

ADMISSIONS TO A NEW UNIT FOR ADOLESCENT FEMALES IN A SUBNORMALITY HOSPITAL

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INTRODUCTION

In April 1964, an in-patient unit for 28 adolescent females was set up in Borocourt Hospital, a hospital principally catering for the subnormal. This occurred as the result of increasing awareness within the psychiatric and social services of the area served by the hospital, for a unit where adolescents showing disturbances of behaviour could be investigated and, if necessary, receive prolonged in-patient care.

The unit has been functioning for too short a time for a study to be made in any detail of the results of treatment and care. Although a few patients were discharged within a few weeks, the majority required longer periods of stay, often more than a year. However, this preliminary study is mainly of the social, family, and medical backgrounds of the patients, with some detail of in-patient investigation and diagnosis.

SUBJECTS

In the sixteen months between the opening of the unit and the commencement of this investigation, there were 36 admissions and all have been included in this study. The ages on admission ranged from 12 years 11 months to 18 years 10 months, with an average of 16 years 0 months.

DIAGNOSTIC CATEGORIES

After full physical, psychiatric, and psychological assessment, an attempt was made to classify each case in terms of the categories as in Table I (Cameron 1955; Warren 1965). The one patient classified as Neurotic had a reactive depression with a suicidal attempt, following family difficulties.

TABLE I
Diagnostic Categories

	Neurotic Disorders	Conduct Disorders	Mixed Conduct and Neurotic Disorders	Psychotic Disorders	Other	Total
Number	1	8	17	2	8	36
%	2.8	22.2	47.3	5.5	22.2	

The group admitted as Conduct disorders with various and anti-social activities had usually been through the range of legal and disciplinary measures and admission to this unit was to see if psychiatric treatment would be of any help.

The patients with Mixed neurotic and conduct disorders comprised the largest group and were indeed very mixed. Anxiety with depression, hysterical or obsessive features, enuresis and tics, were evident, although in most cases it was the Conduct aspect that originally brought them to psychiatric notice.

There were only two cases which could be classified as Psychotic, one being a recurrent depression in a patient with gonadal dysgenesis. The Others group consisted of six subnormals; one case of cerebral palsy with deafness, speech defect and epilepsy; and one which could not be definitely classified but contained elements of psychosis, neurosis, and conduct disorder.

REASONS FOR REFERRAL FOR PSYCHIATRIC HELP

As can be seen from the previous section, the clinical features were many and diverse. However, there was no doubt that certain features in the histories given by the referring authorities and departments appeared frequently. Table II shows the incidence of some of the more common items of behaviour which, however, were not necessarily the presenting symptoms.

TABLE II
Important Features of Behaviour in Clinical Histories

	Suicidal Attempts	Absconding from Home. Wandering	Sexual Promiscuity & Related Problems	Aggression to parents & Authority	Stealing	Poor Work Record
Number	7	14	17	14	4	5
%	19.4	39	47.2	39	11	13.9

Of those who had attempted suicide, one was diagnosed as Neurotic and the remainder as either Conduct or Mixed neurotic and conduct disorders. All those with sexual problems and with absconding from home, wandering, etc., were either in the Conduct disorder or the Mixed neurotic and conduct disorder groups.

It should be mentioned here that a number of those in the conduct and mixed disorder groups were of "borderline E.S.N." intelligence and some had had special education or had been classed as E.S.N. at an early age. The diagnostic categories applied above were based on opinions of the unit staff after assessment in hospital and, in a few cases, were different from earlier assessments.

INTELLIGENCE

The intelligence levels by no means followed the normal distribution in the general population. The intelligent quotients considered were obtained on tests where the mean was 100 and the standard deviation 15 points (Castell and Mittler 1965; Mittler 1965).

The numbers of subjects in the various ranges as seen in Table III. Four are not considered, either because they were not tested or because the tests were not appropriate.

TABLE III
Range of Intelligence
I.Q. Levels

	>120	110-119	100-109	90-99	80-89	70-79	<70
Number N=32	1	1	3	3	5	15	4

The I.Q. 70 to 79 range, the "borderline" range, is obviously of great importance in the overall picture of admissions. It was within this group that many of those who had received at least some E.S.N. education fell (see Personal Histories—(j) Education). It was noticeable that the intelligence levels obtained in hospital were frequently higher than those obtained in other situations, as for example, when being tested for Education Authorities.

LEGAL STATUS ON ADMISSION

By far the greatest number were admitted as informal (27 patients), but many of these were in care of the Children's Departments and have been considered as a separate group (see Table IV).

TABLE IV
Status on Admission

	Informal	Informal Child Care	Detention under Mental Health Act					Place of Safety
			Sect. 29	Sect. 25	Sect. 26	Sect. 60	Sect. 61	
Number	11	16	1	1	3	1	2	1
%	30.6	44.4	2.8	2.8	8.3	2.8	5.5	2.8

The patient admitted under Section 29 was subsequently detained under Section 26.

Of the informal patients under the care of the Children's Department, 4 were admitted to the unit for a period as a condition of probation.

PERSONAL HISTORIES

(a) Social Class of Parents

This could be ascertained in 33 cases, there being 15 (45.5%) in Class V, 11 (33.3%) in Class IV, 4 (12.1%) in Class III, 0 in Class II, and 3 (9.1%) in Class I. The children of all parents in Class I and 1 in Class III, comprised 4 of the 6 sub-normals.

(b) Illegitimacy

5 patients were of illegitimate birth and the parents of one of these married after the birth.

(c) Separations from Family

Almost all the patients had spent some time away from their natural family or had lost one of their parents. There were 15 subjects (41.1%) who had spent a total of more than six months away from home before the age of 12 years and in 7 the period had begun before the age of 2 years. In addition, a further 4 patients suffered the loss of either father or mother but continued in the care of the remaining parent. 6 cases were parted from their families in the first year of life and were still separated when admitted to the Unit.

(d) In Care of the Children's Departments

22 subjects had been "in care" of the Children's Departments some time during their life, although parental rights had not been transferred in many cases. The length of time "in care" was a wide range, as can be seen from Table V.

TABLE V
Time "in care" of Children's Departments

	>10 years	2-10 years	6 months— 2 years	<6 months	Nil
Number	5	6	3	8	14
%	13.9	15	8.3	22.2	39

(e) Adoption and Fostering

As already seen, a considerable number had been "in care" of the Children's Departments. 7 (19.4%) were placed with foster parents at some period before admission, but only two were adopted.

(f) Legal Aspects

17 patients (47.3%) had appeared in Court at some time in their lives. Usually it would be because they were deemed "out of control", "in need of care and protection", etc. (12 cases—33.3%), mostly resulting in a Fit Persons Order. "Sexual intercourse under age" was an item involved in 5 instances. Criminal offences (all larceny) were the reasons for court appearance in 5 instances, and lack of proper school attendance for 1 other. Some patients had appeared more than once for different reasons.

The majority of patients had never been placed in any legal institution. Of the 30.3% who had, 8 had been in Remand Homes, 1 in an Approved School, and 1 in prison.

(g) Previous Psychiatric Treatment

This only included those patients who had received advice and treatment prior to the assessment interview, usually conducted before admission was arranged.

20 patients (55.6%) had received such treatment and, of these, 8 had been on an out-patient basis only. The remainder had spent at least one spell in a psychiatric hospital. 7 were transferred to the unit from other wards in the same hospital when the unit opened, and it was considered they would be better placed. Another 4 had been in-patients in other psychiatric hospitals and the remaining 1 had been admitted to a psychiatric ward of a general hospital.

(h) Physical Health before Admission

In the assessment, the usual childhood affections were ignored. No attempt to grade the severity of the illness was made, mainly because of the difficulty and unreliability in a retrospective study such as this.

Of the 34 patients in which an adequate medical history was obtained, 15 (44.2%) had definite, usually chronic, illness. This included such conditions as chronic sinusitis (2), deafness (3), epilepsy (2), strabismus with myopia which was marked (2), bronchiectasis (1), and cerebral palsy (1). In addition, there were two

patients who had been pregnant, one who was pregnant at the time of admission, and one who had been treated for venereal disease.

(i) Education

In assessing this aspect, it was difficult to establish a pattern because of the wide variation, but it was considered reasonable to divide the patients into the following educational categories:—

- (i) Those who had received full education in normal schools;
- (ii) Those who had received mainly E.S.N. education, usually beginning before the age of 10 years;
- (iii) Those who had received mainly full education, but had had some E.S.N. education; and
- (iv) Miscellaneous.

The numbers of subjects in the various categories are given in Table VI.

One of the subjects who had received full normal education had been ascertained as E.S.N. at the age of 7, but never received special education.

The Miscellaneous group includes 1 patient who had received largely home teaching, 2 who had attended Training Centres, 1 who had attended a school for the deaf and a craft school, 1 a hospital school, and 1 a P.N.E.U. establishment.

TABLE VI
Type of Education

	Full Normal	Mostly E.S.N.	Mostly Normal	Miscellaneous
Number	19	4	7	6
% N=36	52.8	11.1	19.4	16.7

(j) Mental Health of Parents and Siblings

This was often not easy to establish and the results given below are based largely on Social Workers' and Child Care Officers' opinions. If there seemed any doubt about the history of mental illness or instability, it was not considered in this study.

There was a history of mental disorder in 11 of the mothers (30.5%), including 2 treated neurotics, 3 dull and illiterate persons, 1 with pre-senile dementia, 1 with recurrent depression, 2 subnormal, 1 dull, convicted prostitute, and 1 with an admission to a mental hospital, the reason for which could not be established.

In 10 of the fathers (27.7%) there was a similar history with 3 cases of treated neurosis, 3 of recurrent depression, 1 of paranoid schizophrenia, 1 of dementia following head injury, and 2 who were dull and illiterate.

In 5 instances, both parents were affected.

10 of the patients had siblings with some emotional or mental disturbance, including 3 who had siblings who had received E.S.N. education, 1 with a subnormal

sister, 1 whose 2 siblings had attempted suicide and were receiving psychiatric treatment, 1 with an enuretic, emotionally disturbed 14-year-old brother, 1 with a blind sister with behaviour problems, 2 who had at least one sibling under a Fit Persons Order, and showing disturbed behaviour, 1 with a spastic subnormal brother, and 1 with a brother in a school for the maladjusted.

SUMMARY OF RESULTS AND DISCUSSION

Over two-thirds of the adolescent females admitted to this unit, showed disorder of conduct, but most of these had added neurotic features (a finding similar to that of Warren 1965). A not unexpected finding was a relatively high proportion diagnosed as subnormal, since this is a hospital mainly for the mentally subnormal and the various Authorities in the area could be expected to tend to refer this type, and the psychiatrists would be known for their interest in subnormality. In this respect, the intelligence levels would seem, perhaps, to confirm this, since few had I.Q. levels of 100 or above, the greatest number being in the 70-79 range. This "borderline" group would seem to be not dissimilar in intelligence to the group from 20 hospitals for the subnormal, classified as Subnormal according to the Mental Health Act 1959 (Castell and Mittler 1965) and with a mean Wechsler Full Scale I.Q. of 71.4 (S.D. 12.3); and which is, in turn, similar to the findings of O'Connor and Tizard (1954) that the average I.Q. as measured by the Progressive Matrices Test in a sample of certified young adult feeble-minded defectives in the London Area was above 70.

A further point with regard to intellectual abilities, was that although a few cases were found to be of subnormal intelligence on testing in hospital, nearly half of all the admissions had attended establishments catering for those of E.S.N. or of lower grades of intelligence. It is likely that the disturbed environment so obvious in the histories of this group was often responsible for poor educational attainment.

The patients of informal status comprised over three-quarters of all admissions but over half of these were, nevertheless, in the hospital as placements of the Children's Departments and, therefore, had some limitation of their freedom to leave in that the Children's Officers usually returned them to the hospital if they absconded.

The backgrounds of these adolescents seem particularly disturbed in many aspects. Although only 5 were illegitimate and 2 adopted, nearly half of all admissions had spent at least 6 months away from home surroundings, and a few had been away from their families from before the age of 2 years. Nearly two-thirds had been in the care of the Children's Departments at some time in their life and, of these, a number had been "in care" more than 10 years.

Although almost half had appeared in Court at some time in their lives, in most cases it was because of circumstances leading to the issuing of a Fit Person's Order. Criminal offences such as larceny were involved in a relatively small number.

The presence of mental ill-health or instability in the family, particularly in the parents, could be considered as a likely indirect cause of disturbance, as well as producing direct inherited effects. Nearly one-third of the mothers and one-third of the fathers were found to have some obvious psychiatric or related disorder and, in a few cases, both parents were affected. Disturbance in siblings was a common finding, too. Nearly half of the patients had never received psychiatric attention before admission, but the majority of those who had, had been in-patients in psychiatric hospitals or departments at some time or other.

Although it was not possible to use controls, it would seem that the existence of chronic marked physical abnormality in nearly half of the admissions was a high proportion. It was often difficult to see what part these handicaps played in the

aetiology of the disturbance leading to admission, but presumably social rejection was relevant in such disorders as deafness, epilepsy, and cerebral palsy.

These indications of disturbed background are similar in many respects to those discussed by Hilliard (1956) when referring to a group of feeble-minded women certified under the Mental Deficiency Act. Many of these were from inadequate homes and poor families; had committed minor offences, or had associated physical disorders such as deafness and spasticity. It was considered that these factors had been more responsible for the resulting certification as "Mental Defectives" than a low level of intelligence. Hilliard also noted that illegitimate pregnancies were the commonest reason for certification of an adult for the first time. This was not evident in this group of adolescents, possibly because of their relative youth; but sexual promiscuity or being "in sexual danger" were frequently mentioned in the histories given by their referring Authorities, usually the Children's Departments.

It would seem, therefore, that this group contains—as did Hilliard's—many whom society has failed, and in whom the prognosis is good if opportunities to become independent are given. This is the justification for a unit where training is the major intent, even though facilities may be inadequate.

SUMMARY

36 admissions to a new unit in a hospital for the mentally subnormal designed to investigate and care for disturbed adolescent females who were not necessarily of subnormal intelligence, have been considered. It was found that they tended to be of below average intelligence, many being within the "borderline" range. The majority had disorders of conduct, often with added neurotic features. The backgrounds were frequently disturbed, with separations from families, long period in care of Children's Departments, and a considerable number of mentally or emotionally disturbed relatives. Slightly more than half had never received psychiatric advice or care, and many had chronic physical abnormality. These patients are comparable in many respects to those admitted before the Mental Health Act who were certified as "Feeble-minded Mental Defectives".

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