Pharmacological Treatment of Adolescent Sex Offenders

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Disclaimer - General

This presentation was developed as an overview of pharmacological treatment of adolescent sex offenders. The emphasis is on material relevant to mental health care clinicians, who might be tasked with conducting initial evaluations and treatment planning of adolescents with sexual offending histories. The content was selected to provide an overview in the allotted time rather than all inclusive coverage, but with resources to enable participants to further their understanding in the pharmacological treatment of adolescent sex offenders.

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Financial Disclosure

The presenter or his spouse have not had a relevant financial relationship in the past twelve months with proprietary entities producing health care goods or services presented herein.

Case Report

- 17-year-old male with a diagnosis of bipolar disorder, ADHD, and borderline intellectual functioning.
- Described as "occasionally" hypomanic, hypersexual, and impulsive.
- Reports recurrent "urges of having sex with children."
- Reports current use marijuana and alcohol.

Case Report cont'd

- Current meds: VPA 1000 mg bid (level 75mcg/mL), and fluoxetine 80mg/day, Concerta 27 mg/day. Presents with a history of medication non-compliance.
- Legal History: Significant for Indecent Assault and Battery on Child Under 14 (on three separate occasions) and Indecent Exposure.

- What are the treatment goals?

1. Reduce the risk for future sexual misconduct/sexual offending behavior
2. Improve quality of life of the adolescent
   - Decrease psychiatric symptoms (suffering)
   - Increase personal autonomy
   - Reintegrate into the community, where appropriate

- How to accomplish these goals?

How to accomplish these goals?

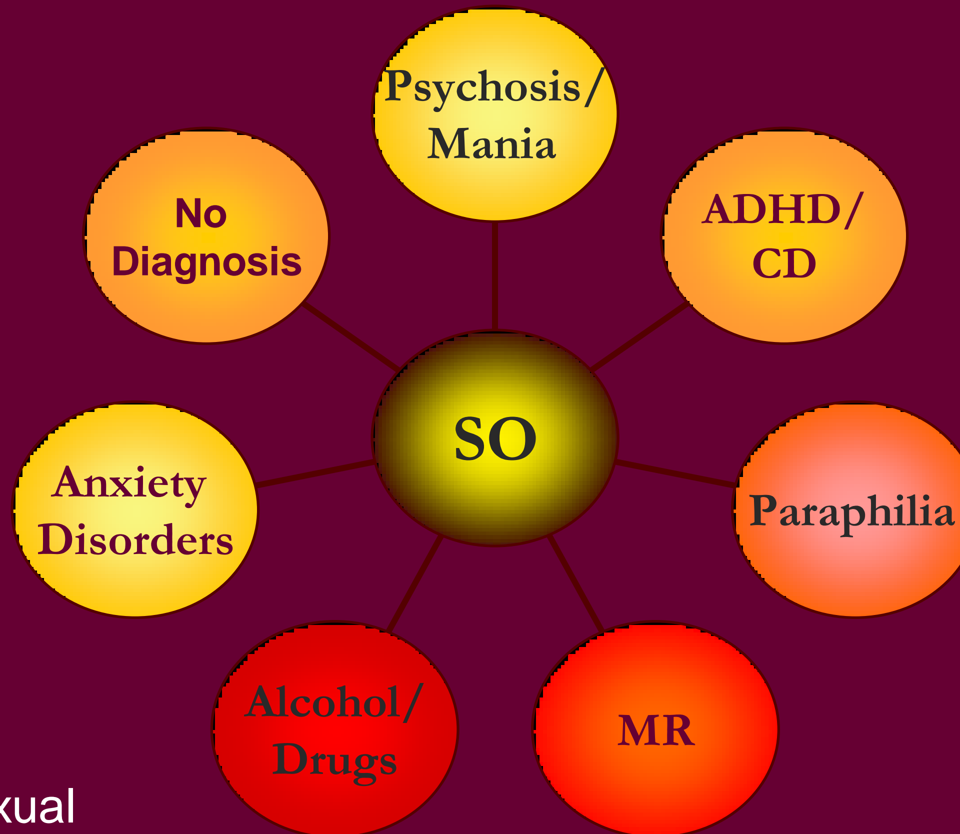
- Accurate diagnosis & differential diagnosis
- Use of evidence based treatments
  - Treatment of co-morbid psychiatric, neurological and/or medical disorders
- Ongoing violence risk assessment

- Adolescent Sexual Offenders

Characteristics of Adolescent Sexual Offenders

- Global patterns of conduct problems
- Pervasive impairments in interpersonal relationships
- Isolated, opportunistic or impulsive sexual problem behaviors
- Time-limited, reactive patterns of over-sexualized behaviors
- Sexual offending behavior as a symptom of an underlying psychiatric, neuropsychiatric, neurological disorders

Differential Diagnosis of Sexual Offending Behavior



SO: Sexual Offending

Galli et al, 1998

- N=22 (♂, age 13 to 17 years)
- All subjects had molested ≥ 1 child
- Structured clinical interviews for DSM-III-R Axis I disorders
- All met lifetime DSM-III-R criteria for pedophilia (exception for the age requirement)

Prevalence of psychiatric disorders in adolescents who “sexually molested” other children (Galli et al, 1998)

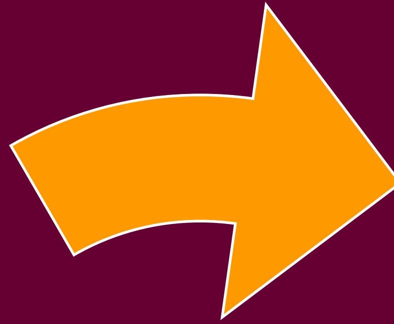
- 95% had 2 or ≥ paraphilias
- 94% CD
- 71% ADHD
- 82% mood disorder (12 [55%] for bipolar disorder)
- 55% anxiety disorder
- 55% impulse-control disorder
- 50% substance use disorder

Dent and Jowitt (2003) found the following in the juvenile sex offender population:

- Family dysfunction
- Learning difficulties
- Disordered behavior (ADHD/CD)
- Posttraumatic stress
- Substance abuse
- Mood disorders

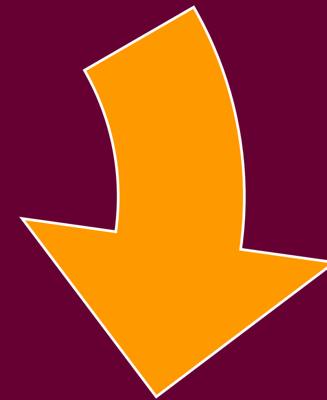
- Recognition and treatment of co-morbidities is important.

Recurrent

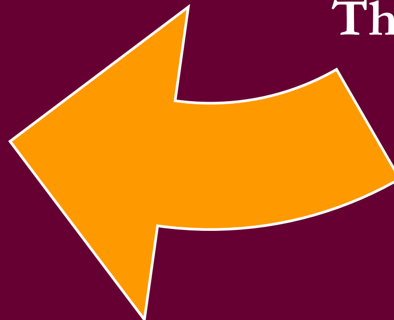


Intense

PARAPHILIA



Deviant sexual
Thoughts/fantasies



or
Behaviors

DSM-IV-TR definition of Paraphilia (criterion A)

DSM-IV-TR categories for paraphilias

- Pedophilia
- Exhibitionism
- Sexual masochism/sadism
- Transvestic Fetishism
- Voyeurism
- Fetishism
- Frotteurism
- Paraphilia N.O.S.

What else is known about paraphilic disorders?

- 50 named paraphilias in the sexological literature.
- Some appear to be quite rare while others, especially in their non-obligatory form, seem relatively common.
- Most frequently encountered paraphilias:
  - Pedophilia (which typically includes ephebophilia)
  - Voyeurism
  - Exhibitionism

Stages of development (natural course of paraphilic disorders)

- Stage I: Deviant sexual fantasies are first experienced around the time of puberty
- Stage II: Deviant behaviors are enacted after 2-3 years
- Stage III: Patterns of sexual deviant behaviors are established not until early adulthood

Age of onset

- 42% of paraphiliacs report deviant sexual arousal at 15 years of age
- 57% at 19 years of age

(Abel)

Co-morbidity

- Mood disorders
- Anxiety disorders
- Substance abuse disorders
- CD/ADHD
- Paraphilias

Assessment

Medical work-up

- Some patients need a comprehensive medical (endocrinological) and laboratory work-up that should include a complete physical and vital signs, 12-lead ECG, hematological and biochemical tests, as well as hormonal studies.

Hormonal Profile

- Free testosterone
- Estradiol
- Luteinizing Hormone (LH)
- Follicle Stimulating Hormone (FSH)
- Sex hormone binding globulin
- Prolactin and TSH

Treatment Goals

1. Reduce the risk for future sexual misconduct/sexual offending behavior
2. Improve quality of life of the adolescent
   - Decrease psychiatric symptoms (suffering)
   - Increase personal autonomy
   - Reintegrate into the community, where appropriate

Issues to be addressed in treatment

- Acceptance of responsibility for behavior
- Identification of pattern or cycle of offense behavior
- Effective interventions to interrupt the sexual abuse cycle
- Victimization (e.g. sexual abuse) and issues for the offender
- Capacity for empathy with others, especially past victims

(National Task Force on Juvenile Sexual Offending,1993)

Treatment targets

- Role of sexual arousal in offenses
- Sexual identity
- Consequences of offending
- Family issues that support offending behaviors
- Cognitive distortions related to offending behaviors
- Expression of feelings
- Skill deficits (social and academic)
- Substance use/abuse
- Relapse prevention
- Management of concurrent psychiatric disorders

Treatment modalities

- Psychosocial
- Pharmacotherapy
  - Androgen (sex hormone) reducing medications (in selected cases)
  - Medications that do not lower androgens

Other treatment modalities

- Anger management
- Relaxation techniques
- Interventions that promote victim empathy and awareness
- Social skills building
- etc.

Rationale for pharmacotherapy

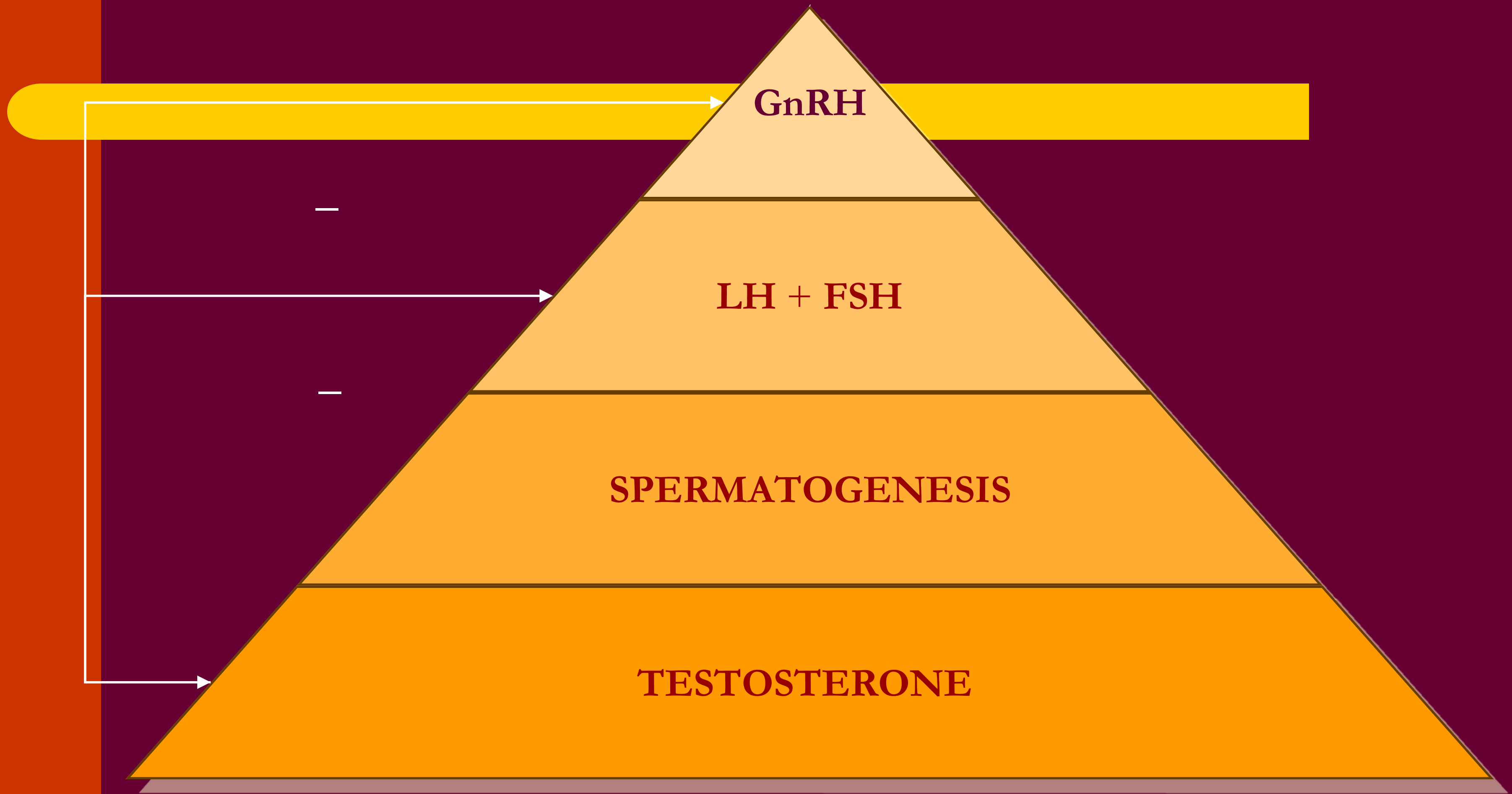
- Treat co-morbid psychiatric disorders.
- Specific symptoms are not fully amenable to other treatment modalities (i.e., psychotherapeutic interventions).
- Cravings for sexual acts become/are intense and/or overpowering.

Caveats

- As with all pharmacological treatments, the choice of which drug to use should be based on:
  - Presenting symptoms
  - Concomitant psychiatric disorders
  - Concurrent medical conditions

Normative and deviant sexual behaviors are modulated and influenced by intricate neurobiological systems

- Testosterone and dihydrotestosterone (sex hormones)
- Other hormones (e.g., GnRH)
- Neurotransmitters (e.g., 5-HT, dopamine, NE)
- Other brain substances: Neurosteroids



- Sex hormones exert a negative feedback on the HP unit

Testosterone lowering medications

- Luteinizing hormone-releasing-hormone agonists (LHRH-A).
- Medroxyprogesterone acetate (MPA).
- Cyproterone acetate (CPA).

Serotonergic agents (SSRIs)

- Easy dosing.
- Familiarity w/ SSRIs.
- Commonly used to Rx other psychiatric disorders.
- Benign side effect profile.
- No special work-up needed
- FDA status

Conclusion

- Adolescent sex offenders should have a comprehensive psychosexual assessment which should include a formal risk assessment.
- Offense specific treatment should be part of a more comprehensive treatment plan.
- The majority of adolescent sex offenders do not become adult offenders.

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