Treating a sexual offender who categorically denies committing the offense

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ABSTRACT

This case study describes a strategy for treating a sexual offender who categorically denies committing the offense. These offenders usually refuse to participate in treatment or are deemed ineligible or unsuitable for sex offender treatment programs on the basis of their denial of responsibility. The treatment approach outlined in this case study reflects an adaptation of conventional sex offender treatment programs such that the focus is on the problems in the offender's life which led to him to be in a position where he could be "accused" of an offense. This case study demonstrates how an offender who was categorically denying responsibility for his offending was engaged therapeutically in treatment. Treatment implications of this approach are discussed.

1 THEORETICAL AND RESEARCH BASIS

It should come as no surprise that an individual accused of sexual abuse will deny aspects of the sexually abusive behavior. There are plenty of reasons why this may occur. Lord and Wilmott (2004) interviewed offenders who were admitting to their offenses after having denied then initially. They found that the reasons why these sexual offenders had denied committing their offenses could be categorized into three psychological processes; (1) low motivation or a lack of insight, (2) threats to self-esteem and self-image, and (3) fear of negative, extrinsic consequences such as losing their family and friends (to whom they had previously maintained their innocence). These sorts of reasons match those which we routinely see within our respective clinical experiences. It is worth noting that

denial is often viewed as a common and understandable coping strategy outside of forensic settings (see Kendell, 1992).

The concept of denial is also multifaceted (Marshall, Marshall, Serran, & Fernandez, 2006). Sexual offenders may minimize or deny aspects of their behavior (i.e., denies planning/fantasizing/harm to victim), may partially deny responsibility (i.e., denies having a problem or that he needs treatment), or they may completely or adamantly deny committing the offense. Denial in these various forms is characteristic of sexual offenders. Barbaree (1991), for example, described 98% of all sexual offenders within his sample as either denying or minimizing to some degree. Kennedy and Grubin (1992) found that one third of treatment participants denied involvement in their offenses. Marshall (1994) found that 32% of a sample of sexual offenders significantly minimized aspects of their offending while a further 31% completely denied having offended.

Those offenders who completely deny committing the sexual offense tend to either claim memory loss or believe they were falsely accused or were mistakenly identified. The management and treatment of these offenders has posed significant difficulties. These offenders usually refuse to participate in treatment or are deemed ineligible or unsuitable for conventional sex offender treatment programs on the basis of their denial of responsibility. The assumption being that admitting to the offense is a necessary pre-requisite for successful treatment progress (Schneider & Wright, 2004). Consequently, deniers are often refused release by parole authorities on the basis of being untreated, are

incarcerated for longer periods of time than is necessary, or are otherwise viewed as "resistant" or "problematic" by those within correctional systems.

Serran and Marshall (2005) have discussed the issues pertinent to treating offenders where they claim no recall of the offense and have outlined a specific treatment strategy called the "Memory Recovery Technique". The treatment of sexual offenders who state categorically that they did not commit the offense appears to have taken a number of forms with varying levels of success (Laws, 2002; Marshall, Thornton, Marshall, Fernandez, & Mann, 2001).

Strategies for overcoming categorical denial have included intensive or "aggressive" community supervision for offenders partly at least because they have not received treatment (Laws, 2002). However, the evidence suggests that this is not an effective approach (Gendreau, Goggin, Cullen, & Andrews, 2000). Other strategies have focused on pre-treatment motivational approaches, either through individual motivational interviewing (Mann, Ginsburg, & Weekes, 2002; Miller & Rollnick, 2002), individual assessment feedback procedures including the results of phallometry (Bradford & Greenburg, 1998), or group based approaches specifically aimed at overcoming denial (Brake & Shannon, 1997; O'Donohue & Letourneau, 1993; Schlank & Shaw, 1997). The evidence for each of these approaches is limited. Another strategy is to simply offer sexual offenders who categorically deny committing offenses entry into conventional sex offender programs alongside those who admit to their offending. This assumes that they will volunteer for this treatment which in our clinical opinion is very unlikely. Indeed, it

is our experience that in most treatment centers these offenders are more likely to be excluded or discharged from treatment.

Two further issues are fundamentally important. Denial and minimization of offending has not been reliably linked to recidivism risk (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004) nor has it been reliably demonstrated to predict within-treatment gains (Beckett, Beech, Fisher, & Fordham, 1994; Kennedy & Grubin, 1992). Secondly, treatment for sexual offending has been shown to be effective (Hanson et al., 2002; Losel & Schmucker, 2005; Marshall & McGuire, 2003), therefore it can be assumed that treatment does not need to produce changes in an offender's denial in order to be effective.

The following case describes a strategy for treating a sexual offender who categorically denies committing the offense. It reflects an adaptation of conventional sex offender treatment programs such that the focus is on the problems in the offender's life which led to him to be in a position where he could be "accused" of an offense. Accordingly we have developed an approach where the focus is on helping the offender prevent any further "allegations", and in so doing, we target the same relevant criminogenic needs (Andrews & Bonta, 2003) as would normally be addressed (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). The earlier description of the approach (Marshall et al., 2001) did not provide any evidence of its value so the current case description is the first illustration of its effectiveness.

2 CASE INTRODUCTION

"James" (not his real name) is a Caucasian 42-year-old male who was convicted in 1997 of sexually abusing a 16-year-old developmentally disabled male. The victim was approached while delivering newspapers and coerced into a nearby secluded school grounds. He was anally raped while being forcefully held down. According to police records the victim felt extremely frightened and feared for his life. James received an 11-year sentence and was eligible for parole after seven years.

James completed an intensive sex offender treatment program, but was not granted parole due to a lack of progress. Treatment reports indicated that he took no responsibility for his offending behavior, lacked an understanding of his offense process and as a result was not able to develop an adequate relapse prevention plan. Moreover, he had not demonstrated any significant gains in other areas of treatment. His presentation during treatment was described as "evasive", "non-disclosing" and "defensive". His release plans were also viewed as problematic.

3 PRESENTING COMPLAINTS AND HISTORY

James maintained that he was wrongfully convicted. He adamantly stated that he was not in the vicinity of the school at the time that the sexual assault was alleged to have taken place, although acknowledged seeing the victim earlier that day. James further claimed that the mother of the victim "set him up" and he said that the victim's brother was the

"most likely suspect". Although James reported that he "hardly knew the family", file information suggests he had associated with the family on many occasions (all of whom were assessed as developmentally delayed or disabled by community agencies). Police records indicated that the time James spent with the family had increased after the father of the victim had died of a physical illness.

Of further note, James's mother and father also strongly believe that their son is innocent. They were present in court and indicated that they believe the evidence given by the prosecution was "limited" and "inexact". His parents support James and believe that the judicial system has treated him unfairly because of his past history and convictions. They referred to the successful appeal against the severity of the initial sentence and statements made by the judge at sentencing as further evidence of this.

James has six previous convictions for sexual offenses over a period of 17 years. These offenses occurred in two different countries. The victims were children aged between 7 to 11 years, both male and female, and for the most part not known to James prior to the sexual abuse. The sexually abusive acts involved rubbing the children's genitalia, on all but one occasion from the outside of the victim's clothes. James received mostly community sentences with only one prior custodial sentence for these offenses. He served 2.5 years in prison between 1990 and 1992.

James reported attending a prison-based sex offender program during 1991-92 in Australia before being deported back to his country of birth (i.e., New Zealand) without

any support or supervision. Although unwilling or unable to discuss the contents of that program, James reported gaining significant benefits from it however he was not able to clearly state what the benefits were. The current offense occurred within 12 months of his return to New Zealand.

James described his childhood as "dysfunctional" stating that he believed his father to be emotionally unavailable with excessively high expectations, and his mother to be overly critical and dominant. His relationship with his two older brothers appeared to be marked by rivalry and jealousy. He felt like an "outcast" throughout his childhood and was consistently teased by other children, resulting in him feeling lonely, rejected, and inadequate. Even at this early age, it appears that James was most comfortable when with younger children.

As an adult, James continued to fear rejection in both intimate and social relationships. He reported a number of casual sexual encounters with adult females, but only one longer-term relationship (six months duration). James reported that these were proof of his sexual adequacy and abilities. His responses to questions regarding these relationships suggest that they were not emotionally fulfilling, nor were they satisfying. James continued to feel lonely and desired friendships with those who would not "reject" him. He has had few close friends, preferring to spend time alone, or around children at parks, beaches, or in shopping malls. James lacked social skills and always appeared to others to be emotionally expressionless. James' sense of self-esteem and self efficacy was low.

James was clearly sexually preoccupied for many years. He viewed pornography regularly, used sexual fantasy and masturbation to cope with negative emotions (particularly loneliness and anger), and appeared to repeatedly think about children in a sexual manner. James was adamant that he had ceased viewing children in these ways, although he acknowledged still feeling most comfortable with children.

It appears that James' sexual offending was most likely to occur when he experienced relationship difficulties. At these times, James would feel rejected and lonely. He felt unable to cope with these feelings and would seek to isolate himself at these times. He would "go for walks" almost always to parks or beaches. At these public areas, James would seek to befriend children. James said that in these circumstances he felt emotionally safe, accepted, and comforted.

4 ASSESSMENT

James was assessed as a high risk sexual offender on the basis of the STATIC-99 risk assessment instrument (Hanson & Thornton, 1999). A comprehensive battery of standardized tests were administered as part of the sex offender treatment program which James recently completed (Hudson, Wales, & Ward, 1998). Pre- and post-group treatment assessments revealed almost identical results. Consistent with James's presentation, there were limited changes after treatment on a variety of instruments measuring a broad range of issues.

5 CASE CONCEPTUALISATION

James volunteered for sex offender treatment after six years of incarceration and this occurred just before his first parole board hearing. When asked what he expected to gain from treatment, James replied "early release" and continued to adamantly state that he was innocent of these convictions. In fact, he was initially unwilling to enter treatment until he was told that he could work on the thoughts, feelings, and behaviors related to his earlier sexual convictions (to which he admitted) rather than those related to his latest conviction.

James's initial treatment progress after commencing a high intensity group-based treatment program was best described as limited. He maintained his innocence with respect to his most recent offense at every opportunity and was increasingly evasive and defensive when asked questions about his previous offenses. Instead, James preferred to focus on the deficiencies in the court case relating to his current conviction. James stated that he was "wary" of the therapist trying to "trick" him into discussing things from his past as a way of gaining a confession about his current offenses. He subsequently externalized responsibility for all of his past behaviors (i.e., blamed the victims), blamed his previous offending on a lack of support/treatment, and participated minimally within the group treatment context. Reports indicate that the therapists were concerned over the effect James's poor participation was having on other members of the treatment group. It

is clear that James' continued evasiveness had a detrimental effect on his treatment progress.

James completed the 8- month treatment program but received a very poor report at its conclusion. On the basis of this report, the Parole Board stated emphatically that it would not release James until he had made satisfactory treatment progress specifically addressing his most recent offense (which he continues to deny). The Parole Board noted the significant escalation in his sexual offending (from touching to penetrative intercourse) and the apparent lack of treatment progress.

This created a case management dilemma. James was a high risk sexual offender who had not benefited from treatment; largely it seems, due to his continued denial of responsibility and culpability for this offense. It appeared unlikely that James would benefit from repeating the same treatment program but it was clear that without some form of treatment he would not be released from prison until his sentence expired. If he was to be released to the community at warrant expiry he would not have any supervision, no restrictive conditions could be applied, and he would have no structured support. Clearly this was not ideal and an effective resource efficient solution to this dilemma had to be found.

Our preferred approach with sexual offenders who categorically deny responsibility for their offenses is to adapt a conventional sex offender program so that the risk factors associated with sexual offending are addressed without participants needing to admit to

the actual offending (see Marshall et al., 2001). Instead, it is the risk factors that the offenders need to take responsibility for. Conventional sex offender treatment programs target the following issues: self-esteem, acceptance of responsibility, offense pathway understanding, self- and affect-regulation, coping styles/skills, relationship and social skills training, sexual interests, and self-management and release/reintegration planning. Other offense-related targets (e.g., substance abuse, anger management) are often included either within the treatment program itself or by way of other specialized programs.

The treatment targets of a program for deniers should address all of these issues with the exception of acceptance of responsibility. Within these components, the goal is to help the offender identify problems in his life that led him to be in a position where he could be accused of sexual offending. These problems may have been longstanding and indirectly relevant (i.e., relationship or intimacy difficulties), or immediate precursors to the "alleged" offense. The former problems are what have been described as "stable dynamic risk factors" while the latter represent "acute dynamic risk factors" (Hanson & Harris, 2000). In this deniers program it is suggested to the offender that it may have been something about his behaviors, attitudes, thoughts and feelings, within the situations that led to the allegation, and may therefore lead to more allegations in the future unless he is able to modify or manage them. The offender is, therefore, required to take responsibility for these problematic behaviors. This matches what is done within conventional treatment programs. Offenders are taught to recognize warning signs and high risk situations which lead to an offense with the goal being to avoid or manage these

situations. In this sense, from a treatment perspective, what actually happens *during* an offense can be seen as largely irrelevant to the goal of reducing further offending.

The following describes the treatment provided to James with this treatment being derived from Marshall et al.'s (2001) earlier description of a proposed Denier's Program except that it was provided in a one-to-one format rather than a group setting. For the purposes of this article, only the motivational intervention, the disclosure, and offense pathways components will be described in detail. For a detailed description of the other components that were addressed the reader is referred to Marshall, Marshall, Serran, and Fernandez' (2006) description of their treatment program for admitting sexual offenders.

6 COURSE OF TREATMENT AND ASSESSMENT OF PROGRESS

James completed 18 individual 1-hour sessions over the course of four months. These sessions initially focused on identifying the behaviors, emotions, and problems that led James to be in a position to be accused of a sexual offense. It took a substantial amount of therapeutic effort to overcome James' fear that his treatment was aimed at getting him to admit responsibility for the most recent offense. James became more cooperative and was able to identify various problematic issues in his life, including his decision to be in the near vicinity of the victim's paper route. Therapeutic efforts after the successful identification of these various issues, was aimed at helping James acquire the attitudes, skills, and emotional and behavioral self-regulation that hopefully would increase his

capacity to meet his needs in prosocial ways. Since James had already spent some time focusing on these issues in the previous treatment program, despite the fact that he showed little change, it turned out that extensive treatment addressing these issues was not required. Once he felt at ease in treatment James made very good progress in all aspects of treatment.

Motivational intervention

James was initially very reluctant to consent to further treatment. He stated repeatedly that the "system had failed him" or that he had been "picked on" by therapists and treatment group participants alike. Using motivational interviewing techniques (Miller & Rollnick, 2002; Mann & Ginsburg, 2002), James was offered the opportunity to complete further treatment under agreed upon conditions. It was agreed that under no circumstances would the therapist discuss the current offense, nor would the therapist attempt to challenge James' denial. James was told that treatment would instead focus on helping him to develop an understanding of the contextual and psychological factors that together resulted in him being "wrongfully convicted". Once this understanding was developed, James would then be supported in developing plans and strategies so that he would not allow himself to get into a psychological state, or place himself in a situation, when he could be "falsely" accused again. It was suggested to James that he *must* have acted in ways which allowed for an allegation to be made, otherwise the police and the courts would either not have pursued the matter or would have found him not guilty. James was told that if he developed more effective ways of dealing with the problems

that plagues his life (i.e., loneliness and poor coping skills as well as low self-esteem) he would be unlikely to ever find himself in a situation where he could be falsely accused. It was suggested to James that it must have been something about his attitudes, feelings, behaviors, and the situations he placed himself in that led to the possibility of a false allegation being made. The therapist told James that given his previous history, it was in his best interest to be even more vigilant in the future with respect to the behaviors that led to the allegation.

James was also told that his difficulties in his previous treatment had unfortunately prevented him from gaining all of the positive benefits of the program. He was encouraged to consider working on his self-esteem, relationship and intimacy skills, emotional and sexual self-regulation skills in a context where he could trust the therapist. It was suggested that this would help him lead a more positive and satisfying life which would thereby reduce his risk of being falsely accused again.

This motivational approach was critical in this case. James' adverse treatment experiences left him to be wary of further treatment. It was necessary to increase his motivation and belief in the benefits of treatment in order to commence an individual treatment program adapted to accommodate his categorical denial. It was also important for the therapist to demonstrate positive therapist characteristics (warmth, empathy, rewarding and directiveness; Marshall et al., 2003), to commence the development of a therapeutic alliance, and to assist James in believing he could actually benefit from treatment. It also apparently had the initial effect of reducing James' tendency to want to

discuss the “wrongful” conviction as he had done so previously. James cautiously agreed to individual treatment as long as it was agreed that he did not have to talk about an offense that he claimed he did not commit.

Disclosure component

The disclosure component is usually one of the first tasks of treatment. Of course in the case of a categorical denier, this disclosure does not involve presenting the details of the offense but rather only the factors that led to the offense. Identifying these precursors to the offense illustrates the issues that need to be addressed in treatment. For example, it may be that the offender was feeling lonely and isolated from other adults, or it may be that he was not coping well with various problems in his life. These factors may cause an offender to seek solace, or release anger, through sexual abuse.

Whereas an offender is usually asked to tell the treatment group about his offense, James was asked to discuss what had happened on the day when the offense took place with a view to understanding how he could have been falsely accused of sexual abuse. Initially James took the opportunity to again blame the victim’s brother for the abuse. The therapist gently encouraged James to consider how it was that *he* was accused of the offending not the brother, pointing out that it may have been because of the ways in which James had acted. At that point James agreed to discuss his behaviors on the day of the offense. In an encouraging and supportive manner, the therapist continued to ask further questions, each designed to elicit details regarding the thoughts, feelings, and

behaviors that preceded the alleged offense. The therapist actively rewarded each detail of this disclosure and maintained a collaborative stance. Throughout this process the therapist repeatedly indicated to James that he could see how his behaviors could have led to an allegation. As a result James began to acknowledge this and in so doing began to take responsibility for behaving in problematic ways on the day of the offense.

James disclosed the following. On the day in question he had fought with his parents. He had left the house angry and depressed. Fighting with his parents elicited very strong emotions in James. He felt rejected and punished by them. James also said he had thought about other relationship difficulties that he was having with other adults in general and in particular with a woman who he regarded as a friend. He had taken public transport to another suburb in order to, so James claimed, get away from his parents. James was initially unable to state why he specifically chose to go to the particular suburb where the victim was, except to say that he intended to go for a walk in a large park so that he could think things though. He did, however, see very clearly how this was a problematic strategy on his part. With encouragement from his therapist, James came to recognize that he did not cope with his emotions on that day and that traveling to a different suburb meant that he was alone and without his support persons. As a convicted sex offender, he was placing himself in a situation similar to those in which he had previously offended (i.e., in a public park) while still in a negative emotional state. As treatment progressed James was able to see how his previous offending had taken place only when he was angry or feeling rejected, usually after relationship discord. The therapist gently encouraged James to discuss seeing the victim on the day in question.

James cautiously acknowledged seeing the victim, even talking to him, but then became defensive. Again, the therapist was able to steer James away from this by focusing on what he may have said or done that prompted the victim to falsely accuse him. James stated that he had spoken to him only briefly, but he did acknowledge that this conversation took place within a street of the school where the offense was said to have taken place. James was able to see how even talking to this victim could be viewed as a problematic decision on his part, given the details of his past offending history. James said he felt sorry for the victim because of the boy's disability and loneliness and that he would never hurt him. When asked to expand further, James reported identifying with the boy and enjoying his company. He believed the boy also enjoyed his company.

Offense pathway understanding

The disclosure provided by James presented the therapist with opportunities for further exploration. Even though James was categorically denying responsibility for the offense, he was now acknowledging responsibility for a series of attitudes, feelings, and behaviors that placed him at risk of being accused of offending. The next step was to help James understand the background and situation factors that combined to allow him to act in ways that put him at risk and to help him understand how these same factors had led to his previous offending. Detailing his offence pathway allowed James to see how his prior offending, and the accusation of offending, did not just happen, but rather occurred as a consequence of predictable and explainable events over which he had some control.

James identified a series of background factors that reflected ongoing difficulties in his life, and in his decisions and problematic attempts to cope with these difficulties. He was encouraged to draw parallels between these problems and the different times in his life when he had offended. He was also encouraged to consider times when these background events were present but he did not engage in sexually abusive behaviors or behave in ways where he could be accused of this. This allowed James to build a sense of control over his future life. It also gave him an opportunity to examine the mistaken strategies he had used to cope with difficulties. He came to see that his typical coping response was to actually stay away from people with whom he felt safe and comforted.

In summary then, James identified social and intimate relationship difficulties, feelings of rejection and loneliness resulting in anger and frustration, feeling inferior or inadequate, a sense of helplessness, using sexual fantasy to cope, and seeking to be around younger people where he felt more comfortable, and financial or work stresses as both distal and more immediate background factors. James recognized that he had previously selected victims who he believed were similar to himself; that is he saw them as lonely and in need of comfort. Finally, he was also able to articulate the exact series of situations, thoughts, and feelings, as well as his choice of behaviors, that led to him placing himself in the situation where he was "accused" of offending.

As a result of the factors revealed within the disclosure and offense pathways components, the therapist developed a clear idea of the required treatment targets relating to James' ongoing risk of sexual re-offending. These targets (i.e., those outlined above)

were identified and targeted within the rest of the treatment process. Since detailed descriptions of how these factors area addressed appear elsewhere (see, for example, Marshall, Marshall, Serran, & Fernandez, 2006) we will not elaborate on them here. The aim of this paper was to illustrate how it is possible to therapeutically engage a person convicted of a sexual offense who is categorically denying responsibility for the offending.

7 TREATMENT IMPLICATIONS OF THE CASE

Sexual offenders will invariably deny aspects of their sexually abusive behaviours. Some will even categorically deny responsibility for committing an offense. These offenders are often deemed ineligible or unsuitable for sex offender treatment programs on the basis of their denial of responsibility even though denial and minimization of offending has not been reliably linked to recidivism risk (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2004). Sex offenders may in fact categorically deny responsibility due to threats to their self-esteem or due to other negative extrinsic consequences rather than due to an explicit desire to re-offend (Lord & Wilmott, 2004). Consequently, refusing to treat such offenders does not appear warranted. Treatment efforts which specifically attempt to change this denial have had limited success (Laws, 2002).

This case demonstrates that a treatment approach that focuses on the problems in the offender's life that led to him to be in a position where he could be "accused" of an offense is effective at motivating otherwise "resistant" sexual offenders into treatment. Furthermore, it also allows for the targeting of the same relevant criminogenic needs as

would normally be addressed within conventional sex offender treatment (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). It is our experience that sexual offenders who categorically deny responsibility for the sexual offense do benefit from such a treatment approach. In fact, they complete treatment with similar knowledge and skills as do those offenders admitting their offenses, including a detailed understanding of their risk factors and comprehensive relapse prevention plans.

8 RECOMMENDATIONS TO CLINICIANS AND STUDENTS

Sexual offenders who categorically deny having committed the sexual abuse can be motivated to engage in effective treatment. The treatment targets of a program for deniers are consistent with those of a program for admitters with the exception of acceptance of responsibility (Marshall et al., 2006). When treating a categorical denier, the goal is to help the offender identify problems in his life that led him to be in a position where he could be accused of sexual offending. Given the reluctance and mistrust that these offenders will have initially in treatment, it is imperative that the treatment context reflects an atmosphere of warmth, empathy, rewardingness and directiveness (Marshall et al., 2003). In our view, these offenders can be treated successfully as demonstrated by this case.

Denier's programs based on this approach have been implemented in Canada and are being developed in New South Wales, Australia. An evaluation of the effectiveness of the program at reducing recidivism is currently being completed. It is our view that

sexual offenders who categorically deny responsibility for their offense should and can be treated effectively using the approach outlined (Marshall et al., 2001). Moreover, Laws (2002) summarized this approach and it's value by stating that "This is an extremely clever approach to denial… 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 offense that they say they did not commit in the first place" (p.187).

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