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An Essential Tool for Professionals Working with those who Sexually Abuse or…A Great New Way to Stay Current with Cutting Edge Sexual Abuse Research.

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Dear Colleague,

This month's article is about whether and how to treat individuals who are in denial about their sexually abusive behavior. When the research shows no correlation between denial and recidivism, we are then challenged by the questions:

- What is the best way to treat a client in denial?
- How do you work effectively with the families and other caregivers of a client in denial?

Consider how you would work with that client and then see how Jill Levenson considers these same questions.

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Sincerely,

Joan Tabachnick and Steven Bengis

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How to Work with Adolescents in Denial who Sexually Abuse

by Steven Bengis, David S. Prescott, and Joan Tabachnick

Question
When an adolescent is in denial about his/her offense, what are the clinical and ethical considerations about whether and how to treat this teen?

The Research
Jill S. Levenson reviews research derived both from meta-analysis and single studies and concludes that there is no definitive correlation between denial and recidivism among adult sex offenders. However, some of these studies found that when denial is defined as a continuum of distorted cognitions requiring clinical attention (Langton et al., 2008) decreased denial and increased accountability appear to be associated with greater therapeutic engagement and reduced recidivism for some offenders.

Given the lack of research clarity, Levenson lays out an ethical construct for clinical approaches to denial. Within this framework, Levenson recommends developing a process for ethical decision making based on the standards and ethical code of the profession while considering the available empirical research. She recommends the following:

- Clinicians should consider denial to be an expected defense mechanism and utilize engagement strategies to reduce the shame and anxiety that lead to resistance to treatment;
- Denial should be viewed as a continuum of minimization and rationalization, and addressed as part of the cognitive distortions that are commonly found in sexual offenders; and
- Programs should allow a reasonable time period for clients to engage in the therapeutic process, but should not allow denial to persist indefinitely and should not "Graduate" categorical deniers or consider them "Successful Completers."

Implications for Professionals
According to Levenson, when deciding on how to address denial, practitioners should:

1. Maintain the autonomy of the client (e.g., ensure that clients are not pressured into admitting and have the opportunity to determine their own values and goals)
2. Consider the client's beneficence (e.g., consider the

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by David S. Prescott

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offender's well-being regardless of denial or admission of a crime)
3. Ensure nonmaleficence (e.g., treat someone in denial if they agree to treatment so that harm does not come to offenders or possible victims)
4. Focus on justice (e.g., do not deny treatment to offenders simply because they do not conform to our expectations of the "ideal" client - focus on a client's need to accept responsibility and make amends)

As clinicians, we can encourage approaches that address the possible reasons for denial (e.g., fear of consequences, shame, guilt, threat to self-esteem, and cognitive dissonance) and allow positive peer influence to have an impact. Over time however, if no responsibility is accepted, the client may be better served by the courts or probation (not the practitioner).

Implications for the Field
Because the research shows very little correlation between denial and recidivism, many researchers are advocating for ways to work with clients who are willing to enter into treatment. Although there is no similar research with adolescents, the field needs to coalesce around ethical, supportive and motivational approaches that encourage acceptance of responsibility by adolescents who may deny the crime. Through group, individual and family interventions, initial denial will, in many instances, yield to greater acceptance of responsibility, especially for future actions.

Abstract
This article addresses ethical questions and issues related to the treatment of sex offenders in denial, using the empirical research literature and the ethical codes of American Psychological Association (APA) and National Association of Social Workers (NASW) to guide ethical decision-making process. The empirical literature does not provide an unequivocal link between denial and recidivism, though some studies suggest that decreased denial and increased accountability appear to be associated with greater therapeutic engagement and reduced recidivism for some offenders. Clinicians should view denial as a continuum. It might be considered a responsivity factor that can interfere with treatment progress. Offering a reasonable time period for therapeutic engagement might provide a better alternative than automatically refusing treatment to categorical deniers.

Citation

- Levenson, J. (2010). "But I Didn't Do It!": Ethical Treatment of Sex Offenders in Denial. *Sexual Abuse: A Journal of Research and Treatment*.

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