12 - 7. The sociology of institutions

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© SPMM Course 7. The sociology of institutions Goffman described a ‘total institution’ as one ‘whose character is symbolized by the barrier to social intercourse with the outside’. Total institutions share the following characteristics:

1. All aspects of life are conducted in the same premises and under the same unitary authority.
2. Each member’s daily activities are carried on in the immediate proximity of a large batch of others, who are also required to do the same set of activities.
3. All parts of a single day’s activities are strictly scheduled with one leading into the next.
4. The different enforced activities are based on a single plan whose purpose is the fulfilment of the proposed official (or statutory) aims of the institution. Goffman also described the ‘moral career’ of a mentally ill patient i.e. the process whereby a person with social ties, friends, and family in the community is institutionalized and converted into an inmate whose world is limited to his immediate hospital ambience (Peele et al. 1977). See the figure below for more details.

© SPMM Course According to Goffman although the stripping process and privilege system are offered in the disguise of being in the patient’s best interests and on therapeutic grounds, the real purpose is to break his spirit and make him more manageable. The stripping process and privilege system introduce him to a therapeutic milieu and offer him a new identity – the patient identity. Batch-living: This refers to the pattern in which all inmates did ‘the same thing’ and led a very similar life inside institutions. Binary living: Lives of the staff are in stark contrast as they have power, connection with the outside world and could change their lives in the way they choose. A binary division exists between staff and inmates. Goffman considered ‘secondary adjustments’ as a direct result of institutionalization and as a hallmark of institutionalism. Secondary adjustments refer to the habitual arrangements used by patients who now act as if their major concern is to escape the pervasive control of the institution. These were usually unauthorized activities leading to obtaining of unauthorized ends. Step 1 Step 1 •BETRAYAL FUNNEL: People we trust most –

family and friends – conspire against us when we are unwell, reporting our actions to doctors and mental health professionals (called the ‘circuit of agents’) who run the decision-making process. Step 2 Step 2 •ROLE STRIPPING: The institutionalization process begins with a series of assaults on the recruit’s self. The process of stripping inmates of their identity involves such initiation rituals as trading personal clothes and belongings for hospital issue Step 3 Step 3 •MORTIFICATION: Mortification procedures that consist of a series of assaults on the inmate's self-image. At the end of mortification one becomes a ‘full member’ of the institution. Private, personal activities go on public display; he must request permission for even the most minor activities that were purely volitional on the “outside,” such as smoking, shaving, or going to the toilet. This is termed as civil death. Step 4 Step 4 •PREVILEGE SYSTEM: The patient is then inserted into the lowest rung of an allembracing privilege system. This system is based on the house rules. The privileges are usually reductions in the institution’s control over the patient’s life. Freedom is a token of reward.

© SPMM Course Russell Barton (1976) described 'institutional neurosis', characterized by apathy, lack of initiative, loss of interest and submissiveness. The proposed causes of institutional neurosis include loss of contact with the outside world, enforced idleness, brutality and authoritativeness of staff, loss of friends and personal possessions, poor ward atmosphere and loss of prospects outside the institution. Social reactivity and schizophrenia: Wing & Brown explored social etiology of negative symptoms of schizophrenia. They surveyed asylums (Mapperley Hospital at Nottingham, Netherne in south London and Severalls in Essex) that existed in the late fifties and concluded that social poverty and lack of stimulation were very much related to the severity of blunted affect, poverty of speech, and social withdrawal – these were termed as ‘clinical poverty’. But such relationship was found to be weak in a reappraisal in 1990. (Curson et al., 1992). It was also feared that too much stimulation could provoke positive symptoms in these patients. Thus, social reactivity is considered to be an important phenomenon in the phenomenology of schizophrenia. Morgan (1979) coined the term malignant alienation to describe a process characterised by a progressive deterioration in the relationship between carers (staff in a ward) and a patient, including loss of sympathy and support from members of staff, who tended to construe these patients' behaviour as provocative, unreasonable, or overdependent. In some instances, such alienation may precede suicide / attempted suicide of the patient

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