A Psychi atrist and a Ped iatrician Look at Modern Baby and Child Care

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Dr. Ratner: We're going to have a look at modern baby and child care by a psychiatrist and a pediatrician. On my right is Dr. Robert Mendelson, who is known to many of you and who is an attending physician at Michael Reese Hospital. And at my left is Dr. Marvin Schwarz, who is a psychiatrist and who is connected with the Child Psychiatry Department of Presbyterian-St. Luke's Hospital. Dr. Schwarz will open this up with a little discussion and Dr. Mendelson will follow, and I will try to prove to the world that I can do a minimum of talking.

Dr. Schwarz: It is my understanding that this is to be an informal discussion around questions, and that, essentially, the function of Dr. Mendelson and myself will be to raise certain questions and, subsequently, to deal with such questions as will be raised around such questions. I would like to start by saying that it is my impression that La Leche League International functions on the basis of certain assumptions, and that these assumptions are rarely defined and spelled out. What I would like to do is to define these to some degree and to point out some questions around these assumptions. The first assumption is that the mother-child relationship is important to the child and to the mother. Now you might argue that this seems logical and is valid, and it may be valid, but it is an assumption. The second assumption is that the experiences of the first year are of significance; that they are significant to subsequent character structure. The third assumption is that preparation during pregnancy and breastfeeding are positive contributions to the mother-child relationship. The fourth assumption is that the culturally established role in our society which differentiates being a mother from other areas of adult feminine role is not a valid one. The fifth assumption is that, essentially, the experiences of breast-
feeding and a close mother-child relationship are natural processes, and as such, because they are natural processes, they are therefore both biologically good and ethically good for the child and mother.

Now the data to substantiate these assumptions cannot easily be derived from the practical experiences which one has as an individual. One must certainly have statistical data to substantiate the position that these things are so. I might say from my own standpoint that I have a certain amount of empirical data in terms of our own experience, in that with the birth of our first child my wife attended the exercise groups that Miss Gamper held. In her first delivery the intern, who had been a student of ours at Illinois, came up to me afterwards and said that this was the easiest "primip" delivery he had ever seen, and this certainly sold me on these experiences. Also, both of our children were breastfed for long times, long enough so that our neighbors became uncomfortable. One of my neighbors, who was an intern, came up to me one day and said, "Marv, when's your kid gonna stop?" And I said we took the position that when a child wants to, a child will stop. And I say this be-

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cause I think we have relatively well-adjusted children now, and I feel, personally, that these experiences contributed. On the other hand, one must understand that the organized data to support the positions in terms of the validity of the assumptions of this organization have to come through organized studies of the mother-child relationship, and studies in variation in such relationships and their implications in terms of the development of the character structure of the child. It is unfortunate that there have been very few adequate studies in this area. I do not know of any really adequate studies. There are several groups which are now concerned; one at Yale, another at Syracuse, and a third at the University of Illinois, here in Chicago.

The data which does exist in these areas exist largely in terms of studies and theoretical positions of child psychiatrists. First, child psychiatrists, as a group, maintain—in terms of our knowledge, in terms of psychoanalytic concepts of child development—that the experiences one has in life, and certainly in the formative stages of life, do determine and influence to a considerable degree the development of the character structure. One can say that the initial position, early in the development of psychoanalysis and the field of psychoanalytic psychiatry, was that the first five years of life are the crucial portions toward the development of character structure, that the process which we talked about in terms of the concepts of infantile psycho-sexuality of the first
five years were the crucial ones in which the child developed patterns both internally within his or her own character structure and the capacities for social relationships elsewhere. The findings of the last twenty years tend to support these positions with one modification, namely that the crucial experiences in socialization from the third to the fifth year of life are in themselves determined by the character structure which the child brings into the third year of life, and that this structure is largely a function of the first year of life. And one finds that a major share of the interest in modern ego psychology deals with the period which we call primary narcissism. The first year of life, essentially the first eight months, are crucial for the development of this individual's self concept, for the separation of one's self from one's environment, and for the development of basic attitudes toward the environment. Also, the crucial element to this appears to be the mother-child relationship. There has been considerable research to substantiate such things. Some of the classical work, for example, was that of Spitz of Denver, who during the late nineteen twenties did some studies in Baltimore on the effect of separation of children from their mothers at approximately eight months of life. The studies were done in a foundling home, where the mothers were kept with their children continuously for the first eight months, and then the children were abruptly separated for placement, and the experience was that these children developed severe regressive syndromes, that the death rate of such children in the next three or four years was very high, and the rate of apparent limited intellectual functioning was also very high. And these studies, and the studies from Paris at the International Center for Children where they studied the effect of hospitalization on small children, certainly indicated the importance of the early mother-child relationship. The problem, of course, in research in this area is that, essentially, if children cannot talk to you they cannot tell you the importance of early experiences, and by the time they get old enough to talk about such things, they can no longer describe the experiences in preverbal phases. On the other hand, certainly, the currently accepted theories toward such things as psychosis, toward the development of character disorders would be that the crucial defects occur around the question of resolution of the phase of primary narcissism, and it would certainly appear that a meaningful mother-child relationship at this age is crucial. Now one of the nice things about breast-feeding is that it tends to lead to a comfortable, nice, smooth mother-child relationship. One of the advantages is that it produces a relationship which is comfortable enough that it does not have to be too close. Namely, when one talks about all the attributes of a positive mother-child relationship, one always has to be concerned that people will misinterpret this to mean "smothering." The natural, spontaneous nature of the mother-child relationship
in breastfeeding can be argued to produce sufficient comfort that the mother can use this as a basis for meaningful communication rather than for smothering. One of the problems which one should also talk about in this regard is the fact that when we talk about a meaningful relationship producing character structure and change in the child, we have to talk about how the relationship influences the child. And in this we talk in modern analytic theories about the concepts of optimal frustration. Namely, the child grows, presumably, by experiencing certain degrees of frustration which are then worked through and met. The child who grows with absolutely no frustration does not learn to develop adequate structure. A child who grows up with too much frustration obviously retreats. One can argue that the breastfeeding experience and a meaningful mother-child relationship can potentially contribute in this area.

The other question which has been of equal concern, certainly within our own section of child psychiatry at Presbyterian-St. Luke’s here in Chicago, has been, given the fact that all this appears obvious, why does one run into resistance? Why does one run into resistance in terms of women and in terms of the medical community? The first element of resistance, which is the resistance in terms of women, would appear to have its origin in their own ambivalence about femininity and about the maternal role, and the attempt, essentially, to resolve these mixed feelings by denying some of the implications of their own femininity. To put it another way, if one sees dependency and dependency needs, not only within the frame of reference of the child but also of the mother, one can certainly say that pregnancy and the maternal experience are always a threat, somehow, to a woman’s character structure, because of her fears that instead of being taken care of and given to she will have to give. Also, in terms of threats to her own feelings of adequacy, especially in a culture which tends to deprecate femininity and female adequacy, one of the simplest ways to resolve this is to say that the biological implications of motherhood end with delivery. In doing so the woman then finds herself in the unique position where she can now mechanically define her maternal role and can, for example, talk about no longer having to worry about breastfeeding interfering with social activities, with her own gratification, and with her relationship to her husband. Now I maintain that husbands are much more of a joker in this thing than they would appear to be. If one were to take the position that husbands also have dependent needs, and that the husband, essentially, is threatened by pregnancies in terms of his potential displacement by the child, one can begin to see some of the needs of husbands to delineate the mother’s biological relationship to the child at the earliest possible time, so she can return to feeding him. You disagree? Within such a frame of reference one finds that both the husband and wife are concerned that breastfeeding will
be disfiguring, that breastfeeding will be demanding, and the woman to some degree has to pretend that whatever the biological elements of motherhood are they are over at the end of the pregnancy, so that they do not have to be tied in with this newborn child, which is really more of a threat to the husband than is the pregnancy. The question also comes up as to why the medical profession, as an organized profession, is so resistant, as are hospital administrators, unfortunately, to the obvious humane concepts implied in breastfeeding and in meaningful mother-child relationships. I must confess I do not know. I feel that Dr. Ratner, as a public health officer, is in a better position to speak about the global implications of this. However, I can say that it is only a characteristic of western culture, and that one finds that in the more primitive cultures, such as Asian and African cultures, the medical profession possibly is not exalted enough, but it is not permitted to introduce such artificial barriers as we see in pediatric and obstetrical services routinely in this country. I think that, ultimately, what is involved here is the need on the part of the medical profession, and on the part of nursing groups which go along with it, to repress and deny the biological implications of motherhood and of human life, and to pretend that, essentially, there is something 'dirty' about nursing, there is something 'dirty' about female breasts. In a sense the basic biological primitiveness of all this is tied in with the primitiveness of sexuality, and everyone knows that that is 'dirty.' And the end result is an artificial separation, which is responded to by saying that since this is so and we know that it is so you cannot tell us that it is not so—and that is that. Now some of the questions I hope we will deal with here today will be around the relationship of breastfeeding to very basic human processes, the importance of human processes to child growth and development, to say nothing of their importance to the mother. I think that one of the problems that we, as child psychiatrists, deal with—and this is the point I would like to close on—is that mothers bring their children to us after ten or twelve years as a mother and never really feel their role has been complete, and that mothers tend to feel empty, they tend to feel essentially an adoptive position toward their children, and subsequent to this they tend to develop communication barriers, barriers between mothers and children which ultimately result in many of the emotional problems they bring us as child psychiatrists. I think that this is secondary to certain cultural denials in our particular society. I would like to close my formal presentation on this note and turn things over to Dr. Mendelsohn.

Dr. Mendelsohn: One of the most pleasant aspects of La Leche League, at least as far as I am concerned, is its excellent choices of titles for speeches and round tables. While no one ever reveals exactly who is responsible for these titles, I strongly suspect the touch of my good friend, the panel moderator. But regardless
of who it is, I give my thanks to the entire organization. Take today’s title, for instance. Would you not agree that it gives one remarkable leeway and freedom of choice? No need to struggle over an exact subject, or to examine musty volumes in out-of-the-way libraries in a search for esoteric information, although I am surprised to find how closely my information dovetails with that of Dr. Schwarz. This is an unusual opportunity for free-wheeling, and I intend to make the most of it. Some sober thinkers among you may appropriately object that freedom carries responsibilities, to which I will respectfully nod in agreement, and request permission to leave these more serious aspects for later in this presentation.

I do not know how to tie in modern baby and child care with the problem of parking your car, but this seems like a good place to start. Last night, and now you can tell when this talk was written, I came to watch the League movies (and I will have more to say on this later) upstairs in the hotel. And on leaving I went to my car in the parking lot just on the other side of Michigan Boulevard. If any of you have crossed Michigan Boulevard coming from the Knickerbocker and walked west on Walton Street, you have had an unparalleled opportunity to make some important comparisons between two major institutions in our society, both deeply concerned with and involved in the very same subject. Perhaps I should entitle this part of my talk “East Side, West Side,” because on the east side—east of Michigan Avenue on Walton—is the Knickerbocker Hotel, where La Leche League is in session, and this is an organization concerned, among other things, with the function of the breasts. On the west side, just about as far in—about half a block—is another important organization—I see some of you have been there—also concerned, although I hasten to add somewhat differently, with the subject of breasts. Now for those of you who have not made this trip—I hope you will not interpret this as a plug for the other establishment—you shall not be kept in suspense any longer. On the other side of the street is the Playboy Club. Now I do not think the Playboy Club patrons are any more interested in La Leche League than the League women are in them. Nor do I think there is any appreciable risk of their clients showing up in the Knickerbocker. Yet it seems to me that some of the most basic conflicts in our society are dramatically exemplified by the activities and attitudes in these two places, only one short block away from each other. The physical proximity of these two groups is in dramatic contrast to their emotional and psychological distance. Both have certain superficial similarities. In both, breasts are emphasized; on the one hand for strictly ornamental purposes and in a suggestive fashion, on the other hand for certain functions. And in a very real way our society continually faces the choice: What are breasts for? And what are women for? Shall we raise our children—and here I manage to sneak in the title of the paper—shall we raise
our children with emphasis on becoming nursing mothers or with emphasis on Bunnies? There is undoubtedly enough room in this world for both these institutions. Nevertheless, in this social and ethical struggle how shall we of the League judge our measure of success? I do not think we can look forward—at least not right now—to a La Leche League headquarters building with brilliant flags, overhead searchlights, good entertainment, fine food, and a well-stocked wine cellar, as possessed by our competitor down the street. Nor will we ever, a la Carrie Nation, march militantly on the Playboy Club.

Dr. Ratner: The men might!
Dr. Mendelsohn: Touche!

Dr. Mendelsohn: I think our victories will have to be more subtle, but more substantial and with a view toward eternity.

Now, having finished that theme, I do not know what more to say about modern baby and child care. From the medical standpoint the growth of knowledge is so rapid that much of what we doctors learned ten years ago is either wrong today or needs significant modification. This teaches us that in matters medical we should refrain from being too dogmatic lest we appear ridiculous in the eyes of those of you who will attend the LLL convention in 1974. On other aspects of child care the League has upset much of my thinking. For example, I used to think that babies should be home at night. Second, in medical school I never saw a father in the delivery room. The League’s educational materials have certainly changed that. I used to go to regular movies expecting to see the subject of love usually treated on one of three levels: love between teenagers, or courtship of young adults or a story of infidelity after marriage. But last night I saw movies upstairs that had as a main theme the love relationship within marriage, and I owe that experience to the League. So who knows what part of my already shattered structure of information is next to be discarded? Therefore, since I am not about to preach to you or indoctrinate you with so-called factual information, we must get to the serious part of this talk, in order that I fulfill my responsibility, as I see it, to the League.

The theme is—and this somewhat overlaps Dr. Schwarz’s presentation—that we must not only be in the business of giving answers, important as this is at times, we must also be asking questions. And we must work to develop our talents and resources so that we are just as expert in asking questions as in answering them. And this is the challenge I present to you. In addition to our valuable services in disseminating information and in helping individuals with their problems of motherhood, we must at some point, if we are to develop new and important insights, begin to examine ourselves. In other words the League with its tens of thousands of members and its medical advisory staff offers an unusual resource for research. And how do we start? First, by admitting that we do not know all the answers. And then by looking for
answers to the kinds of questions we hear all around us. For example, these are the kinds of questions I have been asked about the League, that I think are soluble in research terms. When one mother helps another with advice on breastfeeding, how much of the success is due to strict application of technique and how much is due to emotional support and other components? You can see the implications of this in terms of how much arguing we should do about the various techniques of breastfeeding. A second question. How does La Leche League contribute to family stability? While we all have certain subjective feelings on this, what is the actual incidence of family breakdown among League members? What is the incidence of divorce and separation? How do husbands feel about La Leche League? A third question. Are there special personality characteristics of women attracted to the League? And if so, what are they? To me they look like women anywhere, but some observers think otherwise. Many other questions like this will readily occur to you, if your skeptical friends have not already raised them. The honest answers will be important to us in the scientific community and to the public for years to come. Sometimes I hear the membership become all heated up on questions such as the time of introduction of solids, the importance of supplementary iron, the technique of manual expression, as in last night's movie, and other issues. I am always grateful at times like these to belong to an organization where these are the issues, but these must be kept in perspective. And while a little argument often provides a stimulating roundtable discussion, let us keep these issues out of the main arena. Some day, La Leche League will be generally recognized as one of the most potent social movements of our time. It is not like other women's groups. It is not like the feminists of years ago or like women's political groups or the society clubs or women's boards or women's professional organizations. La Leche is not out for women's rights or political reform or social prominence or professional status. It is for women as women, and for their families as families. I believe we are strong enough in our beliefs to maintain a delicate balance between our very important "crusading efforts" on one hand, and a need to challenge ourselves continually with the deepest, most probing questions on the other. We must continue to listen to each other's individual opinions and, simultaneously, organize extensive studies, some in depth, of our own opinions. We must continue to respect our critics, since first they may present us with a challenge to conduct the necessary studies in an effort to find out if our position is indeed justified, and second they may become our most loyal supporters. Now I do not know how to get all this back to modern baby and child care or even back to the Playboy Club, and I hope that the discussion period will fill in what has not been discussed here. Again I am grateful to the League for this opportunity and I will now
turn the discussion back to Dr. Ratner.

Dr. Ratner: And I, in turn, will open the discussion to the floor.

Question: Dr. Schwarz, when a sick mother comes for psychiatric help, is the question of whether she has breastfed part of the normal history-taking of the psychiatrist?

Dr. Schwarz: I think so. Certainly, from the standpoint of the child psychiatrist we routinely examine both mother and child and, certainly, the standard areas of concern are the mother-child relationship. Independent of whether or not the mother breastfed, around such questions one can elicit basic material as to the values and attributes of the mother. For example, sometimes you see a mother who tells you with great nobility now she did breastfeed. Often one sees a woman who cannot breastfeed because she sees this as a blow to her own narcissism. Some women have to be perfect and as part of their perfection, sometimes, have to sit on the other side of the fence. So, again, the crucial question is not only breastfeeding itself, but the mother-child relationship and the attitudes. And I think that to the degree that breastfeeding embodies the basic relationship of the mother and child, it is also one of the most significant areas for obtaining information.

Dr. Ratner: I would like to add one point to this to keep you alerted to something that I think we as doctors tend to be bothered about more than you do. René Spitz in a variety of studies on breastfeeding in cultures where breastfeeding is going on makes the point that some mothers though breastfeeding can still be rejecting the child, so that what really counts is your motivation for breastfeeding. If this is an act communicating love, it is significant; if it is an act communicating resistance and resentment, it is also significant but in the other direction. So do not ever take it for granted that breastfeeding in itself, without the mothering that goes with it, is automatically good.

Dr. Schwarz: If I might give another point in tune with this, I think of one mother that we saw some time back who really did not want the child, who became pregnant accidentally, who then got married as a sequence to this accident, and who had considerable resentment around the pregnancy and the child, who tried to abort around the fourth month of pregnancy and could not, and then when the child came, who was initially quite depressed about having the child, did not want the child, but then had to deny all this and felt that if she breastfed this was going to solve all problems and she would not be a rejecting mother. The problem that came up, of course, was that every time she picked up the baby to breastfeed it, the baby experienced the rejection involved and would not breastfeed. In other cases, of course, it is merely a question of having to learn to breastfeed and of dealing with natural reticence. It is a complicated question. I cannot answer it.

Dr. Mendelsohn: I think it is complicated also in terms of our own group. I would guess that within
the League and its supporters one might almost divide them into three groups: the ones who have breast-fed successfully, the ones who have tried and have not been able to, and the ones who have not tried yet. And I think we have to keep our questions geared to all three levels. I think that most of us have some subjective feelings on breastfeeding. At least I notice this when teaching medical students. When I ask how many are in favor of breastfeeding, everybody raises his hand. I do not think that there is anything in the scientific literature—and I would like some corroboration on this—to indicate that breastfeeding per se and by itself is any prophylactic or preventive measure against the development of mental illness.

Dr. Ratner: To make this very concrete let me give you one example of what we are talking about from one of our parent-child discussions in Oak Park. A woman was having a problem with her nine year old child; he would never let his mother out of his sight. As we got her to talk, she remembered that at about the eighth month or the first year of life when she was breastfeeding her baby, she was always anxious to get going because she had so much work to do and she always used to rush this baby through its breastfeeding. And she now remembers that when she left the baby after breastfeeding the baby would keep his eyes glued on her. The analogy to this would be to go into a fine restaurant where they are serving a fine French meal—seven courses—and then have a waiter who rushes you through each course. And this baby—to use an analogy here—was looking for his mother the way many of us look for a waitress in a restaurant, because we need service. So it is these little things that can have a very dramatic effect. It is not just simply going through the mechanics of breastfeeding that counts. It is whether you are really giving yourself to the total needs of that infant at that moment.

Marian Tompson: Dr. Schwarz, you mentioned that your children were nursed for a long time. What would your answer to the critic who says to a mother you are making your baby too dependent on you by nursing him so long?

Dr. Schwarz: Well, you know, dependency is an interesting question. What is too dependent? How does one define it? And does one really make a person hungrier by gratifying it? Very frequently one finds that the people who talk about over-gratifying are really talking about under-gratifying. Let me put it to you another way. The child learns to be independent through dependence. One could argue that the life goal, in terms of what one wants to see the child work through at the initial level of the five to seven year age and at a more sophisticated level at the fourteen to eighteen year age, is resolving the dependent needs to the point of becoming capable of independent life-function. The child's inability to do so generally exists because the child has received inadequate gratification in the early phases of life and must spend the rest of life looking for what he or
she did not get. If the child has a meaningful, adequate relationship to the mother and the mother is capable of giving up the child as the child is ready, one finds that the natural process of breastfeeding and of the mother-child relationship goes through a normal process of optimum gratification and optimum frustration such that as the child gets older the child will give up the oral needs. One generally finds that the people with the greatest amount of ungratified oral drive and unresolved dependent needs in our culture are not those who have had an adequate mother-child relationship.

*Barbara Pitre:* Just how important is it for the baby and mother to be together in the days after birth? Is it important enough for parents to go to a great deal of trouble and harass their doctor and the hospital in order to have the mother and baby together, if this is not common practice?

*Dr. Schwarz:* I could start on this. The problem in terms of this I think is more a problem of the mother than the baby. Namely, one must say that ultimately one wants to have a comfortable mother-child relationship, hopefully, as soon as possible. To the extent that the hospital artificially takes over responsibilities which it does not intend to maintain, responsibilities associated with the separation of mother and baby, it produces the problems which will exist when the mother takes the baby home. I think of the hospital where my wife had both of our children, where the food and obstetrical service were adequate and very gratifying. Certainly, my wife was well fed. But we ran into the problem in this particular hospital that unless the mother was in the small rooming-in section, everything was extremely mechanical. Dr. Mendelsohn can talk about the problems of infection and nutrition associated with this. I can say that in terms of the women who shared rooms with my wife during this period as well as my experiences in the obstetrical services of our own hospital, which is essentially without an adequate lying-in service, at the time of birth a woman's ambivalence about having a child is resolved by taking the child away from her. Now I have no objection to this if the hospital intends to take care of this kid from then on, but if a hospital intends to do this only for five or six days and then gives the responsibility back to the mother, it's a different matter. There is a ritual in our hospital about going home. A student nurse carries the baby down, and the mother goes in the elevator. They both go to the car and there is the father. The student nurse turns and hands the baby to the mother. She says, "Here." She turns around and walks away. Such an experience means that the mother now at the time that she has to take care of the baby must deal with all her feelings of inadequacy, all her feelings of confusion, all the problems involved. So that, rather than the hospital experience being a preparation, a period of education and training and learning so that she has five or six days to feel comfortable, to work through her anxieties, to discuss
with people the problems involved, essentially the hospital period is a period of rest and denial, which is followed by a period of overwhelming anxiety, largely induced by the hospital experience. So I would, therefore, see this as a crucial area.

Dr. Mendelsohn: Dr. Schwarz has spoken about this from the standpoint of the physician. Let me just speak about this from the standpoint of the physician. It certainly seems to be important for some mothers to have maximum contact with their babies during the early postpartum period. For others it seems less important. Probably the best way to handle this is the way any other medicine or aspect of hospital service is handled by the physician, and that is to prescribe in each individual case how much—or at least afford the patient the opportunity of determining for herself how much—is appropriate for her own needs. What surprises me is that the physicians do not rise in arms against the hospital and argue that this is really an infringement on the prerogative of the physician to prescribe for his patient, because in a sense what the hospitals have done is to circum­scribe the opportunity of the physician to prescribe properly for his patient. And I would guess that at some point the medical profession will begin to recognize this not only from the standpoint of the patient, which is sometimes hard for a doctor to see, but from their own standpoint of freedom of the physician.

Dr. Ratner: I think we have to face this hard and unpleasant fact that what most hospitals do is for their convenience and not for their patients. And second, I would add that anything that contributes to making the baby a stranger to the mother—and here I am talking about that period in the hospital in which the mother is under the illusion that she is vacationing at a hotel—divorced from baby care—cannot but be a hindrance to the fact of life that when she leaves the hospital the baby becomes her full responsibility. I think with the mother who would prefer not to see her baby too often and who would like to take advantage of the golden opportunity to have breakfast served in bed like a lady of leisure you have the problem of weaning her to the reality of life. And you do that by exposing her to the baby, maybe not as often as the next one, but in graduated doses.

Dr. Mendelsohn: Or by moving the hospital into the home on occasion—by moving a nurse into the home when the mother goes home.

Question: We recently had the experience of a baby who was gaining very poorly even though the mother was apparently nursing well, and at the same time the mother’s self-confidence was practically nil. I would like to know whether this would have a direct bearing on the baby’s weight gain and on how well the baby was doing, and if so, how can we help a mother whose breastfeeding failure is attributed to a lack of her own self-confidence?

Dr. Schwarz: I must confess I am very naive as to what is an adequate gain curve, other than to say that these are all purely statistical curves gained in family clinics on the basis
of distribution of $X$ numbers of children going through these clinics. Now as near as I know I have not seen any adults who have been nutritionally deficient or inadequate by virtue of their being breastfed. It is my understanding that the young infant—and again Robert can bear me out—has adequate nutritional reserves to tolerate the early portion and to tolerate the early aspects of the mother-child relationship. The problem here is not the baby. It is the anxiety of pediatricians and the anxiety of mothers who are trying to compete to get a better score on the curve.

Dr. Mendelsohn: I do not think I could say it better, but I can give you an example: a mother, whose baby weighed six pounds at birth, comes in and the baby weighs six and a half pounds at one month of age. Now, when the mother is bottle-feeding there isn’t much the physician can do, because the mother is already bottle-feeding, so in a way he is stuck. But when the mother is breastfeeding, it occurs to him that there is something he can do. So what we really have to do is educate physicians that there is a normal distribution curve and that some babies just do not gain as much as others. And I think we have to be wide open on this, because there are no good statistics in medical literature, except for those Dr. Schwarz mentioned from clinic care. There are no good statistics on what one month and two month weights are in relation to birth weight in breastfed babies. I think La Leche League might at some point serve to collect this kind of data.

Dr. Ratner: I would like to add one point to this. We are all equally responsible for this, both laity and physicians. We have a peculiar, abnormal preoccupation with quantity and numbers and weight. You notice that this is the first thing you tell somebody after you tell them the sex of the child—how much it weighed. Perhaps the worst invention from the viewpoint of normal raising of children has been the scale, because it has brought about so many anxieties. There is one fact I want you all to know about and not to fight. Physicians fight this all the time, but it is a fact that cuts across all of nature. Every newborn animal of every species has a loss of weight, which takes approximately, and analogously in terms of human figures, about ten days to restore. And even though there have been doctors—I think of Dr. Kugelmaas—who felt infants should be fed intravenously to prevent this weight loss, this is part of the normal response of a newborn to the experience of having been delivered. And second, the newborn has many more important problems to worry about than its weight. It has the problem of breathing successfully and things like that. And I think that all of us have to—and I am talking now about the normal baby—all of us have to forget this preoccupation with converting the baby’s health into pounds, because, as Dr. Schwarz has pointed out, the basic concern we have is whether the baby is coming into a world
which is orderly and in which he is being welcomed.

Dr. Schwarz: In this regard one might point out that part of the problem is that it is very difficult to set standards for mothering. And if one has devoted a long time to preparing for this, one wants to be reasonably sure one is doing a good job. And one of the ways of resolving one’s anxieties about the maternal role is to pretend that there is a quantitative scale which measures how good a mother one is. For example, one can hear people play the game of who had whose kids bowel-trained first. And the other game is whose kids are higher on the weight curve and who ate steak first. And, essentially, what happens here is that the mother avoids dealing with the intangible, and resolves her personal problems by saying, “I’m a six pounds good mother or an eight pounds good mother.”

Dr. Mendelsohn: The same problem in an exaggerated form arises with premature infants . . . the whole question as to when they should go home from the hospital. After all, we have determined that the longer the period of separation from care by a child’s own mother or by a substitute mother, the more likely one is to get deleterious psychological effects, and prematures are often kept in premature nurseries for months at a time. Now, recently, there have been efforts, particularly in Arkansas, but in other places, too—to send prematures home at a much lower weight then we did before. Some prematures at three and a half pounds are being sent home with successful results. One of the things we have to do, as Dr. Schwarz mentioned, is to change certain concepts that we have. But we have to be careful that we are not changing some concepts for others that are equally fallacious. I brought some pictures with me today, because recently the formula companies, the companies that supply proprietary formulas, have discovered breast-feeding. And the reason they have discovered it is that they intend to move into the market. The only way to move into it is to indicate to the mother when it is appropriate for her to formula feed the baby. Now the most interesting thing is that this appears in the formal publications of the American Pediatric Society and other learned societies. And these pictures suggest to the mother when she should bottle-feed. For instance, this one shows the mother and father sitting in a movie while the grandmother is feeding the baby at home. The second shows the mother traveling: when she travels she gives the bottle, when she is at home she breastfeeds the baby and you will notice with a completely exposed breast, indicating that there is no other way; you have to have a topless bathing suit in order to breastfeed. Here is one that is particularly inappropriate: in the hospital, while the mother is sleeping, the nurse is feeding the formula in the nursery. And just so that they do not neglect any environment that the mother might be in, they also catch her in the doctor’s office. She formula feeds in the doctor’s office, because after all otherwise she would
have to expose her breasts in the waiting room, or even in front of the doctor.

**Question:** What are the psychological disadvantages of the early introduction of solids, say at one, two or three months?

**Dr. Schwarz:** Well, it depends how you introduce and what you are introducing. I think the crucial question is not what you introduce, but what you take away.

**Dr. Mendelsohn:** I think that is a very good statement. I wish I had made it myself. I have heard this argument up and back about solid foods now for some years and in my own clinical experience I have not been able to corroborate that the early introduction of solids interferes with breastfeeding. I know others feel that it does. There are some mothers in whom I think it probably interferes; there are others who I think probably extend their period of breastfeeding because of the introduction of solid foods. I think it has a lot to do with the particular social group that one happens to be associated with. Medically speaking, I have not been able to find any deleterious results from introducing them. On the other hand, I have not been able to find any bad results from not introducing them.

The general recommendation of the American Academy of Pediatrics, if anyone is interested, and which is more honored in the breach than in the observance, is that solids not be introduced until four to six months of age.

**Dr. Schwarz:** I assume they taste good. At least if they take it and they like it, I assume that it is not hurting them. The real problem is the assumption, firstly, that if one breastfeeds one must have the baby completely and permit no substitution for one's self. Then there is the feeling that if one is giving the child solids, too, somehow one may be a failure or one may dry up or all kinds of other problems may arise. Really, the crucial problem in breastfeeding is the weaning, and, essentially, if one sees the feeding process as one in which one both breastfeeds and gives the child solids, the child will take what the child wants and have no problems. I assume that if the child likes the solids, the solids are good for the child.

**Dr. Ratner:** Let me give a physiologic answer. The human baby's entire digestive system has been exquisitely designed for breast milk, particularly for the first six months. We have all kinds of physiologic data to this effect. Because nature wants to make infant growth as foolproof as possible—and this has great application to the psychiatric field—nature produces a baby who is a most resilient creature and who can survive much mishandling. This includes wrong foods at the wrong times and minor things such as milk at room temperature rather than body temperature. The baby can even survive an incompetent or malfunctioning mother, in most instances, particularly, if the mother is consistent in her malfunctioning so that the baby does not know what it means to have a good mother. The baby will adapt and survive. This is one of nature's devices to protect the
baby, to the extent possible, against the innocent machinations of mothers, pediatricians and other medical personnel.

Additionally, let me give you a relevant physiologic fact as I remember it. Recognizing sweetness and responding to sweetness is one of the baby’s first taste abilities. This is related to the human baby’s unique need for milk sugar for nerve development. When a breastfed baby gets a formula supplement—and most formulas are sweeter than nature intended partially because the baby food people are trying to promote sales and thereby are recommending and promoting excessive sugar additives to formulas—the baby is seduced by the sweeter fluid. This is unfair competition at any age, as we well know: cow’s milk has a hard time competing with malted milks and soft drinks, and natural desserts, such as fruits, have a hard time competing with artificially sweetened desserts. In general, adults and teenagers enjoy all kinds of horrendous snacks, horrendous from a nutritional point of view. The fact that they enjoy them does not establish their worth. The appetite is geared to natural foods not artificial foods. At the same time, to follow up Dr. Schwarz’ point, you do have to be careful. If a baby is enjoying something—or if you enjoy something which is not good for you—this should be handled carefully. You cannot take something away from your teenage child or young child, drastically or suddenly. It is not unlike weaning. The child has to be slowly and gently converted from one to the other.

**Question:** Why does the medical specialist persist in trying to measure the quality of intimate interpersonal relationships with quantitative measuring devices? Can you evaluate happiness in sociometric terms? You take something as intangible as happiness and self-satisfaction and because the scientist studying this feels more comfortable when he is dealing with quantities—I think in repeating the question I will give part of the answer. When we always stick to measuring things that lend themselves to quantity, the quantitative approach, we are frequently leaving out the most important things. For instance, you do not measure sorrow by counting tears. You will never have a one to one correspondence. But the question is why do doctors insist on trying to measure something which itself is not measurable in quantitative terms?

**Dr. Schwarz:** I think part of the problem inherent in this is that while there is nothing wrong with measuring that which is measurable rather than that which is not measurable, there is error in making a value judgment implicit to this, that what is measurable is therefore what is pertinent. To put it another way, the fact that we cannot measure that which is not measurable does not mean that it is not of significance. If one, therefore, says that it follows from the fact that A and B are what we measure, that A and B must be significant, then one finds oneself in the position of having to
convert meaningful values into measurable values and one ends up saying that it follows that that which is not measurable is not meaningful. One can go round and round in circles. Now the medical profession can measure many things and certainly the things which are quantitative, such as weight, are measured. The problem involved is that the medical profession has difficulty in admitting that there are areas which we are not in a position to deal with, to define, to evaluate. On the other hand, it is obvious that such areas exist and that there is no reason why there should be conflict between the two areas.

Dr. Mendelsohn: One short epigram on this: the problem as I see it is that while we try to be scientific and we try to use science, science being derived from the word “know,” we have to be careful not to behave like scientists. In what was just said about the desire to measure immeasurable things—if anything the psychiatrists have been in the forefront in pointing this out—I think what we might say is that it is important to be scientific without being scientific.

Mary Ann Kerwin: Is there any tie-in between after-birth blues and the failure to breastfeed?

Dr. Schwarz: I assume there is. On the other hand, unfortunately, I do not know of any good studies on the subject. For example, there are those who feel that the postpartum depression is completely a physiological process. Now I cannot say they are wrong, and certainly there are physiological changes which take place following birth. On the other hand, the tremendous degree of variation which one sees in postpartum depression certainly leads one to suspect that while there may well be physiological factors involved, what is precipitated and what is produced is a function of the emotional structure of the individual. I would assume that there is a correlation such as you imply, but I really cannot say.

Dr. Ratner: I want to close this discussion—because we have strict orders to bring this to a close—with one thought. It is a complicated one, but it might help you out. When you ask this panel questions there is a sense in which you are asking some of the questions of us not as practicing physicians, but as scientists. When you ask, “Is this true or is this not true?”, basically you are asking a scientific question. And this is why Dr. Schwarz gave you five assumptions, which most of us do not question. But from a scientific point of view these are assumptions, and the scientist likes to be able to say, “This is true because we can demonstrate it.” Now on the other hand we have the art—whether it is the art of medicine or the art of mothering. In an art we are not really concerned about truth as an end in itself. Art is practical not theoretical. We are simply concerned about turning out a good baby. From the point of view of the individual mother, we are not worried about the scientific reasons as such, as to why certain maternal behavior results in a good baby. This knowledge is to be pursued, but for the most part, its pursuit is in the scien-
tific area. In art you do not have to demonstrate how you did it, you just have to do the job of turning out a good product—in this case, a good baby. The mother's work is like that of the artist producing fine art. The artist who paints a picture is not responsible for answering any questions pertaining to what makes his painting great or how he brought it about in terms of techniques. This is the work of the aestheticians and critics. The artist's function is simply to turn out a good or a great work. When that is done, his work is done. Mothering is your work. Your babies are given to you as a kind of blank canvas upon which you devote a lifetime creating a great work of art—your contribution to society. Thank you very much.

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Hope is the enduring belief in the attainability of fervent wishes, in spite of the dark urges and rages which mark the beginning of existence. Hope...is nourished by the adult faith which pervades patterns of care.

Care is the widening concern for what has been generated by love, necessity, or accident; it overcomes the ambivalence adhering to irreversible obligation...Woman's preparation for care is anchored more decisively in her body, which is, as it were, the morphological model of care, at once protective abode and fountain of food.

ERIK H. ERIKSON
Human Strength and the Cycle of Generations, 1960
The Disturbed Child: Help on the Horizon

WHAT MAKES A CHILD DISTURBED?
In an attempt to find out, today’s parents frequently ask such questions as these: Should I feed my baby on demand or should I make him wait? Should I start toilet training early or should I let him train himself? Should I pick him up or let him cry himself out? Should I give him a pacifier? Should I let him eat what he wants to or force him to eat what he should? Should I put him in a playpen?

These and similar questions relating to feeding, sleeping, toilet training, and discipline, spring from certain hypotheses: that there is a right way of doing things; that there is an expert somewhere who knows the right way; that this right way can be communicated; that failure to do things the right way will lead to consequences ranging from unpleasant to dire to catastrophic.

These hypotheses share certain distinguishing characteristics:
1. An absence of any experimentally verifiable evidence.
2. An absence of accurate statistical data.
3. A wealth of conflicting anecdotes and folklore as background.
4. A lack of demonstrable evidence that the hypotheses, proven or unproven, have functional utility.
5. A remarkable tendency to produce feelings of parental inadequacy and guilt.

It is as hard to trace the origins of these hypotheses as it is to understand their widespread acceptance. But they are clearly a modern phenomenon and one can recognize certain generating factors. These include a prevailing sense of man’s omnipotence, reflected in child-rearing in the easy acceptance of the “molding clay” theory of child development. We have accepted (possibly too generally) the psychoanalytic theory which emphasizes the importance of the one-to-one relationship of mother and child. We accept as fact those behavioral science theories and animal experiments (often too readily applied to humans) which indicate the necessity of proper sequential phases of
development. And we accept the notion of “crucial ages” that carries the corollary that “missing something” at any point has irreversible dire consequences.

Since practices based on these hypotheses have been on trial for at least a generation, there has been opportunity to observe and arrive at the following conclusions:

1. Most of the theories are still unproven and some of the important ones have actually been disproven. By way of example, the notion that specific practices of child rearing will lead directly to specific results is probably as fallacious as the now generally discarded notion in the older psychiatric literature that specific symptoms and diseases result from specific personality traits.

2. The practices have not led to any spectacularly good results.

3. The side effects—guilt, feelings of inadequacy, self-deprecation, the search for experts, confusion, frustration—loom larger every year.

Professionals in child development—pediatricians, psychiatrists, psychologists, educators, caseworkers, school teachers, and the rest—must learn to respond to the typical parent questions I presented at the outset with:

I don’t know
No one knows.
There is no good evidence.
There is great variability and flexibility in the human situation. There are no “phases” that must be achieved at a certain time or irrevocably lost. In a well-functioning family a missed opportunity will either recur at a later date or be adequately compensated for. Human development is not an all-or-nothing phenomenon. There is always a second chance—even a third and fourth.

Furthermore, the professional must avoid such glib, general, unhelpful, largely meaningless but nonetheless expert-sounding advice as “act according to your feelings,” “trust your emotions,” and “give more love, security, appreciation, and praise.”

What, then, is the professional to do?

The answer surely is to accept the preeminence of the family and its key role in determining the development of the child. This may seem like taking a step backward—to a family-centered orientation—but it would seem that these questions are vital:

1. What is the nuclear family structure like? Is it intact, divorced, separated, or orphaned?

2. What is the parental physical health status?

3. What is the nature of the parents’ ethical and moral standards?

4. Are members of the “extended family” available for support and aid?

At the same time, some questions frequently are given too much weight in considerations of child development and, even worse, are

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judgmental in nature and tend to increase parental guilt. They must be deemphasized or even omitted. These include: What is the financial situation? Was the baby “planned”? Do the parents fight in front of the children? Has the child witnessed the primal scene?

**Healthy children**

Good families tend strongly to produce good, healthy children; poorly functioning families have strong negative effects on the development of their children. This observation is as true today as it has been in the past, and it leads directly to the family-centered approach.

Since good family life is vital to good child development, the pediatrician (or other child health worker) must move toward strengthening the family through all appropriate private and public avenues rather than devote his valuable training and energies to vainly trying directly to influence the mother, the father, the child or the mother-child relationship. He may even have to create a family for the child.

This family-centered concept was officially recognized by the 1966 Wisconsin Governor’s Conference for Home and Family at which it was “resolved, that social legislation at all levels of government should focus its attention primarily to the needs of the family as a unit rather than to the individual.”

With the crucial unit the family, and not the individual, influence on the child will be indirect rather than direct. Emphasis will be on strengths rather than weaknesses, planning for the future instead of apologizing for the past. And an optimistic outlook of ever-present opportunities for change and improvement will replace the currently favored, grimly fatalistic view of child development.

**Days of crisis**

These are days of crisis in the care of disturbed children. Facilities are jammed or under-utilized due to staff shortages and there is little opportunity for evaluation, let alone care.

But psychiatrists, psychiatric social workers, and others can help prevent future crises by developing programs of instruction and orientation for pediatricians. I am convinced that the pediatrician’s office is a prime detection source and a prime treatment source for the disturbed child. Once the pediatrician better understands the symptoms of the disturbed child, once he is better aware of the family’s role in that child’s development, and once he knows better where and how to refer children, this largely untapped resource—the pediatrician—will help solve the problems that face us all.

**Listen to mother**

Today, when a mother brings her child to the office of a typical pediatrician, it is for the treatment of a specific illness or a specific symptom—a cough, a rash, and so on. It
may not occur to him that the way the mother talks about the child, how she treats the child, and how she relates to the child may have direct bearing on the current illness and, more importantly, on future illnesses. If he routinely paid more attention to family situations and relationships, he would unearth areas of potential disturbance before they became acute. Some problems that develop will be beyond him and should certainly be referred, but I maintain that many children now referred could be treated by the pediatrician if he had the knowledge and got to them soon enough.

The inpatient versus the outpatient approach to the handling of disturbed children has been a matter of considerable debate. Beautiful and expensive buildings have been constructed as outpatient zone centers and are largely unused for lack of staff and other reasons. On the other hand, there have been marvelous advances in state mental hospital facilities, personnel, programs, and patient care.

While, in my view, it is futile to assign priority to either outpatient or inpatient care, the part the pediatrician can play was well revealed by a largely inpatient experiment with which I was closely associated.

Pediatricians' role

This four-year experiment was conducted in the Elgin and Dixon (Illinois) hospitals. Dr. Harold Boverman, a prime mover in the undertaking, approached it with the thought in mind that "experienced pediatricians constitute a large and latent reservoir of experts in behavior child care. Not only are they experts in total knowledge about their children, but they are expert in the training and supervision of neophytes. They are familiar with developmental notions and have been thoroughly impressed with the strength of family relationship. They are also familiar with the effects of regression in children and the means of prevention and treatment of regression in hospital or with illness... It (therefore) occurred to us that it would be profitable to explore the effectiveness of a pediatrician in a traditional large state mental hospital.”

Quick expansion

At first our consultations were confined to issues of pediatric differential diagnosis and treatment—organic versus functional, and dosage of anticonvulsant medication. Quickly, questions of diet and feeding habits, ordinary discipline (how do you get a child to bed?) and staff relations with parents (should we dress Johnny for the visit?) replaced the formal diagnostic sessions. In addition, there were children who needed rehabilitation measures such as standing tables, walkers, and special techniques. Other children were referred for surgical procedures of an elective nature, such as a tonsillectomy, and special review boards were established to prevent any instance of unnecessary surgery.

Later, there was an examination of state hospital routine: Should each child have a chest X-ray every
six months? Are routine laboratory tests necessary? Need an accident report be filed and a letter sent to parents every time a child falls? Should a child with a temperature elevation be removed from his unit to be observed in an infirmary housing senile and psychotic patients? What are the usual community resources available to a family with a disturbed child?

In addition to dealing with general child care issues, the pediatrician met with the children and their parents. His approach was one with which he was extremely familiar—that employed in his office when working collaboratively with a family that had a problem. The directness of his work added a new and helpful dimension to child care for a staff used to “going it alone.” Parents responded by assuming more responsibility for their children and a psychological barrier between staff and family was removed.

Organized parents

The parents formed their own organization, published a newsletter, and “lobbied” in the right places for the children’s unit. In some units, the parents almost became a part of the staff. Their availability in the evening, over weekends, and on holidays, when staff is short, was of infinite value. In families where the parents are seriously incapacitated, aid of the “extended family”—siblings, aunts, uncles, grandparents, cousins, or even close friends and neighbors—was enlisted.

Says Dr. Boverman: “The pediatrician had a clear and positive effect on staff and their care of children; this effect was major and out of proportion to the small amount of time it involved. In addition, he felt that his appreciation of and skill in managing usual behavior problems was sharpened by his encounters with the seriously disturbed. He was not on unfamiliar ground, but was quite familiar with the issues of basic child care.”

At Dixon State School, where the experience has been both inpatient and outpatient, the pediatrician has functioned similarly in consulting on matters of individual patient care and at the same time in critical policy matters and training situations.

Artificial families

Serving as a consultant to the foster-grandparent program, for the inception and development of which the Illinois State Department of Mental Health and others deserve great praise, I have had an opportunity to watch the successful creation of artificial families.

In the opinion of both insiders and outsiders, including the mayor of Dixon, this federally financed program has more than fulfilled the most optimistic predictions.

“Grandparents” are recruited from the local community, paid an hourly rate, and assigned to an individual child, or perhaps two. They attend to the child’s needs half a day, five days a week. The grandparents love it. The nurses are enthusiastically appreciative of the
program. The children have responded well, some making remarkable gains. Parents have been cooperative and helpful.

**Nursery transformed**

In a word, it has transformed the nursery, replacing crying with laughter, soiling with cleanliness, resignation with optimism, and futility with hope. I would say that in the four years I have been consulting at Dixon, this has been the single most valuable addition to the program.

The grandparent program has recently been supplemented by a Big Brother/Big Sister program, using Youth Corps workers and high school students, all on a paid basis. Local clergy have been invaluable in finding substitute families. Nonetheless, we can't keep up with staff requests for this kind of personnel.

Meanwhile, family-centered outpatient activities have been added to already existing inpatient staffings. These are headed by a pediatrician or another member of the group; the parents, family members, interested community people—such as school teachers, school superintendents, and speech therapists—are included in all sessions. The opinions of the parents are sought regarding diagnosis, etiology, patient care, prognosis, and planning. Parents are often present during the physical and neurological examinations performed by the pediatrician in the presence of the staff, often during medical consultations, and occasionally during laboratory tests, hearing, screening, and even, in selected instances, psychologic testing. No decisions are made without their full and active participation. Frequently decisions are made on their initiative.

**Crucial participation**

Parental participation is crucial in decisions involving visiting in the hospital, home visits, and times of admission and discharge. They are encouraged to function as semicaseworkers, seeking out facilities, visiting them personally, and looking into details. Our professional caseworkers offer guidance and are available for consultation, and investigate sources of financial assistance. Some of the parents have become quite expert and have even helped other families in the parents' organization. If the parents know what their children need and the resource is not available or the waiting list too long, we send them to their precinct captain or other political leader or organization. It has been gratifying to see how the American political system can work to help the individual reach his goals.

I must also mention the important role the church is able to play. It represents, in my view, one of our most seriously under utilized resources. It has good leadership, strong community influence, and dedicated people who have many skills of use to our patients.

No one would deny the need for more professionals in the child care field: we need more clinical facilities and more funds. But we must solve the problem facing us now
with the elements and resources at hand. The pediatrician, properly oriented and trained, can be a great help, but his role is that of traffic director, keeping the patient moving in the right channel before and even after referral. Beyond him, the use of existing family units and the building of artificial families are essential.

What has been accomplished at Dixon-Elgin should not be regarded as a solution only for the hospitalized patient. It can and should be applied to the community problem with which we are faced.

Our experience has been that the use of families blurs the divisions between private and public, between home and hospital, between staff and family, and even between the sick and the healthy. Using families doesn't take more money; it often saves money. It doesn't require organizational change, although some might help and may come as an inevitable result.

The changes that parents bring may be small as well as great, but even the small ones can have great significance. At Dixon-Elgin, one state hospital ward made a practice of celebrating all patients' birthdays in any month at a mass party on the first day of the month. The parents deplored this and arranged that each child's birthday be celebrated on the correct day. This simple, human act, in my opinion, was just as important for these disturbed children as all that scientific knowledge, medical and paramedical personnel, and government grants could ever be. We must be aware of the important contribution every family and every parent can make, as expressed in the timeless maxim, "Who is the wise man? He who learns from all men".