# APPENDIX B-TREATMENT OF SEXUAL OFFENDERS

# CHARLES L. SCOTT, MD

I. Green has established five major goals in the treatment of sex offenders:

1. Admitting guilt for offenses and recognizing deviant motivation;
2. Accepting responsibility for behavior and recognizing the need for help;
3. Understanding the dynamics of one’s behavior and working to resolve those dynamics;
4. Identifying one’s own cycle of deviant thought and behavior and developing and using coping strategies;
5. Making restitution in a variety of ways.
6. Behavioral Therapy-used to help persons block or reduce fantasies about deviant behaviors or objects.
7. Covert sensitization-teaches the patient how to imagine the negative social consequences resulting from initial urges to become involved in paraphilic behavior.
8. Olfactory aversion- Can pair noxious stimuli such as odors with deviant arousal. Ammonia is the most commonly used offensive odor.
9. Imaginable desensitization-Patient with assistance of therapist, generates scenes that are capable of re-creating the situation of having strong paraphilic urges and the emotions and feelings associated with them. The patient is taught muscle relaxation methods and then imagines paraphilic scenes that are able to generate the types of urges that typically have led to his committing a paraphilic act.
10. Satiation-Masturbates to the point of ejaculation to nondeviant fantasy and then switches post orgasm to the use of deviant fantasy during masturbation when orgasm cannot occur.
11. Arousal conditioning-masturbatory pleasure and orgasm paired with nondeviant fantasy.

## Cognitive Behavior Therapy

1. Helps to identify cognitive distortions offenders may have regarding their behavior.
2. Cognitive distortions and rationalizations of one paraphilic person may be startlingly different from those of another, even within the same category of paraphilia.
3. Cognitive behavior therapy can include techniques like relapse prevention and victim empathy training. In a research study comparing reoffense rates of offenders treated in an inpatient relapse prevention (RP) program with the rates of offenders in two (untreated) prison control groups, no significant differences were found among the three groups in their rates of sexual or violent reoffending over an 8-year follow up period (Marques et al., 2005)

## Marshall and Marshall (2014) describe integrating Andrews and Bonta’s *Principles of Effective Offender Treatment*, Ward’s “Good Lives Model,” and Miller and Rollnick’s *Motivational Interviewing* into a strength-based approach.

## Other Therapies

#### Group therapy

#### Victim empathy training

#### Psychoeducation

1. Prosocial behavior through skills training
2. Relapse prevention

In this training, offenders learn to identify precursors to sexually inappropriate behavior, learn cognitive and behavioral strategies to cope with precursor events, and learn to engage other supports in helping them cope with their problems.

## Pharmacotherapy

1. Interventions which reduce testosterone.

1. Medroxyprogesterone acetate (MPA, Depo Provera)-This is the most common pharmacologic agent prescribed for sexual offenders in the United States. MPA is a potent progestational agent whose principal biological effect is inhibition of gonadotropin secretion, when administered in high doses. Also works to induce testosterone-A reductase in the liver. Consequently, the secretion of testosterone by the tests is markedly reduced.

1. Reduces recidivism during treatment but paraphilic behavior returns when stopping the drug.
2. Most often given in weekly IM dosages. Loading doses are given at 500 mg per week for 4 weeks, then subjects are maintained on 150 to 800 mg/wk thereafter.
3. Adverse side effects include:

* Weight gain (approximately 50% of individuals)
* Decrease in sperm production;
* Hyperinsulinemic response to a glucose load;
* Gallbladder and gastrointestinal dysfunction;
* General symptoms of headaches, nausea, dizziness, fatigue ;
* Hypertension;
* Single case report of diabetes mellitus.
* Case report of pulmonary embolism.

1. In a five year follow-up of Oregon’s depo-Provera program, men actually receiving depo-Provera and in the community committed no new sexual offenses when compared to sex offenders who were recommended to take depo-Provera and did not take it and men deemed not to need MPA.
2. Desirable effects on sexual functioning for sex offenders:

1) Reductions in sexual drive;

1. Reductions in erotic fantasies-Research findings have suggested that sex offenders treated with MPA may experience suppression of deviant fantasies and behaviors earlier in treatment (one to two weeks) than suppression of nondeviant fantasies and behaviors (two to ten weeks) (Kravitz HM, Haywood TW, Kelly JR, et al:, 1995)
2. Reduction in sexual activity;
3. NOT feminizing-(generally does not cause gynecomastia).

* + - 1. **Cyproterone acetate (CPA)-**principal mode of action is on the androgen receptors, where it blocks the intracellular uptake of testosterone and the intracellular metabolism of the androgen. (Bradford, 1983) Also has a strong progestational action (Schering, 1983) Available in Canada and Europe but not yet in the United States.
         1. In pedophiles, evidence suggests that CPA suppresses pedophilic arousal and enhances nondeviant arousal. (Bradford, 1993)
         2. May be given orally or intramuscularly. Oral dose range for treating paraphilia is 50-200 mg per day; the IM dose range is 200-400 mg every 1-2 weeks.
         3. Effects are largely dose dependant, and the effects on sexual behavior are correlated with a reduction of plasma testosterone. A progressive reduction in testosterone concentrations may be documented with CPA doses over 150 mg/day.
         4. Possible side effects include:

Liver dysfunction;

Adrenal suppression;

Feminization with possible gynecomastia (up to 20% of patients);

Reduction of body hair with increase in scalp hair;

General side effects of fatigue, transient depressed episodes, hypersomnia.;

Up to 20% may have weight gain.

## e. Positive effects as related to sex offenders include:

1. Decrease erections and ejaculate
2. Decrease sexual fantasies
3. Decrease sexual drive
4. Often increase feeling of calmness
   * + 1. MPA and CPA are contraindicated for patients with disease affecting testosterone production and should be used with caution in treating patients with migraine, asthma, or cardiac dysfunction.(Kravitz, 1995).
       2. MPA and CPA both may produce side effects including weight gain, depression, hyperglycemia, hot and cold flashes, headaches, muscle cramps, phlebitis, hypertension, gastrointestinal complaints, gallstones, penile and testicular pain, and diabetes mellitus.
       3. Offenders taking MPA have a higher recidivism rate than those taking CPA. (Meyer & Cole, 1996)
       4. Other drugs that affect testosterone
          1. Flutamide (Eulixin)-nonsteroidal antiandrogen-inhibits androgen uptake-also used in the treatment of carcinoma of the prostate.
5. Lowers testosterone and thus may have thinning of facial or body hair, tenderness or swelling in the breasts.
6. Other side effects may include liver damage, diarrhea, change in urine color to amber or yellow-green.

## Leutinizing hormone-releasing hormone agonists (LHRH )-Leuprolide acetate (Lupron):

* + 1. Leuprolide acetate is one of several synthesized agonist analogs of LHRH, the hypothalamic hormone that stimulates gonadotropin release from the pituitary. LA produces a paradoxical effect on the pituitary, with initial stimulation of the release of luteinizing hormone (LH) and follicle-stimulating hormone (FSH), followed by inhibition after repeated administration.
    2. Appears to avoid unwanted side effects seen with MPA.
    3. Case report of a patient nonresponsive to MPA or CPA with complete cessation of deviant thoughts with a LHRH agonist. (Dickey, 1992)
    4. In a 2005 study of 5 pedophilic men treated with cognitive behavioral therapy and Lupron (Schober et al 2005), cognitive behavioral therapy augmented with LA significantly reduced pedophilic fantasies, urges, and masturbation; however, pedophilic interest did not change during the 1 year of therapy.

## Long-Acting Analogues of Gonadotropin-Releasing Hormone (GNRH). These analogues cause “down-regulation” of the gonadotroph cells, thus inhibiting (instead of stimulating) the secretion of luteinizing hormone, and to a lesser extent follicle-stimulation hormone. Testosterone secretion decreases dramatically.

1. Most studied GNRH is Triptorelin. Triptorelin-a long-acting gonadotropin-releasing hormone analogue. **Can be given in monthly injections.**
2. Promising effects (Rosler and Witzum, 2000)

1. Study of over 40 men with paraphilia have shown no recidivism over 5 year follow up period.
2. Markedly reduces intensity and frequency of sexual fantasies.
3. More potent than MPA and CPA.
4. Can be given parentally every one to three months.
5. Has fewer side effects that antiandrogens.
6. Side effects of Triptorelin in males include:
7. transient feelings of weakness
8. rash
9. hair loss
10. GI disturbances
11. Breast enlargement
12. Vertigo
13. Transient high blood pressure
14. Transient sight disturbances

#### B. Other drugs to treat sexual offending

1. Phenothiazines

* + - * 1. In general not primary treatment of a paraphilia. Consider if sexual deviant behavior secondary to psychosis.
        2. Benperidol-a butyrophenone. Has been shown to be significantly more effective than Thorazine and placebo in decreasing sexual interest. Tennent, 1974)

2. SSRI’s

Treatment response may reflect overlap with OCD like symptoms.

May be safely used in adolescence when compared to antiandrogen treatment.

Buspirone has been reported effective in reducing paraphilic fantasies.

##### C. Surgery

1. Stereotaxic neurosurgery (Bradford, 1985) (Grossman, p 351, 1999)
2. Stereotaxic hypothalamotomy, involves removal of parts of the hypothalamus to disrupt production of male hormones and decrease sexual arousal and impulsive behavior.
3. Mechanism not well understood and not used frequently due to its level of intrusiveness.
4. Surgical castration-Involves removing the testes (orchiectomy) but not the penis.
5. Mediates sexual behavior by suppressing the sexual drive through reduction of plasma testosterone.
6. **Studies of sexual offenders post castration show recidivism rates of less than 5%.** (APA Task Force, p 104, 1999)
7. Recent legislation in permitting voluntary orchiectomy in Texas was coupled with a requirement for follow-up research on recidivism. (Texas Government Code, 1997)