Published in final edited form as:

J Sex Med. 2015 July 01; 12(7): 1591–1600. doi:10.1111/jsm.12920.

Sex Offenders Seeking Treatment for Sexual Dysfunction – Ethics, Medicine, and the Law

Elizabeth A. Phillips, MD^{1,*}, Archana Rajender, MD¹, Thomas Douglas, PhD², Ashley F. Brandon, MD³, Ricardo Munarriz, MD¹

¹Department of Urology, Boston Medical Center, Boston, MA, USA

²Oxford Uehiro Centre for Practical Ethics, University of Oxford, Oxford, UK

³Urology of Virginia, Virginia Beach, VA, USA

Abstract

Introduction—The treatment of sexual dysfunction in patients with prior sexual offenses poses ethical and legal dilemmas. Sex offenders are not obligated by law to disclose this history to medical professionals. Over 20% of sex offenders experience sexual dysfunction, however, the number seeking evaluation for this is unknown.

Aims—To determine the incidence and characteristics of sex offenders seeking treatment in our clinic. To review data regarding sex offender recidivism and ethics pertaining to the issue as it relates to treating physicians.

Methods—Sex offenders were identified via 3 methods: new patient screening in a dedicated sexual medicine clinic, chart review of those on intracavernosal injection (ICI) therapy for erectile dysfunction (ED), and review of those status-post placement of penile prosthesis. Charts were cross-referenced with the U.S. Department of Justice National Sex Offender Public Website (NSOPW). Patient characteristics and details of offenses were collected.

Main Outcome Measures—Self-reported sexual offense and national registry data.

Results—18 male sex offenders were identified: 13 via new patient screening; 3 by review of ICI patients; 1 by review of penile prosthesis data; and 1 prior to penile prosthesis placement. All were primarily referred for ED. At least half were Level 3 offenders. At least half of crimes committed were against children. All those with complete data had multiple counts of misconduct (average 3.6). 94% (17/18) had publicly-funded health care. Twelve (67%) were previously treated for sexual dysfunction.

Conclusions—Registered sex offenders are seeking and receiving treatment for sexual dysfunction. It is unknown whether treatment of sexual dysfunction increases the risk of recidivism of sexual offenses. Physicians currently face a difficult choice in deciding whether to treat sexual dysfunction in sex offenders.

*Corresponding author, Elizabeth A. Phillips MD, Department of Urology, Boston Medical Center, 725 Albany Street, Suite 3B, Boston, Massachusetts 02118, USA. Tel: (617) 638 - 8485 (office); Fax: (617) 638 - 8483; Elizabeth.Phillips@bmc.org.

Keywords

sex offender; sexual dysfunction; erectile dysfunction; ejaculatory dysfunction; registry; sex offense; rape

Introduction

There are over 700,000 registered sex offenders in the U.S.; about one-third are currently under the supervision of a corrections agency, and on average over 100,000 of them will seek or have already sought treatment for sexual dysfunction.^{1,2,3} Though physicians are expected to treat patients equally and without bias or favor, should we treat sex-related complaints in these registered sex offenders? In reality, many of us already have.

Sexual dysfunction among sex offenders is a known entity with a prevalence in excess of 20%^{1,4}, which has been theorized to potentially be greater than the rate in the general population. The prevalence of sex offenders seeking medical evaluation for sexual dysfunction is unknown. Since sex offenders are not obligated by law to disclose their status as offenders to medical professionals, many of them will be treated unknowingly. The treatment of sexual dysfunction in patients with prior sexual offenses poses an ethical and legal dilemma to physicians, especially to primary care physicians and urologists, who see patients with these chief complaints every day. To our knowledge, there is no legal precedent regarding the treatment or withholding of treatment for these patients, but if an offender is aided in restoration of erectile function, for example, and goes on to commit a sex crime, could the physician who assisted him be partially responsible?^{5, 6}

In addition to the ethical and legal concerns, there is a social impact to consider. Public outrage in the early 2000s brought Medicaid spending under scrutiny when it was discovered that sex offenders were provided oral medication for the treatment of impotence, which was covered by their Medicaid benefits. Several states took measures to ban the payment of oral impotence medications for patients who were required to register as sex offenders.⁷ In 2005, Federal Medicaid reimbursement for treatment of impotence in sex offenders was banned in all 50 states and a statement was released calling the use of these medications by sex offenders inappropriate. The Sexual Medicine Society of North America echoed this sentiment in their position statement.⁸ Many states responded by temporarily or permanently suspending reimbursement of these medications for all Medicaid patients.

Around the same time, in 2006, the Adam Walsh Child Protection and Safety Act was signed into United States federal law. The purpose of this act was to establish a comprehensive national system for the registration of sex offenders and offenders against children. Among other things, the law requires all 50 United States, the District of Columbia, United States territories (Puerto Rico, American Samoa, Guam, the Northern Mariana Islands, and the U.S. Virgin Islands), and federally recognized Indian tribes to maintain a sex offender registry publically available on the internet and to participate fully in the Dru Sjodin National Sex Offender Public Website (NSOPW) which was established in 2005. This is a single site maintained by the U.S. Department of Justice to search all jurisdictions for information regarding sex offenders.⁹

The issue regarding public spending for erectile dysfunction treatment was relatively quiescent until 2010 when Senator Tom Coburn, M.D. (Oklahoma) stated that tax payer dollars were still being used to fund impotence treatment in sex offenders, despite the Federal ban.¹⁰ To date, no action has been taken to cross-reference the Medicaid and sex offender databases, thereby making any laws or provisions prohibiting the payment of such treatments impossible to enforce. This separation of law and medicine serves to avoid discrimination of patients when seeking medical care, but also conceals potentially valuable information from the physician who is asked to treat sexual dysfunction in these patients.

With treatment options for sexual dysfunction widely advertised, available, and more affordable, many men are turning to their physicians for help with erectile dysfunction (ED), low testosterone, or ejaculatory problems, necessitating our awareness of this issue. Until a system is instituted to guide such treatment for sex offenders, physicians are tasked with identifying and assessing the appropriateness of treating their sexual dysfunction.

Aims

The primary goal of this study was to determine the incidence and characteristics of sex offenders seeking treatment for sexual dysfunction in a sexual medicine clinic. Additionally, this study aims to bring awareness to the issue of treating sexual dysfunction in registered sex offenders, explore the literature relating to this topic, and suggest future changes for establishment of protocol regarding this subject.

Methods

This is a single institution, IRB-exempt (H-33165), retrospective study of patients identified as sex offenders (December 2012 to December 2014) in a dedicated Center for Sexual Medicine within the Department of Urology at an urban, academic, tertiary-care center. New screening protocol was initiated in December 2012 and is ongoing. New patients are seen first by a clinical psychologist, and then by a urologist, both inquiring independently about a history of sexual offense. If a history of sexual offense or other criminal activity is disclosed by the patient, further questioning is pursued and the U.S. Department of Justice National Sex Offender Public Website (NSOPW) registry is queried for details including level (i.e. 1, 2, 3), type and number of sexual offenses, sentence, and time elapsed since serving the sentence.

Subjects were also identified retrospectively upon chart review of all patients receiving intracavernosal injection therapy between January 2012 and June 2013 and those who had undergone placement of penile prosthesis from 2004 to 2013. Patient names were cross-referenced with the NSOPW. Patients are additionally screened prior to scheduling for penile prosthesis surgery.

Demographic, insurance, and clinical data were collected from patient charts, including the type of sexual dysfunction diagnosed, a prior history of treatment for sexual dysfunction, relationship status, and other medical, psychiatric and social co-morbidities including homelessness. Involvement of the institutional ethics committee and legal counsel was sought.

In some cases, patients reported positive history of sexual offense and provided details of their offense, though they could not be located on the NSOPW. These patients are included in this summary, however data for these patients are incomplete.

Main Study Measures

Self-disclosed information from patients was utilized primarily. Data were collected from the Dru Sjodin U.S. Department of Justice National Sex Offender Public Website (NSOPW) which is an online national registry of sex offenders from all fifty U.S. states, the District of Columbia, U.S. territories and Indian Countries.

Results

Identification

Eighteen male sex offenders (average age at first visit of 54 years, range 46-66 years) were identified. The majority of these patients (n=12, 67%) were identified during new patient screening, voluntarily disclosing the information. Three patients were identified by retrospective review of the intracavernosal injection therapy records (3/781). One patient was identified through review of penile prosthesis patients (1/747), and one patient was identified through pre-surgical screening prior to placement of penile prosthesis. One established patient was identified on clinical suspicion by the physician and did not voluntarily disclose the information. One of the patients identified during screening was actually falsely accused and imprisoned for sexual offense, and was able to produce court documentation of this (Table 1). Over the two full years of initial screening there were an average of 798.5 new patient visits per year.

Demographics and Criminal History

Racial breakdown was white/Caucasian (5), Black/African American (9), and Hispanic (2) (Table 2). Level of sex offender could be confirmed in 14 of the subjects and the majority of those (n=9, 64%) were Level 3 offenders (most likely to re-offend). The remainder were Level 2 offenders, except one who reported that he was Level 1. This could not be confirmed on the NSOPW due to reporting laws in his jurisdiction (Massachusetts). Of the offenders whose information could be collected from NSOPW (10 subjects), all offenders had at least two counts of sexual misconduct, with an average of 3.6 counts per subject (range 2 to 6). Four subjects were convicted of repeated offenses (multiple years of conviction). The type of sexual misconduct is listed in Table 3. At least nine patients (64%) (four patients had unknown offenses) had charges that included sexual offense against a child under 14 years of age. Among those who self-reported number of years incarcerated, the average was 18.5 years (range 4 to 34 years).

Relationship status

Seventeen patients reported their relationship status. Nine (53%) reported being single, divorced or separated; 4 (24%) reported being single, but in a relationship; and 4 (24%) reported being married (Table 2).

Clinical Data

Ten patients had a history of psychiatric diagnoses, seven patients reported substance abuse and 4 patients were homeless at the time of their visit. All patients reported erectile dysfunction as their primary sexual dysfunction. Nine patients had an additional diagnosis including hypogonadism (n=7), Peyronie's disease (n=1), and delayed ejaculation (n=1) (Table 2).

Insurance Data

With the exception of the one patient who was falsely accused of his crime, patients had either Medicaid (n=13) or a MassHealth plan, which is state-funded medical insurance in the Commonwealth of Massachusetts (n=4). Three Medicaid patients had Medicare benefits as well (Table 2).

Treatment of Sexual Dysfunction

Twelve of the eighteen patients (67%) had been previously treated for sexual dysfunction, either in our clinic or another clinic, prior to identification of their sex offender status. All twelve patients (67%) had received treatment in the form of phosphodiesterase type 5 (PDE5) inhibitors (ie Viagra®, Cialis®, Levitra®). In addition, 5 patients (28%) were also treated with intracavernosal injection therapy, 3 (17%) patients received testosterone therapy or another medication to increase testosterone (clomiphene citrate), one patient had undergone placement of a penile prosthesis and one patient had undergone micro-arterial penile bypass surgery (MABS) for erectile dysfunction caused by arterial insufficiency. Six of the patients had received more than one type of treatment (Table 2). Treatment could be confirmed as administered prior to committed offenses in 1 case. This established patient had been treated since 1999 in our clinic and had received a MABS, intracavernosal injections as well as testosterone therapy prior to his offenses in 2001 and 2008-2012.

Discussion

Medicine

Our cohort of patients all presented for treatment of erectile dysfunction, with some having additional diagnoses of other sexual dysfunction. Erectile dysfunction and ejaculatory dysfunction have been the most cited sexual dysfunctions among sex offenders as reported by offenders and by their victims.^{10, 11} Studies have revealed prevalence of sexual dysfunction among sex offenders ranging anywhere from 10 - 34%.^{1, 4, 11, 12} This is significant if we consider that the majority of the offenders in these studies are less than 40 years of age. In comparison, the Massachusetts Male Aging Study found that only about 5% of non-institutionalized 40-year-old men in the general population will experience erectile dysfunction.¹³ In males aged over 40-70, similar to this cohort, the incidence of overall erectile dysfunction rises dramatically to about 52%.¹³

Despite assailants' erectile dysfunction, female victims of these crimes suffer injuries at similar rates to those attacks where sexual dysfunction is not noted. One study found higher rates of non-genital injuries in a subset of victims whose attacker experienced impotence during the attack.¹² Penetrative assaults, however, do appear to cause additional or more

severe physical or emotional trauma, according to most reports.^{14, 15} It is unknown whether treatment of erectile dysfunction will increase the incidence or severity of sexual offenses, prolong duration of sexual attacks, or in any way change them, but it is possible that some individuals may be dissuaded from committing crimes of a sexual nature if they are impotent.

Besides erectile dysfunction, treatment of other sexual dysfunctions may influence sexual attacks in those who have a predilection to sex crimes. It is plausible that treatment of hypogonadism may increase the drive to commit these crimes. In fact, in one study regarding recidivism of sexual offenses by patients who were castrate, the only two recidivates were supplementing testosterone after castration.¹⁶

Testosterone replacement does effectively increase libido and some studies suggest that testosterone augments antisocial traits, externalizing behavior, and sexual behavior.¹⁷ Given that antisocial orientation is one of the strongest predictors of sexual recidivism, one may see this as a serious issue in patients with a history of sexual crimes.¹⁸

The mere treatment of sexual dysfunction may have a significant effect on libido. We know, from well-designed studies by Kolla, et al, that pre-treatment with sildenafil, a PDE5 inhibitor, increases arousal in phallometric testing.^{19, 20, 21} Increased sexual confidence and arousal may lead to increased impulsivity.

In our cohort, patients received treatments for ED ranging from PDE5 inhibitors to intracavernosal therapy, to penile prosthesis placement. Some of these medications or devices provide supra-physiologic abilities. For example, with intracavernosal injections, a man can maintain an erection suitable for penetration for hours, with penile prosthesis, even longer. Erections will be maintained even after ejaculation.

Sexual Deviance and Paraphilias—According to Hanson and Bussiere, the strongest predictors of sexual recidivism are factors related to sexual deviance.²² Sexual deviance or paraphilias have long been associated with sexual offending.^{18, 21, 22, 23, 24} Sexual sadism and rape are distinct entities that often overlap. Though some experts do classify rape as a sexual paraphilia, its inclusion in *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5; American Psychiatric Association, 2013) was rejected in 2012. In contrast, pedophilia (or pedophilic disorder, as it is currently termed) is a clinical diagnosis as well as a crime, at least when acted upon, as are frotteurism (frotteuristic disorder) and exhibitionism (exhibitionistic disorder).²⁵

In that respect, some experts in the fields of psychiatry and psychology, see these sexual deviations as clinical diagnoses benefitting from treatment, and approach the relationship between sexual dysfunction and sexual offense in that way. Metz and Sawyer note that often those patients with paraphilias will resort to paraphilic behavior for sexual arousal as they have found this behavior to be consistently effective. They further state that some men with paraphilias unfortunately will need to “refresh” memories or fantasies of acting on paraphilias by re-offending. They postulate that treatment of sexual dysfunction may allow a patient with a particular paraphilia to have a more fulfilling and socially acceptable

relationship or partner, effectively “expanding” his functional ability to respond to normative sexual content.²⁶ Others believe that deviant sexual preferences, such as pedophilia are exceedingly difficult, if not impossible, to change, and evidence of that sexual deviance is a reliable predictor of recidivism.^{20, 21, 22} In addition, some experts postulate that not all who commit these crimes are distressed by the crime or by the urges that they experience and would have little motivation for change.²⁷

Non-psychiatrist or psychologists should be cautioned regarding treatment of “paraphilia” as this is not generally within the clinical purview of most clinicians whom rarely make these diagnoses and lack the training to assess progress in these patients.

Law

Reporting Sexual Assault—While the number of sex offenders may seem small relative to the total population of the U.S., it is important to keep in mind that rape and other sexual assaults are widely underreported, and therefore all reports of recidivism are underestimates. The estimated lifetime prevalence of sexual victimization for females in the general population varies, with estimates around 30-50%, with some populations up to nearly 70%.²⁸⁻³¹ Over 80% of women never report sexual assault, and over 65% of rapes are never reported to police.³¹ Offenses which are committed by strangers and those which cause injuries are more likely to be reported, but these are the minority.^{28, 31}

It should also be noted that not all states report sex offenders uniformly. Some states do not assign levels to sex offenders and simply give a description of the offenses. Some states, such as Massachusetts, where this study was completed, only report Level 2 and 3 sex offenders to the National database, therefore, no Level 1 sex offender could be identified unless they self-disclosed this information. This introduces bias into the cohort as only higher risk offenders were included, however, this also underestimates the actual number of sex offenders that have been, and continue to be, treated.

Depending on practice location, there may be more or less likelihood of encountering this type of patient. Per the National Center for Missing and Exploited Children (NCMEC) the state with the highest rates of sex offenders is Oregon with 703 sex offenders per 100,000 people.³² Pennsylvania has the lowest rate at 129/100,000. Massachusetts, where the majority of our patients reside, has a relatively low rate as well, with 174/100,000 people. Despite this, in one clinic over two years we have encountered nearly twenty patients. Areas with higher concentrations of sex offenders should expect to treat more.

Risk of Recidivism—Rates of recidivism for sex offenders have been widely studied over the past several decades using a variety of models and evaluation techniques. As physicians who may encounter these patients, it would be practical to consider the risk of recidivism when determining appropriateness of treatment for sexual dysfunction. Though likely an underestimate, statistically 30-40% of sex offenders will re-offend over 20 years of opportunity.^{22, 33} This rate does change considerably based on the number of years that a criminal has refrained from committing a crime.^{33, 34} The highest risk for recidivism appears to be within the first 5 years after release from incarceration. This is especially true for high risk offenders, of whom 7% will recidivate in the first year of release and 22% within 5

years of release.³⁴ The rate of recidivism, however, does decline with number of years “offense-free” after release. Therefore, those patients who are “offense-free” for over 20 years may have a very low likelihood of re-offense. Additionally, rates for “low-risk” offenders, as defined by Hanson et al, remain consistently low at 1-5%.³⁴

The strongest predictors of recidivism, as previously mentioned, appear to be sexual deviance and antisocial personality traits.^{18, 22, 20, 21} Though child molesters and rapists have similar rates of recidivism, deviant sexual interests and victim choices (such as young boys) make recidivism more likely. In a sample of child molesters, those committing crimes against unrelated male victims are more likely to re-offend (almost 40% over 15 years), followed by those who victimize unrelated girls.³³ Phallometry, a measure of penile tumescence in response to stimuli, has been used to determine current or future risk of sex offense in perpetrators, as well as to identify treatment areas and gains.³⁵ It has been used to identify deviant arousal to children, non-consenting sexual interactions and violence and humiliation toward the victim. Kolla *et al* found that administration of PDE5 inhibitors (sildenafil) prior to phallometric testing accentuates the findings of the exam, and may re-categorize “non-responders” into an offender group.^{19, 20, 21} Use of phallometry, therefore, could help guide treatment decisions for the sexual medicine physician, though these measurement devices and materials are likely not readily available to the typical practitioner.

Another strong predictor of recidivism is a history of prior sexual offenses.^{22, 33} Physicians without access to criminal records will largely need to rely on the honesty of the patient with regard to questions of sexual deviance or other offenses, which may or may not have been reported. Therefore, this is unlikely to help in determining those at least risk for re-offense.

In general, the court’s classification of a sex offender should offer some insight into their risk of re-offense. However, each state classifies sex offenders using different criteria, and some are not classified at all. As age and single relationship status are predictors of recidivism, some states take this into account in addition to any history of violent crimes, or a history of drug abuse.^{36, 37} Other objective risk scales have been devised with varying ability to accurately predict sexual recidivism. The STATIC-99 assessment was developed by Hanson and Thornton and is widely used in mental health and corrections.³⁴ This tool may also aid the physician in determining appropriateness of treatment. The developers of this assessment do, however, recommend training prior to use of the instrument.

Many experts believe that psychological treatment of these offenders is of benefit.³⁸ One study found that recidivism over 5 years was 10% in offenders in treatment versus 17% for those not receiving treatment.³⁹ Failing to complete a treatment program once initiated is strongly associated with sexual recidivism.²²

Data are both lacking and antiquated on the effect of castration on sexual recidivism, but it is thought to be more effective than psychosocial therapy, lowering re-offense rates to 0-7%.^{16, 40} Currently, 9 states in the U.S. authorize chemical or surgical castration to varying degrees for sex offenders in an effort to decrease their likelihood of committing another sexually-oriented crime.^{16, 41} It is unknown whether sex offenders supplemented with testosterone are more likely to re-offend, however, this has also been suggested.¹⁶

Medical Malpractice—To our knowledge there are no cases in which a physician was accused of aiding in a crime by treating a patient's sexual dysfunction. There is one known case of rape where sildenafil was implicated as a causative factor due to "aggressive disturbances" caused by the drug. This drug is known to cross the blood-brain barrier and, though the defense was refused, an article written as a result of the case recommends counseling patients and partners regarding possible aggressive behavior prior to starting this medication.⁴² Phosphodiesterase inhibitors, such as sildenafil (Viagra®), have been associated with other crimes as well, such as its alleged use by Gaddafi troops to encourage mass rape in war zones, or the use by an 87 year old grandfather to rape 5 of his granddaughters.^{43, 44}

In states allowing castration in sex offenders, use of medication to "counter" the effect of the androgen deprivation results in further punishment by law. The law does not clarify whether a prescribing physician would face legal action in these cases.⁴¹

Ethics

As mentioned above, there may be some offenders in whom treating sexual dysfunction will help to lower the risk of sexual recidivism or at least to diminish the violence of subsequent sexual attacks. However, in other offenders, treating their sexual dysfunction may increase the risk of sexual recidivism. It will generally be difficult for urologists and general practitioners to determine what effect a treatment is likely to have on recidivism risk, and it will not always be possible to access an expert forensic psychiatric opinion. Thus, in some cases, a decision may need to be made by the treating physician based on population-level risk assessment: does treatment of sexual dysfunction in sex offenders as a group *generally* increase or decrease the risk of recidivism?

More research needs to be done in order to answer this question confidently. However, suppose it eventuates that treatment generally increases the risk of recidivism. Should a physician then withhold treatment? Two arguments could be offered for doing so.

First, the physician may decline to treat on the grounds that the treatment is not in the patient's best interests. It is standardly held that medical treatments ought to be provided to a competent adult patient only if the patient consents to the treatment *and* the treatment is in the patient's best interests. Where a treatment for sexual dysfunction may lead to subsequent sexual offending, there may be grounds for supposing that it will not be in the patient's best interests. First, if the sexual offense is reported and the patient convicted, penal sanctions imposed in response can be expected to make the patient worse off. Second, on certain philosophical views, being inclined to commit moral violations itself diminishes a person's wellbeing, regardless of whether it results in that person being punished.^{45, 46}

In response it might be argued that medical assessments of best interests should be made on strictly medical grounds and that the risk of re-offending goes beyond this. However, there is a second basis on which withholding treatment might be justified. It is normally thought permissible for physicians to decline to offer medical treatments when they have a reasonable moral objection to providing them (so-called 'conscientious objection'), although not all agree, and it is standardly thought the patient must be referred to a physician who

does not conscientiously object.⁴⁷ If a physician correctly believes that, in providing a medical treatment, the physician would increase the risk of a sexual offense, then it would certainly be reasonable to believe that it would be immoral to provide the treatment. He or she may be legitimately concerned that they will become complicit in or partly responsible for the crime, or, even if the physician does not believe they would become complicit or responsible, they may simply object on the grounds that they deem it morally unacceptable to place others at risk of sexual attack through their treatment decisions. If conscientious objection is acceptable in other cases where physicians may have reasonable moral objections, such as abortion, then it would arguably be acceptable in this case as well.

Unfortunately, at present there is no clear evidence on whether treating sexual dysfunction in sex offenders increases or decreases risk of re-offending, leaving physicians with no clear basis on which to make treatment decisions.

Clinical changes and challenges

This issue is one that general practitioners and urologists are bound to face going forward and the fact remains that we are not properly informed or trained to make these treatment decisions. With no prior experience to draw upon regarding this clinical scenario, the practitioners in this study sought institutional guidance. Unfortunately, the institutional ethics committee provided no formal recommendations for practice. The institutional legal counsel was unaware of any legal precedent in this regard, and therefore also had no formal recommendations. It was this lack of expertise in the topic which lead to our clinical interest and further research. In the end, taking into consideration the aforementioned issues, clinicians will need to decide themselves whether or not to treat sexual dysfunction in patients with a history of sexual offense.

This study is limited by the inability to confidently identify all patients who have committed sex crimes due to reporting differences on the NSOPW and the difficulty in screening every single patient in clinic. We are also unable to determine, in the majority of cases, whether any offense was committed following treatment of sexual dysfunction. And, ultimately, it is unknown whether treatment will effect outcomes of recidivism. Our research in this area will continue.

Future Directions

Physicians, and particularly urologists, having limited understanding of the legal complexities or psychiatric co-morbidities related to recidivism, lack appropriate training to make educated decisions regarding the treatment of sexual dysfunctions in sex offenders. In addition, physicians are often unaware of sexual crimes unless disclosed by patients, who are not mandated to divulge this information.

Universally denying treatment is not the goal, but rather, proper assessment for appropriateness of treatment to predict whether treatment represents a significant risk to the public and to the individual. When designing a system of evaluation for these patients review of pertinent criminal, medical, psychological and social records should be included. Typically, these are not at the disposal of the treating physician, and it will likely be necessary to involve practitioners with expertise in the treatment of sex offenders.

As a model, of the nine states allowing for castration, 6 require some form of prior evaluation by a court-appointed physician and/or psychiatrist or expert in the area of sexual offense. The evaluation process for treatment that *decreases* sexual functioning seems a reasonable template for evaluation prior to rendering treatment that *augments* sexual functioning in these same patients.

Additionally, from the social standpoint, although Medicare, Medicaid, and some private insurers deny coverage for certain ED treatments, other treatments are still covered. Our data confirm that registered sex offenders are receiving coverage for these treatments, due to lack of cross-reference between payers, providers, and the sex offender registry.

Conclusions

It is clear that sex offenders are seeking treatment for sexual dysfunction, and a finite number of sex offenders will go on to re-offend. Due to lack of state or federal policy and infrastructure, physicians are currently tasked with making the decision of whether or not to treat sexual dysfunction in this population with little to base the decision-making upon. Assessments of risk should ideally be made by an expert in this area with access to relevant records and evaluation tools. Further research is needed to determine what risk, if any, is conferred with treatment of sexual dysfunction in these patients.

References

1. Raymond NC, Coleman E, Ohlerking F, Christenson GA, Miner M. Psychiatric Comorbidity in pedophilic Sex Offenders. *Am J Psychiatry*. 1999 May; 156(5):786–8. [PubMed: 10327918]
2. "Sex Offender Statistics | Statistic Brain". Web. 23 Sept. 2014
3. Laumann EO, Paik A, Rose RC. Sexual Dysfunction in the United States: Prevalence and Predictors. *JAMA*. 1999 Feb; 281(6):537–544. [PubMed: 10022110]
4. Bownes IT, O'Gorman EC. Assaultants' sexual dysfunction during rape reported by their victims. *Med Sci Law*. 1991 Oct; 31(4):322–8. [PubMed: 1795615]
5. Spurling G. Evidence based answers: could sildenafil cause rape? *Aust Fam Physician*. 2004 May. 33(5):356. [PubMed: 15227867]
6. Berkowitz, K; Prudhomme, A. "Ethical Considerations When Treating Erectile Dysfunction in Patients with Sexually Transmissible Diseases". Department of Veteran Affairs National Ethics Teleconference; 26 May 2004; Teleconference
7. Bacon L. States Ending Payments for Sex Offenders' Erectile Treatments. *The New York Times*. 2005 May 28.
8. Medicaid Benefits for Erectile Dysfunction. (n.d.). Retrieved December 24, 2014, from <http://www.smsna.org/V1/index.php/about/position-statements>
9. CRS Summary. Bill Summary and Status, 109th Congress (2005-2006) H.R.4472 Library of Congress; (n.d.). Retrieved March 6, 2015, from <http://www.loc.gov/>
10. Foxnews.com. Fox News; 2010. Apr 6, GOP Senator: Health Care Law Will Permit Sex Offenders to Get Viagra. Web. 26 Sept. 2014
11. Groth AN, Burgess AW. Sexual Dysfunction During Rape. *NEJM*. 1977 Oct 6; 297(14):764–6. [PubMed: 895806]
12. Jones JS, Rossman L, Wynn BN, Ostovar H. Assaultants' Sexual Dysfunction During Rape: Prevalence and Relationship to Genital Trauma in Female Patients. *J Emerg Med*. 2010 May; 38(4):529–35. [PubMed: 19232872]

13. Feldman HA, Goldstein I, Hatzichristou DG, Krane RJ, McKinlay JB. Impotence and its medical and psychosocial correlates: results of the Massachusetts Male Aging Study. *J Urol.* 1994 Jan; 151(1):54–61. [PubMed: 8254833]
14. Pinhas-Hamiel O, Modan-Moses D, Herman-Raz M, Reichman B. obesity in girls and penetrative sexual abuse in childhood. *Acta Paediatr.* 2009 Jan; 98(1):144–7. [PubMed: 18798832]
15. Canton-Cortes D, Cortes MR, Canton J. Child Sexual Abuses, Attachment Style, and Depression: The Role of the Characteristics of Abuse. *J of Interpersonal Violence.* 2015; 30(3):420–436.
16. 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. [PubMed: 15809235]
17. Jordan K, Fromberger P, Stolpmann G, Müller JL. The Role of Testosterone in Sexuality and Paraphilia – A Neurobiological Approach. Part II: Testosterone and Paraphilia. *J Sex Med.* 2011; 8:3008–3029. [PubMed: 21797985]
18. Hanson RK, Morton-Bourgon KE. The Characteristics of Persistent Sexual Offenders: A Meta-Analysis of Recidivism Studies. *Journal of Consulting and Clinical Psychology.* 2005; 73(6):1154–1163. [PubMed: 16392988]
19. Kolla NJ, Blanchard R, Klassen PE, Kuban ME, Blak T. Effect of Sildenafil on Penile Plethysmography Responding: A Pilot Investigation. *Arch Sex Behav.* 2010; 39:1449–1452. [PubMed: 19472045]
20. Kolla NJ, Klassen PE, Kuban ME, Blak T, Blanchard R. Double-blind, Placebo-controlled Trial of Sildenafil in Phallometric Testing. *J Am Acad Psychiatry Law.* 2010; 38:502–511. [PubMed: 21156909]
21. Bradford JMW, Kingston D, Ahmed AG, Fedoroff JP. Commentary: Sildenafil in Phallometric Testing – An Evidence-Based Assessment of Sexual Offenders. *J Am Acad Psychiatry Law.* 2010; 38:512–15. [PubMed: 21156910]
22. Hanson RK, Bussiere MT. Predicting Relapse: A Meta-Analysis of Sexual Offender Recidivism Studies. *Journal of Consulting and Clinical Psychology.* 1998; 66(2):348–362. [PubMed: 9583338]
23. Groth AN, Burgess AW. Rape: a sexual deviation. *Am J Orthopsychiatry.* 1977 Jul; 47(3):400–6. [PubMed: 560801]
24. Frances A, Wollert R. Sexual sadism: avoiding its misuse in sexually violent predator evaluations. *J Am Acad Psychiatry Law.* 2012; 40(3):409–16. [PubMed: 22960924]
25. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington, DC: 2013.
26. Metz ME, Sawyer SP. Treating Sexual Dysfunction in Sex Offenders: A Case Example. *J Sex Marital Ther.* 2004 May-Jun;30(3):185–97. [PubMed: 15205074]
27. Douglas T, Bonte P, Focquaert F, Devolder K, Sterckx S. Coercion, Incarceration, and Chemical Castration: An Argument From Autonomy. *J Bioeth Inq.* 2013 Oct; 10(3):393–405. [PubMed: 23813324]
28. Feldhaus MK, Houry D, Kaminsky R. Lifetime Sexual Assault Prevalence Rates and Reporting Practices in an Emergency Department Population. *Ann Emerg Med.* 2000 Jul; 36(1):23–7. [PubMed: 10874231]
29. Walch AG, Broadhead WE. Prevalence of lifetime sexual victimization among female patients. *J Fam Pract.* 1992 Nov; 35(5):511–6. [PubMed: 1431766]
30. Rickert VI, Wiemann CM, Vaughan RD, White JW. Rates and risk factors for sexual violence among an ethnically diverse sample of adolescents. *Arch Pediatr Adolesc Med.* 2004 Dec; 158(12):1132–9. [PubMed: 15583097]
31. Kruttschnitt, C, Kalsbeek, WD, House, CC. Estimating the Incidence of Rape and Sexual Assault. Panel on Measuring Rape and Sexual Assault in Bureau of Justice Statistics Household Surveys; Committee on National Statistics; Division on Behavioral and Social Sciences and Education; National Research Council. National Academies Press (US); Washington (DC): 2014 Apr 7.
32. National Center for Missing and Exploited Children. National Center for Missing and Exploited Children; 2014. Jan 3, Registered Sex Offenders in the United States and Its Territories per 100,000 Population. Web. 22 Oct. 2014

33. Hanson RK, Morton KE, Harris AJR. Sexual Offender Recidivism Risk: What We Know and What We Need to Know. *Ann N Y Acad Sci.* 2003 Jun; 989:154–66. [PubMed: 12839896]
34. Hanson RK, Harris AJR, Helmus L, Thornton D. High-Risk Sex Offenders May Not Be High Risk Forever. *Journal of Interpersonal Violence.* 2014; 29(15):2792–2813. [PubMed: 24664250]
35. Marshall WL. Phallometric Assessments of Sexual Interests: An Update. *Curr Psychiatry Rep.* 2014; 16:428. [PubMed: 24318320]
36. Pyle, Robin. "State's Sex Offender Risk Classifications Can Mislead Public". *Lubbock Online.* 2010 Apr 11.
37. Classification of Sex Offenders. (n.d.). Retrieved December 24, 2014, from <http://www.kcsarc.org/FAQ#sexoffenders>
38. Hanson RK, Bourgon G, Helmus L, Hodgson S. The principles of effective correctional treatment also apply to sexual offenders a meta-analysis. *Criminal Justice and Behavior.* 2009; 36(9):865–891.
39. Rice ME, Harris GT. The size and sign of treatment effects in sex offender therapy. *Ann N Y Acad Sci.* 2003 Jun;989:428–40. [PubMed: 12839916]
40. Schmucker M, Lösel F. Does sexual offender treatment work? A systematic review of outcome evaluations. *Psicothema.* 2008 Feb; 20(1):10–9. [PubMed: 18206060]
41. Scott CL, Holmberg T. Castration of Sex Offenders: Prisoners' Rights Versus Public Safety. *J Am Acad Psychiatry Law.* 2003; 31:502–9. [PubMed: 14974806]
42. Milman HA, Arnold SB. Neurologic, psychological, and aggressive disturbances with sildenafil. *Ann Pharmacother.* 2002 Jul-Aug;36(7–8):1129–34. [PubMed: 12086542]
43. Bowcott, O. The Guardian. Guardian News and Media Limited; 2011. Jun 9, Libya Mass Rape Claims: Using Viagra Would Be a Horrific First. Web. 22 Oct. 2014
44. Gallagher, C, Donnelly, Nicola. Independent.ie. Independent.ie; 2010. Nov 30, Man (87) Jailed for Raping Five of His Granddaughters. Web. 22 Oct. 2014
45. Crisp, R, editor. Aristotle. *Nicomachean Ethics.* Cambridge: Cambridge University Press; 2000.
46. Trianosky GW. Rightly Ordered Appetites: How to Live Morally and Live Well. *American Philosophical Quarterly.* 1988 Jan; 25(1):1–12.
47. Savulescu J. Conscientious objection in medicine. *BMJ.* 2006 Feb 4; 332(7536):294–7. [PubMed: 16455733]

Table 1
Method of Identification of Sexual offenders

Method of Identification (n=18)	Patients (%)
Voluntary Disclosure during New Patient Screening	12 (67%)
Retrospective Review of Intracavernosal Injection Records	3 (17%)
Retrospective Review of Penile Prosthesis Records	1 (6%)
Screening of Established Patient due to Clinical Suspicion	1 (6%)
Falsely accused and Imprisoned for Sexual Abuse	1 (6%)

Table 2
Patient Characteristics

Characteristic	Patients (%)
Race (n=18)	
Black/African American	9 (50%)
White/Caucasian	5 (28%)
Hispanic	2 (11%)
Unknown/unidentified	2 (11%)
Level of Sexual Offender* (n=14)	
Level 3	9 (64%)
Level 2	4 (29%)
Level 1	1 (7%)
Relationship Status** (n=17)	
Single, divorced or separated	9 (53%)
Single, but in a relationship	4 (24%)
Married	4 (24%)
Clinical Data (n=18)	
Erectile Dysfunction	18 (100%)
History of Psychiatric Diagnosis	10 (56%)
Substance abuse	7 (39%)
Hypogonadism	7 (39%)
Homelessness	4 (22%)
Peyronie's Disease	1 (6%)
Delayed Ejaculation	1 (6%)
Financial Data (n=18)	
Medicaid/Medicare	13 (72%)
MassHealth plan (state-funded medial insurance)	4 (22%)
Privately insured	1 (6%)
Treatment of Sexual Dysfunction*** (n=18)	
Previously Treated Sexual Dysfunction	12 (67%)
Phosphodiesterase-5 inhibitors	12 (67%)
Intracavernosal Injection Therapy	5 (28%)
Testosterone Therapy or Clomiphene	3 (17%)
Penile Prosthesis	1 (6%)
Micro-arterial Penile Bypass	1 (6%)

* Level of Sex Offense could not be ascertained in all individuals

** Relationship status could not be confirmed in all individuals

*** Some patients received >1 treatment

Table 3
Type of Sexual Offenses Committed*

Sexual Offenses Against Adults	Counts**
Rape	13
Assault with intent to commit rape	3
Indecent assault and battery of a person over 14 years old	2
Open and gross lewdness and lascivious behavior	1
Aggravated rape	1
Sexual Offenses Against Children	
Rape and abuse of child (with or without force)	9
Indecent assault and battery of a child under 14 years old	8
Assault of a child with intent to commit rape	1
Child molestation	1
Child pornography	1
Exhibit child in sexual contact	1

* Descriptions of crimes for those with accessible data (n=14 patients).

** For those with total counts documented, the counts are reported. When count data was not available, it was assumed to be 1 for each crime listed.