EFFECTIVELY WORKING WITH DENIAL IN TREATMENT:

SOLUTIONS, STRATEGIES, AND TECHNIQUES TO WORK WITH THE CLIENT RELUCTANT TO ADMIT

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MEET THE PRESENTERS

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AGENDA

Introduction

Progression of Denial as a Risk Factor

Amenability to Treatment

Adjusting Our Clinical Mind Frame

Treatment Interventions

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OBJECTIVES

- Expand view of resistance and denial.
- Increase insight about issues involved in addressing or not addressing denial.
- Increase knowledge of different strategies, treatment assumptions, principles, and techniques to effectively work with and engage clients who will not admit.

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PROGRESSION OF DENIAL AS A RISK FACTOR

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THE ULTIMATE CLIENT RESISTANCE: DENIAL

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- Miller & Rollnick (1999) provided 4 categories of client resistance behavior
  - Arguing, Interrupting, Ignoring, and Denying:

- Denying:
  - The client expresses an unwillingness to recognize problems, cooperate, accept responsibility, or take advice.
    - Blaming – the client blames other people for problems
    - Disagreeing – the client disagrees with a suggestion that the therapist has made, offering no constructive alternative. This includes the familiar, "Yes, but…" which explains what is wrong with the suggestions that are made.
    - Excusing – the client makes excuses for his or her own behavior.
    - Claiming impunity – the client claims that he or she is not in any danger (e.g. from drinking).
    - Minimizing – the client suggests that the therapist is exaggerating risks or dangers and that it "really isn't so bad."
    - Pessimism – the client makes general statement about self or others that are pessimistic, defeatist, or negativistic in tone.
    - Reluctance - the client expresses reservations and reluctance about information or advice given.
    - Unwillingness to change – the client expresses a lack of desire or an unwillingness to change, or an intention not to change.

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DENIAL AS A MULTIFACETED CONSTRUCT

- Construct of denial is multi-leveled and dimensional
  - Denial of harm (to victim)
  - Denial of responsibility
  - Denial of fantasy or planning
  - Denial of frequency of offending, denial of need for treatment
- Minimization compared to Absolute Denial
- Categorical Denial:
  - The offender categorically states that they did not commit any sexual offense (Marshall, Anderson & Fernandez, 1999)

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HISTORY OF DENIAL IN TREATMENT

- Prior treatment culture consisted of shame based intensive confrontation
- Historically, deniers were excluded from and/or terminated from treatment.
- Previously, programs developed aimed at overcoming denial or using assessment procedures to overcome denial
- Previous belief that overcoming denial is needed for successful treatment (not only admitting to details of current offense, but admitting to all additional offense)
- We now realize that records and versions of the events may vary
- Denial/responsibility may be a mitigating factor for successful treatment

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DENIAL AS A RISK FACTOR?

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- Denial found to NOT be correlated with risk:
  - Kennedy & Grubin (1992)- Sexual offenders who completely denied any offense no more likely than admitters to reoffend
  - Simourd & Malcolm (1998)- 178 newly incarcerated sexual offenders- denial unrelated to risk to recidivate
  - Hanson & Bussiere (1998)- Meta-analysis of sexual offender recidivism studies. Neither full-admission nor denial and minimization of offending were identified as factors that predicted post-discharge or post-treatment re-offenses
  - Nunes (2007)- Denial predicts recidivism (small) in low-risk incest
  - Hogue (2013)- Identified problems with denial (multi-dimensional term)- Mixed findings: 2 studies found denial related to higher recidivism. 4 studies found denial related to lower recidivism.
  - Konopaski (2015)- Small association of nondeceptive polygraph with prediction of recidivism.
- Not recommended to kick out a client due to denial (Marshall et al., 2006; Marshall et al., 2011)

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WHY DENY?

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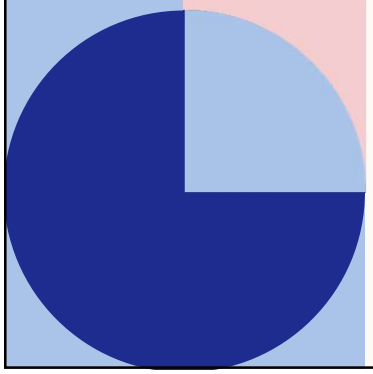
- Protect Self-Image/Self-Concept
  - Effort to maintain a viable identity (not be labeled as sex offender/pervert)
  - Avoid shame/toxic shame
- Avoid Painful Thoughts/Feelings
  - Difficulties facing what happened
  - Want to avoid hurt of what happened (embarrassment, hurt, shame, inadequacy)
- Avoid Resulting Losses/Consequences
  - Fear of losing friends and family
  - Effort to protect ability to secure an intimate adult relationship
  - Avoid the criminal consequences
  - Avoid judgement

Adaptation Model- Decision to admit as a cost-benefit analysis (Rogers & Dickey, 1991)

- Maintain denial if the benefits of continuing to deny outweigh benefits of admitting responsibility
- Example: Although admitting may result in good-time or early release, the fear of the stigma (and possible violence) from other prisoners due to identification as a sex offender results in offender maintaining denial.



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AMENABILITY TO TREATMENT

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NOT AMENABLE TO TREATMENT? WE DISAGREE

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"They just aren't amenable to treatment."

"They can't even admit to their offense, how can we get them through treatment?"

Range of definitions of *amenability to treatment*

- Marriam Webster's dictionary—amenable: "readily brought to yield, submit, or cooperate." In essence, not able to be progressed to the point of cooperation or agreeance with treatment.
- Other sources-- ability to admit or take responsibility for problems.
- Psychological definitions—Varied definitions incorporating: responsibility for problems, ability to engage in treatment, and capacity to benefit from available treatment.
- Theoretical model of treatment amenability-- treatment readiness or the presence of characteristics within either the client or the therapeutic situation that are likely to promote engagement in therapy, thereby likely to enhance therapeutic change (Slobogin, 1999).
- Mulvey and Iselin (2008): acknowledged that amenability and risk for reoffending are related, but argued that they are distinguishable concepts and judgements that should be carefully balanced against each other.

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UNDERSTANDING DENIAL & RESISTANCE

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- Denial manifests itself in multiple ways (e.g., cognitive distortions, defenses)
- Denial serves different purposes
- How denial is viewed and handled is often based upon the professional
- Denial and/or avoiding accountability of offenses, does not have to impede therapy
- Treatment can be successfully done with people in denial.
  - There are some outliers--For incest/family abuse, client needs to take responsibility for offenses to help family heal at the highest level.
- Historically, resistance was considered a barrier to change.
- Often in this work, labels can have a variety of impacts on both clients and professionals.
  - Instead of identifying such clients as *resistant* we can reframe by considering them currently presenting as *reluctant.*

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UNDERSTANDING CLIENTS' BEHAVIORS AS RELUCTANCE INSTEAD OF RESISTANCE

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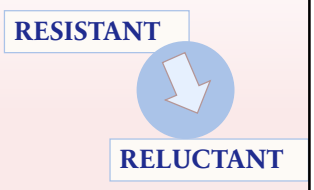
- Resistant client: a client won't change or be compliant.
  - Too often we disregard the client.
- There is a continuum of responsibility for "resistance" ranging from it's all the client or it's all the therapist.
  - Often the therapist sets the tone and presents barriers interfering with the change process.
- Working with the resistant client involves: how we see the client.
  - Clinician's assumptions involve how we see the life, therapy, and the world
  - Inner subjective realities of the human condition.
- If we see the client as resistant, then we will approach them as such.
- How we view the situation involves constructivism
  - We create or construct our own inner realities (Mahoney, 2003)



Instead, adjust to a concept with less connotations of: the client *can't* to the client *chooses not* to engage in the presented material.

- Thus, resistance is referred to as reluctance

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ADJUSTING OUR CLINICAL MIND FRAME

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CLINICAL MIND FRAME

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- Based in post-modern constructivism
- Refers to the subjective inner realities that people construct
- In working with a client, the clinician passes on or superimposes theoretical framework, personality, and their clinical lens onto the client
  - Thus, the clinician's clinical mind frame dictates the therapeutic treatment approach, strategies, and methods used with the client
  - How the therapist thinks about the client and the client's issues influences the outcome.
- Movement in the field towards Positive Psychology supports the perspective of shifting the way we think about and interact with our clients.
  - Shifting our thinking in the field to a holistic approach in that the sexual deviance is only one part of the client.
- Move away from a focus on admitting to the offense, but instead of focusing on ability to internalize and accept treatment based on:
  - Being motivated
  - Being able to respond appropriately (or perceives they can)
  - Seeing the treatment as relevant and meaningful (able to engage)
  - Having the capacities (cognitive, affective, behavioral) to successfully enter the treatment program
- Challenge posed to clinicians:
  - Move focus away from the client's denial and perceived amenability and instead shift focus to how we can implement innovative techniques and approaches to foster success in treatment and beyond.

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RESPONSIVITY PRINCIPLE

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Responsivity Principle- Meet offender's needs or "changing & matching the mode of treatment delivery depending on the learning style & personality of the offender." (ATSA, 2005)

- Match treatment intensity with risk level
- Client receptivity to clinician/messages
- Client responding to clinician
- Motivate the client towards receptivity & goals.
- Meet client's needs
- Client responsible for change & therapist responsible for creating a therapeutic context
- Work with offender at their level
- Delivery is everything
- Delivery based upon how ideas, messages & interventions are packaged.
- Motivational Interviewing

Responsivity is the key: Being responsive to the client's needs, situation, experiences…

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THERAPEUTIC ALLIANCE

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Clinicians can often interfere or place barriers creating reluctant responses

- An emotional/psychological connection (rapport) within a therapeutic context, in which the clinician helps the client create a change (manifested in any number of ways, levels, experiential domains within the client) involving:
  - Bonding process
  - Bonding process with boundaries (firmness with support)
  - Collaboration and cooperation
  - Levels of attachment
  - Boundaries defining the roles and context (overt/covert rules)
  - Psychological contract/connection with boundaries

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BLOCKING THERAPIST BEHAVIORS

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6 Professional Traps

- The Question/Answer trap-
  - elicits yes/no short answer responses
- The Confrontational/Denial trap-
  - confronting denial, power struggles
- The Expert trap-
  - the professional has all of the answers
- The Labeling trap-
  - labeling problems carry stigmas
- The Premature Focus trap-
  - client/therapist focusing on different topics
- The Blaming trap-
  - blame as excuses as to why

Types of Roadblock Responses

- Ordering, directing, or commanding
- Warning or threatening
- Giving advice, making suggestions, providing solutions
- Persuading with logic, arguing, lecturing
- Moralizing, preaching, telling clients what they should do
- Disagreeing, judging, criticizing, blaming
- Agreeing, approving, praising
- Shaming, ridiculing, labeling
- Interpreting, analyzing
- Reassuring, sympathizing, consoling
- Questioning, probing
- Withdrawing, distracting, humoring,

(Miller & Rollnick, 1991)

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FACTORS THAT FOSTER THERAPEUTIC ALLIANCE

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Therapist Style Characteristics

- Style balanced with procedure
- Flexibility
- Structure, not overly rigid
- Directive to a degree
- Empathy
- Respect
- Process
- Humor
- Encounter
- Supportive
- Challenging
- Nonjudgmental

Process/Style & Responsiveness

- Understanding the client (client feels understood)*
- Instill hope
- Collaborative style with the client*
- Doesn't have pre-conceived ideas (rigid boxes/lens)*
- Being fully present*
- Accessible to feedback*
- Forgive self for errors or mistakes*
- Therapist avoids power struggles
- Therapist allows appropriate expression of emotions
- Therapist allows appropriate expression of emotions
- Therapist owns responsibility for mistakes
- Doesn't exhibit people pleasing (seeking) behaviors
- If in groups, avoids secrets
- Directive as needed
- Not overly passive
- Doesn't appear to be emotionally &/or psychologically removed
- Appears comfortable
- Therapist is aware of personal issues

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TREATMENT APPROACHES

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TREATMENT WITH DENIERS

- Use as-if/what-if situation happened and you did it
- Use the hypothetical "I did it" throughout treatment
- Explore the situation looking multiple factors
- Look at how you got into the situation
- Complete treatment to prevent you from ever getting accused again
- Emphasis on current and future responsibility

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AS-IF/WHAT-IF

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- Based in the concept of fictional finalism (Adler, 1941, 1956) in which goals drive future behavior.
- Includes aspects of the self-fulfilling prophecies in which one identifies a future goal that they aspire to achieve and therefore directs their lifestyle to meet the goal.
- Client anticipates, pretends, or enacts a futuristic event, belief, or desired behavior via "as-if/what-if" the thing happened.
  - For our clients, they would engage into as-if/what-if they committed the offense.
- As-if variations of different modalities.
  - Hypnotic therapy-- client can be projected into their future using as-if/what-if statements or suggestions while in trance
  - Psychodrama-- client enacts as-if/what-if scenarios via drama
  - Offender treatment modalities-- client would progress through the therapy or the workbook without needing to admit to the offense(s).
    - Would involve the client discussing sexually abusive behaviors in a manner of "what would pertain *had* they admitted that they had done it."
    - Clinician can preface their work and discussions with statements such as:
      - "If you actually didn't do it or for whatever reason are reluctant to admit to what happened, answer the questions or tasks in the workbook 'as-if' you did it."

Using as-if/what-if approaches allow the clinician and client to explore situations looking at multiple factors with an emphasis on current and future responsibility.

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MOTIVATIONAL INTERVIEWING

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- Motivational Interviewing (MI) is a collection of tactics to motivate clients to change without using a confrontational or shame-based approach (Miller & Rollnick, 1991, 2002, 2013; Prescott, 2014, 2018).
- Prescott (2014) describes MI as:
  - a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion.
- The four key processes in MI are:
  - Engaging: establishing a therapeutic relationship fostered by a helpful connection and working relationship
  - Focusing: the process by which the clinician develops and maintains a specific trajectory in the conversation about change
  - Evocation: eliciting the client's own motivations for change (the primary aspect of MI)
  - Planning: committing to change and formulating a concrete plan of action developed by the client and based on client's unique values, wisdom, and self-awareness (Prescott, 2014).
- Key communication skills associated with motivational interviewing, identified by the acronym OARS are:
  - open questions, affirmations, reflective listening, and summary reflects (Miller & Rollnick, 2013).

Technique to use with deniers to promote change and growth.

May be a way to develop a connection with the client to foster an environment where they may feel safer to take responsibility for their offense(s) but, at minimum, it is a way to promote a safe space for the client to focus on, identify motivations for, and develop a plan for positive change.

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GROUP WORK

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- Group work can be a very powerful modality to work with clients who are presenting as reluctant (Jacobs et al., 2016), especially a group that achieves cohesion.
- Group work also promotes additional therapeutic factors that support change and positive growth for clients who are denying.
- Yalom (2005) identified 11 curative factors operating in groups, many which can promote positive change for deniers:
  - instillation of hope, universality, imparting information, altruism, corrective recapitulation of primary family group, development of socialization techniques, imitative behavior, interpersonal learning, group cohesiveness, catharsis, and existential factors.

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ROCKWOOD
CATEGORICAL DENIERS PROGRAM

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According to categorical deniers: Primary obstacle to entering a treatment program was assumption that providers would then attempt to challenge their claim of innocence.

- Issued clients a promise to not discuss their offense, much less challenge their denial.
- Informed clients that goals are to help them identify problems in their lives that:
  - put them in a position to be accused of sexual offending, or
  - that generated sufficient animosity in others that someone accused them of an offense they claim not to have committed.
- Suggest to clients: it may have been something about their behavior, attitudes, or feelings that put them in this position
  - Need to identify these issues and help them learn to change
- Although set aside the issue of their specific offense, address criminogenic factors identified as important targets in treatment of sexual offenders (consistent with admitters program):
  - Self esteem; coping strategies; victim harm (consequences to victims in general); relapse prevention (identify path that put them in a position where they could be successfully accused of a sexual assault)

Marshall, 2014

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ROCKWOOD

- Groups held twice weekly for 2.5 hours. 12 to 14 weeks. 10 offenders and 1 or 2 therapists in each group. No individual therapy component
- Clients are required to complete other programs as recommended by team (e.g., cognitive skills, anger management, substance abuse, and living without violence)
- Other than avoiding issues to do with denial, program followed the outline in Marshall, Marshall, Serran, and O'Brien,'s (2011) strength-based treatment program. Some differences:
  - "Disclosure" focuses on the problematic issues in the offender's life that were present at the time of the alleged offenses rather than on the victim's report of the details of the crime
  - Relapse prevention plans are specifically aimed at having the offender avoid placing himself in future situations where he could possibly be falsely accused again

Program Components

- Motivation & Engagement
  - Lead-Up to Charges
  - Life-Line/Autobiography
- Primary Treatment
  - Empathy/Victim Harm
  - Problem Analysis (background factors/immediate factors)
  - Relationship Skills (intimacy & attachment, loneliness, communication, jealousy)
  - Sexuality (healthy sexual functioning, reducing deviant interests-behavioral strategies)
- Future Life Strategies
  - Good Life Plans (goal setting)
  - Self-Management Plans (approach goals, limited RP plans, warning signs for self and others)
  - Support Groups (family & friends, professionals, colleagues)
  - Release Plans (accommodation, employment, leisure)

Marshall, 2014

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ROCKWOOD RESULTS

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- Outcome 1: Started 1998; 56 Participants to mid-2005
  - No Failures (87.5%) ; Breach/Revocation (10.0%) ; Sexual Offense (2.5%)
- Outcome II: Updated 2012; 109 Participants to 2012
  - No Failures (78.0%) ; Breach/Revocation/Suspension (16.0%) ; Non-Sexual/Non-Violent Offense (1.2%) ; Violent Offense (1.2%) ; Sexual Offense (2.5%)
  - Mean time at risk: 3.47, SD=2.26, Range: 1 month to 8.89 years
- Marshall 2014: 82 sex offenders (52 child molesters and 30 rapists) evaluated over a 3.5 year follow-up after release from prison.
  - Only 2.5% were found to have committed a further sexual offense
  - Comparisons
    - Calculating the pre-treatment risk of the participants on the RRASOR it was estimated that 13.2% would reoffend.
    - Outcomes of comprehensive treatment program for admitters: reoffense rate over a similar period of 3.2%

Challenges Identified:

- Denial of any problem
- Suspicion about therapist and underlying reason for group
- General disinterest in participating in therapy
- Problematic group behavior
- Poor participation
- Fear of being judged
- Lack of faith in system support for denier group
- Therapist managing own reactions to outlandish stories

Marshall, 2014

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MOTIVATIONAL INTERVIEWING WORKBOOK: TREATING SEXUAL OFFENDING ACROSS THE SPECTRUM OF ACCEPTANCE

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CARICH & HUEBNER, 2022

Set-Up:

- This workbook will help you clarify what happened and your decision-making processes. It has been designed to help you look your decisions to cross sexual lines (boundaries) and help you make better decisions in the future. This workbook can also be a guide to improve your emotional regulation skills, mood management skills, and identify plans to prevent engaging in problematic sexual actions or behaviors going forward. This workbook is meant to act as a guide and does not necessarily need to be completed in the order presented.
- More specifically, this workbook will help you:
  - Figure out who you are and what you are about
  - How you meet your needs
  - Your pathways in life
  - How to develop and maintain relationships
  - How to re-think your thinking that might not work as well
  - How to manage your emotions
  - How to cope with life and meet your needs appropriately
  - How to maintain change

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EXCERPTS-THE ALLEGED OFFENSE

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Clarifying What Happened

- We don't know what happened. Only you and the persons involved actually know. You will have to ask yourself if you are willing to be honest or not with yourself and others. Below are several assignments to help you with that. Be as honest as you can be.
- In general, a sexual offense is any sexually oriented behavior that violates another's boundaries, thus hurting another person. It is a sexual transgression, or violation of another's rights through sexual means. Based upon this definition, answer the following questions.
- **Task 2.1** What happened that brought you here?
- **Task 2.2** What did the "victim" or system say happened?
- **Task 2.3** What do you say happened?
- **Task 2.4** What did the authorities say happened?
- **Task 2.5** If there is a difference, why?

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EXCERPTS-DENIAL OR ADMITTANCE

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The Issue of Denial or Responsibility

- It is quite normal to deny or avoid admitting to stuff that you don't want to admit to because perhaps you are embarrassed, having difficulties facing what happened or the pain involved, or you simply want to avoid the hurt of what happened. Perhaps you want to get out of what happened or maybe nothing happened. Ultimately, it is going to be up to you to be honest about your experiences. No one can force you to do anything. Several exercises are designed to help you sort this out. At any rate, we do not want you to make stuff up. Rather you admit to what happened or not, this workbook will help you. Taking current and future responsibility for life is key.
- **Task 2.6** What would happen if you did admit to whatever happened?
- **Task 2.7** What would happen if you didn't admit to it?
- **Task 2.8** What would be some reasons for not admitting to what happened and your role/part?
- **Task 2.9** What are the pros/benefits of admitting to your part?
- **Task 2.10** What would be the cons if you don't admit your part?

- In the event that you actually didn't do it or for whatever reason are reluctant to admit to what happened, answer the questions or tasks in this workbook "as If" you did it. This is called using a hypothetical "as if" approach. It takes a lot of courage to face up to what one has done!

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EXCERPTS-SHAME

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- **Shame**
  - **Task 2.11** Sometimes people will not admit to stuff they did because of intense shame. Is that your situation? ____yes ___no ____maybe
- **Toxic Shame**
  - In this section, we are looking at how you are feeling up to this point. Remorse is different than toxic shame. Feeling guilty after violating someone is still considered normal. However, when you get to the point of feeling bad about yourself and that you are no good—that actually crosses the line into toxic shame. Toxic shame is the feeling of worthlessness. Your behavior is not the end of the world; however, there are usually impacts. Many people find it a relief to talk about what happened to a trusted person. It lifts the burden. The following tasks will help you sort through toxic shame—if you are experiencing it.
- Perhaps you would feel better by giving back, also called restitution, and making changes in your life so you don't hurt others in the future.

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ALL THAT CAN BE DONE WITHOUT ADMITTING

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- Identification of primary goods
- Addressing criminogenic factors
- Identifying and changing dysfunctional thinking
- Improving interpersonal relationship skills
- Regulation skills & mood management
- Arousal control & sexual regulation skills
- Addressing trauma & core issues
- Insight to victim harm (victims in general)
- Identifying functional & dysfunctional pathways
- Identifying avoid/escape and approach strategies
- Fostering healthy sexual functioning
- Achieving group cohesion
- Development of coherent life plan
- Developing individualized release plans

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THANK YOU

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