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DISCUSSION

Dr W. Carruthers (*Dumfries*): Would Professor Court kindly comment on the desirability of adding cane sugar to infant's milk? It appears to me to be unnatural, to predispose to obesity in infancy and in adult life, and possibly cause arterial disease, known to be widespread in the Western population, by the age of 18.

Professor Court: I would like to say first of all that I am not an obsessional person about infant feeding. This is very much a matter where in most cases the intelligence of the mother can be trusted. Secondly, the wise thing for the doctor advising in this field is to be familiar with a single milk. For almost all cases you can use a full-cream, dried milk from the beginning. If Dr Carruthers is worried about giving sugar then he should give an extra amount of milk powder and leave out the sugar, but in fact I do not know of any evidence that the addition of sugar, which produces not a true equivalent to breast milk but a more physiological mixture, does in fact predispose to subsequent obesity or, as he mentioned to me during the interval, to respiratory disease.

Dr H. Church (*Blantyre*): Is the I.Q. a factor in the incidence of adult criminals? If not, why is there a change from the juvenile pattern?

Mrs Rowbotham: I am not sure of the answer to this. I suspect that in fact the I.Q. among adult criminals is probably very similar to that among juveniles, and that a lot of adult criminals are in the same sort of low average or borderline pattern. I do not know whether Professor Carstairs would feel the same about this.

Professor Carstairs: I read a summary of an investigation published in 1961 which reviewed this whole topic very exhaustively indeed. It really showed that it is wrong to think that the prison population is loaded with persons of low I.Q.—educational back-

wardness is certainly prevalent, but I.Q. tests have not borne this out. On the other hand, one knows that in the early years leavers from educationally subnormal schools get into trouble more than other boys of their age in the community. In the adult population a low I.Q. is not a very important contribution to the prison population.

Dr Hodgkin (*Redcar*): I would like some comment on genetic counselling. The family doctor should put all the facts before the parents. Should he also try to influence their decision by either encouraging or discouraging them?

Professor Court: The basic duty of a doctor is to offer counsel to patients and to leave them to take it or not. That would be my own general principle but I think it is often difficult for the young doctor to accept this. He wants to guide people much more than is within his field, and so I would agree with Dr Hodgkin that the essential thing is to put the facts before the parents in a meaningful way. I am going to ask him in reverse how you do put these facts in a meaningful way to parents, because this is a thing which I am not sure about myself. Whereas in most cases you are going to put the risk to them as simply and plainly as you can and leave them as adults to make the decision about subsequent children, there may be some parents who are not able to accept these facts without support and without guidance. If that is the situation, as it must be sometimes, the family doctor is most certainly the best person to guide them as far as he thinks he should.

Professor Carstairs: If we played safe we would always tell them not to have children. Then they could not reproach us, but your predicament really is when people want very much to have a family and come to you for guidance.

Dr Lowell Lamont (*Edinburgh*): How should we advise our young schizophrenics taking phenothiazines who contemplate marriage?

Professor Carstairs: There is a very wide range of severity of schizophrenic illness and of prognoses. The indications are it is relatively late in onset, in the twenties. If it is of sudden onset and accompanied with a lot of emotional involvement, these are good signs. There may never be another attack, so one factor affecting advice is going to be a consultation with the psychiatrist about the prognosis in the particular case. This is doubly relevant because it is such a patient who is more likely to contemplate marriage. The schizophrenic with the poor prognosis is the one with a gradual, insidious onset, withdrawn, apathetic and much less likely to marry, so this problem is less likely to arise with him. I would endorse what Professor Court said and agree that it is really important for us not to advance our advice but to be prepared, if the patient asks

us, to say what our view about it is. If we anticipate their request for advice we are much less likely to influence the patient.

Mrs Rowbotham: Would you feel that there is some place for education before a problem arises? In one's own family one talks about the sort of marriage that might take place which would be unfortunate and the sort that would be good. If there were some talk at a growing stage before the crisis arises, before the decision has to be made, so that young people before that stage know something of the risks of certain illnesses, would this be any help? For instance, if a person is aware of the risk in certain forms of mental backwardness or schizophrenia or more physical disorders, do you think it ever helps them not to fall in love with the sort of person they should not marry? I think it may.

Chairman: There is one other facet of this, almost the other extreme. Certain physical and also intellectual handicaps segregate children such as the blind and deaf in school and societies and institutions, welfare organizations, and so on. They also keep up this segregation. Many of these conditions are to some extent genetically determined and yet we create closed communities which encourage marriage within those groups. This is, I suppose, our failure as a society to think more imaginatively of other methods.

Dr Hendry: Great stress has been laid on our ability to help the adolescent. What methods can we use to persuade the adolescent to bring his problems to us?

Mrs Rowbotham: It is true that young people on the whole do not want to go to the doctor. They want to feel themselves perfect and entire, unless something miserable and challenging like acne or unpredictable like an accident forces them to go, but it does not mean that some of them do not need help. It can be given. It is not easy just to say to some adolescent in your practice whom you have not seen for a long time: " I need to see you; come along ", because they will probably say: " I haven't the time ", or " It is difficult ", but you can sometimes find ones that are at risk and need you through an enquiry of the parents whom you may be visiting for some other purpose. Nearly always if there is a problem the mother or father will come out with it and give you a clue. If you get the clue then I think you have to use your own best sense of how that particular individual can be got at. Sometimes there can be an excuse like acne even, or sometimes you manage to see him in the street and say: " I haven't seen you for a long time, come round and have a talk ", or something that leaves it open to him very easily to do it without perhaps a specific appointment. In fact, many child psychiatry units give adolescents this right because they are so

unhappy about the appointment. They do not want to be compelled to keep one. When I see adolescents, I never say at the end: " Now, come at such and such a time to me ". I say: " Do you want to come again? " and they nearly always say yes, and I say: " What about such and such a time? Would that suit you? " They love to have a decision to make themselves in this; present them with an alternative to make them feel that it is their choice and then they will come, but you have to make the opportunity.

Professor Court: If Mrs Rowbotham will allow me, I would like to underline something she said herself which I thought was very important, namely this question of letting the child talk to the doctor in his own right. Adolescents of course, have been infants, toddlers, pre-school children and schoolchildren before they have become adolescents. It surprises me how very often children are allowed to reach 13 and 14 while conversations still go on either in their presence or in their absence, over their heads between doctor and parent. I would plead for our talking directly to children at a much earlier age. I had a boy the other day who exemplifies this very well, an intelligent boy of 12 from an excellent family, who had had quite a severe asthma for six years. I had not seen him before. Nobody had explained to him what was wrong. Nobody had asked him what it felt like to have asthma. Nobody tried to explain to him how these symptoms were brought about and what the treatment was really trying to do, and give him any encouragement that this was something that in the end could be managed and from which he would emerge. He was deeply depressed about the whole thing because the conversation had gone on entirely between his parents and the doctor and he had never been included. I think we can do something about getting the adolescents to come to us if we take them into our confidence in childhood and treat them as individuals earlier.

Dr B. C. Hamilton (*Edinburgh*): Regarding treatment of respiratory disease by oxygen rather than antibiotics, is it your view that the importance of treating respiratory infection in hospital outweighs the emotional disturbance to the child caused by hospitalization?

Professor Grant: I would say right away that the problem I was concerned with when I made this point was the fact that we are getting 3,000 deaths from pneumonia a year, of which four out of five children are in the first year of life. It is not in the first year of life that the problem of hospitalization in its emotional effects is greatest; it is in the toddler age group. Secondly, this is a relatively short period in hospital, and with free visiting and explanation to the mother, I do not think that this really comes into it. This is a

straight issue of saving the lives of a good many children that could be saved.

Mrs Rowbotham: I must agree with what Professor Court said. My feeling is that with easy visiting or perhaps the possibility, as we have in Newcastle, of taking the mother in with the child over a small period, this is not a very great factor.

Professor Carstairs: I would entirely endorse what these speakers say. It is a matter of weighing priorities and death, after all, is of greater priority than emotional disturbance, which may be transient. Professor Court pointed to the real area of concern here, the slightly older child and his hospital stay when he has to be admitted. We have all got a responsibility to see what happened in our own areas. I have heard accounts of some hospitals not a hundred miles from here which allow parents to visit only twice a week at strictly limited hours. We tend too easily to believe that what is officially recognized to be the more humane conduct of children's hospitals has been generally accepted. Has it reached your locality yet? If not, I think it is quite proper for general practitioners to take the lead along with parents in trying to urge local hospitals to amend their practice.

Dr I. K. McIntosh (*Isle of Lewis*): Professor Carstairs stressed the dangers of alcoholism. Alcoholism is a big problem in the Highlands and the islands. Can the professor suggest any preventive as against curative measures?

Professor Carstairs: What makes that question so difficult to answer is that drinking is fun, and even drunks are fun, and even Highland ministers who get drunk twice a week are comic. It takes quite an effort when we have finished laughing about it to realize that it has got a tragic element in it too. It is true that alcoholism is more prevalent the further north you go in Scotland. As you go up into the malt whisky country the rate goes higher and higher. I suppose access is easier, for it is something that comes with your employment to begin with. Professor Scott has implied that it is something relating to the whole industrial economic decline of an area and that may be true, but what can we as practitioners do about the economic decline of an area, except to ask questions of our local M.P. to take political action?

The other thing we can do is to focus attention at the point where drinking moves over from being a social and enjoyable activity to being a dangerous activity. Here we have a very important role in health education, in that we can first of all identify alcoholism as a health hazard. So often in the islands it is regarded as a moral lapse, isn't it? Everyone drinks a bit, but the one who drinks too much is a moral reprobate and he is condemned. If we could propagate a clearer recognition of the point at which his health is at

serious risk, perhaps that would be the stage at which you could effectively intervene and do something about the high rates of serious alcoholism.

Dr I. K. McIntosh: I would like to thank Professor Carstairs. I was thinking particularly of young people. One does see in my practice young men of 17 and 18 who start drinking and by the time they have been drinking for a year, many of them are confirmed alcoholics. I have seen many young men of 19 or 20 with their liver down below their umbilicus. I was wondering if Professor Carstairs could suggest a point where one could say to these young people: " Look, this is what is going to happen ".

Professor Carstairs: This is a very interesting point of health education. How do you persuade people to change their behaviour? I think I could draw an analogy between this and a similar problem as put to a colleague of mine who was a medical officer in the paratroops, an American division, which was dropped in France on D plus 1; they knew they were going to be in the very fierce fighting straight away. In their final preparations, their commanding officer became quite worried about the fact that the men would not wear steel helmets and he instructed them that if they did not wear their steel helmets they were going to receive a fatal injury instead of getting away with a minor wound. It was dangerous, but these troops saw themselves as tough fellows who lived dangerously, so they couldn't be frightened into wearing their helmets. So the commanding officer took a different tactic. He always wore his own helmet in and out of season and he let it be known that any soldier who did not was a pretty slovenly soldier hardly fit to be in their particular outfit. The prestige value of wearing a helmet on your shoulder slumped and people began to wear their helmets properly because they had a different image of the man who wore a helmet.

It is not going to be easy telling these 17 and 18-year-olds. I think scaring them out of alcohol will probably not work. I think we have to offer them some other satisfaction and surely this is precisely where the lack of any really good outlet for the activities of 17 and 18-year-olds in an area of economic and industrial decline is a very challenging question.

Chairman: I can commend to you a book which I have just recently come across called *The Cumberland Gap*, which is a very graphic account of the social circumstances of dwellers in the Appalachian Mountains, in a very depressed area. All the way through there are extraordinary close parallels with the need to look at their problem of alcoholism aginst the total background. The Federal Government has just passed a law to drive huge roads over these mountains and bring a great deal of relief and new industry in. It is very interesting

to see how this pocket of a regional problem persists there.

Dr Weir (*Durham*): Should homosexuals be punished by law?

Dr Gaskell (*Edinburgh*): I should like to ask each member of the panel to say how we can contribute to preventing the damage, disease and distress of homosexuality?

Professor Carstairs: I am sure everybody has at the back of their mind the recommendation of the Wolfenden Committee that homosexual practices between consenting adults in private should no longer be punished by law. The conclusion that Committee reached was that this was not a social menace; these people were not harming other people. Homosexuals themselves have strong views about those homosexuals who seduce children, and tend to take very savage punitive action against them, because they bring all homosexuals into disrepute. No one would dispute that homosexuals who interfere with children have to be restrained and it is quite proper that there should be a law controlling that flagrantly anti-social behaviour.

But would it do any good to punish homosexuals who are not in fact soliciting, canvassing, seducing or debauching, but who have despaired or even just shown a disinclination to their rather set homosexual tendencies? Interestingly enough, we have not changed the law, but since the Wolfenden Committee there has been a great change in the attitude of the police, chief constables and magistrates up and down the country. You probably know that an instruction is out that before a prosecution is launched against homosexuality in consenting adults in private this should be turned over to a higher authority for consideration. This is simply in order that similar standards of attitude about prosecution should prevail all over the country and should not be left to the vagary of local opinion. In the past there have been local areas where a chief constable has savagely prosecuted homosexuals. When this is in general contrast to practice in other areas you cannot help wondering why that man regards it as such an important part of his role to seek out and punish homosexuals. Quite often one is forced to the conclusion that he has an unresolved anxiety about this issue which makes him see it as a much greater public threat than perhaps it really is. So my answer is that I think public opinion is changing in the direction of a modification of the law as suggested by the Wolfenden Report, even though the law was not changed at that time. The question is to what extent homosexual behaviour is a menace to others. What is your experience about this? I take it the questioner is concerned about this aspect of the subject.

Dr Gaskell: I was concerned in particular on behalf of my patients who are homosexuals. I have been looking at one or two of them

lately and I have been trying to see how, much earlier in their lives, helpful discussion with the doctor might have been applied to ameliorate their subsequent problems.

Professor Carstairs: This is a point that Mrs Rowbotham could discuss. One can sometimes recognize a family pattern conducive to a homosexual inclination.

Mrs Rowbotham: That is true. Among those that come up as youngsters at risk, you do tend to recognize a family pattern, a strong and curious feeling towards the mother, either for or against, but I think there is always an abnormal relationship with the mother or tends to be in these families in my experience. Very often there is an ineffective father. Having said that, one wonders why all our patients with this background do not become homosexuals. As regards the problem of punishment by imprisonment, I would say no. I would even bring myself to say that the man who has contaminated youngsters should not be punished, because I think punishment is the wrong thing here. I would put him under control in some way, under surveillance of some kind so that his job was one that did not lead him into too great a possibility of doing this; he should report regularly to the doctor in charge of him. Quite a lot can be done with youngsters at risk and the public attitude is changing considerably towards this problem. So often the young homosexual has in the past been badly handled, and what has been a transitory phase, almost a developmental phase, has been prolonged into adult life by unfortunate handling at that time, and there is no doubt that in many schools, especially boarding schools, young people are exposed in a transitory way to this kind of thing. I do not think it necessarily does them a great deal of harm unless everybody leaps on it and a tremendous sinful exposure is made of it, especially when the families cannot accept this and cannot deal with it properly. Quite a good deal of useful work can be done by the family doctor who does not condemn and does not go up in smoke and who helps the family not to do the same, to accept the thing as a transitory phase through which the boy can go and get on to something perfectly healthy, as I am sure can be done. The ones who get fixed at that phase and do not develop past it are the difficult ones but even they can be helped to some extent, but usually the homosexual comes when the pattern is established and treatment often is impossible or ineffective.

Professor Court: I do not think I can contribute to this directly, but I would like to ask Mrs Rowbotham and Professor Carstairs whether they feel that we really know enough about the origins of this in childhood and early adolescence, secondly, whether they feel that there is any risk in the one-sex boarding school, and thirdly, whether psychiatry has something quite definite that they can offer

in the way of treatment to the child seducer, who is, I think, the unhappiest part of this problem, and of course the one we are most concerned about. He is clearly a sick person. I think one would bring him into the category of sick persons, whereas in the consenting adult one could argue perhaps about the right description.

Professor Carstairs: We will certainly agree we need to know a lot more. Kinsey in his surveys came to the conclusion that biological factors determined homosexual outlook in about four and a half per cent of the male population. I do not know that he was right. He may have assumed a little too quickly that there was an irreversible biological bias. The reason I say that is that there have been extensive studies by a group at the John Hopkins Hospital, Baltimore, of the various types of intersex people whose genetic sex and whose external genitalia are sometimes ambiguous. Their most interesting finding was that the sexual orientation of these people as they grow up was determined not by biological factors so much as by the attitude of their parents. The parents decided that this was to be a boy or this was to be a girl, and this seemed to override the biological bias. Admittedly these were exceptional cases, but it shows that the parental attitude can be very important and I would like to cite one celebrated case of a fairly well-off middle class family with two or three children who wanted very much to have a girl. Their youngest child was a boy. The father was an amiable, talented, slightly alcoholic individual. He did not cut much ice in society. The mother was a much more forceful personality and she allowed her disappointment to overrule her judgement to such an extent that she brought up her youngest as if it were a girl. To the age of four the little boy was dressed in petticoats (this is a story of the end of the last century) and that boy grew up to be Oscar Wilde.

Mrs Rowbotham: We had a child who had been discovered at the age of about six or so to be a girl, when she had been brought up as a little boy. We took her in for a time as a day-patient to effect the change from male into female clothing and she had a certain amount of operative procedure, had her hair grown and chose her own name. We could help her in a very specialized community and help her parents also in adjusting to this particular change. Whether that girl will grow up with any homosexual tendency I do not know. There possibly is a risk of this kind in the one-sex school, but there are risks of another kind in the mixed school which perhaps outweigh these. An enormous amount depends upon the headmaster and the masters who are dealing with the problem and their attitude, and this I find on the whole is not good. My experience is that headmasters on the whole are afraid. It matters so much to the school for a thing like this to be discovered that they close their eyes to the real risks. I do not think many of them know what goes

on at all; even when it comes to their notice they are unwilling to believe its extent. It is probably the educationalists that need the education in this case.

Dr A. B. Carmichael *(Edinburgh)*: Could you comment on the role of the family doctor in the handling of prolonged grief?

Professor Carstairs: I heard a very sad story at a conference two days ago. A family doctor was speaking in defence of amphetamines, though I do not share his conviction. He felt very strongly that amphetamines were a good treatment for minor depression and to illustrate his point he said that his 80-year-old father had suffered a bereavement. His mother had died and his 80-year-old father took it very hard, and he thought it a great shame that his family doctor would not give him amphetamines. What an extraordinary attitude! Why shouldn't you take it hard when at 80 your companion of 60 years dies? Should you take immediate recourse to a drug so that you do not mourn? I thought that was a profoundly unhealthy attitude. Surely one should recognize painful experiences.

This question of course, is directed at something different; it is about the prolongation of grief. To this question I would say that mourning is a thing you support a person through, with the help of the kin and the friends just showing that they know that this is a bad time someone is living through. When grief becomes prolonged, you begin to wonder if this is a depression. A recent study from the Tavistock Clinic drew our attention to the fact that after a bereavement the survivor runs a risk of all sorts of illnesses, not just depression. The incidence of minor illnesses was increased during the subsequent year and this is part of the painful period of living through a depression. This is one of those life crisis periods, one of those areas of risk in which we should be alert, not only to a possible development of depression but to other forms of illness too. The best prophylactic to my mind is to see that the person does feel that grief. I keep coming across people who become depressed years later and are only now dealing with the grief they experienced from a sudden bereavement.

Professor Court: Could I just say a word about this from the other end of the scale. I would like to hear from the floor whether my own experience is true here. It seems to me that in my childhood grief was part of family life. Without any difficulty I remember my great-grandmother dying and I remember my grandparents dying. I remember the grief of the family at this and we were included in it; we were not in any sense excluded. Time and time again I find that parents have sent the children away or in some way excluded them from this kind of experience. I would have thought that this may later on make it difficult for the adult to accept death and sorrow

as part of the normal experience of life. I do not know whether my experience is biased or whether that is something that is changing.

Mrs Rowbotham: I agree tremendously with that. I have an adult patient who was bereaved of her mother at the age of six. She is now quite an elderly lady and she has got over this. She was able to share this with nobody, or she maintains to this day that she never could share it, that there was no one she could talk to or feel close to in this and that it still exists and has affected her whole life. We do see children with grief reactions of a very severe kind and I think the general practitioner is the person who can help. So often they get referred to us because the doctor has found it has gone on to an alarming extent. Perhaps a young child is sleepless for a very long period and the mother begins to say: " I can't stand it any longer "; I remember in particular a child of four who lost her father through a cardiac operation and this went on and on. The child lay with his arms clasped round his mother's neck every night talking and talking, afraid to go to sleep because to him sleep and death had become absolutely muddled and he was afraid to sleep and afraid to let her sleep. This was very wearing and the amount of sedation this child was taking was alarming his family doctor, but the role of continuous support and not being anxious if the episode goes on longer than he feels necessary is the right thing. To talk about bereavement and to share it with children is good advice to give to parents. Tell them not to put the photographs away, but to talk about father and feel that he is still the person whom we know and remember and think about. Children can take death fairly well and often we do not give them a reality situation. I should like to tell you just one story. I remember years ago a little boy who was a friend of my children. His father died and I invited this little fellow to stay with me while his father was buried; I told my two youngsters: " Now you've got to very kind ". We arranged to run a treasure hunt all over the area with clues hidden so that they were on the run and doing things all the day. They had a very happy day and the child went back to his family at the end of the day and my two went into the kitchen and said to my old housekeeper: " Of course this was all right for a child, but we shall insist on going to Daddy's funeral ".