Addressing Accountability and Denial in Sex Offense Treatment :

Evolving Practices and Practical Frameworks

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Note: all quotations are personal communication, except where cited

Agenda

- What is Denial and What Role Does it Play for Our Clients
- The Role Remorse & Accountability Play in the U.S. Criminal Justice System, and How that Impacts Sex Offense Treatment
- The Impact of Sexual Abuse and Denial on Victims
- What Does Research Tell Us About Denial
- Incorporating Accountability and Overcoming Denial into Sex Offense Treatment
- Roundtable Discussion on Sex Offense Treatment Practices Related to Denial and Accountability
- Working Around Denial: Clinical Checklist

Our Plan

- Explore different perspectives on accountability by examining historical dialogues and debates over the years.
- Examine victim/survivor interests in offender accountability and how this impacts prevention of sexual violence on multiple levels (i.e., primary, secondary, and tertiary).
- Highlight the various approaches employed in sex offense treatment to address denial in treatment.
- Offer a checklist of considerations that clinicians and supervision officers may use when determining whether or how to address denial of sexual offending.

Learning Objectives

Poll Question #1

- Do you exclude clients in categorical denial from sex offense treatment?
  - Yes
  - No

Poll Question #2

- Do you work with clients in categorical denial in a separate intervention, e.g., denier’s program?
  - Yes
  - No

Poll Question #3

- Do you address clients in categorical denial in:
  - Regular sex offense treatment groups
  - Separate groups for clients in categorical denial
  - Individual sessions for clients in categorical denial

Poll Question #4

- Do you have a time limit for clients in categorical denial to take accountability prior to reassessing best treatment fit?
  - Yes
  - No

Poll Question #5

- If you allow clients in categorical denial to attend sex offense treatment, can they successfully complete treatment while remaining in categorical denial?
  - Yes
  - No
  - Not applicable

Definition of Denial

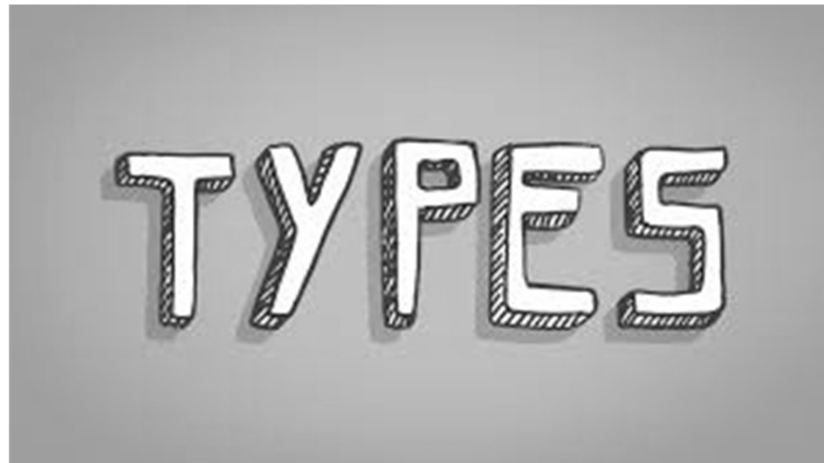
- Seeking a simple definition for a complex phenomenon
- Not accepting responsibility and accountability for sexual offending behavior
- Potential for different definitions of key terms
  - Responsibility
  - Accountability
  - Sexual
  - Offending
  - Behavior

Definition of Denial

- Key Considerations
  - Internal vs. external locus of control
  - The importance of intentionality
  - Behavior vs. behaviors
- Presence of cognitive distortions
  - Justification
  - Minimization
  - Victim blaming

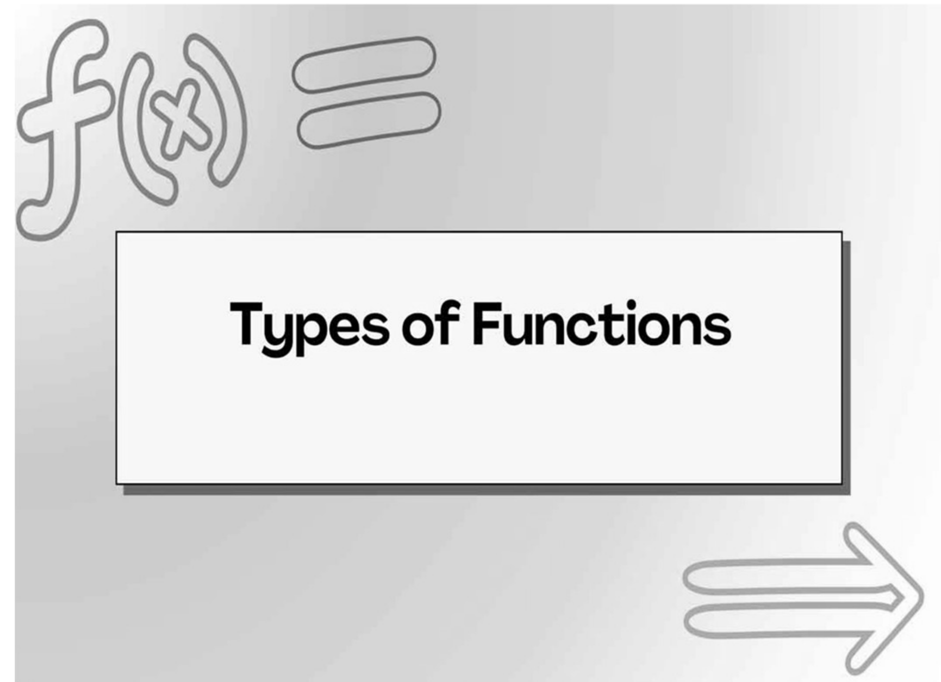
Types of Denial

- Researchers identify two levels of denial (Dietz, 2020; Harkins et al., 2014)
  - Categorical
  - Partial
- Does the research distinguish between the two when make definitive statements about denial?



Functions of Categorical Denial

- Categorical denial predicted by (Ware et al., 2020):
  - Higher shame-proneness
  - Higher impression management
  - Higher social self-esteem
  - Lower social intimacy
  - Lower IQ



Functions of Categorical Denial

- Categorical denial maintained (Blagden et al., 2014):
  - "Social/moral self" by distancing from "sex offender" label (stereotypically derogative)
  - Retaining sense of being "normal" or "upstanding"
  - Keeping continuity and status in social relationships
  - Part of the denial "mindset" involved grievance thinking, constricted (avoidant) thinking, and maintaining continuity of self over time
- Minimization may be normal cognitive process involved in self-esteem maintenance (Craissati, 2015)

Role of the Therapist

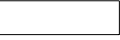
- Whose responsibility is it to accept accountability for the sexual offense?
- How does a therapist remain victim centered related to denial?
- Is the therapist responsible for the impact on the victim?
- What is the best interests of the client related to denial?
- How does a therapist balance accountability and the therapeutic alliance?
- How does a therapist provide an opportunity for change, and not determine guilt or innocence?

Categorical or Partial Denial?

- Admit behavior but no offending intent
- Admit behavior but claim it was not offending (consent)
- Don’t recall due to alcohol/blackout but assume it must have happened
- Take a plea bargain and didn’t do it, but lawyer said to say I did it so I did it
- Admit to 1 sex offense incident when victim says it went on for two years

How Remorse & Accountability Became Foundational in the U.S. Criminal Justice System

Historical Development and Key Influences



Why does denial trigger our sense of right and wrong?

Early Religious & Moral Foundations (1600s–1800s)

Puritan and Protestant traditions framed crime as sin requiring repentance.

Penitentiaries were designed to promote reflection and remorse.

Accountability and sorrow were viewed as prerequisites for moral reform.

Penitentiary Movement

The term 'penitentiary' derives from penitence—remorse for wrongdoing.

Systems emphasized solitude and penitence.

Institutional design reinforced remorse as central to rehabilitation.

Enlightenment & Classical Criminology

Rationality and proportional punishment emphasized.

U.S. reformers blended rationalism with Christian morality.

Accountability became tied to the idea of rational actors making choices.

Progressive Era Rehabilitation (1890s–1960s)

Rise of probation, parole, and indeterminate sentencing.

Remorse and accountability used as criteria for release decisions.

Social work and psychology emphasized insight and acknowledgment of harm.

Cognitive-Behavioral Treatment (CBT) (1970s–present)

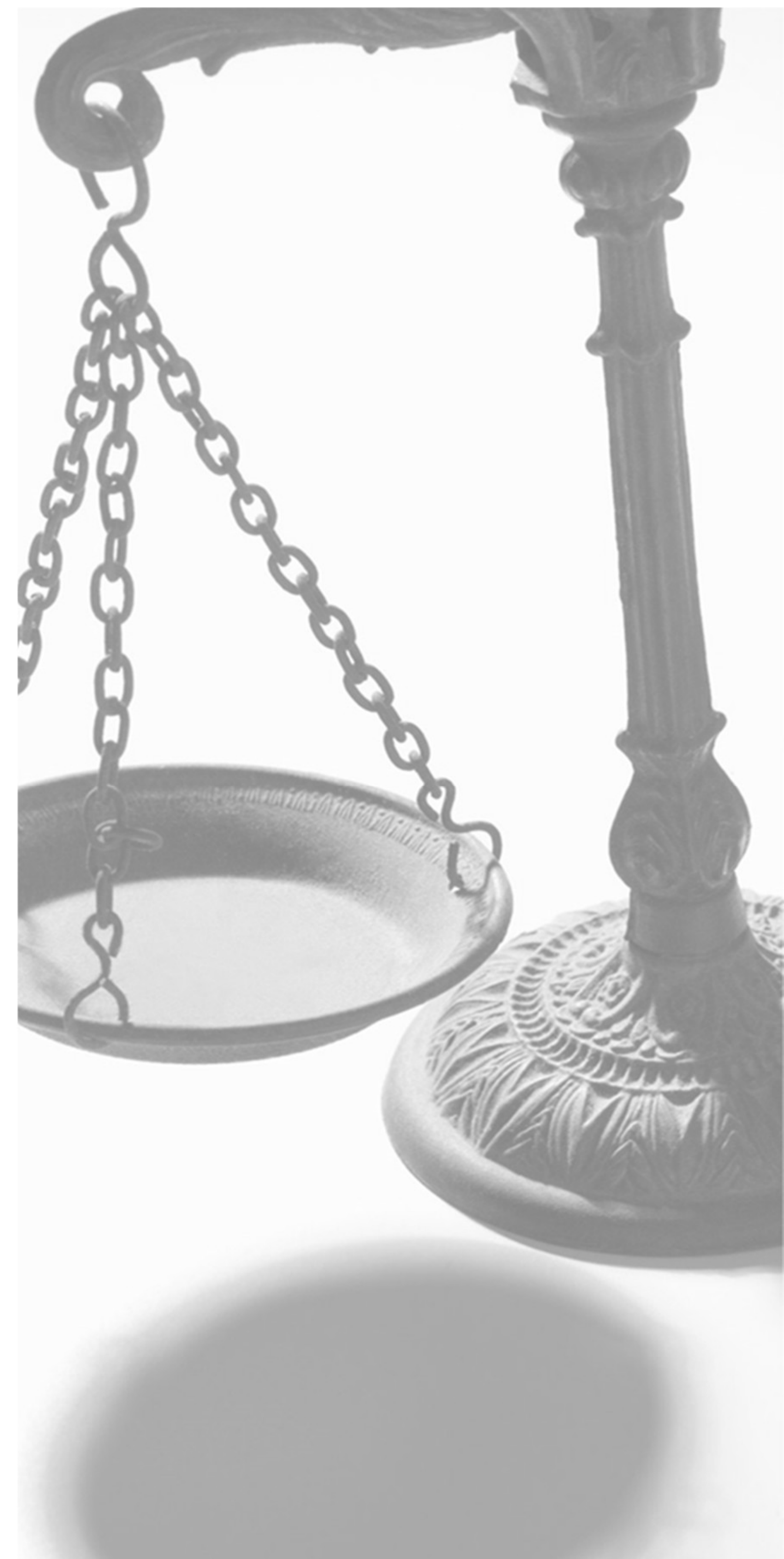
- CBT programs require acknowledgment of thinking errors and offense cycles.
- Accountability framed as necessary for cognitive change.
- Manualized programs cemented remorse and responsibility as treatment benchmarks.

Victims' Rights Movement (1970s–1990s)

Introduced victim impact statements and restorative justice.

Courts increasingly valued offender expressions of remorse.

Remorse tied to moral accountability and harm repair.

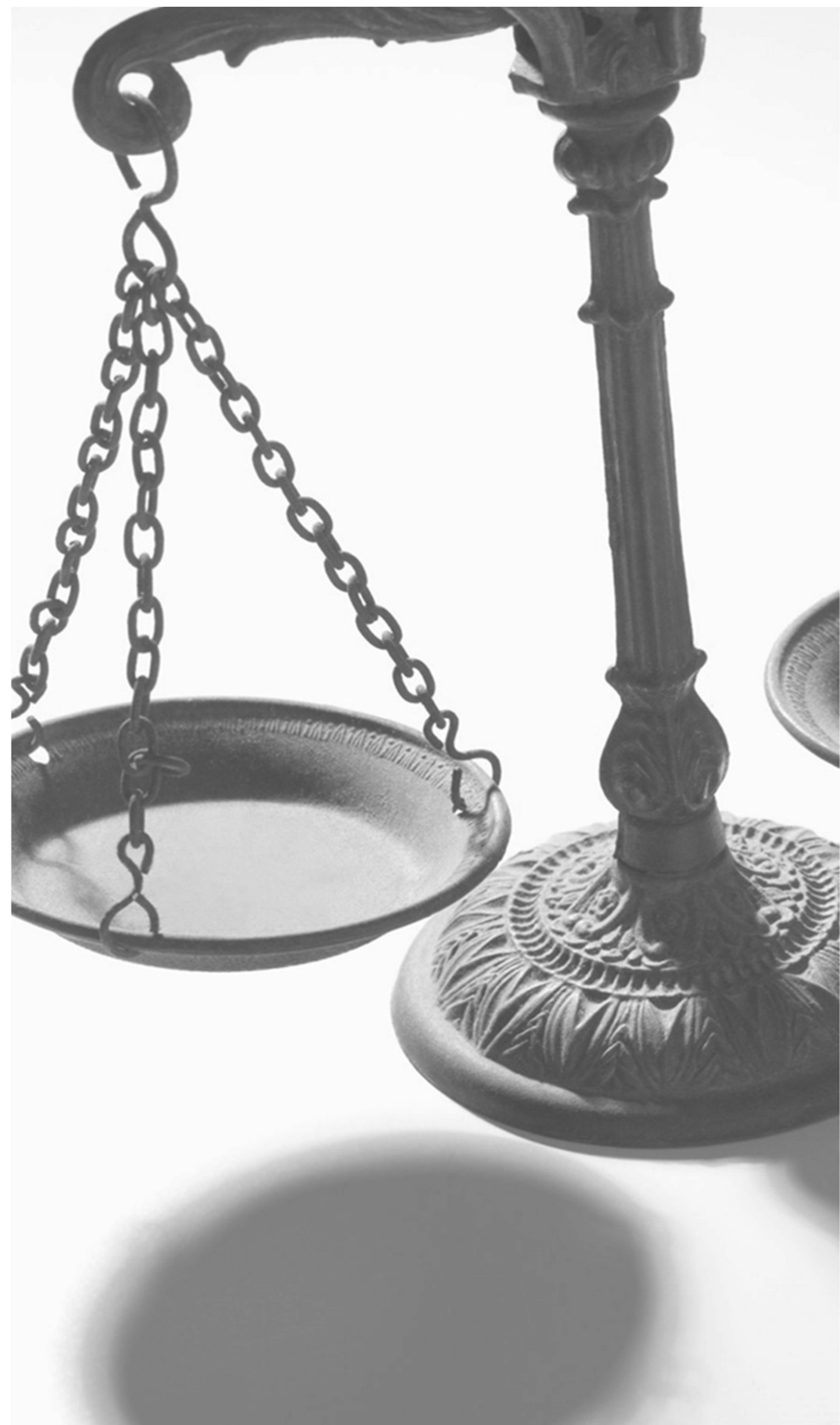


Institutionalization in Courts & Parole Boards

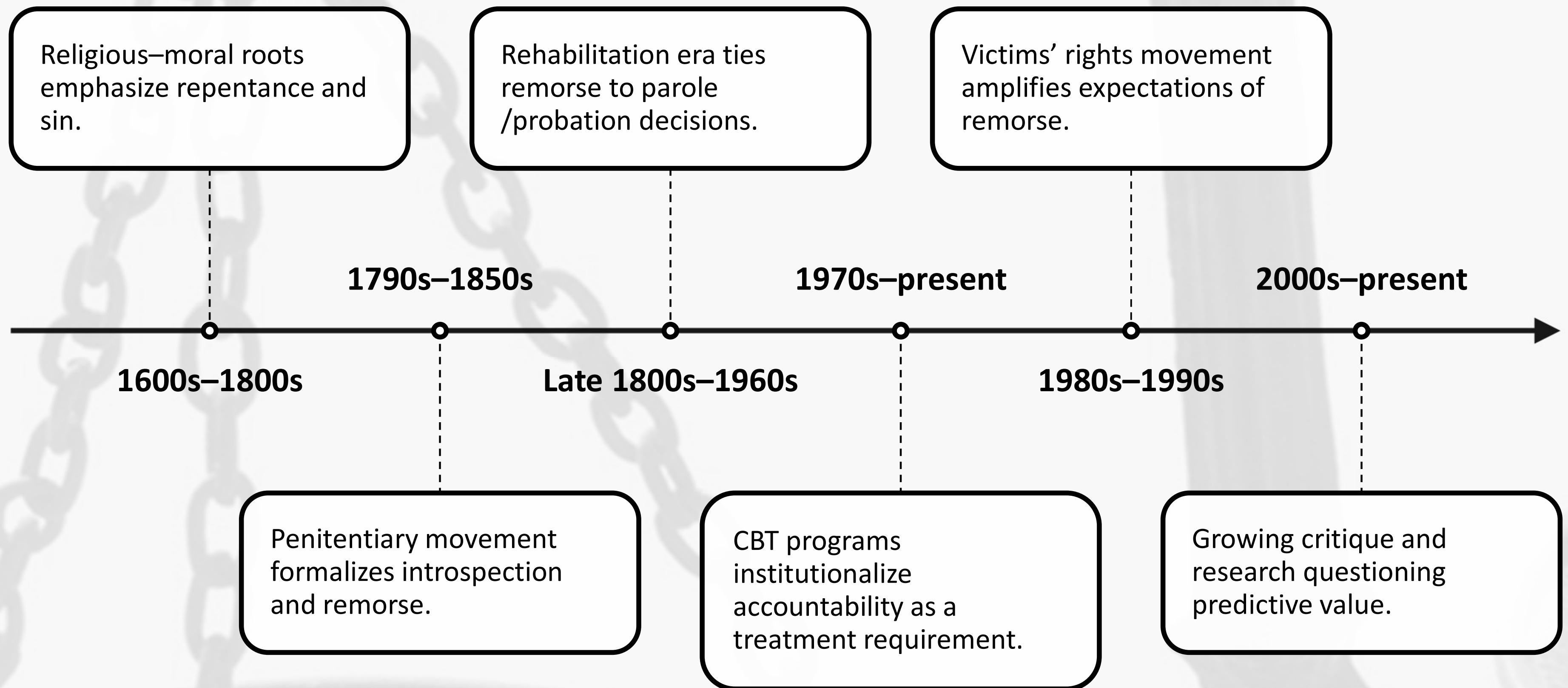
Remorse considered in sentencing as mitigating or aggravating.

Parole boards use accountability and remorse to assess readiness for release.

Became embedded in correctional culture despite mixed empirical support.



Evolution Timeline: Remorse & Accountability in U.S. Justice



Summary

Origins in religious tradition and penitence.

Reinforced by rehabilitation and parole practices.

Embedded through CBT models and victims' rights.

Has evolved into a foundational understanding in assessing offender change and readiness.

Contemporary Critiques of Remorse & Accountability Requirements

Research shows remorse has weak or inconsistent correlations with recidivism or desistance. → Protective factors (social bonds, employment, identity transformation) show stronger effects on desistance.

Remorse and accountability as moral constructs embedded into the system has outpaced empirical support for their predictive value.

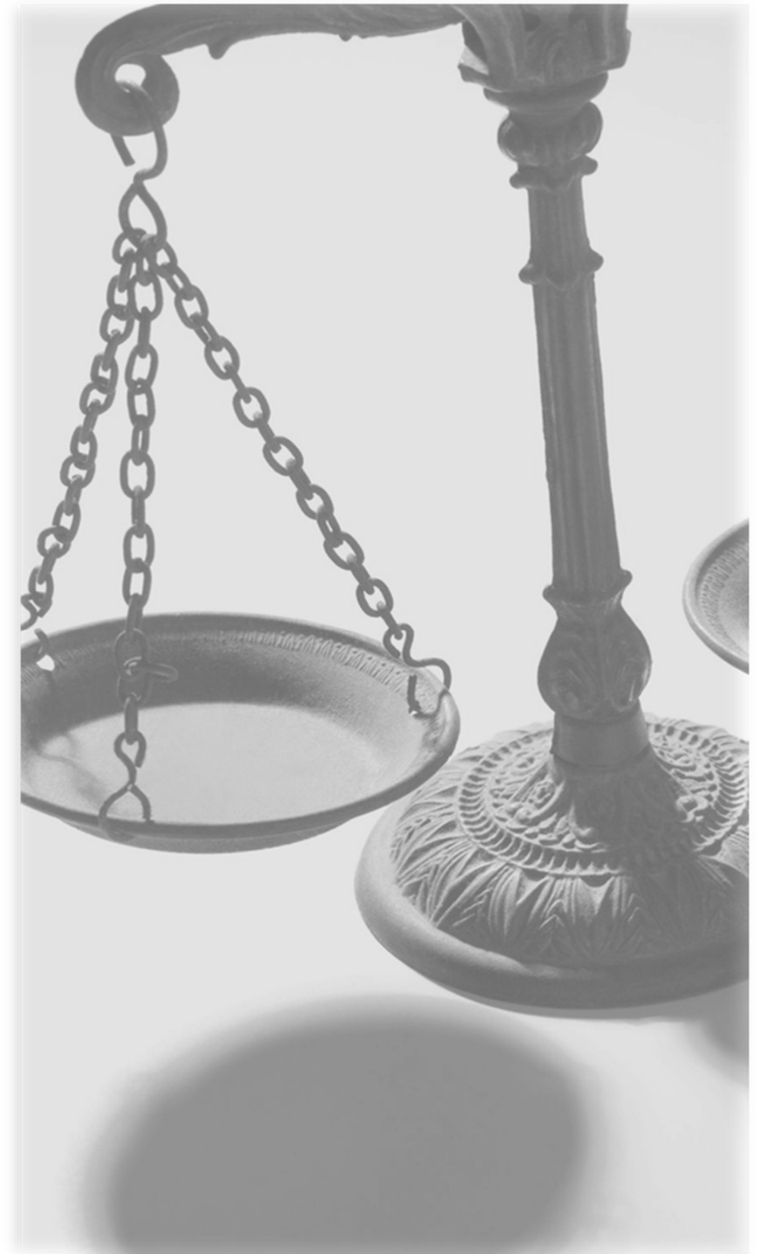
Cultural, racial, psychological, or trauma-related factors may suppress emotional expression.

Forced displays of remorse risk penalizing individuals with autism, PTSD, or flat affect.

Scholars argue remorse is often interpreted subjectively by judges and boards. → Need to attend to behavioral evidence v. emotional/verbal responses

Understandable How We Got Here…

And we can use evidence to help shift our beliefs and approaches.

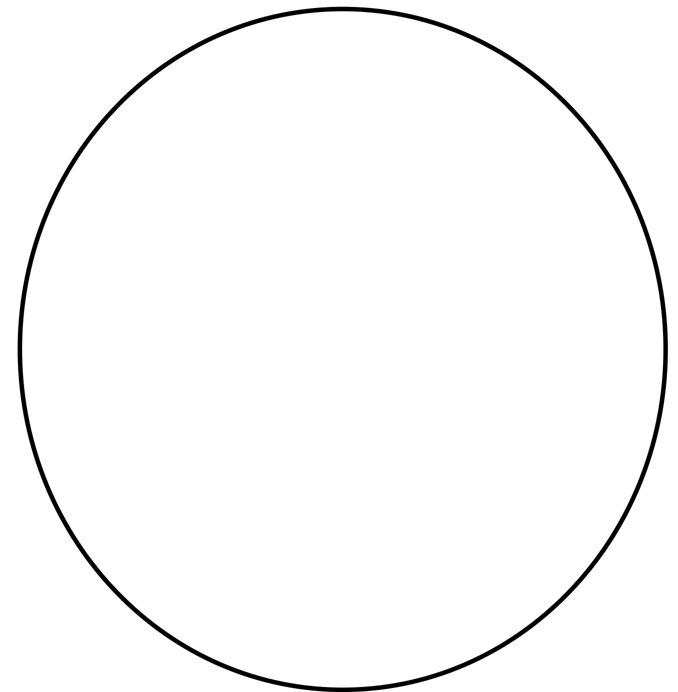


The Voices Of Those Who Have Been Harmed

The Lenses We View This Work Through

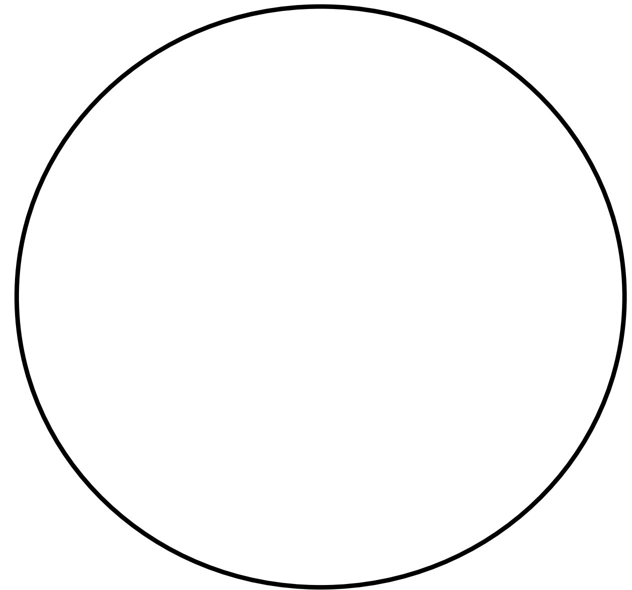
Intention

- Do we want them to re-offend or not?
- What can we do?
- Who should we be?
- Is that enough?



What Is Our Goal?

- Stopping the behavior?
- Justice for the victim?
- Preventing re-offense?
- Building a better life?



REMEMBER

- Safety first!
- Do no harm
- Do no further harm

Ultimately

No intervention that takes power away from the survivor can possibly foster her recovery, no matter how much it appears to be in her immediate best interest (Herman, 1992)

Reframe: Interventions that empower survivors foster recovery

Judith Herman (1992; 2023)

Key needs of survivors:

- Validation & acknowledgment
- Accountability & truth
- Repair & justice
- Empowerment & agency
- Community & systemic change

Judith Herman (1992; 2023)

Additionally:

- Trauma as a social issue
- Moving beyond simply punishment
- The power of truth
- "Survivor mission"

From a Colleague

I think for me, I have always done this work because I can. I have seen the impact of sexual abuse and seen that no one was speaking out about it. I have seen how friends, strong people, have been decimated by flashbacks or other anxieties. And now [as we all get older] I see the long-term impact on their bodies too.

Informal Survey

- Two Questions:

- What do you want to say to the person who abused you?
- What would you want to hear from from the person who abused you?

What Do You Want To Say to the Person Who Abused You?

- *Silence feels like the only appropriate response when addressing male family members who chose to abuse a child they were responsible to keep safe.*

What Would You Want to Hear from the Person Who Abused You?

- *I would love to hear an apology that breaks the cycle of violence, so that I don't have to take responsibility of ensuring that those who harmed me won't harm others.*
- *"Recognition: Specifically acknowledge what you did wrong. This shows you have paid attention to the offense and understand the harm it caused.*
- *Responsibility: Take ownership of your actions without making excuses. Say, "I was wrong to..." or "This is on me".*
- *Remorse: Express genuine regret for causing hurt or damage. This is the sincerity of your "I'm sorry".*
- *Reparation: Make amends for the offense. This can involve fixing what you broke or asking, "What can I do to help you start trusting me again?".*
- *Repetition: Promise to change your behavior. This demonstrates a commitment to not repeating the same mistake in the future."*

What Do You Want to Say to the Person Who Abused You?

Even though you only inappropriately touched me once, it has so deeply affected me and has continued to over decades—as physical chronic physical pain, as sexual and intimacy problems, and as other several PTSD symptoms.

What Would You Want to Hear from the Person Who Abused You?

1. When I first remembered at age 42, I kept wanting to know "Why???" — why would my own brother do that to me?

2. Then I wanted an apology.

3. And I also wished he would express an understanding of how deeply this has affected me… for decades, and how it still does at age 60.

What Do You Want to Say to the Person Who Abused You?

A cross between nothing and shame on you

What Would You Want to Hear from the Person Who Abused You?

- *I was abused by more than one person, so my answers are all different*

What Do You Want to Say to the Person Who Abused You?

The person who abused me was a psychopath. We attempted reconciliation as this person was a close family member, but the denial of sexual and physical abuse, even with evidence, was intense. Additionally, this person attempted to kill me multiple times. Again, the evidence, including police reports and restraining orders did nothing to help that individual come to terms with what they did. In fact, all FIVE of their own children were removed from the home as this person continued to abuse in their life beyond my family.

I am not sure I would want to tell them anything anymore because when I did address them, the denial cut even deeper. Then this person started threatening me, my mom, dad, and brother, again, and our lives were in danger. My internal scars are immense. I cannot tolerate certain kinds of touch, even from trusted loved ones. I am in my 50s and still have nightmares. This is not something that goes away and the person's denial of it just makes it worse.

What Would You Want to Hear from the Person Who Abused You?

The best thing that happened was that this person was killed two years ago, and since then, I have felt the freedom to begin to heal. Maybe some perpetrators need to hear that the folks they damaged would honestly rather see them dead than ever speak to them again.

What Do You Want to Say to the Person Who Abused You?

Learning of the intense abusive childhood you suffered helped me understand how you came to be psychologically damaged enough to enjoy inflicting every form of pain on countless others.

What Would You Want to Hear from the Person Who Abused You?

"My pursuit of dominion over others has never filled my emptiness; I need professional help with this addiction."

What Do You Want to Say to the Person Who Abused You?

If I were to believe that you actually had a part in you that would be able to listen, I would say. I wish you can own what you did, I wish that you can own that what you did was horrible and hurt me so bad, I wish that you would share with me how ashamed you are. I also wish that you know that since you are a family member it hurts so much more, because I can't help but have love for you as well. So I wait and yearn for you to own what you have done, so I can then hopefully love you easily. I really want to forgive you, but how can I forgive if you don't own, as long as you don't own what you did, forgiving you is killing me.

So for now, I will not forgive, I will not forget. For now, I will live with the fiery hate in my heart that says ,this was not ok! I will never be ok with what happened. It was not ok. And even though it feels so wrong, I can also accept that there is love for you in my heart, because thank g-d after all that you did, you still didn't succeed in turning me into a hateful human being.

What Would You Want to Hear from the Person Who Abused You?

I am sorry! What I did was wrong. I am horrified by what I did.

I can never undo what I did. Family members should protect each other, I failed at protecting you! Instead of protecting you, I violated in unimaginable ways.

I am here to say I'm sorry, and I want you to know that I will be here to say it as many times as you need to hear it.

What Do You Want to Say to the Person Who Abused You?

Why didn't you get help for your pain instead of inflicting it on us?

What Would You Want to Hear from the Person Who Abused You?

I was wrong in what I did. You didn't deserve being hurt that way. And I'm too weak to take responsibility for my actions. That's why I blame others.

What Do You Want to Say to the Person Who Abused You?

You took so much from me - you took my self worth, you made me question my reality, and ultimately, you know what you were doing. Criticizing me, putting me down, and giving me the silent treatment was a tool of yours that you thought could control me, and at times, it did. It was hard to leave you. It was hard to stand up for myself and for our daughter. She did not deserve to witness the abuse I went through, and she didn't deserve to be abused either. Your goal was to make me feel like dirt, so you could feel powerful and in charge. Your goal was to unleash your anger on someone who's light you couldn't put out. And you didn't, but what will say is that I only had 1% light left in me the night I escaped. …

What Do You Want to Say to the Person Who Abused You?

… Even now, that we coparent, I have spent the past year grieving. I've allowed the emotions to move through my body like water, passing by, passing along, as my tears finally released pent up trauma that has been stuck in my flesh for years. I have worked so hard on myself, to a point that I laid on my bed for hours allowing my mind to reflect, to process, and to make amends with the fact that this was never my fault. You will never ever take anything else away from me, and I am growing back stronger than you could ever imagine. Everyday, every step, every small task, I've won. Every affirmation I've whispered, every boundary I've set, and every new weight I pick up at the gym is retraining my soul and my spirit into freedom and strength. You thought you could break me down, but I am only rising...at my time, at my speed, and with the mighty power of God who has never allowed me to forget about my worth. I am loved. I am not alone. I am safe.

What Would You Want to Hear from the Person Who Abused You?

At first, I wanted an apology, but now I apologize to myself, knowing that I only knew what I did at the time when I was with him.

What Do You Want to Say to the Person Who Abused You?

Dear MJ,

You smiled. I struggled to breathe, was in shock, and completely shattered. My childhood ended. My future disintegrated. My life forever split into before and after. You turned my body into a crime scene for the first time, and you smiled.

I was just a little girl, and you assaulted me hundreds of times. You forever changed my brain, body, nervous system, and even my DNA. I lost all of my possible future selves, and I had to reinvent myself while in hell. All because you chose to sexually abuse me.

I am sentenced to a lifetime of pain, while you faced no accountability. I have been drained financially to cover the costs of the harm you did. You paid no price for your felonies. …

What Do You Want to Say to the Person Who Abused You?

… You had carefully groomed everyone to think you were a good person, and they believed your facade. After I told on you, you pretended I was the one doing the harm, and you encouraged people to harass, bully, and otherwise harm a child. Your enablers caused extensive damage to me as well.

You betrayed me the worst way an adult can betray a child, all while claiming to love me. What you did is the opposite of love. It's evil, calculating, cruel, and so much more.

I don't know if I can ever forgive you. Some things truly are unforgivable. But I have compassion for you. I have always had compassion for the harm that was done to you as a child. You deserved better than abuse and neglect. All children do. You deserved loving, compassionate, caring, attentive parents who nurtured you. All children do. And my heart goes out to you for the harm you suffered.

What Would You Want to Hear from the Person Who Abused You?

If you felt remorseful, I would like to hear something like the following from my abuser:

Dear D,

There is no excuse for all the harm that I did to you. I am beyond sorry. It was 100% my responsibility, my fault, and my shame. You deserved so much better than the harm I caused by sexually and otherwise abusing you.

I am ready to be accountable in whatever ways you need for justice to be served. I am ready and willing to make whatever amends you need. I will listen to anything you need to or want to say to me, and if you want nothing to do with me, I understand and respect that.

I will never hurt another child again. I am fully participating in therapy and other programs designed to help sexual predators like myself heal. When I am far enough along on my healing journey, I will work with organizations or others who want to prevent sexual abuse.

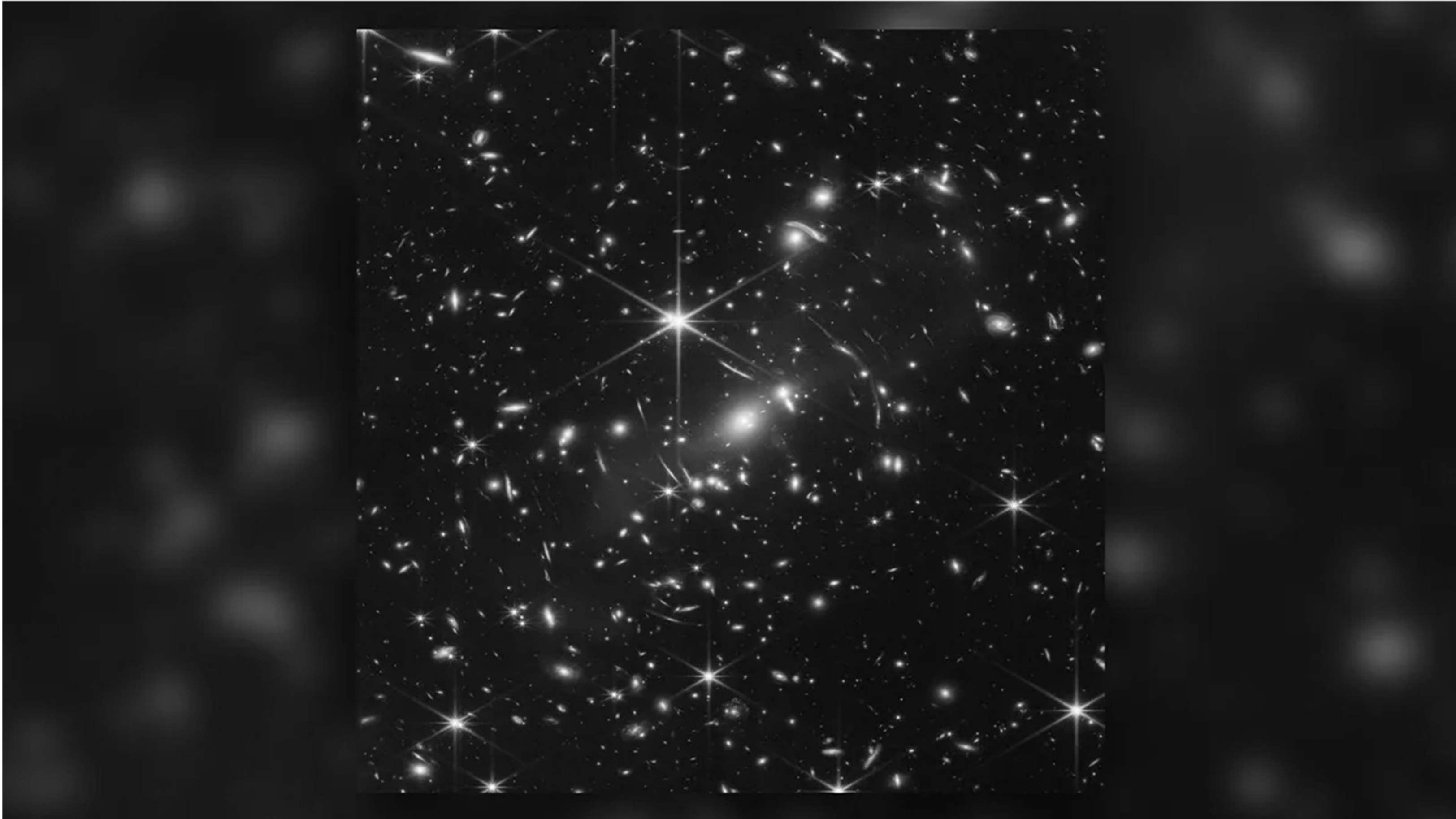
I will be honest about what I've done. As much as possible, I will tell my family and friends and others who harmed you on my behalf that I lied about you, that you told the truth. And I will encourage them to take accountability and make amends.

I am so sorry for all I've done. If there is something I can do to make amends to you, let me know, and I will do it.

Implications

- Everyone is different
- Every program is different
- We are frequently not aligned with the needs of those who have been harmed.
- We are at high risk of being disrespectful if we ignore survivor voices in our policies and practices

Questions?



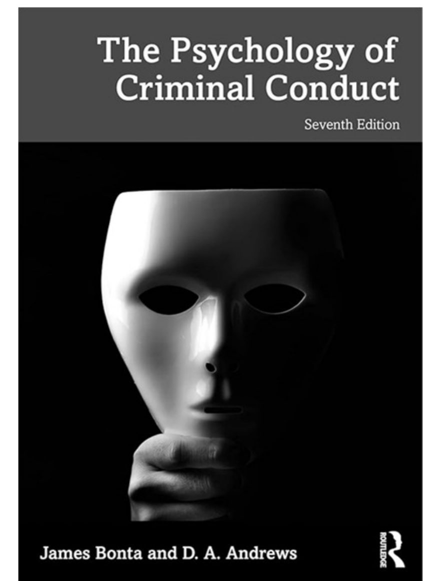
Thank You!

Research On

Denial in Sex Offense Treatment

Is Denial a Risk Factor or a Criminogenic Need from RNR Perspective?

- Denial is not a risk factor (Hanson & Morton-Bourgon, 2005)
- No significant risk factor association over a 2-year follow-up for either categorical or partial denial as measured pre-treatment
    - U.K. sample (n=6,891) (Harkins et al., 2015):
    - Research limitations:
        - Operationalization of categorial and partial denial
        - Pre-treatment vs. post-treatment
        - Lack of control of potential covariates



- Some other studies have found relationship, although difficult to clearly interpret (Witt & Yeoman, 2019)
- Overlap with some dynamic risk items (e.g., SOTIPS sex offense responsibility; VRS-SO cognitive distortions & insight)

Denial as a Responsivity Factor from RNR Perspective

- Meta-analysis found denial significantly associated with treatment attrition, and attrition significantly associated with small increase in recidivism (Olver et al., 2011).
- Young adult men with personality disorder who failed to engage in treatment were more likely to have previous sexual convictions, be in denial, and have entered a not guilty plea (Eastman et al., 2019)
- Men in denial who refused treatment were less aware (interested) in benefits of treatment, less involved or trusting of therapeutic staff, reported negative effects of treatment, higher status in prison, and reported prison would be harder if attending treatment (Mann et al., 2013)
- Treatment refusal scale measured 3 factors (i) pressure to take part in programs, (ii) fear of negative effects, and (iii) program not relevant or appropriate for me (Brown et al., 2014)

Addressing Denial in Sex Offense Treatment – Option 1

- Exclude from sex offense treatment
  - Historical approach
  - Identified as indicative of not just risk, but high risk
  - Accept responsibility for sexual offense prior to being eligible for treatment
  - Challenge – how is denial defined and how much accountability is needed to not be in denial?

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Addressing Denial in Sex Offense Treatment – Option 2

- Specialized program like deniers treatment
  - Recognize that treatment was needed to address denial
  - Evolution from confrontation to therapeutic support
  - Use of polygraph
  - Fixed time limits
  - Accept responsibility for sexual offense prior to being eligible for sex offense treatment

Addressing Denial in Sex Offense Treatment – Option 3

- Address in sexual offense treatment
  - More accepted as a current practice
  - Rely on the therapeutic process and relationship to overcome denial
  - Question of whether denial needs to be a treatment target
  - Is it necessary to accept responsibility for the sexual offense during treatment, or in order to successfully complete treatment
- No research on outcomes for specific types of interventions (Ware et al., 2015)

Treatment Research

- 3 broad approaches to treatment for categorical denial (Ware et al., 2015)
  - Exclude, work around with specific program designs (e.g., deniers treatment), or overcome via sex offense treatment
  - Lack of empirical evaluation of treatment or recidivism outcomes for different approaches
- Interviewed experienced counselors (Carolla, 2022)
  - Traditional confrontation ineffective and potentially harmful, and build rapport and therapeutic alliance to manage shame and facilitate treatment
  - Emerging trend toward finding alternative non-denial targeted interventions to work effectively with clients in denial
- Interviewed small group of clients and therapists in UK (Watson, 2016)
  - Some clients in categorical denial integrated well and gained from mainstream programs, while others had consistently negative experiences

Treatment Research

- Therapeutic alliance and group climate between clients in deniers treatment and sex offense treatment (Ware, 2018)
    - No significant differences in therapeutic alliance or group cohesion
    - Deniers treatment had significantly less open expression of anger and disagreement within the group than in sex offense treatment. Deniers treatment had a significant increase in the emphasis on completing tasks and increased encouragement among group to discuss personal problems
- Treatment benefits between deniers treatment and sex offense treatment (Ware, 2017)
    - Some evidence deniers treatment led to positive changes but tended to be greater for sex offense treatment
    - Sense of agency, sexual self-regulation, cognitive distortions, use and understanding of coping skills, awareness of thoughts, feelings, and events that might relate to further offending
- Evaluated pilot deniers treatment (Marshall, 2014, as cited in Ware et al., 2015):
    - 2.5% reoffended within 3.5 years follow-up period.
    - Lacked comparison group.

Treatment Research

- Utility of peer-support intervention within prison-based setting (Perrin et al., 2018)
  - Pre-group treatment phase, and in extension therapeutic community
  - No evaluations
- Increased program retention but also increased sexual recidivism (Howard et al., 2019)
  - ? risk profile of completers vs. loss treatment effectiveness

Impact of Denial on Victims

- Restorative practices emphasize interest in offender accountability (Koss, 2014)
- Failure to satisfactorily take accountability caused further trauma for intra-familial victims (Paige & Thornton, 2015)

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All tools Edit Convert E-Sign
Find text, tools, or help Share

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Colorado Sex Offender Management Board
Provider Data Collection System
Denial Policy Brief #3
January 19, 2024

Colorado Sex Offender Management Board

In 1992, the Colorado General Assembly passed legislation that created a Sex Offender Treatment Board to develop standards and guidelines for the assessment, evaluation, treatment, and behavioral monitoring of sex offenders. The General Assembly changed the name to the Sex Offender Management Board (SOMB) in 1998 to more accurately reflect the duties assigned to the SOMB.

The Legislative Declaration for the Sex Offender Management Board (SOMB) states:

"(1) The general assembly finds that, to protect the public and to work toward the elimination of sexual offenses, it is necessary to comprehensively evaluate, identify, treat, manage, and monitor adult sex offenders who are subject to the supervision of the criminal justice system and juveniles who have committed sexual offenses who are subject to the supervision of the juvenile justice system. (2) Therefore, the general assembly declares that it is necessary to create a program that establishes evidence-based standards for the evaluation, identification, treatment, management, and monitoring of adult sex offenders and juveniles who have committed sexual offenses at each stage of the criminal or juvenile justice system to prevent offenders from reoffending and enhance the protection of victims and potential victims. The general assembly does not intend to imply that all offenders can or will positively respond to treatment." (§16-11.7-101, C.R.S.)

Provider Data Collection System

Colorado House Bill 16-1345 requires the SOMB to collect data from the evaluators, treatment providers, and polygraph examiners who provide services to adults convicted and juveniles adjudicated for a sex offense. Each provider is required to submit service information about the treatment to the SOMB Provider Data Management System at the time of service completion, regardless of the outcome of each service. Formal data collection began in 2019 and has continued since that time. Annual reports on the data can be found in the SOMB Annual Legislative Reports (add link) beginning in 2020.

Policy Issue

In addition to the annual report on the SOMB Data Collection outcomes, the SOMB will periodically complete policy briefs related to special topics from the data collection by approved providers. This is the third in a series of briefs related to specialized topics and will cover data related to addressing denial with clients convicted of a sexual offense. Issues related to denial of the sexual offense and how to successfully address this in treatment have been a point of discussion at SOMB meetings, with stakeholders, and at the Colorado State Legislature. Concerns have been raised about the impact of denial on the client's risk for recidivism, victim healing and recovery, and for those who have been wrongfully convicted of a sex crime.[1]

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Colorado SOMB Data

- SOMB PDMS data (Oct 2019 to Nov 2022). N=1,481.
- Denial definitions in the SOMB Adult Standards and Guidelines:
    - No Denial: accepts full responsibility, does not place blame elsewhere
    - Low Denial (level 1): accepts most responsibility, places some of the blame elsewhere
    - Moderate Denial (level 2): accepts some responsibility, places most of the blame elsewhere
    - High Denial (level 3): accepts no responsibility, denies committing unlawful sexual behavior

Distribution of Denial Level at Beginning & End of Treatment

Table 1. Client Denial Level Beginning & End Treatment		
Denial Level	Beginning (N=1,481)	End (N=1,472)
None	281 (19%)	550 (37%)
Low	634 (43%)	659 (45%)
Moderate	368 (25%)	183 (12%)
High	198 (13%)	80 (5%)
Total	1481 (100%)	1472 (100%)

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High (Categorical) Denial

- Outcomes
  - 65% of clients progressed to a lower level of denial
  - 35% had high denial at the end of treatment.

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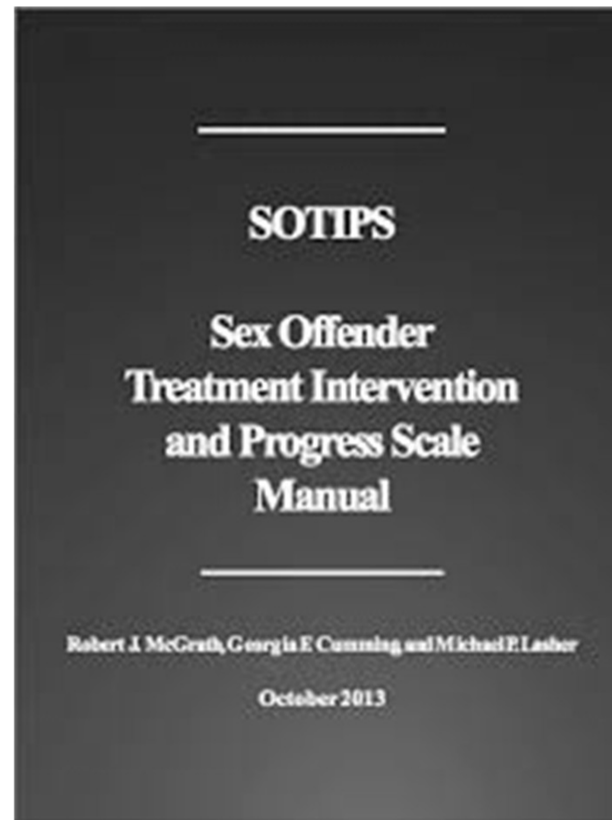
Association with Risk Categorization

- High denial vs. lower levels of denial
  - Not associated with static risk
  - Associated with higher dynamic risk



Treatment Strategies Utilized

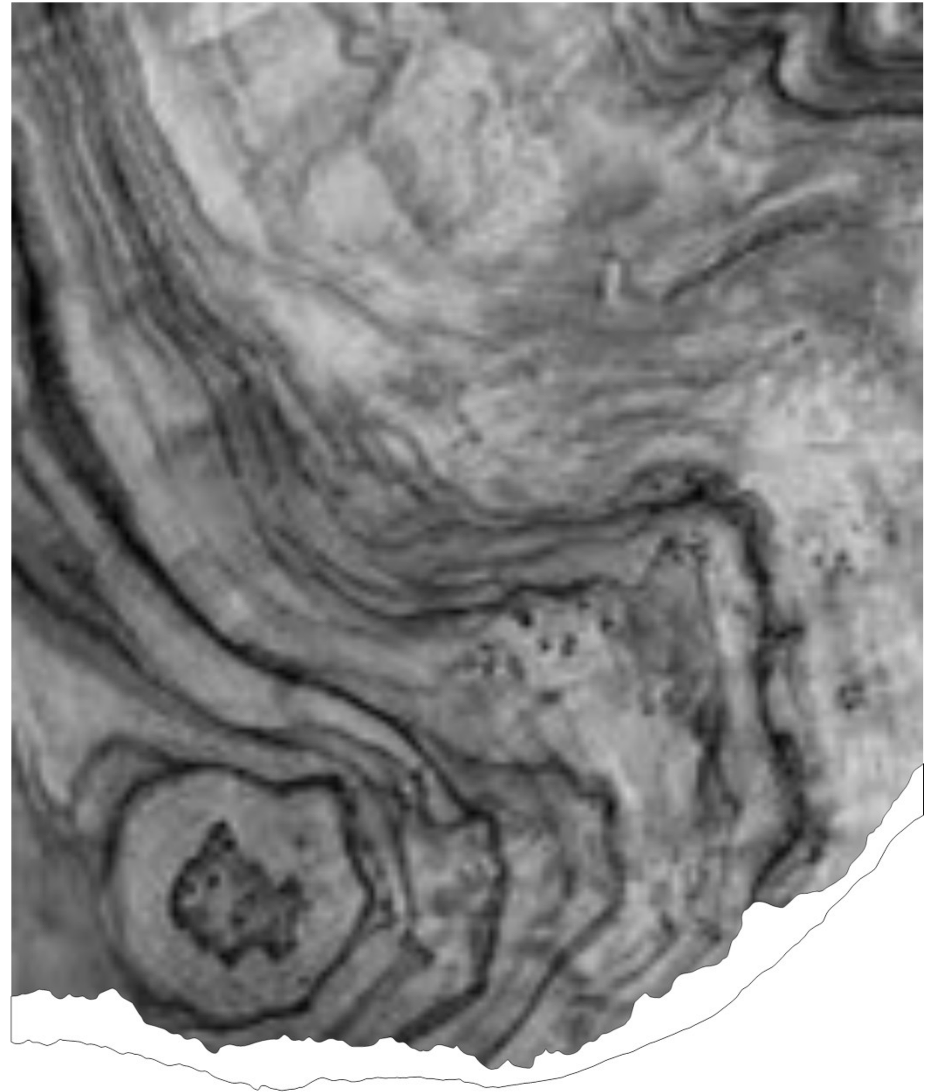
- Use of a denier's intervention as prescribed by the SOMB Standards and Guidelines
- Use of the group process
- Use of a polygraph exam
- Addressing victim impact
- Developing a therapeutic relationship
- Decreasing stigma and shame
- Focusing on distorted thought patterns related to the offense
- Supporting client motivation
- Use of client support systems
- Addressing client trauma history
- Providing psychoeducation

SOMB Standards and Guidelines

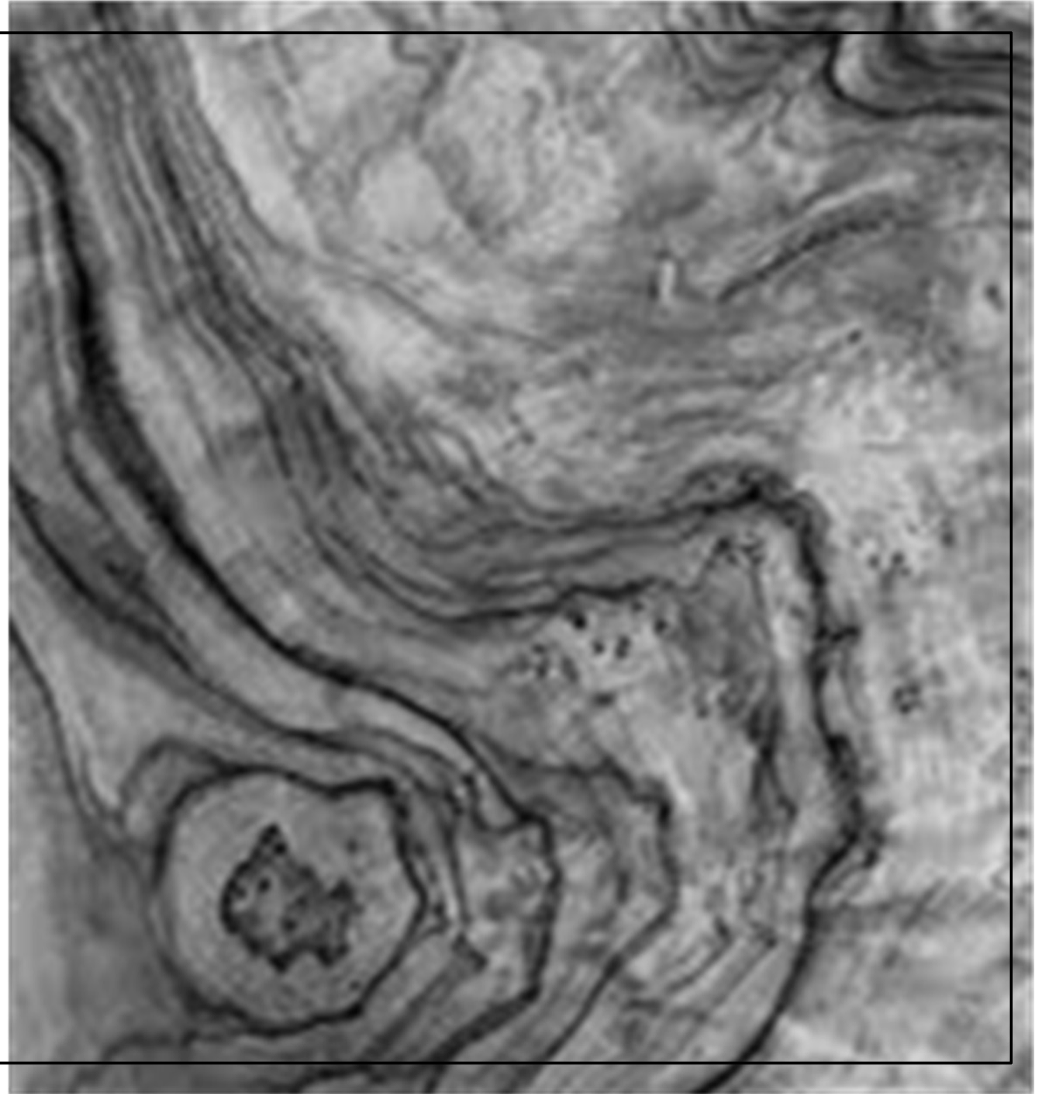
- 3.500 Acceptance of Responsibility and Accountability
  - Use protective factor language rather than deficit-based language
  - Accountability intervention for those in Level 3 – Accepts no responsibility (i.e., categorical denial)
  - 90 days with possible extension based on clinical indicators
  - Purpose not to determine the guilt or innocence of the client
  - Discharge may recommend other non-sex offense-specific treatment interventions for consideration by the Court

Denial in SOT

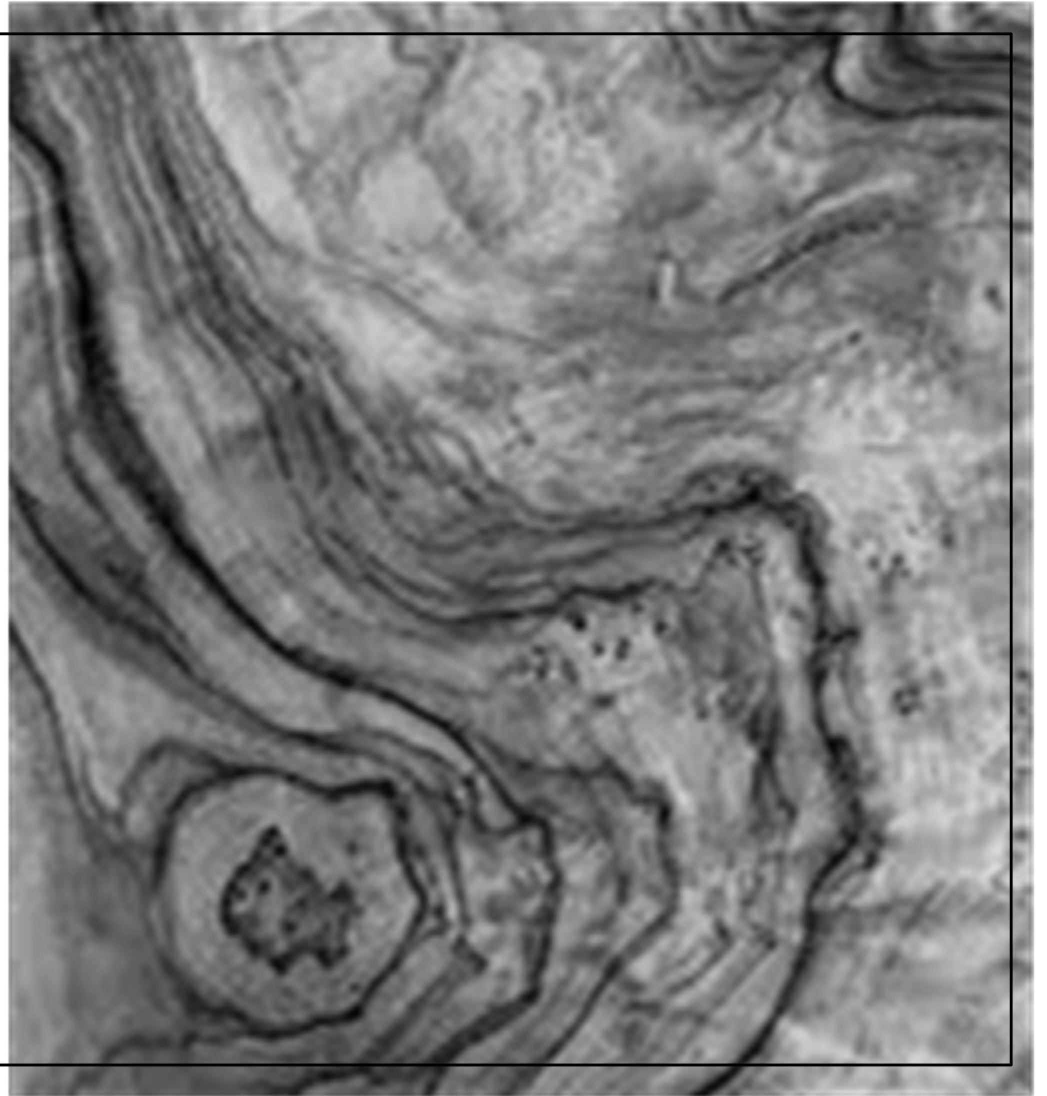
How to be effective in working with Denial



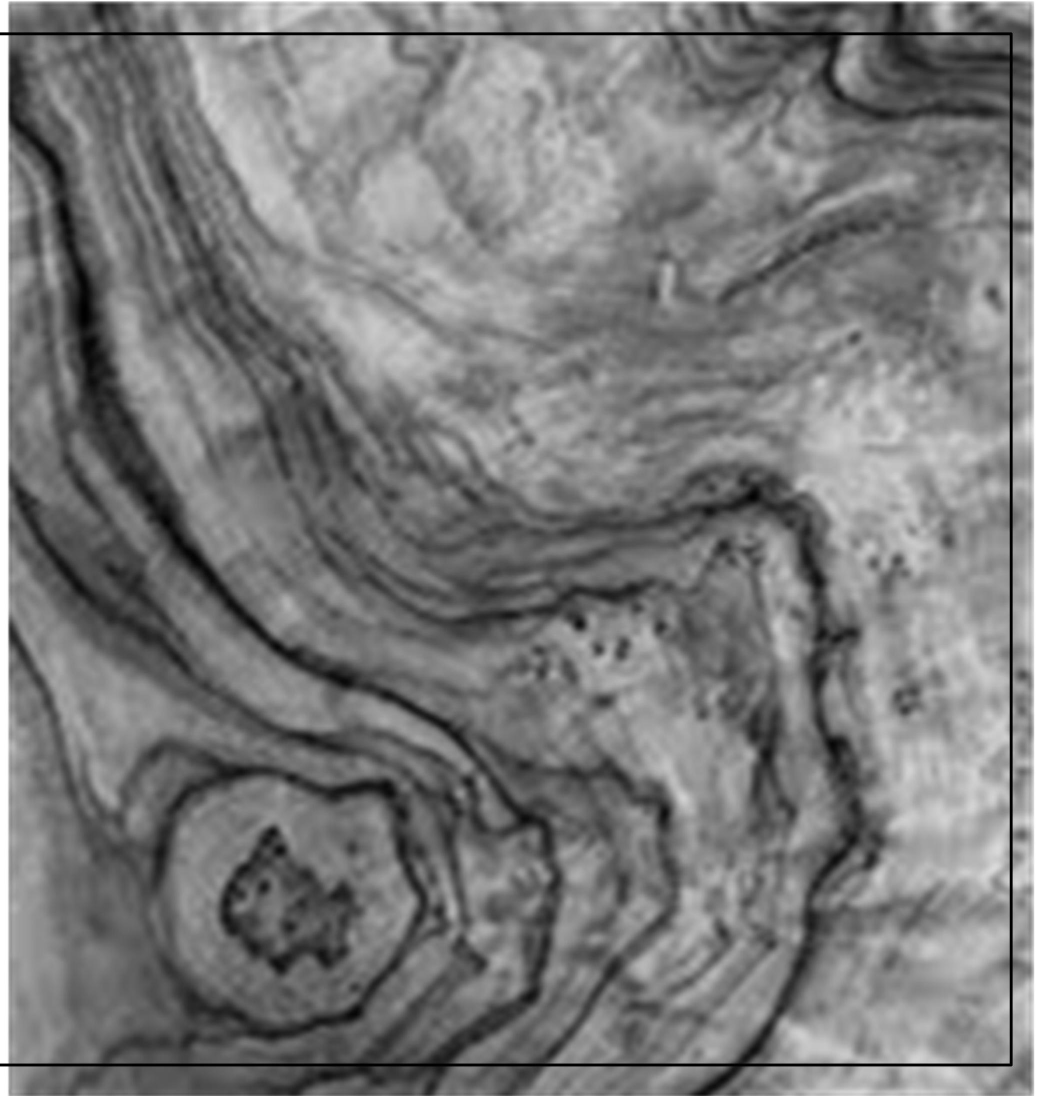
How do you feel when someone is denying in your work?



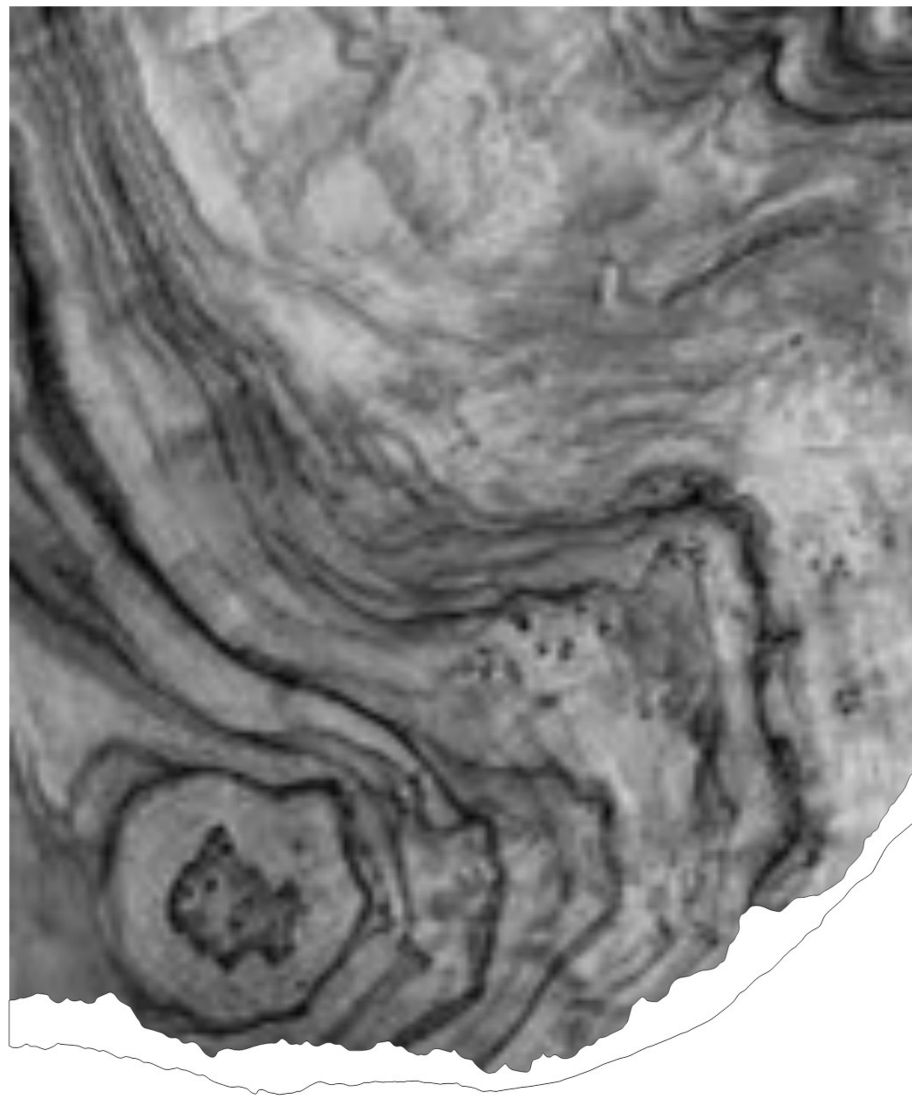
Is it better if their denial is plausible?



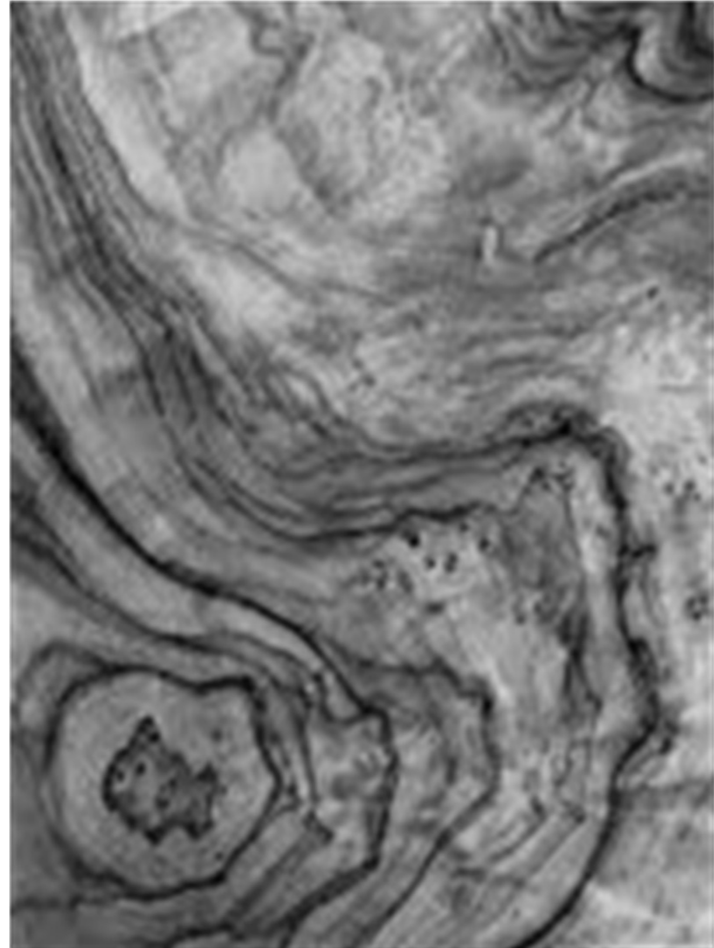
What if their denial is a ridiculous assertion?



What has surfaced for you right now when thinking about working with someone who is in denial?

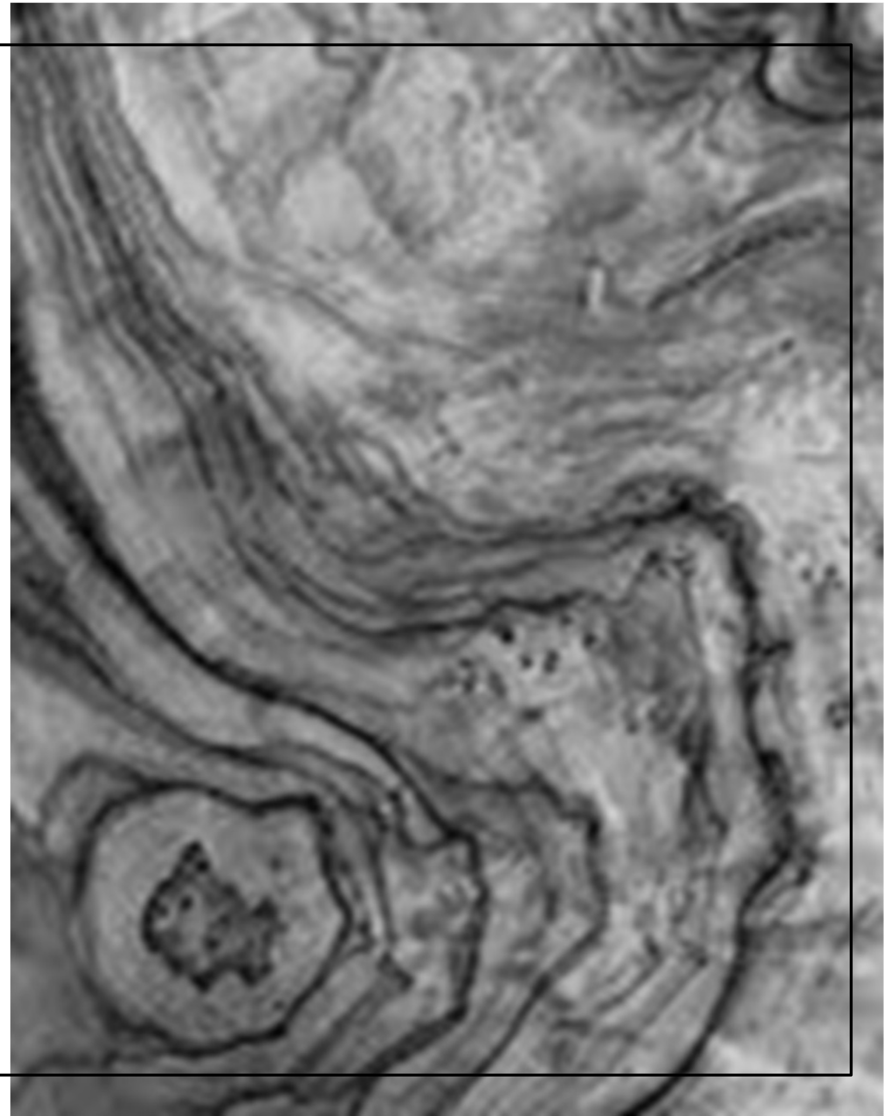


Unmanaged negative countertransference will drive confrontation and not produce transparency.



Denial

- Can be a psychological defense
  - *Shame*
  - *Fear*
  - *Self-esteem*
  - *Cognitive dissonance*
- Is common
- Is understandable
- Not necessarily malicious or pathological



Denial can also stem from:

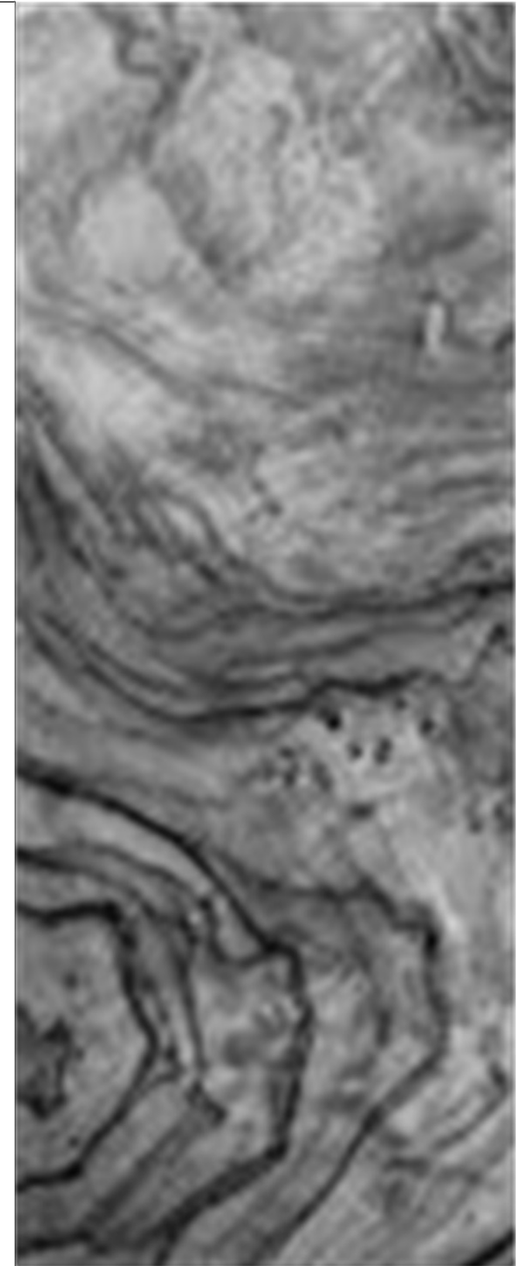
Distrust of staff.

Negative treatment narratives.

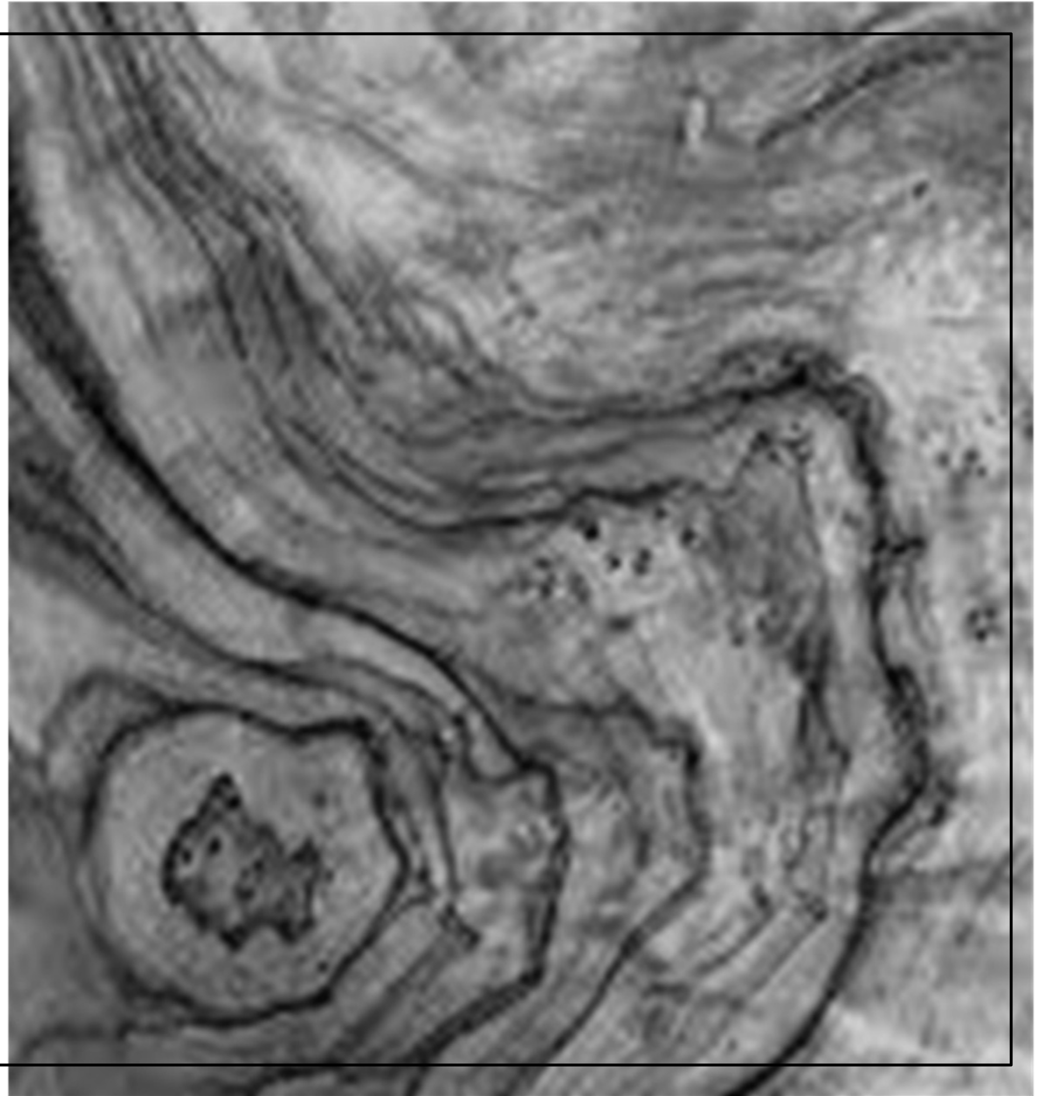
Perceived irrelevance to personal issues.

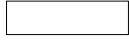
Fear of stigma.

Misunderstanding treatment goals.



Do you believe someone may change without admission?





Accountability and Ethical Tension

Accountability and Ethical Tension

- Clinicians value accountability for therapeutic and moral reasons.

- However, requiring admissions conflicts with principles of autonomy and equitable access to treatment.

(Levenson, 2010)

Ethical considerations

<u>Autonomy:</u>

Clients have the right to self-determination and to choose the extent of disclosure. *Forced admissions are coercive.*

<u>Beneficence:</u>

Treatment benefits clients by reducing harmful behavior and improving well-being. *Denying treatment to categorical deniers may deprive them of these benefits.*

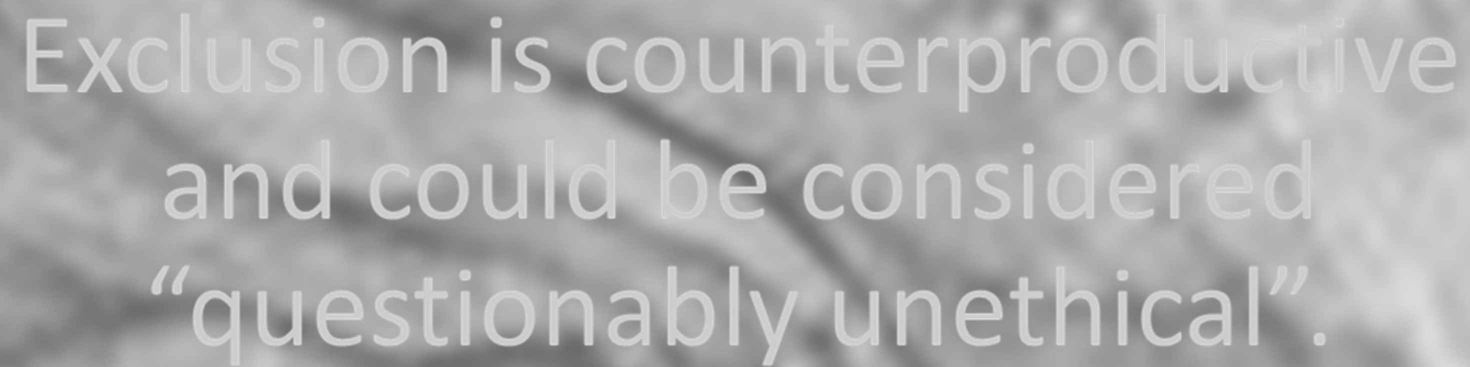
<u>Nonmaleficence:</u>

Clinicians must avoid harm. *Colluding with secrecy, planning treatment around a crime not acknowledged, or coercing admissions can each cause harm.*

<u>Social Justice:</u>

All clients must have fair access to treatment. *Automatically excluding deniers can violate justice and reinforce biases.*

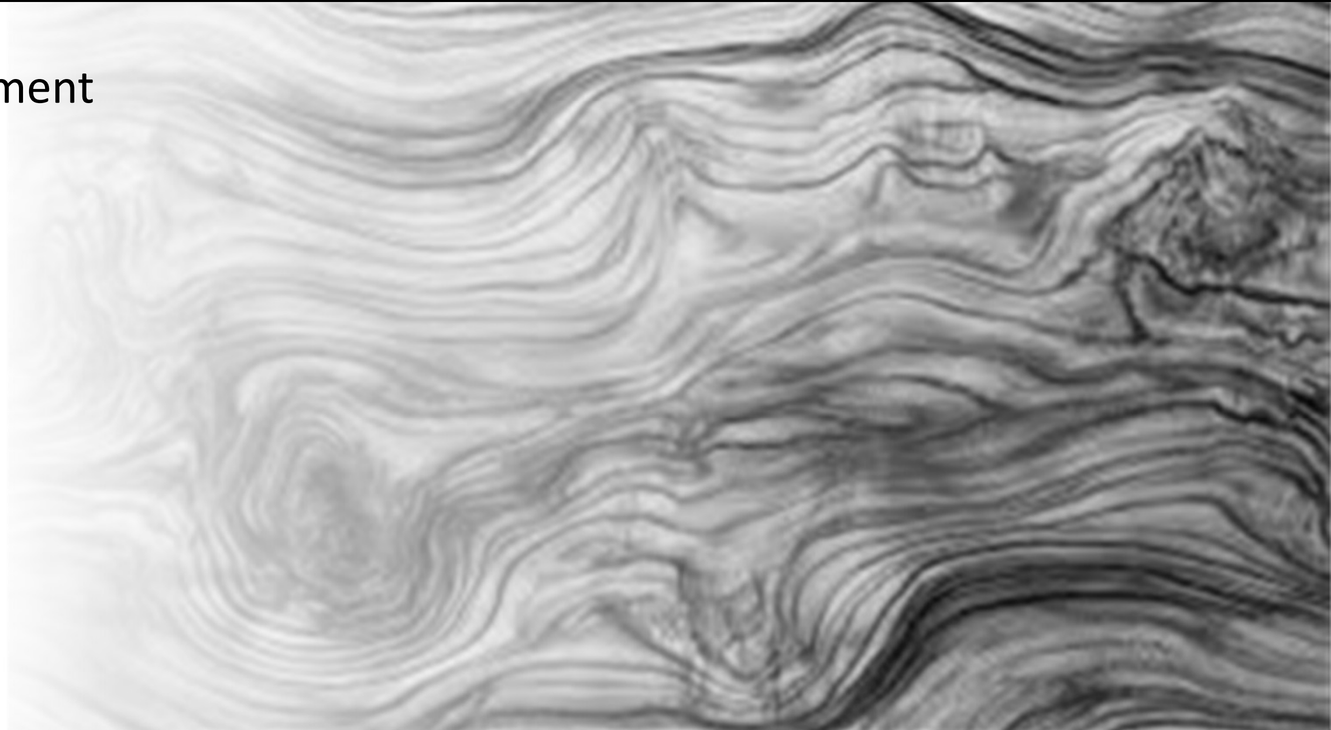
(Levenson, 2010)



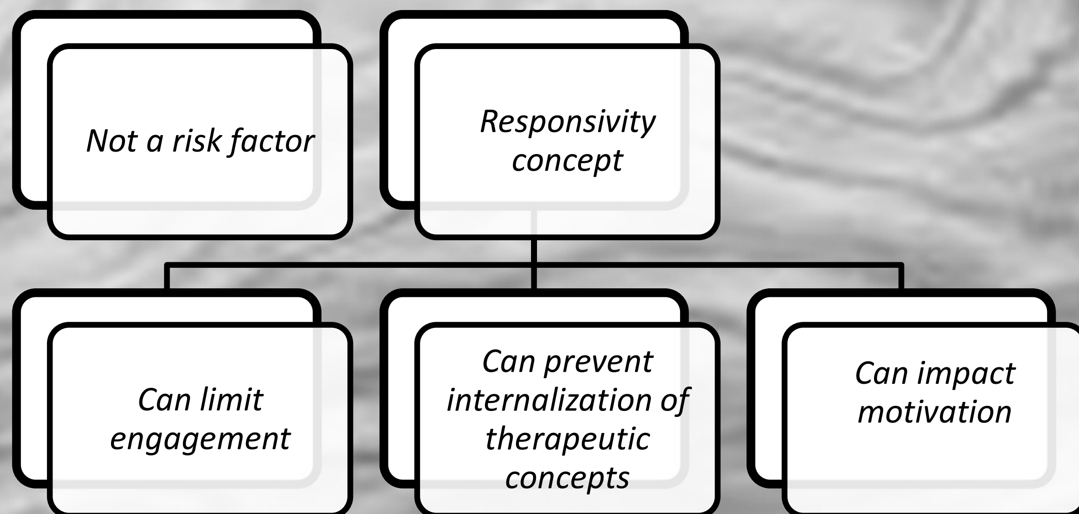
(Levenson, 2010)

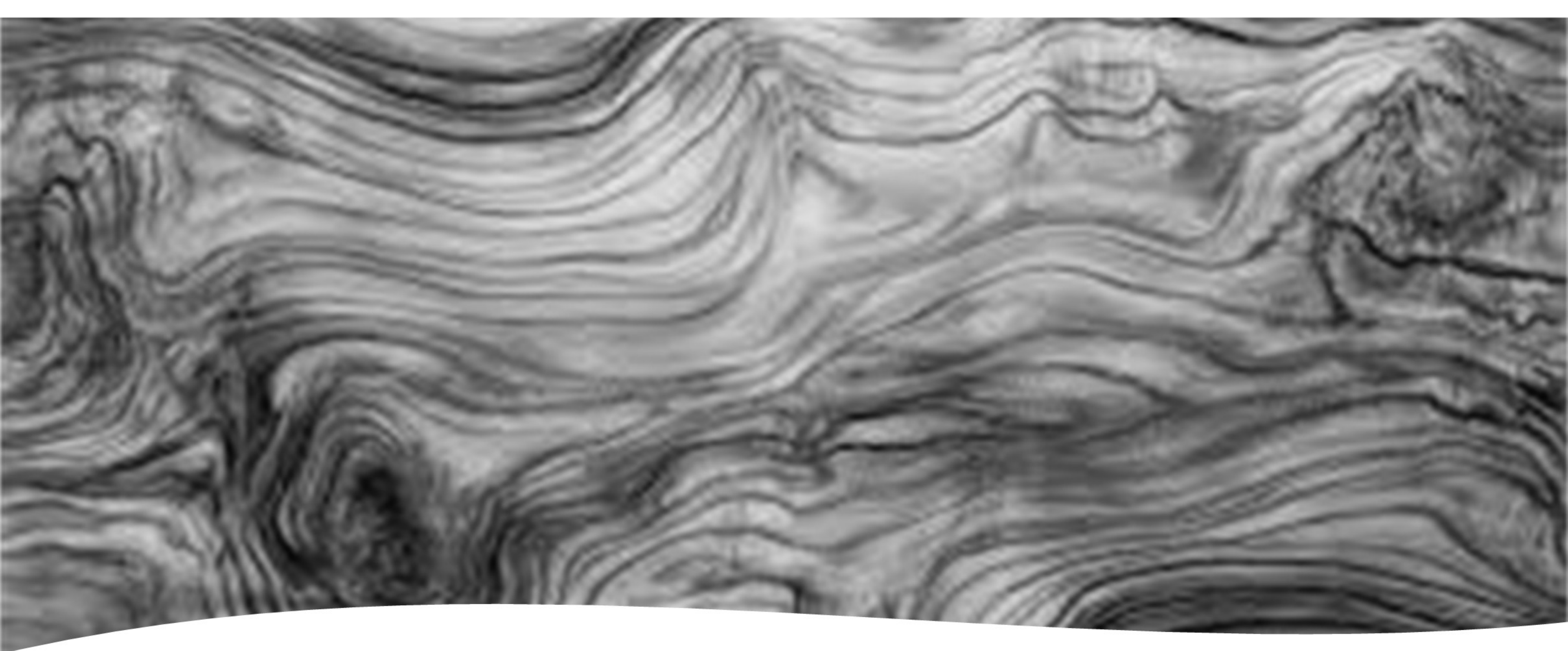
Shifting Our Perspective

Denial in Sexual Offense Treatment



Denial in Sexual Offense Treatment





Ineffective Responses

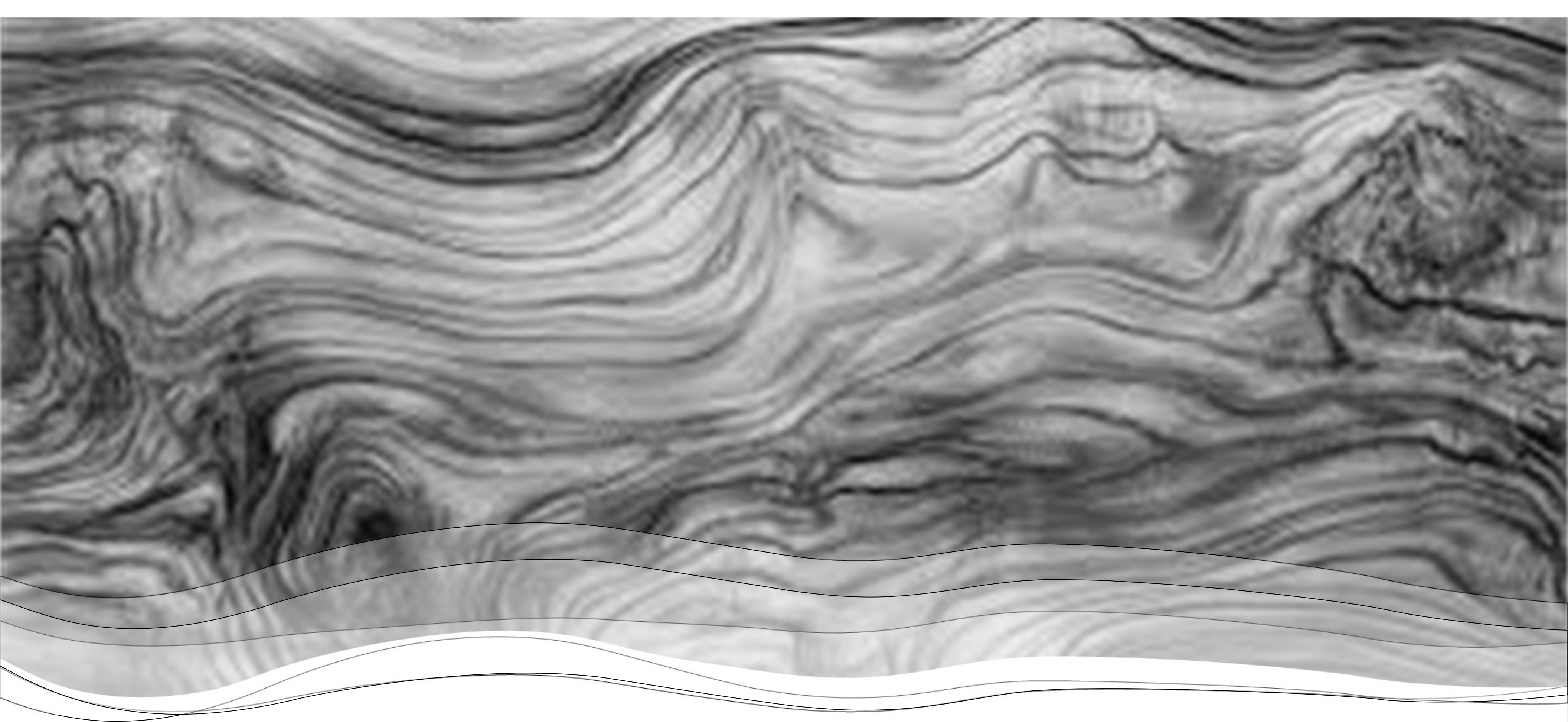
Confrontation increases defensiveness

- *Admission-required programs are harmful*
- *Excluding deniers reduces public safety*
- *Directly aiming at denial in treatment as a change target*

Denial in Sexual Offense Treatment

Requires adaptation on how to deliver treatment with that individual

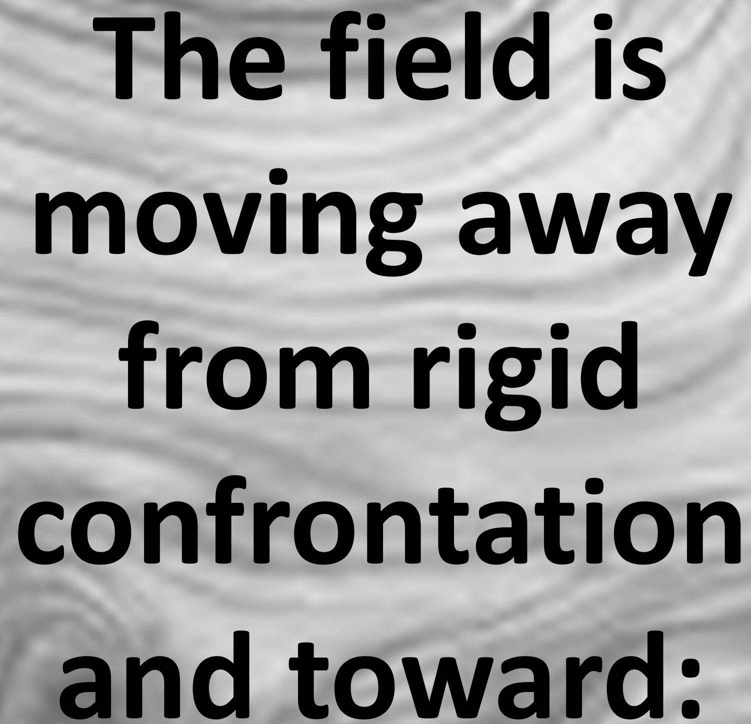
Deniers still have criminogenic needs/dynamic risk factors.



What is your goal in the work you do?

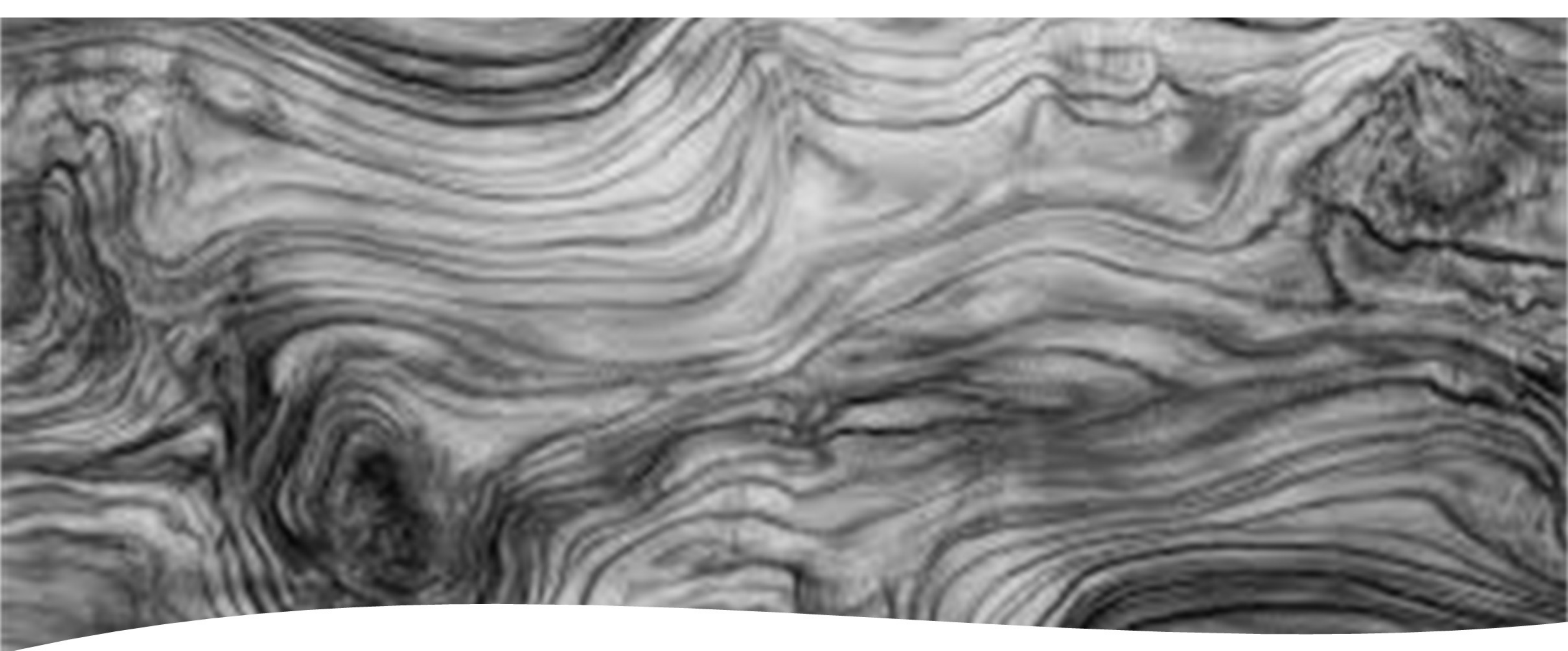
RNR Purist

- Denial is not a risk factor
- Denial as responsivity factor
- Who is my client?
- What is my role/job?
  - *Reduce the likelihood that my client will recidivate (promote public safety)*
  - *Help my client build a "good life"*



The field is moving away from rigid confrontation and toward:

- Person-centered, relational approaches.
- Allowing clients to remain in denial without being removed from treatment.
- Greater flexibility, strengths-based models, and trauma-informed care.



Effective Treatment Approaches

- Motivational interviewing
- Warm, collaborative alliance
- Skills training & emotion regulation
- Focus on future risk + protective factors

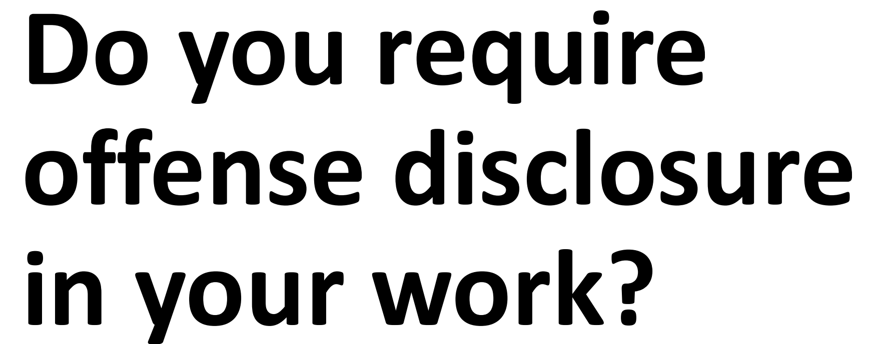
Working Around Denial – so what do you do?

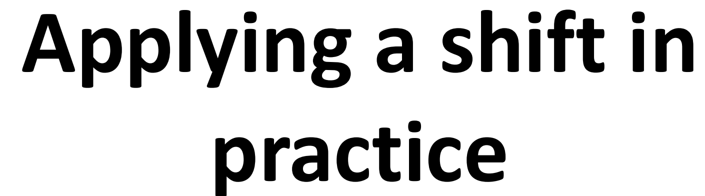
- Foundational step: rapport building
- Transparency
- Informed consent
- Collaborative goals
- Genuine curiosity
- Trust not confrontation facilitates change

Full admission NOT required

- *Marshall's Categorical Deniers Program: strong outcomes*
- *Address risk factors without offense recounting*
- *Focus on skill building – emotion regulation, problem solving, coping, interpersonal relationship*
- *Focus on building protective factors*

(Marshall et al., 2011)


Do you require
offense disclosure
in your work?



Aiming to identify DRFs:

What was going on in your life that people believed you could do this?

Follow up: Genuine curiosity of DRFs and PFs

Education on DRFs & PFs

Collaborative goal identification:

What do you think the Court (decision maker) would like to see you work on/change?

Offering choice regarding sexual interest and arousal

Support emotional regulation

- *Address shame and fear*
- *Strengthen identity + relational functioning*

Restorative Justice Context

Assess offender readiness

- *RJ must be survivor-led*
- *Screen minimization/ pseudo-remorse*
- *Genuineness*

Implications for Treatment

Denial should not automatically exclude individuals from treatment.

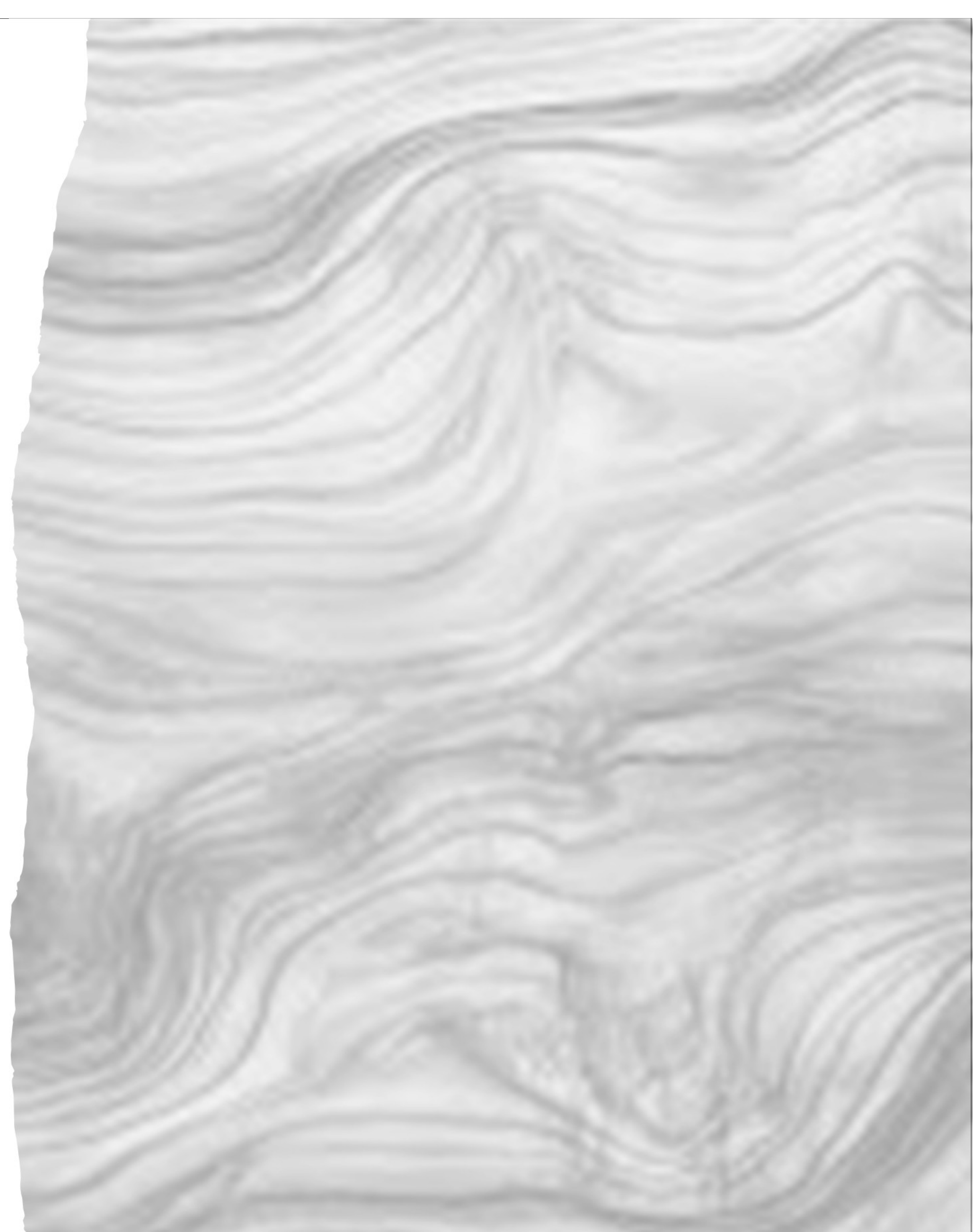
Clinicians should focus on underlying schemas and treatment targets (e.g., hostility, emotion regulation, interpersonal functioning), which do not require admission of guilt.

Positive identity narratives should be supported, not prematurely dismantled.

Denial may serve as scaffolding that can loosen naturally as the individual develops psychological stability.

Summary

- Denial is a complex, meaningful, and often self-protective process.
- Treating denial as a barrier to services is clinically limiting and unsupported by evidence.
- A more nuanced understanding allows for effective therapeutic engagement without requiring disclosure.
- Denial is normal & functional
  - *Effective treatment works without admission*
  - *Responsivity lens improves outcomes*
  - *Supports humane, evidence-based practice*



Roundtable Discussion on Practices

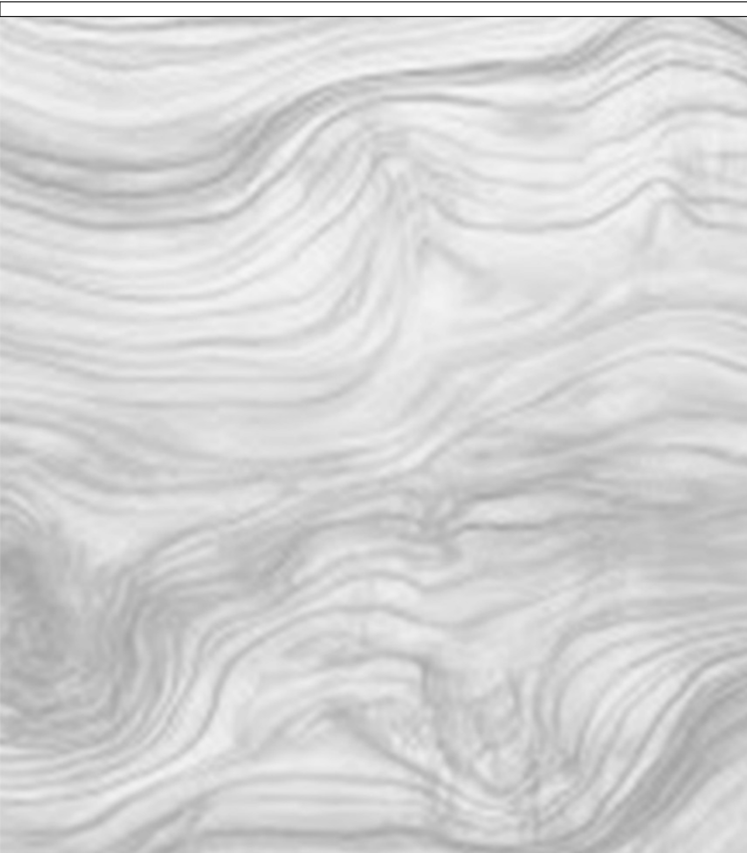
- How do you view denial?
- How do you address in treatment?
- Is accountability a treatment target?
- Does client need to be accountable prior to beginning sex offense treatment?
- Can a client successfully complete treatment in categorical denial?

Working Around Denial: Clinical Checklist

The goal is risk reduction, not confession. Denial may soften naturally as skills, emotional regulation, and identity stability improve. RNR does not require denial to resolve for treatment to be effective.

Denial is not the enemy—risk is. RNR-aligned practice focuses on reducing dynamic risk factors through engagement, skill development, and responsivity-informed delivery. This approach best protects the public, supports victims, and maintains ethical integrity.

Checklist Part 1: Context & Environment



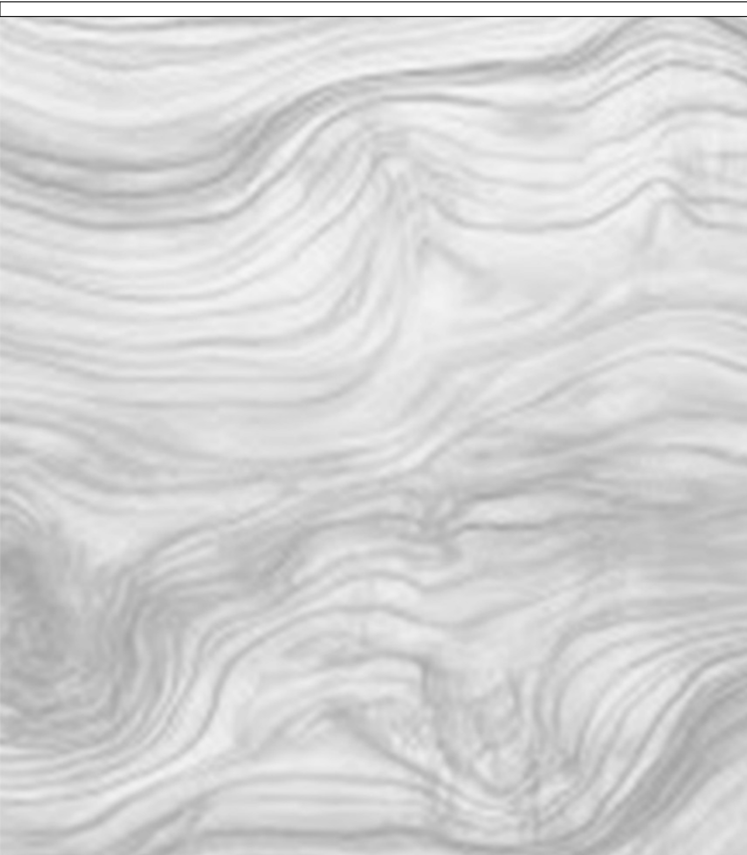
1. Context & Role Clarification

- Who is my client?
- Any dual-role issues?
- Licensing, legal, ethical responsibilities?
- Treatment vs. assessment?
- Informed consent established?

2. Programmatic & Environmental Factors

- Length of program?
- Impact of denial/admission on reintegration?
- Policies that may punish denial?

Checklist Part 2: Impacts of Denial



3. Evaluation of Countertransference (CT)

- *Clinician self-awareness is essential when working with denial. Unmanaged countertransference can unintentionally shift treatment toward confrontation, coercion, or premature demands for admission, undermining engagement and ethical practice.*

4. Understanding the Function of Denial

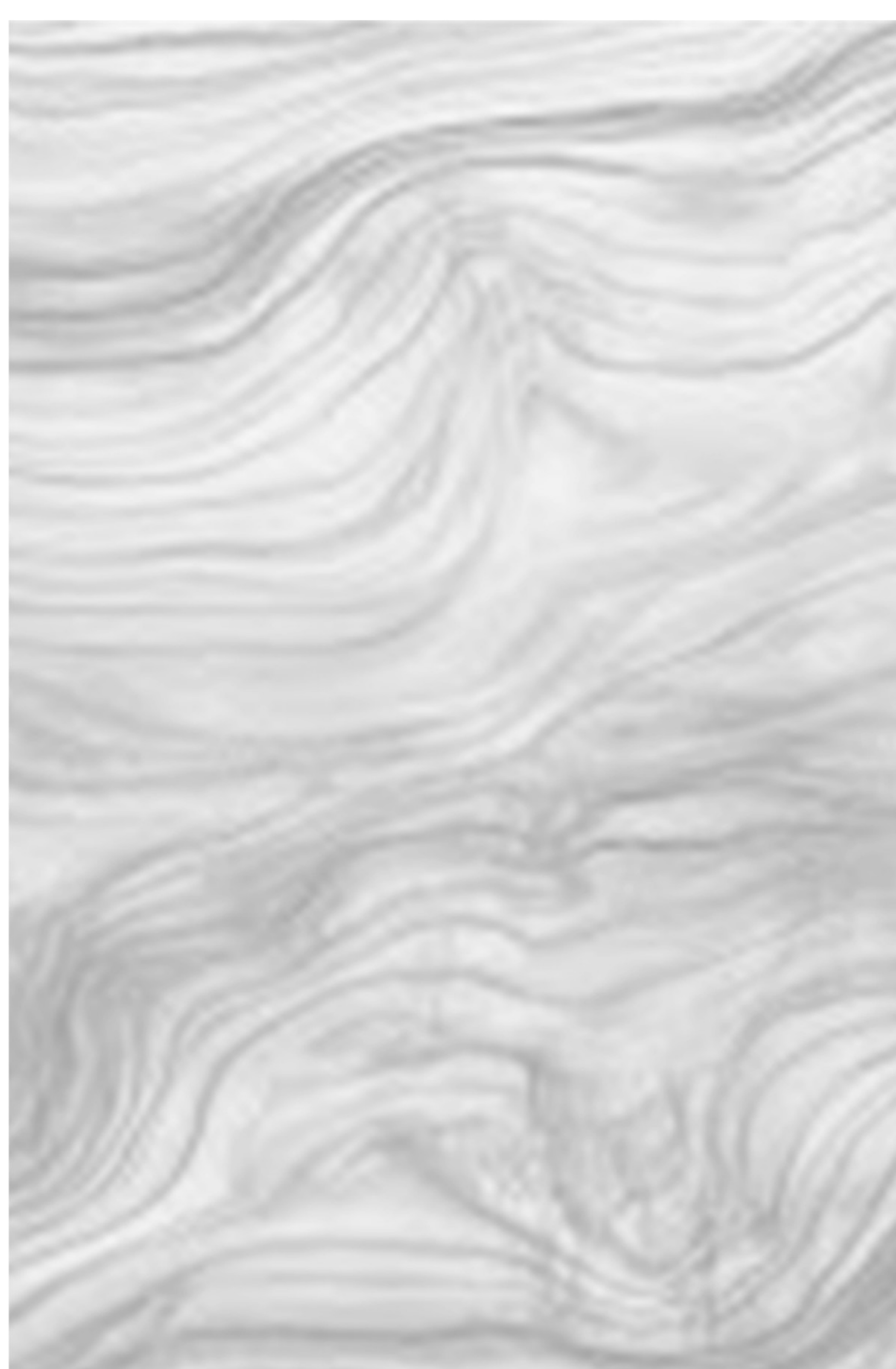
- Function (shame protection, prosocial identity, trauma avoidance)?
- Denial as responsivity, not risk.

Clinician Countertransference & Denial

- Denial often evokes strong clinician reactions (frustration, urgency, moral pressure).
- Unmanaged countertransference increases confrontation and reduces transparency.
- The plausibility of denial can bias clinical judgment.
- Countertransference management is essential to ethical, effective treatment.

Countertransference Quick-Screen (Pause & Reflect)

What emotions am I experiencing right now?
Am I feeling pressure to push for admission?
Is my response driven by risk management—or discomfort?
Would another clinician respond differently?
Does this intervention advance skill-building and safety?



Countertransference Management Strategies

Seek consultation or supervision when strong emotional reactions arise.

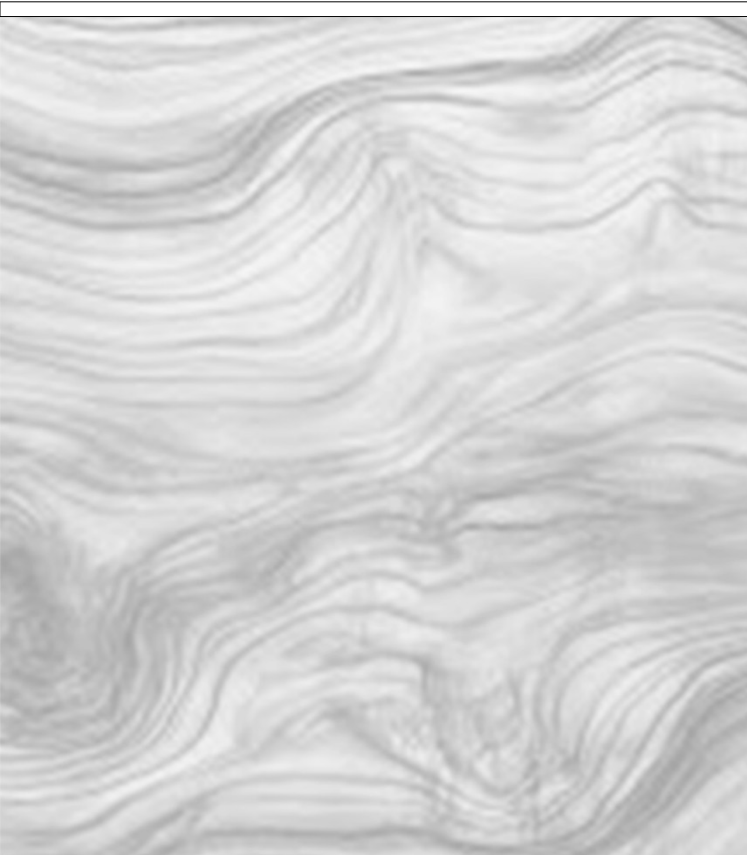
Slow down treatment pacing when urgency to confront appears.

Re-anchor treatment goals to dynamic risk factors and protective skills.

Use curiosity-based questions rather than persuasive or corrective statements.

Document reflective decision-making when choosing not to pursue admission.

Checklist Step 3: Goals, Alliance, and Safety



5. Collaborative Goal Setting
- Client goals?
- Clinician goals?
- How do these overlap as shared goals?

6. Treatment Fit & Progress
- Can DRFs be addressed without admission?
- Is denial a barrier?
- *Would admission change treatment?*
- Client willingness to work on DRFs? Prioritize based on length of program

7. Alliance & Responsivity
- Warmth, empathy, collaboration?
- Avoid confrontation or requiring admission.
- Use MI, trauma-informed work.
- Build future-focused skills.

8. Risk & Safety Considerations
- Any victim-blaming?
- Grievance thinking increasing?
- Costs of pushing for admission (false admissions, rupture, shame).

Executive Summary: Working Effectively With Denial

- Denial is not a risk factor for sexual recidivism; it is best conceptualized as a responsivity issue.
- Effective treatment can proceed without offense admission by targeting dynamic risk factors and protective factors.
- Confrontation and admission-required models increase disengagement, false admissions, and ethical risk.
- Clinicians must actively assess and manage countertransference when denial evokes frustration or urgency.
- Prioritize skills over stories, future safety over confession, and engagement over compliance.