by measuring group process with psychopathic sex offenders whose antisocial characteristics would presumably be least amenable to group bonding. In fact, they found that cohesion could be achieved despite high psychopathy and that it improved over the three stages of group treatment. In the clinical arena, Ward and Groener (2015) published on the unique challenges of leading outpatient groups composed of high-risk psychopathic sex offenders.

Based on the three studies by Beech and other studies from the general nonsex offender literature, Marshall et al. (2013) have posited that group cohesiveness and group expressiveness should be emphasized as essential preconditions for positive behavioral change in sex offenders. In an unpublished study, Davis, Marshall, Bradford, and Marshall (2008) also used the Moos group climate measure with seriously mentally ill sex offenders in a prison and mental health center and found that Cohesiveness and Expressiveness were strong predictors of treatment goal attainment. Similarly, Levenson, Prescott, and D'Amora (2010) found that dealing with emotional issues (expressiveness) was significantly predictive of sex offenders' satisfaction with treatment and that high cohesiveness within treatment groups contributed to reduction in antisocial beliefs.

In his dissertation study of 95 sex offenders in an inpatient SOST program (which used group therapy exclusively), Aylwin (2010) found that cohesion grew most rapidly in the first 4 months, then grew steadily, but more slowly up through 12 to 15 months. Interestingly, the offenders who dropped out of treatment had lower ratings of cohesion but showed the same pattern of rising cohesion in the first 3 months. Aylwin also found that higher group cohesion yielded more positive outcomes on multiple measures, including responsibility, energy, conflict resolution, interpersonal relations, anxiety, and negativity/coldness.

Additional studies have explicitly tested Yalom's theory of therapeutic factors with SOST groups. Of the 12 factors (originally posited as 10 "curative factors"), group cohesiveness is considered the most fundamental factor from which all the others flow. In an early study of group processes with child molesters, Houston, Wrench, and Hosking (1995) found that, consistent with Yalom's theory, the therapy groups developed from the first stage of hesitant participation and testing the waters, to the second stage of conflict, dominance, and rebellion, and to the third stage of belonging and maximal cohesion. In a study of 69 adolescent sex offenders in residential treatment, Sribney and Reddon (2009) used the Yalom Card Sort and found that cohesiveness, along with universality and family relationships, was ranked highest in importance and also that the importance of cohesion continued to increase over the length of treatment, while the family factor decreased. Compared with adult sex offenders, the factors of instillation of hope and universality were rated three ranks higher and interpersonal learning was rated four ranks lower. Reimer and Mathieu (2006) used interviews and a questionnaire to directly assess sex offenders' perceptions of the importance of Yalom's therapeutic factors in group. Defining cohesion as "the group helps me because it is good to belong to a group of people that is together and cares about each person in the group," cohesion was ranked third in importance, while

catharsis (emotional expressiveness) and self-understanding were rated as most helpful.

In contrast, cohesiveness was *not* regarded as one of the most important therapeutic factors in a large survey of 159 group therapists (not specifically those working with sex offenders) across 78 prisons. Morgan, Ferrell, and Winterowd (1999) evaluated the therapists' opinions about the importance of, and group time spent on, therapeutic factors as group goals. The therapists gave the most importance to Yalom's (1970) therapeutic factors of interpersonal learning, universality, and imparting information, and least importance to existential factors and corrective recapitulation of the primary family group.

Therapeutic Factors Affecting Group Engagement

While not concerned with Yalom's theory of therapeutic factors or group process, two other research leaders, Levenson and Frost, have independently published multiple studies on the issue of therapeutic climate in SOST groups—with a shared focus on "engagement."

Frost (2000) has studied child molester groups to understand what factors might inhibit or facilitate offense disclosure. This research was based on the presumption in the SOST field at that time that offense disclosure was a central treatment target that served as a sort of lynchpin to multiple SOST goals of breaking denial, penetrating resistance, taking responsibility, and engaging in treatment in a more honest and meaningful way. Recognizing the profound social stigma that causes child molesters to feel shame and isolate themselves, Frost asserted that the peer group expectation of disclosing deviant intentions and offenses creates "a crisis of belonging" (p. 190). After a lifetime of secrecy, avoidance, deception, and self-loathing, the offenders were understandably averse to making disclosures that would be expected to bring shame and rejection by the peer group. Similarly, in a clinical practice article, Clark and Erooga (1994) asserted that group therapy is inherently well-suited to counteract the characteristic isolation, secretiveness, and shame of being identified as a child molester. Not surprisingly, Frost (2000, p. 195) discovered that the "participants regularly perceived threat in the group therapy environment and doubted, or even assessed as hopeless, their ability to tolerate perceived consequences of that threat." This, in turn, inhibited their ability to engage in treatment.

To test his theory, Frost (2004) conducted a videotaped study of offense disclosure during group therapy sessions of 16 child molesters. Immediately after each session, group members identified three events that were "most personally salient." During a subsequent interview, members viewed the video, identified the three salient episodes, and were questioned about their thoughts and feelings. Instead of using the video data to reveal how *group* process variables may facilitate or inhibit disclosure, Frost explained the reluctance to disclose in terms of four theorized *individual* styles of disclosure, three of which were unfavorable to engagement.

In a third study, Frost and Connolly (2004) found that child molesters in a prison group treatment program make significant movement either toward or away from

engagement during the "out-of-group" time between sessions. Paradoxically, they looked for reasons *outside* of the groups to understand why engagement was or was not occurring *in* group. They again missed the direct question of how group climate itself could promote or discourage engagement even though they cited a general group therapy study showing that group cohesiveness predicts the amount of between session work and the degree of participation during sessions (Budman, Soldz, Demby, Davis, & Merry, 1993). In their clinical work, Clark and Erooga (1994) also assert that group cohesiveness promotes higher levels of engagement and optimism about future recovery.

Levenson and her colleagues have also focused on engagement but have looked more directly at the role of therapeutic climate. In a series of six studies, Levenson has surveyed hundreds of outpatient sex offenders and inpatient civilly committed sexually violent predators (SVPs) for their perceptions about the various aspects of their treatment, including group therapy. As a starting point, Macgowan and Levenson (2003) first developed the psychometrics for reliably measuring group process and engagement in SOST groups. Using a sample of 61 adult male sex offenders in long term, open-ended outpatient treatment, they assessed the strength of correlations between the Group Engagement Measure (including both a therapist- and client-rated version), Group Attitude Scale, Sex Offender Treatment Rating Scale, and Facets of Sexual Offender Denial measure at the scale and subscale levels.

With confidence in the validity and reliability of these measures, they then published the results in a second study (Levenson & Macgowan, 2004). Like Frost, they began with the presumption that overcoming denial and offense disclosure were central targets in treatment that were necessary to promote meaningful engagement in group-based treatment. Levenson and Macgowan found that denial was inversely related to both engagement in group therapy and progress in treatment, and that engagement was positively correlated to progress. Together, engagement and denial explained 60% of the variance in treatment progress, with engagement as a stronger predictor than denial (.52 vs. −.37). They concluded that admitting to offenses (i.e., overcoming denial) was a necessary precondition for engagement and treatment progress.

In a third study, Levenson, Macgowan, Morin, and Cotter (2009) replicated these findings with a sample of 338 sex offenders across three outpatient programs in Florida and Minnesota. Defining "engagement" as actively contributing to group, being connected to other members and to the therapist, and investing in the treatment contract, they again found a strong positive relationship between treatment progress and engagement in group therapy and a negative relationship to denial. They also found a new and strong correlation between engagement and treatment satisfaction. They observed that those who were more actively engaged in group showed higher accountability, less cognitive distortions about offending, and more progress toward treatment goals. They further suggested that group acceptance and a "sense of belonging" to the group facilitated the development of generalized relationship skills.

In a fourth study, Levenson and Prescott (2009) also introduced a new "satisfaction survey" instrument that asked 44 civilly committed SVPs in Wisconsin to rate the

importance of and satisfaction with various components of treatment, group process issues, and perceptions of group and individual therapy. The measures in this survey would be repeated in three subsequent studies as summarized below. Of the treatment components, the sex offenders rated personal accountability, victim empathy, and understanding personal risk factors as the three most helpful and satisfying.

In a fifth study, Levenson et al. (2010) repeated the same survey with 88 convicted sex offenders attending an outpatient treatment program in Connecticut. In this study and two subsequent studies below, they found significant correlations between the offenders' perceptions of the importance of, and satisfaction with, the 18 treatment components. Finding a robust correlation between engagement and satisfaction, they hypothesized that offenders who most actively engage and participate in treatment would better learn healthy interpersonal skills and be less likely to recidivate.

In a sixth study, Levenson, Prescott, and Jumper (2014) surveyed a population of 113 civilly committed SVPs in Illinois. Using the same set of measures, they achieved similar results, such as finding that "getting help and support from others" was viewed as most important and most helpful, whereas confrontation was seen as not important and not helpful.

The following analysis consolidates the empirical results from the Levenson studies and reveals a high degree of commonality across multiple outpatient and inpatient settings that reveals new insights about sex offender treatment, especially group therapy of sex offenders. One of the most remarkable findings is that more sex offenders appear to prefer group therapy over individual therapy. A greater percentage of sex offenders disagreed with the statement "I would rather attend individual therapy instead of group therapy" than agreed. This was true in every sample population except for the Wisconsin SVPs. Despite the obvious bias in the question that individual therapy was presumed preferable, more sex offenders disagreed than agreed with the statement (see Table 2). When all samples were combined, 12% more sex offenders preferred group. When outpatient samples were combined, 16% more preferred group, and when SVP inpatients were combined, 2% more preferred group.

Similarly, Garrett, Oliver, Wilcox, and Middleton (2003) surveyed a group of 13 prison-based and 29 outpatient sex offenders on probation and found that 47% preferred group therapy, 13% favored individual, and 34% had no preference. When combined with Levenson's groups, it appears that nearly half of all sex offenders across settings prefer group over individual, while one third prefer individual, and one fifth have no preference (see Table 2).

With regard to the issue of group therapeutic climate, three of the Levenson studies asked a series of five questions about perceptions of group process. In reviewing the percentages of sex offenders who affirmed each given item as being "very important" and then rank ordering the five items from highest percentage endorsed to the lowest percentage, the most striking finding is that the rank ordering of the perceived importance of the five aspects of group process is *identical* across all groups, both SVPs and outpatient. As shown in Table 3, the aspect rated as most important by the highest percentage of sex offenders across all settings is "getting help and support from others," while "confrontation among group members" was rated as least important.

Table 2. Sex Offender Preferences for Group or Individual Therapy.

I would rather attend individual therapy instead of group therapy.	Total *n*	Disagree or strongly disagree	I do not know	Agree or strongly agree
Illinois SVPs (Levenson, Prescott, & Jumper, 2014)	113	**44%**	19%	38%
Wisconsin SVPs (Levenson & Prescott, 2009)	44	31%	23%	**47%**
Florida and Minnesota outpatient sex offenders (Levenson, Macgowan, Morin, & Cotter, 2009)	338	**49%**	20%	31%
Connecticut outpatient sex offenders (Levenson, Prescott, & D'Amora, 2010)	88	**44%**	19%	36%
All sex offenders combined total	582	**46%**	20%	34%
All SVPs combined	157	**41%**	20%	39%
All outpatient sex offenders combined	426	**48%**	20%	32%
		Prefer group	No prefer	Prefer individual
Prison and outpatient sex offenders (Garrett, Oliver, Wilcox, & Middleton, 2003)	42	**47%**	34%	13%
Garrett and Levenson groups combined	624	**46%**	21%	33%

Note. SVP = sexually violent predators. Highest percentages are bolded.

Similarly, based on a series of seven questions about perceptions of group, there were striking similarities in the absolute rank ordering of the importance of various aspects of group therapy across the populations and settings. The aspect rated as important by the highest percentage of sex offenders across all four studies combined is "I feel comfortable helping others in my group" (ranked first in three of the four populations), while "I feel comfortable participating in my group" is the second highest percentage overall (ranked first or second in three of the four populations). Contrarily, the lowest percentage of offenders gave importance to "I trust other members in my group," which was ranked last in all groups by a sizable margin.

A lengthy interpretation of these results would exceed the scope of this review, but a few comments seem warranted. First, to the degree that "feeling comfortable in helping others" and "participating" in group are reflective of group cohesiveness and bonding, the high ranking of these elements is congruent with other empirical studies showing the importance of cohesion. On the contrary, the decidedly low endorsement of "trusting other members in my group" suggests that cohesion is far from ideal in these SOST groups and that giving more attention to facilitating cohesiveness may improve outcomes.

Moreover, the fact that "helping others in the group" and "getting help and support from others" are ranked highest in importance in the two sets of items also supports the salience of cohesion. It suggests that giving and getting help and support from peers is extremely important to sex offenders. It also points to the unappreciated importance of

Table 3. Sex Offender Perceptions of Group Therapy and Group Process.

Perceptions of group process (Ranking and percentage endorsed as important)	Illinois SVP	Florida and Minnesota outpatient	Connecticut outpatient		All combined
	n = 113	*n* = 338	*n* = 88		*n* = 539
Getting help and support from others	**1st 70%**	**1st 73%**	**1st 86%**		**1st 74%**
Hearing other perspectives and viewpoints	**2nd** 54%	**2nd** 69%	**2nd** 81%		**2nd** 68%
Feeling as though I can relate to the other members of the group	3rd 48%	3rd 54%	3rd 77%		3rd 56%
Sharing my experiences with other sex offenders	4th 42%	4th 50%	4th 63%		4th 50%
Confrontation among the group members	5th 36%	5th 45%	5th 54%		5th 45%
	Illinois SVP	Florida and Minnesota Outpatient	Connecticut Outpatient	Wisconsin SVP	All combined
Perceptions of group therapy	*n* = 113	*n* = 336	*n* = 88	*n* = 44	*n* = 582
I feel comfortable helping others in my group.	**1st** 71%	**1st** 93%	3rd 79%	**1st** 62%	**1st** 85%
I feel comfortable participating in my group.	**2nd** 66%	**2nd** 90%	**1st** 83%	3rd 45%	**2nd** 81%
It is helpful to be able to talk with other people who have committed sex offenses.	3rd 65%	4th 87%	6th 68%	**2nd** 54%	3rd 77%
My group usually feels comfortable.	4th 46%	3rd 89%	2nd 81%	4th 42%	4th 76%
My group members are pretty open and honest most of the time.	6th 43%	5th 81%	7th 64%	6th 39%	5th 68%
My group has enough structure.	5th 45%	7th 76%	4th 78%	7th 35%	6th 67%
My group members are pretty nonjudgmental most of the time.	7th 37%	6th 76%	5th 73%	5th 40%	7th 65%
I trust other members in my group.	8th 34%	NA	8th 55%	8th 23%	8th 40%

Note. SVP = sexually violent predators. Values for the two highest ratings are bolded for each group.

Yalom's therapeutic factor of "altruism" with this population. Some group therapists have observed altruism (expressions of caring) as a frequent and important phenomenon in SOST groups (Jennings & Sawyer, 2003), and altruism is a major primary good in the Good Lives Model. While seemingly unexpected for a population deemed selfish and alienated, perhaps this is an area worth exploring.

The same consolidation and rank ordering of results was applied to Levenson's data regarding the offenders' perceptions of the importance of the 18 components of treatment. The component ranked as important by the highest percentage of SVPs and outpatient sex offenders in all settings was "accepting responsibility." The second highest percentage of endorsement was victim empathy—"understanding the impact of sex abuse on victims and others in my life." Other treatment components had more variability in ranking across studies. Understanding triggers and risk factors, understanding offense chains/cycles, and understanding motivations to offend were ranked third, fourth, and fifth overall. Thinking errors, relapse planning, controlling deviant arousal, creating a more satisfying life, "understanding needs met through sexual abuse and learning healthier ways," and learning about denial were ranked sixth through 11th overall. Learning about grooming patterns, understanding development of sexual behavior problems, and learning new relationship/communication skills were ranked even less important, at 12th, 13th, and 14th overall. Finally, and again with strong consistency in the rankings of treatment components across the samples, sex offenders gave lowest ratings to controlling compulsive sexual behavior, understanding family origins, basic life skills, and basic human sexuality, ranked 15th, 16th, 17th, and 18th, respectively.

The literature pertaining to engagement in offender treatment groups, though not specific to sex offenders, was reviewed by Holdsworth, Bowen, and Brown (2014). Based on 47 studies, they concluded that client characteristics (other than hostility and impulsivity) were *not* predictive of engagement but found that the therapeutic relationship and program objectives showed the most promising evidence that therapeutic climate facilitates engagement.

Finally, in an interesting new area of inquiry, SOST researchers have begun exploring the relationship between attachment style and group therapeutic climate (Garbutt & Hocken, 2014). Garbutt and Palmer (2016) assessed the attachment style of 277 sex offenders and found that those with a "secure attachment" had positive perceptions of leader support, task orientation, order and organization, and self-discovery. Those with "dismissive attachment" only showed positive perceptions of leader support and task orientation, while "pre-occupied attachment" was negatively associated with leader support, and "fearful attachment" was negatively associated with self-discovery. Grady and Swett (2014) found that sex offenders of all attachment styles showed significant improvement in attachment and relationship measures, showing that group therapy can foster healthier attachment. This line of research suggests that SOST group therapists can directly facilitate engagement by knowing and responding differentially to the attachment styles of the group members (Jennings, 2015; Sawyer & Jennings, 2016).

Confrontation Is Counter-Therapeutic

Strong empirical and clinical evidence shows that confrontation is not only ineffective but may be counter-therapeutic. As we have previously seen in the research on therapist qualities by Marshall and his colleagues, confrontational therapist behaviors were strongly negatively correlated with the effectiveness of sex offender therapy groups (Marshall, 2005; Marshall et al., 2013; Marshall et al., 2003; Marshall et al., 2002; Thornton et al., 2000). Likewise, five Levenson studies found that both inpatient SVPs and outpatient sex offenders overwhelmingly rate "confrontation among the group members" as *not* helpful (see Table 3).

Other studies concur. Beech and Fordham (1997) found that a confrontational therapist style reduced treatment effectiveness. Drapeau (2005) and Drapeau et al. (2005) found that child molesters disengaged from therapists who were perceived as confrontational or not supportive. Likewise, Harkins and Beech (2007) completed an empirical review of RNR process factors that can influence the effectiveness of SOST groups and concluded that a positive group climate is crucial to therapeutic change but that confrontational approaches harmed group climate.

The ineffectiveness of confrontation is particularly relevant to SOST programs that emphasize confronting denial and requiring disclosure of sex offenses. From a historical standpoint, this conviction that breaking through denial is a prerequisite for successful treatment has held authoritative power in the SOST field until the late 2000s. For example, at the time of Levenson's first study of engagement and denial in 2004, it was stated that "current standards of practice maintain that admitting to a sex crime is a necessary condition for progress and engagement in treatment" (Levenson & Macgowan, 2004, p. 49). This same presumption shaped Frost's research on the strong reluctance (resistance) of child molesters to engage in disclosing their offenses in group therapy (Frost, 2000, 2004; Frost & Connolly, 2004). In their interview survey of prison SOST programs, Connor, Copes, and Tewksbury (2011) found that the most common complaint of participants was being obliged to disclose the details of their sex offenses in a group setting.

In another example, Marshall, Thornton, Marshall, Fernandez, and Mann (2001) cited seven different SOST programs from the 1990s that were explicitly designed to "overcome denial" as a primary objective of treatment. Based on evidence that denial was not predictive of risk, and recognizing the futility of directly confronting sex offenders who are in "categorical denial," Marshall's team attempted an alternative pilot program in which they explicitly promised offenders that they would *not* have "to discuss their offenses, much less challenge their denial" in the therapy groups (Marshall et al., 2001, p. 208). In its time, this novel approach for treating deniers was notable for its paradoxically nonconfrontational alternative to confrontation.

In what may be the ultimate example of confrontation, Frey (1987) describes the use of marathon group therapy sessions for incest offenders that lasted 6 to 8 hours. Beginning with a movie about victims, the group members were immediately pushed hard to disclose their offenses in detail and then vigorously confronted for any denial, minimization, or rationalizations.

The belief in the necessity of overcoming denial has, all too often, led therapists to believe that they must confront denial—whether it is done harshly in direct confrontation or more gently through "challenging" thinking errors. Indeed, as shown in the historical review, the tradition of confronting denial is rooted in the earliest attempts to treat sex offenders and, arguably, shaped the pioneering work of Albert Ellis that contributed to the formation of cognitive behavioral treatment. To the degree that Rational Emotive Therapy was designed to confront denial in sex offenders, it can be argued that the same underlying philosophy and presumptions are built into CBT itself. So, too, the inclination to confront denial and thinking errors may remain inherent in the primary method we use. More recent research has demonstrated that "denial" is not a dichotomous factor (either present or absent), but exists on a continuum (Gibbons, de Volder, & Casey, 2003), and that the impact of denial on risk for recidivism is influenced greatly by the idiopathic characteristics of each offender (actuarial risk, dynamic risk, offense history, victim type) in surprising and sometimes paradoxical ways (Langton et al., 2008; Nunes et al., 2007).

With the rise of Motivational Interviewing (MI), the sex offender field has become more attune to the importance of motivation and readiness to change (Clark & Liddle, 2012; Prescott, 2008) and generally appears to recognize the ineffectiveness of direct confrontation of denial, minimization, rationalization, and other behaviors commonly conceptualized as "resistance." As clearly demonstrated in the empirical studies described above, all group therapists should avoid an overly confrontational approach. In their group practice guidelines, Jennings and Sawyer (2003) provide good examples of multiple alternatives to confrontation, as well as techniques for timing and tempering interventions to be less confrontational.

Advantages and Preference for Group Therapy Over Individual

Clinicians and researchers have asserted that group treatments for sex offenders may be both more efficient and more effective than individual therapy (Beech & Fordham, 1997; Marshall, Anderson, & Fernandez, 1999; Marshall & Burton, 2010; Reddon, Payne, & Starzyck, 1999). But the available empirical evidence for such a differential effect is limited, and only one study by Di Fazio, Abracen, and Looman (2001) has attempted a direct comparison of group versus individual with sex offenders. In their study, the 143 men in the "full treatment" condition received about five groups per week (on the topics of victim empathy, self-management, human sexuality, and social skills) and two individual sessions. The 62 in the "individual treatment condition" received four individual sessions per week and no groups. They found no difference in reducing rates of recidivism. They did, however, conclude that individual treatment appeared better for individuals with psychiatric and cognitive impairments who might be more likely to misinterpret social cues in a complex group situation.

Despite the lack of direct comparative evidence, however, we have already reviewed empirical evidence showing that group cohesiveness and group expressiveness are

essential preconditions to positive change in sex offenders (Marshall et al., 2013). If this is true, it would logically follow that group therapy must be a necessary component and modality in sex offender treatment programs. In other words, group must offer something vital that can *not* be obtained through individual therapy alone.

Many clinicians have asserted various properties of group therapy that make it especially well-suited, and often superior to individual therapy, for addressing the particular problems and deficits of sex offenders (Jennings & Deming, 2013; Jennings & Sawyer, 2003; Sawyer, 2000, 2002; Sawyer & Jennings, 2014, 2016). Marshall et al. (1999) argued that group therapy is especially useful with sex offenders because they tend to be isolated, lonely, and have pervasive deficits in interpersonal relations and intimacy skills. This same argument has stimulated recent efforts to use SOST groups for treating attachment problems (Garbutt & Hocken, 2014; Garbutt & Palmer, 2016; Jennings, 2015; Sawyer & Jennings, 2016). Group is a chance to explore interpersonal deficiencies, improve social skills, and form meaningful bonds. Unlike individual therapy, group offers a chance to hear and share other viewpoints and to give and receive feedback on one's behavior and social presentation. It is also a rare opportunity to gain emotional support and acceptance—instead of social rejection and contempt.

Coming from the Adlerian school, Johnson and Lokey (2007) assert that group therapy is ideal for helping sex offenders to break out of their characteristically selfish, isolated, and self-absorbed "style of life." Group therapy provides opportunities to develop a healthier sense of "social interest" (community feeling in which the offender feels he belongs) and "relationship" (feeling actively and meaningfully connected to others). In turn, these processes promote self-esteem and counteract the two Adlerian extremes of "inferiority" (i.e., shame and self-loathing) and "superiority" (i.e., narcissistic bravado and callous indifference).

Breaking isolation and secrecy was the predominant theme in Hudson's (2005) study. Based on prison interviews with child molesters and other sex offenders, Hudson found that their primary concern was concealing their offenses to protect their public identity and avoid stigma. Given their extreme secrecy and isolation, group therapy provided a valuable opportunity to become more sociable, share differing perspectives, and develop empathy. In particular, the men felt that the use of role-plays and presenting their offense work before their group peers was most useful in helping them to be more open and accept responsibility for their offending. As observed by Frost and Connolly (2004), the group experience may be the only place where sex offenders can safely share their stigmatized status in society. In addition to breaking the characteristic secrecy and isolation of child molesters, Erooga, Clark, and Bentley (1990) assert that group helps prevent the therapist from becoming "enmeshed" in the perpetrator's view of the world and his abuse. Taken to the extreme, Schwartz (1995) warns that the secret confidential intimacy of individual therapy can unintentionally replicate the dynamics of sexual abuse, and that offenders can covertly sexualize or attempt to seduce the therapist, in reality or in fantasy.

In their review of the SOST literature, Ware, Mann, and Wakeling (2009) summarized the advantages and disadvantages of both group and individual treatment. They

concluded that group treatment appeared to be at least as effective as individual treatment and had several clinical advantages for addressing the particular criminogenic needs of the population. They further observed that open-ended group formats appeared superior to closed groups because they better allow for treatment to be more responsive to individual needs.

In assessing the advantages of group therapy, it is crucial to consider one more major source of empirical evidence: the opinions of the sex offenders themselves. Five different studies suggest that nearly half of all sex offenders across multiple secure inpatient and community outpatient settings prefer group over individual, while one third prefer individual, and one fifth have no preference. In their study of 12 intrafamilial adolescent sex offenders, Halse et al. (2012) found that every participant agreed that group therapy was the most beneficial component of their community-based treatment. To the degree that many or most sex offenders prefer group to individual, it would be expected that they would be more motivated and engaged and able to benefit from treatment that is delivered in a group modality.

Finally, from the standpoint of treatment delivery, it can be argued that group therapy is preferable to individual in terms of cost and efficiency. Empirically derived cost-effectiveness estimates are available from the general group literature that supports the use of group over individual treatment (Burlingame et al., 2011).

Potential Disadvantages of a Group Approach

It is important to also consider the disadvantages of the group modality. The basic argument against group therapy is that group interventions are essentially the same for all members, and the group therapist is limited in delivering interventions to address individualized needs. For example, it could be difficult to adjust interventions within a generic group to adequately accommodate offenders who have different types of offenses and different pathways to offending. Thus, to the degree that rapists, child molesters, incest offenders, and noncontact sex offenders have different treatment issues, they may need and respond differentially to different treatment interventions (this is addressed later in terms of homogeneous and mixed sex offender groups).

A much stronger argument can be made against a general or generic group approach for sex offenders who have dramatically different levels of intellectual, psychiatric, and criminal functioning. It is not beneficial to the individual or the group to include persons whose intellectual, cognitive, or psychiatric deficits hinder concept comprehension and meaningful participation with their peers. This is less clear with regard to offense severity. In the juvenile field, there is compelling evidence that mixing low risk adolescents into groups with more aggressive and deviant peers can result in "deviancy training" and cause significant iatrogenic effects (Weiss et al., 2005). With adults, it has been suggested that some sex offenders might gain deviant arousal or learn new offending from hearing abuse narratives from other offenders in the group or, conversely, might be traumatized to hear others' deviant fantasies and offenses. Colton, Roberts, and Vanstone (2009) found that half of the child molesters in their prison-based SOST complained of being forced to listen to what they perceived as "worse" sexual crimes

and of being corrupted by doing so. While this phenomenon is not empirically supported, it is generally accepted (per the RNR "risk principle" for effective correctional rehabilitation) that resources are best utilized by providing less treatment to low risk offenders and more intensive treatment to moderate and high-risk sex offenders.

There may also be characterological and behavioral deficits that prevent individuals from being placed into groups, at least not without significant preparatory work. These might be individuals who, at one extreme, may be too socially incompetent, bizarre, or passive to relate adequately in a group setting, or, at the other extreme, persons so aggressive and disruptive that they frighten, intimidate or anger other members, and harm group process. These are the types of cases that can and should be identified by group selection criteria and handled on a case by case basis (Sawyer & Jennings, 2016). At first consideration, sex offenders who are very high in psychopathy might be one category that would be contraindicated for group treatment. But Harkins et al. (2012) found that therapy groups for psychopathic sex offenders can—at least when combined together in their own group—achieve cohesion and followed the naturally expected course of group stage development.

Contrarily, Maletzky (1999) complained of the trend in the SOST field toward less individual therapy and more use of group treatment, which appeared driven by extrinsic factors such as provider convenience, scheduling, and cost. Instead, he emphasized that individual therapy offered an "unparalleled opportunity" for highly personalized relapse prevention development and idiosyncratic arousal reduction, which would be impossible in a group setting.

Another potential disadvantage of group is risk to confidentiality, especially in prison settings, where an offender might be "outed" as a child molester and subject to retribution or humiliated by revelations of his deviancy.

Mixed Offender Versus Specific Offender Type Groups

The SOST clinical literature includes many articles about groups organized to treat specific types of sex offenders, but the vast majority have centered on the separate treatment of child molesters as a clinical subgroup. In fact, as described in the "History and Early Group Work With Sex Offenders" section, many of the earliest group treatments of sex offenders focused specifically on child molesters. Otherwise, the vast majority of SOST groups have mixed types of sex offenders.

To date, only one study by Allam, Middleton, and Browne (1997) has shown a clear advantage for one type of specific group. The Allam team experimented with specialized groups at the largest community-based SOST program in England. These included a group for men with learning disabilities, a victim-to-victimizer group for those who were child victims of sexual abuse, and a group exclusive to men who sexually abuse adult women. They reported that the adult-abusers-only group showed increased cohesiveness, more active participation, and more acceptance of personal responsibility than the typically mixed offender groups.

Other studies show no significant difference, suggesting that group composition is not an important factor in sex offender treatment. Tregaskis (2000) found no differences

in the quality of the overall group environment between adult-only offender groups and mixed offender types. Likewise, Beech and Hamilton-Giachritsis (2005) did not find any difference in using mixed or homogeneous groups in fostering treatment change. In a subsequent study, Harkins and Beech (2008) compared the group environment and recidivism outcomes for two rapist-only groups, three child molester-only groups, and 15 mixed offender groups. They directly studied the question of whether to treat rapists and child molesters separately or together in a mixed group. They found that the quality of the group environment was typically quite positive for all groups and did not differ as a function of the composition of the group with one small exception. Of the 10 subscales of the Group Environment Scale, the mixed groups were significantly lower in Expressiveness, which was defined as "how much freedom of action and expression of feelings are encouraged in the group." They suggested that mixing rapists and child molesters decreases the risk that offenders will collude with one another regarding their distorted beliefs.

In an early survey of sex offender programs, Schwartz and Cellini (1988) observed that group therapy was the one universal feature of every SOST program and was often the only treatment provided. They observed that many programs divided rapists, incest offenders, and child molesters and pedophiles into homogeneous groups, but opined that mixing offenders helped to enliven the groups because pedophiles tend to be passive and withdrawn, while rapists tend to be more assertive and talkative, and a mixed group can share more diverse experiences.

Cowburn (1990) looked at a number of mixed offender type groups and found that the "anticipated hierarchy" of offender types (e.g., rapists feeling superior to child molesters) did not develop as was predicted. Cook, Fox, Weaver, and Rooth (1991) separated a subpopulation of 63 sex offenders who were not physically violent and attended an outpatient probation group over a period of 10 years. Two group programs were designed exclusively for incest offenders (Frey, 1987; Ganzarain & Buchele, 1990), but there was no comparison made to outcomes for incest offenders in a mixed group. Costell and Yalom (1972a) reported that homogeneous groups worked best with pedophiles, while heterogeneous groups were most successful with rapists, but provided no empirical support.

In conclusion, without clear empirical evidence of the superiority of homogeneous SOST groups, it remains more practical and a better use of resources to simply mix sex offender types. For example, in prison settings, mixing is typically more practical because of limited treatment resources (e.g., group rooms, clinicians, etc.). In small community outpatient settings and small forensic programs, mixing is often necessitated by the small number of available participants.

Group Practice Guidelines and Alternative Group Approaches to CBT

Several publications provide excellent practice guidelines for conducting group therapy with sex offenders that emphasize the interpersonal therapeutic processes unique to group. Jennings and Sawyer, in particular, have published multiple articles and a

book dedicated to SOST group therapy (Jennings & Deming, 2013; Jennings & Sawyer, 2003; Sawyer, 2000, 2002; Sawyer & Jennings, 2014, 2016). Some articles that purport to be about group work with sex offenders may be less helpful because they describe the content of programs rather than the interpersonal group processes at work (e.g., Schwartz, 1995; Schwartz & Cellini, 1988) and other articles only touch upon group therapy as one of many modalities (e.g., T. Ward, Mann, & Gannon, 2007).

Five other publications are notable for providing details on conducting SOST groups. Aubrey and Dougher (1990) and Sawyer and Prescott (2011) provide details about legal and ethical issues in outpatient group therapy with sex offenders, including managing counter-therapeutic responses to clients, working collaboratively with other criminal justice system agents, and working with the court. Rich (1994) provides useful details about multifaceted clinical challenges of outpatient group therapy with adjudicated sex offenders. Frost, Ware, and Boer (2009) take a broader perspective on groups in describing an integrated "groupwork" methodology from the social work field that can enhance treatment for sex offenders.

Finally, three articles apply the principles of MI to groups for sex offenders who are unprepared or lack appropriate motivation for engaging in meaningful treatment. Prescott (2008) created a program specifically designed to avoid the problems of confrontation, coercion, and so-called "resistance," and Clark and Liddle (2012) describe motivational group role-plays. In a motivational group for adolescents, O'Reilly, Morrison, Sheerin, and Carr (2001) provide useful guidelines and vignettes that can be used to motivate change, develop healthy group norms in treatment, and set individual goals for clients.

While most SOST groups utilize cognitive behavioral principles, there are many published articles that offer alternative approaches and techniques, which may or may not be congruent with traditional CBT. These include Adlerian (Johnson & Lokey, 2007; Newbauer & Blanks, 2001), behavioral (Jennings & Deming, 2013), humanistic (Bauman & Kopp, 2006), psychoanalytic (Ganzarain & Buchele, 1990; Romero & Williams, 1983), psychodynamic (Lothstein, 2001), psychodrama (Schwartz & Bergman, 1997), Rational Emotive Therapy (Ellis, 1961; Whitford & Parr, 1995), marathon groups (Brancale et al., 1972; Frey, 1987; Schwartz & Cellini, 1988), multifamily group (Griffin, Williams, Hawkes, & Vizard, 1997; Nahum & Brewer, 2004; Walker, 2000), self-help (Schwartz & Cellini, 1988), role-play (Clark & Liddle, 2012; Daniels, 2005; Hudson, 2005), use of videotaped sessions (Anderson, 1969; Brancale et al., 1972; Marcus, 1971; Schwartz & Cellini, 1988), and female sex offender groups (Barnett, Corder, & Jehu, 1990; Lindquist, 2001).

Articles specific to adolescent SOST groups are also available, including Haines, Herrman, Baker, and Graber (1986); Whitford and Parr (1995); Mamabolo (1996); Griffin et al. (1997); O'Reilly et al. (2001); Etgar and Prager (2009); Sribney and Reddon (2009); Newbauer and Blanks (2001); Nahum and Brewer (2004); Carpentier, Silovsky, and Chaffin (2006); and Halse et al. (2012).

Conclusion

Even though group therapy has been the predominant modality in SOST since its beginnings in the 1950s, group therapy itself has been, until recently, largely ignored as a topic

of study in the field. Given a recent surge of interest and research related to SOST group therapy, there is enough empirical evidence to support several definitive conclusions about SOST group therapy, which can, and should, be applied to our practice and thinking.

First and foremost, the quality of group cohesion can profoundly affect the effectiveness of SOST. Eleven empirical studies covering the gamut of prison and community settings show that group cohesion (the therapeutic factor considered most important and foundational in the general field of group therapy) fosters an environment in which clients can be more receptive to all sorts of SOST interventions, CBT or otherwise. SOST group therapists should be trained in recognizing, understanding, and fostering cohesion in their groups. Although excluded from this review, there is much to be gained from the mainstream research literature on group therapy—especially regarding cohesion (Sawyer & Jennings, 2016). In particular, SOST group therapists can benefit from the use of quick, easy, valid, and reliable measures of group cohesion and therapeutic climate that can be applied to monitor the ongoing therapeutic quality of their groups and for program evaluation. These include the *Cohesiveness Subscale* and *Therapeutic Factor Inventory-8* (Tasca et al., 2014) and ultrabrief *Group Session Rating Scale* (Duncan & Miller, 2007). SOST therapists can also learn about the "normal" developmental stages of group therapy from the general literature. This will enable them to promote cohesion during the early distrustful and disconnected phase, promote cohesion over the developmental course of group, and maintain and protect cohesion from the inevitable disruptions that will occur.

Second, several empirical studies show that the qualities and behavior of the group therapist—specifically warmth, empathy, encouragement, and guidance—can decisively affect engagement and outcomes. SOST group therapists need to be trained and understand how to optimize these qualities *through* their countenance, behavior, and interventions in SOST groups. "Warmth" and "empathy" are not simply qualities inherent to one's personality style, but can be learned, enhanced, and applied as skills. At the same time, several studies by Levenson and others emphasize the importance of attending to the clients' *perceptions* of therapeutic climate. Clients engage more meaningfully and respond better to treatment to the degree that they perceive their groups as safe and therapeutic places where they belong and feel accepted (cohesion) and can take the risks necessary to try out new prosocial behaviors and attitudes.

Third, 10 empirical studies decisively show that confrontational approaches in group therapy are ineffective, if not counter-therapeutic, and are overwhelmingly rated as not helpful by sex offenders themselves. This, of course, tells us that SOST therapists must be attentive and skilled in delivering interventions in a way that will be *perceived by the clients* themselves as supportive and "challenging" rather than judgmental and "confrontative." This, again, is a matter of technique and skills that can be learned. We need to better understand "how" we articulate interventions that "challenge" clients, especially in groups where challenging a client in front of his peers can heighten fear of public humiliation and social rejection. In particular, the research suggests that MI skills may be especially valuable clinical skills for SOST group therapists (Clark & Liddle, 2012; Prescott, 2008).

Three less strong conclusions can also be drawn from the empirical research. First, there is compelling evidence that sex offenders may generally prefer group therapy over individual therapy. Second, group therapy appears to be at least equally effective

as individual therapy, while having some distinct clinical advantages over individual. Finally, it appears that mixing or separating groups by offense type (e.g., child molesters, rapists, incest offenders) is not important to group therapeutic climate.

The historical review of SOST group therapy also provides perspective for appreciating these empirically based recommendations. Although today's CBT-oriented SOST clinicians might overwhelmingly dismiss the psychoanalytically oriented work that dominated SOST group therapy in the first decades of this field, we might do well in reconsidering their appreciation for how group therapy offers something unique and powerful that individual therapy cannot—and that "individual-therapy-in-a-group" cannot (Sawyer & Jennings, 2014). Among these are the healing power of belonging and acceptance; the transformative power of group norms; the chance to reenter society from a life of isolation, shame, and self-disgust; and the social laboratory for experimenting with new ways of relating. Perhaps our field is coming full circle in returning to its early appreciation for the interpersonal aspects that are unique to group therapy. We believe that the recent trend toward more holistic, multimodal approaches to sex offender treatment, such as the Good Lives Model, reflects a potentially paradigmatic shift toward the re-appreciation of therapeutic factors in general and a more interpersonal approach to treatment, both of which are congruent with a hoped for re-appreciation of group therapy with those who sexually abuse.

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References

Allam, J., Middleton, D., & Browne, K. (1997). Different clients, different needs? Practice issues in community-based treatment for sex offenders. *Criminal Behaviour and Mental Health*, *7*, 69-84.

Anderson, R. (1969). The exchange of tape recordings as a catalyst in group psychotherapy with sex offenders. *International Journal of Group Psychotherapy*, *19*, 214-220.

Andrews, D., & Bonta, J. (2006). *The psychology of criminal conduct*. Cincinnati, OH: Anderson Publishing. (Original work published 1998)

Aubrey, M., & Dougher, M. (1990). Ethical issues in outpatient group therapy with sex offenders. *Journal for Specialists in Group Work*, *15*, 75-82.

Aylwin, A. (2010). *The therapeutic alliance in sex offender treatment: The juxtaposition of violence and care* (Doctoral thesis). University of Alberta, Edmonton, Canada.

Barnett, S., Corder, F., & Jehu, D. (1990). Group treatment for women sex offenders against children. *Groupwork*, *3*, 191-203.

Bauman, S., & Kopp, G. (2006). Integrating a humanistic approach in outpatient sex offender groups. *The Journal for Specialists in Group Work*, *31*, 247-261.

Beech, A., & Fordham, A. (1997). Therapeutic climate of sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, *8*, 219-237.

Beech, A., & Hamilton-Giachritsis, C. (2005). Relationship between therapeutic climate and treatment outcome in group-based sexual offender treatment programs. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 127-140.

Brancale, R., Vinocolo, A., & Prendergast, W. (1972). The New Jersey program for sex offenders. In H. Resnik & M. Wolfgang (Eds.), *Sexual behaviors: Social, clinical, and legal aspects* (pp. 331-350). Boston, MA: Little, Brown.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*, 77-101.

Bromberg, W., & Franklin, G. (1952). The treatment of sexual deviates with group psychodrama. *Group Psychotherapy*, *4*, 274-279.

Budman, S., Soldz, S., Demby, A., Davis, M., & Merry, J. (1993). What is cohesiveness? An empirical examination. *Small Group Research*, *24*, 199-216.

Burlingame, G., McClendon, D., & Alonso, J. (2011). Cohesion in group psychotherapy. In J. Norcross (Ed.), *A guide to psychotherapy relationships that work* (pp. 110-131). New York, NY: Oxford University Press.

Cabeen, C., & Coleman, J. (1961). Group therapy with sex offenders: Description and evaluation of group therapy program in an institutional setting. *Journal of Clinical Psychology*, *17*, 122-129.

Cabeen, C., & Coleman, J. (1962). The selection of sex-offender patients for group psychotherapy. *International Journal of Group Psychotherapy*, *12*, 326-334.

Carpentier, M., Silovsky, J., & Chaffin, M. (2006). Randomized trial of treatment for children with sexual behavior problems: Ten year follow-up. *Journal of Consulting and Clinical Psychology*, *74*, 482-488.

Clark, P., & Erooga, M. (1994). Groupwork with men who sexually abuse children. In T. Morrison, M. Erooga, & R. Beckett (Eds.), *Sexual offending against children: Assessment and treatment of male abusers* (pp. 102-128). New York, NY: Routledge.

Clark, P., & Liddle, M. (2012). Motivational intervention and prosocial role plays in treatment groups. In B. Schwartz (Ed.), *The sex offender* (Vol. 7, pp. 1-18). Kingston, NJ: Civic Research Institute.

Colton, M., Roberts, S., & Vanstone, M. (2009). Child sexual abusers' views on treatment: A study of convicted and imprisoned adult male offenders. *Journal of Child Sexual Abuse*, *18*, 320-338.

Connor, D., Copes, H., & Tewksbury, R. (2011). Incarcerated sex offenders' perceptions of prison sex offender treatment programs. *Justice Policy Journal*, *8*, 1-23.

Cook, D., Fox, C., Weaver, C., & Rooth, F. (1991). The Berkeley group: Ten years' experience of a group for non-violent sex offenders. *British Journal of Psychiatry*, *158*, 238-243.

Costell, R., & Yalom, I. (1972a). Institutional group therapy (of sex offenders). In H. Resnik & E. Wolfgang (Eds.), *Sexual behaviors: Social, clinical, and legal aspects* (pp. 305-330). New York, NY: Little, Brown.

Costell, R., & Yalom, I. (1972b). The institutional treatment of sex offenders. In H. Resnik & E. Wolfgang (Eds.), *Treatment of the sexual offender*. New York, NY: Little, Brown.

Cowburn, M. (1990). Work with male sex offenders in groups. *Groupwork*, *3*, 156-171.

Daniels, M. (2005). The use of role-play to develop victim empathy and relapse prevention. In B. Schwartz (Ed.), *The sex offender* (Vol. 5, pp. 1-18). Kingston, NJ: Civic Research Institute.

Davis, A., Marshall, L., Bradford, J., & Marshall, W. (2008, October). *Group climate in a program for seriously mentally ill sexual offenders*. Paper presented at the 27th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, Atlanta, GA.

DiFazio, R., Abracen, J., & Looman, J. (2001). Group versus individual treatment of sex offenders: A comparison. *Forum on Corrections Research*, *13*, 56-59.

Drapeau, M. (2005). Research on the processes involved in treating sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 117-125.

Drapeau, M., Körner, C., Granger, L., Brunet, L., & Caspar, F. (2004). A plan analysis of pedophile sexual abuser's motivation for treatment: A qualitative pilot study. *International Journal of Offender Therapy and Comparative Criminology, 49*, 308-324.

Duncan, B., & Miller, S. (2007). *The Group Session Rating Scale*. Jensen Beach, FL: Authors.

Ellis, A. (1961). The psychology of sex offenders. In A. Ellis & A. Arbanel (Eds.), *The encyclopedia of sexual behaviour* (Vol. 2, pp. 949-955). New York, NY: Hawthorne Books.

Erooga, M., Clark, P., & Bentley, M. (1990). Protection, control, treatment: Groupwork with child sexual abuse perpetrators. *Groupwork*, *3*, 172-190.

Etgar, T., & Prager, K. (2009). Advantages of group therapy for adolescent participants in the same gang rape. *Journal of Child Sexual Abuse*, *18*, 302-319.

Frey, C. (1987). Mini-marathon group sessions with incest offenders. *Social Work*, *32*, 534-535.

Frost, A. (2000). *New connections: The engagement in group therapy of incarcerated men who have sexually offended against children* (Doctoral thesis). University of Canterbury, Christchurch, New Zealand.

Frost, A. (2004). Therapeutic engagement styles of child sexual offenders in a group treatment program: A grounded theory study. *Sexual Abuse: A Journal of Research and Treatment*, *16*, 191-208.

Frost, A., & Connolly, M. (2004). Reflexivity, reflection, and the change process in offender work. *Sexual Abuse: A Journal of Research and Treatment*, *16*, 365-380.

Frost, A., Ware, J., & Boer, D. (2009). An integrated groupwork methodology for working with sex offenders. *Journal of Sexual Aggression*, *15*, 21-38.

Ganzarain, R., & Buchele, B. (1990). Incest perpetrators in group therapy: A psychodynamic perspective. *Bulletin of the Menninger Clinic*, *54*, 295-310.

Garbutt, K., & Hocken, K. (2014, October 31). *Treatment implications of sex offenders' attachment styles*. Paper presented at the 33rd Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

Garbutt, K., & Palmer, E. (2016). *Client attachment and the perceived environment in sexual offender treatment.* Unpublished manuscript under review.

Garrett, T., Oliver, C., Wilcox, D., & Middleton, D. (2003). Who cares? The views of sexual offenders about the group treatment they receive. *Sexual Abuse: A Journal of Research and Treatment*, *15*, 323-338.

Gibbons, P., de Volder, J., & Casey, P. (2003). Patterns of denial in sex offenders: A replication study. *Journal of the American Academy of Psychiatry and the Law*, *31*, 336-344.

Grady, M., & Swett, L. (2014, October 31). *Effects of CBT treatment on attachment styles of incarcerated sex offenders*. Paper presented at the 33rd Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, San Diego, CA.

Griffin, S., Williams, M., Hawkes, C., & Vizard, E. (1997). The professional carers' group: Supporting group work for young sexual abusers. *Child Abuse and Neglect, 21,* 681-690.

Haines, A., Herrman, L., Baker, A., & Graber, S. (1986). The development of a psycho-educational group program for adolescent sex offenders. *Journal of Offender Counseling Services Rehabilitation*, *11*, 63-76.

Halse, A., Grant, J., Thornton, J., Indermaur, D., Stevens, G., & Chamarette, C. (2012). Intrafamilial adolescent sex offenders' response to psychological treatment. *Psychiatry, Psychology and Law*, *19*, 221-235.

Harkins, L., & Beech, A. (2007). A review of the factors that can influence the effectiveness of sexual offender treatment: Risk, need, responsibility, and process issues. *Aggression and Violent Behavior*, *12*, 615-627.

Harkins, L., & Beech, A. (2008). Examining the impact of mixing child molesters and rapists in group-based cognitive-behavioral treatment for sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, *52*, 31-45.

Harkins, L., Beech, A., & Thornton, D. (2012). The influence of risk and psychopathy on the therapeutic climate in sex offender treatment. *Sexual Abuse: A Journal of Research and Treatment*, *25*, 103-122.

Hartman, V. (1965a). Group psychotherapy with sexually deviant offenders (pedophiles): The peer group as an instrument of mutual control. *Criminal Law Quarterly*, *7*, 464-479.

Hartman, V. (1965b). Notes on group psychotherapy with pedophiles. *Canadian Psychiatric Association Journal*, *10*, 283-288.

Holdsworth, E., Bowen, E., & Brown, S. (2014). Offender engagement in group programs and associations with offender characteristics and treatment factors: A review. *Aggression and Violent Behavior*, *18*, 102-121.

Houston, J., Wrench, M., & Hosking, N. (1995). Group processes in the treatment of child sex offenders. *Journal of Forensic Psychiatry*, *6*, 359-368.

Hudson, K. (2005). *Offending identities: Sex offenders' perspectives of their treatment and management*. Cullompton, UK: Willan.

Jennings, J. (1987). History and issues in the treatment of battering men: A case for unstructured group therapy. *Journal of Family Violence*, *2*, 193-213.

Jennings, J. (1990). Preventing relapse versus "stopping" domestic violence: Do we expect too much too soon from battering men? *Journal of Family Violence*, *5*, 43-60.

Jennings, J. (2015, April 9). *Using group-centered group therapy to directly treat attachment deficits of sex offenders*. Workshop presented to Massachusetts Association for the Treatment of Sexual Abusers, MASOC/MATSA, Marlborough, MA.

Jennings, J., & Deming, A. (2013). Effectively utilizing the "behavioral" in cognitive-behavioral group therapy of sex offenders. *International Journal of Behavioral Consultation and Therapy*, *8*, 7-13.

Jennings, J., & Sawyer, S. (2003). Principles and techniques for maximizing the effectiveness of group therapy with sex offenders. *Sexual Abuse: A Journal of Research and Treatment*, *15*, 251-267.

Johnson, D., & Lokey, J. (2007). *Individual psychology approaches to group sex offender treatment*. Retrieved from http://www.shsu.edu/piic/summer2007/lokey.htm

Langton, C., Harkins, L., Arenovich, T., Mcnamee, J., Peacock, E., Dalton, A., . . . Marcon, H. (2008). Denial and minimization among sexual offenders. *Criminal Justice and Behavior*, *35*, 69-98.

Levenson, J., & Macgowan, M. (2004). Engagement, denial, and treatment progress among sex offenders in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, *16*, 49-63.

Levenson, J., Macgowan, M., Morin, J., & Cotter, L. (2009). Perceptions of sex offenders about treatment: Satisfaction and engagement in group therapy. *Sexual Abuse: A Journal of Research and Treatment*, *21*, 35-56.

Levenson, J., & Prescott, D. (2009). Treatment experiences of civilly committed sex offenders: A consumer satisfaction survey. *Sexual Abuse: A Journal of Research and Treatment*, *21*, 6-20.

Levenson, J., Prescott, D., & D'Amora, D. (2010). Sex offender treatment: Consumer satisfaction and engagement in therapy. *International Journal of Offender Therapy and Comparative Criminology*, *54*, 307-326.

Levenson, J., Prescott, D., & Jumper, S. (2014). A consumer satisfaction survey of civilly committed sex offenders in Illinois. *International Journal of Offender Therapy and Comparative Criminology*, *58*, 474-495.

Lindquist, J. (2001). *An exploratory study of adolescent female sexual offenders in group treatment* (Unpublished doctoral dissertation). Massachusetts School of Professional Psychology, Newton, MA.

Lothstein, L. (2001). Treatment of non-incarcerated sexually compulsive/addictive offenders in an integrated, multimodal, and psychodynamic group therapy model. *International Journal of Group Psychotherapy*, *51*, 553-570.

Macgowan, M., & Levenson, J. (2003). Psychometrics of the group engagement measure with male sex offenders. *Small Group Research*, *34*, 155-160.

Maletzky, B. (1999). Groups of one. *Sexual Abuse: A Journal of Research and Treatment*, *11*, 179-181.

Mamabolo, L. (1996). Group treatment program for sexually and physically assaultive young offenders in a secure custody facility. *Canadian Psychology*, *37*, 154-160.

Marcus, A. (1971). *Nothing is my number: An exploratory study of dangerous sex offenders in Canada*. Toronto, Ontario, Canada: General Publishing.

Marcus, A., & Conway, C. (1971). Canadian group approach study of dangerous sexual offenders. *International Journal of Offender Therapy and Comparative Criminology*, *15*, 59-66.

Marshall, W. (2005). Therapist style in sexual offender treatment: Influence on indices of change. *Sexual Abuse: A Journal of Research and Treatment*, *17*, 109-116.

Marshall, W., Anderson, D., & Fernandez, Y. (1999). *Cognitive behavioral treatment of sexual offenders*. London, England: Wiley.

Marshall, W., & Burton, D. (2010). The importance of group processes in offender treatment. *Aggression and Violent Behavior*, *15*, 141-149.

Marshall, W., Burton, D., & Marshall, L. (2013). Features of treatment delivery and group processes that maximize the effects of offender programs. In J. Wood & T. Gannon (Eds.), *Crime and crime reduction: The importance of group processes* (pp. 159-174). New York, NY: Routledge.

Marshall, W., Fernandez, Y., Serran, G., Mulloy, R., Thornton, D., Mann, R., & Anderson, D. (2003). Process variables in the treatment of sexual offenders: A review of the relevant literature. *Aggression and Violent Behavior*, *8*, 205-234.

Marshall, W., Serran, G., Moulden, H., Mulloy, R., Fernandez, Y., Mann, R., & Thornton, D. (2002). Therapist features in sexual offender treatment: Their reliable identification and influence on behavior change. *Clinical Psychology and Psychotherapy*, *9*, 395-405.

Marshall, W., Thornton, D., Marshall, L., Fernandez, Y., & Mann, R. (2001). Treatment of sexual offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment*, *13*, 205-216.

Moos, R. (1994). *Group Environment Scale: A social climate scale*. Palo Alto, CA: Consulting Psychologists Press.

Morgan, R., Ferrell, S., & Winterowd, C. (1999). Therapist perceptions of important therapeutic factors in psychotherapy groups for male inmates in state correctional facilities. *Small Group Research*, *30*, 712-729.

Nahum, D., & Brewer, M. (2004). Multi-family group therapy for sexually abusive youth. *Journal of Child Sexual Abuse*, *13*, 215-243.

Newbauer, J., & Blanks, J. (2001). Group work with adolescent sexual offenders. *Journal of Individual Psychology*, *57*, 37-50.

Nunes, K., Hanson, R., Firestone, P., Moulden, H., Greenberg, D., & Bradford, J. (2007). Denial predicts recidivism for some sexual offenders. *Sexual Abuse: A Journal of Research and Treatment*, *19*, 91-105.

O'Reilly, G., Morrison, T., Sheerin, D., & Carr, A. (2001). A group-based module for adolescents to improve motivation to change sexually abusive behaviour. *Child Abuse Review*, *10*, 150-169.

Peters, J., Pedigo, J., Steg, J., & McKenna, J. (1968). Group psychotherapy of the sex offender. *Federal Probation*, *32*, 41-46.

Peters, J., & Roether, H. (1972). Group psychotherapy for probationed sex offenders. In H. Resnik & M. Wolfgang (Eds.), *Sexual behaviors: Social, clinical, and legal aspects* (pp. 255-266). Boston, MA: Little, Brown.

Prendergast, W. (1978). *ROARE: Re-education of attitudes (and) repressed emotions*. Avenel, NJ: Adult Diagnostic and Treatment Center Intensive Group Therapy Program.

Prescott, D. (2008). A group for integrating treatment lessons into daily life. *ATSA Forum*, *20*, 1-9.

Quinsey, V. (1977). The assessment and treatment of child molesters: A review. *Canadian Psychological Review*, *18*, 204-220.

Reddon, J., Payne, L., & Starzyck, K. (1999). Therapeutic factors in group treatment evaluated by sex offenders: A consumers' report. *Journal of Offender Rehabilitation*, *28*, 91-101.

Reimer, W., & Mathieu, T. (2006). Therapeutic factors in group treatment as perceived by sex offenders: A consumers' report. *Journal of Offender Rehabilitation*, *42*, 59-73.

Resnik, H., & Peters, J. (1967). Outpatient group therapy with convicted pedophiles. *International Journal of Group Psychotherapy*, *17*, 151-158.

Rich, K. (1994). Outpatient group therapy with adult male sex offenders: Clinical issues and concerns. *Journal for Specialists in Group Work*, *19*, 120-128.

Roether, H. (1972). *A definitive outcome study of a group psychotherapy program with probationed sex offenders* (Unpublished doctoral dissertation). University of Pennsylvania, Philadelphia.

Rogers, C. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

Romero, J., & Williams, L. (1983). Group psychotherapy and intensive probation supervision with sex offenders: A comparative study. *Federal Probation*, *47*, 36-42.

Sawyer, S. (2000). Some thoughts about why we believe group therapy is the preferred modality for treating sex offenders. *ATSA Forum*, *12*, 11-12.

Sawyer, S. (2002). Group therapy with adult sex offenders. In B. Schwartz & H. Cellini (Eds.), *The sex offender* (Vol. 4, pp. 1-14). Kingston, NJ: Civic Research Institute.

Sawyer, S., & Jennings, J. (2014). Facilitating group-centered treatment groups for sex offenders. In M. Carich & S. Mussack (Eds.), *The Safer Society handbook of sexual abuser assessment and treatment* (pp. 125-150). Brandon, VT: Safer Society Press.

Sawyer, S., & Jennings, J. (2016). *Group therapy with those who sexually abuse: Theory, methods, and skills*. Brandon, VT: Safer Society Press.

Sawyer, S., & Prescott, D. (2011). Boundaries and dual relationships. *Sexual Abuse: A Journal of Research and Treatment*, *23*, 365-380.

Schultz, G. (1965). *How many more victims?* Philadelphia, PA: Lippincott.

Schwartz, B. (1995). Group therapy. In B. Schwartz & H. Cellini (Eds.), *The sex offender: Corrections, treatment, and legal practice* (pp. 1-15). Kingston, NJ: Civic Research Institute.

Schwartz, B., & Bergman, J. (1997). Using drama therapy to do personal victimization work with sexual aggressors: A review of the research. In B. Schwartz & H. Cellini (Eds.), *The sex offender* (Vol. 2, pp. 1-23). Kingston, NJ: Civic Research Institute.

Schwartz, B., & Cellini, H. (Eds.). (1988). *A practitioner's guide to treating the incarcerated male sex offender: Breaking the cycle of sexual abuse*. Washington, DC: National Institute of Corrections, U.S. Department of Justice.

Sribney, C., & Reddon, J. (2009). Adolescent sex offenders' rankings of therapeutic factors using the Yalom Card Sort. *Journal of Offender Rehabilitation, 47*, 24-40.

Steg, J., Wright, L., & Peters, J. (1972, February). *Psychoanalytic foundations for group psychotherapy of probationed sex offenders*. Annual Meeting of American Group Psychotherapy Association, New York, NY.

Tasca, G., Cabrera, C., Kristjansson, E., MacNair-Semands, R., Joyce, A., & Ogrodniczuk, J. (2014). The Therapeutic Factor Inventory-8: Using item response theory to create a brief scale for continuous process monitoring for group psychotherapy. *Psychotherapy Research*, *52*, 1-15.

Thornton, D., Mann, R., & Williams, F. (2000). *Therapeutic style in sex offender treatment*. Unpublished manuscript. Retrieved from Offending Behavior Programming Unit, HM Prison Service, London, England.

Tregaskis, D. (2000). *Mix or match? Do adult abusers respond better to treatment in separate or mixed groups?* (Unpublished Master's thesis). University of Birmingham, UK.

Walker, D. (2000). The treatment of adult male child molesters through group family intervention. *Journal of Psychology and Human Sexuality, 11*, 65-74.

Ward, J., & Groener, D. (2015). Group culture in high-risk groups: Developing safety. *The ATSA Forum Newsletter, 27*(1). Retrieved from http://newsmanager.commpartners.com/atsa/issues/2014-12-10/3.html

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

Ware, J., Mann, R., & Wakeling, H. (2009). Group vs. individual treatment: What is the best modality for treating sex offenders? *Sexual Abuse in Australia and New Zealand*, *2*, 2-13.

Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., & Weisz, J. (2005). Iatrogenic effects of group treatment for antisocial youths. *Journal of Consulting and Clinical Psychology*, *73*, 1036-1044.

Whitford, R., & Parr, V. (1995). Uses of rational emotive behavior therapy with juvenile sex offenders. *Journal of Rational-Emotive and Cognitive-Behavior Therapy*, *13*, 273-282.

Yalom, I. (1970). *The theory and practice of group psychotherapy*. New York, NY: Basic Books. (Republished in 1975, 1985, 1995, and 2005).