British Journal of Psychiatry (1986), **149**, 119–125

Correspondence

Hormones, Mood and Sexuality

SIR: We write in reference to the recent article by Alder *et al* (*Journal*, January 1986, **148**, 74–79). The research recorded is in line with the high standards that one has come to expect from the MRC Reproductive Biology Unit at Edinburgh. A number of interesting findings emerged:

Firstly, in terms of hormones, testosterone and androstendione median levels were lower in 5 breast-feeding women taking a progestogen-only pill, in comparison to 14 breast-feeding women who were not taking steroidal contraception.

Secondly, in the breast-feeding women testosterone and androstendione median levels were lower in those assessed at interview as having severely reduced sexual interest.

There is an apparent anomaly here, in that one might presuppose that those women taking steroidal contraception were certainly more concerned about the results of sexual activity (preventing a further pregnancy) and were possibly more interested in sexual activity. As mentioned, their testosterone and androstendione levels were lower, but no comment is made in the paper concerning their *actual* sexual interest, in comparison with the group not taking the pill and who had higher male hormone levels. This information would be of interest in assessing the association between male hormones and sexual activity in this group of people.

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Drs Alder and Bancroft Reply

SIR: Drs Harris and Thomas raise an interesting point in their letter. If the reduced sexual interest in our sub-group of breast-feeding non-pill using women was a result of their lower androgens, did the pill using group whose androgens were also low report sexual interest, and if not why not?

The progestogen-only pill using breast-feeders did not differ from the non-pill using breast-feeders in either sexual interest or activity. This highlights the complexity and often contradictory nature of the evidence of androgens in the sexuality of women which we pointed out in the paper. It is of course possible that the low level of androgens in the non-pill sub-group was a result, not a cause, of the low sexual interest. Or, alternatively, as we warned in the paper, they may have had lower androgens to begin with (i.e. before pregnancy). Although we have no evidence that our pill users were either more concerned about the result of sexual activity or more sexually interested before starting on the pill, they may have differed in some relevant way, e.g. their level of sexual interest may have been brought down by the pill or lowered androgens to the same level as the non-pill users. It is also possible that the androgen lowering effect of the contraceptive pill is different to that of breast feeding in some obscure way.

As yet there is little other evidence of the effects of progestogen-only pills on androgen levels. In a previous study of combined oral contraceptive users (Bancroft *et al*, 1980) we compared women with and without loss of sexual interest. Both groups had equally low androgens. In the "normal interest" group testosterone levels were positively correlated with self-ratings of sexual interest; this was not so in the low interest group. The role of androgens in female sexuality remains an enigma.

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Reference

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Homosexuality in Monozygotic Twins Reared Apart

SIR: I was very surprised to read that female sexuality may be an acquired trait and male due to complex interaction, in which genes play some part (*Journal*, April 1986, **148**, 421–425). It is quite clear that the authors are aware that their sample is small, but the consequences are not accepted (i.e. they dare make conclusions as outlined above. Homosexuality is not a rarity (despite the fact that collecting a large enough sample of homosexual

monozygotic twins reared apart is) and care should be exercised when trying to generalise about it.

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Dexamethasone Suppression Test

SIR: I refer to the review article by Braddock on the dexamethasone suppression test (DST) (*Journal*, April 1986, **148**, 363–374), with particular respect to nonspecific factors which might affect non-suppression. I feel the omission of the effects of caffeine merits updating.

Uhde *et al* (1985) studied 22 normal volunteers and depressed patients (diagnostic criteria not specified). The DST consisted of dexamethasone 1 mg at 11 pm and a 4 pm cortisol sample. Analysis was by radioimmunoassay. All subjects were given a single blind placebo controlled challenge of 480 mg caffeine (equivalent to about 4 cups of filtered coffee) between 2 and 2.30 pm. Caffeine was found to increase the mean post-dexamethasone cortisol value from 2.3 to 5.3 μg/dl ($P<0.001$). For both volunteers and patients, when using the 5.0 μg/dl standard cut-off point, non-suppression occurred in 14% on placebo and 36% on caffeine. This dose of caffeine is not unusual when compared to the average daily consumption (Gilbert *et al*, 1976), and indeed in psychiatric patient populations more caffeine may be used (Galliano, 1982). In addition, depressed patients in particular may actually increase consumption of caffeine as a result of their illness (Greden *et al*, 1978; Neil *et al*, 1978). Caffeine therefore should be added as an additional non-specific factor which might affect non-suppression.

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Is Hysteria (Conversion Reaction) Still Alive?

SIR: The article by Shalev and Munitz entitled Conversion Without Hysteria: A Case Report and Review of Literature brings out the controversy which exists around the diagnosis of hysteria (*Journal*, February 1986, **481**, 198–203).

My experience in a psychiatric hospital in India in a semi-urban area is that there is a well defined group of patients who can be given a diagnosis of hysteria. We have described the clinical features of such a group of 276 patients (Subramaniam *et al*, 1980). Similar patients are very common in most of the psychiatry clinics in India. The following are the common clinical features: presence of physical symptoms, more often monosymptomatic, in motor or sensory system without any organic basis; premorbid hysterical personality traits; age of onset of symptoms before 20 years; more among females; dramatisation of symptoms with belle indifference; presence of some unconscious conflict not necessarily sexual in nature and complete recovery with psychoanalytically oriented psychotherapy. Any physical symptom in the absence of an organic basis should not be considered hysterical. If this is established, it is likely that hysteria or conversion reaction will continue in spite of the obituaries pronounced on it by Slater and others.

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Reference

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On Serious Violence During Sleep-walking

SIR: Drs Oswald and Evans (*Journal*, December 1985, **147**, 688–691) presented some interesting material on somnambulism, including a case of a criminal act committed in sleep. We report another case.

Case report: A young man stayed overnight at his mother's. In the middle of the night he was awakened by an unpleasant dream in which his mother criticised and attacked his girlfriend. He sat up and dressed, with the dream going on in his head, but aware of where he was. Suddenly he got the thought—as if a voice in his head told him—that he should threaten his mother not to be so derogatory and aggressive to his girl-friend. So he went to get a hammer in the basement and went to his mother's bed. Just as he was about to wake her she moved in her sleep. To his surprise he hit her again and again with the hammer without a conscious thought, until after a while he