Treating Sexual Offenders who Deny and Minimise their Offending Behaviour

by

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# TABLE OF CONTENTS

Acknowledgments ................................................................. iii

Abstract .................................................................................. vi

Chapter 1: Treating Sexual Offenders who Deny and Minimise their Sexual Offending Behaviour ................................................................. 1

1.1 Denial and Minimisation – Definitions and Understanding .......... 3

1.2 The Relationship between Denial and Risk of Recidivism ............. 7

1.3 The Function of Denial and Minimisation for Sexual Offenders .... 9

1.4 Approach Approaches – Past and Present .................................. 11

1.5 Summary and Aims of the Current Thesis ................................... 22

Chapter 2: Mr Huy .................................................................... 25

2.1 Summary of the Presentation and Treatment of Mr Huy ............. 25

2.2 Outstanding Treatment Issues and Recommendations .............. 35

2.3 Discussion of Clinical Issues ..................................................... 36

Chapter 3: Mr Alessi ................................................................. 39

3.1 Summary of the Presentation and Treatment of Mr Alessi ......... 39

3.2 Outstanding Treatment Issues and Recommendations .............. 50

3.3 Discussion of Clinical Issues ..................................................... 52

Chapter 4: Mr Bevan ............................................................... 57

4.1 Summary of the Assessment, Presentation and Treatment of Mr Bevan ............................................................. 57

4.2 Assessment Report Section ...................................................... 58
4.3 Summary of Treatment...........................................67
4.4 Outstanding Treatment Issues and Recommendations........78
4.5 Discussion of Clinical Issues.....................................79

Chapter 5: Mr Morgan.....................................................83
5.1 Summary of the Presentation and Treatment of Mr Morgan........83
5.2 Outstanding Treatment Issues and Recommendations..........95
5.3 Discussion of Clinical Issues......................................96

Chapter 6: Summary and Conclusions..................................102

References........................................................................113

Appendix A: Overview of the Content of the Group Based Treatment
Program........................................................................120
ABSTRACT

Sexual offending behaviour remains a societal issue impacting on victims, families of victims, perpetrators and their families, and the broader community. Sexual offending behaviour has received both media and clinical attention over the past several decades, and as such, numerous treatment programs have been developed in Australia and internationally. The predominant aim of these treatment programs is to reduce the risk of re-offence. Cognitive Behaviour Therapy interventions have been demonstrated to be most effective in reducing rates of recidivism in sexual offenders. Treatment resistance remains a significant barrier to the attainment of treatment goals, and processes of denial can contribute to, and maintain treatment resistance. These may form barriers to treatment engagement, goal achievement, and consequentially, impact on risk of recidivism.

The aim of the current clinical thesis is to explore the challenges faced by mental health professionals in providing treatment to sexual offenders who deny engaging in offending behaviour, either categorically, or on another level (e.g. minimisation of victim harm). Specifically, this thesis examines the therapeutic techniques used by professionals and the extent to which these enable offenders who deny to successfully address their risk of recidivism. The thesis begins with a review of the literature relating to denial and minimisation in sexual offenders, functions of denial, and past and present treatment approaches. Four case studies are then presented, illustrating different levels of denial, offending behaviour, and location of treatment provision. The clinical thesis concludes with
a summary of the issues highlighted throughout the case studies, and the implications of these issues in the future treatment of sexual offenders who deny and minimise their sexual offending behaviour.
Chapter 1: Treating Sexual Offenders who Deny and Minimise their Sexual Offending Behaviour.

Sexual offending behaviour remains a societal issue that impacts significantly on victims, the families of victims, perpetrators and their families, and the broader community. Over the past several decades, increased attention clinically and within the media has been centred on sexual offending behaviour, and numerous treatment programs have been developed internationally with the aim of reducing the risk of sexual re-offending behaviour of offenders known to the criminal justice system. Empirical research relating to assessment of risk of recidivism and treatment efficacy has, as such, become a focus for those professionals working within the criminal justice system. Cognitive Behavioural Therapy (CBT) interventions targeting dynamic, or changeable, risk factors specific to the person have been empirically demonstrated to be most effective in reducing the risk of sexual recidivism in sexual offenders (Anderson, Gibeau, & D'Amora, 1995; Laws, Hudson, & Ward, 2000; Marshall, Anderson, & Fernandez, 1999b; Marshall & Eccles, 1995). The overriding goal of sexual offender treatment programs is to reduce the likelihood that offenders will continue to engage in future sexual offending behaviour. However, attaining this goal can prove difficult due to numerous factors, including an incomplete picture of the variables contributing to sexual offending, and more pertinently to this thesis, considerable treatment resistance from offenders in treatment. Processes of denial, to varying levels, can contribute to, and maintain treatment resistance (Schneider & Wright, 2004).
The predominant treatment modalities for sexual offender treatment since the late 1970s have been cognitive behavioural therapies (Marshall & Barbaree, 1990). The aim of these programs has been to provide offenders with the self-management skills required to manage their risk factors and potentially high risk situations in the future by changing attitudes and beliefs that have enabled them from moving from non-offending to offending behaviour, identifying factors on an offence cycle that demonstrates an offence pathway, developing consequential thinking, developing appropriate emotional regulation skills, developing general and victim empathy, establishing pro-social means of meeting needs, and developing appropriate strategies to mitigate high risk factors, such as thoughts, feelings, behaviours, and situations. In general, the effectiveness of treatment programs and the approaches listed above relies on the extent to which an offender is willing to engage in the treatment process.

Mental health professionals (anecdotally, included in the current setting and context; psychologists, psychiatrists, social workers, and nurses), who assess, evaluate, and treat sexual offenders within the criminal justice system are often required to question the reliability and veracity of offenders’ self-reports. Denial of having committed an offence, or some aspect of the offence, occurs with some regularity among sexual offenders in treatment programs (Cooper, 2005; Kennedy & Grubin, 1992; Marshall, 1994). As such, different levels of denial are identified and utilised by offenders, depending upon how widely the net is set in regards to the definitions of denial in this context (Marshall, Thornton, Marshall, Fernandez, & Mann, 2001). Examples include denial of responsibility for the offending, denial of victim harm, denial of sexual deviancy, denial of the role of fantasy and planning in offending,
denial of frequency of offending, denial of the need for treatment or intervention, and
categorical denial (Marshall, et al., 2001). Offenders who deny committing an offence
or deny responsibility or accountability in their offending often present as
noncompliant in treatment tasks, resistant to developing and working toward treatment
goals, and more likely to withdraw or be removed from treatment programs (Hunter &
Figueroado, 1999; O'Donohue & Letourneau, 1993; Salter, 1988). The aim of this
clinical thesis is to explore the challenges and complexities that face mental health
professionals in providing treatment to sexual offenders who deny their offending, to
varying degrees. More specifically, this portfolio aims to examine the efficacy of
applying the CBT model utilised in treatment of offenders who do not deny offending
to those that do deny offending or aspects of offending, by adapting the model to suit
the treatment needs of those in denial. It further aims to determine if the application of
this model presented in a different manner encourages increased motivation and
engagement in treatment. This introductory chapter provides a context for this thesis by
exploring the concept of denial and minimisation, the relationship of denial to risk of
re-offending, the function(s) of denial, and past and present treatment approaches.

1.1 Denial and Minimisation - Definitions and Understanding

Denial of engaging in offending behaviour, or of aspects of offending behaviour
is not an uncommon phenomenon in sexual offenders (Happel & Auffrey, 1995).
Barbaree (1991) proposed that 98% of sex offenders within his sample were either
denying or minimising their offending to a degree, while Marshall (1994) indicated that
32% of his sample of sexual offenders minimised aspects of their offending, while
another 31% of the sample absolutely denied having committed an offence. The concept of denial, however, may vary depending on the breadth of the definition. In the research and clinical literature, professionals articulate denial of responsibility in offending, denial of victim harm, denial of the frequency of offending, denial of targeting, fantasies, or planning of the offence, and denial of the need for treatment (Marshall, 1994; Marshall, et al., 2001). Marshall and colleagues (1999; 2006) identified several broad types of cognitive processes that may be labelled or defined as denial, some with subtypes (Marshall, Anderson, & Fernandez, 1999a; Marshall, Marshall, Serran, & Fernandez, 2006), whereas other authors (e.g. Barbaree, 1991) indicate that some forms of denial, aside from absolute denial, relate more to cognitive distortions, such as minimisations (Barbaree, 1991). For the purpose of this thesis, the definitions of denial developed by Marshall and colleagues (1999; 2006) will be utilised (please see Table 1.1). Those offenders who completely deny offending will be referred to interchangeably as absolute or categorical deniers, indicating that the offender categorically states that [he] did not commit a sexual offence (Marshall, et al., 2001). Other types of denial and minimisation will be defined specifically throughout (e.g. “denial of responsibility” or “minimised responsibility”).
Table 1.1 Features of Denial and Minimisation (Marshall et al. 2006).

COMPLETE DENIAL
False accusation
- Police out to get me
- Victim hates me
- Victim trying to get financial compensation
- Victim’s mother wants to deny access to children
Wrong person
- Victim mistakenly identified the client
Memory loss
- Cannot remember but client sure he did not do it

PARTIAL DENIAL
Memory loss
- Cannot remember but it probably happened
Was not abuse
- Victim consented
- He/she lied about his/her age
- It was only a massage
- It was done for educational/protective purposes
- It was love
Denies having a problem or that he needs treatment
- I did it but I am not a sexual offender
- I have no sexual interest in, or fantasies about, children or rape
- I have learned my lesson so I know I will never do it again

MINIMISATIONS
Concerning offence(s)
- Did not happen as often as victim claims
- No use of threats, coercion, or force
- Less sexually intrusive than victim claimed
- Only one victim

Concerning responsibility
- Victim was prostitute so how can it be rape
- Victim was seductive
- Victim’s parents were neglectful
- I was intoxicated
- I was depressed/stressed/angry
- My partner was not sexually interested
- I have a high sex drive or I am a sex addict
- Victim said no but he/she clearly wanted it

Minimising harm
- Friends/family tell me victim is ok
- Victim’s current problems not caused by me
- I was loving/ affectionate so no harm
- I was not forceful so no harm

Denies planning/ fantasising
- It was a “spur of the moment” thing
- It just happened
- Victim started it
- I have never had deviant sexual thoughts
- I did not think about it before it happened


Offenders that categorically deny have a tendency to claim they were falsely accused of offending or were “mistakenly identified,” and are often considered particularly problematic for treatment providers. Offenders who categorically deny may refuse to participate in treatment programs or in many cases, are deemed ineligible for programs, given the assumption of many programs that admitting to an offence and claiming responsibility for offending behaviour are a necessary requirement for successful engagement and completion of treatment (Happel & Auffrey, 1995; Schneider & Wright, 2004). As a consequence, certainly in the Victorian context, categorical deniers tend to be refused parole by local parole authorities based on their untreated status, and are therefore incarcerated for longer periods or until their sentence expires. Subsequently, they are released back into the community untreated and unable to be provided with the post-release supervision and support provided to parolees.

Given the results of recidivism studies looking at the effects of treatment versus no treatment on rates of sexual recidivism in sexual offenders (Hanson, et al., 1999; Marshall, et al., 1999a), and the potential that denial of a current index offence might have on future offending behaviour, it is a matter of systemic and clinical concern that
those most in need of treatment are all too often those who are excluded from both treatment while in prison and post-release support.

1.2 The Relationship between Denial and Risk of Recidivism

A level of controversy remains regarding whether denial and minimisation of offending predict sexual recidivism (Langton, et al., 2008). Two major meta analyses (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2005) suggest that denial and minimisation of sexual offences do not predict sexual recidivism, however, denial and minimisation continue to be interpreted as a risk factor for sexual recidivism, as evidenced by denial and minimisation being a factor considered in some sexual recidivism risk protocols, such as the Sexual Violence Risk – 20 (SVR-20) (Boer, Hart, Kropp, & Webster, 1997), and the Violence Risk Scale: Sexual Offender version (VRS: SO) (Wong, Olver, Nicholaichuk, & Gordon, 2004), and have further been applied in clinical settings when decisions of risk are being assessed (Amenta, 2006; Langton, et al., 2008). Further, Hanson and Bussiere’s (1998) meta analysis has been criticised, with observations by Lund (2000) highlighting that throughout the meta analysis, operationalisations of denial varied from that of categorical denial in three studies, and that of minimisations or “thinking errors” in the other four (Lund, 2000). Additionally, Lund (2000) highlighted the tendency of removing deniers from data sets in some of the studies included in the analysis, while other studies included their sample of deniers. In their more recent meta-analysis, Hanson and Morton-Bourgon (2005) attempted to combat the aforementioned criticisms by examining studies separately who operationalised denial and minimisation as discrete factors. Their results again
indicated, however, that denial and minimisation did not significantly predict sexual recidivism. Interestingly, it is suggested by Hanson and Morton-Bourgon (2005) that most treatment programs continue to target factors, such as victim empathy and taking responsibility for offending behaviour, that have been empirically demonstrated to have no relationship to risk of recidivism, in addition to targeting those factors in treatment identified as related to risk of recidivism (e.g. deviant sexual interests, unstable lifestyle, intimacy deficits, sexual preoccupation) (Hanson & Morton-Bourgon, 2005). Langton and colleagues (2008) suggest that despite replication in the results of the meta-analyses, that the results should be considered with caution or as “preliminary rather than definitive” as the studies included contained a number of methodological limitations (p. 71).

Langton and colleagues (2008) conducted a study seeking clarification around the relationship between sexual recidivism and denial/minimisation of sexual offending behaviour, whilst controlling for the potential confounds of treatment failures (failure to complete specialised treatment programs), psychopathic traits, sex offender type, and actuarial risk of sexual re-offending (See Langton et al, 2005 for an overview of the contribution of the potential confounds). Their main finding suggested that higher levels of minimisation predicted sexual recidivism among higher risk offenders, when treatment completion status and psychopathic traits were controlled for. This result is in conflict with the conclusions of the meta-analyses completed by Hanson and Morton-Bourgon (1998; 2005). Langton et al. (2008) suggest that more research is required, specifically including designs that employ multiple methods of assessment of pre – and post-treatment changes, “investigation of interaction effects … survival analytic
techniques,” and offer a broader scope of enquiry, inclusive of other aspects of denial that may be relevant “from risk assessment, treatment, and management perspectives” (p. 89), as well as developing a more sophisticated perspective on denial and more advanced measures of denial. Other relevant factors may include denial or minimisation of risk of re-offence (Hanson & Harris, 2000). The major implication of gaining more specialised knowledge about the impact of denial and minimisation relates directly to the development of treatment targets in programs designed to reduce the risk of sexual recidivism in sexual offenders.

1.3 The Function of Denial and Minimisation for Sexual Offenders

Sex offenders, not unlike other clients or patients may be motivated to distort their self-reports in assessment and treatment processes (Rogers, Sewell, & Goldstein, 1994; Rogers, 1990). This is not unexpected; given many offenders enter treatment by mandate, not voluntarily. Lord and Willmot (2004) examined the cognitive process by which sex offender move from denial and the factors that influenced their decision to admit to offences. They interviewed convicted sexual offenders in focus groups and in semi-structured interviews exploring their reasons for “leaving denial.” They conducted a content analysis following group discussions, which revealed three main groups of factors that influence a decision to maintain denial: motivational/insight factors, which relate to deficits in perspective taking or an unwillingness to cease offending; threats to self-esteem and image, which relate to a fear of negative evaluation or threats to self-esteem; and fear of negative, extrinsic consequences, such as being assaulted (Lord & Willmot, 2004). They developed a four-stage model of the process of “overcoming
denial” and recommendations for addressing factors that may inhibit offenders from overcoming denial. This model and recommendations will be discussed further in treatment approaches. Threats to an offender’s social status, family life, integrity and self-esteem further increase pressure to deny offences or distort information by minimising aspects of offending behaviour. These not only serve, for example, purposes of maintaining family stability, but also maintain an offender’s sense of self. Denial may be even further complicated by “the fact that being honest about one’s culpability is not necessarily a straightforward matter” (Schneider & Wright, 2004). That is, evidence suggests that the actions of offenders are entrenched in “elaborate networks” of cognitive distortions developed through “biased processes” (Schneider & Wright, 2004; Ward, Hudson, Johnston, & Marshall, 1997) that enable them not only to deceive others, but to deceive themselves. To some extent, this builds on psychoanalytic theories (e.g. Freud, 1940) where denial was understood as an “unconscious mechanism” whereby offenders may not even admit the truth to themselves (Happel & Auffrey, 1995). Happel and Auffrey (1995) further elaborate that offenders “dance with denial to avoid feelings of shame, confusion, embarrassment, inadequacy, responsibility, and guilt. They are often sensitive about their deviance and afraid to admit the truth, even to themselves. The thought of being a sexual deviate can be so frightening or repugnant to them that they hide from themselves for years” (p. 6). Salter (1988) explains further that many sexual offenders do not consider themselves or the act of offending as deviant, until they admit it (Salter, 1988). Research further indicates that family dynamics may play a role in the development and maintenance of denial. For instance, by denying the offence, an
offender may be acting to protect family members from emotional distress, such as shame and anger. It has been additionally found that families of offenders in denial often support the denial (Sefarbi, 1990). Regardless of the differing explanations for the development and maintenance of denial, exploring offenders' denial and the function of denial for individual offenders provides important clinical information about an offender's beliefs about him – or herself, other people, and the world, which is likely to be relevant in designing treatment programs and interventions to meet the therapeutic needs of these offenders.

1.4 Treatment Approaches – Past and Present

Cognitive Behavioural Therapy (CBT) models of treatment are currently the most utilised and empirically validated approaches to providing treatment of sexual offenders (Laws, et al., 2000). The foundations of CBT emerged in the early 1960s pioneered by Beck and Ellis, whose initial training was psychodynamic, however, they both later developed variants of CBT highlighting cognitive restructuring, and the changing of persistent schemas or beliefs (Beck, 1970; Ellis, 1962). Cognitive Behavioural Therapies now represent a convergence of behavioural and cognitive strategies and processes, with the overarching goal of enacting behaviour and cognitive change. Under the umbrella of the Cognitive Behavioural Therapies, the following therapies are included: Rational Emotive Behaviour Therapy (Ellis, 1962), Cognitive Therapy (Beck, 1970), Self-Instructional Training (Meichenbaum, 1973), Self-Control Treatments, and Acceptance and Commitment Therapy (Hayes, 2004). The aims of CBT within sex offender treatment programs are to alter patterns of cognitions,
emotions, and behaviours that perpetuate and maintain sexual offending behaviour. Best practice at present dictates the targeting of dynamic risk factors (also referred to as criminogenic needs) identified as linked to risk of re-offending (Hanson & Harris, 2000, 2001; Hanson, Harris, Scott, & Helmus, 2007), addressing changes in attitudes and beliefs, challenging and changing cognitive distortions, improving intimacy deficits, developing skills to form and maintain appropriate social, intimate and sexual relationships, developing adaptive general and emotional regulation skills including problem solving and coping skills, reducing deviant sexual arousal, and adaptively managing general and sexual self-regulation (Marshall, et al., 1999a; Yates, 2003). CBT uses a range of techniques and strategies to assist in the development and practice of new skills and self-management strategies so as risk of re-offending is reduced. Sex offender treatment often further targets additional factors previously mentioned, such as general and specific (victim) empathy deficits, and responsibility-taking, despite a lack of empirical research linking these factors to risk of re-offending (Yates, 2009). Follow-up support and maintenance programs to assist behavioural consolidation of treatment concepts and strategies, monitor risk and goal achievement is further recommended post-treatment (Marshall, et al., 2006).

Categorical denial has historically been regarded as a major obstacle to successful cognitive-behavioural treatment, and as such, categorical deniers have often been excluded from treatment programs. Cooper (2005) explains that in the English prison service’s Sex Offender Treatment Programme (Offending Behaviour Programmes Unit, Home Office) this has related to the initial goals of treatment, as designed in the program, whereby an offender acknowledges that s/he has a problem
regarding engaging in inappropriate sexual behaviour. This is closely followed by goals related to understanding underlying motives, predisposing and precipitating factors, and consequences of the offence, to enable the identification and management of problematic behaviour and work towards a non-offending lifestyle. The level to which this can be achieved remains dependant on an offender’s willingness to provide honest accounts of proximal and distal factors leading to the offence, and the offence itself (Cooper, 2005). Clinically, placing categorical deniers in treatment programs, which tend to be group-based, can arouse hostility in other group members who may feel the denier is not engaging appropriately in the program or taking treatment seriously, which may in turn affect how comfortable other group members feel in taking responsibility and openly discussing their own offending behaviour. Certainly, from the author’s clinical experience, admitting group members can be distrusting of the denier, may feel it is unfair that they have admitted and the denier can “get away with” denial, and as such, levels of hostility and frustration are raised within group sessions, especially when the denier is actively defensive and resistant in his or her denial. However, as previously noted, excluding categorical deniers may (a) significantly reduce the number of offenders eligible for treatment; (b) those offenders that do not complete treatment tend to be denied parole or supervised release; and (c) those offenders remain untreated, and therefore continue to pose a risk to society if released untreated and without adequate supervision and support often provided on parole. Research has indicated the presence of significant differences in the re-offences rates between untreated and treated offenders (Hanson, et al., 1999; Marshall, et al., 1999a), including those that deny their offence.
Historically, treatment of sexual offenders who categorically deny offending has developed in numerous ways, taking different forms, and with varying degrees of success (Marshall, et al., 2001). Such treatment programs have included intensive community supervision for deniers as a result of being untreated (Laws, 2002), although it has been suggested that methods such as this remain ineffective (Gendreau, Goggin, Cullen, & Andrews, 2000, in Ware & Marshall, 2008). Other strategies have included feedback of results of assessments, such as phallometry (Bradford & Greenberg, 1998), implementation of pre-treatment motivational interviewing techniques (Miller & Rollnick, 2002), and group based interventions aimed at overcoming denial (O'Donohue & Letourneau, 1993; Schlank & Shaw, 1996). Each of these interventions has had limited empirical support.

Schlank and Shaw (1996) designed and evaluated the effectiveness of a brief intervention program combining elements of relapse prevention and victim empathy training with paradoxical interventions and positive reinforcement (for admitting responsibility for sexual offences) to modify denial in their sample of sex offenders. They found that two (out of an N = 10) clients admitted their guilt during the victim empathy module, and three other clients had admitted by the end of the program, indicating a 50% success rate (Schlank & Shaw, 1996). However, it remains unclear as to which aspects of the program were responsible for “overcoming” the denial. In addition to this, and a small sample size, also of some concern with this study is that participants were informed prior to commencing the program that if they were no longer in denial by the end of the program, they would not be required to undertake
post-testing plethysmograph and polygraph and would be refunded money contributed
towards the evaluations.

O’Donohue and Letourneau (1993) investigated whether brief structured group
treatment could reduce denial of sex offences in males convicted of sexually offending
against children. The treatment program was composed of elements of victim empathy,
cognitive restructuring, sex education, assertiveness and social skills, education about
sex offender therapy, and a discussion of the possible consequences of continued
denial. It was run over seven sessions of 1.5 hours duration per session with 17 denying
child sex offenders who were placed in two treatment groups. The results suggested
that “the majority” (76%) of the offenders had at least partially come out of denial.
Follow-up data indicated that of the participants that went on to complete a sex
offender treatment program, admissions continued. The authors highlight the lack of
experimental design in this study, eliminating the opportunity for causal inference.
Further, the impact of this program on risk of recidivism was not evaluated, and would
require longitudinal follow-up. To the writer’s knowledge, the results of such a follow
up have not been published to date.

Marshall (1994) detailed an initial attempt to describe procedures for
overcoming denial and reducing or eliminating minimisation in sex offenders who
entered treatment in a minimum security Canadian Penitentiary. The program operated
as an open-ended program, meaning offenders entered the program when a position
became available and exited the program when they met the goals of the program. The
procedures for overcoming denial and minimisation were all undertaken within a group
therapy context, with an absence of pre-screening interviews and individual
counselling. The procedures used in treatment relied on group members supportively challenging each others’ accounts or disclosures of the offence(s), the preceding circumstances, thoughts and feelings at the time, emotional and mental state, level of intoxication and how it was induced, and interpretation of victim behaviour and emotional reaction. Following veracious challenging, the therapist read a summary of the victim’s account and the official version of the offence, which was then followed by further challenging by the group regarding inconsistencies in an offender’s account.

The main assumption underlying the process is that

“people are most likely to take the risk to admit to acts they believe others view as repugnant, if they know they are not going to be rejected and if they are assured that support and help will continue. The more clients are treated with respect, the more self-confidence they will feel and the more self-confident they are, the more likely they are to have the courage to admit to heinous crimes” (Marshall, 1994, p. 561).

As such, Marshall and his team made explicit the distinction between an offender’s offending behaviour, which is deemed unacceptable and harmful, and themselves as a “whole person,” highlighting that sexual offending behaviour does not define a person as a whole, and that they have strengths and positive features to their personality. That is, Marshall highlights the distinction between a person and their behaviour. Following the aforementioned therapeutic procedures, each offender repeats his disclosure or account of his offending, followed by further challenges from the group and ‘reconceptualisations’ by the therapist until his self-report of the offence is accepted by the group. The results of the current study indicated that the strategies employed were
effective across different types of offenders (rapists, incest offenders, and non-familial child sex offenders). The authors did note however, that the leverage held over the offenders in the current study, such as parole eligibility upon completion, may indicate that should the program be applied to offenders for whom parole is not an incentive or offenders on community based dispositions, the approach to overcoming denial and minimisation may be less effective.

Although Marshall and his team had some success with the above-mentioned strategies in treating offenders who deny, and included in their programs all sexual offenders who admit to having offended, those who minimise, those who claim memory deficits, and even those who deny most or all aspects of their offending, they observed that most of the offenders who categorically deny their offences and claim to be innocent, tend to refuse to enter treatment aimed at overcoming their denial (Marshall, et al., 2001). This continues to pose problems in regard to the offenders who deny their offence, remain incarcerated until the end of their sentence (i.e. denied parole as a consequence of their non participation in treatment) and who are subsequently released untreated. These issues continue to apply to the Victorian context in a similar manner to the Canadian system context in which Marshall and his colleagues work. Observing this apparent gap in the system, Marshall, Thornton, Marshall, Fernandez, and Mann (2001) designed a program specifically for the categorical deniers.

Following discussions with categorical deniers, Marshall and colleagues identified that the main obstacle to treatment enrolment was the offenders' assumption that they would be challenged regarding their claim of innocence, indicating that as
long as programs were aimed at overcoming denial, categorical deniers would not volunteer entry to programs. As such, they decided to issue a promise not to discuss their offence, nor challenge their denial, believing that this was critical to ensuring the offenders’ cooperation. Within the context of not discussing offending or overcoming the denial, the focus becomes about helping the offenders to identify problems in their lives that put them in a position to be accused of sexual offending or that “generated sufficient animosity in others that someone accused them of an offence they claim not to have committed” (p. 209). It is suggested to the offenders that there may have been something about their behaviour, attitudes, or feelings that put them in such a position, and that therefore, it would be beneficial to identify such issues and assist them to change. So, although the offence proper is not addressed, the criminogenic issues or dynamic risk factors are still addressed – those factors that have been demonstrated empirically to be important targets in sexual offender treatment (Marshall, et al., 1999a).

Treatment is conducted by one or two therapists with 10 offenders per group, meeting for two, 2.5 hour sessions per week for 12-14 weeks. The areas targeted are self-esteem, attitudes and relationships, coping strategies, victim harm (whereby the consequences of victimisation in general are discussed, rather than relating it to any specific victim), and relapse prevention. In regards to relapse prevention, offenders who are in groups of admirers complete an offence process or cycle whereby they are assisted to identify plans to avoid risk in the future. With offenders that deny, it is suggested to the offenders that they must have engaged in behaviours and taken a course of action that placed them in a position where they were successfully accused
and convicted of a sexual offence. It is put to them that most false accusations never get to court or result in a conviction, given evidence requirements, in which case, they must have "made some serious mistakes in judgment, or done some quite inappropriate things, in order for the, supposedly false, case against them to be so strong" (p. 211). Marshall and colleagues indicate that removing the requirement of taking responsibility for their offending allows the deniers the space to examine the circumstances and courses of action surrounding their offence, allowing them to identify a range of background factors and choices made at the time of the offence. Marshall and colleagues observed clinically that the ‘offence chains’ and relapse prevention plans generated by the deniers are often as good as those generated by admiters.

At the time of publication (2001), Marshall and his colleagues had completed three groups in their deniers program in Canada. They articulated that they feel they had achieved the goal of engaging the clients’ full participation, however, not that they had been unable to systematically evaluate the effectiveness of the program in achieving the within-treatment goals. Further, it will be some time before the program can be effectively evaluated in terms of the over-arching goal of reducing risk of recidivism. In an email to the author, L. E. Marshall and W. L. Marshall from Rockwood Psychological Services, Ontario, Canada, provided information from their most recent evaluation of their program for categorical deniers. The Deniers’ Program outcome data from 1998 (program commencement) to mid-2005 detailed that of 40 participants that completed the program, four had re-offended via a breach or revocation, and one participant had re-offended sexually, with an expected rate of sexual recidivism of 13.5% (Based on Rapid Risk Assessment for Sex Offence
Recidivism; RRASOR) (L.E. Marshall & W.L. Marshall, personal communication, February 12, 2010). This appeared to indicate that treatment with offenders in categorical denial is valuable in regard to reducing risk of recidivism.

Since then, Ware and Marshall (2008) have published a case study utilising the intervention described above to illustrate that an approach focusing on the problems in the offender’s life that placed him in a position where he was able to be ‘accused’ of a sexual offence is effective at motivating “resistant” sexual offenders to enter treatment programs (Ware & Marshall, 2008). As such, Ware and his colleagues in New South Wales, Australia, have developed a program based on the model used by Marshall and his colleagues in Canada, while a similar program has been piloted in Western Australia.

In emails to the author, J. Ware and C. Baird from the Sex and Violent Offender Therapeutic Programmes, Corrective Services, NSW, gave details of their clinical experience with treating their first group comprised of sexual offenders who denied committing the offences (J. Ware & C. Baird, personal communication, January 11, 2010; February 2, 2010; February 3, 2010). C. Baird, a treating clinician, indicated that the offenders initially had minimal motivation to change, expecting that they would be expected to admit guilt for their offences by being asked to identify the background factors associated with being accused of sexual offending. However, towards the second half of the program, most of the men indicated that they appreciated the opportunity to identify background factors relevant to their accusation. Of particular note was that the group members reported that they enjoyed the focus in the group on developing a positive and healthy lifestyle in the future, indicating that program
modules including self-esteem, healthy attitudes and coping were well received. In regards to levels of resistance and engagement, once the initial period of confusion was addressed and they understood the aims of the program, their level of engagement was “very high.” It was noted that the primary motivator for their engagement was their release on parole. In fact, the program was initially promoted in this manner to increase the level of engagement of the offenders. As such, in regards to managing resistance and increasing treatment engagement, the program appeared to be successful.

In regards to modules or treatment goals addressed in the program, in general, they appeared similar to the programs for admiters. However, the focus appeared to be on identifying background factors, then developing self-management plans and plans for a healthy life. Self-esteem also appeared to be a significant focus. The modules were presented as means of identifying background factors and as a way to identify strategies to improve quality of life post-release. Overall, at the conclusion of the program, the offenders were pleased with their achievements and spoke highly of their experience in the program. Given the initial program has recently been completed, studies addressing recidivism will not yield results for some years, given the nature of studying recidivism. In communications, J. Ware indicated that the team in NSW are preparing to evaluate their pre-treatment and post-treatment testing, completed by the offenders in the group, which should provide evidence as to the effectiveness of the program thus far.
1.5 Summary and Aims of the Current Thesis

The overall aim of this thesis is to explore the challenges faced, and complexities encountered, by mental health professionals in treating sexual offenders who deny engaging in their offending behaviour, either categorically, or on another level (for example, denial of intent and significant minimisation of victim harm or victim blaming). Specifically, this thesis aims to examine the therapeutic techniques utilised by professionals and the extent to which these enable an offender who denies addressing important dynamic risk factors in their life in order to successfully reduce their risk of re-offending. The literature reviewed in sections 1.1 to 1.4 offers a context for this thesis by examining the complexities inherent in working with sexual offenders who deny their offending, given the function of that denial, and past and present theories on appropriate and effective treatment options. This thesis provides four case illustrations where the offenders have denied their offending behaviour to different degrees, illustrating the relevance of their denial to their treatment gains and treatment techniques utilised to address treatment needs. Further, through the exploration of the four cases, this thesis aims to examine current treatment methods, and address potential gaps in treatment as it functions at present.

The four cases presented in this thesis were derived from clinical placements undertaken by the author in partial fulfilment of the requirements of the Doctor of Psychology (Forensic) degree at Deakin University, Melbourne, Australia. Each case study outlined was seen for group-based treatment by the author and a co-facilitator. Full clinical pre-treatment assessments were not conducted on three of the four cases, given the current practices of the treatment program. As such, treatment needs were
assessed throughout the initial stages of treatment. The cases presented in this thesis were selected based on the different levels of denial, offending behaviour, and location of treatment provision (prison-based, versus community-based). Two cases illustrate two offenders who categorically denied engaging in sexual offending, and the other two cases illustrate offenders who acknowledge engaging in, for example, sexual activity, but deny that it was offending behaviour, or minimise their offending to a significant degree. All names are pseudonyms, to preserve the anonymity of the offenders.

The first case study presented in Chapter 2 is focused on the case of Mr Huy, a 47-year-old man convicted of sexual offences against adolescent female children, who was on a Community Based Order. This case presented as a challenge, not only due to his categorical denial of offending, but also due to his South East Asian cultural origin and how cultural and family further perpetuated his denial of offending. This case was selected as it illustrates how denial may function on a level related to shame, especially when family and cultural factors are pertinent.

The second case study presented in Chapter 3 is focused on the case of Mr Alessi, a 62-year-old man convicted of numerous sexual offences against his step-grandchildren, who was serving his sentence in prison. There were some similarities in this case to that of Mr Huy, given the apparent role of cultural and family factors in perpetuating denial. However, of interest was Mr Alessi’s presentation in group based treatment and his level of engagement throughout the treatment process. This case illustrates the importance of shame in sustaining denial and further, in preventing sufficient treatment gains.
The third case study presented in Chapter 4 is focused on the case of Mr Bevan, a 38-year-old man convicted of offences relating to the possession of Child Pornography, who had received a Community Based Order. This case was selected due to the nature of Mr Bevan’s denial, which tended to be grounded in a theory that he had been “set up” by friends. Additionally, of interest was his resistance to treatment and difficulties in planning for his future.

The final case is presented in Chapter 5. This case study is focused on the case of Mr Morgan, a 27-year-old male convicted of rape, who was serving his sentence in prison. This case was selected due to this offender’s complex presentation, whereby he would oscillate between admitting responsibility and denial consistently throughout treatment. This presented challenges in regards to his treatment and engagement in the treatment process.

The final chapter in this thesis provides a summary of the issues highlighted and examined through the case studies, and considers the difficulties faced by treating clinicians and the implications of the treatment methods utilised. Please see Appendix A for an overview of the key elements of the group based program used in the treatment of the offenders presented in this thesis.
Chapter 2: Mr Huy

2.1 Summary of the Presentation and Treatment of Mr Huy

Name: Mr Huy

Date of Birth: 1962
Age: 47 years old

Purpose of Report

This report is designed to describe the overall participation and progress of Mr Huy in a group-based treatment program and provide an outline of recommendations for him.

Sources of Information

- Perusal of relevant correctional files, including the Victorian/National Criminal History Report (dated 2008), Suspended Sentence Order (dated 2008), and Community Based Order (dated 2008).
- Administration of Static-99.
- Clinical case notes regarding participation in group-based treatment.

Order Details:

Suspended Sentence & Community Based Order

Order start: 2008
Order End: 2010

1 Note that all identifying information reported in this chapter regarding clients, professionals, and agencies has been altered to protect the identity of the individuals and organizations involved.
Offence Details:

According to the Suspended Sentence Order (dated 2008) and Community Based Order (dated 2008), Mr Huy was convicted of 6 counts of Indecent Act with Child Under 16; 3 counts of Offer Agreement Child Sex Service; and 6 counts of Indecent Assault. The victims were five of his former employees who were young females aged between 14 and 18 years. The offences involved hugging the victims, and slapping, squeezing, and grabbing their buttocks and breasts, rubbing his penis against the victims’ bodies, and offering money in exchange for sexual services.

Sexual Offence History and Sentence History

The index offence constitutes Mr Huy’s only episode of sexual offending. He has no prior sentencing history relating to sexual and non-sexual offences.

Actuarial Risk Assessment:

Mr Huy’s risk of sexual re-offending was assessed using an actuarial risk assessment instrument, the Static-99. The Static-99 is an instrument designed to assist in the prediction of sexual and violent recidivism for sexual offenders. The test was developed by Hanson and Thornton (1999) based on follow-up studies from Canada and the United Kingdom with a total sample size of 1,301 sexual offenders. The Static-99 consists of 10 items and produces estimates of future risk based on a number of risk factors present in any one individual. The risk factors included are the presence of prior sexual offences, having committed a current non-sexual violent offence, having a history of non-sexual violence, the number of previous sentencing dates, age less than
25 years, having male victims, having never lived with an intimate partner for two continuous years, having a history of non-contact sexual offences, having unrelated victims, and having stranger victims.

The recidivism estimates provided by the Static-99 are group estimates based on reconvictions, and are derived from groups of individuals with these characteristics. As such, these estimates do not directly correspond to the risk of recidivism of an individual offender. An individual offender’s risk may be higher or lower than the probabilities estimated in the Static-99, depending on the presence or absence of other risk factors not measured by this instrument (for example, dynamic or changeable risk factors).

Based on the Static-99, Mr Huy is placed in the moderate-low risk category relative to other male sexual offenders. Based on his assessed static level of risk, Mr Huy was found to be eligible for a group-based treatment program.

Program Details

The program utilised is a group-based intervention designed to target sexual offending behaviour. It is based on international best-practice principles and has the capacity to be individualised to the needs of each participant. The program offers practical ways of understanding offending, including helping participants admit more fully what they have done, helping them take responsibility for their offences, and providing them with practical ways in which to tackle these problems.
Attendance

Mr Huy attended weekly sessions of the program from early 2009 – mid 2009, attending 26 sessions in total. Overall, his attendance and participation was satisfactory as determined by the treating clinicians.

Treatment Progress:

General Progress

Mr Huy initially presented as motivated to engage in group treatment (e.g. he reported that he believed he could learn something from the program that would assist him to obtain a better life), though appeared anxious during the initial stages of treatment. He was able to articulate feelings of fear and anxiety during this time, and furthermore, when these feelings alleviated. This was likely related to adjustment to the group environment. Communication with his Community Corrections Officer indicated that in the early stages of treatment Mr Huy consistently reported that he was only attending group to comply with his order. Over time, Mr Huy developed motivation to view the program as an opportunity to learn and to understand his problems. By the conclusion of treatment, Mr Huy reported feeling very comfortable in the group, and that he would miss attending sessions once exited. Generally, Mr Huy’s level of participation throughout the program was minimal, however, he contributed when prompted or asked directly for input. Given this, and his identified language difficulties, often his level of understanding of program concepts was uncertain.

Of particular note was that Mr Huy initially presented with language difficulties, which persisted throughout the program. His English language was difficult
to understand at times. However, he generally appeared open to requests for clarification and was additionally willing to seek clarification for questions or directions he did not understand. Mr Huy did not complete the psychometric test battery ordinarily administered pre- and post-treatment due to language difficulties, given he would have been unable to adequately understand the tests or the test instructions, potentially rendering invalid results.

Mr Huy generally presented with a positive attitude regarding his life, despite conditions placed on him as part of his order, and in the early stages of treatment, being separated from his wife and children as a result of a community services agency intervention. As such, it appears Mr Huy was able to focus on what he could do within his restraints, rather than focusing on what he could not do as a result of his conviction and conditions.

At times throughout treatment, it appeared that Mr Huy tended to utilise a somewhat passive communication style. As he progressed through treatment, Mr Huy developed and demonstrated an ability to communicate assertively within the group context, when required. For example, toward the conclusion of treatment, he was able to assertively voice his opinions regarding other group members inappropriately discussing topics of a sexual nature in the facility foyer. He was able to outline how this made him feel and what he would like them to do differently.

Mr Huy appeared to develop an adequate understanding of the cognitive behavioural model of thoughts, feelings, and behaviours and their interaction. He was able to articulate an intellectual understanding and talk through the relationship of thoughts, feelings, and behaviours. However, his ability to implement these concepts in
his daily life remains uncertain. Although towards the conclusion of treatment, Mr Huy demonstrated an understanding of the model, his understanding tended to remain dependent on assistance from the group. This apparent lack of behavioural consolidation and understanding may also relate to his identified language difficulties. In order to ensure Mr Huy works to reduce his level of risk, it would be worthwhile for him to continue to revise the concepts of the model discussed in treatment, and to revise where he can apply these in his daily life.

Offence Specific Progress

Mr Huy denied engaging in offending behaviour throughout the duration of treatment, with a tendency towards minimising the offences against all victims, engaging in a level of victim blaming. This was consistent across both the treatment context and the correctional context, according to communications with staff at other agencies. He initially disclosed that the offending “suddenly happened” and that he was “helping street kids [by allowing them to work in his shop] and giving them a hug to say hello.” He further reported that the “street kids” brought their friends to Mr Huy’s shop and were “bad” (allegedly stole money and threatened the safety of customers). During a disclosure later in treatment, Mr Huy reported that he had allegedly touched five young females who were employed under him. Although he continued to maintain his innocence, by this stage, he indicated that the victims may have perceived his “hugging” as offensive. By this stage of treatment, although denying offending, Mr Huy claimed responsibility for his inappropriate behaviour. It appeared at this stage that Mr Huy had reflected upon feedback given to him during his offence process work,
and further reported that he was continuing to reflect on why he behaved in an inappropriate manner and how this behaviour impacted upon the victims.

During his presentations in group around his life history, Mr Huy described traumatic experiences of war in South East Asia and separation from his family while a young boy. He disclosed how his life changed when he was a young teenager when a political regime assumed power. He described this as a very scary time, disclosing traumatic memories such as when his father had a gun held to his head. He disclosed the fear in having to relocate immediately to the country and having family members killed in the war because they were educated. Throughout disclosing his life story, Mr Huy continually reiterated how “lucky” he was – that he was not separated from his parents for “too long,” that the village he lived in experienced “less violence” than some others did, and that his father nearly died of starvation (but survived). He described these experiences as being in “a dark zone...I didn’t know anything.” From these experiences, the group was able to assist Mr Huy to identify core beliefs relating to the world as an unsafe and dangerous place, a lack of trust in other people, and a belief that other people control his destiny. Following discussing his life story, Mr Huy presented as emotionally distressed, noting that he had not discussed his life in such detail with anyone outside of his family. At times throughout his life story, Mr Huy tended to present with a positive impression, serving to uphold the family respect and name. This may have related to an increased sense of shame regarding his offending behaviour and may have further facilitated denial of offending.
Denial Behaviours

Given Mr Huy's high level of denial in regards to his offences, the offence process was presented as the process he took that enabled him to be accused of offending. During his offence process, Mr Huy initially presented as resistant to discuss any difficulties or anything of an adverse nature that may have contributed to placing himself in a position where he was accused and convicted of sexual offending behaviour. Eventually, he identified how the victims may have misinterpreted his behaviour (e.g. "hugging" them), and that this may have affected them adversely. He initially indicated that the background factors during the time leading up to the offences were unremarkable, and that he had a "happy life." Upon exploration, it appears Mr Huy may have been under a significant amount of stress and pressure during this time. He and his wife had just taken ownership of a business; he spent most of his time working, and there was not a lot of time for his wife and children (especially his wife). He further identified that culturally, it is not appropriate to discuss matters of a sexual nature. Cognitive distortions identified included feeling as though he was "friends" with the victims rather than their employer or boss, thoughts such as "I'm trying to get into the Australian culture," and "if we're friends, it will make work easier." To avoid future conviction, Mr Huy identified that he would refrain from "hugging" employees, set boundaries and maintain personal space, and further consider why he only behaved in this manner with female employees. Although Mr Huy continues to deny his offending behaviour, he is now able to take partial responsibility for how his behaviour may have been perceived by the victims. That is, although he denies any sexual
motivation, he acknowledges that his behaviour may have been perceived in that manner.

*Victim Empathy and Healthy Lifestyle*

Mr Huy articulated an understanding of the purpose of victim empathy exercises and articulated that (although he denies offending or responsibility in offending), that the alleged offences may have, and likely did impact upon his victims negatively. Mr Huy appeared to have an intellectual understanding of victim empathy and was able to articulate an adequate understanding of the short, medium, and long-term effects of abuse on victims, however, appeared to lack an emotional understanding. During a discussion about a victim empathy DVD, Mr Huy presented as somewhat judgmental. Some aspects of the content appeared to trigger a sensitivity, especially in relation to discussions of “sugar daddies” and successful men paying for young women. It may be that Mr Huy was able to relate this to his (offending) behaviour and offence process. It was observed that his language was much more difficult to understand during this session, which may have resulted from his emotional presentation and may have served to avoid discussing his thoughts and feelings around the victim empathy work.

Mr Huy identified predominantly realistic healthy lifestyle goals, and it appears he has discussed his plans with his wife and devised plans should obstacles become apparent. For example, if his health declines, he will be able to cease work, his wife can continue to work, or worst case scenario, they can sell the business and remain financially secure. His goals incorporate a work/life balance, focusing on remaining
gainfully employed but allocating time to spend with his wife and his children. He plans to continue to work on effective open communication with his wife and to allow time for recreational purposes, such as social events and gardening. He has discussed these plans with staff at other supportive agencies and a focus of sessions has reportedly been on planning for his future and risk management. Mr Huy may require continued support to identify potential obstacles to his goals and to assist in the development of realistic, achievable goals.

High Risk Factors and Identified Strategies

Mr Huy appeared to best understand the concept of high risk factors in the context of perception management and was able to reflect on relevant risk management strategies he was already utilising in his day to day life to avoid allegations. He reported that he is able to discuss these with other agency staff and behaviourally consolidates the strategies, such as ensuring he is supervised by a support person, such as his wife, when around others and especially children. In reviewing his high risk factors at the conclusion of treatment, Mr Huy requested and required significant assistance from the group to glean a complete list of high risk factors. High risk thoughts included “it will be ok,” “I’m not doing anything wrong,” “I’m just greeting them,” and “it’s ok because my wife is around.” The only high risk feeling he was able to identify was sadness. Strategies to mitigate his high risk factors included maintaining boundaries with employees; hiring older workers; not “hugging” staff members; ensuring he is supervised when in the presence of children under 16 years of age; ensuring an adult is always on shift with him at work; and internally challenging
cognitive distortions, for example “work is a safe place – not a place to hug people or be too close to people.”

Mr Huy appears to maintain a high level of fear around offending or being accused of offending, predominantly in relation to losing his family and “saving face” within his community. These appear to be a strong motivator for him to remain offence free, paired with a sufficient understanding of his high risk factors and risk management strategies. He is open to the continued use of strategies to contain or mitigate his risk of being accused of offending in the future.

Based on the above information regarding treatment, it is the author’s opinion that Mr Huy has contained his risk of sexual re-offending.

2.2 Outstanding Treatment Issues and Recommendations

It is recommended that Mr Huy maintain an active support and awareness group that can assist him in the early identification of his high risk factors (thoughts, feelings, behaviours, situations), and assist him to maintain his treatment gains and a healthy lifestyle. Should Mr Huy require additional support at any stage during his order, other agencies may request further consultation with the author.

It is further recommended that Mr Huy:

- Have no unsupervised contact with children under the age of 16 years, except as approved by the appropriate authorities.
- Have no direct or indirect contact with his victims or his victims’ families.
2.3 Discussion of Clinical Issues

The case of Mr Huy provided an example of a sexual offender who denies his offending. Table 2.1 reflects the aspects of denial Mr Huy presented with in relation to the categories of denial identified by Marshall and colleagues (2006). Throughout treatment, Mr Huy maintained that he did not commit any sexual offences. His accounts appeared consistent across agencies, however, he appeared to engage in a level of impression management and “saving face” both in relation to his offending behaviour and other important aspects of his life. For example, he neglected to inform treatment facilitators and the therapeutic group that he had been diagnosed as HIV positive. He discussed at times his “illness” in a vague manner, but tended to refer to it as though it was cancer. This, paired with his denial of his offending appeared to indicate the importance of “saving face” for Mr Huy in relation to his family, and his broader community. ‘Saving face’ is a particularly important social phenomenon in Asian culture. It further appeared demonstrative of his avoidance strategies that functioned for him in a self-protective manner throughout treatment.

Table 2.1 Categories of Denial for Mr Huy based on Marshall et al. (2006) Categories.

<table>
<thead>
<tr>
<th>COMPLETE DENIAL</th>
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</thead>
<tbody>
<tr>
<td>- False accusation</td>
</tr>
<tr>
<td>PARTIAL DENIAL</td>
</tr>
<tr>
<td>- “It was only hugging”</td>
</tr>
<tr>
<td>MINIMISATION</td>
</tr>
<tr>
<td>- Less intrusive than victim claimed</td>
</tr>
<tr>
<td>- Victims were “street kids”</td>
</tr>
<tr>
<td>DENIES PLANNING</td>
</tr>
<tr>
<td>- “It suddenly happened”</td>
</tr>
</tbody>
</table>
Of importance is that whilst Mr Huy was placed in a group of sexual offenders who were predominantly admitting their offences, as is current practice in Victoria, he was able to function appropriately and make treatment gains relating to factors that would assist him to reduce his risk of re-offending. During the initial stages of treatment, Mr Huy was encouraged to take responsibility for his offending; however, it became apparent that he would not allow himself to engage in such a process. As such, treatment was tailored differently to enable Mr Huy to explore the process he took in order to be accused and convicted of sexual offending. For example, in regards to the offence process or offence cycle work, Mr Huy was able successfully complete this work. However, instead of the offence being explored, the action of “hugging” young female employees was utilised. This was a behaviour that Mr Huy, after some time, admitted to engaging in. The “hugging” behaviour was explored in relation to how it may have been perceived by the young women, in addition to the background factors leading up to the behaviour, and the attitudes, and beliefs held by Mr Huy that enable him to engage in this behaviour. Through treatment, Mr Huy was able to learn skills related to assertive communication, appropriate behaviour with young people and children, how to manage how his behaviour may be perceived by others, perspective taking skills, and ways of living his life that reduce his risk of re-offending or being accused of offending behaviour in the future.

In summary, although Mr Huy did not make full admissions regarding his sexual offending behaviour, through treatment tailored to his needs he was able to engage in the treatment process and develop risk management strategies similar to those group members who admitted responsibility for their offending. By removing the
need to admit, and framing treatment in a way that addressed how he could avoid being accused of offending in the future, and how he was accused of offending in the first instance, it appeared to give Mr Huy the space to be more open and honest throughout the treatment process. It further appeared to reduce his level of resistance to treatment, and respected his cultural need to “save face,” whilst essentially engaging in the same treatment program and work as those offenders who admit their guilt. Overall, Mr Huy was able to meet treatment targets, address dynamic risk factors, and develop risk management strategies that appeared realistic and manageable in reducing his risk of future sexual offending behaviour. Table 2.2 summarises the treatment goals addressed by Mr Huy and any outstanding treatment needs.

Table 2.2 Treatment Goals Addressed, and Outstanding, for Mr Huy.

<table>
<thead>
<tr>
<th>Addressed During Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exploration of life history in order to identify problematic core beliefs</td>
</tr>
<tr>
<td>Identification of problematic core beliefs related to offending behaviour</td>
</tr>
<tr>
<td>Identification of factors leading to an accusation of sexual offending</td>
</tr>
<tr>
<td>Identification of problematic background factors to offending</td>
</tr>
<tr>
<td>Identification of problematic emotions and cognitive distortions related to offending</td>
</tr>
<tr>
<td>Development of an intellectual understanding of the effects of sexual abuse on victims</td>
</tr>
<tr>
<td>Development of appropriate risk management strategies to avoid future accusation</td>
</tr>
<tr>
<td>Identification of realistic future goals, steps and obstacles to goal achievement</td>
</tr>
<tr>
<td>Development of more adaptive emotional regulation and problem solving skills</td>
</tr>
<tr>
<td>Understanding and implementation of assertive communication skills</td>
</tr>
<tr>
<td>Understanding of healthy sexuality within intimate relationships</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outstanding Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acknowledgment of full responsibility in offending behaviour</td>
</tr>
<tr>
<td>Emotional understanding of empathy, and in particular, victim empathy</td>
</tr>
<tr>
<td>Identification of other significant problematic emotions</td>
</tr>
</tbody>
</table>
Chapter 3: Mr Alessi

3.1 Summary of the Presentation and Treatment of Mr Alessi

Name: Mr Alessi

Date of Birth: 1948

Age: 62 years old

Purpose of Report

This report is designed to describe the overall participation and progress of Mr Alessi in a group-based treatment program and provide an outline of recommendations for him.

Sources of Information

- Perusal of relevant correctional files, including the Victorian/National Criminal History Report (dated 2008), and the Judges Sentencing Comments (JSC; dated 2004).
- Administration of Static-99.
- Clinical case notes regarding participation in group-based treatment.

Order Details

Prison sentence

Aggregate Term: 7 years

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Note that all identifying information reported in this chapter regarding clients, professionals, and agencies has been altered to protect the identity of the individuals and organizations involved.
Offence Details:

Sexual Penetration of a Child Under 16 x 2 counts
Indecent Act with a Child Under 16 x 17 counts
Make Threat to Kill x 1 count
Indecent Act in Presence of Child Under 16 x 1 count

According to the Judges Sentencing Comments (JSC; dated 2004), Mr Alessi offended against his step-grandchildren, aged between five and eleven years of age. One victim was male, and four victims were female. Mr Alessi was convicted of touching the victims inappropriately and in turn having them touch him. The JSC referred to several incidents of the children holding and massaging cream into Mr Alessi’s penis. It was further proven that he twice penetrated his step-granddaughter’s vagina with his finger. These offences took place while Mr Alessi was caring for the children at his house, in the absence of his wife.

Sexual Offence History and Sentence History:

The index offence constitutes Mr Alessi’s only episode of sexual offending.

Actuarial Risk Assessment:

Mr Alessi’s risk of sexual re-offending was assessed using an actuarial risk assessment tool, the Static-99. The Static-99 is an instrument designed to assist in the prediction of sexual and violent recidivism for sexual offenders. The test was developed by Hanson and Thornton (1999) based on follow-up studies from Canada
and the United Kingdom with a total sample size of 1,301 sexual offenders. The Static-99 consists of 10 items and produces estimates of future risk based on a number of risk factors present in any one individual. The risk factors included are the presence of prior sexual offences, having committed a current non-sexual violent offence, having a history of non-sexual violence, the number of previous sentencing dates, age less than 25 years, having male victims, having never lived with an intimate partner for two continuous years, having a history of non-contact sexual offences, having unrelated victims, and having stranger victims.

The recidivism estimates provided by the Static-99 are group estimates based on reconvictions, and are derived from groups of individuals with these characteristics. As such, these estimates do not directly correspond to the risk of recidivism of an individual offender. An individual offender’s risk may be higher or lower than the probabilities estimate in the Static-99, depending on the presence or absence of other risk factors not measure by this instrument (for example, dynamic or changeable risk factors).

Based on the Static-99, Mr Alessi is placed in the moderate to high risk category relative to other male sexual offenders. Based on his assessed static level of risk, Mr Alessi was found to be eligible for a group-based treatment program.

*Program Details*

The program utilised is a group-based intervention designed to target sexual offending behaviour. It is based on international best-practice principles and has the capacity to be individualised to the needs of each participant. The program offers
practical ways of understanding offending, including helping participants admit more fully what they have done, helping them take responsibility for their offences, and providing them with practical ways in which to tackle these problems.

Attendance

Mr Alessi attended twice-weekly sessions of the group-based treatment program from January to August. He participated in 54 sessions, each session being three hours in duration. Overall, his attendance and participation was of a satisfactory standard, as clinically determined by treating clinicians. However, he required considerable prompting to contribute to group discussions.

Treatment Progress:

General Progress

Mr Alessi presented as a quiet group member throughout the program. Initially, he appeared anxious within the group context; however, he was able to settle in to the group over time. He presented himself as a “helpful” or “good” group member, especially to the group facilitators, and appeared on the surface to be a cooperative and motivated group member. However, the manner in which Mr Alessi presented appeared to be an attempt to manage his impression in a positive manner, to convince the other group members and facilitators that he did not commit the offences of which he was convicted. His motivation appeared more related to parole than to reducing his risk of re-offending. It further appeared that Mr Alessi viewed himself as an “advice-giver” within the group, rather than an “advice-receiver.” Initially, the group did not challenge
this image. However, throughout the program, group members began to challenge Mr Alessi, and his projected image on an advice giver gradually began to break down, resulting in him being more receptive to feedback.

Throughout the first half of the program (approximately three and a half months), Mr Alessi’s participation was limited. He tended to remain silent throughout group discussions and was resistant to participating in some activities that he indicated he “could not do.” This avoidance was indicative of a more general passive/avoidant coping style, which was especially evident throughout group activities and interaction with prison officers. Mr Alessi was able to acknowledge that in the past he would withdraw or ignore problems and negative emotions. With assistance from the group, he was able to brainstorm more adaptive strategies to problem solve and cope with negative emotions, for example, by communicating with his family. While Mr Alessi continued to present with a tendency to avoid negative emotionality, after several sessions, he was eventually able to demonstrate behaviour change by seeking out external support when he was experiencing sleeping difficulties associated with witnessing an incident in prison. It remains uncertain as to whether this behaviour change would extend to other problems that did not interfere with Mr Alessi’s level of functioning.

In general, Mr Alessi appeared engaged and listening during group discussions, evidenced by his body language and his ability to relate to others’ contributions when requested. At other times, however, Mr Alessi appeared disengaged throughout group discussions and would state that he was distracted by family difficulties in the community. Despite encouragement and suggestions from other group members, at
times Mr Alessi appeared unable to reengage in sessions, which may be evidence of a
general tendency towards ruminating on negative events. Mr Alessi would benefit from
continued work to develop adaptive ways to manage negative emotions, rather than
ruminating.

Mr Alessi’s participation was challenged by other group members, as when addressed; he appeared surprised that his participation level was perceived to be limited. Following feedback, Mr Alessi did appear to challenge himself in regards to his level of participation, especially in terms of his spontaneous contributions and level of engagement. However, he required considerable prompting throughout the program, especially in relation to offence-specific activities. Mr Alessi’s need for prompting may be related to an overall passive style of communication. While Mr Alessi would frown or shake his head, indicating non-verbally that he had a difference of opinion with others’ contributions, he would not verbalise his opinion unless specifically requested. Mr Alessi would benefit from continued exploration of the benefits of assertive communication, as while he demonstrated insight into his lack of assertive communication, he appeared ambivalent regarding change.

At times throughout treatment, it appeared Mr Alessi did not understand the concepts presented during group sessions, as demonstrated by contributions that did not relate to the topic of discussion, or a failure to follow the directions of a task. Mr Alessi’s level of understanding was challenged by others in the group, and he reassured them that he understood the concepts. However, given Mr Alessi’s limited participation during sessions, it was difficult to further assess his level of understanding. However, when challenged, (for example, asked to explain the topic of discussion and what group
members had said), it appeared that Mr Alessi was following discussions. It remained unclear whether Mr Alessi’s difficulty with some group concepts and activities was due to language difficulties or a general unwillingness to listen and process the concepts presented.

Mr Alessi denied his offending behaviour throughout treatment. When discussing his offence, he presented as evasive and vague and would deviate from questions being asked. His contributions appeared inconsistent throughout the program, and his level of responsibility-taking varied. Mr Alessi reported that he did not know what he had been convicted of, and gave details considerable inconsistent with the Judges Sentencing Comments and other official file information. At times, it appeared Mr Alessi used his language difficulties to avoid answering questions asked of him. His unwillingness to discuss information was not limited to his offending behaviour.

Overall, Mr Alessi was vague when discussing personal information, unless discussing events where he was presented as “helpful” and a “good” person. When he did discuss personal information with the group, the information appeared to be presented in an overly favourable manner, providing further evidence of his tendency to avoid negative events and emotions.

Offence Specific Progress

Due to Mr Alessi’s denial and failure to discuss personal information and offending behaviour, his dynamic risk factors remain relatively unknown. Based on the information gathered during treatment, Mr Alessi’s treatment targets included
emotional regulation, communication skills, problem solving skills, and addressing beliefs indicative of entitlement.

During activities designed to explore the factors that contributed to his offending, Mr Alessi continued to present himself as a victim of false allegations, who was incapable of hurting his victims. Mr Alessi was asked by group facilitators to explore the behaviour that had enabled him to be convicted of sexual offences. Mr Alessi was open to this feedback, and with considerable assistance, was able to identify beliefs, in addition to problematic thoughts, feelings, and behaviours that placed him in a position where he was seen to behave in a sexually inappropriate manner. At times, Mr Alessi stated that he had engaged in affectionate behaviour with the victims (such as hugs and the victims sitting on his lap). He acknowledged that his “affectionate” behaviour was driven by wanting to help and care for his victims. He further identified that he would fantasise about receiving their affection in return. Mr Alessi reported that these thoughts made him feel happy, loved, and respected.

Through challenging from the group, Mr Alessi was able to acknowledge that at the time of the offences he had been feeling sad, unnoticed, powerless, angry and confused within his family. Exploration of his earlier life experiences revealed that Mr Alessi had observed a culture where adult men were “leaders” within the family and where women and children were obedient and showed men respect. As such, it appeared that Mr Alessi developed a belief that he was the “head of [his] family” and that “what [he] say[s] goes.” Mr Alessi reported that at the time of his offending, he was experiencing the aforementioned negative emotions, feeling that he was not being listened to within his family. It is possible that Mr Alessi offended against his victims
as a means of regaining feelings of love, respect, and power within his family. However, he was unable to demonstrate insight into the function of his offences.

While Mr Alessi was able to identify factors that contributed to him placing himself in a position where he was convicted of sexual offences, it appeared that this knowledge and insight was not retained through the program. When asked to discuss his offending behaviour as a process, he was unable to articulate how the factors identified contributed to his offending. Despite limited insight into his offending behaviour, Mr Alessi seemed to accept that measures had to be taken in the future to ensure he did not find himself in a similar situation where he could convicted of a sexual offence.

Through group activities and discussion, Mr Alessi demonstrated a basis understanding of the effects of sexual assault on victims and appeared able to apply this to his own victims. Mr Alessi acknowledged that he may have accidentally behaved in a manner that had caused pain, hurt or anger to his victims, however, that he had not intended this harm. Mr Alessi’s ability to take his victims’ perspective and acknowledge potential negative effects of his behaviour demonstrated some level of empathy. However, this insight was variable throughout treatment Mr Alessi’s denial of harm to his victims fluctuated throughout the program. It remained unclear whether Mr Alessi believed he could have caused harm to his victims or whether he was engaging in impression management.

Through exploration of his earlier life experiences, it became apparent that much of Mr Alessi’s identity was comprised of being a helpful and caring person, whose responsibility was to look after the family. Mr Alessi’s offending behaviour was
at odds with this identity, and as result, he may have experienced difficulties incorporating his offending behaviour into his identity. It appeared that Mr Alessi’s denial and unwillingness to discuss and explore his offending behaviour was due to a level of shame and associated emotions. Mr Alessi would require assistance in incorporating his offending behaviour into his identity, as well as support in developing more adaptive strategies to cope with negative emotions before he will be able to continue to explore his offending behaviour.

Toward the end of the program, Mr Alessi demonstrated an understanding of the importance of leading a balanced life, and identified a variety of areas that would be included in his healthy lifestyle. These included relationships with family, friends, and intimate partners, and recreational activities. However, many of Mr Alessi’s identified recreational interests may not be appropriate, given they would bring him into contact with children. Mr Alessi demonstrated insight into the inappropriateness of these activities, however, would require support in generating activities that would be more appropriate. Mr Alessi was further given the opportunity to explore his future goals, however, the goals appeared vague and predominantly related to supporting his family. Further work is required to assist Mr Alessi develop specific strategies for goal achievement, and to seek external support that would be available to assist him in this. Mr Alessi would further benefit from broadening his social supports, given his current supports consist primarily of family.
High Risk Factors

The high risk factors identified by Mr Alessi in treatment included: being alone with children, associating with negative people (however, it remains unclear what Mr Alessi meant by “negative people” and how this related to his offending behaviour), thoughts such as “I feel sorry for them so I want to make them happy,” “I want to make them feel loved,” and “I’m trying to help” in relation to children.

Additional high risk factors were identified throughout treatment for Mr Alessi by treating clinicians. These included: using avoidant coping strategies to cope with negative emotions, such as feeling unloved, frustrated, powerless, unsettled, and stress; other general self-regulation deficits, including poor cognitive problem solving skills and assertive communication skills; and attitudes supportive of sexual assault, including the attitude that children and females should follow instructions, indicative of a sense of entitlement.

Due to Mr Alessi’s continued denial of his offending behaviour and limited ability or unwillingness to explore the factors that contributed to his offending behaviour, other dynamic risk factors may be relevant, however, remain unknown.

Identified Strategies

The following risk management strategies were identified by Mr Alessi during treatment to manage his identified high risk factors:

- Self-talk and solving the problem himself. However, Mr Alessi was unable to articulate the self-talk he would utilise to do this.
- Not helping other people, aside from his family.
- Talk to family members when experiencing a problem.
- Ensure that contact with children is supervised. However, Mr Alessi was unable to identify strategies to ensure he would be supervised.

Mr Alessi required considerable prompting and challenging from the group to identify the high risk factors and risk management strategies outlined above. Additionally, Mr Alessi’s risk management strategies identified at the end of treatment remained vague and he continued to present as ambivalent about ensuring he have no contact with children, as well as “helping” others, including his victims. Mr Alessi will need to continue to review the high risk thoughts, feelings, and behaviours identified, in addition to developing specific risk management strategies to mitigate high risk factors. Further, Mr Alessi may benefit from parole conditions to have no direct or indirect contact with his victims.

Based on the above information, it the treating clinician’s opinion that Mr Alessi has demonstrated sufficient insight to suggest he could, with the appropriate social and clinical support (see recommendations below), contain his risk of sexual re-offending.

3.2 Outstanding Treatment Issues and Recommendations

Mr Alessi completed the group-based treatment program, however, due to his continued denial and resistance, he has demonstrated a basic or limited awareness and understanding surrounding his offending behaviour. Table While Mr Alessi remains in denial, he does appear to have acknowledged that he may have unintentionally caused
harm to his victims, and that he needs to ensure he does not place himself in a similar situation in the future. Below are a list of areas in which Mr Alessi would benefit from continued support and exploration:

- Difficulties surrounding shame and identity. Mr Alessi may need to address the shame surrounding his offending behaviour and how to incorporate his behaviour into his identity to be better able to explore his offending.
- Assertive communication skills.
- Emotional regulation skills, including developing adaptive ways to cope with emotions. For example, seeking external help when required.
- Developing age-appropriate and positive peer influences.
- Further develop insight into his high risk factors and risk management strategies.
- Developing more specific strategies to achieve goals.

In order to continue to explore and address the above, it is further recommended that Mr Alessi:

- Maintain and utilise an active Support and Awareness Group.
- Participate in a maintenance program post-release.
- Source professional support to further explore shame, identity and emotional regulation deficits.
- Engage in individual counselling with a private psychologist to further explore offending behaviour, once issues of shame have been addressed.
• Receive support in relation to increasing positive age-appropriate peer networks.
• Have no unsupervised contact with children under the age of 16 years, except as approved by the appropriate authorities.
• Have no direct or indirect contact with his victims or their families.

3.3 Discussion of Clinical Issues

The case of Mr Alessi provided a complex case example of a sexual offender who denies his offending, and despite tailoring treatment to better meet his needs, continued to persist with significant resistance throughout the treatment process. Table 3.1 summarises the categories of denial identified by Marshall et al. (2006). Mr Alessi presented with during treatment. Throughout treatment, Mr Alessi predominately evaded discussing his convictions, and would provide inconsistent accounts of what he believed he had been convicted of. When challenged, Mr Alessi tended to become defensive, which may be related to his self-identity whereby he feels he should be the advice-giver and not the advice-receiver. He further appeared to use his language difficulties (English as a second language) as means of presenting as vague, and disengaging further from the treatment process. This proved difficult to assess and address, given he tended to deny engaging in any such behaviour.
Table 3.1 Categories of Denial for Mr Alessi based on Marshall et al. (2006)

Categories.

<table>
<thead>
<tr>
<th>COMPLETE DENIAL</th>
<th>PARTIAL DENIAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>- False accusation</td>
<td></td>
</tr>
<tr>
<td>- “Victims’ mother is out to get me”</td>
<td></td>
</tr>
<tr>
<td>- Denied having a problem or that he needed treatment</td>
<td></td>
</tr>
</tbody>
</table>

Mr Alessi, as with other offenders who deny or minimise their offences or aspects of their offending, was placed in a group of sexual offenders who were predominantly admitting their offending behaviour. Although he was not overtly resistant, such as in the case of Mr Morgan, it became evident throughout treatment that the group, and treating clinicians, really knew nothing about Mr Alessi in regards to his offending behaviour, dynamic risk factors, and other treatment targets. Despite numerous attempts and ongoing feedback, Mr Alessi continued to present as evasive and would not reveal anything he may have perceived as negative to the group or treating clinicians.

Mr Alessi categorically denied engaging in offending behaviour. Although he was able to shift his thinking at times throughout the program, such as considering that the victims perceived his affection to be abusive, he insisted that he had been “set up” by a friend of the family. His account of the events was considerably inconsistent with official court documents, such as the Judges Sentencing Comments, to the level where he denied that he had step-grandchildren. Further, framing the offence specific work, such as the offence process or cycle in a manner in which detracts from the behaviour
itself and focused more on how he placed himself in a position whereby he was accused and convicted of offending. Mr Alessi seemed to make limited sustainable progress, tending to regress quickly to categorical denial. In the court process, Mr Alessi had been found guilty at two trials with juries, and had had two appeals of sentence and conviction denied. However, he refused to believe that anyone could believe he would engage in inappropriate behaviours with children. It was suggested that even through his contact with the criminal justice system, numerous people had believed he was guilty, and that it would be beneficial to explore his behaviour in the sense that he behaved in a manner whereby many people believed him to be capable of sexual offending, so as to develop strategies to avoid future allegations. With other offenders, framing the offence-specific work in this manner has given them the emotional space to explore their problematic behaviour, whether that behaviour is offending or not.

As addressed in the summary of treatment, Mr Alessi identified, with significant assistance, that he would need to be supervised around children in the future in order to protect himself from allegations. However, he appeared unable to generate activities he could engage in, in the community that did not involve children in some respect. Further, despite several discussions around the inappropriateness of living with family members who have children or grandchildren, and that it would most likely be a condition of his parole that he not have contact with children, unless with authorisation, Mr Alessi repeatedly described that children would be a part of his life in the future, and that he was at “no risk” of offending or being accused of offending, because his family and friends “know [him].” As such, it appeared that Mr Alessi continued to
engage in denial not only of his offending behaviour, but of the consequences and restrictions he would face as a result of having sexual offence convictions. It appeared that Mr Alessi possessed a high level of shame that may have been preventing him from confronting the realities he will face upon release into the community, in addition to the offending behaviour itself.

In summary, although treatment was tailored to better meet the needs of Mr Alessi, given his categorical denial, he continued to present as evasive and resistant to treatment. His commitment to denial of the offences and denial of the consequences may have prevented him from further exploring problematic aspects of his behaviour, and the precursors to his behaviour in a more open and honest way. Mr Alessi was able to meet some treatment targets; however, given his resistance and limited engagement in treatment, his dynamic risk factors remain unknown. As such, the strategies he developed to manage his risk also remain unknown in regards to their effectiveness. It was recommended that Mr Alessi address issues of shame and guilt prior to re-engaging in offence-specific treatment in the future. As illustrated in the summary of treatment report, as a result of his continued categorical denial, Mr Alessi will require significant support and professional assistance to manage his future risk of sexual recidivism. Table 3.2 summarises the treatment goals addressed during treatment, in addition to any outstanding issues.
Table 3.2 Treatment Goals Addressed, and Outstanding, for Mr Alessi.

ADDRESSED DURING TREATMENT

Exploration of life history in order to identify problematic core beliefs
Identification of problematic core beliefs related to offending behaviour
Identification of problematic emotions and cognitive distortions related to offending
Development of an intellectual understanding of the effects of sexual abuse on victims
Exploration of more adaptive emotional regulation and problem solving skills

OUTSTANDING ISSUES

Acknowledgment of full responsibility in offending behaviour
Shame around convictions of sexual offences
Identification of problematic background factors to offending
Identification of factors leading to an accusation of sexual offending
Emotional understanding of empathy, and in particular, victim empathy
Development of appropriate risk management strategies to avoid future accusation
Motivation to implement appropriate risk management strategies
Motivation to abide by possible parole conditions, such as no access with children
Identification of realistic future goals, steps and obstacles to goal achievement
Understanding and implementation of assertive communication skills
Development of more adaptive emotional regulation skills
Development of age appropriate peer supports
Chapter 4: Mr Bevan

4.1 Summary of the Assessment, Presentation and Treatment of Mr Bevan

Name: Mr Bevan

Date of Birth: 1971

Age: 38 years old

Purpose of Report(s)

This report is designed to describe the overall participation and progress of Mr Bevan in a group-based treatment program and provide an outline of recommendations for him.

Additionally, due to the nature of Mr Bevan’s offence, namely Child Pornography offences, with no history of any contact sexual offences, Mr Bevan’s dynamic (changeable) risk factors were considered as a means of determining his eligibility for the treatment program.

As such, this report is divided into two sections. The first section comprises a report of a clinical assessment conducted with Mr Bevan. The second section outlines his participation and progress in group-based treatment.

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1 Note that all identifying information reported in this chapter regarding clients, professionals, and agencies has been altered to protect the identity of the individuals and organizations involved.
4.2 Assessment Report Section

Purpose of Report

This section is a summary of the clinical assessment that was conducted for Mr Bevan by the treatment provider. The assessment process assists in the determination of an offender’s treatment needs and suitability for treatment programs.

Sources of Information

- Clinical interview with Mr Bevan (dated 2008)
- Perusal of relevant correctional files, including: Court report on Mr Bevan (dated 2008), Community Based Order (dated 2008), Criminal History Report (dated 2008), Summary of Offences (dated 2008), Pre-sentence report (dated 2008), letter for a solicitor from a doctor (dated 2008), community services’ treating doctor’s report (dated 2005).

Order Details

Community Based Order

Order Start: 2008

Order End: 2009

Presentation

Mr Bevan presented as willing to discuss issues unrelated to his offending behaviour. He consistently denied his offences throughout the interview. He initially presented as uncomfortable, with sweat on his forehead, which visibly decreased as the
interview progressed. At times he engaged in inappropriate social giggling/laughter, in particular, when discussing his acquaintances.

**Current Offence Details**

According to the Community Based Order (dated 2008), Mr Bevan was convicted of one count of Knowingly Possess Child Pornography in relation to offences from 2006 to 2007; and one count of Make/Produce Child Pornography from 2006 to 2007.

The Summary of Offences (dated 2008) indicates that 20 clips were found on his DVDs and hard drives. These clips contained images depicting adult males and females engaging children of both genders in sexual penetration. It was reported that the children appeared to between the ages of four, and 14 years of age. 181 images of pre-pubescent males and females were also found stored on his hard drive.

**Self Report of Current Offence**

Mr Bevan denied knowing the images and clips were on his computers and DVDs. He informed the author that he had set his DVD burner to burn movies, that “ended up” being pornography, and referred to his computer as “having problems.” He maintained this stance throughout the interview, later suggesting that “someone else” could have had access to his computer. When asked about what the court had reported about the content (degree) of the images, Mr Bevan stated that he “did not know.” Krone (2005) suggests five categories of child pornography, where level 1 reflects images such as posing with no sexual activity to level 5 reflecting child pornography
containing sadism or bestiality. The Summary of Offence (dated 2008) indicated that the images included sexual penetration between adults and children, which is reflective of a level 4 or 5 on Krone’s typologies (Krone, 2005).

*Sexual Offence History*

The index offence constitutes Mr Bevan’s only episode of sexual offending.

*Sentence History*

Mr Bevan has prior convictions for the following: Handle/Receive/Dispose of Stolen Goods and Theft. The thefts related to the theft of computer parts from an employer, and money. These offences appeared opportunistic and impulsive in nature, from the account provided by Mr Bevan. He described his behaviour in a manner that minimised his responsibility in this offending, discussing how he was “supposed to have” committed the offences.

*Risk Assessment*

Due to the nature of Mr Bevan’s offences, an actuarial risk assessment was not conducted. Mr Bevan’s dynamic risk factors were considered. Dynamic risk factors are those factors that are related to sexual recidivism and are amenable to change. Hanson and Harris (2000) have identified several reliable dynamic factors that have been consistently related to sexual re-offending. Mr Bevan’s stable dynamic risk factors are considered in turn. Protective factors (dynamic factors that reduce or assist in containing risk) are also considered.
Stable Dynamic Risk Factors:

Significant Social Influences

Mr Bevan reported a limited social network and it appears that his relationships tend to be shallow in nature. He described three primary acquaintances, Shelley, Betty, and Peggy, who it appears contact Mr Bevan when they require his assistance to fix games or computers. Mr Bevan did report, however, social occasions where he spends time at their houses for “some drinks,” although noted that he does not consume alcohol. Mr Bevan indicated that his acquaintances “don’t hold anything against [him]” regarding the index offence. As such, it appears these peers may serve to minimise and collude with Mr Bevan in regards to his offending behaviour, with Mr Bevan reporting that one believes it was “circumstances,” another believes he was “set up” and the other is “reserving judgment.” He noted that if they believed he was guilty of the offences, they would sever ties with him, as they all have children. This may contribute to Mr Bevan’s level of denial of his offending.

Mr Bevan referred to a former acquaintance, John, with whom he co-resided. He reported that whilst they lived together, John “never listened to [him]” and that he felt ignored. He reported that he and John worked on computers and would donate them to children. Mr Bevan reported that John left him with significant debts. From his description of this friendship, it appeared that Mr Bevan has difficulties with assertive communication and appropriately communicating his needs.

Mr Bevan retains contact with his mother, though his description of the relationship indicates some strain. For example, when she was informed of his
offences, she did not speak to him for weeks due to being angry, upset, believing that he committed the offences.

*Intimacy Deficits*

Mr Bevan has a history of social isolation. He described his school years as lonely and was the subject of teasing and bullying. He lived out of the town, and did not spend time with friends or go to parties. He acknowledged that he has always spent time alone and does not know how to behave otherwise, especially in social situations, noting that he finds conversation difficult in company. Despite this, Mr Bevan described enjoying spending time with a group of his relatives at a holiday celebration and appears to seek out contact with acquaintances.

Mr Bevan reported one intimate relationship with a friend he met through his acquaintances. The relationship ended mutually after two months. He reported engaging in sexual intercourse toward the end of the relationship, but was unable to relay whether he found this to be a positive or negative experience. He was further unable to discuss the possibility of developing intimate relationships in the future.

It appears that Mr Bevan’s interest in computers lies in his difficulties in interacting with others. He reported that “computers don’t talk back,” and identified that computers are a strength for him, in that they enable him to work independently. He presented as enthusiastic and animated when discussing the challenges associated with fixing computers, searching for parts, and assisting friends with computer problems. Computers appear to provide an outlet for Mr Bevan to function at a higher level than he can socially. Given his social competency difficulties, viewing
pornography on the internet may enable him to meet his sexual needs in a way he would perceive as non-threatening. Given his tendency to rely on computers as a social outlet, it would be beneficial for him to be assisted to reduce his discomfort in developing social relationships.

According to the pre-sentence report (dated 2008), Mr Bevan was born prematurely and was hospitalised for some months. At 20 months, he entered foster care until his adoption at 24 months. This early disruption in primary care givers may have dislocated his way of attaching to others. It further appears that Mr Bevan has an avoidant personality style, whereby he is dismissive and fearful of attachment to others. His negative experiences with others and social discomfort may reinforce this style of attachment. Mr Bevan reported that his relationship with his mother has “not ever been good,” however stated that he had a closer relationship with his father, who passed away. He described missing his father, as he found him to be “easier to talk to.”

Sexual Self-Regulation

Mr Bevan reported a belief that he has a lower arousal level than other men, and thinks about sex twice per week. He reported accessing adult pornography on two or three occasions per week for one hour at night when he had trouble sleeping or when he was feeling bored. He reported some level of need for pornography as visual stimulation. Given Mr Bevan acknowledged his tendency to utilise adult pornography as means to alleviate boredom, it is possible that Mr Bevan uses adult pornography to cope with negative emotionality, however, he noted hat his level of arousal decreases when depressed.
Mr Bevan acknowledged accessing pornography depicting sexual activity between people and animals. He stated that he viewed these images with a friend to “see how people can be.” There are some unsubstantiated reports from police that Mr Bevan has engaged in sexually inappropriate behaviour with animals, however, this information should be considered with caution.

Despite conviction, Mr Bevan denies knowingly downloading and viewing child pornography. His current convictions, paired with concerns from police and correctional staff that he drives past primary schools may indicate an interest in children. Mr Bevan’s choices in books and films include salient choices for child-like content. Other content he owns includes themes of military, mystery, and adventure.

Given Mr Bevan’s difficulties in interacting with others, he may find the idea of interacting with children or child-like themes less intimidating; however, this requires further exploration in treatment. Furthermore, interacting sexually with impersonal images online would also appear less intimidating than interactions in an age-appropriate relationship.

General Self-Regulation

Mr Bevan reported being diagnosed with “moderate to severe” depression approximately five years ago, following a court evaluation. He has also retained a diagnosis of Schizoid Personality Disorder (SPD) (APA, 2000), as reported in court documents. When discussing the diagnosis of SPD, he identified that he has trouble expressing himself, connecting with others, forming “bonds” with others, and that he
has “always been a loner,” and has lost trust in other people, describing in particular his “best mate” who he believes reported his offences.

Mr Bevan described a limited employment history. He reported that he has applied for approximately 2000 jobs and from this received five interviews and three jobs. He demonstrated some ability to manage stressors appropriately, such as applying for a loan to repay debts, however, much of his financial pressure appears related to irresponsible behaviour, such as using the internet over the phone without an awareness of the cost, and he has further accrued the debts of friends, indicating that friends “took advantage” of him, without him intervening. As such, it appears that Mr Bevan utilised an avoidant style of coping with negative emotions. He further reported that if he is “having a bad day,” he will stay at home, watch a DVD, and read to escape the feelings.

Mr Bevan reported that he suffers from insomnia. He outlined his current strategies as watching television, reading, or playing on the computer. The latter is of particular concern, given he has identified that he has viewed pornography in these instances in the past.

Considering the dynamic risk factors outlined above, it appears the Mr Bevan currently presents at an overall moderate risk of sexual recidivism.

Recommendations

Treatment Targets – Offence Specific

- Self-worth: Mr Bevan’s sense of self-worth is predominantly derived from his skills relating to computers, rather than internal qualities.
• Deviant sexual interests: Despite his denial, file information and information from others indicates that Mr Bevan has a deviant sexual interest in children. Further, there is suggestion that he maintains sexual interest in animals. Mr Bevan should be provided the opportunity to disclose his sexual interests in a safe and secure therapeutic setting, and should be encouraged to consider prosocial sexual interests.

• By denying his offences, Mr Bevan’s understanding of potential high risks remains unclear. Introducing Mr Bevan to alternative means of meeting his needs, understanding his offence cycle, and high risk factors would provide him with greater skills in managing his problematic behaviour.

Treatment Targets – Offence Related

• Communication: Mr Bevan presents with a passive style of communication and conflict resolution, whereby he expresses his needs, they are ignored, and he tolerates the consequences, which has at times cost him significantly financially, and has further contributed to a poor sense of self worth.

• Problem-Solving: Mr Bevan would benefit from developing effective problem-solving techniques to assist him to better manage and cope with issues as they arise.

• Insomnia: Mr Bevan would benefit from education around healthy and adaptive strategies to manage his insomnia, which may assist him to avoid inappropriate behaviour. A referral to a local psychologist has been requested.
Other Relevant Factors

Although there were no formal assessments on file attesting to Mr Bevan’s diagnosis of SPD, the following domains exist may or co-exist as a component of Mr Bevan’s diagnosis of Schizoid Personality Disorder.

- Social isolation: Mr Bevan should be encouraged to engage in pro-social activities to increase the likelihood of positive human interaction. Whilst a diagnosis of SPD suggests a disregard for connectedness with others, during the interview, Mr Bevan demonstrated concern for the opinion of his acquaintances and concern for the potential loss of friendship.

- Difficulty interacting with others: Mr Bevan should be encouraged to practice engaging with others, through role-playing situations and conversations to practice appropriate communication. As such, group-based treatment is recommended to assist Mr Bevan in developing pro-social skills in a safe and non-judgmental environment.

4.3 Summary of Treatment

Sources of Information


- Clinical case notes regarding participation in group-based treatment.
Order Details:
Community Based Order
Order start:  2008
Order end:  2010

Program Details

The program utilised is a group-based intervention designed to target sexual offending behaviour. It is based on international best-practice principles and has the capacity to be individualised to the needs of each participant. The program offers practical ways of understanding offending, including helping participants admit more fully what they have done, helping them take responsibility for their offences, and providing them with practical ways in which to tackle these problems.

Attendance

Mr Bevan attended weekly sessions of the program from early 2009 – mid 2009, attending 26 sessions in total. Overall, his attendance and participation was satisfactory as determined by treating clinicians.

Treatment Progress:

General Progress

Mr Bevan presented as motivated to attend group treatment, but was resistant in engaging in elements of the program, and appeared to be attending due to the requirements of his order, rather than to address problematic behaviour. It was
reported by the corrections officer, that three months prior to Mr Bevan commencing treatment, that he had obtained pre-paid wireless broadband internet each month, to allegedly allow for the use of the internet for banking purposes, emailing, Centrelink, and some computer games. He was lawfully directed not to access pornography of any type on the internet, however, was allowed to access to legal pornography from, for example, an adult bookshop. Concerns were raised that he was accessing the internet without supervision. Although this was addressed in supervision sessions, Mr Bevan neglected to raise any of these concerns or issues in group treatment. When similar issues were addressed with other group members, he tended to collude, expressing beliefs that he required the internet for the above-mentioned purposes. He was unable to take on the perspective of others, and how accessing the internet may be a potential risk for him in regards to offending or being accused of offending. Mr Bevan would, at times, present as a victim, denying responsibility for what happened and continues to happen in his life. He generally presented with a somewhat negative attitude toward his life, and in particular, the conditions placed on him as part of his order. He tended to focus on what he was unable to do, and his perceived sense of unfairness of his situation, rather than on positive changes he could make in his life, despite the restrictions imposed on him. This may have contributed to what already appeared to be an avoidant style of coping in his life, and a tendency towards passive communication, whereby he would avoid conflict. As he progressed through treatment, Mr Bevan recognised the benefits of assertive communication, and appeared more able to use assertive communication within the group context.
Mr Bevan appeared to appease other group members, especially throughout the initial stages of treatment, tending to collude with negative or inappropriate beliefs and attitudes. He may have engaged in this behaviour to attract other group members to “like” or respect him within the group setting. He was observed to change his opinions throughout treatment to align with other group members. This type of behaviour was further observed when inappropriate contact between group members was discovered. Mr Bevan communicated with other group members, for example by text message, outside of sessions. This behaviour was addressed at the commencement of treatment, and was indicated in the “Group Rules” that contact outside of sessions was inappropriate. Mr Bevan, on one occasion, text messaged another group member to inform group facilitators that he would not be absent from the session on that day. The importance of perception management was discussed with Mr Bevan, which he appeared to understand.

Throughout treatment, Mr Bevan presented with an external locus of control, tending to place responsibility for not only his offending behaviour, but his general condition on others or on his psychiatric diagnoses. Mr Bevan used his diagnosis of Schizoid Personality Disorder as an explanation for a lack of participation in group activities, an unwillingness to receive and apply feedback about his behaviour, and for failing to implement general behaviour change in his life (for example, developing positive social supports). However, Mr Bevan appeared to develop rapport with the group and as treatment progresses, he was observed to participate in group discussions to a high level, and would communicate appropriately with other group members not only in sessions, but during break times in sessions. Despite denying a
desire for interpersonal relationships or communication, Mr Bevan behaviourally demonstrated that he was able to develop interpersonal relationships and communicate effectively within these. Mr Bevan appeared to have difficulties applying these skills beyond the group context, however. This may have related to a lack of motivation to develop interpersonal relationships, developed from a core belief that he was a "loner," or to a lack of confidence in approaching others due to communication and social competency deficits.

Mr Bevan developed an adequate intellectual understanding of the cognitive behavioural model of thoughts, feelings, and behaviours, and their interaction, although he appeared to find the practical application of these concepts difficult. For example, he was able to accurately verbalise his understanding of the interactions and links between thoughts, feelings, and behaviours. However, his apparent inability to practically apply the model in his life, and especially to his high risk factors, may be due to his level of motivation to change his behaviour, rather than a lack of practical understanding.

Offence Specific Progress

Mr Bevan denied engaging in offending behaviour throughout the duration of treatment. This presentation was consistent across both the treatment, and correctional supervision context, according to communications with supervising staff at the relevant agencies. Throughout treatment and during supervision sessions with his corrections officer, Mr Bevan maintained he was innocent of his offences and continued to attribute blame with "friends" who he reported had access to his
computers and house at the time of his arrest. In his disclosures in group sessions, he reported that he was confronted by police after a friend had informed them that Mr Bevan had child pornography in his possession, including movies and images. Police removed his computers and hard drives. Somewhat inappropriately, during disclosures, Mr Bevan laughed, indicating that he found it amusing that the police “had filled the whole van” because he had “so much equipment.” Throughout treatment, Mr Bevan did not recognise the impact of accessing child pornography on the victims, and although he maintained his innocence, also did not appear to understand the concept of the problematic nature of accessing child pornography in relation to perpetuating a cycle of abuse.

Mr Bevan presented his life history to the group. He described a long history of spending time alone, as both a child and an adult. He attributed this to, as a child, living on the “other side of town” to the children at his school. He used reading adventure, action, and science fiction novels as a means of both entertaining himself and “escaping.” During the life history, and generally throughout the program, Mr Bevan described himself as a “loner,” preferring to read books and escape “completely to a different world,” indicating he had a “good imagination.” He relayed that he was adopted by his parents, and they informed him of this when he was 14 years old. He indicated that he has never attempted to make contact with his biological parents, although noted that he could, should he wish to do so. He indicated that he chose not to, believing that it would impact negatively on his parents or “be a burden,” especially considering his convictions. He reported that he currently feels he is a burden to his mother. Although he described himself as someone who
preferred to be alone, Mr Bevan acknowledged that there have been times in his life when he wanted friendship, but felt physically or geographically isolated, especially during adolescence. He recalled that he found school to be hurtful place, where he was teased and bullied, but that he “got used to it” and “developed a thick skin.” He noted that he never reported the bullying, and tried to ignore it. This is consistent with Mr Bevan’s current avoidant style of coping. He informed the group that he “[didn’t] care what people [thought] of [him]” and prefers his own company. He further indicated that he believed change is “hard,” and that he does not like change, indicating a level of resistance to behaviour change relating to developing a support network and interpersonal relationships. The core beliefs Mr Bevan identified, with assistance from the group centred around him being a “loner” and being “different” from others. He further reported beliefs that other people cannot be trusted, and that they only deserve “one chance,” and that the world is “unknown” and unsafe. Given his core beliefs, Mr Bevan’s current presentation in regards to his sense of distrust for others, and preferring his own company, may have contributed to him spending time alone, utilising the internet as his primary means of entertainment and connection with the world. He further indicated during treatment that he feels “safer” being alone and consistently denied that he would be able to change his social circumstances, using excuses around living in a regional location and having financial constraints. Mr Bevan would benefit from developing age appropriate relationships to meet his social and entertainment needs, to minimise time spent on the internet and reduce his risk of re-offending.
Given Mr Bevan’s categorical denial of offending, his offence cycle work was focused on his problematic emotions and attitudes that could lead to poor impression and perception management, enabling him to be accused and convicted of a sexual offence. He described background factors such as living in a “hectic household” with high levels of conflict, and experiencing problematic emotions such as loneliness, boredom, anxiety and depression. He identified problematic thoughts related to his persistent avoidance of others and tendency and preference to spend time alone. In regards to fantasies, Mr Bevan prefaced discussions with maintaining that he was unaware that he had downloaded child pornography images and recorded these to a disc. He reported that he masturbated to pornographic images on his computer, rather than using other media such as a DVD. It further appears that his use of pornography and the internet may be a means of regulating his emotional states. He reported that he was “used” to masturbating to pornographic images on the computer, and that he did see one child pornography image and masturbated to this. He denied, however, that he had knowingly downloaded this image. He reported that his fantasy incorporated his wanting to be alone and his love of computers because they “can’t hurt [him].” Since his conviction, Mr Bevan indicated that he no longer downloads pornography and uses the internet primarily for emails and banking. He informed the group that he regularly reformats his hard drive to ensure there are no images on it, indicating some inconsistency with his statements that he uses the internet and his computer only for emails and banking purposes. He was challenged about the appropriateness of accessing the internet unsupervised at home in regards to
perception management, and also about the need to reformat the hard drive if he was not engaging in inappropriate behaviour.

Mr Bevan presented as reluctant to identify his risk factors, especially high risk behaviours and situations, and appeared to lack insight into his minimisation of his responsibility in his conviction. His accounts of the circumstances of the offending differed throughout treatment, for example, he disclosed later in treatment that “the tapes were at the back of [his] garage wall and [he] didn’t what was on the tapes until the police told [him],” versus his acknowledgment of finding one image on his computer and masturbating to it. He was able to acknowledge that he was responsible for his offending later in the program, though this appeared to relate more to his belief that he trusts others easily and can therefore, be taken advantage of.

Mr Bevan demonstrated an understanding of the short, medium, and long-term effects of sexual abuse on victims, through victim empathy exercises. Further, he was able to express some empathic reflections about the affects of abuse on a victim depicted on a DVD. However, Mr Bevan repeatedly relayed that the victim in the DVD was able to go to develop a healthy life for herself, and that the abuse “made her stronger.” Mr Bevan did not articulate an understanding of why thinking about victims in this way might be problematic. It is possible that Mr Bevan focused on the perceived positive element of the victim empathy work to avoid negative emotions experienced when confronted with the realities of the effects of sexual abuse on victims in general.

Mr Bevan identified healthy lifestyle goals that tended to rely heavily on finances. Further, in group discussions about his goals, he presented as highly
resistant to seeking employment, despite having qualifications in may trades (e.g. a truck licence, forklift licence). He reported that he only obtained these qualifications as “something to do,” rather than to seek employment. Mr Bevan acknowledged that his goals relied predominantly on finance, however, continued to generate reasons why he would be unable to seek employment. These reasons ranged from his diagnosis of Schizoid Personality Disorder; “I’m not an outdoors person;” “I’m depressed and anxious;” “my eyesight might get worse;” and “I’m on the disability pension.” He was challenged on these apparent excuses, and was encouraged to seek gainful employment, identifying a number of positives he may gain (e.g. financial security, reduced boredom, sense of purpose). He continued to present as somewhat helpless, with a sense of a lack of motivation to work towards goal achievement. The other goals Mr Bevan identified further required significant financial requirements (e.g. “get out of debt;” and a dream goal to “get an old bus and convert it to a mobile home and travel around the country,” re-engage in TAFE courses around computer programming), or tended not to have identified realistic steps to goal achievement. For example, he expressed an interest in re-connecting with his cousins, however, indicated a lack of motivation to do this, by expressing that he would allow the cousins to “make the first move.” Mr Bevan was encouraged to develop more realistic goals, strategies to overcome his apparent lack of motivation, and to identify appropriate steps to goal achievement. This was conveyed to his corrections officer upon Mr Bevan’s completion of the program. However, in communications with other agencies, despite encouragement to engage in the above, Mr Bevan neglected to develop adult relationships, indicated that he was unlikely to meet an intimate partner
due to his distrust of people, and maintained that he would have difficulties
developing close relationships as a result. Mr Bevan may benefit from motivational
interviewing techniques for him to work towards goal achievement. Should he be
unable to source employment or develop motivation to seek employment, it is likely
he would not be motivated to work towards his other healthy lifestyle goals.

**High Risk Factors and Identified Strategies**

Mr Bevan appeared to understand the concept of perception management in
regard to high risk factors, however, appeared unable to apply this to his own life.
This may relate to his tendency to externalise responsibility. He further continued to
have difficulties in distinguishing the difference between thoughts and feelings in
regards to high risk factors. Mr Bevan was able to identify high risk thoughts,
feelings, and behaviours, with assistance from the group. Mr Bevan’s identified
difficulties in emotional identification and expression may relate in part to the
(hypothesised) diagnosis of Schizoid Personality Disorder, which Mr Bevan
maintained was a contributing factors in his limited emotional range and disinterest in
exploring emotions. The identification of high risk factors and the application of high
risk management strategies were again framed in the context of avoiding future
allegations of sexual offending. High risk feelings identified included loneliness,
boredom, stress, anxiety, depression, and a “lack of emotions.” Strategies included
spending time with trusted friends/supports, watch DVDs, read, play computer games
(however, Mr Bevan was encouraged to communicate with others as a primary risk
management strategy for high risk feelings). High risk behaviours and situations
identified included accessing pornography of any type (reclusive behaviour), letting other people use his computer, and being with children unsupervised. Management strategies included not accessing pornography on the internet, avoid file-sharing programs, establishing and maintaining boundaries with friends (in relation to using his computer), see friends without their children present and discuss these plans with friends, and to practice and utilise assertive communication.

Mr Bevan appeared to maintain a high level of distrust around other people, and appeared to focus on this rather than his responsibility in the offences. He presented as highly resistant in relation to high risk identification and management, and tended to reject suggestions and find reasons for why particular strategies would not work for him. He should be encouraged to further develop appropriate risk management strategies that he feels able to implement in his life to avoid future allegations or convictions for sexual offences.

Based on the above information regarding treatment, it is the author’s opinion that Mr Bevan has contained his risk of sexual re-offending.

4.4 Outstanding Treatment Issues and Recommendations

It is recommended that Mr Bevan develop and maintain an active support and awareness group that can assist him in the early identification of his high risk factors, and assist him to maintain treatment gains and work towards goal achievement. Should he require additional support at any stage during his order, other agencies may request consultation with the author.
It is further recommended that Mr Bevan:

- Have no unsupervised contact with children under the age of 16 years.
- Have his internet history reviewed regularly for inappropriate internet use.
- Receive professional support to address issues associated with interpersonal skills and to further develop social competency and assertive communication skills.
- Receive professional support to address any mental health concerns, such as depression and anxiety, and any concerns regarding the diagnosis of Schizoid Personality Disorder.

4.5 Discussion of Clinical Issues

The case of Mr Bevan provided an interesting contrast to the other three case studies of offenders who deny their sexual offending behaviour. Table 4.1 summarises the facets of denial Mr Bevan presented with, according to the categories identified by Marshall et al. (2006). His accounts of the offending were consistent across agencies in that he denied offending and maintained that he was “set up” by friends. However, his account of the offending did differ throughout treatment, at times maintaining that he had never seen any child pornography images until the police seized his property, at other times reporting that he had viewed one image. Another inconsistency in Mr Bevan’s accounts was his level of arousal to children. Across agencies, he denied deviant sexual arousal to children, however, during his offence cycle work, acknowledged that he masturbated to an image of child pornography. Further, from an external agency, there were reports that he had engaged in inappropriate behaviour with
children, although no official allegations were made and he was not charged. Mr Bevan’s sense of self within the world (for example, that he was a “loner” and that he was “different” from other people) may have served to lower his self esteem and increase his level of shame around his offending. From his self reports, it appeared he maintained a high level of shame regarding his convictions especially in relation to his mother. This may have prevented him from fully exploring his behaviour and contributing factors to his conviction.

Table 4.1. Categories of Denial for Mr Bevan based on Marshall et al. (2006)

*Categories.*

<table>
<thead>
<tr>
<th>COMPLETE DENIAL</th>
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<tbody>
<tr>
<td>- False accusation</td>
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<tr>
<td>- “My friends set me up”</td>
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<tr>
<td>- “My friends made it up”</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MINIMISATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Concerning offence</td>
</tr>
<tr>
<td>- “I only looked at one image”</td>
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</table>

Mr Bevan’s offending appeared to meet his needs for intimacy and entertainment. It remained problematic that at the conclusion of treatment, he continued to insist that he did not require interpersonal relationships, and that the internet and computer games remained a significant interest for leisure. During treatment, the reasons behind his apparent fear of contact with others were explored, however, it would be of benefit that these be explored further. His diagnosis of Schizoid Personality Disorder appeared to function as a major barrier to him being open to
interpersonal relationships, despite him demonstrating in group that he could communicate appropriately and effectively with others and build trust in other people. This again may have related to poor self esteem and it would have been useful to explore the function of him using his diagnosis further, however, due to timelines and program constraints, this was unable to occur to the extent that he may require.

As with Mr Huy, Mr Bevan was able to function in a group of sexual offenders who were admitting their offences, and was able to develop some rapport with some of the other group members. However, given his difficulties with interpersonal skills, he may have functioned better in a group where all group members were categorically denying their offending behaviour. Such a group may have served to lower his resistance to group advice and treatment concepts in general. Although addressed in this treatment program, in Canada and New South Wales, the categorical deniers programs specifically target self esteem, which would be of benefit to Mr Bevan.

In summary, although the treating clinicians in this case attempted to tailor treatment to Mr Bevan’s needs in regards to his high level of denial, Mr Bevan continued to present as resistant to offence-specific concepts and treatment targets throughout the program. Although he was able to identify high risk factors and some appropriate strategies, his level of motivation to apply these in his life remained relatively low from his self-reports. Table 4.2 summarises the treatment goals addressed, and outstanding, for Mr Bevan.
Table 4.2 Treatment Goals Addressed, and Outstanding, for Mr Bevan.

ADDRESS DURING TREATMENT

Exploration of life history in order to identify problematic core beliefs
Identification of problematic core beliefs related to offending behaviour
Identification of problematic emotions and cognitive distortions related to offending
Identification of problematic background factors to offending
Development of an intellectual understanding of the effects of sexual abuse on victims
Exploration of more adaptive emotional regulation and problem solving skills
Development of appropriate risk management strategies to avoid future accusation

OUTSTANDING ISSUES

Acknowledgment of full responsibility in offending behaviour
Emotional understanding of empathy, and in particular, victim empathy
Motivation to implement appropriate risk management strategies
Identification of realistic future goals, steps and obstacles to goal achievement
Understanding and implementation of assertive communication skills
Development of more adaptive emotional regulation skills
Development of peer supports
Chapter 5: Mr Morgan

5.1 Summary of the Presentation and Treatment of Mr Morgan

Name: Mr Morgan

Date of Birth: 1982

Age: 27 years old

Purpose of Report

This report is designed to describe the overall participation and progress of Mr Morgan in treatment and provide an outline of recommendations for him.

Sources of Information

- Perusal of relevant correctional files, including the Victorian/National Criminal History Report (dated 2006), and the Judges Sentencing Comments (dated 2006).
- Administration of Static-99.
- Clinical case notes regarding participation in group-based treatment.

Order Details:

Prison sentence

Aggregate Term: 4 years

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4 Note that all identifying information reported in this chapter regarding clients, professionals, and agencies has been altered to protect the identity of the individuals and organizations involved.
Offence Details:

Rape x 1 count
Rape x 2 counts
Indecent Assault x 1 count

According to the Judges Sentencing Comments (JSC) (dated 2006), Mr Morgan was found guilty of one count of Indecent Assault and three counts of Rape. He met the victim approximately nine months prior to the offences. Mr Morgan took the victim for a drive following a number of telephone calls, after an arranged meeting with the victim at the residence of a friend. He and the victim arrived at a location, whereby the victim stated that there was to be no inappropriate “touching” whilst using the facilities together. Mr Morgan attempted to kiss the victim, to which she responded “no.” He proceeded to give the victim a shoulder massage. Mr Morgan undid her bra, she said “no” and he did it back up again, before taking it off again. The victim reported feeling frightened and that she did not know what to do. According to the JSC, Mr Morgan continued to massage the victim’s body and attempted to pull down her underwear, to which she resisted by saying “no.” It is reported that he became aggressive and forceful; however, the victim reported that she acted in a way so as not to indicate her distress. Mr Morgan penetrated the victim digitally, orally, and vaginally, whilst at the location. He then drove the victim home, whereby she reported to her friend that she had been raped and was taken to the hospital where forensic samples were obtained.
Sexual Offence History

The index offence constitutes Mr Morgan’s only episode of sexual offending behaviour.

Sentence History

Mr Morgan’s significant sentence history, as per the Victorian Criminal History Report (dated 2006), extends back to the early 1990s, comprising both a juvenile and adult history of criminal behaviour. His previous convictions include: theft; burglary; criminal damage; unlawful assault; use indecent language public place; wilfully damage property; numerous driving offences, such as use unregistered motor vehicle, drive at speed over the speed limit, drive whilst authorisation suspended, drive in a manner dangerous, careless driving, drive whilst disqualified, theft of motor vehicle; fail to answer bail; behave in an offensive manner public place; stalk another person; breach intervention order; fail to obey lawful direction of police; possess controlled weapon without excuse; assault with weapon; recklessly cause injury; aggravated burglary; wilful and obscene exposure in public; failure to comply with a correctional order; escape from prison/police gaol; without excuse enter private place. Mr Morgan has previously received both a number of community-based dispositions, and custodial sentences for the above-listed offending.

Actuarial Risk Assessment:

Mr Morgan’s risk of sexual re-offending was assessed using an actuarial risk assessment instrument, the Static-99. The Static-99 is an instrument designed to assist
in the prediction of sexual and violent recidivism for sexual offenders. The test was
developed by Hanson and Thornton (1999) based on follow-up studies from Canada
and the United Kingdom with a total sample size of 1,301 sexual offenders. The Static-
99 consists of 10 items and produces estimates of future risk based on a number of risk
factors present in any one individual. The risk factors included are the presence of prior
sexual offences, having committed a current non-sexual violent offence, having a
history of non-sexual violence, the number of previous sentencing dates, age less than
25 years, having male victims, having never lived with an intimate partner for two
continuous years, having a history of non-contact sexual offences, having unrelated
victims, and having stranger victims.

The recidivism estimates provided by the Static-99 are group estimates based
on reconvictions, and are derived from groups of individuals with these characteristics.
As such, these estimates do not directly correspond to the risk of recidivism of an
individual offender. An individual offender’s risk may be higher or lower than the
probabilities estimated in the Static-99, depending on the presence or absence of other
risk factors not measured by this instrument (for example, dynamic or changeable risk
factors).

Based on the Static-99, Mr Morgan is placed in the high risk category relative
to other male sexual offenders. Based on his assessed static level of risk, Mr Morgan
was found to be eligible for a high intensity group-based treatment program.
Program Details

The program utilised is a group-based intervention designed to target sexual offending behaviour. It is based on international best-practice principles and has the capacity to be individualised to the needs of each participant. The program offers practical ways of understanding offending, including helping participants admit more fully what they have done, helping them take responsibility for their offences, and providing them with practical ways in which to tackle these problems.

Attendance

Mr Morgan attended twice weekly sessions of the program from January – August, attending 52 sessions in total. Overall, his attendance and participation was satisfactory as assessed by treating clinicians.

Treatment Progress

General Progress

Mr Morgan’s presentation fluctuated throughout treatment. He initially reported that he was somewhat motivated to engage and participate in group treatment, but was only attending group to comply with the requirements of parole bodies, indicating that his primary motivation to attend treatment was parole eligibility. He indicated that he did not feel he should be in the group and that he “[felt] dirty” being in group, indicating an initial lack of responsibility taking for his rehabilitation.

Mr Morgan appeared at times throughout treatment to attempt to elevate his status in the group and differentiate himself from other group members. He further
appeared to appease himself and his actions in group individually with group facilitators and to generate a forum whereby he could justify his behaviour in group. Mr Morgan was observed to reflect upon his behaviour and any feedback he had received about such behaviour, however, did not appear able to utilise consequential thinking within the group setting, with a tendency to revert to problematic behaviours such as entitlement, and refusal of a need to make any behavioural changes. He appeared able to leave the session and reflect on how his presentation in group may affect him adversely (for example, in terms of his report and parole) and would later attempt to justify his behaviour and appease group facilitators, engaging in a level of impression management.

Mr Morgan presented with an aggressive communication style from the outset of treatment; for example using inappropriate language and raising his voice at other group members; standing up and assuming intimidating physical postures, such as standing over others. He utilised an aggressive communication style to provide feedback to other group members, express his point of view, communicate with prison staff, and group facilitators. Mr Morgan was continually provided with feedback regarding his style of communication. He reported a belief that if his intentions were not aggressive, then he would not present aggressively, despite ongoing feedback about his intimidating physical presentation. Additionally, when provided with feedback, Mr Morgan would often respond with defensiveness and aggression, using attempts to defend his position rather than consider the feedback. He further presented with a tendency to internalise and personalise feedback from group facilitators. Mr Morgan was observed to associate conflict with violence and aggression, and reported a belief
that conflict only needs to be resolved if it results in physical violence. This may have further compounded and contributed to his aggressive communication style. As Mr Morgan progressed through treatment, he was able to begin to challenge his style of thinking and became more open to conflict being a difference in opinions. He further developed skills to appropriately and assertively communicate with other group members. Mr Morgan was observed to do this when an issue was removed from him emotionally, indicating that he was able to apply concepts and understand them. However, it appears he may have difficulties doing this when this applies to his own thoughts, feelings and behaviours. It appears that when Mr Morgan has an emotional connection to subject matter, he is unable to communicate assertively, tending to allow his emotions to rule his actions. He did not present as open to changing his thoughts, feelings or behaviours, until towards the end of the program.

Mr Morgan attempted to communicate assertively and appropriately, though this tended to require numerous attempts, and he was often required to clarify his intent, as his tendency to present as aggressive and intimidating continued. In the final sessions of treatment, Mr Morgan demonstrated an ability to provide feedback to other group members, for example, regarding their role-play, highlighting a particular group member’s use of excuses and justifications. His behaviour and presentation throughout this was appropriate, with relaxed body language and the use of appropriate language. This indicated that Mr Morgan developed skills to better receive feedback and behaviourally consolidate this in the group environment.

Mr Morgan presented with perspective taking deficits early in treatment. For example, during the administration of the psychometric test battery, completed by all
group members, Mr Morgan refused to complete some questions which he felt did not relate to him, reporting a belief that no one would believe/endorse particular questions, despite explanation and information from group facilitators. Mr Morgan continued to present in a manner indicating that he felt his opinions on whether things were “right” or “wrong,” without considering that other group members may feel differently. As he progressed through treatment, it became apparent that Mr Morgan was often unwilling to perspective take. A major barrier to his ability to perspective take appeared to be his emotions. He demonstrated a tendency to feel an emotion, express it, and be unable to manage it to a level where he was able to take on the perspective of someone else. With ongoing feedback throughout treatment, towards the conclusion of the program, Mr Morgan was better able to take on the perspective of other group members.

Mr Morgan presented with emotional regulation deficits, such as problems with frustration tolerance, emotional identification and appropriate emotional expression. For example, in group he would present as frustrated (e.g. rolling his eyes), however would not raise his frustrations verbally. Mr Morgan at times when frustrated, presented as judgmental and persecutory toward other group members. As an example, he threatened to breach the confidentiality of other group members when he was experiencing anger. His problems with emotional identification and frustration tolerance were further exacerbated when Mr Morgan talked in front of the group. He appeared to have a strong desire to present as capable and knowledgeable within the group, however, would have difficulties in articulating or communicating what he wanted to say. It was observed as treatment progressed that when he was provided more time, Mr Morgan was better able to explain himself and communicate effectively.
He also presented as less frustrated. Mr Morgan initially attributed his poor emotional regulation to problems with his thyroid gland. He further elaborated that problems with his thyroid explain why he was sometimes unable to complete sentences, and present as if he did not understand. Mr Morgan was encouraged to adhere to medical advice given. Although for the remainder of treatment Mr Morgan continued to present with emotional regulation deficits and communication problems, he did not relate this to his thyroid. With ongoing feedback regarding his presentation and behaviour throughout treatment, toward the conclusion of treatment, Mr Morgan appeared better able to manage his frustrations and raise these appropriately during group sessions.

Although Mr Morgan appeared to make positive changes in regards to his emotional regulation and frustration tolerance, reports from custodial and clinical staff at his prison location have indicated that he has reverted to previous behaviours since his completion of treatment. He has repeatedly approached clinical staff regarding the progress of his program report, and has inappropriately and aggressively expressed his opinions and feelings around this. He has expressed anger towards group facilitators and has consistently placed the responsibility of his present position on other people, such as group facilitators. He further expressed negative and problematic attitudes and beliefs regarding other offenders, utilising negative stereotype labels. It is understandable that Mr Morgan is experiencing a significant level of distress and anxiety regarding his parole, and he was able to manage these frustrations appropriately for a short amount of time, for example, by discussing his concerns with his individual counsellor. However, it appears that he has found it difficult to behaviourally
consolidate the concepts and strategies discussed in treatment related to his emotional regulation, frustration tolerance, assertive communication, and perspective taking.

**Offence Specific Progress**

Mr Morgan denied engaging in sexual offending behaviour throughout the duration of treatment, with a tendency towards minimising the offence against his victim, engaging in a significant level of victim blaming. He initially attributed “50%” of the responsibility of his offending behaviour to himself. He consistently reported that his offence was a “consent issue” and initially indicated that he “was not ashamed” of his offence. This attitude initially suggested a lack of remorse for his offending and for the impact of the offence on his victim, in addition to a level of sexual entitlement. For example, when asked what he had learnt about how not to offend in the future, he replied “not to have sex with a girl who has got a boyfriend.” In his initial disclosures, Mr Morgan reported that he “never forced [the victim] to do anything.” He was able to acknowledge that she may have felt uncomfortable, but then continued to discuss the possibility of the victim “crying rape” because she had a boyfriend. Throughout treatment, Mr Morgan demonstrated a tendency to oscillate between taking responsibility for his offending behaviour, and blaming the victim, and presenting as angry and resentful towards her. It remains unclear where his actual sense of responsibility lies. This may have impacted upon Mr Morgan’s level of engagement in offence specific treatment.

Given Mr Morgan’s level of denial and minimisation in regards to his offence, his offence process was presented as the process he took that enabled him to be accused
of offending. The behaviour of being unfaithful to his partner and having sex with another woman was utilised as the focus. Mr Morgan appeared reluctant to discuss some aspects of his offence process, such as fantasy rehearsal and the role played in offending behaviour. He maintained a belief that behaviour “just happens” and initially had difficulties in understanding the purpose of an offence process. Initially, Mr Morgan presented as resistant to discuss any factors that may have contributed to placing himself in a position where he was accused and convicted of sexual offending behaviour. Eventually, he identified background factors and problematic feelings that he experienced leading up to the offence, for example, feeling angry and unwanted, and seeking revenge on his ex-partner. He acknowledged that he had been having sex with many women outside of the relationship and it is possible that this contributed to his expectation of sexual activity with the victim. It appears the most problematic core belief for Mr Morgan related to his offending was “I’m not good enough,” leading him to seek approval and meet his needs of being wanted and needed by having sex with other women, lowering sexual boundaries, and placing himself in a position whereby he was accused of offending. At times throughout his offence process, Mr Morgan presented as angry, expressing that he continues to experience anger at the victim for reporting the offence, continuing to articulate his belief that the intercourse was consensual. Mr Morgan identified strategies to challenge pro-offending or high risk thoughts, such as needing to ensure consent, and communicating thoughts and feelings to his partner.

Although Mr Morgan engaged in a level of victim blaming throughout treatment, towards the conclusion of treatment he acknowledged that he may have
presented in a manner which made his victim feel intimidated or threatened, and therefore unable to communicate that she did not want to engage in intercourse with him. With the assistance of the group, Mr Morgan identified why his victim may have felt scared and intimidated. He appeared to make progress in the identification of his problematic behaviours and how he presents physically to others.

Mr Morgan developed healthy lifestyle goals, which he has discussed with his support group. His goals incorporated a work/life balance, focusing on gaining employment, in addition to allocating time to spend with his sons. He identified steps to goal achievement that appear realistic and achievable. Mr Morgan’s children appeared to be a strong motivator for him to remain offence free, and he expressed a desire to increase his level of custody and access to his children upon release.

*High Risk Factors and Identified Strategies*

Mr Morgan identified high risk thoughts and feelings, such as thinking and feeling he is not good enough (poor self esteem). His high risk behaviours include maintaining negative social influences, emotional regulation deficits, such as suppressing emotions, especially in regards to intimate relationships, intimacy deficits, including a lack of communication in intimate relationships, use of illicit substances, and a tendency to engage in impersonal sexual activity. Strategies identified by Mr Morgan to mitigate his high risk thoughts and feelings include talking to a support person when he is feeling like he is not good enough and expressing his emotions to support persons and intimate partners. In regards to high risk behaviours, strategies include ensuring new friends are a positive influence (e.g. do not engage in illegal
activities) and severing ties with friends that use drugs, and avoid forming friendships with people that use substances. To ensure he has consent in sexual activity, Mr Morgan identified that a strategy would be to ensure open communication, and spend time getting to know women prior to engaging in sexual activity. Other offence-related risk factors for Mr Morgan include difficulties in perspective taking, appropriate communication, poor general self regulation and hostility, and poor cognitive problem solving. Whilst Mr Morgan has worked towards making changes in these areas throughout treatment, it is evident from his current presentation that he requires further treatment and support to further behaviourally consolidate what he has already begun to implement whilst incarcerated.

5.2 Outstanding Treatment Issues and Recommendations

It is recommended that Mr Morgan maintain an active support and awareness group that can assist him in the early identification of his high risk factors, and assist him to maintain a healthy lifestyle. It is further recommended that Mr Morgan receive further treatment in relation to his self-esteem, and social competency skills, including assertive communication, perspective-taking, and emotional regulation. It is recommended that Mr Morgan be referred to a maintenance program upon release into the community to enable further support while he implements behavioural change in his life.

It is recommended that Mr Morgan:

- Have no direct or indirect contact with his victim or his victim’s family.
5.3 Discussion of Clinical Issues

Mr Morgan provided a complex case for treating clinicians given his perspective of his offence and his denial. Table 5.1 summarises the categories of denial relevant to the case of Mr Morgan, utilising Marshall et al. (2006) categorisation. Throughout the duration of treatment, Mr Morgan insisted that his offence was not in fact sexual offending, but was a “consent issue,” whereby he felt he had consent from his victim to engage in sexual activity. Mr Morgan was often highly resistant to considering the perspectives of other people, repeatedly reporting beliefs throughout treatment that his perspective was always the “right” perspective. Prior to commencing offence-specific work with Mr Morgan, it was necessary to address his numerous social competency skill deficits, and in particular, his aggressive communication style. His aggressive communication style and significant resistance to treatment and to the perspectives of others made it difficult to explore his offending behaviour and to challenge many of the distortions he maintained around his offending, in addition to other maladaptive beliefs about himself, other people, and in particular, women, and the world. Another major barrier to treatment progress for Mr Morgan appeared to be his level of shame around the offence. His level of resistance may have functioned to increase his internal defences to protect him from feeling that shame around his behaviour and his conviction of a serious sexual offence. It became evident that Mr Morgan would be unable to admit responsibility for his offending. As with other offenders who deny or minimise aspects of their offending, Mr Morgan remained in a group of sexual offenders who were predominantly admitting responsibility for their
offending. However, Mr Morgan often insisted that he “did not belong,” would align himself with group facilitators, personalise feedback, and often appeared to be attempting to elevate his status in the group above the other group members. This behaviour, in addition to his denial, posed problems for the therapeutic nature of the group. Mr Morgan would further request individual sessions with group facilitators, whereby he would often plead his case as to why he “did not belong” in group treatment. Mr Morgan was informed that he could be withdrawn from the program should he choose to do so, and was further informed, following making threats to the group, that should he further engage in such behaviour that he would be removed from the program. Mr Morgan insisted on remaining in the group, predominantly in order to be eligible for parole at the earliest end date of his sentence.

Table 5.1 Categories of Denial for Mr Morgan  based on Marshall et al. (2006)

Categories.

<table>
<thead>
<tr>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMPLETE DENIAL</td>
</tr>
<tr>
<td>- Victim had a boyfriend and did not want to get caught “cheating”</td>
</tr>
<tr>
<td>PARTIAL DENIAL</td>
</tr>
<tr>
<td>- Victim consented – she did not say “No”</td>
</tr>
<tr>
<td>- Denial of having a problem or requiring treatment</td>
</tr>
<tr>
<td>- “I’m not a sexual offender”</td>
</tr>
<tr>
<td>MINIMISATION</td>
</tr>
<tr>
<td>Concerning offence</td>
</tr>
<tr>
<td>- No use of threats, coercion or force</td>
</tr>
<tr>
<td>Denies planning/fantasising</td>
</tr>
<tr>
<td>- It just happened; behaviour just happens</td>
</tr>
</tbody>
</table>

106
Unlike Mr Huy, who was able to function appropriately in a group of admitting sexual offenders, this proved more difficult for Mr Morgan. This may in part be due to his entrenched use of aggression to meet his needs, as evidenced by his presentation and his significant violent, and other, offence history. It was of some interest that Mr Morgan did not deny engaging in sexual activity with the victim. However, he denied that he did not have consent and repeatedly engaged in blaming the victim for the position in which he found himself — in prison. To enable him to make treatment gains, treatment was tailored to enable Mr Morgan to explore the process he took in order for the victim to perceive that she had been offended against. Akin to the process used by Mr Huy, and others, Mr Morgan was able to complete offence cycle work to identify background factors to the behaviour of cheating on his long-term partner and having impersonal sex with other women, including the victim. It was explored how he was able to lower his internal and external barriers to this behaviour by utilising cognitive distortions, based on beliefs he had about himself, and other people, such as women. As treatment progressed, although reverting to previously-held beliefs about the offence and to aggressive communication and difficulties in perspective-taking, Mr Morgan was able to identify problematic thoughts, feelings, and behaviours that he could change in order to avoid re-offence or being accused of sexual offending in the future. Mr Morgan demonstrated increased motivation to change his behaviour, not only in relation to sexual offending behaviour, but in relation to other areas of his life, such as his peers, the way in which he communicates with others, and his general offending behaviour. A significant motivator for change appeared to be his
children, for whom he indicated he would like to be a positive role model. Mr Morgan was further able to identify aspects of his presentation that could be perceived negatively (such as intimidating or threatening) by others. He was able to relate this to his victim at some points through treatment, whilst at other times, he would become angry and revert to blaming the victim. Even so, Mr Morgan demonstrated in group treatment that he could change these behaviours, by learning to communicate assertively and sitting with the discomfort of listening to other group members' perspectives.

In summary, although Mr Morgan continued to minimise his responsibility in his offending, and continued to deny that it was an offence, through treatment tailored to his needs he was generally able to engage to a higher level in the treatment process and develop risk management strategies addressing how he could avoid future accusations. Although framing treatment in this way appeared to lower Mr Morgan’s level of resistance, a level of resistance was maintained and as such, it is possible that Mr Morgan may not have engaged in treatment to a high level. Mr Morgan’s particular issues with treatment appeared to be the group-based nature of treatment, whereby he was required to listen to the stories of other group members, especially those who had committed offences against children. Further, his commitment to denial and level of shame may have prevented him from exploring his behaviour and the precursors to his behaviour in a more open and honest manner.

Overall, Mr Morgan was able to meet some treatment targets and address some important dynamic risk factors (e.g. intimacy deficits, social influences, attitudes
supportive of sexual assault, entitlement, problematic attitudes relating to sex and women, and general and emotional self-regulation deficits), and develop risk management strategies that will assist him to remain offence-free. However, it was recommended that Mr Morgan address other dynamic risks pertinent to his offending behaviour, such as his possible use of sex as a means of coping with negative emotionality, further work on entitlement, especially sexual entitlement, and his deficits in cognitive problem-solving. This treatment will most likely be conducted individually through another agency, given the constraints of the program. However, the author remains available for consultation around Mr Morgan’s reintegration to the community and his environmental management. Further, Mr Morgan will be required to attend a community-based maintenance program to further assist him to behaviourally consolidate the skills he developed in treatment. Table 5.2 provides a summary of the treatment goals addressed by Mr Morgan, and any outstanding issues.
Table 5.2 *Treatment Goals Addressed, and Outstanding, for Mr Morgan.*

**ADDRESSED DURING TREATMENT**

- Exploration of life history in order to identify problematic core beliefs
- Identification of problematic core beliefs related to offending behaviour
- Identification of problematic emotions and cognitive distortions related to offending
- Identification of problematic background factors to offending
- Development of an intellectual understanding of the effects of sexual abuse on victims
- Exploration of more adaptive emotional regulation and problem solving skills
- Development of appropriate risk management strategies to avoid future accusation
- Understanding and implementation of assertive communication skills
- Identification of realistic future goals, steps and obstacles to goal achievement

**OUTSTANDING ISSUES**

- Acknowledgment of full responsibility in offending behaviour
- Emotional understanding of empathy, and in particular, victim empathy
- Development of more adaptive emotional regulation skills
- Further exploration of entitlement issues
- Further exploration of using sex to cope with negative emotions
- Further exploration of problematic beliefs about women and sex
- Further exploration of cognitive problem solving deficits
Chapter 6: Summary and Conclusions

Denial and minimisation of offending behaviour, or aspects of offending behaviour remains a common phenomenon in sexual offenders (Happel & Auffrey, 1995). Furthermore, sexual offenders, like other clients or patients undergoing psychological assessment or treatment, can be motivated to distort their self-reports throughout assessment and treatment processes (Rogers, et al., 1994; Rogers, 1990). In particular, categorical denial has in the past been regarded as a significant obstacle to successful cognitive-behavioural treatment. Sexual offenders who categorically deny offending may be excluded from treatment programs, or opt out of treatment programs. They are likely to be denied parole and on release from prison, as a consequence of having served their full sentence, are less likely to have access to ongoing clinical support or systemic supervision. Subsequently, they can be at a heightened risk of reoffending.

The overall aim of treatment programs for sexual offenders is to reduce future risk of sexual offending, and given the research literature on recidivism rates of sexual offenders who have received treatment versus no treatment, programs which either do not enrol deniers, or those that fail to adjust their content to allow for the particular needs of deniers, fail to achieve the overarching aims of risk reduction (Marshall, et al., 1999a).

Cognitive Behavioural Therapy (CBT) treatment modalities remain best practice for providing treatment to sexual offenders (Anderson, et al., 1995; Laws, et al., 2000; Marshall, et al., 1999b). The aims of CBT in sex offender treatment programs are to modify problematic patterns of cognitions, emotions, and behaviours that
perpetuate and maintain sexual offending behaviour. Dynamic risk factors are targeted in treatment, and in doing this, have been demonstrated to reduce risk of re-offending (Hanson, et al., 2007).

The current thesis aimed to explore the challenges and complexities faced by mental health professionals in treating sexual offenders who deny engaging in offending behaviour, either categorically, or on a level that significantly impacts on their level of engagement in treatment. Specifically, this thesis aimed to examine therapeutic techniques utilised for offenders that deny, whilst placed in a group of offenders who are admitting their offences, in regards to addressing dynamic risk factors associated with offending behaviour. The four cases were selected for inclusion in this thesis based on the different ways in which they presented within the group treatment setting, their varying levels of denial and minimisation, the type of offending behaviour, and the location of treatment provision (prison based and community based treatment). Each offender presented with different levels of risk of recidivism as assessed statically or clinically, risk factors, levels of motivation to engage in treatment, and functions of denial.

The case of Mr Huy illustrated a sexual offender charged and convicted of several counts of Indecent Act with a Child under 16, counts of Offer Agreement Child Sex Service, and numerous counts of Indecent Assault. Administration of the Static-99 revealed a static risk level in the moderate to low category of risk of re-offending, relative to other male sexual offenders. He completed offence specific treatment in the community. From the commencement of treatment, Mr Huy presented as motivated to
engage, though treating clinicians suspected that Mr Huy may have been engaging in impression management (presenting himself in a positive light so as to alleviate challenging of his problematic attitudes and beliefs). It became apparent that Mr Huy was denying his offending behaviour, and that he was highly invested in his denial. It was hypothesised that this may have related to cultural and family factors, increasing the level of shame he felt about the offending behaviour. As such, offence specific work was structured in a non-threatening manner, whereby Mr Huy was able to identify background factors associated with being accused of sexual offending. Through this process, he was further provided the emotional space (by decreasing his anxieties around discussing his offences) to explore problematic behaviour he had engaged in, such as “hugging” his young female employees. This represented a significant shift in his level of denial and also in his level of motivation to change his behaviour. In acknowledging that he may have behaved in a manner perceived by the victims and others to be inappropriate, he was effectively able to explore strategies to avoid future allegations. By the conclusion of the treatment program, Mr Huy had developed a realistic risk management plan, and positive life goals that he had behaviourally already commenced implementing in his life. The way in which treatment was structured for Mr Huy was not unlike the programs developed in Canada and in NSW, Australia, whereby the conventional sex offender treatment program was adapted. The focus for Mr Huy became about the problems in his life that led him to be in a position where he could be accused of sexual offences. In doing this, Mr Huy’s dynamic risk factors were addressed in a similar manner to those in the treatment group who were admitting guilt,
and his risk management plan was as robust as the admitting group members. As such, the overarching goals of sexual offender treatment appeared to be achieved in this case.

Mr Alessi had convictions relating to numerous counts of sexual abuse against his five step-grandchildren and completed prison based treatment. Whilst Mr Alessi did not present with overtly resistant behaviours, such as aggression, as demonstrated in the case of Mr Morgan, he tended to evade discussing the offences, and anything personal about himself or his history that he may have perceived as negative. Mr Alessi generally presented only positive information about himself and his life prior to prison, at some stages, to the extent where he brought to group “character references” written by his friends and family, attesting his “good character.” Not unlike Mr Huy, perceived negative reactions from his family and his cultural community appeared to be at the root of Mr Alessi’s denial. Further, his level of shame was high and appeared to prevent him from exploring possible background factors that led to allegations of sexual offending. Mr Alessi was highly invested in his identity as a leader of his family, and the person that “helps” others within his family. As such, sexual offending was incongruent with his perceptions of who he was and what he did in his life. Mr Alessi was often challenged by the other group members, and they expressed some hostility toward him at times, as he was unable to shift his beliefs and attitudes about himself or his behaviour. This may have served to increase his resistance to treatment, even when tailored to address an “allegation.” Although Mr Alessi was able to make some treatment gains, and develop a risk management plan, he remained ambivalent to implementing the required behavioural change in his life post-release. Mr Alessi may have functioned to a higher level in a categorical deniers group, whereby he would not
have been challenged around his denial. From communications with the facilitators of the NSW categorical deniers group, levels of treatment resistance reduced significantly once it was established and understood that no group members would be required to admit guilt.

The case of Mr Bevan illustrated a sexual offender on a community based disposition who had been charged with offences relating to child pornography. Mr Bevan maintained throughout the program that he had been falsely accused of offending, indicating that he had been “set up” by friends. Although treatment was structured in a similar manner to that of Mr Huy, Mr Bevan continued to have difficulties engaging to a high level in treatment. His accounts of the offences were inconsistent at times, and Mr Bevan’s resistant presentation persisted throughout treatment. It is possible that Mr Bevan found it difficult to function firstly in a group-based treatment program given his apparent diagnosis of Schizoid Personality Disorder, and further in a program where the majority of group members were admitting their offences on some level. This case highlights the need to consider personality disorders or traits as important clinical information that may need to be harnessed when developing or adapting therapy, and in particular, group therapy. Furthermore, it has been suggested that psychopathology and maladaptive personality functioning may play a role in the aetiology of sexual offending, and in particular, internet sexual offending (such as in Mr Bevan’s case). Internet sexual offenders might experience interpersonal functioning deficits, in addition to affective deficits, and may differ
significantly from the broader population in measures of personality (Laulik, Allam, & Sheridan, 2007).

In the group Mr Bevan was placed in, he was often challenged in relation to the likelihood of him being “falsely accused,” and group members oscillated between indicating that they did not believe his accounts, and colluding with him (for example, in regards to him being “too trusting” of others and therefore placing himself in a position where he was “set up.”). The differences in the groups’ opinions may have served to further ingratiate Mr Bevan’s denial, feeling unable to change his accounts, and sometimes supported in his denial. Mr Bevan further had strong beliefs about himself and his behaviour generally, and was resistant to making any changes in his life. This may have been a component in a long history of a lack of responsibility taking and an external locus of control. Although this was addressed in treatment, Mr Bevan may have required significantly more work in regards to his sense of self efficacy and self esteem. As such, a program developed specifically for offenders in denial, where offences are not discussed, such as the programs in Canada and NSW, Australia, and factors such as self-esteem are focused on to a greater degree, may have provided Mr Bevan with permission to engage to a high level in the treatment process.

Further, such a program may have served to increase Mr Bevan’s motivation to implement change in important areas of his life, such as interpersonal relationships and gainful employment. An additional factor in the maintenance of Mr Bevan’s denial may have been his placement on a community based disposition. Clinically, the author has observed that offenders of community based dispositions are often more resistant to treatment, and engage in higher levels of denial and minimisation. It is possible that
such offenders do not believe their behaviour to be “severe” or “bad” enough for a prison sentence, which may further contribute to denial and significant minimisation of, for example, victim harm and severity of the offence.

The case of Mr Morgan provided an interesting and complex example of the way in which denial and minimisation functions, in that he oscillated between taking responsibility and blaming the victim. It was noteworthy that Mr Morgan did not deny engaging in sexual activities with the victim. Rather, he denied that this was an offence. His often somewhat aggressive presentation posed further problems for treating clinicians. As with the previous three cases, treatment was tailored to better meet the needs of Mr Morgan. In particular, a significant amount of work was focused on perspective taking, in relation to the victim of his offence, and in general. Although initially highly resistant, over time, Mr Morgan identified how his presentation in general might impact on the perceptions and behaviour of others. Given his work in this area, in addition to addressing his other high risk factors, Mr Morgan adequately contained his risk of re-offending. Whether group based treatment with admitting sexual offenders was the most appropriate placement for Mr Morgan remains unclear, for the following reasons. Mr Morgan admitted engaging in sexual activity with the victim. However, he maintained through treatment that the contact was consensual. He was able to address his dynamic risk factors; however, his resistant presentation throughout treatment was at times detrimental to the functioning of the group as a whole, threatening the therapeutic nature of group based treatment. In this case, it would have been unlikely that Mr Morgan would have been appropriate for a categorical deniers program, given he admitted the behaviour. However, his level of
denial of the intent to offend and his responsibility was very high, and impacted not only on his own treatment, but on the treatment of the other group members. Conversely, toward the end of treatment, Mr Morgan appeared to make significant shifts in his behaviour, and was an active group participant. In regards to the efficacy of treatment with Mr Morgan, his treatment gains will require monitoring through a maintenance program. This may enable more rigorous assessment of the appropriateness of the treatment process for him. This case, in addition to the previous three cases, highlights the importance of identifying the function of denial for an offender to enable treatment providers to either address the function of the denial, or adapt to accept the denial within the treatment framework.

Each of the four cases presented illustrated offenders who had committed differing offences, were on community or prison based orders, required different areas of focus in treatment, and whose denial functioned individually. As such, each case presented unique challenges for treating clinicians in regards to their general presentation, but more specifically, in managing their treatment in relation to their denial. In each case, although in denial, the offenders presented with dynamic risk factors that were addressed throughout treatment, and will continue to require risk management strategies in the future. In some of these cases, support is provided for the development of programs tailored to the responsivity requirements and needs of offenders who deny, whereas in the case of, for example, Mr Huy, offenders who, although they deny offending, can function appropriately in a group of admitting offenders. Current practice in Victoria requires offenders referred to sexual offender treatment programs to be assessed on the basis of their static risk level, which does not
require a face-to-face clinical assessment, unless the offender is unable to be statically assessed (as in the case of Mr Bevan), or an issue is flagged during file review (for example, cognitive deficits, intellectual functioning, and mental health concerns). However, to identify offenders that may benefit from a program specifically tailored for offenders who deny, further exploration may be required. At times, file review can indicate an offender is in denial, however, they are placed within treatment groups of admitting offenders. At this time, Victoria does not have a sexual offender treatment program catering for categorical deniers. Rather, they continue to be placed within programs designed for offenders who admit their offences. As such, it would be valuable for treating clinicians to assess factors such as treatment readiness and levels of resistance to treatment engagement prior to an offender’s entry to a treatment program. Ward et al. (2004) propose that “low readiness is as much a feature of the therapy context and setting as it is of the internal characteristics of the client, and that to increase the chances that an intervention will engage an offender, it is necessary to keep in mind the importance of cognitive factors such as treatment expectations and appraisals, motivation, external supports, and an appropriate institutional culture” (Ward, Day, Howells, & Birgden, 2004). The authors propose that treatment readiness of offenders is a function of internal (person) and external (context) factors, whereby offenders who are treatment ready possess features that allow them to function in a therapeutic environment and as such, benefit from the intervention. Contextual factors relate to the circumstances of treatment, such as mandated versus voluntary, the location of the program (e.g. prison versus community), resources of the program, support persons for the offender, and program characteristics. Ward et al. (2004)
propose that once he or she possessed the “cognitive, emotional, volitional and behaviour properties” and resides in an environment where change is supported and promoted, the offender will be ready to change. Different measurement tools that can be used to assess the different aspects of client reluctance and readiness for treatment have been proposed (Scott & King, 2007). Scott and King (2007) note, however, that is a lack of psychometrically robust measures available. Some of these include the Group Engagement Measure (GEM), Stages of Change measures, the University of Rhode Island Change Assessment Scale (URICA), and the Facets of Sexual Offender Denial (FoSOD) (see Scott and King, 2007 for further information on the utility of these, and other assessment measures).

Programs for sexual offenders who categorically deny offending have been developed in Canada and in other areas of Australia. Personal communications from treatment providers have indicated, thus far, that offenders are engaging to a high level in these programs. In regards to the effective management and treatment of dynamic risk factors, and the impact of the way in which this is addressed in treatment within the programs, long-term recidivism studies will need to be undertaken to better assess the effectiveness of the programs in reducing the risk of sexual recidivism. Further, future research could focus on the treatment elements that appear effective in reducing risk of re-offending in sexual offenders who deny. At present, denial of offences is generally viewed in the literature as unrelated to risk of re-offending (Hanson & Bussiere, 1998; Hanson & Morton-Bourgon, 2005), however, this remains somewhat controversial (Langton, et al., 2008). Given the resistance observed clinically, and the tendency for deniers to either refuse treatment or be excluded/withdrawn from
treatment programs, dynamic risk factors for these offenders can remain unaddressed. Further research may be required to attain more specialised knowledge about the relationship of denial and minimisation to offending. Additionally, it would be of benefit for future research to target the personal and cultural factors that serve to enable and maintain denial in sexual offenders and to identify appropriate interventions and strategies that would best meet responsivity needs for such client groups. Again, what remains clear, is that not treating sexual offenders who deny enables offenders to be released into the community with no treatment, and therefore, a lack of knowledge about their own behaviour and changes that they could make to reduce the risk of either re-offending, or placing themselves in a situation where they may be accused of offending in the future.
References


Appendix A: Overview of the Content of the Group Based Treatment Program

1. Commencement module
   - General introduction of participants within group
   - establish group rules and processes
   - exploring group members’ life stories

2. Offence process
   - learning to acknowledge offending behaviour
   - identifying the factors that led to offending behaviour
   - the above become the focus of what needs to change to avoid re offending

3. Victim awareness
   - understanding the effects of sexual offending on victims, both generally and own victims
   - exploring and developing empathy and victim empathy

4. Relapse prevention
   - generating relevant useable strategies that can be applied in every day life in order to reduce risk of re-offending.
   - identification of high risk factors and development of mitigating strategies
   - healthy lifestyle goal generation and strategies to assist in goal achievement

5. Social competency module
   - developing intimacy
   - managing relationships
   - problem solving and coping skills
   - reducing impulsivity
   - conflict resolution
   - healthy sexuality

6. Emotional regulation module
   - definitions and identification of emotions
   - emotions and offending
   - practicing emotional regulation

7. Fantasy reconditioning module (if required)