

CHEMICAL CASTRATION: HOW A MEDICAL THERAPY BECAME
PUNISHMENT AND THE BIOETHICAL IMPERATIVE TO RETURN TO A
REHABILITATIVE MODEL FOR SEX OFFENDERS

BY

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ABSTRACT

Chemical castration is a colloquial term used to refer to the treatment of certain sex offenders with antiandrogenic drugs in order to reduce recidivism. The use of this treatment began in the United States in 1966, at which time the nation favored a rehabilitative approach to criminal justice. In its first thirty years of use, chemical castration proved effective at reducing recidivism rates among one subset of offenders, paraphiliacs, by about fifty percent.

In the late twentieth century, a shift in public opinion led to a prioritization of retributive justice over the existing rehabilitative model. This push toward retribution led to the drafting and subsequent passage of nine state statutes mandating castration therapy for offenders who commit certain crimes. Seven of these statutes remain in effect as of late 2012. These laws incorporated an effective therapy within a model of retributive punishment, a move that continues to raise serious bioethical questions today.

This thesis examines chemical castration within both a therapeutic and punitive context. I discuss the side effects and legal implications of castration as it is currently used, as well as the bioethical issue of how one ought to respect patient rights when treatment is administered as punishment. The bioethical principles of respect for autonomy, beneficence, nonmaleficence, and justice are discussed, as are the appropriateness of a risk reduction argument for castration and several logistic issues related to this treatment. I ultimately argue against the retributive use of chemical castration and propose a return to a rehabilitative approach to this intervention.

CHAPTER 1: INTRODUCTION

Within the criminal justice system, sex crimes are particularly reviled due to the widespread harms they place on victims and society. An average of nearly 210,000 Americans above the age of twelve are sexually victimized each year, and it is estimated that sixteen percent of girls and seven percent of boys under the age of thirteen experience sexual abuse [Rape, Abuse, & Incest National Network (RAINN), 2009b; Thibaut et al., 2010]. Only about half of all sexual assaults are reported to police; this underreporting has been attributed to victims' feelings of shame and/or fear (RAINN, 2009b). Despite the dearth of victims' reports, the national prison population of sex offenders in 2007 was approximately 150,000 [Center for Sex Offender Management (CSOM), 2008]. Sex offenders serve an average of six to seven years in prison, with between 10,000 and 20,000 of them being released from custody annually ("Criminal penalties," 2012; CSOM, 2008). With an overall recidivism rate among sex offenders between fifteen and forty-eight percent, the risk of continued abuse after incarceration is high (Thibaut et al., 2010).¹

Since the 1960s, there has been extensive research conducted in the United States and abroad on the utility of chemical castration as a rehabilitative therapy in sex offenders.^{2, 3} This body of research, conducted within existing sex offender treatment programs, clearly supports and describes the appropriate use of this treatment in a small

¹ Underreporting is a recurring problem in the sexual abuse and recidivism literature. For the purposes of this thesis, I have tried to limit myself to more conservative estimates.

² The vast majority of the research and the focus of the public regarding chemical castration has been on male sex offenders. This thesis will follow this trend: unless explicitly stated otherwise, all references will be to male sex offenders.

³ This thesis focuses on chemical castration, though surgical castration is sometimes used for the same purpose among sex offenders. All textual references to surgical (also known as physical) castration are for the purposes of comparison rather than analysis. Unless explicitly stated otherwise, all references are to chemical castration.

subgroup of offenders. Despite the clarity of the literature on the topic of sex offender castration, several state laws have been passed since 1996 authorizing judges to mandate castration in cases otherwise believed to be inappropriate for such treatment. By permitting the use of castration in instances where it may not serve any rehabilitative purpose, legislators moved castration from the realm of therapy into one of retributive punishment. The use of a medical treatment within a punitive context poses a serious bioethical problem: when medical treatments are administered in a manner that does not support their efficacy, can patients be treated ethically?

This thesis introduces the key concepts related to chemical castration and discusses the appropriateness of these treatments in court-ordered, voluntary, medical, and bioethical contexts. Based on these discussions, I argue against court-mandated castration and support a return to the rehabilitative model that spawned castration research in the first place. I argue that court-ordered castration as it currently stands violates several major principles of bioethics and therefore ought not be done; however, we ought to make this therapy more available to the appropriate sex offenders who desire it.

In this chapter, I discuss the development of chemical castration as a rehabilitative therapy for paraphiliac sex offenders and explain the current professional recommendations for ensuring effective castration. I trace the evolution of castration in response to changing public sentiment regarding the goals of punishment in the twentieth century. In so doing, I illustrate the historical precedent that has led the United States to the castration policy in existence today.

In the following chapters, I will introduce the myriad side effects of castration and how these affect the long-term requirements of treatment, discuss current statutes regarding castration and how they fail to reflect the literature on effective castration, analyze current castration policy within the context of four major bioethical principles, and consider several ideological and logistic issues that arise when considering castration. I conclude with the position that castration ought to be made more available to the sex offenders who will benefit from it, but that all castration procedures should be purely voluntary and laws allowing judges to mandate castration should be repealed.

The Development of Chemical Castration as a Therapy

During the first half of the 20th century, several European countries began using surgical castration—a means of testosterone reduction—as a therapy for sex offenders. Publications from castration programs in Switzerland, Holland, Germany, Finland, Iceland, and Denmark reported a recidivism rate between 1.1 and 7.4 percent among castrated offenders compared with estimated non-castrated rates between fifty and eighty-four percent (Prentky, 1997). The outcome of these programs suggested that reducing testosterone played a key role in reducing recidivism among a certain population of sex offenders. Based on this early work, researchers in the United States began to experiment with chemical means of manipulating hormones. This method was theorized to be advantageous over surgical castration because it is reversible and eliminates the stigma of physical castration for the offender (Ibid.).

The first attempt to chemically manipulate testosterone levels in a sex offender occurred in 1966, when Johns Hopkins psychologist Dr. John Money⁴ used the compound medroxyprogesterone acetate (MPA) in conjunction with mental health counseling to treat a sex offender with a history of cross dressing and pedophilia (Money & Bennett, 1981). In subsequent years at the Johns Hopkins Psychohormonal Research Unit, Money and colleagues conducted research on numerous patients undergoing chemical castration. In 1976, a similar MPA program began at the University of Texas Medical Branch in Galveston (UTMB). This program was soon incorporated into the Rosenberg Clinic and continues today (Emory, Cole, & Meyer, 1992). Research findings from these early programs report a recidivism rate reduction of about fifty percent in a particular subset of offenders called paraphiliacs for the duration of treatment (Thibaut et al., 2010).

In the early 1980s, a group of researchers at the UTMB, spearheaded by psychologist Dr. Paul Walker, proposed a classification system that categorized sex offenders into four types based on their response to their offenses and the motivations therefore. Type I, or denying, offenders either deny having committed a crime or deny that their actions were criminal in nature. Type II, or disinhibited, offenders admit having committed a crime, but blame outside factors such as stress or being under the influence of drugs as the motivation for its commission. They are also likely to assert having committed a sexual offense only once—the time they were caught. Type III, or violent, offenders are motivated by anger, violence, or the need for power. While the sex crimes committed by these offenders have sexual components by definition, the offender

⁴ Dr. Money is better known for his involvement in the controversial Bruce/Brenda case. Money, a sexologist and gender theorist, sought to prove gender was learned by counseling a case in which a child was born male but raised female following a botched circumcision.

was not seeking sexual gain in committing the offense. Finally, Type IV offenders, also known as paraphiliac offenders, are those whose crimes are motivated by overwhelming sexual fantasies or fetishes that the crime in some way actualizes (Walker & Meyer, 1981). In proposing their system, Walker and colleagues summarized their and their peers' research findings by identifying Type IV offenders, paraphiliacs, as being particularly amenable to MPA treatment, now known as chemical castration.⁵

Profiling and Distinguishing Paraphiliac Offenders

In order to fully understand MPA treatments as they were developed, it is important to understand what a paraphilia entails and how this makes the paraphiliac a prime candidate for such therapy. According to the most recent version of the Diagnostic and Statistical Manual (DSM),⁶ the primary diagnostic tool within the mental health field, a paraphilia is defined as a sexual disorder in which the patient experiences “recurrent, intense, sexually arousing fantasies, sexual urges, or behaviors...that occur over a period of at least 6 months” [American Psychiatric Association (APA), 2010, p. 566]. Paraphilias can take on many forms and develop toward a multitude of sexual behaviors, objects, or partners. The DSM acknowledges nine categories of paraphilia, including exhibitionism,⁷ fetishism,⁸ frotteurism,⁹ pedophilia,¹⁰ sexual masochism,¹¹ sexual

⁵ The term “paraphilia” was fairly new at the time of the publication of Walker and Meyer’s taxonomy; the mental health community first incorporated it into their literature in 1980 with its inclusion in the third edition of the Diagnostic and Statistical Manual (DSM). This inclusion marked a formal acknowledgement of paraphilias as a diagnosable mental disorder, thereby medicalizing the condition. However, some paraphiliacs were treated with castration prior to 1980. Dr. Money’s first patient in 1966 met the criteria for a paraphilia, and he wrote extensively on the pathology of the condition years prior to the 1980 DSM inclusion (Money, 1977).

⁶ I am citing the most recent definition of paraphilias provided by the DSM. Early literature discussions of the nature of paraphilia coincide with this definition, which suggests that the understanding of paraphilias has not changed significantly in the fifty years since MPA was first used among this group.

⁷ Paraphilia regarding the exposure of one’s genitals to a stranger (APA, 2010, p. 569).

⁸ Paraphilia regarding the use of nonliving objects, e.g. women’s lingerie, shoes (Ibid.).

⁹ Paraphilia regarding the touching of or rubbing against a nonconsenting person (Ibid., p. 570).

sadism,¹² transvestic fetishism,¹³ voyeurism,¹⁴ and “paraphilia not otherwise specified,” which allows for the diagnosis of paraphilias other than those specifically listed¹⁵ (Ibid., p. 569-576).

The criteria necessary for a person to be diagnosed with a paraphilia vary based upon the category of paraphilia presented. Pedophilia, voyeurism, exhibitionism, and frotteurism are diagnosable if the patient has either acted on the fantasy or if these fantasies cause distress. Sexual sadism is diagnosable if the patient has acted on the fantasy with a nonconsenting partner¹⁶ or if the fantasies cause distress. The remaining four paraphilias—fetishism, sexual masochism, transvestic fetishism, and paraphilia not otherwise specified—are only diagnosable if “the behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning” (Ibid., p. 566). Therefore, while two sex offenders may meet the diagnostic criteria for a paraphilia, there may be vast differences in the nature and victims of their offenses. Historically, pedophilia and exhibitionism have been the two primary forms of paraphilia treated via castration (Walker, Meyer, Emory, & Rubin, 1984).

¹⁰ Paraphilia regarding sexual contact with prepubescent children generally aged thirteen or younger. The pedophile must be at least sixteen years old and be at least five years older than the victim, though the DSM recommends professional judgment in assessing minors who exhibit pedophilic behaviors (Ibid., p. 571).

¹¹ Paraphilia regarding the “act (real, not simulated) of being humiliated, beaten, bound, or otherwise made to suffer” (Ibid., p. 572).

¹² Paraphilia regarding “acts (real, not simulated) in which the individual derives sexual excitement from the psychological or physical suffering (including humiliation) of the victim” (Ibid., p. 573).

¹³ Paraphilia regarding cross-dressing by a male in women’s clothing (Ibid., p. 574).

¹⁴ Paraphilia regarding “the act of observing unsuspecting individuals, usually strangers, who are naked, in the process of disrobing, or engaging in sexual activity” (Ibid., p. 575).

¹⁵ Examples include zoophilia, which targets animals, and partialism, which targets specific parts of the body, e.g. the feet.

¹⁶ Note that this is in effect no different than acting on pedophilia—children cannot give valid consent, and so all acts of pedophilia are committed against a nonconsenting partner as well.

When a person with a paraphilia commits a sex crime, the motivation for his or her behavior is to act out unrelenting sexual fantasies. Unfortunately, many individuals with paraphilias cannot or do not realize these fantasies with consenting parties. While it is not illegal to suffer from a paraphilia, it is when such a paraphilia is realized against a nonconsenting person (Ibid.). This can pose a particular problem for paraphiliacs, who often report that the only effective means of temporarily silencing these troubling fantasies is to act on them (Berlin & Meinecke, 1981). These offenders are no strangers to the emotional distress that is known to accompany paraphilias—they often report feeling remorse and guilt over their crimes and may even verbalize their desire to escape the sexual fantasies that drive them (Bund, 1997). For this reason, paraphiliacs are excellent candidates for MPA treatment: they tend to be keenly aware of the damaging effects of their paraphilia, and often are eager to silence their unrelenting fantasies. Furthermore, because these offenders are primarily motivated by sexual fantasies, they are notoriously unresponsive to traditional methods of deterrence, e.g. the threat of reincarceration, because the existence of deterrent measures does nothing to silence the paraphiliac's troubling thought patterns (Money & Bennett, 1981). For this class of offenders, chemical castration presents an effective and often welcomed treatment.

Paraphiliacs are a unique subgroup of sex offenders, but their offenses can resemble those committed by other non-paraphiliac offenders. The identification of a true paraphiliac is not straightforward because diagnosis is dependent upon the offender's experience and perception rather than the nature of the crime itself. For example, a rapist may meet the criteria for any of the four types of sex offenders mentioned above. A Type III (violent) offender would rape in order to gain power, where a Type IV (paraphiliac)

offender would rape due to intense sexual fantasies regarding the act of committing rape. Furthermore, crimes that would seemingly suggest a paraphiliac offender may not truly be the result of one. For example, pedophiles are responsible for victimizing only eighty-eight percent of all children who are abused; the remaining twelve percent are victims of offenders who offend based on availability rather than true sexual attraction (“The Abel,” n.d.; Stinneford, 2006). For this reason, several early researchers in MPA programs stressed the importance of the clinical interview in determining which offenders are true paraphiliacs (Berlin & Meinecke, 1981; Walker et al., 1984).¹⁷

There has been limited research conducted on the utility of castration in non-paraphiliac sex offenders, and what research does exist suffers from serious methodological challenges (Weinberger, Sreenivasan, Garrick, & Osran, 2005). Despite this, it has been extensively theorized that castration will fail in this population because sexually based crimes motivated by things other than sexual obsessions will not be adequately responsive to interventions that target arousal (Peters, 1993, p. 313). Also, in the absence of distress and the motivation to be treated, the likelihood that these offenders would comply with treatment is low. Researchers have therefore concluded that castrating this population would be a waste of time and resources and might potentially lead to a dangerous false sense of security (Berlin & Meinecke, 1981; Money & Bennett, 1981; Walker et al., 1984; Weinberger et al., 2005). In order to maximize the efficacy of castration therapy, it is essential to limit its use to Type IV paraphiliac offenders.

¹⁷ Many of these early researchers’ recommendations are still relevant today, as little has changed in the administration, recommendations, or intended patients of castration therapy since they were first used in the United States. Throughout this thesis, I will continue to work with texts that might otherwise be considered antiquated. However, their agreement with more recent reports justifies their placement in this discussion.

How Castration Works: The Procedure and Recommendations

Chemical castration is a bit of a misnomer, as the procedure leaves the testes intact. In chemical castration, offenders receive a drug that in some way interferes with the production, use, and/or metabolism of testosterone. The most common drug used for this purpose in the United States is MPA. Marketed to women as a quarterly injectable birth control method under the name Depo-Provera, MPA works to suppress testosterone production in men via each of the pathways mentioned above: it accelerates natural testosterone metabolism, changes the hormone's effects within the body, and affects the pituitary gland's release of precursor hormones to testosterone production (Fitzgerald, 1990, p. 6). While MPA is most commonly used for chemical castration, alternative androgen agonists and antipsychotic drugs have proven effective for this purpose as well (Murray, Bancroft, Anderson, Tennent, & Carr, 1975). Chemical castration differs from its surgical counterpart in that it is temporary, reversible, and does not cause permanent sterility.

MPA treatment is available inside and outside of sex offender rehabilitation programs and in private clinics, hospitals, prisons, and via independent physicians, though the latter group tends to be hesitant to administer the drug (Stinneford, 2006). Offenders may seek out treatment on their own, though these efforts may not be successful. In one case, a Virginia sex offender castrated himself in prison when attempts to access such treatment otherwise failed (Rondeaux, 2006).¹⁸ More commonly, sex offenders are referred to standalone MPA programs or sex offender treatment programs

¹⁸ Extremely satisfied with the outcome of his castration, the offender now speaks in support of the procedure (Rondeaux, 2006).

with MPA capabilities as a condition of parole or at the direct order of a presiding judge (Thibaut et al., 2010).¹⁹

MPA is commonly administered as a weekly intramuscular injection with a starting dose between 100 and 500 mg (Stinneford, 2006).²⁰ This initial dose reduces testosterone to pre-adolescent levels within three to five weeks. After six months of therapy, current professional standards suggest tapering the dose to a level sufficient to keep testosterone at bay and sex drive at a minimum, but also to minimize side effects and maximize patient comfort. This maintenance dosage level is highly variable and determined by the presiding physician based on the individual offender's symptomology and feedback (Thibaut et al., 2010).

An essential feature of chemical castration as repeatedly asserted in the literature is concurrent mental health counseling for the duration of pharmaceutical treatment. Chemical castration is only effective when administered alongside such therapy (Money & Bennett, 1981; Walker et al., 1984; Emory, Cole, & Meyer, 1992; Thibaut et al., 2010). Counseling often occurs on an individual, group, and/or family basis (Thibaut et al., 2010). While the method of counseling has varied since the inception of MPA as a treatment, more recently rehabilitation programs are favoring the use of cognitive-behavioral therapy with their patients (Ibid.). This form of therapy supports the goal of rehabilitation because it teaches offenders to monitor their thoughts and behaviors so as to increase self-awareness and decrease recidivism risk. Furthermore, it is essential for

¹⁹ Standalone chemical castration programs should not be confused with sex offender treatment programs. While both of these programs have similar goals, i.e. reduced recidivism and offender rehabilitation, they operate differently. Standalone castration programs seek primarily to administer chemical treatment and its recommended supportive therapies; sex offender treatment programs primarily offer mental health and life skills interventions with some programs providing supplementary chemical treatment (Sapp & Vaughn, 1991).

²⁰ For comparison, the recommended dose for women taking Depo-Provera is 150 mg every three months (Stinneford, 2006).

offenders to be in regular contact with their healthcare provider and/or rehabilitation program so as to ensure adequate drug dose management and, case depending, to comply with court-ordered supervisory provisions.

Perhaps chemical castration's biggest flaw is the duration of treatment necessary to maintain reduced recidivism rates. Studies have consistently shown that recidivism risk rises with the cessation of MPA injections (Berlin & Meinecke, 1981; Money & Bennett, 1981; Walker, Mayer, Emory, & Rubin, 1984), which suggests that for some sex offenders, chemical castration ought to be a lifelong process (Stinneford, 2006). Some researchers have suggested that recidivism risk reduces with age (Barbaree & Blanchard, 2008), but with many offenders initiating castration treatments between their 20s and 40s, this still implies decades of hormonal injections on a weekly basis. Treatment duration is currently recommended to be determined on an individual basis with close monitoring so as to enable the reinstatement of treatments should recidivistic urges arise following treatment cessation (Thibaut et al., 2010).

The Goals of Criminal Punishment and How Castration Became One

By now it should be clear that chemical castration began as an effective rehabilitative therapy for paraphiliac sex offenders. But why exactly did it begin, and how is it utilized today? In order to answer these questions, we must consider the goals of criminal punishment and how they've changed over time. There exist four primary goals or justifications for punishment within the criminal justice system: deterrence, in which we seek to discourage future crimes via the existence of unappealing punishments; rehabilitation, in which we seek to reform the offender; retribution, in which we seek revenge or reparation; and incapacitation, in which we seek to keep the offender from

committing future crimes via confinement (Packer, 1968). These goals may each contribute or not contribute to criminal sentencing, and over time trends emerge in which one or more of these goals are favored over the others by a society. The United States' attitudes and goals regarding punishment have accordingly evolved over time, but what is particularly interesting is how these trends have shaped the use and legislation of chemical castration.

From the 1950s through the early 1970s, the United States favored a rehabilitative approach to criminal justice (Banks, 2004). The goal in most cases was to identify treatments that might reform the offender and, by quashing deviant tendencies among offenders, increase public safety. At the time, rehabilitation was strongly favored over retribution, which was perceived as an excuse for vengeance (Ibid.). It makes sense, then, that John Money first used MPA in a paraphiliac offender in 1966: Money was working within a societal context that encouraged rehabilitation of criminal offenders, and chemical castration was a promising therapeutic option for attaining precisely this end in sex offenders. From 1966 through the 1990s, MPA was available via treatment programs to paraphiliacs who received it on a completely voluntary and self-funded basis (Money, 1987; Emory, Cole, & Meyer, 1992). As society's chosen goals for punishment evolved, however, the use of castration changed.

The mid to late 1970s saw a shift in public sentiment regarding the goals of punishment. The questioning of the validity of a rehabilitative approach to criminal justice culminated in a 1974 article by sociologist Robert Martinson that condemned this approach on the grounds that "nothing works." In response, policymakers in particular began turning from rehabilitation toward a new model for criminal punishment rooted in

incapacitation and deterrence (Banks, 2004; Haist, 2009). This model persisted through the late 1980s, when prison overcrowding emerged as a consequence of the increased focus on incarceration (Ibid.). During this time, MPA treatment programs continued to operate independent of prisons despite the new focus of criminal punishments.

In response to the issue of prison overcrowding that emerged in the 1980s, the focus on incapacitation and deterrence decreased in favor of a new, retributive approach to criminal justice (Ibid.). This model continues today. Illustrating this new mindset is survey data from 1994 in which eighty percent of the public expressed support for the death penalty—an all-time high for this form of retributive punishment (Jones, 2006). Bolstering this transition toward a retributive model of criminal punishments was a trend in the 1990s of increased attention placed on the victims of crime (Banks, 2004). It should be no surprise, then, that the widely publicized kidnapping and murder of twelve-year-old Polly Klaas in California led the state to pass the first American statute mandating chemical castration for some sex offenders in 1996 (Stadler, 1997). This legislation ushered in a new era of retributive castration that rendered what was originally a rehabilitative treatment a mere punishment. In what follows, I will discuss the medical, legal, bioethical, and logistic issues surrounding this new use of castration.

CHAPTER 2: SIDE EFFECTS

It is nearly impossible to imagine a medical procedure or treatment that causes no side effects, and chemical castration is no exception. What is unique about castration, however, is its duration: where many medical procedures and therapies are time-limited, castration therapy can span decades (Stinneford, 2006). This extended duration of castration treatments has been known to lead to the development of more serious and potentially life-threatening side effects (Gooren, 2011; Giltay & Gooren, 2009). For this reason, chemical castration may pose a serious burden to the sex offenders who undergo it. This issue of burdens is even more important when we consider castration's use outside of a voluntary, therapeutic framework, and this raises several questions. First, what exactly are the side effects of long-term castration therapy? Second, is there any way to mitigate these? Finally, given the answers to the first two questions, is the severity of these side effects justifiable within a court-mandated context? In other words, is it permissible to require sex offenders to undergo castration given the side effects they face in doing so?

To review, chemical castration is a medical procedure that reduces serum testosterone levels in men via the weekly administration of one of several pharmaceutical compounds (Thibaut et al., 2010).²¹ The ultimate goal of chemical castration is to reduce recidivism rates among paraphiliac sex offenders by reducing their sex drive. Because the primary motivation to commit sexual

²¹ Chemical castration is also known as antiandrogenic treatment, however the latter term may also refer to medical efforts to reduce testosterone in men being treated for prostate cancer. The phrase "chemical castration" is used colloquially in reference to its criminal applications, and it is for this reason that I have chosen to use it rather than its synonym.

offenses for this population is sexually related, it follows that a reduction in libido will quell the urge to offend (Money & Bennett, 1981; Walker et al., 1984). Chemical castration achieves this end by manipulating testosterone, the primary male hormone associated with libido (Bancroft, 2005). Therapeutic dosing is highly variable and depends upon patient feedback and self-reporting. The therapy is reversible, and a cessation of injections will allow a male's natural hormone balance and sex drive to resolve itself to pre-intervention levels (Thibaut, 2010).

Manipulating hormones can have unforeseen health consequences due to the role and widespread influence of these hormones within the body. Hormones exist within the body's endocrine system, which is responsible for regulating "growth, metabolism, and sexual development and function" [American Medical Association (AMA), 1998a]. Therefore, manipulating testosterone due to its role as the biological instigator of sex drive causes other changes by limiting the regulatory power of testosterone for other bodily functions.²² These changes have been well documented and can be classified as direct effects, or those that are related to sexual performance, or indirect effects, or those that arise over time, are unrelated to sexual performance, and may originate in other bodily systems.

The Direct Effects of Chemical Castration and How to Address Them

The first direct effect of chemical castration is erectile dysfunction (ED), or the inability to develop or maintain an erection. ED can be caused by a myriad of factors related to aging, psychology, and or physiology (Leiter, 1981). One

²² There is evidence that chemical castration influences the levels of other hormones within the body, which may contribute to these other changes as well (Meyer et al., 1985).

physiological factor known to contribute to ED is reduced testosterone (Rajfer, 2000). Whereas the role of age-related testosterone declines in erectile dysfunction has been questioned,²³ such hormonal fluctuations are widely regarded as responsible for sexual dysfunction among men undergoing castration therapy (Ibid.). Therefore, chemically castrated sex offenders will probably experience some degree of erectile dysfunction due to the therapy's reductive effects on testosterone levels. Furthermore, the extremely low testosterone levels achieved via chemical castration increase the likelihood that patients will experience a more severe form of erectile dysfunction (Ibid.).

While treatments are available that would mitigate the effects of castration-induced ED, whether we ought to use such treatments is another matter entirely. The erectile dysfunction drugs currently available, e.g. Viagra and Cialis, do not affect hormone levels, and so they could be prescribed to castrated offenders without the fear of reversing the endocrine effects of the therapy. That said, the efficacy of ED drugs in patients with low testosterone has been questioned (Roxby, 2010). Some may argue that castrated men ought not to achieve erections, as this may increase their ability to reoffend. While this is a valid concern, it is of note that some sex offenders may desire a sexual relationship with a consenting adult after a certain degree of psychological treatment has been reached.²⁴

²³ For the male not undergoing hormonal therapies, testosterone is believed to be a very rare cause of ED (Rajfer, 2000).

²⁴ Determining when this "certain degree" is reached is a matter of clinical judgment and is beyond the scope of this thesis.

Illustrating this point is one published case in which an offender went on to engage in a consensual adult relationship after three years of ongoing and intensive sex offender rehabilitation at the Rosenberg clinic in Galveston, Texas (Emory, Cole, & Meyer, 1992, p. 131-132). Because the offender had been taught to carefully monitor his desires and avoid further offenses, this relationship ultimately resulted in cohabitation. Though the offender's experience with side effects at the time of this relationship were not known, it is reasonable to assume that he experienced some degree of ED due to his ongoing treatment with chemical castration. Another published case describes the deliberate premature reduction in medroxyprogesterone acetate (MPA) dosage by clinic staff in an offender who experienced "significant marital problems attributed to impotence" (Meyer, Walker, Emory, & Smith, 1985, p. 103). Both of these cases illustrate how the use of ED drugs may prove beneficial for establishing or maintaining adult relationships.²⁵

The second direct effect of castration is infertility. While chemical castration leaves the testes intact, sperm production is nevertheless affected due to testosterone's crucial role in the male spermatogenesis cycle: MPA reduces testosterone, which then is less effective in triggering the production of sperm (Sharpe, 1987; Meyer et al., 1985). The infertility associated with chemical castration is limited: while the offender's sperm count can be expected to decrease with MPA administration, it will not be altogether eliminated. The sperm that are produced under these conditions will also suffer in quality: what sperm are

²⁵ The quality and appropriateness of these relationships can be debated, but such a discussion is beyond the scope of this thesis.

produced have been shown to be less motile and exhibit a higher rate of abnormality than the sperm cells created in individuals not undergoing castration treatments. Despite this, researchers have recorded several incidents of offenders who were able to father children during their MPA therapy (Meyer et al., 1985). Discontinuing MPA injections will allow the body to restore its prior hormone levels and thus begin producing sperm once more at pre-intervention levels, though it can take up to two years for these levels to be fully restored (Liu, Swerdloff, Christenson, Handelsman, & Wang, 2006). No significant treatment options have yet been proposed to mitigate the effects of castration upon fertility.

The Indirect Effects of Chemical Castration and How to Address Them

The indirect effects of reduced testosterone in men have been well documented, with the majority of the literature originating from research on metastatic prostate cancer. These patients' treatment often includes hormonal therapy to reduce testosterone, which has the same functional effects as chemical castration (Smith et al., 2001). While these patients are the most convenient to study due to their availability to physician-researchers, there is also a small body of literature on the physiological changes observed in surgically and chemically castrated men over time.²⁶ Furthermore, research on normal testosterone declines due to the aging process may also shed light on how castration may affect sex offenders who receive such treatment.

It is normal for human sex hormone levels to diminish slowly with age, leading to menopause in women and an analogous process in men. Though the

²⁶ Examples of reports consulted for this thesis include historical retrospectives of groups of eunuchs as well as accounts of the health problems reported among surgically and chemically castrated sex offenders.

appropriateness of the term has been criticized, this analogous male process has been given the moniker andropause (Thompson, Shanafelt, & Loprinzi, 2003). Andropause is a common side effect of chemical castration, in which testosterone levels decline at a significantly faster rate than that experienced during normal aging (Giltay & Gooren, 2009; Gooren, 2011). For this reason, andropause is the first indirect effect of chemical castration.

Among the most common physical symptoms of andropause are hot flashes, hair loss, fatigue, and reduced physical strength due to reduced muscle mass (Thompson, Shanafelt, & Loprinzi, 2003). Bone loss is another common side effect of andropause, and has been linked specifically with the use of MPA and its chemical peers. The sites most greatly affected with bone loss are the spine, hip, and forearm, with significant loss being detectable as early as within one year of the onset of castration treatments (Giltay & Gooren, 2009). A reduction in bone mineral density increases the chance of fractures and can be associated with changes such as reduced height and alterations of posture and/or skeletal alignment. Indeed, one study of eunuchs reported that the most immediately apparent physical manifestation of castration among the subjects observed was extreme hunching of the back, which was attributed to a combination of weakened skeletal structure and reduced supportive muscle mass (Wilson & Roehrborn, 1999).

Hormone replacement therapy is a valued option for those experiencing the negative effects of these age-related disruptions in sex hormone production: it replaces lost hormones and allows men to return to their prior level of functioning

(Snyder et al., 2000). Unfortunately, hormone replacement therapy is not available to castrated sex offenders because synthetic testosterone supplementation would reverse the effects of the castration and thus render it ineffective (Gooren, 2011). Instead, sex offenders experiencing castration-induced andropause must rely solely on palliative methods to manage the symptoms that arise due to their hormonal fluctuations.

Chemical castration has also been linked with psychoneurological changes including increased depression and anxiety and decreased cognitive function over time (Almeida et al., 2004; Thompson et al., 2003). These side effects tend to resolve themselves with the cessation of castration treatments, but must be taken seriously. Further exacerbating the development of these disorders is the fact that many paraphiliac offenders suffer from preexisting comorbid psychological disorders including mood disorders, depression, bipolar disorder, anxiety disorder, impulse control disorder, and avoidant personality disorder (Dunsieth et al., 2004). It is therefore crucial for paraphiliac offenders starting castration therapy to undergo psychological screenings to identify those who are at greatest risk of developing new or intensified mental health problems during treatment (Giltay & Gooren, 2009).

Aside from the physical and psychological effects of castration, research has shown that the procedure can lead to life-threatening health consequences. Several researchers have identified unhealthy changes in cholesterol and blood pressure levels among castrated men over time (Meyer et al., 1985; Giltay & Gooren, 2009; Gooren, 2011). These changes increase the risk of developing

Type II diabetes and heart disease, with the latter being statistically more deadly when it develops than when it is found in the general population (Giltay & Gooren, 2009). Two proposed intermediary factors involved in the development of diabetes is an increase in body fat and weight, which are common among men who have been recently castrated (Meyer et al., 1985). These changes lead to insulin resistance, a diabetes precursor. Basic medical knowledge would suggest that this weight gain also contributes to the noted changes in blood pressure; however, systolic pressure has been shown to increase independently of weight gain, the latter of which may then exacerbate such blood pressure changes (Ibid.).

Meta-analyses of research on the side effects of castration have shown that the treatment causes serious, systemic bodily changes over time, with the risk and severity of any of the abovementioned complications increasing with the duration of treatment (Gooren, 2011; Giltay & Gooren, 2009). That said, multiple interventions have been proposed to mitigate these side effects in order to limit the health consequences of castration in the offenders who may otherwise benefit from such an intervention.

Osteoporosis and muscle loss, though serious, can be managed through pharmaceutical interventions and lifestyle changes. To address osteoporosis, Smith et al. (2001) have identified pamidronate as an effective compound in preventing bone loss. This finding was intended for use among men undergoing treatment for prostate cancer, but it may also be applicable within this context where bone loss as a result of reduced testosterone is a concern. To mitigate muscle loss, offenders may alter their diets to support muscular tissue growth as

well as engage in weight training to strengthen and rebuild lost muscle (Thibaut et al., 2010).

The psychoneurological symptoms associated with castration may be addressed in part via pharmaceuticals for any depression and/or anxiety that may arise as well as through psychotherapy (Ibid.). If castration is administered in accordance with current recommendations, i.e., as a treatment complementary to ongoing psychotherapy, many offenders will have the opportunity to take advantage of mental healthcare to treat any affective disorders that emerge during treatment. Furthermore, this ongoing clinical relationship will allow mental health providers to more easily assess any important changes in their patients' mental status if and when they arise.

Changes to lipid profiles and the increased risk of diabetes and heart disease can be effectively addressed via the administration of the statins and/or anti-diabetic medications currently approved for such use (Giltay & Gooren, 2009). The prevention of such conditions can be aided through proper nutrition and exercise, much as in the case of addressing osteoporosis and muscle loss.

Given that offenders undergoing castration are exposed to a great number of side effects and experience an increased risk of several serious health complications, it is essential that they be closely monitored by medical personnel throughout the duration of castration treatments (Ibid.; Gooren, 2011; Thibaut et al., 2010). This monitoring ought to include the gathering of thorough medical histories for each offender prior to the start of treatment as well as clinical reassessment and/or blood work every six months thereafter. The detailed

recommendations for the medical management of chemically castrated sex offenders, as proposed by Giltay & Gooren (2009), are as follows:

Risk assessment before the initiation of [chemical castration]:

- History taking: prior fractures, prior cardiovascular events, family history of osteoporosis and cardiovascular disease, alcohol consumption, and smoking habits
- Rule out or treat affective disorders
- Advise lifestyle modification, including weight-bearing exercise, healthful dietary pattern, and abstinence from smoking and excessive alcohol use
- Physical examination: especially weight, height, blood pressure
- Complete laboratory screen, with fasting glucose (to detect incident diabetes), lipid profile, hemoglobin, and hematocrit level
- DEXA²⁷

Clinical assessment after the initiation of [chemical castration]:

- History taking and physical examination (every six months): especially evaluate for signs and symptoms of weight gain, hypertension, hot flushes, depression, emotional disturbances, and other constitutional symptoms
- Laboratory examination: fasting glucose, lipid profile, hemoglobin, and hematocrit level
- DEXA (every one or two years) (p. 57)

Examining Patient Burden and Conclusion

Long-term chemical castration is associated with several potentially serious and life-threatening side effects. While these side effects can be severe, the existence of effective pharmaceutical interventions and lifestyle changes that mitigate them should not be discounted. As was stated in the beginning of this chapter, most medical treatments carry at least some risk of side effects. The mere existence of these side effects ought not limit the use of effective therapies, of which chemical castration is one. Instead, efforts ought to be made to ensure that chemical castration is administered in the safest way possible: by conducting

²⁷ Shorthand for dual-energy x-ray absorptiometry, a bone density scan.

regular clinical reassessments of castrated offenders, treating physicians can maximize the therapy's anti-recidivistic effects and minimize its side effects.

The question of patient burden was raised at the beginning of this chapter. The word burden was used to refer to the short- and long-term health and lifestyle consequences associated with maintaining ongoing castration therapy.²⁸ If the side effects associated with chemical castration were unavoidable and untreatable, then the therapy would place a serious health burden on the offender via unpleasant side effects and long-term complications. Still, if a paraphiliac offender and his physician determined this to be an appropriate therapy despite the risks, then perhaps this burden would be appropriate. Fortunately, the side effects of castration are largely avoidable and treatable. This greatly reduces the overall health burden associated with the treatment and supports the therapy's value for the paraphiliac offenders who seek it (and potentially for the sex offenders bound by court order).

In order to avoid some of the more serious side effects of castration and in accordance with the treatment recommendations listed above, offenders may be prescribed dietary and lifestyle changes in addition to vitamin supplementation and other drugs over the duration of castration therapy. For the unlucky offender who shows signs of multiple chronic side effects, this may mean the introduction of several medications per day into his daily routine. At the point where the steps taken to manage the side effects of chemical castration begin to resemble those

²⁸ While this chapter focuses on health and lifestyle burdens, this is hardly an exhaustive list. Other potential burdens of chemical castration include the financial and scheduling costs of maintaining regular MPA injections and follow-up medical care. A discussion of these factors is beyond the scope of this thesis.

taken to manage a chronic disease, a new form of burden arises—a lifestyle burden.

Similar to health burdens, the lifestyle burdens of daily self-care may be justified when an offender and his physician determine that they are outweighed by the benefits of castration. But what about the offender who has received a court order to undergo chemical castration? This offender undergoes no such burden-to-benefit balancing and is instead required to receive a treatment that will surely require a certain level of ongoing self-management. This court order effectively prescribes any of the treatment correlates that may arise through the duration of chemical castration in addition to the castration itself. In other words, courts that order chemical castration for a sex offender in effect sentence that offender to years of ongoing medical care and management. These sentences are extremely burdensome and ought not be issued without both the offender's consent and the consultation of a physician trained in managing chemical castration.

The current retributive approach to chemical castration does not recognize the burdens created by long term therapy: because the courts order castration as a punishment for crimes committed, the lifestyle and/or health burdens associated with such a punishment fall by the wayside. But when we consider castration within the rehabilitative context, these issues once again become important. Thus, by adopting a medical treatment that requires intensive follow-up care into a rehabilitative context, all consideration for how one ought to monitor the patient and encourage the treatment's efficacy is lost. It would seem, then, that effective

chemical castration and punitive chemical castration are mutually exclusive terms. This is only further supported by the failure of the current castration statutes to reflect the treatment standards in the literature. These failures will be discussed in the next chapter.

CHAPTER 3: CASTRATION STATUTES

The use of chemical castration as a treatment for paraphiliac sex offenders began in the United States in 1966 (Scott & Holmberg, 2003). For the following thirty years, several standalone chemical castration programs served the paraphiliac sex offenders who sought treatment by providing a combination of medroxyprogesterone acetate (MPA) and intensive talk therapy. These offenders enrolled in castration therapy via self-referral or referral by family members, physicians, attorneys, or the courts (Emory, Cole, & Meyer, 1992; Kravitz et al., 1995). The programs treated patients on a completely voluntary basis, with some offenders who objected to pharmaceutical treatments serving as the controls in subsequent research (Emory, Cole, & Meyer, 1992). Despite these existing castration programs, media coverage of several child abductions and murders, combined with the new retributive approach to criminal justice, led to significant public outcry by the mid-1990s (Stadler, 1997). In an attempt to respond to this outrage and, more specifically, the 1993 death of twelve-year-old Polly Klaas, California became the first state to pass a castration statute in 1996 (Ibid.; Scott & Holmberg, 2003). Three states followed suit within the following three years, and by the mid-2000s nine American states had legislated the use of chemical and/or surgical castration for sex offenders (Scott & Holmberg, 2003). This chapter includes a discussion and analysis of the purpose and nature of these statutes as compared with current recommended practice among mental health professionals involved in castration programs.²⁹

²⁹ Several attempts have been made to summarize domestic castration laws within the past decade. The most notable of these can be found in Scott & Holmberg, 2003 and Scott & del Busto, 2009. Due to the fact-based nature of these summaries, these texts and what follows are similar in content.

The Intertwining of Treatment with Retribution

When California governor Pete Wilson signed the first state bill on castration into law, he issued a statement that became indicative of the mindset behind that and all future statutes on the matter:

I have a message for those skulking in the shadows. You better stay in the shadows or leave this state, because we will not tolerate your conduct...We are going to win this fight. We are not going to concede one inch of any playground in any neighborhood to vicious predators...Child molesters can't stop because they have a compulsion to do what they do...And as long as they have that urge, they'll keep on victimizing children—unless we do something about it. (Stinneford, 2006, p. 577)

This mixed message is one of retribution and treatment, attack and intervention. While the first two phrases speak of the pathological predator who willingly stalks his (young) victims, the latter two speak more of the profile of a true paraphiliac: compulsive and driven by urges rather than willful decision. This aligning of contradictory criminal motives eliminated the distinction between the paraphiliac offender (and more specifically, the pedophile) and every other type of sex offender previously acknowledged in the mental health and criminal justice literature. It undermined decades of research on paraphilias and the efficacy of castration and also satisfied the ill-informed public that demanded action. This statute and the eight that followed it are the end product of several lawmakers' prioritization of public demand over scientific reality.

In what follows, I will discuss the seven castration statutes still in effect today and how they fail to meet the recommendations set by mental health professionals over the past several decades. I will argue that these statutes are written so poorly as reduce the state's ability to deliver effective castration therapy, thereby removing them from the realm of rehabilitation and giving them the illusion of punishment. I will then condemn

the use of chemical castration within this punitive context on the grounds of its unconstitutionality.

United States Statutory Review³⁰

Between 1996 and 2005, nine American states enacted castration statutes: California, Florida, Georgia, Iowa, Louisiana, Montana, Oregon³¹, Texas, and Wisconsin. These laws addressed the conditions sufficient to allow or require sex offenders to undergo castration, despite the fact that the treatment was already available in some locations without the existence of a law on the matter. Since 2005, two of these statutes have since been repealed. Georgia repealed its castration statute in the 2006 legislative session (Georgia General Assembly, 2006), while Oregon did the same in 2011 (Oregon Legislative Assembly, 2011). The remaining seven statutes have unique standards with regard to three crucial aspects of the administration of castration. These three major points of variability are the crimes that render an offender eligible to undergo castration, which form(s) of castration are permissible, and on what basis (voluntary, discretionary, or mandatory) castration shall occur. Other points of variability include which drugs are acceptable agents to use in chemical castration, when chemical castration treatments ought to begin, and the relationship between undergoing castration and the duration of imprisonment and/or parole eligibility (Scott & Holmberg, 2003).

In California, an offender is eligible for discretionary (i.e. to be determined by the presiding judge) chemical castration upon a first sexual offense and mandatory chemical castration upon a subsequent sexual offense if the victims of these crimes are younger than thirteen years of age. The qualifying offenses named in this statute include sodomy

³⁰ The full text of these statutes appears in the Appendix.

³¹ Oregon's castration statute was unique in that it established a chemical castration pilot program for a limited number of sex offenders. When the program was completed, the law establishing it was repealed.

and/or the aiding and abetting thereof, lewd and lascivious acts with force or menace, oral copulation and/or the aiding and abetting thereof, and sexual penetration with a foreign object (see Appendix). California's discretionary and mandatory chemical castrations are induced via MPA "or its chemical equivalent," but offenders may elect to undergo voluntary surgical castration as an alternative. In the case of chemical castration, initial injections must begin one week prior to the offender's release from custody. The duration of such treatments is determined by the state (California Penal Code, 2012).

In Florida, sex offenders are eligible to undergo chemical castration via MPA following a conviction of sexual battery, regardless of the victim's age. Upon a first conviction, chemical castration may be prescribed on a discretionary basis; thereafter, MPA treatment becomes mandatory. Chemical castration may in no way replace or reduce other punishments sentenced in association with the conviction of sexual battery. Like in California, offenders may choose to undergo surgical rather than chemical castration. MPA treatments are contingent upon approval by a court appointed medical expert, must begin at least one week prior to the offender's release from custody, and must continue for a duration set by the court's discretion. Noncompliance with court ordered chemical castration is a second-degree felony (Florida Statutes, 2012).

Iowa's castration statute applies to sex offenders whose victims are younger than thirteen. Under this law, offenders convicted of a "serious sex offense"³² are eligible for chemical castration on a discretionary basis upon a first offense and a mandatory basis thereafter unless the court finds that such treatment would be ineffective. Chemical castration may be achieved through the use of MPA or an alternative "approved

³² I.e. sexual abuse, lascivious acts, assault with intent, indecent contact, lascivious conduct, and sexual exploitation (Iowa Code 903B.10(3)).

pharmaceutical agent.” Offenders may choose to undergo surgical castration as an alternative to its chemical counterpart. Chemical castration must begin prior to the offender’s release from custody, and if the offender is not in custody at the time of the determination to undergo treatment, then such injections must begin as soon as possible (Iowa Code, 2011).

The Louisiana chemical castration statute targets the perpetrators of aggravated rape, forcible rape, second-degree sexual battery, aggravated incest, molestation of a juvenile under the age of thirteen, and/or aggravated crime against nature. Upon a first offense, MPA treatment is discretionary; MPA is mandatory upon any subsequent offenses. MPA treatment may not replace or reduce any other court-ordered punishments, and offenders may petition the court to undergo surgical castration rather than MPA treatment if they so desire. Like in Florida, all MPA sentences are contingent upon the determination by a medical professional that such therapy is appropriate. Such determinations must be made within sixty days of the delivery of an MPA sentence, and MPA is the only pharmaceutical agent recognized for this use. Courts determine the ultimate duration of MPA therapy, and noncompliance with court-ordered MPA treatment is grounds for imprisonment (Louisiana Revised Statutes, 2012).

Montana’s castration statute is entirely discretionary. It targets first offenders who are at least three years older than their victims and who commit sexual assault, sexual intercourse without consent, or incest against victims younger than sixteen as well as offenders convicted of any second sex-based offense. Montana recognizes the use of MPA “or its chemical equivalent or other medically safe drug treatment that reduces sexual fantasies, sex drive, or both” as treatment options for chemical castration.

Offenders not sentenced to chemical castration may elect to undergo this procedure, and no treatment may be given without fully informing the offender of the treatment's effects. Castration treatments must begin one week prior to release from custody and continue according to the department of corrections' discretion. Individuals who fail to comply with court ordered chemical castration programs will be found in contempt of court. Montana does not recognize surgical castration as an alternative to its chemical counterpart (Montana Code Annotated, 2011).

The Wisconsin castration statute is vague compared to those of the other states listed. According to state law, offenders convicted of sexual assault against a victim younger than sixteen may be ordered to undergo "pharmacological treatment using an antiandrogen or the chemical equivalent of an antiandrogen" as a condition of their parole. The Wisconsin statute does not distinguish between first and subsequent offenses, as all are subject to a castration sentence at the court's discretion. Furthermore, probation and parole decisions may not be made based on a sex offender's perceived eligibility or expressed willingness to undergo such pharmacological treatment. The statute omits guidelines for the timing or duration of such treatments as well as informed consent thereto (Wisconsin Statutes, 2012).

Texas is unique in that it is the only state whose castration program is both entirely voluntary and limited to surgical castration. Sex offenders may elect to undergo surgical castration only if they are repeat offenders with victims younger than seventeen who have been convicted of continuous sexual abuse, indecency, sexual assault, and/or aggravated sexual assault. Sex offenders must also meet the following criteria in order to undergo surgical castration: be at least twenty-one years of age, request castration in

writing, provide a written admission of guilt for all convicted sex crimes, be evaluated and counseled by a court-appointed psychologist or psychiatrist, complete a written informed consent document, and meet with a monitor familiar with mental health, law, and ethics to discuss the procedure. Offenders' castration status may not have any bearing on probation or parole considerations. Finally, offenders are entitled to change their minds at any point leading up to the procedure, but this change renders the offender ineligible to seek it in the future (Texas Government Code, 2011).

Statutory Trends in America and Abroad

As illustrated by the above descriptions, the castration laws in the United States are anything but standardized. There are, however, some general trends across states. First, crimes against minors and repeat offenses are considered particularly relevant to justify a castration sentence. Surgical castration is entirely voluntary, whereas chemical castration is often either mandated by law or ordered at the discretion of individual courts. State laws that address the timing of treatments agree that these should be performed prior to the release of the sex offender. Finally, states that address failure to comply with court ordered castration agree that it such dissent is grounds for reincarceration. The last major trend among states is silence: no state currently releases any sort of regular report on the use or success of its castration statute, and the limited outcome data that exists comes from Oregon's now-defunct pilot program and Florida, where castration is ordered in only ten percent of the cases where it is statutorily required (Stinneford, 2006, p. 582).

Castration of sex offenders has gained significant press coverage in the United States over the years, but there has been a slowing in the adoption of new state policies

since the early 2000s.³³ With the recent repeal of castration laws in Georgia and Oregon, it would appear that the states are moving away from the use of these interventions. This might appear to some to be evidence of the antiquated nature of the punishment, but a cursory search of the global trend of castration law adoption would beg to differ. Where castration in the United States is less of an immediately pressing matter, several nations in Europe, Asia, and elsewhere are just now adopting and enforcing new castration policies.

Like American castration laws, those found abroad tend to prescribe surgical or chemical castration on a discretionary, mandatory, or voluntary basis. Foreign statutes do not require forced surgical castration, but some nations permit mandatory chemical castration. The list of nations with existing castration statutes includes Canada, Argentina, Germany, Poland, the Czech Republic, Great Britain, Denmark, Sweden, Moldova, Estonia, Israel, Australia, New Zealand, and South Korea, among others (“Chemical castration,” 2006; Sinha, 2011; “Germany urged,” 2012), with the Estonian and Moldovan laws being passed within the past six months (“Moldova votes,” 2012; “Estonian parliament,” 2012). Russia and Lithuania are currently considering legislation on the matter, but bills introduced in Turkey and France have been unsuccessful (“Lithuania moves,” 2012; “Moldova votes,” 2012). The adoption of castration laws abroad is not without controversy, however, as Germany and the Czech Republic have been condemned by the Council of Europe’s European Committee for the Prevention of

³³ This is not for lack of trying. Representative Steve Hurst of Alabama has introduced a castration bill into the state House at least three times since 2007, to no avail. When asked to comment on his persistence, he stated that, “If I can’t pass this, I’ll keep bringing the [victim] age down to where it would be utterly ridiculous to not pass it. Kids this young can’t defend themselves, so somebody needs to” (Taylor, 2009). In Virginia, Senator Emmett Hanger proposed legislation in 2011 that would have required that research be conducted on the use of physical castration among violent sex offenders. The bill passed the Senate before stalling in the House (Virginia Senate Bill 1470, 2011).

Torture and Inhuman or Degrading Treatment or Punishment (CPT) due to human rights concerns regarding their mandatory chemical castration policies (CPT, 2009; CPT, 2012).

Criticism of American Castration Statutes

Castration laws are plagued with several serious problems, the greatest being that the desire for retribution against sex offenders largely blinded lawmakers to the existing scientific literature regarding sexual offenses, sex offenders, and the appropriate use of castration therapy. In an attempt to respond to public opinion and appear tough on crime, legislators produced statutes that are over- and under-inclusive in terms of the offenders to be treated and the provisions for maintaining such treatment.

From the beginning of its use within the United States, castration for sex offenders has been largely limited to paraphiliac offenders (Thibaut, 2010). As was discussed in the first chapter, paraphilias exist in many forms, including the sexual attraction to children (i.e. pedophilia) and arousal at exposing ones genitals to unsuspecting strangers (i.e. exhibitionism), among others (APA, 2010). Paraphiliacs are the only subpopulation of sex offenders believed to benefit from castration therapy, and it is only effective when administered with concurrent talk therapy and for the duration of MPA injections (Berlin & Meinecke, 1981; Walker et al., 1984; Thibaut et al., 2010).

The trend among American statutes to limit castration to offenders whose victims are minors seems to be an attempt to target only pedophiles. This omits the remaining paraphilias from the reach of these statutes and instead focuses on what appears to be a particularly reviled group of sex offenders. This move was probably made in response to the public outrage at crimes against children that spurred the creation of these laws.

Perhaps this would be an understandable move if the resultant statutes successfully targeted this group of offenders. Unfortunately, they do not.

The biggest mistake these statutes make is that they are over-inclusive in the sex offenders they target by identifying offenders based on the nature of their crimes rather than their individual pathologies. As was stated previously, not all sex offenders who abuse children are paraphiliacs (Stinneford, 2006). By targeting offenders for state-sponsored castration based on their victims' age rather than their motivations to offend, it is inevitable that non-paraphiliac offenders will be sentenced to castration therapy. These types of offenders are believed to be unresponsive to castration (Berlin & Meinecke, 1981; Money & Bennett, 1981; Walker et al., 1984; Weinberger et al., 2005); therefore, the chemical castration statutes will undoubtedly lead to the ineffective use of this treatment in at least some cases.

A related statutory problem is the under-inclusiveness created by the omission of the term "paraphilia" from any of the seven state laws currently in effect. This is a major oversight when legislating a treatment specifically intended for this population. By omitting this term, the existing statutes overlook every form of paraphilia other than pedophilia despite ample research supporting the use of castration in these cases (Thibaut et al., 2010). It may be argued that the crimes committed as a result of exhibitionism, frotteurism, or any other paraphilia cause less of a societal burden or are less repugnant than pedophilia and therefore need not be addressed by these statutes. However, since research has suggested that offenders suffering from one form of a paraphilia may develop different ones in the future, this assertion lacks foresight (Walker et al., 1984; Abel, Becker, Cunningham-Rathner, Mittelman, & Rouleau, 1988). Furthermore, it

poses the risk of delaying effective treatment until a paraphiliac commits a sufficiently troubling crime, when proper vigilance could otherwise provide therapy at an early point in the offender's trajectory.

The existing American statutes further fail in that they do not reflect the necessary level of understanding of how castration therapies work. For example, several of these laws specify that castration therapies commence prior to the offender's release from custody. This is a prudent decision that reflects the knowledge that these treatments do not have an immediate effect. Rather, it is important to allow adequate time for testosterone levels to adjust in order to render the treatments effective prior to the offender's release. But how much time is adequate for this adjustment to take place? According to a meta-analysis of thirteen studies, it can take one to two months for an offender's maladaptive sexual behavior and fantasies to disappear (Thibaut et al., 2010, p. 622). Why, then, do the states whose statutes address the timing of treatment only specify that it should begin between one and six weeks prior to a release date? This is a serious failure on the part of policymakers to create truly effective legislation.

The next major problem with the current American statutes is that they tend to ignore the existing recommendations for ensuring the long-term efficacy and safety of castration therapy. As was discussed in chapter one, castration must be administered in conjunction with intensive counseling in order for offender recidivism rates to drop (Thibaut et al., 2010). Furthermore, as was discussed in chapter two, ongoing medical follow-up care is crucial to manage the serious side effects such treatment may cause (Giltay & Gooren, 2009; Gooren, 2011). Despite this, none of the existing statutes require mental health counseling for castrated offenders and the four (in Florida, Iowa,

Louisiana, and Texas) that mention any sort of medical oversight only require it to assess the therapy's appropriateness before it begins (Scott & Holmberg, 2003). It is possible that these recommendations are being followed in practice, but such a statement cannot be corroborated considering the absence of state-issued reports on the use and outcomes of their punitive castration programs.

As was mentioned in the previous chapters, it is difficult to determine the exact duration of chemical castration therapy necessary for sex offenders because of the risk of recidivism following its cessation. While this duration has been proposed to last at least two to five years (Thibaut et al., 2010, p. 648), others have suggested that lifelong therapy may be a safer option given what is known about the termination of treatment (Stinneford, 2006). No existing state law sets a specific duration for castration therapy, though every statute other than Wisconsin's states that it ought to continue until it is determined to no longer be necessary. This raises serious questions as to how a currently treated offender might be judged to no longer pose a risk, as well as how such a termination decision might be made. The answers to these questions remain a mystery until states become more forthcoming with details on the day-to-day operations of their statutory castration programs.

The castration statutes fail to reflect an understanding of how to ensure the efficacy of castration for paraphiliac sex offenders, but perhaps a bigger flaw is that they allow judges to practice medicine. Despite not being medical professionals and accordingly having no authority or training to diagnose or treat medical conditions, judges are able to use these laws to prescribe a specific treatment. Prior to the passage of these laws, judges could refer offenders to MPA programs and/or require that they enroll

in sex offender treatment programs. In either case, the determination of whether or not MPA therapy was appropriate was made by the medical staff within these programs. Since the passage of these laws, however, states have permitted the courts to skip this step and have thus given judges prescribing power they are not licensed to have. The pre-castration medical approval requirement in the statutes of Florida, Iowa, Louisiana, and Texas limit this prescribing power, but such authority continues to go unchallenged in California, Montana, and Wisconsin. This is a serious abuse of power that ought not be permitted.

By now it should be clear that the current castration statutes are poorly drafted and over- and under-inclusive in terms of the sex offenders they target. These problems call into question the therapeutic validity of this treatment for the offenders ordered to receive it. Considering the retributive social context that inspired the drafting of these laws (see chapter one), one could defend the statutes on the grounds that statutorily based castration orders are not made to be therapeutic, but to be punitive. In this case, judges are not technically prescribing treatment under these laws, but rather are issuing a criminal punishment. According to this argument, the failure of the laws to reflect current castration recommendations is irrelevant—if the goal is to use medical interventions solely as punishments, then the legal system need not worry about assuring that such interventions are administered in an effective manner. In other words, by transforming the therapy of chemical castration into a punitive retribution, one can reject the standards of therapy commonly prescribed to accompany castration. This move would then justify how the statutes target offenders based on offense rather than

pathology—if the goal is retribution, then it makes sense to castrate the offenders who commit the most reviled sex crimes.

The biggest problem with this argument is that it is easily challenged on the grounds of its unconstitutionality. Indiscriminate and unregulated chemical castration would be both ineffective³⁴ and dangerous³⁵ for at least some of the offenders sentenced to undergo it. The severe health risks and arbitrary assignment of chemical castration under this retributive model qualifies it as a cruel and unusual punishment in violation of the United States Constitution’s Eighth Amendment (Stadler, 1997; Bund, 1997; Stinneford, 2006; Lombardo, 1997). Furthermore, punitive castration as currently prescribed by the law infringes upon the offender’s reproductive freedom,³⁶ fails to treat similar crimes similarly, and violates the offender’s right to decline medical treatment. These factors violate the Fourteenth Amendment’s Due Process and Equal Protections Clauses (Stadler, 1997; Meisenkothen, 1999; Neach, 1997).³⁷

In order for chemical castration to uphold constitutional safeguards, it must be approached as a therapy. The existing chemical castration statutes have serious problems that may lead to the ineffective use of such treatment, and so these statutes must either be repealed or undergo extensive revisions so that they more accurately reflect how and when such treatments ought to be used. Courts should defer to the diagnostic and therapeutic authority of medical professionals and return to a model of referring offenders who may benefit from castration or other treatment to established sex offender rehabilitation or standalone MPA programs. There, professionals can fully evaluate

³⁴ In that it may be used in non-paraphiliac offenders.

³⁵ In that side effects may go unchecked and cause serious health problems.

³⁶ Recall that MPA affects sex drive as well as sperm count and quality (see chapter two).

³⁷ Please see the articles cited for a complete scholarly discussion on the constitutionality of punitive chemical castration.

individual offenders and develop customized treatment programs so as to ultimately reduce their recidivism risk. If these laws are revised, then they ought to be written to support judges' discretion in referring offenders to rehabilitation and/or MPA programs while stopping short of giving judges prescribing power.³⁸ The continued existence of these fundamentally flawed statutes as they exist today will do more to hinder effective use of chemical castration than it will to help it.

³⁸ Assuming that these programs follow current guidelines on safe and effective chemical castration, such a provision would indirectly ensure the pharmacological treatment of paraphiliac offenders only.

CHAPTER 4: BIOETHICS, PRINCIPLISM, AND CHEMICAL CASTRATION

One of the many concerns of the field of bioethics is that of patients' rights and ethical treatment. As such, chemical castration poses a bioethical problem due to its current use as a retributive punishment. In chapter one, a question was raised about whether or not patients can be treated ethically when medical treatments are administered in a manner that does not support their efficacy. This question captures the heart of the chemical castration dilemma as it pertains to bioethics, as in an attempt to address a set of repugnant crimes several statutes were created that limited the intervention's efficacy while creating a framework for its state-sponsored use. This chapter attempts to answer these questions of ethical treatment in the face of ineffective therapies. It contains a principles-based analysis of castration therapy within Beauchamp and Childress' interpretation of respect for autonomy, beneficence, nonmaleficence, and justice. Each principle is considered as it applies to the court-ordered, punitive context in place today as well as the voluntary, therapeutic one of the past. As a consequence of this analysis, I argue that castration is not ethically permissible as a punishment, but it is permissible as a therapy, and that society ought to return to a purely therapeutic model for chemical castration.

An Introduction to Principlism in Bioethics

Tom Beauchamp and James Childress are the co-authors of *Principles of Biomedical Ethics*, an important text in the field of bioethics. Beauchamp and Childress promote a principles-based bioethical theory, one that bases its moral considerations upon four principles—respect for autonomy, beneficence, nonmaleficence, and justice (2009). In an article discussing their theory and others, Beauchamp wrote:

Principles and rules in our approach are explicated on the model of W. D. Ross's account of *prima facie* duties: Principles are always binding *unless* they conflict with other obligations...When a conflict of norms³⁹ occurs, some balance, harmony, or form of equilibrium between two or more norms must be found; or, alternatively, one norm overrides the other. (1995, p. 183)

According to this form of ethics, people's actions would ideally abide by respect for autonomy, beneficence, nonmaleficence, and justice. However, Beauchamp and Childress recognize that there often may be conflicts between these principles. By labeling their four principles *prima facie* duties, the authors allow for situations in which certain principles may be limited or replaced by other more important ones. This particular safeguard is particularly relevant when considering the challenging case of chemical castration.

Given that conflicts are bound to arise, how exactly ought one achieve "some balance, harmony, or form of equilibrium" between two conflicting principles?

Childress and I handle this problem through an account of balancing and specification, both of which involve the exercise of judgment in resolving conflicts. We see no reason why judgment by appeal to general principles should be condemned as "subjective" or merely "intuitive"...From our perspective, these principles are not merely intuitive, and if an agent takes seriously the demands of the applicable set of principles and associated rules, then the judgments are neither subjective nor unprincipled. (Ibid)

Therefore, while Beauchamp and Childress' moral theory cannot give definitive answers to every conflict, their hope is that a thorough explication of the demands of their theory will lead to clear and objective resolutions.

Beauchamp and Childress's bioethical theory has not been universally accepted, though it remains one of the predominant approaches to bioethics today. Alternative theories include impartial rule theory, casuistry, and virtue ethics (see Beauchamp, 1995

³⁹ I.e. principles

for a description of these theories). Despite the existence of these alternative theories, principlism is favored in this thesis for its ability to highlight the issues surrounding chemical castration in a concise yet effective manner. Let us now turn to a principles-based discussion of chemical castration.

Respect for Autonomy

Autonomy is the concept of self-governance, according to which an individual is able to make personal decisions free of absolute external control. As Beauchamp and Childress introduce it, “Personal autonomy encompasses, at a minimum, self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice.” (2009, p. 99). An adult who exercises his or her autonomy when making a healthcare decision may research his or her options, consider the pros and cons of each, and ultimately determine which option to pursue in accordance with his or her needs. In so doing, the autonomous person takes an active role in the decision-making process and thereby influences his or own future.

Respect for autonomy is exhibited through the acknowledgement of others’ ability to make self-governing decisions as well as the act of supporting those decisions where possible (Ibid., p. 103). Beauchamp and Childress argue that respect for autonomy implies both a negative and positive obligation,⁴⁰ respectively: “Autonomous actions should not be subjected to controlling constraints by others...This principle requires both respectful treatment in disclosing information and actions that foster autonomous decision making” (Ibid., p. 104). Within the context of healthcare decision making, to respect the autonomy of a patient would be to not only allow the patient to make the

⁴⁰ A negative obligation is an obligation to refrain from doing something, where a positive obligation dictates action.

ultimate treatment decision for him- or herself but also to encourage the patient to seek the information necessary to make an informed decision or to provide such information oneself where appropriate.

The ability to act autonomously and/or to respect someone's autonomy is dependent upon the existence, use, and/or avoidance of several constructs. The three bioethical constructs related to respect for autonomy that are particularly relevant to the issue of chemical castration are capacity, or the individual's ability to make decisions, informed consent, or the authorization given based on the results of autonomous decision-making, and coercion, or extreme outside influences that prohibit autonomous decision-making (Ibid.). Other relevant considerations here include how autonomy ought to apply to a criminal cohort and how to balance the respect for offender autonomy with public safety concerns. A thorough explication of these constructs and considerations indicates whether or not chemical castration violates the principle of respect for autonomy and if so, whether such a violation is ethically permissible.

Capacity

Capacity refers to "whether patients or potential subjects are capable, psychologically or legally, of adequate decision making" (Ibid., p. 111). If they are not capable of such decisions, then the person's ability to exercise his or her autonomy is severely limited if not altogether absent. Furthermore, Beauchamp and Childress recognize that "our obligations to respect autonomy do not extend to persons who cannot act in a sufficiently autonomous manner" (Ibid., p. 105). This limitation extends to individuals who lack decision-making capacity. Indicators of this lapse in capacity include the inability to communicate choice, the inability to understand a situation, and

the inability to understand relevant information (Ibid., p. 114-155). In the absence of capacity, both medicine and the law permit others to make decisions on the incapacitated person's behalf.

The term "capacity" generally refers to medical scenarios, while "competence" is reserved for use in legal judgments (Ibid.).⁴¹ To illustrate this difference as well as provide examples of situations where decisions are traditionally made on behalf of the incapacitated, consider the following two scenarios. They employ capacity and competence judgments, respectively:

An elderly woman suffering from advanced Alzheimer's disease is unable to understand her recent diagnosis of cancer or to make and communicate a choice regarding her treatment options. Realizing the patient's lack of capacity, the physician defers to the patient's appointed healthcare agent to make these decisions on her behalf. In this situation, the physician makes a determination of incapacity and seeks out a surrogate decision-maker so that medical care may continue despite the patient's inability to make her own decisions.

Another case in which decisions are made on behalf of incapacitated individuals is involuntary commitment. In these situations, judges may commit individuals suffering from mental illnesses and/or substance abuse problems to medical treatment if these individuals pose a threat to themselves or others (NC Magistrates Association, n.d.). Such judgments are dependent upon the legal determination that the person in question is incompetent (Menninger, n.d). The justification for state intervention is based in part on the legal principle of *parens patriae*, which extends to the state the ability to protect citizens who cannot care for themselves (Botts, 2009).

⁴¹ Beauchamp and Childress use these two terms interchangeably.

Capacity and competence are crucial to the exercise of individual autonomy. When capacity is lost, law and medicine have historically permitted alternate decision-makers to make determinations on the incapable/incompetent person's behalf. Now consider court-ordered chemical castration, in which a judge orders treatment for an offender who has committed a certain crime (see chapter three). This process is distinct from other surrogate decision-making scenarios because it does not rely upon the loss of capacity. Furthermore, because competence assessments are not a factor in determining castration sentences, these laws effectively permit the overriding of existing competence.

Informed Consent and Coercion

Informed consent is “an individual’s *autonomous authorization* of a medical intervention” (Beauchamp & Childress, 2009, p. 119). An informed consent is valid if it meets five criteria: competence, or the ability to make decisions; disclosure, or the provision of relevant information by the informed party to the decision maker; understanding, or the decision maker’s comprehension of the given information; voluntariness, or the absence of absolute external influences to the decision-making process; and consent, or the agreement by the decision maker to take part in the process at hand (Ibid., p. 120). Within the therapeutic context of chemical castration, an autonomous paraphiliac offender who retains decision-making capacity may give or withhold his informed consent to undergo treatment.⁴² However, problems with the validity of informed consent arise within the punitive context of the current castration statutes. Even if we assume an offender’s competence and consent within this context,

⁴² The reliance upon voluntary informed consent to initiate therapy is prevalent throughout the early castration literature (Money, 1987; Emory, Cole, & Meyer, 1992).

that is if we assume that the offender is capable of making a decision and has done so, issues of disclosure, understanding, and voluntariness still arise.

Of the six states that currently have chemical castration statutes⁴³, three (California, Louisiana, Montana) require that there be a disclosure process prior to the initiation of castration injections (see chapter three). These states' requirements extend only to information regarding the side effects of treatment. Florida, Iowa, and Wisconsin's statutes make no mention of disclosure prior to chemical castration whatsoever (see Appendix). The problem with these disclosures as listed is that they mostly fail to reflect the information necessary to encourage autonomous decision-making via informed consent. If these offenders were seeking castration outside of a court-ordered context, they would surely want more information than simply which side effects to expect during treatment. For example, an offender may want to know how long such treatment will last, how long it may take before sex drive is reduced, and whether or not the drug administered will interact with other pharmaceuticals the offender is taking. These seem like crucial pieces of information, and yet the statutes in question fail to acknowledge them. Without further statutory specificity and/or better state reporting (see chapter three), we cannot assume that any additional information is being given beyond what is explicit in the text.

While providing information to offenders about castration prior to its initiation may fulfill one of the five criteria of informed consent, it is unrelated to the success of the subsequent criterion, understanding. No existing chemical castration statute addresses how to ensure that the offender understands the presented material (Ibid.). This is not unusual, as even physicians are not bound by such a strong duty. Rather, medical

⁴³ I am omitting Texas here because its statute only recognizes surgical castration.

personnel ought to support patient understanding using simple, clear instructions and explanations and providing an opportunity for the patient to answer questions (AMA Foundation, 2007). Whether this responsibility extends to the practitioners who administer punitive chemical castration is unclear, especially considering that ethical obligations may change within the context of court-appointed medical interventions (Beauchamp & Childress, 2009, p. 312-313). Without further state reporting, we cannot be sure of the extent of the offenders' understanding or of the efforts made by practitioners to support such understanding.

Voluntariness remains the biggest problem with court-ordered chemical castration as it pertains to informed consent. Sex offenders who undergo chemical castration via court order do not do so voluntarily.⁴⁴ Furthermore, the castration statutes of Florida, Louisiana, and Montana violate voluntariness by including safeguards that qualify as coercive. In Florida, noncompliance with court-ordered castration is grounds for a second-degree felony charge and sentencing consistent therewith; in Louisiana, noncompliant offenders are subject to reincarceration for three to five years; in Montana, these offenders can be charged with criminal contempt of court and incarcerated for ten to one hundred years (see Appendix). According to Beauchamp and Childress, "coercion occurs if and only if one person intentionally uses a credible and severe threat of harm or force to control another" (2009, p. 133). The threat of reincarceration by the courts in these states is credible, forcible, and intended to ensure offender compliance. For this reason, these statutes are coercive and fail to meet the voluntariness requirement of informed consent.

⁴⁴ A potential exception here would be if the sex offender agreed with the court order and desired the intervention, but even here the court order leading to castration would remain.

All things considered, informed consents given following a court mandate to undergo chemical castration most likely do not meet the five criteria for informed consent and therefore are not valid. Informed consent is the product of autonomous decision-making, and so invalid informed consent indicates a failure to respect autonomy. Considering the criminal context of chemical castration, is this failure to respect autonomy permissible?

Balancing Respect for Autonomy, Criminal Justice, and Public Safety

The concept of respect for autonomy is complicated when applied in the criminal justice system because this system functions by limiting autonomy (Kekes, 2011). Some examples of these limitations include incarceration itself and the requirements for sex offenders to join public registries and live a certain distance from schools or childcare centers (North Carolina Department of Justice, 2012). While these state policies limit autonomy, they are justified on the basis that the societal interest of protecting its citizens permits the infringement of this right to self-determination (Meisenkothen, 1999).

Based on these autonomy-limiting policies, it would seem natural to limit offenders' medical autonomy as well. Beauchamp and Childress support this argument through their acknowledgement that respect for autonomy is not an absolutely binding principle:

Respect for autonomy has only *prima facie* standing, and competing moral considerations sometimes can override this principle. Examples include the following: If our choices endanger the public health, potentially harm innocent others, or require a scarce resource for which no funds are available, others can justifiably restrict our exercises of autonomy. (1995, p. 105)

Because sexual abuse poses potential harm to the public, it may be permissible to limit sex offenders' autonomy by requiring chemical castration for certain offenders. In

theory, this would not be unprecedented: several scenarios currently exist in which medical procedures or protocols are authorized in the name of public safety and/or health. These examples include compulsory isolation of individuals with certain communicable diseases and the sentencing of drunk drivers to alcohol treatment programs. These examples share the following two features with court-ordered chemical castration: they are both medical interventions in that they seek to treat or prevent the spread of a diagnosable medical condition and they both apply regardless of an individual's capacity status. By examining how these examples compare with the case of court-ordered chemical castration, we can determine if chemical castration poses a particularly strong or inappropriate violation of an offender's autonomy.

In the United States, individuals diagnosed with certain particularly severe and/or communicable diseases may be subject to compulsory isolation. Federal law authorizes the government to order isolation of a person diagnosed with cholera, diphtheria, infectious tuberculosis, plague, smallpox, yellow fever, viral hemorrhagic fevers, SARS, or "flu that can cause a pandemic" [Centers for Disease Control and Prevention (CDC), 2012]. The isolation of sick individuals under this law infringes upon the patient's autonomy for the sake of public health. However, the provisions of this policy are limited in that they do not prescribe any form of pharmacological therapy for the treatment of the patient's disease. Rather, the scope of this intrusion extends only to the control of the patient's movement and contact with others. Patients under compulsory isolation may then refuse medical treatment so long as they retain the capacity to do so (CDC, 2010).

Individual autonomy is also limited in cases where drunk drivers are sentenced to undergo alcohol treatment programs. These programs are effective in reducing drunk driving recidivism rates (Taxman & Piquero, 1998). Court-ordered alcohol treatment is considered a component of the criminal sentence, and may in some cases replace or defer other forms of criminal punishment (Jefferson County Probation Department, n.d.). Treatment programs invariably rely upon the use of some form of mental health treatment. Noncompliance or refusal to complete court-ordered alcohol treatment is a punishable offense (Ibid.).

Compulsory isolation and court-ordered alcohol treatment are examples of situations in which individual autonomy is limited such that the state or federal government may require medical intervention. The differences between these two situations illustrate the different goals of public health and criminal justice autonomy intrusions, respectively. In the case of compulsory isolation, the desire to limit the spread of disease falls short of violating the patient's right to refuse medical treatment. This suggests that such an absolute violation of autonomy is not permissible within the context of public health. In the criminal sentencing of alcohol treatment, however, the offender is extended no such right. That speaks to a more permissive approach to limiting autonomy in criminal contexts.

The similarities and differences between court-ordered chemical castration, as well as the examples of isolation and alcohol treatment, shed light on the permissibility of autonomy intrusions in this case. The extent of the chemical castration autonomy intrusion more closely resembles that of forced alcohol treatment in that neither of these examples preserves the offender's right to refuse treatment. This makes sense, as both of

these treatments exist as a form of criminal punishment. Chemical castration is significantly different from forced alcohol treatment, however, in three major ways. First, court-ordered chemical castration has serious problems that question its therapeutic validity (see chapter three). Second, it is likely to continue for the duration of the offender's life (see chapter one). Third, it invariably causes some potentially severe side effects (see chapter two).

At first glance, the extent of the autonomy intrusion inherent in court-ordered chemical castration appears reasonable in comparison with that of other punitive medical treatments. However, the three major differences between court-ordered chemical castration and forced alcohol treatment set the former apart such that limiting autonomy to provide it would be a particularly strong abuse of power. Where Beauchamp and Childress' theory of bioethics allows for the limiting of autonomy for the sake of public safety, the measures introduced toward this end ought to be effective. The potential lack of efficacy of court-ordered chemical castration is problematic when added to its indeterminate duration and the severity of its potential side effects. Therefore, limiting autonomy to permit possibly ineffective court-ordered castration is unethical and ought not be done. Revising the existing American castration statutes in a manner that better reflects the recommendations for appropriate administration of castration therapy (see chapter one) would make the limiting of autonomy in this case permissible.

Beneficence

The principle of beneficence complements respect for autonomy because it is characterized by an increasing number of positive obligations on the part of medical professionals. Where respect for autonomy is primarily about acknowledging the

capabilities of another person, beneficence is more about how to actively approach the self-ruling other. According to Beauchamp and Children, the principle of beneficence “refers to a statement of moral obligation to act for the benefit of others” (2009, p. 197). Therefore, beneficence dictates that we ought to deliberately do good for others (Ibid.). Most if not all effective medical treatments are supported by the principle of beneficence: if an ailment can be treated, then medical professionals ought to take action to treat the ailment so as to improve the patient’s wellbeing. Much as it is a beneficent act to donate money to a charity, it is similarly beneficent for a physician to prescribe antibiotics to a patient with a bacterial infection. In both these cases, the person acting beneficently engages in an action that promotes good.

Considering its roots as an effective medical therapy, chemical castration may be seen as another tool through which one can act beneficently. Paraphilia is a diagnosable medical condition that can be effectively treated via castration and concurrent psychotherapy (see chapter one), and so to provide such treatment to individuals suffering from a paraphilia qualifies as a beneficent act. It would appear, then, that medical professionals ought to provide this treatment where appropriate.

On the other hand, the principle of beneficence does not obligate medical providers to provide ineffective medical treatments, because doing so fails to promote good. For example, consider the physician who prescribes antibiotics to a patient with a viral infection. This treatment is ineffective and does not promote good because it fails to treat the patient’s illness—viruses do not respond to antibiotics and so the illness will continue unabated.⁴⁵ Furthermore, the administration of this ineffective treatment may

⁴⁵ The administration of antibiotics to patients suffering from viral infections is an ongoing trend in medicine. It is not my intent here to condemn the actions of physicians who do this; rather, I am simply

actually cause harm by promoting the development of drug-resistant bacteria. In that it promotes no good and may potentially promote harm, ordering ineffective medical treatment is not a beneficent act.

Now let us consider court-ordered punitive castration as it relates to beneficence. As was discussed in chapter three, the current chemical castration statutes are written such that they do not support the treatment's efficacy. By targeting inappropriate sex offenders and omitting mention of the concurrent mental health treatment and medical supervision necessary to maintain this intervention (see chapter two), these laws prescribe a potentially ineffective medical treatment for the purpose of punishment (see chapter three). As in the case of the antibiotic prescribed to treat a virus, ineffectively prescribed punitive castration has no therapeutic value. Therefore, the existing chemical castration statutes fail to uphold the obligations of the principle of beneficence. Furthermore, the over- and under-inclusiveness of these statutes may actually cause harm by failing to target the sex offenders who would respond chemical castration.

Effective, therapeutic castration is a beneficent treatment while court-ordered, punitive castration is not. But what exactly are the goods that therapeutic castration promotes? The first such good relates to the paraphiliac offender. Paraphilias are a diagnosable mental disorder characterized by persistent and unrelenting sexual fantasies (see chapter one). These fantasies often serve as the primary motivation for the sex offenses committed by the paraphiliac offender. The primary good promoted by therapeutic chemical castration in paraphiliac offenders is the management of these underlying paraphilias. A secondary benefit of effective treatment is an increase in

arguing that such prescriptions are not beneficent from the standpoint of therapeutic validity. Whether these treatments promote good via patient reassurance and/or the placebo effect is beyond the scope of this thesis.

psychological and social wellbeing: because paraphiliacs often report that their condition causes psychological distress (see chapter one), it would follow that effective treatment would decrease these symptoms. Furthermore, several case studies in the castration literature discuss the treated paraphiliac's return to normal social functioning, which in some cases has led to consensual adult romantic relationships (Emory, Cole, & Meyer, 1992; Money & Bennett, 1981).

Another good promoted by the effective use of chemical castration is that of public safety. This intervention reduces paraphiliac sex offenders' recidivism rate by around fifty percent (Thibaut et al., 2010). As was discussed in relation to respect for autonomy, this matter of public safety is sometimes sufficient to limit individuals' autonomy and mandate treatment. However, considering the efficacy concerns raised in this and other chapters, it must be reiterated that the administration of ineffective (and therefore non-beneficent) treatments cannot justify this intrusion upon an offender. The principle of beneficence supports the use of chemical castration within a voluntary, therapeutic context, but it cannot do so within the flawed court-ordered, punitive context in existence today.

Nonmaleficence

Complementing the principle of beneficence is one of nonmaleficence, or the obligation to not inflict harm (Beauchamp & Childress, 2009, p. 151). Beauchamp and Childress define harm as the process of "thwarting, defeating, or setting back some party's interests" (p. 152). While the concept of harm can be defined very broadly, the authors focus on physical harms, e.g. pain or death, while acknowledging the existence of psychological and other harms (Ibid., p. 152-153). Examples of harms within the

medical context include negligent care by a physician and the refusal to provide life-saving care. The assessment of harms plays a crucial role in assessing court-ordered and therapeutic castration programs.

Most medical treatments and procedures carry a certain risk for harm via side effects and/or complications. The principle of nonmaleficence does not accordingly prohibit the use of these therapies; rather, it recommends a balancing of potential harms with potential benefits (Ibid., p. 150). Therefore, the harms associated with a medical therapy can be justified so long as the potential benefits of the treatment outweigh them (Ibid.). Accordingly, the side effects of castration (see chapter two), while harmful, do not violate the principle of nonmaleficence because a greater good, i.e. rehabilitation, is intended in the process. However, this only holds true so long as the procedures are carried out within the context of current medical practice and professional standards (see chapter one).

The greatest threat to the principle of nonmaleficence as it applies to offender castration is when such interventions are court-ordered on their own without acknowledgement of any greater rehabilitative goal. When judges make these decisions, their rulings can only be interpreted as punitive in intent because they fail to incorporate the measures needed to ensure the treatment's therapeutic validity. Given that chemical castration is known to be ineffective without concurrent mental health counseling, ordering castration as a standalone treatment would only serve to cause harm. Therefore, the current legal attitude regarding court-mandated castration alone violates the principle of nonmaleficence.

The medical community has largely agreed with this sentiment. While states have spent the last fifteen years passing laws permitting court-ordered castration (see chapter three), governing bodies within medicine and psychiatry have spent them on efforts toward standardizing the care and management of castration patients with the goal of reducing side effects and increasing treatment efficacy (Thibaut et al., 2010). The American Medical Association has even gone so far as to incorporate its disapproval of punitive medical procedures into its organizational code of ethics: “Physicians can ethically participate in court-initiated medical treatments only if the procedure being mandated is therapeutically efficacious and is therefore undoubtedly not a form of punishment or solely a mechanism of social control” (AMA, 1998b). These trends embody the principle of nonmaleficence by emphasizing the avoidance of harmful treatments and encouraging the safe and effective use of beneficial treatments.

While nonmaleficence does not support the continued use of castration in a court mandated, punitive context, it does support its use within a voluntary, rehabilitative one. Consider the paraphiliac offender who is voluntarily seeking chemical castration: treating this patient in accordance with existing treatment guidelines has already been identified as an act of beneficence. Strengthening this bioethical duty is the concept that withholding such treatment from this patient would prolong his distress and therefore contribute to the harm he is suffering. Therefore, nonmaleficence demands that properly trained medical professionals provide chemical castration when it is pursued if it is truly appropriate for the patient.⁴⁶ Where the principles of respect for autonomy and beneficence support chemical castration as therapy and discourage it as punishment,

⁴⁶ This is not to suggest that patients’ wishes should override physicians’ professional judgments, but rather to speak of the strength of the duty of nonmaleficence in this case.

nonmaleficence goes beyond these and demands that such treatments be provided and such punishments be prohibited.

Justice

Finally, justice is the bioethical principle that dictates fairness. While justice is most often used to contribute to discussions of fair access and health policy standards, it nevertheless applies in this context as well. The formal principle of justice states that “equals must be treated equally, and unequals must be treated unequally” (Beauchamp & Childress, 2009, p. 242). Traditionally, this principle has been interpreted to support equal access to healthcare and criticize access disparities: people are equals regardless of race or creed, and so they ought to have equal access to medical care.

Regardless of these traditional applications, the principle of justice applies to the issue of chemical castration due to the current statutes’ failure to distinguish between categories of sex offenders (see chapter three). Paraphiliac and non-paraphiliac sex offenders are separate distinct subgroups within the greater sex offender population (Walker & Meyer, 1981). Their motivations to offend and their responses to chemical castration differ greatly, and so they ought to be approached differently (Ibid.).

Because paraphiliac and non-paraphiliac sex offenders are fundamentally different from one another, they qualify as unequals under the principle of justice. Accordingly, this principle would dictate that they be treated unequally. This unequal medical treatment should include the use of chemical castration only in paraphiliac offenders. Limiting chemical castration to this group would reflect the reality that such treatment is only effective when administered to this group (see chapter one).

Regardless of the recidivistic sociopolitical context that led to the creation of the current castration statutes (see chapter one), the fact remains that a serious violation of the principle of justice is occurring as a result of these laws' failure to distinguish between types of sex offenders. As these laws currently stand, not only can non-paraphiliac offenders be required to receive medical treatment that is not appropriate for them, but also it is possible that eligible paraphiliac offenders are being denied treatment because their paraphilias are not consistent with legal eligibility criteria (see chapter three). The continued inappropriate allocation of court-ordered ineffective treatments will only serve to undermine castration as an effective therapy in the long run.

Balancing Principles and the Bioethical Castration Imperative

No principles-based bioethical analysis is complete without the process of balancing, or rather the consideration of all principles in a holistic manner. As was discussed at the beginning of this chapter, respect for autonomy, beneficence, nonmaleficence, and justice can at times conflict with one another (Beauchamp & Childress, 2009). However, a thorough understanding of how these principles relate to the problem at hand should lead to determinations as to the moral permissibility of a situation (Ibid.). In order to conduct such a balancing, let us consider once more the conclusions drawn regarding how each of the four principles discussed applies to castration within a voluntary or punitive context.

Respect for autonomy supports the use of chemical castration in the paraphiliac offenders who seek it according to the safe treatment guidelines discussed in chapter two. However, this principle is not applicable in court-ordered chemical castration. Beauchamp and Childress support the limitation of autonomy on the grounds of public

safety, which would suggest that limiting autonomy in order to prescribe castration therapy might be appropriate. However, I have argued that the limitations of autonomy in this case must be justified by the prescribed treatment's efficacy. Given the efficacy issues inherent in the current castration statutes, such a violation of autonomy should not be permitted. Therefore, the principle of respect for autonomy does not support the use of chemical castration as a punitive measure.

The principle of beneficence also supports the use of chemical castration for the paraphiliac offenders who seek it: providing effective medical treatment promotes good, and so this treatment ought to be given where appropriate. Once again, though, ineffective medical treatments cannot be defended as beneficent and the efficacy issues of the current castration statutes therefore do not support the use of chemical castration via court order.

Nonmaleficence encourages the use of chemical castration where appropriate (i.e. effective) and discourages it where it lacks therapeutic value. Given the bioethical imperative to avoid harm, withholding effective treatments is an unacceptable option; therefore, we ought to treat the paraphiliac offenders who would benefit from chemical castration. On the other hand, because non-paraphiliac sex offenders do not respond to chemical castration, castration among this population lacks therapeutic value and the treatment cannot justify the harms it causes via side effects. For this reason, the principle of nonmaleficence dictates that chemical castration not be used in these offenders. Because the chemical castration statutes fail to remove non-paraphiliac offenders from their scope, chemical castration ordered based on these laws ought not be supported.

Finally, the principle of justice requires that we treat the unequals of paraphiliac and non-paraphiliac offenders unequally. Limiting chemical castration to the former group achieves this goal. This limitation is currently possible within the voluntary context of chemical castration because inappropriate offenders can be denied treatment. However, once again the castration statutes' inability to distinguish between these two fundamentally different groups keeps them from being treated unequally. The principle of justice therefore cannot be served under the use of these statutes.

Based upon these conclusions, the principles-based approach to bioethics supports the use of chemical castration for paraphiliac sex offenders who pursue it voluntarily. Despite the corruptive effects of its use in recent years as a potentially ineffective criminal punishment, the fact remains that chemical castration can be an effective rehabilitative tool for paraphiliac sex offenders. As such, the medical community is bound by a bioethical imperative to make it more available within a rehabilitative context. Furthermore, the repeated failure of chemical castration as a court-ordered punishment to uphold the fundamental principles of bioethics is damning. For this reason, the existing model of poor legislation that questions the therapeutic validity of chemical castration as a criminal punishment must be abandoned immediately. A return to the therapeutic approach of chemical castration will serve the individual and societal goals of both treating sex offenders ethically and promoting the effective treatment of offenders who may benefit from it.

CHAPTER 5: RISK REDUCTION AND OTHER ISSUES

Aside from the medicolegal and bioethical issues that arise in relation to chemical castration therapy for sex offenders, there are several logistic and other concerns that bring to light the practical problems associated with its use. In this chapter, I will discuss the justification for castration on a risk reduction basis, the need for and difficulty in conducting future empirical research on castration, and the role gender plays in the development and use of castration therapy. I argue that while there is substantial evidence to support a risk reduction argument in favor of castration therapy, such an argument conflicts with the goals of the therapeutic approach this thesis espouses. I discuss attempts to conduct empirical research on the efficacy of castration therapy and the challenges such research poses. Finally, I discuss the absence of an effective castration equivalent for female paraphiliac offenders and whether or not such a treatment ought to be pursued.

Risk Reduction

The term “risk reduction” describes an approach to intervention and policy creation that seeks to minimize vulnerabilities and decrease the development or severity of negative outcomes (Agency for Toxic Substances and Disease Registry, 2009; World Meteorological Organization, n.d.). It is based in the premise that if an outcome is inherently bad, then we ought to seek to avoid or eliminate it.

Risk reduction is often confused with the similar yet distinct concept of harm reduction. While these terms are sometimes used interchangeably, they tend to have slightly different goals. Harm reduction is most often employed within the public health field by workers seeking to minimize the negative consequences of ongoing risky health

behaviors. Examples of harm reduction programs in public health include needle exchange programs for intravenous (IV) drug users and condom distribution programs for sex workers (North Carolina Harm Reduction Coalition, 2012). The goal of these programs is not to terminate the risky behaviors, i.e. IV drug use and prostitution, but rather to reduce the harms associated with continuing these behaviors, i.e. disease transmission.

In contrast, risk reduction programs seek to eliminate or prevent risks where possible and increase safety and preparedness prior to the occurrence of a negative outcome (Prime for Life, n.d.). Risk reduction programs arise in a myriad of diverse industries such as healthcare and business (where they are more commonly referred to as risk management programs) and address issues including natural disasters, epidemics, and corporate management (United Nations Office for Disaster Risk Reduction, n.d.; The Risk Management Society, 2012). A risk reduction intervention addressing IV drug use might target at-risk teens and seek to discourage them from taking IV drugs; a risk reduction program currently in use at NASA identifies the locations on the International Space Station that are most vulnerable to debris strikes, engineers shields and other components to limit the damage such strikes create, and monitors the location of debris in order to avoid it when possible (NASA Orbital Debris Program Office, 2010).

The primary goal of risk reduction programs is not to make ongoing problems less hazardous, but rather to prevent and prepare for recurring problems. To summarize, while harm reduction efforts primarily seek to reduce the hazards associated with an existing problem, risk reduction efforts seek to decrease the occurrence of or increase

preparedness for the targeted problem—where harm reduction reactively addresses chronic issues, risk reduction proactively addresses recurring ones.

While risk and harm reduction have slightly different goals, the outcomes of their interventions may overlap. A harm reduction intervention targeting IV drug users may include an educational component that motivates some participants to become sober, thereby reducing the harm of the existing drug-taking behaviors and also preventing the risk of future harms among those participants who stop taking drugs. Furthermore, it can be argued that effective risk reduction programs are also harm reductive by nature: by preventing future events,⁴⁷ the program also prevents the harms that would have arisen from their development. This is even more so the case when the incident being targeted is always harmful: a flu epidemic always causes harm, and so effective measures taken to reduce the risk of such an epidemic also prevent the potential harm the epidemic would have caused if it had occurred.

Because the concept of risk reduction can be so diversely employed, it has also been used to support castration among paraphiliac sex offenders (Petrunik, 2002). Proponents of this argument state that castration reduces the risk of recidivism, a claim supported by the literature: outcome data from repeated observational research indicate that with concurrent intensive talk therapy, the recidivism rate among paraphiliac offenders drops by about half for the duration of castration treatments (Thibaut et al., 2010). Based on this data, these proponents argue that its use can be viewed as a legitimate risk reduction intervention. That said, considering the universal harms caused by sexual abuse, chemical castration as a risk reduction intervention also exhibits some harm reductive features. It is therefore appropriate to consider both the risks and the

⁴⁷ While prevention is being used for the sake of this example, it is not attainable in every scenario.

harms that chemical castration reduces in order to determine the validity of this argument for castration. In what follows, I will analyze castration as a risk reduction intervention with harm reductive features and discuss the appropriateness of this argument within the therapeutic context this thesis promotes.

Chemical castration reduces the risk of future acts of recidivism among paraphiliac sex offenders, and so it can rightfully be considered a method of risk reduction. Interestingly, though, the sexual abuse being avoided via risk reductive chemical castration is not limited to those incidents perpetrated by known sex offenders. Because past sexual abuse influences the risk of future sexual abuse, chemical castration may have generational effects beyond what are readily apparent. Victims who were sexually abused prior to the age of eighteen are at a twofold-increased risk of revictimization as adults (RAINN, 2009a). Furthermore, some victims of childhood sexual abuse go on to perpetrate acts of abuse themselves.⁴⁸ This indicates a cyclic nature of sexual abuse such that reducing the risk of abusive incidents now changes the risk of these incidents in the future as well. In other words, chemical castration may be a stronger risk reductive agent than commonly believed.

In addition to its risks, sexual abuse is associated with several harms. First, there is a risk of physical or medical harm: abuse allows for the communication of sexually transmitted infections (STIs), which have a myriad of short and long term health effects.

⁴⁸ A common misconception among the public is that the victim-to-perpetrator cycle of sexual abuse is strong if not absolute. In reality, this pattern is limited and seems to affect only boys (Glasser et al., 2001): a longitudinal study of male child sex abuse victims by Salter et al. found that only around twelve percent of victims ultimately become perpetrators (2003). While this number is small, it is hardly insignificant. Several risk factors have been identified as increasing the likelihood of a child victim becoming an adult perpetrator. These risk factors include male gender, female perpetrator, neglectful environment, lack of supervision, and exposure to familial violence. The type of sexual abuse that occurred also seems to be a risk factor, though different types of abuse have different effect sizes. The types associated with an elevated risk of future perpetration listed in ascending order of effect size are incest, pedophilia, and combined incest/pedophilia (Ibid.; Glasser et al., 2001).

It may also lead to unwanted pregnancies, and violent attacks can cause other forms of physical injuries (RAINN, 2009c). Second, there is a risk of psychological harm: unwanted sexual contact can lead to serious long term mental health issues, including depression, post traumatic stress, eating disorders, sleep disorders, anxiety disorders, substance abuse, and suicidal ideation in addition to general feelings of shame and isolation (Ibid.; Briere and Runtz, 1987). A third potential harm is related to finances: it is estimated that rape costs adult victims \$110,000⁴⁹, and victims of childhood sexual abuse spend an average of \$5,800 on psychological treatment alone (Minnesota Department of Health, n.d.). Finally, sexual abuse may cause individual and societal social harms: a victim's public perception and interpersonal relationships may change following abuse, and these crimes may change how members of society engage with one another (Ibid.). The harms associated with sexual abuse are clear and burdensome, and we must now consider who exactly suffers from them.

The most obvious sufferers of the sexual abuse-related harms listed above are the victims of the abuse themselves. Rape and molestation victims undoubtedly bear the brunt of the harm burden following their attacks, and these harms can endure years after the abuse ends in the form of psychological and/or physical trauma (RAINN, 2009c). However, victims are not alone in facing these abuse-related harms. Those closest to the victims, e.g. friends and family, may experience psychological harm in response to learning of their loved ones' abuse. On a broader level, the recent exposure of years of sexual abuse at the hands of Penn State coach Jerry Sandusky caused serious social harm to the Penn State community, with feelings of shock, anger, and betrayal being expressed

⁴⁹ These funds are divided between "medical, mental health, social and emergency services; insurance; legal costs; and lost productivity, wages, and fringe benefits" (Minnesota Department of Health, n.d.).

by both personal contacts of Mr. Sandusky and strangers alike (Mihoces, 2012). This is to say that often the harms associated with sexual abuse affect more than simply the victim.

A strong case may also be made for the harms of sexual abuse affecting the paraphiliac sex offender as well.⁵⁰ A consideration of these harms would traditionally be of the utmost importance to risk reduction programs, which focus on the harms incurred by those immediately influenced by an undesirable situation. Instead, risk reduction arguments in favor of chemical castration seem to ignore these harms in favor of those borne by the public. While such a shift in focus is understandable, to ignore the harms affecting paraphiliac offenders is to develop an incomplete understanding of the burdens of sexual abuse. As we have seen, paraphiliac sex offenders are particularly vulnerable to feeling remorse and guilt in response to their crimes (see chapter one). These harms may manifest in clinical depression and/or anxiety disorders, which are found in around thirty percent of paraphiliac offenders (Dunsieth et al., 2004). Paraphiliac offenders may put themselves at risk of being harmed by others by perpetrating their crimes in the first place. Furthermore, imprisoned pedophiles are often the recipients of verbal and physical harassment, physical violence, sexual violence, and/or murder (James, 2003). Therefore, while the paraphiliac offenders who perpetrate abuse inspire little sympathy, it would be careless to assume that they exist outside the reach of the harms of their crimes.

Given the severity and distribution of sexual abuse-related harms, it would follow that risk reduction interventions that limit sexual abuse where possible would provide great benefit to society. To that end, castration has been supported as a recidivism reduction intervention (Weinberger et al., 2005). However, the use of castration as a risk

⁵⁰ A discussion of harms borne by non-paraphiliac offenders is beyond the scope of this thesis.

reductive technique is not consistent with its therapeutic applications. For this reason, a risk reduction argument ought not be used as the basis of this therapy's ideological support.

When we consider castration as a risk reductive agent, we divert the focus of the treatment away from its rehabilitative nature and toward the societal goods it promotes. This may not seem like a dangerous diversion, but this refocusing allows for an automatic re-prioritization of the public's needs and desires over what is right, safe, or effective for the offender who may undergo this therapy. This attitude promotes retributive justice, which is responsible for the poorly drafted castration statutes in effect today. Therefore, while the risk reduction paradigm may be supportable and even appealing for most people to take in regard to sex offender castration, it undoubtedly leads to a revamping of the poor castration policy already in existence. In order to respect the medical rights of paraphiliac offenders and also indirectly work toward a decrease in sexual abuse, we must approach the problem from a therapeutic rather than retributive standpoint.

Studying Non-Paraphiliacs

This thesis has relied upon the use of data to support its claims regarding the efficacy of chemical castration in paraphiliac sex offenders (see chapter one). The body of literature that reports on treatment outcomes from medroxyprogesterone acetate (MPA) programs is extensive. This research is not without its problems. The current scientific consensus on the use of castration solely in paraphiliacs is based on two things: data based on observational research from MPA programs and deductions based on understanding of the motivations for sexual violence and the role castration plays therein. The first of these includes decades' worth of international research that has repeatedly

supported the efficacy of castration therapy in paraphiliac offenders who undergo concurrent mental health counseling (Meyer & Cole, 1997; see chapter one). The latter is not empirically supported, as is the nature of scientific deduction. So while the data has consistently shown that castration is effective in reducing the recidivism rate among paraphiliac offenders, there is no such support for the repeated claim that castration is ineffective in non-paraphiliac offenders. This dearth of information is due to the ethical and logistic challenges such a study design would pose as well as the uniquely uncooperative nature of non-paraphiliac sex offenders.

Conducting research on sex offenders poses an ethical challenge because the outcome measure of recidivism introduces a potential threat to the public. Such research must therefore be designed carefully in a manner that limits this threat. The gold standard for research design is the randomized controlled trial (Stolberg, Norman, & Trop, 2004). A classic randomized controlled trial involves the assignment of subjects to different treatment arms while the outcome in question is monitored (Ibid.). This is easy enough to achieve in a clinical setting for a pharmaceutical drug: the control group receives a placebo while the experimental group receives the new drug, and the outcomes are measured and quantified (Ibid.). Placebo control in a study of chemical castration in non-paraphiliac offenders is inappropriate and dangerous, and so we ought to use a pharmaceutical agent similar to MPA in its place.

Now let us consider how one might go about gathering outcome data on recidivism in this research. Three potential outcome measures exist that may be used individually or collectively to determine the efficacy of MPA treatment in non-paraphiliac sex offenders. The first of these is self-report data, in which researchers rely

upon the sex offenders to report on their recidivistic urges and actions. This method of data collection is highly dependent upon participants' honesty, and so a dishonest participant would skew the resultant data. The second data source is the criminal justice system, in which the researchers use police reports and reincarceration information to determine recidivistic activity. This method relies upon accurate reporting of sexual abuse, but underreporting of these crimes remains a serious problem. Third, researchers could collect data via penile plethysmography, a technology that measures blood flow to the penis upon the presentation of sexually stimulating material. This method relies upon the predictability of the participants' sexual arousal, but a false negative might occur if inappropriate material is presented to the participant. Any combination of these data sources may be used in a study of MPA treatment in non-paraphiliac sex offenders, but the greatest problem with this research project remains: the nature of non-paraphiliac offenders is one of dishonesty and noncompliance.

Consider again the three types of non-paraphiliac sex offender: those that deny their crimes, those that blame their crimes on outside factors, and those motivated by violence (Walker & Meyer, 1981; see chapter one). These offenders are characterized by motives that discourage truth telling and accurate data collection. The denying offender refuses to acknowledge past crimes, which suggests his unwillingness to report on new ones. The disinhibited offender's lack of personal accountability and tendency to only admit having committed one crime undermines the likelihood that he will report any further offenses. Finally, the violent offender's crimes are a function of aggression rather than sexual attraction. Asking this offender to report on his sexual urges will not necessarily speak of desires to commit sexual abuse, and asking him solely to report on

sexual offenses or near-offenses ignores other violent crimes he may commit. These types of offenders may also be more prone to inaccurate penile plethysmography readings because their victims are so diverse; because their crimes are not necessarily sexually motivated, the data from these physiological measurements may not correspond to urges or acts of recidivism. Furthermore, these scenarios assume that non-paraphiliac offenders would consider complying with rehabilitation research. When we recall that one unique feature of the paraphiliac is willingness to comply, the likelihood of finding non-paraphiliac offenders interested in participating in castration research seems low.

Considering the practical problems associated with collecting data about chemical castration in non-paraphiliac offenders, we are left to deduce and postulate regarding the efficacy of such treatment in this population. This is not to suggest that such theories are incorrect. To the contrary, the beliefs currently accepted regarding non-paraphiliac castration show deep understanding of the psychosocial correlates⁵¹ of sexual abuse (Thibaut et al., 2010). Paraphiliac offenders have been targeted for castration therapy because they are unique in their unrelenting sexual urges, emotional distress, and responsiveness to sex hormone fluctuations (see chapter one). It is no mistake that non-paraphiliacs have been differentiated from this group for not sharing these qualities. While there may be no empirical data explicitly supporting the idea that castration is inappropriate for non-paraphiliac sex offenders, an understanding of the role of testosterone in sex drive and sex drive in sexual abuse leads to the conclusion that this is not an appropriate treatment for them.

⁵¹ E.g. the role of paraphilias in the commission of sex crimes, the variable motivations and behavior patterns of sex offenders.

Gender Issues

Gender issues are extremely relevant when we consider castration therapy as a rehabilitative treatment for sex offenders. The vast majority (if not the entirety) of the research and literature on sex offender castration available to date has been focused on male paraphiliac offenders. This is due at least in part to two facts: first, male offenders commit the majority of sex crimes, and second, paraphilias are more prevalent in men than in women (Center for Sex Offender Management, 2007; APA, 2010). While it makes sense to devote more time and funding to male paraphiliacs based on their established treatability and availability for research, this decision has come at a price.

As of late 2012, there is no available research on the utility of chemical castration as an intervention for female sex offenders. What limited data that do exist on female offenders suggest that a female paraphiliac population exists, but is very small (Graham, 2007). Female sex offenders only commit about ten percent of all sex crimes, and it would follow that the proportion of female paraphiliac sex offenders is even lower than this (Center for Sex Offender Management, 2007; Gordon & Grubin, 2004). Regardless of the small population size of female paraphiliac sex offenders, the fact remains that there exists no acknowledged pharmaceutical intervention for this group that is effective at reducing recidivistic urges.

As was discussed in chapter one, the agent used in the majority of chemical castrations in the United States is better known as a women's injectable birth control option under the name Depo-Provera. Where chemical castration in men leads to a substantial lowering of testosterone levels and sex drive, it simply leads to anovulation in women. While there is limited evidence that Depo-Provera affects female libido, the

extent of this effect particularly within the increased dosage parameters of chemical castration is unknown (“Depo-Provera Side Effects,” n.d.). In the absence of significant research on MPA therapy in women, its appropriateness as a recidivism-reduction agent cannot be assumed. Further complicating this situation is that no plausible MPA alternatives for women have yet been proposed (Thibaut et al., 2010). This is due at least in part to inadequate scientific understanding of the complexities underlying female libido: male sex drive tends to be more straightforward and testosterone-driven, where female sex drive seems to depend on a constellation of factors (Bancroft, 2005).

We are currently in the midst of a societal shift in perceptions of sex offenders. With the Federal Bureau of Investigation’s newest definition of rape including sexual abuse against men (2012), we as a society are becoming increasingly aware that both genders may commit and suffer sexual abuse. With this shift, it is possible that an increasing number of female paraphiliacs will be identified and incarcerated as a result of their offenses. For this reason, it is important for efforts to be made now and in the near future to develop pharmacological treatments for female offenders seeking rehabilitation. This is not a breakthrough that can be expected overnight, but one that ought to be undertaken as part of a long-term adjustment in attitude regarding gender equality in the commission of crimes. By including an existent minority, female paraphiliacs, in the dialogue of sex offender castration, we can move ever closer to treating and rehabilitating those seeking such care and reducing public harm from sexual abuse.

CHAPTER 6: CONCLUSION AND FUTURE DIRECTIONS

This thesis contains an analysis of chemical castration as a recidivism-reduction intervention for sex offenders that is often applied within two disparate contexts. The first context focuses on voluntary therapy and rehabilitation and peaked in popularity in the 1970s; the second is rooted in retribution and criminal punishment and predominates today (Banks, 2004). I argue in favor of the use and availability of rehabilitative castration while condemning its use as a punishment. I base my support for therapeutic castration on the success of early treatment programs in achieving a moderate reduction in recidivism among those sex offenders studied (Thibaut et al., 2010). My condemnation of punitive castration is based in the extensive flaws inherent within America's current chemical castration policy: by failing to reflect what is known about the appropriate recipients and administration of this intervention, existing castration statutes question the therapeutic validity of such treatment. In effect, these laws have hijacked a potentially effective medical therapy, stripped it of its rehabilitative value, and repurposed it as a tool for retribution.

Bioethicists concern themselves with issues of patient treatment and fairness. At the beginning of this thesis, I raised the following question: when medical treatments are administered in a manner that does not support their efficacy, can patients be treated ethically? Applied to the topic of this thesis, this question can be asked differently: Can sex offenders sentenced by law to potentially ineffective chemical castration be treated ethically? The simple answer to these questions, as I have argued in this thesis, is no. While concerns for public safety may sometimes permit the limiting of certain bioethical

principles, the desire to keep the public safe from sex offenders does not and cannot extend to the court ordering of potentially ineffective medical treatments.

In this thesis, I argue in favor of a return to a rehabilitative approach to chemical castration. However, I recognize that such a paradigm shift cannot happen overnight. In the meantime there are several changes that can be made to the existing castration statutes that would increase the moral permissibility of punitive castration. The first is the removal of judges' authority to order chemical castration. In its place, laws ought to reaffirm judges' right to refer sex offenders to approved chemical castration or sex offender treatment programs for further evaluation. This change allows medical professionals to make the ultimate treatment decisions. The second change necessary is either the removal of arbitrary qualifying offenses from the statutes or their replacement with phrasing that is truly reflective of paraphiliac offenders. This change will solve the existing problem of targeting inappropriate (i.e. non-paraphiliac) offenders for castration based on the nature of their offenses rather than their motivations to offend. Finally, the statutes ought to be revised to include provisions for both ongoing mental health counseling and medical follow-up care for offenders receiving castration treatments. This will allow for an incorporation of the most recent medical recommendations on safe and effective chemical castration within American castration policy (Thibaut et al., 2010).

My goal in writing this thesis was to inject some realism into a medicolegal issue that often is the subject of much hyperbole. Through the writing process, I found that chemical castration is not in fact the silver bullet the public makes it out to be. It is true that chemical castration is an effective therapy in reducing recidivism among some sex

offenders. However, much like any other medical intervention, chemical castration has its limits. It is only effective in a small minority of sex offenders, called paraphiliacs, and even in this population the treatment only reduces recidivism rates by about half (Ibid.). All things considered, chemical castration is not the ultimate solution to sexual abuse. Furthermore, while seeking retributive punishments for the offenders of sexual abuse may be satisfying, it does nothing to solve the underlying problem. Our society would be better served by seeking new ways to reduce sexual abuse than by spending time causing harms to offenders who have done us wrong.

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APPENDIX: FULL TEXT OF EXISTING STATUTES BY STATE

California Penal Code § 645 (2012):

(a) Any person guilty of a first conviction of any offense specified in subdivision (c), where the victim has not attained 13 years of age, may, upon parole, undergo medroxyprogesterone acetate treatment or its chemical equivalent, in addition to any other punishment prescribed for that offense or any other provision of law, at the discretion of the court.

(b) Any person guilty of a second conviction of any offense specified in subdivision (c), where the victim has not attained 13 years of age, shall, upon parole, undergo medroxyprogesterone acetate treatment or its chemical equivalent, in addition to any other punishment prescribed for that offense or any other provision of law.

(c) This section shall apply to the following offenses:

- (1) Subdivision (c) or (d) of Section 286.⁵²
- (2) Paragraph (1) of subdivision (b) of Section 288.⁵³
- (3) Subdivision (c) or (d) of Section 288a.⁵⁴
- (4) Subdivision (a) or (j) of Section 289.⁵⁵

(d) The parolee shall begin medroxyprogesterone acetate treatment one week prior to his or her release from confinement in the state prison or other institution and shall continue treatments until the Department of Corrections demonstrates to the Board of Prison Terms that this treatment is no longer necessary.

(e) If a person voluntarily undergoes a permanent, surgical alternative to hormonal chemical treatment for sex offenders, he or she shall not be subject to this section.

(f) The Department of Corrections shall administer this section and implement the protocols required by this section. Nothing in the protocols shall require an employee of the Department of Corrections who is a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act to participate against his or her will in the administration of the provisions of this section. These protocols shall include, but not be

⁵² Sodomy (“sexual contact consisting of contact between the penis of one person and the anus of another person”) of a person under the age of fourteen when the offender is more than ten years older than the victim; aiding and abetting sodomy.

⁵³ Lewd and lascivious acts (“arousing, appealing to, or gratifying the lust, passions, or sexual desires of [a person or child under the age of 14]”) by force.

⁵⁴ Oral copulation (“the act of copulating the mouth of one person with the sexual organ or anus of another person”) of a person under the age of fourteen when the offender is more than ten years older than the victim; aiding and abetting oral copulation.

⁵⁵ Forcible sexual penetration (“the act of causing the penetration, however slight of the genital or anal opening of any person or causing another person to so penetrate the defendant’s or another person’s genital or anal opening for the purpose of sexual arousal, gratification, or abuse by any foreign object, substance, instrument, or device, or by any unknown object”); sexual penetration of a person under the age of fourteen when the offender is more than ten years older than the victim.

limited to, a requirement to inform the person about the effect of hormonal chemical treatment and any side effects that may result from it. A person subject to this section shall acknowledge the receipt of this information.

Florida Statutes § 794.0235 (2012):

- (1) Notwithstanding any other law, the court:
 - (a) May sentence a defendant to be treated with medroxyprogesterone acetate (MPA), according to a schedule of administration monitored by the Department of Corrections, if the defendant is convicted of sexual battery as described in s. 794.011.
 - (b) Shall sentence a defendant to be treated with medroxyprogesterone acetate (MPA), according to a schedule of administration monitored by the Department of Corrections, if the defendant is convicted of sexual battery as described in s. 794.011 and the defendant has a prior conviction of sexual battery under s. 794.011.

If the court sentences a defendant to be treated with medroxyprogesterone acetate (MPA), the penalty may not be imposed in lieu of, or reduce, any other penalty prescribed under s. 794.011. However, in lieu of treatment with medroxyprogesterone acetate (MPA), the court may order the defendant to undergo physical castration upon written motion by the defendant providing the defendant's intelligent, knowing, and voluntary consent to physical castration as an alternative penalty.
- (2)
 - (a) An order of the court sentencing a defendant to medroxyprogesterone acetate (MPA) treatment under subsection (1), shall be contingent upon a determination by a court appointed medical expert, that the defendant is an appropriate candidate for treatment. Such determination is to be made not later than 60 days from the imposition of sentence. Notwithstanding the statutory maximum periods of incarceration as provided in s. 775.082, an order of the court sentencing a defendant to medroxyprogesterone acetate (MPA) treatment shall specify the duration of treatment for a specific term of years, or in the discretion of the court, up to the life of the defendant.
 - (b) In all cases involving defendants sentenced to a period of incarceration, the administration of treatment with medroxyprogesterone acetate (MPA) shall commence not later than one week prior to the defendant's release from prison or other institution.
- (3) The Department of Corrections shall provide the services necessary to administer medroxyprogesterone acetate (MPA) treatment. Nothing contained in this section shall be construed to require the continued administration of medroxyprogesterone acetate (MPA) treatment when it is not medically appropriate.
- (4) As used in this section, the term "prior conviction" means a conviction for which sentence was imposed separately prior to the imposition of the sentence for the current offense and which was sentenced separately from any other conviction that is to be counted as a prior conviction under this section.
- (5) If a defendant whom the court has sentenced to be treated with medroxyprogesterone acetate (MPA) fails or refuses to:

- (a) Appear as required by the Department of Corrections for purposes of administering the medroxyprogesterone acetate (MPA); or
- (b) Allow the administration of medroxyprogesterone acetate (MPA), the defendant is guilty of a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Iowa Code § 903B.10 (2011):

1. A person who has been convicted of a serious sex offense may, upon a first conviction and in addition to any other punishment provided by law, be required to undergo medroxyprogesterone acetate treatment as part of any conditions of release imposed by the court or the board of parole. The treatment prescribed in this section may utilize an approved pharmaceutical agent other than medroxyprogesterone acetate. Upon a second or subsequent conviction, the court or the board of parole shall require the person to undergo medroxyprogesterone acetate or other approved pharmaceutical agent treatment as a condition of release, unless, after an appropriate assessment, the court or board determines that the treatment would not be effective. In determining whether a conviction is a first or second conviction under this section, a prior conviction for a criminal offense committed in another jurisdiction which would constitute a violation of section 709.3, subsection 2, if committed in this state, shall be considered a conviction under this section. This section shall not apply if the person voluntarily undergoes a permanent surgical alternative approved by the court or the board of parole.
2. If a person is placed on probation and is not in confinement at the time of sentencing, the presentence investigation shall include a plan for initiation of treatment as soon as is reasonably possible after the person is sentenced. If the person is in confinement prior to release on probation or parole, treatment shall commence prior to the release of the person from confinement. Conviction of a serious sex offense shall constitute exceptional circumstances warranting a presentence investigation under section 901.2.
3. For purposes of this section, a "serious sex offense" means any of the following offenses in which the victim was a child who was, at the time the offense was committed, twelve years of age or younger:
 - a. Sexual abuse in the first degree, in violation of section 709.2.
 - b. Sexual abuse in the second degree, in violation of section 709.3.
 - c. Sexual abuse in the third degree, in violation of section 709.4.
 - d. Lascivious acts with a child, in violation of section 709.8.
 - e. Assault with intent, in violation of section 709.11.
 - f. Indecent contact with a minor, in violation of section 709.12.
 - g. Lascivious conduct with a minor, in violation of section 709.14.
 - h. Sexual exploitation in violation of section 709.15.
 - i. Sexual exploitation of a minor, in violation of section 728.12, subsections 1 and 2.
4. The department of corrections, in consultation with the board of parole, shall adopt rules which provide for the initiation of medroxyprogesterone acetate or other approved pharmaceutical agent treatment prior to the parole or work release of a person who has been convicted of a serious sex offense and who is required to undergo treatment as a condition of release by the board of parole. The department's rules shall also establish standards for the supervision of the treatment by the judicial district department of correctional services during the period of release. Each district department of correctional services shall adopt policies and procedures which provide for the initiation

or continuation of medroxyprogesterone acetate or other approved pharmaceutical agent treatment as a condition of release for each person who is required to undergo the treatment by the court or the board of parole. The board of parole shall, in consultation with the department of corrections, adopt rules which relate to initiation or continuation of medroxyprogesterone acetate or other approved pharmaceutical agent treatment as a condition of any parole or work release. Any rules, standards, and policies and procedures adopted shall provide for the continuation of the treatment until the agency in charge of supervising the treatment determines that the treatment is no longer necessary.

5. A person who is required to undergo medroxyprogesterone acetate treatment, or treatment utilizing another approved pharmaceutical agent, pursuant to this section, shall be required to pay a reasonable fee to pay for the costs of providing the treatment. A requirement that a person pay a fee shall include provision for reduction, deferral, or waiver of payment if the person is financially unable to pay the fee.

6. A person who administers medroxyprogesterone acetate or any other pharmaceutical agent shall not be liable for civil damages for administering such pharmaceutical agents pursuant to this chapter.

Louisiana Revised Statutes § 14:43.6 (2012):

A. Notwithstanding any other provision of law to the contrary, upon a first conviction of R.S. 14:42 (aggravated rape), R.S. 14:42.1 (forcible rape), R.S. 14:43.2 (second degree sexual battery), R.S. 14:78.1 (aggravated incest), R.S. 14:81.2(D)(1) (molestation of a juvenile when the victim is under the age of thirteen), and R.S. 14:89.1 (aggravated crime against nature), the court may sentence the offender to be treated with medroxyprogesterone acetate (MPA), according to a schedule of administration monitored by the Department of Public Safety and Corrections.

B. (1) Notwithstanding any other provision of law to the contrary, upon a second or subsequent conviction of R.S. 14:42 (aggravated rape), R.S. 14:42.1 (forcible rape), R.S. 14:43.2 (second degree sexual battery), R.S. 14:78.1 (aggravated incest), R.S. 14:81.2(D)(1) (molestation of a juvenile when the victim is under the age of thirteen), and R.S. 14:89.1 (aggravated crime against nature), the court shall sentence the offender to be treated with medroxyprogesterone acetate (MPA) according to a schedule of administration monitored by the Department of Public Safety and Corrections.

(2) If the court sentences a defendant to be treated with medroxyprogesterone acetate (MPA), this treatment may not be imposed in lieu of, or reduce, any other penalty prescribed by law. However, in lieu of treatment with medroxyprogesterone acetate (MPA), the court may order the defendant to undergo physical castration provided the defendant file a written motion with the court stating that he intelligently and knowingly, gives his voluntary consent to physical castration as an alternative to the treatment.

C. (1) An order of the court sentencing a defendant to medroxyprogesterone acetate (MPA) treatment under this Section, shall be contingent upon a determination by a court appointed medical expert, that the defendant is an appropriate candidate for treatment. This determination shall be made not later than sixty days from the imposition of sentence. An order of the court sentencing a defendant to medroxyprogesterone acetate (MPA) treatment shall specify the duration of treatment for a specific term of years, or in the discretion of the court, up to the life of the defendant.

(2) In all cases involving defendants sentenced to a period of incarceration or confinement in an institution, the administration of treatment with medroxyprogesterone acetate (MPA) shall commence not later than one week prior to the defendant's release from prison or such institution.

(3) The Department of Public Safety and Corrections shall provide the services necessary to administer medroxyprogesterone acetate (MPA) treatment. Nothing in this Section shall be construed to require the continued administration of medroxyprogesterone acetate (MPA) treatment when it is not medically appropriate.

(4) If a defendant whom the court has sentenced to be treated with medroxyprogesterone acetate (MPA) fails to appear as required by the Department of Public Safety and Corrections for purposes of administering the

medroxyprogesterone acetate (MPA) or who refuses to allow the administration of medroxyprogesterone acetate (MPA), then the defendant shall be charged with a violation of the provisions of this Section. Upon conviction, the offender shall be imprisoned, with or without hard labor, for not less than three years nor more than five years without benefit of probation, parole, or suspension of sentence.

(5) If a defendant whom the court has sentenced to be treated with medroxyprogesterone acetate (MPA) or ordered to undergo physical castration takes any drug or other substance to reverse the effects of the treatment, he shall be held in contempt of court.

Montana Code Annotated § 45-5-512 (2011):

(1) A person convicted of a first offense under 45-5-502(3),⁵⁶ 45-5-503(3),⁵⁷ or 45-5-507(4) or (5)⁵⁸ may, in addition to the sentence imposed under those sections, be sentenced to undergo medically safe medroxyprogesterone acetate treatment or its chemical equivalent or other medically safe drug treatment that reduces sexual fantasies, sex drive, or both, administered by the department of corrections or its agent pursuant to subsection (4) of this section.

(2) A person convicted of a second or subsequent offense under 45-5-502(3), 45-5-503,⁵⁹ or 45-5-507⁶⁰ may, in addition to the sentence imposed under those sections, be sentenced to undergo medically safe medroxyprogesterone acetate treatment or its chemical equivalent or other medically safe drug treatment that reduces sexual fantasies, sex drive, or both, administered by the department of corrections or its agent pursuant to subsection (4) of this section.

(3) A person convicted of a first or subsequent offense under 45-5-502,⁶¹ 45-5-503, or 45-5-507 who is not sentenced to undergo medically safe medroxyprogesterone acetate treatment or its chemical equivalent or other medically safe drug treatment that reduces sexual fantasies, sex drive, or both, may voluntarily undergo such treatment, which must be administered by the department of corrections or its agent and paid for by the department of corrections.

(4) Treatment under subsection (1) or (2) must begin 1 week before release from confinement and must continue until the department of corrections determines that the treatment is no longer necessary. Failure to continue treatment as ordered by the department of corrections constitutes a criminal contempt of court for failure to comply with the sentence, for which the sentencing court shall impose a term of incarceration without possibility of parole of not less than 10 years or more than 100 years.

(5) Prior to chemical treatment under this section, the person must be fully medically informed of its effects.

(6) A state employee who is a professional medical person may not be compelled against the employee's wishes to administer chemical treatment under this section.

⁵⁶ Sexual assault of a person younger than sixteen where the offender is at least three years older than the victim.

⁵⁷ Sexual intercourse without consent of a person younger than sixteen where the offender is at least four years older than the victim.

⁵⁸ Incest with "a descendant, a brother or sister of the whole or half blood, or any stepson or stepdaughter" younger than sixteen where the offender is at least three years older than the victim.

⁵⁹ Sexual intercourse without consent.

⁶⁰ Incest.

⁶¹ Sexual assault.

Texas Government Code § 501.061 (2011):

(a) A physician employed or retained by the department may perform an orchiectomy on an inmate only if:

- (1) the inmate has been convicted of an offense under Section 21.02,⁶² 21.11,⁶³ 22.011(a)(2),⁶⁴ or 22.021(a)(2)(B),⁶⁵ Penal Code, and has previously been convicted under one or more of those sections;
- (2) the inmate is 21 years of age or older;
- (3) the inmate requests the procedure in writing;
- (4) the inmate signs a statement admitting the inmate committed the offense described by Subsection (a)(1) for which the inmate has been convicted;
- (5) a psychiatrist and a psychologist who are appointed by the department and have experience in the treatment of sex offenders:
 - (A) evaluate the inmate and determine that the inmate is a suitable candidate for the procedure; and
 - (B) counsel the inmate before the inmate undergoes the procedure;
- (6) the physician obtains the inmate's informed, written consent to undergo the procedure;
- (7) the inmate has not previously requested that the department perform the procedure and subsequently withdrawn the request; and
- (8) the inmate consults with a monitor as provided by Subsection (f).

(b) The inmate may change his decision to undergo an orchiectomy at any time before the physician performs the procedure. An inmate who withdraws his request to undergo an orchiectomy is ineligible to have the procedure performed by the department.

(c) Either the psychiatrist or psychologist appointed by the department under this section must be a member of the staff of a medical facility under contract with the department or the institutional division to treat inmates in the division.

(d) A physician who performs an orchiectomy on an inmate under this section is not liable for an act or omission relating to the procedure unless the act or omission constitutes negligence.

(e) The name of an inmate who requests an orchiectomy under this section is confidential, and the department may use the inmate's name only for purposes of notifying and providing information to the inmate's spouse if the inmate is married.

⁶² Continuous sexual abuse of a person younger than seventeen.

⁶³ Indecency ("any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of the child" or vice versa; exposure of either the offender's or the child's anus or genitals) with a person younger than seventeen.

⁶⁴ Sexual assault of a person younger than seventeen.

⁶⁵ Aggravated sexual assault of a person younger than fourteen.

(f) The executive director of the Texas State Board of Medical Examiners shall appoint, in consultation with two or more executive directors of college or university institutes or centers for the study of medical ethics or medical humanities, a monitor to assist an inmate in his decision to have an orchiectomy. The monitor must have experience in the mental health field, in law, and in ethics. The monitor shall consult with the inmate to:

- (1) ensure adequate information regarding the orchiectomy has been provided to the inmate by medical professionals providing treatment or advice to the inmate;
- (2) provide information regarding the orchiectomy to the inmate if the monitor believes the inmate is not adequately informed about the orchiectomy;
- (3) determine whether the inmate is free from coercion in his decision regarding the orchiectomy; and
- (4) advise the inmate to withdraw his request for an orchiectomy if the monitor determines the inmate is being coerced to have an orchiectomy.

(g) A monitor appointed under Subsection (f) is not liable for damages arising from an act or omission under Subsection (f) unless the act or omission was intentional or grossly negligent.

Wisconsin Statutes § 304.06(1q) (2012):

- (a) In this subsection, "serious child sex offender" means a person who has been convicted of committing a crime specified in s. 948.02 (1) or (2)⁶⁶ or 948.025 (1)⁶⁷ against a child who had not attained the age of 13 years.
- (b) The parole commission or the department may require as a condition of parole that a serious child sex offender undergo pharmacological treatment using an antiandrogen or the chemical equivalent of an antiandrogen. This paragraph does not prohibit the department from requiring pharmacological treatment using an antiandrogen or the chemical equivalent of an antiandrogen as a condition of probation.
- (c) In deciding whether to grant a serious child sex offender release on parole under this subsection, the parole commission may not consider, as a factor in making its decision, that the offender is a proper subject for pharmacological treatment using an antiandrogen or the chemical equivalent of an antiandrogen or that the offender is willing to participate in pharmacological treatment using an antiandrogen or the chemical equivalent of an antiandrogen.

⁶⁶ Sexual assault.

⁶⁷ Repeated acts of sexual assault of the same child.

CURRICULUM VITAE

Education

Master of Arts, Bioethics
Wake Forest University, Winston-Salem, NC
Fall 2012

Bachelor of Arts, Psychology & Health Science
Rice University, Houston, TX
Spring 2011

Academic Awards and Honors

Wake Forest University:

- Departmental Merit Scholarship, Academic Year 2011-2012

Rice University:

- Rice University President's Honor Roll, Fall 2009 & Spring 2011
- Barbara Jordan Merit Scholarship, Academic Years 2007-2011

Internships and Scholarly Work

Wake Forest University:

- Bioethics Department Research Assistant, Academic Year 2011-2012

Rice University:

- Psychology Department Research Assistant, Fall 2009 & Fall 2010

Community Leadership

Rice University:

- Student Health Advisor, Academic Years 2008-2011

amfAR, The Foundation for AIDS Research:

- Volunteer, Spring 2010, Cannes, France
- Volunteer, Fall 2010, Dallas, Texas

Conferences Attended

American Society for Bioethics and Humanities
"Generation(s) and Transformation(s)"
Minneapolis, Minnesota
October 13-16, 2011