Castration and Sex Offenders

Chemical castration started out as a form of therapy for paraphilic sexual offenders (Vaillancourt 12). But what was once a voluntary supplement to proper mental health counseling has recently been threatened as a punitive action taken against sexual predators. Because castration involves altering hormone levels in the body, it should not be used as a form of punishment against sex offenders.

Testosterone is produced by the testes and is closely tied to feelings of sexual desire and arousal in men (Crooks & Bauer 158). Men who have undergone physical castration report less sexual activity and arousal in the year following the procedure (Crooks & Bauer 158). Chemical castration can be performed by giving intramuscular injections of medroxyprogesterone acetate (MPA) (Crooks & Bauer 158). In women, altering the levels of testosterone can also reduce sexual desire, and MPA has been suggested as a viable chemical castration agent for female sex offenders.

The problem with both physical and chemical castration is that their effects are not targeted to just the reproductive system and sexual desire. A reduction in serum testosterone has been linked to increased blood lipids, cardiovascular disease, and decreased bone density. Side effects of MPA can include deep vein thrombosis and pulmonary embolisms, depression, and anxiety. Removal of the ovaries in women can also cause significant health effects. Estrogen is produced primarily by the ovaries, and reduced serum estrogen is linked to reduced bone density and osteoporosis in women. Castration is therefore a major health consideration for both men and women, and should not be abused as a form of retribution for sexual offenders. The decision to undergo potentially life-altering surgical or pharmaceutical procedures is a personal one that should only involve a sex offender and his/her medical doctor. (Porth 456)

When it comes to female sex offenders, some question the ethics of allowing them to undergo Hormone Replacement Therapy (HRT) during menopause. The benefits and risks of HRT are still under investigation but so far HRT has shown itself to be a viable form of increasing female sexual desire and vaginal lubrication during menopause (Crooks & Bauer 159). The benefits of HRT do not just involve sexual desire though. HRT decreases endometrial hyperplasia, therefore decreasing endometrial cancer rates in post-menopausal women (Porth 472). It improves bone density and HDL/LDL blood lipid ratios and decreases the risk of Alzheimer-associated amyloid plagues developing in the brain. Like chemical castration, the decision of a woman to undergo HRT should not be affected by her sex offender status.

Another problem with castration of sex offenders is it assumes most sexual offenses are crimes purely of sex. While sexual activity may be the method, most sexual predators, especially those convicted of violent rape, are crimes of power. The profile of a sex offender as a hypersexual, paraphilic with a higher-than-normal sexual appetite is false. For these sex offenders, alterations in hormone levels are not going to prevent future sex offenses. (Crooks & Bauer 158).

As a treatment for sexual offenses, castration in any form should be a personal decision between the offender and his/her medical professional. Because of the sweeping effects of
hormone therapies on other aspects of human physiology it is not appropriate to prescribe such a punishment to an entire group. When used in conjunction with mental health counseling, castration can be an effective supplement, but it should only be undertaken at the choice of the individual.
References

