

Chronic Institutionalization in Mental Illnesses and Acquired Institutional Syndrome: A Case Series

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ABSTRACT

Chronic psychiatric institutionalization in severe mental illnesses may result in institutional syndrome in the chronic psychiatric patients which are characterized by dependency upon an institutional care system and manifestation of anxiety and persistent unwillingness at the time of discharge process being initiated. These condition(s) contribute to increasing cost of caring for chronic psychiatric patients and pressing encumbrance upon the Institution. In the present case series, seven chronic psychiatric cases were subjectively studied regarding their stay in psychiatric institution and their attitude towards discharge. All cases reported their unwillingness to get discharged from the Institution. There is an urgent need for a holistic intervention to address the issue of chronic psychiatric institutionalization in severe mental illnesses to socially restore and reintegrate the patients who have been admitted for prolonged period of time.

Key words: Chronic Institutionalism, Institutional Syndrome, Chronic psychiatric disorders

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Introduction

The concept of chronic institutionalism (Institutional neurosis, institutional syndrome, Social Breakdown Syndrome (SBS), hospital dependency) in severe mental illness like schizophrenia, is a widely acknowledged phenomena across many geographical mental health institutions, often alternatively described and understood as an Acquired Institutional Syndrome that develops over a long period of restricted psychiatric institutional admission, is manifested by significant deficits in behavioural and social life skills [1]. The protective, congenial, and overall therapeutic milieu of mental hospital often develop a sense of dependency and put such patients in a psychological state that any effort leading to discharge from the hospital cause them to develop anxiety, so much so that it result in continuous hospitalization. Many residual symptoms in long-stay mental patients were not only deficits of brain but also, consequences of institutional syndrome. In comparison to short-stay patients, the long-stay mental patients were more likely to

experience functional difficulties which often results in re-institutionalization to another care setting, as opposed to living independently in the community [2].

Deinstitutionalization movement initiated in late 20th century emphasised to shift psychiatric treatments and its accessibility at community level to minimize the duration and frequency of hospitalization and to them in their respective environment [3]. It was largely influenced by the approach developed by Pinel and his contemporaries, popularly acknowledged as 'Moral Treatment', which advocated discharging psychiatric patients to treat them in their respective environments on humanitarian grounds [4]. Thus, the deinstitutionalization movement largely advocated for reintegration of such inmates rather than just moulding them to get accustomed into the hospital environment [5].

As a result, deinstitutionalization was encouraged and many studies reported favourable and enhanced social functioning despite the fact that they were still functionally impaired [6]. However, there were some contradictory findings also. Its

repercussion was not as expected. Due to lack of proper implementation, it further added more psychiatric problems among discharged patients at large in the community. In the practical scenario, these patients expressed no enthusiasm to get discharged from their institutions, and much to the contrary, expressed desire to remain in the hospital for the rest of their lives. The numbers of such patients are considerably high and possess substantial challenge for mental health professionals to deal with. They consistently manifest passivity, self-observed behaviour, and poor self-concept about oneself, ambivalence, unwillingness to get discharge and passively accept paternalistic approach towards them in charge of their respective wards [7].

With no hope of their guardian to return and take them back home, most of them remain isolated and lead a cornered life inside hospital premises for years. The long length of imposed hospitalization makes the patient develop a sense of dependency and make them vulnerable to lead a dependent life behind silent walls of institution under close observations of the hospital staff. As a result, the patients adapt themselves in a way that they become accustomed to the hospital environment and their monotonous routines, rules and regulations. Moreover, in general, congenial, protective, and supportive environmental milieu of hospital influences such patients in a manner that any efforts related to discharge make them very anxious. These trends have contributed a lot to increase the quantity and overall magnitude of this problem.

Case Reports

Case 1

A 70-year-old Hindu married lady, known case of diabetes mellitus, diagnosed with Schizophrenia, was maintaining well on treatment. Patient had no active psychopathology. There were no ward management problems observed or reported during interaction with the patient. However, patient had been demonstrating self-absorbed behaviour and was rarely seen mixing with others in the ward. Backdating to the time of her admission, two addresses were provided by her guardians, which were apparently those of the patient's husband. When her symptoms remitted, several letters were sent to the available address without any response from the other side, because the addresses provided at the time of admission had been fabricated. There was little to do besides keeping the patient with an occupied bed for an indefinite period. For the last 34 years, this patient has been institutionalized. Surprisingly, patient herself exhibits no instigation or zeal to get discharged, and in fact requests to be allowed to continue residing in the hospital, as she says, "Where would I go? I have no home to stay in".

Case 2

An 80-year-old married Hindu lady, a known case of Schizophrenia was admitted 37 years ago by her husband with the complaint of being unmanageable at home. She showed good response to psychiatric treatment, after which her guardians were approached, for her to be discharged, they did not respond. Moreover, they refused to accept the patient when she was sent with escort party for discharge. Subsequent efforts to relocate her have also been in vain. Currently she is maintaining well on routine treatment. She has been engaged in activities requiring low-skill in the occupational therapy unit and works as instructed. In the ward, patient remained calm and never expressed her desire to get discharged from the hospital. At present, whenever she is asked about discharge, she becomes quiet. She assists the ward attendant in routine activities with her best possible abilities. So, with no option in hand, she has been institutionalized as she has no other means of reintegration into the society.

Case 3

This married Hindu lady of 60 years, has been hospitalised for the last 35 years. She is a case of epilepsy, who is currently maintaining well on treatment. She performs routine daily activities with minimal supervision. She has no active psychopathology. After appropriate treatment, when patient attained remission, the hospital authorities tried to communicate to the available addresses, but received no response in return. She was maintaining well on medication, but would mostly remain quiet and withdrawn to self. When asked about discharge she would express no concern and would even express irritation at times. In the ward, she is seen engaged in routine activities. She has been the same for many years now and requests to be allowed to remain in the hospital. She participates occasionally in activities of the Occupational therapy units where she performs activities requiring low skills.

Case 4

This 56-year-old male was diagnosed with Psychosis NOS. At the time of admission, patient was uncooperative. His presenting complaints were disturbed sleep, poor self-care, wandering tendency and hallucinatory behaviour. Patient showed satisfactory improvement on treatment within the first few months itself and patient expressed desire to get discharged. Upon being asked his residential address, patient was reluctant to reveal information. Upon repeated interrogation, he vaguely conveyed three different addresses. Letters were sent to these addresses, but there was a complete lack of response. No family member returned to take the patient back or ask for his well-being, despite multiple attempts on the part of the hospital authorities. Even now,

patient is not entirely certain of the exact address at which he may have a guardian. Moreover, he is not too keen on getting discharged and has adapted well to the ward settings, and routine activities at the hospital itself.

Case 5

This middle-aged male was brought for admission with a reception order about ten years in the mental hospital, as a diagnosed case of Paranoid Schizophrenia. After remission of his illness, many discharge letters were sent to the address which the patient conveyed as his place of residence, but there was no response at all. The patient eventually understood that his family members had rejected him, and he was extremely disappointed. After that, he conveyed no wish or enthusiasm to be discharged.

Case 6

Another reception order case was that of a 51-year-old male. No conclusive demographic details could be elicited from either the case record file or the patient, as he kept altering his statement. His symptoms were mainly characterised by wandering tendency, poor self-care and muttering to self. After settlement, many discharge letters were sent to his address but there was no response at all. The patient has now settled with the thought of spending a lifetime inside the institution, and whenever the talk of discharge comes up, he looks unsettled and uneasy.

Case 7

A 35-year-old male, who is a case of epilepsy with mental retardation, was admitted with a reception order ten years back. Patient had shown improvement in symptoms with treatment, after which letters were sent to his guardian concerning his discharge. Patient was very eager to get discharged initially and would keep requesting the hospital authorities to contact his family members. However, after repeated failed attempts, he also gave up and accepted his fate. He then adapted to the ward settings and gave up his pleas to be sent back home. He is currently allotted a bed at the institution, and is still admitted, despite no apparent need for the same.

Discussion

Many of the chronically institutionalized psychiatric patients report problems at time of discharge, and this is just the tip of the iceberg. The larger scenario also includes regression of faculties of intelligence, loss of years which could have spent of education, and disabilities in hearing, speech, locomotion and manual dexterity. It has also been observed that individuals with biological and social handicaps are more prone to institutionalisation [8]. In this case series all had visual and locomotor disabilities which supported the pioneering study. The 'sick role' also plays a part in such

cases as reported 'their persistent sick role attracts the attention of hospital staff and other patients also. Such patients try to find a parental figure in the hospital staff as an ego defence to compensate their parental loss or such a long detachment from their parents' [9]. In present study too, it was observed that patients were found to manifest sick-roles whenever the topic of discharge would emerge.

Chronic illness, less demanding congenial environment like hospital milieu, could be some of the possible favourable conditions that contribute a lot in maintaining the chronic institutionalization. Having been cut off for such long durations with close to no accessibility to the outer world for so many years, create an ambivalent condition and/or weaken their desires to get released from the institution. This might be reason why many chronic psychiatric patients show reluctance towards discharge. Moreover, the monotonous environment and pessimistic attitude secondary to chronic institutionalization, creates challenge for such patients to find independent identity for themselves outside institutions.

In addition, an apprehension of being rejected or labelled in the community might restrict them for independent living in the community. The institutionalized chronic mentally ill patients would exacerbate their symptoms at time of discharge to get relief from intense anxiety induced by instinctual urges to satisfy their ego mechanism. They adopt a sick role to gain sympathy and attention from others as secondary gain to remain in the hospital, instead of being discharged. This could be the possible explanation why in the present study, patients showed interest to remain anchored as institutionalized patients.

The chronic institutional syndrome creates resistance, fear, and a sense of insecurity to accept and prepare for new roles by patients in their respective environment after discharge. Thus, they expressed desire to remain in pleasant, soothing, safe & socially accepted hospital environment. The long periods of institutionalization in mental hospital also promote the process of depersonalization and gradually loss of one's individuality. Despite that, many patients develop attachments and a symbiotic relationship with hospital staffs and like to remain in their psychiatric wards even at the cost of losing self-identity [10].

Conclusion

Chronic Institutionalization in severe mental illnesses poses great challenge for our mental health professionals and mental health care delivery system at large in terms of wastage of professional work force and potential resources. Hence, it requires holistic, integrated and effective efforts at the end of mental health professionals and significant caregivers to nurture optimistic attitude among such patients and reintegrate them to their respective social system to obtain satisfying quality of life, which is ultimate aim of mental health.

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