# Is Denial an Obstacle to Effective Interventions with Perpetrators of Sexual Offences?

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**Summary:** Denial of sexual offending is complex, can hinder the development of positive working relationships between the person who has offended and practitioners, and can represent a barrier in accessing necessary treatment programmes. This paper reviews the literature relating to denial and perpetrators of sexual offences, considers the prevalence of denial, explores the function and motives underpinning denial, and examines the research evidence vis-à-vis the relationship between denial and the risk of sexual reoffending. It is important to explore whether the acceptance of responsibility is a prerequisite to positive treatment outcomes, by exploring the empirical evidence to date. Where the research does not provide an unequivocal link between denial and reoffending, should a focus remain on the acceptance of responsibility? The paper explores some of the developments in treatment programmes, and options for working with deniers. It concludes that excluding those who are perpetrators of sexual offences from treatment, for empirically unsound reasons, denies this significant grouping access to therapeutic supports that may potentially help them and importantly, reduce the risk of their reoffending.
**Keywords:** Denial, Probation Service, sexual offending, risk factors, sex offender treatment programmes, supervision, responsibility, reoffending.

## Introduction

A significant number of perpetrators deny having committed sexual offences. Academic research suggests that individuals who remain in total denial of sexual offences are traditionally excluded from treatment programmes. Historically, denial of sexual offending has been viewed by the Probation Service as an important issue, and there appears to be a very real dilemma as to how it can be addressed. This sizable client group can be difficult to work with therapeutically and often falls into a 'limbo', but nonetheless presents as

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individuals with specific treatment needs. Intuition, in the absence of 'best practice guidelines', dictates that doing no therapeutic work with this group does little to mitigate against the risk of reoffending. Empirical research has suggested that sex offender treatment targeting risk factors for recidivism is more likely to be effective in reducing reoffending (Hanson and Morton-Bourgon, 2005). Therefore, the question of what to do with 'deniers' is ever more pertinent.

This article explores the traditional viewpoint that individuals cannot successfully complete treatment for a problem that they deny. The consensus was often that those in denial were not yet 'treatment-ready', as they had failed to take responsibility for their crime. The article examines denial as a concept in the context of sexual offending, exploring the evidence relating to denial and treatment outcomes. Hanson and Morton-Bourgon (2005) conducted a meta-analysis, which indicated that denial was not a predictor of sexual recidivism. Since then, there is little evidence that an increase in 'accepting responsibility' leads to a reduction in reoffending. Mann *et al.* (2010) postulate that denial may even be a protective factor for offenders. This article explores the function of denial as a protective behaviour and its link to sexual reoffending, focusing on the developments in sex offender treatment, and assessing the importance of accepting responsibility for sexual offending.

## The concept of denial

The concept of denial is not a phenomenon exclusive to the therapeutic processes. 'Wearing blinkers' and 'burying your head in the sand' are everyday phrases alluding to denial.

It has been acknowledged that there is little evidence linking denial with recidivism in the context of sexual offending (Hanson and Morton-Bourgon, 2005; Mann *et al.*, 2010). Research now consistently indicates that successful completion of sex offender treatment programmes reduces risks of recidivism (Schmucker and Lösel, 2017).

As practitioners, we often observe that denial, in the context of committing offences, or in relation to aspects of the offence, is common among perpetrators. Studies examined the demographic and psychological differences between 'deniers' and 'admitters', but research-supported means of differentiating between the two groups, based solely on their response patterns, is lacking (Ware *et al.*, 2020).

We also observe that many individuals often deny or minimise aspects of their sexually abusive behaviour. Despite being a complex issue, many treatment models simplify denial into a dichotomy of right and wrong.

## Denial and empirically supported risk factors

Maletzky (1991, p. 254) reported that 87 per cent of his clients denied all or part of their crimes. Marshall (1994, p. 560) outlined that 32 per cent of a sample of sex offenders significantly minimised aspects of their offending, while a further 31 per cent completely denied their offences. Various research illustrates that between 30 per cent and 35 per cent of incarcerated sex offenders deny resolutely that they have committed the offence (Kennedy and Grubin, 1992; Hood *et al.*, 2002). In a study of treatment programmes in Canada and the United States (US), McGrath *et al.* (2010) found that 91 per cent of programmes for adult sex offenders incorporated 'taking responsibility' as a treatment target. In contrast, Mann *et al.* (2010) did not cite 'not taking responsibility' as an empirically evidenced causal factor for sexual offending or successful treatment outcomes.

While the Association for the Treatment of Sexual Abusers (ATSA) defined denial as the failure of sexual abusers to accept responsibility for their offences (ATSA, 2001, p. 63), the DSM-IV-TR defines denial as 'a defence mechanism in which the individual deals with emotional conflict, or internal or external stressors, by refusing to acknowledge some painful aspect of reality or subjective experience that would be apparent to others'.

Clinical interest in issues of denial and accountability originated in the 1960s (Resnik and Peters, 1967; Hitchens, 1972). Finkelhor (1984) was among the first to acknowledge the role of cognition in explaining sexual abuse. He asserted that individuals must overcome internal and external inhibitions, as well as the resistance of the victim, for sexual abuse to occur. Perpetrators must, therefore, find ways to avoid taking responsibility for, or to deny the harmfulness of, behaviours that they would otherwise understand as abusive.

Abel *et al.* (1984) concluded that explanations provided by perpetrators were not mere excuses and justifications but represented beliefs or cognitive distortions that pre-existed with such individuals to legitimise to themselves sexual contact with children. Ó Ciardha and Ward (2013) describe cognitive distortions in sex offenders as specific or general beliefs and attitudes that violate commonly accepted norms of rationality, and which have been shown to be associated with the onset and maintenance of sexual offending. The

strength of Abel's theory lies in its attention to the functions of distortions and the function of self-esteem maintenance. Critics of the theory, including Ó Ciardha and Ward (2013), argue that it does not address how cognitive distortions develop in those who offend later in life or those not deemed to have a deviant sexual interest.

Subsequently, clinicians began systematically reporting the prevalence and characteristics of denial among their client group (Barbaree, 1991; Maletzky, 1991; Marshall and Barbaree, 1990; Schneider and Wright, 2004; Ware and Marshall, 2008). These reports attest that denial and cognitive distortions were pervasive characteristics among those who committed sexual offences.

Authors who have emphasised complete denial have referred to it as 'categorical denial' (Marshall *et al.*, 2001), or 'absolute denial' (Barbaree, 1991; Schlank and Shaw, 1996). Although the terms vary, these constructions share similar features. They describe individuals as either 'in' or 'out' of denial, often with the assumption that denial results from conscious attempts to evade blame. Research focuses on the dichotomy of 'deniers 'and 'admitters' while largely disregarding or classing other types of denial as minimisation.

A commonsense rationale has traditionally dictated an importance of individuals admitting and taking responsibility for their offending as an integral aspect of treatment. Furthermore, most treatment programmes encourage their participants to take responsibility for their offending (Ware and Mann, 2012). However, Mann *et al.* (2010) excluded 'admitting the offence' or 'taking responsibility' for offending in their inventory of empirically determined risk factors for sexual offending, and consequently they did not include them as treatment targets.

Mann *et al.*, (2010) argue that risk assessment and treatment for sex offenders should focus on individual characteristics associated with the risk of reoffending. They outline that there is no unique risk factor that is associated with reoffending and, therefore, a range of risk factors must be considered. Andrews and Bonta (2010) use the term 'dynamic risk factors' to explain psychological or behavioural traits that increase the risk of reoffending but are potentially changeable.

Regarding sex offender treatment, the most useful variables are those that are amenable to change. Mann *et al.* (2010, p. 199) highlight the risk factors that are empirically supported regarding sexual reoffending. These include sexual preoccupation; sexual preference for children; sexualised violence; multiple paraphilias; offence-supportive attitudes; emotional identity with children; lack of emotionally intimate relationships with adults; lifestyle

impulsivity; poor problem-solving skills – for example, cognitive difficulties in generating and identifying effective solutions to the problems of daily living; resistance to rules and supervision; grievance and hostility; and negative social influences.

## Purpose and functions of denial with perpetrators

Outside the field of sex offender treatment, denial and excuse-making are widely regarded as normal phenomena and observed as a common defence mechanism.

Arguably, those who perpetrate sex offences, more than any offending group, are subject to public indignation, and it is rational that many individuals would deny their offences. Denial in this context could be observed as a protective mechanism in relation to self-identity and minimisation of shame and stigma. Blagden *et al.* (2014) describe themes in relation to the function of sex offender denial – how it allows the person to maintain a sustainable identity of themselves as a parent, spouse, colleague, and so on. Ware *et al.* (2015) also argue that it is not surprising that an individual accused of committing a sexual offence will seek to deny some or all aspects of their responsibility as a self-protective strategy.

Ware and Mann (2012) summarise the motivations for categorical denial as falling into three categories: planning to reoffend; preservation of self-esteem; and fear of negative social consequences.

Individuals with low self-esteem or elevated levels of shame are highly likely to deny or minimise their actions to protect fragile self-worth and avoid emotional distress. Research consistently illustrates low self-worth and elevated levels of shame among sex offenders (Marshall *et al.*, 2009). Ware and Mann (2012) articulate that people usually decide to deny their behaviour following a swift decision-making process, having assessed the potential consequences of accepting responsibility. In practice, we often observe that for this grouping the long-term consequences of accepting responsibility at the point of an allegation are negative.

Schneider and Wright (2004) articulate that given the threat to the person's social status, integrity, and family stability, there is significant pressure to deny and distort information about having committed a sexual offence, not just to others but also to themselves. Others argue that denial is a conscious process. Stevenson *et al.* (1989) outline that 'suppression', rather than denial, may be a more appropriate description for the process that many sex

offenders go through. Ware and Mann (2012) propose that a potential reason for denying sexual offences may be to facilitate the possibility of future offending.

Rogers and Dickey (1991) propose an adaptational model explaining the prevalence of denial among those who commit sexual offences. They argue that denial arises as a response to an adversarial situation where many life-changing negative consequences to admitting an offence exist, and therefore denial seems a better option. The adaptational model proposes that the person has too much to lose by disclosure. Rogers and Dickey assert that such defensiveness is considered an attempt to cope with a highly adversarial setting with far-reaching consequences. This model suggests that the greater the anticipated benefit from denial, the greater the likelihood of it.

Ware *et al.* (2015) conclude that the reason for denial remains unclear and a critical area for future research. They highlight limited evidence that suggests denial serves a function to escape feelings of shame and the probable consequences of being 'branded' as a sex offender, while endeavouring to maintain relationships with family and friends. Dealey (2018) concludes that denial can be self-preservation, but it can also be self-limiting, cutting off the person's access to future focused treatment. The reason why perpetrators of sexual offences deny remains complex and unclear, representing an area for further research. The limited evidence suggests that avoiding feelings of shame and the consequences of being identified as a 'sex offender', as well as an aspiration to maintain relationships with family and friends, represent the motivations for this grouping. The indication that denial reflects a desire to continue offending seems to be unfounded.

## Continuum of denial

The topic of denial may be considered in the context of a continuum. Blagden *et al.* (2014) suggest that most perpetrators of sex offences deny at least one aspect of their offending and these aspects fall along a spectrum of deception.

Denial should not be assumed to be a deliberate and conscious distortion in sex offenders, and there are multiple reasons why people deny, which need our consideration. Denial may refer to denial of harm to the victim, denial of responsibility, denial of a need for treatment, denial of frequency or planning (Marshall *et al.*, 2001). Barbaree (1991) identifies three forms of denial: (1) complete denial; (2) acknowledgment of consensual sexual behaviour but denial of offence; (3) acknowledgment of contact, but denial of sexual contact.

Many authors have made the distinction between minimisation of the offence, or aspects of the offence, and 'absolute 'or 'categorical' denial, where the individual refutes having committed any sexual offence. There is also recognition that there exist 'partial' deniers who admit engaging in forms of sexual activity but deny any actual sexual assault. This category would often allude to the victim consenting, enjoying or gaining from the experience. Marshall *et al.* (1999) describe 'minimisers', sex offenders who admit the offence but minimise responsibility, details of the offence, harm, planning or fantasising.

Denial has often been considered an 'all-or-nothing' phenomenon, in which an individual either denies or admits everything. Salter (1988) argues that denial falls on a continuum, with varying degrees, ranging from admission with justification to absolute admission with acceptance of both responsibility and guilt. Happel and Auffrey (1995) refer to the 'dance of denial' as having twelve steps, including denial of the behaviour itself, denial of intent, planning and premeditation, denial of relapse potential, and possible reoffending. Ware and Mann (2012) describe failure to accept responsibility as ranging from absolute denial through a variety of levels of minimisations to a complete acceptance of responsibility. Craissati (2015) highlights that less has been written about the possible relationship between total denial and partial denial – whether they are distinct traits or features on a single continuum.

Schneider and Wright (2004) used categories of denial identified in various typologies. They contend that many clinicians and scholars have acknowledged that denial is not an all-or-none phenomenon, but a complex, multifaceted construct.

## Constructive denial

Reicher (2013) argues that denial can never be absolute, as some information must be registered for it to be disavowed. Hanson and Bussière (1998) and Yates (2009) propose that denial and cognitive distortions represent an understanding on the part of the individual that their behaviour is wrong; that the person denies their behaviour because, at some level, they recognise that the behaviour is harmful and they are reluctant to admit this. Viewed in this way, denial could be regarded as a healthy response to offending behaviour and as a strong starting point in treatment.

Reicher contends that denial is inherent to sexual abuse and, far from constituting an obstacle, can be used to therapeutic advantage (2013). It may

be viewed as a rich source of information about the client (e.g., cognitive processes, value system, and emotional dynamics). Schneider and Wright (2004) propose that, when viewed as a challenge rather than an obstacle to treatment, denial informs intervention decisions and therapeutic strategy. Denial may offer a source of clinical information about the individual's worldview and values. Schneider and Wright (2004) argue that interventions designed to assess not eliminate denial are likely to produce information that reveals the varying contexts where perpetrators feel justified to avoid responsibility for their deviant behaviours. Maruna (2004) argues that the 'constructive use of cognitive distortions', like externalising blame, may promote desistance and personal reform, which may in itself be a cognitive distortion of sorts. Such information can then become the target of therapeutic efforts.

In the context of sexual offending, denial falls on a continuum, with varying degrees of denial, ranging from admission with justification, to absolute admission with acceptance of both responsibility and guilt.

The literature suggests that denial serves several functions for those who commit sexual offences and their families, and deniers may have certain characteristics distinguishing them from admitters.

Denial may inform intervention decisions and therapeutic strategies and can potentially offer a source of clinical information about the individual's worldview and values.

## The development of sex offender treatment

Most of the significant developments in sex offender treatment have occurred since the 1970s. The move towards behavioural approaches from psychoanalytical or group psychotherapy during the 1960s was accompanied by attempts to evaluate empirically the benefits of treatment.

The 1990s saw the introduction of empirically based risk assessment tools. These tools were considered useful regarding decision-making around supervision and levels of intervention necessary but did not allow for modifiable treatment targets. The tools helped to distinguish higher-risk from lower-risk offenders. Prior to this, perpetrators were placed on the same programme, and therefore to treat those deemed to be higher-risk most effectively, it would have been necessary to overtreat those considered lower-risk.

Hanson and Harris (2001) introduced a changeable risk assessment that identified dynamic risk factors. Hanson and Bussière's (1998) meta-analysis of

reoffending studies involved 61 studies and 28,972 sex offenders and helped to determine the relationship between a wide variety of factors and subsequent reoffending. Andrews and Bonta (2010) developed the Risk–Needs–Responsivity (RNR) model, in which interventions match the intensity of treatment to level of risk. It specifically targets criminogenic needs and tailors treatment to the needs and capacities of participants. However, this model has been criticised for an apparent failure to appreciate the totality of client needs, specifically with respect to offender-responsivity concerns (Wilson and Yates, 2009).

Marshall *et al.* (2005) echoed concerns regarding the RNR model, citing the emphasis on negative issues in both targets of treatment and language used in treatment, an absence of a collaborative focus to work with clients, and a dearth of emphasis on the role of the therapist. Subsequently, Marshall and others proposed a more positive approach to working with perpetrators of sexual offences. The therapists' role was, they believed, to assist the person in identifying the needs being inappropriately met by sexual offending, setting goals that will allow them to lead a socially acceptable and satisfying life without offending. Marshall *et al.* (2005) described the need for a therapeutic climate conducive to generating optimism and hope in the client, regarding achieving the said goals.

Another embodiment of this approach is the 'Good Lives Model' (GLM), which was developed by Ward (2002) and was derived from a focus on research into how people thrive, attain self-satisfaction and successfully meet their goals (Ward, 2002; Ward and Marshall, 2004). The GLM asserts that sexual offending results from a failure to meet basic human needs in ways that do not harm others. It proposes that by developing skills, competency and capabilities to achieve those things they value in life, the person will lead a more positive, fulfilling life and where life goals are no longer consistent with offending behaviour. Critics of this model emphasise the lack of empirical evidence to support its efficacy (Ogloff and Davis, 2004). However, Mann *et al.* (2004) established that therapists working with perpetrators found their clients to be more motivated to live offence-free lifestyles following treatment using the GLM. Dealey (2018) found that the GLM approach can work with denial because of its broad scope, collaborative aims, and orientation towards human good in the form of approach goals.

## The case for denial as a risk factor

Andrews and Bonta (2003), when considering the 'need principle' of offender rehabilitation, outlined that acceptance of responsibility would be an important treatment target only if there was an established relationship between a lack of taking responsibility and risk of recidivism. Early research by Beckett *et al.* (1994) and Kennedy and Grubin (1992) found that reducing denial and minimisation did not produce changes in other treatment targets. Hanson and Morton-Bourgon (2005) and Langton *et al.* (2008) found no overall effect of denial on sexual reoffending. It is noteworthy that despite significant meta-analysis (Hanson and Bussière, 1998; Hanson and Morton-Bourgon, 2005), which clearly indicates that denial of sexual offending behaviour fails to predict sexual reoffending, substantial emphasis remains on the targeting of denial and minimisation within treatment programmes for sex offenders (Maletzky, 1996; McGrath *et al.* 2010). Turner (2022) argues that despite there being no clearly established correlation between admitting to their offence (including showing remorse) and a reduction in reoffending, many treatment providers work from the premise that 'breaking through' denial is a critical step in therapy and would agree that people benefit from accepting responsibility for their offending behaviour.

Harkins *et al.* (2015) reference the Offender Assessment System (OASys) question 'Does the offender accept responsibility for the current offence?' in a sample of 7,000 adult male sex offenders in England and Wales. The results indicated that, in the full sample, denying responsibility was predictive of lower levels of sexual reoffending, independent of risk level.

Mann *et al.* (2010) offer the hypothesis that denial would be a protective factor for an individual demonstrating genuine positive overall change in other areas but, on the other hand, denial may increase the risk for those who remain unyielding to change and committed to a deviant lifestyle. In relation to sex offender treatment, Langton *et al.* (2008) argue that admitting the offence at an early stage of treatment is thought to increase the motivation to participate in treatment.

The previously cited research illustrates that there is not a distinct correlation between denial and reoffending. However, it poses the question as to why there remains such a focus on denial and accepting responsibility within the context of sex offender treatment. More recently, a focus on working with those in denial has emerged in response to the identified unmet needs of this grouping.

## Working with deniers

Most early approaches, as observed by Schneider and Wright (2004), were developed on the supposition that denial of an offence was a barrier to effective treatment, which must be overcome. Marshall *et al.* (2001) acknowledged that a failure to engage therapeutically with this group presented a problem. Blagden *et al.* (2011) found that professionals working with people who had committed sexual offences believed that deniers posed an elevated risk of reoffending, with the basis for these beliefs being intuition.

Donoghue and Letourneau's early work with deniers (1993, p. 300) focused on overcoming denial. They reported that 65 per cent of deniers admitted responsibility after programmes that incorporated cognitive restructuring and educational components. Brake and Shannon (1997) and Schlank and Shaw (1996) described similar programmes, which succeeded in deniers taking responsibility for their offences. Marshall (1994) attempted to combine deniers with admitters in the same treatment programme. Although these approaches generated some success, they were time-consuming and often confrontational (Marshall *et al.*, 2011). As denial has been demonstrated not to be a criminogenic factor (Hanson and Morton-Bourgon, 2005; Marshall *et al.*, 2011), the efforts and goals of such programmes are, therefore, questionable. Marshall contended that those who participate in such programmes are no less likely to reoffend than those who have received no treatment. The assumption with early approaches was that accepting responsibility for the offence was a prerequisite for effective treatment (Barbaree, 1991). However, Hanson and Bussière (1998) and Hanson and Morton-Bourgon (2005) found no relationship between denial of the sexual offence and sexual reoffending in either treated or untreated offenders, while Maletzky (1996) discovered no variances in the long-term outcome of 'treated' admitters versus 'treated' deniers. Beckett *et al.* (1994) and Kennedy and Grubin (1992) demonstrated that reducing denial did not, in turn, produce changes in other treatment targets.

Marshall *et al.* (2001) formulated an alternative approach to treating those in categorical denial. The programme was exclusively for deniers and set aside the issue of denial, instead focusing on empirically identified risk factors. The therapeutic goal was presented to the individual as aiming to identify the pathways that led to their being, in their view, 'falsely' accused of sexual offences, to ensure that the situation was never repeated. Marshall *et al.* (2011) describe this as a motivational approach that addresses the

significant issues leading to the accusation without having to deal directly with the issue of their denial. All other variables of the programme remained relevant. This approach has, therefore, effectively served to engage clients and facilitate a process of addressing issues relevant to risk. Marshall *et al.* (2011) contended that an early evaluation of the 'deniers group' illustrated no difference in treatment outcomes between the deniers group programme and the programme for those who had admitted their offences. The findings emphasise the limitations regarding the focus on individuals accepting responsibility in the context of good treatment outcomes.

Ware *et al.* (2015) conclude that approaches to the treatment of sex offenders in categorical denial have taken three forms: (1) exclusion from treatment; (2) active attempts to overcome denial; and (3) placement in a treatment programme where there is no attempt to overcome the denial, but which otherwise addresses criminogenic features.

## Does taking responsibility matter?

Moral and social norms along with practices in day-to-day life, coupled with the processes of the criminal justice system, view taking responsibility as a noble, worthwhile trait. Considering the research outlined earlier, the question of what taking responsibility means and why it may be important in the context of sex offender treatment prompts more analysis.

Schlank and Shaw (1996) argue that perpetrators take responsibility only when they have stopped denying/minimising and have acknowledged all aspects of their problems that instigated the sexual abuse. Ware and Mann (2012) argue that most definitions of taking responsibility in the context of sex offending require an individual not only to admit that they did it; they must also describe how and why they did it.

In terms of the victim, acceptance of responsibility is beneficial in the context of the healing process and it has a restorative justice function. It is important to acknowledge the importance of the emotional impact experienced by victims and the potential benefit to them of a perpetrator accepting their guilt. Salter (1988) argues that disclosing the truth enables individual offenders to take responsibility for their actions. Theriot (2006) outlines that without agreement between the perpetrator's account and those of the victim, treatment will be more challenging and less likely to be effective. Levenson (2011) proposes that a potential reason for the emphasis by therapists on acceptance of responsibility may lie in such accountability being

considered imperative within our societal values. Levenson also articulates that failure to address the denial during treatment might lead to assertions of collusion with the perpetrator and maintenance of the secrecy in which abuse can prosper.

It is noteworthy that some have reported the value of outlining an account of their offence during treatment. Levenson and Prescott's (2009) study following a treatment programme found that participants described accepting responsibility for their offences as the most important component of the programme. Similarly, Levenson *et al.* (2009, p. 7), in a separate study of a community treatment programme, found that 94 per cent of participants regarded accepting responsibility as a crucial constituent of their programme. Levenson *et al.* (2009) articulated that these studies reflect a long-standing belief among therapists that it is unrealistic to make meaningful progress without the client's acknowledgement of their problem. Such studies would seem to suggest significance in accepting responsibility within the framework of treatment.

However, Wakeling *et al.* (2005, p. 180), in an earlier study, found that only 22 per cent of participants cited accepting responsibility and giving an account of their offence as a helpful aspect of their treatment. Also, Waldram (2008) outlined how participants in treatment programmes often recognise what therapists view as significant and can construct a view to reflect this, whether or not they themselves necessarily believe it. Overall, the evidence is limited for the importance of acceptance of responsibility – it depends more on common logic than on empirical evidence – although former deniers report feeling better having done so.

As noted earlier, those people who deny through a fear of losing family and friends or to ease feelings of shame might be less likely to reoffend than those who deny simply to avoid conviction or to preserve their sexual fantasies. It is, therefore, important when collaborating with this client group to try to understand the function of denial and the role it plays in maintaining a coherent sense of self.

## Accounts of former deniers

There are examples of studies that focus on individuals who had previously denied their offending but subsequently admitted it. Lord and Willmot (2004) conducted a study with 24 sexual offenders and identified three themes relating to the function of categorical denial. The first category exhibited low

motivation and limited insights regarding their offending. The second category outlined the potential destruction of self-image and self-esteem alongside shame and guilt. The third category summarised fear of negative consequences, such as the loss of family and friends. Blagden *et al.* (2011), in a similar study of eleven former deniers, had similar outcomes to the Lord and Wilmot study. Themes for denial and the transition to admitting included: the apprehension of stigma of being labelled a 'sex offender' and the threats to one's identity and self-image. Blagden asserted that denial was likely to be overcome when it was no longer needed.

## Why the emphasis on accepting responsibility?

As it has been contended that perpetrators accepting responsibility is not related to risk, it is important to explore whether the emphasis on acceptance of responsibility in sex offender treatment may be more detrimental than beneficial.

Maruna and Mann (2006) argue that perpetrators may be placed in a no-win situation in the context of treatment programmes. If they continue to minimise or excuse their behaviour, they may be considered resistant or in denial, while if they accept responsibility for their actions, they are categorised as a sexual deviant and characterised negatively by the criminal justice system. It has been argued that cognitive restructuring, which is a process used to challenge irrational or maladaptive thoughts and to persuade individuals to accept responsibility, may be classed as punishment and is not conducive to the individual's wellbeing (Ward, 2010).

It is now generally accepted that confrontational approaches to sex offender treatment are not beneficial to positive outcomes. However, pursuing acceptance of responsibility may often engender a confrontational approach by therapists (Jones, 2009). Ware and Mann (2012) suggest that too much emphasis on accepting responsibility may result in treatment attrition, either from the person being dismissed for failing to accept responsibility or alternatively dropping out due to the confrontational nature of therapy.

## Conclusion

It is evident that denial is often a significant feature in the context of convicted perpetrators of sexual offences. Despite long-held assumptions to the contrary, there is little evidence to link denial to increased sexual reoffending. In some cases, it has been shown that the opposite is true, in so far as some

research has linked denial to reduced reoffending, particularly in higher-risk perpetrators. It is important to acknowledge the psychological and social value for both perpetrators and victims in accepting responsibility. Practitioners must consider the ethical dilemma, where it may be possible for someone to complete treatment successfully without admitting or taking responsibility for their offences. Conversely, treatment options that prioritise denial and responsibility may be counterproductive.

Reasons and the rationale for denial are complex. The limited research into the function of an offender's denial suggests that minimisation is the result of the fear of negative extrinsic consequences, or a threat to one's self-image, rather than motivated by a desire to reoffend. The emphasis on acceptance of responsibility (confession) as a treatment target may, in some circumstances, be unrealistic, and can result in 'no win' situations for the individual.

When deniers are excluded from treatment options, there is a lost opportunity to contribute to a reduction in their risk and that of future victims. Excluding deniers from treatment appears more problematic when we consider that the evidence suggests that those who perpetrate sexual offences may benefit from treatment even while maintaining denial of their offences. Therefore, for practitioners, it is central to explore and understand the function of denial and the role it plays in each individual case.

Sex offender treatment remains an area of development and as much is yet unknown in relation to perpetrators who deny, this area requires ongoing long-term further research.

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