Disclaimers

• Previous pharmaceutical support (including attending lectures & advisory boards, unrestricted educational grants)
  – Janssen-Ortho Inc
  – Eli Lilly
  – Astra-Zeneca
  – Pfizer

• No specific knowledge of the exam
Canadian Academy of Psychiatry & the Law
CAPL
www.capl-acpd.org
Annual Winter Meeting
Fairmont Château Frontenac
(Québec City)
March 1-4, 2015
Forensic Residency Training

- Now officially a sub-specialty via the RCSPC
- First programs started in July 2012
- Talk to your program directors for further info
- Programs accepting applications in September for July start
Goals

• Be prepared for the Royal College Exam
• Have a practical framework to work from when facing a medico-legal issue
• Gain some comfort with medico-legal issues facing all psychiatrists
• Gain some comfort with Disorders of Sexual functioning
2014 Feedback

- Leave all questions until the end
- Give time for questions as they come up
- More concise - too much info for the time
- More detail – not enough info for the time
- You used to be more funny and energetic

- MORE SEX!!!
  - ie More on sexual disorders
The Compromise

• Have included a set of Bonus Forensic notes – recommend reading if you are neurotic and won’t get anxious over tonnes of superfluous detail
• If you find me annoying, just ignore me and read the notes
• What you hate to hear… it’s all in the notes 😊
  – Actually should also inspire further reading
DSM-5

- Will briefly highlight relevant issues:
  - No changes to Antisocial PD formally though possible new criteria
  - Sexual disorders are changing
Review Lecture
What is Forensic Psychiatry?

Forensic Psychiatry is a sub-specialty of psychiatry in which scientific and clinical expertise is applied to legal issues in legal contexts embracing civil, criminal, correctional or legislative matters; forensic psychiatry should be practiced in accordance with the guidelines and ethical principals enunciated by the profession of psychiatry

American Board of Forensic Psychiatry and adopted by AAPL and CAPL
What is Forensic Psychiatry?

In other words

Any interaction between Psychiatry & the Law

All of you will be practicing some aspect of Forensic Psychiatry on a daily basis!
Outline

I Criminal Law & Psychiatry
   Fitness
   NCR
   Violence & Mental Disorder

II Civil Law & Psychiatry
   Duty to Warn, Privacy & Confidentiality
   Informed Consent & Right to Refuse Tx
   Civil Commitment
   Torts/ Negligence

III Normal & Disordered Sexuality
Criminal Law & Psychiatry
Canadian Legal System

Criminal Law
- Canadian Criminal Code
- YCJA
- mainly Federal Laws (Tax, etc)
- the “State” vs the citizen
- Compensation = liberty
- “Beyond a reasonable doubt”

Civil Law
- Common Law
- Provincial Statutes
- Family law, mental health law
- One citizen vs another
- Compensation $$
- “Balance of probabilities”
Criminal Law & Psychiatry

• Fact witness
  – No compensation
  – Tell what saw/ heard/ etc
  – No opinion given
  – Testimony not optional

• Expert witness
  – Paid for time (job is to give an opinion)
  – Can choose not to testify (though could be breach of contract or could be compelled)
Court Ordered Assessments
Court Ordered Assessments

- The “bread & butter” of forensic psychiatry
  - Usually for NCR & Fitness

- Outlined in the criminal code

- Psychiatrists employed as expert witnesses to perform and testify to these issues

- Court is the employer
  - Pays the bill
Assessment Orders

• Court can order for
  – *Fitness to Stand Trial s2*
  – *Not Criminally Responsible on Account of Mental Illness s16*
  – Other reasons
    • infanticide
    • For disposition of an NCR/ unfit person
    • For a stay of proceedings if Unfit
    • For placement hearing

• Duration
  – 5 or 30 days
  – Can be renewed to a maximum of 60 days total
    • Longer breaches Charter of Human Rights
Assessment Orders

• Do not allow treatment

• Statements are protected & can only be used to
  – Determine Fitness or NCR
  – Determine Disposition
  – Challenge credibility of later statements
  – Establish perjury

• Inform accused of the Limits of Confidentiality
Fitness to Stand Trial
(In USA = Competency)
Fitness to Stand Trial

• Reasons
  – To safeguard the accuracy of any criminal adjudication
  – To guarantee a fair trial
  – To preserve the integrity and dignity of the legal process
  – To be certain the accused if found guilty, knows why he is being punished
Fitness to Stand Trial

“peine forte et dure” (long and hard punishment)
Fitness to Stand Trial

“Unfit to stand trial” (UST) means unable on account of mental disorder to conduct a defence at any stage of the proceedings before a verdict is rendered or to instruct counsel to do so, and, in particular, unable on account of mental disorder to (CCC§2):

(a) understand the nature or object of the proceedings
(b) understand the possible consequences of the proceedings, or
(c) communicate with counsel
How to evaluate

- Examine
  - Key personnel, procedures & goals of Court
  - Possible outcomes for the accused
  - Ability & willing to discuss case with lawyer

- McGarry’s criteria
  - 13 criteria examining
  - One of first formal sets of criteria
  - Based on US standard
Fitness Evaluation Tools

• Fitness Interview Test – Revised (FIT-R)

• The Nussbaum Fitness Questionnaire (NFQ)

• Georgia Court Competency Screening Test, Canadian Adaptation

**Precedence vs Prestige**

- **Precedence**
  - The legal tradition of following previous *higher court* decisions
  - *stare decisis* [let the decision stand]
  - The Supreme Court of Canada is the ultimate decision maker

- **Prestige**
  - Provincial courts do not have to follow the decisions of other provincial courts, but may look to respected courts as a guide
Limited Cognitive Capacity

  - A lawyer with Schizophrenia, Paranoid type
  - Stabbed the lawyer acting for the Law Society of Upper Canada while discussing his removal of his license to practice law
  - Had delusions about courts, kept firing lawyers
**Limited Cognitive Capacity**

- The trial judge erred in adopting the “analytic capacity” test for Fitness to Stand Trial
  - which requires that the accused be able to act in his own best interests
- The correct test was the “limited cognitive capacity” test, under which the presence of delusions does not vitiate the accused’s Fitness to Stand Trial unless the delusion distorts the accused’s rudimentary understanding of the judicial process.
  - Capacity to make a rational decision not required; only to tell lawyer your version of events
Limited Cognitive Capacity

• Ontario Court of Appeals decision
  – Has *stare decisis* in Ontario interpretation of the Federal Criminal Code

  – Has prestige influence in other provinces

  – Addresses the 3rd prong of the Fitness test “ability to communicate with counsel”
Fate of the Unfit

• The Crown may request the person be treated for up to 60 days to restore to Fitness – then back to court
• Cannot give ECT or psychosurgery
• Can treat even if the person is competent to refuse treatment!!
  – ie right to trial>right to own body
• If not restored, the accused comes under the Review Board’s jurisdiction
Not Criminally Responsible on Account of Mental Disorder (NCR)

[In the USA, Not Guilty by Reason of Insanity]
NCR

• Components of a Crime
  – Actus Reus
    • Illegal act committed consciously & voluntarily
  – Mens Rea
    • The guilty mind
    • Guilty act done purposely, knowingly or recklessly

• Both must be proven by the Crown beyond a reasonable doubt
Why not hold ill accountable?

• In olden days, recognition back to Aristotle’s time that children, mentally ill and delayed less responsible for actions – ie lacking the *mens rea*

• Punishing does not address purposes of the law so not serving a just purpose

• Canadian standard based on “McNaughtan Rule”
(1) No person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.
(2) Every person is presumed not to suffer from a mental disorder so as to be exempt from criminal responsibility by virtue of subsection (1), until the contrary is proved on the balance of probabilities.
CCC§ 16

(3) The burden of proof that an accused was suffering from a mental disorder so as to be exempt from criminal responsibility is on the party that raises the issue.
Bifurcated Trial

• The person must be proven Guilty of each offence first

• The NCR issue is the second part of the trial
NCR Defence Raised by the Crown

• In Canada, the Crown can raise a “defence” of NCR for the accused

• Can only occur after a finding of Guilty

• May allow more control of a mentally ill offender than the law usually does
Sample Clinical Case

- Please respect the confidentiality of this patient
Fate of NCR’s & Unfit
Review Boards

• Goal is to manage risk, NOT TO PUNISH
• Review Board consists of:
  – one psychiatrist
  – one of a doctor/ psychologist/ 2nd psychiatrist
  – the chair (usually a “legal type”)
  – a lawyer
  – a community person
• Two main questions:
  – Does the person pose a significant threat?
  – If so, how can the threat be reasonably managed (considering right to freedom vs risk)
Dispositions

• If there is a threat, then the disposition must be the least onerous and least restrictive available taking into consideration:
  – the need to protect the public from dangerous persons
  – the mental condition of the accused
  – the reintegration of the accused into society
  – the other needs of the accused
Dispositions

• **Absolute discharge** – “not a significant threat to the safety of the public”

• **If a threat, then least onerous/restrictive:**
  - Conditional discharge – like “probation” w/ conditions (eg drug tests, come to appointments, live a certain place)
  - Detained in hospital – like involuntary hospitalization w/ conditions & privileges (eg living in the community, passes to visit family, etc)
Bill C-14

• Amendment to Criminal code in January 2014
  – Clarifies “significant risk”
  – Dispositions codified as “necessary and appropriate in the circumstances” rather than least restrictive
  – High risk designation for NCR
    • Can only have detention order
    • Limited community access
    • Extends mandatory hearings to q 36 mo vs current 12 mo
Correctional Psychiatry
Correctional Psychiatry

• In 2002, there were 12 700 inmates in Canadian penitentiaries (Federal)
  – 97% were men
  – 84% of inmates have a current DSM-IV diagnosis
  – Substance highest at 75%
  – Excluding substance, 43% have a psychiatric disorder
  – Inmates have an 8% lifetime prevalence of psychotic disorders
  – The suicide rate is 3.7x higher than the general population

Bouchard Can J Public Health
2004; 95: Supp 1
Rates of Mental Illness in Federal Prisons

• More than one-out-of-ten (13%) men offenders in federal custody have been identified at admission as presenting mental health problems and this proportion has almost doubled since 1996/97 (7% to 13%).

• 29% of women offenders in federal custody were identified at admission as presenting mental health problems and this proportion has also risen more than twofold since 1996/97 (13% to 29%).

• Data Source: Offender Management System (OMS) extracted August 4th 2009
Annual report of the office of the correctional investigator
Correctional Service of Canada

• Howard Sapers
• 2008/9 & 2009/2010 Recommendation #1
  – The Service enhance its recruitment efforts for mental health professionals, including exploring the possibility of securing exemptions on rates of pay and to work with professional licensing bodies on scope of practice, training, portability and professional development.

• Raised annually since 2003
• Based on a sample of 1,300 incoming male offenders between February 2008 and April 2009:
  – 38.4% reported or were assessed at intake as showing symptoms associated with possible mental health problems that require follow-up assessment by a mental health professional. These included:
    • Obsessive-Compulsive (29.9%)
    • Depression (36.9%)
    • Anxiety (31.1%)
    • Paranoid Ideation (30.6%)
    • Psychoticism (51%)
  » Cited in 2011 Sapers report
– 78% of those reporting a substantial to severe dependence on alcohol also reported mental health distress (concurrent disorder)
– Aboriginal offenders were five times more likely to be categorized as severely dependent on alcohol as non-Aboriginal offenders
– 29% scored high on scales assessing depression and hopelessness; over 20% endorsed at least one item on the current or historical suicide indicator scale
– 20.10% of deaths in custody due to suicide

- 388 deaths in custody that occurred between 2000-2009 in the provinces of Alberta, British Columbia and Ontario (Winterdyk and Antonowicz 2011)
The USA Sheriff’s stats

• Torrey 2010
  – National Sheriff’s Association
• Now more than 3 x more seriously mentally ill persons in jails and prisons than in hospitals
  – in Arizona and Nevada almost 10x more mentally ill in prisons than in hospital
• “America’s jails and prisons have become our new mental hospitals”
• at least 16 % of inmates in jails and prisons have a serious mental illness
  – in 1983 a similar study reported that the percentage was 6.4 %
• 40 % of individuals with serious mental illnesses have been in jail or prison at some time in their lives
Antisocial Personality Disorder (ASPD)
Unfortunate results of a personality disorder diagnosis

• A reason not to treat a patient

• A reason to discharge from the emergency

• A reason to ignore other symptoms & diagnoses
Classification

- DSM-IV and -5
  - Antisocial PD (301.7)
  - Adult antisocial behaviour (V71.01)
- ICD-10
  - Dissocial Personality Disorder (F60.2)
- Psychopath, Sociopath
- manie sans délire, moral insanity
DSM-IV vs DSM-5

• Initially proposed to change all personality disorders to dimensional model
  – Categorical = is the trait present or not
  – Dimensional = how much of the trait is present

• Now all Axis 1 to 3 on axis one
  – We are more aware of the disorder and there is “no fundamental difference between disorders” all on same axis
DSM-IV vs DSM-5

- Proposal included ASPD impairments:
  - Self-function: egocentric (self-esteem from personal gain/power/pleasure) & goal setting based on personal gratification (absence of prosocial internal standards to conform to law/cultural society norms)
  - Interpersonal probs: empathy (lack of concern for feelings of others/no remorse) & intimacy (exploits relationships with deceit, coercion, dominance)
DSM-IV vs DSM-5

– Antagonism
  • Manipulative, deceitful, callousness, hostility
– Disinhibition
  • Irresponsible, impulsive, risk taker
  • Not due to substance/ GMC
  • Stable across time – they took out the exclusion of mental disorders (mania, schizophrenia)
DSM-IV to DSM-5

- Disruptive, Impulse-Control, and Conduct Disorders
  - ODD has 3 symptom clusters: anger/irritable mood, argumentative/defiant behaviour and vindictiveness – now includes severity rating
  - CD – specifier for “limited prosocial emotions” for kids who are callous/unemotional
  - Intermittent explosive d/o moved here and no longer limited to physical aggression
A Since 15, 3/7 of **CORRUPT**

B ≥18yo

C Conduct d/o symptoms <15yo
   Rule Violating LAD

D Not exclusively in Schizophrenia/Manic episode
Conduct Disorder

- A 3+ in past year & 1 in past 6 mo of 15 symptoms
- “Rule violating LAD”:
  - Rule violations cluster (3) - often stays out late <13 yo against parents wishes; run away 2x overnight or 1x longer; often truant before 13 yo
  - Lie/Theft cluster (3) - lies for goods/favours/avoid; stole w/o confronting victim; broken into car/house
  - Aggression to animals/people cluster (7) - bullies, starts fights, used weapon, physically cruel to animals or people, stolen while confronting victim, forced sex
  - Destruction of property cluster (2) - fire setting to cause damage; deliberately destroyed property
Epidemiology

• Occurs in 3% in ♂ & 1% in ♀ (DSM-IV-TR/ K&S)

• ➤ in urban, esp in mobile pts

• ➤ from large families

• Prison = up to 75%
Anxiety Comorbidity

Goodwin RD, Hamilton SP. Lifetime comorbidity of antisocial personality disorder and anxiety disorders among adults in the community. Psychiatry Research 2003; 117:159-166.
Comorbidity

No ASPD
ASPD
ASPD+Anxiety

MDE
Etoh
Substance
SI
Suic Att
What Causes ASPD?
Hypotheses

1. Biological
   a) Hereditary Hypothesis
   b) Neurotransmitters
   c) Altered Stress System Hypothesis
   d) Brain Dysfunction Hypothesis

2. Psychological

3. Social
1a - Hereditary Hypothesis
(Biology)

Danish cohort of n=14 427 adoptees
(Mednick 1984)
1b - Neurotransmitters

- **Serotonin**
  - 5HT - mixed results showing receptor gene (5HT1D beta) and transporter gene (5HTTT) and variable number tandem rpts associated with aggression
  - 5HT/5HIAA is lower in antisocials/aggressive personality
  - offspring of antisocial mothers have lower 5-HIAA (main 5HT metabolite)
  - Serotonin can also activate the stress system

- **Monoamine Oxidase A**
  - MAOA-uVNTR plus child abuse before 15 yo in males associated with impulsivity in males - possibly more impulsive so more abused

- **GABA**
  - inhibitory neurotransmitter
  - conflicting results currently regarding the role in ASP
• Locus ceruleus and NE projections help mediate fight or flight
Sympathetic Hypoarousal

- Seen in ASPD (both CNS & ANS)
- Lower electrodermal, cardiovascular & cortical (EEG) arousal at 15 yo vs non-criminals
- Adult criminals had lower heart rates at 15 yo vs non-criminals
- Lower resting heart rate (even at 3yo predicts aggression at 11 yo)
- Lower urinary catecholamine levels
HPA Axis

- Hypothalamus
- Hippocampus + Amygdala
- Corticotrophin-Releasing Factor (CRF)
- Arginine Vasopressin (AVP)
- Adrenal Cortex
- ACTH
- Circulation
- Cortisol
- Immune System
- Neuropeptides
- Neurotransmitters
Hypoactive HPA

- Low cortisol in ASPD & aggressive people (kids, teens & adults) [PTSD also has similar drops]
1d – Brain Dysfunction

Frontal Lobes

- Emotional control & regulation and executive function (including planning)
- Damage:
  - difficulties formulating plans
  - reduced ability to reason or recognize consequences
  - limited ability to maintain concentration & focus on long-term goals
  - reduced ability to produce and process language
  - difficulties with behavioural regulation
1d – Brain Dysfunction

Amygdala

- key mediator of emotions
- key mediator of conditioning and extinction of fear
- modulates/ is modulated by multiple systems including CRH projections to the locus ceruleus
- damage to amygdala produces attenuation of SNS and HPA axis to normal fear reactions
2 - Psychological Causes

- Transactional Model
- Attachment Theory
- Object Relations
Social Environment
- antisocial acts seen & occ encouraged
- master environment through antisocial acts
  - substances regulate anxiety

Chaotic & non-validating environment
- modelling of violence
- insecure attachment
- failure to develop soothing interjects
- lack of sense of mastery of environment

Biologic Deficits
- FAE/ FAS
- Birth Trauma
- Early Head Trauma
- Amygdala/ LC/ HPA/ Frontal Lobe/ 5HT due to trauma

Genetically vulnerable individual
- Impulsivity/ aggression
  - ADHD
- Alcohol/ Drugs
- Anxiety/ Depression
Course & Prognosis

• Poorly studied!
• But some improvements
  – 523 child guidance-clinic patients seen between 1922 and 1932
    • 90% evaluated in the mid-1950s
    • 94/523 had lifetime dx of ASPD
    • One third improved
      – 12% remitted
      – 27% improved
      – 61% had not improved

• Many had ongoing interpersonal difficulties, irritability, or marital discord

• Only 2% were considered completely free of personal or emotional problems

• Variety and severity of childhood behavioural problems was the best predictor of adult antisocial behaviour

• Improvement seen with:
  – > 40 years old at follow-up
  – Marriage (>50% improved in married group)
  – <1 yr incarceration
Treatment

• Decide what you are treating
• Pick specific targets
  – Substance use
  – Violence
  – Aggression
  – Impulsivity
• Treat comorbidity
  – Depression
  – Anxiety
  – Substance
  – ADHD
Treatment

• The National Institute for Health and Clinical Excellence (NICE)
  – Special Health Authority for England and Wales
  – Published guidelines in 2009 evaluating evidence for treatment
  – http://guidance.nice.org.uk/CG77
  – Unfortunately, generally poor body of literature limiting suggestions
What is RNR

• RNR is a correctional services approach to criminality
  – the *risk principle* asserts that criminal behaviour can be reliably predicted and that treatment should focus on the higher risk offenders
  – the *need principle* highlights the importance of criminogenic needs in the design and delivery of treatment
  – the *responsivity principle* describes how the treatment should be provided

» http://www.publicsafety.gc.ca
Treatment of Aggression

- Valproic Acid
- Carbamazepine
- SSRIs
- Lithium
- Atypical antipsychotics
- Typical antipsychotics
- $\beta$-blockers
- etc

Use these selectively and monitor the effect on target symptoms
Criminality and ADHD

- ADHD is common in prison populations/ASPD (up to 60%)
- Recent study of 25,656 patients in Sweden followed for 3 years
- Criminality decreased by 32% for men and 41% for women during medicated period vs non-medicated period

» Lichetenstein et al. NEJM Nov 22/12
Violence, Mental Disorders & Risk assessment

The Violence of the Sea
Leila Kubba Kawash
1996
Prediction of Violence
• “Prediction is very difficult, especially if it’s about the future.”

– Niels Bohr, Danish physicist, Nobel laureate (1885–1962)
Prediction of Violence

• Accurate prediction of rare events is very difficult:
  – Homicide rate is 1.4/100,000 population in Canada (dropping since 1975 at 3.03)
  – Suicide rate is 11/100,000 population in Canada (stable since 2007)

• Any ability to accurately predict these rare events usually comes with high false positives
Risk Assessment

• Rather than trying to predict violence, better to …
  – Systematically assess the potential risks
  – Systematically manage the potential risks
Risk Assessment Approach

• Look at Risk Factors
  – Static
  – Dynamic
    • Especially psychiatric diagnoses

• Look for how to reduce or manage the risk factor
  – Eg treat ADHD, mania, psychosis
Risk Assessment

• Evaluate the different characteristics of Potential Violence….
  – Magnitude
  – Likelihood
  – Imminence
  – Frequency
• Studies tend to focus only on likelihood
Static Risk Factors

- previous violence
- substance use
- age - peaks in late teens & early 20's
- gender
- IQ
Static Risk Factors

- childhood factors
- young age of violence
- socioeconomic status
- psychopathy
Dynamic Risk Factors

• This is where we can manage violence risk….
  – current substance abuse/ intoxication
  – agitation
  – supports
  – access to weapons
Dynamic Risk Factors

– stress (ex work, finances, relationships)
– positive attitude towards treatment
– insight
– Impulsivity
– access to victims

– Mental illness
Is Mental Illness a Risk Factor for Violence?

YES!

After years of debate & numerous studies, it appears that mental illness is associated with a small but significant increase in risk (this is still controversial).
• N=18423 from 20 studies between 1970 and 2009 (Fazel et al)
• Schizophrenia associated with violence and violent offending, though mostly due to substance abuse
Violence & Mental Disorder

• Dispositional Factors
  – Anger, Impulsiveness, aggression, psychopathy

• Clinical Factors (ie our job)
  – Substance, psychosis, mental disorders, personality disorders

• Historical & Contextual Factors
  – History of violence, social supports, environment

Important Studies

• MacArthur Violence Risk Assessment
  - 951 patients followed q 10 weeks x 1 year post discharge
  - Little difference compared to violence rates of neighbourhoods
    » Steadman HJ 1998

• Epidemiological Catchment Area (ECA) study
  - Young, male, low SES, mental disorders & substance predicted violence
  - Substance + illness>substance>illness>controls
    » Swanson, J. W., C. E. Holzer, et al. (1990)
<table>
<thead>
<tr>
<th>Disorder</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Drug Abuse or Dependence</td>
<td>35</td>
</tr>
<tr>
<td>Alcohol Abuse or Dependence</td>
<td>25</td>
</tr>
<tr>
<td>Cannabis Abuse or Dependence</td>
<td>19</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>13</td>
</tr>
<tr>
<td>Panic d/o, MDD</td>
<td>12</td>
</tr>
<tr>
<td>OCD, Mania, or Bipolar</td>
<td>11</td>
</tr>
<tr>
<td>No Disorder</td>
<td>2</td>
</tr>
</tbody>
</table>
MI & Violence

- Swanson JW et al, 1990
  - The higher the number of psychiatric diagnoses, the greater the rates of violence
  - Just schizophrenia = 8% (4x base rate)
  - Just substance = 21%
  - Best predictors
    - Substance
    - Major mental d/o
    - Male, age, socioeconomic status
Specific Factors

• Paranoid Psychotics
  – More planned violence
• Delusions
  – “Threat/control-override” delusions appear most risky
• Command hallucinations
• Depression
Personality & Violence

• Impulsive Violence (usually in anger) seen with:
  – Borderline Personality Disorder, Antisocial PD, Paranoid PD, Narcissistic PD
  – The key ingredients are anger, impulsivity & hostility

• Planned Violence (usually w/o emotion)
  – “Psychopathy” a risk - glibness, grandiose self-worth, lying, conning/manipulative, shallow affect, lack of empathy & prone to boredom
Risk Assessment Tools

- Actuarial
  - Examine large group for risk factors
  - Correlate risks to recidivism
  - Historical only (static)
  - Eg Static-99R, VRAG, SORAG, ODARA/DVRAG

- Memory aids (structured)
  - Look at scientifically validated factors
  - HCR-20, SVR-20, SONAR, SARA
  - Often look at Static & Dynamic factor
## Manage the Risk

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Reduction Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosis</td>
<td>Depot neuroleptic</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>Refer to AA, NA</td>
</tr>
<tr>
<td>Living with mother</td>
<td>Move to group home/psychoed to family</td>
</tr>
</tbody>
</table>
Risk Caveats

• Consider hospitalization & consultation

• Remember the duty to protect others

• Document disposition & rationale
Civil Law
&
Psychiatry
Outline

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III Normal & Disordered Sexuality
Fiduciary Duty

• Fiduciary duty = a doctor must act in the patient’s best interests

• A Fiduciary duty exists whenever one person places special trust and confidence in another person and relies upon that person (the fiduciary) to exercise his/her discretion or expertise in acting for the client
Fiduciary Duty

• A doctor (the fiduciary) is in a legal contract with a patient (the principal or beneficiary)

• A fiduciary at risk when:
  – personal interests and fiduciary duty conflict
  – fiduciary duty conflicts with another fiduciary duty
  – Profit, benefit or gain from their fiduciary position is possible
Privilege & Confidentiality

- **PRivilege** - a **P**atient’s **R**ight to decide what happens to their personal information; belongs to the patient, not the doctor!

- **COnfidentiality** - a **C**linician’s **O**bligation to not disclose information
Confidentiality

• Legal Obligation
  – Charter of Rights (Constitution Act) 1982
  – The Privacy Act
  – Personal Information Protection and Electronic Documents Act (PIPEDA)
  – Each province has its own legislation
Confidentiality

• Ethical Obligation
  – CMA Code of Ethics

• Sec 6 - Will keep in confidence information derived from his/her patient, or from a colleague, regarding a patient and divulge it only with the permission of the patient except when the law requires him/her to do so
Exceptions to Confidentiality

• Mandatory Reporting
  – Child Abuse
    • Provincial legislation exists in every province except the Yukon requiring mandatory reporting of child abuse
    • Legal standard is usually “reasonable and probable grounds to believe” or “reasonable grounds to suspect”
    • All include physical and sexual abuse; some include emotional abuse & neglect
Mandatory Reporting

• Occupational hazards
  – Flying hazard (federal) - Under the federal Aeronautics Act, must report flight crew member or air traffic controller if there is “reasonable grounds ... likely to constitute a hazard to aviation safety”
  – Railway hazard (federal) - Railway Safety Act

• Others
  – Elder Abuse, Professional Sexual Misconduct, Driving, Communicable diseases, Gunshot wounds, Health insurance fraud
Other Exceptions

• Civil litigation - if a patient makes their personal health information the subject of a lawsuit (malpractice or disability), their information becomes available to the courts
  – The patient consents; their information belongs to them not the physician

• Court ordered assessments
Duty to Protect

Prosenjit Poddar

Tatiana Tarasoff
Tarasoff

- Tarasoff I (1974) = Duty to Warn
- Tarasoff II (1976) = Duty to Protect
  - “The protective privilege ends where the public peril begins.”
Duty to Protect

Smith v Jones

The Supreme Court said that solicitor-client privilege was the highest. However, it could be subject to breach in the interest of public safety.
Duty to Protect

• Canadian Psychiatric Association Position Paper (2002)
  – As part of the informed consent process, patients need to be warned of limits to confidentiality.
  – A duty to protect (warn, or inform) exists:
    • in the event that a risk to a clearly identifiable person or group of persons is determined
    • when the risk of harm includes severe bodily injury, death, or serious psychological harm
    • when there is an element of imminence, creating a sense of urgency
Informed Consent

“Every adult person of sound mind has the right to establish what is done with his own body”

» Justice Cardoza (US Supreme Court) 1914
Informed Consent

• Competence
  – Having the capacity to understand and act reasonably
  – This is a legal term and competency is determined by legal system

• Capacity
  – The mental ability to make a rational decision based on understanding & appreciating all relevant information
  – A clinical opinion by a clinician
Informed Consent
Legal Basis

- Lack of consent for touching = Battery (Civil Law) or Assault (Civil & Criminal Law)
- Failure to obtain informed consent = Negligence (Civil)
Valid Consent

• Specific to the issue

• Informed – no misrepresentation

• Voluntary – no coercion or persuasion

• Capable

• Implicit vs Explicit
Informed Consent

• Diagnosis & Nature of treatment

• Purpose of proposed treatment

• Risks & Benefits of treatment options

• Alternative treatments & risks

• Prognosis with & without treatment
Reibl v Hughes (1980)

- Reibl was paralyzed after carotid endarterectomy 1 ½ years from retirement
- Not told about risk of stroke & would have opted to live a shorter healthy life vs being “a cripple”
- The Supreme Court of Canada agreed and said that doctors must disclose

“what the average, prudent person, the reasonable person” would want to know, including the “material and special risks”
Involuntary Treatment

- Consent laws across Canada are provincially determined
- Capacity for informed consent requires
  - A person must be able to understand the information that is relevant to making a treatment decision (intellectual - abstract of risks & benefits)
  - A person must be able to appreciate the reasonably foreseeable consequences of the decision or lack of one. (cognitive/affective - apply the information to themselves)
Starson v Swayze
[2003 SCC 32]

- “Professor Starson” aka Scott Shutzman
- Bipolar d/o / Schizoaffective d/o
- Was detained as an NCR
- Refused treatment
- Found Incapable re: Meds in Ontario
- He appealed the decision up to the Supreme Court of Canada
Starson v Swayze

• Precedence
  – The SCC interpreted an Ontario Legislation (the Health Care Consent Act)
  – The SCC’s decision has precedence throughout Canada
  – However, it was an Ontario legislation
  – As such, the decision doesn’t extend to other provinces…. But other courts have looked to the SCC’s discussion around this issue
Starson

• “The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy.”

• “Few medical procedures can be more intrusive than the forcible injection of powerful mind-altering drugs which are often accompanied by severe and sometimes irreversible adverse side effects.”
Starson

• “The right knowingly to be foolish is not unimportant; the right to voluntarily assume risks is to be respected. The State has no business meddling with either. The dignity of the individual is at stake.”
Capacity

- Do they understand (info) & appreciate (apply to themselves/ have capacity to weigh info)
  - Diagnosis - describe condition/problem
  - Treatment - nature & purpose of proposed tx
  - Consequences - risks/benefits of proposed tx (common & deadly ones)
  - Alternatives - viable alternatives incl risks/benefits
  - Prognosis - projected outcome w/ & w/o tx
Substitute Consent

- Varies by province
- Options for Decision Maker include:
  - The courts (a judge) decide treatment
  - The doctor decides
  - A “substitute decision maker” decides
- Decisions made based on
  - the patient’s “best interests”
  - what the patient would have wanted if they were competent
Other Areas of Competence

- Contractual capacity
  - ability to make a contract
- Testamentary capacity
  - ability to make a will
- Testimonial capacity
  - ability to be a witness
- Capacity to marry or divorce
  - ability to enter into a marriage contract
Other Areas of Competence

• Capacity to consent or refuse treatment

• Tort liability of mentally ill

• Guardianship
  – ability to manage one’s affairs (personal, property)

• Financial capacity
  – ability to manage one’s finances
Other Areas of Competence

• To adopt a child

• To be a fit parent

• To be a juror

• To be executed (in the US)
  – aware of his impending execution and the reason for it (Ford v Wainwright, [477 US 399 (1986)])
  – Cannot force meds to restore to Fitness in Louisiana & Carolina
  – May be able to force meds in Arkansas & the 8th Circuit, if it is in the person’s medical interest [319 F.3d 1018 (8th Cir)]
Civil Commitment

• The laws to civilly commit vary from province to province
• Based on both protection of vulnerable people (mentally ill) from coming to harm PLUS protection of public from the ill
• Variables:
  – Have a mental disorder
  – Not suitable for voluntary admission
  – Psychiatric treatment is needed
  – Prevent mental or physical deterioration
  – Risk of harm to self or others
• Some provinces allow treatment as part of Commitment. Others have treatment as a separate question.
Medical Malpractice

- **Tort**
  - a civil suit involving one person wronging another
  - the penalty is $$$
  - basis in Common Law of England
  - specifics can vary by province if specific legislation

- **Torts can be**
  - Intentional – battery, assault
  - Unintentional – negligence

- **Negligence**
  - a type of unintentional tort
  - includes Medical Malpractice
Negligence

- The 4 D’s
  - Duty
  - Dereliction
  - Damages
  - Direct Cause
Duty

• This is a fiduciary duty

• Usually evident - you’ve seen the patient

• Could extend to other cases
  – the “hallway consultation”
  – on-call coverage
  – duty to protect 3rd persons
Dereliction of Duty

• This is defined by the courts and laws of each province.
• The standard is usually that a psychiatrist must exercise a “reasonable degree of knowledge and skill exercised by other members of the profession in similar circumstances.”
• The courts have the discretion to override doctors and define the standard (eg. Reibl v Hughes).
**Damages**

- Can include
  - Physical harm
  - Psychological harm
    - Usually limited to “nervous stress” which includes PTSD, Major Depression

- Compensation
  - $$$ for suffering, financial losses
  - Punitive (the court wants to make an example of you)
Direct Cause

- The mistake must cause the negative outcome

- There are several components:
  - *Cause in fact* - but for the psychiatrist’s act or omission, the negative outcome wouldn’t have occurred
  - *Proximate cause* - the act or omission was a substantial factor in bringing about the outcome
  - *Foreseeable* - flukes don’t count, only reasonably foreseeable outcomes
Malpractice in Canada

- Failure to undertake an appropriate and thorough suicide and/or homicide risk assessment
- Wrongful confinement
- Problems arising from prescription of medication
- Sexual impropriety
- Failure to meet the expected standard of care
Sexual Function & Sexual Dysfunction
From normal Arousal to Zoophilia
Definitions

• **Gender Identity = Social**
  – by 2-3yo a sense that “I’m a boy” or “I’m a girl” is firmly set; sense of masculinity & femininity develop based on biology, parental & cultural attitudes

• **Sexual Orientation**
  – Object of person’s sexual attraction - hetero, homo or bi
Basis of Sexuality

• Biological
  – Genes, hormones, physical issues, brain function

• Psychological
  – Self esteem, unresolved dynamic conflicts, Cognitions

• Social
  – Family values, religious beliefs, cultural proscriptions
Human Sexual Response
(Masters & Johnson, 1966)

Women

Men
Human Sexual Response

• Other models developed for women since biased days of 1966 “Linear Model”
  – See http://www.arhp.org/Publications-and-Resources/Clinical-Fact-Sheets/Female-Sexual-Response (Association of Reproductive Health Professionals)

• Circular Model (Whipple & Brash-McGreer)
  – pleasure and satisfaction during one sexual experience can lead to the seduction phase of the next sexual experience

• Non-linear Model (Basson)
  – Emotional intimacy, sexual stimuli, and relationship satisfaction affect female sexual response
## Aging & Sexual Function

<table>
<thead>
<tr>
<th></th>
<th><strong>MALE</strong></th>
<th><strong>FEMALE</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Desire</strong></td>
<td>Decreased</td>
<td>Decreased</td>
</tr>
<tr>
<td><strong>Excitement</strong></td>
<td>Less full erection</td>
<td>Low estrogen effects</td>
</tr>
<tr>
<td><strong>Plateau</strong></td>
<td>Pre-ejaculation state prolonged</td>
<td></td>
</tr>
<tr>
<td><strong>Orgasm</strong></td>
<td>Shorter, less urgent, less force and volume</td>
<td>Shorter, less vigorous, capable of multiple orgasms</td>
</tr>
<tr>
<td><strong>Resolution</strong></td>
<td>Shorter, prolonged refractory period</td>
<td>More rapid</td>
</tr>
<tr>
<td></td>
<td>Desire</td>
<td>Arousal</td>
</tr>
<tr>
<td>----------------</td>
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<tr>
<td><strong>Dopa</strong></td>
<td>↑</td>
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<td><strong>NE</strong></td>
<td>Low/mod ↑</td>
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<td></td>
<td>High ↓</td>
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<tr>
<td><strong>5HT</strong></td>
<td>↓</td>
<td>↓</td>
</tr>
<tr>
<td><strong>ACh</strong></td>
<td>↑</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Nitrous Oxide</strong></td>
<td>↑</td>
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</tr>
</tbody>
</table>
Sexual Dysfunction
DSM-IV Classification

- Sexual and Gender Identity Disorders
  - Sexual Dysfunctions
  - Paraphilias
  - Gender Identity Disorders
  - Sexual Disorder NOS
DSM-5 Classification

• Sexual Dysfunctions
• Gender Dysphoria
• Paraphilic disorders
DSM-5

• New “Gender Dysphoria” class
  – No longer categorical – a “multicategory” with many conditions
  – Specific developmental criteria (kids vs teen vs adults)
  – No longer “opposite” gender desire; instead is “some alternative gender”
GD Resources

• Good BC resource:
  – http://transhealth.vch.ca/

• World Professional Association for Transgender Health (WPATH) standards of care:
  – http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926
DSM-5

• Sexual dysfunctions
  – Less focus on phases (arousal, desire)
  – Gender specific dysfunctions added
  – For women sexual desire disorder & arousal disorder combined to “Female sexual interest/arousal disorder”
  – Now require 6 months and severity specified
  – Genito-Pelvic Pain/penetration disorder – merges vaginismus and dypareunia
  – Sexual aversion disorder removed
DSM-5

• Paraphilic disorders
  – Now recognizes paraphilias ≠ disorder
  – Requires paraphilia causing distress/impairment or whose satisfaction has entailed personal harm or risk of harm to others
  – Names changes pedophilia now pedophilic disorder
  – Specifiers “in a controlled environment” and “in remission” also clarified
Sexual Dysfunctions
Sexual Dysfunctions

• Sexual Desire Disorders
  – Hypoactive Sexual Desire Disorder
    • Most common sexual complaint in women
    • In National Health & Social Life Survey, 33% of women and 16% of men (most were acquired)
    • Complex evaluation & treatment
    • Self-esteem, body image, stress level, energy levels, mental health diagnoses, medication use (SSRI’s decrease), current sexual context
  • Testosterone?
    – SWAN study (Santoro 2005) 3000 women found minimal correlation between desire, arousal & androgen levels; however some studies suggest on individual basis. Similar results in men.
  • Buproprion – Cochrane review suggested in 1 of 2 RCT’s there was benefit (Rudkin, Taylor & Hawton 2004)
Sexual Dysfunctions

• Sexual Desire Disorders
  – Sexual Aversion Disorder
  – (Hyperactive Sexual Desire Disorder?)
    • Non-paraphilic hypersexuality (Kafka)
    • Like paraphilias, more common in men
    • In past, referred to as “Don Juanism” or satyriasis in men & nymphomania in women
      – Compulsive masturbation
      – Protracted promiscuity
      – Pornography & Telephone sex dependence
      – Cybersex
Sexual Dysfunctions

• Sexual Arousal Disorder
  – Female Sexual Arousal Disorder
  – Male Erectile Disorder
    • Most common male sexual complaint
    • 7% of under 30 yo, 50% of men above 60 yo
    • PDE5 Inhibitors include tadalafil (Cialis), sildenafil (Viagra) & vardenafil (Levitra)
    • Also need to look at relationship issues, desire deficits, partner sexual dysfunctions, medical conditions, psychiatric conditions
Male Erectile Disorder

Male Erectile Disorder

- Psychogenic
  - Psychiatric illness – depression, anxiety
  - Psychosocial probs – relationship, stress, etc
- Neurogenic
- Vascular
- Drugs
- Systemic illness
- Localized issues
Male Erectile Disorder

- Treatment
  - Therapy – psychosexual, couple, CBT
  - Lifestyle modification – decrease EtOH, lose weight, stop smoking, increase exercise
  - PDE-5 inhibitors
    - Sildenafil
    - Vardenifil
    - Tadalafil
    - Udenafil
    - Mirodenafil
PDE-5 Inhibitors

Sexual stimulation (physical/psychological) → Nerves & endothelial cells activated → Release of NO → activates guanylate cyclase → increased cGMP → decreased cellular calcium → relaxes smooth muscle of the corpus cavernosa → erection → PDE-5 breaks down cGMP → normalized cellular calcium → loss of erection
PDE-5 Inhibitors: Mechanism of Action
DSM Classification

• Orgasmic Disorders
  – Female Orgasmic Disorder
  – Male Orgasmic Disorder
  – Premature Ejaculation
    • SSRIs & Therapy
  – (Delayed ejaculation) – 3 to 9% of men

• Sexual Pain Disorders
  – Vaginismus
  – Dyspareunia
    • Some argue these are reactions to actual or anticipated pain, so should be pain disorders not sexual disorders
    • Treatments include gynecology evaluation & mechanical treatments, CBT/psychotherapy, and TCAs
    • ?Pain clinic and pain specialist referral
DSM Classification

• Sexual Dysfunction due to general medical condition
• Substance-induced Sexual Dysfunction

• Specifiers
  – lifelong vs acquired type
  – situation vs generalized type
  – due to psychological factors
  – due to combined factors
<table>
<thead>
<tr>
<th>Approach</th>
<th>Cause</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
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<tr>
<td>Psychological</td>
<td></td>
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<tr>
<td>Social</td>
<td></td>
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</tr>
</tbody>
</table>
Treatment Approaches

• Consultation to other specialties
  – Obs/Gyn, Urology, Pain clinic, Family Medicine for physical causes

• Treat other psychiatric illness first

• Pharmacological
  – PDE-5 Inhibitors (Sildenafil, vardenafil, and tadalafil)
  – Bupropion
  – Lorazepam or propanolol for anticipatory anxiety
  – Cyproheptadine (Periactin) 4 – 8mg daily for women or 2 hrs pre-coitus for men for SSRIs
Psychological Treatments

• Dual-sex therapy
• CBT
• Insight oriented therapy
• Assertiveness training
• Group therapy
Paraphilias

Mad, Bad or Both?
Scope of the Problem

• Sex Crimes are common
  – Sexual Assault
    • ~1/6 American women are victims of attempted/completed sexual assault
    • 3% of men
    • In studies conducted mostly in developed countries, 5–10% of men report being sexually abused as children (Kinsey institute website based on WHO 2004 data)

  – Child Sexual Abuse
    • 1/1000 per year incidence with prevalence of 12-27% of girls and 8-16% of boys
Paraphilic disorders

• Recurrent, intense sexually arousing fantasies, sexual urges, or behaviours generally involving:
  – nonhuman objects
  – suffering or humiliation of oneself or one’s partner or
  – children or other non-consenting persons
• Cause distress/dysfunction or interfere with significant rights of others
• occur over a period of at least 6 months
Continuum for Normal-Abnormal Behavior

Strength of preference for fetish object

Mild preference

Strong preference

Necessity

Substitute for human partner

Abnormal
Paraphilias

• General characteristics
  – Paraphilic urges may be rare, intermittent or compulsive
  
  – Hallmark is a “special fantasy”
    • sexual arousal/orgasm reinforces the fantasy
  
  – Comorbidity is the rule
Paraphilias in DSM-IV

- Pedophilia
- Frotteurism
- Voyeurism
- Exhibitionism
- Fetishism

- Sexual masochism
- Sexual sadism
- Transvestic fetishism
- Paraphilia NOS
Epidemiology

- Unknown prevalence
- ♀ <<< ♂
- Onset usually late teens, early adulthood
Paraphilias in Non-Offenders

• In one study of 94 men in the community reported their fantasies:
  – 62% fantasized about initiating sex with a “young girl”
  – 33% fantasized about rape of a woman
  – 12% fantasized about being humiliated
  – 5% fantasized about sex with an animal
  – 3% fantasized about initiating sex with a “young boy”

Paraphilias in Non-Offenders

• Study of 193 male undergraduates:
  – 21% reported sexual attraction to children
  – 9% fantasized about sex with children
  – 5% masturbated to fantasies of sex with children
  – 7% indicated a likelihood of actual sexual involvement with a child if they could be assured no one would know & they wouldn’t be punished

Paraphilias in Non-Offenders

• Study of 60 undergrads:
  – 42% reported voyeurism, 54% reported a desire
  – 35% reported frottage
  – 8% reported obscene phone calls (telephone scatologia)
  – 5% reported coercive sex
  – 3% reported sexual contact with girls under 12, 5% reported a desire
  – 2% reported exhibitionism, 7% reported desires

Paraphile vs Sexual Offender

Many Sexual offenders have several other reasons to explain illegal behaviours, including high rates of mental illness, mental retardation & substance
Rates of Illness in SOs

- Impulse Control*: 40%
- Anxiety: 30%
- Depression: 30%
- Alcohol: 30%
- MR/DD*: 25%
- Any PD: 25%
- Substance: 10%
- Psychosis*: 5%

Rates of Illness in SOs

- Substance
- Paraphilia
- Mood
- Antisocial PD
- Impulse Control
- Bipolar
- Depression
- Anxiety
- Eating Disorder

Rates of Dx in STU 2 East

- Depression: 43%
- Bipolar: 13%
- Anxiety: 28%
- Psychosis: 16%
- Paraphilia: 65%
- Dementia: 10%
- MR/DD: 31%

N=113
Rates of Dx in STU 2 East

N=113
Paraphilias

• Are very common

• Most don’t come to clinical or legal attention

• Paraphilia ≠ Sex Offender

• Paraphilia ≠ Guilty
Causes of Paraphilias

- Unknown
- Psychological theories
- Biology
- Evolution

*** Major problem in many studies, as involve paraphiles who came into contact with the law (selection bias)
## Perspectives on Paraphilic Behavior

### Theoretical Perspectives on Paraphilic Behavior

<table>
<thead>
<tr>
<th>Perspective</th>
<th>Central Concept(s)</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological</td>
<td>Hormone level abnormalities, brainstem malfunctions, neurochemical imbalances.</td>
<td>Mixed findings, generally inconclusive. Difficulty in knowing whether abnormality preceded or followed paraphilic behavior, especially if chemical abuse is involved.</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>Castration fears.</td>
<td>No supporting scientific evidence.</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Paraphilic behavior is learned via association (classical conditioning) and reinforcement (operant conditioning).</td>
<td>This model is used to design and implement treatments designed to change or control paraphilic behavior.</td>
</tr>
<tr>
<td>Lovemap</td>
<td>Early trauma (abuse, incest, etc.) vandalizes the template (lovement) of what particular stimuli arouse an individual.</td>
<td>Some correlational support.</td>
</tr>
<tr>
<td>Courtship disorder</td>
<td>Disruption in the normal processes of locating a suitable partner, approaching and interacting with that partner, appropriate display of sexual interest, and genital union.</td>
<td>Minimal research support.</td>
</tr>
<tr>
<td>Feminist</td>
<td>Paraphilias as dominance and aggressive behaviors that subordinate women and limit their freedom.</td>
<td>Minimal research support.</td>
</tr>
</tbody>
</table>
Causes of sexual offending

• Pathological “Driving” factors
  – Paraphilias (e.g., pedophilia, sadism)
    • Preferential arousal
    • Exclusive arousal
    • (some drugs/alcohol may enhance)
  – Hypersexuality/high sex drive
    • (some drugs increase drive)

• Non-pathological drives
  – Relationships, acceptance, etc
Causes of sexual offending

• “Disinhibiting” factors
  – Impaired judgment
    • Alcohol, drugs
    • Brain injury
    • Mental disorders/ ID/DD
  – Cognitive distortions
    • Distorted values re: sexual behaviours due to one’s own sexual abuse
    • Distorted values re: victims (Eg many sexual assaults on women by antisocial physically abusive men who see women as objects)
Causes of sexual offending

• Disinhibiting factors
  – Empathy deficits
    • Psychopathy
  – Social deficits
    • More acceptance by children
  – Life situations
    • Work problems
    • Relationship problems
Pedophilia

- 6 mo of sexual urges towards *prepubescent child* (usu ≤13yo)
- Acted on urges or urges caused significant distress, impairment or interpersonal problems
- Person is at least 16yo, victim at least 5 yrs younger
- Subtypes: sexually attracted to ♂, ♀, both; incest only; exclusive/non-exclusive type
Pedophiles

• Overall, <3% of population
• 95% are heterosexual
• 50% have consumed alcohol at time of offence
• >90% are men
• Many have also committed exhibitionism, voyeurism & rape
• Often feel more accepted by kids, have low self-esteem or body image problems
Pedophilia Comorbidity

- Anxiety
- Depression
- Substance
- Personality problems
- Mental retardation
- Other paraphilias, particularly exhibitionism & voyeurism
Treatment

1. External Control
   - Incarceration
     • Can include indeterminate sentencing
     • XXIV of Criminal Code includes the option of long-term offender or dangerous offender status
   - Release conditions
     • Including sex offender registration, community notification, and castration
   - Civil Commitment
     • Not in Canada yet, but in the US
Treatment

• The World Federation of Societies of Biological Psychiatry (WFSBP): Guidelines for the biological treatment of paraphilias
  • FLORENCE THIBAUT, FLORA DE LA BARRA, HARVEY GORDON, PAUL COSYNS, JOHN M. W. BRADFOR & the WFSBP Task Force on Sexual Disorders
Treatment

1. External Control

2. Reduce Sex Drive
   - Partial Sex Drive Reduction
     • SSRI’s
     • Cyproterone (Androcur)
     • Medroxyprogesterone (Provera)
   - Ablation of Testosterone
     • Leuprolide (Lupron)
     • Goserelin (Zoladex)
   - Inhibit peripheral testosterone (adjunct)
     • Finasteride
Hypothalamus-Pituitary-Testes Connection

- Hypothalamus releases GnRH
- Pituitary gland releases the gonadotropins FSH and ICSH
- ICSH stimulates interstitial cells in the testes to produce testosterone
- Testosterone stimulates the development and maintenance of male secondary characteristics, influences male sexual desire, and, with FSH, stimulates the seminiferous tubules in the testes to produce sperm. Testosterone feeds back to the hypothalamus and pituitary to inhibit GnRH production and LH production.
- FSH, with testosterone, stimulates the seminiferous tubules in the testes to produce sperm
- Inhibin released by Sertoli cells; feeds back and inhibits anterior pituitary production of FSH
Treatment

• General workup
  – Premedication
    • LH, FSH, Serum f-Testosterone, LFTs, Hgb, CBC, glucose, renal function, EKG, Bone density, weight, blood pressure
    • Endocrinology consultation
  – On meds
    • Monthly testosterone x 4 then q6mo
    • BUN, Creat, LH, Prolactin q 6mo
    • Bone density yearly if on Leuprolide or Goserelin
Treatment

• Cyproterone (Androcur)
  – Testosterone antagonist
  – 100-500mg/d po or 100-600mg/week IM
  – Contraindicated in liver disease & thromboembolic disease
  – 15-20% get gynecomastia (excess of estradiol/estrogen vs testosterone)
  – Weight gain & decreased body hair often occur
  – Risk of fatigue or depression
Treatment

- Medroxyprogesterone (DepoProvera)
  - Negative feedback to FSH & LH resulting in decreased testosterone
  - 100-600mg/d po or 100-700mg/week IM
  - Contraindicated in liver disease & thromboembolic disorders
  - SE’s include hot flashes, impotence, sweating, fatigue, hypertension, edema
  - Weight gain & increased appetite common
  - Mild depression, insomnia, nervousness and fatigue can also occur
Treatment

• Leuprolide (Lupron)
  – High levels of GnRH, with steady state (require pulsatile release for LH & FSH release)
  – 3.75-7.5mg/month IM; 11.5 or 22.5 mg q 3 months; 30 mg q 4months IM
  – Contraindicated in bone demineralization disorders or hypersensitivity to drug
  – 60% hot flashes, impotence, sweating, rash, edema (3%), myalgia, decreased bone density
Treatment

• Goserelin (Zoladex)
  – 3.6mg/mo or 10.8mg q3mo IM
  – Contraindicated in bone demineralization disorders & hypersensitivity to drug
  – MOA & SE’s similar to Leuprolide
Treatment

1. External Control
2. Reduce Sex Drive
3. Treat Co-morbid Conditions
   - Depression
   - Mania
   - Schizophrenia
   - Relation problems
   - Substance
   - Don’t treat “Manopause”!!
Treatment

1. External Control
2. Reduce Sex Drive
3. Treat Co-morbid Conditions
4. Psychotherapy
   - CBT, covert sensitization, satiation, olfactory aversion
   - Relapse prevention group
   - Social skills groups
Recidivism

Percent of released prisoners rearrested within 3 years, by offense, 1983 and 1994

Offense of prisoners released

- All
- Violent
- Property
- Drug
- Public-order

US Bureau of Justice
Recidivism

• Overall 5 year recidivism\(^1\) = 13.4%
  – 12.7% for child molesters
  – 18.9% for rapists

• Incest offenders the lowest at 4-10%

• Prenky et al.\(^2\) gave a 25 year rate of
  – 39% for rapists
  – 53% for extrafamilial child molesters

1. Hanson RK, Bussiere MT, 1996.
Does Treatment Work?

YES!

Virtually all studies have found that treatment significantly decreases recidivism.
What can non-Forensic Psychiatrists do?

• Treat comorbid conditions
  – Depression
  – Mania
  – Psychosis
  – Social phobia
  – Substance

• See these patients
  – For ongoing non-paraphilia related issues

• Address sexual issues with patients
  – Refer/ consult if concerned
Questions?