Brit. J. Psychiat. (1965), 111, 903–909

Correspondence

INTELLIGENCE OF PATIENTS IN SUBNORMALITY HOSPITALS

DEAR SIR,

The paper by Castell and Mittler (*Journal*, March 1965, pp. 219–225) manifests certain misconceptions about the Mental Health Act and the practice of mental deficiency in the hospitals of the National Health Service, and expresses a view which the mental deficiency Section of the Royal Medico-Psychological Association feels bound to point out is outmoded.

It is surprising to find that the authors and indeed the whole Working Party of the British Psychological Society are trying to revive the attempt to define mental defect in terms of intelligence. This approach characterized the work of American psychologists in the 'twenties and we had assumed that it had long been discarded. The use by the authors of intelligence tests as the sole criterion is all the more surprising in view of their observations on the imperfection of the tests, and the lack of adequate standardization of the Wechsler tests on the British population.

The British approach to the problem since the earliest days of the Royal Commission of 1904–1908 has been to apply social criteria in assessing the total degree of mental defect. That these criteria were also adopted by the Royal Commission of 1957 is abundantly clear from their report. In addition, we had the assurance (given in the course of several discussions) of the late Dr. D. H. H. Thomas, one of the two psychiatric members of the Commission, that at no time did the Commission consider using intelligence as the sole criterion.

A certain naïveté is shown by the authors both in their surprise that the classification of subnormality is used in the same way as was feeble-mindedness under the old Acts, and in their assumption that prognosis is dependent upon legal classification. It cannot be expected that clinical problems and patients' needs will change with the introduction of new nomenclature by an Act of Parliament.

Throughout their paper the authors discuss "severe subnormality" as if it were synonymous with "severe subnormality of intelligence". To do so is not only to misinterpret the Report of the Royal Commission but also to misunderstand the Act. It will be observed that the Act speaks of *subnormality* of intelligence and not *severe* subnormality of intelligence in defining "severe subnormality". The definition in the Act does not mention poor response to training, which the authors also seem to consider a criterion of severe subnormality of intelligence.

The assumption that the term "severely subnormal" should not be applied to "patients whose intelligence level and capacity to respond to suitable training suggest a more favourable prognosis" demonstrates a custodial and nihilistic approach to the treatment and management of these patients which is a generation out of date, and which is not embodied in the Act. The results of Craft's follow-up, quoted by the authors, show that the severely subnormal with I.Q.s well below 3 S.D. can be rehabilitated as readily as the feeble-minded.

It is because of the danger that the severely subnormal may be written off as hopeless that this Section is not in favour of the Ministry's suggestions that the subnormal and severely subnormal should be cared for in separate hospitals. The authors' confusion demonstrates clearly the dangers of equating legal terminology with clinical classification. It would have been preferable if the Mental Health Act had not tried to classify patients using quasi-clinical terms. The definitions in the Act are only concerned with the delimitation of conditions to which certain legal procedures should apply. Identical provisions are in fact made for subnormals and psychopaths; likewise for the severely subnormal and the mentally ill. (This compares with the Northern Ireland Act of 1948 which makes provisions under only two categories.) Thus the legal procedures used do not depend on whether a patient is classified as suffering from subnormality or psychopathic disorder, but on the degree of his social maladjustment, regardless of I.Q. It will be remembered that the Royal Commission recommended that there should be only three categories; all the patients who are now described in the Mental Health Act as being subnormal or psychopathic would have been grouped together under the heading of psychopathic disorder. In classifying patients for the purpose of the Act both intelligence and social adjustment are taken into account—and aetiological factors are ignored. Because of this we do not consider that legal categories afford a sound basis for scientific work; nor can they take the place of clinical diagnosis in determining treatment, training and administrative procedures.

Although it has been suggested that the present classification of patients into subnormal and severely subnormal corresponds to E. O. Lewis's subcultural

and pathological groups, this is only broadly true, exceptions occurring frequently enough to make the equation invalid. For example, cases of phenylketonuria have I.Q.s that cluster round the 30's yet extend into the 70's and 80's, and the range of intelligence of patients with chromosome anomalies stretches from almost zero to normal. Conditions resulting from the complex interaction of many factors cannot be completely assessed on a linear scale with respect to only one aetiological variable. Broad statistical tendencies can do no more than afford general guidance in dealing with individual cases.

It would obviously be desirable to delimit subnormality of intelligence. It must be remembered, however, that intelligence in the general population varies continuously. Subnormality, dullness and low normal intelligence are rough approximations delimiting areas along this continuum. Any sharp limits to these categories must be purely arbitrary and artificial. It is permissible for experts to make authoritative pronouncements of the reliability of tests, their validity and statistical characteristics. Once this is done, they are in no better position than laymen to say whether 1, 1·4, 2 or 3 S.D. should be used to delimit different categories of patients. That is, unless they can show that a certain I.Q. level has a very high correlation with effective social adaptation. This has not yet been done; all that S.D. measurements do is select a certain percentage of the general population. From the point of view of classification and records, particularly if these records are going to be used for research, it would be much more satisfactory if the I.Q. of the patient were given, and this information is available at present in the Ministry records.

If this psychometric information were combined with a clinical diagnosis, scientific work would not have to depend on legal classification designed with a different goal in view, and there would be much less confusion than at present.

The intention of those responsible for the Mental Health Act was, as Dr. Walk has clearly pointed out in his letter, that the legal provisions should apply to people selected according to broad criteria concerned with social adaptation. To impose arbitrary limits based on one facet of personality would not only contravene both the letter and the spirit of the Act, it would rigidly separate patients whose clinical needs might be similar and thus deny treatment to some.

ALEXANDER SHAPIRO.
Hon. Secretary, Mental Deficiency Section of the Royal Medico-Psychological Association.
Harperbury Hospital,
near St. Albans, Herts.

DEAR SIR,

The issues raised by Castell and Mittler (*Journal*, March 1965, pp. 219–225) are of great importance. Unfortunately the authors add to the already alarming amount of confusion existing over diagnosis, classification, and Mental Health Act interpretation in mental deficiency, in addition to encouraging planning based on legal definitions and false prognostic assumptions.

I remain firmly convinced that the terms Subnormality and Severe Subnormality should be strictly limited to the classification of patients dealt with under the Act. The use of these legal terms in a clinical situation immediately gives them at least two meanings. It further ties clinical practice to legal terminology—a situation which can surely have no supporters.

In that the Act mentions subnormality of intelligence without defining it, the consensus of professional opinion should clearly be the guide as to what constitutes this, and the authors are right to reiterate the need for agreement on the upper limit of this *clinical* condition. However, they seem to have overlooked the fact that if, as they state, other clinical and social criteria are important in defining the categories, then the upper limit of the intellectual parameter should be high enough to ensure that *no* patient who might be properly considered subnormal taking into account *all* criteria, would be excluded by this single numerical limit. Thus my view is in complete agreement with that of Heber (1960) who proposes a cut-off point at −1 S.D., which allows, as he points out, flexibility for diagnosis in borderline cases.

The authors appear to have misread the definition of Severe Subnormality. In addition to the points mentioned by Dr. Walk (June 1965, p. 547), the phrase "which includes *subnormality* of intelligence" is used. Thus there is no question of this category being limited by a separate, lower, ceiling.

The authors' discussion reveals a clinical attitude which should be eschewed. Methodologically it is unsound to associate a pessimistic prognosis with a diagnostic category based on behavioural performance, and then to demand revision of the diagnosis when the response to treatment shows the prognosis to have been incorrect. "Severe Subnormality" should be applied where the present behaviour satisfies the legal definitions. No such idea as "poor response to training" should be associated with it, encouraging an attitude of inevitable pessimism and therapeutic nihilism. More correctly, poor training produces little response. The tyranny of words is so powerful that the Ministry of Health is already building and planning separate small hospitals for