

# Psychotic and sexually deviant

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During evaluation for psychotic symptoms, Mr. P, age 21, reveals that he has been viewing child pornography for 2 years, but has not acted on his fantasies. How would you treat him?



## How would you handle this case?

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### CASE Paranoid and distressed

Mr. P, age 21, is a single, white college student who presents to a psychiatric emergency room with his father at his psychotherapist's recommendation. The psychotherapist, who has been treating Mr. P for anxiety and depression, recommended he be evaluated because of increased erratic behavior and paranoia. Mr. P reports that he has been feeling increasingly "anxious" and "paranoid" and thinks the security cameras at his college have been following him. He also describes an increased connection with God and hearing God's voice as a commentary on his behaviors. Mr. P denies euphoria, depression, increased goal-directed activities, distractibility, increased impulsivity, or rapid speech. He is admitted voluntarily to the psychiatric unit for further evaluation.

During the hospitalization, Mr. P discloses that he has been viewing child pornography for 2 years, and during the past 6 months he has been distressed by the intensity of his sexual fantasies involving sexual contact with prepubescent girls. He also continues to experience paranoia and increased religiosity.

Mr. P says he began looking at pornography on the internet at age 14. He says he was watching "regular straight porn" and he would use it to masturbate and achieve orgasm. Mr. P began looking at child pornography at age 19. He stated that "regular porn" was no longer sufficiently arousing for him. Mr. P explains,

"First, I started looking for 15- or 16-year-olds. They would work for a while [referring to sexual gratification], but then I would look for younger girls." He says the images of younger girls are sexually arousing, typically "young girls, 8 to 10 years old" who are nude or involved in sex acts.

Mr. P denies sexual contact with prepubescent individuals and says his thoughts about such contact are "distressing." He reports that he has viewed child pornography even when he wasn't experiencing psychotic or mood symptoms. Mr. P's outpatient psychotherapist reports that Mr. P first disclosed viewing child pornography and his attraction to prepubescent girls 2 years before this admission.

### What would you do first?

- start Mr. P on an atypical antipsychotic
- report his child pornography viewing to the police
- refer him back to his outpatient psychotherapist
- consult with a specialist in paraphilias

### The authors' observations

DSM-IV-TR diagnostic criteria for pedophilia (*Table 1, page 38*)<sup>1</sup> are based on a

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### Clinical Point

Although most schizophrenia patients do not exhibit sexual deviancy, sexual content in hallucinations and delusions is common



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**Table 1**

#### DSM-IV-TR diagnostic criteria for pedophilia

- A) Over a period of  $\geq 6$  months, recurrent, intense sexually arousing fantasies, sexual urges, or behaviors involving sexual activity with a prepubescent child or children (generally age  $\leq 13$ )
- B) The person has acted on these sexual urges, or the sexual urges or fantasies cause marked distress or interpersonal difficulty
- C) The person is age  $\geq 16$  and  $\geq 5$  years older than the child or children in criterion A

**Note:** Do not include an individual in late adolescence involved in an ongoing sexual relationship with a 12- or 13-year-old

**Source:** Reference 1

**Table 2**

#### DSM-IV-TR diagnostic criteria for a paraphilia

The essential features of a paraphilia are recurrent, intense sexually arousing fantasies, sexual urges, or behaviors generally involving:

- A) nonhuman objects, the suffering or humiliation of oneself or one's partner, or children or other nonconsenting persons that occur over a period of  $\geq 6$  months
- B) The behavior, sexual urges, or fantasies cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

**Source:** Reference 1

history of sexual arousal to prepubescent individuals. A subset of sex offenders meet criteria for a paraphilia (*Table 2*),<sup>1</sup> an axis I disorder, and a subset of sex offenders with paraphilia meet diagnostic criteria for pedophilia. Dunsieith et al<sup>2</sup> found that among a sample of 113 male sex offenders, 74% had a diagnosable paraphilia, and 50% of individuals with paraphilia met criteria for pedophilia.

Little is known about the relationship between sexual deviancy and psychosis. Wallace et al<sup>3</sup> linked databases of individuals convicted of serious crimes with public mental health system contact and found a significant association between schizo-

phrenia and sexual offending. Convicted sex offenders were nearly 3 times more likely than non-offenders in the mental health system to be diagnosed with schizophrenia. This effect was stronger for individuals with co-occurring substance abuse. However, few sex offenders had a schizophrenia diagnosis (18 out of 846 offenders). Similarly, Alish et al<sup>4</sup> found that 2% to 5% of sex offenders are thought to have schizophrenia. In a sample of sex offenders with schizophrenia, patients almost always displayed psychotic symptoms at the time of sexual offense, and 33% to 43% showed symptoms of psychosis directly related to the offense.<sup>5</sup>

Although most schizophrenia patients without a history of sexual offenses do not exhibit sexual deviancy, sexual content in hallucinations and delusions is common.<sup>6</sup> Confusion about sexual identity and the boundaries of one's body are common and may contribute to sexual deviancy.<sup>6</sup> Psychiatric inpatients without a history of sexual offenses—including but not limited to psychotic patients—have higher rates of sexually deviant fantasies and behaviors compared with those without psychiatric illness.<sup>6</sup> In one survey, 15% of men with schizophrenia displayed paraphilic behaviors and 20% had atypical sexual thoughts.<sup>7</sup>

Alish et al<sup>4</sup> found that pedophilia was not necessarily linked to psychotic behavior or antisocial personality features when comparing pedophilia rates in individuals with or without schizophrenia. In a sample of 22 adolescent males who sexually molested a child at least once, axis I morbidity was common, and 55% met criteria for bipolar disorder.<sup>8</sup>

### Few experts in paraphilias

A patient who endorses deviant sexual fantasies should be evaluated by a mental health professional with specialized training in paraphilias. Although paraphilias are

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**Table 3**

**Psychosexual evaluation**

Aspect of evaluation	Measures
Sexual behavior history	History of sexual abuse Childhood exposure to sex Masturbation history Preferred sexual partners Kinsey Scale
Sexual addiction or compulsion	Total Sexual Outlet measure Amount of time in sexual fantasy Financial, legal, or social cost of sexual behavior Prior treatment of sexual behavior
Sexual interests	Sex, age, and number of partner(s) Review of criteria for all paraphilias (exposing, voyeurism, cross-dressing, sadistic or masochistic interests)

**Clinical Point**

Clinicians are legally required to report if a patient discloses current sexual behavior with a child with a plan to continue the behavior

not recognized as a subspecialty in psychiatry, diagnosing and treating patients with a paraphilia requires additional training. There is a scarcity of psychiatrists trained to evaluate and treat patients with paraphilias.

**Sexual evaluation.** Evaluating a patient who presents with problematic sexual behaviors includes performing a comprehensive psychiatric history with a focus on sexual history. A psychosexual history is distinct from general psychiatric evaluations because of the level of detail regarding a sexual history (*Table 3*). In addition to the clinical interview, objective testing to determine sexual interests may be useful in some patients (*Table 4*).<sup>9</sup>

Actuarial tools—risk assessment instruments based on statistically significant risk factors—are valid tools for determining the risk of sexual reoffending. There are several validated actuarial tools in the assessment of sex offender recidivism, such as the Static-99R,<sup>10</sup> Stable-2007,<sup>11</sup> and the Sex Offender Risk Appraisal Guide.<sup>12</sup> However, these tools are used for sex offenders, and would not be used for individuals who have not committed a sex offense, such as Mr. P.

Conducting a psychosexual evaluation in a psychiatric hospital is limited by the

confounding presentation of active major mental illness, medications, and medicolegal implications. A valid psychosexual history cannot be obtained when the patient is unable to participate in a meaningful historical report. Mr. P’s attention difficulties and psychosis interfered with his ability to answer questions in a reliable, consistent manner. A psychosexual history should be reserved for when a patient is no longer presenting with significant symptoms of major mental illness.

**Medicolegal aspects** of a psychosexual evaluation may include mandated reporting, confidentiality, and documentation. Mental health professionals are mandated to report to law enforcement or child welfare agencies when they observe or suspect physical, sexual, or other types of abuse in vulnerable populations such as children. In psychosexual evaluations, the evaluator is legally required to report if a patient discloses current sexual behavior with a child with a plan to continue to engage in the behavior. In Mr. P’s case, there was no duty to report because although he described viewing child pornography and had a sexual interest in prepubescent individuals, he did not report a history of engaging in hands-on sexual behaviors with

Table 4

## Objective testing to determine sexual interests

Test	Results
Penile plethysmograph	Measures penis circumference with a mercury-in-rubber strain gauge. Used clinically by measuring circumferential changes in the penis while the patient is listening to audio or video stimuli of various sexual vignettes
Abel Assessment for Sexual Interests-3	An objective method for evaluating deviant sexual interest uses noninvasive means to achieve objective measures of sexual interest. The subject's visual response time is measured while viewing images of males and females of varying age. Visual reaction time is correlated with sexual interests

Source: Reference 9

children or impulses to do so. When an individual has engaged in sexual contact with a prepubescent individual, reporting is not mandated unless the individual continues to engage in sexual behavior with a minor. Mental health professionals are not responsible for calling the police or alerting authorities after a crime has been committed.

The commission of a crime is not an exception to confidentiality. If a clinician reports a patient's criminal activity to the authorities without the patient's consent, he or she has breached confidentiality. It is unknown whether Mr. P and his psychotherapist had a discussion about the legal consequences of his viewing child pornography. No legislation requires clinicians to report patients who view child pornography.

The relationship between viewing child pornography and pedophilia is unclear. Some child pornography viewers are pedophilic, others are sexually compulsive, and others are viewing out of curiosity and have no sexual deviance. Seto et al<sup>13</sup> suggested that child pornography offenders show greater sexual arousal to children than to adults. Persistent child pornography use is a stronger diagnostic indicator of pedophilia than sexually offending against child victims.<sup>13</sup> A clinician who learns that a patient is viewing child pornography should take a detailed sex-

ual history, including a review of criteria for paraphilias. In addition, when appropriate, the clinician should perform a risk assessment to determine the patient's risk of engaging in sexual offenses with children.

**OUTCOME** Expert consultation

We start Mr. P on risperidone, 1 mg/d, to treat his paranoia and request a consultation with an expert in paraphilias to determine if Mr. P has a paraphilia and to discuss treatment options.

Mr. P's initial diagnosis is psychotic disorder not otherwise specified. His viewing of child pornography and sexual interest in prepubescent individuals is not limited to his current mental status, and these interests persist in the absence of mood and psychotic states. Mr. P's viewing of child pornography and sexual attraction to prepubescent girls meet the diagnostic criteria for pedophilia. During hospitalization, we educate Mr. P about his diagnoses and need for continued treatment. We refer him to a sexual disorders outpatient clinic, which continues to address his deviant sexual interests.

**The authors' observations**

A meta-analysis indicates that a combination of pharmacologic and behavioral treatments coupled with close legal supervision seems to reduce the risk of

**Clinical Point**

Persistent child pornography use is a stronger diagnostic indicator of pedophilia than sexually offending against child victims

## Clinical Point

**Pedophilia treatment focuses on minimizing deviant sexual arousal through behavior modification, CBT, and medications**

### Related Resources

- Reijnen L, Bulten E, Nijman H. Demographic and personal characteristics of internet child pornography downloaders in comparison to other offenders. *J Child Sex Abus.* 2009;18(6):611-622.
- Hall RC, Hall RC. A profile of pedophilia: definition, characteristics of offenders, recidivism, treatment outcomes, and forensic issues. *Mayo Clin Proc.* 2007;82(4):457-471.

### Drug Brand Names

Leuprolide • Eligard, Lupron      Risperidone • Risperdal  
Medroxyprogesterone • Cytrin,  
Provera

### Disclosure

The authors report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

repeated sexual offenses.<sup>14</sup> Legal supervision is a general term to describe oversight of offenders in the community by supervisory boards, such as probation or parole, and tracking devices such as GPS. Currently, pedophilia treatment focuses on minimizing deviant sexual arousal through behavioral modification, cognitive-behavioral therapies, and testosterone-lowering medications, such as medroxyprogesterone or leuprolide. The decision to prescribe testosterone-lowering medication should be based on informed consent and the patient's risk of dangerous sexual behaviors.

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## Bottom Line

The relationship between paraphilia and psychosis is unclear. No law requires clinicians to report patients who view child pornography to authorities. Treatment starts with a thorough psychosexual evaluation. Therapies include behavioral modification, cognitive-behavioral therapies, and testosterone-lowering medications.