INSTITUTIONAL NEUROSIS - ITS CAUSES AND REMEDY

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Introduction

The term "Institutional Neurosis" was coined by Russell Barton in 1959. The adjective 'institutional' does not imply that institutions are the only cause of the disorder, but signifies only that institutions are the places where it was first generally recognised. By no means all people in institutions develop it, and probably hermits, some housewives, and old age pensioners are afflicted with similar symptoms although living alone. The term 'neurosis' is used rather than 'psychosis' since the syndrome itself does not interfere with the patient's ability to distinguish between reality and phantasy. 'Neurosis' is used in a general descriptive sense. It describes symptoms and signs not psychodynamic hypotheses.

Barton prefers to use the term 'Institutional Neurosis' because it promotes the syndrome to category of disease, rather than a process, thereby encouraging us to understand, approach, and deal with it in the same way as other diseases.

The condition has been described under different names by different authors. Myerson (1939) claimed that the usual hospital care given to Schizophrenic patients produced a 'Prison Stupor' or 'Prison Psychosis' which interacted with the social retreat of the original Schizophrenia. The patient was put into a motivational vacuum.

Bettelheim and Sylvester (1948) used 'Psychological Institutionalism' to describe the detachment isolation, automation-like rigidity, passive adjustment, and general impoverishment of personality which they noted in emotionally disturbed children in an institution They remark "behaviour disorders in the common sense do not necessarily form part of this clinical picture".

Martin (1955) used the term 'Institutionalization' to denote the syndrome of submissiveness, apathy, and loss of individuality that is encountered in many patients who have been some time in a mental hospital.

Miller (1961) calls it 'Chronic Institutional Reaction'; Wing (1962) refers to the condition as 'Institutionalism'; Vail (1966) discusses it under the title 'Dehumanization' and Zusman (1967) has named it as 'Social Breakdown Syndrome'.

The purpose of this article is to describe the clinical features of the disorder in mental hospitals, its differential diagnosis, aetiology, treatment and prevention.

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Most of the people working in mental hospitals are quite aware of this condition. The idea of this article is to arrange the facts in an orderly manner so that they are more easily understood, more easily accepted and more systematically treated. The theme of this paper is mainly derived from the book "Institutional Neurosis" written by Russell Barton (1966) with some modifications by the author based on his experiences of the condition prevailing in Mental Hospitals in India especially Ranchi Mansik Arogyashala and Hospital for Mental Diseases, Ranchi in Bihar State.

Clinical features

Institutional Neurosis is a disease characterised by apathy, lack of initiative, loss of interests—more marked in things and events not immediately personal or present, submissiveness, and sometimes no expression of feelings of resentment at harsh or unfair orders. There is also lack of interest in the future and an apparent inability to make practical plan for it, a deterioration in personal habits, toilet and standards generally, a loss of individuality and a resigned acceptance that things will go on as they are—unchanging inevitably and indefinitely.

These signs vary in severity from the mute stuporose patient who sits in the same chair day after day, through the ward worker who has without protest surrendered the rest of his existence to the institution, to the active cheerful patient who enjoys the facilities available, often does some handicrafts during the day, but shows no desire to leave the hospital, shows no interest in plans for a future outside hospital and raises numerous difficulties and objections when anyone tries to help him to be discharged.

Occassionally the passive, submissive co-operation of the patient is punctuated by aggressive episodes which are casually attributed to mental illness but which, if carefully investigated, often seems to be provoked by some unkindness from another patient, an attendant, a nurse, a doctor, or visitors. At other times an apparently similar provocation may produce no such response. The patient often adopts a characteristic posture, the hands held across the body, the shoulders drooped and the head held forward. The gait has a shuffling quality, movements at the pelvis, hips and knees are restricted giving an impression that the patient is suffering from Parkinsonian syndrome although, physical examination shows a full range of movement at these joints. The muscular power is found to be good when the patient co-operates in testing it. It may be this posture develops through prolonged sitting and too little exercise.

Further evidence that an institutional neurosis is present may be found from the clinical case records of the patients written by nurses and doctors. A severe neurosis will often have resulted in entries such as dull, depressed, apathetic, listless, mute, dirty,

preoccupied, uncommunicative, withdrawn, maintains postures, sits about the whole day, and is quite lost. A mild example of the syndrome may find remarks such as lacking any initiative, or works well but has no spontaneity or "has settled down well or is co-operative, manageable and gives no trouble."

Permutations of these words and phrases, 'institutionalised', 'dull', 'apathetic', 'withdrawn', 'inaccessible', 'solitary', 'unoccupied', 'lacking in spontaneity', 'uncommunicative', 'gives no trouble', 'has settled down well', 'is co-operative', should always make one suspect that the process of institutionalisation has produced a neurosis. Such remarks are often found in the notes of chronic patients who had been in hospital for many years.

Differential diagnosis

It is only in the last few years that the symptoms described above have been recognised as a separate disorder from the one which was responsible for bringing the patient into hospital, and that the disease is produced by methods of looking after the patients in mental hospitals and is not part of the mental illness preceding and sometimes existing with it.

(1) The condition may be indistinguishable from the *latter stage of Schizophrenia*. Often it is complicated by residual Schizophrenic features such as delusions or hallucinations. In such cases the diagnosis can only be made retrospectively after subjecting the patient to an intensive course of rehabilitation.

(2) *Depressive illneses* have many features in common with intitutional neurosis, but the gloominess, sadness, guilt, agitation and despondency of depression are absent in institutional neurosis.

(3) *Organic dementias* such as arrested general paralysis of the insane and those of arteriosclerotic origin are easy to diagnose when neurological signs are present, but it may be difficult to realise that a supervening institutional neurosis is complicating and sometimes largely responsible for the mental picture.

(4) *Myxoedema* may be distinguished by typical face, croaking voice, constipation and raised serum cholesterol.

It may be argued that the fact that treatment causes the disappearance of some of the symptoms ascribed to institutional neurosis is insufficient evidence to justify formulating a disease entity. However, other supporting evidence is that a similar set of symptoms is sometimes found in people in other institutions—prisoner of war camps, displaced persons camps, orphanages, tuberculosis sanatoria, prisons and convents. The symptoms are also encountered as an end result of many different disorders and, as Martin remarks, "It can hardly be argued that mental illness in general, regardless of its type, produces an end state similar to institutionalisation. Hospitals run

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by a staff aware of the neurosis and its aetiology are ceasing to produce it.

Aetiology or factors associated with Institutional Neurosis.

The cause of institutional neurosis is uncertain. It does not seem to have a single cause. However, there are two main view points namely sociogenic and psychogenic regarding the aetiology of institutional neurosis. Earlier to Barton (1966) the Sociogenic view points were emphasised by Goffman (1961). The sociogenic causes deal with the factors commonly found in the environment of the hospital.

These factors commonly found can be conveniently grouped under seven headings. Of course, the divisions are not absolute and these factors overlap one another. These seven factors are—

1. Loss of contact with outside world
2. Enforced idleness
3. Bossiness of medical, nursing and ward attendants
4. Loss of personal friends, possessions, and personal events
5. Drugs
6. Ward atmosphere
7. Loss of prospects outside the institution

These seven groups are clusters of factors each as different from others as possible. They are artificial division of an overall picture. Examination of these groups of factors reveals some overlaps. Although experience may give the impression that correction of a single factor will in some cases bring about the dramatic recovery, i. e. discovery of a relative who begins to make regular visits and take interest in the parient, reflection makes one realise that it is difficult if not impossible for one factor to alter without others.

The psychogenic view point, on the other hand, assigns a major role to the Pre-morbid personality factors in determining the process of institutional neurosis. In his study at New Haven, Connecticut, Rosenberg (1970) felt that personality factors were also equally important in determining the reaction to institutional neurosis. The study conducted by Bhaskaran (1971) in Hospital for mental Mental Diseases, Ranchi, showed that the process of institutional neurosis is not entirely sociogenically determined, but the premobid personality factors and possibly other variables also play an important part in determining the process and its degree. These individuals show high dependency, ambivalence towards authority, a negative sense of self and an overwhelming desire for external confirmation of what they were or were not. Their dependency and ambivalence could be projected on to external authority figures past and present, who could then be experienced as repressive and betraying.

Consideration of the factors associated with Institutional Neurosis.

Here only the sociogenic factors i. e. the factors commonly found in the environment of the institution have been discсussed.

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1. Loss of contact with outside world

The patient's loss of contact with the outside world begins with his illness. The process is increased by removal to a mental hospital, often situated far away from his home, and maintained by detention behind locked doors, locked wards, high boundary wall, formalities in getting parole for certified patients and difficulty in getting leave to go outside.

The patients can maintain contact with the outside world by writing letters to the relatives and receiving replies from them, through regular visits by the relatives and by going out from the hospital regularly. Many patients in the hospital are illiterate. They cannot write letters. Occasionally they are helped by the fellow-patients or sympathetic staff members. Those patients who can write may have genuine difficulties. They can write to relati ves if they can get paper, pen, ink and a quiet place to write. These facilities are not available to them. Even if the relatives write to them the hospital authorities do not write back to say how much letters are appreciated and how much good it is doing to the patient. The patients' contact with the outside world may be maintained if they are regularly visited by the relatives. The patients come from far off places. The relatives do not like to take long and tedious journey. Cost of journey becomes another factor in preventing the relatives to visit their wards regularly in the hospital. Some illiterate relatives do not know the route to the hospital and have to take the help of others for performing the journey, this makes the journey doubly expensive. It is difficult for service holders to get frequent leave and the agriculturist cannot visit during the sowing and harvest seasons. While in the hospital the patients are not allowed to go alone for evening walks or shopping for fear of escaping from the hospital. In case the patient escapes from the hospital explanation may be asked from the Medical Superintendent by the higher authorities. In many hospitals criminal mental patients are kept along with ordinary mental patients. In case they escape the matter becomes more serious. To avoid these complications rigorous screening is done in allowing them to go out of the hospital. Whenever they are sent, they are accompanied by the ward attendants. Because of shortage of ward attendants the patients cannot be sent out. Many patients do not like to go accompanied by hospital attendants in uniform for fear of being spotted as a mental patient by the public. Some patients do not have their own clothes. They use clothes provided by the hospital which bear the name of the ward or the hospital. The patients are reluctant to go out in hospital uniform. Because of the patients awareness of abnormal dress, grotesque appearance and talk they are frightened to meet people outside. Allowing female patients to go out is still more difficult for social reasons.

Because of these difficulties many patients never get the chance to react to a normal

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environment and they become completely cut off from the outside world.

Bhaskaran (1970) in his study conducted in the Hospital for mental Dieseases, Ranchi, found almost total indifference and neglect of the relatives to their wards in the hospital, as revealed by the infrequency of visits and letters.

2. Enforced idleness

The hospital routine is such that the patients are forced to be idle. It may be that the principle that rest assists nature to cure has been drummed into doctors and nurses in their 'training and uncritically applied to mental disorders. The training received by doctors and nurses in general hospitals has tended to make them run mental hospitals on similar lines. If the patient's day is followed from awakening onwards it may give some idea as to how idleness is thrust upon them.

The patients are not allowed to do things themselves. Most of the things are done for them by the hospital staff. They become completely dependent on the ward attendants and the nurses. The hospital does not provide sufficient activities for them. A few may indulge in desultory occupational therapy.

The patients are expected to abide by the routine activities of the hospital. Individual activity of almost any sort may not get the approval of the nurse. The nurse's and ward attendant's behaviour may actually cause an aggressive act which may be countered by sedation. The patient has no hand in purchasing, choosing or deciding about the dietary articles. Patients coming from different parts of the country have different dietary habits. But all of them are given the same monotonous diet. The afternoon often presents another arid vista of idleness—nothing to do, no one to talk to, nowhere to go, the only event to look forward to is afternoon tea. The breakfast, lunch and dinner are served to them and they have just to sit and eat. Patients are given dinner at 6 P. M. and sent to the bed by 7 P. M.

3. Bossiness of medical, nursing and attendant staff

There are probably more kind, friendly and tolerant doctors and nurses than otherwise, but an authoritarian attitude is the rule rather than exception. Senior medical officers doing administration as well are likely to pass on their administrative outlook on to the patients, and their outlook is likely to be imitated by their junior colleagues. There is a tendency for sister, nurses, and ward attendants to decide everything for the patient, such as where they must sit, which bed they must sleep in at night, what personal possessions they can have if any, how much pocket money they can have, if and when they can leave the ward and so on. If the patients do not comply to the whims of the nurses they are restrained and sent to the back wards.

Instead of encouraging independence and nurturing initiative with greater care the nurse

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is imposing on the patient one of her own life by doing everything and making all decisions for them. The nurse very often has no option but to do so because of the way many mental hospitals have been run. The nurse herself is often treated badly by matron and assistant matron if she does not follow the hospital routine. Her views are often ignored and she is subjected to the process of institutionaiization. It is not proper to blame any particular individual in the nursing hierarchy. Henry (1954), Bockoven (1956), and Clark (1958) have suggested that it is a fault of the administrative structure.

4. Loss of personal friends, possessions and personal events.

Relatives and personal friends may visit the patient at first but very soon the combination of expense, difficulty in travelling, gradual loss of interest and fear that the patient may be discharged makes the visits less frequent until they eventually cease. Large number of patients in mental hospitals have no place in which they can keep personal possessions, no lockers by their bed. Often clothes are deposited with the ward sister and is kept in godown. Similarly writing paper and such essentials as combs, tooth-brushes, cosmetics, etc. are difficult and often impossible to keep. Occasionally the patients are seen moving about with their little belongings for fear of being stolen. Hospital refuses to accept personal properties of the patients, like watch, transistor radio, ornaments, etc. These precautions are taken because the patients may be deprived of their belongings by the fellow-patients and unscrupulous attendants. They are not allowed to keep the pocket money with them. It is deposited in the office and the patient is allowed to draw the money once in a week on the recommendation of the ward sister and the doctors. As a result of this difficulty, they are not able to utilise the money properly.

Important personal events in the life of an individual like marriages, visitings friends, going to pictures, playing with children, and many others are completely missing in the hospital. In mental hospitals institutional events exist but the patient plays no part in ordering or altering them; they are largely impersonal.

5. Drugs

Sedatives produce apathy. The main job of medical officers in mental hospitals has been to make daily ward rounds, to prescribe drugs, and to carry out routine physical and mental examinations. It is not surprising that majority of the patients forced to go to bed by 7 P. M. after an idle day require sedative to sleep. In case they wake up in the early hours, they are given more sedatives. The effect of sedative may not wear off for 4 to 12 hours after it is given so that during the morning the apathy produced by absence of a planned routine and loss of contact with the world outside the hospital is furthered by the effects of barbiturates or more modern tranquillising drugs.

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Electric convulsive therapy is sometimes repeatedly given to disturbed patients. It quietens them down, often confuses them for several hours, but has very limited place if any in the long-term treatment of the patients.

6. Ward atmosphere

General impression of the ward has an impact on the patient. Such an impression is the sum total of many defferent factors, such as—

(a) Colour of walls, ceilings, floors.

(b) Colours and designs of furniture, beds, chairs, windows, pictures, curtains.

(c) Intensity of illumination (brightness).

(d) Space, arrangement of beds, etc., and presence or absence of crowding.

(e) Flower gardens around the the ward.

(f) Flies and presence or absence of dirtiness, dinginess and dilapidation,

(g) Appearance of other patients—the manner the clothes are put on.

(h) Noise : clatter or ward activity, patients shouting, shoutings of ward attendants.

(i) Friendliness, smartness and helpfulness or the off-handedness, untidiness and unhelpfulness of the staff members.

(j) Smell of ward , smell of faeces, vomit, urine; disinfectant, or the smell of flowers and incense.

The statement that chronic psychotic patient is oblivious of the surroundings and unable to appreciate the interior decoration and lay-out of the ward is hardly ever true. That many chronic psychotic patients do appreciate all that goes on has been shown over and over again. Drab surroundings communicate to the patient the idea that 'nothing matters' which fosters the apathy being produced by other pressures. Butler (1887) repeatedly pointed out the importance of scrutinising the hospital environments to find out and remove whatever is depressing or disturbing. He insisted that a cheerful sympathetic atmosphere and aesthetic approach are essential for many patients. His goal was to make hospital wards as home-like as possible (Bockoven 1956).

7. Loss of prospects outside the institution

After admission to a mental hospital as time goes by the prospects of finding a place to live, a job to work at, and friends to meet with diminish rapidly. It is difficult to persuade patients that the tremendous efforts to re-enter the world outside is worth the gain. Many patients say they never wish to leave hospital. Similar difficulties have been encountered with patients who have spent a long time in tuberculosis sanatoria (Pugh 1955). On a lesser scale similar attitudes, doubts and difficulties arise with demobilisation of some members of the armed forces, especially long-servicemen.

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Resettlement is often a painful and difficult business. Unless a patient returns to his family fairly quickly the chances are he will find great difficulty in getting back. Unfortunately, there is a prejudice prevalent among the relatives that longer the patient stays in the hospital better the chances of his complete recovery and the lesser the chances of his relapse. In many it seems as though the place the patient leaves in the community to enter hospital gradually seals up. Many patients have lost confidence in their ability ever to work again. The conviction that they will never be able to earn a living or find economic security persuades them to accept the institutions as a permanancy—especially if life is not too unpleasant. After living in the hospital for a long time they think that they are unable to make decisions and have irrational fear of re-entering society.

Treatment of Institutional Neurosis

Various aspects of the treatment of institutional neurosis have been described by some authors (Greenblatt, York and Brown (1955); Stanton and Schwartz (1954). The treatment of institutional neurosis can be done through stages—the patients may remain at different stages at the time the treatment begins.

There is need for the public, social welfare organisations and the doctors to become aware of the social implications and the dangers of admission to hospital. Admission should be resorted to as an expedient way of solving a difficult social situation which cannot be rapidly and easily dealt with by community care. Often admission can be avoided by judicious earlier intervention. The public should try to allow a mentally sick person to float in the community rather than sink in an institution.

The members of the hospital staff should discuss the problem of the patient and see for themselves what they can do personally to prevent the patient from becoming a victim of the institutional neurosis.

The treatment of institutional neurosis should be also considered in association with the aetiological factors. It can be discussed under the following headings :—

1. Re-establishment of patients' contacts—

The patient is usually aware of what goes on but makes no meaningful communication. Attempts should be made that the patient establishes contact with other inmates of the ward, nurses, and doctors. They should participate actively in hospital functions and should be allowed to keep contact from home. The ward doctor needs to talk with the patients for some minutes everyday. This few minutes contact from the ward doctor need to be supplemented by similar individual attention from a nurse and the ward sister. Similarly, a brief word from the Medical Superintendent and the matron when they are doing their rounds matters a lot. It may be months before any flicker of response occurs confirming that contact has

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been made. Contact with the ward is furthered by forming patients into groups of 6 to 10 under the charge of one nurse who concentrates on teaching the patients in her group the pattern of behaviour in the ward. They learn to do things together and also re-acquire simple skills. The patients should be taken for evening walks. Those who do not come to an expected standard of cleanliness and tidiness should be told to do that before they could be included in the group. This will give an incentive to other patients to remain clean. Their attempts to do so should be encouraged and rewarded. They should be also taken to the nearby towns for shopping. The patients should be allowed to do things of their own. The nurse should intervene only when it is absolutely necessary. Individual enterprise must be fostered and not smothered by doing things the patient might be able to do. The art of the nurse is to judge when to intervene to preserve the patients dignity and confidence without robbing him of the chance to do things for himself. Wards should be run on open door lines. Open doors are highly potent weapons in treating institutional neurosis. Local patients should be allowed to visit homes. Psychiatric social worker plays a most important role in sorting out complexities of the home situation. The relatives should be instructed at the time of discharge that the patients should be encouraged to do things at home. Mental patients are considered just like physically ill patients and they are given complete rest at home for the sake of recovery which proves detrimental for them. The relatives should be requested to visit the patients regularly.

2. Provision of daily sequence of useful occupation, recreations and social events.

The ward population may be divided into groups and each group assigned some utility work in the ward or in the hospital. Useful work is very desirable and incentive needs to be given for it by way of suitable remuneration. Work can produce dependence on the hospital as easily as it may produce independence. The doctors, nurses, and other staff must repeatedly ask themselves if the work is therapeutic and what good it is doing to the patient. It has been found that replacing idleness with activities reduces aggression, tearing, picking, hoarding, masturbation and other undesirable behaviour presumably by providing more socially acceptable things to do.

3. Alteration of the attitude of medical and nursing staff.

Any association of crime with mental patients is undesirable. This association has come with the practice of keeping criminal mental patients in the hospital. Much of the strictness and vigilance in the hospital may be because of the presence of such patients. They should be kept in special hospitals or prisons with adequate psychiatric facilities. It is important to change the prevailing attitude of the attendants and nursing staff towards mental patients. Th

need for all types of mental hospital employees to receive educational instructions is stressed by Middleton (1953) in the summary of his very interesting article on the prejudices and opinion of mental hospital employees regarding mental illness. One potential method of combating institutional neurosis could be to increase the medical staffing of the mental hospital. An increase of medical staff is only potentially likely to counter institutional neurosis. To realise this potential the senior medical staff must become aware of this disorder and its attendant causes, and be capable of helping to formulate and execute plans to combat them. It is usually found that the ward attendants are sometimes very rude and unsympathetic to the patients. It will do immense good to the patients if they are replaced by the kind, sympathetic and understanding nurses.

4. Encourage and make it possible for a patient to have friends, possessions and to enjoy personal events.

(a) Friends—

Medical officer should stress to the relatives and friends of the patient the importance of maintaining visits, letters and outings. It may be useful to sit down among the visitors and patients from time to time, talking to them occasionally. The ward sister, the psychiatric social worker and the doctor can help relatives and friends considerably in the early days of illness by correcting misconceptions that lay people so often have about mental disorder and helping them to accept the illness.

(b) Possessions—

Of enormous importance in the treatment of institutional neurosis is the provision of a place for the patient to keep personal possessions. A locker by the bed and a ward-robe for clothes are essential for each patient. Patients should be allowed to have their own discretion regarding things for his daily use and luxury goods, and they should not be imposed on them. They should be allowed to keep the photographs of the relatives with them. It should be remembered that the patient is part of a human family and not an isolated case of mental illness.

(c) Personal managements—

Housewives should be allowed to cook meals. This may only be possible once or twice a week but that is better than never. There should be a household management unit for this purpose in the hospital. They should be allowed to do knitting, embroidery work, and send the finished goods to their family members if they so desire.

5. Reduction of drugs

Drugs should be given only when it is necessary and not because that the patient is in the hospital. Their continuous administration is not necessary for the large majority of the patients. Drugs should be used to counter bewil-

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dering experiences and distressing emotions arising from within. They should never be used to adjust a patient to surroundings or a regimen that any normal person would find intolerable. It would be foolish to say that all patients should be without drugs, but it seems likely that many are better without them. Occupation, recreation and physical exercises may be more effective than tranquillising drugs.

6. Provision of a homely, friendly, permissive ward atmosphere.

The general impression a ward creates is important because it is continuously communicating the patient. Drab surroundings with dingy furniture, locked doors, and barred windows do not encourage a patient to feel that life can be interesting or that effort is worthwhile. Thus it is helpful in treating institutional neurosis to pay attention to everything that can be pereceived in a ward. Gay colours, curtains, pictures, paintings, flower pots, etc., can create an air of optimism which is a valuable contributory factor to other measures of rehabilitation.

Nursing staff morale seems to improve when a ward is well decorated and so does the patients' behaviour. The patients should be encouraged to take care of their appearance without help. It is necessary to provide full length mirror in every dormitory so that they can stand before the mirror and see for themselves their facial appearance, hair, etc. There should be better toilet facilities in the ward. Patients should have regular bath. Incontinent patient should be regularly taken to lavatory. Waterproof materials should be provided on the bed. Sufficient quantity of deodorant and disinfectant should be used. There should be no urinous smell from the ward. Insomnia in an institution is not so much a result of illness as a result of institution. Patients are served their dinner very early and they are expected to go to their beds immediately afterward. In case they can't sleep so early, they are given hypnotics. Sometimes their sleep is disturbed by noisy, excited patients.

7. Make the patient aware of prospects of accommodation, work and friends outside hospital

(a) Accommodation

In case patients have no place to go back arrangements should be made for them to stay in hostel, supervised lodgings, etc., and such facilities should be provided to them by the Government. Such places should be situated not near the hospital but away from the hospital in the community. The system of boarding out may be very useful. Poor people willing to keep such patients should be given sufficient monetary help for maintaining them in their homes.

(b) Work

Employers should have sympathetic attitudes towards mentally ill and their occasional odd behaviour should not be taken seriously.

The Government should try to reserve small percentage of jobs for such people. The importance of work can never be over-emphasised. The importance of regular occupation has been known for many years. Galen wrote in 172 A. D., "Employment is nature's best physician and is essential to human happiness". Tuke, Connolly and Brown put forward similar ideas over 100 years ago and Bleuler (1906) and Jasper (1913) emphasised the importance of regular occupation. Bleuler "trained his nurses and attendants to supervise the patients' activities so that they gave him satisfaction and if possible some personal responsibility" (Mayer-Gross, Slater and Roth, 1954). Regular work by patients results in considerable increase of production although there may not be measurable change in social behaviour. Their work should be suitably rewarded by money to maintain the tempo of work. Some patients have faulty attitudes towards work. They think hospital is a place of rest and they refuse to work especially so when they are paying patients. This attitude can only be changed by suitable education.

(c) Loneliness

Loneliness may be a problem for some patients discharged from the hospital especially so if they have no relatives to look after them. This problem can be dealt with by social welfare agencies which can provide social clubs and recreation centres for them in the community.

More important than all these is the dire necessity of providing more accommodation to mental patients. At present we have very limited number of beds for them in the hospital which is grossly inadequate. The hospitals should be located at short distances from the community. Bennet and May have shown that closer a patient's relatives live to the mental hospital the more likely is he to be discharged. All mental patients do not need admission in a mental hospital. There should be facilities for their treatment in general hospitals and even at the block level. Patients are not taken away from the hospital because it is difficult to get a bed allotted for them again. The procedure for allotment of bed by Government is very cumbersome and time consuming. If the bed can be easily made available to the patient in times of need the relatives will surely come forward to have him discharged from the hospital. The Indian Lunacy Act of 1912 is obsolete. It requires thorough revision. The process of admission and discharge should be very easy. The system of allotment of bed by Government is very defective. The beds are allotted to them on the basis of the lists maintained in the Health Department without taking into consideration the individual case. As a result of this procedure, sometimes the patients have to wait for a long time for their turn to come and during this long waiting they are kept in jails and by the time they come to the hospital they become chronic and possibly institutionalised. Moreover the medical superinten-

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dent has got less control in the discharge of patients admitted in Government quota. There should be separate hospitals for chronic and acute patients. Chronic patients do not require treatment on the same lines as acute cases. The most important point in their treatment is rehabilitative measures which is not available in ordinary mental hospitals. They should be provided different types of work in the hospital. Working merely for the sake of recreation in the occupational therapy is not enough. In an agricultural country like ours, they should be made to work in field. There should be separate hospitals for criminal mental patients. This will bring about a change in the attitude of hospital staff and they will tend to provide more freedom and less restraint to the other patients. Some intelligent and well-behaved patients should be given more responsibility with adequate remuneration. Patients representative should be given opportunity to ventilate problems of other patients and their grievances should be looked into immediately.

References

1. Barton, (1966)—Institutional Neurosis—John Wright & Sons Ltd., 1966, Second Edition.

2. Bettelheim, B , and Sylvestar, E. (1948)—Amer. J. Ortho—Psychiat. 18. 191.

3. Bhaskaran, K. (1970)—The unwanted patient—Ind. J. of Psychiat. Vol. 12, 1-12.

4. Bhaskaran, K., Dhawan, N., and Mohan, Y. (1971)—A study of the effects of prolonged hospitalisation on Schizophrenics – Paper read at the Scientific Session of the annual conference of Indian Psychiatric Society at Madurai, January, 1971.

5. Bleuler, E. (1905) — Psychiat — Neurol. Wschr. 6, 441, (Quoted by Mayer Gross and others).

6. Bockoven, J. S. (1956)—J. Nerv. Ment. Dis.. 124, 194, 319.

7. Butler, J. S. (1887)—Curability of insanity and the individualized treatment of the insane. New York : G. P. Putnam's Sons (Quoted by Bockoven, 1956).

8. Clark, D. H. (1958)—Laneet, 1, 805.

9. Goffmann, E. — Asylums—Essays on the Social situation of mental patients and inmates—New York, Doubledey, 1961.

10. Greenblatt, M., York, R., and Brown, E (1955)— From custodial to therapeutic patient care in Mental Hospitals. New York : Russels Sage foundation, Hand book for mental nurses, 1954, 8th Ed. Page 306 Published in conjunction with the Royal Medico-Psychological Association, London Bailliere, Tindall & Cox.

11. Henry, J. (1954)—Psychiatry, 17, 129.

12. Jaspers, K. (1913)—Allgemeine Psychopathologie, 14th Ed. (1948), 700 Berlin quoted by Barton, Russel in Institutional Neurosis —2nd Ed. 1966.

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13. Martin, D. (1955)—Lancet, 2, 1188.

14. Mayer-Gross, W., Slater, E. and Roth, M. (1954)—Clinical Psychiatry, 281. London; Cassell & Co.

15. Middleton, J. (1953)—Amer. J. Psychiat, 110, 133.

16. Miller, D. H. (1961)—Psychological factors in the Aetiology of disturbed behaviour, British Jour. Med. Psychol, 34: 43-52.

17. Myerson, A. (1939)—Amer. J. Psychiat. 95, 1197.

18. Pugh, D. L. (1955)—Lancet, 1, 614.

19. Rosenberg, S. D. (1970)—The Discultura-tion Hypothesis and the Chronic patient syndrome. Social Psychiatry, 5: 155-165.

20. Stanton, A. H. and Schwatz, M. S. (1954)—A study of the institutional participation in Psychiatric illness and treatment. London: Tavistock.

21. Vail, D. H. (1966)—Dehumanization and the institutional career. Springfield, III: Thomas.

22 Wing, J. K. (1962)—Brit. J. Soc. Clin. Psychol., 1, 38.

23. Zusman, J. (1967)—The social breakdown syndrome — International Jour. of Soc. Psychiat, 3: 216-243.

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