Group versus individual treatment:
What is the best modality for treating sexual offenders?

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Abstract

This paper reviews the different treatment modalities used for treating sexual offenders. We provide an overview of the literature comparing group therapy with individual treatment and summarise the main advantages and disadvantages of both treatment modalities. Group treatment appears to be at least as effective as individual treatment, and there are several clinical advantages obtained through group processes which helpfully address the particular criminogenic needs of the sexual offender population and which are less easily obtained in individual therapy. In addition, we also address the debate about the advantages of open-ended versus closed-group formats. Open-ended groups seem to offer more clinical advantages than closed groups, and in particular allow for treatment to be more responsive to individual needs, although there have been no direct comparisons of the two approaches with sexual offenders. We conclude by identifying the next steps for research.

The content of sexual offender treatment programs and the manner in which they are delivered is based on a large body of theoretical and empirical literature that has evolved considerably over the past 40 years. Notwithstanding these advances, those responsible for implementing treatment programs, and indeed clinicians themselves, should still attempt to hone our knowledge about what is the most effective treatment and how it should be structured and delivered. This is particularly important given that it appears that approximately one of ten sexual offenders will still re-offend even after completing treatment (Hanson et al., 2002; Lösel & Schmucker, 2005). We clearly have an obligation to continue to strive for increased effectiveness.

Group therapy appears to be the treatment modality of choice when working with sexual offenders (McGrath, Cumming, & Burchard, 2003) and, in fact, is preferred for most purposes in correctional settings (Morgan, Winterowd & Ferrell, 1999). A North American nationwide survey of sex offender treatment programs reported that 89.9% used group therapy as a primary treatment modality (McGrath, Cumming, & Burchard, 2003), whereas within Lösel & Schmucker's (2005) meta-analysis of 69 studies of sex offender treatment effectiveness, only seven studies exclusively used individual treatment while a further eight studies using what was described as 'mainly individual treatment'. Within an earlier meta-analysis of 43 studies (Hanson et al., 2002), the type of treatment modality used was not coded although only one study was noted as offering individual treatment. Of the 15 treatment programs for adult male sexual offenders outlined in a sourcebook of sexual offender treatment (Marshall, Fernandez, Hudson, & Ward, 1998), all offered group therapy as the main treatment service. Individual therapy was offered in addition to group therapy as a standard component of treatment in nine out of the 15 programs.

What is not immediately clear, however, is the rationale as to why group therapy is so popular. Is it simply a case of practical considerations - that group treatment is more time- and cost-efficient (Sawyer, 2002)? Or, is it the case that there are important clinical advantages to the use of a group treatment format with sexual offenders? If, as clinical opinion seems to suggest, there are such advantages then have these been empirically demonstrated?

Group treatment can also be delivered in different formats with the use of an open-ended (rolling) format appearing to be gaining in popularity within sexual offender treatment (Fernandez & Marshall, 2000; Ware & Bright, 2008). Yet again, we should be interested in whether any differences between the two formats have been

empirically examined? Is an open-ended group format better than a closed group format? If so – in what ways? We believe that these questions are fundamentally important to those planning to deliver, or who are currently delivering, treatment for sexual offenders, particularly as we endeavour to increase sexual offender treatment effectiveness.

What about the evidence for the use of individual treatment with sexual offenders? In our experience, some offenders voice a strong preference for individual therapy rather than group therapy. Reasons given for this preference are wide-ranging. Perhaps the offender has grave concerns as to confidentiality afforded by a treatment group, especially if it is facilitated within a prison or if he is a notorious offender; or he believes that he is "not like" other sexual offenders; or he suffers from social anxiety and feels he could not function in a group setting; or he suffers from a disability such as profound deafness that means he could not cope with the communication demands of group therapy (e.g., even with excellent lip reading skills, a profoundly deaf offender may be unable to follow a fast-moving conversation involving several people seated in different directions).

Within this paper, we set out to investigate whether or not these questions can be answered by examining the available research to establish the evidence for the use of group treatment. We firstly review what empirical evidence exists that compares group and individual treatment. As only one such study has been published that focuses specifically on sexual offenders as the patient group (Di Fazio, Abracen & Looman, 2001), we also consider studies of cognitive-behavioural programmes and general psychotherapy for a range of other psychological conditions. Aware that the evidence base for each of these questions is limited, we then aim to summarise and evaluate clinical opinion as to the relative merits of group and individual treatment. Additionally, we consider the evidence for the two variants of the group modality: the *closed* group, where all group members start and finish the programme at the same time, and the *open-ended* or rolling group, where admissions and discharges from group are "perpetual and ongoing" (Morgan-Lopez & Fals-Stewart, 2007).

We are aware that there are currently no definitive answers to any of these questions but we aim to articulate the issues and highlight the gaps in knowledge, hoping to inspire empirical consideration of these questions in the future. We also hope to assist those planning to deliver sexual offender treatment, or those who are contemplating changing the format of their treatment, by drawing together the available

information so that those responsible for these decisions are sufficiently informed about current notions of best practice, yet mindful that these notions rely upon clinical opinion as opposed to empirical evidence.

Comparisons of group vs. individual treatment

Sex offender treatment

The contrasts between individual and group-based treatment for sexual offenders have been discussed in detail in a handful of reports (Abracen & Looman, 2004; Maletzky, 1999; Mann & Fernandez, 2006; Sawyer, 2002; Schwartz, 1995). However, experimental studies comparing the two modalities with specific regard to sexual offenders are practically absent (Kirsch & Becker, 2006). This is probably largely due to the usual practical and ethical difficulties that have prevented effective evaluation of sex offender treatment. Many offenders may have been treated both within a group and individual setting, or individual treatment may have only been used to augment sex offender specific treatment (e.g., to reduce social anxiety difficulties) and therefore was not the main modality of change with specific regard to risk of sexual recidivism. It is also difficult to compare different modes of treatments when they may be vastly different in other respects such as intensity of treatment, treatment content, or theoretical orientation.

For example, McGrath, Hoke, and Vojtisek (1998) included offenders who had completed both group treatment and individual treatment in their "specialised treatment" group for their evaluation of their programme's effectiveness. Sexual offenders received group-based treatment for an average of 27 months whereas those receiving individual treatment completed it within an average of 11.5 months. Offenders who received individual treatment were either cognitively-impaired or judged to require less intensive services. In Lösel and Schmucker's (2005) meta-analysis of sex offender treatment effectiveness, they noted that although there were no significant outcome differences between individual and group therapy formats, this was likely to have been confounded by the grouping of highly effective medical/hormonal treatments such as surgical castration under individual treatment. Maletzky (1999) reported that whilst a number of his early studies apparently demonstrated the effectiveness of individual treatment compared to group-based treatment (Maletzky

1993, 1998), these studies were “retrospective, uncontrolled, and geographically limited” (p180).

In the only study that has tried to compare treatment modalities, Di Fazio, Abracen, and Looman (2001) reported that high risk sexual offenders selected for individual treatment based on their cognitive deficits or psychiatric symptoms were as likely to benefit from this treatment as sexual offenders who participated in the full treatment program. Importantly, both forms of treatment were delivered within the same prison unit so that the offenders were exposed to the same therapeutic environment or milieu. Di Fazio and colleagues reported that 14.7% of those who received the full treatment programme (n = 143) re-offended in comparison to 19.4% (n = 62) of those who received individual treatment, at a follow up periods of approximately 5 years. This was not a significant difference.

There are some drawbacks to the Di Fazio et al. study, unfortunately, which mean that it cannot be seen as the definitive answer to our question. First, the participants were not randomly allocated to the two treatment modalities. Indeed the groups were probably not comparable at all, in that those participants allocated to individual therapy had been assessed as not suitable for group work due to cognitive impairment, psychiatric disorder or difficulties with daily living skills. Second, the treatment provided was also not entirely comparable. Individual therapy involved less contact time, and delivered a different programme, tailored to the responsivity needs of the client group. For instance, because of the number of clients with cognitive impairment, the curriculum was translated into more concrete terms in the individual programme than the group programme. Third, although the participants in both modalities were described as “high risk, high treatment need, or both”, the risk assessment procedure used was not described, raising the possibility that the categorisation was not based on a structured scheme. If so, groups may not have been sufficiently similar, in terms of risk of recidivism, to be compared. Fourth, the participants in the group therapy option also received individual therapy, so the study did not involve a pure comparison of two alternative modalities. Indeed, as the group participants received four group sessions a week and three individual sessions, the individual component of the “group” modality was very significant. The participants in the “individual” modality received just one additional hour of individual treatment per week than those in the group modality. In reality, therefore, the study perhaps simply demonstrated that adding group sessions to an individual treatment programme for

those who seemed able to cope with group work did not enhance effectiveness. Finally, the authors emphasised the importance of the wider milieu in which treatment is set, and is clear that in their case, considerable attention had been paid to creating a highly supportive and pro-social milieu or therapeutic community (Abracen & Looman, 2004; see also Baker & Price, 1995 for review of therapeutic communities). It is therefore possible that the milieu in which treatment was set, and the skills of the therapists delivering the various interventions, could mean that the group vs. individual modality was a relatively unimportant difference for the clients in this programme.

In a non-experimental study, Garrett, Oliver, Wilcox, and Middleton (2003) asked a small sample of sexual offenders who had participated in group treatment about their experiences. Of these offenders, 46% indicated that they preferred group treatment (as opposed to individual treatment) and 34% said they would be happy with either. The majority of these offenders reported a positive treatment experience and listed many positive aspects of group therapy, although it appears that few, if any, had actually undertaken individual treatment. A number of these offenders indicated that they would have liked individual treatment as an additional adjunct to group treatment. When asked about the specific benefits of group treatment, offenders referred to the benefits of shared experiences, the opportunity to learn from other with different viewpoints and perspectives, and the experience of being challenged by other group members. Garrett and her colleagues reflected on the lack of available evidence contrasting group and individual treatment.

General psychotherapy literature

In the wider cognitive behavioural treatment and psychotherapy field, more examples of experimentally robust comparisons can be found. Earlier meta-analyses seemed to favour individual therapy (Dush, Hirt & Schroeder, 1983; Nietzel, Russell, Hemmings & Gretter, 1987) but more recent literature reviews (Toseland & Sipiron, 1986) and meta-analyses point to equivalent outcomes for the two modalities (Hoag & Burlingame, 1997; McRoberts, Burlingame & Hoag, 1998). McRoberts et al.'s meta-analysis is particularly robust because these authors also explored whether client, therapist, treatment, methodological or group differences might explain any differential outcome - although their conclusions were limited because the majority of the studies reviewed had failed to report the relevant information. Such an approach is valuable because many comparison studies are extremely limited by confounding variables such

as differences in patient characteristics (as with Di Fazio et al., reviewed above). McRoberts et al. found, overall, little difference between group and individual outcomes. Even when statistically significant differences were observed, these were very small and unlikely to have been clinically significant. Looking more specifically at the cognitive-behavioural therapy studies they found a better outcome for individual treatment over group therapy. The number of cognitive-behavioural studies included, however, was too small for this to be considered a robust finding.

More recent studies with various non-forensic populations underscore the finding that the two modalities are equally successful, or seem to be slightly in favour of group treatment over individual treatment. For instance, Renjilian et al. (2001) compared the effectiveness of individual and group therapies for obese adults, randomly assigning participants to either their preferred or non-preferred modality. Group therapy produced significantly greater weight loss at follow-up than individual therapy regardless of the individual's preference. Similarly, female survivors of child sexual abuse seem to do better in group therapy, although there are some indications that a combination of group with individual therapy may be more successful than either modality alone (Lubin, 2007). A review of comparison studies for adults with depression revealed that individual and group therapies were comparable with each other and either modality was effective (Lockwood, Page & Conroy-Hiller, 2004). Similarly, for adults with insomnia, group therapy, individual face to face therapy and individual telephone consultations were all equally effective (Bastien et al., 2004). The treatment of children with anxiety disorders is also effective, irrespective of whether it is conducted in a group or individual format (Manassis et al., 2002).

Weiss, Jaffee, de Menil, and Cogley (2004) reviewed the use of group and individual therapy for individuals with substance use disorders. Of particular note, they used six research design categories, including group vs. individual therapy, group therapy plus individual therapy vs. individual therapy alone, and more group therapy vs. less group therapy. Their review concluded that few differences were found between group and individual therapy. They concluded that these two modalities of treatment can be equally effective when treatment content, intensity, and length of treatment are kept equivalent (se also Marques & Formigoni, 2001). They further concluded that given the relative cost-effectiveness of group therapy, this should be the modality of choice.

Tucker and Oei (2007) reviewed the comparative cost effectiveness of group versus individual cognitive behavioural therapies for a range of mental disorders. Although critical of methodological weaknesses in the 36 studies that they reviewed, they concluded that there was only weak evidence as to the relative cost effectiveness of group therapy. Tucker and Oei also reviewed the comparative efficacy of group versus individual treatment formats for mentally disordered individuals. On this matter, they concluded that "the balance of evidence appears to fall somewhere between equal treatment effects and individual CBT being superior" (p. 83), particularly for those individuals who are severely impaired (see also Manassis et al., 2002).

Although this is only a brief review, it appears that the consensus from the general psychotherapy literature is that the two modalities of treatment are equally effective for most mental disorders. There is some, albeit weak, evidence that group therapy is a more cost effective approach to treatment.

Clinical opinion regarding group therapy vs. individual treatment for sexual offenders

Advantages of group treatment

In a climate of restricted fiscal resources, an important advantage of group treatment is often assumed to be that it is more time- and cost-efficient (Sawyer, 2002). Two therapists running a group with eight participants will treat four times as many patients in the same time as two therapists working with patients individually. This advantage seems undeniable; however, it does not justify group work in preference to individual work unless it is also effective. Some commentators have claimed that sexual offenders are treated via group work *purely* because it is cheaper; but there are other advantages as well.

One such argument is that group treatment is a more beneficial modality because sexual offending is an interpersonal behaviour and sexual offenders tend to demonstrate pervasive deficits and distortions in interpersonal relationships (Jennings & Sawyer, 2003; Marshall, Anderson, & Fernandez, 1999). Group-based treatment, by its very format, offers opportunities to explore interpersonal deficiencies and develop new skills such as resolving conflict, communicating emotions and learning about one's impact on other people. Ward, Vess, Collie, and Gannon (2006) noted that every aspect of group treatment involves the opportunity for interpersonal skills training and,

further, that the "therapy group is an external condition that can act as a catalyst for the development of a whole range of treatment related competencies" (p 389).

Group treatment provides opportunities for multiple sources of challenge, positive feedback and support, vicarious learning, and (within a residential setting such as a prison) reflection upon each others' behaviours outside of the group room (Frost & Connolly, 2004; Marshall et al., 1999; Salter, 1988; Sawyer, 2002). Furthermore, given that sexual offenders are a stigmatised group in almost all cultures, the distress associated with this stigma could be alleviated by finding others who share the same problems. Glaser and Frosh (1993) suggested that group treatment was the most appropriate treatment method with sexual offenders as it breaks down the secrecy inherent in sexual offending. Perry and Orchard (1992) noted that, with adolescent sexual offenders, peer interactions including both support and confrontation are an advantage of group therapy. Spencer (1999) discussed the need for groups to be heterogeneous, including a range of different offence types, so that challenges can be made from differing viewpoints.

Indeed, in the English and Welsh prison programme (Friendship, Mann & Beech, 2003); the use of group process is formally defined as one of the expected agents of change (HM Prison Service, 2000). It is intended within this programme that (provided therapists create cohesive groups with pro-change norms and a sense of optimism about change) peers in the group will motivate each other to change, will provide feedback and suggestions about thinking errors, and will participate in role-plays with each other that will provide rich and powerful experiences of alternative functioning. None of these benefits would be so readily available in individual therapy sessions. As Marshall and Barbaree (1990) wrote, "Other group members can often provide insight into fellow patients' problems on the basis of personal experiences which the therapists do not have" (p. 370).

Therefore, group treatment probably provides opportunities for change that individual therapy cannot provide, because of the greater range of potential learning sources to which a group member is exposed. These clinical opinions appear to be backed by research evidence, albeit in the general psychotherapy literature. As an example, to explore this particular opportunity offered by group work, Fuhriman and Burlingame (1990) compared group and individual psychotherapy in terms of process variables. Both modalities shared the goal of creating a helping relationship, and both modalities were characterised by the same factors of insight, catharsis, reality testing,

hope, disclosure and identification. Unique to group work were vicarious learning, role flexibility (client being able to act both as help-seeker and help-provider), universality (group members realising that others share their problems), altruism, family re-enactment and interpersonal learning. Similarly, Holmes and Kivlighan (2000) found (with university student counselling clients) that group therapy seemed to enhance opportunities for feeling supported and encouraged, and learning about other people. While it is possible for such factors to be present in individual treatment, group therapy offers a wider network of others from whom learning can take place.

These advantages uniquely distinguish the clinical value of the group therapy over individual treatment for sexual offenders and are consistent with Yalom's (1995) views on group work. Yalom identified a range of what he termed "curative factors", or therapeutic factors, related to the success of group treatment. These are listed as follows: instillation of hope, universality, imparting information, altruism, the corrective recapitulation of the family group, development of socialization techniques, imitative behaviour, interpersonal learning, group cohesiveness, catharsis, and existential factors. If these factors do enhance the effectiveness of treatment, and are unique to group work, then the argument for group treatment over individual treatment is strengthened (Clark & Erooga, 1994; Sawyer, 2002). These curative factors have been studied extensively within the general psychotherapy literature (Scheidlinger, 1997), to some degree within forensic settings (e.g., Morgan, Ferrell, & Winterowd, 1999), and only recently and in a limited capacity with sexual offenders (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005).

Beech and Hamilton-Giachritsis (2005) administered the Group Environment Scale (GES, Moos, 1986) to 12 different sexual offender treatment groups at six different prisons within England and Wales. Pre and post-treatment measures was also assessed to determine treatment induced changes in offending attitudes. They found that group cohesiveness and expressiveness were strongly related to positive treatment outcome (significant reductions in pro-offending attitudes), particularly when other potentially confounding variables such as content of treatment were kept constant.

To conclude this section, we have reported on the view that group work has unique characteristics, and have suggested that these unique characteristics, such as the ability to learn from peers, are particularly likely to benefit sexual offenders.

Disadvantages of group treatment

Both Maletzky (1999) and Di Fazio et al. (2001) surmised that those jurisdictions or agencies who choose only to offer group treatment to sexual offenders do so for financial or convenience reasons, not for effectiveness reasons. Both concluded that group treatment is likely to be efficacious for most sexual offenders, but importantly, not all. They advised that individual treatment should be available as an alternative for those offenders who are less likely to benefit from group therapy. Such a recommendation sounds sensible and is certainly in line with the responsivity principle of offender rehabilitation and the ethical and practice guidelines of the Association for the Treatment of Sexual Abusers (Andrews & Bonta, 2003; ATSA, 2005).

Specific to adolescent sexual offenders, it has been argued that behavioural problems in high risk adolescents may increase as a result of group treatment formats due to "deviancy training" – where the exposure to other anti-social peers leads to reinforcement of criminal attitudes and behaviour (Dishion, McCord, & Poulin, 1999). Brown (2005) noted that it is possible that group therapy encourages offenders to set up problematic networks, possibly resulting in increased offending post-treatment. However, Weiss et al (2005) argued that the influence of peers within a treatment group was far less than the influence of other anti-social peers outside group sessions and found little support for the deviancy training hypothesis. Brown (2005) warned that sexual offenders may enjoy listening to other's offending details, learn new techniques for offending, or develop new sexual fantasies, although she noted that there is very little empirical evidence suggesting this to be the case (p. 100). The opposite may also be true. Some offenders object to hearing the offence details of others. In these instances, there may be an opportunity for an offender to experience vicarious traumatisation, although again this has not been examined empirically.

Kirsch and Becker (2006) argued that treatment delivered within a group format is "essentially the same for all members, which limits a clinician's ability to modify treatment or provide individualised therapy that is geared towards an offender's unique needs" (p. 215). Arguably, this statement appears more valid with closed group treatment formats compared to the more flexible open-ended group approach (see below).

Maletzky (1999) cautioned against the "tyranny of the group" where therapists place too much emphasis on the decisions of the therapy group as a whole. He noted that this often culminated in offenders within the group having an artificially inflated sense of importance, fighting amongst themselves, and placing undue importance on

the group setting, often with chaotic results. Maletzky (1999) further notes that a treatment group where there is a pervailing lack of trust and confidentiality may also decrease treatment effectiveness.

It is possible that men may be more likely to react negatively to the idea of group treatment, especially if they are "gender-role conflicted" (Blazina & Marks, 2001). That is, men who have been traditionally socialised may feel that help-seeking is at odds with being masculine; they may fear intimacy and emotional vulnerability; and they may dislike the idea of exploring their emotional inner lives. Blazina and Marks also suggested that men may believe that entering therapy equates to a loss of power, which may be particularly problematic if the therapist is a woman. Blazina and Marks found that men with a higher gender-role conflict felt more negatively about therapy (both group and individual) but their most negative reaction was directed at the idea of a men's support group in particular, compared to individual therapy or a psychoeducational group. This study did not find a negative reaction to therapy in gender-role conflicted men who had previous experience of therapy, suggesting that an aversion to group therapy is overcome once the group environment has been experienced. Given that gender-role conflict is associated with hyper masculinity, a risk factor for sexual offending, it may therefore have criminogenic benefits to encourage male offenders to overcome an aversion to group therapy, but in so doing the therapist may have to expect, and manage, some resistance on the part of the offender.

Finally, where individual treatment is not offered as an alternative, there may be high rates of treatment drop outs or discharges from group therapy, purely because the sexual offenders who have expressed an unwillingness to attend may feel forced to do so, or are unable to cope adequately with the group therapy context. Given that treatment discharges and drop-outs are at increased risk of sexual recidivism (Hanson et al., 2002), this is an important consideration.

Advantages of individual treatment

Individual treatment has certain practical advantages (Abracen & Looman, 2004). Group therapy might not be possible in certain prison or community contexts, either due to physical constraints such as lack of sufficiently sized rooms or in certain prison environments where to be identified as a sexual offender is potentially life threatening. Private practitioners working in the community are less likely to facilitate group treatments either due to environmental constraints, funding difficulties as it can

actually be more expensive to run facilitate group therapy programs, or perhaps due to safety considerations (e.g., the problem of a female therapist running group therapy sessions in the community in the evening). As noted earlier in this paper, offenders may state emphatically that they would prefer individual treatment and unless it is offered either refuse all other offers of treatment, or drop out of treatment before completion. Offenders may be so socially impaired so as to make group treatment practically impossible or they may have committed crimes considered to be so unusual or bizarre (e.g., necrophilia) that they may find group treatment with other sexual offenders too difficult (Schwarz, 1995). Individual treatment is also reported to be preferred with highly disruptive offenders, who would otherwise be a negative influence in a group treatment setting (Serin, 1995).

Maletzky (1999) noted that individual treatment is likely to offer more idiosyncratic treatment and attention and that certain individuals may simply respond better to individual treatment. Salter (1988) also noted that within individual treatment, the offender cannot receive any reward by failing to complete treatment assignments as opposed to within group therapy where an offender can effectively remain silent for periods of time. Consistent with this notion, Holmes and Kivlighan (2000) found that compared to group treatment, individual treatment produced greater insight and clarity about how to address problems. As an example of this, Williams (1995) suggested that individual treatment offers the best opportunity to explore an individual's offending details (e.g. the offence chain). Abracen and Looman, (2004) noted that the individual mode offers treatment opportunities to those who may be unlikely to cope in conventional group settings, and greater flexibility within sessions and in terms of overall treatment length. In addition, Maletzky (1993) argued that behavioural techniques, specifically designed to modify deviant sexual interest, are more easily applied within an individual treatment context.

Schwartz (1995) in considering the pros and cons of individual treatment listed a number of possible advantages. The offender is likely to receive more individual attention than is available within group sessions. There is likely to be more confidentiality afforded to the individual (a common reason sexual offenders give for refusing to participate in group treatment) and greater opportunities for the therapist to build a therapeutic alliance and to work on trust and engagement issues. It could be argued that the trust being built between a sexual offender and an individual therapist

mirror the dynamics of interpersonal intimate relationships where many sexual offenders have significant deficits or problems.

Disadvantages of individual treatment

Schwarz (1995) listed almost twice as many disadvantages of individual treatment. In doing so, she stated that sexual offenders are especially difficult to treat within individual treatment largely due to their characteristics of denial and secrecy. Schwarz also noted that "individual therapy may replicate the dynamics of sexual assault" (p14-2) in that the offender may view the therapeutic relationship as "secret", "exercise power and control within the relationship", and even may attempt to "covertly sexually assault" the therapist. Other disadvantages noted by Schwarz included that the therapist may be easily manipulated, offender denial may be more easily maintained, there is less opportunity to practice and develop social skills, and less opportunity to learn empathy or to engage in the helping of others. There is also greater pressure upon the individual therapist to question the offender over his distorted beliefs and attitudes rather than being able to facilitate peers to guide each other in assessing biases in their thinking.

Many clinicians advocate for individual treatment to be used, but only in addition to group treatment (e.g., Salter, 1988). However even when individual treatment is used as an adjunct, Schwarz (1995) cautioned that it may have the effect of undermining group treatment participation, giving the offender the opportunity to form an alliance with the therapist within an individual treatment context and, in so doing, resist the pressures of the group to "open up" in front of them (p14-3).

Mann and Fernandez (2006) noted that the biggest organisational disadvantages to individual treatment are the perceived issues relating to cost and time.

Comparisons of open-ended (rolling) and closed-group formats

Sex offender treatment

Open-ended (or rolling) treatment groups are different from closed-groups in that offenders within the group do not start treatment at the same time, although they will complete the same treatment modules. At any given time offenders within an open-ended group may be working on different modules (e.g., offence analyses, motivational exercises, or relationship skills) and the time taken to complete treatment

may differ greatly (Fernandez & Marshall, 2000). Some jurisdictions use open-ended groups only with low and moderate risk sexual offenders (Mann & Beech, 2003) whereas other jurisdictions use that format with all offenders including those assessed as high risk of recidivism (Marshall et al., 2006; Ware & Bright, 2008).

In describing changes made to a high intensity sexual offender treatment program, Ware and Bright (2008) identified numerous advantages to an open-ended format over a closed group. First, an open-ended format allows for greater individualisation of treatment, because each group member can spend as much or as little time as they need on each treatment target, rather than having to move at the pace of the majority. The individualisation is possible to an extent that is equates with that possible in individual therapy (Proeve, 2003). Because of this, an open-ended group is particularly good at meeting the risk principle of offender rehabilitation, whereby higher risk offenders need higher doses of treatment (Andrews & Bonta, 2003). Second, group members can be suspended from the programme if they behave problematically or if they have crises to attend to outside the group, and can re-enter at a later date without having to return to the beginning of the programme. This is not possible in closed groups. Third, open-ended groups can take referrals into treatment at short notice, whereas referrals to closed groups have to wait until the start of the next programme. This advantage is particularly useful in rural community programmes where it could take months to collect enough group members to start a closed group. Fourth, open-ended groups can treat offenders more efficiently. Ware and Bright estimated that 55-60 offenders can be treated in an open-ended group format for the same resources that would be needed to treat 40 offenders in a closed group. Lastly, open-ended groups offer particular advantages to group members in that senior group members (those who have been in the programme longer) can adopt a mentoring role towards newly-entered group members. Open-ended groups therefore maximise opportunities for vicarious learning and for offenders to practice interpersonally nurturing behaviours towards others.

To this end, the use of an open-ended group format may minimise a number of the disadvantages of group therapy that were outlined above. Notably, the existence of senior members who have made positive treatment progress as well as "new" members may decrease the likelihood of "deviancy training" (Dishion, McCord, & Poulin, 1999) and the development of problematic (antisocial) networks. The use of suspensions

rather than discharges also allows increased control over disruptive behaviours (and therefore less treatment non-completions).

There is, as yet, little empirical evidence to support these views. It appears that although the relative advantages of open-ended groups has been outlined, there does not appear to have been any qualitative or quantitative research investigating the relative merits and effectiveness of open-ended versus closed-group formats when treating sexual offenders. Further, it is not clear whether open-ended groups would be effective with all types of sexual offenders, such as individuals with developmental disability. To make these comparisons every more difficult, it is often unclear in existing treatment outcome studies which group treatment format was used. It appears that the majority have used closed-group formats, with some notable exceptions (e.g., Levenson & Macgowan, 2004; McGrath, Hoke, & Vojtisek, 1998; Marshall et al., 2006).

Ware and Bright (2008), however, described an interesting array of benefits when they changed from running a closed programme to an open programme, including benefits in terms of resource co-ordination, treatment process, and for the therapists who facilitate them – all of which are important to consider when planning treatment. Where under the closed programme sometimes as few as 50% of treatment places were filled, under the open-ended programme all beds were continuously filled. The treatment attrition rate dropped dramatically (paralleling Hoffman et al., cited above); and drop-outs from previous closed programmes returned and completed their treatment. The milieu of treatment improved and staff reported feeling more effective and positive in their work. Staff also reported that they felt less pressure to achieve change at any particular point in the programme.

In line with these latter findings about the views of staff on open-ended programmes, Fernandez and Marshall (2000) reported that therapists who facilitate open-ended groups found them more interesting and felt that therapeutic relationship with group participants were more easily attained. Conversely, however, therapists also often state that open-ended groups require greater flexibility which, in turn, requires a greater knowledge of treatment concepts and methods and the ability to "think on your feet". In our view these attributes are desirable in therapists (Frost, Ware, & Boer, 2008) and are consistent with what research has suggested are features of therapists positively related to beneficial treatment change. The most important influencing features were appropriate levels of empathy and warmth, rewarding offenders for their

achievements, and the provision of some degree of directiveness (see Marshall, Serran, Fernandez, Mulloy, Mann, & Thornton, 2003).

General psychotherapy literature

Again, due to the paucity of research in the sexual offender area we turn to the general psychotherapy literature to investigate what evidence exists concerning the comparative utility of open-ended versus closed group treatment formats. What is immediately apparent is that there seems to be an across-the-board lack of research into this question, although plenty of clinical opinion – notably supporting the conclusion that open-ended groups are superior because of their logistical advantages (Galinsky & Schopler, 1987; Schopler & Galinsky, 2005). Morgan-Lopez and Fals-Stewart (2007) report that the relative difficulties inherent in studying open-ended groups has resulted in a lack of research efforts, and importantly, in their view it may have also contributed to researchers simply not including open-ended groups in their research designs. Roback (2000), in his overview of the literature relating to adverse outcomes in psychotherapy, recommended that more research is needed using different group formats, particularly open-ended versus closed groups.

In an early study, Tomsovic (1976) compared the use of closed group encounter therapy and open group therapy with a group of alcoholics. The open group therapy involved a group experience in which members were constantly entering and leaving the group. The two groups observed were similar in demographic, social and psychological characteristics. The study found that the closed group resulted in greater changes in self-concept compared to the open group experience. Treatment teams also felt that the closed groups achieved more cohesiveness and trust than the open groups. However this finding may have been to do with the size of the groups, with the closed groups being generally smaller than the open groups.

Hoffmann, Gedanken & Zim (1993) described their experiences of running an open group therapy at a university counselling service compared with the traditional closed group model. The open group model differed from the traditional closed group structure in that members were not screened prior to their acceptance on the group; members were not obliged to attend on a regular basis if they did not wish to; the number of participants and life span of the group was not predetermined; and new members were able to join the group at any time. The treatment providers found that the open group format facilitated and expedited group cohesiveness. In particular, the

fact that students had a choice to attend (or not), seemed to increase their motivation and willingness to engage, as well as their self-esteem. Interestingly the rate of drop out in the open group was also lower than the traditional groups' drop out rate.

Graham (1999) examined the comparative effectiveness of open-ended and closed children's grief support groups. She noted that both groups were equally effective in alleviating symptoms associated with the children's grief, such as increasing the child's sense of self-concept and reducing their experiences of grief, although open-ended groups appeared to have a longer lasting impact on grief than the closed group.

Finally, Tourigny and Hebert (2007) directly contrasted closed and open-ended groups used with sexually abused adolescent girls. Establishing firstly that both types of group therapy did produce significant treatment results, they also concluded that the two modalities were equally efficient in reducing the symptoms associated with sexual abuse. Given the relative equivalence between the two group therapy modes they then point out the relative logistical advantages of open-ended groups, notably the reduction of waitlists and the decreased problems with treatment drop outs.

There is a surprising lack of available evidence within the general psychotherapy literature as to the comparative utility of open-ended versus closed groups. The evidence that does exist seems to suggest that both formats are equally effective at producing significant treatment results, although there are considerable logistical advances provided by open-ended groups.

Conclusions and research directions

This review aimed to examine the evidence about whether group or individual treatment should be used with sexual offenders and the advantages and disadvantages of each modality. While there are no conclusive answers in what is a small and equivocal literature, it appears on current evidence that group treatment is likely to be at least as effective as individual work, if not better. There are also persuasive clinical reasons to suppose that the processes involved in group treatment will particularly benefit sexual offenders because of the nature of their known deficits; and on balance the advantages of group treatments seem to outweigh their disadvantages. Group treatments are also more extensively evaluated and they are probably cheaper. In our view, group-based treatment can be justified as the usual approach to take with sexual offenders.

That is not to say individual treatment should be abandoned. It is likely that many sexual offenders would benefit from individual treatment, and certainly some offenders indicate that this would be their preference, although we are also mindful that group treatment programmes can be specifically adapted in content or delivery to suit most offenders (e.g., Keeling, Rose, & Beech, 2006; Ware & Marshall, 2008). However, it is clear that certain offenders may respond more positively to certain modalities (i.e., group-based or individual treatment) at certain times or within certain contexts. What is not yet clear enough is who these offenders may be?

On the basis of the available evidence, our review suggests that open-ended groups may have significant advantages over closed groups. To further our understanding of these issues, the sexual offender field needs to produce studies whereby offenders are randomly allocated to group treatment, individual treatment, or a combination of both. In particular, it is our view that research categories such as those outlined within the Weiss, Jaffee, de Menil, and Cogley (2004) review need to be evaluated for sexual offenders. Of course, we acknowledge that there are practical difficulties in doing so, not least the difficulties inherent in establishing that these treatment formats actually deliver the same treatment. The sex offender field has struggled to conduct randomised controlled trials involving a no-treatment option. However the ethical objections to such designs would not apply to studies comparing different treatment modalities, so such studies should in theory be easier to set up. Weiss and colleagues noted that this problem also exists within the general psychotherapy literature. They stated that "the discrepancy between the wide spread use of group therapy in clinical practice and the paucity of research on this topic stems, in part, from the inherent difficulties in conducting meaningful research on group therapy" (p. 348).

Other key questions remain unanswered and we encourage researchers within the field to attempt to address these. For example, we suggest that there is a need to test the hypothesis that group treatment produces enhanced interpersonal learning through the group process itself. If group process produces benefits in relation to criminogenic targets, then this is an important reason for group work to be the preferred modality. Given that one of the most oft-mentioned concerns about group treatment is that this modality limits individualisation, we recommend this as another topic for investigation. Many clinicians believe there is considerable scope for individualisation possible within group treatment, but this needs further empirical confirmation. It would

also be useful to investigate the nature and impact of the processes that occur in individual therapy, from both the patient's and the therapist's perspective. The complicated dysfunctions observed in sexual offenders' attachments and personal relationships may be more disruptive to individual therapy than in group therapy.

Such studies do not necessarily require large sample sizes, so should be within the reach of many of those providing treatment to sexual offenders. At the very least, we hope that treatment providers who change their treatment modality for whatever reason will follow the example of Ware and Bright (2008) and document the impact of the changes, as this information is valuable to other jurisdictions. Finally, we believe that one of the most pressing research questions that needs to be answered, is who would benefit most from individual treatment as opposed to who would benefit most from group treatment, and what are the characteristics of these offenders?

These research questions are important issues to explore as we continue to strive for the enhancement of our treatment effectiveness, and we hope that this review will stimulate research interest in the future.

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