Current PSYCHIATRY

Letters

Sexual addiction: disorder vs. personality

The two articles in your July issue on sexual addiction address two different subjects.

Steven L. Mahorney, MD (p. 29), writes about a problem that troubles patients and for which they seek help. These people are troubled by how their sexual activities disturb their lives. Since we physicians may be able to help these troubled persons, we call it a "disorder."

Neal W. Dunsieth, MD (p. 37), writes about people whose sexual acts disturb others and thus create a problem for society. Society tries to cope with these disturbers of our peace in several ways, one of which is to lock them up in hospitals and in jails. If we confine these offenders and try to treat them, we are more or less obligated to give them a medical diagnosis. But it should not bear the same name as the disorder that applies to the people Dr. Mahorney writes about.

The distinction is similar to the difference between "obsessive-compulsive disorder" and "obsessive-compulsive personality." The person with the "disorder" is troubled by it, but the one with the "personality" sees himself as orderly, neat, and thinks that "if a task is worth doing, it is worth doing correctly." Others may find that person to be a problem.

Unfortunately, some lawyers think that a client with a medical diagnosis should not be held responsible for his or her behavior, which may be seen as part of the diagnosis. This type of thinking would dictate that a person with a smoking addiction is not responsible for quitting smoking.

Yehuda Sherman, MD
Lafayette, CA

Dr. Dunsieth responds

Although I agree there may be an analogy between degrees of problem sexual behavior and obsessive-compulsive disorder versus obsessive-compulsive personality, I view the distinction somewhat differently.

We probably have a "neurotic/organic" split that sorts self-identified patients from felons. This would follow somewhat logically because the felons have lost control of their impulses to the point that their infractions are severe and harmful to society. Therefore, their underlying problems probably are more severe. This may have implications for treatment.

Overall, though, there is too much heterogeneity among individuals with problem sexual behavior to make many generalizations. I will hold to only one generalization with these patients as a whole: Defensiveness surrounding problem sexual behavior runs higher among individuals than it does for virtually any other problem in psychiatry. When treating sexual behavior, the clinician must employ a high degree of structure and a somewhat skeptical ear.

Neal W. Dunsieth, MD
University of Cincinnati
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Dr. Mahorney responds

I appreciate Dr. Sherman's letter. I had the same reaction to the juxtaposition of my article with that of Dr. Dunsieth.

The combination of DSM labeling, pharmaceutical marketing, and managed care has left many of us feeling that the best a psychiatrist can hope for is to sign the prescriptions and orders of a multidisciplinary team in a prison or jail, give the prisoners structured interviews, and pass the statistical analysis of those interviews off as "research." The "research" can be published and the authors declared "experts" whose testimony can then be peddled to lawyers and their clients. I didn't get the idea from Dr. Hillard's first editorial, justifying the creation of a new journal, that that was the only vision out there. It certainly isn't what my article was about.

I still think that as doctors, we should try to find ways to help our patients—before they go to jail.

I also want to disavow the automatic connection some have seen in my article between the usefulness of the sexual addiction paradigm and 12-step programs as treatment modalities. An exciting debate on this subject is emerging in clinical psychology circles. Psychiatrists should be part of that debate, and we can be if we could just tear ourselves away from our DSM bean counting.

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