

RUNNING HEAD: Chemical Castration of Sex Offenders

An Ethical Analysis of the Use of  
Medroxyprogesterone Acetate and Cyproterone Acetate to treat Repeat Sex Offenders

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Abstract

Among the most heinous, and unfortunately common, crimes known to human society are rape and child molestation. Recidivism rates for offenders of these crimes are extremely high. Treatment of perpetrators of these crimes is of great consequence to mental health professionals, policymakers and the general public. Unfortunately, the traditional treatments for rehabilitation, including cognitive-behavioral therapy and SSRIs, have shown only minimal success rates and incarceration is expensive for the state. One proposed alternative is chemical castration. This paper reviews ethical considerations regarding the practice of chemical castration for sex offenders.

## An Ethical Analysis of the Chemical Castration of Sex Offenders

### *The Crime and its Impact*

Sexual assault is sexual contact involving forcible (actual or threatened) coercion or involving an individual who is not able to give consent (e.g. under the influence, a child). Legal statutes define sexual assault in varying degrees. Legal definitions of sexual assault differ by country and state; however, for New York State, offenders may be charged with rape (used when penetration is involved), sexual abuse (does not require penetration, only touching, either directly or through clothing) or sodomy (penetration of areas other than the vagina) in the first, second or third degrees. All of the above charges are considered felonies.

The prevalence of sexual assault depends on its definition, which varies among studies. In 2004, the Uniform Crime Reports indicated 94,635 reports of women being forcibly raped. The U.S. Department of Justice (1998) estimated a lifetime prevalence of 1 in 3 women experiencing rape or attempted rape. The majority occurred in metropolitan areas and over a third occurred in the South. This data reflects only reported crimes. Factors which affect rates of reported rapes include community education, service availability, social support, victim age and the relationship between the victim and the assailant. Studies have estimated that for each woman who reports to the authorities four to fifteen more rapes occur but remain unreported (Hanson & Gidycz, 1993; Koss, Gidycz & Wisniewski, 1987). Russell and Howell (1983) calculated a 46 percent probability that a woman will be raped in her lifetime based on a survey of 930 women.

Physical injury is relatively rare, occurring in about one-third of cases (Ledray, 1999), and increases in likelihood in cases involving older victims and male victims and in cases of stranger rape (Bownes, O’Gorman & Saters, 1991; Ledray, 1998; Petrak & Claydon, 1995;

Tintinelli & Hoelzer, 1985). Rape victims' risk for STIs is also low; 6-12% for gonorrhea, 4-17% for Chlamydia, 0.5-3% for syphilis and <1% for HIV infection as estimated by the Centers for Disease Control (1993) and the risk of pregnancy is 2-4% (Yuzpe, Smith & Rademaker, 1982). Indirect health risks may affect more victims than immediate physical injury. Psychological distress is common. Rape victims are at greater risk for anxiety, depression and post-traumatic stress disorder (PTSD) (Frazier, 1997). Between a third and half of victims of sexual assault report contemplating suicide (Ellis, Atkeson & Calhoun, 1981; Resnick, Jordan, Girelli, Kotsis Hutter, & Marhoefer-Dvorak, 1988) and up to twenty percent of victims attempt suicide (Kilpatrick, Saunders, Veronon, Best, & Von, 1987). Stress caused by sexual assault can result in a suppressed immune system and greater risk of disease. It can also result in an increase in self-injurious behaviors like substance abuse and/or eating disorders, increased sexual activity with multiple partners leading to increased exposure to disease, or emotional difficulties manifested as physical symptoms (Cohen & Williamson, 1991; Felitti, 1991; Golding, 1994; Koss, Woodruff, & Koss, 1990; Ledray, 1994). Another common problem following sexual assault is sexual dysfunction, including avoidance, loss of interest, loss of pleasure, painful intercourse and fear (Abel & Rouleau, 1995; Burgess & Homstrom, 1979, Kimmerling & Calhoun, 1994; Koss, 1993).

Like sexual assault committed against adults, the prevalence varies based on the definition of abuse. In cases of childhood abuse, the definition of childhood also varies among studies. The age group most affected by sexual violence is adolescents and young adults. Of female rape victims in the United States, 54% are younger than 18 (Tjaden & Thoennes, 1998). Data from a study by Muram and colleagues (1995) indicates that, compared to adult victims, adolescents are significantly less likely to have been physically injured or to have had a weapon

used against them and are more likely to have experienced alcohol- or drug-facilitated assault, suggesting that sex offenders may coerce adolescent victims more easily than adults without weapons or physical injury.

Children who are sexually abused commonly experience fear, PTSD, poor sex esteem and display sexual inappropriateness (Kendall-Tacket, Williams & Finkelhor, 1993; McConaghy, 1998). Long term sexual symptoms resemble that of adult victims (Leonard & Follette, 2002; Loeb, Williams, Carmona, Rivkin, Wyatt, Chin, & Asuan-O'Brian, 2002). Childhood sexual abuse has also been linked to psychopathology in adulthood (Chu & Dill, 1990; Fossati, Madeddu & Maffei, 1999).

Victims of these crimes experience extreme trauma and may suffer chronically as a result. Families and friends are also significantly impacted by sexual violence. In addition to the pain suffered by victims as a result of psychological and physical difficulties resulting from an assault, treatment also places a burden on health care systems as well.

### *The Perpetrators*

The majority of rapists are male. Ward and colleagues (1997) found that rapists are more likely than non-offenders to come from a low socioeconomic background (though date rapists are more likely to come from a middle- or upper-class background) and have a criminal record. FBI Uniform Crime Reports indicate that, of the rapists with police records, perpetrators tend to be under 25. Hudson & Ward (1997) further found that they are more likely to have a history of sexual abuse, a childhood violent home environment, and inconsistent caregiving in childhood.

Rapists are exemplified by impulsivity, quick tempers, insensitivity to social cues and limited intimate relationships (Giotakos, Markianos, Vaidakis, & Christodoulou, 2004). They also display hostile masculinity, emotional detachment and predatory personalities (LeVay &

Valente, 2003). They show limited understanding of the feelings and intentions of others, for example, reading friendly behaviors as sexual and the inability to read negative cues (Ward et al., 1997; Emmers-Sommer, Allen, Bourhis, Sahlstein, Laskowski, Falato, Ackerman, Erian, Barringer, & Weiner, 2004). However, Lisak & Miller (2002) found that, on average, rapists had more consensual sex than their peers.

Abel & Rouleau (1990) reported that some rapists are also affected by a paraphilia. Of the participants in their study, 28% met some criteria for exhibitionism; 18%, for voyeurism. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* defines pedophilia as acting on or impairment caused by "recurring, intense sexually arousing fantasies, urges or behaviors involving sexual activating with a prepubescent child or children (generally age 13 or younger)". Though some pedophiles display no preference for the sex of their victims, most are either exclusively heterosexual or homosexual. Homosexual pedophiles abuse a greater number of victims than heterosexual pedophiles (Blanchard, Barbaree, Bogaert, Dickey, Klassen, Kuban, & Zucker, 2000; Cohen & Galynker, 2002).

Lee and colleagues (2002) reported that, compared to rapists, pedophiles were more likely to have experienced childhood sexual abuse. Common among men with pedophilia is an idealization of traits associated with childhood like innocence (Cohen & Galynker, 2002). Pedophiles often believe that sexual contact is not harmful to children or that children desire sexual contact, sometimes to the point of believing that the victim initiated sexual contact (Cohen & Galynker, 2002; Segal & Stermac, 1990).

Sex offenders display atypical arousal patterns. Like normal non-offending men, most rapists find depictions of consensual sex to be arousing; however, the offender subset of the male population was also aroused by depictions of sex involving an unwilling victim (Abel &

Rouleau, 1990). Among pedophiles, those with female victims show greater or equal arousal for picture of nude or semi-nude girls than similar pictures of adult women (Seto, Lalumiere & Kuban, 1999).

### *Recidivism Rates*

In 1994, seven-year-old Megan Kanka was raped and strangled by a neighbor, who had previously been convicted of child molestation. Public outrage following her murder led to the passage of Megan's Law by the State of New Jersey, which required the post-release registration of convicted sex offenders and community notification of sex offenders moving into the neighborhood. Since then, many other states have passed Megan's Laws. While these laws have been controversial, they speak to the recognition of high recidivism rates for sex offenders.

Indeed, recidivism rates for offenders of these crimes are extremely high. In a study of 1,882 men, 63% of those who had committed rape had committed more than one, with an average of 5.8 rapes each (Lisak & Miller, 2002). In a longitudinal study of over 300 sex offenders, Langevin and colleagues (2004) found that over half were charged with one or more sexual offences. Some types of offenders have higher rates of recidivism than others; generally the highest are those with deviant sexual preferences, such as exhibitionists, sadists, and pedophiles (Dickey, Nussbaum, Chevonneau & Davidson, 2002; Langevin et al., 2004). Aging reduces recidivism rates (Dickey et al, 2002; Hanson, 2002).

## **Treatment Options**

### *Incarceration*

As previously noted, many sex offenders go undetected because reports are not made. Many cases are not brought to trial by the state and still more are decided in favor of the

defendant. This paper deals with offenders who have been convicted of their crime. Among men convicted of rape, approximately one-third do not serve jail time (LeVay & Valente, 2006).

Those who are imprisoned face risks in prison because of the nature of their crime. Sex offenders must often be separated from the mainstream population to protect them from harassment, physical injury, rape and murder committed by other prisoners. While for the protection of prisoners who have committed sex crimes, segregation can result in limited access to prison facilities and feelings of fear.

While ideally the penal system should provide rehabilitation, in practice, jail time is punishment rather than treatment. Incarceration prevents reoffending only for the length of the prison sentence. McGuire (2002) concluded that punishment and deterrence methods are ineffective in preventing future offences.

### *Cognitive-Behavioral*

The current psychotherapies employed involve modifying patterns of arousal, thinking patterns and behavior to reduce reoffending. In aversion therapy, deviant sexual arousal patterns are altered by pairing a paraphilic stimulus with mild electric shock, foul odor or induced nausea at peak arousal (Quinsey & Earls, 1990). Positive reinforcement is also used to replace the sex offender's typical pattern of arousal with acceptable stimuli (i.e. consenting adults) by having the subject masturbate as they would usually, then switch to imagining an appropriate fantasy right before orgasm (Maletzky, 2002; Earls & Quinsey, 1985; Quinsey & Earls, 1990). Another technique, cognitive restructuring, aims to adjust the subjects' sexual views. Cognitive restructuring involves challenging the cognitive distortions (such as believing that women enjoy being raped or that children can consent or initiate sexual activity) of the sex offender (Maletzky, 2002). Treatment of sex offenders may also include social skills training to teach offenders how



to correctly interpret social situations as non-sexual and how to appropriately respond (Maletzky, 2002; McFall, 1990) Reports on the efficacy of these therapies outside the laboratory setting show mixed results – some report modest outcomes, others report virtually no difference between offenders who received treatment and those who did not (Alexander, 1999; Maletzky & Steinhauser, 2002; Marshall, Jones, Ward, Johnston, Barbaree, 1991).

### *SSRIs*

The selective serotonin reuptake inhibitor (SSRI) fluoxetine has been successfully used to reduce deviant urges in a number of paraphilias including pedophilia (Perilstein, Lipper & Friedman, 1991). SSRIs have also been tested in patients with hypersexuality as well as one case study of a rapist (Kafka, 1991; Kafka & Prentky, 1992). In this population, reduced sexual interest was reported.

The recent success of SSRI use to treat paraphilias and hypersexuality has generated questions about the possible relation of these diseases to obsessive-compulsive disorders (Stein, Hollander, Anthony, Schneifer, Fallon & Liebowitz, 1992)). Those with paraphilias may be suffering from impulse control disorders. In this conceptualization of the disease, deviant sexual fantasies are the compulsion and acting on these deviant sexual urges is the compulsive behavior. Further research is needed in this area.

### *Surgical Castration*

Throughout history, surgical castration has been used for a variety of purposes (Stelizer, 1997). In some cultures, female living quarters were served and guarded by eunuchs. In the 1700s, the practice of castration was used to maintain the high singing voices of male choir members past puberty. The eugenics movement in the early 20<sup>th</sup> century promoted sterilization of criminals and the mentally ill. As a punishment for rape, castration has been used for centuries

(Heim & Hirsch, 1979). Surgical castration for sex offenders was the legal standard of care in many European countries, including Denmark, Germany, Norway, Finland, Estonia, Iceland, Latvia and Sweden, for much of the twentieth century and was also legal in many U.S. states.

Bilateral orchiectomy, that is, the excision of both testes, results in significantly decreased sexual drive and activity; however, in some cases, erectile response is still possible (Aass, Grunfeld, & Kaalhus, 1993; Van Basten, Van Driel, & Hoeskstra, 1999; Van Basten, Van Driel, & Jonker- Pool, 1997). This invasive surgical procedure is permanent. Suppression of libido and arousal and erectile dysfunction are experienced across the board, not just in deviant sexual behaviors and urges. Sexual recidivism among surgically castrated felons is remarkably low - about 1% of subjects (Sturup, 1972). In other studies, those who did reoffend were being treated with testosterone to reduce the symptoms associated with castration (Hansen, 1991; Hansen & Lykke-Olesen, 1997).

Side effects of the surgery can be quite severe. In addition to the sex-related physical changes, there are health risks beyond those normally associated with surgery. Most patients undergoing surgical castration reported reduced body hair and slack and flabby skin. Many experience enlarged breasts. Castrated sex offenders experienced heart and respiratory problems, chronic pain, hot flashes, night sweats, and vertigo (Langeluddeke, 1963).

Surgical castration has been rejected by most courts in the United States on the basis that it qualifies as cruel and unusual punishment. Especially since the advent of a non-invasive alternative – chemical castration, surgical castration has been abandoned as the standard treatment in the U.S. In cases where the chemical castration may pose significant health risks or treatment-resistant cases, surgical castration is still sometimes performed on sex offenders.

## Chemical Castration

Chemical castration is not castration, per se, in that there is no cutting involved. This hormone therapy reduces circulating levels of testosterone by chemical means. Androgens - testosterone and dihydrotestosterone - are critical in the regulation of male sexuality (Rubinow & Schmidt, 1996). Erection and ejaculation are both influenced by testosterone levels (Bradford, 2001). Conversely, testosterone levels increase with sexual activity (Jannini et al, 1999). Testosterone is also linked to aggression. Testosterone levels have been correlated with violent crime (Ehrenkranz, Bliss, & Sheard, 1974; Kreuz & Rose, 1972; Virkkunen, Rawlings, et al., 1994), but the precise relationship between aggression and testosterone is unclear (Volavka, 1995). Steroid antiandrogen drugs reduce sex drive by blocking androgen receptors.

### *Medroxyprogesterone Acetate*

Medroxyprogesterone acetate (MPA), also known by brand names Clinovir, Cycrin, Depo-Provera, and Hystron, is the hormone used for chemical castration in the United States. MPA first came to the market to treat gynecological problems in females. The Food and Drug Administration (FDA) withdrew MPA from the market in 1978. MPA is available outside the U.S. as birth control; however, the FDA has never approved it for this use. Heller, Laidlaw, Hervey and Nelson (1958) first reported that progestational compounds decreased testicular size and suppressed completely male libido. MPA was first used with sex offenders by Money (1970) in conjunction with behavioral treatments.

MPA reduces testosterone production by inhibiting gonadotropin secretion (Gijs & Gooren, 1996). MPA accelerates testosterone metabolism in the liver leading to lower circulating levels of testosterone (Southren, Gordon, Vittek, Altman, 1977). MPA is administered as an intramuscular injection of about 400 milligrams weekly. (Blumer & Migeon, 1975; Gagne,

1981; Money, 1970). In one study, MPA was also delivered orally in 60mg daily doses (Gottesman & Schubert, 1993).

Effects are seen within two to three weeks of starting a course of MPA (Gagne, 1981). In a study of 48 participants, Gagne (1981) reported forty participants who positively responded to MPA and that all participants experienced lowered sexual fantasy, arousal and urges (particularly masturbation). MPA leads to significant reduction in time spent engaging in sexual fantasies, number of morning erections, number of ejaculations, frequency of paraphilic behavior and circulating testosterone levels (Gottesman & Schubert, 1993). Berlin & Meinecke (1981) treated 20 patients and reported a 15% relapse rate. Risk factors for relapse include elevated baseline testosterone, previous head injury, and substance abuse (Meyer, Collier, Emory, 1992).

Side effects reported by patients varied in severity, but common side effects included fatigue following injections, headache, nausea, hot flashes, and insomnia. Physical changes as a result of taking MPA included gynecomastia and weight gain (Gagne, 1981; Meyer, Collier & Emory, 1992). More serious side effects seen in a smaller percentage of patients included phlebitis, hypertension, gastrointestinal complaints, gallstones, and diabetes (Kravitz, Haywood, & Kelly, 1995; Meyer, Collier, Emory, 1992).

### *Cyproterone Acetate*

Cyproterone acetate (CPA), marketed under the names Androcur, Cyprone, Cyprostat, and Dianette, is not officially approved in the United States, but is used in Canada, the United Kingdom and Germany. Comparative studies of MPA and CPA are difficult because the drugs are not available in the same countries.

In their seminal study on the clinical uses of CPA, Laschet & Laschet (1971) observed significantly reduced or eliminated sexual drive, erections and orgasms in 100 sexually deviant

male participants. CPA decreases testosterone production by competitive inhibition of testosterone and dihydrotestosterone in androgen receptors. CPA is available in pill form given daily and as an intramuscular injection given every two weeks. Laschet & Laschet (1971) used either 100mg oral doses daily or 300mg intramuscularly every two weeks. Currently, oral dosages range from 50-200mg daily and intramuscular dosages range from 200-400mg each week or every other week.

Mothes, Lehnert, Samimi and Ufer (1997) found that CPA decreases sex drive within one to two weeks. In a study by Bancroft and colleagues (1974), patients receiving CPA scored lower on written measures of sexual interest and sexual activity. Like MPA, CPA suppresses sexual fantasies, libido, number of morning erections, number of ejaculations and spermatogenesis (Neumann & Schleusener, 1980). Bradford & Pawlak (1993) reported patients treated with CPA showed a reduction in anxiety and irritability. Side effects of CPA include depression, nightmares, headaches, gynecomastia, weight gain, muscular cramps, dyspepsia, gallstones, increased blood sugar levels, diabetes mellitus and liver dysfunction (Bancroft et al, 1974; Cremonocini, Viginati, & Libroia, 1976; Gijs & Gooren, 1996; Neuman, 1977).

## **Ethical Considerations**

### *Public Costs and Benefits*

A utilitarian argument which sought to obtain the most good for the greatest amount of people favors chemical castration for repeat sex offenders. As previously stated, sex offenders pose a severe threat to public well-being. Most offenders have many victims and the cost to the victim is quite high. Curbing the deviant behaviors of sex offenders would be beneficial in ensuring the security of many individuals. Sexual assault can have serious physical and mental health outcomes for victims. In addition to the pain and suffering of victims and family

members, treating survivors of sexual assault can be expensive. Stopping sexual assaults results in significant financial benefits as well. Resources that would have gone to treating victims of sexual assault could be used for numerous other beneficial programs.

While there are other options to prevent sex offenders from reoffending, the option of chemical castration for policymakers with a utilitarian perspective is attractive because of the financial savings it provides. The cost of incarceration to the taxpayer is extremely high. For each U.S. resident, state prisons spend \$204 yearly. According to figures put out by the Department of Justice (2001), the average annual cost per state inmate is \$22,650 in state operated facilities and \$22,632 per inmate in federal prisons. Comparatively, each injection of Depo-Provera costs between \$35-75. Even taking the highest figure for medication and the lowest figure for incarceration costs, the yearly cost to furnish felons with Depo-Provera is more than eighteen thousand dollars per felon. Again, some of the resources currently provided to the penal system could be diverted to other programs.

The benefits of chemical castration in terms of the public good seem to outweigh the costs. The security of the public needs to be maintained and, to do this, certain rights of the few need to be compromised. Yet incarceration satisfies the goal of keeping the public safe while limiting fewer rights than chemical castration, despite being more expensive to the taxpayer.

#### *Compliance Issues*

Furthermore, chemical castration is not a fool-proof way to achieve public safety. In certain experimental studies MPA and CPA have been administered by the patient in pill form daily. On top of the fact that this is a drug with unpleasant side effect being taking by a possibly not-so-willing population, anyone who takes daily medication can testify to how easy it is to forget to take your pills.

When used by the justice system, the drug used for chemical castration in the United States is dispensed via intramuscular injection by a medical professional rather than self-medication, but compliance cannot be ensured by this method of administration either. An injection of testosterone can counteract the effect of medroxyprogesterone acetate. Testosterone has been used in cancer patients who have undergone a bilateral orchiectomy to limit the sexual side effects. As in cases of surgical removal of the testes, testosterone can alter the effects of chemical castration as well. Felons seeking to counteract the MPA or CPA can obtain testosterone, which is freely available on the black market.

Problems with compliance counter the utilitarian argument that achieving safety for the greatest number of individuals justifies chemical castration. Since even with monitoring administration, patients can reverse the effects, it could potentially be a danger to the public if sex offenders likely to repeat their crimes were released, especially if the public believed they were safe because of the drug being given. In addition to the threat to the public, felons taking drugs on the black market might endanger their health as well. Neither the safety of the public nor the safety of the criminals could be guaranteed.

### *Safety Concerns*

The safety of the antiandrogen drugs themselves is also questionable. Those taking MPA or CPA face considerable health risks as a result of the medication. Proponents of chemical castration argue that the side effects are comparable to medications used to treat other diseases. Every commercial for a prescription drug ends with a long list of side effects that can range from minor discomfort to life-threatening problems; what is so different about the side effects for antiandrogen drugs? MPA, the only drug used for chemical castration in the United States, is not

FDA approved. Giving antiandrogen drugs to sex offenders violates the moral principle of non-maleficence, i.e. the responsibility to avoid inflicting harm.

Chemical castration is often viewed as more palatable than surgical castration because it is a reversible procedure. Conversely, though, the side effects of the drug may not be reversible even after the medication is discontinued. Because the side effects are so unpleasant or jeopardizing to their health, many patients do not continue with treatment. Thus, longitudinal studies of the side effects are incomplete, because those with the severest side effects drop out.

Other problems with empirical study of these drugs exist. Due to concerns for public safety, randomized, double-blind, and placebo-controlled studies are not ethically possible and have not been conducted. Researchers could not ethically allow known offenders to be released without providing some sort of treatment. Without a placebo group, measurements of effectiveness are not entirely accurate.

#### *Parole Board Coercion*

The practice of chemical castration using MPA and CPA severely limits the autonomy of patients undergoing the treatment. Criminals necessarily forfeit some rights to freedom, but sex offenders up for parole in states which offer chemical castration are forced to accept medical treatment or return to jail. In California, Michigan and Florida, taking MPA is a mandatory condition of release for repeat offenders and for particularly violent first time offenders. If prisoners choose not to undergo MPA treatment, they can opt for either surgical castration or life imprisonment (Carpenter, 1998; Harrison, 2007). Some may claim it is sufficient that prisoners have a choice about whether to accept treatment, but when prisoners are forced to choose between the exercise of their right to freedom and their right to health and bodily integrity, it can hardly be claimed to be a free choice.



In the UK, Canada, Germany, Austria and other countries which offer pharmacotherapy for sex offenders, participation is voluntary (Harrison, 2008). Harrison (2008) suggests that those eligible for chemical castration meet with a mental health professional to determine that they are not acting out of a desire to punish themselves and that they are able to consent to the risks. If chemical castration is to be offered, this seems to be a necessary precaution. However, understanding the risks and freely consenting to the risks are two different things. Maletzky (1980) found no significant difference between court-referred and self-referred pedophiles in terms of compliance, attendance and recidivism rates. This suggests that even if MPA or CPA treatment is not officially linked to parole, offenders will opt to participate because they hope to impress the parole board rather than a desire to suppress deviant thoughts. Their ability to consent to the medical procedure is compromised by the potential outcomes of participation which could lead to a drastic change in lifestyle.

### *Equal Access to Drugs*

After discussing the element of coercion in chemical castration, the issue of distributive justice may seem incongruent. Yet, Harrison (2008) notes that there are some outside the criminal justice system seeking to take antiandrogen drugs. As previously noted in this paper, a high number of sexual assaults are unreported and offenders never prosecuted. Currently, antiandrogen treatments are only available to those in the criminal justice system; that is, those who have legal convictions and, for countries where programs are voluntary, meet referral criteria. Should those who recognize that they have a problem and threaten public safety be denied treatment just because they do not have a criminal record?

Those outside the criminal justice system would be free of coercion and presumably be more aware of the risks if they had to do their own research about the subject. Also those who

really wanted to take these drugs might attempt to find the medication by any means and so it would be better to have a qualified medical professional administer the drug. It would be unethical to jeopardize public safety and the patient safety by denying them treatment; however, appropriate protocols should be set up to determine whether the patient is able to consent to the course of treatment.

#### *Reinforcement of Sexual Assault Myths*

An arguably less weighty moral objection to the use of antiandrogens to chemically castrate is the possible reinforcement of sexual assault myths. By stating that there is a cure for offenders that is only available to a subset of offenders effectively confirms the stereotypical image of a sex offender and sexual assault. There is no typical assault, and survivors of crimes that are not like the majority of cases may feel marginalized. These drugs are only available to male offenders, despite the fact that female sex offenders, while not as prevalent, exist. A parolee taking these medications may not be able to maintain an erection, but this does not preclude touching or the use of a foreign object. Further, while these drugs limit sexual drive and fantasies, there is some evidence that these drugs do not significantly reduce violent tendencies and offenders could commit other, related crimes.

#### *Treatment or Punishment and Issues of Proportional Punishment*

Baker (1984) correctly notes that there is a difference between preventing criminal offending and preventing all sexual activity. MPA and CPA limit criminal offending in some patients, but at the cost of limiting all sexual activity. By subjecting prisoners to a treatment which exceeds what is needed for the cure, we further violate the principle of non-maleficence.

The etiology and pathophysiology of paraphilias are unclear. The neurobiological basis of sexual arousal, drive and behavior is extremely complex. Different sexual processes occur in the

central nervous system, the peripheral nerves and the primary and secondary genital organs (Meston & Frohlich, 2000). Deviant sexual behaviors could be caused by brain chemistry, brain abnormality, learned behaviors or some unknown mechanism. The drugs used to chemically castrate sex offenders reduce arousal and sex drive in all contexts, not just inappropriate ones. A drug which properly *treated* pedophilia would suppress only deviant sexual urges, but would allow for appropriate sexual encounters with adults. Chemical castration is threat reduction, not treatment.

More complicated than the case for child molesters, who suffer from a diagnosable disease, is the issue of rapists with adult victims. While they may suffer from other mental illnesses, rapists do not receive a special DSM diagnosis. One of the proposed revisions to the DSM-V under review by the paraphilias subworkgroup is “Paraphilic Coercive Disorder”, defined as “recurrent, and intense sexual arousal from sexual coercion, as manifested by fantasies, urges, or behaviors” resulting in distress or seeking “sexual stimulation from forcing sex on three or more non-consenting persons on separate occasions” (APA, n.d.). But currently the field of psychopathology does not recognize those who commit rape as mentally ill based on the act alone. (The inclusion of paraphilic coercive disorder is morally troubling in and of itself, both because of the implications for the criminal justice system and the potential financial benefit to pharmaceuticals. If this is defined as a disorder, they will be able to market SSRIs for this use.) Medication for something that is not a disease cannot really be called treatment. If these medications are not treatments, then we must name them punishment. Just as treatment should not exceed cure, punishment should not exceed the crime.

## **Conclusions – What should be done?**

The ethical dilemma posed by the possibility of castrating repeat sex offenders is, in essence, a question of the opposing needs of public safety and personal rights. Granted, felons do lose certain rights as citizens; for instance, they are not allowed to bear arms. In the interest of public safety, those who are incarcerated lose the exercise of their right to personal freedom for the duration of their prison sentence.

However, chemical castration represents a policy nominally in the interest of public safety. It compromises the rights of the all in compromising the rights of the few. We do not need to go into the hypothetical to understand how this medical technology may be used; we may look to history for example. Encouraged by the eugenics movement, several U.S. states passed laws allowing for the involuntary sterilization of mental patients (Sofair & Kaldjian, 2000). Nazi Germany also embraced the eugenics movement and performed mass sterilizations of people with schizophrenia, epilepsy, alcoholism, manic depression, hereditary deafness or blindness, severe hereditary physical deformity, Huntington chorea, and congenital feeble-mindedness. Feeble-mindedness, a diagnosis based on the discretion of the physician, targeted race (Sofair & Kaldjian, 2000). Eugenic sterilization has largely fallen out of favor due to its association with the massive human rights violations perpetrated by the Nazis, but if we allow the chemical castration of sex offenders, we open the door to eugenics once again – how can we determine who is deserving of castration?

In addition to the potential costs to society, the costs to the individual undergoing chemical castration are excessively high. A drug which is not approved in the United States for its on-label use is approved for an off-label, experimental use on felons. The use of MPA and CPA violate prisoner rights to health and human dignity. A violation of these rights is

disproportional in comparison to what is needed to provide security to society. Lastly, MPA and CPA do not ensure full security because of the unclear effectiveness of the drug and the possibility of non-compliance.

For these reasons, I find that the use of MPA and CPA for chemical castration of sex offenders to be unethical.

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