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Correspondence

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SPEECH DISORDER, PARTIAL SYNDROME OF GILLES DE LA TOURETTE, AND DRUG THERAPY

DEAR SIR,

Numerous conflicting reports of the efficacy of drug treatment in speech disorders have been published (1, 2, & 3). In an attempt to clarify the problems, a trial was planned of flupenthixol, 6 mg. daily, against diazepam, 6 mg. daily, and a placebo. Though the results are open to criticism, some worthwhile information has emerged.

General practitioners serving a population of 250,000 were asked to refer cases, and a cross-section of speech disorders presented among the 26 volunteers. The high dose of flupenthixol caused 5 of 9 receiving this in the trial to withdraw as a result of extrapyramidal effects and dystonic reactions. The results of diazepam-treated and placebo-treated groups differed little. Those subjects having tics and vocal interjections who had first received diazepam or placebo were offered an increasing dose of flupenthixol, commencing with 1·5 mg. daily and rising every third day by 1·5 mg. daily. At the end of two weeks they were much improved.

Trial results at two weeks

	Number	*Average change in Time	Repetitions	Interjections
Diazepam ..	7	−15	+2	−3
Placebo ..	8	−5	+2	−3
Flupenthixol ..	4	−9	−1	0
Subjects with tics and vocal interjections.. .. (subsequently given flupenthixol —average dose 6 mg. daily at two weeks).	5	−133	−5	−11

* Time was measured in seconds and was the average of that taken for three groups of 100 words. Repetitions and interjections in the same speech were noted when the tape recordings were played back.

It is clear from these results that there is a comparatively small group of people with speech disorders who respond to drug therapy, and that they are the group who manifest a partial syndrome of Gilles de la Tourette. They are unlikely to respond to psychological methods of treatment.

A better designed trial, with controls, to study prognosis and maintenance therapy is still required, but provided a regular review to detect the occasional side-effects of drowsiness, dystonia and depression is undertaken, treatment of this disabling condition should be offered. A study of the aetiology in this group (4 and 5) is possible, as I feel that this condition is not as rare as may be believed.

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SOCIAL ASPECTS OF THE BABY BATTERING SYNDROME IN RELATION TO FAMILY PLANNING

DEAR SIR,

Many battering parents have the 'baby doll' attitude to their children. They have produced this baby/child, which belongs to them. If somebody is going to take the child away they will have another. The child is there to comfort them in their lonely

world, and should love them (the parents). They readily become responsible for new children, only to ill-treat them again. Contraceptive advice, however skillfully given, appears to be ignored *to start with.*

Selwyn Smith *et al.* (1) emphasize the 'high incidence of personality disorders and youthfulness (of the battering parents)'. They conclude '. . . that various birth control measures are unlikely to be effective in reducing the prevalence of battered babies'. Their data seem to point to the conclusion that birth control measures (in Birmingham) have so far been ineffective in influencing this group of battering parents or in reducing their tendency to breed before they are capable of rearing.

We are cited in support of pessimism about birth control for abusive families (2, 3). This aspect was taken up in the Press. It is easy to be disheartened when a battering mother has her third or fourth child when she is failing to rear the first two by acceptable standards. However, we see family planning as part of the treatment of large problem families with poorly reared youngsters, and believe this helps prevent battering and neglect in this and the next generation. Some of the abusive parents with whom we discussed family planning three or four years ago now accept it, even if they do not remember the people who originally first discussed the issue with them, and whom they originally ignored, resented, or disbelieved.

I concur fully with the main findings of the Birmingham team. '. . . Baby battering occurs alongside a constellation of other social inadequacies, or failure of adaptation, rather than in isolation'. Nevertheless this is no excuse for not being insistent in the provision of contraceptive advice.

Family planning must also be directed at the much larger numbers of less severely pathological families to raise the quality of rearing in this and the next generation. One cannot easily stop a disturbed child who repeatedly damages or neglects a doll or pet, from wanting more dolls or pets. Nevertheless, by a combination of concern, firmness and reason, one tries! The same applies to family planning for abusive or neglectful parents.

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