

the test therefore picks out all but the most sophisticated malingerers because most choose wrong answers throughout and score near zero. Normal people identify 35-40 correctly, and patients with partial anosmia score 15-35. One advantage is that after simple instruction the patient can perform the test unsupervised. Also available are sets of plastic squeeze bottles producing serial dilutions of pyridine vapour.⁴ These measure the threshold concentration at which an odour can be detected, but for the non-specialist centre this test has little advantage over the scratch and sniff tests.

Finally, merely testing the sense of smell is not synonymous with investigating a complaint of olfactory disorder. All patients need a history taken and examination performed, with particular reference to neurological and nasopharyngeal problems. When no cause can be found for demonstrable olfactory loss, or when the patient's complaint persists despite negative findings on simple tests, referral to a specialist centre for more detailed assessment is necessary. Smell, the Cinderella of the senses, should be taken seriously.

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Sterilisation and the mentally handicapped

Last week's authorisation by the Court of Appeal that a severely mentally handicapped girl could be sterilised weeks before her 18th birthday evoked widespread comment and illustrated many of the anxieties and myths that surround the sexuality of the mentally handicapped (p 825). Coincidentally, this month has also seen the publication of a level headed scholarly book on mental handicap and sexuality edited by Ann Craft,¹ who has done much of the pioneering work on this often ignored subject.² She describes the two contradictory myths that tend to influence many discussions on the sexuality of the mentally handicapped: firstly, that they have strong sexual inclinations combined with lack of control; and, secondly, that they are in some sense children and so should not display any sexual tendencies. In fact, most mentally handicapped people are only mildly to moderately retarded and given the right circumstances and education can enjoy sex lives. My records for the last 10 years of working with mentally handicapped people show that I have only once recommended sterilisation—and that was to a mentally handicapped couple who already had two children. I suggested that the man should have a vasectomy, but they decided that the woman would be sterilised.

Contraception will usually do away with the need for sterilisation. Contraceptives—for example, intrauterine devices—can be used in even the most severely mentally handicapped.³ Sometimes medroxyprogesterone acetate (Depo-Provera) will be necessary, but the contraceptive pill is best avoided because of possible interactions with anti-convulsants and antibiotics. Moreover, it is always a problem whether a mentally handicapped woman will take the pill regularly. Unfortunately because of the prevailing myths many people find it difficult to think about contraception when dealing with the mentally handicapped.

Craft describes four ways in which people, including parents and carers, may respond to the sexuality of the mentally handicapped: elimination, toleration, acceptance, or cultivation.¹ Cultivation is rare, yet mentally handicapped people should have the same sexual rights as anybody else, which includes the right to sex education. The United Nations in 1971 stated in its declaration of the rights of mentally handicapped people: "The mentally retarded person has the same basic rights as other citizens of the same country and same age." Most studies of the sex education of the mentally handicapped show it to be woefully inadequate,¹ and yet it can be done. Craft points to the difference between understanding and behaviour: just as many people drive cars successfully all their lives with little or no understanding of how a car works so a mentally handicapped person can be taught to behave sexually in an acceptable manner without understanding some of the complexities of sexuality.¹

The mentally handicapped also have other sexual rights—not to be abused and to have access to circumstances in which they can be sexually active in private. They are very vulnerable to sexual abuse and have often had to live in circumstances that made expressing sexuality difficult. Much research shows that the more normal the environments experienced by people—including the mentally handicapped—the more normal their behaviour.¹ This is why community care in normal housing and by proper care staff is so important.

Sterilisation may be necessary in a tiny number of cases when all else has failed. The decision to sterilise a mentally handicapped person is extremely difficult, and all those caring for the person will need to participate. Indeed, for minors the parents or carers will have to apply to the courts; for adults the law is not clear (p 825). Proper counselling is essential before sterilisation, and the counsellor must consider several aspects: the person's fertility; whether consent can be informed; and the effect on sexual functioning.⁴ Sometimes mentally handicapped couples request sterilisation so that parenthood will not threaten their capacity to cope,² and sterilisation should be available to all but imposed without consent in only the most exceptional circumstances. And, to repeat, contraception will almost always do away with the need for sterilisation.

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