Treatment of Pedophiles

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Pedophilia (more specifically, Pedophilic disorder) is a paraphilic disorder. Paraphilia is an intense and persistent sexual interest other than normophilic sexual interests; Paraphilic disorder, in turn, is a paraphilia that causes distress or impairment to the individual or a paraphilia that causes harm or risk of harm to others. The *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) identifies the following diagnostic criteria for pedophilic disorder:

A. Over a period of at least 6 months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with prepubescent child or children (13 years or younger);

B. The individual has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty;

C. The individual is at least 16 years old and at least 5 years older than the child or children in Criterion A.

Childhood sexual abuse has both dramatic short and long-term consequences for victims. Sexual disturbance, anxiety and fear, depression, suicide are some of the symptoms seen in adults who have been victims of sexual abuse as a child (Beitchman et al., 1992). Such severity of consequences of abuse for victims makes treating pedophilia very urgent. In the ensuing paragraphs, we look into various studies examining effectiveness of different treatment methods for pedophilia, roughly in the chronological order of development of treatments. We also investigate various ethical and practical questions surrounding individual treatment methods and possibility of differential treatment for pedophiles with specific characteristics.

Effective treatments for pedophilia aim to either reduce sexual arousal or increase the patient's ability to manage their urges and prevent engaging in sexual behaviour with children. Therefore,

recidivism rate is a particularly relevant statistic for quantifying success of treatments. Published recidivism rate is generally between 10% to 50% (Guay, 2009).

One of the first attempts to treat sexual offenders was to surgically castrate them. The goal of castration is to reduce testosterone levels, and hence sexual arousal by removing the testes of pedophilic patients. This procedure supposedly produces "definitive results", with recidivism rates between 2% to 5% (Bradford, 1999). Although this method is largely discarded in the modern society, it illustrates ethical problems associated with most treatments for pedophilia, since most effective modern treatments are a form of "chemical castration". The first issue is that of autonomy. Surgical castration was really a form of punishment (Heim & Hursch, 1979), and it is difficult to believe that patients would agree to it if they were given a meaningful choice. This treatment, being so extreme, also illustrates the "irreversibility" issue. Arguably, the goal of any treatment is to cure the individual while preserving their dignity and identity. The patient should ideally remain the same person after treatment except for the illness that is treated.

Contemporary treatments for paraphilic disorders act by reducing the sexual drive either by suppressing testosterone or limiting libido through other mechanisms (Khan et al., 2015). We will first look into two examples of the former kind, namely use of Medroxyprogesterone acetate (MPA) and Cyproterone acetate (CPA).

MPA and CPA are antiandrogenic substances that have been used in treatment of various paraphilias, including pedophilia. In their 1992 case study, Cooper et al. note that "a consensus has emerged that MPA and CPA should be the drugs of choice in the management of socially unacceptable sexual acting out (for example, the paraphilias)", although this view might have changed recently. Both MPA and CPA suppress testosterone and thus libido. MPA, in particular,

also inhibits gonadotropin and is “extremely effective in reducing testosterone levels in 1-2 weeks to complete ablation” (Guay, 2009).

These two drugs have been studied in pedophiles both within the same trial and in individual experiments. Cooper et al. (1992) study effects of administering MPA and CPA sequentially, interleaved with placebo, on 7 pedophiles over the period of 28 weeks. They find the two substances equally effective in reducing hormone (i.e. serum testosterone) levels and sexual fantasies in short term while detecting “no clear side effects attributable to either drug”. It is also observed that the hormone levels return to pre-trial levels by the end of the last placebo phase. Overall, this study confirms effectiveness of MPA and CPA in reducing sexual arousal in the short term (i.e. during the time the drug is administered), although the strength of this conclusion is restricted due to the low number of participants. However, soon after the placebo phase is entered, the psychological effect of the drugs is reversed. Both sexual fantasies and arousal return to baseline levels along testosterone levels.

Gagné (1981), on the other hand, describes treatment of 48 individuals with unspecified paraphilias, and observes that “Forty subjects responded positively, all within 3 weeks, with diminished frequency of sexual fantasies and arousal, decreased desire for deviant sexual behavior, increased control over sexual urges, and improvement in psychosocial functioning. Improvement in deviant sexual behavior and psychosocial functioning was maintained after treatment ended, and there was no evidence of permanent physiological changes.” This contradicts results of Cooper et al. (1992) with its claim that the beneficial effect of the treatment regarding the undesired sexual arousal and fantasies persists after the treatment is ceased. This result, if reproducible, would be tantamount to an almost ideal treatment for paraphilias in question. Unfortunately, the details of the study are not very clear. Moreover, even if it was the

case that benefits of MPA treatment persists, it may still not be applicable to pedophilia. This means that pedophilia might be more resistant to treatment than paraphilias in general.

In general, there seems to be scientific consensus regarding effectiveness of MPA and CPA in decreasing testosterone levels. It is, however, just as important to consider recidivism rates since reducing sexual drive is the means, not the goal. Given that, at least in case of pedophilia, MPA and CPA don't seem to have a beneficial permanent effect, the patients would need to take the medicines over an extended period of time. However, Cooper et al. mention an "anti-drug" sentiment that developed among patients as the study progressed. Moreover, the authors had to contend with difficulties in recruiting subjects and high dropout rates. They concluded that "pedophiles are unlikely -- look up this from cooper). This means that patients may be unwilling to take the two aforementioned drugs over extended periods of time, thus reducing treatment efficiency. Another reason pedophiles may decide to stop their course of treatment is presence of severe side effects. Cooper's finding about lack of side effects is contradicted by Gagné (1981) and Krueger, Hembree, & Hill (2006). (add more things about known bad side effects of mpa cpa). Therefore, we conclude that MPA and CPA may not be very effective in reducing recidivism rates due to difficulties with taking them over long periods of time.

Although similar, MPA and CPA are not exactly the same. CPA is more "balanced" than MPA (Guay, 2009). It thus can take up to 12 months for CPA to reduce testosterone levels to minimum. However, CPA is known to have less severe side effects than MPA. This illustrates a first possibility for differential treatment of pedophiles: If one of these two treatments is to be chosen, depending on the risk of offence, a slower but less destructive option CPA might be selected.

Within the class of treatments targeting testosterone levels, Luteinizing Hormone-Releasing Hormone (LHRH) agonists are drugs recently introduced to treatment of paraphilic disorders. These agents "produce complete chemical castration with hypoandrogenism as the only clinical effect" (Guay, 2009), and "are believed to more specifically and completely inhibit testosterone synthesis and release with fewer side effects than MPA and CPA" (Turner & Briken, 2018). The latter can be explained by the fact that these agents, compared to antiandrogens, operate "more upstream" in testosterone pathways of the brain.

Leuprolide acetate (LA) is one the most widely used LHRH agonists in treatment of paraphilias. For example, Schober et al. (2005) compare effectiveness of combination of LA and Cognitive Behavioral Therapy (CBT) with that of CBT alone. It is observed that after receiving LA for 12 months, testosterone levels of all 5 subjects decreased to castrate levels. Moreover, according to self-reports verified using a polygraph, sexual urges toward children and masturbatory frequency involving thoughts of children both decreased in all subjects.

This corroborates the statement by Turner & Briken (2018) regarding short-term effectiveness of LHRH agonists. However, the authors also report that during the placebo period, when testosterone levels of subjects were recovering, their self-reports became deceptive. This suggests that just like it was the case with MPA and CPA, effects of LA may not persist for long after treatment. Finally, the authors observe that during the treatment period, even though testosterone levels and deviant sexual fantasies were reduced, pedophilic interest could still be detected by phallography. This suggests that changing pedophilic interest might be much more difficult (or even impossible) compared to lowering testosterone levels. LHRH, even though potent, doesn't remove the pedophilic interest.

Surprisingly, Schober et al. (2005) also report that none of the subjects experienced significant side effects. This, however, is contradicted by Koo, Ahn, Hong, Lee, & Chung (2014) in a study carried out on a larger sample of subjects (56), again using LA. This study too finds LHRH to be extremely effective in decreasing testosterone levels. However, it reports a wide range of side effects such as hot flashes, weight gain, injection site pain, diaphoresis, also BMD loss and depressed mood (Koo et al., 2014).

A 2018 review of LHRH treatments by Turner et al. concludes that LHRH is extremely effective in reducing testosterone levels, even to below castrate levels, and in fact, might cause fewer side effects compared to MPA and CPA. Such efficacy, however, creates an ethical question: when is it appropriate to use such agents? Turner & Briken (2018) conclude that LHRH agonists should be used in high-risk offenders, as its administration comes close to depriving the subject of sexual arousal completely.

We have previously mentioned the problem of high rates of dropouts from studies (e.g. Cooper, 2009). Such dropouts are indicative of a bigger problem associated with endocrine therapies: it might be very difficult for the subjects to continue treatment for long enough to observe effects due to perceived dehumanization or the side effects of the treatment. Guay (2009), Turner & Briken (2018), and Gagné (1981) all suggest the drug therapy to be complemented with a form of psychotherapy. Schober et al., in fact, use CBT as placebo. Such therapies, in addition to assisting the patients in completing the treatment, can also be used afterwards to offer support and help prevent relapse. However, patient-tailored CBT might be costly or inaccessible to many.

Finally, Selective Serotonin Reuptake Inhibitors (SSRIs) can sometimes be effective in treating paraphilias. SSRIs do not affect the testosterone pathways. “The World Federation of Societies

of Biological Psychiatry (WFSBP) Guidelines for the biological treatment of paraphilias" (2010) suggest that these should be used for patients with low offense risk.

In the above analysis, we examined development of various treatments for paraphilias and, in particular, for pedophilia. Unfortunately, it seems to be the case that there is no single treatment supported by a significant body of evidence that can genuinely cure pedophilia by changing (or removing) the subject's abnormal attraction without completely depriving them of sexuality. The current dominant approaches are endocrine treatments, including antiandrogens and LHRH agonists. Both of these agents have been shown to be successful in reducing testosterone levels and sexual fantasies during treatment. However, accomplishing the true objective of treatment (i.e. preventing relapse) is harder. One reason for this is that hormonal therapies inhibit unacceptable sexual behaviour by inhibiting all of sexual behaviour. And as soon as the treatment ends, all inhibited fantasies and urges return. In addition to this severe effect, continued treatment is hindered by side effects associated with most such therapies. Therefore, current recommendations usually include some form of psychotherapy (e.g. CBT).

We also saw that advances in our biological understanding has led to development of different approaches to treatment of pedophilia that allow certain flexibility when choosing a treatment. For example, the more modern and potent LHRH agents can be used for treating patients with high-risk of offense in the near future. SSRIs, on the other hand, might be more applicable to cases where comorbid depression is present. However, it is also the case that all treatments for pedophilia are treatments for paraphilias in general. Therefore, understanding the causes and mechanisms involved in pedophilia might be the only way to develop treatments that truly cure this illness.

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