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# “But I Didn’t Do It!”: Ethical Treatment of Sex Offenders in Denial

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## Abstract

This article addresses ethical questions and issues related to the treatment of sex offenders in denial, using the empirical research literature and the ethical codes of American Psychological Association (APA) and National Association of Social Workers (NASW) to guide the ethical decision-making process. The empirical literature does not provide an unequivocal link between denial and recidivism, though some studies suggest that decreased denial and increased accountability appear to be associated with greater therapeutic engagement and reduced recidivism for some offenders. The ethical codes of APA and NASW value the client’s self-determination and autonomy, and psychologists and social workers have a duty to empower individual well-being while doing no harm to clients or others. Clinicians should view denial not as a categorical construct but as a continuum of distorted cognitions requiring clinical attention. Denial might also be considered as a responsivity factor that can interfere with treatment progress. Offering a reasonable time period for therapeutic engagement might provide a better alternative than automatically refusing treatment to categorical deniers.

## Keywords

sex offender, denial, treatment, ethics, therapeutic engagement

## Introduction

Interdisciplinary response to crime has become a common part of the landscape of contemporary jurisprudence. Across the United States and abroad, management, monitoring, and rehabilitation services for sexual offenders are frequently included in

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criminal sentencing requirements. Examples of such policies include civil commitment, community notification, registration, and mandatory community-based treatment, which are designed to promote rehabilitation and community safety simultaneously.

It is widely recognized by courts and clinicians that some individuals, especially those who engage in criminal behavior or who suffer from addiction or mental illness, are unlikely to acknowledge their symptoms and seek therapy for their problems. In cases of interpersonal violence, it is not uncommon for denial, entitlement, and resistance, as well as shame, fear, and family loyalty, to preclude voluntary initiation of services for both victims and perpetrators. The justice system thus enlists mental health professionals to assist with the goal of rehabilitation in such cases.

Glaser (2003) pointed out that an important distinction exists between punishment (infliction of a penalty) and treatment (an intervention aimed at relieving the patient's distress). The boundaries have the potential to become blurred, however, when therapeutic intervention is a component of a criminal sentence, such as in cases where sex offenders are required to attend treatment while in prison or on probation (Ward, Gannon, & Vess, 2009; Ward & Salmon, 2009). Clearly, rehabilitative criminal justice differs from traditional types of psychotherapy commonly sought by other types of patients, and requires careful consideration by the therapist of ethical dilemmas and the potential abuse of power. This article will specifically address ethical questions and issues related to the treatment of sex offenders in denial, using the empirical research literature and the ethical codes of the American Psychological Association (APA) and the National Association of Social Workers (NASW) to guide a decision-making process in search of ethical solutions.

## The Problem of Denial

The first problem with denial is trying to define it in the context of sex offender treatment. Although denial sometimes refers to a complete refutation of the facts related to an offense, denial more commonly exists on a continuum which includes minimizing the impact of sexual assault on victims, externalizing blame, or refusing to acknowledge the severity or chronicity of the sexual behavior problem (Jenkins, 1990; Marshall, Anderson, & Fernandez, 1999; Schneider & Wright, 2001; Trepper & Barrett, 1989; Yates, 2009). The *DSM-IV-TR* (APA, 2000) defined denial as a defense mechanism in which the person "deals with emotional conflict or internal or external stressors by refusing to acknowledge some painful aspect of external reality or subjective experience that would be apparent to others" (p. 811). Defense mechanisms, according to the *DSM*, are "automatic psychological processes that protect the individual against anxiety and from the awareness of internal or external dangers or stressors. . . [they] mediate the individual's reaction to emotional conflicts" (p. 807). The Association for the Treatment of Sexual Abusers (ATSA) described denial simply as "the failure of sexual abusers to accept responsibility for their offenses" (ATSA, 2001, p. 63). Thus, the word denial is used to describe a wide array of circumstances

ranging from categorical denial to different degrees of distorted cognitions that encompass minimization and rationalization about the offense and its impact.

There is a consensus among clinicians that offense responsibility is an important treatment target. Over 90% of residential and community-based treatment programs in the United States identify offense responsibility as a treatment component (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010) suggesting that therapists believe that offenders must overcome denial in order for therapy to be effective. Some degree of denial is commonly observed in sex offenders presenting for treatment, ranging from absolute denial of the facts of the case, to minimization or justification of the offense, to distorted attributions of responsibility (Schneider & Wright, 2001; Schwartz, 1995; Trepper & Barrett, 1989; Yates, 2009). Less consensus exists about how to handle denial as it persists in the therapeutic setting. When considering criteria for successful completion of treatment, more than 80% of adult programs in the United States require disclosures that are at least reasonably consistent with official records in order to obtain program completion (McGrath et al., 2010). Only 6% of U.S. programs said that they did not require clients to admit to any offense in order to complete the program. In contrast, no Canadian programs require full admission of sexual offending behavior in order to successfully complete treatment and 26.3% of Canadian community programs required no offense disclosures at all (McGrath et al., 2010).

Perhaps one reason that clinicians value acceptance of responsibility is that in an ethical and moral society, we expect and respect acknowledgment of fault and efforts to make amends. Apologies and restitution provided by a wrongdoer can offer emotional and practical relief to a victim. To do so is considered to be "the right thing to do" and a wrongdoer is viewed as a "bigger person" when admitting fault with a willingness to accept whatever consequences follow.

If we accept the notion that denial is not simply lying, but a defense mechanism fueled by shame, guilt, threat to self-esteem, cognitive dissonance, and fear of consequences, then we can expect sex offender clients to present with varying degrees of denial and the defensive functions of denial can be recognized and validated while personal accountability is pursued as a therapeutic goal (Schneider & Wright, 2001). On one hand, clients have the right to self-determination, and therapeutic encounters should allow and empower clients to move at their own pace and choose their own path for personal growth. To reject deniers from treatment is to prevent an opportunity for change, and might be unethical. On the other hand, some might argue that it is difficult, if not impossible, to treat a client for a problem which he says he does not have, and that to do so might be unethical. Treating deniers might facilitate collusion with clients to maintain the secrecy by which sexual abuse thrives, and by allowing clients to withhold information relevant to assessment and treatment, their ability to receive appropriate interventions might be impaired.

There are several ethical issues related to denial. We are socialized from a young age to believe in the importance of acknowledging fault and the need to make amends. There is psychological and social value for both offenders and victims in accepting

responsibility. As well, clinicians may send a mixed message to deniers if we treat them without acknowledgment of responsibility: We think you need help for something you might not have done. There is also a possibility of continuing harm to potential victims if deniers are not treated, but at the same time, we may fail to respect the autonomy and dignity of denier if we insist on admission. These dilemmas will be explored throughout the paper.

## Research Findings

The research literature provides a starting place to explore the role of denial in recidivism and treatment progress. Understanding the empirical relationship between risk factors and recidivism can help clinicians make informed decisions about which treatment targets to emphasize in their programs. Cognitive behavioral sex offender treatment programs have historically included offense responsibility as an important component and some treatment centers exclude categorical deniers from participating in therapy (McGrath et al., 2010; Yates, 2009). On the other end of the spectrum are programs that allow even deniers to successfully complete treatment. Few studies are available to help us evaluate the role that denial might play in recidivism and treatment success, but the limited research can nonetheless inform the debate.

In 1998, Hanson and Bussiere published their meta-analysis identifying risk factors for sexual recidivism, setting in motion a rapidly evolving body of inquiry testing and validating empirically derived risk assessment tools. Evaluating more than 60 studies involving nearly 30,000 subjects from North America and Europe, the authors explored the relationship between recidivism outcomes and dozens of potentially influential static, dynamic, and clinical factors. Six studies included a measure of denial as an independent variable, but the meta-analysis did not reveal denial as a significant predictor of recidivism (Hanson & Bussiere, 1998). A subsequent meta-analysis with additional and updated studies also concluded that there was no significant relationship between denial and recidivism (Hanson & Morton-Bourgon, 2005). It has been suggested that perhaps denial is actually a healthy response to offending and, therefore, a mitigating factor in risk: The offender denies because he knows that sexual assault is wrong and it is his shame and concern about the perceptions of others that lead him to deny the crime (Yates, 2009).

Lund (2000) challenged the results of the first meta-analysis, arguing that the definitions of denial varied considerably among the studies examined. Some studies excluded absolute deniers and in others, denial was measured at intake with no indication of whether denial had changed over the course of treatment. It is also likely that dichotomous measures do not adequately capture the inherent complexities of denial (Lund, 2000; Schneider & Wright, 2001). Various operationalizations of the construct of denial were tested in a recent study (Langton et al., 2008). When denial was defined as an *either/or* variable, there was no significant association with sexual recidivism. When denial was defined as a continuous variable, higher levels of minimization

predicted sexual recidivism among higher risk offenders when controlling for treatment completion status and psychopathic traits (Langton et al., 2008).

Denial and risk also displayed interactions in another study, as did the offender's relationship with the victim (Nunes et al., 2007). Lower risk offenders who denied all of their offenses sexually reoffended at higher rates than did lower risk offenders who admitted to any of their offenses. Contrary to what might be expected among higher risk offenders, denial was associated with lower recidivism while high-risk admitters reoffended at higher rates. Interestingly, incest offenders who were in denial reoffended more often than incestuous admitters, and deniers with unrelated victims reoffended at lower rates than admitters with unrelated victims (Nunes et al., 2007). Nunes et al. (2007) suggested that higher recidivism rates among denying incestuous offenders might result from convincing significant others of their innocence, thereby reducing barriers to prevention and allowing access to new opportunities for victimization.

Another study found few differences in the recidivism rates of low-risk offenders who admitted or denied whereas high-risk offenders who were in denial demonstrated decreased recidivism (Harkins, Beech, & Goodwill, 2010). A similar pattern to that reported by Nunes et al. (2007) was seen; the low-risk deniers had a higher sexual recidivism rate than the low-risk admitters. Lund (2000) suggested that denial presents a risk factor for recidivism primarily when other risk factors are absent. Curiously, Harkins et al. found that high motivation for treatment was also associated with higher recidivism rates, though this effect disappeared when controlling for static risk scores. When examining offenders' perception of their own risk, those who believed themselves to be low risk were less likely to reoffend than those who perceived their risk as high. This result suggests perhaps that offenders are good judges of their need for treatment. It is also possible that high-risk offenders who readily admit their deviant interests do so because the behavior is ego-syntonic: They have less shame or guilt about their behavior, which ultimately provides less inhibition about victimizing others (Harkins et al., 2010). Denial may then provide a protective effect for some offenders, because it is motivated by prosocial characteristics such as fear of consequences and a desire to be viewed positively by others. Harkins et al. speculated that "to ease this discomfort between the competing thoughts/feelings, the individuals change their behaviors to be more consistent with someone who would not commit such offenses" (p. 89).

Despite the varied findings related to denial and recidivism, offenders themselves consistently rate offense accountability as one of the most important treatment components. In three separate studies across four states involving nearly 500 sex offenders in outpatient and in-patient treatment, the items rated as most important by the clients were accountability and victim empathy (Levenson, Macgowan, Morin, & Cotter, 2009; Levenson & Prescott, 2009; Levenson, Prescott, & D'Amora, 2010). Since these two concepts have not been consistently correlated with reduced recidivism, some have questioned whether they should be considered relevant treatment targets (Yates, 2009). It is possible that sex offender clients rated offense responsibility as so

important because they perceive it to be important to their therapists; after all, more than 90% of American sex offender treatment programs include offense accountability as a treatment target (McGrath et al., 2010). But when presented with a list of 18 common treatment targets and asked to rate the importance of each item, the overwhelming majority rated offense responsibility as “very important” (Levenson et al., 2009, 2010; Levenson & Prescott, 2009). Clients appear to believe that successfully altering sexually abusive behavior depends, in part, on recognizing and acknowledging the problem and its deleterious impact on others.

Successful correctional rehabilitation programs follow principles of risk, need, and responsivity (Andrews & Bonta, 2007). It may be that denial is more directly related to responsivity than risk. In other words, although denial might not directly contribute to a reoffense, it can prevent access to meaningful treatment opportunities that reduce the likelihood of future sexual aggression. Furthermore, readily accepting responsibility for one’s own damaging behavior might contribute to one’s enhanced belief that he has actually changed his ways as opposed to simply having attended treatment (Bem, 1972; Maruna, 2001).

Other researchers found that denial is associated with lower levels of therapeutic engagement and treatment progress and that offense responsibility predicted stronger engagement and higher measures of progress (Levenson & Macgowan, 2004). They concluded that reduction of denial should be emphasized as an integral part of the treatment plan, because failure to complete treatment is a risk factor for recidivism (Hanson & Bussiere, 1998). In a related study exploring motivation in treatment, sex offenders who displayed more remorse and accountability reported that they were more motivated to prevent reoffense (Barrett, Wilson, & Long, 2003).

In summary, though some studies identify denial and accountability as important treatment constructs, the research literature offers no clear and unequivocal empirical link between denial and sexual recidivism. Yates (2009) wrote:

Given this research, exclusion or termination of deniers from treatment would result in a significant number of offenders who do not complete treatment that could potentially reduce recidivism, based on a factor that may be unrelated to risk. This would appear to be a risky proposition indeed, and could, in fact, be considered ethically questionable (pp. 186-187).

The other side of the coin, however, is whether or not it is ethical for a therapist to treat a client for a problem he says he does not have. The clinician is faced with the dilemma of whether or not, and for how long, to work with a client in denial.

## Ethical Standards

Because the empirical literature offers no clear path for clinicians to follow, we turn now to the ethical codes of our professions. Over the past decade, the mental health professions have revised and modified their codes of ethics to incorporate the increasing

reality of court-ordered service provision. Both the APA (2003) and the NASW (1999) codes of ethics acknowledge that psychologists and social workers must tread cautiously and offer specific standards for working with mandated clients. For our purposes here, we will focus on the codes of APA and NASW, since according to the executive director of ATSA, psychologists and clinical social workers most typically provide sex offender services in North America.

### *Fundamental Values of Mental Health Professionals*

Professional ethical codes provide the foundation for decision making in clinical practice. The ethical codes of APA and NASW differ from each other in content, but they have important similarities in their emphasis of important fundamental concepts of ethical practice: Autonomy, beneficence, nonmaleficence, and social justice (APA, 2003; Glaser, 2003; NASW, 1999; Parsons, 2001; Ward et al., 2009). Autonomy implies that offenders should not be pressured into admitting; they have the right to determine their own values and goals. Beneficence is related to the therapeutic value in promoting offender well-being regardless of denial or admission of a crime. Nonmaleficence means ensuring that harm does not come to offenders or possible victims and hence it may make sense to treat deniers if they agree. Justice means not denying treatment to offenders simply because they do not conform to our expectations of the “ideal” client, but could also be interpreted in terms of accountability and the need to accept responsibility and make amends. Of course, sometimes these principles can conflict with each other when implemented in practice, complicating our decision making and creating a situation in which different and contradictory ethical actions might be appropriate. We will explore the issue of denial in sex offenders in the context of these important professional values.

### *Autonomy*

Both APA and NASW explicitly state that psychologists and social workers should respect the dignity and worth of the client. This concept is broadly known as the value of autonomy (Parsons, 2001) and notes the importance of and respect for a client’s right to self-determination. NASW further explains that “social workers seek to enhance clients’ capacity and opportunity to change and to address their own needs,” (Ethical Principles)<sup>1</sup> and APA speaks to protecting clients’ “autonomous decision making” (General Principles). Ward et al. (2009) described this principle as a “reminder that individuals have the right to formulate their life plans and decide what goals to adopt and how to realize them within the bounds of acceptable community standards” (p. 136).

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<sup>1</sup>The APA and NASW codes of ethics are obtained online and thus it is difficult to provide page numbers for quotations. Therefore the applicable sections are noted in lieu of page numbers.

Ethical sex offender treatment promotes autonomy by empowering clients to take responsibility for long-term behavior change and accepting their perception of their treatment needs. Because the most common path to sex offender assessment and treatment is through the courts, clients typically initiate services on a nonvoluntary basis and resistance and lack of motivation are, therefore, not unusual. Clinicians are challenged to recognize and reduce psychological defenses while appreciating clients' right to self-determination. At the same time, setting clear limits and boundaries can help clients become aware of the potential consequences of their decisions and facilitate informed choices. By modeling and promoting thoughtful rather than impulsive decision making, clinicians help clients enhance the potential for meaningful change.

Court-ordered therapy might have the potential to become coercive and it could be argued that "involuntary therapy" is an oxymoron. Coercion involves the use of force, intimidation, or threats to dictate the actions of others. Coercion can also be used as a form of motivation to compel an act or choice. Coercion in helping relationships can develop when there is a power imbalance between the practitioner and the client (Peterson, 1992). In court ordered services, an "unequal power balance in the relationship and the omnipresent threat of consequences to the client makes full consent impossible" (Peterson, 1992; p. 124) and, therefore, voluntariness is compromised. Yates (2009) expressed concern that some programs exclude deniers from treatment, while others might engage in coercive tactics to persuade clients to reveal all details of all their offenses.

However, court-ordered interventions need not be coercive. When clients are sent to treatment as part of the criminal sentence, it is the court that is requiring therapy, not the therapist. Treatment programs merely provide the mechanism for change if the client chooses to comply with the order of the court. Clients ultimately have a choice about whether or not to enroll or participate in treatment, and the court, not the treatment program, is responsible for imposing the penalties for those choices. One of the consequences of offending is that some degree of freedom is removed. Arguably, mandated treatment may be viewed by some as coercive, but the aims of treatment are partly to benefit offenders and, therefore, not intended as sanctions. While it is important not to ignore the possible autonomy violations that mandated treatment entails, the principles of beneficence and nonmaleficence might mitigate autonomy violations if the good of offenders and victims is promoted.

Of course, the principle of autonomy also implies that clients have the right to choose the extent to which they disclose information in treatment. But offenders in court-ordered treatment relinquished the "right" to deny their crime if they pleaded guilty to a sex crime. Often, this plea bargain was exchanged for a less severe sentence that included referral to treatment. Court-ordered interventions can create opportunities for change and growth that are otherwise unavailable to offenders. For instance, sex offenders rarely seek therapy voluntarily because they fear that mandatory abuse-reporting laws will lead to legal consequences. Thus, perhaps for the first time, mandated programs afford the offender an experience in which there is more to be gained

than lost by being open and honest about one's problems. Ultimately, the client must choose whether or not to engage.

The APA code of Ethics (2002) speaks directly to court-mandated services in section 3.10(c): "When psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding." NASW (1999) requires that "in instances when clients are receiving services involuntarily, social workers should provide information about the nature and extent of services and about the extent of clients' right to refuse service." (section 1.03(d)). Both APA and NASW caution against client abandonment; however, and social workers treating sex offenders in denial might heed the warning that they

should take reasonable steps to avoid abandoning clients who are still in need of services. Social workers should withdraw services precipitously only under unusual circumstances, giving careful consideration to all factors in the situation and taking care to minimize possible adverse effects (section 1.16(b)).

So, when sex offenders deny their offense and their need for treatment, what choices do clinicians have? In traditional psychotherapy, clients define the presenting problem and may not even enter into therapeutic services unless they perceive themselves to have a problem. In sex offender treatment, clients are required to seek treatment for a problem they might not agree that they have. The client has the right to self-determination and can refuse services, but must understand through the informed consent process that to be unsuccessfully discharged might be considered a violation of his sentencing conditions. The client is faced, then, with the choice to engage in the therapeutic intervention or not.

### *Benevolence and Nonmaleficence*

Benevolence and nonmaleficence can be described simply as the intent to improve the well-being of individuals and communities while doing no harm. The APA, in its description of its general ethical principles, overtly states: "Psychologists strive to benefit those with whom they work and take care to do no harm. In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons." The reference to other affected persons implies that when psychologists become aware that someone other than their client might be harmed, there can be, under certain circumstances, a professional duty to attempt to prevent that harm even when it may compromise the client's privacy or autonomy. NASW does not specifically refer to benevolence and nonmaleficence but does identify its first ethical principle as "to help people in need and to address social problems." The NASW code goes on to allow social workers to "limit clients' right to self-determination when, in the social workers' professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent

risk to themselves or others” (section 1.02). Thus, both ethical codes seek to maximize the benefit to client well-being while minimizing any potential harm to the client or others.

The central question here seems to be whether the decision to allow the denying client to remain in treatment will benefit or harm the client, and whether it might even benefit or harm others (potential victims). Yates (2009) argued that it would be ethically questionable to refuse a sex offender therapeutic services that could potentially reduce recidivism, based on a factor that may be unrelated to risk. In other words, if denying clients are not at higher risk to reoffend than admitting clients, Yates argued that there is no justification for discontinuing services. If therapy might be of some benefit to them even without admitting to the offense, then they should be allowed to continue in therapy.

The inference, however, that it is in the best interest of the client to maintain the secrecy by which sexual abuse thrives might also be perceived as ethically questionable. Allowing clients to withhold information relevant to assessment and treatment impairs the therapist’s ability to properly evaluate risk thereby compromising the client’s capacity to receive appropriate services to reduce risk and also to lead a better life. It is true that clients of all types may need time to develop trust and rapport and to fully share the nature of their problems with a therapist. It is generally expected, however, that in the initial stages of therapy, the client and therapist work together to define the presenting problem and develop a treatment plan which should be assessment-driven. In cases where sex offender clients categorically deny that they committed a sex offense, it might be unethical to develop a treatment plan to address problematic sexual behavior or to assume that the client can successfully complete sex offender treatment goals.

Preventing recidivism is one measure of successful sex offender treatment, but contemporary programs also incorporate other important goals and objectives. Relapse prevention goals focus on identifying the thoughts, feelings, and behaviors that culminate in the commission of a sex offense (Marques & Nelson, 1989). After better understanding offense patterns, offenders work on mastering alternative coping strategies in order to intervene in at different stages and stop the progression of unlawful and destructive sexual behaviors. Good lives models (Ward & Brown, 2004) emphasize the need for offender clients to find satisfying and fulfilling ways of encountering meaning and purpose in their lives socially, occupationally, and practically *as well as* reducing risk. In this way, treatment can focus on helping clients move toward positive and rewarding behavior rather than simply avoiding the negative consequences of sex offending behavior. As clients begin to understand the emotional needs that have been met through sexual assault, they can develop new strategies for meeting those needs in healthy and adaptive ways (Morin & Levenson, 2002; Ward & Brown, 2004).

Glaser (2003) has called sex offender treatment “paternalistic” and suggested that we are presumptuous and patronizing in our belief that we know what is best for clients. But surely, some of our actions are consistent with ethical principles of

beneficence and nonmaleficence. Courts and communities have become less willing to tolerate the behavior of persons who threaten the safety of others. Therapists are enlisted as instruments of change. Through therapeutic intervention, future victims are prevented while sex offender clients are helped to reduce the distress (and avoid the consequences) of engaging in unhealthy or unlawful behavior. Such an endeavor does indeed serve a client's best interest (beneficence) and reduces the likelihood of future harm to self and others (nonmaleficence). To collude with a client's absolute denial would be to disallow him the opportunity to change a behavior that leads to negative outcomes for himself and others, which might contradict the duty to "do no harm." Thus, it is evident that multiple ethical problems arise in practice. Sometimes the solutions to these ethical problems can conflict and clinicians need to make sure that a decision to override some ethical principles in certain contexts is justifiable (e.g., overriding autonomy to promote safety).

### *Social Justice*

NASW declares justice as one of its core values, and encourages social workers to strive to ensure that all people have fair and reasonable access to services, resources, opportunity, and meaningful participation in decision making. Similarly, APA proclaims the importance of equal access to quality psychological services. Ward et al. (2009) described how in forensic settings "this task can be challenging in light of clinicians' personal reactions to the difficult interpersonal characteristics of some offenders" (p. 135) and cautioned that "overt and covert prejudices" can potentially result in hostile or discriminatory practices with offender clients. Refusing to treat categorical deniers might be seen as contrary to the goal of social justice. We should heed Ward's warning to examine our own feelings, attitudes, and values to ascertain that our practices with clients reflect their needs and not our own.

Yates (2009) suggested that alternative treatment models such as the "preparatory" intervention in which categorical deniers can enroll in time-limited psychoeducational programming may provide an ethically acceptable alternative to simply excluding them from treatment programs (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Shaw & Schlank, 1996). Such a model provides therapeutic modules as if the client had committed an offense but does not require offense disclosure. The client then has the opportunity to explore how they came to be accused of a sexual crime, target thoughts and behaviors that led to the misunderstanding or misinterpretation, and prepare for how to prevent themselves from landing in such a position again. The hope is that through exposure to treatment concepts such as recognizing risk factors and restructuring distorted thinking, some clients might choose to acknowledge their sexual behavior problems but that all will nonetheless receive some benefit and internalize self-regulation skills (Yates, 2009).

Although categorical denier groups provide one alternative to traditional treatment, the question remains whether we can ethically say that after such a program clients have "successfully completed" sex offender treatment. This raises the issue of what

successful completion really means. From an ethical viewpoint it could mean actually accepting full responsibility for the offenses, making a commitment to personal change, and seeking to make amends. In part, this may include addressing aspects of their lives that were instrumental in contributing to their offenses. Successful completion is more than simple attendance at or exposure to therapy; it should mean that the client incorporates demonstrable changes into his life that render him less likely to sexually harm others in the future (Levenson & Prescott, 2007).

Other ethical considerations also exist in the context of social justice. When deniers are placed in traditional sex offender therapy groups, they have the potential to change the dynamics of the group process, sometimes even to poison the process. Especially when more than one denier exists in a group, the focus can shift from productive work to a focus on defensive posture and external attributions of blame. Though these proclamations sometimes provide opportunities for appropriate and helpful peer confrontation, when denial persists, it can inhibit other clients from freely participating instead of reinforcing a climate of openness and willingness to change. Because denial appears to interfere with meaningful engagement in therapy (Levenson & Macgowan, 2004), clients who alter the group process to something less than fruitful might be seen as denying social justice to those who have a desire to change.

## **Implications for Treatment**

A dilemma is defined by Merriam-Webster's Dictionary as "an argument presenting two or more equally conclusive alternatives; a usually undesirable or unpleasant choice; a situation involving such a choice; a problem involving a difficult choice." Thus, ethical dilemmas have no clear answer, and in clinical practice, the best solution is to develop a process for ethical decision making based on the standards and ethical code of your profession while considering the available empirical research. The issue of denial creates various ethical dilemmas for practitioners and there are no easy answers. The following considerations might be helpful when therapists are confronted with decisions about clients in denial. They are not specific prescriptions, but rather food for thought when contemplating the right thing to do.

### *Clinicians Should Consider Denial to be an Expected Defense Mechanism and Utilize Engagement Strategies to Reduce the Shame and Anxiety That Lead to Resistance to Treatment*

It is expected that sex offender clients will present with varying degrees of denial, and the defensive functions of denial should be recognized while reduction of denial and promotion of accountability are pursued as therapeutic goals (Schneider & Wright, 2001). Though confrontational approaches to sex offender treatment have been historically common, motivational approaches are now becoming more popular (Brown,

Carich, & Christie, 2010). When a direct but supportive style of treatment is offered, resistance may be reduced and clients perceive respect and hope (Marshall, 2005; Marshall et al., 2003; Yates, 2009). A recent and growing literature has encouraged sex offender therapists to utilize a positive and empathic approach that facilitates and supports client ownership of change rather than confrontational or punitive approaches (Beech & Fordham, 1997; Jenkins, 1990; Kear-Colwell & Pollock, 1997; Marshall, 2005; Marshall et al., 2001, 2003; Winn, 1996; Yates, 2009). The goal of such an approach is to promote change by creating a more constructive and nonjudgmental environment that gives clients permission to choose to engage in treatment. By providing acceptance of clients without condoning their behavior, clinicians can encourage them to acknowledge behaviors and characteristics that upon reflection they may wish to alter. Motivational approaches can facilitate cognitive dissonance, inducing a desire to engage in treatment and leading to the belief that change is possible (Kear-Colwell & Pollock, 1997; Prescott, 2009). Ultimately, motivational models empower the client to choose to participate in the therapeutic process rather than have the intervention imposed by the therapist (Birgden & Vincent, 2000; Prescott, 2009).

When clinicians fail to respond effectively to hostile, resistant, or critical sentiments expressed by clients a negative process can occur, inhibiting the client's engagement (Binder & Strupp, 1997; Teyber & McClure, 2000) and creating both an ethical and a pragmatic therapeutic failure. Some researchers suggest that therapists of every theoretical orientation respond at times to clients' resistance with anger, emotional withdrawal, or subtle rejection (Binder & Strupp, 1997). Therapists who treat sexual abusers may be especially vulnerable to this negative process, since most offender clients are nonvoluntary and often enter treatment programs with resistance and denial (Jenkins-Hall, 1994; Jennings & Sawyer, 2003; Marshall et al., 2001; Serran, Fernandez, Marshall, & Mann, 2003; Winn, 1996). Binder and Strupp noted that negative process has seldom been addressed by researchers but may account for treatment failures in all therapeutic modalities and client populations. Sex offender therapists are encouraged to explore the ways in which their own beliefs, values, attitudes, and experiences might impact their own engagement skills and to seek peer consultation when they experience negative affect toward a client. Approaching these negative encounters through an ethical as well as a therapeutic lens can help practitioners to avoid clinical pitfalls.

At the same time, negative process can affect group dynamics as well, and when deniers dominate group therapy sessions, little work can be done. Though peer confrontation can be useful, persistent denial can inhibit other clients from being forthcoming in treatment. Therapists can foster a group climate in which members establish norms regarding peer support and confrontation, model helpful interactions, and practice effective communication skills (Macgowan, in press). Denying clients might be most responsive when confrontation is initiated by peers rather than authority figures (Clark & Erooga, 1994). When members see honesty and disclosure being rewarded with support and encouragement, anxiety and threat are reduced, thereby decreasing the need for defensive posturing.

### *Denial Should Be Viewed as a Continuum of Minimization and Rationalization, and Addressed as Part of the Cognitive Distortions That Are Commonly Found in Sexual Offenders*

Most forms of denial represent thinking errors typically intended to rationalize behavior and diminish responsibility—a defensive process that is not unique to sexual offenders (Yates, 2009). Yates (2009) pointed out that excessively emphasizing the disclosure of offense details may not be the best use of treatment time and resources. It is important for the clinician to have an overall understanding of the client's offense history in order to properly assess behavior patterns and risk factors to help with prevention planning. But a primary focus on offense details may prove less crucial than addressing the thinking errors and distorted attributions that accompanied those behaviors (Marshall et al., 1999). Research suggests that viewing denial as a continuous rather than a categorical construct might be useful in gauging a client's progress, risk, and responsivity while establishing cognitive targets for change (Langton et al., 2008; Levenson & Macgowan, 2004; Nunes et al., 2007; Schneider & Wright, 2001).

When challenging denial with sex offenders, Winn (1996) advised therapists to respect the protective function of denial while empathically challenging the offender's need to protect himself. Winn suggested confronting not the content of the offender's position, but rather the defenses responsible for reinforcing the distortions, and described this meta-confrontation as a process of challenging the offender to challenge himself (Winn, 1996). Therapeutic confrontation of denial involves more than simply disputing the facts or inconsistencies in an offender's description of his case. Asking an offender to explain the discrepancies in his story often causes the client to respond with defensive affect. More useful and effective is the confrontation of the defensive barriers to disclosure. Trepper and Barrett (1989) suggested that the therapist should acknowledge the negative consequences of giving up denial. Asking an offender what it would feel like for him to admit to a sexual crime will reveal the internal conflicts the offender is experiencing, and by acknowledging those potential conflicts in an accepting manner, the therapist leads the offender to believe that he will be understood if he discloses (Trepper & Barrett, 1989). Winn (1996) agreed that therapists should acknowledge the real and perceived consequences of change that underlie denial and may cause clients to resist engagement.

### *Programs Should Allow a Reasonable Time Period for Clients to Engage in the Therapeutic Process, but Should Not Allow Denial to Persist Indefinitely and Should Not “Graduate” Categorical Deniers or Consider Them “Successful Completers.”*

Many practitioners agree that it is difficult, if not impossible (and probably unethical), to treat a client for a problem which he says he does not have. Therefore, most contemporary treatment programs identify the acknowledgment of an offense and acceptance

of responsibility as necessary treatment goals. It is also clear that all psychotherapy clients need time to develop trust and rapport and that change is difficult.

Even after using the best therapeutic tools they have available, clinicians might find themselves unsuccessful at engaging some clients. Because negative group process can inhibit individual participation, and because some clients will hold onto their categorical denial for as long as they are able, forcing the choice can in fact be a therapeutic approach. When faced with the consequences of nondisclosure, an absolute denier may ultimately decide that there is more to be gained by admitting than denying. There is no way to prescribe or designate a specific time frame for allowing deniers to engage (this respects autonomy). The decision should be based on a clinician's estimate of the client's response to engagement techniques, the interaction between group members and the consequences of the denial on the group process, and collaboration with correctional supervisors. Anecdotally, some clinicians suggest a range of 1-6 months in a good working group. One therapist observed that whatever the time period allotted, some clients will hold onto their denial as long as allowed, so a shorter time frame for engagement might be more fruitful. Again, this time should be used for engagement purposes, and framed to the client as an opportunity to listen and observe what treatment has to offer. Ultimately, the clinician must ask, and be prepared to defensibly answer: How can a client successfully complete treatment for a problem he does not have? And, is it ethical to indefinitely take payment from a client for a treatment he says he does not need?

### *What If He Really Didn't Do It?*

There is no available research to ascertain the number of clients in treatment settings who are innocent, and perhaps there is no valid and reliable way to study the question. I can say from my own experience after counseling more than 1,000 sex offenders in outpatient therapy that clients have persisted in declaring their innocence very infrequently. The overwhelming majority of clients, after spending a few months in an engaging and accepting clinical atmosphere, acknowledge at least some problematic aspect of their sexual behavior and express a need for treatment. If, however, despite the clinician's best efforts at engagement, a client claims to have been wrongly convicted by a jury or encouraged by his legal counsel to enter an undesirable plea, his denial is more properly addressed in a legal setting than a clinical setting. Therapy is designed to assist clients to alter their undesirable behaviors, improve their psychosocial functioning, and enhance their adaptive coping skills and interpersonal relationships. Unfortunately, the therapeutic environment cannot right a wrong in the criminal justice system, and that goal is not properly addressed in our treatment programs.

## **Summary and Conclusions**

Denial is a defense mechanism common to all individuals, including those charged with unlawful sexual behavior. Clinicians should view denial not as a categorical

construct but as a continuum of distorted cognitions requiring clinical attention. The empirical literature does not provide an unequivocal link between denial and recidivism, though a decreased level of minimization and increased personal accountability appear to be associated with greater therapeutic engagement and, for some clients, reduced recidivism. It could also be argued that acceptance of responsibility for offending is one place where the ethical and therapeutic aspects of treatment most clearly converge; accountability and amends are components of a moral and just society and are also factors in the therapeutic change process. Denial might be best perceived as a responsivity factor that can interfere with treatment progress. The ethical codes of APA and NASW value the client's self-determination and autonomy, and encourage practitioners to be mindful of the universal right to access services. Psychologists and social workers have a duty to empower individual well-being while doing no harm to clients or others. The ethical codes offer no clear resolution to the problem of sex offender denial, but therapists should balance opportunities to facilitate treatment from which clients might benefit with the dangers of collusive practices and damage to group dynamics.

The major ethical considerations when addressing denial include autonomy, beneficence and nonmaleficence, and social justice. Clinicians should respect clients' autonomy and self-determination and should never abuse their authority or coerce clients. Our role is to promote the well-being of clients and communities while doing no harm; we can simultaneously help sex offender clients to lead better lives and prevent future victimization by encouraging the ethical and therapeutic values of accountability and amends. Finally, justice is facilitated when all clients have equal access to quality services and when therapists provide fair opportunities for clients to realize the benefits of treatment.

Practitioners should create a safe, nurturing environment where clients perceive for the first time ever that there is more to be gained than lost by talking about their sexually abusive behavior. Offering a reasonable time period for therapeutic engagement might provide a better alternative than automatically refusing treatment to categorical deniers. Therapists can work collaboratively with corrections to modify the contingencies of reinforcement that encourage client participation in treatment. Ultimately, it may not be ethical to treat someone for a problem they say they do not have, and those who claim to have been wronged by the criminal justice system are better served by legal counsel than by clinicians.

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