DEAR SIR,

In reply to Dr. Kraft's letter, I think that his point of view, summarized in his concluding sentences, is not incompatible with my argument.

I had hoped, however, that I had made it clear in my article that I did not think that behavioural therapy was limited to the aversive type. Although there are many forms of behavioural therapy which I did not mention (and one sometimes gets the impression that whenever a therapist tries out a technique that is somewhat different from what he has used before a new kind of therapy has been invented), there are several references in my paper to other forms of behaviour therapy, specifically to desensitization, operant conditioning, and reciprocal inhibition.

The reason for concentrating on aversion treatment was because of the parallels it afforded to the past experience of the two patients presented; and this seemed particularly appropriate because both of these patients had symptoms of sexual deviation, although it was the chief complaint for only one of them. I think that most people reading the literature on behaviour therapy would agree that for many, if not most, behavioural therapists aversive therapy is considered the treatment of choice for such symptoms.

On the important problem of what is the crucial factor in recovery or improvement, we know very little indeed. It is my belief, and here I think that I am in accord with Dr. Kraft, that it has far more to do with either the techniques used or with the accuracy of the therapist's ideas concerning aetiology. However, it would be very surprising indeed if all 'thinking . . . behaviour therapists' agreed with Dr. Kraft's statement that the efficiency of their therapy 'largely depends on the personality of the therapist carrying out the treatment.' If this were true I fear we would have to exclude some rather distinguished names from the ranks of 'thinking' behavioural therapists.

D. Y. MAYER.

*113 Grantchester Meadows,*
*Cambridge*

## COMMUNITY PSYCHIATRY

DEAR SIR,

I write concerning the paper by Dr. Oldham (*Journal*, April 1969, p. 465) on Community Psychiatry in London.

Dr. Oldham anticipates that 20 years hence 'provision for adult psychiatric beds will need to be less than one per thousand population'. It is, to say the least, surprising that he makes no reference to the Manchester Region where the kind of service he envisages has been operative in some centres for many years. My own service is in its seventeenth year, and, for example, as far back as 1963 I pointed out that at that time (Silverman, 1963) 0·4 beds per thousand population were coping with 96 per cent of unselected admissions from a catchment area of 250,000! More recently (Silverman, 1968), it has been shown that by 1965 the Department was coping with 97·3 per cent of all admissions from the area. In other words, the type of service which Dr. Oldham envisages already exists.

MAURICE SILVERMAN.

*Queen's Park Hospital,*
*Blackburn, BB2 3HH*

### REFERENCES

SILVERMAN, M. (1963). *Lancet, ii*, 587.
—— (1968). *Brit. J. Psychiat.*, **114**, 493.

## HYPOGONADISM PRESENTING AS A PSYCHIATRIC DISORDER

DEAR SIR,

Primary male hypogonadism usually presents to the general physician or endocrinologist on account of the physical appearance or lack of sexual potency of the patient. The case described below, which was of severe hypogonadism, presented with psychiatric symptoms.

### CASE REPORT

The patient, a man aged 47, gave a twelve month history of increasing apathy, weight loss, anorexia and evident unhappiness which had followed the severance of a relationship with a girl friend.

*Family History*

Two of his five siblings had attended the Maudsley Hospital, one brother with obsessional symptoms and social phobias, the other showing a personality disorder with aggressive behaviour.

*Personal history*

The patient had always been shy and a poor social mixer. His only regular occupation has been running a 'woollens shop' with a girl friend. He remembered at the age of six his parents saying that he was abnormal, and although brought up as a boy he preferred female company. He had never experienced sexual desire. He had had one girl friend with whom he had experienced a sexual dependent relationship; he was described by her and his family as being 'child like', enjoying 'fondling' in a child like manner and often seeking reassurance. He regarded himself as being physically abnormal but denied worrying about this.

On examination he was of eunuchoid appearance (infantile testes and penis, and virtually absent body hair)

and was obviously depressed. Psychiatric testing showed he was of normal intelligence. He was thought to be suffering from Primary Hypogonadism with a psychiatric diagnosis of depressive illness in an abnormal child-like, and over-dependent personality. Buccal smears were chromatin negative, and testicular biopsy was thought unnecessary as he did not wish for any treatment of his sexual underdevelopment. He was admitted to hospital, given amitriptyline and involved in the general in-patient routine, and rapidly became less depressed.

## Discussion

The personality of our patient resembles that of others with hypogonadism e.g. Nielsen and Fischer who in an account of 14 patients with hypogonadism described them as immature, lacking in initiative, spontaneity, endurance and originality. Pasqualini has emphasized that some of these patients showed low intelligence scores, and that loss of libido whilst common is not universally found. Our patient had normal intelligence and absence of libido.

Although there is a strong family history of neurotic disability in this patient's case, it is very suggestive that like others described in the literature he is suffering from a developmental disorder of personality which may be attributed to the direct effects of androgen deficiency and the consequent failure of the individual to become established in the male role.

B. D. Hore.

*Maudsley Hospital,*
*Denmark Hill,*
*London, S.E.5*

## References

Nielsen, J., and Fischer, M. (1965). 'Sex chromatin and sex chromosome abnormalities in male hypogonadal mental patients.' *Brit. J. Psychiat.*, **111**, 641.

Pasqualini, R. Q., Vidal, G., and Bur, G. E. (1957). 'Psychopathology of Klinefelter's Syndrome.' *Lancet*, *ii*, 164.