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Correspondence

INTELLIGENCE OF PATIENTS IN SUBNORMALITY HOSPITALS

DEAR SIR,

May I draw our readers' attention to the implications of the article by Castell and Mittler (March, 1965, pp. 219–225), as far as concerns "severe subnormality"?

The authors, supported apparently by a number of psychologists who replied to their questionnaire, hold that classification as "severely subnormal" should be linked to a particular intelligence level—"scores of more than three standard deviation units below the mean". In recommending this, they are, it seems to me, inviting psychiatrists to depart from, and indeed to flout, both the letter of the law and the intentions of those who framed it and of the Royal Commission.

One would have thought it hardly necessary to remind the authors that the definition of "severe subnormality" is: "a state of incomplete or arrested development of mind which includes subnormality of intelligence, and is of such a *nature* or degree that the patient is incapable, etc.". "Nature" is here deliberately inserted as an alternative to "degree"; and even "degree" refers to the degree of incomplete development as a whole, not to intelligence alone.

This is entirely in line with the views of the Royal Commission, which the authors, as I see it, seriously misrepresent. For they say that the Commission's category of "severe subnormality" implied "very low intelligence" among other things; but this is expressly contradicted by the Commission's own explanations on pages 61–63, paragraphs 188–193, of their Report:

"This group includes all the patients at present described as idiots and imbeciles and some of the feeble-minded. . . . In deciding whether a patient is to be regarded as severely subnormal . . . it is the patient's whole personality which should be considered, not only or even mainly the level of his intelligence. . . . It is . . . both tempting and misleading to use the intelligence quotient to indicate the distinction . . . The broad dividing line. . . . comes in the middle ranges of what is now called feeble-mindedness. . . . In some cases it may be true to say that patients are seriously subnormal . . . even if their intelligence quotient is, say, 60 or higher. . . . We doubt if it would be safe to assume that less than about a half to two-thirds of the patients in institutions who are at present classified as feeble-minded would come into the severely subnormal group."

These very passages were quoted and emphasized by the then Lord Chancellor during the passage of the Bill through the House of Lords, at which stage the definition of "severe subnormality" was altered by adding the words "(incapable) of guarding himself against serious exploitation". This was because of anxiety expressed by Lord Stonham and others that patients liable to be exploited might otherwise be discharged at the age of 25 without adequate protection. As Lord Taylor put it, the change "converts the subnormal patient who is in danger of exploitation into a severely subnormal patient who can in his own interests be detained". Clearly there was no intention here of altering a previously prescribed intelligence level, still less of transferring the feeble-minded girl "liable to be overworked as a domestic servant" to the company of low-grade patients in a different institution.

The authors suggest that classification as "severely subnormal" necessarily implies a hopeless prognosis and should not be used where there is a "potential ultimately to leave hospital". This, again, was not the intention of the Royal Commission, who emphasized (paragraph 188) that their terms should not be permanent labels, and that patients should be re-classified whenever this seemed desirable.

It may well be, as the authors say on page 224, that the legal categories are being used much too loosely for purposes for which they were never intended. Their quotation from the Hospital Plan is certainly an example of such loose usage, and representations might with advantage be made to the Ministry about this. But surely the Hospital Plan was meant to be a direction to Hospital Boards as to the kind of institutions they ought to provide, not a direction to psychiatrists as to where each individual patient should be admitted. Here, too, the Royal Commission's Report is explicit (paragraph 188): "There should be no legal or administrative barriers to prevent a patient from receiving care with patients in other groups when this is appropriate for his individual needs". Nor will there be if the allocation of individual cases remains in professional hands.

I am writing as one outside this branch of our

specialty, but who happens to be well acquainted with the history of the Royal Commission and the Mental Health Act. It is much to be hoped that our Mental Deficiency Section will, in due course, formulate and publish its views on this important matter.

A. WALK

HOMOSEXUALITY—A PSYCHOANALYTIC STUDY OF MALE HOMOSEXUALITY

DEAR SIR,

I wonder what experience Dr. Kräupl Taylor has had of the analysis of homosexuals which permits him to condemn in such outright fashion the work of Dr. Bieber and his colleagues. (*Br. J. Psychiat.* Sept. 1964, p. 744). If he studies the literature, he will find that the experience of a great many psychiatrists accords more with that of Dr. Bieber and his co-workers than with his own views.

Successful cases have been published in the past few years by Hadfield (1), Oversey, Gaylin, and Hendin (2), Ellis (3), Glover (4), and myself (5). Older cases were published by London (6), Naftaly (7), Lilienstein (8), Laforgue (9), Stekel (10), Serog (11), Frey (12), Virchon (13), Bircher (14), Sumbaer (15), Sullivan (16), Poe (17), Karpman (18), and many others.

Oversey, Gaylin and Hendin published three cases treated by analytical psychotherapy in which the patients attained complete heterosexuality, confirmed by observation over some years. Ellis treated 28 male and 12 female patients who were homosexual, with an overall change of 64 per cent. towards heterosexuality; indeed, of the males who had some desire to become normal (23) 80 per cent. became distinctly or considerably more heterosexual. Ellis's terminology may be ambiguous, but there was undoubtedly a marked change. Whitener and Nikelly give an overall prognosis in all types of psychosexual disorder (which must include many homosexuals) of 50 per cent.

I have published a series of cases of homosexuality (19), and out of 23 patients had 16 successes confirmed by follow-up, four cases which showed only social success, inasmuch as they lived asexual lives, and three failures. My successes were confirmed by follow-up. Glover has published a series in which 44 per cent. of the patients showed no further homosexual impulses (but treatment was complicated by hormone therapy). Some 51 per cent. of the bisexuals lost their homosexual impulses.

Since it is well known that cases treated privately do much better than those treated in clinics, I cannot see why Dr. Bieber and his colleagues should not have the successes they claim.

The causal situations which they describe as producing homosexuality are similar to those I have described in my book (19). There I stated that "One may say that it is only those who have never treated a case of homosexuality, or have treated it wrongly, who have never had a cure", and this I still believe to be true after 35 years of treating these patients.

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DEAR SIR,

I cannot see the logic in Dr. Clifford Allen's argument. Even if his impressively long list of references proved a high proportion of psychotherapeutic cures in homosexuals—and they certainly do not prove anything of the kind—how could this possibly confirm the work of Bieber and his colleagues who do not claim to have achieved what is usually called a therapeutic success. May I refer Dr. Clifford Allen to Dr. Bieber's previous letter