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Men with sexual convictions and denial

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ABSTRACT

Purpose of review

We review the evidence-base for men who categorically deny responsibility for their sexual crimes. Specifically, we consider the characteristics of these individuals and the purpose or function of the denial, whether denial leads to an increased risk of re-offending, and the evidence for different treatment options available for deniers.

Recent findings

Whilst there is some evidence that deniers differ from admitters, it appears that categorical denial is a strategy used to reduce negative consequences such as a sense of shame or the fear of losing family support. The common assumption that deniers are more likely to commit further sexual crimes is not supported by the evidence to date. There remains a lack of evidence as to the best treatment approach to use.

Summary

We conclude that more research is necessary. We suggest that a lack of consideration of the function of denial or the adaptive benefits of denial could explain inconsistent findings in relation to the characteristics of deniers and why denial does not appear related to recidivism. Whilst the available evidence does not support most approaches aimed at overcoming denial, we suggest some of the most promising approaches seem to be non-disclosure-based focusing on reducing stigma, however it is conceded the evidence for such approaches is still emerging.

KEYWORDS: men with sexual convictions; denial, characteristics, risk, treatment

INTRODUCTION

Anyone accused of committing a sexual crime should be expected to initially deny culpability. The list of potential negative consequences to these individuals is wide-ranging and might arise at the time of being accused (e.g., fear of losing the support of family), during the judicial processes (in an attempt to avoid conviction), or after being incarcerated (e.g., fear of being physically harmed). Whilst the majority of men with sexual convictions appear to make excuses for their sexual crimes through omitting or underplaying certain aspects or its consequences, a small number will categorically deny responsibility [1]. These individuals maintain that they are innocent and have been wrongly accused or convicted.

How often, and under what circumstances, categorical denial occurs, remains difficult to ascertain. Incidence rates vary widely depending upon when and where the individual was assessed. Unsurprisingly, categorical denial seems highest for individuals awaiting trial or not yet convicted (e.g., 57%) [2], reduces after conviction and when the individual is in prison (e.g., 21%) [3], and is lower still after treatment (e.g., 7%) [4]. What makes this even more complex is the observation that individuals may admit to some offenses yet maintain their innocence for others, and some who initially admit responsibility change their position later on and deny all allegations. As we will go on to explore, categorical denial, in this sense, may be seen in most of these offenders as perhaps a fluctuating strategy to achieve some advantage rather than as an expression of their true belief [5].

We note that, despite the smaller numbers of categorical deniers, they tend to evoke great concern. Professionals have strong and polarised views about this group of offenders [6], most notably in terms of whether denial equates to an increased risk of recidivism [7], and how deniers can be treated [8], or even if they should receive treatment at all [9]. We will examine the evidence for these issues later, but note here that we believe that these strong views can come from either long-standing personal attitudes held by professionals, or as a consequence of the strong emotions professionals can experience when working with these offenders.

Despite these concerns, it is our view that further research is still needed to clearly understand the nature of denial, the purposes it serves for the offender, how to understand the (lack of) relationship between denial and increased recidivism, and how best to address denial in treatment. Of interest to us, these views echo those reviewers before us who have examined denial. We note here that initial reviews of what was known about men with sexual convictions and categorical denial were completed by Cooper [10] and Yates [11] yet in both

instances these were limited in scope. Ware, Marshall, and Marshall [12] subsequently completed the most comprehensive review to date of men with sexual convictions and categorical denial and we will use their conclusions as our starting point to examine what is known about these individuals.

Before we commence our review, we need to highlight that the research to date has been limited by methodological weaknesses, some of which are yet to be addressed. Researchers have used different definitions of denial often apparently in an attempt to increase sample sizes. Many studies have used small sample sizes, particularly those that have used strict definitions of categorical denial, or have used qualitative methods. In both instances this limits the generalizability of the results. Other methodological issues that limit our understanding of categorical denial include the use of both outpatient and incarcerated samples (where the function of denial may be different) and the examination of denial at different time points, such as prior to or after conviction compared to after treatment (where the incidence rates and function of denial will be different). For these reasons, our advice, similar to that issued by Ware et al. [12], is the reader should cautiously interpret all research examining categorical denial amongst men with sexual convictions.

Notwithstanding these issues, we will briefly state what we know about categorical denial and examine what research has been completed since the comprehensive work of Ware et al. [12]. In the event that no additional research has been completed for certain aspects of categorical denial we will simply establish what we believe are the key remaining research questions. Our review is organised into the following sections: what is known about the characteristics of these individuals and the purpose or function of denial; the relationship of denial and risk of reoffending; and treatment options for these individuals.

DEFINITION AND CHARACTERISTICS OF DENIERS

As noted previously the conflation between denial, minimisations and other cognitive distortions hampers the conclusions that can be made about ‘denial’. This conflation occurs when research does not precisely define denial or when vague or overly inclusive definitions are used. Research has shown that denial and minimisations are related to, but are distinct from cognitive distortions [13]. It has been argued [24] that there are many ‘types’ of denial and that denial is best conceptualised as being on a continuum between the extremes of total denial and full admission, offenders will vary in the level of responsibility they take for their actions. However, Gibbons, de Volder and Casey [48] found no difference between offence type and denial type, (i.e. there was no type of denial which was characteristic of either

rapists or child molesters and instead they found the spread on the continuum of denial to be variable). This finding calls into question the clinical utility of a typology/continuum approach. If denial is on a continuum, then the continuum needs to have clinical utility. It would need to include more intense forms of denial and what they are empirically related to, it would need to indicate what types of denial are more or less progressive and to distinguish denial from other phenomena such as cognitive distortions. In our view, labelling distortions and offence supportive attitudes as forms of denial only adds to the confusion [1].

In most jurisdictions, minimisations are routinely addressed in treatment, but categorical denial tends to be an organising principle of treatment (i.e., if you totally deny you are ineligible for treatment) [26, 49]. In order to understand categorical denial, it is worth considering whether such individuals differ from other men with sexual convictions in any particular way. There is some evidence that men with sexual convictions who categorically deny responsibility have been found to differ from those who admit, but most studies are dated. In terms of demographic and psychological profiles such as deviant sexual interests, their positive impression management and response biases on personality tests, the findings have been mixed [2, 14]. In a recent study which strictly defined categorical denial, Ware, Blagden, and Harper [15] compared 40 untreated deniers and 40 admitting but untreated men with sexual convictions. They found that deniers had lower IQs, were older, and were more likely to be child molesters. Psychologically, offenders denying their offences were significantly more shame-prone, and likely to use externalization as a method of impression-management. They were also more compulsive than those admitting their offences, but less antisocial and sadistic, when compared on personality indices. While understanding the differences between admitters and deniers can be useful, we argue that the link between shame proneness and denial remains an important consideration. However, consistent with the findings of Ware et al. [12, 15], we contend that the purpose or function of denial for the individual should be considered as central to further research efforts. Similarly, Blagden et al. have argued denial can be viewed as a form of “sense making” and that clinically relevant treatment targets can be elicited without disclosure. It is concluded that viewing denial as a barrier to treatment impedes constructive work with offenders, and implications for treatment are discussed below.

FUNCTION OF DENIAL

While understanding differences between admitters and deniers in terms of characteristics can perhaps guide us to important group differences, they are not wholly

informative about the function of denial. In order to work constructively with an individual in denial it is important to understand the function of their denial (Ware et al. [1], Blagden, et al. [26]). In their examination of responsibility-taking Ware and Mann [1] suggested the following broad reasons why men with sexual convictions might deny complicity: 1) they may be attempting to retain their freedom, status, reputation, and support of loved ones; 2) they may be attempting to protect their already damaged self-esteem and to reduce feelings of shame; or 3) they may want to continue offending and may wish to maintain their deviant fantasies and arousal. Lord and Wilmot [16] found that denial was adaptational and that it mitigated against threats to self-esteem and negative external consequences. Blagden et al. [5] found that denial reduced stigma, perceived negative reactions from others and helped maintain a coherent sense of self. Importantly overcoming denial was similarly centered on having a viable and desirable identity.

Recent studies have suggested that denial may be a method of conserving one's identity management [26]. Denial and identity transformation are shaped by and through social interactions [27], therefore it is necessary to consider the relational properties of denial in forensic contexts and the latitude denial allows for maintaining identity management and deviance disavowal. In Blagden et al.'s [26] study all deniers rejected the label "sex offender" and actively distanced themselves from such a label. However, this is likely an adaptive strategy as it allows the individual to resist internalising a problem category that may impair one's ability to achieve self-respect and affiliation with mainstream society. Similarly, Hulley [28] found neutralizations appeared to assist desistance narratives from sexual offending by allowing for the negotiation of stigma and rejection of the "sex offender" label, thus providing for the development of a non-offending, prosocial identity. These studies link with Maruna's [29] assertion that "personal reform or rehabilitation may itself be a cognitive distortion of sorts" (p. 190). Thus, personal reform may be the result of accentuating positive qualities thereby boosting self-esteem and self-worth while simultaneously reducing anxiety. In Farmer, McAlinden, and Maruna's [30] study of men with sexual convictions who had desisted for a long period of time, they found that when participants accounted for their offending behaviour, they were more likely to externalise to situational rather than dispositional factors. This enabled the participants to manage shame attached to their offences and gave them a means of accounting for the harm they had caused to others. Thus a denier's presentation of someone not capable of doing such offences or of someone with 'moral character' (See Blagden et al. [26]), may allow for enacting of such identities. Such narratives may allow deniers to create good and moral selves by rejecting and distancing

themselves from ‘sexual offenders’; thus highlighting how their crime does not reflect the real them [26, 27], presenting a desirable identity and thus denying is not surprising. Walton’s [47] recent exploration of denial as an evolutionary response reminds us that responses like denial are archetypal forms—ancient biological motives that are manifesting in our cognition. Such positions do the important evolutionary work of allowing us to belong to desirable in-groups, a core human desire. This also allows individuals the ability to distance themselves from groups that are a ‘social curse’ (i.e. those groups which are a burden, that impact on your ability cope and which stigmatise your identity) [46].

DENIAL AND THE RISK TO REOFFEND

The evidence-base for denial as a treatment target is weak. Indeed, contrary to common-sense assumptions, there is no clear evidence to link denial to increased sexual recidivism for most offenders [18]. Interestingly, the opposite may be true insofar as a number of studies link denial to reduced recidivism, particularly in higher-risk sex offenders. Explanations for this counter-intuitive position include the assertion that denial is functional because it relates to a number of adaptive characteristics, such as a capacity for shame, distaste for the behaviour, and attachment to social networks [25].

Large scale meta-analyses have found no consistent relationship between denial and reoffending [19, 20]. Recent studies examining moderating factors have consistently found no overall effect of denial on sexual recidivism. However, a few studies have found denial to be related to small but meaningful increases in sexual reoffending. Harkins [4], Kingston [22], and Nunes et al. [23], for example, found that for low risk men with sexual convictions, categorical denial was related to increased reoffending rates. However, in other research [4, 22], any relationship between denial and recidivism for denial disappeared when controlling for variables such as psychopathy.

Interestingly, whilst Harkins et al. [21] found that denial of responsibility was not significantly associated with sexual or violent recidivism they noted that lower levels of sexual recidivism were found for those who denied responsibility for their offense, independent of static risk. Despite the importance of this study, the broad definition of denial (i.e., not accepting responsibility) means that this may not be applicable to categorical denial. Our conclusions are that the overall magnitude of the relationship between denial and recidivism is small, non-significant, and consistent with the results from meta-analytic reviews [21, 23].

We contend that, to make sense of these inconsistent findings, a number of research strategies are required. Larger sample sizes are required especially as, in some studies, the number of categorical deniers has been as low as 12 [4]. Denial has also been measured prior to treatment which, as we noted earlier when discussing incidence rates, confuses definitions particularly as rates of denial change over time [24]. Ware et al. [12] also suggested that future studies should control for the influence of other well-established risk factors, such as sexual preoccupation. Most importantly, we suggest that a careful consideration of the function or purpose of the categorical denial is necessary. As we noted earlier, those offenders who deny due to the fear of losing family or support or to reduce feelings of shame or low self-worth, might be less likely to reoffend than those who deny simply to avoid conviction or to retain their sexual fantasies. Understanding the function of denial and the role denial plays in maintaining a coherent sense of self are important when working clinically with this population.

TREATMENT OF CATEGORICAL DENIERS

Irrespective of whether the relationship of denial and recidivism risk has been clarified, treatment options for categorical deniers need to be carefully considered. There have been three approaches used: 1) the offender is excluded from treatment, 2) they enter a treatment program where there is an explicitly expressed attempt to overcome the denial, or, 3) treatment is provided but there is no attempt to overcome the denial.

We do not believe simply excluding deniers from treatment to be an evidence-based approach. Within this approach the offender needs to somehow acknowledge culpability of their own accord or be excluded from treatment, even if presenting as higher risk of committing further sexual crimes. While there is some evidence that categorical deniers can admit responsibility without any treatment, a supportive therapeutic context of some description appears necessary [16]. An alternative option is to target the denial within pre-treatment or engagement groups, or individual sessions. Overall, the evidence for this approach appears at best to be mixed [31]. Again, as has been the case with many studies of categorical denial, the samples have been small and there have been methodological weaknesses [31, 32].

The most common treatment option seems to be to allow deniers to enter treatment along with those who admit and then attempt to overcome denial throughout the program. McGrath et al. [33] reported that approximately half of the surveyed US and Canadian programs combined categorical deniers and admitters in the same groups. Despite its

apparent popularity, as noted by Ware et al. [12], little is known about the effectiveness of this approach. In our view, important research contributions can be made in this area. It is apparent that, if categorical deniers are included in treatment programs alongside admitters and are able to complete treatment even whilst maintaining their innocence, the benefits they derive from treatment appear to be equal to admitters [35]. Treatment providers who focus on keeping the deniers in treatment can achieve positive results [4, 36]. Marshall [37], as an example, reported significantly reduced rates of categorical denial as a result of treatment (from 31% prior to treatment to 2% after treatment). We note, however, that treating deniers alongside admitters is reportedly challenging with professionals often viewing denial as a serious impediment to treatment [6, 38]. A subsequent disadvantage of this approach is that deniers can be discharged from treatment due to their lack of progress, or may voluntarily drop out, particularly if aggressively challenged in an effort to overcome the denial [34].

Given that the efficacy of traditional sex offender therapy has been questioned [39] and, in particular noting the weak evidence-base for denial as a treatment target, perhaps the best way forward is to focus on treatment being non-disclosure focused. In an effort to provide some form of treatment exclusive to categorical deniers who refused to volunteer to be treated alongside admitters, Marshall, Thornton, Marshall, Fernandez, and Mann [37] established a treatment approach where denial was not challenged, yet there was still a focus on the risk factors associated with sexual offending. Within this approach, categorical deniers were assisted to identify problems in their lives that led them to be in a position where they could be accused of sexual offending, and to focus on reducing their risk of being accused again.

We believe that this is a promising approach with a growing evidence base including helpful case studies [17, 42]. In an initial long-term evaluation reported by L. E. Marshall [41] 82 sex offenders (52 child molesters and 30 rapists) treated in this program, all of whom of course were categorical deniers, were in evaluated over a 3.5 year follow-up after release from prison. Only 2.5% were found to have committed a further sexual offense. Ware [43] demonstrated through the use of both psychometric testing and therapist rating scales that 40 deniers who attended a non-disclosure program made significant within-treatment changes across a range of treatment targets such as sexual self-regulation, empathic responding, and risk factor understanding. These changes were comparable to those made by admitting sex offenders completing treatment programs of a similar length, content, and structure, that were facilitated by the same therapists. In a second study using the same participants, Ware [43] also demonstrated that therapeutic engagement and group climate in the non-disclosure

program, as reported by both participants and therapists, was comparable to the conventional programs towards the end of treatment. These results support Ware and Mann's [1] assertions that, if the need to challenge men who deny their sexual convictions is removed from treatment, treatment engagement and benefits can be maximized. Further research is, however, clearly necessary to examine the merits of this approach in comparison to including deniers into treatment alongside with those who admit, and to treatment as usual approaches. We also note that there remains some skepticism over the ethics and effectiveness of the approach [9]. Whilst this approach has been praised by some as being innovative, it is yet to be used in more than a few jurisdictions and we note that the evidence, albeit promising, requires increased rigor. We call for increased efforts from those using this approach to examine reoffending rates against a comparison of matched untreated deniers.

CONCLUSIONS

A number of men with sexual convictions categorically deny having offended and will steadfastly maintain this denial. Much is yet to be learned about these individuals. Research efforts aimed at clarifying the characteristic of deniers, whether denial should be considered a treatment target, and how to treat these offenders have been hampered by small sample sizes and a lack of a consistent definition of denial. In particular, more research is needed to clearly understand the nature of denial and the purposes it serves for the offender. Without this knowledge, it is our view that assessors and treatment providers alike will continue to struggle to identify the circumstances when deniers may be a greater risk to reoffending and when treatment efforts are required. What is known is that denial does not appear to be reliably related to recidivism [21]. Treatment options range from the offender being excluded from treatment; to the offender entering a program where there is an explicitly expressed attempt to overcome the denial, to an alternative approach where treatment is provided but there is no attempt to overcome denial. Our view is that the latter is most consistent with principles of good therapeutic practice. Given that shame is linked with denial [15], it is important that the therapeutic relationship avoids confrontation and practices which may increase shame. The shift towards non-disclosure and non-confrontational practices with individuals with sexual convictions is consistent with positive, as well as trauma-informed [44], and compassion-focused practices [45]. However, the evidence for such approaches is still emerging.

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