

Denial and its relationship with treatment perceptions among sex offenders

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We examined the relationship between denial/minimization and treatment perceptions using multiple measures of each construct in a sample of 185 adult male sex offenders. Denial/minimization was measured with the Comprehensive Inventory of Denial—Sex Offender version (CID-SO), Sex Offender Acceptance of Responsibility Scales (SOARS), and an item from a risk assessment measure (Sexual Violence Risk-20; SVR-20). Treatment perceptions were measured with the treatment readiness scale of the Multiphasic Sex Inventory (MSI and MSI-II) and the treatment rejection scale of the Personality Assessment Inventory (PAI). Most aspects of denial and minimization had significant moderate to strong associations with more negative perceptions of treatment. Questions about the distinctiveness versus overlap between measures of denial/minimization and treatment perceptions notwithstanding, our findings are consistent with conceptualizations in past research and practice that greater denial/minimization is associated with lower motivation for treatment. Rather than excluding deniers from treatment, additional efforts are required to engage higher risk sex offenders exhibiting denial and minimization.

Keywords: denial; minimization; treatment motivation; sex offenders

Introduction

The sex offender treatment literature has observed and eschewed the practice of treating offenders who deny responsibility for their offending behavior. Many programs acknowledge that not all referred sex offenders are treated (McGrath, Cumming, Burchard, Zeoli, & Ellerby, 2010), and oftentimes, sex offenders go untreated because they are deemed unamenable due to poor motivation or denial of responsibility for their offences (Happel & Auffrey, 1995). Clinicians often note that denial and treatment motivation go

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hand-in-hand, and this association has been borne out in research (e.g. Levenson & Macgowan, 2004). The purpose of this paper is to examine the relationship between denial and treatment perceptions in sex offenders.

Denial and minimization refer to some degree of refuting facts related to an offence whereby denial may be complete refutation and minimization may include some degree of refusal to acknowledge victim impact, the commission of a sexual offence, wrongdoing or seriousness of the offence, and/or the need to be sanctioned or receive treatment as a result of the offence behavior (Jung & Daniels, 2012; Levenson, 2011; Yates, 2009). Sex offender denial specifically makes reference to the offender's own sexual offences rather than sexual offending in general. When one examines the sex offender literature, there has been tremendous progress made that has seen an evolution from viewing denial as a dichotomous construct (i.e. as present or absent; Barbaree & Marshall, 1988) to a multifaceted view (e.g. Gibbons, de Volder, & Casey, 2003; Kennedy & Grubin, 1992). Moreover, several measures have been developed to assess denial among sex offenders, such as the Comprehensive Inventory of Denial–Sex Offender version (CID-SO; Jung & Daniels, 2012); Denial and Minimization Checklist–III (DMCL-III; Langton, Barbaree, & McNamee, 2003); Facets of Sex Offender Denial (FoSOD; Schneider & Wright, 2001); and Sex Offender Acceptance of Responsibility Scales (SOARS; Peacock, 2000). Such measures provide structured methods of assessing denial. All of these denial-specific measures have multiple items and subscales and conceptualize denial as a dynamic construct that may change with time or with intervention.

Treatment motivation has been broadly described as a dynamic variable that involves a complex interaction of environmental, cognitive, emotive, and behavioral variables that lead to a readiness to change sexual behaviors (Jones, Pelissier, & Klein-Saffran, 2006; Tierney & McCabe, 2002). Some have focused on how motivation for treatment can be improved among sex offenders (Garland & Dougher, 1991; Kear-Colwell & Pollock, 1997); however, little empirical attention has been given to examining the construct itself. For example, although many general psychometric instruments are available for assessing treatment motivation (e.g. MMPI-2, PAI), there are only a few psychometric measures of treatment motivation validated for use with sex offenders, such as the treatment readiness scale of the MSI-II (Nichols & Molinder, 1984, 2000) and the Stages of Change Questionnaire (Tierney & McCabe, 2001, 2004).

In practice and research there seems to be a belief – implicit or explicit – that denial and minimization are strongly linked with treatment engagement, motivation, and progress (Levenson, 2011). In the Safer Society survey, McGrath et al. (2010) found that a third of adult programs and a quarter of adolescent programs in the US require that participants provide full disclosure of their sexual offending in order for them to successfully

complete their programs. Although none of the Canadian programs surveyed indicated that they required offenders to fully admit their sexual offending behavior, some disclosure was still expected in 75% of the programs surveyed (McGrath et al., 2010).

Turning to research, several studies have included denial and minimization in operational definitions of treatment engagement, motivation, and treatment progress. For example, Tierney and McCabe's (2001) adaptation of the Stages of Change model to sex offender treatment motivation clearly includes a precontemplative stage whereby the offender may deny, minimize, or use defenses to avoid threatening information. Similarly, the measure of treatment progress used by Levenson and MacGowan (2004) was scored, in part, based on offense disclosure. Thus, all other things being equal, an offender who denied would be viewed as making poorer treatment progress than an offender who admitted. This overlap also goes in the other direction with measures of denial and minimization including subscales that address readiness for treatment. For example, the SOARS includes a *motivation to change* subscale (Peacock, 2000) and the CID-SO includes a *denying need for treatment or management of sexual offending* subscale (Jung & Daniels, 2012). Thus, denial and minimization are often considered key aspects of treatment engagement, motivation, and progress, and vice versa.

The available evidence suggests that greater denial/minimization is generally associated with lower motivation and more negative perceptions of treatment. Specifically, using denial measures that include a treatment motivation subscale, small to large correlations between treatment motivation and denial of guilt and responsibility have been reported in various studies (e.g. MSI, Harkins, Beech, & Goodwill, 2010; CID-SO, Nunes & Jung, 2011; SOARS, Peacock, 2000). Also, Levenson and Macgowan (2004) investigated the relationship between denial as measured by the FoSOD and treatment engagement as measured by the Group Engagement Measure with a nonrandom sample of outpatient sex offenders. A negative correlation emerged with higher levels of denial associated with lower levels of engagement.

The purpose of the current study is to add to this literature by examining the relationship between denial and treatment perceptions. Denial was measured via a checklist completed by a clinician (CID-SO), a self-report paper-and-pencil questionnaire (SOARS), and a single-item behavioral rating on a clinician-administered risk measure (SVR-20). Perceptions of treatment (e.g. evaluation, openness, motivation, rejection) were measured with two self-report questionnaires: the treatment readiness scale of the MSI (and MSI-II) and the treatment rejection scale of the Personality Assessment Inventory (PAI). We hypothesized that greater denial/minimization would be associated with more negative perceptions of treatment and lower motivation for treatment.

Method

Participants

The sample consisted of 185 male sex offenders who were court-mandated for an assessment and/or treatment at a forensic psychiatric outpatient clinic (see Jung & Gulayets, 2011, for further description of the program). The age of the sex offenders ranged from 19 to 81 years ($M = 39.0$; $SD = 12.33$). Fifty-three percent offended against children (i.e. under the age of 16), 24.3% offended against adults or non-minors (i.e. ages 16 and up), 10.3% committed non-contact offence(s), such as exposure, voyeurism, and possession of child pornography, and for 12.4%, these offence details were unknown. The majority of the sample were first time offenders (68.6%), whereas 9.7% had prior sex offences, and for 21.6% the number of prior sex offences was unknown.

Measures

Comprehensive Inventory of Denial—Sex Offender version (CID-SO)

The CID-SO is an inventory with 18 items that are scored on a 3-point scale by a clinician (Jung & Daniels, 2012). The items are clustered to form four types of denial that include (A) Denying Sexually Deviant Behaviors and Arousal, (B) Denying Need for Treatment/Management of Sexual Offending, (C) Denying Responsibility, and (D) Minimizing Harm. Denial is assessed by both an interview and a thorough review of collateral information, such as the police narrative of the offence and a criminal record. The interrater reliability of the CID-SO has been demonstrated to be more than adequate (e.g. $rs = 0.91$ – 0.97) and the CID-SO is related to other denial measures, including the SOARS and the Denial subscale on the MSI (both measures are described below; see Jung & Daniels, 2012).

Sex Offender Acceptance of Responsibility Scales (SOARS)

The SOARS (Peacock, 2000) is a self-report inventory that comprises 53 items scored on a 5-point scale and forms six subscales: Acceptance of Sexual Offence, Acceptance of Offence Planning, Acceptance of Victim Harm, Motivation to Change, Justification for Sexual Offending, and Acceptance of Sexual Interests. Cronbach's alphas for the subscales range from .69 to .92 (Peacock, 2000).

Sexual Violence Risk measure (SVR-20)

The SVR-20 is a 20-item checklist completed by clinicians to assess three domains of risk for sexual violence: psychosocial adjustment, sexual offence, and future planning (Boer, Hart, Kropp, & Webster, 1997). The items

are rated as 'not present', 'somewhat or possibly present', or 'clearly present'. For the purpose of this study, we were interested in item #17, extreme minimization or denial of sex offences. A moderate degree of interrater consistency has been found for the denial item, with an intraclass correlation of .42 based on 30 cases (de Vogel, de Ruiter, van Beek, & Mead, 2004).

Multiphasic Sex Inventory (MSI) measures

The original (MSI; Nichols & Molinder, 1984) and second edition (MSI-II; Nichols & Molinder, 2000) of the MSI measures assess a wide range of psychosexual characteristics of sex offenders, and both versions contain a treatment readiness scale, which provides an indication of an individual's attitude regarding his or her openness for treatment. The treatment readiness scales on both the MSI and MSI-II consist of eight yes/no items; however, only two items are exactly the same on both versions. For the overall original MSI measure, three-month test-retest reliability was .79 (Simkins, Ward, Bowman, & Rinck, 1989), and for the second edition, 15-month test-retest reliability was .87 (Nichols & Molinder, 2000).

Personality Assessment Inventory (PAI)

The PAI (Morey, 1991) is a 344-item self-report inventory of adult personality and psychopathology. Included in this study was the treatment rejection scale (i.e. denoted on the PAI profile as 'RXR') that consists of eight items that are responded to on a 4-point scale. The PAI has well-established reliability and a range of studies attest to its validity (see Duellman & Bowers, 2004; Morey, 1991, 1996). This measure is also considered to be particularly well suited for use with forensic populations (see Morey & Quigley, 2002).

Procedure

Measures of the participants' denial of their sexual offending and treatment attitudes were either administered as a questionnaire to the offender (SOARS) or completed by the clinician (CID-SO). Two measures were rated by clinicians who were trained on the psychometric background and the administration of the measures, and who were licensed psychologists or psychiatrists. Three measures were self-report measures that were administered by trained psychometrists.

Files at the outpatient clinic were searched between the years 2001 to 2009 for sex offenders' files that contained a measure of denial (e.g. CID-SO, SOARS, item #17 on the SVR-20); hence, research participants were not solicited for this study. All measures had been completed by offenders

(SOARS, PAI, and MSI) or trained and licensed psychologists and psychiatrists (CID-SO and SVR-20) at the time of initial assessment. The items on the selected measures were transcribed directly from inventories or rating forms included in the files. The SOARS was scored by the first author and the PAI and MSI measures were scored by either a published computer program or submitted to the publisher for scoring. It was not possible to determine inter-rater reliability for the CID-SO or Item 17 of the SVR-20 because a second assessment had not been conducted at the time of the initial assessment. However, as reported above, the inter-rater reliability of scores on these measures has been examined in other studies and was found to be excellent for the CID-SO and moderate for Item 17 of the SVR-20. Some measures were missing from some analyses because the assessments did not always include the same measures.

Results

Intercorrelations between measures of denial and minimization

Intercorrelations between the CID-SO and SOARS could only be calculated for a small subset of the entire sample ($n = 36$) and all four CID-SO clusters were negatively correlated with Acceptance of Sexual Offence and Acceptance of Victim Harm of the SOARS (coefficients ranged from $-.40$ to $-.62$). Negative correlations were also found between cluster A (denying sexually deviant behaviors and arousal) and Justification for Sexual Offending, cluster B (denying need for treatment or management of sexual offending) and Motivation to Change, cluster C (denying responsibility for the offence) and Acceptance of Offence Planning, and cluster D (minimizing harm) and Motivation to Change ($r_s = -.36$ to $-.51$). The CID-SO clusters were also positively correlated with item #17 on the SVR-20 ($r_s = .61$ to $.73$). Correlations could not be calculated between the SVR-20 item and the SOARS subscales given that only three cases overlapped.

Intercorrelations between measures of treatment perceptions

Significant correlations were found between the treatment rejection scale on the PAI and the treatment readiness scale of the original MSI, $r(36) = -.49$, $p < .01$, and the MSI-II, $r(53) = -.52$, $p < .01$, among the small portion of the sample who were administered both measures.

Intercorrelations between measures of denial/minimization and treatment perceptions

Pearson product-moment correlations between denial and the treatment perception scales are reported in Table 1.

Table 1. Intercorrelations between the CID-SO clusters, SOARS subscales, SVR-20, and the treatment perception scales of the MSI and PAI.

Denial/minimization variables		Treatment readiness		Treatment rejection PAI
		MSI-II	MSI (original)	
CID-SO				
A	Denying sexually deviant behaviors and arousal	-.43** (<i>n</i> = 43)	-.54** (<i>n</i> = 43)	.31*** (<i>n</i> = 133)
B	Denying need for treatment or management of sexual offending	-.63*** (<i>n</i> = 42)	-.50** (<i>n</i> = 43)	.34*** (<i>n</i> = 133)
C	Denying responsibility for the offence	-.57*** (<i>n</i> = 44)	-.45** (<i>n</i> = 43)	.37*** (<i>n</i> = 134)
D	Minimizing harm done by the offence	-.52*** (<i>n</i> = 41)	-.64*** (<i>n</i> = 25)	.39*** (<i>n</i> = 135)
SOARS				
ASO	Acceptance of sexual offence	—	.50* (<i>n</i> = 25)	-.36* (<i>n</i> = 46)
AOP	Acceptance of offence planning	—	.25 (<i>n</i> = 23)	-.14 (<i>n</i> = 44)
AVH	Acceptance of victim harm	—	.39 (<i>n</i> = 24)	-.53*** (<i>n</i> = 44)
MC	Motivation to change	—	.64** (<i>n</i> = 25)	-.46** (<i>n</i> = 47)
JSO	Justifications for sexual offending	—	.11 (<i>n</i> = 24)	-.31* (<i>n</i> = 46)
ASI	Acceptance of sexual interests	—	.48* (<i>n</i> = 24)	-.30* (<i>n</i> = 45)
SVR-20 item: Extreme minimization or denial		-.58*** (<i>n</i> = 52)	—	.22 (<i>n</i> = 77)

Note: **p* < .05. ***p* < .01. ****p* < .001.

CID-SO

Significant correlations with the treatment readiness scales of each MSI and the treatment rejection scale of the PAI were found for all of the CID-SO subscales. Denying sexually deviant behaviors and arousal, denying need for treatment or management of sexual offending, denying responsibility for the offence, and minimizing harm were all significantly associated with lower treatment readiness on the MSI measures and greater treatment rejection on the PAI. Most of the correlations were large between the CID-SO clusters and treatment perceptions as measured by the MSI (–.43 to –.64), but only medium correlations were found when treatment perceptions were measured by the PAI (.31 to .39).

SOARS

Given that there were no cases where both the SOARS and the MSI-II were completed, correlations were only calculated for the SOARS subscales with

the original MSI and the PAI. Three of the six SOARS subscales were significantly correlated with treatment readiness on the original MSI, and five of the SOARS subscales were significantly correlated with treatment rejection on the PAI. Specifically, Acceptance of Sex Offence, Motivation to Change, and Acceptance of Sexual Interest were associated with greater treatment readiness (MSI) and lower treatment rejection (PAI). Acceptance of Victim Harm was also significantly associated with lower treatment rejection (PAI). Surprisingly, Justifications for Sexual Offending was significantly associated with *less* treatment rejection (PAI). Correlations between the SOARS and either measure of treatment perceptions ranged from small to large (.11 to .64 on the MSI; $-.14$ to $-.53$ on the PAI).

SVR-20

The individual clinician-rated item on the SVR-20, Extreme Minimization or Denial, was significantly associated with lower treatment readiness on the MSI-II ($-.58$), but was not significantly associated with treatment rejection on the PAI scale (.22).

Discussion

The purpose of this study was to examine the extent to which denial was associated with treatment perceptions of sex offenders. Consistent with past research, most aspects of denial and minimization were significantly correlated with treatment perceptions. Almost all of the significant correlations were in the expected direction; greater denial and minimization was associated with greater treatment rejection and less treatment readiness. A single correlation showing that justifications for sexual offending on the SOARS were associated with *less* treatment rejection on the PAI, emerged. In hindsight, this finding does not seem so surprising. Some of the items on the Justifications subscale of the SOARS involve acknowledgement of personal/psychological problems; for example, "My sexual offending happened because I was a very sick person at the time" and "I sexually offended because no one would take my problems seriously". The same is true of some of the PAI treatment scale items; for example, "I have some inner struggles that cause problems for me" and "I need some help to deal with important problems". Perhaps this negative correlation was found because more justifications and less treatment rejection both reflect acknowledgment of personal/psychological problems on these scales.

The strongest correlations between measures of denial/minimization and treatment perceptions were generally found for the MSI treatment readiness scale. This is not surprising given that many of the items on the MSI treatment readiness scale seem to reflect sex-offender-specific denial and

minimization; for example, "I have not indulged in sex activities which are unusual" and "My sexual problem is not as serious as that of others". In contrast, the PAI treatment rejection scale items are much more general and do not mention sex offending or sexual deviance; e.g., "I need to change some things about myself, even if it hurts" and "I can solve my problems by myself" (reverse scored). A sex offender denying or minimizing aspects of his offence would be expected to score low on many of the items of the MSI treatment readiness scale, but not necessarily so on the items of the PAI treatment rejection scale. It was also not surprising that the strongest correlations with the MSI and PAI treatment motivation scales were found for the CID-SO and SOARS subscales that addressed treatment motivation. However, even more prototypical aspects of denial (e.g. denying guilt) of the CID-SO, SOARS, and SVR-20 were moderately to strongly associated with treatment readiness.

Although our findings are consistent with conceptualizations in past research and practice of a close relationship between denial/minimization and treatment perceptions, the issues noted in the preceding paragraph and in the introduction section raise questions about their distinctiveness. To what extent do these measures conflate denial/minimization with treatment readiness? As noted above, examination of the items suggests considerable overlap between some measures. When items do overlap, which should be considered as indicators of denial/minimization versus treatment motivation? The observed correlations are much less interesting if they simply reflect overlapping items rather than a meaningful association (perhaps causal) in which denying or minimizing detracts from one's motivation to engage in treatment. The former may be the case to some extent with the MSI treatment readiness scale because of the similarity between many of its items and items from the denial/minimization measures. However, the PAI treatment rejection scale items seem more distinct and, therefore, do suggest that there may be a "real" relationship between denial/minimization and motivation for treatment. This is consistent with the research finding that greater denial/minimization is associated with less treatment engagement even when using more clearly distinct operational definitions of these constructs (e.g. Levenson & Macgowan, 2004). Nevertheless, an important next step for research is to clarify whether we are dealing with measures of distinct constructs or different measures of the same construct. The overlap versus distinctiveness between measures of denial/minimization and treatment motivation could be examined through factor analysis of several measures of each construct with a large sample of sex offenders.

Although conclusions can be drawn from this study to guide clinical and research understanding of the relationship between sex offender denial and perceived need for treatment, there are some limitations. The overall sample size was reasonable, but the number of cases included in each analysis was sometimes small. This limited our statistical power to detect significant

associations between measures and scales. It also made it impossible to meaningfully test for differences in the observed correlations between the different measures of denial/minimization and treatment motivation. Hence, replication with larger samples would be encouraged. Another potential problem was that our sample was not evenly balanced between sexual offender groups as we included relatively more child molesters and a majority were first time offenders, which could have some effect on the pattern of denial and the responses on the PAI and MSI items (e.g. Langevin, 2006). Similarly, the offenders in the sample were court-mandated to receive an assessment and/or treatment and this may limit our findings to those who receive such services more willingly. An equally plausible possibility would be that the significant findings reflect a true association between denial and treatment perceptions, but replication of the study that includes a sample of voluntary or non-court-mandated offenders would strengthen this conclusion.

Consistent with conceptualizations in past research and practice, denial and minimization are moderately to strongly associated with motivation for treatment. Although this may be interpreted as support for the exclusion of deniers from treatment, the risk and responsivity principles clearly state otherwise (Andrews & Bonta, 2006). The risk principle holds that the intensity of treatment should reflect the offender's risk level, such that higher risk offenders should receive the most treatment. The responsivity principle holds that treatment should be tailored to have the best chance of getting through to the offender. Thus, every effort should be made to deliver treatment to higher risk sex offenders exhibiting high levels of denial and minimization. Such sex offenders require not only more intense treatment but also more intense efforts to engage them in treatment. This supports the importance of efforts designed to bolster motivation either before (e.g., preparatory programs; Theodosi & McMurran, 2006) or during sex offender treatment (e.g. Marshall, Thornton, Marshall, Fernandez, & Mann, 2001).

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