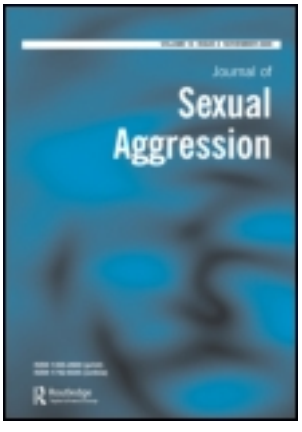

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Sex offender treatment is not punishment

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Sex offender treatment is not punishment

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Abstract *The treatment of sexual offenders can be fraught with ethical dilemmas. Practitioners must balance the therapeutic needs of sex offender clients alongside the risks they might pose to others. These ethical challenges include balancing community safety with the rights of the offender, the privileged therapeutic relationship and the potential for coerced treatment. In this paper, we respond to Glaser's argument that treatment is punishment and that sex offender treatment providers breach ethical codes by violating confidentiality, engaging in coercion, and ultimately causing harm to clients. We first consider whether sex offender treatment is indeed punishment. We argue that it is not, and that mandated treatment can and should be conducted in a fashion consistent with professional codes of ethics familiar to mental health providers. We then discuss the human rights model, which we agree is an essential lens through which to view the psychological treatment of sexual offenders. We attempt, as have other scholars, to illustrate the ways in which human rights principles intersect with traditional mental health codes of ethics particularly in the case of sex offender treatment. We conclude that sex offender treatment can be conducted ethically, that treatment differs from punishment in clear and distinct ways, and that ethical treatment conforms to a human rights perspective.*

Keywords *Punishment; sex offenders; treatment*

Introduction

The treatment of sexual offenders is fraught with ethical dilemmas. Attempting to balance the therapeutic needs of the clients alongside the risks they might pose to others requires a delicate and thoughtful approach. Professional ethics require practitioners to respect the rights of clients regarding confidentiality, informed consent and the right to self-determination while recognizing the duty to prevent harm to the client and others. When counselling clients with a history of interpersonal violence, these competing values are challenged. Ethical dilemmas are described as situations in which concerns arise and a clinician must choose one of two or more unsatisfactory alternatives; to choose one course of action that seems like an ethical solution may in fact contradict a conflicting guiding principle of psychological intervention.

In *Sex offender programmes: New technology coping with old ethics*, Glaser (2010) offers thoughts and perspectives on ethical questions that sexual offender treatment providers have

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addressed for many years. In it, he notes the many ethical dilemmas that sexual offender treatment providers face when they take on this work. These include balancing community safety with the rights of the offender, the limits on confidentiality and the potential for coerced treatment. Glaser refers to sexual offender treatment providers as "agents of social control" who do "harm" to their clients by "grossly intruding upon their rights". Without citation, he states that these therapists "cynically display false kindness and empathy in order to keep their clients in line. Sadly, such displays then develop into models for the treatment of cognitive distortions which are so characteristic of sex offending behaviours". Glaser has written about these dilemmas previously (Glaser, 2003, 2009), and other scholars have responded in exquisite detail to his arguments (Levenson & D'Amora, 2005; Ward & Salmon, 2009). In this paper we will simply respond to some of Glaser's salient points in the current journal issue, and accentuate some ideas that we think bear repeating.

Human rights perspectives can and should inform this most challenging arena of rehabilitation and Glaser's interest in this vital topic is praiseworthy. However, his attempts to provide an avenue forward would have been more helpful had he depicted more accurately some critical aspects of sexual offender treatment. His characterization of treatment providers, their work and the legal context, beyond being incorrect, undermines his efforts to contribute to the advancement of rehabilitative efforts.

In this paper, we first consider whether sex offender treatment is indeed punishment. We argue that it is not, and that mandated treatment can be conducted in a fashion consistent with professional codes of ethics familiar to mental health providers. Even when part of a sentencing scheme, treatment is not intended to punish, but to assist offenders to correct behaviours that have harmed others (and in the process themselves). For example, punishment and rehabilitation are two of the four primary objectives of the criminal justice system in the United States (with incapacitation and deterrence being the others). According to *Webster's Dictionary* (1989), punishment is defined as a penalty imposed for wrongdoing. Rehabilitation is defined as restoring an individual to good health or a useful life through therapy and education. Punishment and rehabilitation are distinct goals of criminal justice, although they may both be facilitated through a sentence pronounced after conviction of a crime.

We then discuss the human rights perspective, which we agree is an essential lens through which to view the psychological treatment of sexual offenders. We attempt, as have other scholars, to illustrate the ways in which human rights principles intersect with traditional mental health codes of ethics. We argue that sex offender treatment can and generally does adhere to a human rights model and to the guiding values of the mental health professions.

Does the current state of sexual offender treatment represent a breach of mental health ethics and violate offenders' human rights?

Glaser states that current sexual offender treatment is a "form of punishment" and that it is coercive and inflicts harm. He argues that current treatment models force the offender to undertake the therapy chosen by the clinician, demand that confidentiality be broken, and compromise the client's autonomy. Glaser contends that current ethical guidelines such as those espoused by the Association for the Treatment of Sexual Abusers (ATSA) "represent blatant breaches of the ethical codes which traditionally guide mental health practitioners". He states that a primary problem with the *status quo* is that clinicians working in these programmes "cannot serve (the) two masters" of community safety and client interests. He adds that traditional ethical codes, such as those published by the American Psychological

Association (APA, 2003) and National Association of Social Workers (NASW, 1999), offer little guidance for therapists who counsel sex offenders. There is no question that some clinicians attend to the competing needs and other challenges of this work better than others, which is why organizations such as ATSA, APA and NASW enforce their ethical codes. In fact, meeting these seemingly competing demands is what most sexual offender treatment providers do every day. By speaking in such categorical terms, Glaser undermines the strength of his own arguments.

In the end, while Glaser says that current sexual offender programmes are unethical because they "cannot serve" the "two masters" of client rights and community safety, his proposal suggests a way to do exactly that. Glaser states, "We thus need a set of ethical guidelines which both promotes respect for offenders' human rights and which justifies the clinician's infringements on those rights even though such infringements have the worthy aim of forcing an offender to recognize an obligation to respect the rights of others". So, Glaser condemns sexual offender treatment providers for being agents of social control, but still proposes a means by which they can infringe upon offenders' rights in the interest of communities. Glaser seems to recognize that sexual offender treatment providers are sometimes obliged to put community safety above the client's autonomy.

We propose that, in fact, this circular logic is well-trodden ground within the sexual offender treatment world and that while Glaser's ideas have merit and are worthy of further discussion, he has founded them on inaccurate premises. Glaser certainly makes an important point that there should be a more clearly defined nexus between the promotion of client autonomy and dominion and the infringement on their rights. He has also given voice to many concerns that we have ourselves expressed in many other venues: that many current policies are scientifically unsound and potentially harmful not only to sexual offenders, but to the communities they purport to protect. It is our fervent hope that this dialogue continues. Our concern is that Glaser's statements do not reflect accurately the realities of sex offender treatment.

The two masters: client rights versus community safety

Glaser argues that the needs of offenders are not taken into account when they take part in court-mandated treatment. Sex offender therapists are not alone, however, in balancing the needs of the community with the needs of the client. In the United States, for example, every state has a "duty to warn" law that limits confidentiality when patients make a credible threat of harm against an identifiable person. Moreover, all therapists have an obligation to intervene when patients express intent to harm themselves. Every state also has a mandatory requirement to report suspected abuse or neglect of children, elderly and disabled adults. These laws acknowledge the ethical conflicts that occur when clinicians must balance the needs of the client and community. These clear exceptions to confidentiality exist to protect vulnerable individuals who might be otherwise unable to protect themselves, and professional ethical codes provide clear direction for balancing the duty to protect the privileged relationship with the ethical obligation to prevent harm (APA, 2003; NASW, 1999). Ethical codes are designed to guide decision making when dilemmas surface, but do not prescribe specific rules of conduct. For example, the NASW code actually states: " . . . the *NASW Code of Ethics* does not specify which values, principles, and standards are most important and ought to outweigh others in instances when they conflict. Reasonable differences of opinion can and do exist among social workers . . . " The personal and professional values of clinicians will naturally play a role in practice decisions and therapists need to be aware

of and manage situations in which their own values conflict with those of the client (Day & Ward, 2009).

In fact, contrary to Glaser's argument, the APA and the NASW clearly acknowledge these ethical dilemmas and the "two masters" in their codes of ethics. For instance, when explaining the principle value of beneficence and non-maleficence, the APA code reads "psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons . . . ". The NASW code reads: "Social workers' primary responsibility is to promote the well being of clients. In general, clients' interests are primary. However, social workers' responsibility to the larger society or specific legal obligations may on limited occasions supersede the loyalty owed clients, and clients should be so advised." The NASW does not specify practice guidelines in forensic or correctional settings, but speaks generally about collaboration, avoiding conflicts of interest, respecting clients and the primacy of the social worker/client relationship. The APA addresses ethics in forensic cases but focuses primarily upon forensic assessments.

Not everyone enters traditional, community-based mental health treatment of his or her own volition. Clients often arrive at our doors because of intense family or peer pressure (e.g. "If you don't do something about your gambling, I will divorce you and take our children to another region"). Some clients are unlikely to seek services because they do not recognize their illness (such as in the case of some mental disorders), or because they are unable or unwilling to change their behaviour (such as in cases of substance addiction or domestic violence). In many cases, the legal system compels clients to engage in effortful intervention in the wake of harm (such as child protective services) or high-risk behaviour (such as drunk driving). In such cases, efforts at change often begin only with outside pressure while the client develops his or her own internal motivation (Ryan & Deci, 2000). Treatment methods that are purely coercive rarely produce meaningful change. This is precisely why methods that respect the inherent autonomy of each client (e.g. motivational interviewing) have gained currency in recent years.

It is also the case that acutely psychotic patients sometimes require immediate restraint or medication in order to remain safely in the community, which is why we have laws enabling psychiatric commitment in certain circumstances. Under these conditions, professionals assess that a patient's actions are jeopardizing their own safety and that of others. These are difficult decisions that psychiatrists must make, which may be at odds with traditional values of therapeutic beneficence and autonomy. One might reasonably ask how this differs from the decisions that sexual offender treatment providers ask themselves about balancing client rights with the safety of others.

Some examples might help to illustrate the point. Sex offender treatment clients are encouraged to discuss past offence history in an effort to better understand their deviant patterns and treatment needs. Sometimes, clients reveal information that might be incriminating. The desire to attain information to help with treatment planning and consideration of the privileged relationship must be balanced with the competing value of protecting others from harm. First, therapists often take care to solicit case information without seeking identities of victims. Secondly, sexual crimes in which the victim is now an adult do not, in most of the United States, fall under mandatory reporting requirements. Finally, when ongoing abuse is revealed, the offender's right to confidentiality is balanced with a child's right to be protected from abuse, and mandatory reporting trumps privilege. This would be true in any case (not only sex offender treatment) where a client revealed abuse of a child to a mental health professional. It is noted further that the number of areas in the world with mandatory reporting laws is increasing (Bennett, 2005).

Confidentiality and informed consent

When clients partake in therapeutic services that are court-ordered, they sign an informed consent statement clarifying the boundaries of confidentiality and disclosure (APA, 2003; NASW, 1999). Glaser does not mention that programmes treating sexual aggression make clear at the outset of treatment that part of their intent is risk reduction, and that this is accomplished, in part, through limited confidentiality and collaboration with other professionals. Limitations on professional confidentiality are established firmly in a number of regions in the world (Gordon & Grubin, 2004). Especially in outpatient settings, parole agents typically understand and accept the need to balance correctional supervision with the therapeutic engagement of the client in therapy, and treatment providers reveal only what is necessary for the parole officer to do his job. This may involve sharing the client's attendance and a summary of his level of participation and treatment progress. When possible and appropriate, therapists take care to paint a picture of a client's offence patterns for the purpose of appropriate supervision without revealing detailed information that might be unnecessarily incriminating.

Coercion and autonomy

Glaser states, "Most treatment programmes are ordered by courts, parole boards or similar bodies as a component of a punishment regime". The argument can certainly be made that this arrangement represents a form of coercion. When treatment is mandated, can clients truly exercise their right to self-determination if faced with negative consequences for non-participation? If the client refuses to waive the right to confidentiality, and the result is revocation of parole for non-cooperation with treatment, is that coercion? Perhaps. In many cases, the legal system offers treatment as an option for reducing the severity of a sentence. Many clients, of course, view this through a different lens and see themselves as coerced into treatment.

This dilemma is not unique to sex offender treatment. For example, individuals across the United States who interact with the criminal court system are required routinely to participate in rehabilitation services as part of their sentence. Such programmes are common in cases of drug crimes, driving under the influence of alcohol or other substances, domestic violence, assaults, and when mental disorder leads to behaviours that rise to the threshold of criminal activity. In child protection cases, parents are required to participate in therapeutic services or risk losing their parental rights (Adoption and Safe Families Act, 1997). In criminal cases, the right to self-determination is exercised during the sentencing process, when clients and their legal counsel agree to rehabilitation services in exchange for an opportunity to return to the community rather than remain in prison. In other words, the criminal justice system provides an opportunity to live in the community only if the client makes a commitment to altering his behaviour and living safely in the community. The criminal justice system views one of its prime purposes as rehabilitation, and an interdisciplinary response to crime is designed to prevent crime recurrence for the benefit of both the offender and society.

Glaser claims that if an aim of rehabilitation is to prevent crime then it follows that offenders' interests are not the primary goals of intervention even if they may benefit indirectly from treatment. We disagree. Treatment programmes prioritize the prevention of crimes in the context of enhancing the lives of offenders by improving their socialization skills and thereby strengthening their stakes in conformity. When offenders function in prosocial roles not only can they resist crime more strongly, but they create more fulfilling, productive and

hopeful lives (Ward & Brown, 2004; Yates, 2007). We could achieve crime prevention without treatment simply by incapacitating offenders. Treatment is designed to accomplish reduction of crime not through punitive measures, but by facilitating internal incentives for change and improvements in the offenders' lives.

Glaser appears to paint current treatment programmes for sexual offenders with two brushes. He first insists that they are punishment in and of themselves, and then says that the concept of "dominion" is congruent "with what actually happens in sex offender treatment programmes, which aim at future-directed goals or targets (community safety) rather than punishment for past wrongs and largely morally neutral techniques for achieving these targets". If what actually happens in treatment programmes is congruent with the concept of dominion, why say that treatment is punishment? In fact, treatment is not punishment, although there may be some treatment providers who go about their work in a punitive or abusive way. Although some might argue that treatment which is court-ordered as part of the sentencing scheme is therefore punishment, therapists in such contexts are still required to uphold ethical principles. The APA and the NASW codes of ethics provide direction for treatment of "non-voluntary" clients, including guidelines for informed consent. In essence, all clients are voluntary and must give informed consent, albeit in some instances they may be asked to waive certain privileges. Treatment providers do not counsel clients who refuse services, as to do so would be unethical. Clients can choose whether or not to agree to the limits of confidentiality, and although there may be consequences for choosing not to participate in the programme, these sanctions are determined and enforced by the court, not the treatment provider.

Further, Glaser's proposal does not take into account that many sexual offenders ask for treatment. Nor does he consider that many sex offenders report satisfaction with the treatment that they receive (Colton, Robers & Vanstone, 2009; Garrett, Oliver, Wilcox & Middleton, 2003; Levenson, Macgowan, Morin & Cotter, 2009a; Levenson & Prescott, 2009; Levenson, Prescott & D'Amora, 2009b). There is no question that all treatment providers must protect the rights of their clients, and that some programmes might fall short of this mark. Glaser's proposed dominion model certainly contributes to greater ethical accountability, but would be more helpful by taking into account the heterogeneity of existing treatment programmes.

Infliction of harm

In a particularly strong statement about sexual offender treatment providers, Glaser states, "They deliberately inflict harm on their offender clients by using techniques such as cognitive restructuring (which forces offenders to accept responsibility for their behaviours) or empathy training (which deliberately induces distress in offenders about their abuse of their victims)". To characterize cognitive restructuring as a harmful technique is, frankly, inexplicable. Feeling bad about doing something bad (guilt) is part of the socialization process we learn as children. There is a benefit to recognizing that causing harm to others is not appropriate; when we wrong others the guilt we feel is instrumental in behaving in more altruistic and less harmful ways in the future. Helping individuals recognize the impact of their destructive actions may induce distress, but this is an accepted and common practice among parents, teachers and clergy—it contributes to the collective conscience and guides a consensus of desirable and undesirable behaviour. We believe that these cognitive strategies have a place in therapeutic intervention, as long as they target the behaviour and not the person. Shame, wherein someone believes themselves to be fundamentally bad or inadequate, on the other hand, is not beneficial (Tangney & Dearing, 2002). Shaming makes another person feel less worthy or

valued as a result of engaging in harmful behaviour, reinforcing one's view of oneself as a bad person who might be incapable of good things. In other words, we can and should convey acceptance and validation of our clients while encouraging a less egocentric view of their own harmful behaviour. We agree with Glaser that shaming is a harmful technique and that therapists should not engage in such a tactic (Tangney & Dearing, 2002). We disagree, however, with Glaser's view that cognitive strategies designed to facilitate empathy for another's perspective are inherently or intentionally harmful.

First, cognitive restructuring does not necessarily *force* offenders to accept responsibility for their behaviours. Personal responsibility is one element of any cognitive–behavioural therapy. Using a cognitive restructuring model, clients examine and challenge their thought patterns in an effort to clarify that they can control only themselves and their own behaviour rather than trying to change others. Personal responsibility promotes empowerment; it rightly places the power of change into the hands of the individual rather than leaving one feeling at the mercy of others. Exploring and changing how one's thoughts influence behaviours is a central tenet of the vast majority of contemporary psychotherapy modalities with a wide range of problems and populations. The process of change is very difficult for most people, including sexual offenders for whom the consequences of continued abuse are dire for both themselves and others. In therapy, many sex offenders acknowledge that, for the first time in their lives, there is more to be gained than lost by acknowledging their abusive behaviours. Most aspects of cognitive restructuring are indeed intended to benefit the offender and thus are wellbeing-enhancing. Thus this type of intervention cannot be construed as punishment. A key distinction lies within the practitioner's skill level. Cognitive restructuring will be more helpful when it elicits the client's own internal reasons for change rather than attempting to force change onto the client. We certainly agree that poor practice can become abusive and therefore unacceptable and unethical. However, this is more related to the behaviour of individual practitioners than it is to cognitive restructuring as a component of treatment. Categorical statements that clinicians deliberately cause harm by offering cognitive restructuring is like saying that surgeons cause harm by breaking chest plates in order to perform a heart operation. This is the critical issue—it is the intention or aim of the practitioners that is central to deciding whether an intervention has aspects of punishment. The aim of cognitive behavioural therapy is not to inflict distress, but to assist offenders to understand more clearly the ways in which their thinking influences their behaviour. By helping clients to perceive their internal locus of control, they can be empowered to embrace the personal choices they have made and can make in the future. Cognitive behavioural therapy is, in general, one of the most empirically supported therapeutic interventions, and demonstrates effectiveness in reducing recidivism for sex offenders (Hanson et al., 2002).

Secondly, *forcing* human beings to accept responsibility and develop empathy for their victims is ineffective and unsound practice (Marshall 2005). However, sexual offenders in treatment have told researchers that arriving at an ability to accept responsibility and develop victim empathy are among the most important elements of treatment itself (Colton et al., 2009; Levenson et al., 2009a; Levenson & Prescott, 2009; Levenson et al., 2009b). Most sex offender treatment providers recognize that it may take some time for clients to become comfortable in the therapy setting and develop a trusting rapport with the therapist. Therefore, clients who initially present with denial are not usually refused treatment, but rather the initial stages of treatment involve collaborating with the client to identify treatment goals. On the other hand, after failed attempts to sufficiently engage clients in treatment—when clients perpetually deny that they have the problem for which they are in therapy—it is unethical to continue to treat them. An ethical clinician cannot treat a client for a problem

they do not have—or do not want to admit to. For that reason, treatment providers have an ethical obligation to withdraw services when the client does not acknowledge a need to change. Ironically, this may be seen by some, such as Glaser, as coercing clients to accept responsibility for their problematic behaviours and punishing them if they do not.

Typically, the client's hopes, dreams and visions of the future are also a serious focus of treatment for practical as well as humanitarian reasons. The literature on sexual offender treatment is replete with findings that personally meaningful goals that a client can embrace are likely to be more helpful than goals based solely on avoiding an undesirable outcome (Ward & Brown, 2004; Yates, 2007). It is common for sex offender clients to desire counselling in specific areas that supplement sexual abuse prevention (e.g. personal victimization, marital problems, drug and alcohol dependence and general wellbeing). These additional treatment goals further the therapeutic principle of promoting the welfare of the client.

The human rights perspective

The human rights model is an excellent paradigm for contextualizing the ethical responsibilities of clinical practitioners. Because a natural human reaction to sex offenders is often disdain, mental health providers need to be especially careful to examine their own personal attitudes and reactions to avoid poisoning the therapeutic process (Day & Ward, 2009). Glaser rightly reminds us that sex offender clients, even though they have caused harm to others, have experienced enormous stigma and incapacity. Glaser challenges us to understand the moral seriousness of therapy, which seeks to produce dramatic and long-lasting changes in clients' characters.

In a number of places in his paper, Glaser implies that sexual offender treatment providers share commonalities with those who engaged in torture at the Abu Ghraib prison earlier this decade, and with the pathologizing of dissidents in the Soviet Union. While it would normally be understood that treatment providers are not torturers, Glaser's assertion and the implications that follow from it are unhelpful and incorrect. There is an enormous conceptual leap from the provision of treatment following conviction for a crime after due process to participation in an outrageous and obviously unacceptable violation of international law. If Glaser's point is to outline the ethical challenges that all professionals face when interacting with the legal system, his examples bear little fruit. We already have the works of Milgram, Zimbardo and others to inform us of the grimmer aspects of human nature, regardless of national origin.

The human rights perspective identifies a fundamental set of basic needs that are necessary to the wellbeing of each individual (personal freedom, material subsistence, personal security, equality and social recognition) and has been codified by the Universal Declaration of Human Rights, published originally by the United Nations in 1948. The human rights perspective has been applied to the treatment of those in contemporary criminal justice settings by Ward, Gannon and Vess (2009). These authors examined specifically the APA ethical code in the context of forensic psychology and applied the human rights model explicitly as an additional resource for resolving ethical dilemmas (Ward et al., 2009). Using case studies and examples of sexual offenders, they acknowledged the need for psychologists to proceed with caution and consider the relationship between human rights and forensic intervention.

Mental health providers are ethically bound to do no harm and to promote the wellbeing of the individual. This guiding principle is linked to human rights of security and equality by

ensuring that offenders are not discriminated against (Ward et al., 2009). Indeed, mental health providers have been instrumental in speaking out against policies that interfere with sex offenders' basic human needs and material subsistence. For instance, 30 states have passed residential restriction laws, creating a crisis for offenders in many jurisdictions where housing options been diminished significantly. In Miami, Florida, housing restrictions have forced offenders to live under bridges because the laws make it impossible to secure lodging elsewhere. Treatment providers have spoken out vociferously against this inhumane treatment in court testimony, in newspaper editorials, via interviews with the press and by testifying before state legislatures and municipal governments. Examples of this advocacy can be found in recent media such as *Newsweek*, *British Broadcasting Corporation* and the *Associated Press*, and in position statements such as those promulgated by the *California Sex Offender Management Board* and the *Broward County (Florida) Sex Offender Task Force*.

The right to social justice and fair and equal treatment is a guiding principle of mental health ethical codes. The NASW code of ethics identifies social and political action explicitly as an ethical obligation whereby social workers promote social welfare and social justice by advocating (among other things) "for living conditions conducive to the fulfillment of basic human needs". The NASW code goes on to say that social workers should advocate that "all people have equal access to the resources, employment, services, and opportunities they require to meet their basic human needs and to develop fully" and to "be aware of the impact of the political arena on practice".

The principle of fidelity requires psychologists to engage in honest relationships with clients through informed consent. When working in forensic or court-ordered settings, describing clearly the service contract and its entitlements and obligations is essential (Ward et al., 2009). Ensuring that clients understand these conditions allows clinicians to exercise their ethical obligations to protect clients and others. APA and NASW ethical codes state that practitioners have obligations to both clients and to the community and provide guidance in balancing both.

Another core principle of the APA ethical principles is that of integrity, which requires that psychologists avoid deceiving or misleading clients. Glaser suggests that sex offender clients are "more vulnerable to the effects of therapist deceit, no matter how benign the intention of such deception". Unfortunately, Glaser provides no direct evidence of deceit by sexual offender treatment providers. His assertions, therefore, seem to take place more in the service of his own ideas than in the truth itself. To say that sex offender treatment providers as a group deceive offenders routinely and intentionally leaves Glaser perched precariously on the edge of reason; if this were true, thousands of errant practitioners would be at risk for ethical, legal, criminal and civil sanctions. In the absence of any compelling or specific examples of deceit or deception given by Glaser, our best response is to quote President Obama: "Such a charge would be laughable if it weren't so cynical and irresponsible" (as said in the President's speech to the nation about healthcare on 9 September 2009, when responding to allegations of "death panels").

Finally, psychologists, social workers and others are bound by an obligation to respect the rights and dignity of individuals. This overarching principle of the human rights model is congruent with ethical duties of confidentiality, self-determination and informed consent (Ward et al., 2009). Although breaches of ethics can happen, and unethical practitioners exist in all professions, it would seem that the vast majority of mental health providers come to the job motivated by compassion for others. Those who choose to work with undesirable populations such as sex offenders do so, in our experience, because they possess a special kind of empathy necessary to understand sexually violent behaviour without judging the person who commits the behaviour.

Conclusion

Clinicians working with criminal populations in general, and sex offenders specifically, are faced with ethical challenges which need to be navigated carefully. Courts rely upon mental health providers to contribute to the goal of community safety by engaging them to offer rehabilitation services to those at risk for sexually harming others.Glaser's unequivocal disdain for sexual offender treatment providers does more harm than good. Both the present authors have written and lectured extensively on the need for reasonable efforts to build healthier lives and safer communities. We, too, are concerned that ethical treatment provision is fraught with peril. But Glaser's description of sexual offender treatment providers as deceitful, harmful and coercive does little to advance the legitimacy of his ideas.

In his paper, Glaser outlines ethical dilemmas faced by all sexual offender treatment providers. His advocacy of a human-rights perspective is both timely and welcome. However, his inaccurate attack on the current state of sexual offender treatment undermines his efforts to provide a clearer way forward. At the end of the day, we must conclude that despite its shortcomings and ethical challenges, sexual offender treatment can produce better lives and safer societies. In fact, Glaser acknowledges that sex offender treatment has demonstrated some success in reducing recidivism. Providing treatment to sex offenders in the corrections system has its inherent ethical challenges, and the advancement of human-rights perspectives is vital. Glaser's promulgation of dominion is certainly welcome. It will no doubt receive wider acceptance when he explores more accurately the complexities of treatment provision.

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