

Treating a sexual offender who categorically denies committing the offence



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Sex offenders deny

- “failure of sexual abusers to accept responsibility for their offences” (ATSA, 2005)
- Denial is a characteristic of sexual offenders.
 - Maletzky (1991) – 87% of offenders in sample denied all or part of their crimes
 - Kennedy & Grubin (1992) – 1/3 offenders in sample absolutely denied involvement
 - Marshall (1994) found that 32% of a sample of sexual offenders significantly minimized aspects of their offending while a further 31% completely denied having offended.



Types of denial

- Denial is normal and not always viewed as problematic (Kendell, 1992)
- Concept of denial is also multifaceted (Marshall et al., 2006)
 - Minimisation
 - Partial denial
 - Claim memory loss
 - Categorical denial "I did not do it"! - falsely accused or were mistakenly identified
- Denial not the same as dysfunctional cognitions (i.e., distortions, social information processing deficits, etc.) (Ward et al., 1997)



Why do sex offenders deny?

- Lord and Wilmott (2004) interviewed offenders who were admitting to their offenses after having denied them initially.
- low motivation or a lack of insight,
- threats to self-esteem and self-image, and
- fear of negative, extrinsic consequences such as:
 - losing their family and friends (to whom they had previously maintained their innocence).
 - Losing appeals against conviction/sentence.
 - Being seen as a sex offender in prison is dangerous



Problem of categorical denial

- The management and treatment of these sex offenders who categorically (completely) deny committing the offence pose significant difficulties:
 - These offenders refuse to participate in sex offender treatment
 - They are often deemed ineligible or unsuitable for treatment on the basis of their complete denial of responsibility. The assumption being that admitting to the offence is a necessary pre-requisite for successful treatment progress (Schneider & Wright, 2004).
 - When these offenders have commenced treatment they are often discharged before completion due to lack of progress and/or disruptions to the treatment process.
 - Consequently, no treatment, no release, longer incarceration, viewed as “resistant”, etc.



Categorical denial & treatment

- Denial and minimization of offending has not been reliably linked to sexual recidivism risk (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004)
 - But denial associated with increased sexual recidivism in low risk incest offenders (Nunes et al., 2007)
 - And... the relationship between denial and recidivism may be masked by moderator variables (i.e., psychopathic v non-psychopathic)
- Denial has not been reliably demonstrated to predict within-treatment gains (Beckett, Beech, Fisher, & Fordham, 1994; Kennedy & Grubin, 1992).
- And... treatment for sexual offending has been shown to be effective (Hanson et al., 2002; Losel & Schmucker, 2005; Marshall & McGuire, 2003), therefore can it be assumed that treatment does not need to produce changes in an offender's denial in order to be effective?



Treatment issues to consider (1)

- Ethical implications of treating individual for a problem they persistently deny having (ATSA, 2005)
- ATSA practice guidelines (statement 28.03) - Clients who completely deny their offences should not be represented as having successfully completed a sexual abuser treatment program (ATSA, 2005)
- Sex offenders may in fact categorically deny responsibility due to threats to their self-esteem or due to other negative extrinsic consequences rather than due to an explicit desire to re-offend (Lord & Wilmott, 2004). Consequently, *refusing* to treat such offenders does not appear warranted.



Treatment issues to consider (2)

- The offender is actually innocent (ref?)
- If they are not admitting anything then what are you actually treating?
- If we treat these 'deniers' are we not just building their antisocial confidence that they can get away with it (Brake & Shannon, 1997)?
- Is denial directly related to the causation and/or maintenance of offending? Or does it occur afterwards? If afterwards – how is it important?



Approaches to treating categorical denial in sex offenders (1)

- Intensive or “aggressive” community supervision for offenders partly at least because they have not received treatment (Gendreau, Goggin, Cullen, & Andrews, 2000; Laws, 2002). Little evidence of effectiveness
- Other strategies have focused on pre-treatment motivational approaches, either through individual motivational interviewing (Mann, Ginsburg, & Weekes, 2002; Miller & Rollnick, 2002), individual assessment feedback procedures including the results of phallometry (Bradford & Greenburg, 1998). The evidence for each of these approaches is limited.




Approaches to treating categorical denial in sex offenders (2)

- Group based treatment approaches specifically aimed at overcoming denial have been developed (Brake & Shannon, 1997; O'Donohue & Letourneau, 1993; Schlank & Shaw, 1997). Again, the evidence for this approach is limited.
- Another strategy is to simply offer sexual offenders who categorically deny committing offences entry into conventional sex offender programs alongside those who admit to their offending. As noted above, this is not an effective strategy as these offenders either (a) refuse to participate or (b) and/or are discharged due to poor performance.



Specific categorical Deniers program (Marshall et al., 2001; Ware & Marshall, 2007)

- Adaptation of conventional sex offender treatment programs
 - the focus is on the problems in the offender's life which led to him to be in a position where he could be "accused" of an offense.
 - Longstanding (stable) or precursors (acute) to alleged offending
 - The goal is to help the offender prevent any further "allegations", and in so doing,
 - we target the same relevant criminogenic needs as would normally be addressed (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001).

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- the risk factors associated with sexual offending are addressed without participants needing to admit to the actual offending
 - It is these risk factors that the offenders need to take responsibility for!
 - it is suggested to the offender that it may have been something about his behaviors, attitudes, thoughts and feelings, within the situations that led to the allegation, and may therefore lead to more allegations in the future unless he is able to modify or manage them.
 - It is further suggested that the offender *must* have acted in ways which allowed for an allegation to be made, otherwise the police and the courts would either not have pursued the matter or would have found him not guilty.



Treatment targets

- Similar to conventional sex offender treatment programs, a Deniers Program will target the following areas:
 - self-esteem (*conventional*)
 - acceptance of responsibility (*for risk factors*)
 - Victim empathy (*in general*)
 - offence pathway understanding (*for allegation*)
 - self- and affect-regulation (*conventional*)
 - coping styles/skills (*conventional*)
 - relationship and social skills training (*conventional*)
 - sexual interests (*in general*)
 - self-management and release/reintegration planning. (*for risk factors*)
 - + other offence-related targets (anger, A&D, etc.)



Treatment process

- Themes of the treatment approach
 - Initial motivation
 - Offender wants to maintain innocence
 - Believes he has no problem to treat
 - Focus on external/situational factors initially
 - Access internal factors (i.e., deviant sexual interests if opportunity)
 - Use “hypothetical” examples
 - How would smoker excuse behaviour?
 - How would violent offender excuse behaviour?
 - How would Mr X (sex offender) excuse behaviour?



Treatment approach: Evidence

- Limited as yet.
- Few programs
 - Canada program at Bath Institution
 - NSW program about to commence
- Single case studies (i.e., Ware & Marshall, 2007)
- Canadian program (Marshall et al., 2007)
 - 58 participants, released for average 3.3 years
 - Range of risk
 - 2% recidivism rate