Current Psychiatry

CASES THAT TEST YOUR SKILLS

A psychiatrist becomes morally outraged while hearing a convicted pedophile's story. How can the therapist confront his emotions without compromising the evaluation?

Nothing more than feelings?

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HISTORY REPEAT OFFENDER

Mr. V, age 68, was incarcerated for 13 years for two separate pedophilia convictions. During that time, he passed numerous rehabilitative courses. With several years left on his sentence, he was paroled on condition that he undergo a bilateral orchiectomy,

Eight months later, Mr. V complained to his primary care physician that he could not have sex with his girlfriend, even after taking 50 mg of sildenafil, which he had obtained from a friend. He requested testosterone injections to allow him to have intercourse. After consulting an endocrinologist, the physician ordered Mr. V to undergo a psychiatric assessment before receiving testosterone. He was referred to our outpatient clinic.

During our evaluation, Mr. V described both pedophilia incidents. In the first, he had fondled a 14-year-old girl who was a friend of his family. He pled guilty to a charge of inappropriate sexual contact with a minor and was sentenced to 3 years in a state prison for sex offenders.

Less than 2 years after he was paroled, Mr. V said, he fondled his 12-year-old granddaughter. He said his daughter "should have known better" than to leave him home alone with the child. Again he was convicted of illegal sexual relations with a minor and sentenced to 10 years at the state hospital for the criminally insane.

As Mr. V describes his past offenses, we begin feeling tremendously uneasy. Although forthcoming, he blandly denies responsibility for either incident. He acknowledges that society views his actions as wrong, but he never indicates that he believes them to be wrong. At times he tries to normalize his behavior, saying "What man would have acted differently?"

Mr. V is polite and appropriate and promises to abide by our recommendation, yet he sees no reason for us to deny his request and no connection

Box 1

The typical pedophile: male, middle-aged, and in denial

Most pedophiles are unemployed men ages 30 to 42.[1] In one clinical study, 70% of convicted pedophiles reported fewer than 10 victims, and 23% reported 10 to 40 victims.[1] Conte et al[2] found that the average number of victims per offender may exceed 7.

Poor insight and denial are common among pedophiles. In one study that explored the relationship between denial of hostility and psychopathology, 37 of 82 patients denied the charges against them.[3] The study's authors state that their data "support the contention that alleged sex offenders' self-reports and their scores on obvious-item hostility inventories are highly suspect and should not be accepted at face value."

During evaluation, a sex offender who minimizes his psychopathology is less likely to admit to hostility, whereas those who exaggerate psychopathology usually acknowledge more hostility. In one study,[3] no offenders who denied charges acknowledged psychopathology, but offenders who denied allegations admitted to less hostility than those who did acknowledge them.

between his criminal record and the nature of his crimes or the terms of his parole. His denial and lack of insight are typical of convicted pedophiles (*Box 1*).

How should the psychiatrist manage his negative feelings toward Mr. V?

- **ignore or suppress them**
- **try to see the patient's viewpoint**
- **acknowledge them, but continue to assess the patient**

The authors' observations

Anyone evaluating Mr. V would be inclined to treat or dismiss him, or to suppress his or her feelings to avoid prejudice.

Treat or dismiss. As physicians, we are trained to "First, do no harm." In this case, however, we must consider who could be harmed by treatment or dismissal.

"First, do no harm" is usually taken to mean "no harm to the patient" but could also be interpreted as "no harm to society." Even if testosterone treatment did not physically harm Mr. V, activating his sex drive could endanger society by spurring him on to molest another child (*Box 2, page 85*). The treatment could also harm Mr. V by making it easier for him to violate parole.

Although failure to treat Mr. V's sexual dysfunction would likely pose no harm to society, not assessing him might endanger society by clearing the path toward this treatment.

Avoiding prejudice. When facing an unpleasant task, people often tell themselves consciously or unconsciously that their reaction is wrong and that they must carry on.[7] Our revulsion toward Mr. V prompted us to be dispassionate and objective, but suppressing our emotions altogether could have obscured potentially serious objections. At the same time, giving ascendancy to negative emotions without questioning them could harm the patient—or at least obscure an opportunity to do good.

When treating patients such as Mr. V, we must not dismiss our feelings—however uncomfortable or unprofessional they might seem—so that we

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can manage them appropriately. Don't be ashamed of your feelings—or at least be aware of your shame.

In such cases, these important steps can minimize the risk of compromising treatment or assessment:

• **Be aware of your feelings.** Reflecting on countertransference after the session, either alone or with other therapists, can help you recognize your feelings.

• **Seek peer supervision** when evaluating a patient such as Mr. V to help identify potential "blind spots."

• **Be aware of your limitations.** Hubris is among a therapist's most serious potential pitfalls. We all have strengths and weaknesses and should be mindful of them.

At this point, you would:

- **immediately reject Mr. V's request**
- **wait and consider the facts**
- **seek additional advice from colleagues before deciding**

The authors' observations

We took a passive-neutral stance. Sitting with Mr. V without deciding a course of action gave us time to assess our own reactions and limitations and how they might influence our actions.

CONSULTATION: OTHER OPINIONS

The examining psychiatrist (a psychiatric resident) sought advice from an experienced geriatric psychiatrist, a neuropsychologist, and other residents. We discussed our countertransference toward Mr. V and provided mutual supervision. We then acknowledged that none of us had expertise in treating

pedophiles and that treating an unfamiliar mental condition would be unethical.

The authors' observations

In requesting other opinions, we also weighed these important questions:

Is Mr. V violating parole by requesting testosterone injections and taking (unprescribed) sildenafil? We felt we could not rightfully answer this question, since our expertise in the standard of care for patients such as Mr. V was insufficient and any recommendation would be ill-informed.

Sildenafil use is fairly common among convicted sex offenders, as evidenced by the recent controversy over Medicaid providing the drug to this group (see *Related resources, page 86*).

Assuming the testosterone injections promote intercourse, would they increase Mr. V's arousal? Hall found that offenders who can voluntarily and completely inhibit sexual arousal are less deviant when not attempting to inhibit arousal than are those who cannot completely inhibit arousal.[8]

Hall, however, urges clinicians to consider variables that influence sexual response before determining how arousal affects an offender's behavior. With no objective measure of sexual arousal, it is unclear whether increasing Mr. V's testosterone would heighten it—and his potential threat to society.

The Abel Assessment of Sexual Interest was devised to determine sexual pathology, but evidence suggests this test is clinically unreliable.

Would enhancing Mr. V's arousal increase his risk of recidivism? Although some studies have found that castration decreases a sex offender's sexual activity, evidence suggests that sexual responsiveness after castration varies considerably. Heim found that:

- 31% of castrates could still have intercourse
- rapists are more sexually active than pedophiles after castration
- men ages 46 to 59 experience a greater reduction in sexual behavior than do men age <45 after castration.[9]

> **Box 2**
>
> ### Pedophilia: A hidden epidemic
>
> Sexual abuse of children and adolescents is common but underreported.[4]
>
> The National Crime Victimization Survey estimates that 110,000 sexual assaults in 1996 involved victims ≤age 12, yet only one-third of these assaults were reported to police.[5] Data from law enforcement agencies in 12 states indicate that 67% of victims who reported a sexual assault were age <18, 34% were age <12, and 1 in 7 were age <6.[6]

These findings suggest that castration's effects on male sexuality are unpredictable, making it an unreliable treatment for incarcerated sex offenders.[9] They also suggest that enhancing Mr. V's arousal could increase his odds of recidivism. Stone et al,[10] however, recorded recidivism rates of 3% across 30 years among castrated sex offenders, compared with 58% among non-castrates.

What standard of care applies to Mr. V? Treating pedophilia is difficult and poorly understood. Psychotherapy is considered an adjunct to medication or surgery. Surgical interventions are akin to punishment, whereas medications—well-studied and often augmented with psychotherapy—are associated with high recidivism rates.[11-14]

Surgery. Orchiectomy is by far the most common surgical intervention. Experimental procedures have targeted stereotaxic ablation of specific parts of the brain, usually the hypothalamus or amygdala, but these techniques have not been adequately studied in humans.[11] Even so, testosterone therapy can restore sexual function after castration.[10]

Medications. Antiandrogens such as medroxyprogesterone acetate (MPA) inhibit intracellular uptake of androgens (such as testosterone) by

Related resources

- Sex offenders get Medicaid-paid Viagra. *Associated Press* May 22, 2005. http://msnbc.msn.com/id/7946129/.
- Conte JR, Wolf S, Smith T. What sexual offenders tell us about prevention strategies. *Child Abuse Negl* 1989;13:293-301.
- U.S. Department of Justice, Bureau of Justice Statistics. Statistics on sex offenders and victims. www.ojp.usdoj.gov/bjs/abstract/saycrle.htm.

DRUG BRAND NAMES

Goserelin • Zoladex
Leuprolide • Eligard, others
Medroxyprogesterone acetate • Depo-Provera, others
Nafarelin • Synarel
Sildenafil • Viagra
Triptorelin • Trelstar Depot

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blocking their binding to the receptor.[12] MPA is most frequently used in the United States.

Long-acting analogs of gonadotropin-releasing hormone (GnRH), such as leuprolide, nafarelin, goserelin, and triptorelin, have shown efficacy in early studies.[12] These agents down-regulate gonadotroph cells, inducing severe but reversible hypogonadism with few other side effects.

Although decreased libido is a common side effect of selective serotonin reuptake inhibitors (SSRIs), use of these agents to reduce sex drive in convicted pedophiles has not been studied. Because onset of decreased libido with SSRI use is unpredictable, we cannot recommend their use to reduce sex drive in convicted offenders.

Psychotherapy. Power[14] nicely outlines the elements of psychotherapy for pedophilia:

- explanation and education
- manipulating the environment
- suggestion, including hypnosis and persuasion
- superficial analysis
- deep-transference analysis
- sublimation.

If Mr. V commits another sexual offense after receiving testosterone, can the doctors who prescribed, authorized, or gave the injections be held liable?

Stone et al[10] draw several germane conclusions:

- Sentencing laws are often unclear or do not take into account scientific research on pedophilia. For example, psychological testing often is not ordered before a treatment is mandated, even though knowing the patient's psychological profile and the nature of his predilections are crucial to treatment and prognosis.[12]
- Many laws do not suggest an instrument of implementation. For example, most laws that mandate a patient evaluation do not specify whether a licensed psychiatrist, psychologist, or other clinician should evaluate the patient.
- Many laws directed against pedophilia are punitive in nature. Mandated treatment—or the informed consent that precedes it—is often inadequate,[10] and physicians can be held liable in either case. However, we could not determine the liability that could result from enhancing a convicted pedophile's libido.

Bottom Line

Suppressing negative feelings during an emotionally difficult consultation can obscure a potentially serious problem or objection. Don't let feelings guide treatment but stay aware of them so they can be properly managed. Seek advice from colleagues or superiors when troubled by a patient or the presenting request.

REFERRAL: TREATMENT ADVICE

We referred Mr. V back to his primary care physician and advised the doctor to:

- discuss the testosterone treatment request with physicians who treated Mr. V at the state prison

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- call our hospital's attorney to investigate the legal implications of treating Mr. V.

We also recommended against enhancing Mr. V's libido, given his poor insight and denial and the primary care physician's lack of expertise in this treatment. A recent check of Mr. V's electronic record indicated that he was not given medication to enhance sexual performance.

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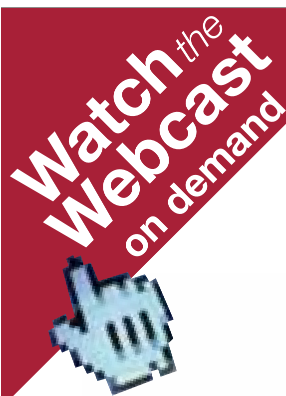

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