

Correspondence

Sir: Overall, I feel that the article by Holloway (1998) was very helpful, and I have great respect for my colleague. However, I wish to draw your attention to one deficit. As I am sure you are aware, the role of the psychiatrist in the treatment of sexual offenders has been restricted over the years with the advance in psychological therapy, the primary therapists now being probation officers and psychologists. However, psychiatrists do have a specific role to play in the assessment of the relationship between any mental disorder and sexual offending and specifically the presence or absence of hypersexuality or deviant arousal which may be amenable to adjunctive therapy by medication. Although the number of patients with sexual deviancy and sexual offending who are suitable for adjunctive physical treatments is small, they are a significant cohort. I appreciate that Holloway makes reference to the treatment obliquely ("address heightened sexual drive if this is relevant"), but I think it is regrettable that she did not refer to the need for treatment with specific anti-libidinal agents or antidepressants

in certain cases. I hope this will be seen as constructive criticism.

Holloway, J. (1998) Management of adult sex offenders. *Advances in Psychiatric Treatment*, 4, 70-76.

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Author's reply: I agree with Dr Brockman on the importance of assessing and treating high sexual drive when present. Though this role is specific to psychiatrists, the psychiatrist has other important contributions to make as a member of a team in managing sexual offenders.

My article was not about the role of the psychiatrist in the management of sexual offenders, but a general article on the issues involved in managing these patients. Given the new legislation and readership of the journal, I chose to highlight the relevant legislation and multi-agency involvement in management.

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