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CASTRATING PEDOPHILES CONVICTED OF SEX OFFENSES AGAINST CHILDREN: NEW TREATMENT OR OLD PUNISHMENT?

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I. INTRODUCTION

PERSONS who are convicted of sex offenses¹ involving children² are among the most reviled members of society.³ The offenses these persons commit are profoundly tragic in several respects.⁴ Children are the most vulnerable of victims, suffering traumatic and frequently life-long physical and emotional damage.⁵ Many of these child victims may themselves subsequently commit sex offenses against children, compounding the perniciousness of such offenses.⁶ Aside from the horror of victimizing children, sex offenders who have paraphilic disorders such as *pedophilia*—defined as socially reprobativ sexual desires for or sexual behavior involving children by an adult⁷—often have many vic-

1. The definition of the term "sex offense" varies by jurisdiction; here, the term is intended broadly, and is meant to include any criminally chargeable act that involves conduct of a sexual nature. Such conduct may include, for example, homosexual conduct, lewdness, indecency, sexual battery, distribution of sexually oriented material to children, and sodomy. See, e.g., TEX. PENAL CODE ANN. §§ 21.06-08 & 11 (Vernon 1996) (providing as sexual offenses homosexual conduct, where a person engages in deviate sexual intercourse; public lewdness; indecent exposure; and indecency with a child); CAL. PENAL CODE §§ 290(n)(1)(B), 286.5, 288(a), 288a, & 289 (West 1996) (defining sexual offenses under these sections as, for example, penetration against the person's will of another's genital or anal opening by a foreign object for the purpose of sexual arousal or gratification; oral copulation between the mouth of one person and the sexual organ or anus of another person; sexual assault on an animal for the purpose of arousing or gratifying the sexual desire of the person; lewd or lascivious acts involving children under age 14 with the intent of arousing, appealing to, or gratifying the lust, passions or sexual desires of that person or the child); MISS. CODE ANN. §§ 97-5-23, 97-5-27, & 97-3-95 (West 1996) (defining sex offenses as, for example, the touching of a child for lustful purposes, disseminating sexually oriented material to children, and sexual battery); N.Y. PENAL LAW §§ 130.20(3), 130.50 (McKinney 1997) (including as a sex offense any sexual conduct with an animal or a dead human body, and sodomy). Thus, persons convicted of such offenses are referred to as "sex offenders." See, e.g., COLO. REV. STAT. § 16-11.7-102(2) (West 1996).

2. The definition of "children" or "child" under criminal statutes also varies by jurisdiction and is generally limited by chronological age. See, e.g., TEX. PENAL CODE ANN. § 21.11 (Vernon 1996) (defining child under this section as a person younger than 17 years). Where relevant for purposes of this paper, the terms children or child will be explained either in text or citation.

3. See, e.g., *Child Molester Killed by Inmates*, COM. APPEAL, Oct. 19, 1996, at B2; Doug Nurse, *Station Denies Tie of Show to Killing*, TAMPA TRIBUNE, Oct. 3, 1996, at 1 (reporting killing of Donald Glenn McDougall—who was convicted of the torture-slaying of a five-year-old girl by prison inmates shortly after a radio show aired details of the case and after other inmates indicated to prison officials that McDougall's life was in danger); Larry D. Hatfield, *No Special Treatment for Convicted Child-Killer Davis, Warden Says*, ORANGE COUNTY REGISTER, Sept. 29, 1996, at A13 (reporting that "child molesters are at the bottom of a prison's respect hierarchy").

4. See *infra* Part II.A.2.b.

5. See *id.*

6. See *id.*

7. DIAGNOSTIC AND STATISTICAL MANUAL 527-28 (4th ed. 1994) [hereinafter DSM-IV]. See also STEDMAN'S CONCISE MEDICAL DICTIONARY 751, 759 (2d ed. 1994) [hereinafter STEDMAN'S MEDICAL DICTIONARY]. Using this definition of pedophilia, it is clear that not all sex offenders whose victims are children are pedophiles. Some offenders may not be drawn like pedophiles to children at all, but may instead victimize children inadvertently, such as under an intoxicated state, impaired mental state, or mistaken belief. Distinguishing between pedophile and non-pedophile sex offenders is important because the possible treatment alternatives for each may be markedly different. See *infra* Part II.A.1.

tims, sometimes numbering into hundreds over a lifetime of offending.⁸ Finally, pedophilic sex offenders frequently continue to commit sex offenses after incarceration, even after receiving treatment for the pedophilic disorder.⁹ Given the inarguably tragic consequences of sex offenses involving child victims, the sensationalism generated by several cases,¹⁰ and an increase in reported sex offense cases involving children,¹¹ the public hue and cry is not surprising.¹² What is remarkable, however, are some of the means enacted or proposed by public officials to deal with such sex offenders. One touted method is to permit—and perhaps implicitly encourage—surgical castration, also called “orchietomy,” of incarcerated sex offenders whose victims were children.¹³ Some propo-

Not *all* adults who have paraphilias involving children are classified as pedophiles. WILLIAM E. PRENDERGAST, *TREATING SEX OFFENDERS IN CORRECTIONAL INSTITUTIONS AND OUTPATIENT CLINICS: A GUIDE TO CLINICAL PRACTICE* 137 (1991). Those whose sexual interests involve post-pubertal children are called “hebophiles.” *See id.* at 140. Hebophiles are quite distinct from pedophiles, with important implications for treatment. *See id.* at 141-42; *see also infra* note 25.

8. *See infra* Part II.A.2.a.

9. *See generally* Gordon C. Nagayama Hall, *Sexual Offender Recidivism Revisited: A Meta-Analysis of Recent Treatment Studies*, J. CONSULTING & CLINICAL PATHOLOGY 802, 805-07 (1995) (reviewing 12 published studies between 1988 and 1992, and finding through a meta-analysis of the studies that 19% of the study participants committed additional sexual offenses following completion of treatment).

10. *See generally* PHILIP JENKINS, *PEDOPHILES AND PRIESTS: ANATOMY OF A CONTEMPORARY CRISIS* 33-76 (1996) (chronicling and reviewing some of the 31 mass media reports of “sexual misbehavior” by priests); *see also* George Flynn, *Sex Abuse Lawsuit Accuses HISD and Former Teacher*, HOUS. CHRON., Mar. 11, 1997, at 15A, available in 1997 WL 6544772 (reporting on a 10 million dollar lawsuit filed against a local school board district after one of its former teachers—found liable for 45.5 million dollars in damages in a previous child sexual abuse case, believed to be the largest verdict ever against a teacher in a molestation case, was subsequently charged with abusing a second student).

11. *See infra* Part II.A.2.a.

12. *See, e.g.*, Mireya Navarro, *A Figure of Infamy is Held in a Second Outrage*, N.Y. TIMES, Feb. 21, 1997, at A10 (reporting that Lawrence Singleton, who was convicted in 1979 for the rape and axmutilation of a 15-year-old girl and whose crime led to tougher sentencing in many states, was now charged with the murder of a woman); Marlise Simons, *Sex Slayings Alarm France on Peril of Repeat Offenders*, N.Y. TIMES, Feb. 25, 1997, at A6 (reporting that the rapes and slayings of four women, two of whom were 17 years old, sent thousands of protesters into the streets screaming, “[b]ring back the death penalty,” and that these recent crimes together with similar crimes in the U.S. and other western countries raise perplexing questions on how to deal with sex offenders).

13. *See* S.B. 123, 75th Legis. Sess. (Tex. 1997) (a bill entitled *An Act Relating to the Treatment of Repeat Sex Offenders*); A.B. 3339, 1995-96 Reg. Sess. (Ca. 1996) (hereinafter CAL. ASSEMBLY BILL 3339). The California law repeals and adds § 6445 of the state’s penal code. *See id.* § 1. The California law also provides that a judge may impose—upon any person guilty of a first offense of any one of several sex offenses involving children—treatment involving the use of MPA, an antiandrogenic compound drug believed to lower testosterone levels and therefore reduce sexual drive and aggression. *See id.* § 2; *see also* A. Kenneth Fuller, *Child Molestation and Pedophilia: An Overview for the Physician*, 261(4) JAMA 602, 604 (1989) (reviewing the various treatments available for paraphilic syndromes such as pedophilia). The judge *must* impose such treatment upon persons twice-convicted for such offenses. *See* CAL. ASSEMBLY BILL 3339 § 2. However, no person will be subject to such treatment if the “person voluntarily undergoes a permanent, surgical alternative . . .” *Id.*

For purposes of this Article, surgical castration, or bilateral *orchietomy*, involves the removal of a man’s testes. *See* STEDMAN’S MEDICAL DICTIONARY, *supra* note 7, at 164, 721. The term surgical castration also includes bilateral *oophorectomy*, or the removal of a

nents of surgical castration argue that orchiectomies may be an appropriate clinical response for certain repeat sex offenders and should therefore be made available to such offenders.¹⁴ These proponents point to evidence that essentially shows that surgical castration is a minimally invasive, efficacious and long-lasting clinical intervention that reduces a pedophile's urge to recidivate.¹⁵ Other proponents suggest that surgical castration is a justifiable penological response to intractable criminal behavior.¹⁶ These proponents find that surgical castration is a deserving punishment for sex offenders, and some even suggest that a death sentence may be more appropriate.¹⁷ Opponents of surgical castration object for several reasons, citing, for example, the lack of sufficient research that establishes the procedure's effectiveness, the procedure's barbarity, its potential for abuse, and the multifactorial etiology of sexual deviance for which castration may be an inadequate or inappropriate response.¹⁸

woman's ovaries, though this is not the subject of this Article. See *id.* at 164, 715; BENJAMIN MILLER AND CLAIRE BRACKMAN KEANE, *ENCYCLOPEDIA AND DICTIONARY OF MEDICINE, NURSING, AND ALLIED HEALTH* 216 (4th ed. 1987) [hereinafter MILLER & KEANE, *ENCYCLOPEDIA & DICTIONARY OF MEDICINE*]. The terms surgical castration, castration, bilateral orchiectomy, and orchiectomy may be used interchangeably throughout this Article, and mean the removal of both testes. For a description of surgical castration, see *infra* Part II.B.2.c.

14. See *infra* Part II.B.c.; D.A.G. Cook, *There is a Place for Surgical Castration in the Management of Recidivist Sex Offenders*, 307 *BRIT. MED. J.* 791, 791 (1993) (explaining that when psychological and behavioral programs fail and chemical methods to suppress libido have been unsatisfactory, "there may be a case for surgical castration").

15. See *infra* Part II.B.2.c.

16. See, e.g., Anita Szoke, *Man Pleads Guilty to Assaulting 6-Year-Old Girl*, *STATE J. REGISTER* (Springfield, IL), Jan. 14, 1997, at 2 (reporting that the father of a child molestation victim wants to have a state law that would impose a death penalty upon child molesters); Jim Breig, *Labeling Sex Offenders Won't Protect Children*, 61(11) *U.S. CATHOLIC* 13 (1996) (summarizing selected responses from readers to advance copies of an article on sex offenders, one response which stated, "[s]top opposing the death penalty for murder and other heinous crimes"); Maria Soledad Bejarano & Asieh Namdar, *President of Ecuador Demands Tougher Punishment for Child Molesters*, *CNN WORLD REPORT* (transcript #96102007V79), Oct. 20, 1996, available in *LEXIS*, News Library, Curnws file (stating that the President of Ecuador has proposed harsher punishment, including the death penalty, for convicted child molesters); Kellie McMaster, *Network Points Out Convicted Child Molesters*, *STUART NEWS/PORT ST. LUCIE NEWS* (Stuart, Fla.), Oct. 14, 1996, at A1 (reporting on a vigilante group distributing fliers containing names of convicted child molesters to city residents; one resident stated, "[i]t's just a matter of time before this information will make someone murder someone . . . [b]ut that's a small price to protect children, isn't it? . . . [t]he death of a child molester"); Marlise Simons, *Belgium's Pedophile Case Inciting Support for Restoration of Death Penalty*, *DALLAS MORNING NEWS*, Aug. 23, 1996, at 49A.

17. See generally Simons, *supra* note 16.

18. See, e.g., John Gunn, *Controversies in Treatment: Castration is Not the Answer*, 307 *BRIT. MED. J.* 790, 790-791 (1993) (arguing that results following surgery have been conflicting, that the operation is mutilating and has a risk of being carried out coercively, that more effective alternatives exist, that suicide is a known hazard resulting from surgical castration, and that other more serious clinical needs, such as personality and behavior problems, may go unmet) [hereinafter Gunn, *Controversies*]; Nigel Eastman, *Surgical Castration for Sex Offenders*, 307 *BRIT. MED. J.* 1140-41 (1993) (remarking that some persons suggest that all pedophilic offenders may have personality disorders, making them inappropriate candidates for surgical castration because such patients may have many underlying reasons for requesting surgical castration that have little to do with desiring treatment for a well-defined disorder); Reinhard Wille & Klaus M. Beier, *Castration in Germany*, 2 *ANALS SEX RES.* 103, 109-110 (1989).

Courts have relied on arguments from both sides at different times to uphold or invalidate laws that purport to punish or to provide treatment for persons who are incarcerated, albeit in dissimilar contexts, and it is likely that the same arguments will be used to enact or to challenge legislation or laws providing for the surgical castration of sex offenders such as pedophiles.¹⁹

The implications of enacting laws that permit the surgical castration of incarcerated sex offenders, especially as such laws apply to pedophilic offenders, is the subject of this Article. In Part II, the nature of sex offending, pedophilia disorder, and its treatment, with a particular focus on surgical castration, is reviewed in detail. Four examples of recent legislative responses to the problem of sex offending involving children, all of which were enacted and more or less sanction surgical castration, are analyzed in Part III. Parts IV and V provide an examination of the most significant legal issues raised by surgical castration and include analyses of cases specific to castration and to other cases relevant to our discussion. These cases provide some insight as to how legislation pertaining to surgical castration may be legally and ethically construed in the context of medical treatment. We conclude by suggesting that permitting incarcerated pedophiles—convicted of sex offenses against children—to undergo voluntarily surgical castration within the context of treatment for their pedophilia disorder is both constitutionally defensible and morally permissible.

II. PEDOPHILIA AND ITS TREATMENT

Despite what appears to be some agreement among experts who deal in such matters as the harmful effects of sexual abuse upon child victims,²⁰ a review of the relevant literature reveals variability as to what is

The revival or implementation of penological practices that invoke “punishments from Puritan days” is nothing new, despite a history of being rejected. *See, e.g.*, Adam Nossiter, *Judge Rules Against Alabama’s Prison “Hitching Posts,”* N.Y. TIMES, Jan. 31, 1997, at A14 (reporting on a federal magistrate’s decision declaring as unconstitutional punishment an Alabama prison’s use since 1993 of hitching posts—or “restraining bars,” described as similar or worse than pillories—to discipline inmates, apparently for upwards of seven hours at a time in high or low temperatures without food, water, or the use of toilets).

19. *See, e.g., infra* Part IV.A.

20. *See* Clare E. Cosentino & Michelle Collins, *Sexual Abuse of Children: Prevalence, Effects, and Treatment*, 789 ANNALS N.Y. ACAD. SCIENCES 45, 49-51, 54-59 (1996). The authors’ review of recent research leads them to observe that, aside from “psychosexual disturbances,” sexually abused children have symptoms—such as anxiety, depression, and academic problems—often seen in child psychiatric patients, and although sexually abused children have more serious behavior problems than non-abused children who have no outpatient psychiatric history, sexually abused children have fewer behavior problems than children with outpatient psychiatric histories. *See id.* at 50. Problems most specifically related to child sexual abuse are sexualized behavior and gender conflict. *See id.* at 49-50. Sexualized behavior refers to inappropriate and interpersonally dysfunctional behavior that is influenced and shaped by sexual abuse, where misconceptions about sexual behavior and sexual morality are acquired. *See id.* at 56. For example, a child may exchange sex for affection and attention, and may associate sexuality with violence and aggression. *See id.* Compulsive masturbation and seductive behavior may also occur. *See id.*

meant by pedophilia, what causes it, and how it is most effectively treated.

A. THE NATURE OF PEDOPHILIA

1. *Definition of Pedophilia*

Pedophilia is one among many disorders loosely categorized as paraphilias—psychosexual disorders such as transvestitism, exhibitionism, sexual masochism, and sexual sadism in which unusual or bizarre imagery or acts are necessary for realization of sexual excitement.²¹ One medical reference describes a paraphilia as a “[g]ross impairment in the capacity for affectionate sexual activity between adult human partners” and notes that a paraphilia can be diagnosed by a person’s behavior *or*, in the absence of behavior, where a person is “markedly distressed by ‘recurrent intense sexual urges and sexually arousing fantasies of at least 6 [months] duration.’”²² Interestingly, many paraphiliacs have multiple sexual deviations, and many progress from one deviation to another.²³

As a particular paraphilic disorder, pedophilia is a desire or preference for sexual relations with prepubertal children.²⁴ The disorder is labeled child molestation instead of pedophilia where the child victim is postpubertal, but the distinction is sometimes characterized as arbitrary; persons who have sexual interests in postpubertal children are called hebophiles, but clearly both pedophiles and hebophiles are child molest-

Gender conflicts refer to a child’s ambivalence about his or her own gender and manifestations of cross-gender behavior. *See id.* Sexually abused children may act like, and wish to be, the opposite sex. *See id.* at 49. Sexually abused girls acquire negative associations with being female and may identify with masculine roles in order to deny their victim roles and overcome fright and helplessness associated with trauma. *See id.* at 56-57. Sexually abused boys experience sexual identity confusion and fears about homosexuality, “which may be related to the homoerotic implications of the sexual contact,” as well as fears that they may become child sexual abusers themselves. *See id.* at 57. Sexually abused children also experience attachment disturbances, including distrust of adults and therapists, as well as dissociation, including suppression of conscious awareness of the sexual abuse. *See id.* at 57-59. The degree of symptomology is influenced when the victimizer is someone close to the child, when the abuse occurs over a long period of time, and when the frequency of sexual contact is high. *See id.* at 50. Sexual acts that involve oral, anal, or vaginal penetration or that is violent or involve physical force are associated with increased trauma. *See id.* Some differences between sexually abused boys and girls have been noted, the most apparent being that girls tend to exhibit sexually reactive (e.g., sexualized or seductive) behavior that may place them at further risk of sexual abuse, while boys have a greater tendency towards sexual aggression and engaging in coercive sexual behavior with other children, especially if the boys experienced physical violence and anal penetration. *See id.* at 51.

21. *See* TABER’S CYCLOPEDIA MEDICAL DICTIONARY 1326 (16th ed. 1989) [hereinafter TABER’S MEDICAL DICTIONARY].

22. MERCK MANUAL OF DIAGNOSIS AND THERAPY 1570 (16th ed. 1992) [hereinafter MERCK MANUAL].

23. *See* J. D. Bloom et. al., *An Overview of Psychiatric Treatment Approaches to Three Offender Groups*, 39(2) HOSP. AND COMMUNITY PSYCHIATRY 152; *see also* Saunders & Awad, *infra* note 78, at 573.

24. *See* TABER’S MEDICAL DICTIONARY, *supra* note 21, at 1344; MERCK MANUAL, *supra* note 22, at 1570.

ers.²⁵ THE DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS gives the following criteria for pedophilia:

- 1) An impairment lasting at least 6 months, with recurrent and intense sexually arousing fantasies, sexual urges, or behaviors that involve sexual activity with a prepubescent child or children (generally age 13 years or younger);

25. See MERCK MANUAL, *supra* note 22; *but cf.* Prendergast, *supra* note 7, at 140-42. The author explains the important characteristics of, and distinctions between, pedophiles—whose sexual interests involve prepubertal children, and hebophiles—whose sexual interests involve postpubertal, orgasmic children. The following schematic is useful:

Pedophiles

Hebophiles

1

Victim age preference: pre-pubertal, anorgasmic.

Victim age preference: post-pubertal, orgasmic.

2

Age bracket choice depends on the level of inadequacy. A general rule is that the more inadequate the offender, the younger the child victim.

Age bracket choice usually reflects that age at which he was happiest sexually and otherwise. This may be considered his age of psychosexual fixation.

3

Offender is usually fixated.

Offender is usually regressed. The group includes the incestuous fathers.

4

Offender's need is to please the child sexually for acceptance. Often uses "sex education" as a ploy.

Offender's need is to have a sex partner. Considers his behavior as "having an affair."

5

The sexual behavior is usually one-sided with the offender "pleasing" the child victim.

The sexual behavior is usually two-sided with reciprocation a need of the offender.

6

Gross immaturity and inadequacy prevail.

This group is usually more mature with a good adult façade.

7

Employment goals are usually below potential. This group prefers passive and subservient positions.

Employment goals are age and potential oriented. This group often contains professionals and successful businessmen.

8

Socially, this group fears both their peers as well as adults. They are comfortable only with other inadequate males or children.

Socially, this group gets along well with peers on most levels except sexually.

9

Treatment time is usually a long-term battle for the smallest, visible or observable changes.

Treatment time usually reflects rapid growth; changes appear sooner and are more easily observed or proven.

10

Prognosis is extremely poor. This group comprises the most failures of all sex offender groups in treatment.

Prognosis is good. There are more strengths to work with and the success rate is relatively high.

Id. at 141. For purposes of this Article, pedophilia and pedophiles will include hebophiles and child molestation; distinctions, where relevant, will be noted.

- 2) Fantasies, sexual urges, or behaviors that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning; and,
- 3) The impaired person is at least aged 16 years, and at least 5 years older than the child or children.²⁶

From these definitions, it is clear that a pedophile is not a sex offender until he engages in a legally proscribed act.²⁷ Conversely, a person who commits a sexual offense that involves a child may not be a pedophile if, for example, the behavior or fixation is short-lived. A man who rapes a child, for instance, may not be a pedophile. The popular notion that rapists are motivated by power and pedophiles by sex not only seems facile, but is of little help in determining who should be eligible for what kinds of treatment. With this in mind, the next section contains data concerning both what are normally categorized as pedophilic acts and sexual assaults.

2. Sex Offenses and Sex Offenders

a. Incidence of Sex Offenses

Many persons now in prison were placed there based upon convictions for "violent sex offenses," including rape and sexual assault.²⁸ The U.S. Department of Justice reports that 9.7% of state prisoners in 1994 were violent sex offenders.²⁹ The self-reports of state prisoners convicted of rape or sexual assault indicate that two-thirds were "child victimizers" (victims aged seventeen years or less), and fifty-eight percent of those said their victims were twelve years or younger.³⁰ Additionally, in one study of crime data reported to police in three states, fifteen percent of rape victims were under age twelve, and twenty-nine percent of rape victims were between the ages of twelve and seventeen.³¹ The U.S. Department of Justice also reports that ninety percent of rape victims under age

26. See DSM-IV, *supra* note 7, at 527-28; see also MERCK MANUAL, *supra* note 22, at 1570. The age difference and the age of the person with this diagnosis are arbitrary. See *id.*

27. Absent the act, a person cannot generally be compelled to undergo treatment or otherwise be charged with a crime or be incarcerated simply because the person has a pedophilia disorder. See *Robinson v. California*, 370 U.S. 660, 666 (1962) (finding a state law that made having a disease—in this case a narcotic addiction—a crime punishable by imprisonment to be in violation of the Eighth and Fourteenth Amendments).

28. See LAWRENCE A. GREENFELD, U.S. DEP'T OF JUSTICE, CHILD VICTIMIZERS: VIOLENT OFFENDERS AND THEIR VICTIMS 1 (1996) [hereinafter CHILD VICTIMIZERS]. Violent sex offenses categorized under rape and sexual assault include forcible rape, forcible sodomy, statutory rape, lewd acts with children (fondling, molestation, or indecent practices) and other sexual assault. See *id.* at 2. The numbers presented in this report were extrapolated from interviews of 13,986 state prison inmates to the entire U.S. state prison population, using data collected from 277 state prisons. See *id.* at 23-24. The survey was conducted for the Bureau of Justice Statistics by the U.S. Bureau of the Census over a three-month period in 1991. See *id.* at 23.

29. See LAWRENCE A. GREENFELD, U.S. DEP'T OF JUSTICE, SEX OFFENSES AND OFFENDERS: AN ANALYSIS OF DATA ON RAPES AND SEXUAL ASSAULT 2 (1997) [hereinafter SEX OFFENDERS].

30. See *id.* at iii.

31. See Fox Butterfield, *1995 Data Show Sharp Drop in Reported Rapes*, N.Y. TIMES, Feb. 3, 1997, at A14.

twelve knew the offender, and that two-thirds of victims eighteen to twenty-nine years old had a prior relationship with their rapist.³² Startlingly, while the average annual growth in the number of prisoners since 1980 has been about 7.6%, the number of prisoners sentenced for violent sexual assault other than rape increased by an annual average of nearly fifteen percent, faster than any other category except drug trafficking.³³

More recent reports appear to confirm that typical rape or sexual assault victims are children or adolescent girls, and that one of the most notable risk factors for rape or sexual assault, especially for girls, is the presence of a stepfather as part of the household.³⁴ Girls raised with stepfathers are over seven times more likely to be sexually abused by them than girls raised in households with their natural fathers.³⁵ Although studies suggest that girls rather than boys are at a higher risk for sexual abuse, with two to four girls for every boy sexually assaulted, boys are believed to be underrepresented and may therefore be at greater risk of sexual assault than is now known.³⁶ This underrepresentation may be due to the "male enculturation" process, which may make boys less likely to admit to victimization, especially since sexual abuse for boys can carry the stigma of homosexuality.³⁷ Girls are considered more willing than boys to disclose sexual abuse, and girls often serve as a third-party conduit through which sexual abuse of their brothers is discovered.³⁸ Unlike girls, however, boys are more frequently subject to anal abuse and have more physical indicators of abuse; they are also more likely to be forcefully abused, to be victimized outside the family, and to be abused by younger offenders, typically older adolescents.³⁹

32. See SEX OFFENDERS, *supra* note 29, at iii. The statistic comes from police-recorded incident data. See *id.*

33. See *id.* at vi.

34. See Cosentino & Collins, *supra* note 20, at 48.

35. See *id.*

36. See *id.* at 47-48.

37. *Id.*; see also Bill Watkins & Arnon Bentovim, *The Sexual Abuse of Male Children and Adolescents: A Review of Current Research*, 33 J. CHILD PSYCHOL. & PSYCHIATRY 197, 201-03 (1992). The authors describe boys' enculturation process whereby "self-reliance, independence, and sexual prowess are valued," whereas showing hurt or homosexuality is disparaged. *Id.* at 202. Once victimized, boys may repress the sexual abuse experience and consequently fail to report the abuse. See *id.* The authors state that it is a "common clinical experience for boys to feel that because they responded [to the sexual abuse], it must mean that whoever victimized them knew they would react and had therefore picked them out because of some 'sign' of homosexuality." *Id.* The authors also state that shame may be a powerful factor in keeping boys from reporting sexual abuse, and that even when sexual abuse is uncovered, boys may be extremely reluctant to discuss the sexual abuse during therapy regardless of the therapeutic setting or the therapist's gender. See *id.* Many other factors may also account for underreporting of sexual abuse of boys, including lack of supervision, differential reaction by boys to sexual abuse, missing alertors to sexual abuse of boys, blaming the boy for the sexual abuse experience, and denial of sexual abuse of boys. See *id.* at 202-09.

38. See Cosentino & Collins, *supra* note 20, at 48. A review of samples taken from other studies lead the authors to state that between 3 and 29% of boys experience sexual assault. See *id.* at 47-48.

39. See *id.* at 48 (citations omitted).

Another distinctive feature of child sexual offending is that a single child molester may have many victims or may victimize the same child many times over, committing hundreds of sexual acts on many children.⁴⁰ One study found that self-reported child molesters had an average of seventy-two victims, but given the tendency of offenders to minimize their number of offenses, this number may be even higher.⁴¹ Another study indicates that pedophiles who are interdicted but who go untreated will often repeat their offending behavior—sex offense recidivism rates for untreated pedophiles who engage in incest⁴² are between four and ten percent, while sex offense recidivism rates for untreated, non-familial child sexual abusers are between ten and forty percent.⁴³ Sex offense recidivism rates for male sex offenders are reportedly as high as fifty percent, and depend upon such factors as demographic characteristics, criminal history and legal disposition of the offender, the offender's particular paraphilia, amenability of the offender to treatment, and the amount of community and family support available to the offender.⁴⁴

All told, it is estimated that between 100,000 and 500,000 children in the United States are sexually molested each year.⁴⁵ Between 1980 and 1992, the number of child sexual abuse cases tripled, from 37,336 cases in 1980 to 128,556 in 1992.⁴⁶ This increase has been attributed to an increase in actual identification and reporting of child sexual abuse rather than an increase in the actual occurrence of child sexual abuse.⁴⁷ Generally, however, the actual scope of child sexual abuse is not known but only estimated because the majority of sexually abused children never

40. See Fuller, *supra* note 13, at 603.

41. See Margit C. Henderson, *Sexually Deviant Behavior and Schizotypy: A Theoretical Perspective With Supportive Data*, 61 *PSYCHIATRIC QUARTERLY* 273 (1990).

42. "Incest" is defined as "sexual relations between persons immediately related by blood." *STEDMAN'S MEDICAL DICTIONARY*, *supra* note 7, at 507. Legal definitions of incest may be broader and may include, for example, sexual intercourse between members of a family whether or not the participants are immediately related by blood. See, e.g., *TEX. PENAL CODE ANN.* § 25.02(a) (Vernon 1994) (providing that an individual commits a third degree felony if the individual engages in sexual intercourse or deviate sexual intercourse with a person he knows to be an ancestor or descendant by adoption, a stepchild or step-parent, or the children of a brother or sister of the whole or half blood or by adoption).

43. See Fred S. Berlin et al., *A Five-Year Plus Follow-Up Survey of Criminal Recidivism Within a Treated Cohort of 406 Pedophiles, 111 Exhibitionists and 109 Sexual Aggressives: Issues and Outcome*, 12 *AM. J. FORENSIC PSYCHIATRY* 5, 8 (1991) [hereinafter Berlin, *Five-Year Follow-Up*] (citing W.L. Marshall & H.E. Barbaree, *Outcome of Comprehensive Cognitive-Behavioral-Treatment Programs*, *HANDBOOK OF SEXUAL ASSAULT: ISSUES, THEORIES AND TREATMENT OF THE OFFENDER* (W.L. Marshall et al. eds, 1990)).

44. See Monique Richer and M. Lynn Crimson, *Pharmacotherapy of Sexual Offenders*, 27 *ANNALS OF PHARMACOTHERAPY* 317 (1993).

45. See Fuller, *supra* note 13, at 602 (citations omitted).

46. See Cosentino & Collins, *supra* note 20, at 47; see also Fred S. Berlin, *The Case for Castration, Part 2*, *WASH. MONTHLY*, May 1994, at 28 [hereinafter Berlin, *Case for Castration*]; Berlin, *Five-Year Follow-Up*, *supra* note 43, at 6 (citing a 1986 study by the U.S. Department of Health and Human Services that found that two out of every 1000 children in the U.S. have been sexually abused, a figure that totaled 138,000).

47. See Cosentino & Collins, *supra* note 20, at 47.

come to the attention of child protection agencies or professionals.⁴⁸ Additionally, the nature of sexual abuse, including “the secrecy and shame surrounding it, the criminal prohibitions against it, and the young age and dependent status of its victim[s],” serves to limit identification, disclosure, and reporting of child sexual abuse.⁴⁹ In essence, child sexual abuse may be a much larger problem than it appears.

b. Characteristics of and Distinctions Among Sex Offenders

The majority of sexual abuse is committed by males who exhibit the following characteristics: a lack of close, healthy relationships with other persons; feelings of having been deprived of love in infancy; and marked dependency needs that indicate the offender is unable to communicate correctly.⁵⁰ Male sex offenders also tend to be rigid in their ways of adjusting to their environment—regardless of their intelligence level—and the majority of male sex offenders believe that sex is dirty and disgusting.⁵¹ One study found that pedophiles in particular typically have inadequate relationships with adult women, are emotionally and physically underdeveloped, and have immature personalities.⁵²

Researchers have tried to categorize sexual offenders based upon their behaviors and characteristics. One such attempt resulted in the delineation of three types of sexual offenders: the pedophile-fixated type, who has never been able to maintain mature relationships with peers; the pedophile-regressive type, who manages to have some mature relationships, but following a confrontation with another person concerning his sexual adequacy or a threat to his masculine image, starts engaging in pedophilic acts; and the pedophile-aggressive type, who generally selects boys for sexually sadistic acts.⁵³ Another study supported the pedophilic stereotype of a weak, passive, socially isolated, inept man who uses children for sexual fulfillment; this study found that characteristics common to sex offenders included the offenders having lower IQs; a higher frequency of avoidant and dependent personalities; a tendency to present themselves as introverted, shy, sensitive, lonely, depressed, and humorless; and having a greater number of siblings with psychiatric problems.⁵⁴ Additionally, it has been found that pedophiles are less prone to drug and alcohol abuse, are sickly as children, and have been given diagnoses that support their view of themselves.⁵⁵ Somewhat similarly but noteworthy,

48. See *id.*; see also Fuller, *supra* note 13, at 603 (citing a 1983 article that indicated that less than six percent of child molestations are ever reported).

49. Cosentino & Collins, *supra* note 20, at 47.

50. See Guilio di Furia, *On the Treatment and Disposition of Sexual Offenders*, 65 N.W. MED. 629, 631 (1966).

51. See *id.*

52. See Sheldon Travin et al., *Pedophile Types and Treatment Perspectives*, 31 J. FORENSIC SCI. 614, 615 (1986) [hereinafter Travin, *Pedophile Types*].

53. *Id.*

54. See M. Ashley Ames, *Legal, Social, and Biological Definitions of Pedophilia*, 19 ARCHIVES SOC. BEHAV. 333, 337-38 (1990).

55. See *id.* at 338.

a 1991 study involving males who were engaged in man-boy lover relationships indicated that those males had feelings of guilt, low self-esteem, depressive moods, and an extreme concern about their erotic and sexual feelings being discovered.⁵⁶ Given this profile, it is not surprising that pedophiles and child molesters generally refuse to admit to their abusive acts and the extent of their sexual acts, and will often only acknowledge their activities as fondling.⁵⁷ As a rule, it has only been in therapy that sexual offenders admit to having feelings of gratification, revenge, excitement, escape, revulsion, and severe guilt for their offending sex behavior.⁵⁸ Unfortunately, the abhorrent attitude that society has toward sexual disorders may make them more difficult to detect and to research.

Interestingly, one of the studies referred to above found that the characteristics of men who were involved in incestuous relationships are significantly different from the characteristics of non-familial pedophiles. In incest cases, alcohol use by the sex offender is frequently involved, diagnosable mental problems are seldom displayed, the offenders are either very dominant or very passive but rarely in between, and families where incest occurs have pronounced disorganization and disturbed marital relationships.⁵⁹ However, many behaviorists see incest as the cause rather than the result of the dysfunctional state of the family, and an adult incest offender is not usually differentiated from a pedophile other than by his access to the victim.⁶⁰

A number of researchers have found that pedophiles exhibit an excessively high sexual drive, which may be physiological in nature and which causes their deviant behavior.⁶¹ Other physiological characteristics have been studied, and the research indicates that penile arousal patterns to audio and visual stimuli can be used to identify rapists and child molesters in order to determine age and gender preferences, as well as to document the offender's propensity for violence.⁶² A supporting study found

56. See Alex van Naerssen, *Man-Boy Lovers: Assessment, Counseling, and Psychotherapy*, 20 J. HOMOSEXUALITY 175, 180 (1990).

57. See Travin, *Pedophile Types*, *supra* note 52, at 617.

58. See di Furia, *supra* note 50, at 631.

59. See *id.*

60. See Travin, *Pedophile Types*, *supra* note 52, at 615.

61. See Gertjan Van Zessen, *A Model for Group Counseling with Male Pedophiles*, 20 J. HOMOSEXUALITY 189, 190 (1990); see also Travin, *Pedophile Types*, *supra* note 52, at 615-16.

62. See Fuller, *supra* note 13, at 603. The technical term for the study of penile erectile measurements is "penile plethysmography" or "phallometry." See D. Richard Laws, *Direct Monitoring by Penile Plethysmography*, in *RELAPSE PREVENTION WITH SEX OFFENDERS* 105, 105 (D. Richard Laws ed., 1989). An electronic sensor device, called a penile transducer, is attached around the shaft of the penis. See *id.* at 105-06. The penile transducer sensor detects changes in penis size, beginning from a state of flaccidity to one of complete engorgement. See *id.* at 106. Measurements of the patient's penis are taken while erotic stimuli are provided to the patient; this erotic stimuli include slides or audiotaped descriptions of both deviant and non-deviant behavior. See *id.* Since patients may respond differently to some stimuli over others, such measured differential amplitudes in response provide the patient's clinicians with indications about the patient's sexual interests and preferences. See *id.* The author states that many researchers and clinicians believe that erectile response is a highly powerful measure for assessing and treating sexual

that pedophiles are more easily identified by using penile erectile measurements than by any other technique, and that violent pedophiles show significant arousal in the laboratory to physical aggression.⁶³

Females represent another, although smaller, group of child sexual abusers. One study found that women are responsible for five percent of the reported sexual abuse cases involving girls and twenty percent of the cases involving boys,⁶⁴ and a second study found that women were responsible for child sexual abuse in six to fourteen percent of the cases involving girls and in fourteen to twenty-four percent of the cases involving boys.⁶⁵ However, a study of twenty-three cases of child sexual abuse by females found that in twenty-one of the cases of forced sexual intercourse, the females were acting in consort with a male perpetrator.⁶⁶

Not surprisingly, the characteristics of female pedophiles and child molesters differ somewhat from males. In general, female sex offenders not only have more severe levels of psychopathology and personal victimization than their male counterparts,⁶⁷ but they also frequently exhibit a history of psychiatric impairment and disturbed childhood, including sexual victimization, as well as a high incidence of major depression and substance abuse, which appear to be related to their mistreatment by, and disappointment with, parental figures and adult love objects.⁶⁸

Adolescents comprise the last category of child sexual abusers. A juvenile sexual offender is defined as a youth, from puberty to the legal age of majority, who commits any sexual act with a person of any age, against the victim's will, without consent, or in an aggressive, exploitative or threatening manner.⁶⁹ Historically, sexual abuse and molestation of children by teens has been labeled "curiosity" or "experimentation," and many sexual offenses have been termed "adolescent adjustment reac-

disorders, especially when used in conjunction with other assessment tools. *See id.* In fact, penile plethysmography may "equal or exceed" the psychometric properties of more traditional measurement techniques, and is thought to be an essential component of an effective sex offender treatment program. *Id.* This is because penile plethysmography is able to measure a core element of deviant sexual orientation, deviant sexual fantasy and arousal, that may otherwise not be effectively addressed by a particular treatment program. *See id.* However, it is said that 73% of sex offender treatment programs in the U.S. do not undertake penile measurement as part of the program. *See id.* at 113. For this reason, it may be difficult to assess the value of any sex offender treatment program, or to measure success rates between various treatment programs, absent standardized measurements that devices such as the penile plethysmography appear to provide.

63. *See* Travin, *Pedophile Types*, *supra* note 52, at 616.

64. *See* Sheldon Travin et al., *Female Sex Offenders: Severe Victims and Victimiziers*, 35 J. FORENSIC SCI. 140, 141 (1990) [hereinafter Travin, *Female Sex Offenders*]; *see also* Fuller, *supra* note 13, at 602.

65. *See* Arthur H. Green & Meg S. Kaplan, *Psychiatric Impairment and Childhood Victimization Experiences in Female Child Molesters*, 33 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 954 (1994) (citing AM. HUMANE ASS'N (1981); NAT'L CENTER FOR CHILD ABUSE AND NEGLECT, (1981)).

66. *See* Travin, *Female Sex Offenders*, *supra* note 64, at 141.

67. *See id.* at 140.

68. *See* Green & Kaplan, *supra* note 65, at 954, 960.

69. *See* Gail Ryan et al., *Juvenile Sex Offenders: Development and Correction*, 11 CHILD ABUSE AND NEGLECT 385, 385-86 (1987).

tions."⁷⁰ This may contribute to the fact that, although incidence figures that are obtained from victim reports and arrest statistics indicate that approximately twenty percent of all rapes and thirty to fifty percent of child molestation cases were perpetrated by adolescent offenders,⁷¹ child sexual abuse may be underreported by as much as eighty percent, meaning that only about twenty percent of the sexual abuse victims actually have their victimization reported.⁷²

Unfortunately, more adolescent pedophiles than adult pedophiles seem to be resistant to any form of treatment, and to have significantly higher sex offense relapse rates.⁷³ One study of 221 juvenile sex offenders found that 44.8% were convicted of one or more subsequent criminal offenses; however, of those offenders who recidivate, the rate of new convictions for violent crimes was 6.6%, while the rate of new convictions for sexual crimes was 7.5%.⁷⁴ Thus, although nearly half of the juvenile sexual offenders committed new misdemeanors and non-violent felonies, sexual reoffenses were relatively rare.⁷⁵

Another study, involving a review of the research literature covering twenty-one different treatment outcome investigations of child or adolescent offenders occurring between 1942 and 1992, found that the rate of sexual reoffense among sex offenders who were adolescents ranged between two and seventy-five percent, an extremely high variance.⁷⁶ An important concern raised by the lack of more rigorous studies and better understanding of the nature, treatment, and treatment outcome of adolescent pedophilia is that it will be difficult to undertake effective interdiction and treatment for the high number of young sex offenders who go on to a lifetime of child sexual abuse.⁷⁷

Not surprisingly, adolescent male sex offenders share a number of characteristics with their adult male and female counterparts. Specifically, adolescent male sex offenders repeatedly exhibit a history of delinquency and psychiatric impairment before their first sexual offense; severe family problems; separations from parents and placements away from home; neglect and abuse, both physical and sexual; social awkwardness or isolation; academic or behavioral problems at school; low IQs; psychopathology, including primarily neurotic, conduct, and personality

70. See *id.*; see also Eileen Vizard et al., *Child and Adolescent Sex Abuse Perpetrators: A Review of the Research Literature*, 36 J. CHILD PSYCHOL. & PSYCHIATRY 731, 734 (1995). Vizard and her co-authors suggest that such characterizations may lead to underreporting and underestimating the incidence and prevalence of child sexual abuse by other children or adolescents. See *id.*

71. See Judith V. Becker et al., *Measuring the Effectiveness of Treatment for the Aggressive Adolescent Sexual Offender*, 528 ANNALS N.Y. ACAD. SCI. 215 (1988).

72. See Vizard et al., *supra* note 70, at 735.

73. See Nathaniel McConaghy et al., *Resistance to Treatment of Adolescent Sex Offenders*, 18 ARCHIVES SEXUAL BEHAV. 97 (1989).

74. See Timothy J. Kahn & Heather J. Chambers, *Assessing Reoffense Risk with Juvenile Sexual Offenders*, 70 CHILD WELFARE 333 (1991).

75. See *id.*

76. See Vizard et al., *supra* note 70, at 746-47.

77. See *id.* at 749-50.

disorders; and neurological impairment.⁷⁸ The history of sexual victimization common in both juvenile and adult sex offenders suggests a cyclical pattern of sexual abuse, which is not only a characteristic of sexual abuse, but may be a part of its etiology as well.⁷⁹

B. ETIOLOGY AND TREATMENT

1. *Etiology and Course of Pedophilia*

Simply stated, there is no consensus as to the etiology or cause of pedophilia. Some researchers argue that the cause of pedophilia remains undetermined.⁸⁰ Other researchers claim that pedophilia's etiology *is* established, and argue that sexual deviance is a learned phenomenon in which early sexual experience is significant, as opposed to sexual deviance having a genetic or biological origin.⁸¹ What is clear is that the motivation for and cause of child sexual abuse are complex, consist of both sexual and non-sexual factors, and that "[i]ndividuality with regard to etiology of paraphilia is the [general] rule."⁸²

Research has shown that predisposing and maintaining factors of pedophilia include "stress, dysfunctional home situations, familial violence, substance abuse, interpersonal deficits, failure of the incest taboo, anti-social mores, . . . distorted beliefs," and previous experience of sexual abuse.⁸³ Child molesting behavior has also been associated with "hypothalamic lesions, alterations in neurotransmitters, seizure disorders, postencephalitic parkinsonism, and other organic mental syndromes."⁸⁴ One review of the literature took pedophilia in a broad sense as encompassing all sexual activity with a child and yielded a four-factor summary of theoretical formulations with respect to the causes of pedophilia:

[(1)] *Sexual arousal*[:] For an adult to be "turned on" by a child, there has to have been cultural or familial conditioning to sexual activity with children, victimization as a child, or early fantasy reinforced by masturbation[;]

[(2)] *Emotional congruence*[:] For emotional congruence, there is a level of comfort and satisfaction in relating to a child and a fit of emotional need. Frequently this is due to arrested development either through retardation, immaturity, or low self-esteem[;]

78. See Elisabeth B. Saunders & George A. Awad, *Assessment, Management, and Treatment Planning for Male Adolescent Sexual Offenders*, 58 AM. J. ORTHOPSYCHIATRY 571, at 571-72 (October 1988).

79. See Ryan, *supra* note 69, at 386.

80. See David M. Greenberg et al., *A Comparison of Sexual Victimization in the Childhoods of Pedophiles and Hebephiles*, 38 J. FORENSIC SCI. 432 (1993); see also di Furia, *supra* note 50, at 629.

81. See Patricia Sermabeikian & D. Martinez, *Treatment of Adolescent Sexual Offenders: Theory-Based Practice*, 18 CHILD ABUSE & NEGLECT 969, 970 (1994).

82. Fuller, *supra* note 13, at 603.

83. *Id.*

84. *Id.*

[(3)] *Blockage*[:] Adult sexual opportunities may be blocked by traumatic experience with adult sexuality, sexual dysfunction, inadequate social skills, or marital disturbance[: and]

[(4)] *Disinhibition*[:] The pedophile may be disinhibited or lose control characterologically via impulse disorder, chronically via organicity or psychosis, acutely via alcohol, drugs, or situational stress, or culturofamilially via nonexistent family rules.⁸⁵

One researcher notes that, because of the reinforcing nature of sexual behaviors, the deviant acts of a sex offender may become repetitive, ingraining deviant patterns that become habitual, and that such sexual behaviors may progress to incorporate more serious and more deviant sexual acts.⁸⁶ Moreover, the sex offender's perception of positive feelings of power and control, combined with physical gratification provided by the sexual offense, begins to outweigh the potential negative consequences of the sex-offending behavior.⁸⁷ Given the divergent nature of reported findings and opinions related to the etiology and course of pedophilia and pedophilic sex-offending, it follows that the treatment for these conditions is also marked by variability.

2. Treatment

There are a number of different types of treatment available for pedophiles and child molesters. These include the use of biological or pharmacological approaches, stereotaxic neurosurgery, and surgical castration—an important objective of which is to bring about a reduction in an offender's sexual drive or urges by, for example, inhibiting an offender's testosterone level.⁸⁸ All of the above methods are dependent upon the complex interactions between higher central nervous system functions, located in the cortex and limbic systems, and neuroendocrine mechanisms mediated via the hypothalamic pituitary axis, the gonads, and their various feed-back mechanisms.⁸⁹ Other forms of treatment include traditional individual, group, and family psychotherapy, as well as psychotherapy which emphasizes cognitive or behavioral approaches, one or more of which may even be used in conjunction with biological or pharmacological treatment.⁹⁰

85. Edward L. Rowan, *Predicting the Effectiveness of Treatment for Pedophilia*, 33 J. FORENSIC SCI. 204, 205 (1988).

86. See Ryan, *supra* note 69, at 389-92.

87. See *id.*

88. See John M. W. Bradford, *The Hormonal Treatment of Sexual Offenders*, 11 BULL. AM. ACAD. PSYCHIATRIC L. 159 (1983); see also John M. W. Bradford & Anne Pawlak, *Effects of Cyproterone Acetate on Sexual Arousal Patterns of Pedophiles*, 22 ARCHIVES SEXUAL BEHAV. 629 (1993); see generally SEX OFFENDER TREATMENT: PSYCHOLOGICAL AND MEDICAL APPROACHES (Eli Coleman et al. eds., 1992) [hereinafter SEX OFFENDER TREATMENT]. The editors suggest that current treatment of sex offenders "involves interactive biomedical plus psychiatric plus psychological approaches based upon sound perceptions of the sources of criminal sexual behavior." *Id.* at 2.

89. SEX OFFENDER TREATMENT, *supra* note 88, at 2.

90. See Sheldon Travin et al., *Pedophilia: An Update on Theory and Practice*, 57 PSYCHIATRIC Q. 89, 99 (1985) [hereinafter Travin, *Update*]; J. Paul Federoff et al., *Medroxy-Progesterone Acetate in the Treatment of Paraphilic Sexual Disorders: Rate of Relapse in*

a. Biological or Pharmacological Treatment

The biological or pharmacological approach to the treatment of sex offenders involves the use of various types of medications and hormones, most intended to inhibit testosterone production in the body in order to reduce sex drive; these medications and hormones are widely accepted as treatment for suppressing paraphilic symptoms.⁹¹ Non-hormonal pharmacological agents—such as serotonergic antidepressants—have also been tried and show promise, but these results are based upon limited studies and further research may need to be undertaken before such drugs are more widely used.⁹² Some researchers argue that only biological or organic treatments such as anti-androgen treatment are feasible as therapy for sex offending behavior at this time, but this position is clearly contradicted by other researchers and clinicians who argue that an integral part of any sex offender treatment program involves psychotherapeutic intervention—such as individual and group therapy—at least as long as an offender receives pharmacological therapy.⁹³

Paraphilic Men Treated in Long-Term Group Psychotherapy With or Without Medroxyprogesterone Acetate, in *SEX OFFENDER TREATMENT*, *supra* note 88, at 109, 120-21.

91. See Fuller, *supra* note 13, at 604. One such pharmacologic agent is an anti-androgen called *medroxyprogesterone acetate* (also called MPA, as well as the trade name DepoProvera®). See also Lee E. Emory et al., *The Texas Experience with DepoProvera: 1980-1990*, in *SEX OFFENDER TREATMENT*, *supra* note 88, at 125, 130. MPA has been used in the U.S. since 1966 to control and ultimately eliminate sexual aggressiveness and deviancy in males. See *id.* at 126. A counterpart drug, called *cyproteroneacetate* (CPA), is used in Western Europe and Canada. See *id.* MPA lacks the side effects often associated with hormone therapy, such as feminization (which includes breast enlargement, penile atrophy, and female fat distribution). See *id.* MPA's main pharmacologic action is to inhibit testosterone production in the testes, but MPA has an initial effect on mood that occurs before any reported changes in sexual fantasies. See *id.* A number of parameters are considered to determine if an offender is suitable for MPA treatment, including whether the persons admits to the offense, the presence of compelling sexual fantasies, compulsions that tend to be overwhelming, and whether the person's deviant imagery or fantasy for sexual gratification is so entrenched that they are even used in normal sexual activities with a consenting partner. See *id.* at 127. The patient must understand that MPA needs to be given over a long period of time, possibly three to five years, and often in conjunction with psychotherapy. See *id.* Situations that are used to *exclude* the use of MPA include persons who do not admit to their sexual offenses, but blame drugs, alcohol or their own abused childhood, as well as persons who have severe dyssocial tendencies, such as brutal physical assault resulting from severe sado-sexual tendencies. See *id.* at 128. Medical exclusion criteria include a patient's potential for developing diabetes or a family history of diabetes, and caution is exercised for persons with elevated serum cholesterol or increased risk for gall bladder disease. See *id.* The initial dose of MPA (DepoProvera®) is 400 mg IM, which is maintained weekly as the patient is interviewed for changes in sexual thought patterns. See *id.* at 130-31. Experience has shown that three 400 mg doses, each a week apart, are necessary before changes in sexual thought patterns are noticed. See *id.* at 131. Severe fatigue is usually the first indication for a dose reduction, to 300 mg IM. See *id.* Three hundred mg IM weekly or every other week thereafter is an acceptable dose for most men, and the typical patient receives MPA for about two years before further dose tapering. See *id.*

92. See Eli Coleman et al., *An Exploratory Study of the Role of Psychotropic Medications in the Treatment of Sex Offenders*, in *SEX OFFENDER TREATMENT*, *supra* note 88, at 75, 84-86; John Bancroft et al., *The Control of Deviant Sexual Behaviour by Drugs: I. Behavioural Changes Following Oestrogens and Anti-Androgens*, 125 *BRIT. J. PSYCHIATRY* 310 (1974).

93. See Bradford & Pawlak, *supra* note 88, at 629-30; Emory et al., *supra* note 91, at 125, 130. The authors indicate that as part of the psychotherapeutic component of the sex

Biological or pharmacological treatment does have drawbacks, however. For example, the use of estrogens has been known to cause nausea, vomiting, feminization, and, though rarely, carcinoma of the breast.⁹⁴ Another commonly used drug, medroxyprogesterone acetate (MPA), may cause weight gain, hypertension, mild lethargy, cold sweats, nightmares, hot flashes, and muscle aches, and has been known to cause breast and uterine cancer in animals.⁹⁵ One eminent researcher also found that pharmacological treatment with antiandrogens yielded inconsistent results and that recidivism occurred if treatment was stopped.⁹⁶

Proponents of the biological or pharmacological approach to the treatment of sex offenders argue that it is superior to surgical castration because it involves no surgery and because compliance can readily be monitored by means of periodic injections.⁹⁷ Other proponents claim that such drugs benefit the patient by helping the patient gain a greater capacity for self-control, obtain relief from intrusive erotic obsessional fantasies, and avoid the necessity for quarantine from the community.⁹⁸ Moreover, chemical castration is more likely to be accepted by "squeamish" society than is surgical castration.⁹⁹

b. Psychotherapeutic Treatment

Another widely accepted form of treatment for pedophiles and child molesters is psychotherapy such as behavioral therapy, covert sensitization, hypnosis, and marital therapy. Through psychotherapy, factors that are associated with the offender's deviant acting-out are explored and the offender's cognitive distortions are systematically broken down, with the intention of enabling the offender to recognize the wrongfulness of his behavior and to conform his behavior accordingly.¹⁰⁰ Some researchers

offender treatment program, which has been operating since 1976, offenders participate in a monthly men's group where support and confrontation are seen as key elements for uncovering the factors that are associated with the offenders' cognitive distortions that have been used to perpetuate their behavior. *See id.* Through this psychotherapeutic component of the program, offenders come to recognize that their behavior was "victimizing and hurtful to others, often with serious and lifelong consequences." *Id.*

But cf. Prendergast, *supra* note 7, at 175-82. The author observes that one of the first things that those who work with sex offenders learn is that "conventional techniques usually fail." *Id.* at 175. The author argues for a "holistic" approach to sex offender treatment. *See id.* at 175-76.

94. *See* Bancroft et al., *supra* note 92, at 310.

95. *See* Fred S. Berlin & Edgar Krout, *Pedophilia: Diagnostic Concepts, Treatment, and Ethical Considerations*, 7 AM. J. FORENSIC PSYCHIATRY 13, 25 (1986).

96. *See* John M. W. Bradford, *Organic Treatment for the Male Sexual Offender*, 528 ANNALS N.Y. ACAD. SCI. 193, 197 (1988) [hereinafter Bradford, *Organic Treatment*].

97. *See* Berlin, *supra* note 46, at 29.

98. *See* J. T. Melella et al., *Legal and Ethical Issues in the Use of Antiandrogens in Treating Sex Offenders*, 17 BULL. AM. ACAD. PSYCHIATRY & L. 223, 229 (1989).

99. *See* Berlin, *Case for Castration*, *supra* note 46, at 29 (noting that chemical castration might be far more palatable to a society in which many people are squeamish about mandating surgical castration).

100. *See* Emory et al., *supra* note 91, at 130; Peter R. Kilman et al., *The Treatment of Sexual Paraphilias: A Review of the Outcome Research*, 18(3) J. SEX RES. 193, 197 (1982). For a much more thorough review of a promising treatment method, relapse prevention,

have noted that a variety of other kinds of psychotherapies, including family therapy, conjoint therapy, marital counseling, and cognitive therapy, have been used in treating child molesters and pedophiles, but that none has emerged as clearly superior.¹⁰¹ Other researchers and clinicians who treat sexual offenders agree "that it is desirable to prevent new sexual [offenses] by a purely psychological-sexological treatment[; and that] . . . in a large number of cases[,] it would be possible to render sufficient aid by psychological treatment, possibly combined with social measures."¹⁰² A variant of the psychotherapy approach is a multi-factorial treatment approach that includes corrective cognitive distortion; social skills and sex education; decreased deviant arousal and increased non-deviant arousal;¹⁰³ and orgasmic reconditioning in which the subjects masturbate to orgasm while viewing different stimuli that change from unacceptable to acceptable.¹⁰⁴

However, research has indicated that there are some problems with psychotherapy; specifically, there is disagreement as to whether any form of psychotherapy, in and of itself—individual or group, superficial or deep—is of any practical value in the treatment of the sexual offender *if* reduction in reconviction rate is taken as a measure of success.¹⁰⁵ For example, one study concluded that "psychoanalysis and individual (insight-orient[ed]) psychotherapy, when not used in conjunction with other forms of psychotherapy, are of little value in the treatment of pedophiles."¹⁰⁶ Moreover, even if the various forms of psychotherapy are successful in treating some sexual offenders, there may still be a large percentage of offenders who are not helped by psychotherapy.¹⁰⁷ For this reason, many advocates of a psychotherapeutic approach to the treatment of pedophilia and child molestation support psychotherapy in con-

see generally RELAPSE PREVENTION, *supra* note 62, at 2. Relapse prevention is a self-control program designed to teach individuals who are trying to change their behavior how to anticipate and cope with the problems of relapse, or a breakdown or failure in a person's attempt to change or modify any targeted behavior. *See id.* A relapse prevention program focuses on enabling a person to prevent relapse and maintain a newly adopted and acceptable behavior pattern, through a psychoeducational thrust that combines behavioral skills training with cognitive intervention techniques. *See id.* Preliminary findings indicate that persons who have participated in relapse prevention programs have more coping strategies at their disposal and have learned the value of ongoing monitoring in the prevention of relapse. *See id.* at 288. Unfortunately for child molesters, the lay community's response to programs such as relapse prevention has been negative, with punishment and banishment more often preferred than treatment. *See id.* And unfortunately for future victims, the lay public finds it difficult to see the relationship between providing treatment to the offender and protecting future victims. *See id.*

101. *See* Fuller, *supra* note 13, at 604.

102. Jorgen Ortmann, *The Treatment of Sexual Offenders*, 3 INT'L J. L. & PSYCHIATRY 443 (1980).

103. *See* Rowan, *supra* note 85, at 205.

104. *See* A. D. VanDeventer & D. R. Laws, *Orgasmic Reconditioning to Redirect Sexual Arousal in Pedophiles*, 9 BEHAV. THERAPY 748 (1978).

105. *See* L. H. Field, *Benperidol in the Treatment of Sexual Offenders*, 13 MED. SCI. L. 195 (1973).

106. Van Zessen, *supra* note 61, at 190.

107. *See* Ortmann, *supra* note 102, at 443-44.

junction with some form of biological or pharmacological treatment.¹⁰⁸

c. Surgical Castration

Surgical castration involves the removal of a man's testes—which produce the male hormones: testicular androgens, such as testosterone, and suprarenal sexual hormones—and has been used as a treatment for sex offenders in a number of European countries.¹⁰⁹ Castration lowers the level of testosterone in the body and diminishes the subject's sexual drive; it must be emphasized that surgical castration *does not involve removal of the penis*.¹¹⁰ Surgical castration is not an uncommon procedure, and in fact is frequently clinically indicated in cases of testicular and prostrate cancer, as well as in cases of injury to the testes. The effect of castration upon sexual libido and sexual activity for persons who undergo orchiectomy for purposes of treating cancer or injury is essentially no different than for persons who undergo orchiectomy for the purposes of treating sexual deviant behavior such as pedophilia, except that the effect is *intended* for the latter.¹¹¹

108. See Fuller, *supra* note 13, at 604.

109. See Wille & Beier, *supra* note 18, at 107; Bradford, *Organic Treatment*, *supra* note 96, at 193; Berlin, *Case for Castration*, *supra* note 46, at 28-29.

110. See G. K. Sturup, *Treatment of Sexual Offenders in Herstedvester, Denmark, the Rapists*, 204 ACTA PSYCHIATRY SCANDANAVIA 14 (1968); Berlin, *Case for Castration*, *supra* note 46, at 28.

111. Several techniques for performing orchiectomies exist, and the technique used depends on the intent of the surgery. See Dane K. Hermansen, *Techniques of Orchiectomy*, in UROLOGIC SURGERY 900 (James F. Glenn ed., 4th ed. 1991). The most invasive orchiectomy technique is a radical or inguinal orchiectomy, in which both the testes and the spermatic cord within the scrotum, and the inguinal canal, are removed. See DAVID A. CULP ET AL., SURGICAL UROLOGY 506, 510 (5th ed. 1985). This procedure requires an incision similar to that made in inguinal hernia repair. See *id.* The procedure is performed under general or spinal anesthesia and *only* if testicular carcinoma is suspected. See Brad A. Wolfson & Jacob Rajfer, *Simple and Radical Orchiectomy*, in OPERATIVE UROLOGY 357, 357-58 (Fray F. Marshall ed., 1991) (emphasis added).

Another technique, particularly relevant here, is simple orchiectomy, which is done almost exclusively as a means of androgen deprivation therapy in patients with advanced prostate cancer. See JACKSON E. FOWLER, MANUAL OF UROLOGIC SURGERY 201 (1990). Under local anesthesia, a single, relatively bloodless, five centimeter longitudinal incision is made down the middle of the scrotum. See *id.*; CULP ET AL., *supra*, at 506; Wolfson & Rajfer, *supra*, at 357. Through this small incision, both testes can be removed. See PATRICK C. WALSH ET AL., CAMPBELL'S UROLOGY 2960 (5th ed. 1986). During this procedure, the testicular vessels and the vas deferens are identified, clamped separately, and divided, and meticulous attention is given to minimizing bleeding (or obtaining excellent hemostasis), which is done using cautery. See Wolfson & Rajfer, *supra*, at 357; Hermansen, *supra*, at 902; STEDMAN'S MEDICAL DICTIONARY, *supra* note 7, at 458. The epididymis (essentially a reservoir for the spermatozoa) can be severed from the testes so that only the latter is removed, leaving some tissue behind in the scrotum, but it is preferable that both are removed when the procedure is meant to eliminate testicular androgen secretion; pursuant to removal of the testes (and if applicable, the epididymis) a normal looking scrotum—arguably a legitimate concern for any patient undergoing castration—can be obtained with prosthetic implants. See WALSH ET AL., *supra*, at 2960-61; Hermansen, *supra*, at 902; FOWLER, *supra*, at 201; STEDMAN'S MEDICAL DICTIONARY, *supra* note 7, at 342. Once the testicles are removed and hemostasis is obtained, the incision is closed in two layers with sutures. See Hermansen, *supra*, at 902. Drainage of the wound is not usually necessary, but can be done if there is a doubt as to hemostasis or if the procedure involved complications. See *id.*; CULP ET AL., *supra*, at 506. Following the orchiectomy, a

For many years, surgical castration has been advocated as a preventive treatment for sexual offenders; nonetheless, like biological treatments such as MPA treatment (loosely characterized, along with other pharmacological therapies used to reduce testosterone levels, as "chemical castration"), surgical castration does not completely preclude sexual functioning, and—similar to the pharmacologic therapies noted earlier—the effects of surgical castration upon libido can actually be reversed by taking testosterone.¹¹² One small study in particular found that forty percent of castrates (eight of twenty) continue to have sexual intercourse within three to seven years after the procedure, while another study found that fifty percent of castrates (nineteen of thirty-eight) have full erections while watching a sexually explicit movie within three to five years after being castrated.¹¹³ A somewhat larger post-operative study involving 104 sex offenders who underwent castration five years earlier found that libido and sexual activity among the offenders was practically *extinct* within six months of castration for over seventy-five percent of castrates; libido and sexual activity were possible with intensive stimulation for about fifteen percent of castrates, while about ten percent of the castrates had reduced levels of libido and sexual activity.¹¹⁴

Studies of libido and sexual activity aside, one of the most important benefits of surgical castration is that it is very effective in reducing the recidivism rates of pedophiles and child molesters. One researcher reports that the four main studies investigating surgical castration demonstrate that surgical castration is followed by a significant reduction in

dressing, scrotal support, and ice pack are usually applied. See WALSH ET AL., *supra*, at 2961; Wolfson & Rajfer, *supra*, at 357-58. The most frequent complication of orchiectomies is postoperative hemorrhage, but this can be avoided with attention to hemostasis during surgery and with pressure dressing. See Wolfson & Rajfer, *supra*, at 358.

Prosthetic implants of varying sizes can be used following an orchiectomy. See CULP ET AL., *supra*, at 508. However, this should not be done through a scrotal incision, and great care should be taken to avoid infection since this will necessitate removal of the implants. See *id.*; Hermansen, *supra*, at 902.

Bilateral orchiectomies performed before puberty prevents the development of secondary sex characteristics because of testosterone deficit. See MILLER & KEANE, *ENCYCLOPEDIA & DICTIONARY OF MEDICINE*, *supra* note 13, at 889. Replacement therapy may be necessary to maintain a desirable level of the hormone. See *id.* If the procedure is done after puberty, when the masculine characters have already developed, the effects are much less extreme. See *id.*

A patient having an orchiectomy will have special needs, and may need assistance dealing with problems related to his masculinity, self-concept and non-deviant sexual activity. See *id.* The patient should be given time to think about and discuss the effects of surgical castration. See *id.* The surgeon is generally responsible for informing the patient about the procedure and its anticipated long-term effects. See *id.* at 890. The nurse and other health care personnel can clarify any information that the patient and his family may have been unable to assimilate during their conference with the surgeon. See *id.* All members of the health care team should know the expected prognosis and be prepared to answer the patient's questions truthfully and matter-of-factly. See *id.* Given the extensive literature available with respect to orchiectomies and the detailed care plan that accompanies such procedures, it is clear that performing surgical castrations is not a novel undertaking with unknown risks or effects.

112. See Bloom et al., *supra* note 23, at 153.

113. See Travin, *Update*, *supra* note 90, at 99.

114. See Wille & Beier, *supra* note 18, at 127-28.

recidivism rates, with recidivism rates of non-castrates up to eighty percent compared to as little as 2.2% for castrates, over periods of six months to thirty years.¹¹⁵ Another study indicated that only three percent of persons who underwent surgical castration were involved in a subsequent sex offense, while the sex reoffense rate for a non-castrate control group was forty-six percent; subsequent rates for *any* reoffense (including sex reoffense) were twenty-five percent among those castrates and forty-three percent among non-castrates.¹¹⁶ Reductions in sex reoffense rates such as these have led researchers to claim that castration is very effective from a criminological point of view.¹¹⁷

Surgical castration does have side effects, but this is true of pharmacologic interventions for pedophilia as well; these may include: changes in metabolic processes, loss of protein, augmentation of pituitary functions, augmentation of kreatin found in urine, lowering of the hemoglobin percentage, changes in fat distribution in the body, diminution of the calcium content of bones after a period of time, hot flashes and sweating, and diminishment of beard and body hair.¹¹⁸ Additionally, castrates may exhibit a number of mental effects that require consideration; these include depressive reactions, suicidal tendencies, emotional lability, and indifference to life.¹¹⁹ However, due to the lack of comparable homogenous study results, these mental effects are very much in dispute.¹²⁰

Those who oppose surgical castration for pedophiles and child molesters do so for a variety of reasons. The overriding argument is that there is no need to perform surgical castrations because it is clear that pharmacological means, such as cyproteronacetate and MPA treatments, may be just as or more effective at reducing testosterone levels—and hence sexual drive and sex offending—than surgical castration.¹²¹ Opponents of surgical castration also argue that the operation is mutilating and carries the distinct risk that it can be carried out coercively.¹²² One commenta-

115. See Bradford, *Organic Treatment*, *supra* note 96, at 193-94; Fred S. Berlin, *Pedophilia: Driven By An Invisible Force*, in PARTNERS IN CHANGE: GROWTH THROUGH THE THERAPEUTIC (forthcoming).

116. See Wille & Beier, *supra* note 18, at 124-26.

117. See Van Zessen, *supra* note 61, at 190.

118. See Sturup, *supra* note 110, at 14-15.

119. See Wille & Beier, *supra* note 18, at 108.

120. See *id.*

121. See *Treating Sexual Disorders with MPA: An Interview with Fred S. Berlin*, 6 CURRENTS IN AFFECTIVE ILLNESS 5, 9 (1987) [hereinafter *Interview with Berlin*].

122. See Gunn, *supra* note 18, at 790; see generally *infra* Part IV.A. An additional argument that is that surgical castration for the treatment of sexual deviant behavior is just the type of procedure for which a patient will be unable to provide consent, and that the procedure is simply too experimental or innovative for medical and health professionals to perform on patients who are incarcerated. See, e.g., *Bailey v. Lally*, 481 F. Supp. 203, 220-21 (D. Md. 1979). The court in *Bailey* reviewed whether an inmate's constitutional rights were violated by improper inducements offered regarding participation in a voluntary medical research program, many of whose research procedures involved contagious diseases. See *id.* at 204-05. The court took notice of the oft-referenced case of *Kaimowitz v. Dep't of Mental Health*, 42 U.S.L.W. 101 (Cir. Ct. Wayne County July 31, 1973), in which the capacity of involuntarily confined mental patients to consent to a psychosurgical procedure on the brain was examined. See *Bailey*, 481 F. Supp. at 220 (citation omitted). The

tor observes that there may be a case for surgical castration when psychological and behavioral programs fail, and when chemical suppression of libido has been unsatisfactory, but that there is no overriding clinical reason to proceed to surgery without first trying chemical suppressants.¹²³ However, two of the most notable castration studies undertaken—involving sex offenders in Denmark and Germany who voluntarily underwent the procedure pursuant to laws specifically providing for such treatment—bear close inspection.

The use of surgical castration as treatment for sexual disorders in the country of Denmark is well-known and is instructive when considering surgical castration in the context of treatment for pedophilic disorders in this country. Denmark has been one of the few pioneers in permitting sexual offenders to voluntarily undergo surgical castration, which has been advocated as a treatment for sexual offenses for clearly forensic psychiatric reasons.¹²⁴ Moreover, the use of voluntary castration in Den-

court in *Bailey* observed that the *Kaimowitz* court's focused on whether the psychosurgical procedure in question was innovative or experimental, the procedure's intended use and "uncertain benefit to the patient and society" (ameliorating anti-social behavior), the substantial danger, intrusiveness and irreversibility of the procedure, and the particularly vulnerable status of an involuntarily confined mental patient. *See id.* at 220-21 (citations omitted). In finding no constitutional infirmities in the prison's research program, the court in *Bailey* found that unlike the circumstances in *Kaimowitz*, the research program did not involve uncertainties inherent in experimental procedures, nor were the research procedures "dangerous, intrusive, irreversible, [or] of uncertain benefit to the patient and to society." *Id.* at 221 (citation omitted). The court observed that the diseases being researched were well-known, that cures were easily administered, and that the doctors involved testified that there was almost complete lack of danger to an inmate's life or future health, and that only temporary illness and discomfort were involved. *See id.* Moreover, the court found that great care was taken by the researchers to explain all the research risks to the inmates who wished to participate in the research. *See id.*

In evaluating surgical castration in the context of the *Bailey* and *Kaimowitz* cases, it is fairly obvious that surgical castration is not the type of procedure that runs a risk of being found impermissible. First, surgical castration is not experimental or innovative, and the disorder for which the procedure is intended to ameliorate is well-researched and documented. *See supra* Part II.B.2.c. and note 111. Second, the procedure's benefits to individuals who suffer from pedophilia have been followed over many years involving many individuals, and in reducing sex offense recidivism, benefit society as well. *See supra* Part II.B.2.c. Third, the procedure is only minimally physically invasive with few risks, and the care plan for castration is well-documented and cognizant of the special needs of patients who undergo such procedures. *See supra* note 111. For these reasons, surgical castration satisfies *Kaimowitz*-type concerns.

123. *See* Gunn, *supra* note 18, at 791.

124. *See* Sturup, *supra* note 110, at 11. Initially, Denmark created a committee to study the criminal code; that committee concluded that castration could not be used as punishment or as a substitute for punishment for sexual offenders. *See id.* at 12 (emphasis added). The committee also found that voluntary castration could be permitted for humanitarian reasons in cases where the person was unable to control his sexual urges and was likely to resort to criminal means to satisfy them. *See id.* The committee proposed legislation to permit castration with proper safeguards, namely a stipulation that persons over 21 years of age, upon application, should be allowed to obtain permission for castration or other sexual intervention to their sexual organs, if their sexual drive, because of abnormal strength or direction, placed them in danger of committing a crime such that they represented a threat or danger to themselves or society. *See id.* The first law permitting voluntary castration in Denmark went into effect in 1929; an amended version was passed in 1935. *See id.* at 13; Ortmann, *supra* note 102, at 444-45. The law permitted the castration of a person whose sexual drive entails considerable psychic sufferings or social

mark has been considered both effective and successful. In a study of 900 castrates followed over a period of thirty years, asexualization resulted in ninety-seven percent of the cases, while recidivism occurred in twenty cases (a reoffense rate of 2.2%).¹²⁵ Another study of 738 sexual offenders castrated under Denmark law followed cases from 1929 through 1959, and found that only ten of the castrated men relapsed into sexual criminality, a relapse rate of 1.4% after castration; if statistical variation is taken into account because of the shorter follow-up time for some subjects, the sex offense relapse rate in this second study is between 1.4% and 2.4%.¹²⁶ Thus, voluntary castration reduced the expected relapse rate among sexual offenders from rates of up to fifty percent without castration, to reoffense rates of no more than three percent and probably less than two percent.¹²⁷ The Denmark experience in the field of reducing sex reoffense rates through castration has been confirmed by similar findings in Germany (a recidivism rate of 1.1% among castrates), Norway (a recidivism rate of 7.3% among castrates), Sweden (one recidivist out of a study population of 307 castrates), Netherlands (a recidivism rate of 1.3% among castrates), and Switzerland (a recidivism rate of 7.2% among castrates).¹²⁸

Observers of the Denmark castration scheme are satisfied that the purposes of surgical intervention provided under Denmark law were achieved.¹²⁹ Specifically, there was a decrease in castrates' sexual drive, with no significant physical or psychological damage to persons who underwent castration.¹³⁰ One researcher argues that a person who suffers greatly as a result of his deviant sexual drive will, following castration, experience significant relief at being freed from his deviant sexual

devaluation; it also included a provision for forced castration of very serious sexual criminals, but since no forced castration was ever done, and that provision was deleted from the law in 1967. See Sturup, *supra* note 110, at 13; Ortmann, *supra* note 102, at 445.

To obtain permission for a voluntary castration in Denmark, a sexual offender must first establish his fear of committing a new sex offense, and it must be shown that such a possibility is likely. See Sturup, *supra* note 110, at 18. Next, the possibility of relief through castration is mentioned to the sexual offender, and the sexual offender and his treating physician fully discuss the advantages and disadvantages of the procedure. See *id.* The sexual offender must then be given time to consider his decision even if his decision has probably already been made. See *id.* If the sexual offender chooses castration, he files his application for the procedure, which requests permission for the castration, with the appropriate governmental agency, which reviews the sexual offender's complete history and psychiatric evaluation and rules on the request. See *id.* The surgery must be done by a specially authorized surgeon; the patient is hospitalized for a few days and released into the population in 10 to 14 days. See *id.* Castration is never advised unless it is medically indicated and is part of a total treatment plan. See *id.* at 19. The treatment is designed to make life more bearable for the offender and to reduce the risk of relapse. See *id.* The main effect of castration on men with serious sexual difficulties is that their capacity to respond to sexual stimuli is diminished, as is their sexual fantasy life, and their sexual interests in general. See *id.* at 17.

125. See Sturup, *supra* note 110, at 13, 14.

126. See Ortmann, *supra* note 102, at 445.

127. See *id.*; Sturup, *supra* note 110, at 13-14, 16.

128. See Sturup, *supra* note 110, at 16.

129. See *id.* at 17.

130. See *id.*

urges.¹³¹ Another commentator argues that as long as more effective medical treatment is unavailable, voluntary castration should not be denied to sexual offenders who, after being carefully advised, choose to be relieved of their suffering through the procedure.¹³² Another indication of the success of Denmark's castration program is demonstrated by the follow-up responses of castrates—more than ninety percent of whom indicated that they were satisfied with their operation.¹³³

A few caveats over the Denmark's castration scheme deserve mention. First, only 4.4% of all Danish male sexual offenders recorded during the period of 1929 to 1939 were considered suitable candidates for the procedure and ultimately underwent castration.¹³⁴ Second, in later years, the number of sex offenders who underwent castration under the law steadily declined; since 1972, no sexual offender in Denmark has undergone castration.¹³⁵ One possible explanation for the decrease in the voluntary castration rate is that some physicians are reluctant to recommend this operation because of its side effects, and increasingly, because many physicians believe that similarly effective results in reducing sex offending behavior are obtained through biological and pharmacological treatment.¹³⁶

An important and more recent study of orchiectomies involves sex offenders in Germany. Orchiectomy for sex offenders in Germany is voluntary; sex offenders apply to a "castration committee," of which there is one in each federal state in Germany—consisting of two physicians and one lawyer.¹³⁷ One physician must examine the applicant, and the castration committee considers whether the benefits of orchiectomy outweigh the harms as well as the chances of success with alternative treatments.¹³⁸ An important consideration to the castration committee is the extent to which castration will assist the applicant cope with life in the community, as well as prevent further sex offenses.¹³⁹ Despite its legal permissibility, castration is by no means common in Germany, and is becoming even less so. Between 1970 and 1980, 400 sex offenders underwent castrations, out of a total of 770 applicants;¹⁴⁰ between 1980 and 1989, only about five applicants underwent castration each year, out of approximately 5000 persons convicted of various sex offenses.¹⁴¹

The German study involved 104 castrates, as well as fifty-three non-castrates who had previously applied for castration under the German

131. *See id.*

132. *See id.*

133. *See id.* at 14-15.

134. *See Ortmann, supra* note 102, at 445.

135. *See id.*

136. *See id.* at 445-46; *see also supra* Part II.B.2.a.

137. *See Wille & Beier, supra* note 18, at 111.

138. *See id.*

139. *See id.*

140. *See id.*

141. *See id.*

law.¹⁴² Based upon a collection of personal observations, interviews, inspection of files, case histories, and prison records, researchers in the study came up with several noteworthy findings. For instance, the researchers found that all 104 castrates showed reduced sexual interest and activity, reduced erotic fantasies, and reduced capability of spontaneous or stimulated erections.¹⁴³ About twenty-five percent of castrates were capable of intercourse after three years, and twenty percent after five years—although at greater intervals between intercourse, and only after intensive stimulation.¹⁴⁴ In some cases, libido and erection returned to pre-operative level within six months.¹⁴⁵

Another significant finding from the German study was that the most dramatically changed variable from the time of application for castration to the follow-up investigation after castration was the subject's place of abode.¹⁴⁶ Significantly more non-castrated applicants than castrates remained in penal institutions or psychiatric hospitals; significantly more castrates than non-castrates had residences in private apartments.¹⁴⁷ A total of 70.2% of castrates lived in an abode of their own at follow-up, compared to just 8.7% prior to application for castration.¹⁴⁸ The study did note, however, that even non-castrates showed some improvements in their living situations, possibly due to aging and to the help of social workers and probation officers.¹⁴⁹

The results of the German study clearly suggest a relationship between castration and recidivism rates for sex offenses.¹⁵⁰ Both sexual and non-sexual offenses recorded in criminal records—as well as sexual offenses discovered by researchers but unknown to police or which had not led to conviction—were examined to reveal the effects of castration on recidivism.¹⁵¹ The follow-up investigation revealed that three percent of castrates had been involved in sex offenses and twenty-five percent in non-sex offenses, compared to forty-six percent of non-castrates involved in sex offenses and forty-three percent in non-sex crimes.¹⁵² A total of twenty-five percent of castrated men recidivated in some form as opposed to seventy-four percent of the non-castrated group.¹⁵³ Further statistical analysis revealed that the difference between recidivism of castrates and non-castrates was only significant for sex offenses, however, and not for non-sex crimes.¹⁵⁴

142. *See id.*

143. *See id.* at 127.

144. *See id.* at 128.

145. *See id.* at 127.

146. *See id.* at 121.

147. *See id.*

148. *See id.* at 120, 122.

149. *See id.* at 122.

150. *See id.* at 125.

151. *See id.* at 113, 125.

152. *See id.* at 125.

153. *See id.*

154. *See id.*

Lastly, 71.4% of castrates evaluated were pleased with their situation following castration, while 19.5% were undecided and 9.1% were dissatisfied.¹⁵⁵ The castrates were apparently not given prosthetic implants, and the study's authors state that the greatest impairment to the castrates' masculinity was their empty scrota.¹⁵⁶ This may account for some of the dissatisfaction felt by some of the castrates. However, all men involved reported surprise at the understanding shown by their female partners.¹⁵⁷

In sum, there is clear and uncontroverted evidence that surgical castration as a therapeutic intervention for persons who have pedophilic disorders is effective, both with respect to reduced libido and sexual activity and, importantly, reduced sex offending. While castration does have side effects, this is also true for alternatives such as pharmacologic regimes. And while castration may no longer be practiced in Denmark, one of the countries studied, this is because *chemical* interventions are now the treatment of choice, not because castration has been found ineffective. For purposes of providing a clinically appropriate means for providing relief from what is a debilitating and life-long disorder, surgical castration simply cannot be discounted. Recent legislation supports this position.

III. LEGISLATIVE RESPONSE TO SEX OFFENDERS WHO VICTIMIZE CHILDREN

The response among state legislatures to sex offenses involving child victims has been divergent. Four recently enacted examples of these responses bear examination: California Assembly Bill 3339, signed into law in 1996;¹⁵⁸ Montana Senate Bill 31 and House Bill 268, a compromise of earlier bills that were vetoed by Montana Governor Racicot, but whose vetoes were overridden;¹⁵⁹ Florida House Bill 83, which became effective for crimes committed on or after October 1, 1997; and Texas Senate Bill 123, entitled "An Act Relating to the Treatment of Repeat Sex Offenders," signed into law in May 1997.¹⁶⁰ All four laws expressly sanction surgical castration for persons convicted of specified sex offenses involving child victims, but in ways and with purposes that vary significantly.¹⁶¹

155. *See id.* at 128.

156. *See id.*; cf. CULP ET AL., *supra* note 111 (indicating that a normal-looking scrotum can be obtained with implants).

157. *See* Wille & Beier, *supra* note 18, at 128.

158. *See* Act of Sep. 17, 1996, ch. 596, § 2, 1996 Cal. Legis. Serv. 2711 (West) (codified as amended at CAL. PENAL CODE § 645 (West Supp. 1997)); *see also* Bill Kisliuk, *Broadman Weighs in on Chemical Castration*, THE RECORDER, Jan. 9, 1997, at 1.

159. *See* Act of Apr. 19, 1997, ch. 334, § 2, 1997 Mont. Laws H.B. 268 (to be codified as amended at MONT. CODE ANN. § 45-5-512 (1997)).

160. *See* Act of May 5, 1997, 75th Legs. R.S., ch. 144, §§ 1-5, 1997 Tex. Sess. Law Serv. 287 (Vernon) (to be codified as an amendment to TEX. GOV'T CODE ANN. § 501.061-.062; TEX. CODE CRIM. PROC. ANN. art. 37.07, § 3(h), art. 42.12, § 11(f), art. 42.18, § 8(s)).

161. *See infra* Parts III.A.-C.

A. CALIFORNIA'S ASSEMBLY BILL 3339 REGARDING THE
PENAL CODE

California Assembly Bill 3339 (A.B. 3339) reworks Section 645 of the state's Penal Code,¹⁶² which had permitted courts to impose sterilization for the purpose of preventing procreation upon persons who were convicted of specified sex offenses against female victims under the age of ten years.¹⁶³ In its place, the revamped section 645 provides instead that courts may impose medroxyprogesterone acetate (MPA) treatment (commonly but inaccurately referred to as "chemical castration") as punishment upon persons who are convicted of their first specified sex offense¹⁶⁴ against a victim under the age of thirteen years.¹⁶⁵ The new law does not indicate under what circumstances a court "may"¹⁶⁶ impose MPA treatment upon offenders who are convicted for the first time of one or more of the specific sex offenses. The law is silent regarding persons convicted of their third or subsequent offense. However, the court is *required* to impose MPA treatment as punishment upon persons who are convicted of a second such offense.¹⁶⁷ The law does not set a minimum age limit for a convict subject to MPA treatment, with the result that a person of any age convicted of one or more of the enumerated offenses is subject to such treatment. Under section 645, MPA treatment shall commence one week prior to the offender's release from prison or other state institution, and continues until the California Department of Corrections demonstrates to the state's Board of Prison Terms that MPA treatment for the parolee is no longer necessary.¹⁶⁸ Conceivably, such treatment could be lifelong. A physician or surgeon who is an employee of the department may not be forced to participate unwillingly in MPA treatment.¹⁶⁹ Section 645 directs the California Department of Corrections to implement protocols "required" under the new law, the only statutorily specified requirement being that the offender be informed "about the effect of hormonal chemical treatment and any side effects that may result from it."¹⁷⁰ Significantly, an offender who *voluntarily* undergoes a "permanent, surgical alternative" (an orchiectomy) to MPA treatment is not otherwise subject to the new law.¹⁷¹ This provision may serve to induce

162. See Act of Sept. 1, 1996, ch. 596, § 2, 1997 Cal. Legis. Serv. 2711 (West) (codified as amended at CAL. PENAL CODE § 645 (West Supp. 1998)).

163. This version of § 645 was repealed and replaced upon the enactment of A.B. 3339, §§ 1-2, 1995-1996 Reg. Sess., 1997 Cal. Legis. Serv. 2711 (West). See CAL. PENAL CODE § 645 (West Supp. 1998).

164. The specified sex offenses include lewd & lascivious acts; oral copulation; sodomy; and penetration by a foreign object where the victim is under 13 years of age. See CAL. PENAL CODE § 645(c)(1)-(4) (1996). For a description of MPA treatment, see *supra* note 91.

165. See CAL. PENAL CODE § 645(a) (West Supp. 1997).

166. See *id.*

167. See *id.* § 645(b).

168. See *id.* § 645(d).

169. See *id.* § 645(f).

170. *Id.*

171. *Id.* § 645(e).

offenders to undergo surgical castration, given the prospect of life-long MPA treatment and consequent life-long parole supervision.

Section 645 makes no pretense of the fact that the imposition of MPA treatment upon offenders convicted of specified sex offenses is considered punishment.¹⁷² The language of the new law and the role of courts in applying the law to convicted sex offenders clearly establish the new law's punitive objective.¹⁷³ The characterization of MPA treatment as punishment, together with the lack of any reference to the use of professional medical judgment as the basis for initiating, continuing, or discontinuing MPA treatment, is important: this characterization subjects the law to analysis under the Eighth Amendment of the U.S. Constitution.¹⁷⁴ Had MPA been characterized under section 645 as treatment, and attended by the usual considerations—such as the need for treatment, risks and benefits, and the like—the law would less likely be subject to an Eighth Amendment analysis altogether.¹⁷⁵ Although the legislative analysis underlying section 645 states that MPA treatment has been shown to lower testosterone levels in males and that such drugs serve to suppress sexual offending, particularly among pedophiles, section 645 does not require that persons convicted of sex offenses suffer from the types of paraphilic disorders for which MPA treatment is considered clinically appropriate.¹⁷⁶ Moreover, the law does not require that a particularized finding be made by medical and health professionals with respect to specific offenders upon whom MPA treatment will be imposed that such treatment is medically appropriate and clinically indicated.¹⁷⁷ Conceivably then, MPA treatment could be imposed upon an individual for whom such treatment is clinically inappropriate and even dangerous. Finally, there is no indication in the law or its legislative history that a “permanent, surgical alternative” may for some persons be more effective than MPA treatment,¹⁷⁸ with the result that some persons may feel compelled to undergo surgical castration simply to escape the long-term supervision possible with MPA treatment, even if surgical castration may not be appropriate for that individual. Requirements such as these are the types of questions that clearly call for professional medical judgment and that, in cases involving constitutional challenges to state laws that permit involuntary medical treatment, have generally served to insulate medical decision-making under these laws from court scrutiny.¹⁷⁹ The lack of such

172. *See id.* § 645(a), (b).

173. *See id.*

174. *See infra* Part IV.A. (examining the contours of Eighth Amendment jurisprudence).

175. *See infra* Part IV.B. (examining how medical treatment schemes have fared under Eighth Amendment analysis).

176. *See Sex Offenders: Chemical Castration, Hearing on A.B. 3339 Before the Senate Rules Comm.*, 1995-96 Reg. Sess. (Cal. 1996) [hereinafter *Hearing*].

177. *See* CAL. PENAL CODE § 645 (West Supp. 1998).

178. *Id.*; *Hearing, supra* note 176.

179. *See, e.g.,* *Washington v. Harper*, 494 U.S. 210, 231-33 (1990). In *Harper*, a state prisoner challenged a prison policy that authorized involuntary treatment with anti-psychotic drugs if certain substantive and procedural components were met as violative of

findings in section 645 and its failure to require that such findings be made prior to imposing MPA treatment upon offenders suggest that section 645 will not receive the traditional court deference accorded to professional medical judgment, thus leaving section 645 more vulnerable to constitutional challenge.¹⁸⁰

B. MONTANA SENATE BILL 31

Montana Senate Bill 31 (S.B. 31), passed into law on April 19, 1997, on an override of the Governor's veto, provides that persons convicted of certain offenses "may . . . be sentenced" to undergo MPA treatment in addition to sentencing imposed under current law.¹⁸¹ These offenses include first time offenses for sexual assault, sexual intercourse without consent, or incest, where the victim is less than sixteen years old and the offender is three or more years older than the victim.¹⁸² Also included are any of the above offenses, regardless of the victim's age, where the

the Due Process Clause of both the Federal and Washington State Constitutions. The inmate was initially diagnosed by prison psychiatrists as suffering from a manic-depressive disorder and later as schizophrenia. *See id.* at 214. For several months after being incarcerated, he voluntarily consented to the administration of anti-psychotic drugs, but in November 1982, he refused to continue taking the medications. *See id.* Pursuant to a prison policy, the treating physician sought to involuntarily administer the prescribed medications to the inmate. *See id.*

The policy provided that an inmate could be involuntarily treated if he: "(1) suffers from a 'mental disorder' and (2) is 'gravely disabled' or poses a 'likelihood of serious harm' to himself, others, or their property." *Id.* at 215. In addition, the inmate was entitled to a hearing before a special committee, which was comprised of a psychiatrist, psychologist, and the Associate Superintendent of the Special Offender Center, none of whom could be involved in the treatment or diagnosis of the inmate at the time of the hearing. *See id.* At the hearing, the inmate had "the right to attend; to present evidence, including witnesses; to cross-examine staff witnesses; and to the assistance of a lay adviser who has not been involved in his case and who understands the psychiatric issues involved." *Id.* at 216. The inmate was also entitled to certain procedural rights, including at least 24 hours' notice of the Center's intent to seek involuntary medication of the inmate, as well as notice of his tentative diagnosis, the facts supporting that diagnosis, and the reasons why medication is believed to be necessary. *See id.* A right to appeal the committee's decision to the Center Superintendent and then to seek judicial review was also available to the inmate. *See id.*

The Court held that while Harper had a liberty interest conferred by both state law and the Due Process Clause of the Fourteenth Amendment, the prison's policy nonetheless satisfied both the Clause's procedural and substantive requirements. *See id.* at 221-23. The Court concluded that "[t]he extent of a prisoner's right . . . to avoid the unwanted administration of antipsychotic drugs must be defined in the context of the inmate's confinement." *Id.* at 222. Viewed in this light, the Court held that the procedural protections established by the policy were sufficient to ensure that the decision to administer anti-psychotic drugs to the inmate was not made arbitrarily or erroneously and that a judicial hearing was not required as the Washington Supreme Court had held. *See id.* at 228. Most importantly, the Court indicated that the policy's delegation of the decision to medical professionals was perhaps preferable than having it made by a judge who, the Court thought, may not appreciate and appropriately balance the potential side-effects of the medication and the inmate's interest in avoiding forced medication with the governmental interests at stake. *See id.* at 229-33.

180. *See supra* note 176; *See, e.g., infra* Parts IV.A.-B.

181. *See* Act of Apr. 19, 1997, ch. 334, 52, 1997 Mont. Laws H.B. 268n (codified as amended at MONT. CODE ANN. § 45-5-512 (1997)).

182. *See* MONT. CODE ANN. §§ 45-5-502(3), 45-5-503(3), 45-5-507(4), 45-5-512(1) (1997).

offender inflicts bodily harm upon the victim in the course of committing the offense.¹⁸³ The provisions under S.B. 31 also apply to persons convicted of second or subsequent offenses for sexual assault where the victim is aged less than sixteen years and the offender is three or more years older than the victim, as well as sexual intercourse without consent or incest regardless of the victim's age.¹⁸⁴

Like California, Montana's S.B. 31 characterizes MPA or its chemical equivalent as punishment.¹⁸⁵ The treatment is imposed by a court upon the applicable offender and commences one week prior to the offender's release from confinement.¹⁸⁶ Treatment is administered by the Montana Department of Corrections or its agent and is paid for by the state.¹⁸⁷ Treatment continues until the Department of Corrections determines that treatment is no longer necessary, which, of course, could conceivably be life-long.¹⁸⁸ In terms of safeguards, S.B. 31 requires that the offender be "fully medically informed" of the treatment's effects;¹⁸⁹ professional medical employees of the department may not be compelled against their wishes to administer any treatment under S.B. 31.¹⁹⁰

However, unlike California, at no time are Montana courts *required* to impose MPA treatment; the decision to order MPA treatment or its chemical equivalent is entirely within the court's discretion.¹⁹¹ Nonetheless, an offender's failure to continue the treatment as ordered by a court constitutes criminal contempt, in which case the court *is* required to impose a prison term of not less than ten years but not more than 100 years.¹⁹² Offenders who are not sentenced to undergo MPA or its chemical equivalent may *volunteer* to undergo such treatment or surgical castration, in which case the treatment or castration must be administered by the Department of Corrections or its agent and paid for by the department, although the timing of the treatment or its duration is not specified.¹⁹³ For reasons similar to those discussed regarding California Penal Code section 645, S.B. 31 does not represent the type of involuntary medical treatment statute under which decisions regarding medical treatment are accorded deference by courts.¹⁹⁴ For this reason, S.B. 31 is vulnerable to constitutional challenge.¹⁹⁵

Interestingly, a later amendment to S.B. 31, Montana House Bill 268 (H.B. 268), amended the language of S.B. 31 by inserting the terms,

183. *See id.*

184. *See id.* § 45-5-512(2).

185. *See id.* § 45-5-512(1)-(3).

186. *See id.* § 45-5-512(4).

187. *See id.* § 45-5-512(1)-(3).

188. *See id.* § 45-5-512(4).

189. *Id.* § 45-5-512(5).

190. *See id.* § 45-5-512(6).

191. *See id.* § 45-5-512(1)-(3) (stating that a convicted person "may . . . be sentenced to undergo [MPA] treatment").

192. *See id.* § 45-5-512(4).

193. *See id.* § 45-5-512(3).

194. *See supra* Part III.A.

195. *See supra* notes 173-77 and accompanying text; *see also infra* Part IV.

"medically safe," before the terms "MPA treatment."¹⁹⁶ H.B. 268 also amended the language of S.B. 31 by inserting the terms "or other medically safe drug treatment" after the terms "chemical equivalent."¹⁹⁷ The amending language appears to prohibit any MPA treatment or its chemical equivalent that poses a medical risk to the offender. Whether treatment posing only the slightest risk, a reasonable risk, or a substantial risk is prohibited is not specified. The resulting ambiguity raises the strange possibility that no such treatment can be imposed or administered since these treatments pose at least some risk. It also is not clear who determines whether treatment is "medically safe," (e.g., the courts, the department, or the medical professionals), or whether courts may resentence offenders for whom MPA treatment or its chemical equivalent poses a medical risk and for whom such treatment is prohibited. Furthermore, it is unclear whether, in the event such treatment is deemed unsafe by a medical professional, a court that imposed the treatment is compelled to recognize such a medical finding and to forego forcible treatment. Thus, while the provisions of S.B. 31 and H.B. 268 are drafted to ensure that only medically safe treatment is imposed or permitted—an obvious improvement over California H.B. 3339—ambiguous language in the Montana laws raise some potentially troublesome issues.

C. FLORIDA HOUSE BILL 83

Florida House Bill 83 (H.B. 83), which became effective May 30, 1997, for crimes committed on or after October 1, 1997, is similar to California's A.B. 3339 in that a Florida court may (for a first offense) or must (for a subsequent offense) impose MPA treatment as part of a sentence upon a defendant who is convicted of sexual battery under chapter 794.011 of the Florida Statutes.¹⁹⁸ Thus, the same troubling issues raised by the California law apply here as well.

H.B. 83 is clearly a punitive response to sexual offending: only courts are authorized to direct or order MPA treatment or physical castration of an offender; additionally, the offender's failure or refusal to undergo MPA treatment is itself an additional felony.¹⁹⁹ This may not be so remarkable since the law is intended to address sex crimes in particular, and not sexual paraphilias in general. For the same reason, it is not remarkable that the new law does not set a lower age limit, with the result that a

196. H.B. 268, 55th Leg., Reg. Sess., 1997 Mont. Laws 341, § 2(2)(A) (codified as amended at MONT. CODE ANN. § 45-5-512(a)(A) (1997)).

197. *Id.* § 45-5-512(2)(B)-(C).

198. H.B. 83, 1997 Reg. Sess. (Fla. 1997) (codified at FLA. STAT. ANN. § 794.0235 (West Supp. 1998)). Sexual battery under chapter 794.011 of the Florida Statutes is defined as "oral, anal, or vaginal penetration by, or union with, the sexual organ of another or the anal or vaginal penetration of another by any other object" FLA. STAT. ANN. § 794.011(1)(h) (West 1996). The offense is a capital felony if committed by a person 18 years of age or older upon a person who is less than 12 years of age, or a life felony if committed by a person less than 18 years of age upon a person who is less than 12 years of age. *Id.* at § (2)(a), (b).

199. *See* FLA. STAT. ANN. § 794.0235(1), (5)(a)-(b) (West Supp. 1998).

person of any age convicted of the specified offense could be subjected to MPA treatment.

Under H.B. 83, MPA treatment is to commence no later than one week prior to the offender's release from prison or other institution.²⁰⁰ MPA treatment may not be imposed in lieu of, or reduce, any other penalty provided for by the sexual battery statute.²⁰¹ The court must also specify the duration of treatment for a term of years, which may—if the court so chooses—require that the offender undergo MPA treatment for life.²⁰² However, H.B. 83 provides that “[n]othing contained in this section shall be construed to require the continued administration of [MPA treatment] when it is not medically appropriate.”²⁰³ MPA treatment is to be provided by the state Department of Corrections.²⁰⁴

However, unlike the California law but somewhat similar to Montana's S.B. 31, MPA treatment under H.B. 83 is contingent upon a court-appointed medical expert's finding that the defendant is an appropriate candidate for MPA treatment.²⁰⁵ This language appears to reflect some concern that imposing mandatory MPA treatment be validated by medical expertise, as well as the concern that MPA treatment is not suitable for all offenders convicted of sexual battery. Unfortunately, H.B. 83 does not define what is meant by “court-appointed medical expert,” such as whether the expert should simply be a licensed physician or other practitioner, or whether the expert should have demonstrated expertise specific to MPA or other related treatment, sexual paraphilias, sexual violence, or criminality. Given the divergence of opinion on treatment responses for paraphilias and the level of expertise required to render sex offender treatment programs successful,²⁰⁶ more specificity with respect to who may serve as a court appointed medical expert may be warranted.

Additionally, H.B. 83 does not clearly indicate what is meant by “appropriate candidate.”²⁰⁷ Thus, it is not known whether, for example, the medical expert must personally examine the defendant or may base his or her determination on who is an appropriate candidate on medical records, or may make such a determination on no medical records at all. Nor is it clear that the defendant must evidence a particular paraphilic disorder for which MPA is considered an appropriate treatment response, or whether a conviction for sexual battery will suffice to establish the presence of such a disorder, before the defendant is considered an appropriate candidate for MPA treatment. Moreover, it is not known whether the term “appropriate candidate” is meant to include only defendants for whom it is established that MPA poses no unacceptable risk given the

200. *See id.* § 794.0235(2)(b).

201. *See id.* § 794.0235(i).

202. *See id.* § 794.0235(2)(a).

203. *See id.* § 794.0235(3).

204. *See id.*

205. *See id.* § 794.0235(2)(a).

206. *See supra* Part II.B.

207. *See* FLA. STAT. ANN. § 794.0235(2)(a) (West. Supp. 1998).

defendant's circumstances, regardless of whether MPA would be of any use. An additional uncertainty is whether the term "appropriate candidate" means a defendant that is competent to make treatment decisions. This uncertainty is significant because it is possible that some defendants, incompetent or not, would rather refuse MPA treatment and incur a felony offense penalty, and restricting the term "appropriate candidate" to only competent defendants would appear to be unfairly restrictive.

More ambiguities are raised by the terms: "[n]othing contained in this section shall be construed to require the continued administration of medroxyprogesterone acetate (MPA) treatment *when it is not medically appropriate.*"²⁰⁸ For example, it is not clear who shall make this post-sentencing determination,²⁰⁹ on what basis,²¹⁰ and whether alternative treatment will be offered.²¹¹ The lack of clarity or the defining of key terms in the language of H.B. 83 are especially troubling given that the clinical knowledge and experience with respect to the use of chemical or biologic agents such as MPA for the treatment of paraphilias is both extensive as well as varied, and that—had the provisions been more well-defined to incorporate this knowledge and experience—could have at least served to help ensure that any treatment provided pursuant to the law is not inconsistent with current treatment practices for sexual paraphilias.²¹²

For purposes of our discussion, H.B. 83 is also significant because, similar to California's A.B. 3339 and Montana's S.B. 31, a defendant may voluntarily undergo surgical castration.²¹³ Under H.B. 83, the defendant may accomplish this by requesting the sentencing court, upon motion, to order the defendant to undergo "physical castration" as an alternative penalty to MPA treatment.²¹⁴ Castration under this law may be ordered on the condition that the defendant's consent to undergo physical castration is "intelligent, knowing, and voluntary."²¹⁵ Based upon this language, H.B. 83's sponsors and the legislature appear to have some concerns about permitting courts to order involuntarily castration or permitting castration to be performed in the absence of the offender's consent.

The provision for consent also appears to reflect some important elements of the standard for informed consent generally required in any

208. *Id.* § 794.0235(3) (emphasis added).

209. *See id.* § 794.0235(2)(a) (providing that a court appointed medical expert shall make such a determination at the time of sentencing).

210. Such as, for example, whether MPA treatment poses unacceptable risks that were not known at the time of sentencing; the offender fails after a period of time to benefit from MPA treatment; or the offender is no longer competent to consent to continued treatment.

211. *See supra* Part II.B.2. for examples of alternative treatment for sexual paraphilias.

212. *See id.*

213. *See* FLA. STAT. ANN. § 794.0235(1) (West Supp. 1998).

214. *Id.*

215. *Id.*

medical treatment context, but is clearly not the equivalent.²¹⁶ Adding to H.B. 83's already ambiguous language is the fact that nowhere in the law is it specified that a candidate for castration receive the same consideration for "appropriate" treatment that is required for a defendant subject to MPA treatment.²¹⁷ Such an omission might arguably be interpreted as a willingness on the state's part to condone surgical castration as a punitive response to sexual offending, without any regard as to whether castration has any therapeutic benefit. Removing castration even further from a therapeutic context and closer to a punitive one, H.B. 83 fails to indicate—as it does indicate for MPA treatment—who may perform castration, or under what conditions castration may be undertaken. These omissions, together with H.B. 83's ambiguous language regarding both MPA treatment and castration, create conditions that inevitably give rise to legal challenges,²¹⁸ rendering H.B. 83, in this respect, similar to California's A.B. 3339 and Montana's S.B. 31.

D. TEXAS SENATE BILL 123

Texas Senate Bill 123, *An Act Relating to the Treatment of Repeat Sex Offenders* (S.B. 123)—permitting physicians to perform surgical castration (also called an "orchiectomy") upon certain inmates—amends the

216. For a general discussion of the history of the informed consent doctrine and the substantive requirements for informed consent, see Emidio A. Bianco & Harold L. Hirsh, *Consent To and Refusal of Medical Treatment*, in *LEGAL MEDICINE: LEGAL DYNAMICS OF MEDICAL ENCOUNTERS* (American College of Legal Medicine ed., 1995). See also *Canterbury v. Spence*, 464 F.2d 772, 779-83, 786-88 (D.C. Cir. 1972). *Canterbury* is a widely cited case that reflects the legal standard for informed consent in the majority of jurisdictions. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 337-40 (1991).

In *Canterbury*, the issue was, in part, whether the appellee-defendant physician was negligent for failing to inform the appellant-patient prior to undergoing a laminectomy (surgical procedure involving excision of the posterior arch of the vertebra) of the risk of paralysis associated with the procedure. 464 F.2d at 776, 778. The appellant-plaintiff's claim was based upon the physician's duty to disclose relevant information to his or her patient about the options and risks associated with a given treatment plan. See *id.* at 780, 781-82. The court followed its recitation of the litigation's history with a review of the history of holding physicians responsible for "satisfying the vital informational needs of the patient." *Id.* at 779-84. In reversing the lower court and finding for the appellant-patient, the court went beyond reaffirming the physician's duty to disclose and undertook the task of developing some substantive requirements of the physician's duty. See *id.* at 779. The court observed that, despite the fact that courts have frequently been confronted with the scope of the duty, "no uniform standard defining the adequacy of the divulgence emerges from the decisions." *Id.* at 786. The court began this analysis by observing that the "patient's right of self-decision shapes the boundaries of the [physician's] duty to reveal" and that the scope of the required disclosure "must be measured by the patient's need, and that need is the information material to the [patient's] decision." *Id.* Based upon these observations, the court stated the scope of the duty to disclose is not subjective as to the physician or the patient, and that "a risk is . . . material when a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy." *Id.* at 787 (citation omitted). Topics of disclosure include inherent and potential hazards associated with proposed treatment, any alternatives to the proposed treatment, and the results likely to ensue if the patient were to forego treatment. *Id.* at 787-88.

217. See FLA. STAT. ANN. § 794.0235(2)(a) (West Supp. 1998).

218. See *infra* Part IV.A. for a discussion of these possible legal challenges.

Texas Government Code and the Code of Criminal Procedure and was signed into law on May 20, 1997.²¹⁹ Under S.B. 123, only prison inmates who have been twice convicted for indecency, sexual assault, or aggravated sexual assault involving a child younger than seventeen years are eligible to undergo surgical castration.²²⁰ There are several provisions in S.B. 123 that, unlike the California and Montana laws discussed previously, are clearly intended to ensure that surgical castration is a voluntary, non-coercive, and clearly therapeutic undertaking.

First and foremost, S.B. 123 is entirely divorced from any penal objective whatsoever, minimizing any potential coercive influence over the offender's decision to voluntarily undergo castration. Judges are expressly prohibited from requiring defendants to undergo surgical castration as a condition of community supervision, and parole boards may not require inmates to undergo surgical castration as a condition of parole or release to mandatory supervision.²²¹ Moreover, before sentencing, neither the state nor the defendant may offer into evidence the fact that the defendant plans to undergo surgical castration.²²² This further minimizes any possible inducement—such as reduced sentencing or probation in lieu of sentencing—for the offender to undergo castration. In essence, an offender's decision to undergo surgical castration assumes no penal significance.

Second, other provisions in S.B. 123 are intended to ensure that the decision to permit inmates to voluntarily undergo castration is clearly therapeutically driven. For example, the inmate must be at least twenty-one years of age and must request a surgical castration in writing.²²³ The physician who is to perform the surgical castration must first obtain "the inmate's informed, written consent to undergo the procedure."²²⁴ Additionally, a psychiatrist and a psychologist who have experience in treating sex offenders must evaluate the inmate and find that the inmate is a "suitable candidate for the procedure," as well as counsel the inmate before the procedure.²²⁵ Furthermore, a "monitor" with experience in mental health, law, and ethics must also consult with the inmate—after the inmate has provided informed consent to undergo castration and has been evaluated by a psychiatrist and psychologist—to ensure that the inmate has actually been adequately informed about the procedure, or to provide the inmate with such information, as well as to determine that the inmate is free of coercion in the inmate's decision to undergo surgical castra-

219. See Act of May 5, 1997, 75th Leg., R.S., ch. 144, §§ 1-5, 1997 Tex. Sess. Law Serv. 287 (Vernon) (to be codified as an amendment to TEX. GOV'T CODE ANN. §§ 501.061-.062; TEX. CODE CRIM. PROC. ANN. art. 37.07, § 3(h), art. 42.12, § 11(f), art. 42.18, § 8(5)).

220. See *id.* § 1(a)(1); TEX. PEN. CODE ANN. §§ 21.11, 22.011(a)(2), 22.021(a)(2)(B) (Vernon 1994 & Supp. 1997).

221. See *id.* §§ 3, 4.

222. See *id.* § 2.

223. See *id.* § 1(a)(2) to (3) (amending TEX. GOV'T CODE ANN. § 501.061).

224. *Id.* § 1(a)(6).

225. *Id.* § 1(a)(5).

tion.²²⁶ In the event the monitor determines that an inmate who elects to undergo surgical castration is *not* free of coercive influence, the monitor has a legal obligation to advise the inmate to withdraw the inmate's request for surgical castration.²²⁷ S.B. 123 also requires that psychiatric or psychological examinations be provided to the inmate for a period of at least ten years following castration. It also requires that longitudinal studies and monitoring of inmates are undertaken, in part to compare the relapse rates of sex offending behavior between inmates who undergo surgical castration and those who do not.²²⁸

Statutory restrictions that expressly bar any penal association with an inmate's decision to seek surgical castration and other restrictions (e.g., age, written, voluntary requests from inmates, written informed consent, psychiatric and psychological evaluations, consultation by a monitor on issues of consent and coercion, and follow-up evaluations and studies) provide a level of precaution that is simply unprecedented for obtaining medical treatment. Given the various concerns expressed about surgical castration for the treatment of pedophilic disorders, at least in the United States, such heightened precautions are appropriate; at a minimum, the presence of such precautions demonstrates that, unlike the California, Montana, and Florida laws, Texas's S.B. 123 cannot be characterized as punitive. In sum, S.B. 123 lacks the legal infirmities that are apparent in the California, Montana, and Florida laws upon which legal challenges are sure to materialize.

IV. SURGICAL CASTRATION AND CRUEL AND UNUSUAL PUNISHMENT UNDER THE EIGHTH AMENDMENT

Although clinical evidence suggests that surgical castration is effective in reducing testosterone levels—and, hence, the frequently debilitating impulse to engage in behavior that may result in sex offenses²²⁹—the performance of a surgical castration upon incarcerated chronic pedophiles by physicians employed or retained by government officials is quite likely to be challenged or criticized as cruel and unusual punishment under the Eighth Amendment of the U.S. Constitution. This should come as no surprise, since the history of castration is marked chiefly by abuse and injustice:²³⁰ castration was used on slaves and captives of war,²³¹ and was widely practiced in Nazi Germany as a compulsory punitive procedure for sex offenders.²³² In the early part of this century, castration as a crim-

226. See *id.* § 1(f).

227. See *id.* § 1(f)(4).

228. See *id.* § 1(a), (b) (amending TEX. GOV'T CODE ANN. § 501.062). These procedures are in accord with, and even exceed, the "special needs" considerations that should be addressed by health care professionals with their patients who undergo castration. See MILLER & KEANE, *supra* note 13.

229. See *supra* Part II.B.2.c.

230. See *infra* Part IV.A.

231. See William L. Baker, Comment, *Castration of the Male Sexual Offender: A Legally Impermissible Alternative*, 30 LOY. L. REV. 377, 378-79 (1984).

232. See *id.* at 379; see also Wille & Beier, *supra* note 18, at 105.

inal penalty in the U.S. fell almost exclusively upon minority groups.²³³ Given this history, later courts have included castration of prisoners in the class of punishments prohibited as cruel and unusual.²³⁴ Therefore, it is highly improbable that as a method of *punishment*, castration would ever find judicial acceptance in the future.

However, an orchiectomy performed for a purely therapeutic purpose is an entirely different proposition and not unprecedented: surgical castration for sexual disorders is still practiced in Europe,²³⁵ and is performed on patients with testicular or prostate cancer in the U.S.²³⁶ Evidence from these cases and other research provide compelling evidence that castration reduces libido and sexual activity, and, in turn, sexual paraphilias that often result in sexual offending.²³⁷ Used therapeutically, surgical castration may very well survive a constitutional "cruel and unusual punishment" challenge, provided that in each particular case the decision to undergo surgical castration is made voluntarily by the inmate, that the inmate is free from coercion in the inmate's decision to undergo castration, and that surgical castration is clinically indicated.²³⁸ Absent such conditions, orchiectomy should be eschewed and rightly prohibited.²³⁹

A. CASTRATION AS PUNISHMENT

The U.S. Supreme Court defines punishment as a "deliberate act intended to chastise or deter."²⁴⁰ The term has been used by courts to describe not only the obvious types of punishment (which are usually imposed by sentencing courts), such as execution, terms of imprisonment, probation, fines, and community service, but may also include less obvious manifestations such as failure to provide medical treatment, failure to protect vulnerable inmates from harm, solitary confinement, hard labor, mandatory treatment for disorders that may manifest in risk or harm to self or even others, and reduced privileges (e.g., shower, exercise and visitation) that are usually imposed by correctional authorities.²⁴¹

233. See *Graham v. Collins*, 506 U.S. 461, 482 (1993) (Thomas, J., concurring); *United States v. Clary*, 846 F. Supp. 768, 774 (E.D. Mo.), *rev'd*, 34 F.3d 709 (8th Cir. 1994), *cert. denied*, *Clary v. U.S.*, 513 U.S. 1182 (1995).

234. See *infra* Part IV.A.

235. See *Wille & Beier*, *supra* note 18, at 105.

236. See *id.*

237. See *supra* Part II.B.2.c.

238. See *infra* Parts IV.B. & C.

239. Most states have their own constitutional provisions that prohibit cruel and unusual, or cruel *or* unusual, punishments that are derived directly from the common law and generally mirror the Eighth Amendment of the U.S. Constitution. See, e.g., *Furman v. Georgia*, 408 U.S. 238, 319-20 (1972).

240. *Wilson v. Seiter*, 501 U.S. 294, 300 (1991).

241. See, e.g., *Trop v. Dulles*, 356 U.S. 86, 100 (1958) (death penalty, fines, hard labor); *Estelle v. Gamble*, 429 U.S. 97, 102-03 (1976) (failure to provide medical care); *Farmer v. Brennan*, 511 U.S. 825, 847 (1994) (failure to protect vulnerable inmate from other assaultive inmates); *Jihad v. Wright*, 929 F. Supp. 325, 332 (N.D. Ind. 1996) (isolation for refusing tuberculosis screening).

There are, however, limits on the extent to which persons convicted of crimes may punished. The Eighth Amendment of the U.S. Constitution provides that “[e]xcessive bail shall not be required, nor excessive fines imposed, *nor cruel and unusual punishments inflicted.*”²⁴² The Eighth Amendment applies to states, and therefore to state prisons, through the Fourteenth Amendment.²⁴³ Generally, early Eighth Amendment lawsuits, as well as lawsuits brought under similar “cruel and unusual” provisions found in *state* constitutions, involve challenges to the punishments that were imposed. For example, prisoners argued that the sentence length imposed upon them was disproportionate to the crimes that the prisoners committed or that certain punishments, such as the death penalty, were barbarous or torturous.²⁴⁴ In some of these early decisions, the challenged punishment was voided by the court if the term of imprisonment for a crime clearly exceeded the term of imprisonment for similar offenses.²⁴⁵ In other decisions, the challenged punishment was voided if no common law precedent to the punishment could be found.²⁴⁶

Nevertheless, the U.S. Supreme Court has established no clear standard for determining whether a particular punishment or term of incarceration is permissible under the Eighth Amendment.²⁴⁷ The resulting ambiguity, however, is not unintended.²⁴⁸ The Supreme Court years ago indicated that the Eighth Amendment “draw[s] its meaning from the evolving standards of decency that mark the progress of a maturing society” and “that the words of the Eighth Amendment are not precise, and . . . their scope is not static.”²⁴⁹ These Eighth Amendment principles still hold true today²⁵⁰ and have been relied upon by the Supreme Court, as well as lower courts, to acknowledge changed social values towards a prisoner’s sentencing, conditions of incarceration, and health care.²⁵¹ Re-

242. U.S. CONST. amend. VIII (emphasis added).

243. See *Robinson v. California*, 370 U.S. 660, 666 (1962).

244. See *Gregg v. Georgia*, 428 U.S. 153, 169-73 (1976); *Trop*, 356 U.S. at 100-01.

245. See, e.g., *Weems v. United States*, 217 U.S. 349, 357, 366, 380-81 (1910) (comparing the plaintiff public official’s sentence for 15 years in chains, at hard and painful labor without assistance from family or friends, for the crime of falsifying a public and official document to sentences imposed for some other crimes, such as homicide, forgery and embezzlement, which were not as severely punished).

246. See *Mickle v. Henrichs*, 262 F. 687, 689-90 (D. Nev. 1918); cf. *Washington v. Feilen*, 126 P. 75, 78 (Wash. 1912). The court in *Feilen* observed that some of these “barbarous” punishments included burning at the stake, breaking on the wheel, strangling to death, and *cutting off the nose, ears or limbs*. See *id.* Nevertheless, the court also found that the portion of a prisoner’s sentence requiring that a vasectomy be performed upon the prisoner was not cruel and unusual punishment under the Washington Constitution. See *id.* It is interesting to note, however, that the court prefaced its finding that vasectomies were permissible with the observation that “modern scientific investigation shows that . . . criminality [is] congenital and hereditary . . . and that [t]here appears to be a wonderful unanimity of favoring opinion as to the advisability of the sterilization of criminals and the prevention of their further propagation.” *Id.* at 76-77.

247. *Trop*, 356 U.S. at 99-100; *Estelle*, 429 U.S. at 102-03.

248. See, e.g., *Trop*, 356 U.S. at 100-01.

249. *Id.* at 100-01.

250. See *Helling v. McKinney*, 509 U.S. 25, 36 (1993); *Wilson*, 501 U.S. at 308 (1991) (White, J., concurring).

251. See, e.g., *Helling*, 509 U.S. at 32-33.

cent court decisions, for example, may permit prisoners to sue correctional officials for housing vulnerable inmates with prisoners who are known to sexually assault weaker cell mates, when those vulnerable inmates are later sexually assaulted;²⁵² for exposing prisoners to environmental ("second-hand") tobacco smoke;²⁵³ or for placing inmates in medical isolation for refusing to undergo a tuberculosis test when isolation results in restricted access to law libraries or other prison programs.²⁵⁴

Characterizing castration as anything *but* punishment may be difficult because castration of persons accused or charged with criminal conduct has been historically intended.²⁵⁵ Even the U.S. Supreme Court observes as much.²⁵⁶ In *Weems v. United States*,²⁵⁷ the Court grouped castration together with other punishments it considered barbarous and therefore impermissible, such as quartering and hanging in chains.²⁵⁸ More recent court decisions mention castration and its pernicious application in the first half of this century to African-American males for certain crimes. In the Supreme Court case of *Graham v. Collins*,²⁵⁹ for instance, Justice Thomas commented in a concurring opinion on the use of mandatory death sentences and castration for black—but not white—men convicted of the rape or attempted rape of white women.²⁶⁰ The district court in *United States v. Clary*²⁶¹ made a similar observation.²⁶² Today, it scarcely can be argued that some measure of vengeance, tinged with outright hatred, is altogether unintended by recent legislation or other public proposals pertaining to sexual offenders.²⁶³ Recent controversy over the

252. See, e.g., *Farmer v. Brennan*, 511 U.S. at 848-49; *Billman v. Indiana Dep't of Corrections*, 56 F.3d 785, 790 (7th Cir. 1995).

253. See *Helling*, 509 U.S. at 36-37.

254. See *Jolly v. Coughlin*, 76 F.3d 468, 480-82 (2d Cir. 1996); *Jihad*, 929 F. Supp. at 331.

255. See, e.g., *Davis v. Berry*, 216 F. 413, 416 (S.D. Iowa 1914), *rev'd*, 242 U.S. 468 (1917) (recalling how castration was imposed as a punishment for treason); *Smith v. Wayne*, 204 N.W. 140, 148 (Mich. 1925) (Wiest, J., dissenting) (observing, while dissenting from court ruling that sterilization of persons with mental defects was constitutionally permissible, that the framers of the Bill of Rights had knowledge that castration was a cruel and unusual punishment); *but see Briley v. California*, 564 F.2d 849, 857-58 (9th Cir. 1977) (remanding a lower court's dismissal of an ex-probationer's claim that his plea bargained castration, in lieu of incarceration, was unconstitutional, but observing in remand instructions that if the California statute permitted the court to order the probationer to undergo castration, then immunity from the probationer's constitutional claims would attach to the court, district attorneys, and the physicians involved in the plea bargain process).

256. See *supra* notes 236-37 and accompanying text.

257. 217 U.S. 349 (1910).

258. See *id.* at 377. In contrast, the concept that the *death penalty* might constitute cruel and unusual punishment has yet to strike a similar resonance in Supreme Court decisions. See, e.g., *Trop*, 356 U.S. at 86, 99.

259. 506 U.S. 461 (1993).

260. See *id.* at 482 (Thomas, J., concurring).

261. 846 F. Supp. 768 (E.D. Mo. 1994), *rev'd*, 34 F.3d 709 (8th Cir. 1994), *cert. denied*, 513 U.S. 1182 (1995).

262. See *id.* at 774 (referring to a 1697 Pennsylvania law under which black men who raped white women were subject to the death penalty, and those who were found to have attempted the rape of white women were subject to castration).

263. See, e.g., *Doe v. Pataki*, 940 F. Supp. 603, 604-05 (S.D.N.Y. 1996) (observing that, in passing a law regarding sex offenders, members of the New York State Legislature de-

public notice and involuntary civil commitment required of recently released sex offenders demonstrates our profound repugnance and ambivalence towards persons convicted of sexual abuse involving children.²⁶⁴ Despite attempts to characterize some of this legislation as having no punitive purpose, some courts have found otherwise and have invalidated these laws as constitutionally impermissible.²⁶⁵

Aside from the U.S. Supreme Court, other courts have passed judgment on castration either indirectly or directly, and *none* have ruled that castration is permissible under a cruel and unusual punishment analysis. For example, in *State v. Brown*,²⁶⁶ a case involving three offenders who had pleaded guilty to first degree sexual conduct involving a sexual assault, the South Carolina Supreme Court ruled that castration "is a form of mutilation" and was therefore prohibited by that state's constitutional provision on cruel and unusual punishment.²⁶⁷ The case reached the South Carolina Supreme Court after the three offenders unsuccessfully sought to compel the trial court to suspend their sentences and five years probation, in lieu of thirty years incarceration, that the trial court judge had conditioned upon the offenders receiving surgical castration.²⁶⁸ The South Carolina Supreme Court observed that while state law provides trial judges with certain powers to suspend sentences upon conditions that the trial judges determine are appropriate, such discretion is not unlimited and is restricted by public policy considerations derived by implication from the Constitution, state statutes, and judicial decisions.²⁶⁹ The court found that since castration is prohibited by the state's constitution, the trial judge's suspended sentence, conditioned upon the offenders receiving castration, was illegal and void as against public policy.²⁷⁰

In *Davis v. Berry*, a federal district court analogized the state of Iowa's practice of performing vasectomies upon persons convicted of two or more felonies to the historical practice of performing castrations.²⁷¹ In

scribed sex offenders as "depraved," "the lowest of the low," "animals," and "the human equivalent of toxic waste"); *see supra* text accompanying note 16 (describing some of the public response to incidents of child molestation).

264. *See Kansas v. Hendricks*, 117 S. Ct. 2072, 2071-77 (1997) (discussing Kansas's statute for involuntary civil commitment following incarceration); *Pataki*, 940 F. Supp. at 604 (reviewing public notification); *see also* Matthew Purdy, "I Watch Him Like a Hawk," *Sex Offenders are Shadowed by Wary Parole Officers*, N.Y. TIMES, June 8, 1997, at 26 (following the work of parole officers whose caseload includes sex offenders). One officer supervises 25 rapists and child molesters whose misdeeds "are the kind that stir feelings of revenge in the hearts of most people and sympathy in few;" the parole officer observes, "[y]ou can't hate these people . . . [b]ut you can't forget who they are." *Id.*

265. *See Pataki*, 940 F. Supp. at 604-05; *but see Hendricks*, 117 S. Ct. at 2078-80 (finding permissible under the U.S. Constitution a state's involuntary commitment scheme involving inmates deemed to have a "mental abnormality" or "personality disorder" and who are likely to engage in predatory acts of sexual violence, and who are about to be released from prison).

266. 326 S.E.2d 410 (S.C. 1985).

267. *Id.* at 412.

268. *See id.* at 411.

269. *See id.* at 411-12.

270. *See id.* at 412.

271. *See Davis*, 216 F. at 416-17; *but see Feilen*, 126 P. at 78; *Briley*, 564 F.2d at 858.

striking down the constitutionality of that state's vasectomy statute, the district court observed that vasectomy and castration are essentially the same in purpose and result—with castration being “coarser and more vulgar”—and that either operation would follow a man for the rest of his life.²⁷² The court also observed that while the physical suffering of either operation may not be so great, physical suffering is not the only test of cruel punishment.²⁷³ The court stated that imposing “the humiliation, the degradation, [and] the mental suffering [of a vasectomy]” as punishment may be just as unacceptably cruel as physical punishment.²⁷⁴ The idea that castration as punishment is impermissible under the Constitution was also noted by the Georgia Court of Appeals in *Kenimer v. State*.²⁷⁵ There, the court suggested, without actually having a particular claim involving castration before it, that the Eighth Amendment was “doubtless, intended to prohibit the barbarities of quartering, hanging in chains, [and] castration.”²⁷⁶ Taken together, the U.S. Supreme Court's comments, as well as lower court decisions or observations on castration, demonstrate that—at least where imposed as punishment or provided for as a purely penological objective—surgical castration violates constitutional prohibitions on cruel and unusual punishment.²⁷⁷

B. CASTRATION AS MEDICALLY ACCEPTABLE TREATMENT

It is worthwhile to note, however, that in none of the cases discussed above was the decision or underlying reasoning based upon evidence, an explicit awareness, or an intent that castration has a therapeutic—other than destroying the power of procreation—rather than punitive purpose. Had a therapeutic rather than punitive purpose for castration been established at the time, the outcomes or judicial observations in those cases may have been different. Even now, there are only a few studies that involve sex offenders who have undergone surgical castration, and none of these involve clinical investigations in the United States. The studies that are available took place in Europe, and are considered by some researchers and clinicians to be dated and not especially rigorous;²⁷⁸ this may suffice to convince some U.S. courts that castration for the purpose of treating incarcerated pedophiles is impermissible under the Eighth Amendment.

Whether courts would reach the same result if castration is accepted by medical and health professionals as therapeutic for treating the sexual disorders of incarcerated pedophiles is not certain. It is clear that merely

272. *Davis*, 216 F. at 416.

273. *See id.*

274. *Id.*

275. 59 S.E.2d 296 (Ga. Ct. App. 1950).

276. *Id.* at 309 (emphasis added).

277. *See supra* Part IV.A.

278. *See Ortman*, *supra* note 102, at 443-45 (stating that since 1972, no sexual offender has undergone castration in Denmark); Bradford, *supra* note 96, at 193-94; *see also supra* Part II.B.2.c.

characterizing castration as treatment is unlikely to save a statute that authorizes such a procedure from scrutiny under the Eighth Amendment: the U.S. Supreme Court clearly finds that the mere characterization would not alter its effect.²⁷⁹ If castration were shown by U.S. medical or health professionals to be a promising therapeutic intervention for pedophilic sex offenders, courts might permit such a procedure, especially given unmistakably clear legislative enactment so providing, together with substantially heightened protection for inmates who voluntarily request castration.²⁸⁰ In fact, a court may even mandate treatment in lieu of a lengthier sentence, as did the court in *People v. Harris*,²⁸¹ when it overturned a lower court's twenty-five-year sentence that was imposed upon a defendant convicted of sexual assault crimes involving a seven-year old victim.²⁸² The court stated that the sentence was excessive and that the lower court abused its discretion when it stated that "little or no treatment" was available to the defendant.²⁸³ In remanding the case back to the lower court to balance sentencing and rehabilitation, the appellate court took judicial notice of the fact that treatment for paraphilias, including surgical castration, is available and successful.²⁸⁴

In determining whether surgical castration is sufficiently therapeutic to satisfy constitutional scrutiny, a court would find certain questions important, such as whether a given procedure as novel (at least in the U.S., and at least with respect to sex offender treatment) as surgical castration had gone beyond an experimental stage and had become an accepted modality of treatment for sexual deviance; the risks to the inmate posed by castration; and the nature of the inmate's consent to undergo the procedure.²⁸⁵ Several appellate and federal district courts have interpreted the Eighth Amendment as prohibiting correctional and custodial officials from providing medical treatment that is not a recognized and acceptable medical practice.²⁸⁶ In the often-cited case of *Knecht v. Gillman*,²⁸⁷ for example, the Court of Appeals for the Eighth Circuit found that a state

279. *Trop*, 356 U.S. at 95 (observing that "even a clear legislative classification of a statute as 'non-penal' would not alter the fundamental nature of a plainly penal statute").

280. See *supra* Part III.C.

281. 543 N.E.2d 859 (Ill. App. Ct. 1989).

282. See *id.* at 868.

283. *Id.* at 867-68.

284. See *id.*

285. See, e.g., *Bailey v. Lally*, 481 F. Supp. 203, 219-21 (D. Md. 1979).

286. See, e.g., *Knecht v. Gillman*, 488 F.2d 1136, 1139-40 (8th Cir. 1973); see also *Pena v. New York State Div. for Youth*, 419 F. Supp. 203, 207 (S.D.N.Y. 1976) (determining that the use of thiorazine, among other practices, was anti-therapeutic and unconstitutional under the Eighth Amendment); *Nelson v. Heyne*, 355 F. Supp. 451, 455 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (deciding that intermuscular tranquilizers must meet minimal medical standards in order to be constitutional); cf. *Rennie v. Klein*, 462 F. Supp. 1131, 1143 (D. N.J. 1978) (holding that use of a psychotropic drug with side effects does not violate the Eighth Amendment because its use was part of a treatment program rather than punishment); *In re Mental Health of K.K.B.*, 609 P.2d 747, 751 (Okla. 1980) (determining that a legally competent adult in a mental institution could refuse to give consent to the administration of antipsychotic drugs).

287. 488 F.2d 1136 (8th Cir. 1973).

correctional facility's use of apomorphine upon inmates as part of an aversive therapy program was impermissible under the Eighth Amendment and enjoined its further use except under narrowly drawn circumstances.²⁸⁸ The court relied in part upon expert testimony related to the medical acceptability of the use of apomorphine, which indicated that, although success rates of between twenty to fifty percent were claimed, such use was highly questionable and did not support the drug's use.²⁸⁹

After indicating that the evidence did not establish whether the inmates had provided informed consent to undergo apomorphine treatment, the court prohibited the use of apomorphine treatment unless the inmate's written, informed consent was obtained beforehand.²⁹⁰ This consent process required, in part, informing the inmate of the specific nature of the treatment, "a written description of the purpose, risks and effects of treatment, and advising the inmate of his right to terminate the consent at any time."²⁹¹ The court also mandated that the consent include a certification by a physician that the inmate read and understood all terms of the consent and that the inmate was mentally competent to fully understand the consent's provisions and to give consent.²⁹²

Findings similar to those articulated by the court in *Knecht* have been expressed in *Mackey v. Procunier*,²⁹³ another often-cited case in which a prison treatment scheme lacked acceptance in the medical community.²⁹⁴ In *Mackey*, the use of succinylcholine as part of shock therapy in a men's prison was challenged as cruel and unusual by an inmate who had undergone the treatment, despite the fact that the challenging inmate had initially consented to shock therapy.²⁹⁵ A lower court dismissed the inmate's claim, finding that the inmate was essentially "asking the court to assess the propriety of a particular course of treatment," which the court characterized as a malpractice claim for which no violation of the inmate's civil rights could be ascertained.²⁹⁶ The Ninth Circuit court reversed the lower court, ruling that the lower court erred in dismissing the inmate's Eighth Amendment claim. According to records available to the Circuit Court, succinylcholine was recommended at the time as an adjunct to electric shock therapy and as a relaxant together with anesthesia; it was also described as "breath-stopping and paralyzing."²⁹⁷ Succinylcholine was not recommended for use upon fully conscious patients because of its frightening effects.²⁹⁸ The Circuit Court stated that proof of the above matters could raise "serious constitutional questions respect-

288. *See id.* at 1140.

289. *See id.* at 1138-39.

290. *See id.* at 1138, 1140.

291. *Id.* at 1140.

292. *See id.*

293. 477 F.2d 877 (9th Cir. 1973).

294. *See id.* at 877-78.

295. *See id.*

296. *Id.* at 878.

297. *See id.* at 877-78.

298. *See id.* at 878.

ing cruel and unusual punishment," and that, therefore, it was error for the lower court to have dismissed the inmate's claim.²⁹⁹

Given the concerns expressed by the courts in the above cases with respect to procedures that might be deemed to lack medical acceptance, proponents of castration must be prepared to defend the practice by demonstrating, for example, that orchiectomies are not experimental in the treatment of sexual disorders such as pedophilia; that the risks of such a procedure are known, minimal, and can be mitigated; that substantially heightened precautions are taken to ensure that inmates who elect to undergo surgical castration have made their decisions voluntarily and without coercion; that the inmates who elect to undergo castration have provided their informed consent; and that surgical castration is medically acceptable to other clinicians in the community who have patients with similar conditions. Under conditions such as these, courts may eschew second-guessing clinicians as to the appropriateness of surgical castration against similarly effective treatment alternatives, rendering castration possible in narrowly drawn circumstances.

C. DENIAL OF CASTRATION AS DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED

Heretofore, the assumption has essentially been that permitting convicted sex offenders who have a pedophilia disorder to voluntarily undergo surgical castration must be addressed as a possible infliction of cruel and unusual punishment, which is proscribed by the Eighth Amendment.³⁰⁰ If the argument proceeds that surgical castration is indeed therapeutic and clinically indicated for at least some offenders with a pedophilia disorder—and that these offenders should be permitted to voluntarily undergo castration—then surgical castration must also be addressed as a possible infliction of cruel and unusual punishment when castration is *denied* to those offenders. In this respect, the Eighth Amendment is a double-edged sword; it is not only the measurement of permissible punishment meted out by government, but it also prohibits prison and other government officials from being deliberately indifferent to prisoners' serious medical needs.³⁰¹ The dilemma for proponents of surgical castration is that, once touted as treatment for offenders with a pedophilia disorder, it would be somewhat disingenuous to deny castration to inmates for whom the procedure holds therapeutic promise.

The seminal case imposing an Eighth Amendment requirement upon prison officials to provide inmates with medical care is *Estelle v. Gamble*. In *Estelle*, a Texas state prison inmate brought a civil rights claim against various prison officials for their failure to properly diagnose and adequately treat a back injury that the inmate sustained while working at the

299. *Id.*

300. See *supra* Parts IV.A.-B.

301. See *Estelle*, 429 U.S. at 102-03.

prison.³⁰² The U.S. Supreme Court began by observing that prior interpretations of the Eighth Amendment establish "the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met."³⁰³ The Court proceeded to set forth the applicable test for when the denial of medical treatment would give rise to a cognizable claim:

[D]eliberate indifference to serious medical needs of prisoners constitutes the "unnecessary and wanton infliction of pain" proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regard[less] of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under [section] 1983.³⁰⁴

Based upon this test, the U.S. Supreme Court found that the inmate did not state a cognizable claim, given that the inmate had been seen by medical personnel on seventeen occasions and that the inmate's injuries had been treated, albeit not to the inmate's satisfaction; differences in medical judgment as to diagnostic techniques or forms of treatment constituted at best, the Court observed, medical malpractice and not cruel and unusual punishment.³⁰⁵

While the Supreme Court has never directly confronted the applicability of the Eighth Amendment's right to treatment to mental disorders, it is the "general consensus among the courts that there is no logical distinction between the right to medical care for physical ailments and the right to mental health care for psychological or psychiatric impairments."³⁰⁶ Therefore, in the context of being *denied* surgical castration, an inmate, in order to establish an Eighth Amendment claim, would need to show: (1) that the inmate suffers from a pedophilia disorder and that this constitutes a "serious medical need," either in the form of a physical or psycho-

302. See *id.* at 98. For a summary of cases dealing with denial by prison officials of medication, see Michael S. Vaughn, *Section 1983 Civil Liability of Prison Officials for Denying and Delaying Medication and Drugs to Prison Inmates*, 11 ISSUES IN L. & MED. 47 (1995).

303. *Estelle*, 429 U.S. at 103.

304. *Id.* at 104-05 (citations omitted).

305. See *id.* at 107.

306. Connie Mayer, *Survey of Case Law Establishing Constitutional Minima for the Provision of Mental Health Services to Psychiatrically Involved Inmates*, 15 NEW ENG. J. CRIM. & CIV. CONFINEMENT 243, 244-45 (1989); see also *Waldrop v. Evans*, 871 F.2d 1030 (11th Cir. 1989); *Rogers v. Evans*, 792 F.2d 1052 (11th Cir. 1986); *Partridge v. Two Unknown Police Officers*, 791 F.2d 1182 (5th Cir. 1986); *Bee v. Greaves*, 744 F.2d 1387 (10th Cir. 1984), *cert. denied*, 469 U.S. 1214 (1985); *Wellman v. Faulkner*, 715 F.2d 269 (7th Cir. 1983), *cert. denied*, 468 U.S. 1217, 104 S. Ct. 3587 (1984); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982); *Inmates of Allegheny County Jail v. Pierce*, 612 F.2d 754 (3d Cir. 1979); *Bowring v. Godwin*, 551 F.2d 44 (4th Cir. 1977); Fred Cohen & Joel Dvoskin, *Inmates with Mental Disorders: A Guide to Law and Practice*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 339, 339-40 (1992); James R. P. Ogloff et al., *Mental Health Services in Jails and Prisons: Legal, Clinical, and Policy Issues*, 18 LAW & PSYCHOL. REV. 109, 119-20 (1994).

logical disorder;³⁰⁷ and (2) that prison officials' failure to provide the inmate with surgical castration evinces "deliberate indifference" to the inmate's serious medical need. However, because the U.S. Supreme Court in *Estelle* failed to give clear definitions of what the terms "serious medical needs" and "deliberate indifference" mean, determining whether a particular illness, injury, or method of treatment comes within the test has only been discerned through later cases.³⁰⁸

1. *Pedophilia as a Serious Medical Need*

One of the earliest and most influential cases addressing mental disabilities as an Eighth Amendment concern is *Bowring v. Godwin*,³⁰⁹ there, the Fourth Circuit Court of Appeals concluded that prison inmates are entitled under the Eighth Amendment to

psychological or psychiatric treatment if a physician or other health care provider, exercising ordinary skill and care at the time of observation, concludes with reasonable medical certainty (1) that the prisoner's symptoms evidence a serious disease or injury; (2) that such disease or injury is curable or may be substantially alleviated; and (3) that the potential for harm to the prisoner by reason of delay or the denial of care would be substantial. The right to treatment is, of course, limited to that which may be provided upon a reasonable cost and time basis and the essential test is one of medical necessity and not simply that which may be considered merely desirable.³¹⁰

The court's opinion in *Bowring* is consistent with other circuit courts that have examined the general contours of what is meant by "serious medical need." For example, the Eighth Circuit defines "serious medical need" as "one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a layperson would easily recognize the necessity for a doctor's attention."³¹¹ The Ninth Circuit defines "serious medical need" as "[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain"³¹² Whatever definition is applied, whether or not pedophilia qualifies as a serious medical need will obviously depend, in large part, on the testimony of experts in the mental health profession.³¹³

307. See *supra* Parts II.A.1.-2.

308. See *supra* notes 301-07 and accompanying text; *infra* notes 309-17 and accompanying text.

309. 551 F.2d 44 (4th Cir. 1977).

310. *Id.* at 47-48.

311. MANUAL OF MODEL CIVIL JURY INSTRUCTIONS FOR THE DISTRICT COURTS OF THE EIGHTH CIRCUIT § 4.31 (1995); *Johnson v. Busby*, 953 F.2d 349, 351 (8th Cir. 1991) (adopting these jury instructions).

312. *McGuckin v. Smith*, 974 F.2d 1050, 1059-60 (9th Cir. 1992).

313. *Cohen & Dvoskin*, *supra* note 306, at 341 (noting that while minor depression or "behavioral and emotional problems alone do not qualify as serious mental illness, acute depression, paranoid schizophrenia, 'nervous collapse,' and suicidal tendencies" do).

The level of medical research and studies being conducted that seek to find appropriate, effective treatments for pedophilia is compelling evidence that, in and of itself, pedophilia disorder is a serious medical need.³¹⁴ Additionally, a state's own actions towards sex offenders also evidence a recognition that a pedophilia disorder is a serious medical need. For example, many states now mandate that convicted sex offenders undergo rehabilitation before they can be eligible for parole.³¹⁵ Other states, concerned that a released pedophile will again act out his or her sexual desires despite the threat of prison or the revocation of probation, have enacted statutes providing for the involuntary civil commitment of certain inmates at the conclusion of their prison sentence.³¹⁶ Still other states have developed sexual offender counseling and treatment programs within their prisons.³¹⁷ Thus, if a psychiatrist or clinical psychologist diagnoses an inmate's pedophilia as a physical or mental disorder based on some acceptable diagnostic tool and categorizes that disorder as serious, the first prong under *Estelle v. Gamble* has been satisfied. Of course, simply classifying pedophilia as a serious medical need, however, does not entitle an inmate to his requested orchiectomy; the second prong of the *Estelle* test, deliberate indifference, must also be satisfied.

2. *Deliberate Indifference*

The deliberate indifference standard under the Eighth Amendment is met when an act or failure to act "entails something more than mere negligence, . . . [but] something less than acts or omissions for the very pur-

314. See *supra* Parts II.A.-B.

315. See CAL. PENAL CODE § 1203.067 (West 1995 & Supp. 1997); COLO. REV. STAT. ANN. § 16-11.7-105 (West 1996); HAW. REV. STAT. ANN. § 706-606.3 (Michie 1995 & Supp. 1996); KY. REV. STAT. ANN. §§ 439.340, 532.045 (Banks-Baldwin 1995 & Supp. 1996); LA. REV. STAT. ANN. § 14:81.2 (West 1995 & Supp. 1997); MO. ANN. STAT. § 566.140 (West 1996 & Supp. 1997); OKLA. STAT. ANN. tit. 10, § 991(a) (West 1995); TENN. CODE ANN. § 39-13-706 (1996).

316. See CAL. WELF. & INST. CODE § 6600 *et seq.* (West 1995 & Supp. 1997). In the Bill that enacted the 1995 amendments to provide for the commitment of sexually violent predators, the legislature made the following findings:

The Legislature finds and declares that a small but extremely dangerous group of sexually violent predators that have diagnosable mental disorders can be identified while they are incarcerated. . . . The Legislature further finds and declares that while these individuals have been duly punished for their criminal acts, they are, if adjudicated sexually violent predators, a continuing threat to society. The continuing danger posed by these individuals and the continuing basis for their judicial commitment is a currently diagnosed mental disorder which predisposes them to engage in sexually violent criminal behavior. It is the intent of the Legislature that these individuals be committed and treated for their disorders only as long as the disorders persist and not for any punitive purposes.

Id.; see also S.B. 3, 76th Leg., 1st Reg. Sess. (Kan. 1995); H.B. 406, 1996 Reg. Sess. (Ky. 1996); S.B. 2040, 54th Leg. (N.D. 1995); S.B. 5088, 54th Leg., 1995 Reg. Sess. (Wash. 1995).

317. See ARK. CODE ANN. § 12-29-406 (Michie 1995); KAN. STAT. ANN. § 75-5210 (1995 & Supp. 1996); KY. REV. STAT. ANN. § 197.400 *et seq.* (Banks-Baldwin 1995); MO. ANN. STAT. § 217.139 (West 1996); TENN. CODE ANN. § 33-6-306 (1995 & Supp. 1996).

pose of causing harm or with knowledge that harm will result.”³¹⁸ The deliberate indifference standard has been applied not only to medical treatment cases, but also to cases involving the conditions of an inmate’s confinement.³¹⁹ It is in the context of inmate complaints over prison conditions that the Supreme Court has most recently elaborated on what constitutes deliberate indifference for the purpose of establishing an Eighth Amendment violation.

For example, in the case of *Farmer v. Brennan*,³²⁰ a preoperative transsexual inmate claimed that prison officials had demonstrated deliberate indifference by failing to keep the inmate from harm allegedly inflicted by other prisoners.³²¹ The inmate, who had spent time in both administrative segregation and in the prison’s general population, claimed that prison officials deliberately placed him in the general population despite the officials having knowledge that the prison had a history of inmate assaults, that the inmate with whom the transsexual inmate had been housed was known to have sexually assaulted other vulnerable inmates, and that the transsexual inmate, in particular, was vulnerable to sexual assault and would in fact be sexually assaulted by his cell-mate.³²² The Supreme Court first observed that recklessly disregarding a substantial risk of serious harm to a prisoner was tantamount to deliberate indifference under the Eighth Amendment.³²³ A finding of recklessness for Eighth Amendment liability requires that the prison official “know[] of and disregard[] an excessive risk to inmate health or safety; [that] the official . . . be [both] aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and [that the official] draw [that] inference.”³²⁴ The Supreme Court found that the district court below had entered judgment for the prison officials based upon a standard that was inconsistent with the standard enunciated by the Court, and remanded the case to the court below to determine—consistent with the Court’s new standard—whether deliberate indifference had occurred.³²⁵

In order to establish deliberate indifference based upon *Farmer*, an inmate must show that prison officials: (1) were aware of the inmate’s serious medical need, from which it could be inferred that medical attention was warranted and that the failure to receive medical treatment posed a substantial risk of serious harm; and (2) disregarded, ignored, or refused to provide the inmate with treatment for that serious medical need.³²⁶

318. *Farmer*, 511 U.S. at 835.

319. See *Wilson v. Seiter*, 501 U.S. 294, 303 (1991) (holding that prisoners claiming that conditions of confinement constituted cruel and unusual punishment were required to show deliberate indifference on the part of prison officials).

320. 511 U.S. 825 (1994).

321. See *id.* at 830.

322. See *id.* at 831.

323. See *id.* at 836.

324. *Id.* at 837.

325. See *id.* at 849.

326. See *id.* at 837.

Courts have found deliberate indifference in medical cases where, for example, the prison's medical staff or facilities are deficient; prison officials prevent inmates from receiving prescribed treatment; inmates are denied access to medical personnel for the purpose of evaluating the inmates' need for treatment; and prison officials cause unreasonable delays in providing medical services.³²⁷

While no cases thus far have challenged the refusal of surgical castration on Eighth Amendment grounds, some cases are sufficiently analogous to be instructive. For example, in *Supre v. Ricketts*,³²⁸ a transsexual inmate brought suit against prison officials alleging that his Eighth Amendment rights were violated when prison officials refused to provide him with the female hormone estrogen.³²⁹ The Tenth Circuit found that *some* treatment was required for the inmate. However, there were a variety of options available, and the inmate was unable to show that the failure to treat him with estrogen—which the record indicated was a controversial therapy—would constitute deliberate indifference to his serious medical need.³³⁰ Other courts have held similarly; while transsexualism is a serious medical need, inmates do not have a right under the Eighth Amendment to a *particular* type of treatment, so long as some other treatment option is made available to them.³³¹

In contrast, in the case of *Woodall v. Foti*,³³² an inmate brought suit against the sheriff in charge of the prison, claiming that his incarceration was a result of engaging in deviant sexual behavior; that the prison psychiatrist had advised the inmate that the inmate required psychiatric counseling; that the inmate had requested such counseling; and that the request for specialized treatment was refused by the sheriff in violation of the Eighth Amendment.³³³ Allegedly, the prison psychiatrist could not provide the type of counseling necessary to treat the inmate's pedophilia because the psychiatrist was not qualified to administer psychotherapy, and, moreover, the psychiatrist's heavy case load prevented him from

327. See Mayer, *supra* note 284, at 246; but see Vaughn, *supra* note 280, at 62, 69-73 (stating that there is no deliberate indifference, hence no liability, in cases involving the delay or denial of medication where the delay is not life-threatening, or where the delay does not pose long-term deleterious effects, or where a medical practitioner has not prescribed a medication).

328. 792 F.2d 958 (10th Cir. 1986).

329. See *id.* at 960.

330. See *id.* at 963.

331. See *Meriwether v. Faulkner*, 821 F.2d 408, 413 (7th Cir. 1987), *cert. denied*, 484 U.S. 935 (1987); see also *Farmer v. Carlson*, 685 F. Supp. 1335, 1341 (M.D. Pa. 1988) (no denial of medical care where denial of conjugated estrogen was the result of informed medical opinion); *White v. Farrier*, 849 F.2d 322, 325 (8th Cir. 1988) (transsexualism is a serious medical need); *Phillips v. Mich. Dep't of Corrections*, 731 F. Supp. 792, 800-01 (W.D. Mich. 1990), *aff'd*, 932 F.2d 969 (6th Cir. 1991) (transsexualism is a serious medical need and the inmate was entitled to preliminary injunction to receive estrogen therapy); *Long v. Nix*, 877 F. Supp. 1358, 1365 (S.D. Iowa 1995), *aff'd*, 86 F.3d 761, (8th Cir. 1996) (transsexuals have the right to treatment, but not to any particular type of treatment); *Brown v. Zavaras*, 63 F.3d 967, 970 (10th Cir. 1995) (transsexual has a general right to medical treatment for gender dysphoria).

332. 648 F.2d 268 (5th Cir. June 1981) (5th Cir. split in 1981).

333. See *id.* at 270-71.

rendering effective medical assistance.³³⁴

The lower court dismissed the inmate's action for failure to state a cognizable claim under section 1983.³³⁵ Upon appeal, the Fifth Circuit vacated the lower court's order, finding that the inmate's allegations, taken as true, could in fact entitle him to relief.³³⁶ The Fifth Circuit set out the competing considerations a court should take into account when deciding whether the denial of the psychiatric treatment amounts to deliberate indifference to the inmate's serious medical needs:

On the one hand, it should consider the seriousness of the prisoner's illness, the need for immediate treatment, the likely duration of his incarceration, the possibility of substantial harm caused by postponed treatment, the prospects of some cure or substantial improvement in his condition, and the extent to which the prisoner presents a risk of danger to himself or other inmates. On the other hand, the court should consider the availability and expense of providing psychiatric treatment and the effect of such unusual care on ordinary jail administration.³³⁷

The court observed that when assessing the merits of an inmate's Eighth Amendment claim, the "essential test is one of medical necessity and not one simply of desirability."³³⁸

While the number of cases involving sex offenders' Eighth Amendment claims is limited, the courts with rare exception have consistently denied the inmates' claims, either holding that: (1) the inmate, despite showing that he has been convicted of a sexual offense, did not show that he had a serious medical need;³³⁹ or that (2) although the inmate's sexual disorder did constitute a serious medical need, the treatment provided at the prison was sufficient, and therefore did not merit a finding of deliberate indifference.³⁴⁰ Cases such as these reflect the maxim among courts that some treatment, but not necessarily every or even the best available treat-

334. *See id.*

335. *See id.* at 270.

336. *See id.* at 272.

337. *Id.*

338. *Id.*

339. *See, e.g.,* Riddle v. Mondragon, 83 F.3d 1197, 1204 (10th Cir. 1996) (mere allegations by inmates that they had serious mental disorders are insufficient to constitute an Eighth Amendment violation, absent a diagnosis by a physician or a condition that a layperson would easily recognize as requiring attention); State v. Drennen, 842 P.2d 698, 702 (Idaho Ct. App. 1992) (diagnosis of a sexual disorder, including a recommended inpatient treatment, is insufficient to establish a serious medical need that will not be met while in confinement); Patterson v. Webster, 760 F. Supp. 150, 154 (E.D. Mo. 1991) (sex offenders do not have a serious medical need for sex offender treatment, even where required to be eligible for parole); Ramos v. Vaughn, No. CIV.A.94-2596, 1995 WL 386573, at *5-6 (E.D. Pa. June 27, 1995) (inmate's alleged need for sex offender treatment does not constitute a serious medical need for Eighth Amendment purposes).

340. *See, e.g.,* Stillwell v. State, 859 P.2d 964, 968 (Idaho Ct. App. 1994), *cert. denied*, 511 U.S. 1056 (incarceration without psychological or psychiatric treatment for sex offenders is not violative of the Eighth Amendment); Bailey v. Gardebring, 940 F.2d 1150, 1155 (8th Cir. 1991) (absence of treatment programs specifically directed toward psychopathic individuals who have committed sexual offenses, without evidence of cure or generally accepted method of treatment, does not constitute deliberate indifference).

ment, should be provided to inmates. "Amid the ambiguity regarding what prison health care must include, courts and commentators have made clear that inmates have no right to perfect or optimal health care . . . [n]or . . . to absolutely every potentially beneficial medical procedure, regardless of how rare or experimental."³⁴¹

The same maxim will apply to inmates with pedophilia disorders who demand surgical castration under the Eighth Amendment; courts will require evidence, based on expert testimony, that the inmate's pedophilia constitutes a serious medical need, and that prison officials are aware of this medical need but nevertheless refuse to provide castration. Prison officials will be required to demonstrate that pedophilia disorders do not constitute a serious medical need; that even if pedophilia is a serious medical need, the inmate is not entitled to castration because other treatment is being provided; or that the failure to provide castration did not amount to deliberate indifference.

At present, even if pedophilia is considered a serious medical need, surgical castration has not yet been shown to have acquired medical acceptance among medical and health professionals as a treatment for that disorder.³⁴² Additionally, courts dealing with incarcerated pedophiles who seek treatment are reticent to provide even minimal levels of psychiatric and psychological *counseling*, and may therefore be quite unwilling to require a treatment that is still a matter of some debate.³⁴³ Nonetheless, it is almost a certainty that if surgical castration acquires medical acceptance as a treatment for pedophilic disorders, an inmate who requests and is denied such a procedure has a strong Eighth Amendment claim. Given the Eighth Amendment's "evolving standards of decency"³⁴⁴ and the recognition that inmates with paraphilic disabilities such as pedophilia are in need of treatment, such a claim could one day prevail.

V. DUE PROCESS CONSIDERATIONS

Apart from Eighth Amendment concerns, there may also be Due Process considerations associated with the issue of inmates undergoing surgical castration as treatment for their pedophilia disorders. Despite incarceration, "a prisoner is not wholly stripped of constitutional protections when he is imprisoned for crime."³⁴⁵ Inmates have been found by

341. Michael Cameron Friedman, *Cruel and Unusual Punishment in the Provision of Prison Medical Care: Challenging the Deliberate Indifference Standard*, 45 VAND. L. REV. 921, 933-34 (1992).

342. *But see supra* Part II.B.2.c.

343. *See generally* Daniel L. Icenogle, *Sentencing Male Sex Offenders to the Use of Biological Treatments: A Constitutional Analysis*, 15 J. LEGAL MED. 279, 280 (1994).

344. *See supra* Part IV.A.

345. *Wolff v. McDonnell*, 418 U.S. 539, 555-56 (1974) (observing that constitutional guarantees such as prisoners' religious freedoms, access to courts, equal protection, and Due Process rights may not be deprived); *Riggins v. Nevada*, 504 U.S. 127, 132-37 (1992) (declaring that prisoners have a constitutional liberty interest in avoiding forced medication, and that forced medication may implicate an inmate's right to a full and fair trial);

the U.S. Supreme Court to enjoy First Amendment religious freedoms, Sixth Amendment right of access to courts, and other constitutional privileges that free-world persons enjoy,³⁴⁶ although for inmates such rights may be "diminished" by the "needs and exigencies" of the prison environment.³⁴⁷ In addition, inmates' substantive federal constitutional rights or other liberties provided by federal or state law are protected under the Fifth and Fourteenth amendments, which essentially state that no person shall be deprived of these liberties without Due Process of law.³⁴⁸ This Due Process protection has both substantive and procedural components.³⁴⁹ The substantive component is determined by the particular constitutional liberty interest at stake, which is balanced against opposing state interests.³⁵⁰ The procedural component "concerns the minimum procedures required by the [U.S.] Constitution for determining that the individual's liberty interest actually is outweighed in a particular instance."³⁵¹ In other words, the state's deprivation of a substantive Due Process liberty interest is not by itself impermissible; what is impermissible is the deprivation of such a protected liberty interest *without Due Process*.³⁵² Although at first glance Due Process considerations might not find much resonance in the context of inmate medical claims regarding a program of *voluntary* surgical castration, an examination of such a treatment scheme without taking such considerations into account is incomplete.

A. INMATES' SUBSTANTIVE DUE PROCESS LIBERTY INTERESTS

For our purposes, the substantive Due Process issue is first framed by inquiring whether a person with a pedophilia disorder has a protected liberty interest in: (a) obtaining a surgical castration as treatment; or (b) avoiding surgical castration without informed consent or the procedural safeguards commensurate with involuntary treatment. Since the question involves *offenders* with a medical claim, the first inquiry is properly an Eighth Amendment rather than a substantive Due Process issue.³⁵³ And

Washington v. Harper, 494 U.S. 210, 229 (1990); Turner v. Safley, 482 U.S. 78, 96-99 (1987) (finding prisoner's right to marry protected under the constitution); Estelle v. Gamble, 429 U.S. 97, 104-05 (1976) (stating that prison inmates may not be subjected to deliberate indifference to their serious medical needs under the Eighth Amendment); *but cf.* Hudson v. Palmer, 468 U.S. 517, 525-26 (1984) (finding that prisoners have no reasonable expectation of privacy from search and seizure under the Fourth Amendment).

346. *See* Wolff, 418 U.S. at 555-56.

347. *Id.* at 555.

348. U.S. CONST. amends. V & XIV, sect. 1.

349. *See* Harper, 494 U.S. at 220. The Due Process Clause is sometimes said to be comprised of *three* components: the specific protections found in the Bill of Rights; the substantive component that prohibits arbitrary and wrongful government actions "regardless of the fairness of the procedures used to implement them;" and the guarantee of fair procedure. Zinermon v. Burch, 494 U.S. 113, 125 (1990) (citation omitted).

350. *See* Zinermon, 494 U.S. at 220.

351. *Id.* (citing Mills v. Rogers, 457 U.S. 291, 299 (1982)).

352. *See id.* at 125-26.

353. *See, e.g.,* Estelle, 429 U.S. at 102-03 (establishing firmly for the first time in Supreme Court jurisprudence the principle that the government has an "obligation to pro-

as the question of whether inmates with pedophilic disorders have a right to surgical orchiectomy protected by the Eighth Amendment has already been discussed in the previous section, no further deliberation on that issue is required here.³⁵⁴

The second substantive Due Process inquiry—whether an inmate has a protected liberty interest in avoiding surgical castration in the absence of informed consent or the procedural safeguards commensurate with involuntary treatment—can be answered by reference to the two Supreme Court cases invoking Due Process protection where inmates were subject to involuntary medication with anti-psychotic drugs, *Washington v. Harper*³⁵⁵ and *Riggins v. Nevada*.³⁵⁶ In *Harper*, the Court stated quite strongly that the respondent-prisoner has a *significant* liberty interest in avoiding the unwanted administration of anti-psychotic drugs under the Due Process Clause of the Fourteenth Amendment, and that forcing anti-psychotic drugs upon an unconsenting prisoner is impermissible absent a finding of a state's overriding justification as well as the medical appropri-

vide medical care for those whom it is punishing by incarceration," and that deliberate indifference to an inmate's serious medical needs constitutes the "unnecessary and wanton infliction of pain" in violation of the Eighth Amendment) (citations omitted).

The leading U.S. Supreme Court case establishing the standard of review for inmate constitutional substantive Due Process *non-medical* claims is *Turner v. Safley*, 482 U.S. 78 (1987). In *Turner*, the Supreme Court reviewed a lower court's decision that found prison regulations prohibiting or limiting inmate marriages and inmate-to-inmate correspondence unconstitutional. *See id.* The Court said that two principles guide the consideration of inmates' constitutional claims: one is that federal courts must take cognizance of the valid constitutional claims of prison inmates. *Id.* at 84 (citation omitted). The Court noted that "(p)risons do not form a barrier separating prison inmates from the protection of the Constitution." *Id.* The other principle is that "courts are ill-equipped to deal with the increasingly urgent problems of prison administration and reform." *Id.* (citation omitted). As a general rule, prison officials are accorded considerable deference in "[r]unning a prison." *Id.* at 84-85. The Court then indicated that its decisions will be responsive to both principles in establishing a standard of review for inmates' constitutional claims. *Id.* at 84. In *Turner*, the Court was careful to announce the proper standard of review for prisoners' constitutional claims unlike previous Court decisions: "[w]hen a prison regulation impinges on inmates' constitutional rights, the regulation is valid if it is reasonably related to legitimate penological interests." *Id.* at 89; *see id.* at 85-89 (discussing prior Court decisions). This reasonableness standard applies whether or not the claimed constitutional right is fundamental, and applies even where the state would otherwise be required to satisfy a more rigorous standard of review. *See Harper*, 494 U.S. at 223 (citation omitted). The *Turner* reasonableness standard is comprised of several factors relevant to determining a prison regulation's reasonableness: first, whether there was a valid, rational connection between the prison regulation and a legitimate, neutral governmental interest that justifies the regulation; second, whether alternative means of exercising the claimed right remain open to prison inmates; third, the impact that accommodation of the claimed right would have upon guards and other inmates, and upon the allocation of prison resources generally; and fourth, the absence of obvious and easy alternatives to the challenged regulation. *See Turner*, 482 U.S. at 89, 90.

354. *See supra* Part IV (arguing that inmates with pedophilic disorders are unlikely to succeed on a claim that the Eighth Amendment requires prison officials to make surgical castration available on demand, absent a clear showing that, first, pedophilia is a serious medical need and that, second, refusing inmates surgical castration treatment evinces deliberate indifference to that medical need).

355. 494 U.S. 210 (1990) (involving an prison inmate in Washington state).

356. 504 U.S. 127 (1992) (involving a pretrial detainee).

ateness of the treatment.³⁵⁷ In *Riggins*, the Court observed that other courts have recognized a protected liberty interest in avoiding unwanted medication, and in referring to the *Harper* case, stated that pretrial detainees “retain at least those constitutional rights that we have held are enjoyed by convicted prisoners.”³⁵⁸ An important factor in these decisions was the recognition that the purpose of the anti-psychotic medications at issue was to alter the chemical balances in a patient’s brain, leading to changes in the patient’s cognitive processes, and the recognition that such drugs may have serious and even fatal side effects.³⁵⁹

In the *Harper* and *Riggins* cases, weighing against the inmates’ substantive Due Process liberty interest in avoiding unwanted medications are the states’ interests in preventing harm to the inmate or to others if the inmate were left untreated,³⁶⁰ and in *Riggins*, the additional state interest in bringing the inmate to trial.³⁶¹ In *Harper*, the Court held that the state’s interest—which the Court found was clearly articulated by the state and limited by well-established procedural mechanisms that included, along with notice and the right to be present at hearing, a finding of mental disorder as well as dangerousness, committee review as well as change of the type and dosage of medication, and impartial decision-makers—sufficiently accommodated the inmate’s liberty interest to survive the inmates’ Due Process challenge.³⁶² In contrast, having failed to acknowledge the inmate’s liberty interest or demonstrate the contravening state interest in forcibly medicating the inmate, the Court in *Riggins* concluded that it was error for the lower court to order the inmate’s involuntary treatment.³⁶³ Despite their different outcomes, both *Harper* and *Riggins* unambiguously support the proposition that inmates do have a substantive Due Process liberty interest in determining what may or may not be done to their bodies, even if the proposed medical treatment is involuntary and the failure to treat the inmate represents a threat of harm to the inmate or to others.³⁶⁴ There is no plausible reason to suggest or believe that surgical castration eludes this protection.

In contrast, the *procedural* Due Process inquiry has less in the way of settled jurisprudence to guide it. As with any procedural Due Process analysis, this inquiry rests on two assumptions. The first assumption is that surgical castration represents a government deprivation of an in-

357. See *Harper*, 494 U.S. at 221-22, 227 (citing *Youngberg v. Romeo*, 457 U.S. 307, 316 (1982); *Parham v. J.R.*, 442 U.S. 584, 600-01 (1979)) (emphasis added). The notion of controlling one’s own body is long established. See, e.g., *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (1914) (stating that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body”) (Cardozo, J.).

358. *Riggins*, 504 U.S. at 135.

359. See *id.* at 134. The Court went as far as observing that the medications might even impair the inmate’s right to obtain a fair trial since the inmate’s demeanor might be affected. See *id.* at 136.

360. See *Harper*, 494 U.S. at 222; *Riggins*, 504 U.S. at 135.

361. See *Riggins*, 504 U.S. at 136.

362. See *Harper*, 494 U.S. at 232-36.

363. See *Riggins*, 504 U.S. at 138.

364. See *Schloendorff*, 105 N.E. at 93.

mate's protected substantive Due Process liberty interest, which we now know to be the inmate's bodily integrity, regardless of the inmate's consent. The second assumption is that such a deprivation is impermissible absent a procedural undertaking that ensures that the deprivation is not arbitrary or unfair.³⁶⁵ An analysis of the few relevant cases provides some indication of whether and what procedural process is due an inmate before surgical castration may be performed.

B. INMATES' PROCEDURAL DUE PROCESS RIGHTS

The procedural Due Process protection afforded to inmates was firmly acknowledged in *Wolff v. McDonnell*.³⁶⁶ In *Wolff*, the Supreme Court was asked to decide whether the revocation of "good time" credits earned by an inmate was impermissible absent a full Due Process proceeding that included, among other elements, an opportunity to confront and cross-examine witnesses as well as a right to retained or appointed counsel.³⁶⁷ In determining the extent of the procedural protections due an inmate, the Court observed that "one cannot automatically apply procedural rules designed for free citizens in an open society . . . to the very different situation presented . . . in a state prison."³⁶⁸ In rejecting the inmates' claim for full Due Process proceedings in favor of partial Due Process proceedings that included written notice, right to call witnesses and present evidence, and an impartial hearing committee, the Court found what it termed a "reasonable accommodation between the interests of the inmates and the needs of the [prison] institution."³⁶⁹

The U.S. Supreme Court's latest iteration of an inmate's procedural Due Process right is found in *Sandin v. Conner*,³⁷⁰ a case in which a prison inmate challenged a prison policy under which the inmate was placed in disciplinary segregation while appealing a misconduct finding.³⁷¹ In relevant part, the inmate in *Sandin* relied on post-*Wolff* cases to argue that disciplinary segregation was such a departure from the basic and expected conditions of confinement that Due Process proceedings were required before such segregation could be effected.³⁷² In rejecting the inmate's claim, the Court took pains to emphasize *Wolff* as the standard against which inmate procedural Due Process claims are measured,³⁷³ but stated that "segregated confinement did not present the

365. See, e.g., *Harper*, 494 U.S. at 221 (commenting that the forcible medication of a non-consenting inmate is a substantial interference with the inmate's liberty interest).

366. 418 U.S. 539 (1974).

367. See *id.* at 544, 553.

368. *Id.* at 560.

369. *Id.* at 572; see *Sandin v. Conner*, 515 U.S. 472, 478 (1995) (stating that "[m]uch of *Wolff's* contribution to the landscape of prisoners' Due Process derived not from its description of liberty interests, but rather from its intricate balancing of prison management concerns with prisoners' liberty in determining the amount of process due").

370. See *Sandin*, 515 U.S. at 472.

371. See *id.*

372. See *id.* at 485 (citation omitted).

373. See *id.* at 484.

type of atypical, significant deprivation in which a state might conceivably create a liberty interest.”³⁷⁴ In so doing, the Court found that disciplinary segregation was less a deprivation than that posed by the revocation of “good time” credits at issue in *Wolff*, and held that partial Due Process proceedings of the type required by the Court in *Wolff* were not required.³⁷⁵ Together, *Wolff* and *Sandin* suggest that inmate substantive liberty interests are protected by procedural Due Process—though not necessarily and perhaps not even likely *full* procedural Due Process—and that for deprivations that are neither atypical or significant, no procedural Due Process protection whatsoever. Assuming what is known about surgical castration as a treatment response to pedophilia disorders,³⁷⁶ it is entirely plausible that a court may characterize a state’s assent to perform the procedure, as well as an inmate’s request to undergo it, as a potentially atypical and significant deprivation of an inmate’s substantive Due Process liberty interest. For this reason, such an event must be attended by an appropriate level of procedural protection.

C. MEDICAL TREATMENT AND PROCEDURAL DUE PROCESS

Although instructive, neither *Wolff* nor *Sandin* directly address the issue of what process is due with respect to inmate claims that pertain to medical treatment. Both cases are confined to what are essentially claims over additional state-imposed confinement, matters that are closely related to the incidents of incarceration. Despite this fact, the Court in *Sandin* recognizes that, “independent of any state regulation,” an inmate may also have a liberty interest conferred directly by the Due Process Clause itself.³⁷⁷ One of the cases cited in *Sandin* for that very proposition, *Washington v. Harper*,³⁷⁸ is perhaps the most influential case with respect to Due Process requirements in medical treatment cases involving prison inmates.³⁷⁹

In *Harper*, the Supreme Court reviewed a severely mentally disordered inmate’s claim that the failure of prison officials to provide the inmate with a judicial hearing prior to involuntarily medicating the inmate with anti-psychotic medications was constitutionally impermissible under the Fourteenth Amendment’s Due Process Clause.³⁸⁰ Under prison regulations that existed at the time, a non-consenting inmate could not be invol-

374. *Id.* at 485.

375. *See id.* at 485-86.

376. *See supra* Part II.2.c.

377. *See Sandin*, 515 U.S. at 479 n.4.

378. 494 U.S. 210 (1990). For inmates who are not sentenced but who are detained for trial, the same Due Process protection established in *Harper* applies. *Riggins*, 504 U.S. at 135. The Supreme Court stated that the Fourteenth Amendment “affords at least as much protection to persons the State detains for trial[]” as it affords to sentenced inmates. *Id.* Here, however, prison officials failed to make a finding of a need to involuntarily medicate the inmate during the inmate’s trial, and may have thereby denied the inmate a full and fair trial in violation of the inmate’s substantive Due Process rights. *See id.* at 136.

379. *See Sandin*, 515 U.S. at 479 n.4.

380. *See Harper*, 494 U.S. at 213.

untarily medicated with anti-psychotic drugs unless both: (1) the inmate suffers from a "mental disorder;" and (2) the inmate is "gravely disabled" or posed a "likelihood of serious harm to himself, others, or their property."³⁸¹ Any inmate who refuses to take the anti-psychotic medication is entitled to a hearing before a committee consisting of a non-treating psychiatrist, a psychologist, and the Associate Superintendent of the treatment center for inmates with severe mental disorders.³⁸²

A number of procedural rights are accorded the inmate before, during, and after the hearing, including, in part, twenty-four hour notice of the prison official's intent to convene a hearing (during which time the inmate may not be medicated); notice of the factual basis for his or her diagnosis and the need for medication; the right to attend the hearing; to present evidence; to cross-examine staff witnesses; the assistance of a lay advisor; a right of appeal; and a right of review in a state court.³⁸³ If a majority of the committee agrees that the inmate has a mental disorder and is gravely disabled or dangerous, then the inmate may be involuntarily medicated.³⁸⁴

In *Harper*, the Court acknowledged that prison inmates have—both by operation of the state prison policy and by the Fourteenth Amendment—a liberty interest in avoiding unwanted administration of anti-psychotic medications.³⁸⁵ However, the Court found that the state's administrative scheme for safeguarding the inmate's liberty interest met the demands of the Due Process Clause without the need for a judicial hearing.³⁸⁶ The Court observed that the inmate's interests are perhaps better served by having the decision to medicate be made by medical professionals rather than judges, and rejected the idea that the "shortcomings of [medical] specialists can always be avoided by shifting the decision . . . to an untrained judge or administrative hearing officer after a judicial-type hearing."³⁸⁷ Furthermore, the Court was satisfied with the independence of the decision-maker in such hearings, noting that there was no indication that institutional biases would affect or alter the decision to forcibly medicate an inmate.³⁸⁸ Finally, the Court remarked that the practical effect of requiring outside decision makers may be "chimerical" because outside decision makers concur in most cases anyway.³⁸⁹ Because the Court found that the prison regulations sufficiently safeguarded the inmate's liberty interests without the need for a judicial hearing, the lower court's finding was reversed.³⁹⁰

381. *Id.* at 215.

382. *See id.*

383. *See id.* at 215-16.

384. *See id.*

385. *See id.* at 221-22.

386. *See id.* at 229-34.

387. *Id.* at 232.

388. *See id.* at 233.

389. *See id.* at 235.

390. *See id.* at 236.

With respect to *voluntary* treatment, the case of *Zinermon v. Burch*³⁹¹ appears particularly instructive.³⁹² In *Zinermon*, the Supreme Court found constitutionally defective a hospital's acceptance of a voluntary patient admission.³⁹³ In that case, a patient was voluntarily admitted to a state mental hospital while suffering from a psychotic disorder, after the patient had been found bruised, bloodied, hurt and disoriented and wandering along a Florida highway.³⁹⁴ Various hospital records indicated that the patient was at times hallucinating, confused, and psychotic, and that on at least two occasions, the patient believed he was "in heaven."³⁹⁵ At no point during his five-month hospitalization was a hearing held regarding the patient's hospitalization and treatment.³⁹⁶ Subsequent to his release, the patient sued the hospital, claiming deprivation of his liberty

391. 494 U.S. 113 (1990).

392. Another interesting but somewhat less relevant (and unreported) case is *Kaimowitz v. Michigan Department of Mental Health*, 42 U.S.L.W. 101 (Cir. Ct. Wayne County, July 31, 1973) (reported in full in ALEXANDER D. BROOKS, LAW, PSYCHIATRY AND THE MENTAL HEALTH SYSTEM 902-24 (1974)). Despite being unreported, *Kaimowitz* has been widely discussed. See BROOKS, *supra* at 904 (commenting on the publicity); *id.* at 924 (stating that the case has been extensively explored, and providing relevant citations).

In *Kaimowitz*, the court was asked to issue a declaratory judgment involving the case of "John Doe," a patient involuntarily housed in a Michigan state hospital as a "criminal sexual psychopath" following charges of murder and rape of a student nurse. See *id.* at 902-03, 905. John Doe was selected as a research subject to undergo what was considered an experimental and innovative surgical procedure that involved the placement of electrical wires into John Doe's brain, through which weak electrical currents would be passed to determine if one or more areas of the brain trigger aggressive or violent sexual episodes. See *id.* at 903. The established therapies at the time, temporal lobectomy or other neurological surgical procedures, were not involved. See *id.* at 906. When word of the experiment became known, the declaratory suit was filed. See *id.* at 904.

The issue the court framed was whether an adult or legally appointed guardian may if the adult is involuntarily detained, at a facility within the jurisdiction of the State Department of Mental Health give legally adequate consent to an innovative or experimental surgical procedure on the brain, if there is demonstrable physical abnormality of the brain, and the procedure is designed to ameliorate behavior, which is either personally tormenting to the patient, or so profoundly disruptive that the patient cannot safely live, or live with others. . . .

Id. at 905. The court concluded no, but with the proviso that, when the state of medical knowledge develops to such a degree that the procedure becomes medically acceptable, and is no longer experimental, "it is possible, with appropriate review mechanisms," that a patient such as John Doe could consent to the procedure. *Id.* at 920. The court stated specifically that an involuntarily detained mental patient could give legally adequate consent to *accepted* neurological procedures. See *id.*

The implications of a case like *Kaimowitz* to surgical castration of prisons with pedophilia disorders appear obvious: the consent to surgical castration of involuntarily confined mental patients who are deemed criminal sexual psychopaths is ineffective if surgical castration is characterized as experimental. However, if surgical castration is considered medically acceptable, the informed consent of an individual, competent or otherwise at the time the decision is made, is legally adequate. Nonetheless, this Article only suggests that inmates who are deemed competent should be afforded the opportunity to voluntarily request surgical castration.

393. See *Zinermon*, 494 U.S. at 131, 139.

394. See *id.* at 118.

395. See *id.* at 118-19.

396. See *id.* at 120.

without Due Process.³⁹⁷ The patient claimed that the hospital knew or should have known that the patient was not competent to give informed consent to his admission, and that the hospital should have instead sought to have the patient involuntarily admitted, under which pre-deprivation procedural safeguards exist.³⁹⁸

The Court agreed with the patient, finding “foreseeable that a person needing mental health care will be unable to understand any proffered ‘explanation and disclosure of the subject matter’ of the forms that person is asked to sign, and will be unable ‘to make a knowing and willful decision’ whether to consent to admission.”³⁹⁹ The Court stated that even if the state might be justified in taking at face value a person’s voluntary request for admission, the state may not be justified in doing so without further inquiry as to the person’s request for treatment and admission.⁴⁰⁰ In finding for the patient, the Court carefully reviewed the type of procedural protections due in particular circumstances that were established in other Due Process cases, and weighed the arguments favoring either pre- or post-deprivation hearings.⁴⁰¹ In reaching its conclusion, the Court was firm in rejecting the state’s argument that a post-deprivation hearing would have satisfied the patient’s Due Process liberty interest,⁴⁰² indicating that the state is in a position to provide a pre-deprivation process, and because a post-deprivation hearing will not be of any use in preventing the kind of deprivation alleged.⁴⁰³

What *Zinerman* does is to equate—at least where persons with mental disorders are concerned—the requirements for voluntary treatment with requirements for involuntary treatment, necessitating more formal determinations of a mentally disordered person’s competency to provide informed consent *before* the requested treatment is provided.⁴⁰⁴ Such determinations include, in part, a medical finding, confirmed by at least one other medical professional, that a patient meets the criteria for the proposed treatment; a right to notice about the proposed treatment; a judicial hearing; appointed counsel; access to medical records and personnel; and an independent expert examination.⁴⁰⁵ Interestingly, the move towards more formal determinations in *Zinerman* contrasts with the move away from such determinations for mentally disordered prisoners that is observed in the cases of *Harper* and *Riggins*.

Cases such as *Zinerman*, *Harper* and *Riggins* are instructive because they indicate, as a threshold matter, that inmates are clearly protected by

397. *See id.* at 114-15.

398. *See id.* at 115.

399. *Id.* at 133.

400. *See id.*

401. *See id.* at 127-38 (citations omitted).

402. *See id.* at 136, 138-39 (citations omitted).

403. *Id.*

404. *See* Bruce J. Winnick, *Competency to Consent to Voluntary Hospitalization: A Therapeutic Jurisprudence Analysis of Zinerman v. Burch*, in *ESSAYS IN THERAPEUTIC JURISPRUDENCE* 83, 93-94 (1991).

405. *See Zinerman*, 494 U.S. at 123-24.

procedural Due Process. For our purposes, the cases suggest that, whether or not surgical castration is undertaken voluntarily, such a procedure could under some circumstances evince a government deprivation of an inmate's protected liberty interest. Most important, the cases indicate that so long as pre-deprivation procedures are sufficiently adequate to guard against arbitrary or unfair government action, surgical castration would not conflict with the procedural Due Process rights of inmates. Giving due regard to the diverse findings of the relevant cases may also require that inmates who voluntarily request surgical castration, but whose capacity to provide informed consent is questionable, not be provided with surgical castration unless preceded by a judicial hearing before the requested medical treatment is provided. Although this does not imply that persons with pedophilia disorders are, simply because of their pedophilia disorder, mentally disordered, paraphilias such as pedophilia may be interpreted to impair an afflicted person's capacity to provide informed consent to treatment.

Under any circumstance, it is clear that surgical castration should be preceded by a minimum level of procedural protection, which should include, in part, restricting the procedure to inmates who are competent to make their own medical treatment decisions; clear eligibility criteria such as medical appropriateness; assurances that consent is indeed informed, such as providing full information regarding the procedure and any alternative treatment, and written consent; and outside, professional review of the inmate's request to undergo castration.⁴⁰⁶ It is only through such pre-deprivation proceedings that surgical castration can be considered legally defensible under the Due Process Clause of the Fifth and Fourteenth Amendments.

VI. CONCLUSION

It is undeniable that pedophilic sex offenders pose a grave risk to the health and safety of many of the most vulnerable members of society: children. The effects of sexual abuse inflict lifelong physical and psychological damage to children and may even predispose such victims as adolescents or adults to, in turn, sexually abuse children themselves. Preventing pedophilic sex offending is therefore an important social and criminological objective.

Research clearly demonstrates that pedophilic behavior may be effectively suppressed through a number of treatment regimes that reduce male testosterone levels or reduces the motivation to engage in deviant sexual conduct involving child victims. Given the consequences of pedophilic sex offending and the ability to treat such conditions, permitting convicted pedophile sex offenders to voluntarily undergo any one or a combination of these treatments—including surgical castration—ap-

406. See *supra* Part III.D. for a more complete listing of what elements might be included in order to ensure a procedural process that is consistent with *Zinermon*, *Wolff*, and *Sandin*.

pears quite reasonable. Some jurisdictions, including California, Montana, Florida, and Texas, have already enacted laws that provide for, or at least sanction, surgical castration as a meaningful response to sexual disorders that result in offenses involving child victims.

However, permitting convicted sex offenders to voluntarily undergo surgical castration, ostensibly as one of a number of treatment alternatives, raises important legal considerations, essentially because surgical castration has a dubious and pernicious history, and because surgical castration has yet to find substantial support in the United States as an alternative treatment among those who treat sex offenders. The strongest legal challenge to laws that provide for surgical castration of sex offenders whose victims are children is likely to rest upon the Eighth Amendment of the U.S. Constitution, which prohibits cruel and unusual punishment.

But, as our analysis indicates, permitting incarcerated sex offenders who have a pedophilic sexual disorder to voluntarily request surgical castration within a carefully regulated therapeutic context, accompanied by heightened precautions that bar any penological considerations, does not infringe on an inmate's right against cruel and unusual punishment, and might even be required if an inmate demonstrates that such treatment is manifestly appropriate for a serious medical need.

Additional legal challenges may arise as Due Process claims under the Fifth and Fourteenth amendments, which protect inmates from impermissible deprivations of their liberty interests with regard to informed consent and bodily integrity. In order to withstand such a challenge, it is evident that surgical castration must be *preceded* by a minimum level of procedural protections, which should include an inmate's competency to make treatment decisions; the inmate's informed consent to undergo surgical castration; that the castration be a clinically appropriate response to the particular inmate's physical and psychological condition; and that the inmate's request for castration be subject to outside professional review. With these assurances, surgical castration may be characterized as legally and morally defensible, as well as an appropriate response, to pedophilia disorders among inmates.

