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Commentary An Ethical Paradigm for Sex Offender Treatment: Response to Glaser

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ABSTRACT

This paper responds to the recent article Therapeutic Jurisprudence: An ethical paradigm for therapists in sex offender treatment programs, in which the author argued that sex offender treatment is antithetical to the traditional values and ethics of the mental health professions. This paper will argue that sex offender treatment does in fact occur in a context that is consistent with the ethical codes of mental health professions, including APA and NASW. Evidence countering Glaser's six examples of ethical breaches will be offered. Finally, this paper will discuss the existing published code of ethics that pertains specifically to the treatment of sex offenders. Ultimately, we suggest that current practices are already very much in line with Glaser's therapeutic jurisprudence model.

KEYWORDS: therapeutic jurisprudence; sex offender treatment; ethics; ethical paradigm; mental health ethics; court ordered therapy.

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In his recent article Therapeutic Jurisprudence: An Ethical Paradigm for Therapists in Sex Offender Treatment Programs, Bill Glaser argued that sex offender treatment is antithetical to the traditional values and ethics of the mental health professions (Glaser 2003). Specifically, he stated that "staff in such programs have been encouraged to breach traditional ethical codes of mental health practice" and that such programs "require therapeutic staff to explicitly and uncompromisingly adopt particular values practices...which cannot be reconciled with traditional mental health ethics in any way" (Glaser:144). Glaser further asserted that "sex offender treatment programs remain a form of punishment," and he ultimately attempted to design an ethical code that applies the principles of therapeutic jurisprudence to sex offender treatment.

This paper will argue that sex offender treatment does in fact occur in a context that is consistent with the ethical codes of mental health professions. Two of the largest existing professional organizations, the American Psychological Association (APA) and the National Association of Social Workers (NASW), will be cited as examples. Evidence countering Glaser's six examples of ethical breaches as listed below will be offered. Finally, this paper will discuss the existing code of ethics that pertains specifically to the treatment of sex offenders, which has been established by the Association for the Treatment of Sexual Abusers

(Association for the Treatment of Sexual Abusers 2001).

TREATMENT OR PUNISHMENT?

Contemporary jurisprudence recognizes the need for an interdisciplinary response to crime, and courts have increasingly come to rely upon the collaboration of judges, court personnel, probation officers, and treatment providers (National Criminal Justice Reference Source 2003). In response to the problem of sexual violence, states across the U.S. have instituted policies that allow for a combination of punishment, management, and rehabilitation for sexual offenders. Examples of such policies include civil commitment, community notification, registration, and mandatory community based treatment, which are designed to promote rehabilitation and community simultaneously.

Non-voluntary treatment is not exclusive to sex offenders. Courts and clinicians have long recognized that some individuals, especially those suffering from addiction or mental illness, are unlikely to recognize their symptoms and seek treatment for their problems. When such disorders go untreated, they can lead to harm to self or others, or to crime. Similarly, courts acknowledge that in cases of interpersonal violence, it is common for denial, entitlement, and resistance, as well as shame, fear, and family loyalty to preclude the voluntary initiation of services for both victims and perpetrators. Drug courts and mental health courts are

increasing in numbers across the U.S., and domestic batterers and child abusers are commonly court-ordered to treatment by criminal and civil courts alike. These alternative sentencing approaches are intended to emphasize rehabilitation rather than punishment, and to divert cases away from the overburdened criminal justice system.

Glaser (2003) rightly notes that an important distinction exists between punishment (an authority's infliction of a penalty) and treatment (an intervention aimed at relieving the patient's distress). The boundaries can potentially become blurred when treatment is a component of a criminal sentence, such as in cases where offenders are required to attend treatment while on probation. However, treatment and probation are not mutually exclusive, nor are court ordered interventions necessarily coercive. It is important to remember that courts are requiring therapy, not programs. Treatment programs merely provide the mechanism for change if the client chooses to comply with the order of the court. Ultimately, clients always have a choice about whether or not to enroll or participate in treatment, and the court, not the treatment program, imposes the consequences of those choices.

On the other hand, it could be argued that "involuntary therapy" is an oxymoron. Coercion is the use of force, intimidation, or threats to dictate the actions of others (American Heritage 2000). Coercion can be a form of motivation, and is often used for that purpose in various contexts to compel an act or choice. Coercive helping relationships exist when there is a power imbalance between the practitioner and the client (Peterson 1992). In court ordered treatment, an "unequal power balance in the relationship and the omnipresent threat of consequences to the client makes full consent impossible" (Peterson:124) and, therefore, volunteerism is compromised.

Nonetheless, there are four basic purposes to criminal sentencing: retribution (punishment or reprisal for wrongdoing), deterrence (to discourage others from committing crimes), rehabilitation (to help criminals change their behavior and become responsible citizens), and incapacitation (to protect society from dangerous, lawbreaking persons). The justice system enlists mental health professionals to assist with the goal of rehabilitation. Clearly, rehabilitative criminal justice differs from the traditional psychotherapy commonly sought by other types of patients, and requires careful consideration by the therapist of ethical dilemmas and the potential abuse of power.

Over the past decade, the mental health professions have revised and modified their codes of ethics to incorporate the increasing reality of court ordered service provision. Both the APA (2003) and the NASW (1999) codes of ethics acknowledge that psychologists and social workers must adhere to specific standards for

working with mandated clients. The Code of Ethics promulgated by the Association for the Treatment of Sexual Abusers (ATSA 2001b) specifically addresses the specialized treatment of sex offenders.

Far from being encouraged to breach ethical codes, sex offender treatment providers are expected to acknowledge the potential for coercion in court ordered treatment and to balance the best interests of the client with those of the community (ATSA 2001b). To suggest, as Glaser did, that sex offender treatment is not in a patient's best interest is simply illogical. To suggest that clear breaches of traditional codes of ethics pervade all aspects of sex offender programs is equally erroneous. By illustration, an itemized examination and refutation of Glaser's points follows.

RESPONSE TO GLASER'S POINTS

1. The primary measure of treatment success is that of the protection of society rather than alleviation of the offender's suffering.

Glaser correctly noted that treatment effectiveness studies have focused almost exclusively on measuring recidivism rates, and that other measures of client progress or satisfaction have been largely ignored. We agree that measuring the skills, behaviors, and attitudes that clients gain through treatment should be acknowledged as an important measure of success. Moreover, few studies have surveyed consumers of sex offender treatment services to elicit feedback about what would be most beneficial to them, although this type of research is beginning to emerge (Garrett, Oliver, Wilcox, and Middleton 2003). More research is needed to determine the specific ways that current practice can be more helpful to clients (Hanson, Gordon, Harris, Marques, Murphy, Quinsey, and Seto 2002). Though Glaser's points are good ones, we contend that decreased recidivism as a measure of treatment success does reflect the dual need to protect society and reduce offenders' suffering.

Community safety and alleviation of client distress are goals that can be mutually rewarding for patients and society. Although the behavior of some sex offenders is ego-syntonic, most are indeed disturbed by their behavior and desire to improve their functioning in law-abiding activities and age-appropriate relationships. Whether they are motivated to become sexually healthy adults, or simply want to avoid being re-arrested or incarcerated, many sex offenders articulate a wish to change the self-destructive patterns that led them to hurt others and suffer personal consequences. Many sex offender clients who are court ordered to receive treatment are initially angry, resistant, and unwilling to admit responsibility for their crimes. But as they become engaged in treatment, those same clients often begin to stop regarding the therapist as intrusive in their

lives. Ultimately, many offenders find that their lives begin to improve and that the maladaptive behaviors that led to their offenses have lessened considerably. They often report feeling more in control of their lives. Through treatment, they learn to substitute inner controls for external ones, and sex offender clients who were recently surveyed reported that they found this process to be empowering and rewarding (Garrett, Oliver, Wilcox, and Middleton 2003).

The goal of the offender to create a more promising future for himself is thus incorporated into the evidence-based modalities of sex offender treatment. Treatment offered to incarcerated offenders is intended to increase the likelihood that inmates will make a satisfactory community adjustment following release. Treatment offered to probationers is intended to increase the offender's likelihood of remaining safely in the community. Both of these forms of treatment are designed to help offenders succeed as well as to protect society.

Reduced recidivism is certainly the outcome most widely cited in the research literature, but by no means is it the only measure of treatment success. Although difficult to empirically investigate, therapists assess changes in behavior and thinking as measures of treatment progress. Relapse prevention techniques help offenders learn to identify the chains of thoughts, feelings, and behaviors that culminate in the commission of a sex offense (Marques and Nelson 1989). Once they can identify their offense patterns, offenders work on mastering alternative coping strategies with which to intervene in the cycle and stop the progression of unlawful and destructive sexual behaviors. In addition, Marshall et al. (1999) proposed that by changing the contingencies of reinforcement to help clients better meet their emotional needs, treatment can focus on helping clients move toward positive and rewarding behavior rather than simply avoiding the negative consequences of sex offending behavior. As clients begin to understand the emotional needs that have been met through sexual assault, they can develop more fulfilling strategies for meeting those needs in healthy and adaptive ways (Morin and Levenson 2002).

Glaser might call this approach "paternalism" and suggest that we are presumptuous and patronizing in our belief that we know what is best for clients. And to some extent he would be right. Courts and society have become less willing to tolerate the behavior of persons who threaten the safety of the community. Therapists are used as instruments of change. Through treatment future criminal acts are prevented, while sex offender clients are helped to reduce the distress (and avoid the consequences) created by engaging in unhealthy or unlawful behavior. We do believe (paternalistically, perhaps) that helping clients to improve their

interpersonal functioning does indeed serve a client's best interest.

2. Treatment, to be effective, must usually be involuntary.

Glaser argued here that prominent scholars in the field boldly advocate for coercive therapy. It is true that researchers and practitioners recognize that many sex offenders will not seek treatment voluntarily because they enjoy what they are doing and do not want to stop. Thus, the vast majority of sex offenders enter therapy only after offenses are detected, reported, and sanctioned.

We suggest, however, that some sex offenders who desire to change their behavior are reluctant to seek help because to do so will almost surely result in legal consequences. This is an unfortunate dilemma for both clients and practitioners, but sex offender programs do not create this conundrum, nor is it unique to sex offender therapists. Every social worker, psychologist, psychiatrist, family therapist, or mental health counselor in the U.S. (and in many other countries) is required by law to report suspected abuse to the proper authorities. In fact, to encourage voluntary treatment by which clients might very well incriminate themselves would be unethical.

Glaser misreads the suggestion made by Marshall et al. (1999) that treatment should be combined with incarceration. Marshall does not advocate for coercive therapy; rather, he advocates for interventions that promote personal responsibility, reinforced through negative sanctions (punishment) combined with positive reinforcement (treatment gains). Moreover, Glaser's analogy of sex offender treatment to involuntary commitment of the mentally ill is a poor one. It is true that involuntary psychiatric treatment or civil commitment is typically an intervention of last resort, the primary goal of which is to prevent future harm. Sex offenders, on the other hand, have already committed a criminal act causing harm to others, and rehabilitative treatment is a part of the sentence imposed.

3. Effective treatment requires that confidentiality be breached.

As Glaser accurately noted, it is routine for sex offender therapists to offer limited confidentiality. However, we believe that this practice does not constitute a breach unless the client is denied informed consent. If the client signs a release form allowing the exchange of information and explaining its purpose, then confidentiality is not compromised. As noted above, ATSA, APA, and NASW codes of ethics all address the bounds of confidentiality with non-voluntary clients and in cases where threat of harm is present. Specifically, NASW (1999) requires that "social workers should inform clients, to the extent

possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent" (section 1.07 (d)). The APA (2003) similarly states that "when psychological services are court ordered or otherwise mandated, psychologists inform the individual of the nature of the anticipated services, including whether the services are court ordered or mandated and any limits of confidentiality, before proceeding" (section 3.10 (c)).

We are all familiar with professional ethics and state laws allowing exceptions to confidentiality under specific circumstances which involve threat of harm to oneself or others. It is also universally accepted that abuse of children and disabled or elderly adults must be reported to protective service agencies. When a clinical assessment reveals risks that may not fall under traditional duty to warn or mandatory reporting exceptions, the evaluator must practice within the bounds of confidentiality while attempting to facilitate community safety and avoid collusion with abusive clients. The clients' consent to the exchange of information between professionals serves to protect vulnerable children and women and also serves to protect the clients from the consequences of engaging in self-destructive behavior that they may be unable to manage successfully by themselves.

Sex offender treatment information is often shared between probation officers, child protection workers, and the court in an effort to enhance collaborative treatment and supervision. Ultimately, this collaboration is intended to help the client to improve selfmanagement and self-regulation, and facilitates an exchange of information that allows others to support the client in his recovery. Sharing of information should, of course, always be done in accordance with prevailing ethical principles and statutory requirements. A non-voluntary client can have a therapeutic experience if safeguards are in place for the sharing of information. In the United States, sex offender treatment is bound by federal HIPPA regulation which specifies the limitations of disclosures to any outside parties unless approved by the client.

4. Generally, the offender must not be allowed any choice of therapy or therapist.

Glaser argued that assigning sex offenders to specific therapists is dogmatic and that it interferes with clients' right to self determination. It is true that sex offenders are usually required to seek treatment from "approved" providers. While this practice is perhaps seemingly narcissistic or grandiose on the part of sex offender treatment specialists, it is necessary. Ethical sex offender treatment requires training and expertise

unfamiliar to most mental health professionals. If one had a brain tumor, he would not seek medical services from a family practitioner or a dermatologist. It is widely accepted in the medical profession that a license to practice medicine does not imply expertise in the treatment of all medical conditions. The same is true in mental health, where clinicians develop experience and expertise regarding a particular problem area or client population. In fact, mental health professional codes of ethics clearly warn against practicing outside of one's area of expertise (American Psychological Association 2003; National Association of Social Workers 1999).

We argue that the treatment of sex offenders by unqualified practitioners constitutes an ethical violation. The treatment of sex offenders comes with a higher risk of liability for practitioners, and a high risk of harm to the client and others if clients recidivate. Inferior treatment may lead to increased recidivism, perpetuating the myth that sex offender treatment is not effective. To promote the client's right to self-determination, responsible referral sources often allow clients to choose from multiple qualified sex offender programs if more than one exists in a particular geographical area.

Although Glaser somewhat facetiously noted a "morbid and irrational preoccupation with the ability of sex offenders to manipulate gullible and vulnerable therapists" (Glaser:146), he acknowledged elsewhere that:

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 (Glaser:151).

It is for these very reasons that sex offenders are often referred by courts or probation officers to sex offender specific programs that are known to have the knowledge and experience necessary to effectively address such resistance.

5. Offenders may be forced to accept therapy from non-clinicians or unqualified staff.

Glaser stated: "A large number of sex offender treatment programs rely heavily on the use of prison officers and other unqualified staff" (Glaser:146). He cites a 1996 ATSA policy statement to support this claim, which he appears to have misinterpreted. In the position paper posted on ATSA's website titled Reducing Sexual Abuse Through Treatment and Intervention with Abusers (Association for the Treatment of Sexual Abusers 1996), the following statement appears: "Following the prison term, a correctional officer supervises and monitors the

individual in the community." This statement is not meant to imply that correctional officers provide treatment, but that most sex offenders, when released from incarceration, are sentenced to a period of probationary supervision in which a parole officer monitors compliance with court ordered conditions, including treatment.

The best current information about the qualifications of treatment providers comes from a survey conducted in 2002 by the Safer Society Foundation, which analyzed data from nearly 1,000 U.S. sex offender programs (McGrath, Cumming, and Burchard 2003). Overall, community-based programs treating adult sex offenders reported that 89 percent of treatment staff held a Master's or Doctorate degree. In residential programs (which presumably included prison-based programs), about 26 percent of treatment staff held a graduate degree, and 13 percent held a Bachelor's degree. The qualifications of non-degreed staff were unknown, as was their specific role in providing treatment related services. Certainly, it is preferable to have clinically professionals mental health therapeutic services. Overall, 86 percent of adult sex offender programs are community based, and so it appears that the vast majority of clients are served by clinicians with graduate degrees (McGrath, Cumming, and Burchard 2003).

The ATSA code of Ethics (ATSA 2001b), first published in 1993 and revised in 1997 and 2001, has an entire section devoted to members' training and expertise (Section 4). Moreover, Section A of the ATSA Practice Standards and Guidelines (ATSA 2001a) spans three pages outlining training and qualifications. Although ATSA recognized that the educational and professional backgrounds of its members are diverse and multi-disciplinary, and that practice is regulated by state licensure boards, it emphasized that competent practice is reflected by a combination of academic coursework, continuing education, and practice experience. Members providing clinical services are required to have at least 2,000 supervised hours of direct client contact, and usually possess a graduate degree or specific training and experience. So, although nonclinicians or unqualified staff can be found in all areas of mental health, the published ethics and standards of sex offender treatment clearly define and emphasize the importance of competent practice.

6. Effective therapy requires multiple other infringements on an offender's dignity and autonomy.

Glaser first pointed out that "clients are not allowed to deny their offending behaviors...and are routinely required to waive that right or else be regarded as untreatable and face harsher penalties" (Glaser:146). Next, he asserted that sex offender clients are required

to incriminate themselves by admitting to undetected criminal activities. Finally, Glaser suggested that sex offender programs control clients in a manner akin to brainwashing (Glaser:146):

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. ... They clearly infringe upon an offender's right to self determination as enshrined in all of the ethical codes cited above.

We contend that all three of these claims can be countered based on ethical, legal, and therapeutic principles.

First, it is important to explore Glaser's assertion that clients in treatment are required to "waive their right" to deny their crimes. It is true that most sex offender programs require clients to admit their behaviors as a first step in treatment. But offenders in court-ordered treatment have already relinquished the "right" to deny when they pleaded guilty to a sex crime and agreed to a sentence which included treatment -often in exchange for reduced incarceration. If a client claims to have been wrongly convicted by a jury, his denial is more properly addressed in a legal setting rather than a clinical setting. Of course, clients have the right to choose the extent to which they disclose information in treatment. But if denial is a manifestation of resistance to treatment, then it must be addressed as such.

Denial is a common problem in sex offenders presenting for treatment, and most practitioners agree that it is necessary for offenders to overcome denial in order for treatment to be effective (Marshall, Thornton, Marshall, Fernandez, and Mann 2001). Offenders often begin treatment with some degree of denial, ranging from denial of the facts of the case, to minimization or rationalization of the offense, to distorted attributions of responsibility (Schneider and Wright 2001; Schwartz 1995; Trepper and Barrett 1989). Although Hanson and Bussiere (1998) found no correlation between denial and recidivism, the role and relevance of denial has not been fully clarified and further studies of denial's role in treatment success and risk prediction are needed (Lund 2000). New research has suggested that denial is associated with lower levels of therapeutic engagement and treatment progress (Levenson and Macgowan 2004).

Many practitioners agree that it is difficult, if not impossible (and probably unethical), to treat a client for a problem which he says he does not have. Therefore, most contemporary treatment programs identify the acknowledgement of an offense and acceptance of responsibility as necessary treatment goals. It is expected that sex offender clients will present with varying degrees of denial, and the defensive functions of denial should be recognized while reduction of denial and promotion of accountability are pursued as therapeutic goals (Schneider and Wright 2001). The inference, which could be drawn by some, that in the name of self determination it is in the best interest of the client to maintain the secrecy by which sexual abuse thrives, is questionable at best. Encouraging clients to withhold information relevant to assessment and treatment impairs their ability to receive appropriate interventions.

Along these same lines, clients are encouraged to reveal past offenses in an effort to better understand their patterns of behavior, but they are neither encouraged nor required to incriminate themselves. Because a history of sexually deviant behavior and continued deviant sexual interest have been linked to risk and recidivism (Hanson and Bussiere 1998: Hanson and Harris 2001; Quinsey, Lalumiere, Rice, and Harris 1995), interventions that promote honest disclosure have clinical value. Without accurate information about past history, clinicians are handicapped in assessing risk and facilitating collaborative treatment plans with clients. Past offense information should, of course, be elicited in a way that protects clients from selfincrimination. Informed consent should be obtained regarding the risks and benefits of disclosure, including a clear explication of how admissions of new crimes and past offenses will be handled and an explanation of mandatory abuse reporting requirements. Historical offenses are typically elicited in an anonymous fashion by asking offenders not to reveal the names of victims. or, in some jurisdictions, negotiating conditional immunity from prosecution as long as the client remains in and successfully completes treatment.

Finally, we dispute Glaser's assertion that sex offender treatment is akin to brainwashing, and that clients are punished for questioning the goals set by the therapist. It is possible that this perception stems from the fact that research and practice have identified certain treatment goals which are unilaterally accepted by providers as important. Predetermined treatment plans do contradict the traditional practice of allowing the patient to set the therapeutic agenda. However, while treatment planning with sex offenders may include some standardized goals such as relapse prevention and victim empathy, clients are also encouraged to identify individualized goals, and the field is moving away from modularized treatment (Hudson and Ward 1996; Laws,

Hudson, and Ward 2000; Ward and Hudson 1996). There are certain "buzzwords" or "jargon" that are commonly found in sex offender treatment programs and workbooks. Clients are encouraged to learn and internalize concepts such as empathy, accountability, triggers, cycles, and relapse prevention. However, to say that such psycho-educational techniques are akin to brainwashing seems a little bit skewed.

Perhaps the term "brainwashing" also refers to the reputation of sex offender therapists as highly confrontational. Although confrontational approaches to sex offender treatment have historically been common, motivational approaches, alternatively, are becoming more popular. Marshall et al. (1999) suggested that when a challenging but supportive style of treatment is offered, resistance may be reduced and respect for clients is promoted. A recent and growing literature has encouraged therapists to utilize a positive, empathic approach that encourages and supports client ownership of change rather than confrontational or punitive approaches (Jennings and Sawyer 2003; Kear-Colwell and Pollock 1997; Marshall et al. 2001; Winn 1996). The goal of such an approach is to promote change by creating a non-judgmental environment which produces cognitive dissonance and encourages hope, leading to the belief that change is possible (Kear-Colwell and Pollock 1997). Ultimately, such treatment empowers the client to choose to engage in the therapeutic process rather than have the intervention imposed by the therapist (Birgden and Vincent 2000).

AN ETHICAL PARADIGM FOR SEX OFFENDER TREATMENT DOES INDEED EXIST

The Association for the Treatment of Sexual Abusers has long recognized the need for special ethical considerations when working with sex offender populations. For this reason, ethical and practice guidelines were first developed in 1993 and have been modified over the past decade to keep pace with changing social policy and the growing empirical literature. In fact, ATSA's ethical code existed at the time Glaser wrote and published his article, although mention of it was conspicuously absent from his paper.

ATSA's code of ethics endorses standards of professional conduct that promote competent practice, and as such, they represent a public commitment to clients and society toward the goal of preventing sexual violence. ATSA has a mechanism by which ethical breaches can be reported, investigated, and sanctioned. A focus on evidence-based practice is emphasized, as is the development of treatment strategies that respect the needs of individuals rather than delivering a "one size fits all" approach. As well, existing codes such as those promulgated by APA and NASW address the provision of non-voluntary and court-ordered services, and such standards can be also applied to sex offender treatment.

These ethics conform to the principles outlined by Glaser: respect for autonomy, non-maleficence, beneficence, and justice.

Ethical sex offender treatment promotes autonomy by empowering clients to take responsibility for longterm behavior change. Because the vast majority of sex offender clients initiate assessment and treatment on a non-voluntary basis, resistance and lack of motivation are common. Clinicians are challenged to assist clients to reduce psychological defenses while recognizing that court ordered treatment has the potential to become, at times, coercive, and interfere with our appreciation for clients' right to self-determination. At the same time, setting clear limits and helping clients become aware of the possible consequences of their choices can provide healthy boundaries and encourage clients to make informed decisions. By modeling and promoting thoughtful rather than impulsive decision-making, clinicians help clients enhance the potential for meaningful change.

The rule of "first, do no harm" applies, of course, to specialized sexual offender treatment as well as in any other therapy or intervention. Glaser rightly points out that offenders should be treated with fairness and respect, and that interventions should be determined by the seriousness of the offenders' treatment needs. Clinicians are trained in graduate programs to develop a therapeutic alliance with their clients, and to encourage clients to participate in their own treatment planning. These principles of therapeutic engagement are certainly recognized as important components of sex offender treatment. However, responsible treatment of a sex also involves assessing the client's environment and the potential risk and safety of others with whom he may come in contact-for his own protection as well as the protection of others.

Justice is served when public safety is enhanced and negative repercussions for the client are diminished through effective therapeutic intervention. Sex offense recidivism results in grave consequences for the victim, the offender, and the community. Thus, identification and collaborative management of risk and safety factors are indeed in the best interests of both sex offender clients and potential victims.

Glaser acknowledged that there are pragmatic reasons for mental health clinicians to provide sex offender treatment. There is evidence that contemporary cognitive-behavioral relapse prevention treatment conducted by qualified practitioners leads to reductions in both sexual and general recidivism (Hanson et al. 2002). Overall, in a recent meta-analysis of 43 studies that included 9,454 subjects, treated groups sexually recidivated at a rate of 10 percent compared with a 17.4 percent recidivism rate for untreated control groups, suggesting that cognitive-behavioral treatment programs reduced recidivism by almost 40 percent (Hanson et al.

2002). So, as with any presenting problem, clients should be referred to providers with expertise treating the disorder in a setting designed to meet the needs of the population.

Established sex offender programs generally offer group therapy that includes specific components such as relapse prevention, victim empathy, and cognitive distortion restructuring (Marshall, Anderson, and Fernandez 1999). Group work is viewed as having the potential to be more effective than individual therapy, because it offers peer confrontation as well as peer support (Beech and Fordham 1997). Because sex offenders often have difficulty with social relationships, intimacy, and coping skills (Marshall, Serran, and Cortoni 2000), group therapy also provides clients the opportunity to address interactional problems in the group setting and to develop and practice new interpersonal skills (Jennings and Sawyer 2003; Schwartz 1995).

Glaser's article, while pointing out the shortcomings and the ethical dilemmas of sex offender treatment in general, did suggest a "compromise" ethical paradigm for those therapists treating sex offenders which involves "therapeutic jurisprudence" (the study of the role of the law as a therapeutic agent) (Glaser:149). The Therapeutic Jurisprudence Model proposed by Dr. Glaser is not antithetical to that which is currently espoused by clinicians and researchers in the field of sex offender treatment. In fact, it is remarkably similar to existing "best practice" standards and ethical guidelines promulgated by ATSA.

Glaser questioned whether mental health clinicians should abandon sex offender treatment programs because they operate in an "ethical vacuum" (Glaser: 146). We hope that we have clarified the ethical principles by which sex offender programs and treatment providers practice. We ask: if mental health providers refuse to provide court ordered services for sex offenders, what is the alternative? No treatment at all? Treatment by non-clinicians who have no ethical dilemmas because they are not bound by ethical codes? Wait for sex offenders to voluntarily initiate treatment? We need responsible, knowledgeable, experienced clinicians who can thoughtfully and compassionately navigate the ethical land-mines of sex offender treatment, while balancing the dual goals of offender healing and public safety.

In conclusion, our contemporary criminal justice system incorporates a goal of rehabilitation, by which offenders can learn skills which may lead to a more promising future. Paternalistic? Yes, perhaps. But as the saying goes, you can lead a horse to water, but you can't make him drink. Court ordered interventions create opportunities for change and growth that offenders might otherwise be unwilling or unable to take advantage of. Ultimately, the client must choose

whether or not to engage. Clinicians should never abuse their authority or coerce clients, but should create a safe, accepting environment where, for perhaps the first time, there is more to be gained than lost by being open and honest about one's problems.

Sex offender treatment does create the potential for ethical dilemmas that must be acknowledged by clinicians and thoughtfully addressed. Clinicians must be equally committed to client success and community safety and must acknowledge that with sex offender populations, some of the traditional methods of mental health intervention are not only ineffective, but may increase the risk of failure. A continuing dialogue is needed, not to determine where current practice fits under traditional rules, but rather to better determine, with as much empirical support as possible, which models are most effective in successfully treating and managing clients with sexually abusive behaviors.

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