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Disorders of mental handicap institutions

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In each of three mental handicap hospitals I have observed an institutional disorder. From consideration of these I have suggested a classification. I have analysed the aetiology and pathogenesis of some of these disorders and discuss the treatment and prognosis.

The study

Symptomatology

Case 1 A 300 bed recently built mental handicap hospital experienced pockets of low morale. Standards of care were higher on wards nursing physically dependent patients. Standards of care on wards nursing psychiatrically disordered patients were low. There were many minor disputes as to areas of authority and an anti-medical bias persisted on these wards. Admissions were rare and discharges rarer.

The lead consultant was highly respected for work in another sphere outside the hospital. He/she virtually never visited the wards. Purely psychiatric opinion was unavailable. The day-to-day running of the hospital was effected by the senior nurse. He/she and the nursing officers were equally baffled by the psychiatric disorders. The senior psychologist was frustrated by lack of involvement in higher order decision-making.

Many of the wards seemed quasi-autonomous and in some cases absenteeism was high. Uniforms were not worn. Attitudes were generally pessimistic, defensive and protective of the *status quo*.

Case 2 A 250 bed old-established mental handicap hospital evidenced high standards of care. Nursing staff were all uniformed and seemed to wish to keep it that way. There was a very large turnover of short-stay patients and a considerable success in discharge of long-stay patients. The hospital had been denied a consultant for some years and the lead role was ostensibly in the hands of a Director of Nursing, highly respected but based elsewhere and with major interests in another sphere. In practice, therefore, the lead role was taken by the hospital-based deputy whose finger was in every pie. As standards of care rose expectations of staff increased and an inquiry into certain allegations against the deputy regarding the misuse of authority led to his/her dismissal. The reverberations of that regime and its attendant inquiry continue to plague the hospital.

Case 3 A 370 bed old-established mental handicap hospital had had difficulty recruiting consultant staff for many years and had relied on a single consultant who eschewed the lead role. Authority had drifted over the years and had ended with the senior nurse baffled by the complexities of budgeting and struggling to maintain standards of care. Nursing officers spent most of their time juggling staff dispositions to maintain staffing-levels above the danger mark.

Very few admissions occurred and even fewer discharges. The hospital seemed isolated and going nowhere. Normalisation had been seized upon as providing all solutions but in the event merely provided an excuse for not doing things that would have contributed to higher standards. Uniforms were not worn. Much authority with regard to admission, transfer between wards, discharge and even treatment was effectively delegated to charge nurses. Attitudes on the wards were defensive, and pessimistic and staff saw themselves as the patients' advocates against outside interests. When confronted by psychiatric disorders in patients who endured the worst conditions, refuge was taken in nursing process type procedures and in behaviour therapy without material success. An inquiry into a particular incident became a management review which stopped short of the consideration of leadership.

Classification

These three cases of disorder are just sufficient to suggest a classification.

The first attribute to consider is that of 'Authority'. It does not encompass all that is implied by 'Leadership' – one other vital component is 'Vision' – but it is the most obvious of leadership qualities.

Consequently such disorders can be divided into those which demonstrate 'under-Authority' and those which demonstrate 'over-Authority'. In practice 'under-Authority' means that authority is dissipated to a variety of individuals whether acting alone or in groups. Again 'over-Authority' implies that it is concentrated in an individual either acting alone or through a group.

Thus we have:

Disorders of Institutions

Over-Authoritarian	Under-Authoritarian

A second attribute of profound importance is the end-product rather than the means by which it is produced and that is the standard of patient care. Of prime importance to the clinician it must nevertheless not be forgotten as to how it is achieved with reference to the first attribute, that of authority. Disorders may then involve either high or low standards of patient care.

Thus we now have:

Disorders of Institutions

Over-Authoritarian		Under-Authoritarian	
High Standards (type A)	Low Standards (type B)	High Standards (type C)	Low Standards (type D)

That disorder type A exists is shown by case 2 where high standards of patient care were possible under the concentration and misuse of authority by an individual. That disorder type D exists is shown by cases 1 and 3, whereby dissipation of authority, limited in case 1 but more general in case 3, was accompanied by low standards of care, in particular areas in case 1 and more generally in case 3.

Logically disorder type B should undoubtedly exist and might simply be a result of stringent, concentrated management coupled with resource deprivation. The existence of disorder type C is more theoretical. Some might hold that at most the combination of high standards and devolved authority is unlikely, others might hold that in reality it is non-existent. It is perhaps wise to embrace the possibility.

Aetiology

In considering the aetiology of disorder types A and D it is necessary to examine the nature of the 'lead' or 'alpha-male' role. Sarwer-Foner (1972) proposed that the ethological findings on territoriality in animals is sublimated in humans but driven by the same instinct. The intra-psychic visualisation of intellectual spheres of activity, the intra-psychic responses to social intercourse in terms of their individual hierarchical social positioning, the personal concepts of worth, external social signs of acceptance and recognition, the occupation of social, business or professional posts signifying authority and prestige or of acquiring social rewards showing augmented or august personal worth – all are propelled by the same instinctual drives as a mammal instinctively endows that territory necessary for individual and species survival. All humans do not have the same biological endowment for aggressive possessiveness and competitiveness. Similarly successful humans treat the 'symbolised territories as though they really were hunting, living and mating territories. The alpha-male is found in mammalia including *homo sapiens*.

An interesting clue as to the *modus operandi* of the human alpha-male is provided by Shenken (1973) in his description and analysis of The Two Committees. In the first of the two committees a long-established dominant chairman personally decided every issue and yet other committee members, apart from the author, were satisfied with the situation even though they acknowledged their lack of influence. (This is clearly an over-authoritarian disorder but it is unclear whether of type A or B). This example demonstrates the attributes of the alpha-male and his socially and psychically 'organising' effect.

The second committee involved a reluctant new chairman presiding over a situation of dissipated authority and anxiously demanding support only to fall quickly from office. (This is clearly a disorder type C or D). The important implication is that imposed authority seems to create greater cohesion than delegated authority and that this in ethological terms is a function of alpha-maleness.

The alpha-male is the individual around whom the organisation is disposed and from whom the hierarchy is derived. The mate of the alpha-male is the alpha-female and she has a separate role. In humans the female may fulfil the alpha-male role but she is not then acting as the alpha-female. It is important to realise that alpha-ness has boundaries or spheres of interest.

In cases 1 and 2 it is apparent that these spheres of interest only partially coincided with those required, so that in part of each hierarchy in those cases the alpha-male was only a figurehead. This permitted the partial accession of a subordinate figure to a part of the alpha-male's authority. The result of this in case 1 was a sin of omission – the psychiatric field endured low standards because of a lack of leadership in that field.

In case 2 the effect was far worse because the partial accession to alpha-position was more extensive and permitted authority to be freely-wielded by someone who, at the least, lacked vision and at the worst had criminal intentions. As Kramer (1977) notes, there are constraints on human alpha-maleness and he cites Hallowell as having emphasised that the study of human evolution cannot disregard the evolution of the human psyche and its attributes – repression, identification, shame, guilt and so forth – without which human social and cultural evolution would not have emerged. Indeed, if any individuals are judged not to possess these psychic characteristics, they are isolated in institutions and ostracised from society.

In its chronic lack of an alpha-male, case 3 demonstrates the state to which an institution may arrive as the prerequisites of alpha-ness are distributed among sub-groups and individuals comprising a now loosely associated hierarchical structure. Inter-group feuding, promotion of self-defence as a priority for those groups, lack of security in an ordered environment, over-identification with patients, misguided loyalties and propagation of misinformation are only some of the evident results.

It might be said now that the aetiology of some of the disorders of institutions is the complete or partial lack of alpha-maleness and the pathogenesis, particular in each case, is the flow of that authority, unaccompanied by the necessary vision, to subordinate groups who dissipate that authority in aimless struggles for dominance. This underlying process may be euphemistically described as 'democracy' or in mental handicap institutions as 'normalisation'.

Treatment

Treatment of these disorders is simple in concept but uncomfortable to a degree. It must always involve the importation of an alpha-male, at least as regards the neglected sphere of influence.

Existing alpha-males may well be truly valued – indeed were in cases 1 and 2. Yet the alpha-less sphere must be filled and this may not be easy. Even if the role is filled it may not be clear to the incumbent what the task is he/she is expected to perform. Those who determine how such a role is filled may not realise either the extent of the task that they are expecting the alpha-male to perform. The difficulties indeed may overwhelm the alpha-male for that very reason, that is the size and difficulty in the task of wresting back devolved authority from individuals whose one common pursuit is the defence of the *status quo* and a combined resistance against intruders.

It is clearly necessary to diagnose accurately where alpha-maleness is lacking and to import the new alpha-male with this in mind. It should be made evident to an alpha-male what is expected of him/her. It is unworkable for him/her to exercise the role when it involves direct territorial conflict with established alpha-males. Secure hierarchical arrangements will be a long time coming under those circumstances. Likewise it is difficult when other alpha-males appreciate the lack of alpha-ness in a group, seek to redress that by importing into the role and then support existing subordinates while failing to support, or even showing direct antagonism to, the newcomer.

Prognosis

Prognosis seems related to the extent of the devolution of authority – dissipation, and the breakdown in total-group activity – standard of patient care. It is often the erroneous belief that to close the institution effects a cure. However, the disorder merely dissipates itself further into all the provisions in the wider field. Good practice in the field can only emanate from good practice in the centre: another re-statement of the alpha-male function.

Prognosis is best where a true alpha-male exists with a lapsed interest that can be filled. It is also quite good where subordinate accession has perverted authority. It would seem to be worse where the alpha-male has been long absent and a whole sub-culture, developed on widely dissipated authority, has emerged. Such situations may be beyond redress without causing intolerable controversy, antagonism and disruption. In that case a limited recoupment should be attempted, designed to maintain patient care standards at an acceptable, that is non-dangerous, level – the aim is to make a type C disorder out of a type D disorder.

Comment

Finally it may be worthwhile to comment briefly on the intra-psychic origins of alpha-ness. It is suggested that the driven behaviour patterns called instincts may provide predominantly for manifestations of the sexual and aggressive forces which propel the alpha-male into prominence and maintain him there. However the performance of the group as a cohesive entity may well be more a product of the alpha-male's learning than of the strength of his basic drives. As early as 1939 Lorenz wrote: "In the case of a man working only with the motivation of earning his bread, however, the behaviour directed at this end encompasses practically all the higher mental functions of which he is capable; the motive, the instinctive act of 'breaking and eating' striven after as a goal, has withdrawn a long way to the end of a series of actions, but without in any way disowning its basic instinctive nature in the process".

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