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How should “acceptance of responsibility” be addressed in sexual offending treatment programs?

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ABSTRACT

Sexual offenders in treatment programs are usually expected to take responsibility for their offending—which we define, on the basis of a literature review, as giving a detailed and precise disclosure of events which avoids external attributions of cause and matches the official/victim's account of the offense. However, research has not established that a failure to take responsibility for offending is a risk factor for future recidivism. In this paper, we critically review and evaluate the literature on taking responsibility for offending, to determine the rationale for the popularity of this treatment target. We consider the reasons why sex offenders fail to take responsibility for their offending and examine some potential problems with focusing on this goal in treatment programs. We also describe alternative treatment strategies for taking responsibility and conclude that there is less need for offenders to take responsibility for their past offending than there is for them to take responsibility for their future actions.

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1. Introduction

Most sex offender treatment programs encourage their participants to "take responsibility for their offending". The latest Safer Society Press survey of United States and Canadian sexual offender treatment programs (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) reported that 91% of both residential and community based programs for adult offenders in the United States included "offender responsibility" as a treatment target. However, Mann, Hanson, and Thornton (2010) did not include "lack of responsibility for offending" in their list of empirically established causal risk factors for sexual offending; and hence did not recommend "responsibility for offending" as a treatment target. Why, then, do treatment programs place such a focus on taking responsibility for offending? Is there genuine rehabilitative value in taking responsibility, or is it possible that therapists have fallen victim to "correctional quackery" (Gendreau, Smith, & Theriault, 2009), where they prioritize personal experience, values, and anecdotal evidence, or the pressure from non-therapists involved in sex offender management or even the general public, above evidence resulting from rigorous, large-scale research efforts.

In this article, we will examine the existing literature to establish the extent to which "taking responsibility for offending" is, in fact, an evidence-based treatment target. To address this issue we will review the literature in relation to a number of key questions. First, we will address the matter of how "taking responsibility" is defined: what does it mean to take responsibility for offending? In order to examine this, we will look at what are often viewed as the opposites of taking responsibility—denial and minimization—as well as examining what programs actually require from their participants in terms of taking responsibility. Second, we will identify and review the main arguments for the role of offender responsibility in the prevention of re-offending. Why it is that taking responsibility is so widely thought to matter? Third, we will examine the extent to which an empirical relationship has been observed between taking responsibility and recidivism; and fourth the relationship between taking responsibility and treatment engagement/treatment attrition. Fifth, as a way of potentially explaining why taking responsibility may or may not be related to risk of re-offending, we examine why sex offenders might fail to take responsibility. What do we know about why sex offenders might deny or minimize their offending and to what extent are these behaviors part of the pathology of sexual offending rather than being normal human reluctance to admit one's errors? We will then examine whether there might be any potential dangers in continuing to place a significant focus on taking responsibility within sex offender treatment. Lastly, we provide suggestions as to how taking responsibility should be conceptualized within treatment.

2. Definition

"Taking responsibility" has been defined as "being able to answer for one's conduct and obligations" or "being the cause or explanation" (e.g., Delbridge & Berbard, 2000). In correctional practice, it appears that taking responsibility is defined in a range of ways, both in terms of what it constitutes and what is incongruent with taking responsibility. Below we review some of the various ways in which researchers and practitioners have chosen to define "taking responsibility".

2.1. Taking responsibility as a full and precise description of offending

The most basic definition of taking responsibility would be that the offender acknowledges that he committed a sexual offense. But to those providing treatment to a sex offender, the simple statement "I did it" is often seen as insufficient (Schneider & Wright, 2004) because although the statement apparently takes responsibility, it is not clear that there is an absence of denial, minimization and excuses. What is usually sought by therapists is "full" responsibility on the part of the sex offender—when he or she is no longer denying the offense(s) and is also no longer minimizing or justifying any aspects of it. This might be best reflected by an offender stating "I did it—all of it, exactly how the official records said I did it". Others would argue that a sex offender only takes responsibility when he is no longer denying or minimizing and is also acknowledging all of his problems or deficits that caused the sexual abuse (Schlank & Shaw, 1996). Some therapists have even gone so far as to argue that acceptance of responsibility is only accomplished when an offender has acknowledged his sexual problems and behaviors over and above what he has been convicted of (e.g., Salter, 1988; Schlank & Shaw, 1996) including other previously non-disclosed offending (e.g., Heil, Ahlmeyer, & Simons, 2003).

The recent Safer Society survey of treatment programs within the United States and Canada illustrates the variations in the level of responsibility that treatment providers have deemed to be necessary in order for a sex offender to have successfully completed the treatment program. McGrath et al. (2010) found that within the United States, approximately 36% of residential and 33% of community based treatment programs for adult sex offenders require an "offense disclosure" within treatment that is "*very consistent with official records*" in order for the offender to have successfully completed treatment. A disclosure that is "*reasonably consistent with official records*" is required in 42% of residential and 48% of community based programs, while a disclosure of "*at least some sexual offense history, even if it is inconsistent with official records*" is required in 14% of residential and 12% of community based programs. Only a very small percentage of residential and community based treatment programs (6%) did not require an offense disclosure.

What is actually required to accomplish a *full* disclosure is often not explicit. Typically it involves a description of the behaviors that occurred both immediately preceding and during the actual offense. The offender is often expected to describe what happened "in detail" and may be asked to use explicit language to demonstrate his responsibility-taking (e.g., "I put my finger into her vagina", see Salter, 1988) as opposed to what appears to be a common or natural tendency of these men to describe their offenses in legalistic terms (e.g., "I committed an indecent assault on a 12 year old"). Usually the offender is required to give a detailed offense disclosure, which may amount to two to three efforts often under the scrutiny of the therapist and other group members. Both the therapist and group members usually actively (perhaps even harshly) challenge the offender's account—most notably any apparent denial or minimizations. As noted above, often the therapist will compare the offender's account with official records, such as the Police Statement of Facts, and will seek to have the offender take responsibility to the point whereby his account matches that of the victim or police. The degree to which an offender has taken responsibility is often measured through the use of a polygraph (McGrath et al., 2010).

As part of their offense disclosure, offenders are often expected to describe their (sexually deviant) thoughts, feelings, and physiological arousal. So, it is clear that to meet most definitions of "taking responsibility", an offender needs to say even more than "I did it—all of it, exactly how the victim said I did it". Rather, he or she must also describe why and how they did it. This requirement assumes that a sexual offender can accurately identify and label their thoughts and feelings and, in fact, can recall them (which may be particularly difficult in the cases of historical or multiple offenses or when the offender has multiple victims) (see also Marshall, Marshall, & Ware, 2009).

2.2. Denial and minimization: the opposites of taking responsibility?

A sex offender is most usually described as *not* taking responsibility when he is either denying or minimizing his sexually abusive behaviors. The Association for the Treatment of Sexual Abusers (ATSA), for example, has defined denial as "the failure of sexual abusers to accept responsibility for their offenses" (ATSA, 2001, p. 63). This failure to accept responsibility may range from absolute or categorical denial ("I did not do it") through various degrees of minimization and rationalization to a full acceptance of responsibility. For the sake of clarity, we will use the term denial to mean categorical rejection of the conviction, and the term minimization to refer to the common tendency to omit or underplay certain aspects of the offending or its consequences. Many sex offenders deny or minimize some aspect of their sexually abusive behaviors. Maletzky (1991), for example, reported that 87% of his clients denied all or part of their crimes. 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. Given how prevalent denial and minimization are, it is easy to see how therapists have naturally assumed that they are important issues for treatment.

Dean, Mann, Milner, and Maruna (2008) outlined three broad types of sex offender cognitions: (1) statements of attitude or belief that justify sexual offending in general, (2) reports of specific thoughts during commission of the offense, and (3) statements that give reasons as to why the offense occurred. Denial and minimizations are examples of the third type of cognition as they are typically formed *post hoc* (after the offense), as are excuses, which are defined as statements of cause that attribute responsibility to someone or something other than oneself. Because of their prevalence, denial, minimization and excuse-making are typically assumed to be part of the pathology of sexual offending. However, given that these post-hoc accounts occur after an offense, they are likely to be situational rather than dispositional and related to a particular context or circumstance (Heckert & Goldolf, 2000).

Maruna and Mann (2006) noted that the fact that denial and minimizations occur *after* the offending is an important point that has often largely been ignored. If denial and minimizations occur after offending then it is difficult to conclude that they are causally related to offending—particularly to the first instance of sexual offending. Maruna and Copes (2005) noted that historically therapists and researchers have almost universally accepted that denial and minimizations cause offending when it is probably the opposite—that offending causes excuses. Given the universal human tendency to make excuses when one has transgressed (Saxe, 1991), it should come as no surprise that anyone accused, charged, or convicted of a sexual offense will readily deny aspects of his sexually abusive behaviors (Ware & Marshall, 2008).

One argument has been that denial and minimizations cause the continuation of offending once the first offense has been committed—that is, that they play a maintenance role (Abel et al., 1989; Murphy, 1990). Further, some researchers and therapists also view post hoc excuses and denial to be grounded in distorted cognitions, in that the denial or minimization reflects or represents pre-existing beliefs or attitudes supportive of sexual abuse (see Schneider & Wright, 2004 for discussion of this issue). Wright and Schneider (1999) noted that when using repeated justifications or minimizations a sex offender may in effect engage in self-deception and convince himself that his stated rationale for his sexually abusive behavior was, in fact, accurate. This seems consistent with the classical Finkelhor (1984) descriptive model of sexual offending in which excuse-making takes place before offending in order for the offender to "overcome internal inhibitors" to the idea of committing a sexual crime.

On the basis of the literature reviewed above, therefore, we define the concept of "taking responsibility for offending" as "giving a detailed and precise disclosure of the events involved in the sexual offense which avoids any external attribution of cause and which matches the official/victim's account of the offense". In creating this definition, we aim to simply reflect the meaning of the term "taking responsibility" as it is most commonly used, and do not intend any implication about the appropriateness or desirability of taking responsibility for offending.

3. Why does taking responsibility matter?

Any rehabilitative practice should draw upon a "model of change"—that is, an account of what should change and why changing this feature would be associated with successful rehabilitation. Models of change should ideally be evidence based—tested out by robust experimental studies—or, failing that, theory-based, so that the account of the process of change is based on established rehabilitation theory. In this section, we review the models of change that explicitly or implicitly explain the inclusion of "taking responsibility" as a treatment goal in so many rehabilitation programs. In most cases, the model of change for taking responsibility seems to be assumed rather than formally articulated. That is, there is often an assumption that it is common sense that offenders need to take responsibility for their offending in order to reduce their risk of further sexual assault.

3.1. The common-sense rationale—"taking responsibility is the right thing to do"

Salter (1988), for example, stated that, "a primary goal of any treatment program is to enable offenders to take responsibility for their behavior. Perhaps the single greatest obstacle to treatment is denying, minimizing, and externalizing" (p175). McCaghy (1968) stated that "sexual offenders must assume responsibility for their past behaviors and set aside all excuses" while more recently, Theriot (2006) argued that "without congruence between the offender's version of the events and those other recorded versions, treatment will be more difficult and most likely ineffective" (p. 34).

The importance of taking responsibility as a treatment goal often appears to be based on the simple assumption that if an offender does not take responsibility then he could not be expected to fully participate in, and benefit from, treatment. Levenson (2011) suggested that a possible reason why therapists appear to place such importance on responsibility is because apologies and accountability are considered "the right thing to do" within our societal values (p. 3). Blagden (2011) has questioned whether this stance may have its roots in Christian religious principles of confession and repentance. Further, Levenson noted that by not targeting acceptance of responsibility, therapists might "facilitate collusion with clients to maintain the secrecy by which sexual abuse thrives" or "may send a mixed message to deniers if we treat them without taking responsibility".

3.2. Taking responsibility is necessary to identify risk factors

A better rationale for the focus on taking responsibility in treatment is the argument that if an offender cannot describe how and why he committed his offense, then it is not possible to discern

what his dynamic risk factors (treatment needs) are. A step by step account of offending (such as that obtained through the cognitive-behavioral chain method; Nelson & Jackson, 1989) is thought to be the best way to "concretely highlight the interactions among various elements and provide offenders with an opportunity to analyze the progression of the precipitants of their illicit sexual acts… Inspecting such chains highlights points for intervention with coping responses that will divert the offense pattern" (Nelson & Jackson, 1989, p. 167–168). In other words, it is necessary to give a detailed offense account to identify which risk factors were operating for the perpetrator in the build up to an offense. This knowledge then enables the treatment provider to design a personalized intervention strategy to help the perpetrator avoid offending again.

One problem with this model of change is that the legitimate goal of understanding the build up to the offense is not the same as the goal of describing the offense behaviors themselves in the kind of detail that is usually required by treatment programs. Nelson and Jackson's aims could easily be achieved by an account of the lead up to the offense without requiring any *disclosure* of the offense itself.

3.3. Offenders report that acceptance of responsibility is valuable

It should also be recognized that offenders themselves invariably report that they value the treatment activity of giving an offense account. In each of three recent "service user feedback" studies, offenders who reflected on their treatment experiences rated acceptance of responsibility as personally important. Levenson and Prescott (2009) studied the views of 44 civil commitment patients in Wisconsin including asking them to rate the importance of each component of treatment on a 5-point Likert scale along with their satisfaction with each component of treatment. Participants gave their highest ratings for both importance and satisfaction to "accepting responsibility for my sexual offenses (accountability)". Levenson, Macgowan, Morin, and Cotter (2009) similarly studied 338 sexual offenders in outpatient group therapy in Florida and Minnesota. In this survey, 94% of participants rated "accepting responsibility" as "very important", and 82% rated "understanding my tendency to distort, deny and make excuses" as very important. These two surveys suggest that offenders see considerable value in taking responsibility. Levenson et al. (2009) concluded that "It has long been intuitive among practitioners that it is unrealistic to expect treatment progress without the client's acknowledgement of his problem, and these subjects appeared to affirm that widely held therapeutic tenet" (p. 50). In an earlier study examining reactions to HM Prison Service's Sex Offender Treatment Program, Wakeling, Webster, and Mann (2005) reported more mixed reactions to the task of giving an offense account, with 22% of respondents citing this as the most helpful part of their treatment experience, but 11% describing this activity as unhelpful. These researchers used grounded theory analysis to examine reactions to treatment more closely, and this revealed that participants felt that giving an offense account helped them with self-development and awareness, but also produced negative emotions. The authors cited one respondent as saying "It helped to talk about the offense and get it out into the open. I felt better sharing the problem with others" (p. 181). This quotation implies that there is some kind of cathartic and bonding effect from describing one's offense in a group session.

There are, however, reasons why a sex offender, particularly someone who has commenced or completed a treatment program (and we note that in the studies described above, all the participants were treatment completers), may report that taking responsibility is important other than their finding it personally beneficial. For example, Lacombe (2008) and Waldram (2008) have both reported how treatment participants easily detect the issues that their therapists see as being important and respond by constructing a presentation that matches the therapists' priorities, whether or not the offender himself recognizes any importance in these issues. In addition, in at least two of the studies described above (Levenson & Prescott, 2009; Wakeling et al., 2005), the investigators were connected with the treatment program being reviewed. It is likely, therefore, that demand characteristics will have considerably biased the accounts of the participants in these studies.

3.4. Models of change: conclusions

The three potential models of change for acceptance of responsibility are not very robust. They seem to be based on common sense rather than evidence, and the evidence cited in terms of service users' views is rather flawed. We conclude that there is no well-articulated model of change for the popular treatment target of taking responsibility. This weakness would, however, be forgivable if there were empirical data indicating that taking responsibility is associated with reduced recidivism, or other positive treatment outcomes such as retention in treatment. We will examine these matters next.

4. Taking responsibility and recidivism

According to the Need Principle of offender rehabilitation (Andrews & Bonta, 2003), acceptance of responsibility will be an important treatment target only if there is an established relationship between a lack of taking responsibility and recidivism risk. Is this actually the case? Hanson and Morton-Bourgon (2005) completed a large meta-analysis with a total of 95 studies involving over 31,000 offenders finding that neither denial (mean effect size $d = .02 \pm .17$, 9 studies with 1,780 offenders) nor minimizations (mean effect size $d = .06 \pm .24$, 6 studies with 768 offenders) were related to sexual recidivism. This was true whether or not these offenders received treatment. On the basis of these results Hanson and Morton-Bourgon (2005) described denial as a 'potentially misleading risk factor" (p. 1158). These results have not been unconditionally accepted (see Lund, 2000) which, in our view, methodological issues aside, is not surprising given the importance attached to taking responsibility by therapists.

A number of subsequent studies have looked at potential moderating factors (such as risk of recidivism) in an attempt to clarify the relationship between denial or minimizations and sexual recidivism. These studies have not consistently demonstrated an overall link between denial or minimizations and sexual recidivism but they have suggested that for certain offenders, categorical denial is related to increased sexual recidivism. What complicates these findings is that the types of offender for whom denial might lead to increased recidivism differ across studies. Nunes et al. (2007) found that low risk offenders, particularly incest offenders, who denied their offenses were more likely to re-offend than admitters. High risk offenders who denied were *less* likely to re-offend than admitters. Harkins, Beech, and Goodwill (2010) found similar results with denial predicting decreased re-offending rates in higher risk offenders and increased offending amongst lower risk offenders. Langton et al. (2008) reported the opposite. They found that higher levels of minimization/denial predicted sexual recidivism among higher risk offenders and decreased the risk for low risk offenders. Thornton and Knight (2007) found that denial was associated with increased recidivism risk for rapists and decreased recidivism risk for child molesters.

A number of studies suggest that sex offenders who deny or minimize their offenses are at lower risk to re-offend than those who are taking responsibility (Barbaree & Marshall, 1988; Hood, Shute, Feilzer, & Wilcox, 2002; Ryan & Miyoshi, 1990; Smith & Monastersky, 1986). Moreover, continued denial does not appear to necessarily prevent on-going treatment gains (Beckett, Beech, Fisher, & Fordham, 1994; Maletzky & Steinhauser, 1998; Ware & Marshall, 2008).

How does one make sense of these contrasting results? The answer may lie in understanding for each sex offender what was the *function* or *purpose* of the denial or minimization. We will expand on this important point in a following section. Mann et al. (2010) noted that denial is probably protective in certain circumstances

and criminogenic in others. As we have already highlighted denial and minimization occur *after* the offending and are likely to be situational rather than necessarily representing some pathology of sexual offenders. For this reason, the static risk level of the offender (i.e., low or high) may be irrelevant. Whether the offender is a child molester or rapist may also be irrelevant.

5. Taking responsibility and treatment engagement/attrition

Even if denial is not a criminogenic need, treatment engagement and attrition represent other relevant outcomes which may be related to denial. If taking responsibility improves treatment engagement, there could be an argument for encouraging offenders to take responsibility as a within-treatment target to aid the offender in benefiting from treatment. Schneider and Wright (2004) noted that "it has been argued that offenders cannot be expected to fully participate in treatment or work towards changing their behavior without acknowledging their own responsibility…." (p. 4). Is there evidence to support this assertion? Levenson and Macgowan (2004) studied the relationship between treatment engagement and denial, using the Facets of Denial (FoSOD; Schneider & Wright, 2001) rating scale which measures accountability for offending, synonymous with taking responsibility. Engagement was measured using two versions of the Group Engagement Measure (Macgowan, 1997, 2000)—a client version and a therapist version—as well as therapist ratings of client progress. The measures were completed in relation to 61 male offenders in outpatient treatment. Levenson and Macgowan reported a strong inverse relationship between denial and progress as rated by therapists, and also between denial and engagement. However these findings are unsurprising and unrevealing, because the client progress rating scale used (SOTRS; Anderson, Gibeau, & D'Amora, 1995) strongly emphasized insight, admission of deviant thoughts, and disclosure and so it was clearly already assumed that these features were associated with treatment progress. It is therefore not possible to draw the conclusion from this study that clients who take more responsibility are more engaged in the process of change.

There are similar limitations to Barrett, Wilson, and Long's (2003) study of the relationship between motivation to change and treatment engagement. In this study, motivation was defined in terms of five indices (acceptance of guilt, acceptance of personal responsibility, disclosure of personal information, motivation to change behavior, and participation in treatment), the first three of which are clearly related to taking responsibility. Scores on these indices were taken at four time points: before institutional treatment, after institutional treatment, upon release, and after 12 weeks of treatment in the community. Taking responsibility (as measured by the index of "acceptance of personal responsibility") increased after institutional treatment, had reduced by the point of release, and then increased again following community treatment. There was a significant correlation between higher acceptance of responsibility and guilt following community treatment and successful outcome in terms of reoffending. However there were no correlations between taking responsibility indices measured at any other point in time and outcome.

A lack of acceptance of responsibility is often implicated as a reason for the high rates of attrition within sex offender treatment (Beyko & Wong, 2005; Brake & Shannon, 1997; Hunter & Figueredo, 1999). This is an important consideration given that the re-offense rates for offenders who do not complete treatment are reported to be greater than those offenders who did not enter treatment at all (see Hanson et al., 2002). Does a lack of acceptance of responsibility cause treatment drop outs or discharges? Jones (2009) noted that sex offenders most often voluntarily drop out when they are completing offense disclosures. At this point, sex offenders are required to fully take responsibility which, as we outline shortly, is a very difficult task. It should come as no surprise that any sex offender who feels coerced into a "confession" within treatment may choose to opt out of this process. Ware and Bright (2008) reported on a program with a high level of treatment attrition and also noted that offenders were most often discharged from treatment for lack of progress during offense disclosures (when they were required to take responsibility). They further noted that this was when the therapists felt the most pressure to achieve results.

Marshall et al. (2009) pointed out that treatment attrition in these cases may actually be the responsibility of the therapist. It may be, for example, the therapist's confrontational attempts to elicit offense details, or the therapist's negative reaction to excuses with the offender being seen as uncooperative with treatment, that leads the offender to be discharged or to drop-out rather than his minimizations, *per* se. They further noted that therapists would be better advised to change their views on this issue and alter their treatment approach. This argument provides another perspective on the nature of any relationship between lack of taking responsibility and attrition: suggesting that attrition results from therapists' emphasis on confession and consequent frustration with the offender's lack of putative responsibility, rather than the lack of taking responsibility in itself.

6. Why might sex offenders fail to take responsibility for their offending?

Given the lack of a relationship between acceptance of responsibility and recidivism, we must now examine the question of whether there is any theoretical reason to believe that a failure to accept responsibility is part of the pathology of sexual offending and therefore worthy of correction. We therefore ask, why might sexual offenders fail to take responsibility for their offending?

6.1. Because excuse-making is normal

Most people will, at times, fail to take responsibility for something they have done either by concealing some aspect of it or by offering plausible or sometimes implausible excuses (Snyder & Higgins, 1988). Within the social psychology literature such behavior has been described in terms of causal attributions whereby individuals tend to excuse behaviors that others perceive to be problematic by using explanations that are either external, uncontrollable, or unintentional (see Maruna & Mann, 2006 for discussion). Outside the sex offender treatment field, denial and excuse-making are widely regarded as normal phenomena: Freud (1937) listed denial as a common defense mechanism. There is empirical evidence from non-offending related studies that denial can be functional, adaptive, and even has health benefits (see Coleman, 1989).

Sex offender programs that emphasize taking responsibility tend, as we have shown, to require accounts of offending that focus on the offender's personal responsibility and which, therefore, reject explanations of cause that implicate external factors such as drinking alcohol or the behavior of others. Maruna and Mann (2006) called upon attribution theory as a way of understanding what types of explanations are typically seen as unacceptable in the perpetrators' accounts of their sexual offending. Treatment programs typically prefer accounts that refer to internal and stable attributions of cause—such as "I did it because I have a deviant sexual preference". We think that this is a problematic treatment approach and we will discuss our reasons for later within this paper.

External and/or unstable attributions—such as "I did it because I was drunk"—have been labeled as "cognitive distortions" and seen as incompatible with acceptance of responsibility. However, as Maruna and Mann explained, it seems illogical that offenders who make these kinds of attributions are viewed as more dangerous and less treatable because of their external attributions of cause. Yet, in other walks of life excuses and justifications are expected, welcomed and accepted following a transgression. Maruna and Mann also pointed out that people's actions really are influenced by external and

unstable forces, including their upbringing, their social and financial circumstances, their relationships, their mood states, and by drugs and alcohol. To require offenders to omit all mention of such external factors from their explanations of their offending is unreasonable and contradicts the rules applied to everyday human (non-criminal) behavior.

6.2. To manage low self-esteem and shame

Marshall et al. (2009) noted the evidence from the general psychology literature that suggests that people with low self esteem or with high levels of shame have a well established tendency to lie about or minimize their behaviors in order to cope with cognitive dissonance, protect their fragile sense of self-worth, and to avoid emotional distress (see also Miller & Ross, 1975; Tangney & Dearing, 2002). Sex offenders have been consistently found to have low self worth (Marshall, Anderson, & Champagne, 1996) and strong feelings of shame (Marshall, Marshall, Serran, & O'Brien, 2009).

6.3. To retain freedom, status, reputation or the support of loved ones

People usually choose to deny or excuse behavior after a simple decision making process whereby they quickly weigh the potential negative and/or positive consequences of taking responsibility (see Zuckerman, 1979). Marshall et al. (2009) noted that, for sex offenders, the consequences of accepting responsibility at the time of the initial allegation, throughout the investigation and prosecution process, and then even after they have been sent to prison, would often appear to be primarily negative. For example, Kaden (1999) observed that offenders who plead not guilty and testify in their own defense who then admit guilt in therapy may risk legal incriminations for perjury. A sexual offender who is considering whether or not to accept responsibility for their offending faces many other possible negative consequences, including personal, family, social, and economic costs (e.g., stigmatization, threats to personal safety, and loss of family and friends) (Yates, 2009). To illustrate, both authors of this paper have worked with sex offenders in categorical denial whose families have made statements such as “if he did it, then he has lost us [his family] forever”. In this case, the offender considering the consequences of accepting responsibility would likely maintain his categorical denial even if it means serving more time in prison as he may perceive the costs of taking responsibility to be too high.

6.4. To continue offending

Another plausible reason for failing to take responsibility might simply be that the offender wants to continue offending or maintain his deviant sexual fantasies and behaviors. His denial in this situation is a strategy to avoid engaging with the criminal justice system, knowing that their objective is to try to thwart similar future behavior. Similarly, denial might reflect a specific function such as allowing continued access to victims (Nunes et al., 2007).

Historically, sex offender researchers and therapists appear to have believed that this was why sex offenders denied (see Salter, 1988). This clearly reinforced a therapeutic strategy of attempting to overcome denial and minimizations that was confrontational and aggressive and has since been shown to be problematic (see Marshall et al., 2003; Ware & Bright, 2008). There is no evidence of which we are aware to support the notion that this underlying intention is a cause of denial. On the contrary, one study of treatment “failures” (i.e., those who reoffended after treatment; Webster, 2005) found that treatment clients who intended to continue offending made a purposeful effort to identify the wishes of their treatment providers and behave accordingly—so if anything they were more likely to adopt a stance of accepting responsibility rather than choosing to deny their offending.

6.5. Ex-deniers' accounts of the reasons for their denial

We are aware of only two studies that specifically address this issue (there is of course other research looking at the characteristics of deniers (e.g., see Cooper, 2005). Both of these studies interviewed sexual offenders who had previously been in categorical denial but then had admitted to their offenses.

Lord and Willmot (2004) conducted focus groups and individual interviews with a sample of 24 sexual offenders and through a content analysis identified three different psychological themes related to the function of the categorical denial:

1. Low motivation or a lack of insight (e.g., deficits in perspective taking or a desire to continue offending). This theme reflects the traditional view of treatment providers that denial must be overcome as it signals an intention on the part of the offender to re-offend. It also probably captures information processing deficits.
2. Threats to self-esteem and self-image, including shame and guilt. This function reflects psychological characteristics or phenomena that suggest clear treatment targets if we assume that the denial must be overcome.
3. Fear of negative extrinsic consequences such as losing their family and friends. Of particular note 67% (16/24) of the offenders were specifically worried that admitting to their offending would lead to the loss of family and friends. Denial in this respect clearly reflects a functional decision on the part of the offender, perhaps resulting from a simple cost/benefit analysis as to whether to deny or not (see Rogers & Dicky, 1990).

Aside from this stated percentage, it was unclear from Lord and Willmot's study what numbers of sex offenders fell into each category and given that it is a small sample this might not be truly representative of categorical deniers.

Blagden, Winder, Horne, and Gregson (2011) interviewed 11 ex-deniers and through interpretative phenomenological analysis arrived at similar conclusions to those of Lord and Wilmot. They found that there were a number of key themes that emerged to understand why these men denied categorically and how they transitioned towards admittance. Notably the stigma associated with being labeled as a sex offender, the threats to one's own self-image or self-identity, and fear and shame all were key reasons for the denial. Blagden and his colleagues also noted that denial was more likely to be overcome when it was not needed anymore. In our view these two qualitative studies have provided an insight to the function of an offender choosing not to take responsibility. However given that small scale and qualitative nature of both studies, larger scale quantitative investigations of the function of denial is certainly warranted in order to produce more generalizable findings. Future research with ex-deniers should also explicitly endeavor to overcome possible investigator effects, where the interviewer may be perceived as part of the justice system providing treatment, therefore affecting the openness of participants.

In our view, this research together with the lack of relationship between recidivism risk and denial/minimizations clearly emphasizes the importance of understanding the actual function of denial or minimization for the individual offender (Lord & Willmot, 2004; Yates, 2009). The function of denial is of course not always readily apparent and furthermore, a therapist who places a lot of importance on offender responsibility for common-sense reasons may easily overlook the functions served by denial (Beyko & Wong, 2005; Marshall et al., 2009). For example, if the offender realistically understands that if he admits to his offending his family will disown him then is forcing this admission an appropriate treatment goal? The presence of strong familial support and stable intimate relationships is likely to be a protective factor. It would seem in this case that if a therapist was to insist on acceptance of responsibility, this could result in more costs than benefits from treatment.

7. Have we got it wrong? Why the emphasis on taking responsibility might be too great

We have argued that it is understandable that sex offenders might not take responsibility for their offenses and that these insights can help us understand why offender responsibility is not related to risk of re-offending. If excuse making is normal, and responsibility is unrelated to risk, it is important to explore the possibility that a focus on offender responsibility in the treatment process might actually be more harmful than beneficial. We will now articulate a number of reasons why this might be the case, although this list is not exhaustive.

7.1. Excuse-making is not as problematic as we might think

It is possible that excuse-making should be considered normal or even acceptable behavior for sexual offenders, just as it is for most people who have transgressed. Excuse making conveys the implicit acknowledgement that the behavior was wrong. There is a large body of psychological literature indicating that, not only are excuses normal and common, but that they are actually likely to have a positive effect. Snyder and Higgins (1988), for example, note that excuse making is a highly adaptive process for coping with stress, relieving anxiety, and for maintaining one's self-esteem.

Should excuse-making therefore be considered as problematic from a treatment perspective? The assumption behind acceptance of responsibility as a treatment target is that these excuses need to be overcome to facilitate progress in treatment. However it is also important to consider that making excuses for one's past unacceptable behaviors in certain contexts can lead to an increase in one's sense of control over similar context in the future (Snyder, Higgins, & Stucky, 1983). Naturally, we want sex offenders to believe in their ability to control similar situations in the future. In contrast, it appears that accepting full responsibility for one's actions can lead to, among other negative symptoms, depression, a sense of helplessness or hopelessness, and low self-esteem (Seligman, 1991). This does not immediately seem like a beneficial goal for treatment. In fact, as Garrett and Thomas-Peter (2009) theorized, when an offender takes responsibility and internalizes a view that he is "bad" or "deviant" this can lead to an increase in offending behavior (see also Braithwaite & Braithwaite, 2001). If a typical sexual offender was to believe (in our view probably wrongly) that they were likely to be a "sex offender for life" or "always at risk" then this belief may actually have the effect of increasing the likelihood of an offender thinking or behaving in sexually inappropriate ways.

The critical question is whether an emphasis on eliminating excuses in sex offender treatment is warranted particularly if the outcome (for the offender) might be negative. If the outcome for the offender taking responsibility is that they are to have internalized a sense of being a "bad" or deviant" person then this is potentially contraindicative to treatment progress. In fact, a sex offender who maintained that he sexually offended only because he was drunk might have much better treatment prospects than a similar offender who instead concludes that he committed the sexually abusive behavior because he was in fact "deviant" and therefore unchangeable. The ability to control one's future would seem much more manageable and realistic for the offender who ascribes his behavior to an external and unstable cause (i.e., a state of drunkenness not a trait of sexual deviance).

Maruna and Mann (2006) also pointed out that the excuses offered up by an offender may be therapeutically useful, because they are probably a good indication of the offender's dynamic risk factors. For example, an offender who tells us that "I did it because I was stressed" could actually be seen as telling us that he has poor coping skills rather than avoiding taking responsibility for his behavior. Many therapists however would view this statement is as an excuse that is preventing the offender from taking responsibility and blocking his progress in treatment. In our view, dismissing the excuse offered ("…because I was stressed") in favor of seeking an internal stable attribution of cause such as 'I did it because I wanted to" has no therapeutic advantage and, if anything, reduces the amount of treatment material available to the therapist.

7.2. Taking responsibility is unrealistic and causes no-win situations for offenders

Another concern with the condition of "full responsibility" that many programs set is that it is potentially an unrealistic goal. As Waldram (2008) noted, offenders may disagree with the details of the official records (or the official records are, in fact, inaccurate), or will have only limited recollections of the events preceding the offending, particularly if it occurred some years ago or if they committed the offense(s) under the influence of alcohol and/or drugs. Even with a general acceptance of the facts and adequate recollection, they are also likely to be worried about hostile peer reactions to their disclosure (Jones, 2009), to be experiencing shame or guilt (Lord & Willmot, 2004), to have not understood the requirements of the disclosure adequately, or to be otherwise concerned about the outcomes of their disclosure (Waldram, 2008). To place an offender under heavy pressure to give a full disclosure without understanding these concerns may be setting an impossible task, with the likely consequence that the offender will either disengage from the therapy or will begin to tell the therapist what they believe the therapist wants to hear, but with no personal commitment to the story being offered.

It also is likely that the goal of disclosure will not be one of the offender's own goals for an intervention. Where the goals of therapist and client conflict, then therapy is less likely to be successful, and the therapeutic relationship is flawed. These concerns are exacerbated if the therapist is clearly not even attempting to match their goals to the client's goals. Conversely, if the therapist and client collaborate on goal-setting, and if treatment targets are articulated in relation to agreed goals, the therapeutic endeavor has a greater chance of success. Marshall, Marshall, Serran, and Fernandez (2006) highlighted this issue succinctly when they stated that "attempts to essentially bully clients into producing precisely the same description of events as the victim may not only be misplaced but are likely to force the offender into saying what he thinks the assessor or therapist want to hear".

Waldram (2007, 2008) has painted a particularly telling picture of how the issue of disclosure dominates and damages interactions between offenders and correctional therapists: "From the moment he is arrested, the question of 'the truth' dominates an offender's life… The first major activity he is required to undertake in treatment is to stand before staff and peers and tell his story to them…The inmate is successful in this aspect of treatment so far as he accepts the official truth, participates in the rewriting of his life story, and communicates a cognitive shift in its meaning" (pp 146–147). Although offenders are often keen to relate and reflect upon their life stories, "in the case of sexual offenders, their sexual crimes are expected to occupy a central place within the story" (p. 149). Waldram refers to the telling of the life story as "a performance", where the narrator frequently "surrenders" to the dominating expectations of how he should tell his story, producing a narrative that "is more simulation than real"(p. 153), and gives up on his own coherence in doing so. The act, therefore, of giving an offense disclosure is not an act by which the perpetrator achieves greater psychological insight into or resolution of his life story. It is an act by which he attempts to survive through his period of correction by telling the story that others want him to tell, rather than the story he actually has to tell.

Maruna and Mann (2006) noted that offenders can often be placed in a 'no win' situation by treatment providers. If they continue to make excuses for their behaviors then they may be labeled "resistant", "in denial", "not taking full responsibility", and "distorted [in their thinking]". All of these labels suggest poor treatment progress. By contrast, if an offender was to fully take responsibility for his offending, and gives internal stable attributions of cause (which are necessary in

order to avoid being charged with "cognitive distortions") by acknowledging committing an offense because "they just wanted to" or because they are a "sexual deviant", then this will often also be labeled negatively by a criminal justice system. Waldram (2007, 2008) explains in detail how this dynamic plays out within treatment sessions, with the offender frequently learning that the only way to "make progress" is to give up control of his story (e.g., by agreeing to what he "must have been" thinking or feeling)—a process which Waldram describes as "creating new truths"[p. 164]).

7.3. Taking responsibility may be more punitive than rehabilitative

Ward (2010) has argued that cognitive restructuring (as a way of attempting to get offenders to accept responsibility) meets a strict definition of punishment and is unlikely to be of direct relevance to the enhancement of the offender's wellbeing. This possibility raises the ultimate issue of whether the requirement that treatment participants take responsibility for their offending, particularly if this is judged by the extensiveness of disclosure, is even ethical (Ward & Birgden, 2010). Glaser (2010) has similarly argued against a focus on offense disclosure as operationalized by some programs on the ethical grounds that "treatment often requires the client to incriminate himself by discussing offending behaviors not known to the criminal justice system" (p. 266). Glaser's suggested solutions to this uncomfortable situation include the recommendation that harm-causing aspects of interventions will be used parsimoniously. While Glaser's concerns are controversial and not universally accepted (e.g., Prescott & Levenson, 2010) in our view they cannot be easily disregarded (see also Ward, 2010).

7.4. Pursuing acceptance of responsibility encourages the use of confrontational therapist approaches

Given that acceptance of responsibility is usually an initial treatment target and given that in many programs, the offender's continuation of treatment depends on his taking responsibility, the therapist can feel under significant pressure to "get results". Such pressure can result in the therapist being far more confrontational and challenging than is warranted or is helpful, particularly when confronted with "over-rehearsed narratives" (Jones, 2009).

Although it is now well established that confrontational approaches to sex offender treatment are more likely to prevent the offender's progress rather than assist it (Marshall et al., 2003), some therapists will admit that there are situations where they still feel compelled to challenge and at times aggressively challenge. For example, Blagden, Winder, and Gregson (in press), in their study of treatment professionals' experiences of working with deniers, quote experienced professionals expressing serious frustration at not being able to "get people out of" denial, using phrases like "I could have had him there". Blagden et al. speculated that therapists view taking responsibility as a signal of their competence and so are prone to feelings of failure when deniers will not change their stance. If this is the underlying dynamic for the therapist, even supportive challenging may result in the offender feeling threatened, not trusted, and reluctant to taking responsibility (Marshall et al., 2009) or he may submit to the perceived demand from the therapist to provide a particular account of the offenses without the associated personal commitment to this disclosure. The offender's response may be to become even more cautious in what he reveals, to try to provide what he believes the therapist wants him to say, to disengage from the treatment process or potentially to become antagonistic towards the therapist or treatment program.

Clearly then, an over emphasis on acceptance of responsibility early in treatment may have adverse outcomes. Although most therapists would argue that their treatment endeavors are positive and supportive and not confrontational we note that therapists themselves are not necessarily good judges of this (Orlinsky, Grawe, & Parks, 1994).

7.5. Over-emphasis on confession is an inefficient use of scarce treatment resources

Garrett and Thomas-Peter (2009) argued that there seems little clinical difference between three or even 10 similar offenses and to spend time (and considerable effort and difficulty if the offender is reluctant) requiring the offender to disclose the details of each offense seems unnecessary or even counterproductive. In fact, the insistence on such a level of detail will usually only serve to reduce the offender's trust and belief in a therapist (see Drapeau, 2005 for a discussion of the importance of this) and runs the risk of becoming a confrontational and ultimately unhelpful process (Marshall et al., 2003). Further, therapists will often insist on a level of detail that is guided by the victim's accounts or other such official documentation. In our view, it is hard to justify seeking such a level of detail when there is little to be gained, as admitting to the details of an offense is not related to risk of re-offending or even to treatment engagement (see Ware & Marshall, 2008). There is much more to be gained from focusing on those aspects of the offense that the offender will more readily admit to (e.g., alcohol abuse, impulsivity, relationship discord, poor coping strategies). Further, it is also possible that the victim's account does not match the actual events. This may lead to the offender being adamant that he will not change his version or as previously suggested may lead to the offender simply saying what the therapist wants him to say (see Marshall et al., 2009 for discussion of eyewitness accounts and memory processes).

7.6. An emphasis on taking responsibility may lead to poor treatment engagement or treatment attrition

Too great an emphasis on acceptance of responsibility may result in a lack of genuine offender engagement with treatment or even treatment attrition. Treatment attrition may result from either the offender being discharged through a lack of responsibility or the offender voluntarily dropping out of treatment as a result of the counterproductive therapist strategies we outlined above. In this sense, we agree with Beyko and Wong (2005) that in these instances treatment attrition should be seen as "areas where programs could make improvements to better address the needs of the offender" (p. 387).

8. Are there other ways of approaching acceptance of responsibility in treatment?

Given the lack of evidence for "confession" as the cornerstone of a model of change for sexual offending, and the difficulty in seeing how under any psychological treatment model it can be desirable for those in treatment to have to construct a narrative in order to "survive" the intervention (see Waldram, 2007), we believe it is necessary to rethink how acceptance of responsibility in sex offender programs is conceptualized. Maruna and Mann (2006) argued that "taking responsibility for one's actions is about more than attributions for past behavior" (p. 167). Using a framework posed by Bovens (1998) they differentiated between *passive* and *active* responsibility. *Passive* responsibility involves seeing oneself as responsible for past actions ("I did it"). *Active* responsibility involves seeing oneself as responsible for changing one's future behavior for the better ("What do I need to do to make sure it is not done again?").

Passive responsibility therefore reflects what most therapists currently target within treatment. Passive responsibility is reflected in treatment components with labels, such as "offense disclosure" or "acceptance of responsibility", within which offenders are required to describe their sexually abusive behaviors and in so doing take responsibility for committing the sexual offenses. If an offender

indicates that he did indeed commit the sexually abusive acts as was suggested by the victim or courts, most programs (as noted above) will consider this to be satisfactory responsibility.

However, is such a disclosure an indication of active/future responsibility as well as passive responsibility? In some cases, the process of seeking passive responsibility may be unnecessary or have negative consequences. Take, for example, a sexual offender who readily acknowledges (possibly in graphic detail) his offending against a young male child and acknowledges that it was wrong and offers little in the way of excuses or justifications. This offender may be considered to have taken full *passive* responsibility or responsibility for his past actions.

If this offender then proceeded to make very little treatment progress, appearing to have little personal investment in changing in the future, then it could be said that he has not taken *active* responsibility. *Active* responsibility is future oriented and reflects the primary focus of treatment. It is reflected by offenders actively pursuing change in their thinking, attitudes, and behaviors. In other words it is a focus on what needs to be done in order to make sure that there is no re-offending and that the offender's life can be enhanced more generally (Dean et al., 2008; Maruna & Mann, 2006). Whereas passive responsibility might simply reflect an offender saying that "I did it", active responsibility reflects an offender saying and demonstrating that "I am going to change".

Arguably, passive responsibility is not a necessary condition for active responsibility. Presumably, it is possible to genuinely want (and attempt) to change even without admitting to an offense. Marshall et al. (2009) argue that the essential requirements for change are simply an acknowledgement and understanding of the background and events or psychological states preceding the sexual crime. This can be gathered without seeking a "confession" from an offender. In fact, Marshall et al. (2009) note that it is highly likely that all important risk factors can be identified without the offender having to describe the details of what he actually did during the commission of the sexual crime. It is these factors leading up to the sexual behavior that are important treatment targets (e.g., sexual arousal, problematic sexual attitudes towards children, problems with coping, relationship instability).

We believe, therefore, that the strongest argument for retaining an offense disclosure as part of a treatment program is to enable the accurate identification of relevant risk factors. If this is achieved, then "full" acceptance of responsibility as many programs currently define it need not be insisted upon. Dean et al. (2008) proposed that when offenders offer unstable or external attributions, such as "I was stressed" or "I was drunk", these accounts can be useful signposts to causal risk factors (e.g., poor coping with stress, or substance misuse) for offending. We therefore suggest that therapy providers clarify the extent to which "confession" forms part of the model of change of the program. According to Blagden's (2011) and Waldram's (2007) research, even if there is no formal statement that confession is the key goal of a program, and even if in fact the program designers did not intend this to be the case, this is clearly the message that treatment participants receive. We suggest instead that therapists focus on using disclosure of offenses as an information gathering strategy that ultimately informs case conceptualization, but that disclosure is not seen as the end game (Blagden, 2011) in treatment.

9. Summary and conclusions

We conclude that there is currently an over-emphasis on sex offenders taking passive responsibility in treatment. Acceptance of responsibility appears to be defined inconsistently but most often refers to an offender giving a full and precise account of the offense. This focus on taking responsibility is most likely based on "common sense" rather than a coherent evidence based rationale. There is a lack of consistent reliable evidence indicating that denial and minimizations leads to increased recidivism. In fact, there is some evidence that offenders who deny or minimize may re-offend at lower rates. A lack of offender responsibility has also been implicated in treatment attrition or a lack of treatment engagement. However, attrition in such cases might be due to the expectations and negative reactions of the therapist rather than the offender's denial or minimizations, *per* se.

This review also identified many understandable reasons why an offender might not take responsibility. The limited research into the function of an offender's denial or minimizations suggests that minimization is most likely the result of the fear of negative extrinsic consequences, or a threat to one's self esteem and self-image, rather than caused by a desire to re-offend. We also noted that excuse making is normal and can be healthy, that an emphasis on acceptance of responsibility is unrealistic and creates a "no-win" situation for the sex offender, that a focus on full and precise responsibility (i.e., a confession) might actually be more akin to punishment, and that acceptance of responsibility as a treatment target can promote the use of confrontational therapist approaches. Finally, we have suggested that acceptance of responsibility could be approached differently within sex offender treatment programs. From a treatment perspective, a full and precise account of the offense is of less importance than the background and preceding events and psychological states. There should also be an increased focus on active responsibility whereby the emphasis is on the future rather than the past.

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