

Sex Offender Treatment

The Clinical Importance of Thorough Evaluation of Axis I Comorbid Diagnoses in Male Sex Offenders

by Martin Kafka

Competent clinicians and researchers routinely wrestle with the complexity of deriving empirically validated risk factors and treatment modalities associated with reducing the serious effects of repetitive sexual coercion. In the meantime, a research-based literature has slowly developed that documents Axis I psychiatric disorders that appear to be associated with paraphilic sex offending. This literature is of particular relevance for clinicians as well as for our clients, as these Axis I disorders, as will be enumerated, can be easily overlooked during clinical assessment. In addition, I will suggest in this article that appropriate diagnosis, psycho-education, and pharmacological treatment of these disorders will enhance compliance for the necessary rigorous psychotherapeutic treatments.

Comorbid Conditions

Research on Axis I comorbid conditions associated with sex offending is still comparatively new. The published data that is available suggests that most paraphilic sex offenders have at least one, but usually several, lifetime psychiatric diagnoses. The most common psychiatric diagnoses may be mood disorders, especially chronic low-grade depression (dysthymic disorder, early onset subtype), major depression or bipolar-spectrum disorders, anxiety disorders (social phobia, PTSD), psychoactive substance abuse (alcohol abuse, cocaine abuse), and impulsivity disorders (attention deficit-hyperactivity disorder, conduct disorder).

Obviously, this is a "laundry list" of psychiatric diagnoses and each paraphilic sex offender may have none, one or several of these disorders. I would emphasize, however, that mood disorders, psychoactive substance abuse disorders and attention deficit hyperactivity disorders (ADHD) in particular are most often overlooked and actually represent a diagnostic challenge even for the

most sophisticated clinicians. In addition, each of these disorders is associated with behavioral impulsivity and disinhibition.

Combinations of these diagnoses can be associated with a lowered threshold for impulsivity. Dysthymic disorder, which is a psychiatric diagnosis, first codified in 1980, can be insidious and have childhood or adolescent age of onset, is commonly associated with social anxiety (social skills deficits) and low self-esteem. It has been noted to have a lifetime prevalence of 3% in large community-based studies in the United States. The most recent research, likely to be incorporated in DSM-V, suggests that the core symptoms of dysthymic disorder do not typically include the neurovegetative features associated with major depression, but instead include pessimism, irritability, social withdrawal, fatigue and low motivation. In comparison to women, males who are depressed are less likely to self-report depressed mood and tend to respond to dysphoric affects, like depression, with an action-oriented response.

Bipolar Disorder

Bipolar disorder, or manic-depression, used to be comparatively easy to diagnose. Overtly manic behavior is hard to miss and can usually be uncovered during clinical inquiry. In the last 15 years, however, "bipolar spectrum" disorders have been identified. Hypomania, characterized by, at times, relatively brief periods of symptoms, can include periods of mild euphoria, racing thoughts, increased energy, irritability, and risk-taking behaviors. At times, clients with hypomania may describe what first sounds like a remission of depression. Clinicians must look for recovery periods when psychosocial functioning is almost "too good," in as much as most clients with bipolar spectrum disorders spend much more time in the depressed phase.

Bipolar spectrum disorders have been identified in about 6% of the population in community-based studies. Antidepressants can cause a "dramatic improvement" or behavioral activation followed by relapse into worse depression or a combination of both manic and depressive symptoms (mixed

states and rapid cycling). Thus, pharmacological treatments that only target depression can "unmask" a bipolar spectrum diathesis and exacerbate impulsivity disorders. It has been suggested that the average person with bipolar illness sees many mental health clinicians before appropriate diagnosis and treatment is provided.

Attention Deficit Hyperactivity Disorder

The recognition that attenuated forms and significant disability associated with childhood Attention Deficit Hyperactivity Disorder (ADHD) enduring into adulthood is also a relatively recent empirically validated diagnostic development. Childhood onset ADHD affects approximately 5% of children. Unless your clinical practice is exclusively with children or adolescents, most "adults" who grew up with ADHD were not diagnosed during their formative years because such a diagnosis did not exist. If clinicians are not specifically inquiring as to early childhood school and social behaviors and using the specific diagnostic criteria associated with ADHD, this condition, like the aforementioned ones, is being overlooked. ADHD is associated with both an earlier onset and increased severity of other psychiatric conditions, such as bipolar disorder, psychoactive substance abuse and major depression.

Adults with ADHD, while less likely to still be overtly hyperactive, can be persistently disorganized (i.e. procrastinate), inattentive, prone to anger episodes, have low self-esteem, act impulsively and typically have poor self-observational skills. Some ADHD adults have persistent learning disabilities. In my clinical research, ADHD, dysthymic disorder, early onset subtype, bipolar spectrum disorders and psychoactive substance abuse are predominant Axis I disorders specifically associated with socially deviant sexual behaviors.

Sex Offender Relapse

There is direct relevance for the role of these conditions in the behavioral cycle associated with sex offender relapse. Sex offenders, for

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example, have been noted to have certain “dysphoric affects” that precede sexual preoccupation and impulsivity. These affects can include anger/irritability, boredom, sadness and “loneliness.” These are certainly the affects associated with mood disorder vulnerability and ADHD as well as psychoactive substance abuse. Thus, it is not only that sex offenders may experience these affective precursors, but they have markedly increased vulnerability to experience these dysphoric affects and, at the same time, have less ability to cope effectively with these feeling states because of undiagnosed and untreated Axis I disorders. Next, consider the possibility that males who drop out of psychotherapeutic treatments for sex offending do so, in part, because they chronically have problems sustaining motivation, cannot effectively manage repetitive practices and may have subtle learning disabilities.

Reducing Sexual Arousal

Lastly, there is a growing research-based literature suggesting that treating Axis I comorbidity directly reduces deviant sexual arousal and sexual preoccupation. This is especially true for the use of serotonergic antidepressants, now the most commonly prescribed pharmacological agents for sex offenders in North America. In addition, I have reported that psychostimulants can be safely added to antidepressants when clinically indicated. The integration of psychiatric diagnosis and pharmacological treatments for sexual offenders lags behind this combined treatment in comparison with many other psychiatric disorders. We need more research and more rigorous methodology as well as treatment studies before these concepts become more integrated into the “mainstream” thinking about sexual offenders.

Further Resources

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