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Putting the humans back into human services

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The question of how and where psychologists draw the lines of ethical conduct has flourished in the news recently. Revelations of the American Psychological Association's (APA) connections with the CIA interrogation-torture have surfaced both inside the Washington DC beltway (with the [US Senate Select Committee's report](#)) and out (e.g., James Risen's [Pay and Price: Greed, Power, and Endless War](#), which inspired the [APA to re-open their investigation](#)).

Although the torture of detainees is very different from the treatment and supervision of people who have sexually abused, some points are worth noting as we consider the effects of our actions on our clients and society. CIA detainees and sexual offenders are often more vulnerable populations than they appear. It can be easy to feel an urgent need to use whatever means are necessary to reduce risks as quickly as possible. It can be easy for professionals to lose sight of just how much power they hold over the people in their charge. Finally, it can be easy to believe that one is not capable of causing harm to people in our care or custody. As one extreme example, CIA psychologist Kirk M. Hubbard stated in a journal article titled [Psychologists and interrogations: What's torture got to do with it?](#)

Constanzo (et al.) argue that 'psychologists should not be involved in interrogations that make use of torture or other forms of cruel, inhumane, or degrading treatment' . . . Their statement is ironic for torture is illegal in the United States. But even more importantly, it seems to come from and apply to a world that no longer exists. . . . We no longer live in a world where people agree on what is ethical or even acceptable, and where concern for other humans transcends familial ties.

This statement does indeed contain ironies (e.g., it seems that no one is disputing that torture took place outside the US, or the belief that whatever happened could not be torture because that would be illegal, or that because it took place outside the US it was somehow less unethical). This statement also illustrates how people in the helping professions can find or imagine exceptions to standards of professional conduct (e.g., behavior that would be unethical under other circumstances is ethical when the world is changing and we believe that old rules don't apply). Certainly, the behavior of nations in wartime is beyond the scope of this blog and the expertise of this author. However, professionals at the



intersection of mental health and the law will want to consider factors that influence our understanding of ethical conduct, as well as how these same factors may appear to change over time. Lost in the current media discussion are other discussions about the involvement of mental health professionals in interrogations (e.g., Chaffin, 2010).

A new article appeared in the *Journal of the American Academy of Psychiatry and the Law*, this time by psychiatrist and retired Brigadier General Stephen Xenakis, titled, [The role and responsibilities of psychiatry in 21st century warfare](#). In it, he states:

When I first worked with detainees at Guantanamo Bay, I was troubled by a peculiar and unsettling awareness . . . Here I was, focusing on torture and cruel, inhuman, and degrading treatment of prisoners and yet, these were the very men who were the “enemy.” As a career Army officer, I pledged to protect our nation against all enemies, foreign and domestic. As a physician, I pledged to care for all who were hurting and needed help. Facing some detainees who were tortured because they were our enemies, sometimes with the aid of military physicians, I felt I had entered a domain in which the old paradigms ceased to apply. Perhaps that is one of the fundamental problems with Guantanamo. . . . I have always believed that doctors are champions of human rights, no matter what role or assignment we accept. After all, every society endows their doctors and healers with special trust and confidence. We symbolically wear the white coat at all times, even as psychiatric experts for the prosecution or in military uniform.

What does this have to do with the treatment of sexual violence?

In 2010, the late psychiatrist Bill Glaser wrote (among other things) that in its current state, [sex offender treatment is punishment](#) and that professionals should not kid themselves about this. Jill Levenson and I wrote a [reply](#) in which we argued that this is simply not the case, and that licensed professionals are bound by ethical codes that make it unlikely for treatment to be entirely punitive. Just the same, Glaser’s point was well-taken, in that our clients don’t always view their treatment to be as helpful as their therapists do ([Beech and Fordham, 1997](#)), even though consumer-satisfaction surveys of sex offenders have often produced positive results (e.g., [Levenson, Prescott, & Jumper, 2013](#)).

In 2011, Steve Sawyer and I published an article on [boundaries and ethics](#) in sex offender treatment. We observed that:

The licensed therapist treating sexual offenders has an *ethical* responsibility to the client, a *legal* responsibility to the court, and an ethical/moral responsibility to the community. Specifically, the therapist’s primary responsibility to the client’s welfare is checked in part by the standard of practice to share information with county/state corrections and/or the community as required by law or by contractual obligations or as needed to protect the community. This is done with informed consent from the client or as needed by law. Within these limits of confidentiality, however, the therapist’s focus is on the sexual offender client. This situation recognizes that the client is best served—and the public is best served—when the therapist and the client develop a therapist–client relationship that is separate from the sexual offender’s relationship with the probation officer and the court.

This seems clear enough; professionals in our field are almost always involved in balancing the rights and welfare of others and develop specific practice skills for doing so. Yet the recent events involving large agencies and organizations (the APA, CIA, etc.) should still make us wonder if there aren’t other concerns to bear in mind. In what ways might we go wrong? What should we look out for in order to

prevent harm to clients? How can we maintain the highest level of professional conduct? Anecdotally, it seems to the author that the most common forms of grievances and ethics complaints (when they occur) are in the areas of misuse of evaluation measures, and coercive treatment experiences.

Readers may be aware of an ongoing class-action suit in Minnesota. After 20 years of operation, only three people of a current census of over 700 have ever received provisional discharges (one within the past few days), raising inevitable questions of constitutionality of the program. The federal judge in the case established an expert panel to examine the program; their [report](#) was published recently. This expert panel consisted of four experts, three of whom have served as directors of civil commitment programs. After nearly a year of reviewing the program, they released a 108-page report with 44 broad recommendations. Within their (at times devastating) conclusions, the panel comments on the apparent failure of many clients to advance in treatment, although they note efforts to expand a pre-release portion of the program:

This delay appears to be a result of a pervasive belief on the part of MSOP administration and staff that it is not their responsibility to proactively petition and rigorously advocate for clients to advance in phases and to CPS. There is a shared belief of having no control because the structure of the law and its processes have created the inability to release clients. . . Clinical staff and clinical supervisors do not appear to be supported or encouraged to appropriately modify the treatment offered in order to appropriately respond to the individual and complex needs of these clients. From a clinical point of view, this population seems to be administratively unrecognized, misunderstood, and inappropriately served (or underserved). It was clear to the Panel that staff who work with these clients have genuine and compassionate concern for the wellbeing and future aspirations of their clients, in spite of feeling unsupported in their attempts to advocate for programmatic changes.

Although there is always more to any story, two themes emerge for purposes of this discussion:

- One is the theme (often heard in discussions as diverse as CIA abuses and good programs that fall on hard times) of good, decent staff at the front lines feeling powerless and helpless (apparently, a parallel process to the experiences of the clients in the program).
- Another is the theme that apparently no one was advocating for the rights or wellbeing of the clients.

In my view, there may be two areas of focus for professionals that might be helpful and that are often outside strict interpretations of ethical codes.

The first is advocacy of [quaternary prevention](#), as described in our field by [Géral Blanchard](#) and others. While primary, secondary, and tertiary efforts focus on preventing sexual violence among specific populations, quaternary prevention focuses on the prevention of harm being caused by these same efforts. Most, if not all professionals who enter our field want to practice ethically. Yet, [many providers and treatments have caused harm](#) under the mantle of helping others.

The second is that all people in our field should re-visit the idea of advocacy, alluded to recently in an article titled [Where has all the psychology gone?](#) by Gannon and Ward. Where our field once advocated for community safety to the point of placing clients' needs second to community safety, it may be time to consider just how far back that second place is. For example, the Texas Department of State Health Services defines sexual offender treatment, in part, as: "Sex offender treatment is different than traditional psychotherapy in that treatment is mandated, structured, victim centered, and the treatment

provider imposes values and limits. Providers cannot remain neutral because of the risk of colluding with, adding to, and/or contributing to the offender's denial" (Texas Department of State Health Services, 2012).

As an example of context of advocacy elsewhere, consider this section of the preamble of the [NASW Code of Ethics](#):

Social workers promote social justice and social change with and on behalf of clients. "Clients" is used inclusively to refer to individuals, families, groups, organizations, and communities. Social workers are sensitive to cultural and ethnic diversity and strive to end discrimination, oppression, poverty, and other forms of social injustice. These activities may be in the form of direct practice, community organizing, supervision, consultation administration, advocacy, social and political action, policy development and implementation, education, and research and evaluation. Social workers seek to enhance the capacity of people to address their own needs. Social workers also seek to promote the responsiveness of organizations, communities, and other social institutions to individuals' needs and social problems.

The mission of the social work profession is rooted in a set of core values. These core values, embraced by social workers throughout the profession's history, are the foundation of social work's unique purpose and perspective:

- service
- social justice
- dignity and worth of the person
- importance of human relationships
- integrity
- competence

The preamble to the [APA Code of Ethics](#) is more succinct: "Psychologists respect and protect civil and human rights."

Perhaps our next step as professionals is to ask ourselves:

- Even though our clients provide informed consent to our treatments, how much duress must they be under to do so before it is not meaningful consent to treatment (e.g., "I am only consenting because if I don't it's four years added to my sentence")
- To what extent are we advocating for both our clients' needs as well as community safety?
- At what point is it acceptable for a mental health professional to induce suffering, whether directly or indirectly?
- At what point do mental health providers in large institutions (such as civil commitment programs) have an ethical obligation to advocate for their clients over and above what the administration is (or is not) doing?

And in the shorter term, and against the backdrop of the axiom that *the only thing necessary for the triumph of evil is that good men do nothing*, how can professionals best discuss these topics publicly while maintaining the highest standards of professional conduct?