

Policing "Perversions": Depo-Provera and John Money's New Sexual Order

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SUMMARY. The use of the drug Depo-Provera (medroxyprogesterone acetate [MPA]) in the treatment of sexual minorities, such as sadomasochists, transvestites, sexually active children and teenagers, and adults sexually attracted to minors, is the latest development in a long tradition of dangerous and crude experimentation by psychiatrists and clinical psychologists with biodeterministic and reductionist views of human sexuality. Among them is clinical psychologist John Money, whose zealous advocacy of such treatments ignores or downplays critical issues of ethics, informed consent, and the side effects of the drug. The U.S. Food and Drug Administration has failed to effectively regulate such uses of Depo-Provera. Public outcry, more stringent regulation, and a new acceptance of the rights of

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sexual minorities are necessary to forestall the imposition of a repressive, new sexual order.

Since the nineteenth century, psychiatry and clinical psychology have policed sexual behavior that previously either was ignored or fell within the domain of law enforcement. According to Michel Foucault (1978) the sexual mission of psychiatry and clinical psychology, which at times has taken on the character of purity crusades, has been carried out in two ways. First, it has silently favored heterosexual monogamy and the family, a form of sexual behavior not scrutinized by professionals or scientists as long as it operates within prescribed boundaries. Second, for some sexualities, including homosexuality, it has resorted to the “implantation of perversions,” the multiplication of forbidden sexualities for the purpose of exposure, control, and, in some cases, outright suppression.

In the early twentieth century the medical interventions into “perverse sexualities” took on the form of what Elliot Valenstein (1986) has called “great and desperate cures” to which the so-called sexual psychopaths and offenders were involuntarily subjected. These include the use of surgery for testicular castration and transplants, the destruction of particular areas of the hypothalamus, and the removal of the frontal lobes of the cerebral cortex (e.g., Banay & Davidoff, 1942). According to Valenstein, the same factors that promoted these drastic sexual “therapies” are still part of mainstream psychiatry and clinical psychology. Today, however, the favored treatment is to drug the brain rather than excise parts of it.

In his *Gay American History* (1976, pp. 129-207), historian Jonathan Katz has chronicled and abstracted the horrifying variety of medical treatments conducted on homosexuals from 1884 to 1974. Sylvere Lotringer (1988), in his book *Overexposed: Treating Sexual Perversion in America*, documents, sometimes from the anguished perspective of the sex offender, the frightening lengths to which modern-day “helping professionals” will go to manipulate, control, and suppress one’s sexual fantasies. His composite stories illustrate the proliferation of sex offender treatment programs that attempt to prescribe “cures” for societally tabooed sex, including pedophilia.

Among the “cures” is the drug, known by its trade name, Depo-Provera, which has been used in the United States as a means of

suppressing certain sexual behaviors for over two and a half decades. Depo-Provera is a synthetic hormone manufactured by the Kalamazoo, Michigan-based Upjohn Company. Its chemical name is medroxyprogesterone acetate (or MPA). The drug has often been administered to men arrested for or convicted of a sex offense involving children. The treatment is usually given while the accused is in prison or on probation, parole, or even out on bail.

Because biochemistry is a relatively new field of study, little is known about the complex interactions and effects of hormones on brain functioning. Natural hormones are substances which are conveyed by the blood to an organ to stimulate it either to act or to secrete another hormone. Androgens, for example, are secreted by the tissues of the testicles in the male and, in both sexes, by the adrenal gland located at the top of the kidney. In males the androgens stimulate the growth of pubic and facial hair, the deepening of the voice, the development of muscle tissue, the distribution of fat, and the development of the genitals ("Androgen," 1986). Androgens are a class of hormones (Thomas, 1989). It is incorrect to call them "male hormones" since they are also present in females.

Depo-Provera is classified as an "antiandrogen." In the case of men incarcerated for sex offenses, Depo-Provera is administered to block the release into the blood stream of one of the androgens, testosterone. Testosterone is believed to govern the intensity of a putative male sex drive. In adult males the prolonged use of Depo-Provera can reduce the testosterone level to that of the prepubertal boy (Money, 1979a, p. [1]; 1987b, p. 220). Testosterone is a derivative of still another hormone, progesterone (sometimes called the "pregnancy hormone")—hence the chemical name (i.e., medroxyprogesterone acetate).

One national survey of juvenile and adult sex offender programs and providers found that out of 643 treatment programs for sex offenders, 14% of the adult programs and 6% of the juvenile programs regularly used Depo-Provera (Knopp, Rosenberg, & Stevenson, 1986, pp. 9, 14). As a "treatment" for sex offenders, the drug is usually administered on a weekly basis by intramuscular injection into the buttocks, sometimes in massive doses, up to 500 milligrams or more, depending on a subjective judgement of the survival strength of the person's inclination to repeat the forbidden sexual

behavior (Money, 1987b, p. 221). In comparison, when used as a contraceptive on women, the recommended dosage is 150 milligrams every *three months* (Vaid, 1985, p. 8). The non-Depo form of the drug, Provera, marketed as a tablet, is “not well absorbed in the gut and is not satisfactory for the treatment of paraphilia,” according to Money (1987b, p. 221).¹ The strength of this inscrutable tendency is determined either through the inmate’s self-report or measured by devices attached to the inmate’s penis to detect minute changes in circumference and length while he views photographs of his *object d’amour*, or by assaying every few months testosterone levels in the blood. Treatment may be continued for a period of two to three years.

In addition to its use for preventing men from having sex with minors, the drug has been used on children who are considered sexually precocious (see below). But more attention has been devoted to its use on men convicted of rape or attempted rape. Instead of imprisonment, such men are sometimes sentenced to undergo Depo-Provera treatment during probation or parole (Tempest, 1983; Abrams, 1985; McFarland, 1986). Such drug therapy for rape cases, however, goes against the feminist view of rape as a crime involving violence and domination of women, and assumes rape to be primarily a sexual act (Vaid, 1985, p. 9). Feminists would argue that reducing the “libido” would do nothing to reduce the threat of violence. With sexual desire supposedly reduced or erased, murder might well be a more likely outcome. Another dubious assumption is that rapists are “abnormal, oversexed men” (*ibid.*), thus discounting the effect of a chauvinistic culture on the crime.

Depo-Provera is more widely used as a contraceptive for females; it is marketed in more than 90 countries and used by an estimated 30 million women worldwide (Cimons, 1992a). Although approved for restricted use as a contraceptive in some countries (e.g., Veitch, 1984), its use in the United States for birth control had been banned by the Food and Drug Administration (FDA) until late 1992 because of a correlation with uterine and breast cancer (e.g., Minkin, 1981). However, in late October 1992 the FDA approved its use as a contraceptive, downplaying or discounting any adverse effects (Cimons, 1992b; Leary, 1992). Groups such as the National Women’s Health Network, the National Latina Health Association,

and the National Black Women's Health Project remained adamantly opposed to FDA approval because of persistent doubts about its safety and the documented risk increase for breast cancer in women under the age of 35 during the first four years of use (Cimons, 1992a; Hilts, 1992; *Ms. Editors*, 1993). Dr. Sidney Wolfe, director of consumer advocate Ralph Nader's Health Research Group, called the FDA action "reckless." He noted: "Just because a drug has been in use for a long time doesn't mean it is safe" (cited in Cimons, 1992a, p. A11). Whether or not its prolonged use in men is also carcinogenic remains as yet unknown.

Despite the then FDA ban, the drug had been promoted as a contraceptive on Indian Reservations in the United States by the Indian Health Service (U.S. Congress, 1988b; Swenson, 1987, p. 3). So many gynecologists in the San Francisco Bay Area were privately prescribing Depo-Provera that the National Women's Health Network filed a class action lawsuit against the drug's manufacturer, Upjohn Company, in the 1980s (Fraser, 1985, p. 19). In drug trials in the United States, some 1,100 Detroit-area women, including inner-city drug addicts, those with mental impairments, and others awaiting sterilization, received Depo-Provera from 1971 to 1974. Over 100 of them reported abnormal vaginal bleeding (Haenlein, 1983a, p. A8).

Upjohn has aggressively marketed it to women, especially in Third World countries, producing sales of about \$100 million a year (Hilts, 1992; Minkin, 1981; "One Shot Too Many," 1983, p. 12; Swenson, 1987, 1988; cf. McDonough, 1988). With Depo-Provera's approval as a contraceptive in the United States, Upjohn, which is about to lose patent protection on three other major products, stands to gain another \$100 million in annual sales ("Upjohn," 1992). In 1983, Upjohn made Ralph Nader's top ten Corporate Hall of Shame list for its campaign to gain governmental approval to market the drug in the United States (United Press International, 1983).

Ethical concerns have been raised about the high rate at which women in the Third World, compared with the industrialized world, have been injected with this suspected carcinogen. Tonga, for example, has the highest rate of usage in the world of Depo-Provera as a birth control method, but it probably has the most inadequate

monitoring of its usage, calling into question whether there was really informed consent (Parsons, 1990, pp. 106, 109).

In Hong Kong, it was being injected into Vietnamese refugee girls and women to prevent pregnancy, reportedly without their full, informed consent. In 1989, 539 (or 37%) of the new Vietnamese cases seen by Hong Kong's Family Planning Association were injected with Depo-Provera (Davies & Howells, 1990; Howard, 1990). And in Nepal, almost 60% of the women receiving Depo-Provera complained of side effects (Acharya et al., 1978, p. 9).

Prior to October 1992 the FDA had approved the drug in the United States only to treat certain inoperable cancers of the endometrium (cervical lining) and the kidneys, even though it causes cancer in beagles and monkeys. Through a glaring loophole in the law, it could also be used in the "individualized practice of medicine" (Vaid, 1985, p. 7). This is because any drug already on the market for any approved use, with the authorization of any physician, can be prescribed for any other use, without further FDA approval or regulation, but subject only to "personal liability for an unorthodox use" (Adkinson, 1983, p. [1]). According to the national registry of drug prescriptions, National Disease and Therapeutic Index, some 3,000 prescriptions for Depo-Provera were written between October 1982 and September 1983 to treat "sexual deviation" (cited in Vaid, 1985, p. 8).

Legislation to permit the use of Depo-Provera by the government on rapists has been approved in Oregon (Haenlein, 1983b, p. A8; Vaid, 1985, p. 8). But Connecticut's prison system (Vaid, 1985, p. 8) has rejected its use, citing uncertainty about its safety. In 1994, Florida citizens were debating a Senate bill to mandate Depo-Provera treatment on rapists and other sex offenders (see debate on *Sonya Live!* 1994).

Beginning in 1966, clinical psychologist John Money and two physicians at Johns Hopkins Hospital in Baltimore, Maryland, were the first researchers in the United States to use Depo-Provera on "sex offenders" (Money, 1970, p. 165; Boodman, 1992), even though the drug had not been approved by the FDA for that purpose. The FDA viewed Money and his colleagues' use to be the "individualized practice of medicine," and refused to monitor it (Meyer, 1983). The FDA maintained its position even though

Money could not practice medicine, since he was a clinical psychologist and not a psychiatrist. Similarly, Johns Hopkins' Joint Committee on Clinical Investigation, which is the hospital's internal review board, refused to get involved, and decided that the Hopkins team was not doing a "clinical investigation" subject to oversight (Hendrix, 1983). Whether called patient care or research, drug treatment continued, and in 1984, 192 men were treated with the drug at Money's Biosexual and Psychohormonal Clinic (also called Sexual Disorders Clinic), 20% of whom were incarcerated in prison, and the rest (80%) were on parole or probation (Vaid, 1985, p. 8). Another account placed a third of the "outpatients" there as "pedophiles" (Gardner, 1984).

In 1985, Ralph Nader's Public Citizen Litigation Group (Glitzstein et al., 1984) pressured Johns Hopkins Hospital to seek official FDA permission to conduct a research study on the use of Depo-Provera to control sexual behavior. The Hospital obtained from the FDA an Investigational Exemption for a New Drug (IND), which permitted the "research" use of Depo-Provera. With an IND, there are supposed to be more stringent reporting and control requirements for such uses of a drug (Vaid, 1985, p. 8). However, the formal results of that "study" are as yet unknown. Money's colleague, psychiatrist Fred Berlin, admitted that he refuses to conduct double-blind studies because of the risk such a study would pose to children (Cardinal's Commission, 1992, Appendix C, p. 62).

An Upjohn Company spokesman, Joseph Galligan, told an investigative newsletter that Upjohn was not interested in marketing the drug as therapy for sex offenders for two reasons: (1) "We just don't feel it's worth the time and expense that would be required to have the drug approved." (2) "When administration of a drug becomes a condition of sentence or parole, you're taking the issue beyond the normal medical practice of prescribing medicine." Galligan added, "If Upjohn continued to be active in [these] studies . . . we could be construed as encouraging the inappropriate prescribing of a non-approved drug" ("Depo-Provera," 1984, p. 3). Nonetheless, Upjohn continues to supply the drug to Johns Hopkins.

Besides Johns Hopkins, other Depo-Provera treatment programs (apart from private physicians' offices) have included: the Sex Offender Unit, Oregon State Hospital (Salem); New Hampshire State

Hospital (Concord); Isaac Ray Center (Chicago); Gender Clinic, University of Texas Medical Branch (Galveston); Northwest Treatment Associates (Seattle, Washington); Rosenberg Paraphilia Treatment Clinic (Galveston); Ka Cor Associates (San Diego, California) (Vaid, 1985, p. 8); Atascadero State Hospital (California) (Kiersch, 1990); Rush Presbyterian St. Luke's Medical Center (Chicago) (Foreman, 1984, p. 24); St. Luke's Institute (Suitland, Maryland); Servants of the Paraclete Center (Jemez Springs, New Mexico); and "antiandrogenic treatment" at the Vermont Treatment Program for Sexual Aggressors, a legislature-mandated program treating sex offenders in prison and in the community (Pithers, Martin, & Cumming, 1989, p. 298). The Isaac Ray Center, St. Luke's Institute, and Servants of The Paraclete Center are sites where Catholic priests accused of having sex with minors are treated (Cardinal's Commission, 1992, p. 35; Money, 1988, p. 179; "Priestly Sins," 1992, p. 22).

Worldwide, doctors are prescribing other chemically castrating drugs for sexually taboo behavior, such as cyproterone acetate (CPA), norhydroxyprogesterone caproate, oestrone, oestrogen, progesterone, and the tranquilizer benperidol (Herrmann & Beach, 1980, p. 182). In Canada, although Depo-Provera has not been officially approved for use to treat sexual "anomalies," Pierre Gagné of Quebec's Sherbrooke Hospital has been prescribing it since 1974 (Gagné, 1981). It is also used at the Clarke Institute of Psychiatry in Toronto by S. J. Hucker (1985). Elsewhere in Canada, CPA, which is unavailable in the United States (Berlin, 1983, p. 105), has been used extensively at the Sexual Behaviors Clinic of the Royal Ottawa Hospital and the University of Ottawa (Bradford, 1988, p. 199). It has also been used at Calgary General Hospital (Belanger, 1981). In Europe, the predominant medication is CPA (Herrmann & Beach, 1980, p. 182). Proponents claim that it is superior to Depo-Provera, although it has been linked to testicular atrophy (Langevin, 1983, p. 59). In Germany, the Division for Sex Research at the University of Hamburg stopped the routine use of antiandrogens as a sex offender treatment because of the serious effects on the bones and liver. According to its director, Gunter Schmidt, "the use of anti-androgens only is justified in special cases of sex offenders, for very short periods, to be able to get the psychotherapeutic contact be-

gun” (Schmidt, 1989, p. 7). In the United Kingdom, a similar drug, Goserelin (also known by its trade name, Zoladex), was ordered to be used on a 25-year-old male patient *without his consent* in order to “modify his attitude towards women” (“Mental Patient,” 1988). One writer subsequently described this collaboration of state, judiciary, and the medical establishment as “lynch mobs in white coats” (Levin, 1988).

The list of effects and side effects associated with Depo-Provera when used on males reads like a phantasmagoria of medical symptoms, including: increased appetite and weight gain of 15-20 pounds, fatigue, mental depression, hyperglycemia, impotence, abnormal sperm, lowered frequency and intensity of thoughts/ erections/ejaculations, lowered ejaculatory volume, insomnia, nightmares, dyspnea (difficulty in breathing), hot and cold flashes, loss of body hair, nausea, leg cramps, irregular gall bladder function, diverticulitis, aggravation of migraine, hypogonadism, elevation of the blood pressure, hypertension, phlebitis, diabetic sequelae, thrombosis (leading to heart attack), and shrinkage of the prostate and seminal vessels (Hucker, 1985; Bradford, 1983, p. 163; Brooks, 1983, p. 4; Langevin, 1983, p. 58).

The consent form that has been used by The Johns Hopkins Hospital Clinic warns of the following dangers:

Depo-Provera is a hormone which is similar to those contained in birth control pills. Therefore, the risk of developing blood clots may exist. Depo-Provera has been found to increase the frequency of malignant breast tumors (breast cancer) in female beagle dogs, and of uterine cancer in female monkeys. There have been no reports of this drug causing cancer in men. (Consent Form, 1989, p. [78])

Although the form does state that the “most common” side effects are weight gain and higher blood pressure, no mention is made of the World Health Organization data (cited in Minkin, 1981, p. 52) showing the increase in cancer in Thai women in a location where over half have used the drug.² Neither is any mention made of the reason Depo-Provera had been banned as a contraceptive in the United States. In the paragraph preceding the statement quoted, patients are warned of “less common side effects,” including night-

mares, cold sweats, hot flashes, sexual impotence, muscle cramps, and “a tendency to become easily fatigued.” It does not inform the patient that hypertension is often an irreversible side effect or that atypical sperm might result and produce malformed offspring (Brooks, 1983, pp. 3-4). Nor is it disclosed that Hopkins researchers have never undertaken any controlled, double-blind, scientifically-sound studies of Depo-Provera. It also fails to disclose that the medical school’s internal review committee withdrew its approval of the drug’s experimental use in the early 1980s (Adkinson, 1983). Additionally, no mention is made as well that as a substitute for rigorous research, sex offenders are paraded before the press as “success stories” (Kobren, 1984). Nor is the potential patient told that the Connecticut Department of Corrections has rejected the drug’s use on inmates because of “real concerns” about its safety (Brooks, 1983).

It has been widely touted that those who take the drug lose their interest in having sex. Women who have taken the drug as a contraceptive have also complained about a loss of “sex drive” (“Limp Libidos,” 1981). In males, Depo-Provera does lessen the frequency of erections and ejaculations. In the words of John Money (1988, p. 233), “[i]t . . . induces a period of sexual quiescence in which the feeling of sex drive is at rest. The patient ‘has a vacation’ from his or her sex drive.” Money’s former colleague, psychologist Paul Walker, echoes Money when he states that Depo-Provera just “provides a vacation from sex and sexual fantasizing until these men learn to do it right” (Foreman, 1984). But this cannot be an enjoyable vacation. One can well imagine that a drug that produces depression and lethargy, leaving the person with a general feeling of bodily dysfunction, would reduce interest not only in sex but in being alive.

It is naive to believe that hormones are more basic in shaping sexual desire and behavior in human beings than personal experience and social norms. With the evolution of the human brain, the control that hormones have over sexual desire and behavior has arguably been progressively relaxed. At this point in the evolution of the human brain and of civilization, it is impossible to isolate the influence of hormones in shaping our sexuality from the influence of personal experience (see, e.g., Vines, 1994).

The belief that human sexuality is determined by hormones,

however, has been zealously propagated by John Money. He headed the “psychohormonal unit” in John Hopkins’ medical school, even though he never earned a degree in medicine. *Psychology Today*, however, has called Money the “Doctor of Sexology” (Holden, 1988). At Hopkins, he also was associated with its surgical program for transsexuals, which was shut down in 1979 after a study revealed surgery alone did nothing for the patient’s emotional adjustment (Mitzel, 1981, p. 22). Since the 1960s, he has zealously promoted the use of Depo-Provera in the treatment of paraphilias (his neologism for sexual perversions), among which he includes pedophilia, ephebophilia, cross dressing, voyeurism, and sado-masochism (Money, 1988, pp. 179-180).

Money’s strenuous advocacy of Depo-Provera as a means of eliminating forbidden forms of sexual behavior is anchored in his general view of human sexuality. Money has spent a long career writing about and even occasionally studying the causes of human sexual behavior. According to Ruth Doell (1990, p. 121), a biologist:

Money’s view of what a human being is . . . is that of an advanced ape, one whose behaviors, primed by prenatal hormonal exposure, reflect his primate inheritance. Not that we don’t inherit much from our primate ancestry. We do. But Money ignores the intervening several million years of evolution of the human brain since we parted from the great apes, which have allowed the development of a quite different mode of behaving at the conscious level.

Money does not seem to believe that human beings are able to exercise any discretion over their sexual behavior, including the decision to be abstinent. Although he endlessly declares that his theories are interactionist, that is, they embrace both biological and social factors, he reiterates his belief that prenatal hormone exposure is the *primary* determinant of the character of our sexual desires, including the adult sexual interest in children and other so-called paraphilias. Early social conditioning is considered secondary.

For example, Money is pleased that the Catholic Church is injecting Depo-Provera into wayward priests accused of being “pedophiles” or “ephebophiles.” He asserts:

This adoption of a biomedical treatment is the thin edge of a wedge that may have far-reaching consequences on Vatican sexology . . . It gives official recognition to the proposition that sexual behavior is not attributable exclusively to the morality of good and evil, righteousness and sin. Repentance, prayer, and penance alone are not sufficient for the governance of paraphiliac sexuality, even among those in holy orders. Nor are punishment and imprisonment. (Money, 1988, p. 179)

Money and his colleagues have not been shy to rush to the press and claim success for their biochemical treatment, even without conducting any controlled studies. As far back as 1982, they were publicly proclaiming success in curbing the “sexual appetite” of pedophiles and exhibitionists treated with Depo-Provera. Money and his colleague Fred Berlin told *Science News* that they had identified a cluster of biological abnormalities in such sex offenders. They claimed such findings called into question the idea that early life experiences alone lead to deviancy in adulthood. They reported that 20 of their subjects had unusual brain scans that showed cortical atrophy, unusual brain electrical activity, and significantly higher levels of testosterone and pituitary hormones. Seventeen of the twenty patients were able to avoid illegal sexual behaviors, in one case for 15 years (“Curbing Sexual Appetite,” 1982).

In an article headlined “Is Sexual Deviance a Biological Problem?” *Psychology Today* (1983) similarly reported that Money and Berlin had “discovered a surprising number of physiological abnormalities” in the sex offenders they treated, and were “now launching more detailed studies of brain metabolism with new PET (positron emission tomography) scanner equipment,” with an aim of identifying “key biological differences between the sexes and among those with different sexual preferences.” The magazine predicted that Money and Berlin’s research “could lead to a new theory of sexual desire, drive, and behavior, and do much to promote a more humane approach to sex offenders” (McAuliffe, 1983).

In Toronto, Canada, as a defense witness in the 1979 indecency trial of the Pink Triangle Press and the editors of the now defunct Canadian gay liberation monthly *The Body Politic* for publishing an

essay on pedophilia, Money testified that it is biology that determines pedophilia, not the environment. Pedophilia, Money told the court, “is a condition which develops within the person and it’s an internal complex developmental process that takes place and it’s not a simple response to the act of reading one piece of material” such as the *Body Politic* article (cited in Adelman, 1981, p. 319). Asked by the prosecutor why he would not condone pedophilia, Money replied incongruously, “[b]ecause of its disparity in the equilibrium” (“The Body Politic Trial,” 1979, p. 99).

Professor Doell has discussed Money’s biological fatalism (1990, p. 123), pointing out:

The most that biology can be shown to determine in humans is a capacity for sexual behavior which each of us can integrate into the experiences of our childhood and adolescence to come to some conclusion as to what is in our own best interests with respect to sexual behavior. This is in contrast to Money’s statement . . . that self conscious decision plays no role in developing homosexual behavior.

Money’s theories of sexuality are heterosexist. They assume that heterosexual reproduction is the biological *sine qua non* of human gender and sexuality. Over a period of thirty years, he has tediously litanized the “immutable and irreducible” sex differences (e.g., Money, 1988, p. 54): “They are specific to reproduction: men impregnate and women menstruate, gestate, and lactate.” Forms of sexuality that preclude reproduction, including homosexual behavior, are categorized as sexual perversions or paraphilias. Homosexual pedophilia and pederasty, in Money’s system of thought, are particularly perverse not only because the man/boy contact itself precludes reproduction, but also because it undermines the possibility of the boy in the future performing his biologically-mandated, heterosexual mission-impregnation. These so-called pedophiles and pederasts have no control over their condition, for “[p]edophilia and ephebophilia are no more a matter of voluntary choice than are left-handedness or color blindness,” according to Money (1987a, p. 6). He further acknowledges, despite his advocacy of Depo-Provera as a treatment for these sexual differences, that “[t]here is no known method of treatment by which they can be

effectively and permanently altered, suppressed, or replaced. Punishment is useless” (ibid.). He even goes so far as to argue that they are “unnatural” and irrelevant to evolution: “There is no satisfactory hypothesis, evolutionary or otherwise, as to why they exist in nature’s overall scheme of things” (ibid.). But, condescendingly, he advises, “[o]ne must simply accept the fact that they do exist, and then, with optimum enlightenment, formulate a policy of what to do about it” (ibid.). He told a reporter he would like to see all convicted sex offenders offered a “choice” between incarceration and placement in a halfway house that provided Depo-Provera treatment. Discounting fears of a “Brave New World,” Money proclaimed, “We’ve been doing it ever since we invented alcohol in ancient Egypt” (Colen, 1975). Money even gained the support of the embattled then-director of the Kinsey Institute, June Reinisch, who told a Bloomington, Indiana, public radio station that Depo-Provera should be used to rehabilitate nonviolent sex criminals because it helps “individuals to stop their obsessive behavior . . . [and] return to a normal and healthy sex life with their wives” (Jackson, 1984).³

Money’s “enlightened” policy is clearly far from benign. After reducing human beings to sexual robots, Money can justify all manner of reprogramming for those who do not operate within the social norms. Since the social norms are treated as brute reality, it is the robots that must change. Obviously, since robots cannot change themselves, the reprogramming must be done for them by the self-appointed guardians of heterosexual privilege.

Money also advocates the early detection and treatment of “potential” sex offenders, especially for young boys who have engaged in taboo sex, or for girls with an early onset of puberty. Money admits that he did not consider Depo-Provera dangerous because “it had been used a great deal in pediatric endocrine health care with children who were getting into puberty too early, from as early as 18 months up to six years of age” (Money, 1991, p. 11). According to Money, his “patients” at the clinic are usually aware of their “problem” by age 13 (Gardner, 1984). A 15-year-old girl was treated at the clinic with Depo-Provera for “periodic psychosis of puberty,” which included incoherent speech, insomnia, and hallucinations (Berlin, Bergey, & Money, 1985). It is nothing short of

outrageous that at his clinic, girls as young as one year old reportedly have been treated with Depo-Provera, in an attempt “to retard the onset of incredibly early adolescence” (Mitzel, 1981, p. 22). Today, such girls and boys would be labelled child perpetrators (see Okami, 1992). Given the rhetoric about protection of children, it is ironic that they have become the newest guinea pigs in the war against taboo sex. Psychologist Toni C. Johnson coined the term “mini-perps” to describe these children. When questioned by this author, she admitted that the “little ones,” who are “sexual all the time,” have been treated with the drug Clonidine, rather than Depo-Provera, to control their sexual behavior (Johnson, 1991; see also Johnson, 1988).

Ironically, Money's advocacy of Depo-Provera occurs at the same time as he readily passes himself off as a friend and supporter of adults sexually attracted to minors. As indicated above, he testified for the editors of the *Body Politic*, defending their publication of an essay on pedophilia. He wrote a favorable introduction to Theo Sandfort's *Boys on Their Contacts with Men* (1987). Sandfort's publisher, Global Academic Publishers (a pro-pedophilia press), has also brought out a collection of essays by Money (1992). In addition, he has been sought out and interviewed favorably by pedophile movement publications such as *Paidika* (Money, 1991) and *OK* (Cobelens, 1991), both based in the Netherlands. Even the New York City-based *NAMBLA Bulletin* featured him on the cover and reported his comments supportive of man/boy love in the *Paidika* interview (Andriette, 1991). Whether Money is being disingenuous, merely opportunistic, or acting out of guilt is a question that is beyond the scope of this paper. But one might speculate that his behavior might not be so different from that of a nineteenth-century missionary who saw himself on a quest to save the lost souls of “savages” and who enjoyed mingling with them. After all, Money probably believes he has the “pedophile's” best interests in mind.

In order to disguise his role of sexual policeman and master reprogrammer, Money sounds what is intended to be a compassionate note in offering his magical chemical cures. In the case of pedophilia, Money tries to convince the patient that the suppression of the behavior in question will free him from the tyranny of those awful impulses and thereby enable him to take his rightful and

satisfying place among the husbands and fathers of the world. As *60 Minutes* correspondent Ed Bradley remarked in a program on Depo-Provera and the Hopkins' role, "the treatment is controversial, but the doctors say that Depo-Provera can actually help control the behavior of men like those you are about to meet, men who suffer from hormonal imbalances that they say make them fall victim to their own unbearable urges" (Bradley, 1984, p. 2). Or as an *Omni* interviewer wrote about Money's work, "The shared principle of all paraphilias, says Money, is that they represent tragedy turned into triumph. The tragedy is the defacement of the ordinary lovemap" (Stein, 1986, p. 80), that is, the failure to perform one's heterosexually mandated mission. The triumph "is the rescue of lust from total wreckage and obliteration. The new map gives lust . . . a second chance but at a price: that 'saintly' love and 'sinful' lust are separated" (ibid.). Money has asserted that the use of antiandrogens like Depo-Provera "really depends on how much humanitarian concern you have for people that are in trouble. Are you willing to do something to try and help them?" he asked rhetorically (Money, 1991, p. 11).

This sanctimonious note of compassion about perverts being given a "second chance" is found in a memorandum Money addressed to the Maine House Judiciary Committee. In this two-page memorandum, Money (1979b) declares he has "no hesitation" in recommending the use of Depo-Provera, and asserts that it is "by far the most effective method known":

There is now available for sex offenders a form of treatment that enables them to self-regulate their pathological behavior (paraphilia) instead of being the victims of it. Without treatment, they are as much the victims of their pathology as untreated epileptics are victims of their epileptic seizures. The new treatment combines the use of medication, a hormone, an anti-androgen, to induce a time-limited antisexual effect, with the use of counseling to enable the person to take advantage of the hormonal reduction in sex drive in order to begin and maintain a new pattern of sexual life.

This quote summarizes his argument for the use of Depo-Provera. With the propensity simultaneously to inform, shock, enter-

tain, and advise in detached and macabre scientific jargon, Money's main defense for the use of the drug is that it is preferable to surgical castration, which had been facing constitutional challenges for "cruel and unusual punishment." Depo-Provera treatment is preferable not because of the obvious brutality of castration, but because castration does not really get rid of behavior. In what comprises two thirds of the memorandum, he explains why castration does not work. The memorandum is accompanied by a treatment protocol (Money, 1979a) for the use of Depo-Provera. The protocol varies little from that published as an article (Money, 1987b) and later as an appendix in Money (1988). Money also has stated, even though he lacks medical training, "I don't think it's my business to refuse to treat" someone who volunteers for hormonal therapy. However, he has not treated anyone since his retirement (Money, 1991, p. 12).

Does Money's paternalistic concern for the welfare of sex offenders settle the ethical questions involved in using Depo-Provera for inmates in prison hospitals and those under the custody of the courts? This question arises since it is foolish to claim that prisoners can freely give informed consent to submit to treatment if doing so is a condition of their earlier release and probation (Tsang, 1989, p. [5]). In fact, in *People v. Gauntlett*, the Michigan Supreme Court found that requiring Depo-Provera treatment as a condition of probation was "unlawful," because Money's program was still experimental. Ironically, the case involved Roger A. Gauntlett, an heir to the Upjohn fortune (Melella et al., 1989, pp. 228-229). A congressional report, noting that some prison administrators have proposed using the drug on all inmates to control violence and homosexual activity, concluded that "[s]uch broad and general use of the drug might meet the Supreme Court's test for cruel and unusual punishment: 'shocking to the conscience of reasonably civilized people'" (U.S. Congress, 1988a, p. 43). Yet Money (1977, pp. 122) cavalierly dismisses this ethical issue with these words: "That is a specious argument, if not a vindictive argument, for being in jail is a fact of life for a prisoner just as being in a hospital is for a patient. The facts of our lives shape all of our judgments, including those of informed consent." The cynicism of this statement is not surprising when we recall that its

author believes that the concepts of choice and will are pre-scientific. Money has elsewhere also evaded this ethical issue by claiming that sex offenders are not usually forced into treatment by the law: “Usually, when someone is in trouble with the law it is their lawyer who recommends that they come to the clinic”! (Money, 1991, p. 12).

Money’s colleague at Johns Hopkins who continues to direct the clinic, Fred Berlin, echoes this cynicism when he argues that if Depo-Provera “is effective, as it often seems to be, then it is difficult to see why a person should be denied the opportunity to take it just because he is on probation or perhaps even incarcerated” (Berlin & Krout, 1986, p. 25). Berlin also dismisses any concern about the drug’s side effects by stating they are comparable to those of birth control pills, which can cause blood clots in the legs, leading to a stroke or pulmonary embolism. Berlin believes that pharmacological therapy helps take the edge off a person and lessens his sexual preoccupation. He admits that the clinic, which has treated over 600 patients, does not rely much on behavioral therapy (Cardinal’s Commission, 1992, Appendix C, pp. 61, 62, 64). Testifying in the trial of a Pennsylvania man whom he treated at his clinic after the man was charged with receiving child pornography, Berlin blamed the man’s past sexual behavior on the body’s high production of a hormone that “fuels the sex drive” (Muir, 1985). Berlin believes that there is a biological predisposition to sexual orientation, implying that sexual attraction is not under our conscious control (*ibid.*, p. 62).

Berlin (1981, p. 1516) has further claimed that such psychotropic drugs are “not given to control attitudes and behaviors such as those concerning political beliefs or personal affiliations. They are not ‘mind controlling.’ Rather they may be given to help a person whose thinking is clearly out of touch with reality.” He continues, “antiandrogenic medications are given with the intent of increasing rather than decreasing a person’s capacity for self control.” He also has argued, “it is difficult to see how helping a willing patient to be better able to free his mind from obsessional cravings and ruminations about unacceptable forms of sexual behavior, could be considered any form of ‘mind control’” (Berlin, 1989, p. 236). That argument is misleading, according to forensic attorney John T. Me-

lella et al. (1989, p. 277), for Depo-Provera affects one's thought processes by inhibiting the chemical messenger that stimulates the production of androgen. "This in turn inhibits the offender's sexual fantasies" (ibid.). Melella et al. conclude that convicted felons still retain rights to procreate, refuse intrusive medical treatments, and generate ideas, all rights violated by the use of involuntary antian-drogen treatment. Informed consent, as applied to research subjects, requires (1) that the person be told the risk and benefits of the procedures, (2) that he understand what he is told, and (3) that he be allowed to refuse participation without any threat of punishment. The Money/Berlin protocol for informed consent fails on all three counts.

First, it does not name all the physical risks, including all the short-term side effects. Money himself dismisses the side effects and claims that they "might have occurred without the treatment anyway" (Money, 1991, p. 11).

Second, it does not inform the person of the very high likelihood he will resume the forbidden behavior as soon as he is free to do so without the threat of punishment. He is not told that when Depo-Provera "is discontinued, allowing the sexual appetite to heighten or return, behaviors engaged in to satisfy that appetite are also likely to be reinstituted" (Berlin & Meinecke, 1981, p. 607). Back in 1975 Money boasted that Depo-Provera could free a sex offender of his compulsion, by turning down the "thermostat" on his sex drive. However, "[t]he nice thing about the thermostat analogy . . . is you can turn (the sex drive) back up again," he added (Colen, 1975). Data from Money's own clinic indicate that when medication is discontinued, patients "relapse" in most cases (Berlin, 1983, p. 110).⁴

Finally, despite Money's insistence that patients give "completely informed consent" (Money, 1991, p. 12), the language of the treatment protocol, which is signed by the patient as evidence of being informed, is likely beyond the understanding of the prisoner, as in the following example (Money, 1988, p. 234): "The size of the maintenance dosage is judged on the basis of the patient's subjective report of how well the paraphilic imagery and ideation is under control, together with the lowered blood level of testosterone." One can imagine the terror and confusion of the person who is facing a

sentence of several years on a charge of child molestation and who knows that submission to treatment is his only hope for probation or a short sentence, trying to decipher this language and weigh the consequences of his consent. One physician, Dr. Sidney Wolfe, of the Health Research Group, calls this a travesty: "It makes a mockery of the whole concept of informed consent when your option is to go to jail or get injected with a carcinogen that can increase the risk of heart attack . . . It's human experimentation" (Engel, 1983, p. A5). The American Civil Liberties Union (ACLU) has also protested that inmates are, in effect, being "coerced" to participate in any Depo-Provera treatment program (U.S. Congress, 1988a, p. 43). Judicial clarification expected in 1992 failed to materialize. In November 1992 the U.S. Supreme Court refused to decide whether sex offenders could be required to undergo therapy as a condition of staying out of jail if the therapy required the offender to acknowledge guilt denied at trial. This let stand a 1991 Montana Supreme Court ruling that outlawed such forced therapy (Greenhouse, 1992a, p. A15; 1992b, p. A10). Prison psychologist Nicholas Groth and his colleagues do admit that "[b]asically treatment is coercive—the offender, realizing the social and legal consequences of disclosure does not self-refer. Therefore, treatment must be confrontative" (Groth et al., 1982, p. 142).

The veiled threat of incarceration appears in the informed consent form that has been used at the Johns Hopkins Hospital: "Even if you are in this treatment program as a condition of probation, you are still not obligated to take Depo-Provera. If you are receiving counseling here as a condition of probation and you fail to adhere to your agreed-upon appointment schedule, we will notify your Probation Officer that you have been noncompliant" (Consent Form, 1989, p. [79].) The patient is thereby reminded that the word of the medical authorities could send him to prison. Dr. Berlin himself admitted on the Phil Donahue Show that "[i]f a man misses an injection the court is notified. Any noncompliance is notified" ("Depo-Provera," 1983, p. 17). Although he is willing to send his patient back to jail, Berlin has also told a reporter that jail is not the appropriate punishment for some sex offenders, because there "is a moral issue of whether it is right to punish someone for not control-

ling that which they cannot control. Even if someone else is hurt” (Tempest, 1983, part I, p. 12).

Resistance to treatment is no secret to those who prescribe or advocate the use of Depo-Provera. Dr. Judith Becker, professor of psychiatry and psychology at the University of Arizona College of Medicine, who has treated hundreds of sex offenders, concedes that “many men stop taking” Depo-Provera because of its side effects (Boodman, 1992). Nonetheless, the former (dissenting) member of then Attorney General Edwin Meese’s Commission on Pornography continues to recommend its use, most recently when consulted by the Chicago Archdiocese Cardinal Joseph Bernadin’s Commission on what to do with priests who are sexually attracted to teenage boys. According to the commission report, Becker recommends the use of Depo-Provera on priests with multiple “victims” (Cardinal’s Commission, 1992, Appendix C, p. 57).

Even compliance with the protocol is no guarantee of avoiding prison, as Ray Latham found out. As an outpatient at Money’s clinic, and an unrepentant boy lover, Latham, who opted for Money’s program so that he could get probation for having had consensual sex with boys, eventually realized that “at age 66, I needed [Depo] like a hole in the head” (cited in Mitzel, 1981, p. 22). He later made the mistake of “bragging” to his Johns Hopkins Depo counselor about helping turn around the life of a teenage runaway. There was no sexual contact. But his counselor promptly informed his probation officer, his probation was revoked and he was sentenced to 16 years’ imprisonment (Latham, 1981; Mitzel, 1981, p. 22). As Groth and his colleagues have argued, “[a]lthough confidentiality may be appropriate when treating non-criminal behavior, it is not appropriate when dealing with the child sex offender. . . .” (Groth, Hobson, & Gray, 1982, p. 144). Berlin claims to be against mandatory reporting laws for child sexual abuse (Berlin, 1988). He asserts that his patients have “voluntarily” come to Johns Hopkins in Maryland to receive treatment because Maryland, unlike other states, requires therapists to report sexual abuse only after a child is examined (Berlin, 1989, p. 238). But clearly, as a court-referred convicted sex offender in Maryland, Latham forfeited his right to confidentiality. Berlin justifies exposing Latham, stating that Latham “hadn’t done anything sexually wrong, but he was uncooperative. There was no

evidence that he had become sexually involved. . . . But it was only a matter of time” (Weiss, 1984, p. A9). Latham (1984) remained unrepentant, declaring that he would continue speaking out, even if it meant sacrificing his last chance for freedom by submitting to Berlin and confessing, “I am one of the sick,” a step he resolutely refused to take.

It is a travesty of justice that any human being under the law is subjected to coercive treatment that severely reduces brain function and could eventually result in death from cancer (at least among women). It is a barbaric practice that cries for reform when we recall that some of the men subjected to such cruel treatment are punished for having sex with teenagers who encouraged, consented to, and enjoyed the sexual encounter. The same system that savages their adult partners makes these young people feel they are victims of their own sexual desires and enjoyment.

“This combination of judicial ignorance and medical zeal has frequently had catastrophic results, and sometimes lethal ones,” writes a critic of such treatment (Levin, 1988). In England some three decades ago, computer inventor and World War II codebreaker Alan Turing was imprisoned for illegal homosexual sex.

He was ‘sentenced’ by a judge whose vocation should have been burning witches, and ‘treated’ by a doctor who would have been more at home diagnosing his patients’ ailments by examining the entrails of a freshly killed chicken, to a course of hormonal injections which were supposed to correct his abnormal sexual propensities. (ibid.)

In the end, Turing committed suicide, another victim of a system that considers homosexuals, highly talented or not, to be sex fiends or sex addicts. That the medical profession, whose members have each taken the Hippocratic Oath, should allow itself to be misled by sexological moralists is a bitter irony. In fact, “[h]istorically, physicians who have used biological intervention to treat criminals have tended to exaggerate both the dangerousness of the deviant person’s behavior and the social benefit that comes from eradicating it. At the same time, they have often underestimated the harm the treatment imposes on the offender,” declared an editorial in the *American Journal of Psychiatry*, which also called for the development

of ethical guidelines for the use of antiandrogen drugs (Halleck, 1981, pp. 642-643). This perspective is echoed by a Canadian study of the construction of "dangerousness" about sex offenders, noting that "our present knowledge of the biomedical and behavioral effects of antiandrogenic (sic) drugs is very imperfect," raising important ethical issues (Webster et al., 1985, p. 55). Bancroft (1989, p. 721) similarly notes that

[a]lmost all the evidence of the efficacy of these pharmacological agents [like Depo-Provera] is of an uncontrolled kind and therefore cannot be regarded as conclusive. . . . The use of drugs to control sexual offenses is therefore still of uncertain value. This is of particular relevance when using them for social control, when it is necessary to be more certain of such effects before using drugs as an alternative to imprisonment. In addition, the potentially irreversible side-effects . . . pose major ethical problems when used in this context.

As psychiatric abuse critic Thomas Szasz (1987, p. 171), has observed:

By separating church and state, religion was deprived of its power to abuse the individual and the state was deprived of one of its major justifications for the use of force. The upshot was a quantum jump toward greater individual liberty such as the world had never seen. By separating Psychiatry and the State, we would do the same for our age: At one fell swoop, psychiatry would be deprived of its power to abuse the individual and the State would be deprived of one its major justifications for the use of force. The result would be another major advance for individual liberty—or, perhaps, the advent of another system of justificatory rhetoric and persecutory practice, replacing both the religious and psychiatric systems.

The ease with which the public, politicians, media, police, social workers, therapists, the Church, and the medical establishment are aroused to moral panic over pederasty and pedophilia in particular suggests a refusal to accept children as sexual beings. Instead of poisoning alleged offenders with Depo-Provera, or imprisoning

them, the diversity of our sexualities must be accepted. A minimal first step would be to reform our age of consent laws (while retaining sanctions against coercive or violent acts) so that young people will no longer be “jail-bait” or sexual outlaws but recognized as human beings with the capacity to say not only “no” but also “yes” to sex.

It is also surely time, as Professor Valenstein has argued, for more effective regulation of dangerous medical interventions. Valenstein remains unconvinced that a professional ethics code alone will be sufficient, for “[i]t is rare that codes of conduct apply unambiguously to the specific cases under dispute. Physicians who can be shown in retrospect to have caused great harm can always claim to have been motivated by the noblest of goals and the highest ethical principles” (Valenstein, 1988, p. 436). Valenstein’s view “is that in most cases the undesirable effects of reasonable regulation and restraint have been exaggerated, certainly when compared to the cost of the unbridled use of dangerous treatments. Ultimately, some effective regulation will have to be instituted” (Valenstein, 1988, p. 437). Federal regulations should be changed to bar such experimentation under the guise of individualized patient care. Until restrained by the state or public outcry, Money and his sex police are, indeed, parading like “lynch mobs in white coats,” with no qualms about using sexually active children, adults who love minors, transvestites, S&M practitioners, and pederasts as guinea pigs in their quest for a biologically determined new sexual order.

In short, John Money (cf. Money, 1986, p. 17) has found his vocation, having left the religion of his childhood in New Zealand, to become, even in retirement, the misguided missionary zealot of Depo-Provera in his Brave New World.

AUTHOR NOTE

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NOTES

1. Lotringer (1988, pp. 136-137) reports the case of a “pedophile” given 100 milligrams a day who rejected the treatment “because I was getting sick” and then pinched himself to prevent erections when tested.
2. Later WHO studies show the risk of breast cancer to be no greater than that associated with birth control pills (Cimons, 1992a; “Depot-Medroxyprogesterone Acetate,” 1993).
3. Reinisch’s position would undoubtedly make Alfred Kinsey—a scientist who studied rather than condemned sexual behavior—roll over in his grave.
4. However, Berlin was later to claim there was only a 5% recidivism rate (that is, those who “reoffend” and were caught) among his patients (Cardinal’s Commission, 1992, Appendix C, p. 61).

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