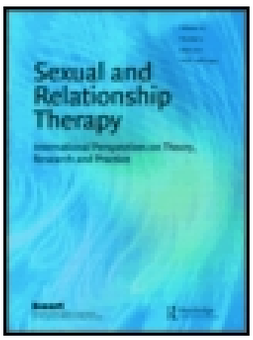

Routledge
Taylor & Francis Group

Sexual and Marital Therapy

ISSN: 0267-4653 (Print) (Online) Journal homepage: http://tandfonline.com/loi/csmt19

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To cite this article: Don Grubin (1999) Therapist or public protector? Ethical responses to anti-social sexual behaviour, Sexual and Marital Therapy, 14:3, 277-288, DOI: 10.1080/02674659908405412

To link to this article: http://dx.doi.org/10.1080/02674659908405412

Therapist or public protector? Ethical responses to anti-social sexual behaviour

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ABSTRACT *This paper explores some of the ethical dilemmas, in particular confidentiality, compulsory treatment and preventive detention, that emerge in the context of treating individuals whose sexual behaviour becomes a problem for society. The primary conflict is between one's professional and civic obligations. Two cases are described which illustrate these difficulties, and show how ethical arguments can become subsumed within pragmatic decision making. Although court rulings and official guidelines help to clarify some of the issues, they perhaps raise more questions then they answer. Resolution is handicapped by deficiencies in our knowledge of the origins of antisocial sexual behaviour, our insufficient understanding of risk, and the limitations of risk assessment.*

Introduction

When sexual problems in a patient or client lead to concerns about sexual danger to others, a number of ethical dilemmas begin to emerge for those involved therapeutically with that individual. In particular, the limits of confidentiality may become tested, and thoughts can wander to the possibility of compulsory detention and treatment. Anxious therapists may have to make a moral decision between their obligations to the person they are treating and their duty to the public, either in the form of a specific individual (such as a partner or child), or in relation to potential but unidentified victims. As the degree of risk increases, possible responses may become more extreme, but the ethical foundation on which they are based remains the same.

Although there are exceptions, treatment usually begins at the request of the individual, and what takes place in the therapeutic setting is done with that individual's consent. When concerns about risk surface, these dynamics begin to change. While individuals from different professional backgrounds work within varying frameworks of confidentiality, as well as differing in terms of the type of practical response open to them—a sex therapist, for example, may be limited to ensuring that others know of the risk a client represents, while a psychiatrist in certain circumstances may be able to detain a patient in hospital without his or her consent—the background of the therapist is irrelevant to the ethical implications

0267-4653/99/030277-12

associated with disclosure or containment. Thus, while this paper is written from my medical perspective as a forensic psychiatrist, as well as from my experience of both British and North American cultural settings, the ethical view is the same for all those who set out to provide assessment or treatment, in whatever country.

Confidentiality

As this is a paper concerned with ethics, it goes without saying that, although all the case reports described here are based on actual patients, they have been extensively modified to ensure that none of the individuals concerned can be recognised.

Case 1

William is a 40 year-old man who attended his local casualty department on four occasions over a six-week period, having made attempts to harm himself by taking overdoses of tablets. Followed-up by his general practitioner, William finally disclosed that he was becoming increasingly distressed by intrusive fantasies of abducting and sexually assaulting pre-pubescent boys, and the overdoses were taken at times when the urge to act became particularly strong; William was afraid of losing control. On learning this, his doctor requested an urgent psychiatric assessment.

William was seen the following day by the catchment area psychiatrist who obtained a similar account, but William also told him that on a number of occasions during the past six weeks he had followed young boys in a local park, and he had identified possible abduction sites. Symptoms of depression were also elicited, although it was unclear whether these were associated with a primary depressive illness that precipitated the current crisis, or were secondary to William's distress about his fantasies. William readily agreed to admission to a psychiatric ward for further assessment and treatment, which in itself appeared to bring about an improvement in his presentation, as well as bringing relief to the psychiatrist.

About one week after his admission the psychiatrist received a letter from a nearby Social Services Department asking for information about William. Over the preceding year he had formed a relationship with a 25 year-old woman with a history of mental health problems, who had a 4 year-old daughter living with her, as well as an 11 year-old boy in long-term foster care. They did not have any particular concerns about William, but the child was on the Child Protection Register, and Social Services were simply checking whether there was any reason to believe her new partner represented a risk to the child.

In deciding how to respond to the letter from Social Services, the clinical team considered William's background. In brief, he never knew his father, and from an early age he was neglected by his alcoholic mother. He was taken into care at the age of 8, and lived in a children's home until he was 16. He reported that in the children's home he was bullied by older children, and was sexually abused by an older boy from the ages of 12 to 14, as well as by a group of men around the same time. On leaving the children's home he had lived for a time with an older man, and then from the age of 20 alone. He admitted that in his 20s he frequently engaged in

sexual activity with young boys, with a preference for boys between the age of 10 and puberty. He said that from about the age of 30 he had not had any further sexual contact with boys, and in fact had had three brief relationships with women—all of whom, he reluctantly acknowledged, had young sons.

The majority of the clinical team decided that, on the grounds of patient confidentiality, they would not provide any information about William to social services. Although they recognised there was a potential risk to his girlfriend's child, they were as yet unsure about the extent of this risk, and in any case the sex and age of her child did not match what was known of his sexual preferences. The social worker on the team, however, did not agree with this decision, and took it upon himself to inform Social Services of William's background. The result was that the social worker of William's girlfriend told her about William's history, and she promptly ended their relationship. This in turn led to a worsening of William's mental state.

Should William's confidentiality have been broken? Doctors have a strict code relating to confidentially, traditionally associated with the Hippocratic Oath, in which they pledge that "all that may come to my knowledge in the course of my medical practice which ought not to be spread abroad, I will keep secret". This includes any information learned by a doctor as a direct result of his or her professional position, even if that information is already in the public domain. Doctors are simply not expected to talk about their patients.

The obligation to maintain confidentiality is not a pedantic adherence to archaic practices. In a case where an English Court of Law was asked to decide whether it was in the public interest to disclose medically confidential information concerning two general practitioners who were continuing to practise in spite of being HIV positive, it was observed by the court that the preservation of a duty of confidence was *in itself* in the public interest:

> In the long run, preservation of confidentiality is the only way of securing public health ... patients will not come forward if doctors are going to squeal on them. (X v. Y, 1988, p. 653)

Confidentiality means the keeping of secrets. However, it has long been recognized that this does not mean keeping one's silence no matter what. Even for doctors confidentiality has its limitations, particularly when public safety is an issue, giving rise to ethical dilemmas. In deciding whether confidential information should be disclosed, therefore, it is necessary to balance two *public* interests: one concerning the need to ensure patients will trust their doctors enough to disclose incriminating material about themselves, the other involving the implications of that very material for public safety.

The Tarasoff ruling

Although there is no equivalent precedent in the UK, British doctors are greatly influenced by the US case of Tarasoff (Tarasoff v. Regents of the University of California, 1976; Stone, 1976). In 1969, Prosenjit Poddar, a student at the

University of California, Berkeley, consulted a psychiatrist at the student health centre to whom he described a pathological attachment to another student, Titiana Tarasoff, and spoke of his intention to buy a gun to resolve his problems. Initially steps were taken to commit Poddar to hospital, but in the event he was not admitted, and no attempt was made to warn Ms Tarasoff or her family of the danger posed by Poddar. Two months later Poddar killed the young woman. The Tarasoff family sued the therapists (amongst others) who had dealt with Poddar, and the Supreme Court of California ruled in their favour: it determined that therapists have a duty to protect third parties from a threat of serious danger posed by patients under their care. This included, but went beyond, a duty to warn. As the court put it (Tarasoff v. Regents of the University of California, 1976):

> In this risk infested society we can hardly tolerate the further exposure to danger that would result from a concealed knowledge of the therapist that his patient was lethal. (p. 27)

This decision gave birth to something often referred to as a 'Tarasoff Warning', which means breaking confidentiality in order to warn potential victims; in North America, when threats against others are made during therapy, the therapist can be held liable if he or she maintains the patient's confidentiality. This is in spite of arguments by the American Psychiatric Association that psychiatrists (and clinicians generally) are unable to predict dangerousness with sufficient reliability to make such a position tenable.

Disclosure in the UK

As mentioned above, British doctors tend to be well aware of the Tarasoff ruling, although no British doctor has been successfully sued for not disclosing information about a patient. In the converse situation, however, where a psychiatrist did disclose confidential information about risk, the doctor and his disclosure were supported by the British courts. This case involved a psychiatrist who had assessed a patient in a special (i.e. high security) hospital who was seeking transfer to a hospital of lower security (W. v Egdell and others, 1990). Dr Egdell saw the patient on behalf of the patient's solicitors, and based on the information he learned during the assessment he concluded that the patient was too dangerous for such a move. The solicitors chose not to disclose the report but, because of his concerns, Dr Egdell himself sent it, without the permission of either the patient or his solicitors, to the hospital and the Home Office. The patient sought an injunction to restrain use of the report, and sued Dr Egdell for breaching the duty of confidence owed to him. In its opinion, the court observed that, "the question ... is not whether Dr Egdell was under a duty of confidence; he plainly was. The question is as to the breadth of that duty." The court concluded:

> The duty of confidentiality owed by Dr Egdell to W was subordinate to Dr Egdell's public duty to disclose the results of his examination.

In its guidance to doctors in the UK, the UK General Medical Council (GMC) states that breaching confidentiality *may* be necessary where a failure to disclose information could expose the patient, or others, to risk of death or serious harm (General Medical Council, 1995). Examples given relate to disclosure of information to the UK government driving licensing authority about a patient who is unfit to drive, to a local authority about a patient with a notifiable disease (such as cholera), and to the GMC itself about a doctor who is a patient and who may be unfit to practise. It also condones disclosure of confidential information in order to aid in the detection or prevention of a serious crime which includes physical violence, or the sexual abuse of a child.

But, while the GMC makes clear that a doctor is entitled to disclose confidential information provided he or she is able to justify the decision to do so, it does not go so far as to say that doctors must disclose in order to safeguard the public. Although some argue that the Children Act 1989 places a duty on anyone, including doctors, with knowledge about the abuse of a child to disclose this information, this is by no means clear, and certainly has never been tested in the UK. Unlike in North America, so long as a doctor does not give misleading information about a patient, there is no obligation, statutory or otherwise, to break confidentiality to ensure public safety. Indeed, in relation to offending, it is only in recent years that the GMC guidance has spoken of 'detection' as well as 'prevention' of serious crime.

Disclosure in practice

Where does this leave us with William? One might argue that, although he was a potential risk to his girlfriend's child, he was not an immediate risk: there was no evidence to suggest that he was sexually interested in girls, or in very young children and, perhaps more to the point, he was in hospital, away from the child. On the other hand, there was only his self-report of his sexual interests to go by (and he did admit to previous relationships with women who had children). His history contained a number of worrying ingredients and, although in hospital, he was there on a voluntary basis and could walk out at any time. One might have (and in fact arguably should have) sought his permission to talk to Social Services about him, but if he had refused, what could be done then?

In trying to resolve this dilemma, it is important to disentangle personal from professional views about protecting potential victims from harm. As an ordinary member of society, one is entitled to have a low threshold in relation to disclosing information relevant to the safety of other individuals, with, for example, any risk to a child being unacceptable. Professionally, however, for the reasons outlined above in X v. Y (1988), such instincts can not be given free reign. The therapist, as opposed to the citizen, must consider a number of factors, including:

- the extent to which risk can be quantified, both in terms of the likelihood of the behaviour occurring as well as the degree of harm that might be caused;

- whether risk really will be reduced by disclosure (as opposed to simply easing the therapist's conscience);
- whether the short-term gain achieved by disclosure will be at the expense of an increase in risk in the long term, which might occur if the therapeutic relationship is brought to an end by the disclosure, thus negating any possibility of a future reduction in risk through treatment or monitoring.

In practice, it is often difficult to answer any of these questions with confidence, and one is left to make a judgement call, usually based on something called 'clinical experience'. The problem with this is that, because it is impossible to determine whether decisions to break confidentiality were actually necessary, there is a bias towards disclosure. In cases where disclosure takes place, who knows what, if anything, would have happened had confidentiality not been breached; when a decision not to disclose is followed by what, in retrospect, may appear to have been a preventable event, failure is glaringly visible. Decisions taken from a sound self-preservationist point of view, however, should not be confused with reasoned moral argument: 'watching one's back' does not make a decision ethical.

Thus, while in William's case one can argue around the edges about whether breaching his confidentiality should have been more fully discussed with him, should have been delayed, or should have been the result of a team decision to which the dissenters were bound, the reality is that our judgements are usually neither objective nor well founded in moral reasoning. Perhaps the best one can do is rely on the general principles that were outlined by W's barrister in W v. Egdell and others (1990), who suggested that, when a breach of confidentiality is justified by an appeal to public safety, it must be shown that:

- the risk is real, immediate and serious;
- the risk will be reduced by disclosure;
- disclosure is no more than needed to reduce risk;
- the damage to the public interest in relation to broken confidentiality is outweighed by the public interest of reducing risk.

These principles, if adapted, can also be applied to the ethical dilemmas associated with treating sexually dangerous individuals.

Treatment

Case 2

John is a 29 year-old man who was released from prison after serving a five-year sentence for indecent assault and robbery. He was too disruptive to take part in standard prison sex offender treatment programmes, and individual therapy he received from a female prison psychologist was stopped when sexually explicit writings about her were found in his cell. In one prison it was necessary to move him to another wing when he told a female prison officer of his sexual fantasies about her.

John's first conviction for indecent assault was at the age of 15. Before his current sentence he was convicted of indecently exposing himself on two occasions, and indecently

assaulting young women on three occasions. He also admitted to making obscene phone calls, although he was never convicted of this. His indecent assault offences tended to follow a similar pattern: in the early evening he would follow a woman, making little attempt to disguise what he was doing. Eventually he approached the woman and demanded her purse. Whether she resisted or not he would rub the victim's breasts and vagina before running off. His more recent offences had become more prolonged and violent. On at least two occasions he subsequently rang his victims on the telephone to tell them he was watching them, and to warn them not to report him to the police.

John's probation officer was understandably concerned about the risk he posed and asked for a psychiatric opinion. Previously John had denied any sexual psychopathology, blaming his offending on drugs or alcohol and insisting that theft was his primary motive. On this occasion, however, he admitted to experiencing marked sexual arousal to fantasies of frightened women over whom he had power. He said his indecent assaults/robberies gave him greater sexual satisfaction than sexual intercourse with his girlfriend, who refused his requests for sado-masochistic activity. He also described numerous incidents of frotteurism. He was willing to see the psychiatrist for treatment in relation to his alcohol use, but not to address his sexual offending, as he claimed he was confident he would not re-offend so long as he did not abuse alcohol. He expressed no remorse in respect of any of his victims, and indeed tended to blame them for his offending, a way of thinking that has been shown to be common in sex offenders who re-offend.

Both the probation officer and the psychiatrist had little doubt that John would sexually offend again, and that this was likely to happen sooner rather than later. Both also agreed that there was little in the way of effective treatment that could be offered him—John had little motivation to cooperate with cognitive–behavioural programmes, and previous treatment attempts only provided him with another means of feeding his sadistic fantasies. Nevertheless, the probation officer raised the possibility of compulsory admission to hospital to protect women from serious harm. The psychiatrist refused to go along with the suggestion. One year after his release from prison John was arrested while attempting to break into the flat of one of his former victims.

Should the psychiatrist have agreed to John's forced admission to hospital? My own view is that he was right not to do so, even in the light of subsequent events.

The criteria for compulsory detention

Psychiatrists in the UK can detain individuals in hospital against their will under the provisions of the Mental Health Act (1983), provided that the person suffers from a mental disorder as defined in the Act; mental disorder means mental illness, mental impairment (i.e. mental handicap associated with aggressive behaviour), or psychopathic disorder (defined as "a persistent disorder or disability of mind ... which results in abnormally aggressive or seriously irresponsible conduct"). In the case of psychopathic disorder, however, it must also be the case that treatment is likely to "alleviate or prevent a deterioration" in the patient's condition.

Although abnormally aggressive, does John have a 'persistent disorder or disability of mind'? Interestingly, in its definitions the Mental Health Act explicitly

states that sexual behaviour that does not conform to community norms, either in terms of its frequency or its nature, does not equate to mental disorder, nor does it make an individual liable to be treated against his or her will. Specifically, 'promiscuity', 'immoral conduct', and 'sexual deviancy' on their own do not bring an individual within the scope of the Act.

Some would argue, however, that paraphilias which result in anti-social behaviour are another matter. If John simply followed women but did no more, keeping his fantasies to himself, there would be no question of detaining him in hospital. Similarly, if his robberies, no matter how prolific, did not involve the indecent assault of his victims, it is unlikely that anyone would advocate his preventive detention in hospital. Sexual violence seems to carry with it an implicit assumption that the perpetrator is mentally disordered, on the somewhat circular basis that a normal person would not act in such a way. And it would seem to follow that, if mental disorder is the cause of such behaviour, then the individual is neither fully in control of his actions, nor can he be held fully responsible for them.

Is sexual deviancy a mental disorder?

The concept that sexual deviancy in general, and sexual offending behaviour in particular, are related to mental disorder is perhaps further perpetuated by the willingness of therapists to *treat* sex offenders. Treatment, after all, implies pathology that can be made better. Psychoanalytic formulations that perversions are caused by profound developmental disruption in early life also lend themselves to the view that paraphilic sexual offenders like John are better dealt with in therapeutic as opposed to penal settings, even if they themselves do not have the insight to acknowledge or agree to this.

The reality is, however, that we remain ignorant about the origins of these behaviours. Faulty toilet training, psychological imprinting or conditioning, brain damage, as well as more mainstream candidates such as childhood family dysfunction and childhood sexual abuse have all been suggested as key causative factors (see Laws & O'Donohue, 1997, for mention of many of the theories that have been put forward to explain sexual deviance at one time or another), but empirical support for any overriding theory is sparse. Given the diversity of sexual offending and sex offenders, this is hardly surprising, but it has handicapped the search for a 'cure'. Even if the aetiology or aetiologies of sexual deviance were to be discovered, however, it would still be necessary to elucidate the link between deviance and anti-social behaviour.

In recent years it has become clear that cognitive-type programmes and behavioural management aimed at helping an individual regulate his behaviour, rather than fundamental personality or psychosexual change, are the most effective means of reducing sexual dangerousness in men who exhibit anti-social sexual behaviour (Marshall & Barbaree, 1990; Ward *et al.*, 1998). Indeed, some would argue that speculative exploration of the 'cause' of an individual's sexual offending can be counterproductive, as it allows attention to drift from the individual finding ways to control his behaviour to a search for excuses and justification, with the

offender casting himself in the role of victim. For example, in one of the few random allocation studies involving psychotherapy where sex offenders received either psychodynamic group psychotherapy or intensive probation supervision, the re-arrest rate for those in the psychotherapy group was twice that of those who received probation supervision (Romero & Williams, 1983).

With a change in views about treatment has come a shift in focus from underlying psychopathology to individual responsibility, and a recognition that with help an offender can modify his anti-social behaviour. Failure to do so reflects an individual's choice and motivation, not his succumbing to inner irresistible forces or urges. Compulsory treatment, therefore, by suggesting that an individual may not be responsible for his actions, runs the risk of undermining treatment effectiveness. Admitting a dangerous sex offender to hospital compulsorily (assuming he is not mentally ill in the traditional sense) is therefore more about preventative detention than it is about treatment. As prisons, however, hospitals function poorly.

Preventive detention of the sexually dangerous

British law does not allow individuals to be detained in prison if they have not committed a crime. Once his sentence was completed, therefore, John had to be released, and he could not be recalled to prison on the basis of something he might do in the future. The only conceivable way of keeping him off the streets would have been through a flexible use of the Mental Health Act, arguing that his aggressive behaviour made him a psychopath, and his admission to hospital would prevent a worsening in his condition. Many believe that this course of action would have been justified on public safety grounds. Arguing in this way, however, contains within it the seeds of a subtle moral shift: if psychiatrists are expected to act as guardians of public safety, then they are open to blame when they fail to do so, and it is the psychiatrist rather than the offender who becomes responsible for the offender's actions.

But if society is prepared for sex offenders to be detained on a preventive basis, why rely on doctors and hospitals? Why not modify the criminal law to allow men like John to be detained in prison on the grounds of public safety? The moral position, at least, would be clear. One reason for not doing so is the need for the fig leaf that 'treatment' provides: if society decides that someone is so dangerous that he must be detained, then, some would argue, it has an obligation to provide treatment to make him less dangerous. But this obscures the two real difficulties in adopting such an approach, regardless of whether preventive detention takes place in prison or in hospital—determining who to detain, and deciding when to release them.

In terms of the first issue, I have to assess when someone poses sufficient risk, even in the absence of criminal behaviour, to justify depriving him of his liberty. But this still leaves the question of the timescale over which the risk relates—does it cover a few days, a few months, or years? Although it is often possible to specify the sort of conditions under which an individual's risk increases, it is much more difficult to forecast when, if ever, those conditions are likely to be met, and hence,

whether any risk will be actualised. In these circumstances, my view is that preventative detention can only be justified when the risk is immediate, that is, current.

Risk assessment

Risk assessment has become increasingly sophisticated in recent years, and there are now a number of instruments that allow for an objective assessment of the risk that a sexual offender will re-offend, or more accurately, be re-convicted for another sexual offence (see Grubin, 1998, for a discussion of two of these instruments). In theory, these can be used to ensure that the highest-risk individuals are identified, relieving the assessor of some of the burden of selecting the right subjects. Difficulties arise, however, in the interpretation of their results.

Risk assessment instruments are constructed by incorporating characteristics known to be associated with re-offending, such as having more than one previous sexual offence, young age, or having a history of substance abuse. They are based on the follow-up of large numbers of individuals in whom it has been found that greater proportions of men with certain 'profiles' composed of these types of feature re-offend than do those with other 'profiles'; it may be, for example, that, in a group of men with a certain set of characteristics, 80% (i.e. four out of five) committed a further sexual offence. Generalising from this, individuals with that set of characteristics are then said to have an 80% chance of re-offending.

It is a significant leap, however, to move from the statement that an individual is a member of a group in whom 80% re-offend, to asserting that that individual has an 80% chance of re-offending. In the first instance, one is saying that eight out of 10 men <u>like</u> that man re-offend, while in the second one is implying that, given the same set of circumstances, <u>that</u> man will re-offend eight out of 10 times (rather like a weather forecast in which there is said to be an 80% chance of rain). This is then often further confused with yet another meaning of risk, more akin to a subjective statement about one's *belief* about the likelihood of re-offending: saying that an individual has an 80% chance of re-offending means that one is more confident that he will re-offend than if he had a 60% rating, but less confident than if it were 90%. This latter is perhaps equivalent to the setting of betting odds.

The importance of this distinction between different meanings of risk, and the confusion between them, is that even given a high degree of 'certainty' in relation to an individual's risk, one is really making a statement about a group rather than a specific individual—just because you live in Newcastle does not mean that your car will be stolen. Even with sophisticated risk assessment tools we are still apt to get it wrong a significant number of times (Grubin & Wingate, 1996), an error rate that may be exacerbated when offenders come from different cultural groups from those on which the instruments were standardised. This is best illustrated with a mathematical example.

For sex offenders in general, the recidivism rate for committing another sexual offence is roughly 20% over a three-year period. At present, the best risk assessment

measures available have an accuracy of about 70%. Thus, for a group of 1000 sex offenders, 20%, or 200 men, will in theory commit a further sex offence. Because our prediction tool has a 70% accuracy, 140 (70%) of these men will be identified correctly, but 60 will be missed. Of the 800 men who in theory will not re-offend, 560 (70%) will be correctly identified, but the remaining 240 will not (that is, they are wrongly placed in the re-offending group). Overall, therefore, of the 380 men (140 + 240) placed in the 're-offending' group, 240 (63%) should not be there, a not insignificant figure if the consequence is preventive detention; 380 men would have be detained to prevent 140 offences, a ratio of 2.7 to 1. How many 'false' detentions are we, as a society, prepared to accept to prevent one offence?

Having detained a man who has not yet offended, there is then the question of when to let him out. Because most of our prediction tools are based on historical factors that will not change, there may be little that an individual can do to prove that he is safe, particularly when housed in an environment where the majority of factors that may increase his risk of offending are not present. Even if he participates in a treatment programme, the nature of the potential harm he could potentially cause may delay substantially any decision to release independently of any progress he may have made.

In the case of John, even though he proved us right by re-offending, he did not re-offend for over a year. Again, the time lag is of great importance. I have my doubts about the ethical correctness of locking up an individual because of what he might do many years in the future.

Conclusion

Although in my clinical practice I often have to make decisions like those described above, I can still give no definitive answer as to how conflicts between one's therapeutic relationship with a patient or client and one's responsibility to society should be resolved. I tend to assume that it is not only society and specific victims who suffer when a sex offender commits a sexual crime—whatever the immediate gratification, most offenders recognise that it is not in their long-term interests to offend either. But how far one should go in this paternalistic looking after the interests of our patients in spite of themselves is unclear.

The most prudent course of action when one becomes concerned about the potential dangerousness of one of our patients may not always be the most morally correct one, but in the current climate of litigation and blame most of us will err on the side of caution. In the end, however, it is up to society to decide where to draw the moral line. If society wants its therapists to be guardians of public safety, that is its prerogative. But society, in the form of our political leaders, needs to be clear about this, both in terms of the amount of risk that is to be tolerated, and the measures that can be taken to reduce risk. When I, a psychiatrist, believe that society has gone too far, then I have to go through another moral exercise to decide how to respond.

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