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DISCUSSION

Chairman: Before we go on to answering the questions which you have kindly produced for us, I ought to say that we are highly honoured in having the president of the College, DR F. M. ROSE, with us this afternoon. This would be an appropriate time to have from him a word of greeting from the parent body. Dr Rose, we welcome you, sir.

Dr Rose: I have been at many of these symposia and I think most of them have been organized very much along these lines and owe their inception to the same firm as this one does. I think they do an enormous amount of good. I was here in this faculty at its inauguration approximately ten years ago. One of the most biologically interesting points about that was the letter of congratulation from its daughter sub-faculty in Hull, the only incident in which the daughter sent a telegram of congratulation at the birth of the mother. I am very glad to bring the greetings of the College to you all, and particularly to welcome those here who are not members; I hope that they will perhaps have a closer association with the College in the future.

Question: I found Dr Scott's dictum that the deflated chest measurement should be two inches greater than that at the umbilicus most interesting. Does he have a special type of tape measure for the fair sex, and does he consider these measurements of use in females?

Dr Scott: It is not the easiest question to answer. I do use a tape measure in female patients, but it is more a question of seeing whether or not they are losing weight. It is more difficult to show that the chest measurement is two inches greater than that at the umbilicus, but as regards loss or gain of weight the tape measure gives as great a feeling of accuracy to me as do the scales.

Dr A. U. McKinnon: Do the panel agree that many of the hazards

of middle age proceed from moral rather than from pathological reasons?

Professor Roth: If by pathological reasons you refer to physical illness or physical disability and by moral you refer to the very wide range of emotional disturbances, then I would accept this, I think that emotional disturbances are probably among the commonest of the sources of disability in middle age. I would not agree that people who come with a disability in middle age will necessarily suffer from moral defect in the strict sense of that term. Even where you can define some failure to face such problems as death or changing strength and vitality, I think it is dangerous to assume that you may not have something which goes well beyond what can be accounted for in terms of moral deficiency. One of the most important advances in psychological medicine has been the recognition that a great deal that used to pass, both in middle age and old age, for natural and inescapable adversity or decline is due to relatively specific processes which can be mitigated and sometimes cured; at the same time I would accept that moral factors play their part. I suppose I'm like a cobbler who says that there is no stuff like leather, but I suspect that too much emphasis has been laid on endocrine changes and physical decline as opposed to emotional difficulties in relation to the problems of middle age.

Dr McKinnon: May I enlarge my question, sir? I would like the responder to enlarge his answer. The Bible says, "The wages of sin is death", and I really am meaning sin. Some of you may have heard of a book by a cardiologist in the Middle West who argued cogently that one very important factor in coronary thrombosis was living a sinful life. In the beginning of his book, he quotes the famous reference from I Samuel 26 about the churlish Nabal who who didn't give the right answer to David, and David nearly slew him and ended up by taking his wife. This man led a sinful life and had a coronary thrombosis, the first reference in literature to it. Is not a wrong way of living or wrong attitude to life not a much more important primary factor in disease than even you psychiatrists acknowledge?

Professor Roth: Does Dr McKinnon mean self-indulgence, because that would include a very wide range of things. I don't like the idea that the doctor or the psychiatrist or anybody else should moralize over his patient, because this does no good whatsoever; if anything, it ends doing harm. The patient comes to the doctor in the expectation that his problems will be dealt with in a tolerant, dispassionate, and detached manner. If the doctor takes up moral attitudes towards his disability, he removes a very important part of his therapeutic armamentarium. Although what I've had to say in relation to such things as attitudes to death may seem to have

moral overtones, I believe that we have progressed beyond the last century, where in psychiatric textbooks all the things that you mention are named as causes of illness—lust, self-indulgence, gluttony, cowardliness and lechery. There are two dangers in this. First of all, there is the danger of moralizing, the second is that if you identify a moral defect you explain everything that the patient has in terms of it, and this may be quite a false way of associating things, because the patient may have an illness that goes beyond anything that can be explained in terms of his pattern of life. Self-indulgence in the broad sense probably does contribute to disability in middle age, but I do not like the sound of suggesting that sinfulness is the cause of our trouble.

Dr McKinnon: The patient may really be full of guilt, but you as a post-Freudian are excusing his guilt feeling to him. This man may be happier if he contrives to make atonement in his life for his guilt; if you excuse him he merely continues on his way. You are not acting as a true confessor of his sins. You've explained his sins away, and he has had grace.

Professor Roth: If a patient complains of guilt in this way and perpetually accuses himself, I begin to worry about whether he is going to swallow a bottle of tablets or hurl himself through the window the following morning. People who accuse themselves perpetually in this way are those who are sick in a sense which we apply to physical medicine. One needn't argue about this; anytime you care to come in our clinic, I will take you to patients who complain one week that they have committed all the sins in the universe and within a short time, under purely biochemical procedures (although I don't think they ever constitute full treatment in any sense), these self-accusatory, sinful men become zestful and able to face life with cheerfulness and composure again.

Sir Derrick Dunlop: I think it splendid that this question should have come from a McKinnon, because we've all got a great sense of sin in Scotland: "I sinned three times last night" and that sort of thing are very common expressions. I did talk about the sin of gluttony and the sin of indolence, and so on but you are talking about some more recondite sins. Professor Roth was simply saying what the Holy Church has said for ages, that the patient wants mental purgation or confession, not necessarily to anyone in particular, and he is not going to adopt a high moral tone, but it does people good to purge themselves by confession. I suppose that wouldn't appeal to a McKinnon, of course.

Question: How does Dr Kuenssberg obtain evidence from children about a parent without: (1) being suspected of snooping and (2) without abusing the confidences of the parent.

Dr Kuenssberg: Personally, I find this an extraordinary question. If I talked to an old person, would I be snooping if I asked whether her daughter was nice to her or not. One converses with children as one converses with one's contemporaries, and I think a great deal of our current difficulties are due to our inclination to divide everybody up into tiresome age-groups and keep them separate. As for abusing the confidences of the parent, I don't ask the child whether its mother is menstruating or something of the sort. By children I am inferring people with a parent living in middle age; this applies a great deal to the students whom I work with on tutorial terms in small groups.

Question: Consultants generally seem to depreciate the use of stilboestrol and similar hormones in the treatment of menopausal symptoms. General practitioners find them almost invaluable. Why the discrepancy?

Dr Kuenssberg: Being neither a consultant nor a general practitioner now, I find this a little difficult. The problem is that hormones have to be given under direct and continuous supervision. There is a loss of continuity with a consultant, because his follow-up is very frequently done by others whereas the general practitioner is the family doctor, and the end-product of his patient is his interest. The consultant rarely sees his end-product; his mistakes don't come back.

Sir Derrick Dunlop: As you have suggested, a talk to the patient and reassurance is probably all that is necessary for the majority of cases of mild menopausal disturbance, but for very bad ones I should have thought that oestrogens were invaluable; most people should start with a pretty big dose in the first week and get symptoms under control, then they will usually be able to carry on with tiny doses, which are invaluable both psychologically and physically.

Chairman: Might I make the point that sometimes if a menopausal woman is given stilboestrol or something like that it is extremely difficult to wean her off it when you feel that she should not continue having it. How does one deal with that kind of problem?

Dr Scott: To show one way in which this can be dealt with, I always recommend 0.5 mg. of stilboestrol twice a day until the flushings have stopped. As soon as they have stopped the drug is taken once a day; and when they have been stopped for a week it is taken twice a week, and at the end of a month it is stopped. Should the flushes come back, the same routine is followed; it is up to the patients to demote themselves, and I find people do.

Professor Roth: Long-continued dosage of oestrogens, in a substantial minority of patients, is responsible for depressive symptoms, which may become quite severe. Depressive and other psychiatric

disturbances may be just as bad after months of treatment with stilboestrol as they are with corticoids.

Sir Derrick Dunlop: Dr Scott's way of doing this is the ideal way, I am sure.

Question: Do people who have had their prostates removed for carcinoma and who are on big doses of stilboestrol get more depressions?

Professor Roth: I have never followed up the effects of this, but many years ago I worked in Lord Brain's clinic where a good many patients were given very large doses of oestrogen, which was considered to be good treatment for inhibiting the anterior pituitary. I did see some very severe depressive reactions in these cases, but I must confess that I have not had referred cases given large doses of oestrogen for carcinoma of the prostate.

Chairman: What treatment, if any, would you advocate for severe premenstrual depression and irritability?

Dr Kuenssberg: I think that the essence of this is to explain to your subject at what period in time this occurs. I have been discussing this with a scientist who is acutely involved with premenstrual depression; it is only in the last few years that she has realized the link between the week of diminished judgment and increased irritability and her endocrine state. The intriguing factor is that she is on a 35-day cycle, not a 28-day cycle as most of us should be, and says that if she is going away on holiday she gets so upset with the pleasures of going on holiday that she postpones her menstrual period entirely, whether it occurs in that holiday period or not, which is a very significant feature of the hypothalamic-pituitary-ovarian chain.

I think that a lot of women are unaware of this significant time; in the last few years I have been discussing it with students in our small groups, both females and the males. One or two women told me that when examinations had been coming up in this period they had always recollected that it was the time of their premenstrual tension and therefore used their mind, psychologically outside their body so to speak, to produce more effective work. A couple of men have told me that this knowledge has helped them very much in the family. Among other processes, water retention appears to happen (I know Russell has denied this recently, but Zuckermann considers that this water retention is due to sodium retention). Reducing sodium intake giving diuresis before the menstrual period does lead to a certain amount of relief. There is the odd somatic reaction that if a diuretic is given immediately previous to the menstrual flow, for 2—4 months, diuresis starts spontaneously by about the fifth or sixth month, and the premenstrual tension reduces.

Whether this is the endocrine cart or the hypothalamic horse I am not sure.

Professor Roth: Premenstrual tension, which is of course a form of anxiety (heightened state of tension with irritability, impatience, some initial insomnia), is hardly ever a condition in isolation. I express a personal view here, but I believe it is almost invariably a caricature of straits of personality, of emotional characteristics which exist all the time. This does not mean that one proceeds to psychiatric investigation or treatment of all patients with premenstrual tension. In the great majority of cases the administration of ethisterone in 10 mg. doses for the premenstrual period is perfectly adequate, but when symptoms are severe there is a danger of selective questioning directed only towards the premenstrual period and only to certain symptoms. If the whole problem of the person is studied, you will find that in addition to being more irritable, more impatient, tense and exhausted in the premenstrual period, the patient may have panics in the street, difficulties in going into shops, tendency to attacks of dizziness which are quite terrifying, and tendency to depression. At times other than the premenstrual period the patient has fears of loss of control, inability to go into crowded rooms without a sense of panic, and so on. The patient will have learnt from her reading that premenstrual tension is a pattern recognized by doctors and she will come with this, but it is very important in the bad cases to try to assess whether or not there is a severe anxiety neurosis or reactive depression, or anxiety state can be quite a serious matter. A lot of attempted suicides—and you know that attempted suicide is far commoner in women than in men—occur in this sort of setting. In brief, I would say that simple endocrine measures are highly effective in the mild cases, but in the severe cases I am sure that a general psychiatric appraisal is necessary, in addition perhaps to endocrine treatment.

Question: Most practices have a small number of obese patients who genuinely cannot lose weight on the 1,000—1,200 calorie diet, or lose it so slowly that they become discouraged after six weeks or so.

Sir Derrick Dunlop: We all know, of course, that most of these patients on a 1,000 or 1,200 calorie diet are not sticking to the diet. That is the common explanation of it; if they really are in a metabolic ward and are put on 1,000 calories under really strict circumstances most of them lose weight perfectly well. I agree that there are some extraordinary patients who seem to be able, even in a metabolic ward, to maintain their weight on a 1,000 calorie diet, and it is physiologically almost inexplicable, for you can calculate that their ordinary vital function is very nearly sufficient to use up that. It has been said that they are simply retaining water, but there must come

an end to that or they would turn into a jelly-fish otherwise. However, some patients apparently use extraordinarily little energy and move about very little. If they can be encouraged to take more exercise they usually lose weight well, but people who are very obese cannot take much exercise with their flat feet, varicose veins, osteoarthritis of the knees and hips, and their gallstones bobbing about in their gallbladder. They have to come down sometimes to very low diets to lose weight satisfactorily.

I agree that there are exceptional cases of that sort. How can you help them? With the help of amphetamine or tenuate to which they rapidly become tolerant? It is quite true that these meretricious drugs are no answer to the question of obesity. Everyone becomes tolerant to them, usually well within two months. They lose their anorectic effect entirely within two months, and they have many other drawbacks—behaviour problems, dependence, even addiction in some cases. Is there any other way of producing satisfactory weight loss, e.g. with thyroid? No, because the anterior pituitary immediately says, “I am not going to work if he gives me that”, and thyroid simply inhibits the anterior pituitary by that amount. If you give 1, 2 or 3 grains of thyroid or 0.1, 0.2 or 0.3 mg. of thyroxine, the anterior pituitary stops by that amount and so you are not getting any further, unless you give large doses of thyroid to make the person actually hyperthyroid, which takes 5 or 6 grains of thyroid a day, which is obviously most undesirable. What else can you do? You can put them onto a 600, 700 or 800 calorie diet and perhaps use a food substitute like methylcellulose biscuits or metercal for one of the meals, which may help. However, very few of these patients require a 600 or 700 calorie diet, but when they do I think some of these substitutes may be of help.

Question: Some weeks ago there arrived in my house a book called *Strong Medicine*. It was priced 18s. and came from American sources. I understand that 2,000 of them have been distributed amongst doctors in Great Britain. It recommends a very high fat diet. I thought that was humbug, but I read in this week's *British Medical Journal* about a symposium of the Royal College of Surgeons, in which it was stated that some people in Middlesex have been giving their elderly gynaecological patients large doses of fat to produce loss of weight.

Sir Derrick Dunlop: I think that loss of weight is entirely due to calories; if you eat nothing but fat and nothing but carbohydrate—you hear people saying, “You ought to eat nothing but potatoes and you will lose weight”—you can, because you are very unlikely, if you eat nothing but a certain specified type of food, to take enough calories. Loss of weight is entirely a matter of calories, and I do

not believe that the actual constituents, the proximate principles of the diet, are of the faintest importance at all. If you go on to queer diets such as nothing but carbohydrate or nothing but fat, you probably will lose weight simply because you do not eat an adequate amount.

Question: (1) Surely this problem of compulsive eating is a psychological state. Can these people not be helped in any other way? I know from many people who are on amphetamines that they become tolerant of them or addicted to them or they just fail to adhere to the diet, and yet they seem to eat compulsively. (2) Is treatment with the hypoglycaemic drugs for producing anorexia coming into use?

Sir Derrick Dunlop: I think that a great deal of obesity in women is due to frustration. They run to cream puffs and pastry as a man goes to the pub, and there is no doubt that there are psychological causes for that sort of eating. Giving the diguanides seems to me to be even worse than giving the other drugs, because the diguanides will act only if they take the appetite away and cause nausea and diarrhoea. To give a poison to cause nausea and diarrhoea seems to me to be a poor answer to the treatment of obesity.

Professor Roth: The most clearly established example we have of compulsive eating is the phase which follows treatment in anorexia nervosa. This is a relatively common condition, far commoner now, it seems to me, than when I was a student. These girls are frequently quite fat when they start, in fact what they most want is to be slim. The first step is an attempt to acquire a figure which approximates to the elegance portrayed in *Vogue*, and then this condition gets out of hand and patients become cadaverous. Sometimes treatment is too successful and they swing over into a state of compulsive gorging in which they may steal food or even take it out of the dust-bin, as one of our patients did, whilst two of our patients quite recently have been prosecuted for stealing food from shops.

There is no doubt that something has gone wrong in these patients in their relationship to the large overbearing, termagant mothers who often dominate the scene; anyone who has dealt with these cases will know that this is a consistent phenomenon. In the largest series studied very carefully, feeding disturbances were common in childhood (it is, of course, difficult to separate cause and effect in these patients). I think compulsive eating can be brought under control by psychology combined with chemical means. The larger question of obesity in middle age is related to some extent to the problem of people who eat whenever they are unhappy or frustrated. This is a natural response with a psychological element, sometimes associated with personality traits which one can define. These individuals

are hungry for many things, with a natural greed in a proportion of instances. I do not know the result of treating a large number of people of this sort for obesity by psychological means, because nobody has attempted to do it or has published results upon an adequately scientific basis. The difficulty is that by the time middle age comes along, feeding habits have become long-established and firmly ingrained. It is very difficult to change a person's personality, and feeding habits are part of their personality, but this does not mean that one should not have a try at mitigating the degree of disability. I think there is probably a body-type relationship. It has been shown that body-type can be defined fairly precisely in terms of two very simple dimensions; at one extreme are those people who have girth instead of longitudinal dimensions and at the other extreme there is the reverse. The pyknics, the people with large visceral cavities, seem to be very prone to put on weight in middle age. Sir Winston Churchill is a very good example—in youth, quite elegant with small limbs and characteristic stature, in later life and middle age tending to put on more and more weight. Far too little work has been done on the relationship of body-types.

Sir Derrick Dunlop: The best example of compulsive eating is in rats with certain experimental lesions in the hypothalamus, who eat vastly and grow into enormous beasts. They eat compulsively all day if given the chance. After all, the hypothalamus is the mysterious region in the brain where psyche and soma are supposed to meet, isn't it?

Professor Roth: The same thing happens in prefrontal leucotomy. There are sometimes enormous gains in weight within a very short time, and here again the frontal lobe which is de-afferented is the site of projection of the posterior part of the hypothalamus. After antidepressant drugs compulsive eating is also seen sometimes.

Question: Is anything to be gained by a low cholesterol diet in the comparatively young patient suffering from myocardial infarction who has a plasma cholesterol level of 250 mg. or over?

Sir Derrick Dunlop: This is a matter of personal opinion. Many authorities believe strongly that everyone should go on these low-saturated fat diets but, as I suggested, one would have to start earlier than the myocardial infarction, and there really is very little evidence that people whose plasma cholesterol level has been lowered as the result either of dieting or of drugs after they have had a myocardial infarction do not have further incidents. As I said, Oliver has lowered the plasma cholesterol level with oestrogens in a large group and there is no definite difference between them and controls. If you are a believer, as some people are, in lowering the plasma cholesterol level of comparatively young people who have had a

myocardial infarction, it could be much easier done by the use of the new drugs, such as atomid, which has been produced lately by I.C.I. and which has now been tested on about two thousand people and which certainly lowers the plasma cholesterol and seems to do it without the side-effects of other drugs.

Dr Scott: There is one other way of lowering the cholesterol level of the blood that is not always recognized. If you have a good meal, up goes the cholesterol content; if an hour after the meal you get up and go for a walk, within a quarter of an hour the level has fallen considerably.

CONCLUDING REMARKS

Chairman: Before we disperse, I will ask the provost of our faculty, Dr Ollerenshaw, to come forward to propose a vote of thanks.

Dr J. G. Ollerenshaw: The true vote of thanks this afternoon is to the number of people who have turned up to hear our speakers and listened with such attention. From the personal point of view, as one clinging rather desperately to middle age and looking at the panel of depressingly slim speakers, I must admit to a certain amount of depression which has been mounting in the course of the afternoon. Dr Scott and Professor Dunlop have been gradually impressing on me that I have got to give up the things of which I am rather fond—giving up cigarettes would be a great effort, but my wife is rather a good cook and to have to divorce her as well would be too much. However, when on top of that Dr McKinnon tells me that my sins are finding me out, I am content to give up and live to the same age as Sir Winston Churchill! Dr Kuenssberg has, I think, given a most valuable contribution this afternoon in bringing to our notice the great need there is for more time to be spent on, and more research to be done on, the problem of the menopause. We all have these ladies coming to our surgeries, and I am afraid that very often we use the same routine for all of them. Dr Kuenssberg has shown how complicated the matter is and how much more attention we should pay to it. There is very much of Dr Roth's contribution that I would like to talk about. One thing is his attitude to death, which I found of considerable interest. I would like to repeat a story I heard some time ago about a Lapland tribe who, of course, have to