The Use of Anti-Libidinal Medication with Intellectually Disabled Sex Offenders: Client Characteristics and Response

Context

Her Majesty's Prison Whatton

- **840 adult males convicted of a sexual offence**
- **25% are ID and borderline ID**
- **Medication commenced in November 2009**
- **96 referrals**
  - Approximately 90% of these receive medication
- **Medications used:**
  - SSRI (Fluoxetine)
  - Anti-androgen (Cyproterone acetate / Androcur)
  - GnRH agonist (Triptorelin)

The Evaluation

Mixed method design

- **Quantitative components to assess effects on sexual preoccupation and hypersexuality**
- **Qualitative component to explore in depth experiences of the medication**

Sample

- N = 95 referred for meds
- Age 25-80, mean = 45 years (sd=14.7)
- 29.3% of the sample were serving determinate sentences
- 41.4% were serving indeterminate sentence for public protection
- 10.3% were life sentenced offenders
  17.3% were recalled offenders
- 1.7% were licence revoke

Victims and risk

- Majority are child offenders
- Mean RM2000S = high
- RM2000V = medium

IQ profile

- 32.2 % are considered to have intellectual disability or borderline ID
- 13.8% participants with intellectual disability as defined by their IQ score being 69<.
- 18.4% participants were borderline with their IQ scores between 70-79.

WASI (Weschler Adult Intelligence Scale) or WAIS (Weschler Adult Intelligence Scale).

Possible hypotheses for over representation

- Less psychological resources to cope with their sexual thoughts and feelings – need external mechanism
- They are less inhibited in their self report of sexual thoughts and less likely/able to evade detection
- Staff perceive them to be less in control and more likely to refer
- They are more sexually preoccupied

Psychometric Measures

- Multiphasic Sex Inventory (MSI) (Nichols & Molinder, 1984)
- Personality Assessment Inventory (PAI) (Morey, 1991)
- Severity Indices of Personality Problems (SIPP-118) (Verheul et al, 2008)
- Sexual Compulsivity Scale (SCS) (Kalichman et al, 1994)
- Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983)

Clinical measures

- Frequency of masturbation
- Strength of sexual urges
- Time spent thinking about sex
- Ability to distract from sexual thoughts
- Subjective levels of sexual excitement

Analysis

- The IQ score was used to group participants into two categories; lower functioning (<79, n= 28) and non-lower functioning (80>, n = 45).
- First differences between the groups were analysed before medication

Level of dysfunction PAI

- Compared to general population both groups showed dysfunction for Anxiety Related Disorder, Depression, Mania, Schizophrenia, Borderline and Antisocial.
- Non-ID group showed dysfunction for Alcohol.
- ID showed dysfunction for Somatic Complaint.

Level of dysfunction

- HADS, SIPP-18, MSI and SCS, neither group show dysfunction from the norm samples.
- No difference between the groups on the clinical measures
- ID group show signficant difference on the MSI Cognitive Distortions and Immaturity scale

Response to treatment

- Measures were analysed 6 months after starting medication (<79, n= 7) and non-lower functioning (80> n = 14).
- No difference in response to the psychometric measures between groups
- Frequency of orgasm – ID group were reporting significantly lower frequency

Conclusions

- ID group do not appear to be more dysfunctional than non-ID group
- Both groups seem to respond similarly to medication with the exception of orgasm frequency
- Detection evasion and level of openness a more likely explanation for over representation

Participants experiences

Four broad clinical themes emerged:

1. Effects of the medication
2. Compliance and engagement
3. Participant understanding
4. Participant concerns

1. Effects of the medication

Reduced sexual preoccupation and arousal

- Decreased frequency & intensity of sexual thoughts, fantasies and urges
- Reduction in arousal and masturbatory frequency
- Increased control of sexual thoughts & ability to distract
- Difficulty in achieving or maintaining an erection
- Difficulty achieving or delayed ejaculation

1. Effects of the medication

Impulse and emotional control

- Increased ability to recognise inappropriate sexual thoughts

I needed just that little bit of extra help

- Improved management of emotions and urges

I kind of like more relaxed, more chilled out but there again I was very bouncy, I was off the wall all the time

- Better subjective control of sexual thoughts

I think I'm always going to have them thoughts there, they are always going to pop in at some stage in my, in the day or some, you know, I'm just going to turn around and say 'don't want to know'

Side effects

- Tiredness, nausea, headaches and difficulty sleeping
- All short lived or easily overcome

2. Compliance and engagement

- Some non-compliance
- Forgetting, wanting to be aroused, avoid side effects, belief they don't need them anymore
- Routine / structure is important

All resumed
Future plans

- Some planned to take for life and saw it as an impiorant part of risk management
- Others wanted to stop as soon as their licence period was up – fear of depdnedy, wanting a relationship

3. Participant understanding

- Mixed understanding
- Some were not sure how it would effect their feritlity

- Therapeutic relationship between individuals and staff appears vital in providing participants with a safe environment to voice and discuss their concerns and ask questions

4. Participant concerns

Initial concerns

- Unsure what to expect re. impact and potential side effects
- Lack of control or choice

Continued concerns

- Long term effects – e.g. impact on future sexual relationships, fertility, becoming dependent, if I will stop working

Future

- Need to use ID friendly measures
- Different methods for examining clinical significance