Denial

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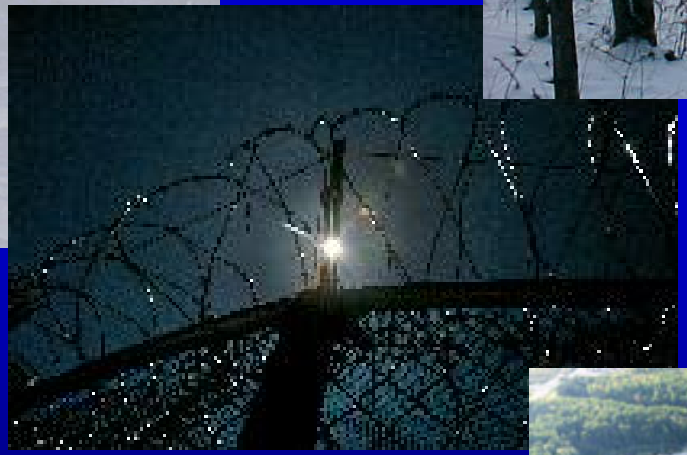
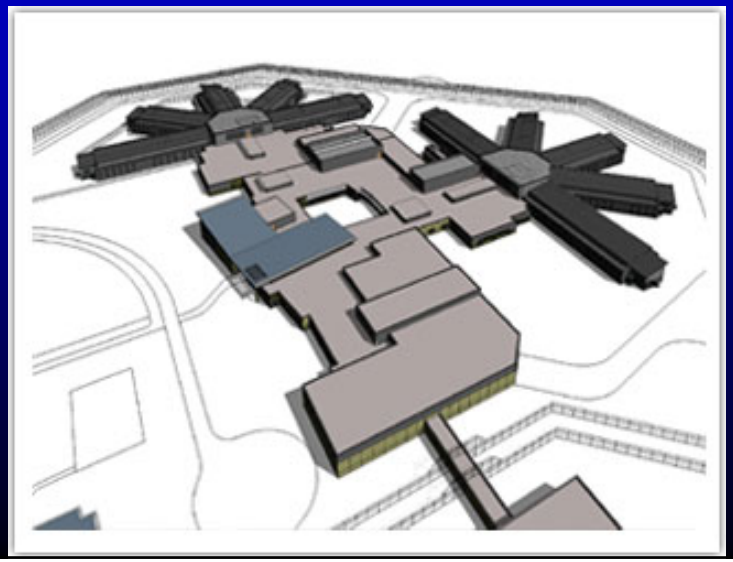
Huge thanks!

- To Pamela Yates, who has pursued the same questions to the same conclusions

David Prescott: Friend or Foe?





Welcome newcomers!

Don’t worry!

- No role plays
- No calling on people for answers
- No references to rivers in Egypt

Focus

- Controversies
- Research
- Options

The problem

- I am looking for suggestions for a client I am working with. He was in outpatient treatment for two years and has continued to deny his offense. The legal evidence is not clear but he is adjudicated because he made a plea per attorney's recommendation. He is on probation and mother is following a safety plan to "keep him from getting accused again". He was placed in our facility for a probation violation not necessarily for the denial. Story has changed none in 2 years, suggestions please for how to decide if he should continue in residential and for how to proceed with treatment in a denier. Thank you in advance.

An important question

- How does a client "complete treatment" for a problem he doesn't have?

It makes my head hurt

- I am getting very confused here. From what I understand there are about as many studies that indicate treatment works as there are that indicate treatment doesn't work. Other studies indicate that really it depends upon the type of offender as to whether or not denial makes a difference. So, if treatment doesn't work, what is the big deal about denying deniers treatment? It seems like there should be some consideration for the clients who are not in denial, and making an effort. But if treatment doesn't work, I guess it wouldn't matter to them either? However Marshall and Marshall, 2007 in defense of treatment argued that many of the aforementioned studies are flawed due to the numerous variables that cannot be accounted for. So if treatment does work, do we know if it works better for deniers, or for those that are willing to accept responsibility?

  Therefore if one is to accept, or reject a denier, would it make a difference if one was a familial abuser as compared to one who is a psychopathic adult rapist?

Food fight coming...

- I don't think that's true. It seems to me that Margaret Alexander's huge meta-analysis (published in Sexual Abuse in about 2000 or 2002 - help me on this folks, I don't have time to check) showed a treatment effect with rapists also.

  I hate it when we make blanket statements about a class of offenders. They are individuals with differing psychological make-ups, histories, and responsiveness. They are not all the same, and we shouldn't treat them as such. We have to find the types of treatment that work the best for the particular individual as well as group.

  Why are you in this field if you do not believe in treatment, and aren't looking to find the most effective treatments.

Watch out!

- What message might the victims receive when we treat and have graduation parties for offenders who don't admit? Just our thoughts!!

One perspective

- Thank you for asking. Here are some thoughts on "messages a victim might receive"

  - that the abuse/assault didn't happen because s/he denies the abuse
  - the party just reinforces that I am not believed
  - my survival is invisible to others
  - no one celebrated me for coming forward, or surviving
  - everyone just wants it all to go away, as if it never happened

  I am sure there are many others. These are just the ones that came quickly to mind.

From outside the US

- Another way of looking at this is, *if* treating deniers (including a graduation party) reduces recidivism, then what message might the new victim of an untreated denier get?

  In other words, higher recidivism translates to someone getting hurt who would not otherwise have been hurt. What do we say to this person?

  The debate should not be offender versus victim, it makes more sense to debate the last victim versus the next victim. Is an insult to the last victim worth the next victim not happening at all?

Another perspective

- If treatment helps reduce reoffenses, who cares if people deny or not. Our goal is to prevent reoffense. We do care, of course, because they are difficult to work with -- which is why polygraphs are so useful. And, I do believe, that certain deniers have a higher reoffense rate. So I think they should have more rather than less treatment. I have never agreed with that ridiculous standard.

From the same author...

- It is critical that victims be believed, assured that the offender was the guilty one, and helped to heal. It is also important to explain to victims that sometimes perpetrators have difficulty admitting for various reasons - such as loss of profession, ego issues, loss of spouse, etc., and that the perp really knows he/she did the offense, and at least is working on the problem.

One step towards clarity

- In no way were we suggesting not to treat the denier. It's more of the certificate/celebration, rather than discharging at some point and encouraging further treatment, etc. The celebration may have a behavioral impact by possibly reinforcing for the deniers whatever mistaken beliefs they were already holding onto regarding the abuse. You're right it shouldn't be offender vs. victim of course; however, we cannot lose focus that the victim is part of the entire process.

Or not...

- One way some "professionals" get around this whole issue is to not require accountability for all victims. They simply don't require an offender to disclose each offense. This sends the messages to victims that even the professional doesn't think the victim is important enough to discover who they are so they can receive treatment.

  In our Juvenile program we help the young men to become accountable through disclosure and reporting all offenses. We find that those that hold onto even one victim through denial or non-disclosure struggle to complete treatment, even if they disclose other offenses. They are also holding onto the shame that comes with offending and therefore they struggle with their own core beliefs. The implications for allowing denial to continue are serious, both for the victim as well as the youth who struggles with sexual behavior problems. This is also true if the youth in treatment has also been victimized and doesn't disclose but holds onto the abuse as well as the shame.

- Note the disdain for “professionals”
- What research is there that full disclosure is necessary?

Another question

- Is there any research which shows that someone in denial is more likely to re-offend sexually than someone who admits to the instant offense?

Another answer

- The Hanson and Bussiere meta analysis of sexual offender recidivism studies (1998) indicated low predictive power for Denial of sex offense (.02). This statistic was replicated in the Hanson & Morton-Bourgon 2004 meta-analysis.

An adjunct

- Denial is not an either/or construct. While we see clients who state simply "I didn't do it" there are other types of "denial" stances that offenders take, such as denial of intent, denial of extent, denial of planning, etc. These are best reflected in the Facet of Denial Scale.

  As an aside, my dissertation research (unpublished) found that admitters are more likely to show significant PPG arousal to deviant stimuli than deniers (no kidding, right?). And I used a definition of denial as "categorical"….. as in flat refusal of the perpetration of an offense.

Completion

- Sex offenders never "complete" treatment, deniers or not. They have to work on their problem their entire life, as do anorexics (who often deny their problem too). At least, denying sex offenders know they have a problem even if they don't admit it. They know what they did. Completing treatment is just completing the formal education/therapy part. We always had people coming back later for "touch- ups" when problems came up. Aftercare should be encouraged for all.

Innocence aspect

- We often forget that there actually are some innocent people who are wrongly convicted. Extremely infrequent, but it does happen. They can benefit from treatment because they can apply what they learn to other problems in their lives. We have always told deniers who have been convicted that we have to assume they committed their offenses, and that they can benefit from treatment. We also work on the motivations for denying which can be overwhelming to some (especially those with weak egos for whom their offenses are a terrible shame and disgrace). It's amazing how many admit eventually with the help of a group of admitters.

Jill’s on it...

- If someone is wrongly convicted, isn't that a legal problem rather than a clinical problem? Or, in the alternative, you'd be counseling them for the distress derived from wrongful conviction, rather than sex offense prevention treatment goals, which would be irrelevant for a wrongly convicted person. How can a wrongly convicted person "graduate" from sex offender treatment?

  Jill Levenson, Ph.D.

From Canada, treating high-risk clients

- Our program has always accepted deniers. It actually is policy in CSC that we can't deny people treatment based on denial, but even before then e accepted them. My thinking has been even if they don't admit, if hey are willing to come I have something to work with.

  Just for the sake of throwing numbers around - in my data set I have information on denial for 305 men who completed treatment (i.e. made it to the end of the program - our program has a fixed start and endpoint - it's about 7 months). By the way for those who don't know our program is a prison based program that treats men assessed as high risk and high treatment needs. The average Static-99 score in this particular subgroup is 5.1.

Continued...

- Pretreatment 37 (12.1%) complete denial; 64 (21%) partial denial; 107 (35.1%) minimizing; 97 (31.8%) complete admission - I defined complete denial as "I wasn't there and don't know anyone who was" type of presentation; partial denial might be "We had sex but she consented"

  Post-treatment 19(6.2%) complete denial; 17 (5.6%) partial denial; 67 (22%) minimizing; 202 (66%) complete admission.

Continued

- So, some guys remain in denial even after treatment. We tend to take the stance that if someone is attending the program, allowing us the opportunity to question him about his behavior and not behaving in a manner that interferes with other offender's treatment, he can stay. If his denial is disruptive to other's treatment, he goes - not because he is in denial, but because of his disruptive behavior.

  Someone asked how do you address a problem they don't have. We start by asking question like "If you didn't do it why are you here?" "How did you get convicted?" "Why was the victim willing to go through all that trouble to get you convicted?" - pointing out the rather difficult process victims go through. The answer to these sorts of questions usually gives lots of fodder for gentle prodding in the direction of admitting to something. If they admit to something then further questioning will lead to further admissions and so on.

Case example

- There was a well known SVP case, wherein the SVP individual volunteered for the SVP treatment program admitting his sex crimes. After a few years he stated he lied in the treatment program about being guilty of the sex crimes in an effort to look good for the court. Evaluators and treatment providers, myself included, were (still are) split about whether we believe him. The victims actually recanted. His primary therapist, believing him, left the hospital over the issue. There was a book written about it (which has not been published yet). Afterwards, the other SVPs and the hospital
staff were deeply affected for a long time. The integrity of the program an SVP law in general were questioned.

  We questioned how the system we were all a part of contributed to deception of all kinds. We questioned our own judgment and whether our time and efforts actually tip the scale in the direction of helping. Guilty or “faking guilty", the SVP was very skilled at deception. We presumed such high degree of "psychopathy" was related to his offending. The greatest lesson I learned was to be mindful of the fact that there are outliers to every known statistical finding. When one weds them self to a belief over other possibilities, there is a natural limitation of perspective that is unavoidable.

Opinions are strong

What does the research say

Is Denial Related to Recidivism? Hanson & Bussière (1998) Meta-Analysis

- Recidivism rates low overall
- Strongest predictor of sexual recidivism = sexual deviancy, preference
- Criminal lifestyle, antisocial personality = predictors of sexual recidivism but better predictors of violent and general recidivism
- Psychological problems (e.g., self-esteem, anxiety), psychological maladjustment (e.g., negative mood, low motivation for treatment, lack of victim empathy, lack of remorse, and denial) had little or no relationship to recidivism
- **Offenders who completed treatment had lower sexual and overall recidivism rates than those who did not complete treatment

Possible Conclusions
(Hanson & Bussière, 1998)

- Denial is unrelated to recidivism
- Denial is related to recidivism but relationship not detected due to measurement issues and unknown treatment status

Lund (2000)

- Seven studies of denial in Hanson & Bussière meta-analysis
- Denial = variously defined across studies – denial of offense, denial of responsibility, thinking errors, attribution of responsibility
- Treatment failure variously defined across studies
- Various methods of assessment of denial used
- Objectives of these studies were not to evaluate impact of denial *per se,* so measurement of denial = a peripheral variable
- In some studies, categorical deniers excluded from treatment
- Hypothesized that denial may interact with other factors such as risk, resulting in apparent absence of a relationship between denial and recidivism:
  - Specifically, that denial may influence recidivism among lower risk offenders in the absence of other risk factors but could be eclipsed by other risk factors among higher risk offenders

Possible Conclusions (Lund, 2000)

- Denial is unrelated to recidivism
- Denial is related to recidivism via interaction with other factors, particularly risk
- Denial is related or unrelated to recidivism but methodological issues prohibit definitive conclusion

Hanson & Morton-Bourgon (2005) Meta-Analysis

- Two broad risk domains – deviant sexual interests and antisocial orientation/lifestyle instability – predictive of recidivism
- Strongest predictors of sexual recidivism =
  - Sexual deviance (deviant sexual interest, sexual preoccupation)
  - Antisocial personality disorder, antisocial traits (problems with general self-regulation, employment instability, hostility), psychopathy
- Personal distress (e.g., low self-esteem, loneliness), low motivation, denial not predictive of sexual recidivism
- Denial not predictive of violent recidivism
- Very small but significant relationship between denial and any type of recidivism

Possible Conclusions (Hanson & Morton-Bourgon, 2005)

- Denial is unrelated to sexual or violent recidivism
- Denial may have a small relationship to any type of recidivism

Nunes, Hanson, Firestone, Moulden, Greenberg, & Bradford (2007)

- Hypotheses:
  - Denial would be associated with recidivism among higher risk offenders and unrelated to recidivism among lower risk offenders
  - Denial among psychopaths may represent hostility, lying, manipulation
- Overall small and *ns* relationship between denial and recidivism (n's of samples = 489,490, & 73)
- Offenders who denied committing all index sexual offenses did not differ from those who admitted offenses on risk or psychopathy
- Offenders who denied committing all index sexual offenses did not differ from those who admitted offenses on sexual or violent recidivism
- Denial did not contribute independently to prediction of sexual recidivism over and above risk and psychopathy in interaction

Nunes, Hanson, Firestone, Moulden, Greenberg, & Bradford (2007)

Denial/Risk Interaction:

- Lower risk offenders who denied offenses re-offended sexually at higher rates than lower risk offenders who admitted their offenses
- Higher risk offenders who denied their offenses re-offended sexually at lower rates than higher risk offenders who admitted their offenses
- Neither denial nor interaction was significant for violent reoffending
- Interaction moderated by relationship to victim:
  - For incest offenders, denial was associated with increased sexual recidivism (deniers reoffending at higher rates than admitters)
  - For non-incest offenders, denial was associated with decreased sexual recidivism (deniers re-offended at lower rates than admitters)

Nunes, Hanson, Firestone, Moulden, Greenberg, & Bradford (2007)

- Significant interaction not found in two additional independent samples, but overall results consistent and findings from three samples combined were the same:
  - Lower risk offenders who denied offenses were more likely to re-offend than lower risk offenders who admitted their offenses
  - Higher risk offenders who denied offenses re-offended at lower rates than higher risk offenders who admitted their offenses
  - Findings for incest offenders replicated, but findings for offenders with unrelated victims not replicated
- Although statistically significant, overall absolute differences in re-offending rates between deniers and admitters small (5% to 17%)

Possible Conclusions (Nunes et al., 2007)

- Denial overall unrelated to recidivism
- Denial associated with recidivism among low risk offenders but not among high risk offenders
- Denial may represent a risk factor for some offenders, specifically low risk and incest offenders
- Denial may be a minor risk factor when few risk factors and other major risk factors absent (e.g., sexual deviance, antisociality)

Harkins, Beech, & Goodwill, 2010

- Examined denial, motivation, and risk (n=180)
- High-risk offenders in absolute denial re-offended at lower risk than their admitting peers.
- Low-risk offenders in absolute denial re-offended more (but results were ns).

Harkins, Beech, & Goodwill, 2010

- Denial of risk:
- Those denying that they presented a risk for future re-offense were less likely to re-offend than those who reported seeing themselves as high risk.

- Motivation for treatment was positively correlated with recidivism, but this effect disappeared once static risk was controlled.

One response to Harkins et al

- So I'm thinking (not for the first time) well, maybe I should disband my group? after all, I'm just making them more dangerous by admitting their risk and becoming aware of their risk factors? maybe we should stop pushing people into treatment? maybe we should encourage denial and just threaten all our offenders with "if we ever catch you again you're *really* gonna get it? o.k., I'm exaggerating, but you get the point.

“Think of it as self-report”

- Most of these findings are straightforwardly explicable if you assume that sexual offenders have some insight into how likely they are to re-offending and into the degree to which their past offending was affected by situational factors.

  The moral of the story might be to do more careful listening to what offenders say about their offenses and less pressuring them into agreeing with our presuppositions.

  The only deviation from what you would expect on the basis of that hypothesis is that Denial was associated with greater recidivism for lower risk offenders - I suspect this arises because for some familial offenders denial is a victim-access behavior.

Is Denial Related to Recidivism? Overall Conclusions

- Denial is generally unrelated to recidivism
- Denial may be a minor risk factor for a subgroup of lower risk offenders
- We need to check our opinions at the door

Ways forward

- Pre-treatment group using motivational interviewing (Prescott & Ross, 2009; in press)
- Deniers program aimed at admission (Marshall, Thornton, et al, 2001)
- Deniers program aimed at reducing dynamic risk factors (Serran & O'Brien, 2009)

Marshall et al, 2001

- Primary obstacle: belief that admission will be mandatory
- Goals:
  - Self-esteem
  - Attitudes and relationships
  - Coping strategies
  - Understanding victim harm
  - Relapse prevention (i.e. How can you live so that no one can make these accusations again)

Prescott & Ross, 2009

- Pre-treatment
- Motivational interviewing
- Decisional balance (good and not-so-good things about admitting)
- Consider what it would mean if client “shifted” his or her position
- Refer for assessment, treatment or back to supervising authority

Serran & O'Brien, 2009

- Rockwood Deniers' Program
- Positive group climate/cohesion is primary emphasis.
- Preparatory sessions (what behaviors will contribute to goal attainment, rules, etc.)
- Disclosure of allegations against them
- Life story
- Explore intimacy and relationships
- Coping strategies and emotional management
- Victim harm
- Problem analysis (what was happening at the time of their arrest)
- Self-management and release planning

Possible language

- Mr. X has participated in a treatment program that addresses risk factors known to contribute to sexual re-offense. Mr. X maintains that he did not commit the crime for which he received a conviction. This means that that he has not identified the specific factors that contributed to his crime, assuming that it happened. For this reason, the author cannot report that Mr. X has completed a course of abuse-specific treatment.

Is Denial Related to Treatment Success/Failure? Possible Conclusions

- Denial is common
- Denial can be changed/not changed in treatment
- Denial is related/unrelated to treatment failure
- Denial can be changed in treatment, and treatment objectives attained regardless of denial
- Relationship of denial to treatment failure not established due to definitions, confounds, methodological limitations. It is also too often influenced by provider beliefs.
- Deniers commonly excluded from sexual offender treatment
- It is common to include deniers in many other forms of psychotherapy/treatment

The Bottom Line

- Denial has not been convincingly demonstrated to be related to recidivism, except possibly among lower risk offenders
- Research on relationship between denial and treatment success is inconclusive due to methodological and measurement, problems, confounding factors, etc.
- *But* no convincing evidence yet that denial interferes with treatment progress, attaining treatment gains, or treatment success or that denial cannot be changed through treatment.

- There is likely too great a focus in treatment on denial given the lack of support for its influence on progress and recidivism, at the expense of targeting known risk factors with stronger demonstrated relationships to recidivism

Treatment Implications and Recommendations

- Offenders who complete treatment reoffend at lower recidivism rates than those who don't (Hanson & Bussière, 1998).
- Treatment tailored to risk, need, and responsivity is effective in reducing recidivism (Hanson & Bourgon, 2009).
- Cognitive-behavioral interventions targeting known risk factors are most likely to be effective in reducing re-offending (Hanson, et al., 2002; Lösel & Schmucker, 2005).

Implications and Recommendations

- Do not exclude deniers from treatment. Two options:
  - Consider having a small number of categorical deniers in group
  - Create separate deniers' group/program for offenders in categorical denial (see Marshall et al., 2001; Prescott & Ross, 2009; Serran & O'Brien, 2009)
- Tailor programs to risk/need/responsivity principles – treat denial as a responsivity factor
- You may not need to focus on full disclosure of all details of all offences – work with what you get
- Consider that denial is a common cognitive distortion process (and potentially as a self-protective factor for some offenders)
- Measure treatment progress separately from admission of offending (i.e., measure change on dynamic risk factors)

Implications and Recommendations

- Determine function denial/minimisation serves for individual
- Cognitive restructuring using collaborative approach:
  - Understand role of cognitive distortions (including minimization and denial) in offending
  - Provide corrective information and assistance to identify cognitive distortions
  - Learn to challenge distorted views and perceptions
  - Meta-cognitive approach – target global attitudes and cognitive schema
- Use preparatory program

So What Now?

- Use of effective therapeutic techniques and development of working alliance (see Marshall & Marshall, 2007; Prescott, 2009)
  - Motivational enhancement approach/techniques
  - Positive reinforcement & successive approximations (generally and for admission)
  - Empathy
  - Supportive challenging rather than confrontation
  - Acknowledge that denial may or may not be intentional misrepresentation
  - “Face-saving” techniques for admission after denial
  - Work toward development of positive lifestyle

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