Groups of One

The offender wore rough, but clean, clothing. His hands were soiled from the job he had left 30 minutes earlier and he looked downcast, even distraught. “I’m being kicked out of my treatment program because I couldn’t finish my assignments. I had to work two jobs to support two households. Now my PO will put me back in jail and I’ll lose my jobs.” Sexual offender matters are rarely that straightforward so I called his therapist. “Bob attended regularly but said his work got in the way of completing his assignments. The group voted to evict him.” What did the therapist think of the group’s collective wisdom? “We have to go with what the group elects.”

During the 1960s, in what was called “milieu therapy,” groups reached decisions on dozens of important issues, not only about the patient’s day-to-day life but about his treatment plan as well, including when to discharge him from an inpatient program, whether he should take medications, or even whether he should continue in therapy. The theory driving this type of treatment was that of self-determination: The more involved and responsible a patient was in therapy, the greater the benefit derived. Not only were such groups usually not helpful to individuals with psychiatric illnesses, they were sometimes destructive. In the frenzy of patient liberation and democracy were born ill-conceived treatment programs directed by whim and guess, often informed solely by implication and innuendo. As we enter the next millennium, such programs appear only rarely in inpatient settings; they were abandoned after proving harmful.

However, tyranny of the group may persist in specialized programs relying on group therapy as the chief venue of treatment for the sexual offender. Bob’s case is not unique. A number of both inpatient and outpatient programs continue to rely upon group decisions on matters ranging from adequacy of a disclosure letter to approval of returning home to a potential victim. However, it is in just these crucial areas that the therapist, hopefully, possesses the expertise and training to render an informed opinion and the requisite courage to take decisive action. Leaving decisions to groups of offenders not only abrogates this responsibility, it places an unfair burden on individual patients to make choices of which they are not capable. In some unfortunate cases, it artificially inflates their sense of importance.
and promotes infighting and schisms within groups. While group choice appears to promote democracy and determination, it may produce chaotic results.

Group choice may be an effect secondary to group culture. If group therapy is the sole treatment modality, the weekly meetings become enshrined, imbued with an almost religious aura of significance. The primary purpose of any such therapy, however, is to reduce sexual offending, not to promote self-esteem or independence. Indeed, secondary measures of efficacy, such as increased self-disclosure and honesty, enhanced assertiveness, and elevated social skills, cannot substitute for direct measurements of treatment efficacy because they have not been validated as independent measures of recidivism (Hanson, 1997) and they vary too greatly from individual to individual.

Indeed, in this issue, McConaghy echoes the concerns voiced by Barbaree (1997) that treatment effects, as measured by recidivism studies, are still flawed by methodologic problems and are too weak statistically to convince the skeptical investigator that treatment is effective. To some extent, these criticisms are valid, if gloomy, and need to be addressed with the type of corrective research already proposed (Maletzky, 1998) and recently initiated (Hanson, 1998). However, the vast majority of programs investigated (Hall, 1995) have employed group therapy as the only medium providing "cognitive/behavioral treatment to offenders." This therapy was originally (Maletzky, 1993; Pithers, 1990) offered in one-to-one fashion. Could such individual treatment prove superior?

While several studies demonstrate the efficacy of individual, as opposed to group cognitive/behavioral therapy (Maletzky, 1993, 1998), these are retrospective, uncontrolled, and geographically limited. It is common to urge additional research in this area, but it might also prove instructive to explore the reasons why individual treatment is not often offered, particularly in an area as idiosyncratic as sexual response. Group therapy could be more effective but there is no evidence for this. It is more likely that group is often chosen due to extrinsic factors such as therapist convenience, scheduling, and cost. These are not unimportant but appear to be generated by concerns other than maximum efficacy.

Providing one-to-one therapy is time-consuming, labor-intensive, and expensive, yet it offers an unparalleled opportunity to explore individual parameters of relapse prevention and to decondition idiosyncratic patterns of arousal not possible in a group setting. It offers the advantages of more personal and intensive treatment and the opportunity to reassess continually how each patient is progressing. Moreover, we certainly can do more 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. (Treatment for drug and alcohol abuse was considered radical two decades ago; now universal coverage is common.) Nothing will undo our field more surely than the perception that it is entered solely for financial gain.