UNDERSTANDING DENIAL IN SEXUAL OFFENDERS

A Review of Cognitive and Motivational Processes to Avoid Responsibility

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Treatment of sexual offenders is routinely complicated by the presence of denial. This article examines how denial is related to the willingness to take responsibility for offense-related thoughts and actions and how conceptualizations of denial have developed and changed over time. Multiple facets of denial are described in detail, along with an assessment of how different forms of denial undermine acceptance of responsibility throughout treatment. Evidence is presented to show that resistance and denial often hinge on cognitive and motivational processes that are commonly accepted as fundamental treatment targets rather than treatment obstacles. The authors propose that denial may be best understood as the acceptance of explanations that reduce accountability and are reinforced by distorted beliefs and self-deceptive thinking processes. The article concludes with a discussion of the rich clinical information embedded in different expressions of denial and the benefits of treatment strategies designed to assess and work through them.

Key words: *denial, accountability, responsibility, cognitive distortions, explanations, refutation, minimization, depersonalization, FoSOD*

AN OVERALL GOAL of sexual offender treatment programs is to reduce the likelihood that offenders will engage in future acts of sexually abusive behavior. Reaching this goal is difficult both because the variables leading to sexual abuse are not yet fully understood and because there is often considerable resistance on the part of the offender to become engaged in the treatment process. This treatment resistance is largely the product of processes of denial.

The purpose of this article is to trace conceptualizations and treatments of denial as well as related cognitive and motivational processes in child molesters. This article provides a framework to evaluate the relationship between various forms of denial and treatment progress, emphasizing the advantages of recognizing forms of denial that go beyond complete disavowal of an offense. A preview of important points is provided in Key Points of the Research Review.

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ACCOUNTABILITY AND DENIAL AS TREATMENT GOALS

Since their introduction in the late 1970s, cognitive-behavioral therapies have become the dominant approach to the treatment of sexual offenders (Marshall & Barbaree, 1990). The overall aim of cognitive-behavioral treatment programs is to equip sexual offenders with self-management skills that can be used to manage or avoid situations that increase their risk of reoffending. To accomplish this, offenders are trained to alter their views in a prosocial direction, attend to negative consequences of their actions both for themselves and others, establish a less distorted view of their deviant behavior, develop more acceptable responses to meet their needs, and learn strategies to control deviant sexual arousal and manage risky situations (Marshall, Laws, & Barbaree, 1990).

The effectiveness of these approaches rests to a large extent on the offender's cooperation and investment in treatment. However, as clinicians working with this population are well aware, some offenders entering treatment totally deny any involvement in the sexual offense, and many continue to deny critical aspects of their offense even after being convicted (Barbaree, 1991; Denton, Konopasky, & Street, 1994; Grossman & Cavanaugh, 1990; Happel & Auffrey, 1995; Langevin, 1988; Marshall, 1994; Quinsey, 1986; Schlank & Shaw, 1996, 1997). It has been argued that offenders cannot be expected to fully participate in treatment or to work toward changing their behavior without acknowledging their own responsibility for the offense and their problem with sexual behaviors (O'Donohue & Letourneau, 1993; Salter, 1988; Schlank & Shaw, 1996, 1997). As a result, offenders who disavow the commission of an offense or deny accountability are likely to be noncompliant with treatment tasks, resistant to accepting ownership of treatment goals, and more likely to fail to complete treatment (Brake & Shannon, 1997; Hunter & Figueredo, 1999; O'Donohue & Letourneau, 1993; Salter, 1988).

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KEY POINTS OF THE RESEARCH REVIEW

- Accountability and offender denial are inversely related and should be approached as treatment targets rather than treatment obstacles.
- A conceptualization of denial as a coherent construct with multiple forms holds distinct clinical advantages over a view of denial as a dichotomous construct.
- Denial is closely related to the construct of cognitive distortions; denial often results in distorted and biased thinking stemming from explanations used to excuse the offender's behavior.

Given this, it is not surprising that accountability is viewed as an essential component of treatment and that denial is considered a central obstacle that stands in the way of accepting responsibility for the offense. In her now classic guide to treating sexual offenders, Anna Salter (1988) (see also Furniss, 1984) emphasized that "offenders must take responsibility for child sexual abuse without minimizing, externalizing, or projecting blame onto others" (p. 67). The U.S. Department of Health and Human Services has also issued a report stating that offenders must be required to accept responsibility for the abusive acts, without relying on any excuses for or minimizations of the behavior (Faller, 1993). Similarly, in its *Practice Standards and Guidelines*, the Association for the Treatment of Sexual Abusers (ATSA Professional Issues Committee, 2001) advises that most clients present with some degree of denial and that clients' acceptance of responsibility concerning their sexually abusive behaviors should be a treatment goal. Denial is defined in the manual as "the failure of sexual abusers to accept responsibility for their offenses" (p. 63) and is characterized as an obstacle to treatment progress and to compliance with treatment requirements.

As these examples demonstrate, there is a clear consensus that accountability and denial are fundamental issues in the treatment of sex-

ual offenders. Although this consensus includes the implication that reducing denial and increasing accountability go hand-in-hand, there have been subtle—and not so subtle—differences in how the two constructs are delimited within the literature. Denial is almost always characterized as an obstacle to treatment progress, whereas acceptance of responsibility is typically considered a treatment goal. Those who focus on denial tend to view clients in terms of readiness for treatment, exploring how to prepare clients to be sufficiently motivated to engage in the treatment process (e.g., O'Donohue & LeTourneau, 1993). In contrast, those who focus on responsibility bypass the issue of readiness for treatment and focus on treatment interventions that can modify distorted attitudes and beliefs to improve motivation to control deviant behavior (Salter, 1988).

THE EVOLUTION OF INTEREST IN DENIAL AND ACCOUNTABILITY

Clinical interest in issues of denial and accountability in sexual offenders can be traced as far back as the 1960s and 1970s (Cowden & Morse, 1970; Hitchens, 1972; McCaghy, 1968; Resnik & Peters, 1967). Nevertheless, there was virtually no systematic theoretical or empirical attention to the larger role of cognitive processes in the treatment of child molesters until the mid-1980s. Common approaches to research and treatment prior to that time focused on issues such as psychodynamic motives (Fenichel, 1945; Freud, 1918/1950; Hammer & Glueck, 1957; Justice & Justice, 1979), sources of deviant sexual preferences and arousal (Adams, Tollison, & Carson, 1981; Groth, 1979; Little & Curran, 1978; Marks, 1981), family dysfunction and related developmental deficits (Bell & Hall, 1976; deYoung, 1982; Gaddini, 1983; Herman & Hirshman, 1981; Howells, 1981; Kaufman, Peck, & Tagiuri, 1954; Lustig, Dresser, Spellman, & Murray, 1966; Storr, 1965; Weiner, 1962), and predictive or predisposing personality variables (Gebhard, Gagnon, & Pomeroy, 1967; Kirkland & Bauer, 1982; Meiselman, 1978; Panton, 1978/1979; Weinberg, 1955).

By early in the 1980s, it was becoming increasingly apparent that the interpersonal tactics of child molesters tend to be strategic (deYoung, 1982; Frude, 1982; Justice & Justice, 1979). Such formulations implied the presence of cognitive processes that allow offenders to simultaneously overcome their own inhibitions and the resistance of the victim. Finkelhor (1984) was among the first to explicitly acknowledge the role of cognition in explaining sexual abuse. In his integrative theory, Finkelhor included a cognitive or strategic component within his four fundamental prerequisites to sexual abuse. He argued that offenders must overcome both internal and external inhibitions as well as the resistance of the victim in order for abuse to occur. In other words, offenders must find a way to avoid taking responsibility for or to deny the harmfulness of behaviors that they would otherwise recognize as abusive.

Others also began to point to the need to investigate cognitive contributors to sexual offending and to include them as targets in treatment interventions (see Ward, Hudson, Johnston, & Marshall, 1997 for a review). Conte (1985) paved the way for these efforts by suggesting that the personality constructs commonly being used to differentiate sexual offenders were less useful to clinicians than problem-focused dimensions such as denial, sexual arousal, sexual fantasies, cognitive distortions, social sexual deficits, and other psychological and social problems. At roughly the same time, Abel and his colleagues argued that the explanations provided by child molesters are not simply excuses and justifications but represent preexisting beliefs or cognitive distortions that evolve to legitimize sexual contact with children (Abel, Becker, & Cunningham-Rathner, 1984). They conceptualized cognitive distortions to consist of rationalizations developed by offenders prior to and during offending to justify their continued abuse of children (Abel et al., 1989; see also Murphy, 1990).

A major assumption underlying this work was that distortions promote and maintain offending behavior and need to be directly targeted in treatment (Abel et al., 1984; Murphy, 1990; Stermac & Segal, 1989). As a result, inves-

tigators began to emphasize that offenders' portrayal of their offense was not simply intentional deceit to avoid the consequences of their actions. Instead, their explanations were likely to reflect biased and distorted views stemming from preexisting beliefs (Barbaree, 1991; Marshall & Eccles, 1991). Soon clinicians began systematically reporting the prevalence and characteristics of denial and distortions among their clients (Barbaree, 1991; Fowler, Burns, & Roehl, 1983; French, 1989; Geller, Devlin, Flynn, & Kaliski, 1985; Maletsky, 1991; Marshall & Barbaree, 1990; Pithers, 1990; Stevenson, Castillo, & Sefarbi, 1989). These reports made it clear that denial and cognitive distortions were pervasive characteristics among offenders. However, little distinction was made between them, and both denial and cognitive distortions were frequently used interchangeably to refer to diminished accounts of offense behavior.

THE FOCUS ON COMPLETE DENIAL

During the 1990s, research and theorizing concerning denial, accountability, and cognitive distortions grew at an impressive rate. Although this helped bring needed attention to the constructs, it also brought confusion to the literature. There was not always agreement about what was meant by these constructs, and different authors often defined the terms differently. As a result, a critical rift developed in which some authors used the construct of denial in a restricted sense to refer only to the disavowal of having committed an offense, whereas others used denial to refer to a broader range of explanations provided by offenders to justify or minimize offense-related behavior.

Those who have emphasized complete denial have variously referred to it as "categorical denial" (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001), "full denial" (Brake & Shannon, 1997), or "absolute denial" (Barbaree, 1991; Schlank & Shaw, 1996). Despite the use of different terms, each of these formulations shares similar core features. Each describes the offender dichotomously as either "in" or "out of" denial, often with the accompanying assumption that denial results from deliberate attempts to avoid blame. Research based on this view is typically concerned with differences between "deniers" and "admitters" (e.g., Baldwin & Roys, 1998; Grossman & Cavanaugh, 1990; Haywood & Grossman, 1994; Haywood, Grossman, & Hardy, 1993; Nugent & Kroner, 1996; Sefarbi, 1990). In addition, other types of denial are generally disregarded or redefined as minimization. The focus for these authors is placed on "eliminating denial" (i.e., convincing offenders to admit that they did engage in inappropriate sexual behavior) as a prerequisite to beginning offense-specific treatment. From this perspective, denial has been viewed as a problem that is of importance primarily in the early stages of treatment (e.g., Schlank & Shaw, 1997).

The impact of this narrower definition of denial has been pivotal for several reasons. First, by focusing exclusively on complete deniers and methods to eliminate complete denial in advance of standard treatment, the perceived relevance of denial has been largely discounted in all but the initial stage of treatment. Second, the work of those who have adopted a broader view of denial has been overshadowed by the focus on eliminating complete denial on the one hand and characteristics ascribed to cognitive distortions on the other. As a result, for many, denial has come to be narrowly associated with intentional deceit, despite empirical support suggesting that denial is also likely to be grounded in distorted cognitions (Ward et al., 1997; Wright & Schneider, 1999).

Third, many authors subscribing to an all-or-none view of denial have interpreted the complete disavowal of an offense to indicate poor amenability to treatment and, in response, have excluded these offenders from programs because they have been deemed untreatable (Frenken, 1994; McGrath, 1991). These practitioners reason that if offenders deny their offense, they are not motivated to learn self-management skills because they do not view themselves to have a problem or to have done something wrong (O'Donohue & Letourneau, 1993; Schlank & Shaw, 1996, 1997). Moreover, some providers are concerned that if these offenders are allowed to remain in programs without admitting to their offense, that clinicians are in effect reinforcing the illusion that of-

fenders can benefit from treatment without taking responsibility for their offense. This latter argument seems especially objectionable given practice standards that specifically include acceptance of responsibility as a fundamental goal of treatment (ATSA Professional Issues Committee, 2001).

Those with a contrasting point of view argue that complete denial cannot be a prerequisite for continuation in a program precisely *because* taking responsibility is a goal of treatment (Maletzky, 1996; Wright & Schneider, in press). From this viewpoint, requiring that offenders must be out of denial before starting treatment is tantamount to requiring them to (at least partially) cure themselves before they can receive treatment. Such contradictory views of the role of offender accountability (i.e., prerequisite or treatment goal) have not been resolved and continue to significantly affect how denial is conceptualized and treated.

Nevertheless, there has been a significant reduction in the practice of excluding offenders from treatment if they are denying the commission of their offense. The most notable reason for this stems from findings suggesting that those who fail to complete treatment (for any reason) evidence a higher rate of recidivism than those who complete treatment programs (Hall, 1995; Hanson & Bussiere, 1998; Marshall, 1994; Marshall, Anderson, & Fernandez, 1999). In addition, a series of court rulings, including *State v. Imlay* (1991), concluded that an offender could not be punished on the basis of denial alone. Therefore, offenders could not have their probation revoked if dismissed from a treatment program due to their refusal to admit to an offense. Such rulings created an ethical dilemma for clinicians: If they judged deniers to be inappropriate for treatment, but the court system did not return them to prison, then these offenders would in effect be discharged to the community with no further attempt to reduce their risk of recidivism. In consequence, it has been argued that the practice of dismissing deniers from treatment increases the risk to the community by essentially preventing some of the most at-risk offenders from participating in treatment programs (Marshall, 1994).

Yet another concern generated by the lack of agreement over how to conceptualize denial is the difficulty in determining the relationship between denial and recidivism. The few existing studies have focused exclusively on complete denial (Hanson & Bussiere, 1998; Kennedy & Grubin, 1992). Although neither of these studies revealed a clear link between denial and recidivism, the results are likely to be misleading and to potentially cause scholars to dismiss the importance of denial prematurely. This is unfortunate given reliable findings that those who are unsuccessfully discharged from treatment (typically because they deny their offense) (Hunter & Figueredo, 1999; Salter, 1988; Schlank & Shaw, 1997) do have a reliably greater risk of reoffending (Hall, 1995; Marques, Day, Nelson, & West, 1994; Marshall, 1994; Marshall & Barbaree, 1990; McGrath, 1995). Resolving this conflict in findings may require a more sophisticated view of denial, along with improved measures of denial. The link to recidivism may not be discernible in previous studies because of problems inherent in accepting a static, dichotomous conceptualization of denial (Wright & Schneider, in press) as well as methodological weaknesses associated with operationalizing denial (Lund, 2000; see also Barbaree, 1997).

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DENIAL AS A MULTIFACETED CONSTRUCT

Although many have focused on denial as a dichotomous construct, a large number of clinicians and scholars have acknowledged that denial is not an all-or-none phenomenon but rather a complex, multifaceted construct. Dur-

ing the late 1980s and throughout the 1990s, several descriptive typologies of denial were created primarily based on clinical observations of different types and degrees of denial (Barbaree, 1991; Barrett, Sykes, & Byrnes, 1986; Brake & Shannon, 1997; Happel & Auffrey, 1995; Laflen & Sturm, 1994; Langevin, 1988; Orlando, 1998; Salter, 1988; Trepper & Barrett, 1989; Winn, 1996/1997). The findings from descriptive empirical studies (e.g., Kennedy & Grubin, 1992; Pollock & Hashmall, 1991) have resulted in categories similar to those produced on the basis of clinical experience alone. Table 1 provides a summary of the many types of denial that have been described in these efforts.

Perhaps the most striking finding across all of the typologies shown in Table 1 is the similarity in the identified categories of sexual offender denial. In a recent study, we attempted to empirically verify the existence of these various forms of denial through the creation of a self-report measure (Schneider & Wright, 2001). Using factor analytic techniques, empirical support was found for virtually all of these different components of denial.

In what follows, we discuss these components within a framework that is graphically represented in Figure 1 and that is designed to distinguish denial on the basis of three levels of accountability (see also Wright & Schneider, in press). The framework expands on Barbaree's (1991) differentiation of two levels of accountability represented by absolute denial, described here as refutation, and various forms of minimization. In addition to these, a third level of accountability associated with depersonalization is also included to account for more deeply entrenched forms of denial.

Refutation

Refutation provides a mechanism for completely alleviating the offender from having to take any responsibility for the offense. If the offender's explanation is that there was no offense or that there was a harmless interaction that should not be thought of as an offense, then there is nothing for which to take responsibility. Refutation involves complete denial that an offense occurred, coupled with claims that nothing harmful happened to the alleged victim and that the offender himself (or herself) is the one who has been wronged.

Virtually every author who has addressed issues of denial among sexual offenders acknowledges that complete denial of the offense is a serious issue in treatment. For some authors (described in the previous section), this is the only type of denial that is acknowledged, but for many others this is the extreme of a continuum of denial. Within typologies of denial, this has also been referred to as denial of the offense, denial of the facts, denial of the behavior, or denial of the crime. As shown in Table 1, all of the typologies distinguish complete denial (e.g., "I never touched her") from other types of denial. The typical description is that the offender totally denies any involvement in a sexual offense. Despite the fact that this suggests a clear all-or-none assertion that "I didn't do it," there may be some subtle variations in what offenders mean by this claim. In some cases, the offender may be willing to concede that something happened, but they may insist that the event was not sexual or harmful in any way so that it should not be construed as an offense (see, e.g., Pollock & Hashmall, 1991).

Complete denial of the offense is highly related to another aspect of denial that contributes directly to refutation and the desire to avoid all responsibility. The assertion that nothing happened implies that the alleged victim was not harmed. In fact, several authors have specifically identified denial of victim impact as a distinct form of denial. Denial of victim harm is also apparent in the large literature focused on empathy deficits in offenders (e.g., Hilton, 1993; Hudson & Ward, 2000; Marshall, Hamilton, & Fernandez, 2001; McGrath, Cann, & Konopasky, 1998; Pithers, 1994). Indeed, empathy training is an important component in many cognitive-behavioral treatment interventions. In our empirical evaluation, denial of victim impact accompanied complete denial in virtually all cases (Schneider & Wright, 2001). In fact, complete denial and denial of victim harm combined to form a single factor, along with items suggesting that the offender was adopting a victim stance. These items included alleged

TABLE 1: A Comparison of Typologies of Sexual Offender Denial

	Types of Denial							
Author	*Denial of Offense*	*Denial of Victim Impact*	*Denial of Extent*	*Denial of Responsibility*	*Denial of Planning*	*Denial of Sexual Deviancy*	*Denial of Relapse Potential*	*Other*
Barbaree (1991)	Denial of the facts	Minimization of victim harm	Minimization of extent of behavior	Minimization of responsibility				
Barrett, Sykes, & Byrnes (1986)	Denial of facts	Denial of impact	Denial of facts	Denial of responsibility, denial of awareness				
Brake & Shannon (1997)	Full denial, plausible denial, pathological denial	Partial denial-minimizations (of harm)	History-specific denial, denial "screen," current incident-specific denial	Partial denial-justifications, false dissociation	Denial of arousal	Denial of arousal	Denial of future behavior	
Happel & Auffrey (1995)	Denial of the crime	Denial of injury and impact on the victim	Denial of intrusiveness or extent of the behavior, denial of frequency of deviant acts	Denial of responsibility, denial of intent, planning, and premeditation	Denial of intent, planning, and premeditation; denial of deviant arousal and fantasies; denial of physical, mental, and environmental grooming	Denial of deviant arousal and fantasies; denial of gratification and sexual pleasure	Denial of relapse potential and possible recidivism; denial of risk management activities; denial of difficulty to change and need for help	
Kennedy & Grubin (1992)	Denial of offense	Denial of effect	Denial of effect	Denial of responsibility, denial of internal attribution, assertion of external attribution		Denial of deviant sexual preference		Denial of need for social sanction
Laflen & Sturm (1994)	Denial of behavior (Stage 1)		Minimization of seriousness of behavior (Stage 2)	Denial of responsibility (Stage 3)	Denial of planning (Stage 3)		Denial of risk of relapse (Stage 4)	

TABLE 1 (continued)

	Types of Denial							
Author	*Denial of Offense*	*Denial of Victim Impact*	*Denial of Extent*	*Denial of Responsibility*	*Denial of Planning*	*Denial of Sexual Deviancy*	*Denial of Relapse Potential*	*Other*
Langevin (1988)	Denying everything			Claiming special circumstances		Denial of anomalous sexual preferences		
Orlando (1998)	Denial of the offense	Denial of harm	Denial of extent or magnitude of the abuse	Denial of responsibility, denial of sexual intent	Denial of planning	Denial of sexual gratification, denial of sexual arousal	Denial of likelihood of reoccurrence	
Pollock & Hashmall (1991)	Denial of fact	Denial of wrongfulness	Denial of sexual intent, denial of wrongfulness	Denial of responsibility, denial of self-determination, denial of sexual intent				
Salter (1988)	Denial of the acts themselves	Denial of internal guilt for behavior, denial of seriousness of behavior	Denial of seriousness of behavior	Denial of responsibility for the acts, denial of internal guilt for the behavior	Denial of fantasy and planning	Denial of fantasy and planning	Denial of difficulty in changing abusive patterns	
Trepper & Barrett (1989)	Denial of facts	Denial of impact	Denial of facts	Denial of responsibility, denial of awareness	Denial of grooming	Denial of deviant sexual arousal		Denial of denial
Winn (1996)	Denial of facts	Denial of impact	Denial of facts	Denial of responsibility, denial of awareness	Denial of grooming oneself and the environment	Denial of deviant sexual arousal and inappropriate sexualization of nonsexual problems	Denial of deviant sexual arousal and inappropriate sexualization of nonsexual problems	Denial of denial

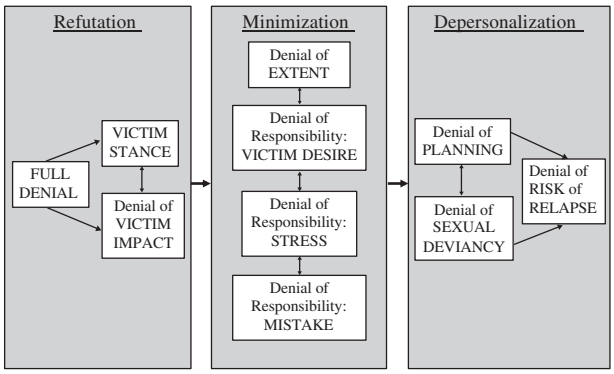

Figure 1: Framework for Organizing Types of Denial According to Level of Accountability

mistreatment by the system, the lack of credibility of the victim, and a focus on self-harm.

According to Winn (1996), denial of victim impact derives largely from the offenders' tendency to be self-focused. Often, offenders report that they are the ones who have been harmed and who are most negatively affected by the accusation of sexual violence. This theme of self-focus represents a third characteristic of refutation. By suggesting that nothing happened, the offender also maintains that he or she has been wronged.

Minimization

Once offenders admit that something inappropriate happened, they frequently attempt to deny their active participation in and responsibility for the offense. Although some (e.g., Barbaree, 1991; Marshall, 1994; Rogers & Dickey, 1990) have used the term "minimization" to distinguish these processes from complete denial, several other authors have recognized these explicitly as alternative forms of denial (e.g., Salter, 1988; Trepper & Barrett, 1989). Denial in these cases typically involves blaming and justifications that have at different times been categorized as partial denial, denial of responsibility, or denial of extent (see Table 1) (e.g., "It was an accident," "I was drunk," "I didn't do as much as people think I did"). Three of the factors we identified empirically fall into this group. They include (a) denial of the extent of the offense, (b) denial of intent to commit an offense (either because of a stressful situation or a mistake), and (c) denial of responsibility based on the assertion of victim desire.

These forms of denial all share a common goal. Offenders admit that something about their offense-related behavior was problematic or potentially harmful but then try to discount their responsibility through explanations focused on external circumstances and other excuses. Interestingly, we also found that these forms of denial were systematically related to measures of cognitive distortions (Schneider & Wright, 2001). Nevertheless, the three denial factors—but not the cognitive distortions measures—could distinguish offenders as a function of treatment progress. This provided evidence in support of distinguishing denial concerning responsibility for the offense from cognitive distortions concerning general beliefs.

Depersonalization

Even after offenders acknowledge their responsibility for an offense, they may not be prepared to admit that they are the type of person who is vulnerable to committing sexual offenses. Several authors have identified these more deeply ingrained forms of denial, which include denial of (a) planning the offense, (b) grooming, (c) deviant arousal, (d) fantasizing, (e) sexual gratification, (f) need for help, and (g) future risk or relapse potential. These issues were empirically discernable in two factors of the Facets of Sexual Offender Denial Scale (FoSOD): denial of planning and denial of relapse potential (which included items concerning deviant sexual interests).

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Attempts to deny these abuse-related tendencies often exist even after offenders acknowledge considerable responsibility for an isolated offense (e.g., Laflen & Sturm, 1994). Depersonalizing explanations reduce accountability by preventing the offender from coming to terms with predispositions that contribute to the likelihood of future deviant thoughts and behavior.

PERSPECTIVES ON DENIAL AND APPROACHES TO TREATMENT

It should come as no surprise that practitioners' perspectives on denial are likely to have a substantial impact on approaches to treatment. For those who concentrate on issues surrounding complete denial, the focus has shifted from excluding deniers from treatment to issues concerning (a) how long to allow deniers to stay in treatment without admitting and (b) how best to eliminate (complete) denial so real treatment can begin. In this context, several authors have developed pretreatment interventions to diminish denial before entering an offense-specific sexual offender program (Brake & Shannon, 1997; Burditt, 1995; Murphy & Berry, 1995; O'Donohue & LeTourneau, 1993; Schlank & Shaw, 1996).

Other interventions have been designed to modify the offender's denial in the early stages of treatment (Barbaree, 1991; Barnard, Fuller, Robbins, & Shaw, 1989; Maletzky, 1991; Marshall, 1994; Murphy, 1990; Schwartz, 1995). Tools adopted to assist in reducing denial have included phallometry (e.g., Launay, 1994), polygraphy (e.g., Hagler, 1995; Wilcox, 2000; Williams, 1995), survivor reports (Valente & Borthwick, 1995), and directed group work (Crighton, 1995; cf. Barker & Beech, 1993). In general, these types of programs have reported moderate success at reducing denial in some offenders. Although such reports have supported the use of incorporating interventions to modify denial in child molesters, many are based on small numbers, are anecdotal or descriptive in nature, are designed as program evaluations rather than controlled studies, or have not employed standardized measures to assess changes on the specific constructs described (Maletzky, 1991).

More recently, investigators have reported the development of separate group treatment protocols targeting what they refer to as categorical deniers (Marshall et al., 2001). This type of program is designed to reduce the risk of reoffending for those offenders who completely deny the commission of an offense. The treatment strategy consists of eliminating the requirement of personal accountability for the commission of an offense and instead targeting ancillary criminogenic variables associated with sexual offending, such as unstable lifestyle and social skills deficits. This approach appears to rest on the assumption that it is not necessary for offenders to take responsibility for their deviant sexual behavior at any time. Instead, the authors hypothesize that the modification of deficits associated with ancillary criminogenic factors is sufficient to reduce the likelihood of recidivism for this population. This represents a decisive departure from established treatment goals and implies that motivational issues (i.e., accepting oneself as a sexual offender) are not essential targets of offense-specific sexual offender treatment—at least for categorical deniers. It is not clear on what basis the authors separate treatment goals for categorical deniers versus admitters and what implications their approach has for larger motivational issues that permeate treatment programs. The rationale for the effectiveness of the criminogenic approach in the absence of accountability needs to be made clearer, although the validity of the approach is ultimately an empirical issue. To date, the authors have not yet evaluated the effectiveness of their program for achieving within-treatment goals.

Consistent with other treatments designed to reduce denial (Barrett et al., 1986; Brake & Shannon, 1997; Happel & Auffrey, 1995; Schlank & Shaw, 1996; Winn, 1996/1997), the Marshall et al. (2001) approach does suggest the potential use of indirect strategies to reduce resistance to treatment rather than relying on confrontational techniques that may provoke additional opposition or yield only compliant behavior. If the Marshall et al. approach were coupled with follow-up treatment that returns to the issue of

TABLE 2: Relationship of Types of Denial to Salter's (1988) Recommended Goals of a Sexual Offender Treatment Program

Salter's (1988) Recommended Treatment Program Goals	*Treatment Goals Rephrased in Terms of Type of Denial to Be Reduced*
Physical participation	Denial of offense
Accepting responsibility for offense	Denial of extent, responsibility
Intellectual understanding of offense chain and therapeutic techniques	Denial of planning, sexual deviancy, relapse potential
Emotional understanding of impact of offenses	Denial of victim impact
Attempts to change behavior	Denial of responsibility, planning, sexual deviancy, relapse potential
Assertiveness and willingness to help other group members prevent relapse	—

TABLE 3: Relationship of Denial to Green's (1995) Recommended Goals of a Sexual Offender Treatment Program

Green's (1995) Recommended Treatment Program Goals	*Treatment Goals Rephrased in Terms of Type of Denial to Be Reduced*
1. Admitting guilt	Denial of offense, extent
2. Accepting responsibility	Denial of responsibility
3. Understanding dynamics	Denial of planning
4. Identifying deviant cycle	Denial of planning, sexual deviancy, relapse potential
5. Making restitution	Denial of victim impact

accountability, it might reveal that offenders become gradually more likely to accept responsibility as they learn to make improvements on other problematic issues within their lives.

Perspectives that acknowledge the larger continuum of denial may be more likely to provide this kind of comprehensive approach to issues associated with accepting responsibility throughout the entire course of treatment. This seems especially true in cases wherein denial is characterized as a treatment target rather than an obstacle to treatment. Tables 2 and 3 provide a summary of the goals of treatment itemized by Salter (1988) and Green (1995), respectively. These tables demonstrate how reductions in the different types of denial can be characterized as fulfilling or contributing to almost all of these treatment goals. The goal of accepting responsibility for a particular offense, for instance, requires reductions in denial of extent, denial of intent, and denial based on the assertion of victim desire. To diminish these forms of denial, offenders must recognize that their offense behavior represents a serious intrusion over which they had control. Similarly, understanding the offense cycle ultimately requires that offenders admit that the offense was planned, that their deviant sexual interests played a role, and that the cycle is likely to continue in the future if actions are not taken to disrupt problematic thoughts and behaviors. Getting and staying out of denial (of several types) are likely to be continuing goals that the offender must adopt to motivate and maintain lasting changes.

In support of this view, we have recently found empirical evidence that various forms of denial are critically linked to treatment progress in both early and advanced stages of treatment (Wright & Schneider, in press). Specifically, we monitored offenders over the course of 18 months. Those who progressed during that time from an early to an advanced level in treatment showed significant reductions in complete denial (i.e., refutation) and minimization but remained relatively high in other forms of denial. Those who did not graduate to an advanced level started and stayed with relatively high scores on all forms of denial.

Of perhaps greater interest are the reductions in denial that were observed among offenders who were "out of" complete denial at the start of the study. Offenders who began the study in an advanced level of treatment and progressed to an even higher level remained low in refutation throughout the study period. Nevertheless, their continuing progress in treatment was tied to reductions in denial of responsibility for their offense (i.e., minimization) and in denial of planning, sexual deviancy, and relapse risk (i.e., depersonalization). The latter forms of denial remained high for all but offenders in the most advanced levels of treatment. These findings suggest that changes in various types of denial are strongly and systematically related to making progress across all stages of treatment, even

the most advanced (Wright & Schneider, in press).

INTERRELATIONSHIPS BETWEEN DENIAL, ACCOUNTABILITY, AND COGNITIVE DISTORTIONS

Even with awareness of the continuum of types of denial and the close association between denial and accountability, there is still the question of how cognitive distortions can best be understood in this context. A variety of investigators have noted a close relationship between these constructs, although the nature of these relationships has never been made explicit (Conte, 1985; Gudjonsson, 1990; Johnston & Ward, 1996; Ward et al., 1997; Ward, Hudson, & Marshall, 1995; Wright & Schneider, 1999). A closer examination of the literature suggests both similarities and differences between denial and cognitive distortions. In general, cognitive distortions have been described as biased accounts stemming from preexisting beliefs, whereas denial has typically referred to deliberate excuses and justifications intended to deceive. Both have been described to reduce offenders' accountability for their offenses.

Conte (1985) was one of the first to suggest that there may be a relationship between distortions and denial, arguing that cognitive distortions are likely to make it easier for offenders to misconstrue their behavior and its consequences. This emphasis converged with the focus on justifications and excuses typically associated with denial and provided a framework that suggested a relationship between them (Barbaree, 1991; Marshall, 1994; Murphy, 1990; Pollock & Hashmall, 1991). Within this perspective, denial has come to refer to explanations made with reference to a specific offense, whereas distortions have been construed as broader preexisting beliefs that must be true for denial-based explanations to be plausible. For example, the cognitive distortion that little girls enjoy sex may serve as the basis to deny victim harm by claiming that a particular victim was a willing participant.

Nevertheless, denial has come to be associated more with deliberate acts of deception, and cognitive distortions have been linked to faulty beliefs and social information-processing deficits. In part, this is because denial typically involves a dispute about seemingly specific, objectively verifiable events, whereas distortions more often involve disagreements about more subjective interpretations of the general significance of events. For example, categorical denial is assumed to focus on factual events that can be answered through a direct access of memory (e.g., "I didn't do it") and thus it has been presumed to entail intentional deceit. On closer inspection, what appear to be assertions of fact may also involve beliefs, opinions, or subjective interpretations. A claim that one did not commit a deviant act may include definitional distinctions over what is meant by a term such as "deviant" or disputes over the presence of deliberate intentions implied by the term "commit." As a result, there are any number of "apparent facts" that must be considered and interpreted to determine the truth or falsity of the aforementioned assertion (see also Jenkins-Hall & Marlatt, 1989). As a result, even disputes over apparently objective facts are likely to involve any number of cognitive processes that allow the offender to believe what he (or she) wants without explicit awareness. Hence, denial is likely to include both more and less intentional attempts to deceive.

In addition, it is not clear that biases and distortions stem from preexisting beliefs or whether they occur during the commission of an offense (Abel et al., 1984; Ward et al., 1997). Some investigators have suggested that the accounts provided by offenders may simply represent rationalizations after the fact and suggest that there is no empirical evidence to support the position that they represent preexisting beliefs (Pollock & Hashmall, 1991; Quinsey, 1986; Stermac & Segal, 1989). Hence, it is unclear whether it is even necessary to change preexisting beliefs to produce positive therapeutic outcomes. It may be more valuable to focus on well-learned strategies that justify or excuse deviant behavior (Ward et al., 1997).

Although the origin of cognitive distortions has not been empirically validated, the existence of biased and distorted cognitions are well-documented in offenders' accounts of their offense (e.g., Bumby, 1996; Hartley, 1998;

Stermac & Segal, 1989). Explanations generated by offenders to excuse or deny their behaviors are themselves likely to produce biased and distorted thinking (Wright & Schneider, in press). Over time, offenders are likely to become increasingly confident in the accuracy of reasons that they generate to explain their behavior (Anderson, 1982; Anderson & Sechler, 1986; Koehler, 1991; Ross, Lepper, & Hubbard, 1975). For this reason, some have suggested that offenders' beliefs about their own behavior may be better predictors of future offense risk than more general attitudes toward offense-related issues (Hogue, 1994; Kennedy & Grubin, 1992). Both denial and distortions, then, are likely to be products of some combination of intentional deceit and biased reasoning processes that serve to protect offenders from facing their responsibility for committing sexual offenses.

Although the distinctions between distortions and denial are not yet entirely clear, both constructs serve to emphasize the importance of (a) the offender's current view of his or her offense, (b) the cognitions that fortify that view, and (c) the extent to which the offender is cognizant of the validity of his or her view. Whether the offender's portrayal of the offense stems from preexisting beliefs, is grounded in evidence accrued through biased data collection strategies, or reflects a deliberate attempt to avoid perceived consequences, it still represents an absence of personal accountability for one's actions. It is for this reason that authors have emphasized the importance of changing the way that offenders think about their offending behaviors (Ward et al., 1997).

The primary vehicle for assessing and modifying offenders' cognitions is likely to be found in the explanations provided by offenders to account for their offenses (Hogue, 1994; Pollock & Hashmall, 1991; Wright & Schneider, in press). Pollock and Hashmall (1991) pointed out that the basic units of analysis that are accessible to clinicians are the explanatory statements provided by offenders with regard to their offense. These explanations serve as a window into understanding the offender's point of view as well as the network of ideas that need to be transformed to motivate positive behavior change.

This focus on explanations to excuse or justify deviant behavior is not unique to sex offenders. Researchers have previously evaluated the significance of attempts by non-sexual offenders to reinterpret their actions in ways that diminish their culpability or neutralize its consequences (Saxe, 1991; Scott & Lyman, 1968), and others have specified verbal tactics used by non-sexual offenders to justify or legitimize deviant behaviors (Bandura, 1973; Stokes & Hewitt, 1976). Regardless of their source of origin, changes in explanations generated by offenders to deny their actions are likely to be critical to progress in treatment. Explanations represent a dynamic factor maintained by ongoing cognitive processes, both intentional and implicit. Changes in explanations are likely to have clinical use because they reflect reductions of both intentional deceit and cognitive distortions that prevent offenders from taking responsibility for their offenses.

Whether the offender's portrayal of the offense stems from preexisting beliefs, is grounded in evidence accrued through biased data collection strategies, or reflects a deliberate attempt to avoid perceived consequences, it still represents an absence of personal accountability for one's actions.

DENIAL AND THE MOTIVATION TO TAKE RESPONSIBILITY

Deceptive explanations in the clinical setting are not new phenomena. They have been regularly observed in association with a wide variety of clinical disorders (Rogers, 1997; Rogers, Sewell, & Goldstein, 1994). Dishonest and biased accounts of offending behavior appear to be endemic within the sexual offender treatment setting. This is hardly unexpected given that most offenders do not enter treatment voluntarily. Instead, they are mandated to participate as a condition of their probation or parole. Given the threat to the offender's social status, integrity, and family stability, there is tremendous pressure to deny and distort information about having committed a sexual offense—not just to others but also to the offender himself (or herself).

Sexual offender denial is also complicated by the fact that being honest about one's culpability is not necessarily a straightforward matter. As described in the previous section, significant evidence exists that the deviant actions of offenders are embedded in an elaborate network of distorted ideas, grounded in evidence accrued through biased processes (Ward et al., 1997; Wright & Schneider, 1997, 1999). It is not at all surprising, especially when the penalties are severe, that individuals can develop cognitions that allow them to deceive others and themselves.

Determining whether offenders' biased explanations stem from preexisting beliefs, self-serving information-gathering strategies, or justifications after the fact may be of less consequence than recognizing that effective interventions require a therapeutic approach to evaluating these explanations in order to find ways to change them.

Clearly, there is an enduring need to reduce denial and distortion in sexual offenders and to promote honest self-assessments. Although it would be a mistake to reinforce biased views or to excuse dishonesty, it may be just as harmful to attack these excuses and explanations without appreciating their meaning to the offender. Our understanding of denial needs to encompass the fact that, to a large extent, offenders are likely to believe the assertions and arguments they make and that abandoning their position is likely to exact a huge cost in their self-view and perceived social status. Determining whether offenders' biased explanations stem from preexisting beliefs, self-serving information-gathering strategies, or justifications after the fact may be of less consequence than recognizing that effective interventions require a therapeutic approach to evaluating these explanations in order to find ways to change them. Even if we know that an offender is intentionally misrepresenting certain facts, understanding the lie from the perspective of the offender may be essential to developing strategies to modify it.

Adopting more sophisticated views of denial, and the related motivations to avoid versus accept responsibility, will allow us to better understand not only the factors that make deviant behaviors acceptable to offenders but also the changes that are likely to be required to render those same behaviors unacceptable to offenders. Explorations of offenders' denial provide a rich source of clinical information about how offenders view the world and what ideas are critical in their thinking. Interventions designed to assess rather than eliminate denial are likely to produce information that reveals the varying contexts within which offenders feel justified to avoid responsibility for their deviant behaviors. Such information can then become the target of therapeutic efforts, with an individualized basis for redirecting thinking processes to help offenders more accurately assess and develop their capacities to take responsibility for and control their deviant thoughts and behaviors.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Denial is best viewed as a source of rich clinical information about the offender's view of the world rather than as an obstacle that interferes with treatment.
- Because denial stems from a combination of intentional deceit and distorted thinking, indirect approaches designed to analyze denial, rather than immediately eliminate it, are likely to be more effective.
- The recent development of a psychometric- ally sound measure of denial, the Facets of Sexual Offender Denial Scale (Schneider & Wright, 2001), holds promise as a measure of within-treatment change and should improve methods of examining the relationship between denial and recidivism.

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