

Group versus individual treatment of sex offenders: A comparison

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Some authors have argued that group treatment is a more effective treatment modality than individual treatment. However, this may be a matter of confusing cost and time effectiveness with treatment efficacy. Further scrutiny reveals there are still unanswered questions with reference to treatment efficacy. This study examined the efficacy of the Regional Treatment Centre (Ontario) Sex Offender Program (RTCSOP), which consisted of group plus individual therapy (i.e., full treatment program), versus individual therapy alone (i.e., individual treatment program). The treated sample included high-risk/high-needs sex offenders. The relative efficacy of group versus individual treatment of sex offenders was assessed.

Participants

All offenders who participated in this study were referred to the RTCSOP for assessment or treatment and completed treatment in the period between January 1, 1989 and January 1, 1996. The individuals selected represented consecutive admissions to either the RTCSOP full treatment program or the individual treatment program. The full treatment program was only offered to sexual offenders or offenders for whom there was a sexual component to their crimes. Furthermore, the target group for the full treatment program were those sexual offenders identified as being a high risk to re-offend, who also presented with high treatment needs, or both. In total, 205 offenders were considered to meet the criteria for the RTCSOP. One hundred forty-three sex offenders were treated in the full treatment program during the period of this study. Those participants were compared with a group of 62 sex offenders who were provided the individual treatment program. Those individuals who were not considered appropriate referrals for the group therapy modality were screened into the individual treatment program. Reasons for offenders being considered more appropriate for individual therapy included, for example, their having more cognitive impairments (low cognitive functioning), psychiatric based difficulties (psychosis), or difficulties with daily living skills. For individuals involved in both treatment programs, the index offence referred to the offence for which the offender was referred to treatment.

Background

The RTCSOP is the oldest continuously run sexual offender treatment program offered by the Correctional Service of Canada. From its inception in 1973, Dr. W.L. Marshall and Dr. S. M. Williams designed the program for offenders deemed to be at high risk for sexual recidivism or who presented with significant treatment needs or both. Rather than treat offenders for an extended period of time it was felt from the outset that a time-limited treatment program of relatively short duration would be the preferable mode of treatment delivery. Given the available resources it was felt that providing a larger group of offenders with treatment made more sense than providing in-depth treatment to a small number of clients.²

There are three primary components to the RTCSOP program: group therapy, individual therapy, and milieu therapy. The program meets the basic requirement of being sensitive to a client's level of treatment responsiveness. Andrews and Bonta³ first described the responsiveness principle as "delivering treatment programs in a style and mode that is consistent with the ability and learning style of the offender." As demonstrated by recent outcome study which have focussed on the RTCSOP, this philosophy and approach to treating sex offenders has met with some success. Abracen, Looman, and Nicholaichuk found a greater than 2:1 ratio (51.7% vs. 23.6%) with regards to sexual recidivism between untreated and treated sexual offenders, respectively.⁴

Treatment approaches

Full treatment program

All clients attended two groups a week related to victim empathy and self-management. Clients also attended two groups per week run by nursing staff (which included a human sexuality component). The social skills groups related to a variety of issues frequently encountered with high-risk/high-need forensic clients. For example, modules dealing with communication skills, assertiveness, anger

management and problem solving were included. With regards to victim empathy, clients discussed the impact of sexual assault upon victims. Sessions related to relapse prevention were also included as a core component of the program. These sessions included discussions on high-risk situations, lifestyle balancing and the development of relapse prevention plans.

All clients in the full treatment program attended two individual sessions a week with a psychologist and one individual therapy session with a nurse. Each of the individual sessions lasted approximately one hour. Individual sessions with nursing staff were scheduled on an as needed basis. The content of individual sessions varied. With lower functioning clients (cognitive impairment), a number of individual sessions may have been dedicated to discussing material presented in group and clarifying any issues about which the client was confused. The approach was most often on a concrete level except when dealing with higher functioning clients. In other cases, clients may have needed to confront issues associated with minimization and denial in more detail than could be discussed in group. In other circumstances, a number of sessions may have been dedicated to the discussion of thoughts and behaviours related to institutional maladjustment (impulsive or manipulative behaviours). This last issue was particularly true for individuals who met the criteria for psychopathy as measured by the Hare Psychopathy Checklist-Revised.⁵ Finally, all clients attending the full treatment program were provided the benefits associated with living in a therapeutic milieu.

Individual treatment program

Clients assigned to the individual treatment program were provided three individual session a week with a psychologist and one hour of individual treatment with a nurse. Each session lasted approximately one hour in length. Many of the same issues presented in the full treatment program were discussed with the individual treatment clients. However, with low functioning clients the material may have been presented in a more leisurely and concrete fashion. Typically, all the information presented in the full treatment program was not discussed with the individual treatment clients. Nonetheless, basic information related to relationship skills and the self-management component of the full treatment program was typically presented to individual treatment clients. Further, all clients attending the individual treatment program were provided the benefits associated with milieu therapy as they were housed in the same living unit as those individuals who attended the full treatment program.

Milieu therapy

The residential nature of the program was considered to be an integral part of the treatment approach. In addition to the full and individual treatment components, nursing staff spend at least two hours per shift on the unit. Interactions with clients were either formal or informal. Aside from reinforcing the behaviours discussed in-group or individual therapy, nursing staff were able to monitor the behaviour of clients when the clients were not engaged in therapy. Any inconsistencies between what clients said regarding their behaviour in-group or individual sessions and their actual behaviour on the unit were discussed.

Program evolution

As might be expected the RTC SOP has undergone a series of changes since its inception. One of the most significant changes to the program occurred in 1989 with the formal introduction of Relapse Prevention training. Previous to that, specific treatment techniques aimed at empathy enhancement were added in 1986, and the length of the program has changed over time. At the time the study was conducted, the program lasted approximately 5 to 6 months, with clients receiving approximately 8 hours of group therapy and three hours of individual therapy per week.

Procedure

The participants screened as candidates for the two treatment groups were compared with reference to sexual offence category. Participants were coded, based on their sexual offending histories, as rapists (victim 16 years or older), paedophiles (victims 12 years or younger), hebephiles (victims 13-15 years of age), and incest offenders. Offender categories were established for all 143 of the men in the full treatment program and 59 of the 62 men in the individual treatment program. Treatment files were used to classify offenders in this study. Of those offenders for whom offence specific information could be located, 57.3% of the full treatment sample and 52.5% of the individual treatment sample offended against adults. The remaining participants offended against children or adolescents. More specifically, 11.2% of the full treatment sample and 15.3% of the individual treatment sample were coded as paedophiles (victims aged 12 years or younger). In addition, 10.5% of the full treatment sample and 15.3% of the individual treatment sample were coded as hebephiles (victims aged 13-15 years). Finally, 21.0% of the full treatment sample and 16.9% of the individual treatment sample were coded as incest offenders. None of the differences between groups reached acceptable levels of significance.

Results

Matching variables

Analyses were conducted to determine similarities between the two samples of participants, those in the full treatment program and the individual treatment program. Results indicated that participants in the full treatment program and individual treatment program did not significantly differ on most of the pre-treatment variables. Categories of specific interest that were investigated included: age at first conviction, age at index offence, pre-treatment number of sexual offences, and subsequent age at time of release following treatment at the RTC SOP (see Table 1). The two groups were not found to significantly differ on any of the pre-treatment variables.

Treatment outcome

Follow-up analyses were performed among those sex offenders released to the community. For the purpose of the present analysis all offences not classified as sexual according to the *Criminal Code* of Canada were grouped under the heading of non-sexual offences and thus not considered relevant for our analyses. The follow-up periods were $M = 5.05$ ($SD = 2.23$) for the participants in the full treatment program and $M = 6.98$ ($SD = 1.90$) for those participants in the individual treatment program. This difference, that is, the number of years before follow-up was completed with each treatment group, was considered significant, $t(203) = -5.95$, $p < .001$. In order to control for the differing periods of follow-up, a survival analysis was conducted. Results indicated that there was no significant difference in the rates of recidivism for the two groups, Wilcoxon(1) = 2.67, ns. At follow-up, no difference was found between the full treatment program and the individual treatment program when they were compared in terms of number of individuals who recidivated versus those who did not recidivate following post-treatment release, $\chi^2(1, N = 205) = 0.70$, ns. Of those individuals who had been in the full treatment program ($N = 143$), 21 (14.7%) were convicted of a new sexual offence, while 12 (19.4%) of those individuals who had been participants in the individual treatment program ($N = 62$) were convicted of a new sexual offence.

Discussion

Researchers continue to debate whether or not sex offenders benefit from treatment aimed at reducing rates of sexual recidivism. Moving beyond this debate, more specific and pointed issues come to light. One such issue is that of treatment modality

Table 1

Demographic Characteristics	Pre-treatment demographic characteristics						
	Full treatment			Individual treatment			
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>	<i>t</i>
Age at first conviction	20.67	6.45	143	22.94	10.46	62	-1.90
Age at index offence	31.18	7.84	143	33.15	9.49	62	-1.55
Pre-treatment number of sexual offences	1.46	.86	143	1.45	1.21	62	+0.07
Age at time of release	34.48	8.02	143	36.97	9.48	62	-1.93

efficacy. Specifically, this study addressed the relative efficacy of group therapy versus individual therapy in treating and subsequently reducing the risk of sexual recidivism among high-risk/high-needs sex offenders. The current research attempted to assist in clarifying this issue by providing treatment to a group of high-risk/high-need sex offenders in the form of a full treatment program (group plus individual therapy) and an individual treatment program (individual therapy alone). It is, perhaps surprising that no difference in the effectiveness of either the full treatment program or the individual treatment program in reducing rates of sexual recidivism was noted to exist when the treated sample was comprised of high-risk/high-need sex offenders.

Of interest, was the fact that no significant differences in rates of sexual recidivism between the full treatment and individual treatment approaches emerged even though the intensity of the treatments provided to the samples was dramatically different. Overall, clients in the individual treatment program sample received less total treatment (direct contact hours) than did those clients in the full treatment program. The rationale for the discrepancy in the provision of treatment hours was that the level of functioning of clients in individual therapy was such that they could not participate in the full treatment program. For example, such clients may have been more psychiatric, low functioning, or more likely to misinterpret social cues. It may be hypothesized that changes in both groups of offenders resulted from increases in feelings of self-efficacy derived from participation in treatment, regardless of modality. Self-efficacy is believed to arise in clients when they perceive an effective and realistic change strategy to be available and that they are capable of carrying it out.⁶ Clearly, more work needs to be conducted in this area before any definite conclusions can be made.

Implications

Group therapy is typically regarded as more convenient and cost-effective while individual therapy is viewed as more idiosyncratic though it does provide clients with increased levels of confidentiality. One possible implication of the present findings for researchers and practitioners is that rather than endeavour to champion one treatment modality over the other, it may be that more specific recommendations for client treatment modality should be sought. For example, the full treatment program might be better designated for those sex offenders who are of a high-risk/high-need nature but lack the additional burden of cognitive difficulties, social skills deficits or psychiatric problems. In much the same fashion, individual therapy can be reserved for those sex offenders who in addition to being high-risk/high-need have some form of cognitive impairment, social skills deficits, or psychiatric history. Of note, is the fact that decisions such as those described above would include accounting for whether the clients in the individual therapy program are equally high risk as the full treatment clients.

For sex offenders who are cognitively impaired part of the treatment strategy might be to reduce the complexity of the treatment package. One approach might involve reducing the complexity of such an individual's relapse prevention plan. Relapse prevention is aimed at having offenders identify those behaviours, thoughts, and feelings which suggest an increased likelihood that they will re-offend in a sexual fashion. As such, the ultimate goal of a relapse prevention plan is to help reinforce the maintenance of positive behaviour change with sexual offenders. Eccles and Marshall⁷ recognized a

divergence in the amount of material some clients are capable of handling. Rather than striving for an unrealistic objective, they proposed instead aiming for simplicity. In this vein, possibilities include options such as reducing the jargon involved in the relapse prevention plan, defining warning signs in a more specific and concrete fashion (for example, avoid the local shopping mall), and not conveying to offenders the belief that their plan must attempt to encompass all possible future events. Ultimately, they advocate instilling within offenders a more generic problem-solving approach. Early data would suggest that less time spent on developing relapse prevention plans may not prove deleterious to rates of recidivism among sex offenders.⁸ As such, sessions otherwise spent can subsequently be restructured to meet an individual's or a group's idiosyncratic needs. For example, therapists may choose to focus, to a greater degree, on such topics as enhancing intimacy and relationship skills.

Ultimately, as therapists we should be more concerned with benefit to clients. Some high-risk/high-need clients may indeed be sufficiently well served by a full treatment program. Nevertheless, with some clients individual therapy may be more effective. If indeed individual therapy is the more efficacious of the two approaches, among high-risk or at least high-need sex offenders who have additional difficulties, then rather than denying the procedure to clients we should look "to lower the financial burden of treatment by individualizing and lowering fees, adopting long-term payment plans, seeking government and agency contracts to reduce costs, and lobbying for improved third-party coverage for sexual offender treatment."⁹ ■

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