

THE INSTITUTIONAL MIND AND THE SUBNORMAL MIND*

RUSSELL BARTON, M.B., M.R.C.P., D.P.M.

Physician Superintendent, Severalls Hospital,
Consultant Psychiatrist, Essex County Council.

The institutional mind does not really exist. It is a personification of attitudes and procedures that existed and still exist in some institutions. It has, however, a very real, and sometimes sinister, existence in the minds of inmates of institutions.

This is not very scientific, where science is defined as a systematised collection of facts obtained by observation and experiment. But in defence I would point out that most of the important decisions we make in life, such as choice of marriage partner or career, are not arrived at scientifically. Indeed, as Bertrand Russell (9) remarked:

“ The development of science of our commonsense has not been by way of a radically new start at any moment, but rather by way of successive approximations — that is to say, when some difficulty has arisen which current commonsense could not solve, a modification has been made at some point, while the rest of the commonsense view of the world has been retained. Subsequently, using this modification, another modification has been introduced elsewhere and so on. Thus science has been an historical growth, and has assumed at each moment, a more or less vague background of theory devised from commonsense.”

As I see it, we sometimes use science where commonsense would be more appropriate and sometimes use commonsense when science could have given a far more satisfactory solution.

Piaget (7) described syncretic thought, a stage in the development of thinking, as “ that first wide and comprehensive but obscure inaccurate language of childhood.” Global precedes analytical thinking.

If, then, I follow Goffman (4) and present a somewhat systematised approach to institutions, emphasising the features which predominate, it is left to the reader to abstract from Goffman's description an intuitive, syncretic notion of the Institutional mind.

Much of what follows comes from Goffman who gave a general view of institutions. Often they are encompassed by a barrier to the world outside — high walls, locked doors, railings, barbed wire, cliffs and water and so forth. Institutions fall into five groups — a neither neat nor exhaustive list is as follows:—

Groups and Purposes of Institutions in Western Civilisation

1. Institutions established for the care of people who are both incapable and harmless — homes for the blind, aged, orphaned and indigent.
2. Places established to care for people unable to look after themselves and who are an unintentional threat to the community — tuberculosis sanatoria, leprosia and mental hospitals.
3. Places established for persons intentionally dangerous to the community — gaols, penitentiaries, P.O.W. camps and concentration camps. (These differ from other institutions since the welfare of inmates is not the primary nor immediate issue).

*A paper read to the Midland Society for the Study of Mental Subnormality on May 13th, 1961

4. Institutions established to pursue some technical task — Army barracks, ships, boarding schools, certain colleges at universities, work camps, colonial compounds and the servants' quarters of large mansions.
5. Establishments designed as retreats from the world or as training stations for the religious — abbeys, monasteries, convents and other cloisters.

There are three features which predominate in such institutions to a far greater extent than in the world outside:

- (a) The inmates tend to sleep, play and work in the same place — normally places of work, sleep and play are separated and distinct from each other.
- (b) Each phase of the members' daily activity is carried out in the immediate company of a large batch of others, all of whom are treated more or less alike and required to do the same thing together.
- (c) All phases of a day's activity — of idleness — are tightly scheduled and pre-arranged, the whole circle of activities being imposed from above through a system of explicit formal rulings and a body of officials. This handling of the many diverse and often conflicting human needs of whole blocks of people by a bureaucratic organisation may be one of the key factors producing the pattern of institutions. I am not sure.

The characteristic authority system evolved in institutions has three distinctive elements, each basic to total institutions.

First, to a degree authority is of the echelon kind; any member of the staff class has certain rights to discipline any member of the inmate class. This arrangement, it may be noted, is similar to the one which gives any adult in some small American town certain rights to correct, and demand small services from, any child not in the immediate presence of his parents. In our society, the adult himself, however, is typically under the authority of a single immediate superior in connection with his work. He is also subject to other more remote authority such as the police who are usually neither constantly nor relevantly present, except perhaps in the case of traffic law enforcement.

Second, the authority of corrective sanctions is directed to a great multitude of conducts of the kind that are constantly occurring and constantly coming up for judgement. In brief, authority is directed to matters of dress, deportment, social intercourse, manners and the like. In prisons these regulations regarding situational properties may even extend to a point where silence during meal times is enforced, while in some convents explicit demands may be made concerning the custody of the eyes during prayer.

The **third** feature of authority in total institutions is that misbehaviours in one sphere of life are held against one's standing in other spheres. Thus, an individual who fails to participate with proper enthusiasm in sports may be brought to the attention of the person who determines where he will sleep and what kind of work task will be accorded to him.

When we combine these three aspects of authority in total institutions, we see that the inmate cannot easily escape from the press of judgemental officials and from the enveloping tissue of constraint. The system of authority undermines the basis for control that adults in our society expect to exert over their interpersonal environment, and may produce the terror of feeling that one is being radically demoted on the age grading system. Outside institutions, the rules are sufficiently

lax and the individual sufficiently agreeable to required self-discipline to ensure that others will rarely have cause for pouncing on him. He need not constantly look over his shoulder to see if criticism and other sanctions are coming. On the inside, however, rulings are abundant, novel and closely enforced so that quite characteristically, inmates live with the chronic anxiety about breaking the rules and chronic worry about the consequences of breaking them. The desire to "stay out of trouble" in a total institution is likely to require persistent conscious effort, and may lead the inmate to adjure certain levels of sociability with his fellows in order to avoid the incidents that may occur in these circumstances.

May I turn from the nature of the social organisation of institutions and their differences from everyday life to their usual, but not invariable, effect? The effect is a production of a pattern of culture — attitudes, behaviour and values — so different from the pattern of culture in the rest of the community that adaptation to life outside the institution requires considerable and difficult readjustments.

In hospitals for the mentally disordered and subnormal, the effect of the institution has been to produce a more or less constant psychiatric syndrome, characterised by apathy, lack of initiative, loss of interest more marked in things and events not immediately personal or present, submissiveness, and sometimes no expression of feelings of resentment at hard or unfair orders. There is also a lack of interest in the future and an apparent inability to make practical plans for it, a deterioration in personal habits, conduct and standards generally, a loss of individuality, and a resigned acceptance that things will go on as they are — unchangingly, inevitably and indefinitely.

Until recently this condition was considered to be the end result of the illness bringing the patient into hospital. Nowadays it has been distinguished from the end result of psychosis and subnormality, and should be considered a disease entity in its own right (Institutional Neurosis — Barton, 1959).

If now, one attempts to go beyond the global and adopt the analytical approach, using analytical in its true sense, one may group the factors associated with hospitals for the mentally subnormal under seven headings. Of course, the divisions are not absolute and these factors overlap. They are artificial divisions of an overall picture and they may be wrong, but 'Truth springs more readily from error than confusion.'

Seven Deadly Sins of Institutions

1. Loss of contact with the outside world.
2. Enforced idleness.
3. Bossiness of medical and nursing staff.
4. Loss of personal friends, possessions and personal events.
5. Excessive use of drugs.
6. Bad ward atmosphere.
7. Loss of prospects outside the institution.

Loss of contact is a multifactorial effect — certification, locked doors, railings, restricted visiting, parsimonious parole, distance from home town and expense entailed by visiting which may be the cost of fares and the loss of earnings for a day's work, are the more obvious factors. More subtle ones arise because the clothes, hairstyle, gait or posture of a patient may make ordinary people turn away from him or regard him with apprehension or pity. Sometimes doctors may have told visitors that there is no point in visiting; sometimes the hospital regime and stigma deter relations from visiting.

Enforced idleness may be absolute for certain periods of admission or during the day. It may be enforced by putting the patient to bed or by sitting them round in a day room or garden with nothing to do. In an institution for mental subnormality, a great deal of mental thrust is required to visualise, organise and sustain a programme whereby inmates are given optimum opportunities for learning. Again idleness may be engendered by the nurse's good nature, who deems it her duty to do everything for her patients, adopting the mixed role of a servant and parent.

Bossiness of medical and nursing staff is felt by patients to be present in a great number of us. Implicit assumption of personal, effortless superiority is so easy to make: yet the best of us are but $1\frac{3}{4}$ paces out of the mouth of the primitive cave of our origin, and the mentally subnormal creature is $1\frac{1}{2}$ paces — not really so far behind — but alas, I am hoist by my own petard; I have confessed to thinking I am $\frac{1}{4}$ of a pace superior — we must all “watch it.” The man in the street is often far more arrogant; he, lacking training and experience, is often prepared to predict how mental patients or mentally subnormal people will behave — what they will do. Humility and self-criticism are singularly lacking when the questions of madness, bringing up children or education are raised. Doctors have told patients lies “for their own good” — well-meaning lies about divorces, family deaths and disasters which imply that the doctor can predict how the patient will react and how much he will stand. If one accords to oneself such prescience, and believes one has it to the extent that it justifies telling untruths, then it seems to me to suggest an unjustified conviction of superiority. This is always a tender subject — it may end up with unnecessary E.C.T. or brain surgery.

It was Dr. Hilliard, late Superintendent of the Fountain Hospital, who first made me realise that loss of personal possessions is a terrible catastrophe to most of us. Nothing erodes our sense of identity so quickly as a complete absence of familiar possessions. Yet, until recently, some hospitals would accept no personal property with patients. This ghastly social and sexual stripping was part of the initiation rites of many if not most hospitals. Even today, many patients have no locker on which they could be encouraged to put photographs, no wardrobe in which to hang their frocks and suits, no chest of drawers in which to keep their clothes. Personal events punctuate time. A personal event may be defined as one in which the patient plays a significant role — it may be he merely makes a decision to go or not to go on or it may be he conceives, formulates and executes the plan. Institutions tend to provide everything the patient does, regardless of his wishes, preferences or willingness to co-operate.

Drugs used to adjust an individual to the emotional storms that sweep him from within or the cognitive experiences that confuse and cause him to lose his trust in the world rather than in his senses. Alas, too often drugs are used to adjust the patient to the world without, to make him accept the unpleasantness of his surroundings, the injustice of his incarceration, and terrible lack of care and foresight of some (but not all) doctors, committees and legislative bodies who undertake to make decisions about things of which they know little or nothing. Cook (2) tells how, in 1938, over half a ton of paraldehyde and $\frac{1}{2}$ ton of chloral hydrate were used in one hospital alone. This in itself facilitates the imposition of idleness.

Ward atmosphere is that impression a ward gives you when you first enter. It depends on colours, lightness, furniture, fittings, noise, smell, attitude of nursing staff and the appearance and occupation of other patients. There is a danger here: a committee may be persuaded its contribution is finished when the wards look nice and well furnished. This is only 15% of the task — the six other deadly sins need recognising and then correcting before members of a committee, medical, nursing and other staff can rest with any justification.

Prospects of a place to live in, a job to work at and friends to stop loneliness, become increasingly distant the longer a patient is in hospital. It is not sufficient to tell him he might get a job and get out — he might fly or strike oil in the lavatories. The best advertisement is a patient who works outside hospital and brings home a fist full of crisp, crinkly pound notes in a wage packet. One picture is worth a thousand words. Maybe one practical real life demonstration such as this is worth a thousand pictures.

No individual can correct all these defects alone. Unless a sizeable proportion of the people concerned is prepared to appraise the present and acknowledge what is wrong at the risk of indicting the past nothing can be done. If, and when, the deadly sins are found to exist, then each individual needs to decide his role in correcting them. He can do one of two things: he can do something or he can manifest concern that something is or is not done. Both roles are invaluable.

Each individual having employment or interest in an institution should ask himself: What can I do to

1. Re-establish patients' contacts with the outside world.
2. Provide a daily sequence of useful occupations, recreations and social events — fourteen hours a day, seven days a week.
3. Alter the attitude of medical and nursing staff.
4. Encourage and make it possible for a patient to have friends, possessions, and to enjoy personal events.
5. Reduce drugs.
6. Provide a homely, friendly, permissive ward atmosphere.
7. Make the patient aware of prospects of accommodation, work and friends outside hospital.

I would repeat, contributions fall into two categories — active and passive, i.e., on the one hand you can actively help to counter the factor, and on the other hand you can, so to speak, passively manifest concern so that somebody else does something to correct the factor.

Perhaps manifesting concern should be your chief role — to guide, but not to push, to appraise and formulate the effect of other people's actions and apathies and to present it in discussion so that a collective attitude can be formed which will prevent institutional neurosis arising in the future and cure it when it has arisen in the past, or maybe your part is the more rewarding one of actually doing the job. Encouraging visitors, befriending relatives, talking to the lost and lonely, helping patients up the rungs of the ladder that may eventually lead to discharge and a home outside — it can happen with the mentally subnormal as well as the chronic psychotic.

Now let me turn from consideration of a phantasy, the non-existent institutional mind, to something real — the subnormal mind.

The term mental age is a misnomer like the term conditioned reflex. The former should be called a test age, the latter should be called an association response. Test age implies a value obtained by testing, thus our minds are immediately directed to the raw material — the nature of the test. Different tests, correlating well when applied to normal populations, may give a difference of 30 points when applied to the subnormal.

The subnormal mind has difficulties in grasping abstract concepts. Language does not communicate concepts, ideas, mental images, to the same extent as in the

normal. Thus words may keep the doctor or nurse happy "doing their bit" but they may only be significant to the subnormal mind in another dimension—whether they sound angry or pleased. This fall out of significance of language also applies to that wonderful penumbra and profusion of ideas that hover, marginally conscious, when a normal person considers any proposition. The normal person may have a wide choice of psychic material confronting him, may have a host of words from which to select and a fund of mental thrust and expression to energise his enquiry and communication. He can take and double take, and rapidly and efficiently interpret what is going on with what has gone before.

A second difference is that the normal person can recollect more efficiently than the subnormal, and by recollection I mean the voluntary process of contacting previous experience, whereas recognition — a feeling of familiarity when confronted by a situation or object previously experienced—may be present equally. But probably even recognition is better sensed by the normal mind — such is the inequality of nature.

In addition to a reduction of cognitive function in which thinking, memory and often perception are impaired, there is another less-easy-to-detect characteristic of the subnormal mind — slowness. Intellectual efficiency is a construct combining intelligence with speed of its application. The subnormal mind often goes slower, sometimes much slower, than the normal. It laboriously attempts to marshal its abilities and applies them not only with less skill and effect, but with **less speed**. It always behoves us when dealing with the subnormal to seek the signs that our patient is following our demonstration and to make sure that we are not out-distancing him—baffling him with what we consider normal concepts put over at a slow pace to match his ability, yet to him so fast and complicated that he fails to grasp our meaning and becomes bewildered, disheartened and often disinclined to try again.

I have mentioned mental thrust, by which analogy I refer to the driving force, energy, will power, constancy to purpose, effort, striving or conative aspects of the mind. It often appears lacking in the subnormal and it seems reasonable to suppose it is less powerful than in normal people. Yet the correlation cannot be great. We all know highly intelligent people who are indolent and bone lazy, and dullards who are energetic and industrious. Again, we encounter a great deal of energy in certain imbeciles, especially if they are annoyed or doing something they like. This question of energy and voluntary effort is not well understood. Manic patients appear brimming over with energy yet accomplish little; children amaze us with their vitality yet much of their play is repetitive; so that qualities other than sheer mental drive are required — it must be steered and harnessed. Since there is little scientific data about these matters, the nurse or teacher or psychologist or doctor must use her common sense and experience in provoking enthusiasm in mentally subnormal patients. Similarly, in predicting the capabilities and whether adjustment outside an institution is possible, scientific testing of abilities gives no more than an indication. Many other factors matter; Porteus (8) stresses the importance of social efficiency, and Doll (3) has studied closely the use of the Vineland social maturity scale. The temperament of the patient is important, as is his appearance and presence or absence of bad habits. Carelessness with bodily excretions from any of the orifices pushes a patient inexorably towards institutional life (as with geriatric patients).

Final factors, but the list is by no means exhaustive, are the tolerance of the relatives or friends of the patient and the attitude of his employers.

In spite of the limitations of intelligence testing, about which most if not all psychologists agree, application of appropriate standardized and graded tests give a better idea of intelligence than other methods.

Mental age is assessed by giving the subject progressively difficult tests. His mental age is reckoned as that age at which an average child would pass the same tests successfully.

In the past the mentally subnormal were graded as idiots, imbeciles and feeble minded.

An idiot was the lowest grade with an I.Q. up to around 20, or a mental age up to about 3 years. E. O. Lewis (6) described them as "scarcely capable of receiving any permanent benefit from training — they can seldom be trained in clean habits, to dress themselves or use a knife and fork when eating, nor can they learn to do the simplest form of handiwork and are unable to guard against common physical damage."

An imbecile was said to have an I.Q. between 20 and 45-50 and a mental age of 3 to 8 years. The criteria for inclusion in this class were largely educational. Again we owe to E. O. Lewis (who had a far higher reputation abroad than in his own country) the following description — "only regard a child as an imbecile if after a year or two at a special school he was unable to reach the achievements of the lowest class in an ordinary infants' school — he was unable to recognise his letters or had not reached the level of a child of half his age — unable to dress, keep clean, play simple games, find his way out of a building, to do simple calculations." The highest can usually wash and dress themselves, but only learn to do so very late in childhood, and such matters as buttoning boots or tying shoelaces often remain entirely beyond their powers.

The feeble minded or morons were said to have an I.Q. between 50 and 80 or a mental age between 8 to 12 years. Usually patients classified as feeble minded were a mixed bag; a few were true simpletons where intelligence was close to the imbecile, some were dullards who learned to read and write with varying degrees of success, and some were delinquents or female dullards capable of getting pregnant.

These groups are capable of criticism; every class or group has a fringe of uncertainty, but they are helpful in attempting to systematise our knowledge and I think useful as a background to clinical practice to add to and subtract from.

Where I disagree with some is that I do not think we are justified in assigning a patient to a class — idiot, imbecile or feeble minded — and then predicting his limitations from our impressions of the usual limitations and shortcomings of members of that class. After all, a sheepdog has an intelligence of a child of about 18 months old, and yet it can be taught to do a useful job rounding up sheep. A worm with a much more primitive nervous system, can learn simple responses and I cannot believe it is beyond our wit to produce methods of training for some idiots and imbeciles which together with simplified techniques would enable many of them to do a useful job. A man does not need to be intelligent enough to drive a lorry to pick up dustbins and empty them. Reading and writing are not really so essential; most of the world's work was done until a hundred or so years ago by people who could neither read nor write. A tragedy of our contemporary civilisation is the status value put on achievements which the individual may not use — Latin, public schools, university, etc. If a subnormal patient can learn to sign his name he will get by in most situations, even in the complicated world of today, and a little assistance from social workers may enable him to float in the community instead of sinking into an institution. Slowness should be no bar. When you consider that a bricklayer can lay between 1,000 and 1,200 bricks a day, yet his Trade Union may restrict him to laying only about 450, you will agree that the slow, sub-

normal patient should fit in well with his Union and maybe achieve special distinction in it.

Again we all know of the tenderness lavished on dumb animals by so many people. I find it hard to believe that this fund of affection cannot be put to a more worthy cause — diverted to some of the many subnormal patients who desperately need someone to care about them. It is not easy, and yet if our information services were better, if our propaganda were more powerful and we seized opportunities instead of frittering them away with countless committees, I am convinced we could all do far more to help the mentally subnormal patient make the most of what little he has got.

References

1. Barton, R. (1959). "Institutional Neurosis." John Wright and Sons, Bristol.
2. Cook, L. C. (1958). "Journal of Mental Science," 104, p. 933.
3. Doll, E. A. (1953). "The Measurement of Social Competence." Minneapolis.
4. Goffman, E. (1957). "Proceedings of the Symposium on preventive and social psychiatry." Walter Reed Army Institution of Research, Washington, D.C. April 19.
5. Hilliard, C. T. (1954). "Personal Communication."
6. Lewis, E. O. (1929). "An Investigation into the incidence of Mental Deficiency." Report of the Mental Deficiency Committee (Wood Report), Part IV, London.
7. Piaget, J. (1932). "The Language and Thought of the Child." Kegan Paul, London.
8. Porteus, D. (1941). "The Practice of Clinical Psychology," New York.
9. Russell, B. (1923). "Analysis of Matter," page 193-4.