INTERNATIONAL JOURNAL OF BEHAVIORAL CONSULTATION AND THERAPY
2013, VOL. 8, NO. 2

ISSN: 1555–7855

Effectively Utilizing the "Behavioral" in Cognitive-Behavioral Group Therapy of Sex Offenders

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Abstract

Although cognitive-behavioral therapy (CBT) is touted as the predominant approach in sex offender-specific group treatment, a review of the field shows that the "behavioral" part of CBT has become minimal in relation to that which is cognitive. The authors show how a revitalized "behavioral sensibility" may help to enhance group treatment by focusing greater attention on directly observable behaviors. This clinical practice article presents an array of behaviorally-oriented techniques for conducting groups, beginning with the establishment of an operant group environment that supports behavior change; expanding empirical awareness of events occurring in group; streamlining interventions with non-verbal signals; targeted reinforcement of social interaction and bonding; and more. The article also describes several behavioral techniques designed specifically for sex offender-specific groups, which can enhance self-disclosure, social awareness, self-esteem, empathy, and management of deviant thoughts.

For better or worse, the bulk of today's sex offender-specific (SOS) treatment for adults is delivered in group formats and most interventions tend to be cognitive in nature. Although most SOS clinicians and programs would describe their primary orientation as cognitive-behavioral (McGrath, Cumming, Burchard, Zeoli & Ellerby, 2010), the actual amount of SOS treatment that is explicitly "behavioral" appears minimal in relation to that which is "cognitive."

Forty years ago, the opposite was true. In the 1960s, SOS treatment was explicitly behavioral and largely took place in individual formats. As reflected in the name "Association for the *Behavioral* Treatment of Sexual Abusers," the SOS practitioners and researchers who formed the first professional guild in 1984 were grounded in traditional behavior therapy and guided by the presumption that deviant sexual preferences and paraphilias resulted from conditioned behavior. For this reason, their early work focused almost exclusively on decreasing deviant sexual responses through the use of counter-conditioning techniques, often using aversion therapy. They emphasized the development of accurate, objective measures of change; most notably, phallometry (Laws & Marshall, 2003; Marshall & Laws, 2003).

Almost by definition, the early behaviorally-oriented proponents were determined to disavow any psychoanalytic and psychodynamic "insight-oriented" approaches to either explaining or treating sexually deviant behavior. By extension, anything "cognitive" was also avoided as weak science and, if allowed, was subject to careful grounding in behavioral principles. By its very nature, behavioral conditioning techniques entailed hours of intensive individual work, which meant that group-based treatment was more limited in its application to treating sexual deviance.

In the 1970s, however, the field began to broaden behavioral interventions to include cognitive processes and treatment programs became more comprehensive in scope. In the 1980s, the new cognitive therapy of Beck exploded onto the scene and swept over the sex offender-specific field along with the rest of the treatment world (Beck, Rush, Shaw & Emery, 1979; Burns, 1980). The new cognitive therapy offered a treatment that appeared capable of fixing serious psychological problems through the straightforward process of showing clients how to apply clear thinking and eliminate thinking errors. For SOS clinicians, in particular, cognitive therapy was much easier to use than behavioral conditioning and easy to adapt to psychoeducational group formats. Moreover, at a personal level, cognitive therapy offered an optimistic and empowering sense of efficacy for SOS clinicians, who had the added responsibility of protecting society from a clinical population for whom treatment effectiveness was still an open question (Furby, Weinrott & Blackshaw, 1989).

By the late 1980s, relapse prevention principles from the field of addictions were being applied to domestic and sexual violence – and cognitive therapy found a compelling and powerful new ally (Laws, 1989; Jennings, 1990). With this marriage, the cognitive transformation of SOS treatment was decisive. Although the foundational principles of behavior therapy continued to be acknowledged with the term "cognitive-behavioral," the practical reality was that cognitive therapy ruled supreme in day-to-day sex offender-specific treatment. The decidedly cognitive character of cognitive-behavioral SOS treatment continued to gain in popularity and achieved widespread acceptance through the 1990s. By 1995, one national survey found that only two of 1,784 sex offender treatment programs identified themselves as behavioral (Freeman-Longo, Bird, Stevenson & Fiske, 1995). In fact, the emphasis on cognition threatened to become so total that Maletzky (1996) used the editorial bullhorn of ATSA's own journal to bemoan how "cognitive-behavioral" therapy had become "cognitive-cognitive" therapy. Maletzky (1996, p. 263) posed a practical explanation for "the decline of behavior therapy" in SOS treatment.

> *"Aversive conditioning is messy, expensive, cumbersome and unattractive. Worse, it is hard work, with the therapist doing most of it – a tough sell to most of us who have been trained, and may prefer, simply to sit and chat… Cognitive therapy gives the appearance of being more thorough: it can teach methods of self-monitoring and extend treatment well beyond the end of formal visits…"*

Not surprisingly, the popular dominance of cognitive interventions in so-called "cognitive-behavioral" SOS treatment continued unperturbed by Maletzky's concern. Fifteen years later, behavior therapy remains resigned to an important, but small and circumscribed role that focuses on conditioning procedures and phallometry.

Current Sex Offender Treatment Models

It is interesting that the first serious challenge to the dominance of cognitive SOS therapy arose indirectly through more recent attacks on its marriage partner, relapse prevention (RP). Both the Self-Regulation Model (Ward & Hudson, 1998) and the Good Lives Model (Ward & Stewart, 2003) have attacked Relapse Prevention for its narrow emphasis on offense abstinence, avoidance goals and faulty presumption of a motivation to change (Yates & Ward, 2009). The Self-Regulation Model exploded the traditional RP notion of a singular offense cycle by showing multiple offense pathways with corresponding self-regulation styles, while the Good Lives Model expanded the focus of treatment to encompass areas of life beyond offending behavior, such as friendship, relatedness, spirituality, self-efficacy, intimacy, purpose and personal meaning. Together, these two complimentary models have gained rapidly in opening the SOS field to a broader, more holistic understanding of the complex dynamics of sexual offending and the importance of fostering the individual's intrinsic motivation. The Motivational Interviewing Model has also grown in popularity, including SOS groups, because it can accommodate RP's problematic presumption that offenders are motivated to change (Prescott, 2008).

The recent emergence of integrated models of SOS treatment (Bauman & Kopp, 2004; Longo, 2004; Marshall, Marshall, Serran & Fernandez, 2006; Yates & Ward, 2008) serves as another indication that the field is moving away from a generic cognitive model and toward multi-modal, evidence-based treatment approaches. For example, Marshall and his colleagues describe an integrated sex offender treatment program in which the diverse targets of treatment include self-esteem, acceptance of responsibility, coping and social skills, offense pathways and sexual interests (Marshall et. al, 2006). The treatment interventions used in Marshall's program are explicitly multi-modal and include an array of cognitive, behavioral, and supportive psychotherapeutic techniques, such as role playing, modeling, group discussion, written exercises, shaping, over-learning, rehearsal and self-monitoring. Simi-

larly, Deming (2009) proposed an Integrated Model of Sex Offender Treatment (IMSOT), in which treatment intensity and duration are largely based on actuarial risk for recidivism, while treatment targets are individualized and based on assessed dynamic risk factors such as those identified in the Stable 2007 (Hanson, Harris, Scott & Helmus, 2007). The emphasis is on using treatment interventions that have shown efficacy, either with sex offenders or other populations, in changing specific maladaptive behavioral, emotional and/or cognitive problems. Group therapy remains the preferred and primary treatment modality in the IMSOT, but individual, couples and family therapy modalities are also encouraged when appropriate. In particular, relapse prevention is *not* used as a core component of treatment. RP is used as an adjunct to the therapy process, only to be applied as appropriate *after* the individual has made relevant gains in treatment.

A similar revolt against relapse prevention has occurred in the field of juvenile SOS treatment, where clinicians and researchers have had to reassess and modify traditional adult SOS cognitive-behavioral relapse prevention to accommodate the differing developmental complexities of youth. Here, too, a holistic appreciation for the broader importance of family, school, peers, physical fun, neurological development and personal strengths has tempered the heavily cognitive, heavily group-based, heavily offense-focused SOS treatment methods for adults. Examples include the application of the Good Lives model (Thakker, Ward & Tidmarsh, 2006), Multisystemic Treatment (Borduin, Schaeffer & Heiblum, 2009) and social-ecological models that emphasize community-based rather than residential treatment of youth (Hunter, Gilbertson, Vedros & Morton, 2004).

Given these trends toward more holistic treatment, the field of SOS treatment may have never been as open as it is now for innovations that go beyond the generic cognitive-behavioral RP paradigm. So why, at a time when the horizon is at its widest, would it be a good time to propose a revival of behavioral approaches? Wouldn't that be moving in the opposite direction? On the contrary, this article is dedicated to a reawakening of the behavioral perspective because of its unique value in grounding sex offender-specific group practice in directly observable, and perhaps more reliable, terms.

"Behavioral Sensibility" vs. Behavior Therapy

In truth, there have been almost no explicitly behavioral techniques designed specifically for SOS groups as distinguished from individual treatment. Rather than pushing for the renewed use of prescriptive behavior therapy techniques like conditioning, this article endeavors to show clinicians how to capitalize on a "behavioral sensibility" to enhance their SOS group treatment. In other words, "behavioral" can be redefined as the practical, naturalistic application of a behavioral perspective that can fully utilize the crucial interpersonal processes that are unique to the group modality. There are many ways that clinicians can, in faithful accordance with behaviorism's insistence on observable events, enhance their observational skills in group treatment to better identify and target individual and interpersonal behavior for positive change.

This article will present an array of behaviorally-oriented techniques across several dimensions, beginning with the establishment of an operant group environment that supports behavior change, expanding empirical awareness of events occurring in group, streamlining interventions with non-verbal signals, and more. In all cases, our emphasis is on practical utility, illuminating how clinicians can use a behavioral sensibility to improve *group* treatment for sex offenders. Although this article will describe behavioral techniques designed specifically for sex offender group treatment, it does *not* address the many behavioral techniques that are currently used in individual therapy, most of which focus on modifying deviant or unhealthy sexual arousal (e.g., minimal arousal conditioning, olfactory aversive conditioning, covert sensitization). At the same time, the group-specific techniques presented here would meet the following definition of "behavioral":

> *Behavioral interventions [are] classified as strategies that focused on changing behaviors by setting behavioral goals and using positive and negative reinforcement to encourage or discourage clearly identified behaviors" (Cautilli & Weinberg, 2007, p. 256)*

Six Ways to Apply a "Behavioral Sensibility" to Improve SOS Group Treatment

1. Pre-organization of the Physical Space

A behaviorist or behavior therapist attends carefully to the details of the operant environment before starting the experiment or treatment process. This enables him/her to control for variation and reduce the number of potential impacting stimuli in order to optimize the opportunities for reinforcement of the desired behavior. Likewise every group therapist needs to be rigorously attentive to the physical environment of the group treatment room prior to conducting the group. There are dozens of physical variables that can diminish or enhance the therapeutic environment of the group room and, thereby, increase opportunities for reinforcing desired prosocial behavior.

a. ***Physical Comfort.*** To begin with, the group room should be as comfortable as possible. The group therapist should systematically assess each of the following factors and do everything in his/her power to maintain a comfortable group room. The temperature should be acceptable; not too hot, not too cold. When the group room is clean, odor-free, quiet and neat, it embodies dignity, respect and concern. The room can literally serve as a discriminative stimulus that signals the opportunity for positive reinforcement—or its opposite. Members may be more alert and attuned for learning in a pleasant room. Room privacy and freedom from distraction is also vital. Interruptions disrupt process. They convey disdain, disrespect and devaluing of the group and its members, whether intentional or not. Most group therapists can control whether they can be interrupted by intercoms and phone calls and set conditions that prevent people from entering and leaving during group.

Of course, in the real world of SOS treatment, therapists often have to conduct groups in less-than-optimal spaces within prisons, jails, secure forensic units, parole offices and outpatient practices. To illustrate this point, the authors have conducted groups in an outdoor pavilion in a Florida prison in soaring 100° heat and in a New Jersey church basement so cold that we puffed clouds of steam. Undoubtedly, we accomplished little under such brutal conditions except perhaps to "extinguish" the desired behavior of attendance. But a group therapist is ethically responsible for trying to remedy such conditions. Perhaps it may entail a more creative response (arriving one hour early to turn the furnace on) or require going to a higher ranking authority (prioritizing the need for air conditioning).

b. ***Using Equidistance to Avoid "Seats of Power."*** To the degree possible, all participants in a group, including the group leader(s), should be seated in an evenly spaced circle in the same kind of chairs where everyone can see everyone else. There are dozens of ways that seating may facilitate negative power and undermine open, respectful communication. Participants may claim the most comfortable upholstered chairs in accordance with perceived pecking order. The newer and less powerful members may get the hard plastic, or folding wooden chairs, while the least powerful may, at worst, squat on the floor because there is no chair at all. Some group members may choose to sit in the corner and/or outside the circle, or they may remove themselves from the circle by pushing their chairs backward to gain a vantage point from which they can observe others without being readily seen themselves. A cushy chair or chair outside the circle often provides a "seat of power," conveying that member's superiority or specialness and/or providing a convenient way to avoid group participation and escape the vulnerability of being on equal ground with peers. Moreover, group members may seize upon the same chairs, week after week, recreating and cementing the same power ordering, and reducing flexibility.

To combat the problem of seats of power, the group leader must do everything possible to arrange the available chairs in the most even and equidistant fashion possible. This can be done before group begins, or can even be incorporated into a ritual performed by the members themselves. The continuous message must be that all members are equal—in importance, value, respect and basic

rights—and are equally challenged to face their own issues and strive for betterment, whether veteran or newcomer, rapist or pedophile. The key discriminative stimulus is the equidistant circle.

c. ***Visual Reminders of Treatment Themes/Goals.*** In the same way that a light is the discriminative stimulus that signals the availability of reinforcement in a Skinner box, the group room can use visual cues related to the purpose of treatment. The possibilities can include all sorts of images and words that capture a vital theme in treatment, such as self-disclosure, honesty, responsibility and empathy. The visual cue could be a poster, picture, painting, photograph, flip chart, special motto or quote, or even a mural. These visual cues can have even greater impact if they have been chosen or created by members of the group themselves, such as a phrase that occurred one day in group and holds special meaning to the members.

One author uses a behavioral technique that combines the principle of successive approximations with program treatment goals. The wall poster depicts a dart-board like "target" in which the bulls-eye is the ideal goal, the next ring is closer to the ideal and the outside ring is far from the ideal. The sample given uses Full Self-responsibility, Partial Self-responsibility, Denial and Blaming (see Figure 1). Other target charts could use concepts that center around reinforcing honesty (e.g., Honesty, Evasiveness, Deception), self-awareness (e.g., Self-awareness, Blind spots, Lying to oneself), or self-disclosure (e.g., Full self-disclosure, Selective disclosure, and Closed off). When group members engage in discussion relating to these treatment targets, therapists can use verbal and non-verbal reinforcement of the client's behavior by looking at, gesturing toward, or making comments specifically related to the visual cues in the group room. Performed in the correct manner, the therapist's actions can be a powerful reinforcement of the client's attention to and discussion of these treatment targets. Particular reinforcement and comment should be made when the client shows movement in their behavior toward the center of the target for any given treatment goal.

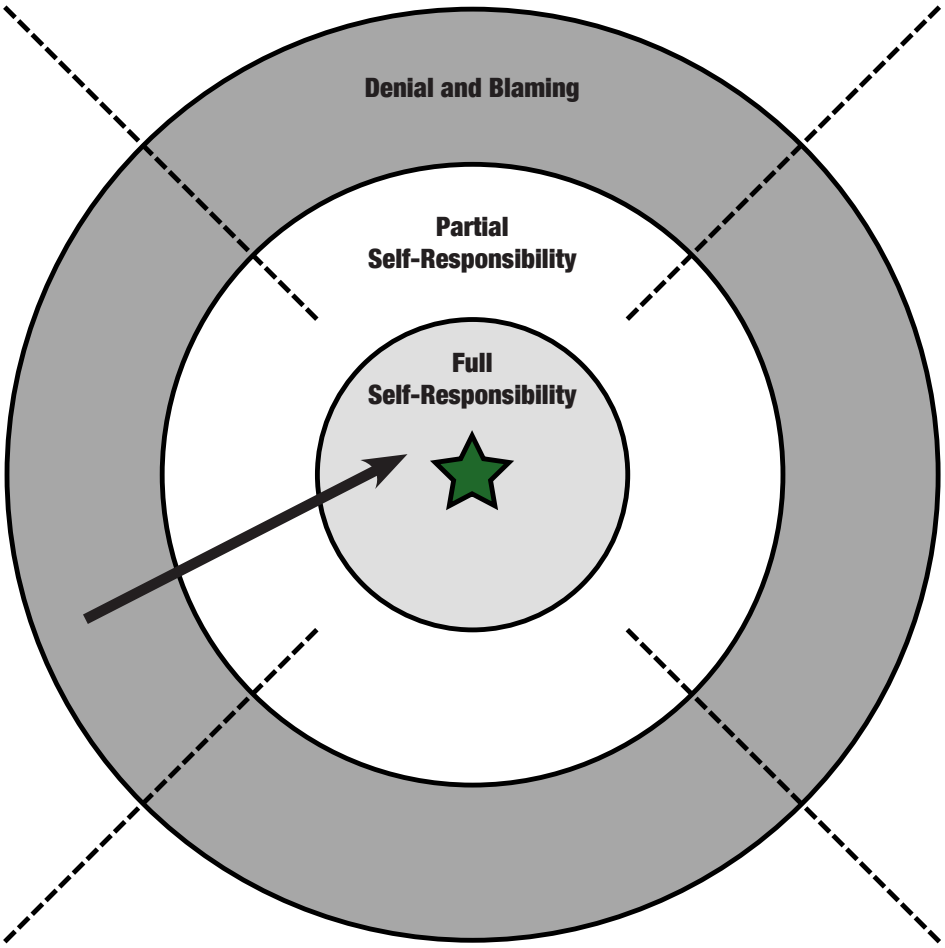

Figure 1.

2. Establish Basic Structural Rules that Support/ Reinforce Pro-social Behavior

a. ***Timeliness.*** In addition to managing the physical features of the operant environment, the group therapist can establish expectations and group rules that facilitate conditions for learning. The first is the often forgotten importance of time as a discriminative stimulus. Group sessions should occur on time, every time, as scheduled, and with consistent starting and ending times. It is fine if a group starts or runs five minutes late, as long as it is consistently so. Strict adherence to timeliness has multiple importance in protecting the privacy and respectfulness of the group room (see #1a on page 8), signaling the value of the group and its limited time, establishing a normative behavioral cue of commitment among group members, and strengthening the association between the time of the group and opportunities for reinforcement. Cancelling groups can be a negative signal that the group is not a prized opportunity.

b. ***Empty Hands.*** Any eating, drinking and smoking by the therapist or the members should be forbidden as distractions to group process, as competing sources of reinforcement and as potential symbols of status or power. Some group members may avoid engagement and manage their anxiety in the group by handling their coffee cups, sipping water, nibbling on candy, chewing gum and fiddling with objects like pencils and swizzle sticks. If some members have coffee or water and others don't, it may convey that members do not have equal status in the group. Moreover, the group leader may need to keep his or her hands completely free in order to direct communications within the group (see #4 on page 10).

c. ***Ground Rules.*** Most treatment programs have some basic ground rules for participating in a group. These can be verbal and/or written, or even posted on the wall or signed like a behavioral contract. The content can vary from group to group, but should reflect core values that are vital to the group, such as being respectful; honoring the confidentiality of others; timely attendance; refraining from yelling, threats, interruptions and disruptions; or even paying fees on time. Group rules are probably most effective when they are simple and few, stated as positive do's rather than negative don'ts and, if possible, have been developed by or amended by the group members themselves. For example, different groups may have different rules about whether and how much profanity is acceptable.

3. Roving Eye Contact as the Foundation Stone of Group Therapy

Roving eye contact (REC) is an absolutely crucial foundation for effective observation and intervention in group therapy (Jennings & Sawyer, 2005). By continually attending to one group member after another, the group therapist can greatly enhance the range, depth and utility of behavioral data about the group, which improves assessment and intervention, while also role-modeling and reinforcing pro-social interaction for the clients.

a. ***REC as Reinforcement.*** Roving eye contact may be the simplest and easiest reinforcement that can be delivered by the group therapist. Although fleeting, a moment of eye contact can be a very potent, positive acknowledgement of each member as a person. Through REC, every group member gets repeated, tangible attention regardless of his/her level

of verbal engagement in the group. Knowing that one cannot escape attention and is being observed by someone else, particularly an authority figure, helps to encourage participation because group members tend to be more alert, reminded of the expectation of participation and aware of their current level of participation (or lack of). REC communicates that something important is happening in group right now and it is worth attending to. REC is also a continuous reminder to each group member that he/she is not alone, that this is a social group and that he/she is connected to others in the group, like it or not.

b. ***REC as Competing Response to Egotism.*** It is fascinating to watch how group members become acculturated to roving eye contact. Through simple observational learning, group members may begin to use roving eye contact themselves. Acquisition of this skill should be a desired goal in group treatment because it heightens each offender's own social awareness. Use of REC literally opens the offender's eyes to the presence and individuality of the other people in the group and the relatedness within the group. In behavior therapy terms, REC is a "competing response" to self-absorbed cognition. An offender cannot engage in both behaviors at the same time. Thus REC naturally counteracts egocentric behavior and thinking, and can, in conjunction with other interventions, promote empathy, listening skills and relatedness.

c. ***REC for Expanded and Enriched Observational Data.*** It is crucial that the group therapist is continually observing every member of the group, which is another reason for maintaining an equidistant circle of seats (see #1b on page 8). Through REC, the group therapist can gain more behavioral data about each member and the interactions among them. Much of this information may be non-verbal body language–posture, attentiveness, facial reactions, emotional tone, mood, energy level and other visible responses to the immediate topic of discussion—but it may be informative of progress toward key treatment objectives and skill development in such areas as empathy, moral conscience, emotional self-regulation, friendship, intimacy, cooperation and much more.

d. ***REC for Interpersonal Data.*** At the same time, REC helps to shift the group therapist's observational focus from individual behavior to social relations and interactions within the group, which may further expand the range of useful observational data. In a traditional group, it would be typical for the group therapist and everyone in group to focus intently on a group member who is showing intense emotions during a critical therapeutic moment. By using REC, the group therapist will also be looking at each and every member of the group and observing his/her response to that event. Group members may show concern, skepticism, hostility, caring, apathy, confusion, fear, or any number of responses that can provide important information about each individual and relations within the group. For example, one author led a group in which one tearful member dominated the group's attention with his suicidal drama. By using REC, however, it was quickly apparent that the group was not only unsympathetic; they were annoyed to the point of hostility because they viewed his behavior as a repeated display to gain the spotlight. The group therapist was able to redirect the crying member and open a discussion with the entire group about the need for social acceptance and exploration of more appropriate and satisfying ways of finding acceptance (e.g. not manipulative). Roving eye contact provides reassurance to group members that the group leader is alert and aware of their individual welfare as well as his/her concern with the group as a whole. In addition, REC can be used to counteract the use of "fixed stare" tactics by some offenders who wish to unnerve or intimidate the group therapist.

4. Use of Non-intrusive, Non-verbal Reinforcement by Therapist

A group therapist can make many effective interventions without speaking. All too often, group therapists make unnecessary verbal interventions that can disrupt the natural flow of interactions in group. For example, it is much easier and less intrusive for a group therapist to touch a finger to his lip than to interrupt group process to say "Please don't interrupt" or "please let Jack finish what he was saying." A verbal intervention takes more time and may cause the whole group to stop and redirect their attention to the verbal communication from the therapist. In the same way that a traffic cop can direct drivers without words, the group therapist can direct communication in the group. A simple nod or smile or open palm can encourage a given group member to speak, or to continue speaking. A "thumbs up" or nod can instantly say "well done" to reinforce an offender's behavior. Eye contact and a nod can let a group member know that what is being said in group right now is especially pertinent to him, or that the group therapist is aware that the member desires to speak and "can't get a word in edgewise" at this moment. By leaning forward and/or raising eyebrows, a group therapist can indicate that something important is happening that deserves the group's full attention. Or, by leaning back or rubbing his/her chin, a group therapist can indicate that he/she has some concerns, doubts or confusion about what is being said or that it calls for some more careful thought by the group. A head scratch or chin-rub can be used as a cue for group members to think or ponder an issue.

Hand motions can redirect and channel communications within the group, including redirecting questions for the group therapist back to the group, or steering communications between specific members of the group. For example, an easy hand motion can cue a group member to address his response, not to the therapist, but to the group member for whom the feedback is intended, or to someone for whom that response would have special meaning. There are also a variety of hand gestures that can effectively communicate degrees of intervention. such as raising one finger as a cue to "wait a second before you speak," or raising two fingers to say "wait a bit longer to speak," or using full erect palm to indicate that this is no time to interrupt.

5. Use of Selective Verbal Reinforcement by Therapist

Although non-verbal gestures offer a very effective short-hand for delivering reinforcements and channeling communications within the group, there may be times where it might be preferable for the therapist to verbalize reinforcement of behavior. Whereas a private nod or smile may limit reinforcement to one group member, the therapist can use simple words such as "yes," "very good," "well said," and "thank you" to make the reinforcement public to the entire group. Another useful instance of verbal reinforcement is to bring extra attention of the group to a particularly important event in group. The group therapist might draw attention to one client's use of "I statements" and taking responsibility, or to verbally commend group members for disclosing offense-related behaviors or beliefs, or to praise someone's efforts to offer constructive criticism or provide supportive feedback to another client. One example of such praise might be, "Your ability to talk openly about your offense history takes a lot of courage and it will help you become a healthier person." Verbal praise can also be valuable for modeling social communication skills, such as assertiveness and giving and receiving criticism.

6. Facilitating (= Reinforcing) Healthy, Meaningful Social Interaction and Bonds

In an article on group therapy with sex offenders, Jennings and Sawyer (2003) asserted that all group therapy gains its therapeutic potency from the interactions and relationships that emerge during the group process (Yalom, 1995; Rutan & Stone, 1993). Jennings and Sawyer (2003) urged SOS group therapists to capitalize on the power of group therapy by explicitly using the group medium. They criticized the all-too-common practice of "spokes-of-the-wheel" group therapy in which attention is focused on one group member at a time. In effect, this can produce a series of one-to-one therapy encounters between the therapist and individuals within the group, which inadvertently stifles group interaction and bonding. The members attend to their singular relationship with the therapist rather than their important relationships with others.

The point is that healthy, vigorous, egalitarian group process is inherently loaded with positive reinforcers for everyone in group. Any given group can be a safe learning laboratory (i.e., operant environment) where members can engage in observational learning, gain awareness, practice communication and social skills, and build and experience relationships—all while enjoying the natural reinforcements of praise, acceptance, friendship, support, belongingness and much more. Group members (and group therapists) like to come to a well-run group. Conversely, "poor" group process could po-

tentially become a "punishment" for group members that can stifle learning, openness, alertness, receptivity and sensitivity to others.

Sexual abuse and offending, at least in part, entails social behavior problems and many sex offenders suffer pervasive deficits and distortions in the realm of social relations. Many are isolated, alienated, lonely, defensive and avoidant; many others are threatening, antagonistic, manipulative and demanding; many more are distrustful and self-absorbed. A safe and well-run therapy group can be an ideal operant environment for testing out new, pro-social behaviors and developing attachments—gradually, of course, through successive approximations and reinforcement by social praise and acceptance. Readers are referred to Jennings and Sawyer (2003) for a number of additional practical tips for "maximizing" group process for sex offenders.

Specific Behavioral Techniques for Sex Offender Group Therapy

This section of the article is devoted to six behavioral techniques or exercises that have been designed or used specifically for sex offender-specific treatment groups.

1. Problem Cards Technique to Encourage Disclosure

In this technique, the group therapist instructs the group members to write down two current personal problems on index cards in preparation for the next group session. One problem should be more immediate and difficult, while the other problem can be less so. Subsequently, at the next group session, the group therapist does nothing more than ask if members have brought their problem cards. The group therapist does not ask to see the cards and starts the group session. If a group member asks about the problem cards, the therapist offers the choice to disclose either problem or disclose neither and talk about something else. The purpose of this technique is to stimulate more self-disclosure. Research has shown that groups who were instructed to write two problems had the highest rate of self-disclosure; while groups who wrote one problem had the second highest; and groups without problem cards had the lowest rate of self-disclosure (Flowers, 1975; Upper & Flowers, 1994). It is hypothesized that this technique may prompt members to prepare for upcoming group sessions by giving active thought to their private issues and the potential consequences of self-disclosure. Also, by listing one's problems, the offender may be taking a step toward acknowledging and operationalizing his/her problem.

2. Seat Rotation Technique to Stimulate Activity

This simple technique is designed to reinvigorate group process by altering established discriminative stimuli and response contingencies. The group leader asks the members to stand up and shift over one or two seats. If desired, the therapist can directly solicit their reactions to the change of position and perspective. The seat rotation technique can be useful for breaking out of unproductive habitual patterns of responding. Benefits may include stirring up a dull and lethargic group, disrupting unhealthy use of "seats of power," increasing participation by typically quiet or avoidant members and bringing awareness to defensive postures in the group.

3. The "Why the Prize?" Technique

In this technique, one group member is chosen (at random or by plan) to be the Token-Giver, who gives "tokens" to other members as "prizes" for having done something "good" during the group process. If desired, the Token Giver can give one token for something good, or can give two for something exceptional. The group therapist provides no instruction or guidelines to the Token Giver regarding what is "good." The group member must decide, but cannot speak out loud. As the group session proceeds, the members are usually curious as to why some members receive tokens. They may wonder if the reward was given for showing insight, being supportive, demonstrating empathy, giving constructive criticism, or some other prosocial behavior. The reward contingency of the token-giving may also motivate members to be more active in group and to be more thoughtful about what they say and do in order to earn a token.

Subsequently, the group leader might ask various recipients of tokens, "What do *you* think that you did well that earned that token?" This inquiry process may stimulate a thoughtful discussion that heightens everyone's attention to the "how" of healthy pro-social behavior and relatedness. It can also illuminate caring relationships between group members. If needed or useful, the group therapist can also query the Token-Giver to explain what each member did that deserved a reward of recognition. The "Why Prize" technique can be useful for empowering a particularly shy or non-participating member. It can also be useful to counteract a overly domineering or talkative member because he/she is forbidden to talk and is forced to be attentive to others rather than him/herself.

4. Group Reinforcement Response Contingency

A group reinforcement response contingency is a behavioral technique that can be used broadly to reinforce a wide variety of desired behaviors. In this technique, all members are reinforced, rather than individual members. A typical example would involve setting a task for the whole group, such as a homework assignment like journaling or tracking the occurrence of an adaptive, healthy or targeted behavior goal. If all members of the group complete the task on time and with an appropriate level of effort and quality, the group therapist gives a small tangible reward to everyone. Journaling can be particularly useful as a response contingency given its wide use in most sex offender treatment programs. Given the diversity in treatment needs among group members at any given time, it is not necessary for all members to journal or track the same targeted behavior. Additionally, therapists should not expect the same quantity or quality of journaling from all group members. Rather, completion of the task and successive approximations toward more detailed or relevant journaling is reinforced. Thus, the group is reinforced as a group, but the targets can be individualized to suit individual needs and abilities.

Often, in secure treatment settings, such as prisons, detention centers and civil commitment facilities, the range of choices for such rewards can be more limited. Nonetheless, even rather simple rewards, such as new pens, pencils, or notebooks can be powerful motivators. Further, this technique often has its greatest impact, not on individual group members, but in facilitating cohesion and cooperation within and amongst group members as they work toward a common goal(s).

5. Functional Analysis for Process Groups

As described by Hoekstra (2008), functional analysis can be applied to process groups using the behavior therapy principles of Functional Analytic Psychotherapy (Kohlenberg & Tsai, 1991). It entails a thoughtful, detailed analysis of the operant contingencies occurring in the group in order to target particularly desired and undesired behaviors for reinforcement or extinction. It can be used to focus on a single group member or the group as a whole.

The procedure begins with the identification of the Clinically Relevant Behaviors (CRBs) of targeted concern. "CRB1s" are problem behaviors that interfere with the member's ability to make meaningful connections in the group. For example, Henry's problem behaviors include talking constantly, talking loudly, refusing to be interrupted, and boring the group with excessive, unimportant details. "CRB2s" are improvements in desired behavior. They entail successive approximations of the desired adaptive responses. In Henry's case, positive behavior changes might include pausing, allowing others to speak, remaining silent and listening, using less detail, lowering his voice volume and speaking less rapidly. Finally, CRB3s are verbal statements that show awareness of the problem behavior. Thus, Henry might say things like, "I'm afraid no one wants to hear me...", "I don't know when to shut up…", "I'm a leaky faucet...", "I want others to like me…", "When it's quiet, I'm anxious…"

By clarifying the behavioral specifics of the target behavior and its improvement, the group therapist can more directly reward the improvements—spontaneously within the group and in private consultation. The therapist can now be alert to opportunities to reinforce CRB2s and CRB3s when they occur. Thus, in this example, the group therapist might smile and nod at Henry when Henry allows himself to be interrupted (reinforcing a CRB2). Or the therapist might take a moment to publicly compliment Henry for making an important insight for the group. "It's interesting. Some people have an urge to talk when they feel anxious, while others get very quiet. It's great that Henry says he can rec-

ognize that feeling because now he can control his urge to talk when he feels anxious."

6. Objective Behavioral Definitions (Measures) of Group Process

Some may find it helpful to apply a behavioral sensibility to SOS groups by finding objective measures or correlates of desired behaviors that are more readily, though perhaps less reliably, expressed verbally and cognitively. Group therapists often complain of particular group members who "talk the talk," but don't "walk the walk." They may use the right concepts and terms, they may show mastery of thinking errors, they may be polite and attentive—but it is not consistent with other behavior that may be aloof, exploitative, self-serving or even belligerent (especially in peer relations outside of group).

As one example, group concepts as abstract as "cohesiveness" can be grounded in observable behavior. "Cohesiveness" is one of the classic "curative factors" in group treatment defined by Yalom (1995) and has been identified for its value in group therapy with sex offenders (Jennings & Sawyer, 2003; Marshall & Burton, 2009; Beech & Hamilton-Giachritsis, 2005). In fact, cohesiveness is considered the primary therapeutic factor from which all others flow. Humans are social animals with an instinctive need to belong to groups and personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging, acceptance and validation. Researchers have created objective behavioral definitions to better identify and measure the occurrence of group cohesion such as, increased eye contact with persons speaking, increased member to member interaction, increased positive verbalizations by group members, increased disclosure of problems, increased ratings of trust in other members, and increased satisfaction with sessions and with group itself (Upper & Flowers, 1994; Taube-Schiff, Suvak, Antony, Bieling & McCabe, 2007).

At the same time, efforts to operationally define a concept can be valuable in forcing researchers to think more clearly about a phenomenon. To use a classic example, the field of sex offender-specific treatment continues to vigorously debate the degree to which empathy deficits are related to sex offending (e.g., Hennessy, Walter & Vess, 2002). In trying to design effective measures of empathy, researchers have asked if empathy is a multi-component, contextually-specific trait or a stable generalized characteristic? Is empathy a complex mix of perspective taking, emotional responding and behavioral choices related to perspective-taking and affect? A behavioral sensibility urges more rigor in our use of constructs like empathy in group work.

7. Using Behavioral Techniques with Specific Treatment Targets

Provided here are three specific treatment targets, often cited as important areas of behavior change to be addressed in sexual offender treatment, and examples of behavioral approaches that can be used to enhance behavioral deficits or eliminate behavior excesses:

a. ***Enhancing Self-Esteem.*** As developed by Marshall, Marshall, Serran and Fernandez (2006), this behavioral technique asks each group member to create a reminder card that lists eight to ten positive statements about him/herself and another list of healthy and appropriate social activities that he/she would personally find pleasurable. Group members are encouraged to pursue such social activities, pausing to review the positive self-statements prior to, and if possible, during the activity. The treatment group can provide support and reinforcement as group members help each other to develop realistic, positive self-statements and find pleasurable outlets where they can express their positive traits and talents. Group sessions can provide opportunities to share and reinforce successful experiences and to problem-solve and refine behaviors based on less successful experiences.

b. ***Enhancing Empathy.*** This technique is heavily reliant upon the group therapist to identify and reinforce empathy-related emotional experiences occurring in the group with verbal or non-verbal praise. This could include redirecting an individual to recognize and label his/her own internal emotions; or praising a group member for accurately recognizing emotion in others; or reinforcing a group member for showing compassion and active empathy to other group members. The group therapist might selectively reinforce group members for recognizing and articulating the harmful effects of sexual abuse on victims, especially their own victims. The group therapist may attempt to extend the empathy activity by giving homework assignments for members to engage in "active empathy" behavior outside of group. Ideally, over time, it is expected that group members themselves may begin to imitate the same reinforcement of positive empathy with their peers.

c. ***Managing Deviant Thoughts.*** Research has consistently shown that "thought suppression" is not an effective method for managing deviant or unwanted thoughts (Wegner, Schneider, Carter & White, 1987; Abramowitz, Tolin & Street, 2001). At worst, efforts at willful suppression can increase self-absorbed thinking, generate irritability and moodiness, or even backfire into exaggerated rebounds of more intensive deviant thinking. As applied in a group therapy context, the group therapist can explain and demonstrate how to develop specific, detailed "focused distracters" as an effective alternative to manage deviant thinking and/or using "thought" approach goals in conjunction with cognitive restructuring (Shingler, 2009). The group then reinforces success through mutual support, encouragement and problem-solving.

d. ***Managing Deviant Sexual Arousal.*** Behavioral and cognitive-behavioral techniques for reconditioning and managing deviant sexual arousal are typically assumed to be interventions to be used privately in individual therapy. For example, Marshall, et. al. (2006) are explicit in indicating that techniques like odor aversion, covert association, masturbatory reconditioning, and verbal satiation are conducted in individual sessions. Laws (2001) provides a very detailed discussion of olfactory aversion with sexual offenders, but does not mention the role of the therapy group in that process. In their review of CBT with sex offenders, Moster, Wnuk & Jeglic (2008) also say nothing about the role of the therapy group in CBT interventions for deviant sexual arousal.

Clearly, many of the therapeutic interventions used to change unhealthy sexual arousal patterns are private in nature (e.g., masturbation) and should not be introduced or practiced in a group format. However, there are aspects of this process that are well suited for a group format, and for which behavioral group interventions can be used effectively. For example, one of the authors uses an "Arousal Management Orientation Group" for sexual abusers prior to their involvement in an individual modification program. This time limited group provides basic information regarding classical and operant conditioning principles and the mechanisms through which the client may learn to alter their sexual arousal. The group modality enables offenders to ask questions and see how other men manage the process, which can diffuse anxiety and reinforce continued efforts to practice the conditioning procedures.

Once the individual has begun practicing arousal conditioning techniques privately, the therapy group can continue to provide a highly reinforcing environment in which the participants hear about how others are having success in changing their deviant sexual arousal. Reinforcement for behavior change can also take place when offenders discuss "what's working" and the importance of maintaining regular practice of the techniques. In addition, since therapists are not engaged in behavioral modification themselves, the group modality can increase the power of peer reinforcement as offenders share information about their experiences and successes.

Conclusion

The commonly understood and widely accepted treatment of choice for sexual offenders is cognitive-behavioral group therapy. But the quantity of sex offender group treatment that is explicitly "behavioral" has become minimal in relation to that which is overwhelmingly "cognitive." Moreover, the emphasis on cognition is virtually synonymous with an emphasis on verbal communication—talking. By renewing our appreciation for the behavioral perspective in group therapy, we are also calling for greater appreciation of the valuable *non*-verbal interpersonal data that is available in group sex offender treatment.

One training technique that is used by the authors is to present a scenario in which the therapist has lost all ability to speak. The therapist is then asked to conduct a group session without words. Typical-

ly, this forces the mute group therapist to make a dramatic shift in focus and approach. First, as described in this article, the group therapist must use hand signals and body language to direct communication between and among group members and also to express approval, confusion, doubt, concern and other responses (i.e., reinforcement). But more importantly, the mute group therapist is forced to use his or her eyes to see more of what is already happening in the group. This, in turn, leads the therapist to discover the amazing power of *roving eye contact*, which is identified here as the foundation stone of effective group therapy (see also Jennings & Sawyer, 2003).

We believe that this fundamental shift of focus from primary, if not exclusive, attention to cognitive verbal data to observable social behavioral data has the greatest implication for group treatment providers because it opens up a rich and expanded range of useful clinical data, especially interpersonal data. Instead of looking for thinking errors, the therapist is looking for actual interpersonal *behavior* in the group, which can reveal and reflect so-called "Good Lives" issues, such as bonding vs. isolation, attachment vs. loneliness, social competency vs. dominance, social awareness vs. self-absorption, empathy vs. exploitation, friendship vs. avoidance, and much more.

We believe that putting the behavioral back into cognitive behavioral group treatment is entirely consistent with current trends in the field as sex offender treatment moves away from a generic cognitive model and toward a multi-model, integrated, and holistic treatment approach. Treatment models that emphasize approach goals provide excellent opportunities to use behavioral paradigms to reward sexual abusers for a variety of healthy behaviors they exhibit, from simply attending and participating in the therapy process, to making meaningful changes in thinking and behavior as it relates to their sexuality and relationships. Although the use of behavioral interventions is often unfairly perceived as contrived, mechanical, and impersonal, these methods can be surprisingly spontaneous, enjoyable and effective in group therapy with sexual offenders.

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