

## FRED ESHER AWARD ESSAY 1967

*The Midland Society for the Study of Mental Subnormality offers a yearly award for a paper or article on a specified aspect of work in Mental Subnormality. The 1966 award went to Mr. P. Williams, a Psychologist, for his paper on "Industrial Training and Remunerative Employment of the Profoundly Retarded" (published in the Journal of Mental Subnormality, June 1967). The present paper by Mr. J. O'Hara, a Nurse, is the award-winning essay for 1967 on "Nursing". The 1968 Award will be given to an essay or paper on "Welfare and Social Work".*

### THE ROLE OF THE NURSE IN SUBNORMALITY: A RE-APPRAISAL

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One of the reasons why the treatment of subnormals received scant attention in the past was the paucity of literature on the subject. This omission has now been remedied but still no voice has yet been raised to outline the proper role of the nurse in the subnormal community, nor any attempt been made to trace his history. This essay is a humble effort to right the situation.

#### HISTORICAL REVIEW

Our roots lie in the Workhouses and the Poor Law institutions. In the nineteenth century "all the nursing in workhouses was done by able bodied paupers" (Abel Smith 1960) i.e. the inmates themselves, and though some mental defective institutions had opened "a return in 1881 found only 3% receiving treatment in institutions designed for them" (ibid).

The situation had only slightly improved at the beginning of the 20th century. In a survey in 1902 in Wiltshire and Worcester "34 sane paupers assisted 64 paid attendants in the care of 1124 imbeciles and epileptics. Only 2/3 of these nurses had received training (ibid)".

Alarm about the continued presence in the community of so many defectives led to the 1913 Act. Alarm about their criminal tendencies, their drunkenness, their prolific breeding. In a very minor way Galton did for the eugenic problem what Malthus had done for the population problem. There was talk of "the fear of National Degeneracy", of the "menace of the feeble-minded", of the "submerged tenth".

As a result of the 1913 Act the policy towards mental defectives turned from reluctant housing to forcible detention and the mould of the attendant altered likewise.

The Economic Depression of the 1930's, with its high unemployment rate caused an influx of a better type of person. People who would not otherwise have thought of entering the profession came in to make a good contribution and lift the standard. (Many of these people are now in the process of retiring.)

Two factors produced a further change. The war drained many hospitals of their staff, and consequently a higher value was put on those remaining. The other factor was the emergence of a new and enlightened outlook. The fears that had

surrounded the 1913 Act had proved to have little substance in fact. It was seen that there was after all no justification for the custodial policy: the doors started to open again.

Unfortunately no attempt was made to re-educate the nursing staff to implement what was to them a revolutionary move. It was of no value to open the doors of a hospital if its policy was still being carried out by closed minds. Nurses were expected to put into practice overnight, a policy that was alien to their training, and quite often to their nature. As to their training: the Charge Nurse was a punitive authoritarian figure whose skill was equated in terms of maintaining order, "Disquiet on any ward which is usually peaceable suggests to the authorities failure on the part of one or more nurses to be sufficiently firm." (Manual for Mental Deficiency Nurses 1936-7) He was steeped in the custodial tradition. "It is essential that the nurse should never through negligence, leave open a door which is meant to be locked" (ibid) and "Escapes should be prevented, so far as possible, by watchfulness on the part of the nurses." (ibid). There is some pathos in the fact that many of them for the rest of their careers were unable to throw off the stigma of the absconding patient. As to their nature: working in the field of subnormality afforded the staff great opportunities to adopt superior attitudes and too often they saw their relationship with the patient as that of a personal contest in which they, the staff, should always emerge the winner. Small wonder then, that, to use a sartorial metaphor, the new garments fitted them oddly.

This failure to re-educate the nurse to his new role was symptomatic of the medical attitude that existed then. The social structure in mental defective hospitals was very much a medieval one. At the top was the Medical Superintendent. There was built around him a fence of sanctity, and he occupied his position with such a demeanour of majesty, that he was well nigh unapproachable. He was a remote being who offered a limp hand on Christmas morning. One of the great pioneers of the new thinking was Dr. Earl and we find this passage in his book "Subnormal Personalities" (1961):

"It is a bitter paradox that all concerned educationists, sociologists, psychologists, psychiatrists, find it easier to deal with complex intelligent patients than with simple subnormals."

The nurse? He did not rate inclusion in the "all concerned", he was well beyond the intellectual pale.

It would be easy to say this was Dr. Earl's "blind spot", but the reason for the general medical indifference lay in the attitude of the nursing staff themselves: they exuded servility. The explanation was to be found in the composition of the staff, who were ex. R.A.M.C. men, imbued with old fashioned military discipline, refugees from the Depression, and some who lingered from the Poor Law days. If they held themselves cheaply then they would be rated cheaply.

Another reason for the attitude of subservience was the title "nurse". One was saddled with "hospital etiquette" and controlled, however remotely, by a Victorian mentality i.e. the General Nursing Council. This is a title that is with us still and I submit that it is no longer justified.

### THE ARGUMENT AGAINST NURSING

In a recent investigation of the medical, nursing, and social needs of the mentally subnormal in Birmingham hospitals, it was found that only 0.3% required skilled nursing (a figure so insignificant we can dismiss it) 35% required basic nursing, and 64% required no nursing at all. Basic nursing was defined as "washing,

dressing, feeding, lifting, attention to bladder and bowel of the incontinent" (Leck, Gordon, McKeown 1967). That these figures for basic nursing were over generous can be seen from the directions to the investigators: "Activities such as bowel bladder care should be regarded as assisted even if what the patients needs is checking rather than physical assistance".

With enlightened patient education I submit that the figure requiring basic nursing would be nearer 15%.

Some would not even call it basic nursing. Surveying the work in Geriatric hospitals a Nuffield report says:

"In it, there is the work concerned with the health of the patient, the nursing care, which requires the attention of the trained nurse, and the work concerned with the patients well being, which we prefer to call personal service, not basic nursing. This is the care that any sick person obtains at home from relatives or attendants other than nurses" (Adams and McIlwraith 1963).

Why then with such a small number requiring "personal service" do we find ourselves classified as nurses? One explanation has been given. "It is *traditional* in hospitals of this nature that assistance with certain aspects of basic self help have always been defined as nursing." (Stanley 1963). (My italics).

Now it is *my* submission that while we are saddled with the title "nurse" we are diverted from the true nature of our work. A nursing tutor expresses it thus, "Is it the title "nurse" that holds us back in developing the kind of person we need to help the mentally ill?" Nurse "suggests beds, medicines, washing, yet the mentally ill seldom require any more skilled degree of nursing than is carried out by the housewife for her family" (Budge 1967).

For it is not just a title i.e. "nurse" or not nurse but a whole attitude of mind that is inculcated from the start. Trained as nurses it is inevitable they see the patient more in medical terms than welfare terms. They do not see the patients as people but as objects for the application of technical manual skills. Of the patient they do not ask the question "Is this man's potential being developed to the full?" but "From what physical ailments does he suffer?" They have their sights on the wrong objectives.

Their training as nurses fashions not only the content of their thinking it fashions the manner of their thinking. Nursing depends on established procedures: in a given situation you do this or that; it is comfortable to cushion yourself with routine but the price you pay is rigidity of thought. "One of the inherent problems is that nurses have in the past been trained to a rather passive repetitive role" (Maxwell Jones 1967). That this attitude is not confined to the past can be seen from a recent article in the "Guardian" by a reporter who had worked as a nurse in a Mental Hospital. "The nurses' limitations were derived not so much from their own personalities as from the hospital organisation within which they worked, a system which is designed to destroy its members' capacity for independent thought" (Bingham 1968). Subnormality hospitals cannot afford such a mentality; it leads to institutionalization—for what is institutionalization but an atrophy of the imagination? The right approach was outlined thus: "Direct her interest, encourage her to ask questions, train her to use her observation, you can turn her from a thoughtless dispirited flighty drudge into a self respecting person more concerned with the day to day life of the patient" (Barton 1959).

Their training as nurses, with its strong accent on hygiene, makes it inevitable they see the ward not as a home, but as a clinical setting. Nurses absorb a tradition

that is sprinkled with maxims like "a place for everything and everything in its place". Orderliness takes precedence over homeliness.

Nurse training makes them efficient (with all that that word implies) yet impersonal, and involvement is essential; there is no place for detachment. This was said of mental nursing, but it applies with even greater force in subnormality hospitals: "Mental nursing has a different orientation from general nursing. The aim of the good general nurse is to care for her patient, and the patient's role is necessarily a dependent one. The aim of the good psychiatric nurse is to foster the patient's independence. Talking to patients, taking an interest in their emotional reactions are more important than the ritual of pulse and temperature taking. The stringent discipline and order which may be necessary in the general hospital are quite out of place in dealing with psychiatric patients, who need a slower pace and a more personal relationship with the nursing staff. Yet in fact, most of the psychiatrically trained nurses come under the direction of the general nursing hierarchy" (Jones 1962).

Most hospitals stipulate that candidates for higher posts be general trained, and these people while paying lip service to subnormality are cast in a certain mould; they cannot help applying general nursing yardsticks. "The thinking and practice of nurses is greatly influenced by their experience during training, and many of them aspire for the rest of their lives to reproduce the pattern of care which they saw as students" (H.M.S.O. 1963).

So insignificant is the part nursing plays in subnormality hospitals, it is inevitable in the larger family of nursing we are regarded as inferiors. How can we, doing "basic nursing" expect parity with nurses with theatre techniques etc., the world of saline drips is as remote as Shangri-La. Surely it is self debasing and even masochistic to continue as the "Cinderellas" of the wrong family?

As members of this family we are committed to all reports concerning nursing and such a report is the Salmon report (1967). Study how they justify their new nursing structure. After surveying the past and then the present they introduce their new proposals, "The New Staffing Structure". "It is natural that nurses should feel dissatisfied with any role in which their contribution to nursing care is diminished. The patient himself should be seen however as *fighting in the front line of the battle against illness (?)*, with the nursing, medical and other staff together providing the *forward support*, the *intelligence* and *weapons*, and the *supplies*. Thus conceived, the role of senior nurses could be recognised as vital: jobs should be re-organised and re-assigned, delegation would be properly practised and the contribution to be made by middle management would seem to be more effective by reasons of the importance of the decisions taken." (My italics).

Really, the absurdity of it all! The panacea for all our ills is to see ourselves as an army unit. This is the "military heritage showing in the language."

Looking at a problem in military terms you can preserve hierarchy. "British hospitals hang on to hierarchy like an ambassador clutching his plumes in a monsoon", (Cohen 1960). But hierarchy has no place in a therapeutic community. It has been rightly pointed out that "In a world of rigid hierarchies the patient is very much at the bottom and is made to feel so" (Barton 1959). Each frustrated member of the staff vents his irritability on the person below.

That the present system is unsatisfactory from a recruiting point of view can be seen from the student nurse wastage figures. During 1958 and 1959 while the national average in general hospitals was 27%, in hospitals for the mentally subnormal it was 48%. During the period 1.4.64 to 31.3.65 the wastage figure rose to the alarming proportion of 70%.

Why do they leave? The R.C.N. says "It is possible that the poor recruitment and high wastage are due in part to lack of job satisfaction and low regard in the community and in the eyes of their peers," "Lack of job satisfaction"? Whether people are satisfied or disappointed depends on what they expect; recruited as nurses people will expect opportunities to display nursing skills. The R.C.N.'s proposed solution to the problem is that nurses should take over the duties of the occupational therapist and the social worker, but if I have done nothing else, I hope I have made the point that the wings of psychotherapy are of no use if your feet are bedded in the concrete of nursing.

### THE PROPOSED SOLUTION

What are we to do then? The solution was put into our lap some forty years ago. In 1929 the Wood Committee laid down that "The mental deficiency institution should be not a stagnant pool but a flowing lake; it should be equipped with a school, workshops, playing fields, and a small hospital block, the general outline being closer to that of a boarding school than to that of a hospital", (Jones 1962).

"Closer to a boarding school than to a hospital:" therein lies the answer. Our work has more similarity with, and bears a closer resemblance to the Housefather than to the general nurse and we should undergo somewhat similar training. The examining body would be the Social Science department of a University and successful trainees would receive the Certificate in Subnormality Welfare. No need to raise the eyebrows here. Many of the old subjects would be retained, but they would no longer be taught in an atmosphere of "starch and status". The time formerly spent on nurse training could be used to absorb teaching techniques; we could move from the role of nurse to that of teachers; not a teacher in the three "R's" sense but as developers of latent abilities.

Is the idea of "latent ability" a myth? All the modern thinking agrees that it is not.

"Training for the specific purpose of decreasing the subnormals dependence on others should contribute considerably to a more efficient utilization of a potential which has not even been tapped yet, owing to our pre-occupation with I.Q. and M. A. We can be confident that increases in social competence will take place with practically all subnormals if tuition is given and that this advance will be considerably more substantial than if the subnormal is left to himself." (Gunzburg 1965).

The teaching of the subnormal has been comprehensively covered by Gunzburg, 1960, but the role I visualize is connected with the long stay patient for "It remains clear that for those patients who will not leave us, and they are the majority, simple storage or hotel keeping, however humane, can no longer be regarded as an adequate objective" (Stanley 1963).

We have progressed a long way then from the Workhouse to University affiliated training, but surely no one would begrudge the elevated status. All the factors that I have outlined here: the enforcing of the custodial policy, the tradition of servility, the strong maintenance of discipline, plus the stultifying effects of nurse training, have coalesced to produce a dull stolid type of person when what is needed is the "questioning mind". It has been said that "General nurses come from a middle class background and look upon their work as a vocation, whereas nurses in the mental field come from the working class and look upon their work as a job (Altschul 1962), and "the bulk of mental nursing is carried out by nurses who are middle aged, or foreign, or ill educated" (Brook and Clark 1962). Nobody would doubt that the old policy that it did not matter who staffed the ward provided it was

"covered", was a short sighted one. Do not let us be content with the second rate; improved status will attract the right kind of recruit and make the job worthwhile. Let us leave the concept of the nurse-cum-warder-cum-storekeeper in the page books of history where it surely now belongs.

### SUMMARY

The history of the nurse in mental subnormality is traced, outlining the various factors that affected his moulding. An obstacle towards a better status lies in the title "nurse", and it is proposed this title should be discarded and that the nurse should move towards the role of teacher.

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