

## **An Integrated Humanistic Approach to Outpatient Groups for Adult Sex Offenders**

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### **Introduction**

This article describes an integrated/humanistic approach to outpatient group treatment of relatively low-risk adult sex offenders deemed appropriate to manage in the community. Group therapy is often utilized as a major component of sex offender treatment (Loss, 2001). The approach described herein emphasizes positive relationships among group members and a safe climate as the foundation of treatment. We contend that therapeutic gains are more likely when clinicians employ and promote a climate of acceptance of the offender while condemning the offense. Our approach is grounded in the ideas espoused by Blanchard (1995). This article will be useful for practitioners at all experience levels who may work with sex offenders and for counselor educators who train those practitioners.

Many approaches to sex offender group treatment stress confrontation as a primary therapeutic tool and focus on breaking through denial. We believe that such approaches result in pseudo-compliance by clients (i.e., clients say what they believe the counselor wants to hear using the vocabulary that has been prescribed). However, clients are more likely to explore underlying dynamics that contributed to their offense, such as low-self-esteem and shame, when they feel safe. They are more likely to improve social skills and decrease isolation when they feel understood, accepted, and supported. Our clientele benefit from being treated as complex individuals who

have committed a sex offense, rather than as *sex offenders*, who are defined by their crime.

We provide outpatient treatment to offenders at various points in the adjudication process. Some begin treatment prior to sentencing, while for others treatment is part of the sentence. Some are on parole after serving prison time for their offense. The group is an open group, with members beginning and leaving the group as appropriate to their treatment and legal status.

The goals of our outpatient sex offender groups are as follows: (a) to prevent recidivism, (b) to explore the offender's history as a victim of abuse and the relationship of those experiences to the offenses, (c) to explore intrapersonal characteristics that contributed to the offense, (d) to use the interpersonal relationships within the group as a template for improvement of clients' social skills, (e) to educate about and explore offender dynamics related to offending behaviors, and (f) to assist the offender in accepting responsibility for his behavior.

It is appropriate to discuss here requisite clinician characteristics for conducting this type of group. Because few clinicians receive specialized training in working with sex offenders in graduate programs, they often rely on continuing education, reading, networking, and mentorships for their training (Smith, 1995). The clinician's personal history of abuse must be addressed before undertaking the facilitation of this type of group to ensure that countertransference does not drive their behavior in the group. Clinicians must reflect on their attitudes and beliefs about sex offenders. If they perceive offenders as despicable individuals who should be removed from society, they will be unable to effectively facilitate this type of group. If clinicians believe that all offenders are manipulative, conniving narcissists who prey on others, they are unlikely to create an atmosphere in which important self-disclosure will occur. Clinicians must be able to tolerate hearing about horrendous behaviors and, at the same time, not condemn the perpetrator of those behaviors. It is recommended that a cofacilitation model be used to provide support and an opportunity to process difficult material.

In addition to the dynamics found in all groups, there are several issues that are unique to outpatient sex offender groups that clinicians must be prepared to address. An important consideration is that of denial of the offense. As Schwartz (1995) observed, offenders frequently deny the offense, offering a range of rationalizations for the event. Some programs may refuse to treat individuals who do not admit to at least the index offense. Others focus on confronting the denial, which often increases the resistance of the client. We agree with Schwartz that “paper-thin defenses will crumble once the individual understands that the clinician will not reject him and brand him as a sex-crazed pervert” (p. 14–6).

The development of empathy for others, both for members of the group and for victims, is an ongoing challenge that requires continual monitoring. Offenders may be preoccupied with their own problems and fears and may have difficulty appreciating the feelings of others. Facilitators need to intervene actively to encourage the development of empathy.

Transference takes on particular significance in this type of group. Members make assumptions about each other and about group facilitators that, in a safe and accepting environment, can be explored and distortions corrected. Having male/female cofacilitators increases opportunities for transference distortions, particularly as members perceive different aspects of the relationship between co-facilitators. This is very valuable as a tool for the offender to better understand himself and his relationships.

Shame is another major theme in these groups. In many cases, shame is a contributor to the offense, in that the individual may have been traumatized sexually himself, an experience that was never dealt with. In most cases, shame is also a consequence of the offense. Offenders in our groups had conventional attitudes toward sex offenders prior to their own offense. They believed anyone who could commit such an act was a sick, perverted individual unworthy of compassion. Those beliefs do not disappear when the person commits a sex offense; rather those beliefs lead to deep shame about their behavior.

Predictably, the impact of sex offender registration becomes a focus of discussion. Offenders must grapple with the impact of registration on their efforts to seek employment and interact with neighbors and fear the consequences of being publicly labeled (<http://www.appa-net.org/revisitingmegan.pdf>). A related issue is the difficult process of disclosure to significant others. Sex offenders must decide to whom they should reveal their shameful secret, when, and under what conditions. Almost universally, they derive support from others in the group as they struggle with these decisions and their outcomes.

Building a support system is an essential element of preventing recidivism for sex offenders. This is directly related to the issue of disclosure, because one cannot gain the necessary support from individuals who do not know of the offense. Offenders' efforts to gather a cadre of supportive people who understand their need for vigilance, and so on, can be effectively encouraged and supported in the group situation.

The climate and process of integrated humanistic groups for sex offenders depend on the presence of the core conditions of genuineness, accurate empathy, and unconditional positive regard (for the person, not the actions). Such conditions create a sense of emotional safety that permits group members to explore difficult and painful issues. It is also useful to teach group members about group process. Clients who appreciate the value of process as well as content are more engaged and alert to the interpersonal events that occur. To facilitate this awareness of process, we use process notes as a therapeutic tool. After each weekly meeting, group notes, including process comments and questions, are prepared by the facilitators and distributed prior to the next group meeting. Members have found this assists them in focusing, and also stimulates discussions and reactions that might otherwise go unnoticed. Several group members reported that they saved all the notes as a review of what they had learned. Members requested copies of the notes for any group they missed as a way of keeping current.

In an effort to understand the curative factors in such a group, we developed a weekly feedback form that members completed at

the end of each meeting. Nine different individuals completed at least one form in the 9-month data collection period. All respondents were male. Age ranged from 23 to 49, with a mean of 37 years. Regarding ethnicity, five were Caucasian, three were Hispanic, and one was Native American. Five of the nine were currently married, and six had children. Six were employed full-time, one was a student, one retired, and one unemployed. A list of curative factors based on Yalom (1995) was included on the form, and members were asked to check all factors that contributed to their experience in that session. Based on 103 completed feedback forms, the frequency with which each curative factor was marked is as follows: Cohesion (being part of the group), 77%; Catharsis (expressing feelings), 76%; Universality ("I'm not alone"), 72%; Altruism (helping others), 69%; Self Learning, 64%; Development of socializing techniques, 69%; Instillation of Hope, 57%; Imitative Behavior, 52%. Respondents also specified which factor was most salient in that particular session. Ranking of those was: Self Learning (21%); Altruism (12%); Catharsis (11%); Learning New Skills (11%); Imitative behavior (10%); Instillation of Hope and Acceptance in the Group, (7% each); and Universality, (5%).

Group members were invited to complete an evaluation form once treatment was completed. Comments from those evaluations add substance to the theoretical statements above. In response to the question, "How would your life be different now if you had not experienced the group?" one member said, "I'd probably be in trouble." Another responded, "If I never committed my crime, I would still be the same person: not showing my feelings, not accepting that I am gay. I wished [*sic*] I could have had a type of group like this but a long time ago. You didn't know who to talk to." Another observed, "I would still be working on correcting my patterns. Individual therapy helps to point out how we behave in situations and our patterns in life. Group therapy helped us to practice changing those patterns." To the question, "What general effect has the group experience had on your life?" one member replied, "It helped me know why I committed my crime and helped me accept that I am gay and to find love in other adults instead of children."

One group member, who had previously attended a group facilitated by a more confrontive leader, said, “If I had stayed in the first group, I would be in prison today!” Another with a similar experience explained, “I feel their [authors’] style was very good! To help people see things without making them feel like shit and then putting up a wall! This is a group I feel helps and that is because of the way the leaders work the group.” He also said, “This group was forced upon me, which it is on most people. However, after going, it was something I enjoyed and felt good about doing and would not hesitate going back to it if I felt the need.” Commenting about the style of the group leaders, another member said, “I liked the way they just didn’t preach to us but rather let us talk with them and the other group members, letting us all work out the problems as a group.” To our knowledge, none of the nine members included in this research has re-offended.

We expect that readers of this article will be able to appreciate the value of integrated humanistic groups as an alternative or adjunct to traditional sex offender treatment models, to describe the characteristics of humanistic sex offender clinicians as they impact group processes, to compare and contrast this approach with their present treatment strategies, and to identify the curative factors (Yalom, 1985) that are operational in this type of group for adult sex offenders. For clinicians interested in implementing these ideas, we recommend they explore their own beliefs and attitudes about sex offenders and read the Blanchard (1995) book. This approach is highly dependent on the attitude and values of the counselor, and because others may perceive this approach as “soft” on offenders, it is desirable to obtain supervision when first employing this approach.

## **Summary**

This article has recommended an integrative, humanistic approach to outpatient group treatment of sex offenders. Our clinical experience, supported by data from our action research, indicates that clients in this type of group are able to delve more deeply into

underlying dynamics that contributed to the sex offending behavior and to utilize the interpersonal processes of the group to make significant changes. Participants rated their group experience very highly and believed they gained an understanding of the dynamics that contributed to their offenses. Participants most often identified cohesion as an aspect of their group experience, while self-learning and altruism were rated as the two most important factors.

## **Conclusions**

In contrast to sex offender treatment models that rely on cognitive behavioral strategies and employ confrontation as the primary intervention technique, we found that an emphasis on the creation of a supportive environment based on humanistic principles leads to positive outcomes in clients. Psychoeducational and relapse prevention techniques, as well as cognitive behavioral elements, can be utilized more effectively in the context of an integrated humanistic model.

## **References**

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