

PSYCHOSIS IN THE SUBNORMAL AND ITS RELATION TO ENVIRONMENT IN THERAPY

M. R. WALLLEY, M.B., Ch.B., D.P.M.

Deputy Medical Superintendent and Consultant Psychiatrist, Prudhoe and Monkton Hospital

Throughout the field of psychiatry, a recurring problem is that of the doubly-handicapped patient who can no longer be maintained in the community. Combinations of physical and mental handicaps, with needs that may conflict, are to some extent being dealt with by the creation of special units but the patient with a combination of different forms of mental disorder still presents difficulties which may tax all our resources.

The ending of the legal concept of designated hospitals has been brought about so that the psychiatrist is not hindered in his endeavours to give his patient the best environment for his treatment. The new Mental Health Act emphasises that the hospital chosen must be known to be able and willing to offer the facilities that the patient needs and carries with it the assumption that placement is no longer a question of administrative convenience but a vital therapeutic decision. To regard it otherwise is to put the clock back to the days when the subnormal and the senile, the inadequate and the insane were lumped together in inglorious confusion.

When confronted with a retarded patient who is further incapacitated by psychosis, it is no longer good enough to allow his placement to be governed by a mere fortuitous referral to a particular clinic. It is true that the prognosis sometimes tends to be poor but that increases the care needed if long-term treatment is envisaged.

Unfortunately, such persons do not always fit well into the Hospitals for the Subnormal or the Mental Hospitals. The former find that the patient with irrational behaviour is constantly disrupting the training routine which is necessary for the rehabilitation of the more stable retardate, and also that the impulsive psychotic is a very real danger to the more helpless patients. Mental Hospitals on the other hand may find the patient's retardation a major difficulty in applying their therapeutic measures, nor do they always fit into the normal ward life where some patients may resent bitterly the subnormal person in their midst. In placing these patients, therefore, the first consideration is to decide whether the psychosis or the intellectual deficiency is the predominant factor.

To begin with, while the subnormal person may be emotionally labile and inclined to lack foresight, his intellectual deficit per se will not produce acute symptoms requiring constant psychiatric nursing. Should such symptoms appear, they will be due to super-added mental illness, and require mental hospital treatment. On the other hand, in the lower grades with severe cerebral pathology, one would naturally expect the diseased brain at times to produce distorted behaviour analogous to the organic psychoses. One would not however expect such a patient to express delusions or complain of hallucinations—this would presuppose an articulateness and capacity for abstract thought incompatible with a diagnosis of severe subnormality.

The difficulty chiefly arises with the patient who is mute or nearly so, aggressive, destructive and possibly incontinent, a picture which can be produced both in the brain damaged retardate and the demented schizophrenic. The history is,

of course, most helpful if a reliable one can be found. For instance if such a patient attended school, the disorder is certainly dementia rather than subnormality, since no school could cope with such a child nor would any employer take on such a person, even for a day. Thus a history of any form of independent social adaptation precludes a diagnosis of severe subnormality.

Another point is the observation of any fundamental change in response to drugs or physical treatment, which should only occur in the psychotic.

One feels that the distinction is important and since it is generally believed that the schizophrenic retains some awareness of his surroundings long after he has ceased to communicate, it cannot do anything but harm for such a patient to be placed in a ward with very severely subnormal patients.

The patient with persistent uncontrollable aggressive behaviour or other evidence of gross psychotic symptoms, is best nursed in a mental hospital. Few Hospitals for the Subnormal are equipped to treat them properly, for unless there is a special unit built for them, these patients either have to be nursed alongside helplessness or else are found to be constantly impeding the orderly and disciplined routine necessary for the building up of stability and security of atmosphere amongst the more trainable patients. It is not unusual for the subnormal patient to copy psychotic behaviour in order to seek attention. On the other hand there is a small group of "burnt-out" schizophrenics who are functioning at mildly retarded level who may, once the acute symptoms have subsided, settle happily in a hospital for the subnormal and from there be rehabilitated.

It is not suggested that the mental hospital should take the difficult, whilst the hospital for the subnormal retain the manageable patients, but it must be remembered that the former is geared primarily to intensive medical treatment whilst in the latter the aspects of training and rehabilitation tend to predominate, and with each advance in therapy and education the roles of the two hospitals may diverge still further. In all cases, a close and intelligent liaison between the different psychiatric hospitals, based on a recognition of these different and yet complementary functions is necessary to bring the problem of placement out of the realm of mere administrative convenience and into its proper sphere of therapy.

This is not to say that the hospitals for the Subnormal have nothing to offer the psychotic retardee, once the problem has been properly assessed. Whether he be basically of dull intelligence or not, it is never sufficient to label him psychotic and load him with tranquillisers. The content of his disordered mind must be studied and the nature of his illness analysed before planned therapy begins, a task which may be rendered more difficult by the inarticulateness of the subnormal and the frequent complication of organic factors.

Easily the most common psychoses in the backward are the epileptic psychoses and the schizophrenias. Simple schizophrenia and hebephrenia are more often found than the paranoid states while psychotic depression and mania are relatively rare. If the latter do occur the response to E.C.T. is as good as in the intellectually normal while the epileptic and hebephrenic states may respond well to sufficient doses of the tranquillisers. Spontaneous recovery is not uncommon and much of the gloom re the prognosis in these patients is based on the naive expectation that with recovery from the psychosis, the patient's retardation should somehow disappear as well!

Perhaps most important of all, the hospital can provide the tolerant and accepting background which may be a striking contrast to the rejecting and critical atmosphere with which the patient may have had to contend. In many ways the hospitals for the Subnormal may be said to have pioneered the open ward move-

ment since in many such hospitals they have never been closed. The patient inaccessible to psychotherapy may still respond to the group activities of the ward—the parties, the walks, the impromptu concerts which seem much more an integral part of the life of the subnormal than of the mental hospital patient.

The rehabilitation of the psychotic is based on leading him back to the world of reality and reorientating him in the social contacts which he has known and lost. The subnormal on the other hand must be taught skills he has never known and not least the art of managing himself and his emotions. It is only in the hospital training situation that these two needs can be integrated. Independence is the goal, but a rational independence based on the patient's full capabilities, not on his castles in the air. Thus an insistence on a degree of social conformity aids the psychotic retardate both to a consciousness of the community and to a faith in his own ability to meet its demands.

Let us now turn to the problem as applied to children. By the psychotic child is meant one who is rendered ineducable, less by intellectual defect than by behaviour and personality difficulties so gross that they cannot be managed either at home or even in a school for the maladjusted. Whilst this is scarcely a scientific definition, it does cover a group of children which at present causes considerable therapeutic and administrative problems.

These patients generally have a low aggregate score on psychometric testing but the scatter suggests that this is an underestimate of their potential ability and, therefore in considering them, a full psychologist's report is necessary, rather than a simple statement of mental age. On the other hand, it seems likely that the onset early in life of what amounts to a catastrophic breakdown in social adaptation, generally indicates an excessive vulnerability to stress. This may be either constitutional or else due to organic disease of the brain.

The problem therefore is to decide in each case whether the child's basic intelligence is such that he would or would not be educable without considering his other symptoms and whether the organic or psychogenic aspects predominate in causation. This requires a careful study of all the factors involved in the child's illness.

An incontrovertible history of normal development for at least the first few years suggests that the child has at least some capacity for normal adaptation. A very early onset suggests a poor prognosis and that the child will always function at subnormal level. Similarly, a history of severe emotional stress suggests a predominant psychogenesis and therefore the possibility of reversal. If, however, there is a history of severe organic brain disease the prognosis is correspondingly poor.

Secondly an estimate of the severity of the disability should be made in terms of social incompetence. The child who is mute, withdrawn and doubly incontinent is obviously less likely to be accessible to psychiatric treatment unless the disorder is of acute and recent onset. Such a child will be untestable psychometrically and not out of place amongst the severely subnormal.

On the other hand a child who has a good vocabulary and can show near normal responses on parts of intelligence tests should not be regarded as untreatable whatever the total I.Q. rating may be. Another sign of psychogenic illness is variability of behaviour according to environment. For example if a child's behaviour is significantly more abnormal at home than in hospital, he must be regarded as disturbed rather than subnormal. Delusions and hallucinations are, of course, diagnostic of psychosis, but carry a poor prognosis.

A severely disabled child, whether psychotic or mentally subnormal, is better nursed amongst other children than amongst mentally ill adults. The exception is the child, who in spite of sedation, is so violent as to be a danger to other children. There is no doubt that the child with severe behaviour disorder will seriously disrupt the training routine of the more stable subnormal children, but, in the absence of special facilities, the Hospital for the Subnormal has much to offer the grossly disturbed child. Experience shows that the average nurse trained at these hospitals has more tolerance and understanding of the acute behaviour disorder in children than the children's nurse or even the mental trained nurse. Furthermore, access to some sort of schooling is generally important and this can be most economically provided by a special class in the hospital school.

If it is possible to establish within the hospital a separate unit for these children, even more can be done to help them. It is time we ceased to accept the old idea of the psychotic child needing to be "rescued" from the hospitals for the subnormal. It may not be possible to give frequent and formal psychotherapy but, as with the adult, the establishment of an atmosphere of tolerance and understanding may do more. The child is freed from the restrictions of possessive parents or complaining neighbours and yet has the benefits of an ordered regime and consistent discipline. Unlike the schools for the maladjusted, regular visiting is generally possible and thus the child is not, unless it is desirable, cut off from contact with his home.

Here again the diagnosis of psychosis is only a beginning. One often finds that mental disease in children and childhood schizophrenia are referred to as if interchangeable words but there is of course as wide a variety of syndromes in the child as in the adult. Probably the most common are the epileptic psychoses and infantile autism but gross neurotic breakdowns are not infrequently seen in the vulnerable child.

Physical treatments are rarely if ever successful in the child and one doubts if they are altogether harmless to the immature brain but good response can sometimes be obtained with tranquillising drugs. Most children tolerate these remarkably well, often to the point of requiring adult doses and side effects are rare. Here the advantages of hospital treatment are immense since one can push dosage to an extent that would seem unsafe in outpatient practice.

In conclusion, it may be said that with the patient who is both psychotic and subnormal, the hospital offers not a second best alternative to community care but a positive therapeutic environment which may in itself produce remarkable and gratifying results.