

RESEARCH

The Characteristics of Patients with Intellectual Disabilities Held in Forensic Asylums in Norway: 1915–1987

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A significant number of patients with intellectual disability (ID) were admitted to forensic mental health asylums during the period 1915–1987. Many of these patients stayed for more than a decade, because of previous offending behaviour. We investigated the daily lives of 262 patients with an ID using casebooks. Two of the patients were studied more in detail. The available documents describe most of these patients as sociable, well-behaved and socially engaged although they missed having contacts outside the hospital. Long-stay patients were studied more in detail.

Keywords: Intellectual disabilities; Forensic; Mental health

Introduction

A short historical overview

Norwegian urbanisation in the latter part of the 19th century involved an important structural economic shift from an economy in which most jobs were in fisheries and agriculture to one with a larger industrial employment sector. The early development of the welfare state in the late 19th century resulted in significant changes in attitude towards people with intellectual disabilities (ID). From being part of a family in rural communities, the urban culture with less familiar influence made people with disabilities more visible and made it more difficult to care for them (McDonagh, 2008). Understanding of ID became much more developed as psychological and genetic elements of the condition were described and distinctions within this broad diagnostic category became more widely used. The innovation and implementation of psychological tests in the early 1900s proved to be a double-edged sword. Although it improved identification of persons with ID it also enabled increased institutionalisation. Testing made ID seem more prevalent, since it led to the identification of mildly disabled people who would not otherwise have been given a diagnosis (Beirne-Smith, Patton, and Kim 2006). During the 19th century people with ID had been viewed as unfortunates or innocents, who benefited from proper training. In the late 19th and early 20th century they began to be looked on as undesirables and were cast as the great evil of humanity, being viewed as social parasites, criminals, prostitutes and paupers (Scheerenberger, 1983). The focus in society's approach changed from training to social protection, and a large number of protective institutions were established e.g. Kellerske anstalter in Denmark; Kirkebæk, 1993). In Norway the Kriminalasylet and Reitgjerdet Hospitals housed both forensic mental health patients and patients with ID from 1895 until 1987 (Søndenaa et al., 2015).

Treatment in the forensic hospitals was based on a moral treatment paradigm (Thomassen 2015). In the early 1800s moral treatment developed simultaneously in several European countries, in the context of the Enlightenment focus on social welfare and individual rights. Pinel and Tuke are recognised as the pioneers of moral treatment (Borthwick et al., 2001, Pelouquin 1989) and Edouard Seguin is known as a pioneer of treatment for people with ID. Moral treatment was based on a structured, predictable regime of meaningful activities. Architecture and surroundings were recognised as significant treatment factors (Riaunet 2014). The historian (Bell 1980) argued that moral treatment arose from an empathic perspective as the patient was placed in a therapeutic community where he or she would be protected and could receive personalised care and labour therapy and take part in recreational activities.

The physicians in charge of these asylums were domineering men who kept all authority in their hands. Every aspect of asylum life was stamped with their personality. As practical, hard-working individuals who indulged in little theorising about the nature and aetiology of insanity they sought to mitigate the harsh, crude practices of their contemporaries. Under their guidance moral treatment became recognised as a specific method of therapy.

The Norwegian setting

Until 1987 forensic mental health services in Norway were based in two national units in Trondheim. Norway passed legislation stating that offenders with certain mental disorders were unfit to plead in 1842, but it was not until 1895 that the first institution for offenders with mental disorders was established (Kriminalasylet). For half a century Kriminalasylet and later Reitgjerdet (which was established in 1923) dealt with cases in which the individual detained had a mental disorder that excluded him or her from the standard criminal justice system. Unlike most other western countries Norway did not establish a segregated forensic hospital system for offenders with ID during the first two decades of the 20th century (Søndenaas, Gudde, and Thomassen 2015).

Around the time the criminal asylums were established in Norway a large number of forensic institutions for people with ID were established in other Western countries. Among the main reasons for the emergence of these new institutions were industrialisation, urbanisation and the eugenics movement (Thomassen 2015). Because Norway was a small country with a sparse population establishing specialist forensic institutions for people with ID was not given priority. This contrasts with the situation in Denmark, which pioneered the use of these institutions. The Kellerske anstalter (institutions) and the island-based institutions Livo and Sprogø in Denmark have housed several hundred offenders with ID since they opened in beginning of the 20th century (Kirkebæk 1993, 1997). Promoted by numerous professionals who were dedicated proponents of eugenics similar institutions became common in industrialised Europe and the USA (Rafter 1997). Arguments used to support the placing of “morally disabled” people in institutions and included the public’s fear that they would commit criminal acts (Kirkebæk 1993). During the 20th century the treatment repertoire evolved to include medication, physical restraints and surgery. Seclusion and/or mechanical coercive remedies were commonly used to manage patients who were considered dangerously violent or suicidal. The architecture of the hospitals, which included small rooms, provided for seclusion when restraint measures were needed. By the changing architectural periods after the World War II, with overfilled dormitories, the use of mechanical restraints became more frequent. In the 1930s new somatic treatment methods were introduced in Norway. Insulin coma therapy was used in cases of schizophrenia. In the 1940s insulin therapy and cardiazol were replaced by electroconvulsive therapy for severe depression and schizophrenia; electroconvulsive therapy was very unpleasant for patients until the introduction of modern anaesthesia combined with curare (Kringlen 2004). Paradoxically at Reitgjerdet the use of mechanical restraints increased after the introduction of psychopharmacological therapy (Thomassen 2015).

Aims of this study

The aim of this study was to explore the characteristics of patients with an ID who were detained for forensic hospital treatment in Norway in the period 1915–1987. We explored patients’ participation in daytime activities, social behaviour, behaviour problems, contacts with people outside the hospital, treatment, duration of stay and mortality. The characteristics was based upon the patient casebooks. We attempted to describe the variety of patients with ID who were detained in the service at different times during the twentieth century. Two different patients were presented more in detail to show the more personal perspectives of some long term patients.

Methods

Between 1915 and 1987 Norway’s two forensic mental health hospitals treated 272 patients with ID. Descriptions from each of the patients’ admission period were recorded. Some of the patients are described more in detail to illustrate our findings and the diversity of the group.

Material

Patient casebooks from the forensic hospital Reitgjerdet and its predecessor Kriminalasylet cover 1809 patients who were admitted one or several times during the period 1915–1987. The casebooks included patient journals, letters, pictures, court- and medical reports. All patients were admitted with medical reports and diagnoses, and most had been diagnosed with severe psychotic disorders such as dementia praecox (schizophrenia) or manic depressive psychosis. A minority of the patients, 272 (15%), were diagnosed with ID, labelled debility, imbecility or idiocy. Several patients with other diagnoses such as epilepsy, or conditions covered by the earlier diagnostic terms *insania ex constitutione* and *insania degenerativa* also had considerable intellectual deficits but were not given a diagnosis of ID.

The information from patient casebooks varies in quality, content and structure, and according to the prevailing treatment culture; however it can be used for comparative analysis and to produce analytical descriptions. The data was primarily based on categorizations and definitions made by the staff.

Sample

All the patients with an ID diagnosis (n = 272) were identified from the patient archives. Patient casebooks from the admission period were found for 262 of these patients. In ten cases patient information was missing or of little relevance to our study. The forensic hospital was established in 1895, but the earliest records of a patient with an ID diagnosis date from 1915.

Procedure

All data from the patient casebooks were coded and structured into numeric categories. Because the focus of this study was the patient’s stay in the forensic hospital, we evaluated duration of stay, participation in daytime activities, social behaviour, behaviour problems, contacts outside the hospital, treatment and mortality. This information was supplemented by background information such as information about childhood behaviour, education, residential care, health, criminal activity, employment and mental functioning (IQ and/or mental age). Background information on this sample has been reported elsewhere (Søndena, Gudde, and Thomassen 2015). Short verbal descriptions of critical events or the particularities of the patient were added to the coded information on each patient. Patients who stayed in the hospital for more than ten years were studied more detail.

Research objectives and variables of interest were defined during several consultations among the project group. All patient casebooks were studied and the key information was registered electronically. Analyses were carried out using the Statistical Package for Social Sciences (SPSS) version 22. The study was approved by the regional ethics committee for medical research (REK), reference number 2010/2206-10.

Results

Although some of the patients were admitted several times, most were only admitted once (n = 172, 73.2%). Duration of stay varied from a few days to over 50 years (mean = 11.4 years, SD = 12.4 years). The distribution of duration of stay is presented in **Figure 1**.

Rather less than half the patients (n = 102, 39.1%) spent more than 10 years in the hospital, 59 patients (22.6%) spent more than 20 years there and 33 patients (12.6%) more than 30 years. The mean age on admission to the hospital was 30.04 years (range: 14 to 60 years).

Fifty patients died during their stay in the hospital, 23 from tuberculosis.

Participation in daily activities

The treatment of patients in forensic asylums was based on a diverse range of work activities; participation in such activities was considered to reflect progress. Most patients with ID also took part in these activities to varying degrees. As many as 112 patients (43.1%) were described as being very willing to participate, the attitude of 71 (27.3%) fluctuated from willing to unwilling and 77 (29.6%) were considered unwilling or unfit to participate. The most common activities were farm work and domestic work; 122 of 183 patients were occupied in these activities (66.7%).

Most of the patients took part in daily activities on the ward but there was wide variation in their contributions to occupational therapy. Activities varied from farming and-, small-scale industrial work to domestic work and participation

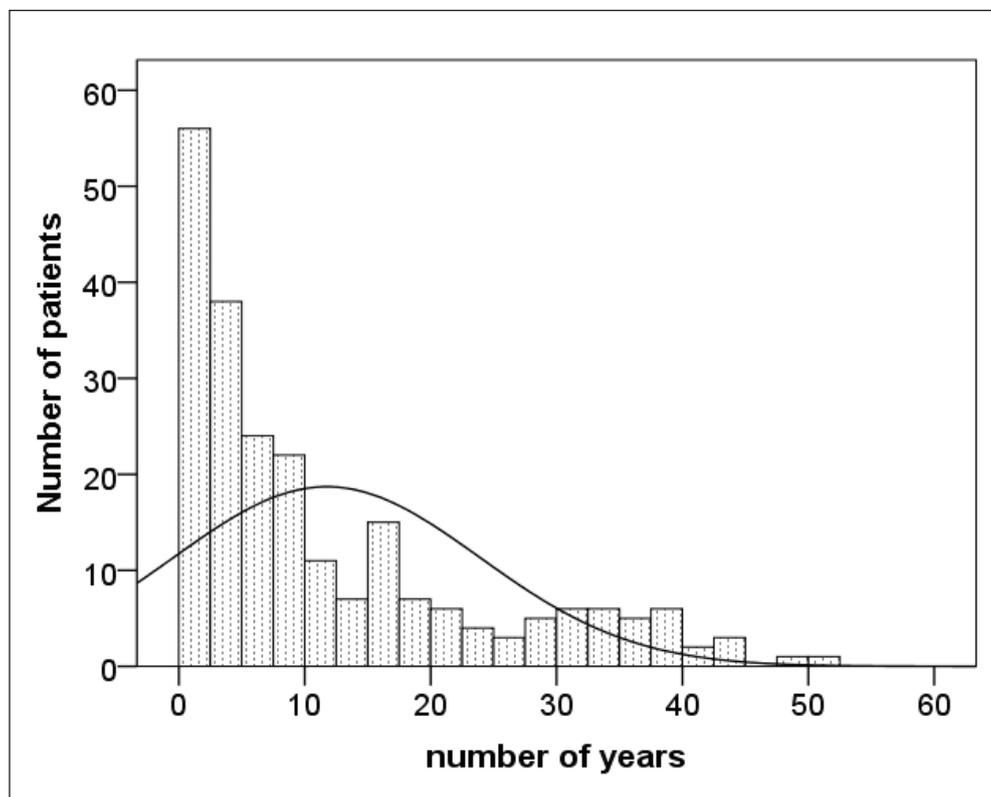


Figure 1: The duration of stay of 272 patients with ID.

was considered an indication of progress. One patient was initially described as stubborn and apathetic, but changed to become an indispensable maid who was quiet and polite. There was also stigmatising characteristics of patients as being “incapacitation idiots”, followed by notes about an hospital misplacement. There was little caution in the use of professional terminology to these patients.

Social behaviour

The patients were assigned to different wards based on their level of social adjustment. A large number of the patients were described as “showing positive social behaviour” ($n = 121, 46.5\%$). These included a patient who was described as being friendly to both the staff and the other patients. He was described by staff as being very involved in caring for a certain horse at the farms. It is also noted that although his functioning was low, he was very sociable. For another group of patients ($n = 85, 32.7\%$) their stay represented a period of seclusion and loneliness. Some were described as having serious conflicts with other patients or staff members ($n = 51, 19.6\%$). The higher functioning patients tended to have conflicts with staff and act out against them, whereas lower functioning patients often acted out with other patients.

Some of the patient casebooks described a pattern of sociability involving friendliness towards both the other patients and the staff. Some of the patients were also valued for their naïveté, which was compared favourably with the hostile or intransigent attitudes of other patients. An instance of patient naïveté is described in which a patient who wanted to write letters to his family and friends outside the ward appealed to other patients for help. His ‘helpers’ wrote letters that were offensive rather than friendly missives. Some of the eccentric patients attracted a lot of nicknames during the early part of their stay, like “the mate”, “mad Harry” and “the woodpecker”.

Behavioural descriptions

A variety of expressions were used to describe patients’ behaviour. The majority of patients ($n = 155, 59.4\%$) were described as behaving in a calm and friendly way; however labels such as ‘violent’, ‘refusing’, ‘damaging behaviour’ or ‘absconding’ were applied to 135 patients (51.7%). Apathy was described in 21 patients (8.0%). There was some overlap between these categories.

Most patients with ID also exhibited some challenging behaviour although rarely to the extent that it necessitated restraint measures such as isolation. These patients might try to abscond despite being friendly and calm, or they might show a “child-like” preoccupation with specific activities (e.g. listening to their radio) that was troublesome for the institution. Some patients were also described exposing serious uncleanness, and were kept separate from other patients. Some patients behaved strangely, for example, the man who shouted “hurrah” repeatedly throughout the national day (17th May) during the eleven years of his stay in the hospital.

Contacts outside the hospital

Many of the patients had some contact with relatives or others outside the hospital, but almost half ($n = 120, 46.0\%$) did not. Forty-two patients (16.1%) had frequent contact with family or friends outside the hospital, 82 (31.4%) had sporadic contact with family or friends and 21 (8.0%) had some contact with family or friends outside the hospital.

Although many of the patients did not have any contacts outside the hospital, there were numerous patients who missed having contact with close relatives and their home community. Others wrote and received letters from relatives, while some of these patients had relatives who made a lot of effort to secure an improvement in their living conditions, or to obtain their discharge or transfer.

Medical treatment

During the whole of our study period, 1915–1987, only 78 patients (29.9%) received any form of psychopharmacotherapy. This is accounted for by the late introduction of such treatment options. Thirty-one out of 48 patients admitted after 1960 (64.6%) were treated with psychopharmaca.

The treatment regime changed during the study period, from a moral treatment therapy based mainly on occupational activities in the earlier years to a more medically oriented regime. Twenty-one of the 35 patients who were castrated at the hospital during the period 1930–45 had an ID (60.0%) (Myhre, Thomassen, 2014). These patients consented to the procedure either by themselves or by their guardian, and those who refused were not castrated. The most common motivation of consenting to castration was an opportunity to be transferred to another institution, or even better, be discharged to freedom. Some incidents of medical maltreatment were reported, although this is difficult to verify beyond the descriptions of e.g. “repeated insulin injections with no behavioural effect”.

Long-stay patients

Patients who spent more than ten years in the hospital ($n = 102$) were studied in more detail. Twenty of these patients were described by the physicians as having adapted fairly well to hospitalisation. They were described as sociable, participating in work activities, well behaved and had some contact with people outside the hospital. Nine patients presented an opposite picture, being described as badly behaved, having none or difficult contact with other patients

and having no contact with people outside the hospital. We have selected two cases from the archives to illustrate these two groups, Ragnar (a well-adapted patient) and Alfred (a more demanding patient).

Ragnar (born 1906)

Ragnar was admitted in 1927 and the first reports describe him as a polite and decent man. He was admitted he had committed a sexual offence and had been assessed as having a mental age of ten years. Two weeks after admission he absconded; he was recaptured four days later. A few months later he was described as a diligent worker who was nevertheless at high risk of absconding and had had several violent conflicts with other patients. As patients at Reitgjerdet progressed in treatment and became less in need of the protecting facilities within the ward, they were frequently treated in the local community under the supervision of the hospital, which remained responsible for them. Several attempts to arrange such placements for Ragnar failed owing to his indiscipline and tendency to exhibit sexual offending behaviour outside the hospital.

Descriptions of his social interactions with other patients and participation in diverse work tasks present a different picture. He is also noted as having contributed positively to the community through painting and guitar playing. Some of his works were added to the archives (see below **Figure 2**). His interest in painting appealed to the other patients, who watched with interest while he was painting. The hospital manager also supported Ragnar's talent by following him to art exhibitions and letting him display his paintings on the ward. This portrait, from 1930, of a fellow patient was drawn at the patient's request.

After five years at the hospital Ragnar had lost much of his positive attitude. He had become blind in one eye as a result of syphilis and he complained about hospital conditions. In 1936, a new attempt was made to arrange treatment in the local community treatment; this succeeded. Ragnar was rehabilitated and eventually discharged in 1942. He was readmitted eight months later because he could not cope with independent living. He had been robbed of all his money and assets was living as a tramp, sleeping outside in barns. After a period of two months he went back to a local community for treatment and remained there for 13 years until he was readmitted to the hospital following a sexual offence. He remained a patient from 1955 until his death in 1978. He was a quiet and well behaved patient throughout this period and was granted many special privileges. In 1959 he was entrusted by the chief physician with keys to the hospital, but this privilege was withdrawn in 1969 because he was abusing it by bringing alcohol onto the ward. He maintained his interest in painting and writing and he occasionally sold some of his works.

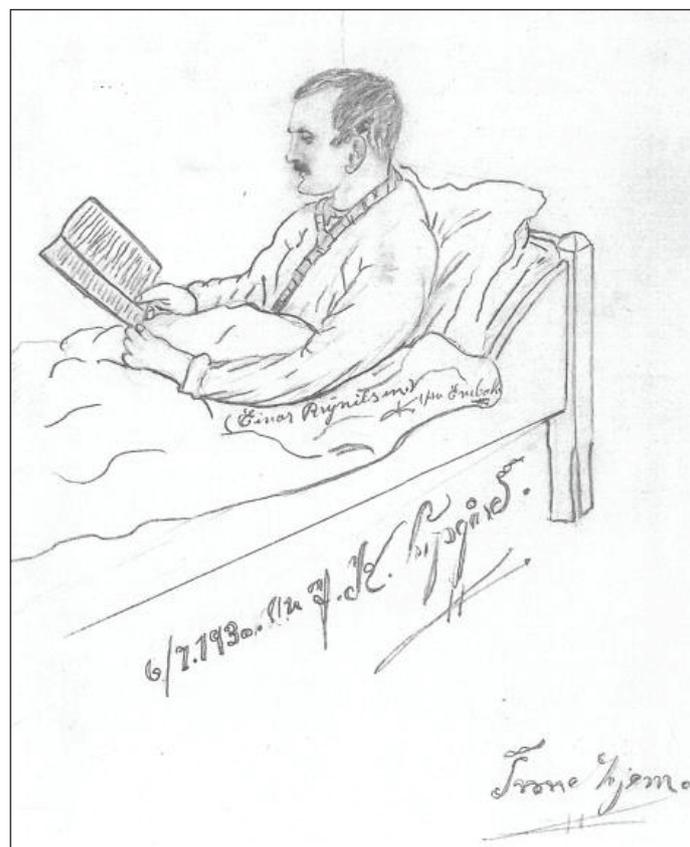


Figure 2: Portrait of a fellow patient.

Alfred (born 1921)

Some patients showed more persistent maladaptive functioning during their stay in hospital. One of these, Alfred, was admitted in 1949 from a prison hospital after being sentenced for an attempted rape. Alfred grew up in a troubled environment. His father was an alcoholic and his mother, who was severely ill, died when Alfred was eight years old. At the age of three he was seriously injured in a car accident. He left school when he was 12 years after repeating the last year of school and until he was 18 he was homeless with occasional periods of employment. He was registered as a sailor at the time of his admission to the hospital.

The main reasons for his admission were tuberculosis and the behaviour problems at the prison hospital. He was diagnosed with psychosis ex. oligophrenia. Descriptions of his mood during the period after admission were varied. Some days he was angry, stubborn and delusional; other days he participated in activities and was cooperative. Delusions about electricity and infections and increasing compulsive behaviours centred on concerns about hygiene resulted in serious conflicts with other patients and created a challenging situation for Alfred.

Two years after admission Alfred began to argue that he should be discharged, and shortly afterwards made several attempts to abscond. His mental health was described as worsening in the next year, with hallucinations, delusions and grandiosity. Over the next ten years the casebook describes a patient who adjusted to the institutional context but was unable to manage independent life outside the ward. His dreams and thoughts about life outside the hospital were expressed through a large number of letters addressed to various people outside the hospital. He wrote to the police authorities, family members, celebrities and the ministry of justice. His letters voiced complaints about his situation and the unfairness that such an important person was kept incarcerated. He appealed and demanded to have his rights restored. When writing letters he titled himself King Alfred, as this example, taken from a letter written in 1969 illustrates:

To the American police in New York in America. I am the king of America, king Alfred and I am the king Alfred of Norway and I am born in 1921 in Norway and I live in Stavanger and according to the American law book of America I have a clean criminal record and reading the Norwegian law book of Norway I have a clean criminal record, and I am incarcerated in Reitgjerdet hospital Trondheim Norway and I demand to be discharged immediately and Parliament in America and parliament in Norway and parliament in all the countries should answer the letter.

American king Alfred in America, Norwegian king Alfred in Norway and king Alfred of the whole world.

His isolation from the social life of the hospital was reflected in the way he saw other patients as rats and himself as a president or king. Alfred was transferred to a local hospital in 1981, but during his last five years at Reitgjerdet he had expressed himself satisfied with living conditions in the hospital and he resisted the transfer. The last letter written by the physician in charge at Reitgjerdet expresses doubts about the diagnosis of intellectual disability, which was based largely on his limited education and deviant behaviour.

Discussion

During the study period the proportion of patients in the forensic asylums with ID was 15%. This was a much higher proportion than in other asylums (the Annual National Statistics give the proportion with a primary diagnosis of ID as 4% in 1920 and 1% in 1965; (Statistisk_Centralbyrå. 1920, Statistisk_Sentralbyrå 1965). Before World War II as many as 21.8% of the patients at Reitgjerdet had ID (Dahl 2016); this proportion decreased during the post-war period as a result of improvements in social services and the development of institutional services specifically for people with ID from 1951 onwards. Some changes in the educational level and social welfare of the patients through this period is described in a previous article (Søndena, Gudde & Thomassen, 2015). The nationwide health care for people with ID in Norway was establishment as late as 1952 and housed at the most more than 6500 people at the late 1960's (Fjermeros, 2009). After 1970 we got a period characterised by improvements followed by institutional dismantling between 1991 and 1996 (Nottestad, 2004).

The large number of patient with ID in Norwegian forensic mental health hospitals can be related to the increasing institutionalisation of people with ID in other Western countries. In contrast to other countries, these patients were not separated from the mental health services. This may have been because the Norwegian economy was weaker than those of neighbouring countries, because of the efforts of dedicated, pioneering professionals such as Keller and Goddard (Kirkebæk 1993, Scheerenberger 1983), or the fact that ID was considered a psychiatric disorder in Norway and not classified separately, as the case was in Denmark i.e. (Skålvåg 2003). Since ID was treated as a part of the mental health services, it became less significant to the comparison services in Denmark and US that were more based on eugenics.

In the forensic mental health services it was common to distinguish two categories of patients. The term 'insane criminals' was applied to patients who exhibited chronic delinquency; they were often also characterised as intellectually or morally challenged or defective. The other group, the 'criminal insane', was people who had committed crimes while being acutely bewildered by their insanity (Dahl, 2017). The Norwegian Insanity Act prevented individuals with a criminal record or showing evidence of criminal behaviour being admitted to standard asylums and 'insane criminals' could not

be transferred into the standard mental health system. This created a problem for the authorities and the establishment of forensic asylums was one solution. These restrictions may account for the heterogeneity of the population of these asylums, illustrated by the cases of Ragnar and Alfred, and the high proportion of patients with ID in (15%).

Even if patients with ID in general were considered as 'insane criminals', the two patient examples represents each of the two afore mentioned groups. Alfred was described as a notoriously offending person, for whom the high security facilities of the forensic hospital was a necessity, whereas Ragnar was admitted following a specific sexual offence in combination with the use of alcohol. The patient descriptions highlight the differences between these two patients. Alfred is described as a man with chronic challenging behaviour and Ragnar as a more peaceful man with a few episodes of challenging, harmful behaviour. Both cases demonstrate some of the possible forensic complications of ID. The two cases describes persons with certain needs for protection that was not available in the local communities at this period. The distance between the daily life in the institution and the community welfare increased and eventually ended up with closure in 1987. Detaining people with ID in a hospital ward was seen as a way of managing their behaviour; practice in the 21st century is different.

The descriptions of Ragnar in the patient casebook are barely compatible with more recent definitions of ID e.g. in the International Classification of Diseases (ICD) versions 10 and 11. Ragnar was assessed as having a mental age of 10 years and he wrote poems and made impressive portraits of his fellow patients. Concerning the increased awareness of persons with ID during the period before the second world war, the services identified mildly disabled people who would possibly not have been given such a diagnosis today (Beirne-Smith, Patton, and Kim 2006).

Concluding remarks

This dive into the history of a group of people with ID which has not previously been described was made possible by a new openness and improvements in access to institutional records. Expectations about treatment of people with ID during the eugenic era have been studied using data from a large number of patient casebooks. The evidence suggests that although some patients suffered as a result of their incarceration most adapted fairly well to institutional life, or at least better than they did to life outside the hospital. Female forensic patients with ID were not admitted to these hospitals and it remains unclear how they were treated during this period.

Patients with ID were a significant proportion of the patient population at Reitgjerdet and Kriminalasylet; they admitted for periods varying from a few days to 50 years. Most were referred to as problematic, difficult or dangerous at the time of their admission and their offences fell into three main categories: theft and robbery, sexual offences and violence (Søndenaa et al., 2015). These two hospitals were the only forensic mental health hospitals in Norway and were reserved for the most severely ill or dangerous patients. Female patients and less dangerous patients were admitted to other institutions. In this respect Norwegian practice differed from that of neighbouring countries as Denmark, which had an institution at Sprogø for female forensic patients with ID (Kirkebæk 2004).

Recent studies have shown that people with disabilities (Dullum 2015, Hauland 2015) and ID (Søndenaa et al., 2008) are over-represented in Norwegian correctional services, and that incarceration is more stressful for this population than for people without disability. Research into the needs of offenders with disabilities continues.

Competing Interests

The authors have no competing interests to declare.

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