

summarise their results, but one fails to draw clinical sense of it or be in a position to use the information in clinical practice. One could be cynical about their findings; the offspring of mothers with schizophrenia or psychotic disorders are expected to be at increased risk, which could vary across studies owing to a multitude of factors, so the findings of the study are no surprise. The increased risk could be genetic, psychosocial or both.

The clinical implications of high-risk studies ought to help identify those at high risk and prevent health problems in them. A number of studies on risk reduction strategies have been reported for common medical problems, including diabetes (Parillo & Ricardi, 2004), cardiac disorders (Ferdinand, 2004) and atherosclerotic vascular disease (Heckam & Anand, 2003) and even complex multi-factorial disorders such as hypertension (Sheridan *et al*, 2003), to name a few. Although little can be done about the genetic component of the risk, the psychosocial and environmental effects can definitely be minimised. Multiple appropriate lifestyle alterations and stress protective strategies may be relevant. Furthermore, one expects that over time, the more recent studies should report relatively lower rates of elevated risk compared with those done decades earlier. Incidentally, Niemi *et al* found an incidence of 6.7%, lower than the 16.2% found in a study reported in 1993, and 13.1% in one reported in 1995, showing a gradually decreasing receding trend. Niemi *et al* attribute these differences to methodological factors, but one wonders whether the reduction can be attributed to preventive measures being implemented with those at high risk, advertently or inadvertently.

What is the point of knowing that people are at increased risk of developing a disorder if nothing can be done with this knowledge?

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Sheridan, S., Pignone, M. & Donahue, K. (2003) Screening for high blood pressure: a review of the evidence for the US Preventive Services Task Force. *American Journal of Preventive Medicine*, **25**, 151–158.

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Author's reply: Dr Chaturvedi questions the clinical relevance of knowing that offspring of mothers with schizophrenia are at increased risk of developing both psychotic and non-psychotic disorders, particularly because preventive measures are not available. However, preventive measures may be available in the future. Clinical high-risk studies already suggest that using specific preventive interventions, it is possible at least to delay the onset of psychosis in patients at incipient risk of psychosis (McGorry *et al*, 2002). However, the criteria for being clinically at high risk require that the individual is already showing psychotic-like symptoms or impaired functioning (McGorry *et al*, 2002). One of the goals in high-risk studies (including ours) is to identify early indicators of emerging psychotic disorders that could be detected before any impairment starts to develop.

Family interventions are rarely targeted at children of mothers with psychotic disorders, who often remain uninformed about

their parent's illness and have to cope alone with their parent's symptoms and take additional responsibility for the family (Valiakalayil *et al*, 2004). We hope that the knowledge that the children are themselves at increased risk of developing mental disorders will enhance the planning and implementation of supportive measures and parental education for families where the parent(s) suffer from psychotic disorder. Such support should begin during pregnancy and continue through childhood and adolescence. These measures could also turn out to be preventive: the Finnish Adoption Study showed that the risk of developing schizophrenia-spectrum disorders among adoptees whose biological mothers had schizophrenia was much lower if they were raised in adoptive families with 'healthy' rearing patterns (Tienari *et al*, 2004).

Finally, Dr Chaturvedi suggests that there might be a genuine decline in the risk of developing schizophrenia among high-risk children. We discussed this possibility in our article, but the method of identifying the mothers in our study differs so much from those of the Copenhagen and New York high-risk studies that we still consider it premature to draw such a conclusion.

McGorry, P. D., Yung, A. R., Phillips, L. J., et al (2002) Randomized controlled trial of interventions designed to reduce the risk of progression to first-episode psychosis in a clinical sample with subthreshold symptoms. *Archives of General Psychiatry*, **59**, 921–928.

Tienari, P., Wynne, L. C., Sorri, A., et al (2004) Genotype–environment interaction in schizophrenia-spectrum disorder: long-term follow-up study of Finnish adoptees. *British Journal of Psychiatry*, **184**, 216–222.

Valiakalayil, A., Paulsen, L. A. & Tibbo, P. (2004) Burden in adolescent children of parents with schizophrenia. The Edmonton High Risk Project. *Social Psychiatry and Psychiatric Epidemiology*, **39**, 528–535.

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One hundred years ago

The care of the feeble-minded

THE problem of the care of the feeble-minded may be said first to have received

attention on anything approaching a general scale in Europe and America towards the middle of the last century. In France the attempt to deal with this question may be

traced to the beginning of that century and that country has been called the birth-place of the new education as it applies to the mentally defective class. Switzerland is

another country which earlier than most occupied itself with the welfare of such defectives, being no doubt largely prompted thereto by the wretched condition of the cretins in its valleys. It is true that isolated efforts to collect the feeble-minded, together with the homeless and the outcast, for the purpose of care and supervision can be traced to much earlier dates but the general movement is associated with the period mentioned. In ancient times, it is well known that the congenitally weak-minded were either destroyed outright or allowed to perish, being deliberately exposed to the risk of death, unless, perchance, they were tolerated for the sake of diversion. The drastic methods of the ancients find a milder modern counterpart in suggestions for the asexualisation of the mentally defective, suggestions which have already in a limited way been put into practice in the United States. In the Middle Ages the feeble-minded appear often to have wandered unmolested, being regarded with a certain superstitious reverence (“les enfants du bon Dieu”), and doubtless some of the fools and the jesters of mediæval times were recruited from this class. The village “fool” is still to be found, although there has of late years been a growing tendency to sweep all such feeble-minded persons

into asylums for the insane, which is undoubtedly a mistaken course.

All schemes for dealing with the feeble-minded are necessarily based upon their classification and also upon the fact that cure does not take place but that even the best of them require a certain amount of supervision at the expiration of the period of training. For practical purposes these defectives may be classified as idiots and low-grade imbeciles, unimprovable or improvable in but slight degree, and mainly in self-help; imbeciles of higher grade, capable of being trained to such a degree as to be partially self-supporting; and the mentally feeble capable of training to the extent of being self-supporting. The needs of the first class are met by the Idiots Act of 1886, which permits the detention of idiots and imbeciles in special institutions. These, however, are far too few, large areas of the country being unprovided for. In default of special institutions these cases, as well as many of the trainable classes, are relegated to workhouses and asylums where they are totally out of place except, perhaps, in those rare instances in which it has been deemed worth while to make separate provision for them. Too often such children are found scattered about asylum wards where their presence is a source of irritation to the insane and is apt to give rise to

degrading practices. It is desirable that it should be made incumbent on county councils to provide accommodation for this class which could be cared for on a simpler and cheaper scale than that required in the case of the insane. It is, however, when we come to considering the second and third classes, as defined above, of defectives that we recognise the inadequacy of the means at present available for their detention and training and the harm which in consequence results to society. Unfit for ordinary school education, turned adrift from home, these feeble-minded individuals wander about living as best they can. Their history is made up of vagabondage, larceny, incendiarism and criminal assaults. Feeble-minded young girls are received in a state of pregnancy into charitable institutions; feeble-minded youths are consigned to prison and transferred to the nearest asylum, where an anthropometric examination reveals abundant and pronounced stigmata of degeneration.

REFERENCE

Lancet, 11 February 1905, 370.

Researched by Henry Rollin, Emeritus Consultant Psychiatrist, Horton Hospital, Epsom, Surrey

Corrigenda

Impact of childhood abuse on the clinical course of bipolar disorder. *BJP*, 186, 121–125. In Table 1 (p. 122) the second column should be headed ‘No history of severe childhood abuse’ and the third column should be headed ‘History of severe childhood abuse’. The online version of this

article has been corrected post-publication in deviation from print and in accordance with this correction.

Career choices for psychiatry: national surveys of graduates of 1974–2000 from UK medical schools. *BJP*, 186, 158–164. The

third ‘Limitation’ (p. 163) should read: Post-questionnaire surveys may not capture some of the subtleties of views about psychiatry and we did not ask those who did not choose psychiatry whether there are factors that might have influenced them to choose it.