# INSTITUTIONAL NEUROSIS: FEATURES AND ASSOCIATED FACTORS*

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## INTRODUCTION

METAL ILLNESS is still regarded with fear and shame despite the many advances in science and technology in the world. In the interest of society, such people are segregated by keeping them in asylums for purposes of caring for them, as they are considered to be both incapable of looking after themselves and a "threat" to the community. Some professionals however, question whether the mental hospital has any beneficial effect whatsoever beyond human custody. They see the goal of the mental hospital as serving to isolate deviant members of society (August, 1968; Goffman, 1961; Gove, 1972).

As a result of the large patient population and the small inadequately-trained staff, it is inevitable that the restrictive measures adopted for the few aggressive or potentially dangerous patients are extended to the rest of the harmless majority. The smooth running of the hospital thus, depends upon the submission of the patient with a minimum of resistance. The encompassing or total character of such a set-up is symbolized by the barrier to social intercourse with the outside world, by locked doors, high walls and windows bars, thus completing the description of a *"total institution"* as described by Goffman (1961).

In a *"total institution"* there is a basic split between a large managed group, conveniently called inmates, and a small supervisory staff. Each grouping tends to conceive of the other in terms of narrow hostile stereotypes; staff often seeing inmates as bitter, secretive and untrustworthy, while inmates often see staff as condescending, high-handed and mean. In this kind of oppressive atmosphere, patients gradually learn to surrender their existence to the staff and are no longer able to feel the need to think for themselves. In other words, they become "institutionalised."

Barton (1976) describes the syndrome of "Institutional Neurosis" seen in chronic patients as characterised by apathy, lack of initiative, loss of interest, submissiveness, lack of interest in the future, deterioration in personal habits, toilets and standards generally, loss of individuality and resigned acceptance that things will go on as they are — unchangingly, inevitably and indefinitely. Rosenham (1973) on the other hand, described the process as of "depersonalization" where patients are gradually robbed of their human dignity, deprived of many of their legal rights, and shorn of credibility by being labelled as "psychiatric". With restricted freedom of movement, he cannot initiate contact with the staff and his personal hygiene and waste evacuation are also monitored. The geographical distance from the general community, the loss of contact with families and the lack of community resources to rehabilitate the mentally ill, also contribute to the problem. Wing and Brown (1970) enumerate various factors which may handicap the resettlement of a mentally-ill patient which can be classified into three large groups as follows:

a) Disabilities present before the onset of illness
b) "Primary" disabilities which are basically part of the illness, such as incoherent thought processes, delusional motivation, catatonic slowness or apathy and,
c) "Secondary" handicaps which have been accumulated during the illness because of his own and other people's reactions to the illness.

The primary disabilities may be influenced by an understimulating social environment (social withdrawal) or social over-stimulation (delusion, hallucinations). Thus, the social environment may influence the patient's illness and also produce a secondary handicap or institutional neurosis.

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on as before (F), 63% were apathetic (A), while thirty-one per cent were found to have deteriorated in personal habits, toilet and standards generally (D). Although some of the patients showed mild to moderate degree of characteristic posture and gait (G), none of them were rated as severe (Table II and III).

After determining the degree of severity of each feature, the next step was to determine the extent to which a patient had the syndrome of "institutional neurosis". Thus, each patient was rated on all the seven features of "institutional neurosis" in terms of the absence or presence of that feature. An arbitrary rating of 1 was given in the absence of a feature and 5 if that feature was present. The lowest score of 7 denotes absence of "institutional neurosis" and the highest score of 35 denotes the presence of all the features of "institutional neurosis". Patients with a range of 8 to 25 were grouped as less severe cases of "institutional neurosis" while those with scores of 26 to 35 were classified as severe cases of "institutional neurosis".

The above table shows the classification of the sample into "severe" and "less severe" degrees of "institutional neurosis". Sixty-four per cent of the males and 54% of the females were rated as severe cases of "institutional neurosis". However, the difference is not statistically significant.

**Table II**

**Degree of Severity for Female Patients (N=50) on each feature of Institutional Neurosis**

| Features | Degree of Severity (No. of Patients) | | | | | Total No. of Patients with severe rating of 4 and 5 |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| A — Apathy, loss of interest | 7 | 4 | 9 | 1 | 29 | 30 |
| B — Submissiveness | 0 | 0 | 3 | 0 | 47 | 47 |
| C — Lack of interest in future | 0 | 0 | 14 | 3 | 33 | 36 |
| D — Deterioration in personal habits | 27 | 4 | 1 | 0 | 18 | 18 |
| E — Loss of individuality | 0 | 1 | 3 | 34 | 12 | 46 |
| F — Resigned acceptance of things | 0 | 0 | 2 | 0 | 48 | 48 |
| G — Posture and gait | 18 | 26 | 6 | 0 | 0 | 0 |

**Table III**

**Degree of Severity for Male Patients (N=50) on each feature of Institutional Neurosis**

| Features | Degree of Severity (No. of Patients) | | | | | Total No. of Patients with severe rating of 4 and 5 |
|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | |
| A — Apathy, loss of interest | 7 | 4 | 6 | 1 | 32 | 33 |
| B — Submissiveness | 3 | 3 | 0 | 0 | 44 | 44 |
| C — Lack of interest in future | 2 | 0 | 4 | 3 | 41 | 44 |
| D — Deterioration in personal habits | 28 | 6 | 3 | 3 | 10 | 13 |
| E — Loss of individuality | 1 | 0 | 2 | 28 | 19 | 47 |
| F — Resigned acceptance of things | 0 | 0 | 2 | 0 | 48 | 48 |
| G — Posture and gait | 20 | 24 | 6 | 0 | 0 | 0 |

For further analysis, the relationship between the sociodemographic factors and the severity of "institutional neurosis" was studied (with the use of statistics). However, the severity of illness was found to be related on only two variables, that is, age and education for male patients. For males, the relationship between age and severity of illness was statistically significant at the 0.05 level and education was also found to be related to severity of illness, and statistically significant at the 0.05 level.

### Factors associated with Institutional Neurosis

The eight factors found to be present in the patient's environment as postulated by Barton (1976) and associated with "institutional neurosis" were also examined in the present study.

### Loss of contact with the outside world

Fifteen female patients were visited at least once in the first six months of admission compared to six male patients. This figure dropped to two visitors each for male and female patients in the past six months prior to the study.

### Enforced Idleness

Enforced idleness was determined in terms of the number of activities a patient was involved in. As shown in Table IV, 29 per cent of the patients made their own beds and 34 per cent helped to clean the wards. Seventy-one per cent of the patients were engaged inactivities ranging from one to three and only 29% were involved in more than four number of activities in the hospital. There were significant differences between the "less severe" and "severe" category of both the sexes in the number of activities and this difference was found to be statistically significant ($p < .001$).

### Brutality, Browbeating and Teasing

As shown in Table V, there were 16 females and 14 males who had a history of abuse and assault. Fourteen females and twelve males were indeterminate as they could or would not give any indication of abuse.

### Bossiness of Staff

Fifty-four per cent of the females and forty-two per cent of the males denied that there were too many regulations. The rest of the patients gave no response when asked about the too many regulations.

### Loss of personal friends, possessions and personal events

All of them had lost their personal friends. Seventy per cent of the patients were unable to form a close relationship. Table VI lists the type of things that the patients had as their personal belongings. Only 20 females and 8 males were reported to have some form of personal belongings. As shown in Table VII, the degree of severity of institutionalisation was found to be related to the number of personal belongings. This difference is statistically significant ($p < .001$) for female patients. As regards to the personal events, only 3 females and 3 males could remember their birthdays, 12 females and 19 males did not even know their names.

**Table IV**

**Number of Patients who are Involved in Various Ward Activities**

| Description of Activity | Females | Males | Total |
|---|---|---|---|
| (1) Make own bed | 13 | 16 | 29 |
| (2) Bathe by own self | 35 | 38 | 73 |
| (3) Help to serve food | 12 | 8 | 20 |
| (4) Wash own dishes | 6 | 1 | 7 |
| (5) Prepare own food | 0 | 1 | 1 |
| (6) Engage in O.T. | 6 | 3 | 9 |
| (7) Help to clean ward | 16 | 18 | 34 |
| (8) Go for walks | 43 | 34 | 77 |
| (9) Do gardening | 1 | 4 | 5 |
| Total | 132 | 123 | 255 |

**Table V**

**History of Abuse in Relation to Severity of Institutional Neurosis**

| History of Abuse | Females | | Males | | |
|---|---|---|---|---|---|
| | Less Severe | Severe | Less Severe | Severe | Total |
| Absent | 12 | 9 | 9 | 15 | 45 |
| Present | 9 | 7 | 7 | 7 | 30 |
| Indeterminate | 2 | 11 | 2 | 10 | 25 |
| Total | 23 | 27 | 18 | 32 | 100 |

$X^2 = 0.9414$ N.S. $X^2 = 0.5638$ N.S.

The aetiology of institutional neurosis is uncertain, however, as it is associated with many factors in the environment of the institution. Barton (1976) postulates eight factors associated with institutional neurosis namely loss of contact with the outside world, enforced idleness, brutality, bossiness of staff, loss of personal friends, possessions and personal events, drugs, ward atmosphere and lastly loss of prospects outside the institution.

Though the syndrome of institutional neurosis has been generally known to be prevalent in our mental institutions, however there has been no previous study done in Malaysia. The present study therefore aims to investigate the features of institutional neurosis as well as to ascertain the factors associated with this syndrome as postulated by Barton (1976), in Hospital Bahagia, a large mental hospital in Malaysia.

## METHOD AND MATERIALS

There were 50 male and 50 female subjects selected on the basis of random sampling from the long-stay wards which were separate buildings located at quite a distance from the main hospital and therefore were often neglected. Data was collected by personal interviews on structured questionaires.

## RESULTS

### Sociodemographic data

#### Age:

With a mean age of 49.1 years, the female age range was 27 to 84 years while the male age range was 24 to 79 years with a mean of 49.7 years.

#### Ethnic Group

The sample population comprised of 66% Chinese, 21% Malays, 11% Indians and 2% others, which is comparable to the hospital population distribution of various ethnic groups.

#### Duration of Stay

The range of stay varies from 2 to 37 years for the females and 2 to 31 years for the males. Average duration of stay for the females was 18.9 years and 19.8 years for males (Table I).

#### Marital Status

Thirty-six per cent were married females, while only 4% of the males were married.

**Table I**

**Duration of Stay in the Hospital**

| No. of Years | Females | Males | Total |
|---|---|---|---|
| 0 — 5 | 5 | 6 | 11 |
| 6 — 10 | 5 | 1 | 6 |
| 11 — 15 | 6 | 8 | 14 |
| 16 — 20 | 8 | 7 | 15 |
| 21 — 25 | 17 | 14 | 31 |
| 26 — 30 | 8 | 13 | 21 |
| 31 — 35 | 0 | 1 | 1 |
| 36 — 40 | 1 | 0 | 1 |
| Total | 50 | 50 | 100 |

#### Occupation

There were only two females who were skilled workers. Seventy-two per cent of the females and 78% of the males were unemployed.

#### Education

There were 7 females and 11 males who had been to primary schools, 2 females and 1 male with a secondary school background and 41 females and 38 males had never been to any school.

#### Diagnosis

A large number of the sample population were diagnosed as schizophrenic (73%) while 10% of the sample were mentally-retarded patients.

#### Features of Institutional Neurosis

Features of institutional neurosis were classified into seven major groups and each feature was further defined in terms of the degree of severity. Tables II and III show the distribution of the sample population according to the degree of severity on each of the seven features. The patients were rated for each feature on a five point scale measuring the degree of severity. A rating of 4 and 5 was considered to be severe and denoting the presence of that feature. On this basis, it was found that 91% of the patients were submissive (B), 90% had lost interest in the future (C), 93% of patients had lost of individuality (E), 96% of them were resigned to accepting that things will go

**Table VI**

**Number of Patients in Possession of Personal Belongings**

| Description of Possession | Females | Males | Total |
|---|---|---|---|
| (1) Suitcase | 1 | 1 | 2 |
| (2) Locker | 0 | 1 | 1 |
| (3) Own Clothes | 2 | 1 | 3 |
| (4) Thermos/Mug | 0 | 2 | 2 |
| (5) Comb/Brush | 11 | 1 | 12 |
| (6) Toothbrush | 5 | 2 | 7 |
| (7) Cosmetic/Shaving set | 1 | 0 | 1 |
| (8) Photographs | 0 | 0 | 0 |
| Total | 20 | 8 | 28 |

**Table VII**

**Number of Patients in Possession of Personal Belongings in relation to severity of Institutional Neurosis.**

| No. of Items Possessed by Patients | Females | | Males | | Total |
|---|---|---|---|---|---|
| | Less Severe | Severe | Less Severe | Severe | |
| Nil | 12 | 26 | 16 | 32 | 86 |
| One or more | 11 | 1 | 2 | 0 | 14 |
| Total | 23 | 27 | 18 | 32 | 100 |
| | $X2 = 13.2561$ $p < 0.001$ | | | | |

**Table VIII**

**Attitude of Patients to Discharge**

| Attitude to Discharge | Females | | | Males | | |
|---|---|---|---|---|---|---|
| | Yes | No | No Response | Yes | No | No Response |
| Contented to Stay | 22 | 17 | 11 | 23 | 10 | 17 |
| Fear of Leaving Security of Hospital | 23 | 16 | 11 | 16 | 17 | 17 |

### Drugs

A survey of patient's medication was made and it was found that only 17 females and 16 males were receiving neuroleptics.

### Ward Atmosphere

When asked to express their feelings about the ward atmosphere, 30 females and 26 males reported that they were happy, 6 females and 6 males reported being unhappy with the ward atmosphere, and 14 females and 18 males were indeterminate about their feelings.

### Loss of prospects outside the Institution

As shown in Table VIII, there were 23 females and 16 male patients who expressed their fear at the prospects of leaving the security of the hospital, 11 females and 17 males did not respond at all. When asked about their feelings of leaving the hospital, 45% of the patients were contented to stay in the hospital.

## DISCUSSION

### Patient Characteristics

This study was conducted on the patients of a long stay ward with an average length of stay being 18.9 and 19.8 years for females and males respectively. It has often been assumed that the long period of stay in the mental hospital would initiate the process of institutionalisation. However there was no such relationship found between the two as the statistical analysis was found to be insignificant.

The age seems to be related to the severity of institutionalisation for the male patients and this was found to be significant at the 0.05 level.

In order to assess the relationship between the severity of "institutional neurosis" and other socio-demographic variables, the data was statistically analysed and only two variables, that is, age and education were found to be significantly related to the severity of institutionalisation for male patients. However, this significance needs to be interpreted cautiously in the light of the fact that growing older is a natural process and growing older in a particular environment could bring about certain changes and it is the effect of that environment over a long period of time that may determine the severity.

Education, on the other hand has been considered an important variable as an indication of good pre-morbid functioning (McCabe, 1976). It is interesting to note that 79% of the patients were uneducated and of these, 51 of the uneducated patients were classified as severe cases of institutionalisation, whereas only 8 out of the 21 educated ones were severe cases of institutionalisation.

It has been stated that the long stay wards tended to have more schizophrenics that any other illness (Sommer and Witney, 1961) and the findings of the present study are not different as the majority of the patients were diagnosed as schizophrenics. The symptom of "institutional neurosis" has been shown to be prevalent in all types of patients irrespective of their diagnosis, which may suggest — that the symptoms of institutionalisation indicate a disorder separate from the one first responsible for bringing the patient into the hospital and the disease is produced by methods of looking after people in mental hospitals and is not part of the mental illness, preceding or existing with it. However, in our sample, it was difficult to verify this as the majority of the patients in our sample were schizophrenics. A further analysis of the clinical features of institutional neurosis as postulated by Barton (1976) showed that all the patients in the present study showed almost all of these features with varying degrees of severity.

A significant proportion of the patients accepted things without challenging and complaining about the system, with total submission expected of the inmates for the smooth running of an institution. This resigned acceptance of things also leads to lack of interest in the future and an inability to make any plans resulting in total apathy and a gradual loss of individuality and identity which started with the initial stripping off of his usual appearance on admission, his accustomed affirmations, satisfaction and defenses and a gradual mortification through restriction of free movement, diffuse authority and communal living. However, the characteristic posture and gait described by Barton, as one of the features was not so prevalent in the present sample. The low prevalence of this feature may relate to the fact that patients were involved in daily evening walks as a routine activity of the hospital. The presence of all these features marks the setting of the process of insitutional neurosis. It is necessary and important to recognise these sysmptoms which indicate a disorder separate from the one which brought the patients to the hospital in the first place.

The fact that these symptoms seen in the patients are different from the ones seen on admission raises an important issue as to what causes them. Though difficult it is to ascertain any direct causation of this illness, a number of studies have postulated and shown the significant importance of the environment in which the patient lives in and the factors associated with that environment. In viewing the hospital as a total system, the ward interaction is considered as a transactional phenomena, that directly affects the patients and permeates every aspect of ward life. Such interaction constitutes the environment which may range from the most impoverished form of custody to the most enlightened form of therapeutic process. Apart from the variables of patients' characteristics and staff characteristics, an important variable related to the hospital effectiveness, is the treatment environment ranging from the extremes of custodial to therapeutic effects.

**Factors associated with Institutional Neurosis**

Considering the factors associated with institutional neurosis, it was found that patients had very little contact with the outside world, and very few of them had been visited in the beginning and even these few gradually had no visitors at all. Being left to live in the same limited environment, they are further faced with enforced idleness, with the main activities being bathing and making their beds and going for a walk. It was found that the number of activities were significantly related to the severity of 'institutional neurosis' for both the sexes. A common occupational therapy unit in the long-stay wards with over 1,000 patients was able to cater for the needs of only about 10 males and 10 female patients. It would seem that a good therapeutic environment embodies more than just frequent interaction to dish out the medication, an active therapeutic day to day environment of the ward may produce the highest therapeutic potential.

Fear of being bullied, physically assaulted and browbeating may also lead to the submissiveness on the part of the patient. Cunningham Dax (1968) noted in his study of mental hospitals in Malaysia that more patients have died from assault than suicide over the past few years. Thirty per cent of the patients reported being abused. Brutality is unsanctioned and usually goes undetected through the misplaced loyalty of other staff and the intimidation of witnesses. Farleigh (1971), Whittingham (1972) and the South Ockendon (1974) reports established beyond reasonable doubt that brutality occurs and should always be watched for and investigated.

Another established feature is the possiness of the staff where the patients are subjected to the boring and dictatorial ways of the staff who decide everything for the patients assuming that they are superior and know more than a mentally ill person. This attitude consequently discourages independence and initiativeness, and results in apathy and lack of interest in the patients. The denial of too many regulations by the patients in the present study could be reflective of their submissiveness and lack of initiativeness, or lack of education and low I.Q.

Loss of personal friends after coming into a mental institution is not surprising. This however, coupled with loss of personal possessions and finally the loss of memory about the important events can be a very important factor which leads to isolation, lack of purpose and loneliness thus begetting apathy which further leads to isolation completing a vicious circle. Wing and Brown's (1970) study on institutionalism and schizophrenia found that patients with the fewest possessions tended to be occupied in the least interesting activities, least in touch with the outside world and spent most of their time doing absolutely nothing. Similar results were found to be statistically significant for the female subjects in the present study where the degree of severity of institutional neurosis was related to the number of possessions. The general impression a ward creates can produce a very substantial response in the chronic patients. Drab surroundings communicate to the patient the idea that 'nothing matters' which fosters the apathy. The walls, floors and ceilings were bleak and beds were cramped with poor ventilation and lighting with smell of urine being pervasive, conditions of the toilets were unsatisfactory without any doors, floors slimy, far from home-like atmosphere. The authorities may defend the poor ward atmosphere by declaring that chronic patient is oblivious to his surroundings, however, there were twelve patients who were dissatisfied with their ward surroundings.

Once in the institution, the patients adapt themselves to the life there, surrendering their responsibilities, losing their skills through disuse and finally they come to the stage of feeling insecure on the prospects of a discharge. They have been away from the outside world for so long that they lose confidence in their ability to adjust or work and have an irrational fear of re-entering the society.

## CONCLUSION

The implications of this study are important indeed, for they point most definitely to that aspect of the hospital which should receive primary attention particularly the ward atmosphere or the treatment milieu which is not only predictive of hospital effectiveness but it has a definite potential in preventing the symptoms of "institutional neurosis". Firstly, these symptoms represent a form of adjustment to the institution to which patients are committed to for an indetermined period. The loss of friends and outside world coupled with the ward atmosphere and its mundane routine leaves very little for the patient's initiative and involvment resulting in apathy, submission and other characteristics of 'institutional neurosis' as described above.

Secondly, while hospitalisation is an important facet of the treatment of a patient, high levels of effectiveness demand much more than just the custodial care for the patient. Since so much of the therapeutic process revolves around the staff-patient interaction process, an extensive effort must be made in the staff training process toward inculcating a realistic set of expectations with regards to patient problems and creating an appropriate ward atmosphere. Functional communication is an important variable which would restrain patients from withdrawing themselves and encouraging them towards a more meaningful participation and interest in the activities of the ward. While patient's symptoms are found to play an important role affecting treatment attempts, the manner in which the patient responds and interacts with his environment as well as his perceptions of such an environment are just as important.

Finally, the success with which the environment creates a therapeutic milieu rather than a custodial one determines the chances for the patient's successful return to the community, instead of developing 'institutional neurosis'.

## SUMMARY

The study was undertaken to examine the characteristics of patients in a long-stay ward and determine the features associated with institutional neurosis. Fifty females and males were selected with average age of 49.1 years for females and 49.7 years for males, who had been staying in

the hospital with an average duration of stay of 18.9 years for females and 19.8 years for males. With an exception of the characteristic posture and gait associated with institutional neurosis, the majority of the patients presented all the features of institutional neurosis as postulated by Barton. The various factors found in the patient's environment which have been associated with institutional neurosis are discussed.


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