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Running head: TREATING SEX OFFENDER DENIAL

Treating Sex Offender Denial: Measuring Client Change and Contributing Therapeutic Factors

Jean P. Hickey

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Acknowledgments

The love and support of my husband and best friend, Brian Hickey, helped me to find the reason why I'm here on Earth (after so many years!). Not simply to work with, study, and write about people who have committed sex offenses, but to be allowed to accompany them and others on their life's journey. And completing this thesis means I'm almost there! Thank you, Brian.

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Abstract

Denial is believed to be a serious impediment to the most effective sex offender treatment. Research in support of this contention is limited, as is research into the specific content and process components which may reduce denial. Additionally, perhaps because sex offenders are so reviled by the public, soliciting their opinions on the efficacy of treatment components is rarely done.

This study utilized a pretest/posttest design to measure the effect of a twelve-week treatment group on types of denial and solicited group members' opinions on the helpfulness of specific components. Results indicated denial was lowered and group cohesiveness contributed most significantly. An implication is that group process factors in sex offender treatment might be studied more rigorously in the future.

Treating Sex Offender Denial: Measuring Client Change and Contributing Therapeutic Factors

Sex offenders are reviled by the public. Their actions cause extensive harm and trauma to many innocent victims as well as victims' families and offenders' families (Marshall, Anderson, & Fernandez, 1999). The U.S. Department of Health and Human Services estimated that 25-33% of adult women and 10% of adult men have been sexually victimized as children (Faller, 1993). Schwartz (1995b) noted that "the media is overflowing with reports of outstanding citizens, religious leaders, judges, doctors, and so on, who are molesting children" (p. 2-4). At a time when resources are increasingly limited, the mental health community has attempted to respond to the public's pressure to protect the community from the harm sex offenders cause by developing effective treatment programs (Marshall & Barbaree, 1990). In the case of sex offenders, efficacy is measured by lower recidivism (re-offending) (Marshall, et al., 1999; Schneider & Wright, 2004). Studies have shown that cognitive-behavioral approaches to treatment are more effective in lower recidivism than traditional approaches such as insight-oriented psychotherapy, physical treatments (including neurosurgery, and physical and chemical castration), pharmacological interventions to reduce sexual arousal, and behavioral reconditioning (Hall, 1995; Hanson, et al., 2002; Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005; Marshall et al., 1999; Yates, 2003). Cognitive-behavioral approaches may be more effective because they address the distorted thoughts, attitudes, beliefs, and perceptions with which sex offenders often present for treatment (Marshall, et al., 1999; Salter, 1988). These distorted thoughts, attitudes, beliefs, and perceptions allow sex offenders to commit the initial act of abuse as well as permit them to justify continuing their abusive behavior (Marshall, et al., 1999; Murphy, 1990).

When considering sex offenders' distorted thoughts, attitudes, beliefs, and perceptions, which are often intertwined with outright lies, Wylie (1998) offered the following observation.

> Offenders live in a society that…considers them the scum of the earth, and many of them if they think about it are inclined to agree, which is why they become such pros at not thinking about it, by denying their own actions and blaming the victim. Denial, in all its guises, is less painful, than looking at the truth. In a sense, they have bought the common argument that the offender is the offense, so to admit the latter is to admit their own irredeemable depravity. There is no way out of this position; either lie and deny, and salvage some remnant of personal worth not to mention avoid jail or tell the truth and be damned. (p. 56)

For purposes of this study, sex offenders' distorted thoughts, attitudes, beliefs, and perceptions, intertwined with their outright lies, have been called *denial*.

While the overarching goal of treatment is to lower recidivism, the first goal of cognitive-behavioral therapy for sex offenders is to *break through* their various forms of denial (Association for the Treatment of Sexual Abusers (ATSA) Professional Issues Committee, 2001; Barbaree, 1991; Faller, 1993; Green, 1995; Green & Franklin, 1999; Marshall, 1994; Marshall, Thornton, Marshall, Fernandez, & Mann, 2001; Northey, 1999; Salter, 1988; Schlank & Shaw, 1996; Ward, Hudson, Johnston, & Marshall, 1997). It is thought that breaking through will allow them to admit their guilt, accept responsibility for their behaviors, identify the distorted thoughts, attitudes, beliefs, and perceptions that support their cycle of offending, and determine ways to prevent themselves from re-offending (Green). This almost universally occurs in the context of a treatment group (Jennings & Sawyer, 2003; Marshall et al., 1999; Marshall & Barbaree, 1990; Salter, 1988; Schwartz, 1995a).

Sex offender treatment programs have found that the most effective format for treatment of denial is the treatment group rather than individual treatment (Jennings & Sawyer, 2003; Marshall et al., 1999; Marshall & Barbaree, 1990; Salter, 1988; Schwartz, 1995a). The treatment group may be a place where sex offenders first recognize that they are not alone in their guilt and shame and can provide their peers with encouragement and support through the treatment process (Jennings & Sawyer; Scott, 1994). A key ingredient of group therapy with sex offenders may be that members recognize denial in their peers more quickly than the therapist, and can challenge that denial more credibly by using their own experience (Beech & Fordham, 1997; Houston, Wrench, Hosking, 1995; Jennings & Sawyer; Marshall et al., 1999; Salter, 1988; Schwartz, 1995a; Scott). Interpersonal aspects of the group context may also contribute to the sex offender's change in level of denial, but there has been a lack of research into which particular aspects of cognitive-behavioral treatment are most effective in encouraging change (Beech & Fordham; Beech & Hamilton-Giachritsis, 2005; Drapeau, 2005; Drapeau, Körner, Granger, & Brunet, 2005; Houston, et al.; Jennings & Sawyer; Marshall, 1994; Marshall et al., 2003; Ward et al., 1997) and sex offenders' views in this regard have generally been ignored (Day, 1999; Drapeau, Körner, Brunet, & Granger, 2004; Drapeau et al., 2005; Garrett, Oliver, Wilcox, & Middleton, 2003; Williams, 2004).

Perhaps the extent of the public's revulsion for the actions of sex offenders has created a negative attitude in researchers and clinicians (Garrett et al., 2003). For whatever reason, there have been very few studies in this field which considered the views of the participants in sex offender treatment programs, although the views of service users have been increasingly seen as important in service evaluation generally (Day, 1999; Garrett, et al.). Sex offenders may provide

critical information on which aspects of treatment were particularly useful to them and this information may increase the efficacy of treatment programs (Day; Williams, 2004).

The hurt experienced by each victim of sexual abuse is profound and the public expects that cognitive-behavioral approaches to treatment, in a group context and with an initial goal of breaking through denial, will be the most effective at lowering recidivism. The purpose of this study was to measure the effectiveness of such a treatment group by evaluating the change in specific types of denial experienced by group members. An additional purpose of this study was to contribute to the knowledge base in the field of sex offender treatment by determining, from the group members' point of view, what aspects of treatment contributed to their change.

Literature Review

The Development of Sex Offender Treatment

Anna Salter, in her now classic work of 1988, traced the history of sex offender treatment and noted that more traditional forms of treatment, including insight-oriented psychotherapy, physical treatments (such as neurosurgery, and physical and chemical castration), pharmacological interventions to reduce sexual arousal, and behavioral reconditioning, appeared to be less effective than cognitive-behavioral approaches (Yates, 2003). According to Salter, in the early 1980s clinicians noted that the most effective treatments for sex offenders were becoming specialized. Specialization occurred because clinicians noted that sex offenders often denied their offenses (Salter). Their denial took many forms but, at its most basic, offenders would deny that their offense took place at all, despite the fact that they had been found guilty in the criminal justice system (Barbaree, 1991; Happel & Auffrey, 1995). Denial that an offense actually transpired placed treatment providers in the position of offering treatment to persons who believed they had no reason to be treated (Marshall, 1994). Thus, many treatment programs

refused to treat sex offenders who were considered to be *in denial* (Green, 1995; Marshall). Current meta-analyses of treatment efficacy point out that some programs continue to screen-out offenders in denial, believing them not to be amenable to treatment (Schneider and Wright, 2004). Screening-out those in denial, however, might result in a sex offender being returned to the community after incarceration without ever accepting responsibility for his actions (Marshall; Schlank & Shaw, 1996). Since he had never accepted responsibility for abusing, a natural assumption would be that he would be more likely to re-offend than a sex offender who had been treated and accepted responsibility for the harm he had caused others (with the subsequent guilt preventing him from re-offending) (Marshall; Schlank & Shaw).

Not treating *deniers* was unacceptable to many (Marshall, 1994; Schlank & Shaw, 1996; Schneider & Wright, 2004). Marshall 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. Treatment programs subsequently began to focus on methods of *breaking through* denial, often making admission of the offense and acceptance of responsibility two of the primary goals of treatment (Green, 1995).

Since denial in all of its forms was found by early clinicians to be pervasive throughout treatment of sex offenders (Salter, 1988), and because traditional treatments did not appear to be effective (Salter), treatment providers began to develop specialized approaches targeting the cognitive processes of offenders in the hope that this would be effective in changing their behavior (Salter; Schneider & Wright, 2004).

Efficacy of Treatment

In 1989, Furby, Weinrott, and Blackshaw confirmed treatment providers' assessments (Salter, 1988) that traditional approaches to treatment of sex offenders were not effective. Since

cognitive-behavioral approaches had begun to be utilized by providers in the early 1980s (Salter), researchers began to investigate whether these approaches were more effective.

Marshall et al.'s (1999) review of cognitive- behavioral treatment approaches with sex offenders concluded that "the treatment of sexual offenders can be effective and that the balance of the evidence weighs in favour of positive treatment outcomes" (p. 162). Their review of the results of eight methodologically sound treatment approaches yielded seven positive evaluations and one negative evaluation (Marshall et al.). Marshall et al. noted that the rates of recidivism in the untreated groups of sex offenders from the seven positive evaluations of treatment ranged from 22 to 77%. The rates of recidivism in the treated groups of sex offenders decreased to 7 to 39%. The one negative evaluation noted by Marshall et al. was done by Marques, Day, Nelson, and Miner (1989, as cited by Marshall et al.) and reported no clear benefits for treatment. However, the final results of their longitudinal investigation of the effectiveness of cognitive-behavioral treatments in California's Sex Offender Treatment and Evaluation Project were reported by Marques, Wiederanders, Day, Nelson and van Ommeren in 2005. Marques et al. (2005) noted that "a closer examination of the…group's performance revealed that individuals who met the program's treatment goals had lower reoffense rates than those who did not" (p. 79). Rice, Harris, and Quinsey (2001) also performed a review of treatment outcome literature for sex offenders and questioned the effectiveness of cognitive-behavioral treatment. They did, however, call the Marques et al. study (2005) "superbly designed" (p. 303) and stated that it included clinical sophistication, random assignment, and reliance on hard outcome data.

Hall's (1995) meta-analysis of twelve studies of treatment with sex offenders supported Marshall et al.'s (1999) conclusion that treatment can be effective. Hall concluded that "the overall recidivism rate for treated sexual offenders was .19 versus .27 for untreated sexual

offenders" (p. 802), a reduction of almost 30%. He further concluded that although this treatment effect may appear to be small, the net effect is 8 fewer sex offenders per 100 (Hall). Hall added that "treatment is most effective with outpatient participants and when it consists of…cognitive-behavioral treatments" (p. 808).

The First Report of the Collaborative Outcome Data Project on the Effectiveness of Psychological Treatment for Sex Offenders (Hanson, et al., 2002), an ongoing project that aims to include all credible studies of sex offender treatment, also confirms earlier evidence that the traditional forms of therapy for sex offenders are ineffective (Salter, 1988) and that cognitive-behavioral treatments are effective. By translating treatment efficacy outcomes for sex offenders to treatment effect sizes, Marshall and McGuire (2003) found "treatment effect sizes equal to or greater than interventions for general criminal behaviors, as well as for various mental and physical health problems" (p. 660).

The analyses above reflect research performed on recidivism rates for sex offenders. Research has not yet focused on which components of cognitive-behavioral treatment might be responsible for lower recidivism rates, and if targeting denial is an effective means of lowering recidivism.

Denial

When sex offenders present for treatment they typically expose only a fraction of their offense at first (Salter, 1988). Conte (1985, as cited by Schneider & Wright, 2004) explained this by noting that "any mental health problem which is illegal, socially stigmatizing, and the disclosure of which is likely to cause the client major problems in living, is not going to be a problem easily revealed" (p. 546). The traditional view of denial is that it is intentional deceit, or an all-or-nothing construct, i.e. *he's in denial* or *he's not in denial* (Schneider & Wright).

Another view is that denial is multi-faceted and complex, intertwined with an offender's misperceptions or distorted ways of viewing the world (Marshall, et al., 1999; Salter; Schneider & Wright; Winn, 1996; Wright & Schneider, 2004).

Marshall et al. (1999) affirmed that all people cognitively distort, not just sex offenders. People search for information that supports their beliefs, behaviors, and goals and ignore what does not (Marshall et al.). The difference between sex offenders and other people is not their habit of distorting, but in the harmful behaviors their distortions serve (Marshall et al.). The distortions of sex offenders may reflect their implicit theories about people (Marshall et al.).

Sex offenders' theories may be about people in general, about women and children, or they may have specific beliefs about particular victims (Marshall, et al., 1999). Sex offenders, for example, may believe in the sexual entitlement of males or may believe that their sexual impulses must be fulfilled (Ward, et al., 1997). Incest offenders often perceive children as sexually attractive and as wanting sex with adults (Ward, et al.). Child molesters may exhibit the following beliefs: "the child enjoyed it," "it didn't hurt her in any way," "she wanted me to do it," "it's an adult's responsibility to teach children about sex," "I wasn't thinking," or "we love each other, so it's okay" (Ward, et al.). It should be noted that even if this distorted thinking is initially done consciously, as a way for a sex offender to allow himself to offend without guilt, once the offending behavior becomes entrenched, the sex offender may come to believe these self-serving distortions (Marshall, et al.).

Starting in the late 1980s, treatment providers began to conceptualize denial (and its intertwined cognitive distortions) by creating descriptive typologies based on clinical observations (Barbaree, 1991; Happel & Auffrey, 1995; Laflen & Sturm, 1994; Salter, 1988; Winn, 1996; and, as cited by Schneider & Wright, 2004: Barrett, Sykes, & Byrnes, 1986; Brake

& Shannon, 1997; Langevin, 1988; Orlando, 1998; Trepper & Barrett, 1989; Winn, 1997). These typologies have been supported by empirical studies and have been found to be strikingly similar (Schneider & Wright, 2004). Table 1 provides a typology developed by Schneider and Wright (2001), including examples of the types of denial.

Schneider and Wright (2004) further distinguished denial on the basis of 3 levels of accountability: refutation, minimization, and depersonalization (see also Wright & Schneider, 2004). Refutation referred to a sex offender not taking any responsibility for his offense (Schneider & Wright). Minimization occurred when a sex offender admitted a problematic or harmful behavior but then discounted his responsibility by focusing on external circumstances ("I was drunk," "she wanted me") (Schneider & Wright). Depersonalization occurred when a sex offender acknowledged his responsibility for an offense, but was not "prepared to admit that they are the type of person who is vulnerable to committing sexual offenses" (Schneider & Wright, p. 11). Schneider and Wright's purpose in distinguishing denial on the basis of levels of accountability was to provide a framework for linking changes in levels to treatment progress.

Treatment progress may be hampered by denial (Levenson & Macgowan, 2004; Schneider & Wright, 2004; Wright & Schneider, 2004). Presenting for treatment at the refutation level of denial (not accepting any responsibility for the offense) has resulted in many sex offenders being denied treatment at all (Green, 1995; Marshall, 1994; Marshall et al., 1999; Salter, 1988). Entering at lower levels of denial (minimization and depersonalization) may reduce amenability to treatment or prevent sex offenders from fully participating, and interfere with engaging in efforts to learn self- management skills and strategies to resist deviant urges (Salter, 1988; Schneider & Wright, 2001). Sex offenders who are experiencing any form of denial may increase their likelihood of failing to complete treatment (Hunter & Figueredo,

Table 1

Examples of Types of Sex Offender Denial

1. Denial of Sexual Offense

I have never committed a sexual offense. (complete denial)

The victim is the kind of person who could make up a story about somebody sexually abusing them. (victim credibility)

The main reason I have to be in sex offender treatment is so others can make money. (system fairness)

There was nothing really harmful about what I did to the victim. (victim harm)

I have suffered at least as much as the victim because of the sexual offense. (self-harm)

2. Denial of Extent

I did touch the victim but I did not go as far as people think.

3. Denial of Intent

The offense happened because I was under stress or was feeling depressed. (stress)

The sexual offense was mostly due to an unusual or bad situation. (mistake)

4. Denial Due to Perceived Victim Desire

The victim made the first sexual advances and I just went along with it.

5. Denial of Planning

I did not arrange things so I could have sexual contact with the victim. (overt)

I did not do things to get the victim to think about sexual things. (victim enticement)

I have not had sexual fantasies about the victim. (fantasizing about the victim)

My view of the victim did not become more sexual over time. (sexualizing victim)

6. Denial of Risk of Relapse

The thought of sexual contact with a child has appealed to me. (sexual deviancy)

I am confident that I will not commit a sexual offense in the future. (future offense risk)

Note. From "The FoSOD: A Measurement Tool for Reconceptualizing the Role of Denial in Child Molesters," by S. L. Schneider and R. C. Wright, 2001, *Journal of Interpersonal Violence*, 16, p. 552. Copyright 2001 by Sage Publications, Inc. Adapted with permission.

1999). Failure to complete treatment has been related to higher rates of recidivism (Hall, 1995; Marques, et al., 2005; Marshall, 1994; Marshall & Barbaree, 1990). In summary, cognitive-behavioral therapy with sex offenders is currently considered to be the most effective method for reducing recidivism (ATSA Professional Issues Committee, 2001; Hall, 1995; Hanson et al., 2002; Marshall et al., 1999) and the initial stages of cognitive-behavioral therapy often focus on denial (Barbaree, 1991; Happel & Auffrey, 1995; Marshall, 1994; Marshall, et al., 1999; Murphy, 1990; Salter, 1988; Schlank & Shaw, 1996; Schneider & Wright, 2004).

Content of Cognitive-Behavioral Approaches to Denial

A review of programs outlined in the literature revealed that in the early stages of treatment many focus on denial (Barbaree, 1991; Happel & Auffrey, 1995; Marshall, 1994; Marshall, et al., 1999; Murphy, 1990; Salter, 1988; Schlank & Shaw, 1996; Schneider & Wright, 2004). The most common approaches began with offering the offender a rationale for the role that denial plays (Marshall, et al.; Murphy; Schlank & Shaw). The rationale distinguished the individual from his crime and discussed that, at some level, the offender knew that he hurt his victim, and did something to avoid feeling guilty or uncomfortable about it (Murphy). One way

to do this was to tell himself what he did was “not so bad,” or “the child really wanted it,” or “it could have been worse” (Murphy). Murphy went on to tell the offender that the therapist’s job, and the group’s job, is to help identify these thoughts and show why many of them are not true. Schlank and Shaw explained that this provides for “the possibility of a client later admitting to his offense without having necessarily to admit that he had been deliberately lying prior to his admission” (p. 20).

Often, the next step in the early stage of treatment was to ask the client to describe his offense in detail (Barbaree, 1991; Happel & Auffrey, 1995; Marshall, 1994; Marshall, et al., 1999; Salter, 1988). This “reveals a whole range of misperceptions, distorted attitudes and beliefs about his victim, his offence, and about other more general attitudes (e.g., negative attitudes about women in general, a sense of entitlement about children)” (Marshall, et al., p. 69). Group members were then encouraged to challenge the offender’s account (Barbaree; Happel & Auffrey; Marshall, 1994; Marshall, et al., 1999; Salter) often focusing on discrepancies between the offender’s account and police reports and victim statements (Barbaree; Happel & Auffrey; Marshall, 1994; Schneider & Wright, 2004).

Many treatment providers believed a victim empathy component was essential (Marshall, 1994; Marshall, et al., 1999; Salter, 1988; Schlank & Shaw, 1996) because clinical observation had shown them that offender attitudes appeared to change if they understood how the victim might feel. This knowledge may inhibit future abuse (Marshall, et al.). Marshall et al. and Murphy (1990) introduced their victim empathy component by asking the offenders to identify their own emotions, sometimes by recounting feelings about their own victimization, as a way to help them recognize emotional states. Marshall et al. and Salter followed this with role-plays of victims, so clients may come to appreciate the way their victim may perceive the abuse.

Marshall et al. have found that asking each group member to write a hypothetical letter from the victim to themselves, describing the emotions and problems the victim has experienced because of the abuse, appeared to be effective. Marshall et al. also asked each group member to write a hypothetical letter to their victim, taking full responsibility for the abuse, accepting and legitimizing the victim's distress, and expressing regret for his actions. These letters were read aloud to the group (Marshall et al.). Schlank and Shaw required their clients to participate in a 10-week program on victim empathy culminating in "a written report discussing the short-term and long-term effects a victim of a crime similar to the one they had been accused of committing would experience" (p. 20).

The initial stage of cognitive-behavioral therapy focusing on denial often incorporated a relapse prevention (RP) model as a framework, and to provide a common language (Marshall et al., 1999). The RP model was originally developed to aid in the maintenance of behavior change after a substance abuser was finished with treatment (Marshall et al.; Pithers, 1990). Some sex offenders may expect treatment to eliminate their desire for unacceptable acts while RP expected them to formulate self-management procedures to reduce deviant interest and arousal patterns if they return (Dowden, Antonowitz, & Andrews, 2003; Pithers & Cumming, 1995). The central premise in regard to sex offenders is that their acts were rarely impulsive (Pithers & Cumming). A typical sequence was that *affect (depression/anger)* lead to *abusive fantasies* which led to *passive planning* which led to *cognitive distortions* which facilitated *disinhibition* and resulted in *the abusive act* (Pithers & Cumming). During the initial stages of treatment, when offenders closely examined their offense and were challenged by other group members, they were often encouraged to isolate the thoughts, feelings, and behaviors that

characterized the steps in their RP offense chain (Marshall et al.; Pithers; Pithers & Cumming; Salter, 1988). This step may also have lead to a decrease in denial (Dowden et al.; Marshall et al.; Schlank & Shaw, 1996).

Process Issues

Until recently the importance of process issues such as group cohesiveness and therapist characteristics have been ignored by cognitive-behavioral treatment providers of sex offenders despite significant evidence across all theories that they may account for considerable variance in treatment outcomes (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Drapeau et al., 2005; Houston et al., 1995; Jennings & Sawyer, 2003; Marshall, 2005; Marshall et al., 1999; Marshall et al., 2003; Marshall & Serran, 2004; Serran, Fernandez, Marshall, & Mann, 2003; Yates, 2003). Marshall et al. (1999) noted only one such study in the field of sex offender treatment (Beech & Fordham). Since group therapy is almost universally recognized as the treatment modality of choice with sex offenders it seems that its processes should be examined to determine how they impact the effectiveness of cognitive-behavioral therapy (Beech & Fordham; Beech & Hamilton-Giachritsis; Jennings & Sawyer; Marshall et al., 2003).

Yalom (1995) characterized group cohesiveness as analogous to the therapeutic alliance in individual therapy, and stated that it is “a necessary condition for other therapeutic factors to function optimally” (p. 49). He described it as “the attractiveness of a group for its members” (p. 48) and elaborated by noting that it is a condition where members feel that they belong, value the group, and are valued, accepted, and supported in return (Yalom). Group cohesiveness is facilitated through the foundational therapist characteristics: empathic understanding, genuineness, and warmth/acceptance (Rogers, 1980; Yalom). These characteristics, as well as effective interpersonal interactions, are modeled by the therapist in the group setting (Yalom).

Group cohesiveness encourages the member to participate in self-exploratory behavior which, in the case of sex offenders, may lead to examining their denial. Yalom indicated that the more attracted a person is to a group the more they will respect the judgment of the group, and pay attention to the discrepancy between how others view their actions and how they view their actions. By changing the pro-offending attitudes and beliefs that have been challenged by other group members, sex offenders can begin to think in ways that may better prevent them from re-offending (Beech & Hamilton-Giachritsis, 2005; Scott, 1994).

Yalom's (1995) theory that group cohesiveness was a necessary pre-condition for other therapeutic factors was supported by two studies in the field of sex offender treatment (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005). Beech and Fordham found that a successful treatment group, including measures of cognitive distortion levels, levels of denial, and admission of offense behaviors, was highly cohesive. In addition, the group was well-organized and led, encouraged the open expression of feelings, produced a sense of group responsibility, and instilled a sense of hope in its members (Beech & Fordham). Beech and Hamilton-Giachritsis found "a clear relationship between how cohesive the members reported the group to be…and treatment outcomes as measured by significant reductions in pro-offending attitudes" (p. 127). They concluded that "having a cohesive group where there is involvement and commitment to the group as well as concern and friendship for each other appears to strongly relate to treatment efficacy" (Beech & Hamilton-Giachritsis, p. 138).

Contributing to the theory that group process is at least as significant as content was a study performed by Schlank and Shaw (1996) of sex offenders "who were judged unamenable to treatment due to total denial of their offense" (p. 17). Results indicated that a victim empathy exercise appeared to be crucial for some clients who began to admit their offenses, while for

others it appeared to be the safe environment and lack of pressure which contributed (Schlank & Shaw). These two factors appeared to contribute to Schlank and Shaw's 50% success rate in modifying the total denial of their group members.

After noting that little attention had been paid to process issues in the treatment of sex offenders, Marshall et al. (2003) performed a review which considered the relevance of process issues in the treatment of sex offenders. A conclusion of their review was that the therapist-client relationship "is the glue that makes treatment work for the full range of problematic behaviors that have been examined" (p. 222) and that there is no reason to believe that the same is not true for sex offender treatment (Marshall et al., 2003). In order to form an effective therapist-client relationship, Serran et al. (2003) found that empathy, warmth, being directive, and rewarding were therapist characteristics identified as being helpful. Therapist warmth and empathy were most strongly predictive of reductions in denial (Marshall & Serran, 2004; Serran et al., 2003). Therapist warmth included respectfully distinguishing between an offender and his behavior while being directive meant helping a client to generate potential solutions (Marshall, 2005; Serran et al.). Being rewarding meant acknowledging the small steps an offender took toward reducing his denial (Marshall, 2005; Serran et al.). Serran et al.'s study noted that being aggressively confrontational (harsh, critical, hostile, sarcastic) appeared not to foster beneficial change in their clients (Marshall, 2005; Yates, 2003).

In summary, treatment providers have begun to look more closely at cognitive-behavioral group therapy with sex offenders and have concluded that group processes and therapist characteristics may make a significant contribution to modifying members' denial, and to treatment outcomes (Beech & Fordham, 1997; Beech & Hamilton-Giachritsis, 2005; Drapeau et al., 2005; Jennings & Sawyer, 2003; Houston et al., 1995; Marshall, 2005; Marshall et al., 1999;

Marshall et al., 2003; Marshall & Serran, 2004; Serran et al., 2003; Schlank & Shaw, 1996; Yates, 2003). The views of sex offenders themselves may also provide valuable insights on their treatment effectiveness.

Views of Sex Offenders on Treatment Effectiveness

While the views of other mental health client groups are regarded as central to the therapeutic process, sex offenders' views have been considered to have little relevance (Day, 1999; Drapeau, Körner, Brunet, & Granger, 2004; Drapeau et al., 2005; Garrett et al., 2003; Williams, 2004). There may be several factors which have contributed to the lack of input from this client group. One may be that some treatment providers approach sexual offenders with cynicism and disbelief (Garrett et al.) given their characteristic high levels of denial. Others may find it more difficult to develop and sustain a therapeutic relationship with this client group (Day) and may disdain their opinions. Presently there is also some disagreement among providers about the effectiveness of treatment for sex offenders at all (Garrett et al.). A final explanation may come from now classic literature on sex offender treatment which indicated that it is the role of the therapist to set therapeutic goals on behalf of the client, who is assumed to be unable to take responsibility for their behavior (Salter, 1988). "There is an implication that client views about treatment are not central to the process of change and are of limited interest in providing feedback to treatment programs" (Day, p. 94). The results of not soliciting client views about their treatment may lead to less effective methods and more recidivism.

One result of ignoring sex offenders' views of their treatment may be to add to their feelings of being undervalued and worthless, thus compounding their problems in interacting with others, which for some are significant in their offending (Garrett et al., 2003). Research has also shown that therapists' and group members' perceptions of what was important about

treatment are significantly different (Drapeau et al., 2004; Garrett et al.; Yalom, 1995). In Drapeau et al.'s study (2004) treatment program staff considered the structural (content) programs to be most important while their clients considered "the emotional mechanisms involved in doing therapy" (p. 40) to be most important. If ignoring sex offenders' views may compound their problems, and if therapists' views are unreliable, then factors which could assist in a reduction of denial and the prevention of relapse might be overlooked.

A few studies that have specifically sought the clients' view of their treatment indicated that therapeutic process rather than content was of primary importance to sex offenders (Day, 1999; Drapeau et al., 2004; Drapeau et al., 2005; Garrett et al., 2003; Lord & Wilmott, 2004; Williams, 2004). Common themes noted in these studies were the importance of therapist characteristics (Drapeau et al., 2004; Drapeau, et al., 2005; Garrett et al.; Williams), the creation of a non-threatening environment (Drapeau et al., 2004; Drapeau et al., 2005; Garrett et al.; Williams), and the value of interpersonal interactions between therapist and client (Day; Drapeau et al., 2004; Drapeau et al., 2005; Garrett et al.; Williams) and between clients (Day; Drapeau et al., 2004; Drapeau et al., 2005; Williams).

Sex offenders indicated that it was important that therapists were respectful, non-judgmental, accepting, warm, patient, encouraging, and welcoming rather than criticizing, de-valuing, or rejecting (Drapeau et al., 2004; Drapeau et al., 2005; Garrett et al., 2003; Williams, 2004). Being sincere, genuine, honest, and trustworthy were also important therapist qualities (Drapeau et al., 2005; Garrett et al.; Williams). Finally, empathy and understanding were prized (Drapeau et al., 2005; Garrett et al.). These qualities closely parallel Rogers' foundational qualities of warmth/acceptance, genuineness, and empathic understanding, which he considered to be necessary conditions for therapeutic change (1980).

Studies showed that sex offenders valued a non-threatening group environment which was safe and predictable, and where they could trust that they would be accepted patiently, without criticism, and not be rejected by therapists and other group members (Drapeau et al., 2004; Drapeau et al., 2005; Williams, 2004). Becoming a member of a group of people sharing similar offending behaviors aided group members in not feeling alone and gave them a sense of belonging (Day, 1999; Drapeau et al., 2004; Drapeau et al., 2005). Hearing about others' experiences helped in forming an important therapeutic bond between group members (Day).

The interaction between therapist and group member, and between group members, was found to be an important therapeutic process for sex offenders. Day (1999) indicated that "clinicians should pay particular attention to the social processes at work in therapeutic groups, as inter-group relationships may be more important in predicting outcomes than program content" (p. 99). Drapeau et al. (2004) noted that sex offenders found that learning was a benefit of treatment saying "they gained sufficient confidence to be able to assert themselves without losing control of their anger and becoming verbally or physically abusive" (p. 36). They were also able to "avoid confrontation if necessary and to make use of a larger repertoire of responses for handling difficult situations" (Drapeau et al., p. 36). Group members said this learning "gave them feelings of confidence, pride, and mastery" (Drapeau et al., p. 36). Group members also reported feeling worthwhile when therapists took time to explain things to them (Drapeau et al., 2005).

These research studies also noted that while firm, supportive challenging from therapists is often important, especially regarding breaking through denial, aggressive confrontation is not considered to be helpful (Garrett et al., 2003; Williams, 2004) and that group leaders should "model effective interpersonal interactions" (Garrett et al., p. 325). Drapeau et al. (2005) noted

that group members thought it was particularly important for leaders to be able to guarantee order, make sure all group members respected the rules and procedures, and control outbursts. Group members in this study (Drapeau et al., 2005) also indicated that they responded best to therapists who were "able to see the good things in (them) and not only what (is) rotten" (p. 106).

Specifically in regard to denial, Lord and Wilmott (2004) reported that "deniers need a supportive environment and direct encouragement to consider leaving the denial state" (p. 58). Sexual offenders who participated in this study also reported looking for a motive to drop their denial (such as wanting change or help, or wanting relief from deceit) and a climate of trust, including appropriate role models, which "gives permission to admit the offending" (p. 58).

Although the studies seeking the clients' view of sex offender treatment indicated that therapeutic process rather than content was of primary importance, the one area of content that was important to sex offenders was understanding the impact of their actions on their victims (Day, 1999; Drapeau et al., 2004; Garrett et al., 2003).

It should be noted that the therapeutic processes found to be of primary importance to sex offenders (therapist characteristics, creation of a non-threatening group environment, and the value of interpersonal interactions between therapist and client, and between clients) contribute to the cohesiveness of the group. Yalom (1995) found group cohesiveness to be one of the most therapeutic attributes of group treatment. Garrett et al. (2003) confirmed that effective treatment programs for sex offenders were characterized by high levels of group cohesiveness.

In summary, various factors can influence the effectiveness of cognitive-behavioral therapy with sex offenders in a group treatment format (Drapeau et al., 2005). Studies which elicited the views of such clients indicated that "process issues appear to be foundational to the therapeutic experience of program participants, while content and technique may be secondary"

(Williams, 2004, p. 158). The way in which a client perceives the behavior of the professional (Williams) and other interpersonal aspects of treatment (Day, 1999) may be central to lasting behavioral change for sex offenders.

Hypotheses

Cognitive-behavioral therapy with sex offenders initially focuses on reducing their levels of denial, assuming that doing so will increase the likelihood that an offender will complete treatment and subsequently refrain from re-offending. Therefore, it is important that treatment providers measure the levels of denial of their clients to insure that treatment is effective and is progressing. The first hypothesis of this study was that levels of denial measured at the end of a twelve week treatment group of sex offenders would be lower than those measured just prior to the beginning of this group.

In addition, a few research studies eliciting the views of sex offenders on their treatment indicated that process issues such as group cohesiveness and therapist characteristics were foundational, and that a victim empathy content component was also important. Providers indicated that challenging the sex offenders' denial was an essential component of treatment. The second hypothesis of this study was that sex offenders would choose group cohesiveness, therapist characteristics, victim empathy, and challenging of denial as the most helpful aspects of their treatment during the twelve week group.

Method

Setting

This study was performed in a sexual behaviors clinic at a Western New York health care organization. The clinic is part of an outpatient facility which provides mental health, chemical dependency, intensive psychiatric rehabilitation, and continuing day treatment programs in an

urban setting. The clinic's team consists of counselors, psychiatrists, psychologists, a registered nurse, and social workers who provide treatment for approximately 250 adult and adolescent sex offenders per year.

Sex offenders who present for treatment at the clinic are screened by the treatment team to determine if Phase I or Phase II treatment would be most appropriate. Phase I treatment consists of participation in the 12 week Access Group and is considered most appropriate for those who have no previous sex offender specific treatment. The Access Group focuses on decreasing the offender's level of denial through use of specific content modules as well as therapeutic group processes. Phase II treatment consists of participation in an ongoing weekly treatment group whose members are already familiar with the cognitive-behavioral treatment approach within a relapse prevention framework. Phase II group members are usually considered to be at lower levels of denial than Access Group members. All Access Group and Phase II group members also participate in individual therapy. (A few clinic patients participate only in individual therapy if the treatment team believes that the group modality would not be appropriate, primarily because of possible disruptive behaviors.) The Access Group, a time-limited (12 week) group, was chosen as the focus of this study. The clinic offers one Access Group during any given time period.

Participants

All 10 adult male members of the particular Access Group selected as the focus of this study were invited to participate. Eight of the 10 members elected to do so. Participant recruitment procedures followed federal guidelines for the ethical treatment of human subjects and were approved by the health system's Institutional Review Board (Appendix C). The age range was 22-67 years with 5 Caucasian-American and 3 African-American participants. Two of

the participants were married (although separated at the time of the study), 3 were divorced, and 3 had never been married. All participants were high school graduates and 4 had completed some college courses. Five of the participants were employed full-time, 2 were unemployed, and 1 was retired.

Most of the clinic's patients are mandated to treatment by New York State Supreme Court or the local County Court as a condition of their parole after incarceration or as a probation condition. Of the study participants, 6 had been mandated to treatment as a condition of probation, the legal case of 1 participant was pending (he was self-referred to treatment), and the remaining participant was self-referred. Six of the participants had been convicted of or pled guilty to felony level sex offenses, 1 participant's legal case was pending, and 1 participant had never been accused of a crime. This participant admitted during treatment to committing a sexually abusive act against a younger child while he was also a child, and had referred himself to treatment for high-risk, sexually compulsive behaviors.

The known victims of the study participants ranged in age from 7 to 16 years. All were female with the exception of one 15 year old male. The victims were all known to the study participants. Two of the victims were participants' step-daughters, 1 was an adopted daughter, 2 were daughter/granddaughter of participants' girlfriends, 1 was a son, 1 was a co-worker, and 1 was a family friend.

Instruments and Procedures

Two instruments were administered to the study participants by the researcher. The Facets of Sex Offender Denial (FoSOD) was administered at the beginning of the first group session and again, 12 weeks later, at the end of the 12th and final group session (see Appendix A). In addition, a questionnaire entitled *What Helped Me Change My Thinking About My*

Offense was administered to the participants at the end of the 12th and final group session (see Appendix B).

The FoSOD was developed by Wright and Schneider (2002) as a tool "in the treatment of sexual offenders with its ability to measure, monitor, and distinguish a variety of forms of denial that are present throughout treatment" (p. 4). The specific constructs of denial measured by the FoSOD are outlined in Table 1 and represent the scales and subscales of the instrument. The FoSOD consists of 66 statements of which 10 are demographic. Study participants were instructed not to complete the 10 demographic items and not to write their names on the test booklets or answer sheets to protect their confidentiality. Participants were asked to circle the response which most closely indicated what they believed about each of the remaining 56 statements. Responses were on a Likert-type scale ranging from Strongly Disagree to Strongly Agree.

Wright and Schneider (2002) indicated that their intent in devising the FoSOD was "to provide a valid and reliable measure" (p. 5) that would allow treatment providers and researchers to "examine assumptions currently held about denial, to explore how denial compromises treatment effectiveness, and to generate additional research based on an empirically sound measurement instrument" (p. 5). Wright and Schneider reported that the FoSOD has both face and content validity "given that the items were based on actual child molester assertions in treatment and given that there is an excellent correspondence between the types of denial described in the literature and the six factors or scales that…comprise the FoSOD" (p. 22). The FoSOD was also shown to have predictive validity when comparing child molesters in early versus advanced levels of treatment (Wright and Schneider). Construct, convergent, and discriminate validity were assessed using six comparison measures and yielded correlations

ranging from .40 to .88 (Wright and Schneider). Higher correlations were found for 3 of the scales: Denial of Sexual Offense - .88, Denial of Planning - .81, and Denial of Risk of Relapse - .72 (Schneider and Wright, 2001). Denial of Extent (.39), Denial of Intent (.54), and Denial Due to Perceived Victim Desire (.39) were not substantially correlated to comparison measures (Schneider and Wright) which may reflect the complex nature of the component parts of the various constructs of denial. In regard to the reliability of the FoSOD, Wright and Schneider completed a research study which indicated that internal consistency yielded an overall Cronbach's α of .94. "The average Cronbach's α for the scales was .84, with a range of values from .71 to .95. For the subscales, the average Cronbach's α was .80, with a range from .71 to .87" (Wright and Schneider, p. 21). Another study conducted by Wright and Schneider (2004) yielded a test-retest correlation of .81. The FoSOD is a new instrument and no independent testing of its validity and reliability has been completed as yet.

The 19-item instrument entitled *What Helped Me Change My Thinking About My Offense* was developed by the researcher to assess participants' opinions of the most helpful content and process components of Access Group treatment. Included in the instrument were questions on the following content components: defense mechanisms, offending cycle, statements of ownership, emotions, and victim empathy. The instrument also included questions regarding the following therapist qualities/characteristics: empathy, genuineness, respect, criticalness, concern/interest, confrontation, and encouragement. Finally, group participants were asked four questions related to group processes: feeling of not being alone, acceptance by other group members, safety and confidentiality, and mutual respect. Participants were asked to circle their responses on a Likert-type scale ranging from Strongly Disagree to Strongly Agree. In order to

confirm their responses to this instrument, study participants were also asked to circle the 3 items out of the total 19 which they believed were most helpful to them about Access Group treatment.

Results

FoSOD Pre and Post-tests of Denial

The FoSOD computerized scoring program calculated standardized scale scores ranging from 25 to 100 for each scale and subscale as well as a Total Denial score. Wright and Schneider (2002) interpret scores from 25-49 as low denial, 50-74 as moderate denial, and 75-100 as high denial. Results of the FoSOD pre-test indicated that scores for all study participants were in the moderate range for Total Denial (see Table 2). In comparison, post-test results showed that Total Denial scores for 3 study participants had dropped into the low denial range (see Table 3). The mean score for Total Denial dropped from 63 to 56: a decline of 18.42%. (Since Wright and Schneider's standardized scale score range is from 25-100, and it was not possible to score below 25, 25 was deducted from each standardized score in order to calculate meaningful percentages.)

Table 2

Summary of FoSOD Pre-Test Results

Distinct Types of Denial	Study Participants								Mean
	#1	#2	#3	#4	#5	#6	#7	#8	
Refutation of the Offense	55	56	44	39	43	49	60	46	49
Complete Denial	50	50	45	50	50	55	50	35	48
Denial of Victim Credibility	56	63	44	31	44	44	75	56	52
Denial of System Fairness	44	50	38	25	44	44	50	50	43

Denial of Victim Harm	63	63	44	38	31	38	50	25	44
Focus on Self-Harm	67	58	50	50	42	67	83	75	62
Denial of Intent	75	59	50	44	63	66	59	66	60
Denial of Intent Due to Stress	75	50	50	42	42	67	33	67	53
Denial of Intent Due to Mistake	75	65	50	45	75	65	75	65	64
Denial of Extent	69	75	50	50	50	69	67	100	66
Assertion of Victim Desire	70	75	80	40	65	50	45	35	58
Denial of Planning	71	75	90	60	60	79	92	81	76
Denial of Overt Planning	75	75	83	75	58	83	83	100	79
Denial of Victim Enticement	75	75	92	75	67	83	100	100	83
Denial of Deviant Fantasies	67	75	92	42	50	75	100	83	73
Denial of Sexualizing the Victim	69	75	94	50	67	75	88	50	71
Denial of Relapse Potential	94	78	78	72	59	84	78	94	80
Denial of Sexual Deviancy	88	81	81	69	69	88	75	88	80
Denial of Future Offense Risk	100	75	75	75	50	81	81	100	80
Total Denial	69	67	63	50	54	64	69	66	63

Interpretation: 25-49 – low denial, 50-74 – moderate denial, 75-100 – high denial

Review of the 6 individual scales indicated that pre-test mean scores were in the high denial range for the Denial of Planning (76) and Denial of Relapse Potential (80) scales, the moderate denial range for the Denial of Intent (60), Denial of Extent (66), and Assertion of Victim Desire (58) scales, and the low denial range for the Refutation of Offense (49) scale (see Table 2). In contrast, the post-test mean scores showed that the Denial of Planning scale had

dropped from the high denial range into the moderate range (score – 64, decline of 23.53%) and the Assertion of Victim Desire scale had dropped from the moderate denial range into the low range (score – 47, decline of 33.33%) (see Table 3).

Table 3

Summary of FoSOD Post-Test Results

Distinct Types of Denial	Study Participants							Mean	Decline
	#1	#2	#3	#4	#5	#6	#7		
Refutation of the Offense	35	53	55	30	34	48	55	44	20.80%
Complete Denial	35	55	50	40	50	40	55	46	8.70%
Denial of Victim Credibility	44	63	69	25	25	50	44	46	22.22%
Denial of System Fairness	25	44	50	25	31	56	50	40	16.67%
Denial of Victim Harm	38	50	50	25	25	38	58	41	15.79%
Focus on Self-Harm	33	50	58	33	33	58	75	49	35.14%
Denial of Intent	31	47	61	31	59	69	78	54	17.14%
Denial of Intent Due to Stress	42	75	63	33	75	75	83	64	39.29%*
Denial of Intent Due to Mistake	25	30	60	30	50	65	75	48	41.03%
Denial of Extent	63	56	75	38	63	100	58	65	2.44%
Assertion of Victim Desire	35	50	60	70	35	35	45	47	33.33%
Denial of Planning	46	60	63	63	54	83	81	64	23.53%
Denial of Overt Planning	50	50	67	67	25	100	83	63	29.63%
Denial of Victim Enticement	58	42	58	50	67	100	75	64	32.76%
Denial of Deviant Fantasies	42	83	67	75	58	50	92	67	12.50%

Denial of Sexualizing the Victim	38	63	63	63	63	81	75	64	15.22%
Denial of Relapse Potential	75	50	88	63	66	97	69	73	12.73%
Denial of Sexual Deviancy	56	50	81	63	56	94	75	68	21.82%
Denial of Future Offense Risk	94	50	94	63	75	100	63	77	5.45%
Total Denial	44	53	64	46	48	68	66	56	18.42%

Interpretation: 25-49 – low denial, 50-74 – moderate denial, 75-100 – high denial

*represents increase

Pre and post-testing showed that the level of denial declined in every scale and sub-scale with the exception of 1 sub-scale. The increase in mean denial score for the Denial of Intent Due to Stress sub-scale was 39.29%, and the decline in mean denial scores for all the remaining scales and sub-scales ranged from 41.03% to 2.44%. The 4 scales/sub-scales which declined the most were Denial of Intent Due to Mistake (41.03%), Focus on Self-Harm (35.14%), Assertion of Victim Desire (33.33%), and Denial of Victim Enticement (32.76%).

Most Helpful Content and Process Components of Access Group Treatment

The *What Helped Me Change My Thinking About My Offense* questionnaire was scored on the following Likert-type scale: strongly disagree – 1, disagree – 2, neutral – 3, agree – 4, and strongly agree – 5. Mean scores were calculated for each of the 19 items and the scores ranged from a high of 4.75 to a low of 3.87. The 3 items with the highest mean scores, meaning that group participants considered these items to be most helpful, were group process: cohesiveness (not alone), group process: safety/confidentiality, and content component: victim empathy (see Table 4). The item receiving the lowest score, meaning that group participants considered it to be the least helpful, was therapist characteristic – criticalness (see Table 4).

Table 4

Summary of What Helped Me Change My Thinking About My Offense Questionnaire

Content and Process Components	Study Participants								Mean
1. Process: therapist - participation	4	5	4	4	5	4	5	4	4.37%
2. Content: defense mechanisms	4	5	4	5	4	4	4	4	4.25%
3. Process: therapist - empathy	4	5	4	5	5	4	3	5	4.37%
4. Process: group confrontation	5	5	4	5	4	4	3	5	4.37%
5. Process: group cohesiveness (not alone)	5	5	5	5	4	4	5	5	4.75%
6. Process: therapist - genuineness	4	5	4	4	5	4	4	4	4.25%
7. Content: offending cycle	4	5	5	5	5	4	4	4	4.50%
8. Process: therapist - respect	4	5	4	5	4	4	4	4	4.25%
9. Process: group cohesiveness (acceptance)	4	5	5	5	4	4	5	4	4.50%
10. Process: therapist - criticalness	4	5	4	5	1	5	3	4	3.87%
11. Content: statement of ownership (reading)	5	5	2	5	4	4	4	4	4.12%
12. Process: safety/confidentiality	4	5	5	5	5	4	5	5	4.75%
13. Process: therapist - concerned/interested	4	5	4	4	4	4	4	4	4.12%
14. Content: statement of ownership (writing)	4	5	5	5	5	4	2	4	4.25%
15. Process: therapist - confrontation	4	5	4	5	5	4	4	4	4.37%
16. Content: emotions	4	5	4	5	4	4	5	5	4.50%
17. Process: therapist - encouragement	4	5	4	4	4	4	5	5	4.37%
18. Process: group members - respect	4	5	4	5	4	4	5	4	4.37%
19. Content: victim empathy	5	5	5	5	5	4	5	4	4.75%

As an additional confirmation of the results of the questionnaire, group participants were asked to circle the 3 items they believed were most helpful to them about Access Group treatment. The items circled *most* often were group process: cohesiveness (not alone), group process: safety/confidentiality, and group process: cohesiveness (acceptance) (see Table 5). The items circled *least* often (receiving scores of 0) were therapist qualities/characteristics and group process: confrontation (see Table 5).

Table 5

Summary of Circled Items

#	Content and Process Components	Study Participants								Total
		#1	#2	#3	#4	#5	#6	#7	#8	
9.	Process: group cohesiveness (acceptance)	1		1				1		3
5.	Process: group cohesiveness (not alone)	1	1	1				1	1	5
12.	Process: safety/confidentiality			1		1		1	1	4
18.	Process: group members - respect		1					1		2
1.	Process: therapist - participation									0
3.	Process: therapist - empathy									0
6.	Process: therapist - genuineness		1							1
8.	Process: therapist - respect									0
10.	Process: therapist - criticalness									0
13.	Process: therapist - concerned/interested									0
17.	Process: therapist - encouragement									0

2.	Content: defense mechanisms		1	1		2
7.	Content: offending cycle			1	1	2
11.	Content: statement of ownership (reading)	1				1
14.	Content: statement of ownership (writing)			1		1
16.	Content: emotions		1	1		2
19.	Content: victim empathy	1	1			2
4.	Process: group - confrontation					0
15.	Process: therapist - confrontation			1		1

Discussion

Lower Denial After Treatment

The researcher's first hypothesis, that levels of denial measured at the end of a twelve week treatment group of sex offenders would be lower than those measured just prior to the beginning of the group, was soundly supported by study results. As reported previously, the level of denial declined in every scale and sub-scale but one.

The most significant level of decline was in the Denial of Intent Due to Mistake sub-scale (see Table 3). This sub-scale measured study participants' belief that their sexual offense was an accident, that it was due to an unusual situation, that there was no thought of committing an offense (that it "just happened"), or that it happened because the offender was drunk or using drugs. Observation indicated that Access Group treatment providers focused specifically on these kinds of distorted beliefs whenever the opportunity was presented by an offender in a group session. Treatment providers firmly and persistently challenged these distorted beliefs at the beginning of the twelve week group. Over the course of twelve weeks, group members

joined treatment providers in challenging fellow group members' distorted thinking. Additionally, a content component on defense mechanisms (rationalization, justification, minimization, etc…) was discussed during one group session and group members completed a homework assignment addressing their own distorted thinking and use of defense mechanisms.

The mean denial score for the sub-scale Denial of Intent Due to Stress increased by 39.29%, representing the only denial score to increase (see Table 3). This increase was inversely related to the significant decrease in Denial of Intent Due to Mistake. The increase may be due to group members' changing belief that their sex offense was not a mistake: that there may have been factors contributing to their decision to offend. One content component used early in the Access Group addressed identifying group members' emotions. Another content component, introduced later in the twelve week program, was the offending cycle or relapse prevention model. This content component required group members to start determining their offending cycle, beginning with the "pretend normal" phase. During the "pretend normal" phase, group members often realized that they were experiencing stressful feelings such as loneliness, inadequacy, fear, anger and depression. The increase in mean score for the Denial of Intent Due to Stress sub-scale may be related to group members' beginning awareness of their stressful feelings prior to offending.

The mean score of the Focus on Self-Harm sub-scale also declined significantly (see Table 3). This sub-scale measured study participants' belief that things have been harder on them than on the victim since being accused of the offense, that it would have been better for everyone if they had never gotten in trouble for the offense, or that they had suffered at least as much as the victim because of the offense. Study participants certainly had been experiencing challenging times. Most had been convicted or pled guilty to felony level offenses with the

related court appearances, jail time, probation conditions, and requirement to register as sex offenders. Two that had been married were now separated from their spouses. All that had children could not see them. Friends, family, and the community reviled them. Their distorted belief about their suffering in comparison with that of their victim's, however, was firmly and persistently challenged by treatment providers at the beginning of the Access Group and by both treatment providers and fellow group members over the course of the twelve weeks. Additionally, a content component on victim empathy was included. This required group members to write a letter to themselves from their victim, describing what the victim had experienced since the offense, and including how the victim had felt, thought, and behaved.

The mean denial scores of the Assertion of Victim Desire scale and the Denial of Victim Enticement sub-scale also declined significantly (see Table 3). The Assertion of Victim Desire scale measured study participants' belief that the victim wanted the sexual contact, the victim made the first advances, and/or the victim did not act like they wanted the offender to stop. The Denial of Victim Enticement sub-scale measured study participants' belief that they did nothing to attract the victim to them, did nothing to get the victim to think about sexual things, and/or did nothing to get the victim to think about them in a sexual way. These distorted beliefs were challenged firmly and persistently by treatment providers and group members over the course of the Access Group. They were addressed as part of the content component on defense mechanisms and cognitive distortions and were addressed during the content component on the offending cycle or relapse prevention model. An additional content component which addressed this type of distorted thinking was the statement of ownership, in which group members were required to write and then read to the group a statement in which they took as much responsibility as they could at that time for their offenses.

The mean denial scores for the Complete Denial sub-scale, the Denial of Extent scale, and the Denial of Future Offense Risk sub-scale declined the least (under 10% - see Table 3). Since 6 of the study participants had already been convicted of or pled guilty to their offenses and the remaining 2 participants had referred themselves to the group, it appeared reasonable that the Complete Denial and Denial of Extent scores did not decline as significantly. The Denial of Future Offense Risk sub-scale measured participants' belief that they would be able to keep themselves from committing another offense in the future. As part of the offending cycle component of Access Group, group members learned to be aware of the factors that composed their "pretend normal" phase, so that might use this knowledge to help prevent themselves from re-offending. The low decline in mean denial score for this sub-scale may indicate that, although group members had new knowledge of their offending cycle, their intent to never re-offend remained at the same level as when they entered Access Group treatment.

Sex Offenders' Views of Content and Process of Treatment

The researcher's second hypothesis, that sex offenders would choose group cohesiveness, therapist characteristics, victim empathy, and challenging of denial as the most helpful aspects of their treatment during the twelve week group, was partially supported by study results. It was evident from the results of the *What Helped Me Change My Thinking About My Offense* questionnaire that participants viewed group cohesiveness as primarily important (see Table 4). Study results supported Yalom's (1995) contention that "group cohesiveness is not only a potent therapeutic force in its own right…it is a necessary precondition for other therapeutic factors to function optimally" (p. 49). Study results also supported Beech and Fordham's (1997) claim that a successful treatment group, measured in part by lowered levels of denial, was highly cohesive.

In addition, Beech and Hamiton-Giachritsis's (2005) assertion that a cohesive group is strongly related to treatment efficacy was also supported.

Therapist characteristics, however, were considered to be the least important factors when study participants were asked to circle the items most helpful to them. In fact, only 1 study participant circled any item regarding therapist characteristics (see Table 5). Therapists played an active role during the twelve week Access Group, initially challenging members distorted thinking and beliefs until group members themselves also began to do so, and introducing content components to the group. It may be that therapists were effective in facilitating the group processes leading to cohesiveness and study participants, therefore, were able to perceive group cohesiveness as the most helpful factor more readily. Although Marshall and Serran (2004) and Serran et al. (2003) indicated that therapist warmth and empathy were most strongly predictive of reductions in denial, it is possible that the time limited and content component structure of this twelve week treatment group, as well as the firm and persistent challenging of cognitive distortions by treatment providers and group members, precluded study participants from encountering much therapist warmth and empathy.

The victim empathy component shared the highest mean score with group cohesiveness, although other content components received equal scores when participants were asked to circle the three most helpful items (see Tables 4 and 5). The victim empathy component used in the Access Group most closely resembled Marshall et al.'s (1999) victim empathy letter. Study results supported Marshall et al.'s clinical observation that offender attitudes appeared to change if they understood how the victim might feel.

Finally, confrontation of denial by therapists and confrontation of denial by group members received identical mean scores from study participants (see Table 4). This may

indicate that participants did not view challenges as more or less effective depending on whether they came from the therapist or another group member. Study participants indicated, though, that a therapist being critical was the least helpful aspect of the Access Group process (see Table 4). This result supports Serran et al.'s (2003) study that indicated that being aggressively confrontational (harsh, critical, hostile, sarcastic) appeared not to foster beneficial change in their clients (Marshall, 2005; Yates, 2003).

Limitations

This study has several limitations. Due to the time limited nature of the study, group members who elected to participate in the study may not be representative of the total population of sex offenders. For example, because the Access Group was selected for testing, female members of the sex offender population were excluded, as were adolescents. In addition, this particular Access Group contained no members who were on parole after spending time in prison and no members who were rapists. Sample size is also small, and results might be generalized with caution.

The instruments used in the study were self-report measures, so it is not possible for the researcher to know how truthfully participants responded. For example, the results of the *What Helped Me Change My Thinking About My Offense* questionnaire included one participant who responded "strongly agree" to every item, indicating that that participant may have been responding in what they perceived to be a socially desirable manner. In addition, although the FoSOD instrument appears to closely match clinical observations of as well as sex offender assertions concerning denial, and appears to be very useful in measuring change in denial, it is a new instrument and there is no independent source of reliability and validity data.

Implications for Practice and Further Research

The sexual behavior clinic's Access Group for sex offenders appeared to be very effective in lowering denial. Since this treatment group mirrored what are considered to be current "best practices" for sex offender treatment providers, it appeared that cognitive-behavioral treatment within a framework of relapse prevention is effective treatment for sex offenders. The public, however, is concerned with recidivism and preventing new victims. Since a review of the literature indicated that there is little research tying lowering of denial to lower recidivism rates (Marshall, 1999), research in this regard may be crucial.

Since it appears to make intuitive sense to treatment providers that lowering denial enhances treatment efficacy and, therefore, lowers recidivism rates, instruments which measure the change in denial may be important. The FoSOD instrument used in this research study appeared to be a comprehensive and useful tool for measuring change in denial. Future research studies might provide independent sources of reliability and validity for this instrument.

The results of this study indicated that group process issues, particularly group cohesiveness, were considered by study participants to be critically important to treatment efficacy. This study supported Marshall et al.'s (2003) contention that "systematic research examining process issues in treatment with sex offenders is necessary" (p. 226).

Finally, although the abusive acts that sex offenders commit cause them to be reviled by the public, and may have caused treatment providers and researchers to ignore their views (Day, 1999; Drapeau et al., 2004; Drapeau et al., 2005; Garrett et al., 2003; Williams, 2004), this study appeared to affirm the assertion that sex offenders' views of their treatment are as important an element of service evaluation as the views of other users (Day; Garrett et al.).

Summary and Conclusions

The results of this study indicated that cognitive-behavioral treatment within a framework of relapse prevention, the current "best practices" method of sex offender treatment providers, was very effective in lowering denial. The most vital finding of this study, however, was that therapeutic *techniques*, such as the content components of treatment groups, and therapeutic *relationships*, such as group cohesiveness, are inherently interrelated and interdependent. In fact, process components may be the most effective aspect of sex offender treatment. Therefore, the most effective procedures in the hands of the most process-oriented and skilled therapists may maximize treatment benefits. In an environment of cost-cutting and managed care, and at a time when the mental health community is responding to the public's pressure to protect it from the harm sex offenders cause, it is vital to be able to quantify treatment benefits.

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Appendix A

RESPONSE INVENTORY

Please read each statement below carefully and circle the number on your answer sheet that best indicates how you feel about it

STRONGLY DISAGREE (1)	DISAGREE (2)	AGREE (3)	STRONGLY AGREE (4)

For items that refer to a sexual offense, please answer in terms of your most recent charge. For items that refer to a victim, please answer in terms of the case child or alleged victim in your most recent charge. If you feel an item does not apply to you, please do your best to answer it anyway.

11) I have had sexual fantasies about the victim.
12) I did things to try to attract the victim to me.
13) The sexual offense was an accident, and it will never happen again.
14) I purposely arranged things so I could have sexual contact with the victim.
15) The main reason I have to be in sex offender treatment is so others can make money.

16) If things had not been so bad, I never would have committed an offense.
17) I sometimes find myself being sexually attracted to children.
18) I have never done anything that could be called a sexual offense.
19) At times, the victim acted like they wanted sexual contact with me.
20) A few years from now, the victim probably won't remember much about the offense or it won't matter much.

21) In general, the victim was telling the truth about what happened during the sexual offense.
22) The sexual offense was not really my fault.
23) People think that I did more things to the victim than I really did.
24) My view of the victim became more sexual over time.
25) Things have been harder on me than on the victim since being accused of an offense.

26) I am certain that I will not commit a sexual offense in the future.
27) The thought of sexual contact with a child has never appealed to me.
28) I committed a sexual offense, but I didn't do many of the things I was accused of.
29) The offense happened because I was under stress or was feeling depressed.
30) I feel bad when I think about all the things that the victim is going through because of what I did.

31) I have a serious problem with my sexual behavior.
32) The victim was lying about the sexual offense.
33) I will easily be able to keep myself from committing another sexual offense.
34) There were times when I masturbated to thoughts of the victim.
35) I found myself sexually desiring the victim.

The FoSOD: An instrument to measure Facets of Sexual Offender Denial in Child Molester. Copyright 2002 by CAPEStrategies, Inc.
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Appendix A

36) People in the system don't care about what is fair, they just want your money.
37) The victim wanted to participate in the sexual offense.
38) I have never committed a sexual offense.
39) The sexual offense was mostly due to an unusual or bad situation.
40) I did things to get the victim to think about sexual things.

41) I never really thought about committing an offense; it just happened.
42) I often found ways to get time alone with the victim.
43) The victim made the first sexual advances and I just went along with it.
44) I don't remember anything about the sexual offense.
45) The victim is the kind of person who could make up a story about somebody sexually abusing them.

46) I did things to get the victim to think about me in a sexual way.
47) There was nothing really harmful about what I did to the victim.
48) I did touch the victim but I did not go as far as people think.
49) Given the right conditions, I could commit another sexual offense.
50) I made myself think that the victim might like having sexual contact with me when they really did not.

51) It would have been better for everyone if I had never gotten in trouble for the offense.
52) I would think about how to get time alone with the victim.
53) The offense happened because things in my life were going badly.
54) It may be difficult for me to avoid committing a sexual offense in the future.
55) I was accused of more sexual behaviors than what I actually did to the victim.

56) The victim did not want me to do the sexual things I did to them.
57) I have suffered at least as much as the victim because of the sexual offense.
58) The idea that I committed a sexual offense was put into the victim's head by someone who did not like me or who wanted to get me into trouble.
59) I have committed at least one sexual offense.
60) My fantasies about the victim came more often over time.

61) The victim would not think anything bad about the offense if people would quit putting ideas into their head.
62) No matter what I do, the system is just out to get me.
63) In general, it would not be difficult for me to become sexually attracted to a child.
64) The victim didn't act like they wanted me to stop what I was doing during the offense.
65) I found myself thinking sexually about the victim even when I didn't want to.
66) The only reason the offense happened is because I was drunk or taking drugs.

The FoSOD: An instrument to measure Facets of Sexual Offender Denial in Child Molester. Copyright 2002 by CAPEStrategies, Inc.
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Appendix B

WHAT HELPED ME CHANGE MY THINKING ABOUT MY OFFENSE?

1) The co-facilitators made sure I participated. This made me think more about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

2) Figuring out my Distorted Thinking (rationalizing, minimizing, justifying, etc…) helped me see my offending behavior more clearly.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

3) I felt understood by the co-facilitators. This helped me be more honest.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

4) The group members confronted me. This helped me "get real" about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

5) I felt that I wasn't alone. I was in a group of people who could understand me. That helped me feel safe enough to be more honest with myself.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

6) I found that I could trust the co-facilitators. This helped me open up about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

7) Working on my Offending Cycle in the group helped me figure out the small thoughts, feelings, and behaviors I experienced before, during, and after my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

8) The co-facilitators respected me and were sincerely trying to help me. This helped me feel safe enough to be more honest about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

9) Feeling accepted by the group members helped me "get real" about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

10) The co-facilitators were critical and harsh. This forced me to see my offense more clearly.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

(Questionnaire created by the Researcher)

Appendix B

WHAT HELPED ME CHANGE MY THINKING ABOUT MY OFFENSE?

11) Reading my Statement of Ownership and getting feedback from group members and co-facilitators helped me think about my offense more clearly.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

12) Having a safe and confidential place to talk about my offense helped me get more "real."

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

13) The co-facilitators were really concerned about me and interested in me. This helped me share my thoughts and feelings in the group.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

14) Writing my Statement of Ownership helped me to accept more responsibility for my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

15) The co-facilitators confronted me about my thinking. This helped me to see my offense more clearly.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

16) Finding out about my emotions helped me to figure out why I committed my offense, and how I can act differently in the future.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

17) The co-facilitators encouraged me when I was more honest and shared a new part of my offense. This helped me to open-up more.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

18) The group members respected me and were sincerely trying to help me. This helped me feel safe enough to be more honest about my offense.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

19) Understanding the many ways (not just physically) my offense hurt my victim helped me to see my offense more clearly.

STRONGLY DISAGREE DISAGREE NEUTRAL AGREE STRONGLY AGREE

(Questionnaire created by the Researcher)

Appendix B

WHAT HELPED ME CHANGE MY THINKING ABOUT MY OFFENSE?

20) PLEASE CIRCLE THE THREE (3) NUMBERS ABOVE THAT YOU FELT WERE THE <u>MOST HELPFUL</u> TO YOU IN "GETTING REAL" or CHANGING YOUR THINKGING.

21) DO YOU HAVE ANY ADDITIONAL COMMENTS ABOUT THE ACCESS GROUP?
(Please write your comments below or tell Jean about them .)

(Questionnaire created by the Researcher)

Appendix C

FWA 00002175 IRB # 308
Date 10/26/05 Expires 9/13/06
Approval K. Stanton

Consent Form

Reasons Group Members May Change Their Thinking Over the Course of a 12-Week Sexual Behaviors Clinic Treatment Group

Introduction:

As a member of the Access Group you are being asked to participate in a research study. It is being conducted as Jean Hickey's (Student Researcher) master's thesis for the Department of Counselor Education at SUNY College at Brockport. The research study was approved by Institutional Review Board and is being conducted through You should read this form carefully and ask the Student Researcher any questions you may have before deciding whether or not to participate.

Purpose of the research study:

The research study is being conducted to see if group members change their thinking about their sexual offense over the course of the 12-week group and what they believe caused them to change. The group members' opinions of what helped them are an important piece of information for the Clinic in order to plan future treatment groups.

Confidentiality and Voluntary Participation:

Although you may be required to participate in treatment as a condition of parole, probation, or court, your participation in the research study is your free choice. Your choice to participate or not to participate will have no effect on your present treatment or on your future treatment. You may change your mind at any time and leave the study without penalty, even after the study has begun.

You will be asked NOT to put your name or any of your background information on any of the research forms. There will be no way to connect your responses to you. The research will be completely anonymous.

All research forms will be kept in a separate locked cabinet, to be viewed only by the Student Researcher, and separate from all treatment clinic files. Research forms and Consent Forms will be destroyed by shredding at the end of May, 2006.

Appendix C

Description of Study Procedures:

You will be asked to complete a questionnaire about your thinking in relation to your sex offense at the beginning of the first group and again, twelve weeks later, at the end of the last group. This questionnaire consists of 66 questions and will take about 20-25 minutes to complete.

You will be asked to complete an additional questionnaire at the end of the last group. This questionnaire asks your opinions of what caused you to change your thinking. It consists of 25 questions and will take about 10-15 minutes to complete.

Risks or Benefits of Participation:

It is possible that the Student Researcher may be able to relate the answers on a given research form to a particular group member if the number of participants in the study falls below 5. Therefore, if less than 5 Access Group members volunteer to participate in the study, the study will be halted.

The research study is designed to gain information that may assist the Clinic to plan more effective treatment groups and be more helpful to future group members.

There are no anticipated risks or benefits to you because of your participation in this research study.

Payment:

There will be no payment for participation in this research study.

Contact Persons:

For more information concerning this research you may contact:

Student Researcher	Jean Hickey (585) 737-5039
Faculty Advisor	Dr. Susan Seem Department of Counselor Education SUNY College at Brockport (585) 395-5492

Appendix C

If you believe you may have suffered a research related injury, contact Jean Hickey at (585) 737-5039 who will give you further instructions.

If you have any questions about your rights as a research subject, you may contact the Office of the Institutional Review Board at , Monday through **Friday, 8:15 a.m. to 5:00 p.m.**

Signature/Date:

I have read (or had read to me) the contents of this consent form and have been encouraged to ask questions. I have received answers to my questions. I give my consent to participate in this study. I have received (or will receive) a copy of this form for my records and future reference.

Study subject: _____ PRINT NAME

Study subject: _____ SIGNATURE

_____ DATE