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Tony Ward¹ and Karen Salmon¹

Abstract

The ethics of care acknowledges the importance of establishing and maintaining practices that help people to meet their needs, develop and protect basic capabilities for problem solving, emotional functioning, and social interaction, and avoid pain and suffering. In this article, we explore the contribution an ethics of care perspective can make to work with sex offenders. First, we briefly describe five classes of ethical problems evident in work with sex offenders. Second, the concept of care is defined and a justification for a version of care theory provided. Third, we apply the care ethical theory to ethical issues with sex offenders and demonstrate its value in responding to the five classes of problems outlined earlier.

Keywords

ethics of care, sex offender treatment

Clinicians are confronted with ethical questions on a daily basis concerning how they should act toward sex offenders in their therapeutic interactions with them. These questions include discussion about what values and corresponding norms ought to guide them when assessing and treating men convicted of sexual crimes. The nature of our obligations toward individuals who have inflicted harm on innocent members of the public and often demonstrated a marked lack of remorse is complex and embedded within an ethical minefield. Some have argued that offenders have forfeited their rights to be regarded as moral equals and should not regain this status until they have

¹Victoria University of Wellington

Corresponding Author:

Tony Ward, School of Psychology, Victoria University of Wellington, PO Box 600, Wellington, New Zealand

Email: tony.ward@vuw.ac.nz

made amends by undergoing punishment and restorative practices (see Kleinig, 2008; Ward & Langlands, 2008). From this viewpoint, it is appropriate to express our condemnation and disgust toward people who have intentionally inflicted serious harm on others. Sometimes this expression might take the form of imposing extremely harsh restrictions and a loss of social and ethical standing on them. Others have countered that we should strive to keep our feelings in check and always attempt to be dispassionate and fair in our dealings with offenders (Golash, 2005). We should keep in mind their inherent dignity and right to be treated with respect and compassion. However, it is reasonable to inquire whether it is ever appropriate to reveal our true feelings in the hope that such disclosures may encourage offenders to make serious attempts to modify their offence related attitudes and behaviors. Making amends and accepting responsibility for moral and legal transgressions has been viewed as a first step in individuals' journey toward redemption, and ultimately, reintegration into the community (Duff, 2001). The above questions point to the importance and complexity of ethical issues confronting individual who assess and treat sex offenders. Furthermore, it is not possible for clinicians to shrug their shoulders and maintain that it is not their job to address ethical conundrums and that they are better employed delivering psychological programs not solving philosophical puzzles. Unfortunately, every aspect of practice is shot through with value commitments and each of us is obligated to think deeply about our responsibilities to sex offenders, victims, the community, and ourselves.

It is possible to group the major ethical issues arising from sex offender treatment into five independent, although related, categories (Ward, 2007). The first category of ethical problems relates to matters arising from *risk management* and the degree to which treatment programs ought to attend to offenders' interests and well-being. The second group of issues is concerned with the utility of utilizing *individually tailored* versus manual-based programs for offenders and to what extent contextual features of offenders lives, including their close relationships, should be taken into account. Third, there is the matter of evaluating the comparative importance of focusing on the *technical aspects* of therapy as opposed to relationship and therapist factors (what have been called process issues as opposed to content). A fourth group involves addressing tension between *protecting the community* and promoting the interests of offenders as evidenced in such initiatives as mandated treatment, civil commitment, and sex offender registries. Five, it is possible to identify another class of ethical difficulties that revolve around *therapist factors* such as self-care, problems of bias, dual roles, and conflict of interests.

Ultimately the kind of questions outlined above center on the issue of what constitutes acceptable professional ethical behavior, and this in turn, depends on the ethical theories, concepts, and standards that clinicians use to evaluate the rightness or wrongness of their actions (Bersoff et al., 2003; Cooper, 2004; Kitchener, 2000; Koocher & Keith-Spiegel, 2009). Without access to additional ethical theoretical resources individuals are forced back upon their intuitive judgments and run the risk of acting without a clear sense of ethical direction, or in some cases, suffering from ethical

blindness and failing to detect problems that exist within their practice (Ward & Syversen, 2009).

Traditional Ethical Theories

Practitioners are faced with both an embarrassment of riches and a lack of direction when it comes to the availability of ethical theories and ideas intended to help address pressing clinical problems. The plethora of riches arises from the extensive traditions and vast writing on ethical matters while the lack of direction can be traced back to the fact that traditional ethical codes alone are insufficient to guide ethical professional practice. Each traditional ethical theory has its own domain of applicability but also demonstrates limitations and, therefore, it is easy to get confused about which one to fall back upon when asked to justify professional actions or when wondering about the legitimacy of a possible assessment or therapeutic intervention. We will now look briefly at the theories relied on to help clinicians' identify and address ethical difficulties in their work with offenders.

The analytic focus of *deontological* ethical theories is on the features of individuals' actions and whether they have been based on a reflective process. This is a backward looking (and duty oriented) process and the consequences of any action are thought to be ethically irrelevant as long as the underlying intention was good and reflective process rigorous (Driver, 2006; Kitchener, 2000). Deontology has been accused of being overly impersonal and ignoring the practical consequences of what people do (Driver, 2006; Kleinig, 2008).

Utilitarians are more concerned about the consequences of what people do and base their evaluation of an action's moral status on whether or not it promotes the greatest possible amount of utility (e.g., desire satisfaction). This is a forward-looking process, and as such, the consideration of intentions is thought to be beside the point (Driver, 2006; Kitchener, 2000). A complaint against utilitarianism is that it may recommend unjust actions against innocent people if the overall amount of good produced by such actions are greater than the possible alternatives (Kleinig, 2008).

The emphasis of *virtue ethics* is on the dispositions or character traits of moral agents that incline them to reliably act in the right way in specific contexts. A strength of virtue perspectives is that they attend to the emotions and thoughts that underpin actions and focus attention on the degree to which practitioners possess the right kind of character to be ethical clinicians. A commonly noted weakness of virtue ethics is that there is a degree of circularity when moral actions are defined in terms of the type of person who is likely to produce ethical outcomes (Driver, 2006).

In recent years writing on professional ethics taken a more pragmatic turn and concentrated on the *ethical principles* thought to underline ethical standards and subsequent actions rather than any particular theory. This move has been defended on the grounds that while ethical theories tend to be built around different major principles (e.g., universality, utility, character traits, etc.) they *all endorse* values such as

beneficence, nonmaleficence, justice, autonomy, and integrity (Beauchamp & Childress, 2009). Thus, it has been argued that is possible to avoid partisan disputes over the status of ethical theories by seeking common ground in the core types of principles accepted by all theories. A problem with this type of pragmatic approach is that little guidance is given as to how to proceed ethically when the different principles result in conflicting advice (Kitchener, 2000).

Finally, some theorists have recommended basing ethical thinking in professional forensic contexts on foundational concepts such as *human rights or human dignity* (see Ward & Syversen, 2009). For example, the key argument of a recent article by Ward and Syversen (2009) is that researchers and practitioners ought to justify their ethical decisions in a stepwise process, typically first relying on their commonsense everyday reasoning and then in successive steps appealing to the standards of ethical codes, principles underling ethical codes (e.g., beneficence, autonomy, justice and integrity), ethical concepts and theory, and ultimately, the concept of human dignity. Although this is a promising approach, it effectively removes theory from practitioners' ethical toolkit, and as such, may be regarded as unnecessarily restrictive.

Although all the above theories and perspectives have merit, they do not on their own provide clinicians with sufficient theoretical resources to deal with the kinds of ethical problems arising from work with sex offenders described earlier. In our view, a relatively new theoretical perspective originating in feminist thinking, the *ethics of care*, may provide a alternative theoretical ethical framework for working with offenders and help practitioners to build trusting and strong therapeutic bonds (Engster, 2007; Held, 2006; Noddings, 1986; Slote, 2007, 2010). At the very least, it constitutes another valuable resource and tool for thinking through the inevitable ethical problems evident in daily practice.

As mental health professionals, sex offender clinicians are placed in a caring role with their clients and are obligated to intervene in ways that are compassionate, supportive, and encourage growth as well as alleviate their potential for further harmful actions. Although this coalface intuition possesses prima facie validity, it is not really adequately dealt with by existing ethical theories. Ethical theories such as deontological, virtue, pragmatic, and utilitarian theories have been designed for interactions with comparative strangers, and as such are arguably less useful for clinical work, which has a more intimate, face-to-face orientation (Held, 2006). An additional advantage of using a care-oriented ethical framework to guide practice is that in its contemporary versions it extends its reach to all members of the community as well as face-to-face relationships with offenders. Furthermore, the ethics of care's inclusion of empathy, compassion, and other related moral emotions, as well as its analytic focus on *relationships* rather than simply individual motives and traits, make it a useful addition to clinicians' conceptual armoury. In brief, care ethics acknowledges the importance of establishing and maintaining practices that help people meet their needs, establish and maintain basic capabilities for emotion, problem solving, emotional functioning and social interaction, and to avoid pain and suffering (Engster, 2007).

In this article, we explore the contribution an ethics of care perspective can make to work with sex offenders. First, we briefly describe five classes of ethical problems

evident in work with sex offenders. Second, the concept of care is defined and a justification for a version of care theory provided. Third, we apply the care ethical theory to ethical issues with sex offenders and demonstrate its value in responding to the five classes of problems outlined earlier. Our aim is to demonstrate the usefulness of an ethics of care framework for ethical practice and, therefore, it is not necessary to prove its superiority to all other ethical theories or perspectives. At bottom, we are pragmatic and pluralists and believe that multiple theories and principles may be required to help clinicians pick their way through the ethical minefield of routine sex offender practice.

Sex Offender Ethical Issues

We have grouped ethical issues into the five categories below for ease of exposition and do not claim that (a) there is no overlap between the classes or (b) that this classification system exhausts the kinds of ethical problems evident in sex offender assessment and treatment. Furthermore, in order to clarify matters the nature of the following ethical problem have been sharpened somewhat and we acknowledge that in reality things are inevitably muddier and less clear-cut.

Ethical Issues Associated With Risk Management

The risk management approach to sex offender treatment recommends the adoption of assessment and treatment strategies that *directly* aim to reduce the potential of sex offenders to commit further crimes (Beech & Ward, 2004; Laws & Ward, 2010). Core values associated with this approach are those of community protection, efficient delivery of services, a view of offenders as bearers of risk, and an emphasis on the rights and interests of nonoffenders. In short, sex offenders are construed as embodiments of discrete risk factors who pose considerable harm to the community. However, some theorists have argued that an exclusive stress on community protection at the expense of promoting offender well-being may amount to a violation of human rights doctrines (Birgden & Perlin, 2009). According to such researchers, a major aim of ethical treatment should be to ensure that sex offenders and nonoffenders have the essential capabilities to live better lives, and this necessarily involves paying attention to offenders' needs as well as containing and reducing their risk. Traditional codes of ethics struggle to resolve the issues included in this group and problems of mandated treatment, stigmatization, and the vulnerability of individuals placed in heavily restricted and controlled environments continue to pose ethical headaches (Laws & Ward, 2010; Overholser, 1987; Regehr, Edwardh, & Bradford, 2000).

Ethical Issues Arising From Program Design

Andrews and Bonta (2003) stress that there are six main elements required in correctional programs if they are to be effective. Specifically, they must be cognitive-behavioral in orientation, highly structured, implemented by trained, qualified, and

appropriately supervised staff, delivered in the correct manner and as intended by program developers, manual based, and delivered within institutions committed to the ideals of rehabilitation (Andrews & Bonta, 2003). Primary values associated with the issue of manual-oriented treatment approaches are those of efficiency, objectivity (impartiality), greater utility (i.e., maximizing outcomes), universality, and reliability. Individuals have objected to what they have perceived as the rigid use of treatment manuals and protocols and argued that some degree of treatment tailoring gives therapists more flexibility, can assist in offender engagement, encourage innovation, and is more responsive to offenders' personal circumstances (Marshall, 2009; Ward & Maruna, 2007). A key value contrast between those advocating for tight treatment protocols and those who support treatment tailoring is between approaching sex offender treatment from the perspective of the individual offender (stressing autonomy and empathic concern) rather than that of maximizing outcome for the benefit of the community. (Although it must be noted that this is a somewhat artificial contrast and attending to client well-being can also make society a safer place.)

Ethical Issues Arising From the Focus of Interventions

There is increasing evidence from risk assessment and research on etiological factors that a number of stable dynamic factors (e.g., deviant sexual interest, intimacy deficits) are causally related to offending, and if directly targeted in treatment, are likely to result in reduced recidivism rates (Beech & Ward, 2004; Hanson, Bourgon, Helmus, & Hodgson, 2009; Hanson & Harris, 2000). It has been argued that sex offender treatment should be entirely focused on these criminogenic needs and only use techniques shown to be effective in modifying or eliminating them (Andrews & Bonta, 2003; Hanson & Harris, 2000). The values associated with this perspective are those of objectivity, community protection, efficiency, and impartiality. On the other hand, research has also noted the crucial importance of therapist and therapy (process) factors in producing good outcomes with sex offenders (Marshall, Marshall, Serran, & Fernandez, 2006). These factors include ability of the therapists to create an appropriate alliance with the offender; the inculcation of the possibility for change; ensuring that the offender will benefit positively from such changes; providing the offender with an opportunity to learn from therapy; and emotionally engaging the individuals in treatment. Thus evidence indicates that efforts to increase offenders' self-esteem are likely to facilitate the primary targets of therapy and working collaboratively with offenders in developing treatment goals may result in a stronger therapeutic alliance (Mann et al., 2004). Furthermore, empathetic, warm therapists who encourage and reward progress appear to be the most effective in motivating change (Marshall et al., 2003). The values associated with a stress on process factors include a concern for offender well-being, respect for the dignity and agency of the offender, an emphasis on interpersonal meaning, and the need to understand the life goals of offenders.

Ethical Issues Associated With Community Protection

Public and correctional policies stress the protection of the community from offenders and courts have imposed tougher sentences and stricter parole conditions on offenders than in previous years (Ward & Birgden, 2007). The community appears to be extremely risk averse and primacy is placed on offenders being securely quarantined from other people (Laws & Ward, 2010; Ward & Maruna, 2007). Initiatives such as civil commitment, geographical restrictions, sex offender registries, strict and extended parole conditions are all examples of policies intended to protect the community from the threat of predation (Vess, 2008). The core values associated with the community protection orientation are nonoffenders' safety and rights, the obligations of offenders, predictability and control, and community harm reduction.

By way of contrast, a comprehensive human rights perspective is concerned with ensuring equal treatment and consideration of offenders in conjunction with safeguarding members of the community (Ward & Birgden, 2007). Unnecessarily harsh parole restrictions may make it extremely difficult for offenders in the community to live lives of minimal dignity and diminish their well-being to a serious degree. Offenders may find it difficult to establish supportive relationships with other people or to develop their interests and personality in healthy directions. For example, laws and policies that legislate intensive monitoring and control of released sex offenders may result in individuals being unable to relocate themselves into social networks and to establish adaptive ways of meeting their needs (Vess, 2008). The primary values associated with the concern of offenders' rights are those of redemption, community reintegration, forgiveness, offender entitlements, community obligations to offenders, and individual dignity.

Ethical Issues Related to Therapist Factors

The ethical issues related to therapists are a combination of self-care matters and how to offset the problem of bias when dealing with individuals who have committed serious offences against the community. The fact that sex offenders have been subject to punishment alongside receiving treatment indicates the ethical complexity of working with this population. It is incumbent on clinicians to be clear about their views on punishment and to ensure that the men they work with are not subject to additional, unjustified punishment in the form of further deprivation of services, overly critical and demeaning comments, failure to respond positively to therapy progress, and so on (Ward & Salmon, 2009). There is evidence that some professionals working with sex offenders support community notification policies regardless of offender risk level (Schiavone & Jeglic, 2009) or in the absence of evidence for their effectiveness (Levenson, Fortney, & Baker, 2010). These attitudes are not supported by the available research evidence and furthermore, may indicate some degree of bias against offenders and underplay their possibility of change (Willis, Levenson, & Ward, 2010).

The self-care issue is one that has been relatively neglected in ethical writings but in our view is of considerable importance for at least two reasons. First, therapists who have neglected their well-being-related interests are likely to struggle with the challenges of clinical work and run the risk of delivering suboptimal interventions (Cooper, 2004; Kitchener, 2000). The delivery of services may weaken the potency of treatment and deny sex offenders the best chance of changing and thus reducing their likelihood of release, and ultimately, integration into the community. Second, individuals may find it difficult to fulfill their social, personal, and civic obligations as well as deny themselves opportunities to live satisfying and well-balanced lives.

The Ethics of Care

The ethics of care has a rich and complex history and can be traced back at least as far to the British sentimentalists of the 18th century (Slote, 2010). Philosophers such as David Hume and Francis Hutcheson argued for the importance of sympathy, compassion, and allied emotional states in moral judgment and did not believe that it was possible for human beings to act ethically without some degree of “fellow feeling” (see Filonowicz, 2008). In the 20th century, feminist scholars such as Gilligan (1982), Held, (2006), Noddings (1986), and Walker (1998) criticized mainstream ethical thinkers for overemphasizing universal principles and ignoring the ethical significance of face-to-face, intimate relationships. Face-to-face or private moral contexts are where women are most visible and their goals revolve about establishing, repairing, and maintaining intimate relationships with friends and family. Women, they asserted, are less concerned with the impersonal interactions between independent and emotionally disconnected strangers. The ethical principles designed to regulate the interactions of this type of relatively autonomous individual, they argue, are more judicial in nature and lack an appreciation of the role of emotions, contexts, and relationships in every day human encounters.

Common Features of Care Theories

There have a number of important and somewhat diverse theoretical contributions made by theorists over the last 30 years to the ethics of care; many explicitly intended to address gender-related injustice and to advance the greater political and social equality of women (Held, 2006; Walker, 1998). Held states that despite this variety of viewpoints, it is possible to identify *five core features* of the ethics of care shared by the majority of theories. First, she asserts that there is an explicit analytic focus on *relationships* and more specifically, “on the compelling moral salience of attending to and meeting the needs of the particular others for whom we take responsibility” (2006, p. 10). Second, and relatedly *persons* are viewed in relational terms rather than construed as self-sufficient autonomous beings. According to this viewpoint, all of us are dependent on others for our sense of who we are, and ultimately, for our survival. Due to our embodied nature, we are vulnerable to numerous threats and require

ongoing physical and psychological scaffolding from other people and social institutions. The facts of human interdependence mean that individuals always require care of some kind if they are to live reasonable lives. Third, acts of caring are most reliably motivated by social or moral *emotions* such as empathic concern, sympathy, and compassion. What this entails from an ethics of care perspective is that ethical thinking is comprised of emotional processes such as responsiveness and sensitivity as well as rational principles such as consistency and generalizability. In fact, Slote (2007) places empathy at the heart of his version of care ethics and states that “actions are wrong if, and only if. . . . they reflect or exhibit or express an absence (or lack) of fully developed empathic concern for (or caring about) others on the part of the agent” (p. 31). Fourth, the focus of an ethics of care is on the concrete specific relationships people are in, often not by choice, rather than the idealized, abstract relationships found in traditional moral theories. More attention is paid to the *contexts* of moral situations and the details of peoples’ lives and characteristics. Some theorists seek to limit the applications of universal rules to impersonal moral contexts such as relationships between strangers or the domain of law, arguing that when it comes to personal, face-to-face social encounters the ethics of care has greater relevance and utility (Walker, 1998). Fifth, there is a rejection of the distinction between *public and private* spheres of functioning. Relationships in what have been regarded as private domains (e.g., domestic households) have, according to care theorists, been regulated by the wishes of dominant individuals without necessarily revealing any explicit concern for the interests of other persons involved, for example, women and children. The important idea captured by a rejection of the public/private distinction is nicely expressed by Held (2006) in her statement that “The ethics of care addresses rather than neglects moral issues arising in relations among the unequal and dependent, relations that are often laden with emotion and involuntary” (p. 13).

A Definition of Care

Although it is possible to formulate some common assumptions held by the majority of care theorists, coming up with an analysis and definition of the concept of care is less easy. Definitions apparent in the literature have either been vague or overly broad and inclusive and, therefore, of little analytic value (Engster, 2007; Held, 2006; Slote, 2010). Taking into account the above five features of an ethics of care ethical approach, we think that the following definition of care, and its associated virtues, formulated by Engster (2007) has the necessary scope, and rely on it in our later application of the ethics of care to the treatment of sex offenders. Engster defines care as:

Everything we do directly to help individuals to meet their vital biological needs, develop or maintain their basic capabilities, and avoid or alleviate unnecessary or unwanted pain and suffering, so that they can survive, develop, and function in society. (p. 29)

Furthermore, Engster states that the aims of care contained in his definition are more likely to be achieved if individuals possess the virtues or character features of *attentiveness* (i.e., noticing when someone is in need, suffering, and lacks capabilities etc.), *responsiveness* (i.e., intervening in ways likely to alleviate need etc., and monitoring whether responses are effective), and *respectfulness* (i.e., acting in ways that reflect others intrinsic worth).

There are some important clarifications that need to be made to this definition so it can serve our purposes. First, the term “basic capabilities” refers to the abilities required to enable individuals to complete certain tasks successfully within a specific environment. Engster’s list includes the abilities for “sensation, movement, emotion, imagination, reason, speech, affiliation. . . and the ability to read, write, and perform basic math” (p. 27). Second, from an ethical viewpoint when working with offenders the question that is most likely to be of relevance is the degree to which offenders are able to *maintain* their basic capabilities although it ought to be acknowledged that some individuals may lack the basic abilities necessary to adaptively function in the world (Marshall et al., 2006). Third, the emphasis in Engster’s definition is on direct action that exhibits caring rather than indirect or unintentional actions. Fourth, and relatedly, the onus is on action rather than motives or wishes. In other words, caring is manifested in what people do to help others and it is not strictly necessary that they feel compassion or empathy while performing these caring actions. At the end of the day, what matters is what is *done* not what is thought or felt. However, it is to be expected that there will be a close connection between inner states and outward actions, especially when people reliably care for others. The virtues of attentiveness responsiveness and respectfulness are likely to lead to sex offender practice that exhibits caring and also, interestingly, result in the formation of a strong therapeutic alliance (see below). Fifth, the three core aims of caring (i.e., meeting basic needs, addressing capabilities, and seeking to reduce suffering) are all interconnected but can occur individually.

Once the above definition of care is outlined, Engster formulates a principle of care that he argues everyone is obligated to adhere to and then provides a sophisticated and rigorous justification of this principle. In brief, Engster states that all human beings value their own survival, development, and the proper functioning of their basic capabilities, and seek to avoid unwanted pain and suffering. Due to their reliance on others in pursuit of these aims, it follows that they expect other people to assist them. Because persons make claims for help, Engster argues, it logically follows they are committed to the following care principle: “*capable human beings ought to help individuals in need when they are able to do so consistent with their other caring obligations*” (p. 48). If individuals accept the legitimacy of this principle with respect to their own care they ought, on grounds of consistency, accept the ethical legitimacy of the claims of others who also require care. Thus, Engster argues that all capable individuals are obligated to help other people meet their basic needs, acquire, develop, and maintain their basic capabilities, and to avoid unwanted pain or suffering. Individuals are only

obligated to assist in the achievement of these aims if in doing so they do not impair their chances for meeting their own needs.

The Ethics of Care and the Treatment of Sex Offenders

It is clear that all people rely on others, at least on some occasions, in the ways described above and, therefore, implicitly or explicitly make claims for care against others. Therefore, they have an obligation, in return, to assist persons requiring care. In the case of mental health professionals, however, they have also voluntarily accepted responsibility for the care of vulnerable individuals who because of mental illness or psychological dysfunction find it difficult to meet their needs and function adequately on their own. The fact that sex offenders are also undergoing state sanctioned and implemented punishment alongside treatment adds a layer of complexity to the clinical picture but does not change the relationship from a caring one. To say that it does is to shift treatment into a punishment framework, which in our view it does not belong, at least, not in its entirety. There are aspects of sex offender treatment that are intended to enhance individuals' well-being, for example, intimacy work. Therefore, standard sex offender treatment as a whole does not meet the criteria for punishment and it follows that sex offender clinicians do have obligations to care for the men they treat (Levenson & D'Amora, 2005; Marshall et al., 2006; Ward & Salmon, 2009).

General Comments

What contribution can the ethics of care make to professional ethics for clinicians treating sex offenders? The sexual offending domain is one where individuals have inflicted serious harm against children or adults and are almost always serving a sentence of some kind as well as undergoing therapy. In this situation, there are valid concerns about the potential safety of the community and the possibility of men in treatment acknowledging their past offences and reoffending in the future. Keeping this normative backdrop in mind, a first task for clinicians is to think about the aims of care as they apply to sex offender treatment. This involves evaluating the degree to which individuals being treated have their basic needs secured for goods such as safety, nutrition, affiliation, warmth, and shelter. Being able to have needs met depends on the availability of resources and personal abilities, for example, opportunities to form relationships and the capacity to respond and communicate with others. The second caring task is more complex and requires clinicians to keep in mind the basic capabilities people require to meet their own needs and to survive in the world. Ultimately the possession of basic capabilities for emotion, movement, imagination, communication, and relationships provide the necessary conditions for agency and the ability of people to evaluate their situation and formulate plans for ensuring they survive in the world, and indeed, have a chance at a flourishing life. From a care perspective,

it is necessary to identify the requirements of the environment an offender is living in and ascertaining what constitutes an acceptable level of functioning in that environment. This analysis will depend on social and cultural norms that stipulate what is acceptable in terms of basic conditions and, therefore, determines what skills are needed. Whether a clinician adopts a risk reduction or strength orientation to sex offender treatment, attention will need to be paid to the array of basic capabilities an offender displays. Absence of the necessary internal and external resources to meet his primary needs and to construct a plan for living that adheres to a society's minimal standards will leave an offender struggling to deal effectively with risk and to successfully reenter the community (Laws & Ward, 2010). A caring clinician is obligated to ensure that sex offenders in treatment acquire the capabilities to function independently when released into the community. This obligation should encourage them to think beyond simply implementing a set of treatment protocols and instead to inquire into the well-being and basic living skills an offender presents with.

The third caring aim is make sure that offenders do not experience unwanted pain needlessly and to do everything that can be reasonably done to alleviate suffering. It is obvious that the pain and suffering in question is more likely to be emotional in nature rather than physical. However, on some occasions the basic living conditions of imprisonment may be unacceptably harsh or threatening and cause individuals a significant degree of discomfort or even pain. In these situations a caring clinician has a responsibility to do everything possible to ease these conditions and help provide the offender with a decent and safe living environment. More pressing problems will center on the emotional pain experienced by offenders during the course of therapy and possibly inflicted outside of the therapy room by the facts of incarceration and isolation from friends and family. In addition, lack of social support or abuse directed by others (e.g., fellow prisoners) could result in negative affective states. Although some degree of suffering is to be expected, and arguably welcomed (e.g., feelings of guilt), during the course of therapy, it should be minimized when it serves no therapeutic or ethical purpose. Clinicians ought to treat offenders in a compassionate, empathic, and caring way and tailor their interventions accordingly. Adopting a constructive, positive treatment approach like that pioneered by Marshall and colleagues, and as outlined in strength-based approaches like the good lives model (Ward & Maruna, 2007), will help align practice with caring norms.

The chances of successfully achieving the caring aims will be enhanced if clinicians have acquired the virtues of attentiveness, responsiveness, and respectfulness. One of the nice features of a caring ethical approach is that viewing offenders respectfully makes it much easier to consider the unique circumstances of their lives and offending, and therefore to become more empathic. It is the process of grasping the concrete details, individuals' unique stories that helps therapists to break away from the grip of stereotypes and to appreciate the person within (Hoffman, 2000; Slote, 2010). Furthermore, modeling empathy and care to offenders may increase the likelihood of them behaving in a similar manner with fellow offenders and toward others outside of the therapy setting. The ethical importance of being attentive, responsive,

and respectful resides in the way these states evoke compassion and empathy, and ultimately help therapists to meet their caring obligations. Viewing sex offenders solely through a simplistic risk lens, whereas raising legitimate concerns for their propensity for future harm, may weaken the sense that they should recipients of our care.

Sex Offender Problems

We will now briefly revisit the five categories' of ethical issues apparent in sex offender practice. First, concerning risk management. From an ethics of care viewpoint the fact that offenders have harmed other human beings, and could pose threats in the future, does not support the abandonment of clinicians caring obligations. However, care means taking someone's *true interests* into account and it may be that after carefully considering the relevant data it is appropriate to recommend strict parole conditions for a high-risk offender. Just as loving parents may insist on their children undergoing medical care, it is consistent for clinicians to practice in a caring way but still recommend outcomes that offenders object to. When making a determination of what is in offenders' true interests, it is important to keep in mind that they are in a vulnerable position and largely dependent on the support and actions of others to attain care-related goods. This fact means that clinicians need to be vigilant and actively inquire into, and consistently monitor, sex offenders' needs, capabilities, and level of suffering.

The question to what degree programs ought to be tailored to mesh with individual circumstances rather than follow a strict manual-based format is one where the ethics of care can make a contribution. Clinicians have an obligation to deliver interventions in ways that are attentive, responsive, and respectful of the offenders concerned and, therefore, they should never ignore salient features of their lives and personal circumstances. In addition, when it is obvious that offenders are unable to effectively meet their basic needs on their own and either lack or struggle to maintain basic capabilities in important domains of human functioning, it is incumbent on clinicians to arrange for appropriate interventions to be delivered to them. The relevant interventions could take the form of therapy techniques or possibly educational and vocational training. However, from a care perspective there is nothing ethically objectionable about manual-based interventions if they have been demonstrated to be effective. Of course, the ethical legitimacy of such programs also depends on whether or not the relevant attention and responsiveness has been paid to offenders' unique circumstances, and whether salient details have been incorporated into a treatment plan.

In best practice sex offender treatment, the focus of interventions is on the reduction of dynamic risk factors or what have been called criminogenic needs (Beech & Ward, 2004; Marshall et al., 2006; Yates & Ward, 2008). In keeping with the responsivity principle, the aim is to deliver interventions in forms that match offenders learning style, motivation, or other personal and setting characteristics (Andrews & Bonta, 2003). However, research on therapist and therapy factors has reminded clinicians about the utility of seeking to establish a strong alliance with offenders (Marshall et al., 2003).

Moreover, strength-based approaches to work with sex offenders stress the importance of helping them build better lives alongside the diminution of their threat to the community (Ward & Maruna, 2007). A particularly valuable aspect of an ethics of care framework is that by attempting to meet offenders' needs, strengthen and maintain capabilities, and reduce suffering in a respectful manner it is possible to attend to both risk reduction, and process and asset building factors. If offence-related dispositions are rooted in problems of need dissatisfaction, skill deficits, or human misery then caring with its focus on whole persons and life situations will likely ameliorate offenders' potential for harm while strengthening their prosocial proclivities (Ward & Maruna, 2007). Offenders respond well to clinicians if they come across as genuinely interested and concerned, and are, therefore, more likely to increase their efforts to change (McNeill, Batchelor, Burnett, & Knox, 2005). These elements are clearly evident in care-informed practice and one would expect to see stronger therapeutic alliances and higher levels of offender motivation when caring practices are manifested.

In its original forms the ethics of care was intended to guide actions between people who regularly engaged in face-to-face contact such as family members or romantic partners. When it came to regulating relationships between strangers, care theorists typically defaulted to traditional normative ethical theories such as utilitarianism or deontology (Driver, 2006; Held, 2006). The major reason for this neglect was the perception that empathic concern and compassion was naturally restricted to people moral agents knew well and, therefore, would not generalize to those outside of their community and close circle. Because early care theories showed little interest in extending their scope to issues such as social justice or national and international ethical behavior these versions have little to offer sex offender clinicians and policy makers. In their role as mental health practitioners clinicians rarely know their clients and if they did, would be unlikely to treat them. Furthermore, the fact that concern was centered on offenders would open them up to the criticism that they neglected the well-being and interests of the wider community.

However, the development of care theory by theorists such as Held (2006), Slote (2010), and Engster has resulted in two major shifts in the scope and nature of care theory. First, evidence was presented from research on empathy and compassion that demonstrated that individuals concern for relative strangers could be developed by focusing on the concrete details of their lives and presenting stories that revealed their humanity (Hoffman, 2000; Slote, 2007). Second, an accent on caring practice or actions rather than feelings meant that from a care perspective the critical element was whether or not individuals' actions *expressed* caring intentions. It was no longer considered necessary for caring actions to be accompanied by internal emotional states of compassion or empathy. From a practical viewpoint, this shift resulted in a greater emphasis on shaping practices and norms that supported caring behavior toward *all* people. A caring clinician will take into account the needs, capabilities, and sufferings of all members of the community when making decisions that have practical consequences for everyone. It is true that as sex offender therapists they have accepted particular responsibility for sex offenders and left others to take care of other peoples'

interests. This is sensible as it is not possible for therapists to take on the burdens of care for every person in the community or all those affected by sexual offending. However, it is obligatory for them when formulating treatment and reintegration plans for offenders, to explicitly think about the well-being of others as well. Therefore, an ethics of care perspective does strive for balance because of its strong commitment to the well-being (care) of all moral agents. There is no neglect of the safety of the community or the rights and core interests of sex offenders.

Finally, a notable feature of the ethics of care is that it stipulates that caregivers have an ethical responsibility to care for themselves before they care for others. The rationale behind this requirement is that if caregivers are impaired they are unlikely to be able to adequately attend or respond to those they have responsibility for in respectful and effective ways. This aspect of care theory is especially relevant for sex offender therapists given the considerable demands made on their emotional and psychological resources and the fact that they are often confronted by hostile and uncomprehending public (Willis et al., in press). The form self-care ought to take will obviously depend on the individual and agency concerned but certainly frequent supervision, manageable workloads, scheduled sabbaticals, conference and workshop allowances, and a reflective, nurturing self-attitude could all be important elements of a self-care package. An additional advantage of the ethics of care is that because offenders are viewed through a lens of empathic concern it is easier to perceive them as fellow human beings and, therefore, avoid becoming overburdened by feelings of fear, dislike, anger, or guilt (Ward & Maruna, 2007).

Conclusions

In this article, we have described the ethics of care and demonstrated how it is able to supply clinicians with an additional set of ethical concepts to guide their practice with sex offenders. It is not our intention to dismiss the value of alternative ethical theories or the recent accent of ethicists on core ethical principles rather than theories. We also acknowledge that different ethical perspectives have their own particular strengths as well as some inevitable limitations. However, in our view, a crucial advantage of the ethics of care is that its emphasis on offenders' relationships helps to create a powerful medium for change. In addition, the concern with empathy, and emotion more generally, opens up the sphere of ethical thinking and decision making to these important and often neglected human phenomena. Finally, the fact that therapists are caregivers and, therefore, obligated to consider offenders' level of well-being as well as their capacity for future harm, makes the ethics of care an ideal fit with sex offender practice.

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