**A case of sexual deviation: Ethical questions relating to management**

**Subahani Shaik**

**Assistant Professor, Department of Psychiatry, Narayana Medical College, Nellore-524003, Andhrapradesh.**

**Abstract:** Despite societal and legal proscriptions, sexual deviations have persisted over the centuries. While some experts consider these deviations as mental disorders, some do not. Nonetheless, many of the persons with sexual deviations may seek clinical attention for treatment of their problems. The treatment of such conditions poses ethical challenges to physicians. These include maintenance of confidentiality, responsibility to protect those in danger, coerced treatment, options of irreversible treatment and aversive treatment. The present write up discussed the potential ethical issues faced while dealing a case of sexual deviation.

**Keywords:** Sexual deviation, Pedophilia, Ethical, Legal, India

**Introduction**

Sexual deviations including pedophilia have persisted in the human society since ages.[1] Though there are relatively strict laws to curb certain offensive practices, they have not been absolute deterrent in preventing these behaviors.[2,3] Psychiatrists have debated whether these behaviors should be considered as a mental disorder or not.[4] The present psychiatric nosological systems do give them a diagnostic label,[5,6] perhaps more from a forensic point of view rather than a therapeutic standpoint. This case discussion explores the ethical aspects encountered while dealing with cases of legally unacceptable sexual deviations.

**Case description**

A 22 years old college dropout and currently unemployed man sought treatment at our outpatient for problems relating to sexual urges. The patient had sought help primarily in relation to his urges towards young boys. The patient described that on a few occasions, he had lured boys as young as 6 or 7 year old to his home with sexual desire by offering them small amounts of money. He would fondle and kiss them, and at times attempted unprotected sexual intercourse. He would feel guilty after completing the act. But after a few days time, he would again have an urge to indulge with a young boy and would try to find opportunities for the same. He had attempted intercourse with about 20 children of age 6 to 17 years. Occasionally, some of the children would scream or run away to tell their parents. On discovery of his deed, he has been beaten up by parents and neighbors of the aggrieved children. However, no police case had yet ensued as the parents had not pressed charges.

On exploration of the sexual history, the patient said that he had started masturbation with male fantasies since 13 years of age. He had gained knowledge of sexual matters from friends. He had had homosexual encounters since the age of about 16 years. The patient was staying in a hostel for the period of time and had receptive and penetrative intercourse with his male roommate which was at times unprotected. He had oral and anal intercourse with this person over a period of three years. He would have desire mainly for males and even when he would see a couple, he would be drawn towards the physique and features of the male. His college colleagues came to know about his activities 3 years back and started teasing him as a ‘hijra’ (eunuch). Feeling embarrassed patient dropped out of college but continued to live away from home. He had not openly discussed about his preferences to his parents. The patient during this time also started to have urges towards young boys and attempted intercourse as described above. He has never had sexual urges towards female and feels uncomfortable that the parents are planning for his marriage. He could not sleep properly and would have distress when he thought about his sexual life. Due to social ridicule and apprehension that he may not be able to satisfy his wife, he sought treatment to change his preference for young boys and men. He did not have any history of fetishism, fetishistic transvestism, exhibitionism or voyeurism.

The patient would also drink alcohol occasionally when more distressed, though not in an abuse or dependent pattern. There was no sustained elevation of mood along with increased energy levels or any other manic symptoms. There would be occasional sadness of mood and sleep disturbance when he would be thinking about his problems. No evidence of other substance use, sustained and pervasive low mood, generalized anxiety or panic attacks were found. No evidence of antisocial personality disorder could be ascertained from the history. A diagnosis of pedophilia (F65.4) and ego-dystonic sexual orientation (homosexuality) (F66.11) was made as per ICD 10. The patient was started on fluoxetine and clonazepam to aid in controlling his urges. Option of psychotherapy and aversion therapy was discussed with the patient.

**Discussion**

The gamut of sexual deviations have spanned from relatively innocuous behaviors like fetishism to potentially dangerous ones like sadomasochism and finally those with serious legal concerns like pedophilia. Many of them go unnoticed as the persons concerned do not report it or seek help to change their ways. Some degree of gratification often accompanies the act. What is considered as sexual deviation may be dependent upon values of the society in a particular region and the point of time. Homosexuality was once considered a sexual deviation by societies which consider it now as a normal variant of human sexuality.[7] The present discussion does not focus upon sexual deviations per se, but on ethical issues in treatment of the same.

Penal code

Before the Protection of Children from Sexual Offences Act, 2012, the Indian Penal Code had certain provisions for dealing for issues relating to child sexual abuse. The provisions for trials of such cases relied with article 354 (outraging the modesty of a woman), 375 (rape) and 377 (unnatural offences). However, the new Protection of Children from Sexual Offences Act, 2012[8] has specific provisions for dealing with such cases. It has provision for minimum sentence of 7 years to even life imprisonment. It also has specific set of guidelines for dealing with child pornographic cases, and cases dealing with abetment of such crimes etc. The Act also provides for *“Any personnel of the media or hotel or lodge or hospital or club or studio or photographic facilities, … on coming across any material or object which is sexually exploitative of the child (including pornographic, sexually-related or making obscene representation of a child or children) through the use of any medium, shall provide such information to the Special Juvenile Police Unit, or to the local police, as the case may be.”*. This means that a medical facility should report a case where an obscene representation of a child has been made. But presently it does not require a person with perversion seeking treatment voluntarily to be reported immediately by medical professionals.

Confidentiality and duty to the aggrieved party

One of the major ethical issues in such a case dwells around the issue of confidentiality. As clinicians, it is our duty to maintain confidentiality towards our patients. This is true especially for embarrassing symptoms as described for the above case. The patient has urges and even acts upon them occasionally, and has guilt thereafter. The duty of the therapist is to attempt to reduce the behavior as well the distress resulting from the behavior enlisting patient’s or other’s help. But entering into a therapeutic contract entails respecting confidentiality so that patient-therapist trust remains. This trust might need to be broken in situations when the court summons a therapist to give evidence against the patient.

However, one of the exceptions to the rule of confidentiality is when a person’s condition is a threat to others. In this case, the threat to the young children remains. Whether the psychiatrist should inform ‘potential’ victims, their parents, the community services, or the legal services for a patient who voluntarily seeks treatment for these problems? From one point of view, it may not be clear when or who the next victim will be as predicting when the urge is insurmountable is difficult. So in case a person is diagnosed with such sexual deviation, the person may be needed to be incarcerated for a long period of time to curtail the risk even if the person is not psychopathic. The patient may not be willing to disclose the names of past or potential victims, an aspect which may not be of much consequence to the therapeutic process. Should the therapist play an additional role of an interrogator in such circumstances to elicit names? Answers to these questions may not be straightforward. Statutory requirements may help potential victims in some cases, but facture therapeutic relationship and keep at bay potentially beneficial treatment for some.

Treatment options including aversive treatment and irreversible treatment

The treatment options available for patients with sexual deviations include pharmacological, psychotherapeutic and surgical (Table 1). The surgical procedure of castration is an irreversible procedure though has shown impressive results in reducing sexually deviant behavior,[9]. Whether such a procedure is ethically correct can be debated. Voluntary request of castration for such persons can still be considered justified in some situations and is legally acceptable in some countries.[10] However, it may on the other hand contravene with the medical oath of *primum nocere*, as the person undergoing the surgery would quite possibly be bereft of sexual ability subsequently. Similar arguments can be put forth for chemical castration with agents like leuprorelin and medroxyprogesterone acetate. As compared to surgical castration, the effects of chemical methods are reversible on discontinuation. The issues of coercion with respect to these methods are discussed subsequently.

Table 1: Therapeutic options for patients with sexual deviations

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| Pharmacological   * Antidepressants like Selective Serotonin Reuptake Inhibitor (SSRIs) * Antipsychotics * Naltrexone * Medroxyprogesterone acetate * Cyproterone acetate * GnRH analogues – Goserelin, leuprorelin * Oestrogens   Psychotherapy based treatment   * Cognitive behavior therapy * Psychodynamic therapy * Group therapy * Therapeutic community * Aversion therapy   Surgical:   * Castration |

Another ethical issue revolves around use of aversion behavioral techniques in the treatment of sexual deviation. Aversion techniques involve the coupling of painful stimulus with sexual urges and thoughts and works by punishment model. Due to inflicting pain, the procedure has fallen out of favor. The ethical question remains whether use of pain is justified for treatment purposes. There are no controlled studies that have evaluated this modality, but the present standard of care in the form of cognitive behavior therapy has been found to been little effective either.[11]

Coercion

One particular issue in this situation pertains to coercion. The patients with problems related to sexual impulses may be under coercion of the justice system to undergo treatment of their condition. Therein, it falls under the purview of the therapist to deliver some therapy (pharmacological, surgical or psychotherapeutic). The patient may not have quite an interest in getting a particular treatment (e.g. chemical or surgical castration),[12] but might have to agree to undergo such procedure to ward off a higher punishment or incarceration. Alternatively the patient might be forced to undergo treatment on the instance of the family or community. The ethical debate is whether the physician or psychiatrist should be a party to such a coerced treatment. Utilitarian principles suggest that there is no deterrent to deliver or partake in a procedure provided it is good for the society, whether initiated by the person or the government-legal system. Deontologists may argue that physicians should act in accordance to their own professional mores and not be influenced by the state. Similar arguments may apply whether physicians and psychiatrists should be party to torture to extract information from ‘terrorists’ which might be beneficial to the society as a whole.[13] The authors are of the opinion that physicians and psychiatrists should be aware of such a possibility and should act in the best interests of their patients.

Conclusion

In conclusion, certain ethical principles need to be borne in mind and some debated when treating persons with sexual deviations, especially those of serious or offensive nature. These concerns relate mainly with issues like confidentiality, duty to present and potential victims, irreversible treatment and coercion for therapeutic options. Some of the questions like whether coercion should be abhorred have no definite answer. But, being aware of these of issues and acting in an ethical manner will help treatment providers maintain dignity of the medical profession.

**References**

1. Peakman J. The pleasure’s all mine: a history of perverse sex. London: Reaktion Books; 2013.

2. Neutze J, Seto MC, Schaefer GA, Mundt IA, Beier KM. Predictors of child pornography offenses and child sexual abuse in a community sample of pedophiles and hebephiles. Sex Abuse J Res Treat 2011;23(2):212–42.

3. Hall RCW, Hall RCW. A profile of pedophilia: definition, characteristics of offenders, recidivism, treatment outcomes, and forensic issues. Mayo Clin Proc 2007;82(4):457–71.

4. Malón A. Pedophilia: a diagnosis in search of a disorder. Arch Sex Behav 2012;41(5):1083–97.

5. The ICD-10 classification of mental and behavioural disorders: diagnostic criteria for research. World Health Organization; 1993.

6. American Psychiatric Association, American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5. 5th ed. Washington, D.C: American Psychiatric Association; 2013.

7. Warner M. The trouble with normal: Sex, politics, and the ethics of queer life. USA: Harvard University Press; 2000.

8. Protection of Children from Sexual Offences Act, 2012 No. 32 of 2012 Reg No DL - (N) 04/0007/2003-12 [19th June, 2012]

9. Heim N, Hursch CJ. Castration for sex offenders: treatment or punishment? A review and critique of recent European literature. Arch Sex Behav 1979;8(3):281–304.

10. Weinberger LE, Sreenivasan S, Garrick T, Osran H. The impact of surgical castration on sexual recidivism risk among sexually violent predatory offenders. J Am Acad Psychiatry Law 2005;33(1):16–36.

11. Kenworthy T, Adams CE, Bilby C, Brooks-Gordon B, Fenton M. Psychological interventions for those who have sexually offended or are at risk of offending. Cochrane Database Syst Rev 2004;(3):CD004858.

12. Garcia FD, Delavenne HG, Assump\ccão A de FA, Thibaut F. Pharmacologic Treatment of Sex Offenders With Paraphilic Disorder. Curr Psychiatry Rep 2013;15(5):1–6.

13. Marks JH. Doctors as pawns? Law and medical ethics at Guantánamo Bay. Seton Hall Law Rev 2007;37(3):711–31.