Pergamon

Psychoneuroendocrinology, Vol. 21, No. 4, pp. 411–419, 1996

Printed in Great Britain
0306-4530/96 $15.00 + .00

PII: S0306-4530(96)00004-2

GONADOTROPHIN HORMONE RELEASING HORMONE AGONIST IN CASES OF SEVERE PARAPHILIA: A LIFETIME TREATMENT?

Florence Thibaut[1], Bernard Cordier[2] and Jean-Marc Kuhn[3]

[1]Groupe de Recherche sur la Schizophrénie, Department of Psychiatry, University of Rouen, Rouen; [2]Foch Hospital, Suresnes; and [3]Group for Hormone Research and Federative Institute for Peptide Research, University of Rouen, Rouen, France

(Received 10 August 1995; in final form 11 December 1995)

SUMMARY

Six patients with severe paraphilia were treated with a long-acting gonadotrophin hormone releasing hormone analogue (GnRH-a). In five cases, the antiandrogen treatment ended their deviant sexual behaviour and markedly decreased their sexual fantasies and activities without significant side-effects. The beneficial effects of this treatment were maintained for 7 years in the patient where there was the longest follow-up. Two patients abruptly withdrew from their antiandrogen treatment at the end of the first and third year, respectively. Both relapsed within 8–10 weeks. One of them asked for resumption of antiandrogen treatment. In another case, in order to phase out antiandrogen treatment, testosterone (T) was added to the GnRH-a. In spite of normal T levels, and of resumption of normal sexual activities and deviant fantasies, deviant sexual behaviour did not return. A smoother phasing out of GnRH-a treatment is thought to be better than an abrupt withdrawal. However, the duration of antiandrogen treatment necessary to ensure a complete disappearance of deviant sexual behaviour remains uncertain, but is at least 4 years. Copyright © 1996 Elsevier Science Ltd.

Keywords—Sex offenders; Paraphilia; GnRH-a; Testosterone.

INTRODUCTION

Reducing sexual arousal by modifying the hormonal control of human sexual behaviour can be used in the treatment of sex offenders. The most commonly used drugs are medroxyprogesterone acetate (MPA) and cyproterone acetate (CPA). Cumulative totals of over 200 and 500 sex offenders treated with either MPA or CPA, respectively, have been reported (for review see Bradford (1983, 1988); Cooper (1986)). Both drugs are equally effective in decreasing sexual tension, fantasies and preoccupations, and the frequency of masturbation (Cooper et al., 1992). Deviant sexual behaviour disappears in approximately 80% of patients within 4–8 weeks.

Side-effects including depression, gynaecomastia, weight gain, thromboembolic phenomena and hyperglycaemia have been observed with these drugs. Moreover, uncontrolled breaks in the therapy, frequently observed with CPA (exclusively administered per os),

Address correspondence and reprint requests to: F. Thibaut, Service Hospitalo Universitaire, CHSR, BP 45, F-76301 Sotteville lès Rouen, France (Fax: 33 35 64 34 31).

limits the benefits of these drugs in the treatment of sex offenders. The availability of long-lasting gonadotrophin hormone releasing hormone analogues (GnRH-a) could avoid such drawbacks and result in the preferential use of these drugs in the treatment of sex offenders. GnRH-a treatment blocks the secretion of gonadotrophin and consequently that of testosterone (T). Side-effects are restricted to hypoandrogenism (Dickey, 1992; Rousseau et al., 1990; Thibaut et al., 1993). However, the question of the duration of treatment necessary to prevent the return of the deviant sexual behaviour after treatment has ended, has remained unanswered.

The aim of this study was firstly to confirm the efficacy of GnRH-a treatment in six cases of paraphilia, and secondly to study different ways of withdrawing treatment.

PATIENTS AND METHODS

Six men complaining of severe paraphilia were openly treated with a long-lasting GnRH-a. All of these patients remained in hospital for the first 21 days of treatment. The ethical committee gave its consent to this trial. Five patients, and both parents for case six, gave their informed consent to participate in the trial.

The patients (aged 17–43 years) received 3.75 mg triptorelin (Decapeptyl^{R}) monthly by intramuscular (IM) injection. In order to prevent a flare-up effect on sexual behaviour, 200 mg CPA was concurrently given daily for at least 1 month. CPA treatment was started 1 week before the first injection of GnRH-a. Psychotherapy was concurrently performed in all patients.

Case 1

Case 1 was a 27-year-old man whose DSM III R diagnosis was mild mental retardation associated with sexual sadism and exhibitionism. Since the age of 16 years, his main complaints have been almost continuous preoccupation with violent sexual fantasies involving young women, unremitted sexual tension, prolonged compulsive masturbation and episodic exhibitionism. At the time of this current treatment, he had three prior criminal arrests (rape and indecent assaults). Previous CPA treatment (150–300 mg/day for 36 months) was unsuccessful. CPA treatment (200 mg/day) was concurrently prescribed with GnRH-a for 4 months and then gradually suppressed over 3 months.

Case 2

Case 2 was a 20-year-old man whose DSM III R diagnosis was moderate mental retardation and paedophilia. Since the age of 17 years, he had been complaining of preoccupation with sexual fantasies involving children. At the time of this current treatment, he had been sentenced once (one sexual assault on a child). He had previously been successfully treated with CPA (150 mg/day for 16 months). The appearance of painful gynaecomastia led to the replacement of CPA with a long lasting GnRH-a. CPA was then gradually phased out over 4 weeks.

Case 3

Case 3 was a 39-year-old man whose DSM III R diagnosis was mixed bipolar disorder and paedophilia. He had been treated for many years with lithium (1.5 g/day), carbamazepine (800 mg/day) and fluphenazine decanoate (125 mg IM monthly). He had been infected with human immunodeficiency virus for 5 years. Since the age of 27 years, his almost continuous