Ethics and the Treatment of Sexual Offenders

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KEYWORDS

- Sex offenders • Ethics • Treatment • Consent • Confidentiality circle • Dual agency

KEY POINTS

- Standardization of assessment procedures is essential.
- Second opinions may be necessary in treating resistance cases and consenting procedures.
- Current evidence of effectiveness is imperative in pharmacologic and psychosocial treatment.
- Limits of acceptable behavior in the patient–therapist relationship depend on the balance of best interests of the patient and public safety.
- Professionals should be aware of the implications of court-ordered mandated treatment.
- Sex offender reporting and notification laws have produced mixed outcomes on treatment access and public safety.

INTRODUCTION

Current clinical practices implicated as a source of ethical dilemmas in sex offender treatment are those that concern the superiority of public safety over the interests of patient, clients, or offenders (hereon referred as to *patients*). When pitched against the best interests of patients, the interest of patient stands no chance if it is considered an either or matter.[1] Restricting the goals of treatment to the sole purpose of reducing the risk of recidivism not only limits the value of but also potentially replaces the traditional ethically informed therapeutic relationship and the joint collaborative goals that flow from it. Usually in a relationship, such as exists between therapist and patient, the voice of the patient is encouraged and is necessary in setting treatment goals and monitoring progress. When coercion is perceived or experienced, treatment is estimated as superficial, short lived, and lacking commitment. In

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involuntary settings, as exist in civil commitment of sex offenders, a therapist's values and goals of public safety assume a more important influence. Some of the ethical moral and legal implications arising from civil commitment include "co-optation of medical authority to legitimate commitment based upon non-medical classifications, ex post facto application of civil commitment statutes to offenders who committed crimes decades earlier, admissibility of treatment records during a civil commitment hearing, and the likelihood of lifetime commitment that results from a finding of future dangerousness."[2] This conflict arises by virtue of treatment goals and values that are predetermined and enforced on a patient rather than self-generated collaboratively in therapy with the patient. Intrinsically derived motivations yield positive behavioral changes, such as better learning, performance, and well-being, as well as longer-lasting results than motivations derived externally.[3] If ethical guidelines recognize the vulnerabilities of sex offenders, therapists' conduct should consider the imbalances of power. Responding adequately without coercion and rapidly with no prejudice is an essential ingredient for navigating the therapeutic relationship and its perceived or real ethical conflict.

Understanding the ethical issues in sex offender treatment requires a summary of the distinct nature of the interventions. First, a diagnosable mental disorder leads to criminal offending affecting a wide range of victims, including children. Adopting a caring approach and providing sex offenders with or without a diagnosable mental disorder (paraphilia) treatment and rehabilitation have been debated extensively.[4,5] Sentiments fly high creating an avenue for conflict in ethics. The extent and contrast of the treatment approaches, content, and delivery compared with the best interest principles and autonomy create an ethical dilemma.[6] Should sex offenders be considered ill and in need of treatment or subject to only punishment for their offenses? Should voluntariness determine the mode of treatment or is there a place for compulsory treatment? Are resistance to disclosure, delay in accepting responsibility, and rationalization for offenses evidence of poor treatment engagement and thus support for punishment approaches? Does castration count as treatment if it offers the best control of offending? These questions require the balancing act that ethical practice demands. The values that delineate boundaries of permissible behavior in a patient–therapist relationship are shaped by the conceptualization of the nature of the problem experienced by the sex offender.[7]

CONCEPTUALIZATION OF SEX OFFENDERS AND TREATMENT

Whether sex offending is a disorder or a choice has received varying reviews.[8] Even paraphilia, previously referred to as sexual deviance, was unclassified as a disorder. Termed perversions, they have been described as inherently fuzzy and controversial.[9] The nosologic place of paraphilias is uncertain.[9,10] What is known is the relevance of sexual deviance as a significant risk factor in sexual offending and recidivism, thus the need for treatment.[11] That knowledge and the acceptance of aspects of sexual offending arising from a disorder influence the concepts and delivery of treatment. Sexual behavior disorder, sexual deviance, and paraphilia are used to identify the disorder component of sexual offending. Currently, treatment has been directed at eliciting treatable parts of the disorder to limit offending.[12] The primary goal of traditional mental health treatment is generally to reduce suffering by the patient and almost always promotes the best interests of the patient. In certain situations these goals may be at loggerheads with the wider goals of public protection. Most, if not all, sex offender treatment providers do not hesitate to completely excise guidance or strategies for a sex offender to avoid detection from the armamentarium of treatment.

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