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Editorials

Chemical castration for sex offenders

Doctors should avoid becoming agents of social control

In November 2009, in response to several high profile sex offences committed against children, Polish President Lech Kaczynski signed a law allowing for the compulsory treatment of some sex offenders with antiandrogenic drugs, commonly referred to as chemical castration. Following a sexual killing carried out by a repeat sex offender in France, the French National Assembly is considering legislation that would make chemical castration mandatory for some sex offenders. Laws in several American states allow compulsory medical treatment of offenders who have committed serious sex offences. Chemical, as well as physical, castration of sex offenders takes place in psychiatric hospitals in the Czech Republic under the legal framework of "protective treatment." Meanwhile, in England the Department of Health is supporting an initiative to facilitate the prescription of drugs on a voluntary basis for sex offenders in the criminal justice system.[1]

Demand for the prescription of antiandrogens or physical castration for sex offenders is a common reaction by lawmakers and politicians when a high profile sexual crime is committed. Although castration is ostensibly for public protection, it also carries with it a sense of symbolic retribution. Whether medical or surgical, the procedure requires the participation of doctors, and this gives rise to questions regarding the basis of medical involvement. Some people argue that not only does medical input in these cases straddle the border between treatment and punishment,[2] but that it also shifts the doctor's focus from the best interests of the patient to one of public safety.

Antiandrogenic drugs and physical castration undoubtedly reduce sexual interest (libido) and sexual performance,[3] and they reduce sexual reoffending. Physical castration of sex offenders was carried out in several European countries in the first part of the 20th century, and although morally dubious and not always targeted at high risk cases (many of those castrated were homosexual, mentally ill, or learning disabled), recidivism rates of less than 5% over long follow-up periods are invariably reported, compared with expected rates of 50% or more.[4]

Studies of the use of antiandrogenic drugs report similar efficacy,[5] [6] [7] and a large meta-analysis of treatment in sex offenders found that "organic" interventions (surgical castration and hormones) reduce recidivism much more than any other treatment approach (although the authors found that nowadays drugs are usually used alongside psychological treatment).[8] Double blind placebo controlled studies of antiandrogens are virtually absent because of the practical difficulties of carrying them out (among other things, it is not easy to convince an ethics committee of the wisdom of giving placebo to dangerous offenders), but the evidence supports the efficacy of these treatments.

It is not surprising that antiandrogens have such a big effect on the risk of sexual offences. Regardless of the strong psychological factors that contribute to sexual offending, at its root lies the pressure exerted by sexual drive and sexual arousal, mediated by biological mechanisms dependent on testosterone. The main drugs used are cyproterone acetate (in the United Kingdom, Europe, and Canada); medroxyprogesterone (in the United States); and increasingly the more expensive but possibly more potent gonadotrophin releasing hormone agonists such as leuprolide, goserelin, and tryptorelin.[9] [10] Although these drugs act in different ways, they all reduce serum testosterone concentrations in men to prepubertal values. Castration, however—whether chemical or physical—is associated with serious side effects, including osteoporosis, cardiovascular disease, metabolic abnormalities, and gynaecomastia. Physical castration is mutilating and irreversible, and it carries the potential for serious psychological disturbance, although some offenders request it nonetheless.[11]

Given the risk to the individual's health, is there a clear medical rather than social reason for prescribing powerful drugs, let alone carrying out such a drastic surgical procedure? Part of the problem lies in the poor diagnostic conceptualisation of the sexual deviations, with DSM-IV-TR (*Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision) and ICD-10 (*International Classification of Diseases*, 10th revision) definitions dominated by notions of the unconventional nature of the drive, rather than its psychological or physical characteristics. When the intensity or ability to control sexual arousal is the presenting feature—whether it manifests as frequent rumination and fantasy or strong and recurrent urges—then treatment directed towards the biological drive makes sense. Treatment protocols can then be based on the medical indication (remembering that drugs other than the antiandrogens, such as selective serotonin reuptake inhibitors, can also be effective, particularly when sexual rumination is the presenting problem[12]) rather than on risk.

When drugs work the clinical effect is often dramatic, with offenders reporting great benefit from no longer being preoccupied by sexual thoughts or dominated by sexual drive. These drugs can also allow offenders to participate in psychological treatment programmes where previously they may have been too distracted to take part. Given the transparency of benefits and risks, there is no obvious reason why an offender should not be able to make an informed choice about drugs. Some argue that freedom of choice is lost in instances where long term detention is the only alternative to drugs,[2] but it is not clear why this should not be part of the person's calculation. Indeed, preventing this choice may condemn men to years of further imprisonment.

Overall, it probably makes most sense for medical treatment to be viewed as part of a wider package of care and supervision, dependent on the individual's consent but with no decisions wholly dependent on compliance. In this context, the doctor does not assume responsibility for public safety but contributes to it by helping the offender to tackle those factors that make him more likely to reoffend.[6] Physical castration as part of a rehabilitative strategy may even have a place, although the observations of the Council of Europe's committee for the prevention of torture (www.cpt.coe.int/documents/cze/2009-08-inf-eng.pdf) should not be overlooked given the significant risk of human rights abuses, with individuals acquiescing rather than consenting in the belief that it is the only way to avoid indefinite confinement.

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