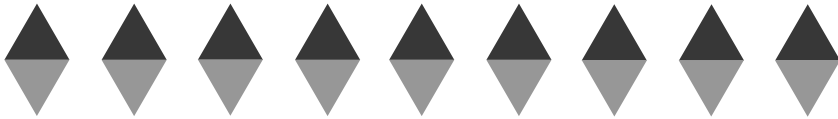


BUILDING  
MOTIVATION  
for CHANGE in  
SEXUAL  
OFFENDERS



David S. Prescott, LICSW  
*Editor and Contributor*

SAFER SOCIETY PRESS  
Brandon, Vermont

Copyright © 2009 by the Safer Society Press, Brandon, Vermont

First Edition

All rights reserved. No part of this book may be reproduced in any form or by any electronic or mechanical means, including information storage and retrieval systems, without permission in writing from the publisher, except by a reviewer who may quote brief passages.

Printed in the United States of America

10 9 8 7 6 5

**Library of Congress Cataloging-in-Publication Data**

Building motivation for change in sexual offenders / David S. Prescott, editor and contributor. -- 1st ed.

p. cm.

Includes bibliographical references and index.

ISBN 978-1-884444-82-1

1. Sex offenders--Rehabilitation. 2. Sex offenders--Psychology. 3. Sex crimes--Prevention. I. Prescott, David S.

RC560.S47B85 2009

616.85'83--dc22

2009031053



P.O. Box 340

Brandon, Vermont 05733

[www.safersociety.org](http://www.safersociety.org)

(802) 247-3132

Safer Society Press is a program of the Safer Society Foundation, a 501(c)3 nonprofit dedicated to the prevention and treatment of sexual abuse. For more information, visit our Web site at [www.safersociety.org](http://www.safersociety.org).

*Building Motivation for Change in Sexual Offenders*

\$35.00 plus shipping and handling

Order #WP138

Copyright 2009 by Safer Society Press. All rights reserved.

# A Treatment Approach for Sexual Offenders in Categorical Denial

*Geris A. Serran and Matt D. O'Brien*

## Introduction

In this chapter, the authors review approaches that have typically been used in sexual offender treatment and compare them to approaches successfully utilized on offenders who categorically deny their sexual offending.

We then critique this treatment approach and provide a discussion of how Marshall, Thornton, Marshall, Fernandez, and Mann (2001) came to develop their innovative approach to treating these clients. We outline our own program's form with reference to Marshall, Marshall, Serran, and Fernandez's (2006) description of their treatment program for admitting sexual offenders. We provide promising early results from this treatment approach. The chapter concludes with a case study that demonstrates treatment gains that clinicians can attain using this approach.

## Approaches to Treating Denial

Over time, many therapists in the sexual offender treatment field have come to see denial of offending as a significant barrier to effective treatment. Consequently, many treatment providers have typically excluded deniers from their treatment programs (Happel and Auffrey 1995; Schwartz 1995).

However, as Cohen (1995) argues, this exclusion is neither therapeutically sensible nor legally appropriate. The authors share Cohen's view that every effort should be made to involve all offenders in treatment, since they all pose future threats to others. As Maletzky (1996) states, "To deny a crime is natural; to deny treatment to those who deny is a crime itself."

A number of published studies have considered treatment interventions designed to move convicted and incarcerated sexual offenders from levels of categorical denial to acceptance of responsibility for their sexual offending, so they can then enter programs designed for those who admit to their offences. As Schneider and Wright (2004) summarise, the assumption of most of these approaches is that admitting to the offence is a necessary pre-requisite for successful treatment progress; this position has certainly been offered by Lombardo and DiGiorgio-Miller (1988), Barbaree and Cortoni (1993), and Winn (1996).

One of the earliest reports of treatment of deniers was the intervention described by O'Donohue and Letourneau (1993). This seven-session program included cognitive restructuring and educational components. The authors reported a 65 percent change from denier to admitter status at post-treatment, although the numbers of participants was small (n=17).

Marshall (1994) reported on a 12-week rolling program that focused on acceptance of the client but not the offence. Central to this approach was having a mix of admitters and deniers in the same program. The senior members of the program were seen as pivotal in helping the client to give a disclosure in which he increasingly admitted to further details. Using this approach, the 25 group members who entered the program as deniers were reduced to just two upon completion of the program.

Schlink and Shaw (1996) presented an account of the procedure they employed, which involved 16 sessions focusing on why people deny and providing face-saving ways in which people could change their position. The sessions included a focus on victim empathy and relapse prevention components. In the authors' study, five of the ten clients admitted to their offences, post-intervention.

Brake and Shannon (1997) reported a similar reduction using their pre-treatment program for categorical deniers. The goal of this program was to "lessen denial about the instant offence . . . once this has been accomplished

the offender is referred to an offence-specific treatment program.” The program consisted of 21 sessions conducted on an individual basis. Brake and Shannon were able to demonstrate that this procedure produced a significant reduction in denial in 54 percent of their participants. The components of this program included: face-saving, motivation about change, explanations of the purpose of denial, reframing, and victim empathy.

Other programs referred to in the literature, but not accompanied by research data, include Jenkins (1990) whose “invitations to responsibility” approach involved three years of individual and group psychotherapy, and Winn (1996), whose approach involved “metac confrontation,” described as “a strategic process of challenging the offender to challenge himself.” Other strategies have focused on individual motivational interviewing (Mann, Ginsburg, and Weekes 2002), and individual assessment feedback procedures, including the results of phallometry (Bradford and Greenberg 1998).

The approaches outlined above appeared to have some limited degree of success, as measured by a reduction in denial, but were mostly seen to be lengthy, in some cases somewhat challenging and confrontational, and in hindsight quite possibly unnecessary, given that their goal was clearly founded on an assumption that moving an offender from denial to acceptance is a necessary condition for successful treatment. No evidence is available to confirm that this is the case, and in fact, some evidence actually indicates—perhaps counter intuitively—that this supposition is wrong. Early research suggests that continued denial is predictive of poor treatment outcome (Marshall and Barbaree 1988; Simkins, Ward, Bowman, and Rinck 1989; Barbaree 1991). In contradiction of these early findings, however, Maletzky (1993) found no differences in the long-term outcome of treated deniers versus treated admitters. Kennedy and Grubin (1992) and Beckett, Beech, Fisher, and Fordham (1994) found that reducing denial and minimization did not necessarily equate with changes in other treatment targets. A number of authors have reported that denial of a sexual offence in adolescents actually means that they are less likely to reoffend sexually (Kahn and Chambers 1991; Langstrom and Grann 2000). In their meta-analyses of sexual-offender recidivism studies of primarily adult males, Hanson and Bussiere (1998) and Hanson and Morton-Bourgon (2004) found no relation between denial of

the sexual offence and sexual-assault recidivism in both treated and untreated offenders.

A possible reason for these surprising findings was offered by Hanson (2003) who provided some evidence that demonstrates that attitudes tolerant of sexual offending are related to recidivism (Hanson and Harris 2000; Hudson, Wales, Bakker, and Ward 2002). Consequently he reasoned that “excusing one’s own behaviour is less problematic than believing that it is okay for others to do the same thing.” Some researchers have also argued that equating denial with risk has been a logical fallacy, citing evidence that many high-risk offenders can be quite open about their offending in contrast to some low-risk offenders who have higher levels of denial (Beech and Fisher 2002; Fisher, Beech, and Browne 1998; Simourd and Malcolm 1998).

The evidence negating the need to work to overcome denial, coupled with the need to provide these offenders with effective treatment, led Marshall et al. (2001) to conceive of an alternative approach for treating sexual offenders in categorical denial. The approach was developed in direct response to the fact that other efforts to have them admit responsibility had not proved wholly successful. Thus attempts to get deniers to admit their guilt were abandoned, while the focus remained on therapists addressing pertinent and problematic issues. The support for focusing on the latter was provided by the work of Andrews, Zinger, Hoge, Bonta, Gendreau, and Cullen (1990) in the general offender literature, and by the work of Hanson et al. (2002), Marshall and McGuire (2003), and Losel and Schmucker (2005) in the specific literature on effective approaches with sexual offenders. In other words, the exact same relevant criminogenic needs that would normally be addressed in the treatment of sexual offenders who admit to their offending are also addressed, separately, with the deniers. As outlined below, this approach is predicated on the premise that offenders are not asked to discuss their offence, and their denial is not challenged. By adopting this approach, offenders are not released untreated and at higher risk to reoffend. Laws (2002) suggests that this method of treatment is an extremely clever approach to denial: “By making a simple promise and keeping to it, the therapists engage the clients in a program they say they do not need, for a problem they say they do not have, to prevent another offence that they say they did not commit in the first place.”

## The “Rockwood” Approach

At Rockwood Psychological Services, the general approach to treating men who have sexually offended is grounded in positive psychology and the Good Lives Model (Ward and Stewart 2003). The foundation of our treatment model is based on group process and emphasizes the importance of therapist characteristics. We encourage group cohesion and a positive group climate. Our approach is flexible and individualized to each client, as opposed to the typical psychoeducational, manualized approach. We emphasize the development of a trusting client–therapist relationship. Our research on therapeutic process in sexual offender treatment demonstrated that positive therapist characteristics were directly related to treatment outcome. Specifically, therapists who displayed warmth, empathy, rewardingness, and directiveness achieved positive treatment change (Marshall, Serran, et al. 2002, 2003).

It is with this foundation that we have developed and implemented our treatment program for deniers.

## Deniers’ Program Outcome

Our Deniers’ Program commenced in 1998 at Bath Institution, a moderate-security institution in Kingston, Ontario, Canada. We had noticed a number of clients refusing treatment because they were categorically denying their offences. Their attitude created a problem, because these clients were therefore “stuck” at Bath. They took up space that could have been used for other potential program candidates, and they were eventually released with no treatment. Often, these men were seen as resistant and treated as such. Some of them stated that they would be willing to participate in programming, but they would not agree to enter a program where they would be forced to admit to their offences.

From 1998 to mid-2005, we had 56 men who completed the Deniers’ Program and were released into the community. We run approximately one program each year, consisting of eight participants. Of these, approximately 68 percent were convicted of sexual assault, while the rest had been convicted of some other sexual offence (e.g., indecent exposure), incest, or murder.

Of these 40 percent had adult victims, 37.5 percent had pubescent victims, and 22.5 percent had prepubescent victims. Over half (52.5 percent) were released on their warrant expiry, 40 percent on their statutory release date, and 7.5 percent achieved a day parole. In our follow-up analyses, 87.5 percent did not reoffend sexually, 10 percent breached their conditions, and 2.5 percent reoffended sexually. These results, while preliminary, are extremely promising. We are in the process of expanding our recidivism study.

## **Our Approach to Treating Denial**

In designing our program, we essentially decided to model after our regular program, with one exception: We assured the group members that we would not challenge their denial regarding their sexual offence. Our goal in treatment is to help participants identify problems in their lives that put them in a position to be accused of sexual offending or that generated sufficient animosity in others that someone accused them of an offence they claim they did not commit. This stated goal motivates these men to fully participate in treatment. Consistent with our admitters' program, we address all dynamic factors relevant to sexual offending. In the following pages, we highlight an overview of our program components.

### **Preparatory Sessions**

Initially, the deniers present as suspicious and distrustful of our program. Generally they are quite focused on re-trying their cases. They might appear disinterested (e.g., falling asleep or sitting slumped over) or they might engage in problematic group behaviour (e.g., whispering, giggling, making inappropriate comments). Others fail to engage meaningfully in session discussions. Due to the clinical value of our general preparatory program for readying offenders for treatment, we begin providing several preparatory sessions for the deniers.

These sessions are motivational in nature and provide information about the behaviour that will best contribute to them achieving their goals (e.g., early release). Group rules (confidentiality, participation, attendance, respect) are discussed and group members are encouraged to contribute to building

group rules. We also provide group members with information about their treatment, final reports, and risk assessments. We generally follow up with an all-inclusive group exercise, usually on the topic of self-esteem. Although self-esteem is not an explicit dynamic risk factor, per se, it is relevant for other factors, such as relationships and lifestyle. Low self-esteem across various domains also characterizes sexual offenders (Fernandez, Anderson, and Marshall 1999; Marshall, Anderson, and Champagne 1996). Enhancing self-esteem is highly motivational and facilitates other aspects of treatment (Marshall, Anderson, and Fernandez 2000). The domains where self-esteem deficits are evident include relationship functioning, physical appearance, academic and occupational performance, and social functioning. Clients are required to identify several strengths in each area of functioning, and to share those strengths with the group during discussion. This exercise allows the therapist to develop insight into each client's view of himself. Group members are encouraged to identify strategies to improve their confidence, usually through engaging in activities such as sports, creativity, etc. All of these opportunities are available in the institution, and group members are encouraged to pursue them.

#### *Disclosure*

Group members begin by providing their versions of the accusations against them. Our purpose is not to challenge their versions. This exercise gives us a good opportunity to demonstrate to the clients that we are not trying to force them to admit to the offence. Doing so would compromise the integrity of the program and damage efforts to engage these difficult clients in treatment. Instead, we focus on themes and key issues, encouraging the clients to explore their decision-making skills and to identify potential poor decisions (e.g., consuming excessive amounts of alcohol, spending time with negative peer groups).

#### *Life Story*

Group members are asked to complete an autobiography, which in turn is presented to the group. Men are encouraged to include in their stories both the problems and the successes in their lives. The problem areas they identify help us to determine the specific issues to concentrate on during treatment.

Their strengths are often aspects we can utilize to encourage positive change. One issue we have noticed is the occasional group member who presents with the “perfect” life. This group member is one of the most challenging to work with as he is not willing to acknowledge any responsibility for his life, in general. In this type of case, we would provide direct feedback to each client, telling him that it is important that he understand and identify problem areas in his life. We use strategies of reinforcing successive approximations, so that initially we reinforce any semblance of the behaviour we want, followed by reinforcing more complex behaviours. If our client continues to insist that he has no problems, we explain the consequences of continuing to present as such. Our overall goal is to identify key themes and to use these during the remainder of the program exercises.

#### *Intimacy and Relationships*

This aspect of treatment involves a discussion of adult attachment, including a presentation of Bartholomew’s four adult styles of attachment (secure, preoccupied, fearful, and dismissive) (Bartholomew and Horowitz 1991). We assist clients in identifying their attachment style and its costs and benefits, and we help them to develop a more secure approach to relationships. We discuss characteristics of a healthy relationship, including trust, communication, the value of equitability, and healthy sexual behaviours. We also address such issues as coping with rejection, loneliness, and jealousy. Group members discuss their previous relationships and are especially encouraged to consider any unhealthy patterns (e.g., numerous casual interactions, tendency to avoid conflict, failure to communicate). Group members identify and practice positive relationship skills, including communication and feedback, compromise, developing trust, and choosing an appropriate partner. Healthy sexuality is discussed in the context of a healthy intimate relationship. Group members are taught that communication and strong intimacy are factors related to increased sexual satisfaction.

#### *Coping Strategies and Emotion Management*

Research has demonstrated that sexual offenders have dysfunctional coping strategies (Cortoni and Marshall 1995, 1996; Marshall, Serran, and Cortoni 2000). Inadequate coping creates increased stress and distress, which increases

the likelihood of coping through sex and fantasy (Looman 1999; McKibben, Proulx, and Lusignan 1994). Group members are required to identify problems from their past and describe how they dealt with those problems. The discussion centres on various alternative strategies, and the benefits and costs of those strategies. We discuss the different coping styles (emotion-focused, task-focused, and avoidance-focused) (Endler and Parker 1990). Group members are encouraged to identify strategies they have used that were not especially effective and to learn to develop more effective strategies. Skill building (e.g., assertiveness) and practice are encouraged. Additionally, we encourage clients to identify and appropriately express their emotions in order to develop better emotional regulation.

#### *Victim Harm*

We discuss the consequences of victimization in general as opposed to dealing with any specific person. Each client is required to identify the effects of sexual abuse on victims both in the short and long term. The participants are then informed that by understanding those effects, they will be more sensitive to the signs of sexual abuse. This approach will help them to avoid or withdraw from situations where abuse might be occurring so that no one can accuse them of offending. We generally wait until later in the program to address this area—until we have established the trust among our clients that we are not trying to trick them into admitting to the offence.

#### *Problem Analysis*

This aspect of treatment is essential, akin to our Understanding of the Offence exercise or the offence analysis. Clients are required to examine the circumstances and their actions around the time of the offence. The goal is to help them identify background problems and action choices made at the time of the offence (e.g., anger, intoxication, perceived failures, problems in relationships). These are in effect the dynamic factors that we want to modify during treatment. Group members are asked to consider lifestyle factors, poor problem solving, poor emotion-management, relationship patterns, and childhood experiences that are relevant.

Group members are then asked to consider factors that would place them at risk of being accused in the future (a risk-factors and awareness exercise).

These factors will differ for each group member although some similarities might be present, as well. The factors could include, for example, having casual sexual relationships, particularly when alcohol is involved; using a computer in an isolated area; having unsupervised contact with minors; feeling depressed, lonely, isolated, or rejected.

### *Self-Management and Release Planning*

Following the problem analysis, group members construct a self-management plan in which they design strategies and learn the behaviours necessary to allow positive approaches. We focus on helping them to build a positive and satisfying lifestyle, noting that this approach will decrease the likelihood of their being falsely accused. Group members are required to set realistic and positive goals for themselves in several domains (knowledge, work, spirituality, relationships, and creativity). Group members are also asked to develop a support network consisting of family, friends, organizations (e.g., John Howard Society, Salvation Army), and professionals (e.g., counsellors). We encourage the development of approach rather than avoidance goals, as these are more motivating and easier to achieve.

Our approach to self-management is centred in Ward and Stewart's (2003) Good Lives Model. By emphasizing the development of skills, attitudes, and beliefs that are supportive of a positive and prosocial lifestyle, group members will be less likely to offend. In a collaborative and constructive manner, we work with each client to help him identify an individualized set of goals consistent with his interests and abilities. Next, we help the client to identify, develop, and practice the skills required to achieve his goals.

## **Case Study**

The following case study describes the application of the approach outlined above for treating a sexual offender who categorically denies committing his offences. The focus is on the problems in the offender's life which led him to being in a position where he could be accused of an offence. By being required to take responsibility for these problematic behaviours, the client achieves the same goal as in our conventional treatment program. The case

study illustrates how offenders can be engaged with this approach and confirms how successful treatment can be.

### **Offending History**

Juan (not his real name) was a 39-year-old Hispanic man serving a sentence of four years for sexual interference, sexual assault, and sexual touching. He pled not guilty but was found guilty at jury trial. Juan advised that he was not appealing his conviction or sentence “for purely financial reasons.” According to official documentation the victim reported that she met Juan through a chat program on the computer and that she told him that she was age 13. During their conversation he lied and informed her that he was 18 years old. The victim reported that she spoke to him on the computer about once or twice a week for about six months. Eventually they agreed to meet and Juan picked the victim up a short distance from her house. He then took her to his mother’s house where he resided. Once at the house they went into his bedroom. Juan met with the victim in this way on about 10 occasions. The sexual offending began with him touching her and quickly progressed to sexual intercourse. The victim disclosed the sexual relationship to a friend who told officials at her school. She explained to the police that she would not have consented to the sexual intercourse had she known his true age. The police found that Juan had been accessing teenage sex sites when they looked at his computer, and additionally found records of sexually suggestive chats he had had with minors.

### **Presentation**

Juan, a teacher, admitted to inviting the victim to his mother’s house but stated he did so because he was providing her with private computing tutoring. He said that he had met her after she had answered an internet advertisement for a tutor. According to him, after a few email messages with regard to session dates and payment options, he agreed to pick the victim up, because she told him that she did not have a ride. He admitted that his computer was in his bedroom, in the house he shared with his mother. He stated that this was where all tutoring sessions took place. Juan claimed that after the fourth session he wrote a note to the girl’s parents advising them of the amount that they owed for the tutoring. Juan stated that after the girl showed up

on the fifth session without payment, he informed her that he was ceasing tuition until payment was received. According to Juan, the police showed up unexpectedly a week later and charged him with sexual offences. Juan stated in interview that he felt that the victim “got herself into a situation,” since she had probably told her friends that she was having a relationship with an older male in order to make herself appear popular and attractive. He suggested that she probably then felt unable to retract this “false information” as it would have caused her great embarrassment in front of her family and friends. He adamantly denied any wrongdoing. Of note, his mother firmly believes that her son is innocent. Juan responded well to the two preparatory sessions held before the program proper commenced. By the end of those sessions, it was clear that all remaining suspiciousness about the approach had gone, and he was expressing an interest at developing a better future for himself.

#### **Problem Analysis (“Disclosure”)**

Juan was asked to discuss what had happened on the days when the alleged offences took place with a view to understanding how he could have placed himself where he could be falsely accused of a sexual offence. Juan’s actual disclosure in group was almost verbatim that which he had provided in both his initial assessment and his pre-program interview. When asked afterward if the accusation had taught him anything, he initially stated that he was “stupid” to have his computer in his bedroom as he had come to realise that it did not look good to others that he was taking a girl into his bedroom. “Tutoring young girls in my bedroom was a dumb idea,” he said. He stressed his plan to move his computer to a public location so as to avoid the chance of further accusation, which he agreed would be even harder to argue against and would make him look guilty of the first set of offences. He expressed frustration at this situation but appeared to accept it as the way things now would need to be for him. Similarly he discussed how he had come to terms with not being able to teach anymore. He said that this depressed him as he loved to impart knowledge to others. Following a really important group discussion on this, and following a group member’s suggestion, Juan became enthused that he could still teach adults and that this could be at least as rewarding. Juan, sensing that perhaps some other group members might question his

version of events, voluntarily stressed that he did not condone sexual activity with young people. He did not initially explain why, however, and so the treatment team invited him to do so. Importantly, Juan then outlined the reasons, saying that to do so would be both morally and legally unacceptable. Juan was then asked, as are all group members in this program, whether there was anything else that he might have done, or ways in which he might have presented, that could have made him more vulnerable to accusation. Juan focused on his passivity, explaining that he has always been a people pleaser, a characteristic of which others have sometimes taken advantage. He elaborated, outlining his tendency toward internalising his problems and withholding them from others. He talked of experiencing some problems with self-esteem, loneliness, and taking on too much work “which leads to stress, which I have difficulty coping with.” These problems were treatment targets that were later worked through with Juan.

### **Life Story (Identification of Relevant Factors)**

Juan was invited to share with the group problems he had encountered in his life within the context of providing an autobiography. The treatment team looks out for problems that are long standing and indirectly relevant, or *stable dynamic risk factors*, and those that are immediate precursors to the alleged offence, or *acute dynamic risk factors*. Juan outlined a difficult early childhood in South America prior to moving to Canada with his family when he was eight years old. He talked of experiencing some difficulties in adapting to life in North America, particularly the racism he experienced and the resulting feelings of loneliness and of being an outsider. Juan stated that he had always lived with his mother and confirmed that he planned to return to the family residence after his release from prison. At this stage of the program, he adamantly denied that this goal got in the way of his developing independence or intimacy with others. He recounted that his father was an alcoholic who verbally abused his mother at times and explained that his father’s behaviour might relate to Juan’s feelings of protectiveness over his mother. To his credit, Juan indicated that he has an ongoing tendency to focus on helping others to the exclusion of ensuring that his own needs were appropriately met. “Ninety-nine percent of the time, if there is a conflict, I am the one to give in. I hate conflict of any kind.” He acknowledged that this tendency

had created problems for him and that, as a result, he probably would have a greater need to appropriately assert himself in the future. He also stated again that he has a tendency to internalize problems and consequently withhold them from others. He appeared willing to try to involve others in his problems, and offered to express his emotions to others to a greater degree in the future. Juan was asked to report back to the group on his efforts at having deeper, more open engagement with others on an ongoing basis during the remainder of the program. He clearly found it quite a challenge initially, but over time, he was able to share positive experiences with the group, for which they reinforced him. In summary, although Juan categorically denied responsibility for the offences, he acknowledged responsibility for certain attitudes, emotions, and behaviours that placed him at risk of being accused.

### **Intimacy and Relationships**

During the component of the program that specifically addressed intimacy and relationships, Juan informed the group that he had had three serious intimate relationships in his lifetime. He informed the group that the first of these ended because he was not prepared to commit at that point. The second relationship had apparently ended because his partner chose to return to her native country. Juan described the third relationship as “great” but it was broken off due to her family’s concern about inter-racial relationships. He cited this last relationship as an example of a time when he should have been more assertive, and the group agreed. Similarly he said that he was coming to see that in the first two cases he had remained with his partners too long after the relationship had really run its course. Juan clearly grasped the impact of his own loneliness and jealousy on his third relationship, though he gave no indication that either conditions had been a particular problem for him in the past. Juan listed a number of qualities in a future partner that he would consider to be desirable and also added the qualities that he believed he would be able to bring to a relationship himself. He outlined the ways in which he believed he could meet future partners. Other group members took this opportunity to raise the fact with him that he was approaching his 40s and still lived with his mother. Juan, though still clearly resistant to this point, agreed to think it through in more detail before coming to a decision. In another session where attachment styles were the main focus, Juan,

not unlike many other group members, stated that his attachment style was secure, citing evidence that he has never been one to go straight from relationship to relationship. The treatment team sensitively addressed with Juan his aforementioned “people-pleasing” tendencies and preference to “focus on the other person.” He acknowledged that he might also have a tendency toward a more preoccupied style, at times, which was a positive outcome, especially since self-esteem issues were to be the next focus on the program.

### **Self-Esteem**

Juan produced an excellent self-esteem assignment in which he outlined a range of positive qualities he possessed, without qualification, across a wide range of dimensions. He also presented with a fairly consistently good level of self-esteem during the program. He did acknowledge, however, with some prompting, that his lack of assertiveness and apparent desire to generally shield his problems and deficiencies from others meant that he did not always feel that he was being attended to himself. Juan updated the group again on his efforts at improving his level of assertiveness. He reported that the efforts were going well and that he felt better about himself—more effective and validated—by what he was doing.

### **Coping Strategies and Emotion Management**

Juan was particularly open to learning and thinking about this element of the program. He said that over the course of the program, he had been coming to recognize that he might be helped by adopting a more communicative coping style at times of stress whereby letting others around him know of his problems in general, or of his problems with them, more specifically. He also said that he could now see that utilizing humour to diffuse situations, while sometimes appropriate, had the capacity to mask the solution to the problem or conflict. He indicated to the group that he was capable of employing good and analytical problem solving much of the time. He appeared to recognize, however, that problems could occur when he spent too much time in analysis before moving into action. He indicated that physical exercise helped him to relieve stress and that his hobbies, while in some ways helping him to avoid thinking about his problems, also gave him some time to further reflect upon them.

### **Victim Harm**

Juan was able to provide a lengthy list of the harmful effects experienced by victims of sexual abuse. His list included the following: nightmares, distrust, intimacy problems, self-loathing, isolation, fear of men, shame, feelings of being out of control, and decreased self-esteem. He took a prominent role in the ensuing discussion and added a number of other likely consequences that he had not previously considered. Juan approached this exercise in a very mature and appropriately serious manner.

### **Self-Management Plan and Release Planning**

Juan came up with what was considered to be a constructive and positive self-management plan. He accepted that a number of key changes needed to be made to his lifestyle so as to minimise the chance of further accusations. For example, he accepted that he would no longer be able to tutor children, should not be around children without other suitable adults being present, should limit his alcohol intake at parties, and should move his computer to a more communal area in the house and avoid chat rooms. In addition to these more avoidance-focused strategies Juan set out a number of more approach-goal and appropriate future-oriented strategies aimed at ensuring that he would lead a more positive and fulfilling life from that point on. He talked of improved dialogue and assertion with those around, and he discussed his plans to set himself up in a new business venture about which he was excited. Juan also talked of teaching adults on a voluntary basis so as to maintain the same rewards he felt he had previously gotten from teaching children. Importantly, he outlined his plan to have a much busier leisure life than he ever had before, with a better “work–life balance.” Finally, and critically, Juan outlined his plans to work toward taking more control in his relationships with others.

Juan produced a good release plan. He produced a good list of supports, outlining the ways in which each would help. He mentioned living with his mother, but also listed the action necessary to find a place of his own should he come to this decision eventually. He outlined the steps he was taking to secure a place in a halfway house and on a pre-release program. This was all taken as evidence of Juan’s commitment to work toward self-improvement in the future. Juan accepted that further treatment might be deemed necessary

and stated that he would be happy to attend as long as it didn't require him to "admit to something that I didn't do."

### **Summary**

Juan was considered to have done well on the program. He identified a number of key areas in which he had experienced problems in the past, and he worked on strategies to address them. He appeared keen to consider alternate viewpoints and to work toward self-improvement. He also indicated that he would continue to consider the validity of points with which he did not immediately agree. He was able to set helpful goals, both approach and avoidance goals, for the future. He planned to develop better relationships with others, to improve his self-esteem, to continue to work on asserting himself, and to focus on enjoying life again and not putting himself under so much stress. Juan had previously been assessed as being a low-moderate risk of sexual recidivism. Following his participation in this program he was considered to have reduced his risk level to low.

### **Professional Concerns and Questions**

We have experienced a wide range of reactions from professionals after describing our treatment approach to dealing with denial. While some people respond positively to the approach, many others are quite sceptical about its likely value. In fact, we ourselves initially found it unusual and personally challenging to conduct a treatment program without challenging denial or encouraging the man to admit to his offence(s). In most instances, in fact, we do encourage admission at the pre-treatment interview. If there is any potential for the man to acknowledge his offence or even very minimal portions of it, and he is receptive to treatment, we treat him in our regular program. The reason we do this is because in general, professionals working with him (e.g., parole officers, community treatment providers) will be more receptive if he is admitting to his offences.

We also know, however, that forcing someone to admit or being confrontational is neither effective nor helpful for him. Therefore, if after motivational discussions it is evident that a client is maintaining a position of denial, we

feel, at least given our limited data, that it is better to do something than nothing. The treatment approach we described above is designed to reduce risk by addressing dynamic risk factors, and it does so in a positive and constructive manner. While some may argue that denial might in fact be a risk factor for recidivism, we would argue that by addressing the strongest risk factors, we reduce the likelihood of recidivism.

Attempting to force admission through confrontation or through the use of a polygraph may feel as though it is producing results in the short term. But what is our long-term goal? If we want individuals to engage and to actually be motivated to address their dynamic risks, what is best practice?

One specific area of caution should be noted. We have not treated high-risk sexual offenders in our deniers' program and therefore we cannot at this time recommend this treatment for those who are high risk. This is not to say that a treatment model for high-risk sexual offenders who deny could not be developed; however, it would need to be based around high-intensity as opposed to moderate-intensity treatment.

## **Recommendation to Clinicians**

The approach taken in this program is strongly recommended for use with clients who present in categorical denial, but who express some interest in working toward a more favourable parole outcome and/or who express some interest in dealing more productively with general problems that they may have encountered in their lives. Such individuals can be motivated to engage in effective treatment aimed at helping them to identify problems that potentially put them in a position in which they could be accused of sexual offending.

## **Conclusions**

Working with categorical deniers has posed a problem for treatment providers. Often these men have refused treatment or have upset the group climate and been suspended from treatment. We have presented an effective and

motivational approach that addresses the key issues resulting in the offending behaviour without directly dealing with the issue of their denial. This approach serves to get clients “on side” (buying into the program) and treated while simultaneously addressing issues relevant to risk.

## REFERENCES

- Andrews, D. A., I. Zinger, R. D. Hoge, J. Bonta, P. Gendreau, and F. T. Cullen. 1990. Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology* 28:369–404.
- Barbaree, H. E. 1991. Denial and minimization among sex offenders: Assessment and treatment outcome. *Forum on Corrections Research* 3:30–33.
- Barbaree, H. E., and F. A. Cortoni. 1993. Treatment of the juvenile sexual offender within the criminal justice and mental health systems. In *The juvenile sex offender*, H. E. Barbaree, 57–76. New York: Guilford Press.
- Bartholomew, K., and L. M. Horowitz. 1991. Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology* 61:226–44.
- Beckett, R., A. Beech, D. Fisher, and A. S. Fordham. 1994. *Community-based treatment of sex offenders: An evaluation of seven treatment programmes*. Home Office Occasional paper. London: Home Office.
- Beech, A. R., and D. D. Fisher. 2002. The rehabilitation of child sex offenders. *Australian Psychologist* 37:206–14.
- Bradford, J. M., and D. M. Greenberg. 1998. Treatment of adult male sexual offenders in a psychiatric setting. In *Sourcebook of treatment programs for sexual offenders*, ed W. L. Marshall, 247–56. New York: Plenum Press.
- Brake, S. C., and D. Shannon. 1997. Using pre-treatment to increase admission in sex offenders. In *The sex offender: New insights, treatment innovations and legal developments*, ed. B. D. Schwartz and H. Cellini. Kingston, NJ: Civic Research Institute.
- Cohen, F. 1995. Right to treatment. In *The sexual offender: Corrections, treatment, and legal practice*, ed. B. K. Schwartz and H. R. Cellini, 24.1–24.18. Kingston, NJ: Civic Research Institute.
- Cortoni, F. A., and W. L. Marshall. 1995. *Childhood attachments, juvenile sexual history and adult coping skills in sex offenders*. Paper presented at the 14th Annual Research and Treatment Conference of the Association for the Treatment of Sexual Abusers, New Orleans.
- . 1996. *Juvenile sexual history, sex and coping strategies: A comparison of sexual and violent offenders*. Paper presented at the International Congress of Psychology, Montreal.
- Endler, N. S., and J. D. Parker. 1990. Multidimensional assessment of coping: A critical evaluation. *Journal of Personality and Social Development* 58:844–54.
- Fernandez, Y. M., D. A. Anderson, and W. L. Marshall. 1999. The relationship among empathy, cognitive distortions, and self-esteem in sexual offenders. In *The sex offender*:

- Theoretical advances, treating special populations and legal developments*, Vol. 111, ed. B. K. Schwartz, 4.1–4.18). Kingston, NJ: Civic Research Institute.
- Fisher, D., A. R. Beech, and K. Browne. 1998. Locus of control and its relationship to treatment change and abuse history in child sexual abusers. *Legal and Criminological Psychology* 3:1–12.
- Hanson, R. K. 2003. Empathy deficits of sexual offenders: A conceptual model. *Journal of Sexual Aggression* 9:13–23.
- Hanson, R. K., and M. T. Bussiere. 1998. Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology* 66:348–62.
- Hanson, R. K., A. Gordon, A. J. R. Harris, J. K. Marques, W. D. Murphy, V. L. Quinsey, and M. C. Seto. 2002. First report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment of Sex Offenders. *Sexual Abuse: A Journal of Research and Treatment* 14:169–95.
- Hanson, R. K., and A. J. R. Harris. 2000. Where should we intervene? Dynamic predictors of sex reoffense recidivism. *Criminal Justice and Behavior* 27:6–35.
- Hanson, R. K., and K. Morton-Bourgon. 2004. *Predictors of sexual recidivism: An updated meta-analysis*. (Cat. No. P53-1/2004-2E-PDF) Ottawa: Public Works and Government Services Canada.
- Happel, R. M., and J. J. Auffrey. 1995. Sex offender assessment: Interrupting the dance of denial. *American Journal of Forensic Psychology* 13:5–22.
- Hudson, S. M., D. S. Wales, L. W. Bakker, and T. Ward. 2002. Dynamic risk factors: The Kia Marama evaluation. *Sexual Abuse: A Journal of Research and Treatment* 14:103–19.
- Jenkins, A. J. 1990. *Invitations to responsibility*. Adelaide, South Australia: Dulwich Centre Publications.
- Kahn, T. J., and H. J. Chambers. 1991. Assessing reoffense risk with juvenile sex offenders. *Child Welfare* 70:333–45.
- Kennedy, H. G., and D. H. Grubin. 1992. Patterns of denial in sex offenders. *Psychological Medicine* 22:191–96.
- Langstrom, N., and M. Grann. 2000. Risk for criminal recidivism among young sex offenders. *Journal of Interpersonal Violence* 15:855–71.
- Laws, D. R. 2002. Owing your own data: The management of denial. In *Motivating offenders to change: A guide to enhancing engagement in therapy*, ed. M. McMurrin, 173–92. New York: John Wiley & Sons, Ltd.
- Lombardo, R., and J. DiGiorgio-Miller. 1988. Concepts and techniques in working with juvenile sex offenders. *Journal of Offender Counseling, Services and Rehabilitation* 13:39–53.
- Looman, J. 1999. Mood, conflict and deviant sexual fantasies. In *The sex offender: Theoretical advances, treating special populations and legal developments*, Vol. III, ed. B.K. Schwartz, 3.1–3.11. Kingston, NJ: Civic Research Institute.
- Losel, F., and M. Schmucker. 2005. The effectiveness of treatment for sexual offenders: A comprehensive meta-analysis. *Journal of Experimental Criminology* 1:117–46.
- Maletzky, B. M. 1993. Factors associated with success and failure in the behavior and cognitive treatment of sexual offenders. *Annals of Sex Research* 6:241–58.
- . 1996. Editorial: Denial of treatment or treatment of denial? *Sexual Abuse: A Journal of Research and Treatment* 8(1):1–5.

- Mann, R. E., J. I. D. Ginsburg, and J. R. Weekes. 2002. Motivational interviewing with offenders. In *Motivating offenders to change*, ed. M. McMurrin. Chichester: Wiley.
- Marshall, W. L. 1994. Treatment effects on denial and minimization in incarcerated sex offenders. *Behavior Research and Therapy* 32:559–64.
- Marshall, W. L., D. A. Anderson, and F. Champagne. 1996. Self-esteem and its relationship to sexual offending. *Psychology, Crime & Law* 3:81–106.
- Marshall, W. L., D. A. Anderson, and Y. M. Fernandez. 2000. *Cognitive behavioural treatment of sexual offenders*. London: John Wiley & Sons.
- Marshall, W. L., and H. E. Barbaree. 1988. The long-term evaluation of a behavioral treatment program for child molesters. *Behavior Research and Therapy* 26:499–511.
- Marshall, W. L., L. E. Marshall, G. A. Serran, and Y. M. Fernandez. 2006. *Treating sexual offenders: An integrated approach*. New York: Taylor & Francis Group.
- Marshall, W. L., and J. McGuire. 2003. Effect sizes in treatment of sexual offenders. *International Journal of Offender Therapy and Comparative Criminology* 46:653–63.
- Marshall, W. L., G. A. Serran, and F. A. Cortoni. 2000. Childhood attachments, sexual abuse, and their relationship to adult coping in child molesters. *Sexual Abuse: A Journal of Research and Treatment* 12:17–26.
- Marshall, W. L., G. A. Serran, Y. M. Fernandez, R. Mulloy, R. E. Mann, and D. Thornton. 2003. Therapist characteristics in the treatment of sexual offenders: Tentative data on their relationship with indices of behaviour change. *Journal of Sexual Aggression* 9:25–30.
- Marshall, W. L., G. A. Serran, H. Moulden, Y. M. Fernandez, R. E. Mann, and D. Thornton. 2002. Therapist features in sexual offender treatment: Their reliable identification and influence on behaviour change. *Clinical Psychology and Psychotherapy* 9:395–405.
- Marshall, W. L., D. Thornton, L. E. Marshall, Y. M. Fernandez, and R. E. Mann. 2001. Treatment of sex offenders who are in categorical denial: A pilot project. *Sexual Abuse: A Journal of Research and Treatment* 14:205–15.
- McKibben, A., J. Proulx, and R. Lusignan. 1994. Relationships between conflict, affect, and deviant sexual behaviours in rapists and pedophiles. *Behaviour Research and Therapy* 32:571–75.
- O'Donohue, W., and E. Letourneau. 1993. A brief group treatment for the modification of denial in child sexual abusers: Outcome and follow-up. *Child Abuse and Neglect* 17:299–304.
- Schlank, A. M., and T. Shaw. 1996. Treating sexual offenders who deny their guilt: A pilot study. *Sexual Abuse: A Journal of Research and Treatment* 8(1):17–23.
- Schneider, S. L., and R. C. Wright. 2004. Understanding denial in sexual offenders: A review of cognitive and motivational processes to avoid responsibility. *Trauma, Violence and Abuse* 5:3–20.
- Schwartz, B. K. 1995. Group therapy. In *The sexual offender: Corrections, treatment, and legal practice*, ed. B. K. Schwartz and H. R. Cellini. Kingston, NJ: Civic Research Institute.
- Simkins, L., W. Ward, S. Bowman, and C. M. Rinck. 1989. The multiphasic sex inventory: Diagnosis and prediction of treatment response in child sexual abusers. *Annals of Sex Research* 2:205–26.
- Simourd, D. J., and P. B. Malcolm. 1998. Reliability and validity of the level of service inventory-revised among federally incarcerated sex offenders. *Journal of Interpersonal Violence* 13:261–74.

- Ward, T., and C. A. Stewart. 2003. The treatment of sex offenders: Risk management and Good Lives. *Professional Psychology Research & Practice* 34:353–60.
- Winn, M. E. 1996. The strategic and systemic management of denial in the cognitive–behavioral treatment of sexual offenders. *Sexual Abuse: A Journal of Research and Treatment* 8(1):25–36.