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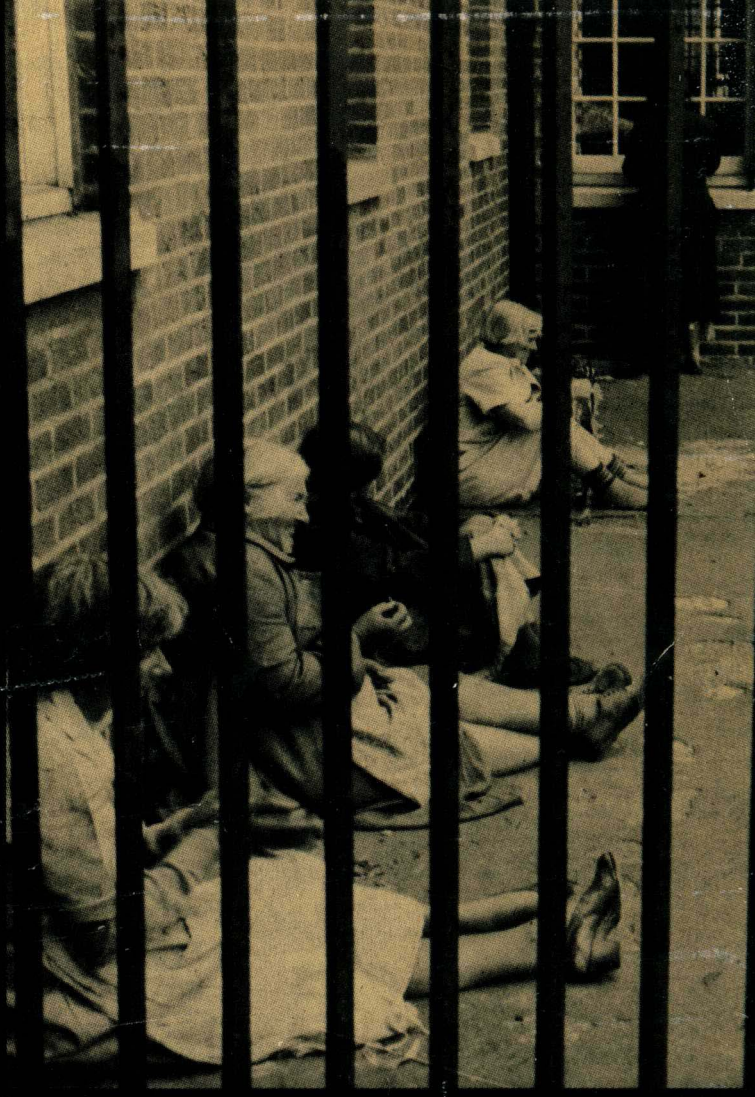

ISTITUTIONAL NEUROSIS

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By

RUSSELL BARTON, M.B., M.R.C.P., D.P.M.

Senior Hospital Medical Officer, Shenley Hospital. Formerly House Physician, Westminster Hospital; Medical Registrar and Clinical Tutor, Westminster Hospital; Psychiatric Registrar and Clinical Tutor, Westminster Hospital; Registrar, Bethlem Royal Hospital and the Maudsley Hospital; Registrar in Charge, St. Francis Observation Ward

With a Foreword by

NOEL GORDON HARRIS, M.D., F.R.C.P., D.P.M.

Physician for Psychological Medicine, The Middlesex Hospital; Lecturer on Psychological Medicine, The Middlesex Hospital Medical School

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"As Oblomov grew older he reverted to a kind of childish timidity, expecting harm and danger from everything that was beyond the range of everyday life—the result of losing touch with external events."

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PREFACE

THE purpose of this booklet is to present in a systematic form the dreadful mental changes that may result from institutional life and the steps that can be taken to cure them.

I would like to have had opportunity for a more complete study of this man-made disease, observing the similarities and differences in prisons, displaced persons camps, orphanages, convents, and other institutions in different parts of the world. I have confined attention to the material readily available to me in mental hospitals where, unfortunately, there has been a tendency to assume that such mental changes are an end result of mental illness. This is not so. Institutional Neurosis is like a bed-sore. It results from factors other than the illness bringing the patient into hospital. It is, so to speak, 'a mental bed-sore'.

My acknowledgements and thanks are due to Dr. Richard Asher who has encouraged me and made many helpful criticisms both literary and technical; to Dr. Desmond Bardon who read and annotated the first draft; and to Dr. Bernard Gilsenan, who supported various attempts to validate the usefulness of the various methods advocated on his Division at Shenley Hospital, and to Sister Michelle Mauchien who put these into action. It was not possible to carry out a scientific study and although the results are most convincing I have omitted them, not wishing to confuse exposition with validation. I am indebted to Miss H. M. Collins, M.A.O.T., who took all the photographs, and to Mr. W. G. Twomey who developed and enlarged them. Also to Miss Constance Orpwood who has typed and re-typed the manuscript.

Finally, I owe a great deal to various members of the staffs of Claybury, Netherne, Warlingham Park, Fulbourne, Hellingly, Banstead, Goodmayes, and Shenley Hospitals, and to others too numerous to mention who have added to, corrected, and clarified my ideas in discussions at various visits and meetings.

Shenley Hospital,
St. Albans,
January, 1959.

RUSSELL BARTON

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FOREWORD

By Noel Gordon Harris, M.D., F.R.C.P., D.P.M.

THIS is a book that should have been written many years ago and Dr. Russell Barton is to be congratulated on writing it now. It must have needed considerable moral courage on his part to do so.

I suppose that the majority of people have at some time or other in their lives cogitated on loneliness and the unhappiness that it can bring. Few have experienced the enforced loneliness of being cut off from normal human contact through, say, imprisonment, solitary confinement, the concentration camp, or the type of illness which necessitates segregation from one's fellow human creatures and ordinary life.

When I first started to specialize in mental illness in 1923—not really so very long ago—I went to a County Mental Hospital as an Assistant Medical Officer. I was very recently qualified and yet I was put in charge of the male side consisting of the admission ward, the infirmary wards, and the 'chronic' wards. In all I was responsible for about five hundred patients as well as other work.

The female side, which contained about eight hundred patients, was looked after by two more senior medical officers. The Medical Superintendent simply did the administrative work and really no clinical work.

I still remember the rows of patients so often sitting doing nothing; especially I recall the 'airing courts', which I do not think Dr. Russell Barton mentions, in which all the year round for an hour or two every morning and afternoon except in very bad weather the patients had to walk round and round on asphalt surrounded in the older courts by high stone walls. Another constant feature was the routine 'ladling' out of sedatives. Yet, the hospital I was at was considered one of the better and more progressive ones.

It was possible to demonstrate, however, that many of the nurses with teaching and enthusiasm were soon able to alter their attitude to patients and that sedatives could be cut down tremendously and prescribed for individual patients.

Dr. Russell Barton has described admirably in his book how with modern progress in some forms of treatment and more knowledge of rehabilitation the patients can be helped infinitely more if only the whole attitude of those who care for the mentally ill be altered towards establishing individual support and friendship.

I think that Dr. Russell Barton has perhaps let off too lightly those of us who have specialized in Psychological Medicine and worked in

Mental Hospitals. After all, it is the medical man who should take the initiative and arouse enthusiasm in those who work with him, and I fear that in the past and even at the present time this has sometimes been lacking.

I hope that the appropriate Authorities and members of the Press will read this book. How can this work be carried out without adequate finance and a sufficient number of staff; how much more difficult it is to be progressive and to take justifiable risks if on the rare occasion when something goes wrong the Press publishes glaring headlines and often a most misleading account of the incident.

I do not like the title of this book very much, but it is hard to choose a more suitable one and the author has explained why he chose this particular title.

In the future there should be many people grateful to Dr. Russell Barton for writing this book.

November, 1959

INSTITUTIONAL NEUROSIS

Chapter 1

CONSIDERATION, CLINICAL FEATURES, AND DIFFERENTIAL DIAGNOSIS OF INSTITUTIONAL NEUROSIS

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, automaton-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.

I prefer the term 'institutional neurosis' because it promotes the syndrome to the category of a disease, rather than a process, thereby encouraging us to understand, approach, and deal with it in the same way as other diseases.

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 recognized, as the use of Bornholm in Bornholm's disease. 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. 'Oblomovism', so often seen, and brilliantly depicted by Goncharov (1858), is probably a kindred disorder, an indolence and lethargy resulting from conditions in the environment in which the patient lives.

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 fantasy. Indeed such passivity adjusts

the individual to the demands of reality in the institution but, at the same time, it hampers or may prevent his return and adjustment to the world outside. 'Neurosis' is used in a general descriptive sense. It describes symptoms and signs, not psychodynamic hypotheses.

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

I feel sure the term 'institutional neurosis' has been used already by workers in hospitals up and down the country who recognize the condition. Furthermore, I claim no originality for the ideas presented; my purpose is to try to arrange them in an orderly manner so that they are more easily understood, more readily accepted, and more systematically treated.

Clinical Features

Institutional neurosis is a disease characterized by apathy, lack of initiative, loss of interest 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 a lack of interest in the future and an apparent inability to make practical plans 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—unchangingly, 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 her existence to the institution, to the active cheerful patient who enjoys the facilities available, often does some handicraft 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 her to be discharged.

Occasionally 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 seem to be provoked by some unkindness from another patient, 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 (*Frontispiece*), the hands held across the body or tucked behind an apron, the shoulders drooped, and the head held forward. The gait has a shuffling quality, movements at the pelvis, hips, and knees are restricted, 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.

New patients arriving at the hospital may notice this posture. One patient in hospital for two months said, "I'm terrified of being sent where the women walk about with their hands under their aprons with no sign of life in them."

Further evidence that an institutional neurosis is present may be found in patients' notes (Martin, 1955). A severe neurosis will often have resulted in entries such as: 'Dull, depressed and solitary', or 'Simple, mute and dirty', or 'Dull, apathetic and childish', or 'Remains uncommunicative, withdrawn and unoccupied', or 'Sits about all day and is quite lost'.

And in a mild example of the syndrome may be found remarks such as: 'Unoccupied and lacking in initiative', or 'Works well but has no spontaneity', or 'Has settled down well', or 'Is co-operative and gives no trouble'.

Permutations of these words and phrases, 'institutionalized', 'dull', 'apathetic', 'withdrawn', 'inaccessible', 'solitary', 'unoccupied', 'lacking in initiative', 'lacking in spontaneity', 'uncommunicative', 'simple', 'childish', 'gives no trouble', 'has settled down well', 'is co-operative', should always make one suspect that the process of institutionalization has produced a neurosis. Such remarks were often found in the notes of chronic patients who had been in hospital for many years but who were sufficiently improved after one year's treatment to leave hospital and lead an independent life outside and others who were considerably improved but remained in hospital.

Differential Diagnosis

It is only in the last years that the symptoms described above have been recognized as a separate disorder from the one which brought the patient into hospital; that the disease is produced by methods of looking after people in mental hospitals and is not part of the mental illness preceding and sometimes existing with it.

The condition may be indistinguishable from the later stages 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.

Depressive illnesses have many features in common with institutional neurosis, but the gloominess, sadness, guilt, agitation, and despondency of depression are absent in institutional neurosis.

Organic dementias, such as arrested General Paralysis of the Insane and those of arteriopathic and allegedly arteriopathic origin, are easy to diagnose when neurological signs are present, but it may be difficult to realize that a supervening institutional neurosis is complicating and sometimes largely responsible for the mental picture. Again the only way to decide is retrospectively to try an intensive rehabilitation