TREATMENT OF INSTITUTIONAL NEUROSIS*

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INTRODUCTION

THE FEATURES and factors associated with institutional neurosis had been described in the preceding paper in this journal. This paper attempts to give an account of the treatment of institutional neurosis based on the therapeutic community model carried out over a nine weeks period at Hospital Bahagia, Ulu Kinta, Perak.

Ideally, the treatment of institutional neurosis should be by prevention. This means that mentally ill patients should be diagnosed early and treated promptly with all available therapies. The idea is to aim at early discharge or the avoidance of admission altogether in order to prevent the accumulation of long-stay institutionalized patients.

However, once a patient had already been institutionalized, then the emphasis should be on rehabilitation and resettlement, through the provision of meaningful domestic and industrial roles within an open hospital setting, leading through transitional communities of various kinds to full participation in community life for a certain proportion of patients (Barton, 1976).

METHOD

In late 1977, the Department of Psychological Medicine, University of Malaya collaborated with the staff of Hospital Bahagia, Ulu Kinta to set up two "model" wards in that hospital. One was a male acute admission ward and the other was a female ward for rehabilitation of chronic patients. This study is based on work done in the latter ward.

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Two wards in the hospital were chosen and renovated. The staffing of the wards was favourable. In the female "model" ward, there was a part-time sister, two staff-nurses, two assistant nurses and several attendants as well as student-nurses who were there for their training.

Fifteen patients were selected from various chronic wards on the basis of, a duration of stay of at least two years, age of less than 50 years, and preferably, but not necessarily, from Perak, so that relatives are more readily contactable.

Those chosen were transferred to the new ward. The severity of institutional neurosis was scored at the time of transfer, according to the rating scale described in the preceding paper in this journal.

TREATMENT

The ward was run along the lines of a therapeutic community. A simple definition of a therapeutic community is "one is which a conscious effort is made to employ all staff and patients' potentials in an overall treatment programme, according to the capacities and training of each individual member." (Sainsbury, 1974).

The aims of running the ward on the therapeutic community model are as follows. Firstly, opening up of communication between patients and staff and amongst staff of different grades and disciplines. This had rarely been possible in the tradition custodial setting. Secondly, the creation of an atmosphere of acceptance of disturbed behaviour with understanding, rather than attempting to control it by arbitary authority and rule. Thirdly, the development of independence and the ability of patients to make decisions to the maximum degree their illness will permit.

The rehabilitation programme may be conveniently described under the headings which

Barton (1976) used as a basis to discuss the correction of factors associated with institutional neurosis.

Re-establishment of Patients' contacts with the outside world

Re-establishment of patients' contact with the outside world starts in the ward. It is essential for the ward staff to talk with the patients for some minutes each day. As there were only 15 patients, they were given a lot of attention by the staff. The patients gradually came to be interested in the staff as people and often inquired about their family and personal life and vice-versa.

To prepare patients for contact with the outside world, their appearances had to be improved so that they would not appear repulsive or be stared at. All of them were given decent clothings donated by the hospital staff. Their hair was attended to by the ward staff. They were encouraged to brush their hair and make themselves neat. One patient was referred to Hospital Besar, Ipoh for dentures and another for a pair of spectacles.

On weekends, they went for walks in the hospital grounds or to Tanjong Rambutan, a town which is close to the hospital. They also went for outings in the hospital bus. Patients were encouraged to write home to their families. Those who could not write were helped by the staff who wrote on their behalf. Relatives were invited to come to the ward for visits.

Provision of a daily sequence of useful occupations, recreations and social events

Wing and Brown (1970) found that the only really important category distinguishing patients who improved clinically from those who did not, was work and occupational therapy. Ideally, each patient should have an individual programme tailored to her needs but this is not practical if it is intended to introduce to model ward for other wards to emulate, the main obstacle being the shortage of staff. Instead, a common ward programme was drawn up by the staff after discussion. Later, patients were invited to give suggestions. Table I shows the final programme agreed upon by the staff and patients.

The ward programme included three group therapy sessions a week, lasting about an hour each. Discussions were conducted in three languages, Bahasa Malaysia, Chinese and Indian language. Communication was not easy in the beginning. Patients were a little unsure of what they were supposed to say. A few patients expressed hostility at having to do so much work, comparing the idle existence in their previous wards. However, as time passes and the community spirit spread, ideas were shared and patients began to contribute suggestions about improving the ward social life. One patient volunteered to make pyjamas which were more comfortable to sleep in and shorts for working and gardening. The patients began to take a real pride in their ward and to form strong attachments to the staff.

The question of transfering a disturbed patient to another ward was a matter of community concern and was discussed at the group meetings. Destructive behaviour was discussed for its meaning and methods of handling it was suggested. Disciplinary action if deemed necessary, was decided upon by consensus of opinions of patients and staff, which carried equal weights.

Patients were encourages to socialize with the patients from the male "model" ward. As seen in Table I, they met on five occasions a week. As a result of these meetings, patients learned to take pride in their appearances and developed a healthy relationship with men.

To encourage the patients to participate in the programme, a system of "token economy" was instituted. This is essentially a simple reward system which is nevertheless effective in modifying behaviour. The system is characterised by the fact that the desired behaviour has to be specified, there must be a feedback of patients' feelings regarding the desired behaviour and the reward, and there must be a good back-up system in terms of rewards. It was pointed out to the patients that the ultimate reward was the return to the community as a useful member.

The staff worked out an arrangement whereby tokens were awarded for desired behaviour and participation in various ward activities. Each patient could earn tokens which could be exchanged for a total of 70 cents a week. If they

Table I

Programme of Ward Activities (In 3 Languages)

TIME \ DAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDRY
7.00 — 8.30	Wake up, Personal Hygiene, Bed making, Laundry, Breakfast and Medication						
8.30 — 9.30	Ward Meeting	Occupational Therapy	Ward Meeting	Complete cleaning of ward and wash Linen, Bedsheet etc.	Ward Meeting	Outing to Tanjong Rambu tan Town (with male Patients).	Morning walk in Hospital (with Male patients
9.30 — 10.30	Gardening or Needlework		Staff Meeting patients do Gardening.		Psychodrama	Letter writing or reading.	Hair Care (Shampoo etc.; Beauty Culture
10.30 — 12.30	Bath, Prepare Lunch, Cooking and Wash up						Male Patients come to ward to have lunch
12.30 — 2.00	Free Period — Relax, sleep, read newspaper, magazines, listen to music, discussions						
2.00 — 4.00	Male Patients come to ward — singing — dancing — games	Tidying the Ward, Needlework, patchwork, ironing clothes.		Patient meet male patients at Hospital Library for discussions	Tidying the ward (sweep floor etc), Needlework (including sewing dresses) patchwork and ironing clothes.		
4.00 — 7.00	Prepare Dinner, cook and wash up, Bathe and Medication.						
7.00 — 9.00	Card-games, reading, listen to music, brush teeth, wash hand and feet, then to bed						

earned a minimum of 40 cents a week, then they were allowed to go to town on weekends to buy whatever they wanted (usually food) with their money.

As patients continued to improve, they were given leadership training. They were divided into three teams of patients each. A team-leader was appointed from each team in rotation. She was responsible for ensuring that her team members did their work and took care of their personal hygiene properly. There was a sense of responsibility and friendly rivalry.

Eradication of brutality, browbeating and teasing

The staff were encouraged to complain about any patient's behaviour during the group meetings. There was no evidence of any ill-treatment during the period of this study, even though some patients could be rather provocative at times.

Alteration of staff attitudes to amiability, acceptance and assistance

Many full-scale mental hospitals in all parts of the world are completely open or have no more than two or three closed wards in the whole hospital and yet there are comparatively few serious problems (Dax, 1969). As a result, the hospital loses its traditional custodial function with the usual restraints, locks and bars. Consequently, the staff have to be reorientated from their previous roles as custodians. In our ward, the staff were able to quickly adjust to their new roles as teachers and friends, working together with the patients instead of merely supervising them as in the past.

Staff meetings were useful in establishing a closer relationship among the staff. Mutual confidence grew and the meetings became increasingly free and helpful. The needs of all staff members were looked into. Any difficulty in the ward, including interpersonal relationships was discussed and resolved.

Encourage and make it possible for patients to have friends and personal possessions and to enjoy personal events

By their constant contact with the staff and fellow-patients, patients gradually grew to feel for others, trust them and accept them as friends. Each patient had her own bed with a locker and a few sets of clothings, a toothbrush, a comb and a pair of slippers. Other facilities were provided such as a dressing table, and some cosmetic for common use. Patients were taught to read calenders and to remember their dates of births.

Reduction of drugs

It was found that several patients were on medication they no longer needed, others were on unsuitable dosages while still others were denied medications which were useful. After their transfer to the ward, patients' medications were reviewed and necessary adjustments were made. Where possible, patients were medicated on a twice daily basis or even on night doses only. The patient with manic-depressive psychosis was treated with lithium carbonate after she was presented at the weekly hospital case-conference.

Provision of a friendly, homely, permissive atmosphere

Before the patients were transferred into the ward, one of the female wards was selected for renovation. (Fig. I). Part of the wall was knocked down and a kitchen was built, equipped with a gas stove, sink and larder, with new melamine crockery. Another area of the ward was converted into a visitor's room, with nice comfortable furniture, and potted plants. The walls were repainted and bright curtains were hung on the windows. The number of beds was reduced from 40 to 15. Partitions were set up so as to enclose four beds together to provide a sense of privacy (Fig. 2). Beautiful pictures of sceneries and attractive ladies decorated the ward. A common dressing-table with a mirror was placed at one corner. The surrounding garden was planted with flower plants and vegetables.

Fig. 1. A gloomy, depressing ward.

Fig. 2. The same ward after renovation. Note the bright and lively atmosphere.

Make the patients aware of prospects of accomodation, work and friends outside the hospital and assist them in realizing these prospects

Although we tried to make the ward as home-like as possible in terms of aesthetic qualities of the interior and outside grounds, the way food is being prepared and served, and the social activities available, we did not intend to make the environment so pleasant that patients may be so contended as to not want to leave.

Right from the beginning, patients were informed that they were being trained for housework so that when they were discharged, they may be an asset to their families. Even if no relatives were available, the patients could still find employment as cooks, washerwomen, babysitters, domestic helps, etc. It was discussed and agreed upon that a registration book be kept by the social worker, so that prospective employers (initially hospital staff but later outsiders) could register and employ patients.

ANALYSIS OF DATA AND RESULTS

There were 12 Chinese, two Malays and one Indian patient. Their mean age was 36 years with a range of 22 to 50 years. The mean duration of stay was 6.27 years with a range of 2 to 16 years. Eleven of the patients were married, one was widowed and the rest were single. The patients were diagnosed as schizophrenia (12), manic depressive psychosis (1), personality disorder (1) and epileptic psychosis (1).

The ratings of severity of institutional neurosis for the patients before and after transfer are as follows. Five patients were rated as severe, 9 patients as moderate and one patient as mild, before their transfer. However, 9 weeks after transfer, no patient was rated as severe, 7 patients were rated as moderate and 8 patients as mild.

The status of patients at the end of study are as follows. Seven patients remained in the ward, one patient was discharged home, 2 patients were transferred out to other wards, 2 patients were employed and 3 patients were expected to be employed soon. (These 3 patients already had prospective employers but they were unable to leave the ward yet, as the social worker was on leave and thus, was unable to register them at the time this study ended).

DISCUSSION

If we consider discharge or employment as a criteria of success in rehabilitation, then six patients may be included, making a success rate of 40%. If clinical improvement is used as the criteria instead, then all patients may be said to have shown some degree of improvement. However, the ultimate criteria of success depends on how long the discharged patients can remain out of hospital and their ability to maintain a viable social adjustment. Brown *et al.* (1958) showed that 2 out of 3 long-stay patients who were discharged after a prolonged stay in hospital succeeded in remaining in the community for at least a year after discharge; and that 2 out of 3 of these successes were maintaining a viable social adjustments.

Those patients who did not show much improvement clinically might have needed more time to respond. Nine weeks of rehabilitation could only be considered as a "crash-course" and hardly adequate time for patients who had been ill for so long. It is therefore gratifying, that there was so much improvement.

The patient/staff ratio was much better than in other wards. However, an active rehabilitation programme obviously demands a greater proportion of staff to patients treated, than does custodial care. Although this may appear more expensive initially, it is in fact more economical as there is a good chance that some patients, who would never otherwise be discharged, may be usefully rehabilitated back into the community. This will save the hospital a great deal of money in terms of upkeep. Active treatment and rehabilitation of patients will enable society to avoid the heavy financial burden of life-long care.

Table II

Result of treatment of 15 female patients in model ward

Ethnic Group	Age	Years of stay	Diagnosis	Ratings		Status of patients at end of study
				Before	9/52 after	
Chinese	39	9	Schizophrenia	20 M	14 L	Remained in ward
Malay	39	7	Schizophrenia	21 M	19 M	Transferred out
Chinese	42	2	Schizophrenia	18 M	11 L	Employed (discharged)
Chinese	37	3	Epileptic Psychosis	23 M	19 M	Remained in ward
Chinese	28	5	Personality Disorder	19 M	8 L	For employment soon
Chinese	32	5	Schizophrenia	15 L	9 L	Remained in ward
Chinese	35	5	Manic-depressive	26 S	13 L	Remained in ward
Malay	40	8	Schizophrenia	20 M	15 L	Discharged home
Chinese	26	3	Schizophrenia	20 M	17 M	Employed (paroled)
Chinese	49	14	Schizophrenia	22 M	11 L	For employment soon
Chinese	50	2	Schizophrenia	19 M	11 L	For employment soon
Chinese	29	16	Schizophrenia	26 S	18 M	Remained in ward
Indian	39	3	Schizophrenia	28 S	21 M	Transferred out
Chinese	22	6	Schizophrenia	27 S	19 M	Remained in ward
Chinese	33	6	Schizophrenia	26 S	20 M	Remained in ward

Note: L = Mild degree of Institutional Neurosis (rating score of 8 — 16)

M = Moderate degree of Institutional Neurosis (rating score of 17 — 25)

S = Severe degree of Institutional Neurosis (rating score of 26 — 35)

A striking observation is the effect of the ward on its staff. There was an almost universal excitement and intense dedication to their work. They were very proud to be associated and chosen for the ward. Even staff from other wards were pleased. As one hospital assistant put it, "The new wards are good for the hospital. We have worked here for so long without change and we feel stagnated. Now, we hope that the new wards signify the beginning of change in the hospital. At the moment, we can feel proud that at least part of the hospital is progressive."

Further improvement in the patients and the future of the wards will depend on the enthusiasm, ability and opportunity of the ward staff.

SUMMARY

15 female patients, who were below the age of 50 years of age and who had stayed at least two years in the hospital were transferred to the "model" ward for rehabilitation, run on the lines of a therapeutic model. Factors associated with institutional neurosis were corrected on the lines suggested by Barton (1976) and consisted of the re-establishment of patient's contacts, the provision of a daily sequence of useful occupations, recreations and social events, the eradication of brutality, browbeating and teasing, the alteration of the attitude of professional staff, the encouragement of patients to have friends, possessions and to enjoy personal events, the reduction of drugs, the provision of a friendly, homely, permissive atmosphere, and the opportunity to make the patients aware of the prospects of accommodation, work and friends outside the hospital.

Before the rehabilitation programme, five

patients were rated as haivng a severe degree of institutional neurosis, nine as moderate and one as mild. After nine weeks of treatment, no patient was rated as severe, seven patients were rated as moderate and eight patients as mild.

Six patients were either discharged, employed or in the process of being employed, giving a success rate of 40%. However, it is most encouraging to see that there was not only clinical and social improvement of all patients but the staff participated with much enthusiasm and constructive ideas.

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