Institutions and institutionalisation:
They're part of everyday life

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This article is part of a longitudinal series on humanities.

Background
Institutions are established patterns of recurrent social relationships playing a fundamental part in all our lives. The family is the best-known institution, but other 'total' institutions serve as organisations directly affecting the lives of many individuals in the healthcare sector.

Objective
This paper examines the sociological theory of institutionalisation as applied to individuals admitted to aged-care facilities, where the complete life-rounds of inmates occur within clearly defined limits. The study provides a framework to enable general practitioners, nurses and healthcare professionals to better appreciate the processes involved as individuals adapt to their new environment.

Discussion
Sociology provides valuable insights for healthcare providers in understanding how individuals adapt to their loss of independent living and find themselves subjected to intimate regulation in the total institution. The biopsychosocial model of healthcare delivery is better understood when we as health professionals have greater insights to appreciate the competing processes at work.

INSTITUTIONS play a surprisingly large part in all our lives, starting from the day we are born. One of the most common social institutions is the family, and it is through this framework that we acquire the norms and values of the society into which we are born. This process is known as 'primary socialisation' and plays a major part in the acquisition of a 'self' – a process most often achieved through nurturing, support and interaction with parents, siblings, close relatives, the local community and friends. Any subsequent (secondary) socialisation is built on this initial 'self'.

Institutions can be defined as established patterns of recurrent social relationships because it is this unique feature that is common to all.[1] We are all familiar with the major social institutions that affect our lives – family, school/education, church/religion, government and the economy. They play a fundamental part in the functioning of society and have their origins in the daily interactions that occur between individuals in that society. The main feature of ordinary social institutions such as the family lies in the fact that that their existence is firmly established in society and recognised as such by its members. Their main purposes are to serve as organisations to promote some public object, meet the needs of people and persist over time. Further, they tend to be stable.

Another interesting, contrasting and challenging type of institution is the 'total' institution. As general practitioners (GPs), we are all very familiar with our role as family physicians providing continuity of care for patients across multiple generations. Most of us will at some stage also interact with inmates of 'total' institutions, and it is this area that I wish to explore further in this paper.

Institutionalisation

The process of 'institutionalisation' occurs when an individual is admitted and initiated into a total institution. Prisons, mental hospitals, concentration camps, boarding schools and army barracks are all examples of total institutions. Their key characteristic is that they provide for the complete life-rounds of their inmates within clearly defined limits. Goffman's classic work *Asylums: Essays on the social situation of mental patients and other inmates*[2] together with Berger and Luckmann's *The social construction of reality*[3] provide enlightened glimpses of how this process of 'secondary socialisation' occurs. It is in stark contrast to the more harmonious and welcoming process that usually occurs when a new child receives primary socialisation through their family.

Some of the best-known total institutions (prisons, mental hospitals and monasteries) have certain punitive or degrading features attached to them. Although prisons and monasteries differ significantly in their classification of the people they accommodate, the process of how individuals are assimilated into them follows very similar patterns. At their core are status degradation ceremonies that can differ significantly

depending on whether admission is voluntary (as in monasteries) or compulsory (as in prisons) – the latter facilitating the assumption of a deviant identity through the legal stigma applied via the court and its officers.[4]

My personal interest in the area is partly reflective of my earlier post-graduate sociology career that preceded my switch to medicine. During that time, I examined the sociological theory of institutionalisation and applied it to a geriatric home setting.[1] Goffman's work on asylums provided the basic theoretical framework that I adapted through both participant observation and analytical work to examine the process of institutionalisation among elderly patients. It was a different type of grounding in the bio-psychosocial model of care that has endured well with me over many decades. Some GPs and nurses might find the nursing home framework I have categorised below useful in their ongoing roles in the care of such patients.

Stripping process versus reorganisation of self

The process of institutionalisation can be systematically analysed based on two dynamic, interacting and evolving processes. These involve: (i) a 'stripping process', whereby the individual's former 'self' is broken down by the total institution – it reduces the effect of a person's past on their present; and (ii) a 'reorganisation of self', in which the individual is gradually built up again by the institution according to its own requirements.[1]

Stripping process

The stripping process involves key overlapping events and processes, including initiation rites, role dispossession, loss of self-determination and lack of privacy.

Initiation rites

Initiation rites are probably best summarised by Goffman as applied to a mental hospital setting:

> *... the recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. In the accurate language of some of our oldest total institutions, he begins a series of abasements, degradations, humiliations and profanations of self. His self is systematically, if often unintentionally, mortified. He begins some radical shifts in his moral career, a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others.*[2]

In Townsend's *The last refuge*,[5] the ritual bath upon admission for all patients was a defining moment. Patients' reactions tended to be similar and usually involved dissatisfaction. For the institution, it represented a test of strength. In Behan's *Borstal boy*,[6] the obedience test on admission to prison was the critical test. The denial of privacy, forced passivity, removal of clothes and horizontal pose represent major symbolic aspects of the process. For many, it represented a definite break with the past and signalled their impending helplessness and dependency on others.

Role dispossession

Role dispossession means that the individual is now a patient, and there is automatic separation from their normal roles in the outside world. Their world narrows once they are cut off from normal contacts. Although adoption of the sick role is offered, many elderly people feel unable to fill the role correctly. Over time, there is a lessening of the effect of role dispossession, which parallels the length of time spent in the institution – and a new and more stable definition of their situation emerges.[1]

Loss of self-determination

Loss of self-determination goes beyond role dispossession in that it replaces the patient's former role-playing in society by a whole series of roles, most of which are minutely regulated by the staff of the institution. This narrowing of role distance is especially felt by those with a history of buddy supports in former days. Some feel frustrated and displeased at their regimented and minutely organised existence. For staff, the smooth and efficient running of the home is paramount and demands rigorous scheduling of events throughout the day. Distance between staff and patients is enforced and maintained, ensuring there is no input into decision making – something that causes alienation among some.[1]

Lack of privacy

Lack of privacy in the total institution is in direct contrast with this outstanding feature of normal community living. For some, communal living arrangements in the nursing home mean no locks on toilet doors and bedside lockers, with organised bathing an essential component. Some patients resent being placed beside other 'undesirable' fellow patients, with some seeing it as a form of contamination from both patients and staff. The overall effect is further dislodgement of the patient from their former self.[1]

Reorganisation of self

The process of reorganisation of self includes the reaction to communal living, modes of adaption, internalisation of norms and values, the privilege system and the fraternalisation process.

Reaction to communal living

The reaction to communal living involves a coming to terms with patients' new environment. For some, this is especially difficult, as many had lived alone prior to entry and are dissatisfied with having to live in close proximity to others. Many discover a sense of insecurity as they struggle to make initial friendships and acutely dislike the absence of privacy. Others relish having a safe, secure place to live in the company of new friends and acquaintances.[1]

Modes of adaptation

Modes of adaptation include: (i) 'situational withdrawal', in which the patient 'withdraws apparent attention from everything except events immediately around his body and sees these in a perspective not employed by others present';[1] (ii) adoption of an 'intransigent line', in which a high morale patient intentionally challenges the institution by flagrantly refusing to cooperate with staff; (iii) 'colonisation', in which the sampling of the outside world provided by the institution is accepted by the patient, and a stable, contented existence is built up (in this mode of adaptation, life on the outside is unfavourable compared to what is being offered and experienced in the institution); and (iv) 'conversion', in which the patient takes on the official or staff view of themselves and tries to act out the role of the model patient. These different modes

of adaptation represent part of a continuum reflecting the degree of institutionalisation reached by the patients involved.

Internalisation of norms and values

Internalisation of norms and values involves a coming to terms with the patient's new environment as they familiarise themselves with the rules and regulations of the institution. This process reflects the ability of the institution to work on the dispossessed individual – a process that is transferred via staff and sometimes other patients. The position of matron or director of nursing can be paramount as the lowest echelon patient implicitly trusts the person at the very top. An initial 'trial and error' or 'wait and see' approach progresses to patients themselves acting as transmitting agents to help others settle in, reflecting the ongoing, dynamic nature of the institution.

The privilege system

The privilege system provides a framework for personal reorganisation, often seen as necessary to enable the patient to become assimilated to the institution. This in many ways is in direct contrast to the stripping process encountered upon admission, which effectively severs previous roles built up over a lifetime. All nursing home patients benefit from rewards and privileges for good behaviour and obedience to staff. This is an important factor in influencing future patient behaviours.[1]

Punishments and privileges are peculiar to many total institutions. Punishments for breaking the rules could mean a loss of privileges and, therefore, have a symbolic effect. In prison systems, loss of privileges could mean isolation and a need to serve a full sentence, while seamen could lose their grog rations! The privilege system strengthens the power of staff to exercise their control over patients. These modes of organisation contrast sharply with family situations in how sanctions and rewards are applied.[1]

Fraternalisation process

Finally, the fraternalisation process helps where socially distant fellow patients can find mutual friendship and support. This assists with the transference of norms and values between new and longer-term residents and helps stabilise their quality of life. In some total institutions, such as prisons and borstals,[6] buddy formation is frowned upon and regularly broken up by guards. Prisoners often develop their own underground lingo to help preserve individual morale. In the family setting, there is generally no need for such morale-boosting approaches.

Conclusion

Institutions – both social and total – play an intricate part in all our daily lives from birth to old age. Their features are remarkably similar across many domains. For some GPs, the ongoing care of residents in total institutions can represent a significant portion of their daily workload. Understanding some of the basic processes at work once patients have to adjust and assimilate to long-term residential care can help GPs improve their understanding of the people we care for.

This reflective analysis has avoided any value judgement on standards of care in individual homes, aiming instead to provide an objective framework to help our understanding of patient adjustment to institutional life. A better appreciation of some of the intricacies of the bio-psychosocial dynamics of families and total institutions can provide valuable insights for GPs, nurses and medical and nursing students involved in primary healthcare delivery.

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