Paternalism and the Good Lives Model of Sex Offender Rehabilitation

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Abstract

The lives of sex offenders are often confused and disorganized. Modern sex offender rehabilitation approaches such as the good lives model emphasize holistic aims such as helping offenders to live more satisfying and fulfilling lives, rather than merely teaching them to avoid risk. The appeal of the model lies in its justification by paternalism: Whatever harms are inflicted on offenders during the rehabilitation process are ultimately for their own good. But paternalism has its limitations, which include potential infringements on offenders' autonomy and human rights, the risk of therapists imposing their own values and attitudes, and false claims that harmful interventions are justified by their benefit for offenders. Furthermore, some recent empirical studies suggest that offenders themselves do not necessarily prefer personal well-being goals over risk management techniques and that some offenders find it distressingly easy to incorporate "good lives" principles into an ongoing antisocial lifestyle. These limitations need to be taken into account when applying a good lives approach.

Keywords

sex offenders, offender rehabilitation, paternalism, ethics of punishment

Therapists working in sex offender treatment programs are ethically obliged to ensure not only the safety of the community but also the best interests of their offender clients. This can be a frustrating and difficult exercise for all concerned: Sex offenders

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are notorious for leading chaotic and aimless lives and for being very resistant to any attempts to recognize their self-destructive behaviors or to make any changes in them (Levenson & D'Amora, 2005). Furthermore, treatment of sex offenders, to be effective, entails practices that, at times, may be ethically dubious, for example, reliance on involuntary treatment, limitations on confidentiality and restrictions on choice of therapy and therapist (Glaser, 2003, 2009).

One potent response to this therapeutic dilemma is that of paternalism—the ethical justification for forcing someone to (not) do something on the grounds that any restriction on his or her rights and liberties will ultimately be for his or her own good. The lure of paternalism is strong. It is an ancient and honorable part of most healing traditions and readily justifies the interventions of therapists attempting to deal with the chaotic lifestyles and confused life-goals characteristic of many sex offenders. Even though offenders refuse to acknowledge them, their problems may be obvious and amenable to change: Inflicting harm in the short-term on offenders to ensure benefits for them in the future seems to be ethically more appropriate than simply forcing them to accept interventions for the public good.

Moreover, paternalism is an important ethical justification for strength-based offender rehabilitation approaches such as the good lives model (Ward, Collie, & Bourke, 2009). These, unlike programs based on the so-called risk–need–responsivity model, have the offender's well-being as his or her primary goal, rather than the mere assessment and management of the his or her risk. The use of interventions that ultimately benefit the offender (as well as ensuring community protection), such as building up an offender's skills and capabilities, appeals as a much more ethical and humane way of rehabilitating offenders than simply ordering them to avoid or reduce high-risk situations or activities.

In this article, after defining, and listing some justifications for, paternalism, we look at the place of paternalistic ideas in the good lives model. We then discuss the limitations that paternalism encounters as a guiding ethical principle in health care and correctional practice. We conclude that paternalistic justifications are important in defining these limitations as applied to the good lives model and, particularly, the limits of what therapists can achieve and the types of offenders who can be helped.

Paternalism and Its Justifications

Paternalism has been usefully defined as

> The intentional overriding of one person's preferences or actions by another person, where the person who overrides justifies this action by appeal to the goal of benefiting or of preventing or mitigating harm to the person whose preferences or actions are overridden. (Beauchamp & Childress, 2009, p. 208)

It is a specific expression of the ideal of beneficence—the obligation to act in the best interests of the patient—which has long been accepted as the primary obligation

of health care and which, since the time of Hippocrates, has been coupled with the idea that "the doctor knows best." Whatever the therapist decides will always be in the best interests of the client and could not possibly conflict with the client's wishes or views. Indeed, it was not until after World War II that Joseph Fletcher, lecturing in the new field of "Bioethics" at Harvard University, declared that, however noble and altruistic the intentions of the doctor, it was the rights of the patient, rather than the doctor's duty, which determined whether a patient used contraception or sought sterilization (Jonsen, 2000, p. 94). A further three decades would elapse before a wave of mental health legislation, in many jurisdictions in the 1980s, mandated limits on, and reviews of, the powers of psychiatrists to involuntarily hospitalize and treat ("for their own good") those who have mental health impairments (Chodoff, 2009).

Yet paternalism is not merely an excuse for health care providers to ignore the desires and values of their clients. In many cases, it provides a fundamental model of care in our society for those who are very vulnerable or disadvantaged: young children, the people with dementia, those with mental health impairments, those with significant intellectual disability, and so forth. For offenders with such vulnerabilities, the "ethical environment" in which they receive care requires carers and professionals to make guesses made on limited evidence about their true aspirations and capabilities (even though the offenders themselves cannot, or will not, express these) and then formulate appropriate responses and interventions accordingly. Of course such formulations must give due consideration to the human rights and the (possibly limited) autonomy of such offenders, but these sorts of considerations are meaningless without a paternalistic vision of how carers might "influence positively the narrative wreckage which comprises the subjectivity of many offenders, and what good it might do" (Clegg, 2004).

Second, the promotion of paternalistic acts says something about the sort of community we would like to be, for example, a community that will not abandon its members who are unable to respond rationally or effectively to life-threatening crises. Furthermore, recent debates about assisted suicide have sometimes downplayed the value our society places on the preservation of human life. Also, the motives of those who attempt suicide are often complex and ambivalent and often become apparent only after the urge to self-harm has passed. Therefore, even though potentially suicidal people may resist efforts to help them, there seems to be good reason to paternalistically "err on the side of preserving life rather than on the side of letting it be lost" (Bloch & Heyd, 2009, p. 246).

Third, paternalistic interventions can usually be justified by balancing the costs of their implementation (e.g., temporary restriction of choice) against their future benefits (e.g., preservation of health or well-being). For example, if I confiscate my drunken friend's car keys I am criminally victimizing him (stealing from him) and causing him monetary loss (unless I pay for his taxi home), but hopefully he will thank me the next morning, when he hears about the appalling road toll in the news. Some ethicists have developed rather complex schemes for determining whether paternalistic actions can be justified by prospective benefits (see, for example, Beauchamp & Childress, 2009,

p. 216). The point to note, however, is that we deceive, mislead, and coerce loved ones, fellow-workers, and clients "for their own good" almost constantly. Hopefully, most of the time, the harms we inflict are outweighed by the benefits they receive.

Good Lives Theory: An Example of Paternalism in Action

Sex offender rehabilitation programs need paternalistic justifications. That is now clear in the developments that have taken place in the field in the past decade. Until the early 1990s, the despair that "nothing works" in offender rehabilitation (Martinson, 1974) had seemingly been confirmed for sex offenders by a gloomy meta-analysis, which concluded that none of the treatment interventions tried so far could be shown to have any real effect on recidivism rates (Furby, Weinrott, & Blackshaw, 1989). At that point, however, evidence started to emerge that some interventions worked some of the time in some circumstances. In particular, the proponents of what is now labeled as the *risk–need–responsivity approach* showed that interventions worked best if their intensity matched the offender's level of risk (indeed high-intensity interventions were as ineffective for low-risk offenders as low-intensity ones were for high-risk offenders), if treatment targeted so-called criminogenic needs (e.g., sexual deviance in sex offenders), and if treatment was tailored to the offender's particular characteristics, including their motivation, cognitive ability, and personal circumstances (Andrews & Bonta, 2007). The effectiveness of these guidelines for reducing recidivism has now been demonstrated for sex offenders and in other offender populations, especially in contexts where the offender was isolated from antisocial peers and exposed to prosocial attitudes and values (Andrews & Dowden, 2007; Wilson & Yates, 2009).

But the risk–need–responsivity approach neglects important dimensions of offender rehabilitation. In its single-minded quest to manage offender risk, it ignores the dispositional factors, unique to each offender, which prompts the offender to engage in risky behaviors in the first place. By encouraging offenders merely to avoid or reduce risk, rather than giving them positive goals to pursue, it provides only a limited vision (if at all) of the benefits of an offence-free lifestyle. Furthermore, at least until recently, little attention has been given to the characteristics of therapy and the therapist, even though the therapist's empathy, warmth, and respect (among other things) are important determinants of treatment outcome (Marshall, Marshall, & Serran, 2006, but see Andrews & Dowden, 2007, for a grudging acknowledgment that offender–therapist relationships need to be characterized by "respect, understanding, care and positive expectations," p. 445). Standard sex offender treatment manuals often provide only limited guidance as to how to engage with offender clients, recognize their needs and aspirations, and enhance their motivations to complete the programs (Ward et al., 2009; Ward, Mann, & Gannon, 2007; Ward & Stewart, 2003).

Sex offender rehabilitation, therefore, has to incorporate an element that is for the offender's "own good" and which takes into account the offender's own goals, needs, and aspirations. A rehabilitation approach that does this is the good lives model that sees offenders as human beings who, like the rest of us, are striving after primary

goods—"actions, states of affairs, characteristics, experiences and states of mind that are viewed as intrinsically beneficial to human beings and are therefore sought for their own sake rather than as means to some more fundamental ends" (Ward & Stewart, 2003, p. 24). These goods include physical needs (e.g., food, warmth), psychological needs (e.g., relatedness—including and, importantly, for sex offenders—intimacy, autonomy, competence), and social needs (e.g., social support, work opportunities). Any individual will choose, prioritize, and relate his or her primary goods to each other in a unique but coherent fashion, depending on that individual's interests, abilities, and opportunities.

When offenders commence a rehabilitation program, they are, in effect, asking their therapists how they might achieve their primary goods in a more prosocial (and hopefully more effective) fashion. The therapist helps them to devise more appropriate means of achieving them, fulfill hitherto neglected needs in other areas of their lives, achieve greater coherence (and reduce the conflict) among their goals, and acquire the capability to fulfill these goals (Ward et al., 2007). These aims are reflected in the specific therapeutic techniques used. For example, for an offender who victimizes children, cognitive restructuring may help him understand his primary need for intimacy, arousal reconditioning may assist him to recognize alternative ways of achieving sexual satisfaction, teaching relationship skills should help him to increase the social supports available to him, and mood management will be important in reducing the disruption to his lifestyle and personal goals caused by seemingly uncontrollable emotional states (Ward et al., 2009; Ward & Gannon, 2006; Ward et al., 2007; Ward & Stewart, 2003). The emphasis is constantly on the enhancement of the offender's skills and capabilities rather than on the mere avoidance of criminogenic risks, although from the point of view of societal protection it is gratifying to see that a good lives model focus in treatment has been shown to result in better offender compliance and completion rates than a "standard" relapse prevention approach (Simons, McCullar, & Tyler, 2008, cited in Wilson & Yates, 2009).

Thus, the good lives model of rehabilitation adopts a more humane, rights-based, and holistic approach than that of the risk–need–responsivity model. But its primary justification (and its appeal over other rehabilitation approaches) seems to be based on paternalism: Whatever harms that are suffered by an offender during the course of his rehabilitation should be outweighed by the benefits he or she receives as a result of rehabilitative interventions. The good lives model does not seek to eliminate all potential harm that might be inflicted on an offender; indeed, where offenders are high risk, it will still be necessary to place (sometimes onerous) restrictions on them (Ward & Birgden, 2007). Rather, the model (at least implicitly) seeks to minimize harmful interventions, which result in little or no improvement in the offender's well-being.

The Risks of Paternalism (and How the Good Lives Model Deals With Them)

There are a number of dangers in using paternalistic justifications in treating offenders, even more so than with nonoffending clients. Paternalistic interventions *restrict*

autonomous choices, that is, choices that are not controlled by others and where the person concerned has the capacity to understand and act intentionally on them (Beauchamp & Childress, 2009, p. 99). Respect for autonomy is often seen as being the primary ethical basis for health care: It is based on the recognition (initially expounded in the writings of philosophers such as Mill and Kant) that all human beings have intrinsic worth and thus have the capacity to determine their moral destiny. They are thus entitled to certain fundamental obligations by health professionals involved in their care, for example, privacy, confidentiality, being informed truthfully of their health status, obtaining consent for procedures, and provision of help with decision making about their health and welfare (Beauchamp & Childress, 2009, pp. 99-105). Such ethical obligations are even more pressing for those treating offenders who, obviously, by reason of the punitive regimes that they experience, often face severe limitations on their ability to plan their lives and act on those plans.

Offenders in treatment programs are often subjected to "hard" paternalism, that is, restricting their autonomous choices when these choices are risky to themselves or others, even though they are also informed, rationally understood, and voluntary (Beauchamp & Childress, 2009, p. 210). The contrast here is with "soft" paternalism where there are substantial doubts about an offender's ability to make autonomous choices, as a result of factors such as youth, intellectual disability, mental illness, and so forth. However, the majority of offenders in treatment programs do not have diminished autonomy and often are striving for values and goals that, although often quite different from those espoused by the therapist, may still be legitimate in the context of the offender's culture or peer group. Thus, particular ethnic groups, for example, may condone sexual coercion of women as a result of culturally fostered misogynistic beliefs (or, at the other extreme, condemn such coercion as bringing shame to the group as a whole; Hall, Teten, & Sue, 2003). A member of the ethnic group concerned may be quite justified in arguing that the misogynistic values underlying his sexually assaultative behaviors were reasonable and appropriate and that, furthermore, in the context of his culture, there would be no benefit to him in changing them.

Whether the good lives model adequately addresses these concerns is unclear. Certainly, it acknowledges that the specific form of an offender's conception of his or her preferred goods will be governed by the his or her own unique abilities, interests and opportunities, and his or her context. Even if an offender wishes to change his or her behavior for purely "self-regarding" reasons (Ward et al., 2007, p. 104), this may be acceptable if the outcome is engagement in treatment (Ward et al., 2007; Ward & Stewart, 2003). However, unless the model specifies some form of universal basis for its ethical principles (perhaps based on its concerns for human rights, see the following), offenders could well argue that, in some circumstances, therapists' attempts to change their belief systems might well be a product of the therapists' own biases and stereotypes rather than of a genuine desire to help offenders achieve more fulfilling lives.

Respect for offenders' autonomy is part of a wider obligation to respect offenders' *rights and dignity*. This is especially important where paternalistic interventions are in

danger of being seen as punitive, for example, therapists imposing lifestyle restrictions on all members of a treatment group, even though not all may require them.. Philosophically, respect for human rights is grounded in the argument that all human beings, as agents pursuing goals of value for them, deserve respect for these goals and protection of the ways in which they are trying to achieve them. That respect must be accorded to all human beings because it would be irrational, for example, to demand respect for one's own valued goals but not for the equally valued goals of others (Gewirth, 1996). Legally, these protections are enshrined in documents such as the Universal Declaration of Human Rights (United Nations, 1948) that, broadly speaking, specifies rights aiming to protect a person's personal freedom, security, subsistence, equality, and social recognition.

The good lives model specifically addresses human rights concerns. Offenders have needs and aspirations that are similar to, and deserve the same respect as, those of the rest of humanity. Human rights objects such as personal freedom and material subsistence are the focus of interventions that both utilize an offender's own primary goods and cherished values (e.g., an offender's goal of achieving relatedness) and equip an offender to realize these goals (including risk reduction by promoting respect for the rights of others; Connolly & Ward, 2008). Offenders are assumed to retain these rights that can only be curtailed in very limited and specific circumstances, for example, legitimate security concerns or the humane and efficient running of correctional facilities. By contrast, the risk–need–responsivity model devotes only limited consideration to the rights and dignity of offenders and then only in relation to reducing their risk (Ward & Birgden, 2007).

A second difficulty with using paternalistic interventions with offenders is that of confusing the aims of therapy. Therapists in sex offender programs serve two masters: community safety and the best interests of the offender. Until recently, the U.S. Association for the Treatment of Sexual Abusers (ATSA) declared that "community safety takes precedence over other considerations and ultimately is in the best interests of sexual abusers and their families" (ATSA, 2001). Though this principle has now been modified (ATSA, 2004), there remains a danger that other interventions espoused by ATSA may effectively continue to dictate the primacy of community protection, for example, a preference for enforced (court-ordered) treatment, the use of criminal investigation and prosecution as "important components" of management, and advice to work "collaboratively" with probation and parole officers (ATSA, 2004). Some authors have pointed out that seemingly nonbeneficial aspects of sex offender treatment programs such as a preference for involuntary treatment, limitations on confidentiality, restrictions on choice of therapy and therapist, and so forth can be justified by other considerations. These include the long-term benefits for all affected by the offending behaviors (including offenders themselves), the value of clinical professionals in reducing the frequency and the impact of these behaviors, and the presence of other ethical safeguards such as professional ethical codes that may provide some limits on the harms that may be inflicted on offenders during treatment (Levenson & D'Amora, 2005). Nevertheless, it remains all too easy to blur the distinction between

the goal of community protection and that of the clients' best interests, and therapists (and offenders) may come to believe that harsh and degrading treatment regimes are justified as paternalistic, even when it is clear that they are punitive and directed at other goals, for example, reducing recidivism (Glaser, 2003, 2009).

The good lives model, by prioritizing the offender's goals over those of society, explicitly tries to avoid such confusion. Often this is not difficult: Recent studies have shown that the goals of community protection and offender welfare need not be at loggerheads with each other: Many treatment interventions can achieve both. For example, the traditional attributes of nurturing psychotherapy such as the therapist's empathy, warmth, openness, and nonconfrontational style, as well as being beneficial for the offender, also help to achieve better compliance with therapy and, hence, socially useful outcomes such as lower reoffending rates (Marshall et al., 2006).

Sometimes, however, the true aim of a particular intervention is unclear; for example, enhancing an offender's social and communication skills would reasonably be regarded as being beneficial for them and thus can be paternalistically justified if the acquisition of such skills involves less harm to them than the ultimate benefit expected. Other sex offender treatment techniques, however, are more frankly punitive; for example, empathy training deliberately induces distress in offenders about the abuse of their victims. This technique risks degenerating into a form of moral condemnation and, indeed, its efficacy is assessed by the harm caused (i.e., the degree of emotional distress; Ward et al., 2007; Ward & Salmon, 2009). The benefits to the offender produced by this sort of intervention are not clear. Offenders have reported the experience of "having a weight lifted off" them when they no longer have to minimize the harm they have caused to their victims (Ward et al., 2007, p. 104). On the other hand, there is no guarantee that this will happen, particularly if the offender perceives the distress caused by empathy training as being deliberately and callously inflicted by a (nonempathic!) therapist.

Sadly enough, history has shown that defining the aims of treatment is not easy to do in the institutional environments where offender treatment is carried out. A recent example is that of the American Psychological Association's apparent condoning of participation by psychologists in the torture of detainees at sites such as Guantanamao Bay and Abu Ghraib, provided that the psychologists' role was defined as that of "organizational consultant" rather than that of "treatment provider" (Birgden & Perlin, 2009). For therapists working in a good lives framework, one response to this sort of dilemma might be to go beyond the simple question of "Whose interests benefit from this intervention?" They also will need to retain a keen awareness of issues such as offenders' autonomy, human rights, and dignity, to prevent themselves from falling into the trap of specious justifications for intrusive interventions and to minimize the harm caused by possibly nonbeneficial interventions (Ward & Salmon, 2009). Furthermore, though interventions such as empathy training may be relatively benign for some offenders, the good lives approach would at least require therapists to carefully consider whether they are applicable to offenders whose good lives plans are sensitive to the influence of therapist-inflicted emotional distress or moral condemnation.

The final and probably most important concern with using paternalistic justifications for offender treatment is that of whether *any* form of punishment (including any form of treatment administered as part of a punishment regime) can be justified by its ultimate benefits for the offender. After all, punishment, by its very nature, involves the intentional infliction of harm on an offender by an authorized agency, because the offender has infringed a societal rule. The intentional and deliberate infliction of harm is what distinguishes punishment from treatment that, by contrast, seeks to avoid harming clients or, at least, harming them to the minimum extent necessary to promote their well-being (Glaser, 2003, 2009).

The use of punishment to benefit offenders has a long history, however. Nineteenth- and twentieth-century initiatives aimed at reforming correctional systems used "illness" models of criminal behavior to plan and implement regimes beneficial for prisoners. Some correctional interventions for conditions such as substance abuse and personality disorders were deliberately designed to be curative rather than punitive. Unfortunately, medical labels for criminal behavior also justified harshly punitive "treatments" such as aversion therapy using electric shocks or paralyzing drugs. But generally most of the programs offered involved "softer" regimes aimed at improving offenders' psychological well-being and social environments, even for offenders who were regarded as being incorrigibly dangerous, the so-called psychopaths (Johnstone, 1996). Punishment could, therefore, be justified paternalistically because it offered offenders access to beneficial interventions, which otherwise might not be available to them.

These beneficial effects of punishment for offenders do not have to be clinical in nature. A venerable philosophical tradition declares that the communicative and educational aspects of punishment regimes improve offenders morally, or at the very least, enhance their moral understanding:

> Penitential punishment that censures criminal wrongdoers, aiming to persuade them to repent their wrong-doing and to embark on the necessary task of self-reform, constitutes a mode of moral communication. (Duff, 2001, p. 113)

Unfortunately, this says little about the content of the "moral communication," which may impose more severe restrictions on an offender than those that are necessary to achieve his well-being (or indeed the protection of society). For example, should we forbid prostitution because it is morally corrupting to sell one's sexual services, even though the harms associated with it could be minimized by, for example, regulating appropriate health services and working conditions for prostitutes? (Dworkin, 2005). Duff, whose communicative justification for punishment we have just cited, would strongly deny that he is advocating this form of moral paternalism: Indeed, he is careful to specify that the offender can only be persuaded (not coerced) to change his views and commence the process of reform even when criticism of the offender's behavior is deserved (Duff, 2001).

Nevertheless, the good lives model may implicitly impose moral views on offenders in the guise of helping them to achieve primary goods. Take, for example, the good

of sexual pleasure. A therapist using the good lives model would probably not insist that an offender masturbate to appropriate sexual fantasies, if the offender believed that masturbation was morally repugnant. Rather, the therapist would recognize the threat to the offender's primary goods of agency and dignity posed by such an intervention. Yet the mere suggestion by the therapist that this sort of intervention is not only possible but morally acceptable (at least to the therapist) implies a particular moral view that the offender is unable to share, even though the offender himself or herself may recognize that compliance with it may produce a better outcome for him or her personally. Such dilemmas can prove to be very distressing even for the most thoughtful and ethically aware. However, using the good lives model, the therapist recognizes the resulting dissonance between the values of the therapist and those of the offender/client as an opportunity for the offender to redefine his or her life goals. The therapist thus continues to emphasize the agency and dignity of the offender who remains in control of these goals and his good lives plan (Ward & Laws, 2010).

A further argument against punishing offenders for their own good is derived from the considerations of offenders' autonomy and rights discussed earlier. If we accept that offenders are people capable of making autonomous choices in determining their goals in life, then we show disrespect to them if we do *not* punish them for the criminal behavior resulting from those choices and goals. Indeed, we are in danger of diminishing offenders' personhood by offering them treatment rather than punishment because we are effectively saying that they are not capable of making the freely and fully informed decisions about their lives that would normally qualify them as human beings of the same moral worth as ourselves. To use a well-known if somewhat bizarre phrase, offenders have a "right to be punished" in order to preserve their human dignity (Kateb, 2007; Morris, 1976). Another version of this argument, first formulated by Hegel, presumes that offenders recognize the necessity for society to punish them for their misdeeds and thus have a "right" to be helped to fulfill their obligation to be punished (Honderich, 1989, p. 47).

Now several points can be made about this analysis. First of all, it seems to be a very strange "right" that involves the infliction of harm on the rights bearer. And in any case there appears to be no corresponding *obligation* on anyone's part to fulfill this right, that is, to inflict punishment on the offender (e.g., correctional facilities administer punishment as part of their duties to the courts, not because of their obligations to offenders; Honderich, 1989, p. 47).

Furthermore, it is doubtful that the good lives model would prioritize the "right to be punished" as a primary good. It substantially conflicts with an offenders' other rights, for example, forgoing the right to a more humane and respectful correctional environment if this happens to be the setting for offender treatment programs (Kateb, 2007). It also seems to justify a rigidly retributive form of punishment that ignores the harm inflicted on the offender, using cynical appeals to concepts of human dignity and self-worth. Although it is a further reminder of the rights generally retained by offenders, it does not, in and of itself, prevent us, in carefully defined circumstances, from "punishing offenders for their own good."

From what we have seen so far, then, paternalism provides an appropriate justification for demanding prolonged sex offenders treatment. If their rehabilitation program follows a good lives approach, offenders are usually right in thinking that their own welfare is the major, if not the only, beneficial outcome of the harms inflicted on them during the course of his punishment, even though, from the point of view of society, their lowered risk of recidivism is at least as useful and important. It is true that their therapists will need to be constantly vigilant to avoid setting goals antithetical to their cultural and moral values. Their therapists will also have to scrupulously avoid spurious justifications of certain interventions (e.g., empathy training) as being for the offenders' own good when this may be in fact not the case. The offenders themselves will have to accept that, should they exhibit high-risk behaviors, feelings, or fantasies, they may be subject to restrictions that do not benefit them at all (although such restrictions will be confined to those who inflict minimum infringements on his or her autonomy and human rights). But overall, they appear to have got a pretty good deal.

But What Do Offenders Really Want?

Is this, however, what offenders really want? Our discussion of paternalistic justifications can now expose some other contentious assumptions of the good lives model. First, it seems to presume that pursuing goals, which are personally meaningful for offenders, will tend to be more personally and ethically satisfying than, say, merely learning strategies to avoid high-risk situations. A second premise is that offenders are at least one of the groups (alongside, for example, clinicians, enlightened corrections workers, concerned community members, etc.) for whom this is true. Third, it postulates that many, if not most, offenders would not offend, or would offend less, if they had better ways to achieve and prioritize their primary goods (Ward, Vess, Collie, & Gannon, 2006).

Recent empirical research, however, as to what offenders want from their lives and from rehabilitation programs has provided complex and subtle findings that appear to cast doubt on these assumptions. The life goals of 129 U.K. prisoners surveyed by McMurran, Theodosi, Sweeney, and Sellen (2008) did not differ from what rehabilitation experts said they needed: Equal emphasis was placed on both "approach" and "avoidance" goals, for example, stopping offending, improving self-control, gaining a job and more general aims of improving their lifestyle, and getting fit. Many of them, however, commented that the mere completion of the survey was an opportunity to define these goals and motivate them to pursue them.

Levenson and her colleagues have looked at the perceptions of treatment experiences in a group of 338 sex offenders participating in outpatient treatment programs (Levenson, Macgowan, Morin, & Cotte, 2009) and in another consisting of 44 civilly committed sex offenders (Levenson & Prescott, 2009). Both groups assign high and equal importance both to treatment aims that seem to represent community protection goals (e.g., accepting responsibility, learning about their denial patterns, understanding the impact of their sexual abuse on their victims, recognizing their offence chains, etc.)

and to those aims that seem to be important for their personal development (e.g., understanding the effects of their early life experiences, learning relationship and communication skills, understanding their emotional needs, learning how to create a more satisfactory life, etc.). Admittedly the outpatient group would have liked to have spent more time on personal concerns such as "self-forgiveness or self-compassion" (as compared with classic criminogenic issues such as "grooming," "responsibility," etc.). One also needs to take into account a social desirability bias in the responses (particularly in the civilly committed group). However, allowing for the methodological limitations of such surveys, this seems to be a fairly convincing demonstration that sex offenders will not necessarily prefer to undertake aspects of treatment aimed at benefiting them rather than society.

One explanation of such findings comes from a Dutch study comparing violent and sexual offenders participating in community treatment programs (Bouman, de Ruiter, & Schene, 2008). This found that, despite objective indicators that both groups had the same (admittedly poor) quality of life, sex offenders were subjectively more satisfied with their quality of life than those who had perpetrated violence, particularly in areas such as family relationships, personal safety, and health. The two groups were significantly different on a number of criminological and psychosocial variables; for example, the violent offender group were more likely to exhibit Cluster B personality traits (borderline, antisocial, or narcissistic), to have a history of violence, to have started their criminal careers earlier, to have a criminal family member, to be troubled by debt, and to be religious. Nevertheless, the authors' conclusion that sex offenders, in line with their usual pattern of cognitive distortions, tend to be less honest than violent offenders regarding problems in their lives, appears to be valid. Therefore, sex offenders may not see much point in pursuing life goals that could personally benefit them because, according to them, life is going pretty well anyway.

Finally, a study by Barnett and Wood (2008) has analyzed selected good lives goals of 42 untreated prisoners convicted of sex offences, including agency, relatedness, and inner peace, which are postulated to be the three primary goods most commonly linked with sexual offending. The authors acknowledge the difficulties of defining these goals in a survey format and of recognizing when they are in "balance." Nevertheless, many of these offenders seem to have difficulty in prioritizing "inner peace," resorting, for example, to alcohol to achieve this while remaining overly focused on goals of agency and relatedness (which themselves were often in conflict due to, for example, the competing demands of employment and personal relationships). On the other hand, about half of the group retained some "balance" in their good lives options. More worryingly, those who prioritized relatedness also tended to be better at problem solving, and the authors express concern that this subgroup of offenders were efficient at using their problem-solving skills to pursue broadly defined relatedness goals, including relationships with potential victims such as children. In other words, some offenders with "approach-explicit" offending patterns (Ward & Hudson, 1998) find it quite easy to incorporate antisocial goals into a good lives model of achieving primary

goods. This would be consistent with the denial of personal problems expressed by the sex offenders in the Dutch study discussed earlier.

To summarize these findings, therefore, there is suggestive evidence that offenders do not prefer treatment focusing on issues that more directly affect their well-being and sense of personal contentment, as compared with treatment that promotes avoidance goals that are of less personal benefit to them. Perhaps this is not surprising: Offenders often have had little chance to think about the concept of life goals, let alone the primary goods they are seeking, whereas avoidance goals are simply an elaboration of the warnings and prohibitions that the criminal justice system has showered upon them for much of their lives. Thus, they may find it easier to understand (and learn) avoidance goals and, paradoxically, achieve certain primary goods (e.g., agency) by doing so.

Furthermore (and more worryingly), it seems that at least some offenders (perhaps a substantial proportion) are quite satisfied with their lives and may be quite convinced that they have achieved their good lives goals, even while maintaining an offending lifestyle. Only a tiny proportion of sex offenders are ever detected, let alone convicted or treated (Sentencing Advisory Council, 2007). It is thus possible that the dysfunctional lifestyles experienced by clients of sex offender treatment programs have more to do with their general lack of success in life (including their failure to avoid detection of their crimes) rather than their offending behaviors as such. For example, child sex tourists in Southeast Asia appear to be otherwise law-abiding and respectable men, who seem to have no difficulties in pursuing and achieving their primary goods in life, and who have chosen to live in cultures that accept or even promote the sexual victimization of children. The real problem here is not that of the offender's goods and his methods of achieving them but rather that of the poverty of his victims, weak law enforcement, and official corruption (Child Wise, 2009).

The Limits of Paternalism (and of the Good Lives Model)

Paternalism provides a strong and, in many cases, compelling justification for the good lives approach to offender rehabilitation. The good lives model is ethically more appealing than other offender rehabilitation approaches precisely because the offender's best interests remain its primary concern. Whatever harms are inflicted on the offender during the rehabilitation process must be justified, as far as possible, as ultimately helping the offender to lead a better life. There seem to be few exceptions to this imperative, and when they are necessary to ensure community safety, the good lives model's consistency with offender autonomy and human rights means that the harm inflicted is kept to a minimum.

Yet the model also has some practical and moral "blind spots," and these are highlighted where paternalistic justifications can be easily overridden or are frankly inapplicable. Therapists may try to impose their own belief systems on offenders in the guise of appropriate good lives goals, particularly if the offender is from a different

religious or cultural background to that of the therapist. Therapists may also (although usually not deliberately) confuse the aims of therapy, justifying a particular harmful intervention as being in the offender's best interests where this is clearly not the case. Offenders may have particular sensitivities to what they consider to be morally repugnant values espoused by the therapist, even if they recognize that such ideals are an appropriate way for them to achieve good lives goals. Many offenders, even after long periods of treatment, may find it difficult to understand the relevance of good lives goals, possibly because they smugly deny any problems in their lives. They may find it simpler (and more personally satisfying) to learn and implement risk-avoidance goals, even though these may not promote their well-being.

Finally, there appears to be a class of offenders, the so-called "approach-explicit" offenders, possibly amounting to a very large number who rarely are detected (and thus rarely enter rehabilitation programs) and whose problem is not that of recognizing and implementing their life goals. Rather, their "problem" is that they have been too successful in their lives and a measure of their success has been the ease with which they have managed to continue to exploit vulnerable victims such as children (e.g., as child sex tourists) or women (e.g., in fundamentalist religious communities). Although some would say that even such "self-regarding" offenders may still benefit from a good lives approach focusing on primary goods of particular interest to them (Ward et al., 2007), I would contend that such offenders represent a limiting case for both paternalism and its justification of the good lives model. The pervasiveness and power of their antisocial values and activities warrant a community-wide, rather than an individual, approach to rehabilitation. In the environments in which such offenders live, it is difficult to set more appropriate good lives goals and to recognize the necessity to do so. Risk management invoking appropriate legal sanctions seems to be the only way of protecting victims and ensuring their ongoing safety.

Fortunately, however, the good lives approach works for many offenders who do eventually make it to rehabilitation programs. It engages them in the rehabilitation process by making the goals of rehabilitation as relevant, meaningful, and satisfying to them as they are for the rest of society. They now have legitimate ways of achieving their own personally chosen goals, and they have as much to lose, both psychologically and spiritually, as the rest of us, if they revert to a criminal lifestyle. These achievements have come at a possibly considerable cost to their dignity and their liberty, but the paternalistic aims of the good lives model have ensured that, for them, their suffering has been worthwhile. If we are going to inflict any sort of harm, even with the best intentions, on our fellow human beings, we should demand that this outcome is the very least we should strive for.

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