

# Denial in Sex Offender Treatment

WORKING WITH, RATHER THAN AGAINST, DENIAL IN SEX  
OFFENDER TREATMENT AND MANAGEMENT

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# Working With Denial

- ▶ Today's Session
  - ▶ Overview of SOTAP and Treatment
  - ▶ Discussion of Denial
  - ▶ Discuss Related Research
  - ▶ Presentation of a Model for Treatment of Deniers
  - ▶ Consider Client Outcomes
  - ▶ Consider Suggestions for the Future



A sizable portion of offenders deny various elements of their official case, and frequently minimize responsibility.

Some categorically deny the offense took place (our focus today).

What is the effect of denial?

- Complicates assessment & treatment

- Often excluded from treatment

# WA DOC SOTAP Policy (570.000)

- ▶ Eligibility Criteria

- ▶ To be considered for SOTAP, offenders must meet eligibility criteria as follows:
  - ▶ Convicted of a sex offense for the current or previous term of confinement.
  - ▶ Eligible for release from Prison at some point in the future.
  - ▶ Acknowledge or recall having committed a sex offense.
  - ▶ Agree to attend SOTAP and follow treatment rules and expectations.



# RNR Model

## The Principles of Who, What, How

### ▶ Risk

- ▶ Match service to identified risk to reoffend. Target treatment towards those assessed as highest risk. Static 99R used to prioritize for treatment.
- ▶ Does denial increase risk?

### ▶ Needs

- ▶ Target dynamic risk factors (DRFS) linked to criminal behavior and future risk.
- ▶ Stable 2007 used to assess criminogenic needs in order to target them in treatment.
- ▶ Clients may have many needs that deserve treatment, but not all are associated with criminal behavior or risk to reoffend.
- ▶ Is denial a needs area?

### ▶ Responsivity

- ▶ Effective interventions tailored to the learning style, motivations, abilities, and strengths of clients served.
- ▶ Clinical interview, collaboration with others including client, testing.
- ▶ Should denial be seen as a responsivity item?



# Treatment Resistance

## ▶ System Factors

- ▶ Lack of trust in professionals
- ▶ Bad experiences in treatment
- ▶ The system may undermine treatment

## ▶ Psychological Factors

- ▶ React to pressure for required programming
- ▶ Lack of insight into problems
- ▶ Lack of insight into risk

## ▶ Social Influences

- ▶ Family believes in innocence
- ▶ Social supports believe in innocence

## ▶ Client's Understanding

- ▶ Is treatment effective?
- ▶ Is treatment difficult?
- ▶ Will I be safe?
- ▶ Will I be released?

# Making Excuses

- ▶ People lie:
  - ▶ To protect themselves
    - ▶ Avoid anxiety and shame
  - ▶ To protect others
    - ▶ Avoid hurting feelings
  - ▶ Out of habit
- ▶ Can we know the truth regarding an event we did not experience, when only two people were there, and they have different stories?
- ▶ Excuse making may help avoid a loss of self-esteem and shame, both blocks for treatment.
- ▶ If a client minimizes his crimes, is this an indication he knows that what he did was wrong?



# Functions of Denial

Denial can be seen as an approach that is used in certain settings and when reacting to specific conditions. We can see it as a state or as a trait, as situational or pathological.

- ▶ Save self esteem
- ▶ Fear of loss of family
- ▶ Fear of loss of support
- ▶ Case under appeal
- ▶ Shame
- ▶ Fear of physical harm
- ▶ Avoid label
- ▶ That isn't me
- ▶ Lack of understanding
- ▶ Don't see it as a sex offense
- ▶ Protect image
- ▶ Mental Illness
- ▶ STG affiliation
- ▶ May be innocent
- ▶ They may want to continue old behaviors
- ▶ Don't want to be around those guys



# Forms of Denial

- ▶ Denial of Harm
- ▶ Denial of Responsibility
- ▶ Denial of Planning or Grooming
- ▶ Denial of Number of Occurrences
- ▶ Denial of Need for Treatment
- ▶ Minimization
- ▶ Denial of Risk
- ▶ Treatment ambivalence – normal, especially in a correctional environment
- ▶ Denies interaction with the victim
- ▶ Denies interaction was sexual
- ▶ Claims the victim consented
- ▶ Denial of risk of recidivism
- ▶ Denial of paraphilic behavior
- ▶ Denial of sexual intent
- ▶ Denial of deviant arousal
- ▶ Categorical Denial

# Examples of Categorical Denial

- ▶ I was falsely accused
- ▶ My lawyer told me to take the plea
- ▶ I pled guilty to spare the victim
- ▶ I am the victim, she/he was sexually aggressive
- ▶ It was consensual
- ▶ I was drunk, or we were both drunk
- ▶ She/they were out to get me, to get my stuff
- ▶ I don't remember
- ▶ I just won't talk about it
- ▶ Case under appeal



# Consequences of Denial

- ▶ Release may be jeopardized
  - ▶ Institutional treatment eligibility
  - ▶ Community treatment eligibility
  - ▶ Camp eligibility
  - ▶ Work release eligibility
- 
- ▶ Can't learn about and mitigate risk

# How unusual is denial?

- ▶ In other types of treatment
- ▶ In psychotherapy
- ▶ In everyday life
  
- ▶ Pre adjudication
- ▶ Post adjudication
- ▶ Post treatment, post release
  
- ▶ In sex offender treatment
  - ▶ 25% - 35%



# How is Denial Viewed Clinically, How is it Managed?

- ▶ Seen as an unmotivated client
- ▶ Seen as a lie
- ▶ Seen as a significant barrier to progress
- ▶ Often excluded from treatment, or from treatment completion
- ▶ Seen as something that needs to be overcome
- ▶ May be seen as the highest risk, as one who wants to continue to offend
- ▶ May have time added to his sentence



# Should We Treat Deniers? Why?

- ▶ Can we mitigate risk for those who deny their offending behavior and have been found not amenable for standard treatment?
- ▶ Treating a denier may fit the Mission of DOC – to improve public safety.
- ▶ A different engagement may increase benefits of treatment for this population
- ▶ Risks and Needs may be the same as clients who admit.
- ▶ Risk for recidivism can be addressed without direct discussion of offending behavior, at least for some populations.
- ▶ It does not appear to be necessary to overcome denial, to require admission.
- ▶ Deniers program engages men who would not otherwise enter treatment and would therefore not reduce their risk.
- ▶ Comfort in treatment may facilitate willingness to engage in standard programming.
- ▶ Address criminogenic risks by three core processes:
  1. Foster sense of necessity to address risks
  2. Increase conscious awareness of both protective and risk factors
  3. Development of skills to strengthen protective factors and mitigate the propensity for risks as they pertain to sexual recidivism.



# Addressing Denial in Sexual Offenders

- ▶ Four Approaches
  - ▶ Exclude deniers from treatment
    - ▶ Preadmission screening, eligibility
  - ▶ Overcoming denial in a regular treatment program
    - ▶ Allow entry, but not completion
  - ▶ Overcoming denial in a pretreatment program
    - ▶ Address barriers, understanding, motivation
  - ▶ Accepting denial and working with it, rather than against it.

# Overcoming denial in regular treatment

- ▶ Does denial increase risk?
- ▶ If denial as seen as a barrier to successful engagement in treatment, eligibility for treatment should be dependent on acknowledging offense.
- ▶ Expectation or requirement of admission of guilt in:
  - ▶ Pre-treatment Screening
  - ▶ Intake
  - ▶ Throughout treatment
  - ▶ For successful completion of treatment



# Overcoming denial in pretreatment

If denial seen as a needs area, it should be addressed in treatment

- ▶ Increase motivation

- ▶ Empathy
- ▶ Collaboration
- ▶ Values
- ▶ Release
- ▶ Civil Commitment

- ▶ Increase understanding of treatment

- ▶ Normalize treatment and offense experience
- ▶ Expectations
- ▶ Disclosures
- ▶ Assignments

# Accepting Denial and Setting it Aside – Moving Forward

- ▶ Does denial fit as a responsivity concern?
- ▶ Moving Forward – A model of treatment for categorical deniers in WA DOC
- ▶ Began in 2015 at Airway Heights Corrections Center
- ▶ Four cohorts, 40 total clients to date
- ▶ Amenability based on risk and denial
  - ▶ No requirement that client desire treatment. Mandated program.
- ▶ Previously screened for standard treatment and found to not be amenable due to denial of offense



# Moving Forward Clients

- ▶ Adult males, incarcerated at Medium Security Facility (AHCC)
- ▶ Convicted of Sex Offense or Crime with Sexual Component
- ▶ Categorically deny guilt in conviction
- ▶ Actuarially assessed Mod-High to High risk for re-offense using Static-99R
  - ▶ (occasional use of other DOC risk assessments)
  - ▶ Average age= 34.9
  - ▶ Average Static 99R= 5.54, High 9
  - ▶ ~50% of group have significant MH needs S2-S3
- ▶ Less emphasis on time structure than in standard treatment

# Moving Forward Structure

- ▶ Approximately 10 clients per cohort
- ▶ 14 week, closed group
  - ▶ 2 X 2 hour groups per week
- ▶ Individual sessions
  - ▶ Pretreatment
    - ▶ Informed consent, address anxiety and anger, enhance motivation (empathy, validation, highlight values), Stable 2007 guided and treatment oriented interviews
  - ▶ Monthly sessions and as needed
  - ▶ Discharge session



# Moving Forward Foundations

## Risk, Needs, Responsivity

Mod-High – High Risk

Dynamic risk factors (DRFs) as conceptualized in the Stable 2007

Similar, but more significant, challenges with sexual DRFs as in standard program

Responsivity similar to standard program

## Acceptance and Commitment Therapy

Focus on function of behavior in context

Focus on workability and stuckness

Prescribes manner of assessing that utilizes here-now experience, and treatment-oriented assessment

Focus on values

Core skill development

## Adverse Childhood Experiences and Developmental Perspective

Using lifetime adversity to validate and contextualize unworkable behavior.

Viewing adversity as stimulus



# Moving Forward Approach

- ▶ Avoid challenging the client's version of his offense story
- ▶ Address criminogenic, dynamic risks
- ▶ Encourage development of positive, value-focused lifestyle
- ▶ Focus: some things in your life allowed others to believe that you were capable of committing this offense. We will work to avoid you being in the place in which you can be "falsely accused" again.
- ▶ False allegations are not beyond your control
- ▶ We do not focus on offense specific details
  - ▶ Demonstrate little interest in either side's version of the case
  - ▶ This is specifically not the place to retry a case



# Behavioral markers of Change

## Moving Forward

- ▶ Change is evidenced by:
  - ▶ Understanding/Acknowledgement of DRFs.
  - ▶ Expressed desire to reduce impacts of DRFs
  - ▶ Increased awareness of core values
  - ▶ Increased ability & willingness to defuse from problematic cognitive content.
  - ▶ Increased ability & willingness to navigate difficult emotional states.
  - ▶ Increased ability to achieve valued behavior in a consistent, committed way.
- ▶ Key Change Ingredients:
  - ▶ Motivation, Approach Goals, Valued Directions.
  - ▶ Awareness: Fusion with Cognitive Content & Avoidance of Unpleasant Emotional States; Focused on Process & Function
  - ▶ Behavior: Defusion, Commitment,

## Standard/Traditional Accountability Model

- ▶ Change is evidenced by:
  - ▶ Correspondence of self-reported offending behavior with official account of offending behavior.
  - ▶ Acknowledgement of responsibility
  - ▶ Acknowledgement of harm/ Victim empathy
  - ▶ Expressed remorse
  - ▶ Commitment to non-offending future
  - ▶ Restructuring of offense facilitating cognitive distortions
  - ▶ Behavioral management skills
- ▶ Key change ingredients:
  - ▶ Motivation: Avoidance: Remorse, prevention of future harm.
  - ▶ Awareness: Permission giving cognitive distortions: Focused on content
  - ▶ Behavior: Skills to stop criminogenic behavior, mostly avoidance oriented.



# First Groups





# Examples of Activities

## Module 1:

### Motivational Enhancement & Fostering Awareness

- Values Identification/Clarification
  - Turn up the pain
  - Reframe pain as indication of values
- Clean Pain/Dirty Pain
- Condensed Autobiography leading up to disclosure of false accusation
- Models of Behavior
- Opening Door to Risk

## Module 2:

### Self-Regulation Skills

- Managing Urges
  - Reframing Skills
  - Shifting the Script
  - Mindfulness
- Behavioral Chain Analysis
- Asking for help
- Consent & Boundaries
- Self-Talk, Auto Thoughts
- Decisional Balance

## Module 3:

### Committing to Success

- Disclosure of High Risks
- Success Plan
- Recommendations

**Background Factors:** These are factors that have been shown to increase vulnerability to adopting risky -health related behaviors in adulthood.

Check all of the items below that have been present in your life.

<input type="checkbox"/>	Childhood Emotional Abuse
<input type="checkbox"/>	Childhood Physical Abuse
<input type="checkbox"/>	Childhood Sexual Abuse
<input type="checkbox"/>	Witnessing physical, or verbal violence towards your mother
<input type="checkbox"/>	Exposure to a family member who was an addict while a child
<input type="checkbox"/>	Having a family member removed from home and imprisoned.
<input type="checkbox"/>	You were not raised by your biological parents.
<input type="checkbox"/>	You didn't have enough food to eat, or you experienced physical neglect.
<input type="checkbox"/>	You didn't get enough attention, or were emotionally neglected.
<input type="checkbox"/>	
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**Encountering Adversity:** Something changes in an unwanted way

**Here & Now Challenging Personal Experiences:** These are challenging emotional states, or risky thinking patterns that you might experience immediately after you encounter adversity.

Rank the most challenging emotions from 1-10, with 1 being the most challenging. Rank problematic thinking from 1-10 with 1 being most like you

Problematic Thinking	Challenging Emotions
Giving Up or "F*%#!" Mentality	Anger
Entitled thinking	Sadness
Survival of the Fittest Mentality	Fear
Escape Mind	Anxiety
Helplessness	Emptiness
Blaming Others	Shame
Believing Others are out to get you	Guilt
Taking Control	Frustration
	Hostility
	Hate

**Behaviors:** Typical Ways that you behave after experiencing challenging Here and Now Personal Experiences.

<input type="checkbox"/>	Get High
<input type="checkbox"/>	Fight
<input type="checkbox"/>	Threaten & Intimidate
<input type="checkbox"/>	Impersonal Sex
<input type="checkbox"/>	Complain
<input type="checkbox"/>	Give up
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

**Risky Situation:** Opportunity for offending, or being accused of an offense, often combined with disinhibitors.

**Post-Accusation Challenging Personal Experiences:** These are all the difficult emotions, thoughts, and behaviors that follow a false accusation, or offense.

In the absence of willingness & skill to cope with challenging here-now experiences, **STUCKNESS** often develops.

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# Challenges with treating Deniers

- ▶ How do we measure change if we can't rely on accepting responsibility, admission of guilt?
- ▶ How do we address risks without addressing offense associated beliefs and attitudes?
- ▶ How do we fix something that doesn't exist, that was never there?
- ▶ Sexual Self Regulation DRFS are particularly difficult to address.
- ▶ Some clients have a very difficult time acknowledging any risks and any problem behavior.
- ▶ Many clients are overly entrenched in innocence.

# Challenges cont.

- ▶ Victim Expectations
- ▶ Community Expectations
- ▶ System expectations
  - ▶ Legal
  - ▶ DOC
- ▶ Our individual expectations
  - ▶ Managing our reactions
- ▶ Denial of any/all problems
- ▶ Significant suspicion
- ▶ Fear of judgement
- ▶ Lack of faith in the system
- ▶ Contagion



# Observations, so far

- ▶ High degree of mistrust of authorities
- ▶ Sincere belief in innocence for some
- ▶ For many, denial seems to be image management or other motivation
- ▶ Majority have history of addiction
- ▶ High level of complex trauma from childhood
- ▶ Normalization of violence and other problem behaviors
- ▶ More distrust of women compared to standard treatment group
- ▶ Family tends to rank very high in values clarification
- ▶ High degree of hopelessness regarding registration and community expectations



# Observations continued

- ▶ Client outcomes to date, non-board cases and board cases
- ▶ Denial related to lower motivation to engage
- ▶ No terminations, no self-terminations
- ▶ Some 'unsuccessful' graduates
- ▶ A few individuals do not seem amenable for group treatment
- ▶ The program has room to grow, interest increasing
- ▶ 14 weeks may not be sufficient
- ▶ Without using file material to challenge story, the story can be quite far off the mark
- ▶ Moving Forward clients very similar to traditional clients, anecdotally
- ▶ Some clients seem to make a fair amount of progress, others little



# Suggestions for the Future

- ▶ Need for a consistent definition of denial
- ▶ Research needed on what type of client is amenable for this type of program
- ▶ The Moving Forward clients who seem to be struggle the most are those who completely deny all risk, all risk related behavior, all problems
- ▶ Research needed on what type of client is at increased risk, who is at decreased risk?
- ▶ What factors interact with denial
- ▶ How are denial and minimization related, when to address or set aside?
- ▶ Can we replace or alter denial towards a goal of increasing responsibility and decreasing distress?



# Feedback from Clients

"This should be longer, but for the next group"

"We were just getting started and it ended"

"We developed an ability to listen more clearly to other people, even in presence of negativity"

"I didn't want to be here, but I am glad I stayed."

"I guess I have things to work on."







Questions?

Thank you!!!!