The Medical-Moral Newsletter

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The guest editor for this issue is Fred S. Berlin, M.D., Ph.D., Assistant Professor, The Johns Hopkins University School of Medicine.

TREATMENT OF PEDOPHILIA. Almost two thousand years ago as an outraged crowd prepared to stone a woman whose sexual behavior they considered offensive, one amongst them stepped forward, admonishing that only he who was without sin should cast the first stone. Some years later, another angry crowd crucified the woman's savior, not wanting to hear any more of a message which mitigated against revenge in favor of compassion, understanding, forgiveness and reformation. That man was crucified because he asked that persons be judged not simply by their behavior, but with some appreciation for their humanity and for their potential to transcend and to change.

A few hundred years ago in New England, misguided parishioners burned at the stake women whose behavior they feared or found offensive. Persons whom we might now treat in psychiatric hospitals were shackled, often for the better part of a lifetime. During the Holy Inquisition, alleged offenders were often tortured, ostensibly as part of the legitimate criminal justice system. In the 1700s the most common cause for execution in the British Royal Navy was the crime of homosexual behavior between consenting adults. Reflecting upon such harsh punishments, one might be tempted to pray "forgive them Father, for they did not know what they were doing." Yet even today, the man who becomes sexually involved with children is quickly scorned, stigmatized and condemned, frequently with little interest in discovering what motivated such behavior initially, let alone with any interest in showing compassion or forgiveness, or in providing him with help.

To provide help is not to condone the behavior. For surely such behaviors need to stop. Surely the needs of those who are victims must also be met. But how does punishing an "offender" help his victim? Restitution might make more sense. And, is punishment in such cases invariably just? The adult who becomes sexually involved with children was often himself sexually involved with an adult when he was a youngster. Thus, in treating the "sex offender," one is often in fact also treating a victim. One is merely treating him after the circumstances of his childhood, or the intricacies of his biological constitution, have produced their psychological sequelae.

It is a deeply rooted aspect of human nature to seek out a partner with whom we can share tenderness, affection, companionship, and physical intimacy. We do not experience feelings of erotic love because it is intellectually

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rational to do so. Rather, there is a certain "chemistry" involved. Most of us can describe attributes both physical and psychological that comprise our archtypal fantasies of an idealized partner or mate. Fortunately, in the overwhelming majority of cases, the object of our erotic affections is an adult.

Almost all of us are aware that infants and children often elicit an emotional response from us. These feelings are ordinarily ones of affection and gentleness, as well as a desire to nurture, cherish and to protect. Although it is sometimes difficult to resist the urge to pick up and cuddle a young infant or child, we do not ordinarily fall in love with children, in a romantic, sexual way. Tragically though, some men do experience feelings of erotic arousal towards young children in the context of what might otherwise by a healthy, platonic relationship (1). The man who, for unknown reasons, discovers that he craves a physically intimate relationship with a child rather than an adult copes with life from a very different perspective. Like the rest of us, however, he may experience recurrent desires to seek out a partner with whom he can satisfy and share his innermost needs.

There are those who choose to believe that any man who becomes sexually intimate with a child is simply a callous predator, unwilling to reflect upon the possibility that such an individual could have a genuine concern for the well-being of children. How could anyone who really cares about a child's well-being show so little concern, and manifest such an abuse of trust? There can be little doubt that children are too unprepared and too vulnerable to fully appreciate the consequences of sexual involvements with an adult. Imagine, however, what life must be like for the man who finds that he never experiences feelings of erotic arousal or romantic love towards adults, as much as he might wish that he could, but who recurrently lusts for, or falls in in love with, young boys in an erotic, sensual, sexual way. When a person falls deeply in love with another person it becomes all too easy to convince himself that the relationship is good and healthy and not harmful or wrong.

Diagnosis. Pedophilia is a diagnostic term used to indicate that an adult finds children to be erotically appealing. Groth classifies men who find both adults and children erotically appealing as regressed pedophiles (2). Some men experience no erotic attraction whatsoever towards adults, but have a great deal of difficulty resisting the sexual temptations that they experience towards children. Groth refers to men who find only children to be erotically appealing as fixated pedophiles. When a man who is attracted sexually to children desires not to be, because such attractions conflict with his conscience and personal moral convictions, and therefore he would like to change, his sexual attraction to children is said to be ego-dystonic.

Pedophilia cannot be diagnosed simply by considering behavior alone. Rather, the physician must try to appreciate the state of mind which contributed to the behavior. For example, a person with schizophrenia may behave in particular ways in response to hallucinations "telling him to do so." A mentally retarded individual may become sexually involved with a child, who incidentally may be the same approximate mental age, because of the lack of availability of adult partners, and the lack of capacity to fully understand the wrongful nature of his actions. In these instances a primary diagnosis of pedophilia would not necessarily apply.

Pedophilia refers to sexual orientation: it says nothing about temperament, or traits of character, such as kindness versus cruelty, caring versus

uncaring, sensitivity versus insensitivity, conscientiousness versus lack of conscience. A diagnosis of pedophilia does not necessarily mean that a person is lacking in conscience, diminished in cognitive capabilities or somehow "characterologically flawed." Rather, he may be a concerned person dealing less than successfully with sexual and affectional temptations of a sort which are very foreign to most men.

The causes of pedophilia are not fully known. Groth has shown that sexual involvements with an adult during early childhood may increase the risk of developing pedophilic attractions later in life (1). Money has proposed that excessive prohibition of early sexual expression may result in a similar outcome (2). Many men with sexual disorders come from homes where even the slightest expression of sexuality, including masturbation, was severely chastised. Berlin has shown that some biological abnormalities (e.g., chromosomal anomalies) may be involved (3). Although hormonal irregularities, chromosomal anomalies, or brain abnormalities cannot be said to be the sole cause of pedophilia, their presence appears to increase the risk of developing an unconventional sexual orientation such as pedophilia.

It is easy for a non-smoker to argue that a smoker could stop if he or she really wanted to. It is easy for a slim person to argue that successful dieting can be accomplished through will power alone. Similarly, it is easy for a person who is not tempted sexually by children to argue that any pedophile could stop having sex with children if he really wanted to and would simply make up his mind to do so. When it comes to appetites or drives such as hunger, or sex, however, biological regulatory systems exist that can cause some individuals to experience recurrent desires to satisfy these needs in ways that cannot invariably be successfully resisted by will power alone (4). Thus, professional assistance may be required. This may be crucial in the case of the pedophile because it is imperative that he stop his prior sexual patterns immediately, one-hundred percent of the time and indefinitely. Though necessary, this can nevertheless be a very formidable goal. Just as the smoker often rationalizes by minimizing his beliefs about the harm he may be causing, the pedophile is sometimes susceptible to doing the same. Such rationalizations may also need to be dealt with in providing care.

Treatment. Four major treatments have been proposed for pedophilia: psychotherapy, behavior therapy, surgery and medication. It is doubtful that a full understanding of the basis of one's own sexual interests can be gained through introspection alone. The average man probably cannot figure out simply by thinking about it why he prefers women rather than men. It also is not certain that the pedophile can figure out the basis of his own sexuality.

Behavior therapists tend to be less concerned with the antecedents of pedophilia than with the question of what can be done about it. Most behavioral approaches try to extinguish erotic feelings associated with children while simultaneously teaching an individual to become sexually aroused by formerly non-arousing age appropriate partners. Most of us can appreciate how difficult it would be to try to stop feeling the sexual attractions that we have experienced as natural throughout our lives. Imagine the average man trying to learn to find little boys sexually appealing, while at the same time losing all erotic interest in adult females. This is precisely what the fixated homosexual pedophile may need to accomplish, however, in reverse.

Castration has been suggested as a treatment for pedophilia because the testes are the major producers of testosterone, a hormone which in a sense

fuels sexual appetite. In virtually every species of animal, lowering testosterone by removing the testes eventually leads to a marked reduction in almost all forms of sexually motivated behavior (5). It appears that the same is true in humans. In one study in Denmark, for example, Sturup reported a 30-year investigation of 900 castrated "sex offenders," including over 4,000 follow up examinations (6). He documented a recidivism rate of less than a 3%. Several other European studies had similarly favorable outcomes. Furthermore, many men did not lose the capacity to perform sexually following castration. This may seem less surprising if one considers the analogy of suppressing hunger: a person may feel less driven to seek out food, but he would not lose the ability to eat.

Today, testosterone levels can be reduced pharmacologically in a graduated way, without the physical or psychological trauma of surgery. In the United States, the drug most often used has been medroxyprogesterone acetate (Depo-Provera) (3). There is no doubt that Depo-Provera consistently decreases serum testosterone levels significantly. This can be confirmed by means of a simple blood test. Lowering testosterone can lower libido which in turn seems to enable some men to more appropriately control their sexual behaviors. Thus, to the extent that unwanted sexual desire can be removed from an otherwise trustworthy relationship between an adult and a child, that relationship may be able to proceed in a healthy fashion.

Most pedophiles receiving Depo-Provera also attend group counseling sessions similar to the kind often employed in treating alcoholics. That is, these men are expected to acknowledge being tempted to do something that they realize they must not do. They then discuss among themselves strategies intended to help them resist such temptations successfully, (e.g., whom to call, what situations to avoid, early warning signs, and so on). Of over 70 men treated at The Johns Hopkins Hospital over the past year for some form of paraphilia (mostly pedophilia and exhibitionism) with Depo-Provera plus counseling, less than 5 percent have relapsed. Approximately 80 others who in our judgment did not require treatment with Depo-Provera have received counseling alone. Compliance rates have been better than 90%. Depo-Provera is not a cure, nor is it a punishment. It does appear, however, that it can be used to help some men help themselves. When such men seek help, understanding, empathy and professional competence is required -- not stigmatization or unenlightened scorn.

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PLEASE NOTE:

The next issue of The Medical-Moral Newsletter will be published in September. Have a safe and pleasant summer.

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