

PATIENTS IN INDIAN HOSPITALS: ENVIRONMENTAL STRESSES AND AFFECTIVE REACTIONS

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Hospitals in India are characterised by urban bias, overcrowding, depersonalisation and routine treatment procedures. Lack of proper communication with medical staff further heightens patients' anxiety. Using an interview schedule, patients' affective reactions to the stressful hospital environment were studied. The six reaction categories taken in this study were: anger, anxiety, depression, helplessness, disengagement and rationalisation (in metaphysical terms). Data were collected on 122 hospitalised patients. It was found that the characteristic responses of both male and female patients were depression, rationalisation and sense of helplessness. Gender differences in affective reactions were observed. Male patients showed less anger and anxiety than females, but were higher on disengagement and rationalisation.

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People *are* generally admitted to a hospital when an illness, disrupting one's normal life activities, becomes acute, necessitating specialised treatment and close monitoring. Though a large proportion of patients get well as a result of hospitalisation, hospitals are associated with suffering, pain and death. Hospitalisation is in itself a major stressful event. The patients, trapped in an alien, impersonal environment, are overawed by rigid hospital schedules, rules and regulations. Hospitalisation uproots the patients from their familiar surrounding, strips them of their social roles and identity, and renders their usual style of functioning ineffective. Western studies show that only 40 per cent of the people who are ill, actually seek medical aid (Kosa and Robertson, 1975), and still fewer are hospitalised. In India, though there are no data, one can conjecture that the percentage of sick people getting hospitalised will be very low.

Hospitals in India have an urban bias. According to the Health Information of India (1987), out of the total number of 7765 hospitals, 6131 (nearly 79 per cent) are located in big towns. Almost all medical colleges are located in cities, where doctors and nurses are educated in the Western medicinal system. The lifestyle, language and urban culture of the medical staff does not instil confidence and assurance in the patients, who (at least in government hospitals) primarily come from the rural and lower socio-economic strata of the society (Dalai and Singh, in press; Siva, 1989). The cultural and status differential between the patients and doctors often results in patients meekly submitting to the authority of their doctors. The patients' hopes and despairs are contingent on the pleasures and displeasures of their attending doctor: their saviour. To a helpless patient, who is caught in the cobweb of complex hospital system, even the lower down paramedical staff appears too invincible to be disobeyed. In such an environment, the patients lose personal control over their lives — all major decisions about them being taken by those who are unfamiliar to them. The hospital ethos, thus, has no congruity with the patient's life in the outside world.

The free-for-service medical colleges have usually qualified and technically more competent doctors than the fee-for-service private and nursing home practitioners. The latter service system is flourishing and proliferating because it lends its services also towards satisfying the emotional needs of the patients (Freidson, 1961). Two-thirds of all medical complaints are usually psychological in nature (Taylor, 1986) which are less attended to by the free-for-service doctors of medical hospitals. They devote less time with patients and discourage patients from coming to them again unless very necessary.

On hospitalisation, the patient's discomfort is aggravated by the depersonalised treatment (s)he receives. In the hospital, a patient is just a number, or a case, or a body to be medicated or operated upon. Patients are expected to remain passive, cooperative and uninvolved in the treatment process. Such role expectations from the patients are universal, but more apt in the Indian setup, due to the illiteracy and rural background of a majority of patients and the heavy role demands on the medical staff. In the perennially overcrowded Indian hospitals, the doctors have to attend to a long array of in-door and out-door patients, besides fulfilling the role demands of a teacher, an administrator and a clinician. Any attempt by doctors to be personal in their approach makes the patients demand more of the doctors' time and energy, with the possibility of leaving many patients unattended.

Such depersonalisation emanates from the hospital bureaucracy and routinisation of treatment procedures in the allopathy system of medicine (Goffman, 1961). Besides, constantly changing duties of junior doctors and nursing staff and shifting of the patient from ward to ward does not allow any personal relationship to develop. The era of superspecialisation in the allopathy system is further enhancing the sense of depersonalisation. Depersonalisation of patients does not fit within the dominant Indian cultural ethos, where most of the social interactions are very personalised (Sinha, 1981). People tend to feel very anxious in an impersonal situation.

Another issue which merits careful consideration in the study of hospital environment is doctor-patient communication. An observation commonly shared by patients is that the doctors have neither time nor inclination to inform them about the diagnosis and treatment course. Doctors believe that the correct information may increase a patient's anxiety, particularly in case of a serious disease. Because of the status differential patients are generally afraid of asking their doctors questions and are thus ill-informed about their illness. Language, at times, becomes a barrier in doctor-patient communication when patients are illiterate. From the patient's point of view, the information provided is often vague and incomprehensible which further enhances his/her anxiety. In one study of surgical patients, Dalai and Singh (in press) found that 60 per cent of the patients in government hospitals did not have even the basic information about the kind of surgery they were undergoing. Doctors seem to underestimate patients' ability to comprehend information about their diagnosis and treatment.

Since the doctors are primarily educated to deal with the biological aspects of the disease, psycho-cultural aspects of the disease are either ignored, or very superficially dealt with. The doctors do not receive any formal training to deal with the anxieties, fears and emotional crises of patients. This further mars the doctor-patient

communication. Carstairs and Kapur (1976) observed that the Indian patients primarily look for symptom relief and alleviation of their anxieties. Since the doctors are unable to attend to patients' anxieties, most of the times patients are dissatisfied with their communication with the doctors.

Another barrier in the doctor-patient communication is divergent beliefs about the illness, its meaning, causes and recovery process. Patients frequently attribute their illness to metaphysical factors and resort to traditional health practices. While visiting a hospital, patients are usually not so much interested in the technical details of their disease. Their interest is in knowing about the correct diagnosis, seriousness of the disease, causes of the disease, side effects of medicines and the course of medicine. The information they receive from doctors is usually about the organic malfunctioning and the treatment regimen. Patients are very much inhibited to discuss their fears and anxieties with the doctor. Such faulty doctor-patient communication often results in imprecise diagnosis and low compliance.

Patient's Reactions

How do patients react to the stressful hospital environment? There could be large variations in the way patients affectively react to hospital stressors depending on their dominant behaviour pattern, socio-economic and educational background and the nature of disease. However, studies suggest that people show some consistency in responding to an unpleasant environment characterised by loss of control, depersonalisation and lack of proper communication.

In our recent study conducted on 122 patients; 88 males and 34 females, from one of the government hospitals located at Allahabad, the patients' affective reactions to the stressful hospital environment were investigated. These patients were admitted either for orthopaedic, respiratory or stomach problems. The average educational level of the patients was below primary level. Their age ranged between 25-55 years, the average age being 38 years. The reactions of the patients were classified into six categories: Anxiety, anger, depression, helplessness, disengagement and rationalisation (in the metaphysical sense). Among these, disengagement refers to withdrawing one's attention from the immediate surrounding and engaging in some other activities like music, day dreaming and so on. Rationalisation, on the other hand, refers to interpreting the crisis within a larger cosmic perspective, e.g., 'happiness and sadness are part of life'; 'there is someone bigger than mankind', 'it is a result of my own *karma*' (see Appendix). Table 1 given below displays means and standard deviations along these six categories (on 4-point scale), both for male and female patients and the results of t-test.

Table 1 shows that the most characteristic affective reactions to hospital environment in case of both males and females were rationalisation, helplessness and depression. On the contrary, the mean rating on anger was the lowest in both the groups, implying that anger is the least probable response among Indian hospitalised patients. Many studies (Taylor, 1983, Thompson, 1981) have shown that helplessness and depression are the expected reactions to loss of personal control in a crisis situation. Similarly patients' lowest response on anger is not surprising in view that the most urgent need of a hospitalised patients is to make himself

acceptable in the surrounding so that needed services are not withheld. Their major task is to please the physicians and the nursing staff. Even in Western hospitals, which have supposedly much more efficient patient services, and a culture in which a patient can sue the doctor for being negligent, similar patterns of reactions have been observed (Tagliacozzo and Mauksch, 1972). According to Lorber (1975) about 75 per cent of all patients are cooperative, compliant, and they passively participate in the treatment process. In an ongoing project by the authors the percentage of such patients was found to be about 98 per cent. However, interviews of some patients and their relatives revealed that they often suppressed their anger for the fear of it affecting their treatment and care by hospital staff.

Table 1
Affective Reactions of Hospitalised Male and Female Patients

Reaction Categories	Males (n = 88)		Females (n = 234)		t
	Mean	SD	Mean	SD	
Anger	1.56	.60	1.87	.60	2.58**
Anxiety	1.75	.68	2.17	.71	3.04**
Depression	2.44	.93	2.66	.90	1.20
Helplessness	2.58	.57	2.72	.55	1.25
Disengagement	2.30	.49	1.95	.54	3.19**
Rationalisation	2.83	.50	2.56	.47	2.78**

** P < .01

Low anger and high rationalisation can be explained in terms of patients' efforts to adapt to the environmental stress by bringing changes in one's affective reactions and cognitions instead of changing the situation which they perceive as beyond control. Explaining the crisis as part of life, God's desire or result of one's own *karma* facilitates in the process of adjustment to the disease (Agrawal and Dalai, in press). The indigenous theory of *karma* helps in explaining a host of undesirable experiences without arousing a feeling of anger or guilt (Paranjpe, 1984).

Although the dominant reaction categories were found to be the same in males and females, yet males and females differed significantly on magnitude of reaction to four of the six reaction categories. Whereas female patients were higher on anger and anxiety, male patients were higher on disengagement and rationalisation. It appears that females are less inhibited in expressing their affective reactions whereas male patients tend to control their affective reactions by disengaging attention from the crisis and philosophising about it.

This is a preliminary report of empirical findings of reactions to hospital environment, needing further support in subsequent work. Study of reactions is important because they have significant consequences in recovery from the disease (Kamen, Rodin and Seligman, 1987).

A preference for the psychomedical approach to the treatment was advocated in a seminar on Psychology as a Policy Science for Eighth Five Year Plan (Dalai, 1989). It was argued that patient's recovery is much faster if his/her psycho-social needs

are also taken care of in the treatment process. It was suggested that social scientists may play an important role in alleviating patients' suffering by generating a positive mental state which not only buffers the deleterious impact of environmental stresses but also facilitates recovery and rehabilitation (Agrawal and Dalai, 1992).

Appendix

During hospitalisation one undergoes a number of thoughts and experiences. Below are listed some of experiences and thoughts which often occur to patients. Kindly think and reply how many times each happens with you these days.

	Always	Often	Some-times	Never
1. Being short tempered	1	2	3	4
2. Anxiety over aggravation of disease	1	2	3	4
3. Have frightening dreams	1	2	3	4
4. Feel helpless	1	2	3	4
5. Get irritated at minor issues	1	2	3	4
6. Think of changing the medicine	1	2	3	4
7. The thought of the pains of other patients	1	2	3	4
8. It seems that nothing can be done by me	1	2	3	4
9. The thought that life is perishable	1	2	3	4
10. To leave everything to fate	1	2	3	4
11. The thought of consulting another doctor	2	3	4	
12. The thought that whatever is bound to happen will happen	1	2	3	4
13. Feeling of despair prevails	1	2	3	4
14. Do not feel like doing anything	1	2	3	4
15. Concentrate in God	1	2	3	4
16. Think of the past good days	1	2	3	4
17. The thought of having the right treatment	1	2	3	4
18. Spend time in religious discourse	1	2	3	4
19. Fear of indulging in fight with someone	1	2	3	4
20. Having pain in every part of the body	1	2	3	4
21. Anxious to know how much the improvement is	1	2	3	4
22. Feeling of helplessness prevails	1	2	3	4
23. Feel disgusted by other's sympathy	1	2	3	4
24. It seems that the pain will be unbearable	1	2	3	4
25. It appears that the world is a delusion	1	2	3	4
26. Desire to talk about my disease	1	2	3	4
27. Think of what all I will do after getting well	1	2	3	4
28. Try to forget that I am sick	1	2	3	4
29. Think that joys and sorrows are part of life	1	2	3	4
30. Engross myself in music	1	2	3	4
31. Dream that I am absolutely well	1	2	3	4
32. Think what else should be done to get well	1	2	3	4
33. Keep thinking why should I be the one to be diseased	1	2	3	4
34. Try to get more information to gain health	1	2	3	4
35. The thought comes that there is also a power bigger than man	1	2	3	4
36. Sadness prevails	1	2	3	4

REFERENCES

- Agrawal, M. and Dalai, A.K. 1992 *Positive Life Orientation and Recovery from Myocardial Infarction* (Unpublished manuscript). M.L.N. Medical College, Allahabad.
- Agrawal, M. and Dalai, A.K. "Beliefs about the 'World' and Recovery from Myocardial Infarction", *Journal of Social Psychology*. In Press.
- Carstairs G.M. and Kapur, R.L. 1976 *The Great Universe of Kota: Stress, change and mental disorder in an Indian Village*. London: Hogarth Press.
- Dalai, A.K. 1989 "Psychomedical Model of Patients Care: Empirical evidence and applications". Paper presented at the conference on *Psychology as a Policy Science*, held in the Department of Psychology, Allahabad University, Allahabad.
- Dalai, A.K. and Singh, A.K. "Role of Casual and Recovery Beliefs in the Psychological Adjustment to a Chronic Disease", *Health and Psychology: An International Journal*. In Press.
- Freidson, E. 1961 *Patients' Views of Medical Practice*, New York: Russell Sage Foundation.
- Goffman, E. 1961 *Asylums*, New York: Garden City, Doubleday.
- Government of India 1987 *Health Information of India*, Ministry of Health, Government of India Publications, India.
- Kamen, L.P., Rodin, J. and Seligman, M.E.P. 1987 *Explanatory Style and Immune Functioning*. (Unpublished Manuscript), University of Pennsylvania, Philadelphia.
- Kosa, J. and Robertson, L. 1975 "The Social Aspects of Health and Illness". In J. Kosa and I. Zola (eds.), *Poverty and Health: A Sociological Analysis*, Cambridge, Mass: Harvard University Press.
- Lorber, J. 1975 "Good Patients and Problem Patients: Conformity and Deviance in a General Hospital", *Journal of Health and Social Behaviour*, 16,213-225.
- Paranjpe, A.C. 1984 *Theoretical Psychology: The Meeting of East and West*, New York: Plenum Press.
- Sinha, D. 1981 "Human Assessment in the Indian Context", *Human Assessment and Cultural Factors*, Queens University, Kingston, Canada.
- Siva, M. 1989 "We have Failed Them All", *The Sunday Observer*, September 17, p. 21.
- Tagliacozzo, D.L. and Mauksch, H.O. 1972 "The Patient's View of the Patient's Role", In E.G. Jaco (ed.), *Patients, Physicians and Illness* (2nd ed.), New York: Free Press.
- Taylor, S.E. 1983 "Adjustment to Threatening Events: A Theory of Cognitive Adaptation", *American Psychologist*, 38,1161-1173.
- 1986 *Health Psychology*, New York: Random House.
- Thompson S.C. 1981 "Will it Hurt Less if I Can Control It? A complex answer to a simple question", *Psychological Bulletin*, (90), 89-101.