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Staff attitudes towards care, treatment and prognosis of a group of aged patients in a private psychiatric hospital

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STAFF ATTITUDES TOWARDS CARE, TREATMENT AND PROGNOSIS OF A GROUP OF AGED PATIENTS IN A PRIVATE PSYCHIATRIC HOSPITAL

A Thesis

Submitted by

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CHAPTER I

INTRODUCTION

Background of the Research Problem

This study was conceived as a preliminary step in exploring the socialization process and potential of a small group of aged, chronic, long-term, male psychotics at McLean Hospital, a private psychiatric hospital. It was throught that the staff attitudes towards this group of patients might be an important factor in the patients' socialization capacity. Twenty-four employees who either worked or had worked with these patients or who made policies affecting these patients were each interviewed. The group, which included administrators, professional staff and nursing personnel, were asked to express their ideas in five specific areas.

1. What they thought these patients were like.
2. What type of hospital service they had received.
3. What other services they might have received.
4. What were their chances for returning to the community.
5. What were the staff's feelings about working with these patients.

These questions were a result of first hand experience. As a social group worker on a ward which was predominantly populated by the above type of patient, the writer questioned their lack of socialization. Why didn't they relate better to the staff and to each other? An added concern of the writer's was the re-socialization of these old men in order that they might be better adjusted to their environment or that they might eventually return to the community.

From conversations with various professional people, both within and outside of the hospital, he found reflections of society's general attitudes towards old people and mental patients, such as: "They are cranky, troublesome and can't change," or "Crazy people are dangerous." Experiments in foster home care for aged state hospital patients in several states[1] have disproved these generalizations.

Staff attitudes play an important role in the rehabilitation of these old patients. Carstairs and Heron state:

> It is now generally accepted that the course of mental illness can be significantly influenced either favorably or unfavorably by the attitudes of those with whom the patient comes in contact in his daily life.[2]

Although most of the ward staff seemed genuinely interested in the welfare of these patients, the rest of the hospital personnel appeared unconcerned about them. In this the personnel also reflected societal attitudes towards aging and the older person which have been well substantiated in the literature. Social workers are part of that society. In her paper given at a recent Boston conference, Jean Maxwell quoted several social workers on the subject of the aged. A few examples were:

> How can you bear to work with older people? It must be depressing. ... There's no challenge in work with the aging -- you can't do anything

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[1] Rupert A. Chittick, et al., The Vermont Story: Rehabilitation of Chronic Schizophrenic Patients; Curtis M. Lyle and Olga Trail, "A Study of Psychiatric Patients in Foster Homes," Social Work, Vol. 6, No. 1 (January 1961), p. 82

[2] G. M. Carstairs and Alastair Heron, "The Social Environment of Mental Hospital Patients: A Measure of Staff Attitudes," in The Patient and the Mental Hospital, p. 218.

> with them. ... I want to put my professional efforts into something that counts.[3]

One could multiply these statements by several thousand. They are a result of a new social phenomenon. Man has sought longevity for centuries; now that it is upon him, it has contributed to a major social problem.

The Problem of the Aged

Geriatrics is, "That department of medicine which treats all problems peculiar to old age and the aging, including the clinical problems of senescence and senility."[4] Gerontology is, "The scientific study of the problems of aging in all their aspects - clinical, biological, historical and sociological"[5] or "... that branch of knowledge which is concerned with situations and changes inherent in increments of time, with particular reference to post maturational stages."[6] The writer's interest in the aged is not new, and stems mainly from his mental hospital work experiences; however, it has only been in the past two years that he has become vividly aware of the so-called problem of the aged.

What is meant by aged? How is it defined?

> The term aged is chronoligically defined -- generally speaking, it refers to people 65 years of age or over. This cutoff point

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[3] Jean M. Maxwell, "Improving Social Work Services to Older People through Education" p.1.

[4] Leslie B. Arey, et al., editors, Dorland's Illustrated Medical Dictionary, p.554.

[5] Ibid., p.555.

[6] Albert I.Lansing, "General Biology of Senescence," in Handbook of Aging and the Individual, p.119.

> has, apparently, been set by socio-economic factors and is in current use for statistical purposes.[7]

This age limit, however, is flexible. Some use sixty; social security has lowered its limit to sixty-two, and fifty-five is used in this study because of the type of group it deals with.

> The aged are still in the process of aging.
>
> Aging is the deterioration of a mature organism, resulting from time dependent essentially irreversible changes intrinsic in all members of a species such that with the passage of time, they become increasingly unable to cope with the stresses of the environment, thereby increasing the probability of death.[8]

Thus, man has been able to influence the aging process which in turn has increased our aged population. An articulate woman of eighty years once wrote, "We old people have been given a present; it comes wrapped in a rather wrinkled cover. Quite a heavy package it is and not too easy to carry."[9] She, of course, was talking about the mixed blessing of longevity. Man's life span has slowly but gradually increased over the past two thousand years.

> At the time when Cicero wrote his De Senectute the average life expectancy at birth for a Roman was but 23 years. According to the information available, the average life expectancy increased very slowly during the next nineteen hundred years. By 1850 it

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[7] Ewald Busse, Psychological and Physical Factors Affecting Social Functioning of Older People, p.3.

[8] F.Marott Sinex, "The Biochemical Aspects of Aging," (lecture).

[9] George Lawton, New Goals for Old Age, p.180.

> was about 40 years to 48 years for the United States. Owing to advances in medical and other sciences, the rise in life expectancy at birth has been rapid and today exceeds 63 years. It is estimated that there are in the region of 9,000,000 persons of 65 years or over ... at the present day.[10]

The above was written in 1945 and fifteen years later, the population sixty-five years and over had increased to more than fifteen million.[11] "By 1970, those sixty-five and over are expected to swell to about twenty-one million or sixty per cent more than 1950."[12] Already born are the twenty-six million persons over sixty-five anticipated for the year 2000.[13] An increased number of elderly persons due to longevity is only one of the many factors in the problem of the aged. Other factors are: the biological decline of this group, the rising cost of living, income maintenance, retirement, widowhood and health factors including chronic illness. It is true that not all of these are unique to this age group; however, when all are found in one segment of the population, they create a social problem.

The Chronically Mentally Ill

Another social problem is chronic mental illness.

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[10] Nolan D.C.Lewis, "Mental Hygiene in Later Maturity," in Mental Disorders in Later Life, p.397.

[11] Eileen M.Lavine, Learning to Work with the Aged, p.1.

[12] Milton L.Barron, The Aging American, p.32.

[13] Leo W.Simmons, "Aging in Pre Industrial Societies," in Handbook of Social Gerontology, p.88.

> There is a hard core of patients in mental hospitals who have resided there for years, some as long as forty years, some even longer. These patients by and large are into old age; the normal problems of aging (are) complicated by the long history of mental disturbance and the effects of continuous hospital existence.[14]

The writer's clients fitted this description; this fact and his previous experience made him raise additional questions. Why can't they socialize more? Why can't they conduct their own activities? Why haven't these patients moved out of the hospital? These seemed to be important questions, especially the last one. There is an obvious possible reason; they are too sick. This might be the case, but many patients are discharged who appear to be just as sick. Possibly, it is cheaper to maintain them in the hospital. When one figures the cost of hospitalization, a person could live just as well outside of the hospital environment. Maybe their relatives don't want them for fear of being embarrassed by them or they haven't any relatives; therefore, they have no place to go. Finally, it may be lack of motivation on the part of the patient, and the patient's motivation may be affected by staff attitudes. "Old Joe never bothers anybody, so we just leave him alone." It is a known fact that many disturbed children in our public schools lack proper attention because they behave and never "bother" their teachers. A similar process may be occurring with aged patients. The staff may not have time and energy for these patients because of their concentrated efforts to help patients in the acute phases of their illnesses.

There is also another factor to consider which von

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[14] Otto von Mering and Stanley H. King, Remotivating the Mental Patient, p.96.

Mering and King call the "Legend of Chronicity."[15] Once a patient is labeled a chronic, all hope is abandoned for his recovery. With a young chronic patient, some of the ward staff continue to hope for a remission. But when an old person is labeled chronic, all hope is truly abandoned. Between priority of staff efforts and the idea that chronicity equals hopelessness, it appears that many chronic patients are relegated to the "back wards."

Prior to World War II, mental patients of increasing age and chronicity were written off as, "essentially untreatable since their illness was thought irreversible."[16] This defeatist attitude was widespread, and it was said that custodial care in institutions was "the answer to chronic illness, invalidity, and the mental disturbances common in old age."[17] Today, staff attitudes toward patients have been given much attention. One author states, "The main point is that mental hospitals need no longer be places of custodial care."[18] Another emphasizes the importance of the hospital community:

> In recent years there has been increasing concern with the idea that recovery of the mental hospital patient depends not merely on specific treatment procedures (psychotherapy, E.S.T., occupational therapy, etc.) but, perhaps even more on the hospital community.[19]

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[15] Ibid.

[16] Milton Greenblatt, et al. From Custodial to Therapeutic Care in Mental Hospitals, p.250.

[17] Ernest W. Burgess, "Aging in Western Culture," in Aging in Western Societies, p.20.

[18] Ibid., p.25.

[19] Morton Kramer, "Problems of Research on the Population Dynamics and Therapeutic Effectiveness of Mental Hospitals," in The Patient and the Mental Hospital, p.145.

Although most of the studies have been done in V.A. and state hospitals, their findings are applicable in any mental hospital setting. Here is what a supervisory nurse and a physical on the chronic service in a V.A. hospital had to say on the subject:

> We forget the patients on the "back wards." I feel this is the greatest challenge -- to determine what can be done for these chronic patients. How do we keep them from being forgotten? ... The most important problem we encounter is the sense of discouragement. Hospital personnel feel nothing can be done for these patients.[20]

This illustrates the concern, tinged with hopelessness, which is felt for the long-term, chronic psychotic who has grown old in the hospital. The problem is that there appears to be a backlog of this type of patient in almost every mental hospital. This is borne out by a study of schizophrenics and senium psychotics in a state hospital.

> The schizophrenics constitute a high proportion of resident patients in all age groups, whereas patients with mental diseases of the senium become a major problem only in the age group 65 and over. Although admissions of senile cases have increased greatly in the last decade, the resident population consists largely of a slowly accumulated core of schizophrenic patients, who are admitted during youth or early maturity and stay, in many cases, for the rest of their lives.[21]

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[21] Kramer, op.cit.p.155.

[20] Greenblatt,et al.,op.cit.,p.325.

The Study Setting

McLean Hospital, where this study was made, is a voluntary, non-profit, 235 bed, psychiatric, Harvard teaching hospital, devoted to the care and treatment of patients with all types of psychiatric illnesses. Founded in 1811 on a 380 acre tract ten miles from Boston, it is the private psychiatric division of the Massachusetts General Hospital. It operates its own accredited school of nursing and has one of the largest psychiatric resident programs in the country. Also, it is engaged in basic psychiatric research. The physical plant is composed of about forty buildings; this includes fifteen resident halls, which house from nine to twenty-one patients. There are 600 hospital employees, of whom about 440 are directly involved in the care and treatment of patients. Since the hospital is almost entirely dependent upon the income from the patients and the care is highly individualized, the fees are high. The population is, therefore, composed of upper-middle and upper class patients.

CHAPTER II

THE PATIENTS, THE STAFF AND THE STUDY

The Patients

In formulating this study, the writer selected eleven of fifteen patients who had resided on the same hall for at least one year. Of the eleven, one was dropped because he had not been hospitalized long enough and one died during the course of the study. The other four patients on the hall were young men. The patients were selected according to their age, diagnosis and length of hospitalization. The group, therefore, were all over fifty-five years of age, diagnosed psychotic and had been hospitalized for a minimum of ten years. Although a person fifty-five is usually not considered "aged," the one patient who was in his fifties was included because he was considered old by the staff, his peers and himself. This was primarily due to his long hospitalization. Simmons states: "As to when old age begins, the simplest and safest rule is to consider a person 'old' whenever he becomes so regarded and treated by his contemporaries."[1]

Thus, the ten patients used in the study ranged in age from fifty-five to seventy-two; their mean age was sixty-three and one half years. They had been in a mental institution on an average of thirty-one years; the minimum was thirteen years and the maximum was forty-six years. All but one had been diagnosed as schizophrenics and that one, although having many schizophrenic characteristics, was diagnosed as manic depressive. The ten patients were considered part of the geriatric service.

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[1] Simmons, op.cit., p.67.

In order to be clear about the type of patient considered in this study, the writer feels that it is necessary to distinguish between the geriatric patient and the aged, long-term, chronic psychotic patient. In most mental hospitals, including the setting where this study was done, all patients in their fifties and sixties and upward are considered part of the geriatric service. The "true" geriatric patient, as the writer sees it, is the one who is admitted to a mental hospital for the first time late in life with some organically based syndrome of the brain or psychosis of the senium. On the other hand, the group of patients considered in this study are:

> ... those who have grown old in psychiatric institutions -- the institution which was probably called the "insane asylum" when they were admitted. ... They have never experienced the same measure of success and achievement or the same feelings of self-esteem which patients in the ...(geriatric) ...group had found. ...Their world is the institution.[2]

These are two distinct groups which can be found in most hospitals. It is true that some clinical evidence of senescence and senility may be found among the latter group but for the most part it is delayed by their life long psychosis.

The Staff

The professional staff assigned to the ward consisted of a hall administrator who was a staff psychiatrist and a resident in psychiatry who had other responsibilities and who changed every three months. Prior to the writer's arrival, there had been no social worker assigned to this ward. The ward was run by nursing personnel who were assigned to three

[2]Minnie Harlow, "Program Content or Group Experience in a Psychiatric Hospital," pp.2-3.

eight hour shifts. The day shift was composed of a "head" registered nurse, a staff nurse and a part-time registered nurse who sometimes worked the evening shift. Beside the nurses, there were three psychiatric aides assigned to the day shift. The evening shift was made up of one registered nurse and two psychiatric aides. One registered nurse and one psychiatric aide were assigned to the night shift. A nursing service supervisor usually made one trip a day on each shift.

Selection of Respondents

The criteria for selecting the hospital personnel to participate in the study were that every interviewee should work, have worked or been administratively responsible for the selected patients. Of the twenty-eight employees considered, four were dropped from the study. One, the night nursing supervisor, was not reached, and one social worker did not meet the criteria. She had a patient on this hall but did not know the other patients. The other two who were dropped were nurses who resigned their positions.

The remaining twenty-four staff members were divided into three groups. Group A was composed of five administrators; this included the psychiatrist in chief, the associate psychiatrist in chief, the director of the hospital, the director of the social work department and the director of the school of nursing and nursing service. The six in group B were all doctors who previously or currently had responsibility for the ward; there were three staff psychiatrists and three residents in psychiatry. One of the staff psychiatrists had worked with the patients as a resident in psychiatry. The largest group was C which had thirteen members. It consisted of two nursing service supervisors, five staff nurses and six psychiatric aides.

Age

The age range of the selected staff was from eighteen to sixty four years and its distribution among the three groups can be seen in Table 1. There was one staff member each in the teen and sixties age brackets and both of them were aides. Seven were approaching the age grouping of the patients.

TABLE 1

THE AGE RANGE OF STAFF MEMBERS INTERVIEWED

Age Group	Staff Groups			
	A	B	C	Total
Teens and twenties		1	6	7
Thirties and forties	2	5	3	10
Fifties and sixties	3	-	4	7
Total	5	6	13	24

Position

Title and position of the staff members were indicative of the amount of training they had had in their respective fields. Groups A and B represented two to ten years of professional training beyond college. The seven nurses in group C all had specialized training and one aide had graduated from college.

Proximity to Patients

The thirteen in group C worked directly with the patients and had the closest contact. Those in group B saw the patients at least once or twice a week. Some spoke of not having worked with these patients for "six years" or "a long time."

All but three had had recent contact with the patients. All of the doctors in this group had had other hospital responsibilities while they worked with this patient group. The five in group A were remote from these patients. When the patient group was identified to them, they responded with such statements as, "I only know a few of these patients," or "I only know these patients from what I hear of them in morning report," or "I am not acquainted with these patients' charts."

Length of Service in Mental Hospitals

The staff members' amount of experience in mental hospitals was thought to be significant to the study. In Table 2 this information is presented.

TABLE 2

THE MEAN YEARS OF EXPERIENCE OF STAFF MEMBERS

Experience	Staff Groups			
	A	B	C	Total
Mean number of years in this hospital	17[a]	3.5	6.4	7.9
Mean number of years in mental hospital work	21.5	5.3	7.3	9.7

[a]These figures are rounded off to the nesrest decimal.

As might be expected, the person with the most experience (34 years) was in group A and the person with the least experience (3 months) was in group C. The least experience in Group A was eleven years. In group B the span of experience ran from

ten and one half years to seven months. The most experience in group C was twenty-two years. Four of the thirteen in group C had less than six months service at the hospital.

Previous Work with Aged Patients

Out of the twenty-four people interviewed, seventeen had never worked with aged patients before except for a few who had done so on a limited basis in student training.

The members of group A had had no concentrated work with aged patients in a psychiatric setting, although the social worker had handled a few "geriatric" cases. In group B, one member worked with aged patients in general practice for seven years but did not specialize with this type of patient. Another had worked two years in a chronic disease hospital and one other had worked with aged patients on another hall in this hospital. Two nurses from group C had worked on other halls, also, with older patients, one year and six months respectively. Another nurse had taken care of aged patients for four years prior to coming to this hospital. Finally, an aide had worked in his mother's nursing home for seven years.

The Study

As was stated in Chapter I, the writer was concerned with the lack of socialization on the part of a group of psychotic patients in the hospital. The patients' motivation in the area of socialization might be affected by staff attitudes toward them. On the other hand, the patients might lack potential in this area. An investigation of staff attitudes might shed some light on the subject. Thus, this study addressed itself to that problem, staff attitudes toward aged patients.

It further considered the specific attitudes of the staff toward care, treatment and prognosis of these patients.

The writer held focused interviews with the selected staff. Generally, they began with his telling the interviewee who he was, what he was doing, why he was doing it, why they were selected and then inquired into the staff member's background. After this, the writer would name the patient group he was interested in, cite the five areas of interest[3] and then proceed at the interviewee's rate or where they wanted to start. Most started on the first area but would give answers related to other areas or even drift to subjects outside the scope of this study. The writer would occasionally comment or question in order to focus the talk on things pertinent to the study. All of the interviewees were cooperative and gave freely of their time to answer questions for the twenty minutes or more of the interview.

[3]See Appendix A for schedule.

CHAPTER III

THE ATTITUDES OF STAFF MEMBERS

The Patients as Seen By Staff

The first major question the personnel were asked to respond to was, "What are these patients like?" Under this heading the investigator attempted to have the respondents cover these more specific questions:

"To what degree are they able to socialize?"

"To what degree are they able to be responsible for themselves?"

"To what degree do they have to be restrained or controlled?"

"What psychiatric classification do they come under?"

"What are the unique characteristics which separate these patients from the rest of the hospital population?"

General Characteristics of the Patients

Over half of the respondents mentioned some sort of chronicity. Exactly half called them chronic schizophrenics. Table 3 shows all of the classifications used by the staff. As would be expected, a large number in group C did not give a psychiatric classification.

The variety of answers under "other" are interesting to note. The member of group B called the patients, "Old men with a variety of thought disorders." The three in group C responded: "Retarded persons rather than mental disorders,"

TABLE 3

STAFF'S PSYCHIATRIC CLASSIFICATION OF THE PATIENT GROUP

Classification	Staff Groups			
	A	B	C	Total
Chronic schizophrenics	4	3	5	12
Chronic psychoneurotics	-	1		1
Chronic psychotics	-	-	1	1
Chronic hospitalized patients	-	1		1
Elderly schizophrenics	-	-	2	2
Geriatric patients with mental illness	1	-	1	2
Old mentally ill patients			1	1
Other	-	1	3	4
Total	5	6	13	24

"Sick old men," and "Men on the verge of senility." Nearly two-thirds of the respondents (15) emphasized the chronicity of the illness. Although only eight emphasized the patients' age group, as shown in Table 1, fifteen of the respondents did mention some specific term (old, elderly, geriatric, senile, etc.) which referred to the age of the men. This was true whether they had used another descriptive term or not.

Table 4 shows how the staff groups responded regarding the patients' age status. Groups A and B tended to speak of psychiatric characteristics rather than of age.

Other factors mentioned were the duration of hospitalization and the "institutionalization" of these patients.

TABLE 4

REFERENCE TO AGE OF THE PATIENTS

Response	Staff Groups			
	A	B	C	Total
Referred to age	2	2	11	15
Did not refer to age	3	4	2	9
Total	5	6	13	24

Duration of hospitalization denotes time where institutionalization implies something about the patient's state of mind. Half of those interviewed mentioned or implied that these patients were "institutionalized"; fifteen of the twenty-four commented on their long hospitalization. Table 5 shows the distribution of these responses

A majority of group A mentioned these factors. Groups B and C were more evenly divided on these factors. It might be postulated that such obvious factors were not mentioned by some of the respondents because they were too close to the situation.

In regard to the isolation of these patients from the rest of the hospital, nineteen of the twenty-four made no mention of it whatsoever. Of the five who did, three were in group A and two were in group C. It may also have been too

TABLE 5

REFERENCE TO LENGTH OF HOSPITALIZATION AND "INSTITUTIONALIZATION"

Response	Staff Groups			
	A	B	C	Total
Mentioned or implied "institutionalization"	4	3	5	12
Did not mention	1	3	8	12
Mentioned long-term hospitalization	4	4	7	15
Did not mention	1	2	6	9

obvious a fact to mention.

Generally speaking, the respondents thought of these patients as old, chronic, long-term psychotics but ignored the fact of their isolation from the rest of the hospital community.

Degree and Description of Socialization

The interviewees, in talking about the degree of socialization, were generally in agreement that the men could all socialize to a certain extent. As is noted in

Table 6, three-fourths of the twenty-four said that the patients could socialize to a limited extent. Only four of the twenty-four felt that they lacked the ability.

TABLE 6

RATING OF PATIENTS' ABILITY TO SOCIALIZE

Degree	Staff Groups			
	A	B	C	Total
Lack ability	1	1	2	4
Limited ability	1	5	10	16
Have ability	1		1	2
Did not know	2			2
Total	5	6	13	24

Group A, the most remote from these patients, appeared to be most doubtful about their ability to socialize. There seemed to be very little doubt in the minds of the members of groups B and C; all but three of them felt that the patients had a limited ability to socialize.

Degree of Self Responsibility

Another topic of interest was the degree to which these patients could be responsible for themselves. Table 7 shows how the different staff groups rated the patients. Eight felt that they could be responsible for themselves, and five thought they could be somewhat responsible for themselves.

TABLE 7

DEGREE OF PATIENTS' SELF RESPONSIBILITY

Degree	Staff Groups			
	A	B	C	Total
Can be responsible	1	2	5	8
Can be somewhat responsible	1	2	2	5
Need supervision	2	2	6	10
No response	1	-	-	1
Total	5	6	13	24

The difference between the two categories "can be somewhat responsible" and "need supervision" is in terms of degree and value. Those who responded under the former appeared to connote hopelessness or negative feelings while those who ascribed to the latter assumed a more positive attitude toward the patients' ability to be responsible for themselves.

Degree of Restraint and Control

A final topic which was covered under this area was the degree to which these patients needed restraint and control. Table 8 indicates the type of restraint or control needed. All of the interviewees felt that there was seldom any time when physical restraint was needed to control the patients. They conjured up situations where they might have to use force but could not recall doing so in the recent past. Almost all said that only verbal restraint or "a structured environment" was needed for these patients.

TABLE 8

RESTRAINT OR CONTROL NEEDED FOR THE PATIENTS

Type	Staff Groups			
	A	B	C	Total
Some physical restraint or control	-	2	1	3
Only verbal restraint or control	3	3	9	15
A structured environment	2	1	3	6
Total	5	6	13	24

Group A appeared to be in favor of using any method for the patients which would help them but would resort to physical force only if it were absolutely necessary. All but one in group C agreed with this concept.

Staff's Concept of Services Patients Receive

In order to understand how the staff viewed the care and treatment these patients were being given, they were asked, "What type of hospital services are the patients receiving?" The writer also looked for answers to the following specific questions: "Would you describe what you see (or think) is being done for these patients?" "What does this include?" "What kind of nursing, social work, therapy, recreation, O.T., etc., do they get?" "What aspects of their care is therapeutic? Custodial?"

The Type of "Care" and "Treatment"

Most of the respondents had definite opinions about the services rendered these patients. In Table 9, the distribution among the three staff groups can be seen. Before describing "care" and "treatment" given the patients, the special meaning for these terms in this study should be understood. "Care" means the maintenance tasks, excluding medical, social and psychiatric services, which would be rendered to anyone in any type of institution. Such things as room, board, laundry, recreation, etc., would come under this heading. On the other hand, "treatment" means the active medical, psychiatric and social services afforded to patients with the aim of improving their physical or psychological conditions. It might appear easier to call one "custodial care" and the other "therapeutic treatment" but this would not be too exact.

This question of therapeutic versus custodial was discussed at length by a member of group A. He was reacting to the question, "What aspect of their care is therapeutic? Custodial?" He was unhappy about the term custodial because it has come to mean anti- or non-therapeutic. He felt that custodial "care" can be therapeutic in itself and by using such terms we only confuse the issue. But over half of the respondents felt that the patients were mainly receiving custodial "care" and they seemed to view it as non-therapeutic.

TABLE 9

STAFF OPINIONS ABOUT THE TYPE OF SERVICE BEING RENDERED TO PATIENTS

Type of Service	Staff Groups			
	A	B	C	Total
"Care"	2	4	9	15
"Treatment"	1	-	1	2
Combination	1	2	2	5
No response	1	-	1	2
Total	5	6	13	24

What the Hospital Services Included

Table 10 indicates the responses of the staff members to the question: "What does this (hospital service) include?" Each gave several different responses to this question which could be classified under the broad categories that follow. Physical maintenance includes all of the general physical needs of all persons in any institution. The somatic needs of the patients are covered under medical and nursing care. Therapy refers exclusively to group psychotherapy, and activities are regarded as any of the leisure time pursuits that the patients indulge in. Social work services were equated with group work services since none of the patients received case work services. Finally, environmental support is used to cover the staff's attempt to surround the patients with a general atmosphere of encouragement and protection.

The respondents regarded activities, physical main-

tenance and medical and nursing care, in that order, to be the three most important services the patients were receiving. More than two-thirds of the respondents mentioned some type of activity. They referred to O.T., R.T., trips, T.V. and the coffee shop as examples. Only one-third thought that the patients received social work service and it is significant that only a small percentage of group C gave a response about this service.

TABLE 10

STAFF DELINEATION OF HOSPITAL SERVICES GIVEN PATIENTS

Services	Staff Groups			
	A	B	C	Total
Physical Maintenance	1	3	12	16
Medical or nursing care	3	4	8	15
Therapy	3	3	4	10
Activities	2	5	10	17
Social work services	2	3	3	8
Environmental support	4	3	3	10

All but two of the interviewees commented on the "care" and "treatment" of these patients. They gave a variety of opinions which denoted maintenance of the patients rather than a program of active treatment. Examples of some verbatim responses follow:

"They are treated like babies."

"The staff utilizes things they (patients) wish to do as part of life experiences."

"Their participation is in activities as an outlet of sociable beings rather than therapy of any type."

"We must keep them up and not let them regress."

"They are encouraged to do things."

Other Services Which Might be Rendered Patients

In response to the question, "What better services might these patients receive?", all but two of those interviewed were in favor of increasing the existing services. The two who did not verbalize this were aides.

The five members of group A were unanimously in favor of expanding the services already being given, and their specific suggestions included more activities, more group therapy and more medical services. One spoke of providing a new service, i.e., a social worker with each family and casework for the patients. Two other ideas from this group dealt with the creation of the atmosphere of an old gentlemen's club and that we should "stop exploiting these patients."

The responses to this question in group B were also characterized by statements of expanding services. Five out of the six named some specific service to be expanded. The sixth spoke of, what was to him, a new service, namely group social work. Activities were emphasized and one idea given was to separate the chronic psychotics from the geriatric type patients.

All but two in group C mentioned more of some service these patients were already receiving. The other two felt that the hospital was doing all it could for these patients and one called it, "the acme of perfection." Two new ideas

were suggested which had to with having each patient specialed for a short period each day and to have in-service training for the hall staff in order to serve the patients better.

Possibility of Returning to Community

The fourth area of inquiry was aimed at the staff's expression of attitudes and/or opinions concerning the possibility of these patients residing in the community. The following questions were covered: "What is the likelihood of these patients going home to relatives, foster homes, male hotels, etc.?" "What kind of living arrangement might they go to?" "What do you think is keeping them from returning to the community: social reasons, medical reasons, or psychiatric reasons?"

Staff Prediction of Patients' Chances

Fourteen of the twenty-four respondents felt that some could return to the community but that most could not. Table 11 gives a picture of the staff's views.

A third of the group felt that none of these patients would ever leave the hospital. Group A did not commit itself to the absolute category as did many in group C. Group B's responses cover the entire range of categories, and since they worked closely with and had responsibility for these patients, they were probably good judges. Several respondents voiced the idea that they did not feel that it was the hospital's

TABLE 11

PREDICTION OF THE POSSIBILITY OF PATIENTS RETURNING TO THE COMMUNITY

Prediction	Staff Groups			
	A	B	C	Total
No possibility for any	-	2	6	8
No possibility for most	1	2	4	7
A remote possibility for a few	3	1	3	7
Did not know	1	1	-	2
Total	5	6	13	24

aim to move these patients back into the community.

Other Living Arrangements

Many of the interviewees were unsure as to whether or not the patients would leave the hospital; therefore, it was difficult for them to conjecture living arrangements outside of the hospital. Table 12 indicates their responses. It should be noted that half of the respondents are listed under the last two categories.

TABLE 12

LIVING ARRANGEMENTS OUTSIDE OF THE HOSPITAL FOR THE FEW PATIENTS WHO MIGHT LEAVE AND NOT LIVE WITH RELATIVES

Setting	Staff Groups			
	A	B	C	Total
Foster home	-	1	4	5
Halfway house	-	-	1	1
Male hotel	-	1	1	2
Nursing home	1	-	1	2
In a supervised setting	1	-	1	2
No workable arrangement	-	2	3	5
No response	3	2	2	7
Total	5	6	13	24

Almost one-third of group C, the closest to the patients, felt that they could function in a foster home. Two-thirds of group C were pessimistic about the patients leaving. More than half of group A felt they could not judge the type of setting which was best unless they knew the patients better.

Twenty-two of the twenty-four respondents mentioned the patients' relatives in regard to other living arrangements. The two who made no mention of relatives were in group B. Nine respondents felt that the relatives could not tolerate the patients; five merely stated that the relatives were a factor; four said that they had no relatives to go to; three felt that some of them could live with their relatives

and one stated that "assurance from the hospital to the relatives that these patients are cured is not forthcoming and, therefore, the relatives block their leaving."

Reasons Patients Are in the Hospital

Besides relatives blocking the patients leaving the hospital, it was thought that psychiatric, medical or social reasons might be keeping patients in the hospital. Table 13 shows the distribution of responses. Three-fourths indicated that there were psychiatric reasons. One-fourth thought only psychiatric reasons, another fourth combined this with social reasons, and the last fourth felt that all three reasons were responsible.

Opinions concerning these patients leaving the hospital were mostly slanted towards having the patients stay for their own good. Four out of the five in group A felt that it was more realistic for them to stay in the hospital. The one who dissented did not say it was better for them to live outside the hospital but only commented on the European system of patients like these living in their own homes.

On the whole, group B felt the same as group A but spoke of moving the patients out of the hospital as not being a good thing or not the hospital's goal, or felt it would be their second choice.

Group C was more optimistic about some of the patients leaving the hospital but they emphasized the need of super-

TABLE 13

FACTORS KEEPING PATIENTS IN THE HOSPITAL

Factors	Staff Groups			
	A	B	C	Total
A combination of all three	2	2	2	6
Psychiatric and social	3	1	2	6
Psychiatric and medical	-	-	1	1
Medical and social	-	-	1	1
Psychiatric only	-	2	4	6
Social only	-	1	1	2
Medical only	-	-	1	1
No response	-	-	1	1
Total	5	6	13	24

vision in all cases.

General Opinions About Work with Aged Patients

The focus of the final area of inquiry was the respondents' feelings about working with these patients. In order to help them think about this, they were primed with the following questions: "How do you feel about working with this type of patient?" "What are your feelings when one does?" "What satisfactions do you have when working with these patients?" "What bothers you about working with these patients?"

Satisfaction from Working with Aged Patients

Eighteen of the twenty-four found some satisfaction in working with these patients but several of them also had some dissatisfactions. In Table 14, the responses are described.

TABLE 14

SATISFACTION DERIVED FROM WORKING WITH AGED PSYCHOTICS

Degree	Staff Groups			
	A	B	C	Total
Some satisfaction	2	5	11	18
Little or no satisfaction	2	1	2	5
No response	1	-	-	1
Total	5	6	13	24

Three of the twenty-four (or only one in each group) felt that they derived no satisfaction from working with these patients. Group B had one member and group C had two members who got "little or no" satisfaction from working with these men. One respondent in group B felt that his primary satisfaction was an edicational one. Group A had never worked closely with these patients; therefore, they generalized their remarks to all old psychotics.

Dissatisfactions in Working with Aged Patients

Only two of the twenty-four had no dissatisfactions about working with these patients. Their complaints came

under the broad categories in Table 15. Thirteen of the respondents found the work not interesting or unrewarding. Nine of the twenty-four found the work unrewarding and five of that nine were in group C.

TABLE 15

DISSATISFACTIONS IN WORKING WITH AGED PSYCHOTICS

Response	Staff Groups			
	A	B	C	Total
Work not interesting	1	2	1	4
Work unrewarding	2	2	5	9
Patients' physical disabilities	-	-	3	3
Not enough time to give	-	2	-	2
Other	-	-	2	2
No dissatisfactions	-	-	2	2
No response	2	-	-	2
Total	5	6	13	24

Feelings about Death

Twenty-three of the twenty-four responded to this topic. Table 16 shows the distribution of the responses. It was felt that personnel working with aged patients might be adversely affected by the death of one. Some of the interviewees had difficulty phrasing their responses while others had decided opinions on the subject. On the whole, their opinions reflected societal attitudes towards death. Another factor to be considered is that one patient died during the course of

the study. Many of the twenty-three respondents specifically related their remarks to this recent death.

TABLE 16

STAFF FEELINGS ABOUT DEATH OF AGED PATIENTS

Feeling	Staff Groups			
	A	B	C	Total
Sympathy and acceptance	2	4	7	13
Upset	1	2	5	8
Ambivalent	1		1	2
No response	1			1
Total	5	6	13	24

In regard to the categories of Table 16, those responses listed under "sympathy and acceptance" appeared to be of a positive nature. Responses such as "bothered" or "reminded of one's own death" were listed under "upset" and the third category is self explanatory. Since death is a subject that is difficult for most people to talk and think about, it seems important that staff working with aged patients understand their own feelings about this subject.

Generally, the twenty-four staff members who took part in this study had a genuine concern for this small segment of the patient population. Their responses also reflected their status, role and position within the institution as well as their experience and training.

CHAPTER IV

SUMMARY AND CONCLUSIONS

This study explored staff attitudes towards care, treatment and prognosis of a group of ten, aged, chronic, long-term, male patients at McLean Hospital, a private psychiatric institution. It was theorized that the staff attitudes towards these patients might in some way affect the patients' socialization ability, capacity or potential. It was felt that knowledge of such attitudes might make it possible to intervene more effectively in the life of the patients in order to help improve their socialization patterns.

Twenty-four staff members between the ages of eighteen and sixty-four, with an average of 9.7 years experience, who worked, had worked with or were administratively responsible for these patients, were interviewed for twenty minutes or more. The interviews were focused on the five areas that follow:

1. Staff's perception of the patient group.

2. Staff's perception of the hospital services rendered the patient group.

3. Staff's ideas concerning other services which the

patient group might receive.

4. Staff's ideas about the possibility of these patients returning to the community.

5. Staff's feelings about working with aged patients.

The respondents were divided into three sub-groups along the lines of the hospital staff structure. The five in group A were psychiatric administrators; group B had six members of the professional staff (psychiatrist and residents); and group C was composed of thirteen personnel from nursing service.

Description of Patients

In describing the patients, the majority of the staff felt that they were chronic, schizophrenic, aged, long-term, "institutionalized" patients who had a limited ability to socialize and only needed verbal restraint or control. Only a third felt that the patients could be responsible for themselves and nearly half felt that they needed supervision.

Although not always the same responsdents, fifteen used the term chronic in regard to these patients, and referred to their age as well as their long hospitalization.

Half of the interviewees classified the patients as chronic schizophrenics and referred to their "institutionalized" state.

Generally, groups A and B agreed on the psychiatric classification of these patients but the members in group C gave eight different responses. The majority of groups A and B did not refer to the patients' age but group C was quite aware of this fact. Most of the members of groups A and B mentioned the patients' long hospitalization andthe effects that it had upon them; a little more than half of group C mentioned this factor and its effects. A large percentage of group A and a small percentage of group C mentioned the patients' apparent isolation. Group B did not mention this factor.

Groups B and C generally agreed that the patients had a limited ability to socialize but group A was more divided on this point. Group C was fairly equally divided on the degree of patient responsibility; group B was divided into thirds on this topic and group A leaned towards the need of supervision. Either half or the majority of all three groups endorsed only verbal restraint or control.

Service to Patients

In this study's terms, "care" is the maintenance tasks rendered in any institution to patients, while "treatment" is the active medical, psychiatric and social services afforded patients with the aim of improving their physical and psychological conditions.

More than half of the respondents felt that the patients were only receiving "care"; however, five thought that the patients received a combination of "care" and "treatment".

In regard to what the "care" and "treatment" included, the majority of the interviewees mentioned activities, physical maintenance and medical and nursing services. Only one-third made any reference to social work services. All but two of the respondents made some comment on this subject of "care" and "treatment".

The majority of groups B and C felt that the patients were receiving "care" but group A was more divided on this topic. In reference to hospital services rendered these patients, all but one in group C mentioned physical maintenance and all but three mentioned some form of activity. All but one in group B mentioned activities while four

referred to medical and nursing service. The majority of group A stressed environmental support as a major service given patients.

Other Services for Patients

Twenty-two of the twenty-four interviewed were in favor of increasing the existing services rendered the patients. Their suggestions covered a wide range from more activities, therapy and medical services to in-service training for the hall staff.

Possibility of Patients Leaving Hospital

More than half of the respondents felt that a few of the patients might possibly return to the community. One-third saw no possibility at all. Two did not offer an opinion.

There were four of group B and ten of group C who felt that there was no possibility of any or most to return to the community, however, three of group A thought there was a remote possibility for a few.

When discussing possible living arrangements for the few who would leave, five felt that they could go to a foster home and five responded that there was no workable arrangement.

Three-fourths of the staff thought that the patients remained in the hospital for psychiatric reasons. One-third of this number felt that social factors also played a part and one-third said that it was a combination of medical, social and psychiatric factors.

Opinions About Work With Patients

Eighteen of the twenty-four respondents found some satisfaction in working with the patients; however, all but two had some dissatisfactions with the work. A little more than half found the work not interesting or unrewarding.

The majority of those who gave direct service to the patients, groups B and C, got some satisfaction from their efforts. Group A was almost evenly divided on this. Five of group C felt the work was unrewarding as did a third of group B and two of group A. Two others in group A did not respond to this question. On the whole, most of the members of all three groups were able to accept death as a fact and possibility in their work with these patients.

Conclusions

The attitudes of staff members are not easily assessed due to the fact that they are not expressed

explicitly like opinions. The writer observed that the interviewees seemed to be divided into two distinct groups by the manner in which they answered the questions. One group relied heavily on their professional and practical knowledge; they gave concise, carefully phrased answers. The other group personalized their answers and gave many examples to illustrate their meaning. It appeared as though the former group took care to be well understood while the latter left room for misunderstanding. Thus, while many opinions were stated, underlying attitudes were not fully tapped.

In view of the limited findings, most of the following speculations are a combination of the study material and the writer's first hand knowledge of the hospital, the staff and the patients. The significant ideas gleaned from the study follow:

1. Due to the nature of their positions, group A's members had a better perspective of these patients but little first hand experience.

2. There is a dearth of social work services provided these patients as evidenced by the one social worker in the study group.

3. In describing the patients, the staff used terms which usually connote a negative meaning.

4. Most of the staff members felt that the patients only receive "care" as it is defined by this study.

5. Apparently, activity was the major type of service the staff thought of in connection with these patients.

6. The staff was interested in expanding the services for these patients but there was an implied lack of resources.

7. In light of the staff's description of the patients and the facts, the extremely guarded prognosis for these patients is realistic.

8. Most of the staff involved in direct service to these patients appeared to gain some satisfactions from their work which out-weighed their dissatisfactions with it. Also, they seemed to have resolved many of their feelings concerning death.

9. Most of the staff segment interviewed had a genuine concern for these patients.

Generally speaking, the staff attitudes towards these ten aged patients are tied in with their positions, their experience, their education and their values. As most of the

members of groups A and B implied, they were interested in these patients but had priorities concerning the use of their time, energy and knowledge. They wanted to put their efforts where they would do the most "good". A major form of this "good" was to return patients to the community who would become productive citizens again. Although it was agreed that most of these patients would not return to the community, this judgment was made on the basis of what was best for the welfare of the patients. Activating these patients in a structured, supportive environment and giving them protective-maintenance appeared to be the most "good" in this case. Thus, the staff attitudes are relative and depend on the individual patients involved.

Accepted 5-24-63
Katherine Spencer

APPENDIX A:
INTERVIEW GUIDE

1. What are these patients like?

   -To what degree can they be responsible for themselves?

   -What are the unique qualities of these patients that separate them from the rest of the hospital population?

   -How much do they have to be restrained or controlled?

   -How much are they able to socialize with other patients or other people?

   -What general psychiatric category would you say they come under?

2. What type of hospital services are they receiving?

   -Would you describe what you see (think) is being done for these patients?

   -What does this include?

   -What aspect of the service is therapeutic and what aspect is custodial?

   -

   -What kind of nursing, social work, therapy, recreation, O.T., etc. do they get?

3. What better hospital services could they be getting?

   -What more can be done for these patients?

4. What are their chances for returning to the community?

   -What is the likelihood of these patients going home

to relatives or to a foster home or male hotel or other setting?

-What kind of living arrangement might they go to?

-What to you think is keeping them from returning to the community? Social reasons? Medical reasons? Psychiatric reasons?

5. What are your feelings about working with these patients?

-How do you feel about working with this type of patient?

-What are your feelings when one dies?

-What satisfactions do you have from working with these patients?

-What bothers you about working with these patients?

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