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A Step to Far - The Cost of Societal Institutionalised Thinking?

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ABSTRACT

This article highlights how treatment ethos, aims and regimes can affect outcome. It views retrospectively how an institutionalization mentality can sabotage efforts to treat. Furthermore, it can potentially cause a conflict between patients and therapists.

Although the example is drawn from personal experiences as a therapist the institutionalization mentality appears to be permeating society in general, by making exceptions for everything, victimisation appears to be in vogue. This is potentially a serious situation leveling down is unhealthy and undermining in terms of a healthy society. A healthy society needs to have survival characteristics such as robustness and resilience allowing for progression and adaptation.

Keywords: Rehabilitation, Institutionalised thinking, Psychiatry, Adherence, Motivation, Resilience, Outcome

Newly appointed to working in a psychiatric hospital and coming from the sphere of general rehabilitation followed by neurological specialisation I was not part of a department with colleagues from whom I could take my cues. I was just a lone therapist feeling my way in the world of mental illness and its various diagnoses and treatments.

My initial training was along military lines: very regimental and prescribed. It was concerned with the physical and mental rehabilitation of patients following trauma from accidents or following a stroke etc. The aim of the medical team whatever the diagnosis was to get the patients back to work and leading a normal life as soon as possible. It involved the commitment of both staff and patients. It was a busy dedicated environment. With very clear aims which both staff and patients understood and appreciated [1].

At the medical rehabilitation centre where I was trained and then subsequently worked, each patient carried a card on which was printed their prescribed programme. The programme was meticulously put together involving the medical team: The centre manager, the surgeon, the general physician, occupational therapists, physiotherapist, remedial gymnasts, industrial therapists. The programme was progressive and updated regularly and a great deal of forethought and commitment was put into these individualised programmes by the treatment team.

If a non-committed patient was found being late or worse still avoiding a particular part of his/her programme their place would be in jeopardy; the regime was strict but fair. A reluctant patient would infect the other patients and the purpose and work of the centre would be undermined. The manager would hold a dance on Wednesday evenings for the enjoyment of the 80 residential patients. However, another element of the dance was to watch patients suddenly motivated to do without their crutches and support and dance a passable quickstep whisking their partners around the dance floor. If they were hanging onto their ailments in an attempt to avoid discharge; the manager; a former Royal Air Force man who understood man management would take notice. Unbeknown to the patients the dance was a valuable source of evaluation and tripped the switch for discharge on the following Friday on some occasions.

Moving to the psychiatric hospital I was ready to contribute to the same rehabilitation ethos where improvement via motivation resilience and discharge were the goals. However, I found adapting to the different aims in the psychiatric hospital confusing [1]. It did not have a focus; the aims were unclear. It seemed it was more about containment and stabilisation. I was confused by the diagnoses they seemed ambiguous. Whereas there was no confusion in general rehabilitation: a fracture is a fracture a

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stroke is a stroke. The role of the therapist is to understand the individuality of the patient and treat the diagnosis to a prescribed regime.

In the psychiatric hospital it was different most patients were receiving medication which meant that the formulation of and understanding the individuality of each patient was difficult, it took time. Furthermore, there was not the compulsion to discharge; the patients were there for as long as it took - perhaps forever. Indeed, some patients had been incarcerated for years. The motivation as a therapist which I had to bring to the treatment and the momentum was curtailed and deficient.

There were no set timescales which both the therapist and patient aimed for. I could never give the psychiatric patients feedback or use an agenda, such as; when you can walk without a stick you can go home. The patients in the psychiatric hospital had relapses, the effect of the medication was not always predictable they were perhaps excitable one day depressed the next.

The staffs too was different, they were not motivated by a proactive approach they were more relaxed, less busy and accepting of the behavior of their patients whatever it happened to be. The hospital was used to the abnormal whatever or however it was manifested however extreme [1].

While I was trying to navigate a role for myself, I noticed a young man who was obviously brain damaged with a right sided hemiplegia. Having specialised in the treatment for brain damage, I found out which ward he was on and asked if I could treat him. The charge nurse made the arrangements for the referral and I started treating him. He had severe deformities which should have been prevented but nevertheless I felt I could improve his physical condition. I suspected he should not have been incarcerated in the first place as a cerebral palsy patient. It appeared inappropriate that he should be in a psychiatric hospital. I hoped that my contribution could get him into a unit catering for cerebral palsy.

One day he came for treatment with a laceration on his arm "Have you been in the wars" I asked? Yes, he said I punched a window. Somewhat concerned I mentioned this to the charge nurse who accepted broken windows as a normal occurrence. Almost encouraging a broken window rather than an assault on another patient in the ward under his care.

On another occasion this patient turned up for treatment with another laceration this time on his nose. Again, I asked him what had happened "Jonny bite my nose" he explained. "How did that happen" I asked concerned." He wakes me up every morning by trying to bite my nose this time he succeeded. Once again, I was annoyed that this behavior was accepted as the norm even by my patient.

My hopes that the patient would eventually be rehabilitated and discharged were unrealistic, if every time when he and other patients felt frustrated, they broke windows. It was considered normal and acceptable behavior. This embedded reaction to frustration would be extremely difficult to extinguish and move him from the asylum and to concentrate on his future [1].

Another incident surprised me: I had instigated games as recreational therapy for the psychiatric patients: a very important ingredient in general rehabilitation; a means of exertion and fitness through enjoyment. At the asylum I also saw it as an alternative activity to deal with the frustrations of the patients. I introduced games such as volleyball, rounders and badminton. Some psychiatric nurses thought the formation of a badminton group would also be good for the staff. I agreed to help them and allowed them to use my equipment and to teach them the rules of the game. On the first night all was going well until a nurse disagreed with the scoring made by her partner. She swore, her language was unprecedented and she threw the racket on the flour breaking it. The next day I felt I needed to apologise for the outrageous behavior of another woman - a nurse, a professional. The nursing officer amazed me by explaining her behavior away excusing her because she was pregnant.

I did not appreciate that what I was witnessing was the effects of institutionalization "referred to as the process of embedding some conception (for example a belief, norm, social role, particular value or mode of behavior) within an organization, social system, or society as a whole. I had to be mindful that I too along with the staff and the patients did not fall fowl of the institutional mentality [1].

Sadly, mental illness isn't treated in a similar manner to physical illness.

In this day and age there appears to be a danger that our society is suffering the same institutional mentality. When all behavior is accepted as causal and excuses are made on the grounds that behavior is understandable. I question if this trend is helpful and sustainable for the general good. At what point should the line be drawn. While every endeavor should be made to maintain a level playing field and include everyone, isn't there an argument that in life the playing field is uneven and we need to navigate it ourselves not to rely on the generosity of others to even it out - because nearly everyone is a victim of something or another. Victimisation and its partner medicalization are bandwagons of increasing proportions which society endorses, even encourages in succinct ways.

This undermines the aim of the therapist. There are incentives to remaining patients. As therapists we need motivation, commitment and resilience, in our patients': characteristics which are crucial to successful rehabilitation and final discharge. But how are we to respond by; leveling down regressing to institutional norms denying our patients:

like the patient I describe normality. The consequences are costly and question the sustainability of such a situation. Or are we going to level up as the natural evolutionary process of progression.

My various published case studies have been intended to help those caring for patients experiencing psychic pain and the outcome if the patients don't get the support they need. There is no excuse: for years for example the suicide rate has increased [1]. An estimated 1 million people worldwide die by suicide every year. It is estimated that global annual suicide fatalities could rise to over 1.5 million by 2020. Globally, suicide ranks among the three leading causes of death among those aged 15-44 years. Attempted suicides are up to 20 times more frequent than completed ones. Theory and statistical trends are businesses in themselves but what is their value if nobody does anything to change - data is dead unless activated.

I am not following my colleagues who suggest more resources and money should be thrown at prevention and intervention by way of treatment [1]. The problems highlighted require a different more common sense and pragmatic way of seeing things. Seeing things in society which need remedying such as marrying for infatuation etc. and having children without the necessary commitment to their overall well - being. Failure to equip children with the foundation they need to thrive and to succeed. Schools educate children for a large part of their developmental lives; however, I can't help wondering if education isn't failing to teach about the core needs of every child - survival.

For those who do need treatment therapists need to understand psychopathology from the point of view of the patient. They need to use the suffering which can be tapped to harness their creativity. Making their experiences part of the journey turning them around. However bad a child's background if they have survived so far it speaks volumes about their self-belief, their resilience and that resilience can be a key factor in their future. It can become the fuel to drive them forward. They then can become good parents and good citizens rather than being a burden on society [1].

Professionals involved in treating and caring frequently come from very different back grounds so often far removed from their patients. The professionals are often privileged and have enjoyed feelings of love and security. They have no idea, despite their best endeavors, at empathising or comprehending what it is like to be a child whose parents feed them drugs to keep them quiet while they go out partying. Or of children forced to have sex because their parents are exploiting them. Such cases are often never disclosed, because the victims from experience know full well, they will never be understood, or believed. Extreme victims of incest or pedophilia for example are so abhorrent they can never be fully healed so compromises have to be made and understood [1].

The task is enormous: The point I am making is that these vulnerable patients are very wary. They test out where and to whom and if it is safe to disclose these past experiences. It was not unusual for me to see patients who had been receiving treatment all their lives but had never felt enough trust to divulge their experiences. Therapists often lack the same power generated by adversity, they need to taste pain and acknowledge what is missing from their tool kit.

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