WESTERN CRIMINOLOGY REVIEW
http://wcr.sonoma.edu

Western Criminology Review 4(2), 143-154 (2003)

Therapeutic Jurisprudence: an Ethical Paradigm for Therapists in Sex Offender Treatment Programs

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ABSTRACT
Clinicians in sex offender treatment programs are required to resolve the ethical dilemmas, which invariably arise in this sort of work, by breaching traditional mental health ethical principles such as maintaining confidentiality and promoting patient autonomy. Indeed the mark of a "good" therapist is their primary focus on the protection of the community rather than on the interests of the offender. Yet the professionals in such programs cannot practice in an ethical vacuum; they need some form of ethical code to publicly commit themselves to professional competence and integrity. A therapeutic jurisprudence approach, it is suggested, can help formulate principles of conduct, which although they do not necessarily aim to serve the best interests of the offender, nevertheless limit the punitive and unjust aspects of such treatment programs to the maximum degree possible.

KEYWORDS: ethics in psychiatry; ethics in psychology; philosophy of punishment; rehabilitation of offenders; sex offender treatment; therapeutic jurisprudence.

> But if a man forges a cheque or sets his house on fire, or robs with violence from the person, or does any other such things as are criminal in our country, he is either taken to a hospital and more carefully tended at the public expense, or if he is in good circumstances, he lets it be known to all his friends that he is suffering from a severe fit of immorality, just as we do when we are ill, and they come and visit him with great solicitude.
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> -- Samuel Butler, *Erewhon*, 1968, pages 111-112.

The dividing-line between treatment and punishment for offenders has always been ill-defined. In his satirical dystopia, *Erewhon* ("Nowhere" spelled backwards), first published in 1872, Samuel Butler depicted a world in which crime was a sickness that deserved not moral censure but sympathy, support, and the best possible care that the community could offer. A century later, the irony of Butler's vision remained lost on post-war correctional reformers who hoped that

> …the formal distinction between prison and hospital will become blurred, and, one may reasonably expect, eventually obliterated all together. Both will simply become "places of safety" in which offenders receive the treatment which experience suggests is most likely to evoke the desired response (Wootton 1963:80).

The rise of retributivist models of punishment over the last three decades has been largely influenced by the recognitions of the hypocrisy and ethical shortcomings of the rehabilitative ideal. Butler himself foresaw these: harsh and disproportionate punishments masquerading as "cures", the denial of the rights of "patients", and the "therapists'" inability to resolve their conflicting loyalties to the state and the patient (Kittrie 1977, chapter 1). Yet, in the face of burgeoning levels of crime, many jurisdictions continue to pour resources into rehabilitative and treatment programs for offenders, which have expanded in terms of both their setting (community as well as institution-based), their mandate (not only formally convicted offenders but also those who have been diverted from the criminal justice system) and, most importantly, their scope (offenders who are not necessarily suffering from significant psychiatric disturbance but who exhibit a range of other behaviours including physical violence, inappropriate or violent sexual behaviours, substance abuse, "anger" problems, etc.). Prominent amongst these are sex offenders, for whom treatment programs have exponentially increased over the last twenty years (Marshall et al. 1999:2).

All of these offender treatment programs, however, continue to pose the same ethical dilemmas inherent in Butler's original version of inverted morality. Resolution of such dilemmas has proved

difficult. They can no longer be ignored; rather, staff working in such programs have been encouraged to breach traditional ethical codes of mental health practice, justifying such breaches by pragmatic considerations (for example, the success of a program in reducing offender recidivism rates). Some offender treatment programs, especially many serving sex offenders, go even further than this: they *require* therapeutic staff to explicitly and uncompromisingly adopt particular vales and practices (e.g. mandatory involuntary treatment for all offenders, regardless of the offender's preference) which cannot be reconciled with traditional mental health ethics in any way.

This paper, after demonstrating that conventional mental health ethical codes no longer provide guidance to professionals working in sex offender treatment programs, gives several reasons for health professionals to nevertheless remain involved with such programs. A therapeutic jurisprudence approach is used to argue that the law's "healing" role in offender treatment programs extends beyond sentencing and parole decisions to the design of appropriate guidelines for therapy. Ultimately sex offender treatment programs remain a form of punishment: the well-accepted principles justifying and limiting the role of punishment in Western legal systems may well be a better ethical guide for therapists in this area than conventional codes of mental health practice.

TREATING THE PUNISHED AND TREATMENT AS PUNISHMENT

Punishment can be broadly defined as an authority's infliction of a penalty on an offender, an offender being someone who has broken a rule or has caused someone else to break a rule, whether negligently or intentionally (Honderich 1989:19). Treatment, at least as far as offenders are concerned, involves an intervention which is administered by, or supervised by, a health professional, often (although not always) with at least one of its aims being the alleviation of an offender's distress. These definitions seem to capture the experiences of most people involved in the criminal justice system. As we have already noted, however, the boundaries between treatment and punishment have become increasingly blurred, with many treatment programs having primary aims which are mainly punitive in nature, e.g. protection of the community from the offender.

A more useful distinction, which is not often explicitly made in the literature, is that between treatments which are administered to those already undergoing punishment (for example, mental health care for prisoners) and treatment which is either implicitly or explicitly a component of punishment (for example, sex offender treatment programs which are a condition of a court order or which are undertaken in expectation of favourable consideration for parole). Although there is some overlap between these two types of treatment, they represent two extremes of an ethical spectrum.

In the former (treatment for those already undergoing punishment), the clinician may often be forced to breach ethical standards but is always obliged to justify such breaches. For example, although confidentiality often cannot be guaranteed in prison settings or court-ordered evaluations, the clinician must be aware that:

> Respect for the individual's right of privacy and the maintenance of confidentiality are major concerns…the psychiatrist maintains confidentiality to the extent possible given the legal context…(American Academy of Psychiatry and Law, *Ethical guidelines for the practice of forensic psychiatry*, Revised 1995, quoted in Gutheil, 1999:348).

Although there are many situations where confidentiality cannot be maintained (e.g. preparing an assessment for a court, reporting an offender's escape plans to prison authorities), such instances are always treated as exceptions to a more general and usually overriding rule, which stresses the primary role of confidentiality in the therapeutic relationship. Breaking confidentiality is a necessary evil that is, at the very least, a hindrance to the development of a therapeutic relationship and, in some cases, destructively anti-therapeutic.

By contrast, in treatment programs which form part of the punishment meted out to offenders, the therapist may not only be allowed but is often required to breach ethical codes of good mental health practice, the justification being that such breaches are the only way that treatment can be made effective. This is especially the case for sex offender treatment programs. In them, confidentiality, for example, can never be guaranteed:

> Limited confidentiality is a necessity if a child sexual abuse treatment team is to function effectively. In this, sexual abuse differs from all other therapeutic programs known to the author…sexual abuse programs differ from the traditional stance on confidentiality in that individuals are asked to surrender their right to have total confidentiality upon entry to the program and may be denied entry if they do not agree…(Salter 1988:89-90).

SEX OFFENDER TREATMENT PROGRAMS: A SYSTEMATIC SABOTAGE OF TRADITIONAL ETHICS

Most sex offender treatment programs are administered as specific components of punishment ordered by a court, parole board, or similar body. Ethically, they thus follow the treatment-as-punishment model described above with the therapist

being required to adopt a value-system which is very much at odds with the codes of practice traditionally used by mental health clinicians. Protection of the community, rather than the welfare of the offender, is the primary aim of treatment.

Of course, no form of mental health intervention is entirely beneficent: for example, diagnosis of a disorder may be a process which the patient experiences as dehumanising, discrediting, and punitive (Reich 1999). Nevertheless, except in some totalitarian regimes such as the former USSR, mental health clinicians are expected to take heed of these risks, using recognised ethical principles such as beneficence and promotion of the patient's autonomy.

However, in sex offender treatment programs, the responses to such ethical dilemmas over-ride traditional ethical guidelines and are usually not in the best interests of the patient. Furthermore, these non-beneficent values are seen as an intrinsic and necessary features of the therapeutic regime: the mark of a good therapist is as much their adherence to these values as is their clinical skill. Even though they constitute clear breaches of traditional codes of mental health ethics, they pervade all aspects of treatment programs for sex offenders.

Examples of these breaches and of the treatment procedures which require their incorporation include the following:

1. The primary measure of treatment success is that of the protection of society rather than alleviation of the offender's suffering. Evaluations of effectiveness of treatment programs tends to focus almost solely on measures such as recidivism rates, delays in onset of reoffending, decreases in the violence and intrusiveness of behaviours of those who do reoffend, and/or decreased cost to the community and victims. Outcome measures such as offender satisfaction with the program appear to be largely ignored or considered to be irrelevant, even though it is acknowledged that some techniques such as promoting an offender's self-esteem are important in achieving decreased recidivism rates (Marshall et al. 1999, chapters 4 and 10).

Nearly all codes of ethics in mental health practice, however, require the patient's interests to be paramount, except in certain well-defined circumstances. For example, ethical standard (3) of the World Psychiatric Association's *Declaration of Madrid* requires that:

> The patient should be accepted as partner by right in the therapeutic process. The therapist-patient relationship must be based on mutual trust and respect…(World Psychiatric Association 1996, reprinted in Bloch et al. 1999:518)

2. Treatment, to be effective, must usually be involuntary. For paedophiles, for example, court ordered therapy is "essential" in that offenders are more likely to persist with therapy and the therapist is less likely to collude with offender denial. Offenders who "volunteer" for treatment generally are considered to have a worse outcome than their involuntary counterparts, whether in a community or institutional setting (Salter 1988: 86-87).

In recent times, prominent writers in the field have become even more blatant about their advocacy for coercive therapy. Marshall and his colleagues firmly believe that:

> Such interventions should sensibly combine treatment with incarceration. These men knowingly engage in behaviours that are unlawful, as evidenced by the fact that they take great care to avoid detection and by the fact that most act to prevent their victims from reporting the offence…clear feedback from society, by way of a prison sentence, makes it apparent to these men, as it does to all other offenders, that their abusive actions are not acceptable (Marshall et al. 1999:3).

Such stances clearly contravene accepted practice. All mental health ethical codes provide that involuntary treatment (for example, for people with severe mental illness) can only be contemplated as an intervention of last resort, based on a finding that the person, "because of mental illness, cannot form a judgement as to what is in his/her own best interests and that, without such treatment, substantial impairment is likely to occur to the person or others" (American Medical Association 1988, reprinted in Bloch et al. 1999:525-526).

3. Effective treatment requires that confidentiality be breached. As noted above, in sex offender treatment programs it is routine to offer only limited confidentiality. Offenders are required to give permission for their cases to be discussed with a wide variety of people and agencies. The recipients of this information may include both clinical and non-clinical personnel, especially judicial officers, parole authorities, corrections officers, members of their family, past and potential victims and those associated with them, and (in the case of group therapy programs) fellow offenders. This is characteristic of even more enlightened programs which seek to use persuasive, rather than confrontational, methods of therapy (see, for example, Birgden and Vincent, 2000). The ethical dilemmas arising from such requirements have been discussed above.

4. *Generally, the offender must not be allowed any choice of therapy or therapist.* Sex offenders are required to complete particular programs, irrespective of any other treatment that they might be receiving, in order to gain parole or (in the case of community programs) avoid imprisonment (Birgden and Vincent 2000; Peebles 1999). The reasons for this insistence

that an offender complete a particular program or a particular type of program are not entirely clear. There is some empirical evidence that programs based on particular treatment methods (particularly cognitive-behaviour therapy supplemented, if necessary, by pharmacological interventions) result in lower recidivism rates (Marshall et al. 1999, chapter 10). There may also be economic and organizational justifications. Nevertheless, there appears to be an almost morbid and irrational preoccupation with the ability of sex offenders to manipulate gullible and vulnerable therapists and a corresponding concern that offenders receive therapy only from those who hold the right kinds of attitudes and values (Salter 1988:91-93; O'Connell et al. 1990).

Whatever the reason, such practices clearly infringe on the therapist's ethical duty to promote the offender's right to self-determination, including (for example) the "general right to engage in and to end the professional relationship…" (European Federation of Professional Psychologists Associations, 1995, reprinted in Francis 1999:234).

5. Offenders may be forced to accept therapy from non-clinicians or unqualified staff. A large number of sex offender treatment programs rely heavily on the use of prison officers and other unqualified staff (ATSA 1996). Such arrangements might be justified by financial constraints or the promotion of a therapeutic environment in the setting concerned. However, they will often contravene the ethical requirement to offer offenders high standards of care provided by appropriately qualified professionals (see, for example, the Declaration of Madrid, 1996, section 2; American Medical Association 1988, sections 1 and 5).

6. Effective therapy requires multiple other infringements on an offender's dignity and autonomy. Not only are offenders forced to accept involuntary treatment, limitations to confidentiality, loss of choice of therapist and services from unqualified staff, they are also required to adopt specific attitudes, values, and behaviours determined largely by the therapist. They are not allowed to deny their offending behaviours, even though this might place them at risk of incriminating themselves in hitherto undetected criminal activities (Kaden 1998). They may be forced to admit to detailed plans for offending or extensive pre-offending sexual fantasies, despite the evidence that, in at least some offenders, such plans or fantasies may be non-existent (Marshall et al. 1999:62-64). They are required to carry out behaviours determined by the therapist, to prevent relapse; although some of these requirements are reasonable (e.g. paedophiles avoiding schools and playgrounds), others may involve quite arbitrary dictates (for example, the standard of personal hygiene which an offender must follow) (Marshall et al. 1999:131-132).

The therapist remains actively in control and the price for the offender of questioning the goals set by the therapist is a heavy one: possible expulsion from the program or at least an unfavourable report to a court or parole board. Although few writers in the field have acknowledged it, this sort of control comes perilously close to brainwashing, with the aversive stimulus being the threat of further punishment if the offender does not comply. Those who have used aversion techniques for sexual dysfunction generally (for example, to change sexual orientation) have concluded that they are not only ineffective but also unethical unless the patient is able to reject or withdraw from treatment (Bancroft 1991). They clearly infringe upon an offender's right to self-determination as enshrined in all of the ethical codes cited above.

SHOULD MENTAL HEALTH CLINICIANS ABANDON SEX OFFENDER TREATMENT PROGRAMS?

Clinicians who treat sex offenders are probably practicing in an ethical vacuum. They are required, as part of "good" clinical practice to violate the precepts of most traditional ethical codes. On the other hand, they are rarely provided with guidance as to appropriate ethical principles that might replace those which they have been obliged to breach.

Where attempts have been made to provide such guidance, they have produced considerable ambiguity. For example, most writers in the field would at least grudgingly acknowledge that sex offenders, as human beings, deserve to be treated with dignity and respect. However, the major justification for doing so is really an instrumental one in that (for example) promotion of self-esteem in sex offenders reduces their tendency to re-offend: people with low self-esteem generally feel more threatened by negative feedback, are less motivated, are more likely to do poorly in tasks, and are generally disinclined to make commitments to change (Marshall et al. 1999:55).

Yet there appear to be good pragmatic reasons for mental health clinicians to continue to be involved in the treatment of sex offenders. Firstly, such programs work; a number of methodologically sophisticated studies have now shown a significant drop in recidivism rates for offenders treated via cognitive-behavioural techniques compared to groups of offenders who were either untreated or treated by a different means. The effect is particularly striking for those programs evaluated within the last few years, i.e. precisely those programs that demand the violations of traditional ethical codes listed above. (For a review, see Marshal et al. 1999, chapter 10). As many have pointed out, these sorts of successes have produced an enormous reduction in the suffering experienced by potential victims and the community and huge savings

in the costs of criminal justice and other interventions for sex offenders and their families.

A second reason for clinicians continuing to treat sex offenders is that the presence of behavioural professionals in correctional institutions and programs, in general, has a humanizing effect. Although often parodied, the world-view of mental health professionals encompasses more than just the rehabilitative ideal. It is important for offenders (and even more important for correctional officers) to know that criminals are not incorrigible, conflict with them is not inevitable, and harsh punishments are not the only solution to the problem of crime (Burt 1993).

Thirdly, at the very least, sex offender treatment programs are not hypocritical (except that the term *treatment* continues to be widely used). The therapist is firmly committed to the good of society rather than the welfare of the offender. Thus, unlike the offender therapy and rehabilitation programs which caused so much concern during the sixties and seventies, therapists are not allowed to fool their clients (or themselves) into believing that the abuses of aversive therapy and pharmacological treatments practiced then represent therapy in any conventional sense (see also Kittrie 1977, chapter 4).

ARE ETHICAL CODES NECESSARY IN OFFENDER TREATMENT?

One way of sorting out the problem is to ask whether ethical codes are necessary in this sort of clinical work. Clinicians and their philosophical advisers use such codes for a variety of purposes. It could be that, for the purposes of treating sex offenders, ethical codes are either irrelevant or unnecessary.

Firstly, codes of ethics can be seen as simply a way of encouraging certain standards of conduct. It is believed (although this is not necessarily supported by the empirical evidence) that members of a profession following a particular ethical code will be more likely to act in certain desirable ways. Lichtenberg (1996) has described some processes by which this might occur: "bringing to consciousness" the relevant rules of conduct, attaching sanctions (for example, censure by fellow professionals) to breaches, increasing people's motivations to act in a certain way (by encouraging people to believe that they can "make a difference" by so acting), and decreasing the sacrifice involved in carrying out such activities (by encouraging widespread conformity with a rule that might otherwise disadvantage those who do conform to it).

The problem with this formulation (as acknowledged by Lichtenberg herself) is that codes of ethics devised for these reasons give little recognition to the motives and values of an individual who has to act to resolve a particular ethical dilemma. They are simply prima facie assumptions as to how an individual ought to act generally. They rarely, if ever, will conclusively decide the specifics of individual cases, and they are always rebuttable by appeal to considerations such as the autonomy of the individual professionals and their right to "conscientiously object" to the provisions of a code which may not apply to them.

At crucial times, therefore, ethical principles fail as guidelines for practice: there is little guidance for the vast majority of ethical dilemmas which involve ambiguous issues or borderline breaches, whereas clear-cut violations (e.g. assaults on clients) are capable of being dealt with by other mechanisms, such as the criminal law.

A second, and more venerable, approach to defining the need for a code of ethics arises from the protection and promotion of particular professional groups (the Hippocratic oath is a notable example). Therapists in sex offender treatment programs are no different from other professionals in wanting to ensure special recognition of their status, knowledge, particular privileges (such as self-regulation, setting their own fees), and generally as a powerful group within society (Bloch and Pargiter 1999). Indeed, cynics might argue that sex offender therapists are no different from other professionals who, in George Bernard Shaw's terms, are "conspiracies against the laity". Ethical codes with this purpose place a high premium on rules, which increase the coerciveness of the professional group involved (e.g. obligations to educate one's junior colleagues and preserve the secrets of one's craft). The duty to serve the best interests of one's client is assumed to be a natural part of the nobility of one's professional calling, rather than a specific ethical requirement of practice.

Clearly, ethical codes with this sort of aim are not appropriate for those working with sex offenders, where one of the most problematic areas of the professional relationship is the already huge power imbalance between therapist and offender. If anything, ethical codes aimed at establishing and strengthening professional privileges are likely to simply increase that imbalance, something that is already being done by the breaches which have been described above.

A third, and possibly more satisfactory approach, is to treat a code of ethics as a public commitment by a professional group to a particular set of standards and rules. In this way, an ethical code becomes part of a group's self-definition and also a justification of its role within society. For example:

> The primary ethical justification of the institutionalisation of medicine seems to be to provide members of the community with the means by which their illnesses can be cured and their pains alleviated. The professional body's activities of credentialing, of further education, of drawing up codes of ethics can also be justified by reference to this purpose and the ethical

> justification of the institution provides a guide as to what should be included in the code of ethics. (Coady 1996:46).

This notion fits nicely with the modern concept of "risk management" in organizations. The best justification that a professional group can have for claiming a special role in society is to point out that misconduct by individual members of the group is an aberration. No matter what stereotypes may be raised about a particular profession in the scandal which invariably accompanies cases of spectacular misconduct, the group as a whole is entitled to defend itself by emphasizing its general commitment to the highest standards of ethical practice (Francis 1999:50).

While they are a relatively new phenomenon, clinicians in sex offender treatment programs increasingly want to define a public role for themselves. The Association for the Treatment of Sexual Abusers, for example, in its position papers, not only provides information about treatment and its effects but also is well aware of its responsibilities to offenders, the victims, and the community at large (ATSA 1996). The public persona of those running sex offender treatment programs is becoming increasingly important, as is a commitment to high standards of practice.

It does seem, therefore, that those involved in treatment of sex offenders need an ethical code for the purposes of defining themselves as a professional entity, committed to certain standards of practice, and ready to uphold such standards should one of their members breach them. But we now return to our original problem: what is to guide clinicians treating sex offenders in resolving ethical dilemmas if they, as part of their routine practice, are required to violate the ethical codes which have performed this important function in the past?

ADAPTING OLD CODES: THE USE OF PATERNALISM

Codes of ethics for mental health professionals rest on a framework of basic principles. Generally these are: respect for autonomy (ensuring that the patient or client is free from external constraints and promoting their capacity to make voluntary informed decisions), non-maleficence (avoiding harm to the client), beneficence (the welfare of the patient is the primary goal of treatment), and justice (ensuring that the patient is treated fairly, equitably, and in accordance with his or her rights and entitlements) (Beauchamp & Childress 1994, chapters 3 – 6, also see the summary in Beauchamp 1999). When these principles conflict (as they invariably must), the norms and rules that they produce should be suitably specified to cover the particular dilemma which demands attention.

Paternalism is an important instance of how such conflicts arise. A person's autonomy is limited in some fashion, with the justification that this limitation will be of benefit to him or her. A classic example in mental health practice is that of the involuntary hospitalisation of mentally ill people. There are usually numerous legal and ethical restrictions as to how paternalistic powers may be exercised. For example, patients have to be unable to provide informed consent to treatment, they must pose a danger to themselves or others, the treatment proposed is necessary and available in the institution to which they are to be admitted, etc. The point to note is that, when these very specific conditions are met, paternalism becomes a justifiable, even laudable, way of approaching the problem of patient treatment.

It is tempting, therefore, to use a notion such as paternalism to justify the multiple restrictions on sex offenders' autonomy and the resultant harms that they suffer when they participate in the sorts of treatment programs described above. These programs can readily be seen as producing long term benefits for the offenders themselves, in addition to their primary aim of protecting society: because they reduce recidivism, offenders will be less likely to suffer the personal consequences of their offending behaviours. Such consequences can be serious and include lengthy periods of incarceration, the loss of an offender's livelihood and reputation, and estrangement from his or her family and friends.

Paternalism, therefore, provides a way for therapists working with sex offenders to adapt traditional mental health codes of ethics to their own needs. It explicitly recognizes that, in specialist treatment programs for offenders, there is a significant conflict between some basic ethical principles underlying mental health practice, but the specifics of the situation justify the dominance of one particular principle, i.e. beneficence, over the rest. Clinicians treating sex offenders can assure themselves that they are, despite a number of ethical irregularities in their own practice, like other mental health practitioners in that they are ultimately (even if only indirectly) interested in the welfare of their clients.

There are two major criticisms of this adaptation of more traditional codes. Firstly, justifications relying on paternalism generally assume that the subject's autonomy has already been impaired in some way even before a decision is made to restrict it further. Involuntary psychiatric patients are generally not able to make informed decisions about their care or treatment. By contrast, most sex offender treatment programs very carefully evaluate the offender's capacity to consent to treatment. If an offender refuses or ceases participating in treatment, they do so autonomously, i.e. they nearly always have been fully informed about the nature of the treatment and the consequences of refusal or non-participation.

One way of getting around this apparent forcing of treatment on those who are competent to refuse it is to appeal to other ethical principles apart from

beneficence. One could say, for example, that, paradoxically enough, the temporary restrictions on an offender's autonomy imposed by treatment programs may be justifiable in that they promote increased long-term autonomy. Indeed, psychological therapies generally often assume an increase in the patient's autonomy as being the long-term primary goal, even if this means some transient and temporary limitations on the patients' ability to determine their own lives. Some types of psychotherapy, such as the "paradoxical techniques" of family therapy, allow therapists to deceive and manipulate patients in order that they may escape from bonds of crippling anxiety and rigid patterns of behaviour. A conscientious clinician should feel no shame if he or she can show that ethically dubious techniques ultimately produced a patient who has a greater capacity for rational and informed decision-making about his or her life (Holmes and Lindley 1991:145-148).

The cognitive-behavioural techniques used in sex offender treatment programs do precisely this: by teaching offenders to understand their patterns of behaviour and to recognize their harmful consequences, these treatment techniques ultimately aim to increase offenders' capacities to make informed and rational choices including that of a non-offending lifestyle. Many writers firmly believe that the offender's learning this "internal management", rather than having to rely on external controls, is itself an important factor in reducing recidivism (Marshall et al. 1999:161-162).

A more cogent criticism of paternalism as a way of adapting traditional codes of practice for sex offender treatment programs is that (as we have already seen) it is an accidental or secondary effect of such treatment. Their primary aim remains the protection of the community. Some might argue that the intention behind a clinical intervention is not important, provided that it ultimately (even if accidentally) benefits the offender. However, practically speaking, the sum total of harmful effects in this case may outweigh long-term benefits, particularly for recidivist offenders. Confidentiality will repeatedly need to be breached to enhance detection of past and potential crimes. The offender's choice of therapy will have to be severely restricted to ensure consistency of treatment and monitoring. The offender's lifestyle will be strictly controlled to limit opportunities for re-offending. These restrictions, if enforced over a prolonged period, may not be justified by the dubious rewards of less time in prison or less ostracism by the community.

Ultimately, therefore, clinicians working in sex offender programs are unable to usefully adapt any codes of ethical mental health practice which are fundamentally based on serving the offender's best interests, i.e. most traditional codes. Yet, as we have seen, these practitioners increasingly recognise the need for some sort of code, not least of all because such a code, rather than their knowledge and skills, will be instrumental in defining their professional roles and responsibilities.

AN ANSWER FROM THERAPEUTIC JURISPRUDENCE

Therapeutic jurisprudence is the "study of the role of the law as a therapeutic agent" and, in particular, the influence of the law on emotions and on psychological well-being (Wexler & Winick, 1996:xvii). It "offers the promise of creating a 'law of healing'", with a particular emphasis on modifying the conflict, stereotyping, and scape-goating which often characterize legal systems and their interactions with those caught up in them (Perlin 2000).

The therapeutic jurisprudence perspective can also be seen as the product of the disquiet regarding both the excesses of the "therapeutic state" and the deficiencies of the criminal justice system which was first raised three or four decades ago. Kittrie's influential work, particularly the book, *The Right to be Different* (Kittrie 1977) provided convincing and distressing details of the abuse of therapeutic zeal in dealing with a wide range of socially deviant populations including the mentally ill, delinquent youths, psychopaths, drug addicts, alcoholics, and the mentally retarded. What needs to be remembered, however, is that Kittrie emphatically refused to blame these excesses on allegedly sinister and power-hungry cabals of mental health professionals seeking, as in *Brave New World* or *A Clockwork Orange*, to brainwash humanity into a mass of dull conformity. Rather, he points out that the applications of mental health therapy techniques to offenders are a direct and necessary outcome of the "inability of classical criminal law to secure order and tranquillity in present-day society" (Kittrie 1977:374). Unfortunately, treatment programs have often become "the receiving ground for past mistakes of criminal law, when society finally repents of its error but is not yet willing to tolerate the offensive activity, even though it is not particularly harmful" (Kittrie 1977:383).

In the particular case of sex offenders, writers on therapeutic jurisprudence have strongly advocated for improvement in legal procedures to facilitate rehabilitation and treatment. Wexler (1993) has suggested that judges should not accept a plea such as *nolo contendere* ("no contest") without questioning the basis for such a plea, otherwise the judicial officer concerned could well be implicitly colluding with an offender's denial ("I didn't really do it, but they told me it would be easier for me this way"). Winick (1998) has emphasized the anti-therapeutic effects of laws which require public notification of the presence of a convicted sex offender in a particular community. Such labelling reinforces the offender's own perception of himself as a person unable to change or take responsibility and may, indeed, become a self-

fulfilling prophecy. Other writers have highlighted the role of therapeutic jurisprudence in justifying "gentler" sentencing options such as extended community supervision (rather than long-term incarceration) as a more cost-effective way of ensuring community protection (Peebles 1999).

On the other hand, "it is clear that an enquiry into therapeutic outcomes does *not* mean that therapeutic concerns 'trump' civil rights and civil liberties" (Perlin 2000, italics in original). Indeed Perlin's comments in this context, applied to legal processes affecting those with mental disabilities, are equally applicable to anyone caught up in the criminal justice system. We must be aware (to extend Perlin's concepts) of disguising, as therapeutic, interventions that are really aimed at allaying our own anxieties about offenders.

At a more practical level, these concerns have recently been elaborated as a subspecialty of therapeutic jurisprudence, rather cumbersomely labelled "jurisprudent therapy". The concept remains poorly developed but essentially it involves

> Different facets of mental health in a social science context [being] evaluated for their 'jurisprudent', neutral, or 'antijurisprudent' effects. The term 'jurisprudent' in this context is defined in terms of legal rights, privileges and options (Drogin 2000:492).

This sort of approach is exemplified by the difficulties sex offenders face when they insist on denying some or all of their offences while in a treatment program. In the US, the Fifth Amendment to the Constitution gives offenders (even after conviction) a fundamental right against self-incrimination. Yet, in treatment programs, they are routinely required to waive that right or else be regarded as untreatable and face harsher penalties. Matters, of course, are made worse by the fact that, as we have seen, sex offender treatment programs will generally guarantee their clients only limited confidentiality, with obvious implications for reporting of disclosed, but previously undetected, offences, by the therapist to the relevant authorities (Kaden 1998).

The courts in the US have adopted different views as to whether an offender's right against self-incrimination can be protected after conviction. The relevant legal considerations appear to include the plea entered at the time of conviction [State v. Imlay, 813P.2d 979 (Mont. 1991); State v. Gleason, 576A.2nd 1246 (Vt.1990)] and the gravity of the consequences of such self-incrimination [McKune v. Lile, WL 1270605 (U.S.) (2002)]. Yet it is clear that this right is not one that should be given up easily. Kaden (1998) has astutely pointed out that there is no good empirical evidence to support the intuitive assumption that confession of one's misdeeds results in a decreased risk of antisocial behaviour. Rather, admission of responsibility for an offence simply is an image of the "rehabilitated" offender, which sits most comfortably with stereotypes adopted by the courts. In practice, as Kaden shows, there are many types of treatment approaches that rely very little or not at all on offenders disclosing their crimes but which are still effective in reducing recidivism rates.

In some cases, a therapeutic jurisprudence approach reveals that the law is exerting both antitherapeutic and antijurisprudent effects. John La Fond (1999) has eloquently demonstrated that sexual predator laws in Washington, Kansas, and other US jurisdictions use treatment as a justification for indeterminate civil detention of sex offenders, thus denying them their constitutional right not to be punished twice for past crimes. Yet it is clear that the same legislators and officials who have devised and implemented these laws cynically doubt the efficacy of any treatment program. They have complied only grudgingly with court injunctions to improve the inadequate programs currently being offered and probably never intended that detained offenders ever be released, even after successful completion of treatment. If one adds to these conditions the dubious ethical practices of the treating clinicians described above, then the potential for abuses of fundamental human rights becomes very high.

Therapeutic jurisprudence and its extensions, therefore, promote an acute awareness of the complex psychological and social processes, which accompany the legal system in all its manifestations. The therapeutic jurisprudence view of sex offenders (if such can be characterized at this early stage of the discipline's development) appears to involve: (a) Mitigation of some of the harsher (anti-therapeutic) sanctions imposed on them (e.g. long sentences, compulsory community registration), justified as much by the benefit to the community as by the effects on offenders themselves, (b) Modification of legal processes that might impede rehabilitation, even though advantageous to offenders themselves (e.g. unquestioning acceptance of a *nolo contendere* plea), and (c) A continuing insistence that treatment techniques, however beneficial for the offender or the community, do not jeopardize the civil and legal rights of individual offenders. The implied model of punishment is essentially a utilitarian one, tempered by some basic principles of retributive justice, or what philosophers have labelled as "teleological retributivism" (Ezorsky 1977). That is to say, the law should promote punishment regimes which minimize suffering to sex offenders while still effectively protecting the interests of society and ensuring the preservation of an offender's basic civil and legal rights. The treatment programs described above are one important (but not the only) way of achieving these goals.

AN ETHICAL CODE SUGGESTED BY THERAPEUTIC JURISPRUDENCE

Therapeutic jurisprudence, at this stage of its development, remains primarily a practical project, focused on humanizing legal processes. Yet, from the above discussion, one can see some important principles emerging which can be applied to offender treatment programmes in general and, in some cases, specifically to programmes for sex offenders. Many of these principles would be familiar to legal professionals in other contexts, for example, as statutory or case law guidelines for sentencing courts. What therapeutic jurisprudence has done, however, is to highlight the importance of these principles for therapeutic programs which are part of a regime of punishment or, to reiterate a concept discussed earlier in this paper, programs of treatment-as-punishment.

For the clinician involved in sex offender treatment, three important groups of principles stand out:

(a) ***The offender must be treated with procedural fairness.*** Therapeutic jurisprudence is concerned, perhaps more than other jurisprudential systems, with an all-encompassing approach to natural justice or due process. This means not only attention to traditional concerns such as the right to notice of a hearing, the right to be heard by an unbiased judge, the right to legal representation etc, but also the provision of a "voice" to all stakeholders in the criminal justice system. Whether they are an offender, victim, or witness, all participants should be entitled to the time and resources to enable them to feel that they have properly put their views to a court or other decision-making body (Freiberg 2001).

For a therapist in a program for sex offenders, this means, at the very least, giving careful and adequate consideration to an offender's views, comments, and explanations; particularly when decisions are being made which might impact on that offender's liberty or personal rights (such as expulsion from the programme, limitations on an offender's ability to visit certain locations, or engaging in particular activities).

This does not necessarily mean that formal judicial processes be followed every time such decisions are made. Rather, there needs to be evidence that appropriate principles of natural justice or due process have been followed. For example, a therapist who develops strong feelings of like (or dislike) for an offender (and this is a common situation) should avoid participating in any decision as to whether an offender continues to remain in the program. Offenders should have some process of appeal against conditions of program participation which appear to place harsh or unnecessary restrictions on their daily activities, such as the maintenance of standards of personal hygiene, requirements to fully confess all past crimes and misdemeanours, however trivial, etc. Such appeals, in the first instance, may well be to other clinical practitioners (perhaps working outside the program) who could form an independent judgement as to whether the restrictions involved were necessary to achieve the aims of the program.

Procedural fairness, like many ethical ideals, is not easy to achieve. As we have already seen, manipulative behaviour and therapist-shopping are hallmarks of sex offenders, particularly those who are trying to deny or minimise their behaviours. They may well use concerns over their rights as excuses for avoiding important therapeutic issues. On the other hand, to allow the therapist to have unfettered powers is an even more unpalatable option: therapeutic jurisprudence hopefully emphasises a middle way between these two extremes.

(b) ***The amount and type of treatment is governed by the seriousness of the offence at least as much as by the need for treatment.*** This is basically a context-based restatement of the well-known sentencing principle of proportionality. The punishment imposed must be proportionate to the seriousness of the offence. There are many offenders with serious psycho-social problems who could probably benefit greatly from prolonged and extensive participation in various treatment and rehabilitation programmes but whose crimes are so minor that they simply do not deserve the imposition of punishments which would enable such interventions to be carried out.

In a therapeutic jurisprudence field, this issue has risen to prominence with the establishment of "problem-solving" or "problem-oriented" courts whose purpose is to consider the wider psycho-social problems being faced by offenders rather than a narrow focus on offence-related issues. Thus (for example) there are now drug courts, mental health courts, domestic violence courts, etc.; all aimed at identifying defendants with particular problems and referring them to specialised clinical agencies, rather than using more traditional methods of disposition such as imprisonment (Freiberg 2001; Rottman & Casey 1999). While there is no doubt that the intentions of these courts are entirely benevolent, the sentences or other forms of disposition, which they encourage, may well be seen as being more burdensome than traditional punishments by the defendants who appear before them. For example, many substance abusers in a UK study say that they prefer imprisonment to the daily reporting and frequent urine testing which are the requirements of a "community" drug treatment program (Walsh 1999).

For clinicians treating sex offenders, the principle of proportionality has wide-ranging ramifications. There is no doubt that treatment programmes, which are longer, more extensive in their use of different modalities, and based on involuntary participation, have a great chance of reducing recidivism. Nevertheless, the "nuisance" crimes such as indecent exposure committed by many sex offenders may not

warrant the imposition of this sort of treatment-as-punishment regime, particularly if it involves onerous restrictions on an offender's lifestyle. Furthermore, the mere establishment of a treatment programme may itself lead to the well-known phenomena of net-widening and sentence escalation: offenders who may not have been previously considered for a custodial sentence may receive one because the prison concerned operates a treatment programme.

The adoption of proportionality as an ethical principle will force many clinicians in sex offender treatment programmes to think more carefully about issues such as their preference for mandatory programmes, the appropriateness of incarceration as part of a treatment regime, and the use of harsh restrictions on an offender's lifestyle to achieve treatment outcomes.

(c) ***Infringements on an offender's legal rights must be minimised.*** In some ways, this principle is analogous to the well-known requirement for the use of the "least restrictive alternative" when clinicians have to treat clients involuntarily. The aim, however, is different. It is not the traditional one of promoting client autonomy (although this may well be an important consideration, see Holmes & Lindley 1991, ch.1). Rather, the guiding rule is that of non-maleficence; minimally restrictive treatment/ punishment interventions are used because unnecessary punishment is intrinsically unethical. A simple, but powerful, justification for this rule is offered by the utilitarians who will:

> [only] justify a particular punishment if the suffering inflicted by that punishment is less than the harm caused by the crime which would have occurred had there been no punishment (Ten 1987:142).

Thus (for example) if two punishments, one harsher than the other, are equally as effective in deterring a crime, then the less harsh one is to be used.

An example that has been referred to throughout this paper is that of forcing offenders to incriminate themselves even when the offending behaviours involved have been the subject of any formal legal attention. The use of this principle would require clinicians to investigate treatment methods which do not require an offender to provide a comprehensive confession of all their past behaviours (and, indeed, such methods are already being tried).

More broadly speaking, this principle also requires clinicians to think carefully about any treatment procedures, which might infringe on offenders' fundamental rights, e.g. rights to privacy, freedom of expression, freedom of movement, etc. Forcing an offender to adopt a therapist's views and attitudes, unnecessarily restricting their daily activities or arbitrarily breaching confidentiality are all demeaning and humiliating experiences which an offender may well not be forced to undergo to the same extent in other punitive environments such as a prison. Under the minimal restriction of rights principle, clinicians would not necessarily be required to abandon these measures but would be asked to justify them and constantly review them with reference to the aims of the treatment programme and the protection of society generally.

PUNISHMENT AND TREATMENT: RE-ESTABLISHING THE BOUNDARY

Clinicians working within the criminal justice system have always faced ambiguous ethical boundaries and irresolvable moral quandaries. Their problems have simply intensified when they have attempted to become involved in the actual administration of punishment, no matter how benevolent their intentions. The central danger has always been that of hypocrisy: pain and suffering inflicted by the state must not be presented as acts of kindness by caring professionals. Yet the boundary between treatment and punishment remains blurred; Butler's ironic image of the tender care which is necessary for a person "suffering from a severe fit of immorality" is only tempered by the sad realisation that mental health professionals have been willing to use such tenderness to disguise harshness and cruelty. It is unfortunately necessary that in treating sex offenders, clinicians abandon any pretence to have a primary or even a principal interest in their clients' personal needs. The empirical evidence is accumulating that mental health technologies can be used to prevent recidivism and thus create immense social benefits. But that promise has come with an ethical cost: in order to achieve these benefits, clinicians are required, at least in part, to abandon their responsibility for their clients' welfare.

No one else, however, can fully assume this burden. And mental health professionals themselves lose out if they live in an ethical vacuum: they lose, in fact, a core component of their identity.

Therapeutic jurisprudence, although not providing all the answers to this dilemma, nevertheless, points out a way. By attempting to apply procedural fairness, proportionate treatment interventions and minimisation of infringements on clients' rights, therapists can acknowledge that they are indeed inflicting pain and suffering on a largely unwilling client population but are nevertheless using their treatment technologies as fairly and as sparingly as they possibly can. This may not fit the image of the perfect therapist but may be sufficient to preserve at least a modicum of professional integrity and honour.

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