*Administrators of 269 public mental hospitals and 53 officials of State or Territorial mental hygiene agencies were surveyed to ascertain their opinions about the potential for rehabilitation of older patients.*

# Opinions About Geriatric Patients in Public Mental Hospitals

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A RECENT overview of the gerontological literature suggests that confusions and conflicts continue among professionals in mental health about the management of elderly mentally ill patients in psychiatric hospitals. Observers have noted, for example, that some professionals in psychiatry still hold that very little can be done for the older patient either in or outside the mental institution. Ostensibly, these professionals are oriented primarily toward custodially supportive care for older patients, preferring to focus treatment almost solely on the alleviation or modification of the somatic manifestations of the illness.

On the other hand, increasing numbers of investigators have demonstrated that judicious intervention has produced significant improvement in the mental and physical health of many older patients. This variation in contemporary orientations toward treatment suggests that old and new conceptions of mental illness and its management may exist side by side within the same hospital system, possibly leading to confusions and inconsistencies in interpreting those institutional policies which determine what may be most desirable or feasible in the psychiatric care of older patients. Such possible disharmony could have long-reaching effects, especially since there appear to be ever-increasing proportions of older psychiatric patients in the resident populations of many mental hospitals and other long-term care institutions.

In this paper we report on an attempt to obtain from the administrators of public mental hospitals and their respective State official mental hygiene agencies (*a*) their perceptions of the dimensions of the geriatric problem and (*b*) the prevailing

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therapeutic climate for the mentally ill aged in their hospitals. This study also is the forerunner for a more detailed investigation of ideologies about the rehabilitation of older psychiatric patients among the several levels of caretakers in California mental hospitals.

## Trends in the Age Group Composition

Although hospitals for the mentally ill have existed in the United States for nearly 200 years, particular attention has only recently been directed toward elderly persons as a group in the resident populations of these hospitals. This phenomenon can be accepted as natural when it is understood that relatively few persons lived to reach senior citizen if not geriatric status until well into this century. Generally attributed to the control of infectious disease (*1*), the mean life expectancy of our general population had increased from about 47 years in 1900 to 70.5 years for both sexes and both races at birth in 1969 (*2–4*).

Resident populations in mental hospitals, having been augmented steadily as the national population increased, thus expanded even more rapidly as patients lived longer and as more elders were admitted. By midcentury, many mental hospital populations had become heavily weighted with patients whose potential for release was considered low. Even as late as 1965 patients who were admitted for less than 1 year constituted only 20 percent of the resident population, and only 15 percent of the total resident population were under 35 years of age (*5*).

The elderly group, on the other hand, accounted for some 30 percent of the resident population (at least 50 percent in some mental hospitals). Were it not that patients 65 years and older had a mortality rate of about 235 per 1,000 average mental hospital resident population (four times that for the same age group in the general population), it is highly probable that the great majority of long-term mental patients would soon have been elderly (*5*).

Nor does the situation appear greatly changed today. Although the national mental hospital discharge rate now exceeds the admission rate among patients over 25 years old, patients over 65 still constitute about 30 percent of the residents. The proportion of elderly in the mental hospitals, however, varies considerably by State. The latest data from California and New York, for example, show these proportions to be 30 percent in California and 44 percent in New York State (*6, 7*).

Modern screening, processing, and intensive treatment have enabled many mental hospitals to release large numbers of patients within 6 months following their admission. Most of these discharged patients, however, were in the pediatric and young adult groups. Those longer term psychiatric patients selected for intensive therapeutic programs and subsequently released after treatment also have been chiefly in the younger groups (*8*). In many instances, the chronic, long-term, little-potential patients may continue to gravitate to less well-staffed, supportive care "back wards" (*9*), and the hospital caseload is further escalated by the increased longevity of these resident patients (*10*).

Consequently, most mental hospitals still face the long-standing problem of not being able to provide the accommodations needed for patients. Under the contemporary budgetary, spatial, and personnel constraints, moreover, mental hospitals are being compelled to discharge a number of long-term resident patients to whatever community facilities may be available. When the hospitals have been able to provide brief predischarge programs of intensive rehabilitation therapy, to arrange for placement in carefully selected nursing and foster homes, or to provide both therapy and careful placement, many dischargees have made reasonably successful adjustments to their new environments (*11–13*). Unfortunately, too many of these discharged patients receive only minimally supervised care in the more commonly available nontherapeutic, custodially oriented facilities (*14*).

## Trends in Management of Aged Patients

The gerontological literature suggests that therapeutic neglect of the mentally ill elderly has long been commonplace, largely because of stereotyping in the perception of needs and capacities among patients in the old-age group. The emergence of the ideology of modern mental hygiene, together with an increased social awareness of the elderly as a problem group in the general population, has led to more critical analysis of indiscriminacy in the admission of older persons to mental hospitals and of stereotypy in their psychiatric management. It has become clear, for exam-

ple, that the mental hospital has long been a catchall for custodial placement not only for those elderly who were confused, but also for those who were physically or socioeconomically infirm (*15, 16*).

Because the legality of a hospital admission most often depended on the diagnosis of psychiatric illness, such diagnoses as "chronic brain syndrome," "organic brain syndrome," "senile brain disease," "mental deterioration due to senility," or "senile dementia" became convenient labels to permit placing many elderly persons in psychiatric institutions (*15, 17*). The casual, almost interchangeable, use of these diagnostic tags has contributed to their meaninglessness in that they imply minimal or no improvement with therapy (*18*). Moreover, the blanket labeling of large numbers of elderly mental hospital residents undoubtedly has contributed to the unfortunate generalization that, with perhaps a few exceptions, older mentally ill persons may be classified as members of homogeneous, little-potential group.

Because until only recently little or no training was available in the specialized management of elderly patients, mental hospital personnel often manifested resigned indifference or destructive condescension toward these apparently "hopeless" patients (*19*). Even as late as the 1950's, only minimal rehabilitative effort was expended on older patients, who were generally and uncritically perceived as poorly motivated, highly debilitated, and too advanced in years to improve significantly (*20, 21*).

These expedient, categorical methods of dealing with emotional problems in the elderly have perpetuated a number of stereotypes regarding their psychiatric management. For example, there has been a persistent belief that everything is wrong with older persons as a natural function of physiological aging; what has caused the particular difficulty is thus relatively unimportant since older patients can have but little potential for rehabilitation (*17*). When physical health and environmental factors are so disregarded, the attendant temptation is to attribute psychiatric symptoms arbitrarily to increased age, thus bypassing important differential diagnostic investigations (*22*).

Furthermore, because the degree and duration of his apparent emotional maladjustment may vary considerably, the older person may be categorized as mentally ill not only following a critical diagnostic appraisal of his patent mental morbidity, but also as a result of too rapid judgment of his condition as irreversible organic brain alteration (*17, 19*). Thus it is often possible that the presenting symptomatology may be reflective only of the later-life emergence of peculiar character traits or of certain pseudosenile behaviorisms associated with sensory deprivation (*23*).

With respect to their therapeutic management, elderly patients have been regarded as having such diminished plasticity of personality and so many irreversible memory defects that they can present but little challenge to the diagnostic skills and therapeutic creativeness of the psychiatrist. Patients who are older are therefore often perceived as incapable of being other than minimally cooperative in the therapeutic process (*24*). These conclusions support the assumption that psychoanalysis or other intensive long-term psychotherapy is wasted on patients of doubtful longevity; if treatment must be given to older patients, probably the most practical is a simple environmental manipulation (*17, 25*).

It is not too surprising, therefore, that in mental hospitals and other institutions in which significant proportions of the residents are aged, the older group may fare less well as compared with younger patients (*20*). As noted earlier, the feeling apparently persists that limited budgets and manpower necessitate focusing treatment energies on younger patients. Younger patients are considered to have greater potential for rehabilitation (*8*) and, following successful treatment, have more socioeconomic value to their communities than older patients might under the same circumstances (*18*).

While some recent studies show that the social and professional emphases on youth still prevail (*26, 27*), many of the pessimisms about the restorative potential of older mentally ill patients have been refuted. For example, comprehensive geriatric screening programs have shown that many apparent psychiatric conditions in the elderly may more properly be diagnosed as temporary confusion primarily associated with somatic or family problems. These programs also help identify certain predictors of emotional outcome (*27–33*).

Comprehensive physical examinations and extensive social histories as a vital part of both the preadmission and admission process aid in determining whether the mental confusion and other presenting symptomatology of older persons are not in fact treatable defense mechanisms reflective

of other conditions—clinical, social, psychological —or the emotional background of the family environment (*25, 34–39*). Since the mental and physical conditions of institutionalized aged persons have been found to be highly interrelated, impairment of either aspect can be regarded as a need for comprehensive medical care (*8, 40, 41*). Many mental hospitals have incorporated special medical facilities in apparent recognition of this phenomenon. It has been found, however, that too strong an emphasis on functional medical problems may obscure recognition of operative psychodynamic factors (*42*).

Treatment programs may entail techniques that are intended to provide the aging patient with insight or to bring about complete change. Other techniques, which are largely supportive, may be designed merely to alleviate anxiety. Or, both kinds of techniques may be employed. On the assumption that many apparently irreversible reactions may in fact be reversible, a number of investigators have explored the comparative efficacy of various approaches in the management of elderly psychiatric patients. These researchers have reported measurable success through the application of individual psychotherapy (*43–45*), brief and crisis therapy (*46, 47*), group therapy (*48–51*), and combined individual and group therapy (*19*). Since aged patients often may reveal character structure defenses more clearly and more rapidly than younger patients, analytic therapy has also been used very successfully in treating the elderly (*52–54*). Intensive and multiapproach treatment programs have thus been reported to be of great value in managing emotional disorders in older patients (*29, 35, 55*).

The advantages of segregating the elderly from younger patients for meeting their physical and emotional needs have been explored and substantiated by a number of investigators (*19, 56, 57*). Others have found particular advantages for patients who live in mixed-age treatment settings (*58, 59*). Studies dealing with the use of milieu-concept therapy in managing older patients have been relatively few, most of these focusing on the recreational, occupational, or combined aspects of such therapy. Measurable progress has been reported for older patients given recreational or occupational therapy (*60–63*), and significant benefits have been observed among older patients in sheltered workshops (*64*).

Studies focusing on the discharge and placement processes have revealed a number of hospital administrative and community problems relating to older patients (*65*). More expeditious discharging of these patients has been highly correlated with periodic reevaluations of their diagnostic status and more accurate reporting of their competencies (*66, 67*). Lack of family interest and paucity of foster homes in the community were identified as major problems (*68*), as were the lack of supportive hospital outpatient and community followup services (*18*). Poorly planned discharge practices thus often nullify the benefits of predischarge, intensive-treatment programs (*69–71*).

In managing both the discharged and not-yet-admitted elderly patients, the use of outpatient or ambulatory clinics has become recognized as an important element in the supportive maintenance of their mental health. Through these clinic services, older patients often may achieve such marked improvement that many can avoid protracted new hospitalization or rehospitalizations (*72–74*). Day hospital programs which provide mixed medical and psychiatric supervision also report maintenance of favorable results, especially when they are combined with home visits and family conferences with therapists and social workers (*75*).

Acutely aware of the limited funding and the critical shortage of professional workers in the mental health disciplines, most investigators have emphasized that the same amount of planning should go into providing services for elderly patients as for younger patients because many of the elderly are as responsive to proper care and treatment as younger patients. Obviously, a planned treatment program which enables the elderly patient to return to his community not only reduces the hospitals' workload, but also provides the opportunity to prove that many older persons with a minimum of psychiatric support can be sufficiently self-sustaining to resume contributory social roles.

Although hopes, expectations, and clinical findings concerning the potential for rehabilitation of elderly mentally ill patients are now being expressed more frequently and with greater authority, positive concepts have not yet become widely accepted as the bases for more promotive treatment ideologies among professional caretakers in mental hospitals. The frequent remarking in the literature on apparent confusions and conflicts in geriatric psychiatric ideology and practice sug-

gested that a survey to document such variation in treatment orientation might well be a useful tool for mental health planning. In this study, therefore, we attempted to determine what official State agency heads and public mental hospital administrators would report concerning their perceptions of the prevailing feelings among their respective hospital therapeutic staff toward the care and potential for rehabilitation of geriatric mental patients.

## Method

Forty generalized treatment position statements were derived from discussions in the literature as reflective of the current mix of promotive and custodial orientations surrounding the care of geriatric mentally ill persons. Pretest results with administrators in private psychiatric hospitals showed real concern about elderly patients and their problems. However, there was mixed antipathy and apathy toward the length and the positive-negative nature of the survey. Most administrators seemed to prefer making brief and sometimes bland comments on the treatment orientations of their professional staffs, while a few also cited statistics about their geriatric caseload.

In order to shorten the survey instrument and, more important, to provoke deliberately a higher rate of more critical comments among the administrators of public mental hospitals, some of the more negatively oriented treatment positions were selected and were combined arbitrarily into eight purposely naive statements concerning the care of older mentally ill patients.

As a supplement to, and presented as a facing page for this brief opinion schedule, a series of six questions was formulated to elicit from the respondents, if not official statistics, at least their best percentage estimates of the proportions of geriatric patients in their mental hospitals. Questions in this series sought estimates also of the proportions of elderly mental patients who probably could derive benefit from psychotherapy, who were regarded as having undifferentiated senile brain disease, who probably could have avoided hospitalization, and who probably could be discharged were more adequate community facilities available. A final question dealt with the perceived extent of need for such community facilities or resources. In keeping with the arbitrarily negative approach used in the opinion statement series, many of the questions in this latter set also were somewhat value laden. We hoped that the judgmental nature would also stimulate respondents' comments.

The questionnaire (two sections) was mailed to the directors of the official mental hygiene agencies on the assumption that these officials not only would have a general picture of the geriatric psychiatric problem in their respective hospital systems, but would probably also have had sufficient personal contact with the professional treatment personnel in their hospitals to be able to gauge the therapeutic climate provided therein for older patients. Included in the survey were the official agencies for each of the 50 States, as well as those for the District of Columbia, Guam, and Puerto Rico. The same questionnaire was mailed to the superintendent or medical director of every public mental hospital in each of the States and Territories.

## Results

Although some form of response was obtained from 216 of the administrators of 269 hospitals and from 48 of the directors of official mental hygiene agencies (response rates of 80 and 91 percent, respectively), usable questionnaire data came from only 178 hospitals and 43 official agencies. Statistical estimates of the problem of geriatric mental patients were not included by eight of the responding agency heads; two agency heads stated that data concerning hospitalized elderly mentally ill persons were not available for their States. A number of mental hospital administrators commented that, although such data might be available at the State level, the administrators did not receive this type of information from their respective official agencies. Only 133 (74 percent) of the administrators of public mental hospitals attempted to estimate at least some aspects of the extent of the geriatric problem for their States. The remaining hospital respondents included data descriptive only of their individual hospital caseloads.

## Scope of the Geriatric Problem

The following questions were asked with respect to the scope of the geriatric problem in public mental hospitals for each State.

1. Of the total resident population in the public mental hospitals in your State, approximately what proportion are over the age of 60 years?

2. What proportion of these geriatric patients probably could benefit from psychotherapeutic treatment?

3. What proportion of these geriatric patients may have been admitted unnecessarily to your mental hospitals?

4. What proportion of aged patients could be discharged from your public mental hospitals if sufficient community, psychiatric, nursing, or other similar facilities were available?

5. What proportions of aged mental hospital patients bear the diagnosis of chronic brain syndrome or senile brain disease or both?

6. If additional extrahospital facilities were seen as a possible solution to the problem of geriatric patients, by what proportion would these facilities have to be increased?

Table 1 presents an overall view of the extent of the geriatric psychiatric problem in the United States, as based on the distribution of responses from the heads of official mental hygiene agencies whose estimates might be expected to represent access to all pertinent information relative to their States.

The distribution of responses to question 1 in table 1 shows that elderly persons in public mental hospitals still constitute 30–44 percent of the hospital populations in almost two-thirds of the States, and 29 percent or less in only about one-fourth of the States. Moreover, although about half of the State officials estimated that less than 30 percent of their elderly patients may have been hospitalized unnecessarily (question 3), a substantial number of agency heads judged this proportion to be much higher in their respective mental hospital systems.

Responses to question 2 indicated a wide variation among the estimates from the State officials concerning the proportion of elderly patients who probably could derive benefit from psychotherapeutic treatment. This dispersion is noted also among the responses to question 5, in which only a few of the State officials felt able to report that relatively low proportions of their elderly patients had conditions diagnosed as chronic brain syndrome or senile brain disease or both.

At least three-fourths of the State agency heads believed, however, that larger numbers of geriatric patients could be discharged from public mental hospitals if sufficient community or other psychiatric care resources were available (question 4). Furthermore, responses to question 6 indicated that, while 10 agency heads believed that only a minimal increase is needed in the number of such extrahospital facilities, fully one-third held that the number of these facilities should be at least doubled to help alleviate the geriatric patient load in their respective State hospital systems.

While recognizing that hospital administrators probably have less access to hospitalization data for the whole State and that their estimates of the extent of the geriatric problem may consequently reflect their personal opinions and attitudes as much as the facts, it is useful to compare the responses of the hospital administrators with those of the officials of State mental hygiene agencies. Table 2 compares numerical and percentage dis-

**Table 1. Responses to six questions on the scope of the geriatric problem by heads of State or Territorial mental health agencies**

| Estimated percentage of aged in mental hospital populations | Comprising hospital caseload | | Could benefit with treatment | | Admitted unnecessarily | | Could be discharged | | Diagnosis of CBS [1] or SBD [2] | | Community facilities needed | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| Less than 15 | 1 | 2.3 | 6 | 14.3 | 8 | 19.1 | 3 | 7.0 | 2 | 4.5 | 4 | 10.9 |
| 15–29 | 11 | 25.0 | 6 | 14.3 | 15 | 35.7 | 2 | 4.6 | 2 | 4.6 | 6 | 16.2 |
| 30–44 | 28 | 63.6 | 6 | 14.3 | 5 | 11.9 | 6 | 14.0 | 15 | 34.2 | 5 | 13.5 |
| 45–59 | 3 | 6.8 | 8 | 19.1 | 5 | 11.9 | 7 | 16.2 | 7 | 15.9 | 6 | 16.2 |
| 60–74 | 1 | 2.3 | 6 | 14.3 | 4 | 9.5 | 8 | 18.6 | 10 | 22.7 | 2 | 5.4 |
| 75–89 | 0 | ... | 7 | 16.6 | 5 | 11.9 | 15 | 35.0 | 6 | 13.7 | 2 | 5.4 |
| 90 or more | 0 | ... | 3 | 7.1 | 0 | ... | 2 | 4.6 | 2 | 4.5 | 12 | 32.4 |
| Total and rate (N = 53) | 44 | 83.0 | 42 | 79.2 | 42 | 79.2 | 43 | 81.1 | 44 | 83.0 | 37 | 69.8 |

[1] Chronic brain syndrome.
[2] Senile brain disease.

tributions of responses from the State officials with the median responses among the public mental hospital administrators for the respective States or Territories for the six questions pertaining to the scope of the geriatric psychiatric problem. Because the number of hospitals per State or Territory varies considerably, median response figures were obtained in order to provide a single figure for comparison with the respective State agency figure.

Analysis of the respective responses to question 1 shows substantial correspondence between the mental hospital administrators and their mental hygiene agencies about the proportion of persons over 60 years of age who are patients in State mental hospitals. There was less agreement concerning question 2 (possible benefit from psychotherapeutic treatment), with the hospital administrators being less optimistic than agency heads. For question 3 (possible unnecessary admissions), administrators' estimates seemed to be dispersed about evenly above, below, and on the line of agreement with the State officials' estimates. With respect to the estimates of possible discharges of older patients were more extrahospital facilities available (question 4), more than one-third of the administrators agreed with the State officials' estimates, but a somewhat greater

**Table 2. Comparison of estimates from officials of State or Territorial mental hygiene agencies with those of their respective administrators of public mental hospitals, by responses to questions on scope of geriatric problem**

| Median of hospital administrators' responses compared with State officials' estimates | Comprising hospital caseload | | Could benefit with treatment | | Admitted unnecessarily | | Could be discharged | | Diagnosis of CBS [1] or SBD [2] | | Community facilities needed | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Number | Percent | Number | Percent | Number | Per cent | Number | Percent | Num- Per- | Percent | Number | Percent |
| 75 percent or more higher | 0 | ... | 0 | ... | 0 | ... | 0 | ... | 0 | ... | 1 | 3.6 |
| 45–74 percent higher | 0 | ... | 4 | 12.9 | 4 | 12.9 | 0 | ... | 1 | 3.1 | 2 | 7.1 |
| 15–44 percent higher | 5 | 15.2 | 2 | 6.5 | 6 | 19.4 | 7 | 21.9 | 14 | 43.8 | 6 | 21.4 |
| Within 14 percent higher or lower | 26 | 78.8 | 12 | 38.7 | 9 | 29.0 | 12 | 37.5 | 10 | 31.2 | 7 | 25.0 |
| 15–44 percent lower | 2 | 6.0 | 9 | 29.0 | 9 | 29.0 | 12 | 37.5 | 6 | 18.8 | 6 | 21.4 |
| 45–74 percent lower | 0 | ... | 4 | 12.9 | 3 | 9.7 | 1 | 3.1 | 1 | 3.1 | 5 | 17.9 |
| At least 75 percent lower | 0 | ... | 0 | ... | 0 | ... | 0 | ... | 0 | ... | 1 | 3.6 |
| Total possible intrastate comparisons | 33 | 100.0 | 31 | 100.0 | 31 | 100.0 | 32 | 100.0 | 32 | 100.0 | 28 | 100.0 |
| Hospital administrators responding (N = 269) | 128 | 47.6 | 123 | 45.7 | 123 | 45.7 | 123 | 45.7 | 125 | 46.5 | 116 | 43.1 |
| Percent of useable responses from hospital administrators (N = 178) | ... | 71.9 | ... | 69.1 | ... | 69.1 | ... | 69.1 | ... | 70.2 | ... | 65.2 |

[1] Chronic brain syndrome.
[2] Senile brain disease.

number of hospital administrators showed less optimism than heads of State agencies.

This imputed pessimism among hospital administrators about the discharge of older patients was further observed in the administrators' responses to question 3 (proportions with the diagnostic labels of chronic brain syndrome or senile brain disease or both). Almost half of the administrators' estimates were significantly higher than those of the agency heads. Administrators' responses were rather widely dispersed with respect to question 6, with only one-fourth of the administrators agreeing with State officials' estimates of the needed increase among community facilities which could absorb discharged geriatric patients. It would appear that administrators who are closer to the problems of care or management of the older patient are less optimistic (or perhaps more realistic?) than officials of mental hygiene agencies about the prognoses and probabilities of discharge for hospitalized geriatric mental patients. Respondents' comments about the questions will be discussed subsequently.

## Reliability of Estimated Data

Aside from the failure of a number of State agency heads and individual hospital administrators to participate in the survey, and the reluctance of many hospital administrators to venture estimates for their respective States as a whole, a number of other problems affected the reliability of the data.

First, there was the variability among the States with respect to the extent of detail and accuracy of the statistical records concerning hospitalized mentally ill patients. A few State officials admitted having some doubts about their own estimated data. The number of public mental hospitals per State varied widely. For example, a number of States have few or no inpatient facilities. Fifteen States have only one State mental hospital. Of these, four State agency heads reported the need to use general, county, and proprietary hospitals and nursing homes for the care of the mentally ill, and one State uses only such facilities for all mentally ill patients. Of the total respondents, four agency heads preferred to use only nursing and sheltered-care homes for aged mentally ill patients.

Another problem was the inconsistency of the age groupings of mentally ill patients. Because the literature characterizes as geriatric the mentally ill patient who is 60 years or older (*19*), we sought information on all mentally ill patients at or over this age level. However, most State agency heads and most hospital directors pointed out that their estimates were based on the numbers of patients aged 65 and over. The tabled estimates therefore reflect only the proportion of mentally ill persons aged 65 and over who currently were patients in public mental hospitals.

Finally, there was the admittedly arbitrary and inadequate nature of the questionnaire itself. While the format and the categorical content of these questions were derived from suggestions offered by the pretested group of administrators, the necessity for brevity precluded extensive clarification of the terms used.

## Therapeutic Climate

The deliberately negative statements concerning the prevailing therapeutic climate for older patients in mental hospitals were the following.

1. As a group, older patients in public mental hospitals have little potential for rehabilitation and return to their communities as functioning individuals.
2. Since older patients usually have a multitude of physical and emotional problems, it is too time consuming and of little real value to diagnose the causes of their particular difficulties.
3. Emotional difficulties among older patients can be based upon a diagnosis of mental deterioration (senility).
4. Since older patients have less plasticity of personality, they tend to be minimally cooperative in therapeutic activities.
5. Because of limitations on funds, facilities, and personnel, it is expedient to focus the available treatment hours on patients with greater rehabilitation potential (the younger patients).
6. The mentally ill geriatric patient usually provides little challenge to the diagnostic skills and therapeutic creativeness of the practicing psychiatrists in public mental hospitals.
7. Given that psychotherapeutic treatment may be successful in both young and old, the rehabilitated younger patient has much more to offer to the outside community than does the geriatric patient.
8. In cases of successful treatment with geriatric patients, the best method of approach is environmental manipulation rather than psychoanalysis or other long-term therapies.

Respondents were requested not only to report their perceptions of how strongly the professional

treatment personnel in public mental hospitals would agree or disagree with these statements (strongly agree, agree, disagree, strongly disagree), but also were urged to make critical comments about the controversial and arbitrary nature of these statements. Table 3 presents a comparison of the numerical and percentage distributions of responses to the eight statements from the official mental hygiene agency heads and the median responses from the administrators of hospitals in the respective State systems. (As for the responses to the questions about the scope of the geriatric problem, medians were calculated among the respondent hospital administrators for each State in order to obtain a hospital response perception which could then be compared with the State official's response for the respective State.)

The data in table 3 show that both the State officials and the hospital administrators disagreed substantially (67 and 54 percent, respectively) with the premise in statement 1, that older mental patients have little potential for rehabilitation. There was considerably more disagreement among the hospital administrators (81 percent), and more particularly among the agency heads (95 percent), with the premise that it is too time consuming and of little real value to attempt to determine causes of emotional problems among older patients (statement 2).

This apparent support of rehabilitative measures for older patients seems to be strengthened by the response to statement 3, in which approximately two-thirds of both groups of respondents disagreed with the premise that emotional difficulties among older patients may be attributed to that state of progressive mental deterioration often described or categorized as "senility." About the same proportions in both groups (two-thirds) also disagreed that older patients are minimally cooperative in therapeutic activities (statement 4).

However, despite current limitations on funds, facilities, and personnel (statement 5), heads of official agencies and hospital administrators seemed about evenly divided concerning the expediency of focusing hospital treatment on patients who may be perceived as having the greater rehabilitative potential (that is, the younger patients). This apparent indecision regarding the best use of treatment hours may be somewhat reflective of the belief among some two-thirds of the respondents in both groups that geriatric patients may in fact present interesting challenges to the creative practice of psychiatry (statement 6), while at the same time at least similar proportions among both respondent groups agreed with the judgmental item (statement 7) that the younger rehabilitated patients have much more to offer to their communities than rehabilitated older patients.

**Table 3. Perceptions among heads of mental hygiene agencies and administrators of public mental hospitals about therapeutic climate for elderly patients, by category of response**

| Negative statements about older patients | Strongly disagree | | | Disagree | | Agree | | Strongly agree | |
|---|---|---|---|---|---|---|---|---|---|
| | Total | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| To agency heads: | | | | | | | | | |
| 1. Have little potential | 46 | 10 | 21.7 | 21 | 45.7 | 13 | 28.3 | 2 | 4.3 |
| 2. Are a waste of diagnostic time | 46 | 22 | 47.8 | 22 | 47.8 | 1 | 2.2 | 1 | 2.2 |
| 3. Have conditions resulting from mental deterioration | 46 | 9 | 19.5 | 20 | 43.5 | 16 | 34.8 | 1 | 2.2 |
| 4. Are minimally cooperative | 46 | 7 | 15.2 | 25 | 54.3 | 13 | 28.3 | 1 | 2.2 |
| 5. Are a poor investment in time, funds, facilities, and personnel | 46 | 6 | 13.0 | 17 | 37.0 | 21 | 45.6 | 2 | 4.4 |
| 6. Offer little challenge | 46 | 14 | 30.4 | 17 | 37.0 | 13 | 28.3 | 2 | 4.3 |
| 7. Have little to offer community | 44 | 3 | 6.8 | 13 | 29.5 | 24 | 54.6 | 4 | 9.1 |
| 8. Can be treated best by manipulating environment | 46 | 0 | ... | 2 | 4.3 | 35 | 76.1 | 9 | 19.6 |
| To hospital administrators: | | | | | | | | | |
| 1. Have little potential | 175 | 23 | 13.1 | 72 | 41.2 | 72 | 41.2 | 8 | 4.5 |
| 2. Are a waste of diagnostic time | 175 | 65 | 37.1 | 77 | 44.0 | 29 | 16.6 | 4 | 2.3 |
| 3. Have conditions resulting from mental deterioration | 175 | 20 | 11.4 | 84 | 48.0 | 65 | 37.2 | 6 | 3.4 |
| 4. Are minimally cooperative | 175 | 15 | 8.6 | 93 | 53.1 | 64 | 36.6 | 3 | 1.7 |
| 5. Are a poor investment in time, funds, facilities, and personnel | 175 | 18 | 10.3 | 64 | 36.6 | 76 | 43.4 | 17 | 9.7 |
| 6. Offer little challenge | 174 | 35 | 20.1 | 74 | 42.5 | 56 | 32.2 | 9 | 5.2 |
| 7. Have little to offer community | 175 | 6 | 3.4 | 40 | 22.9 | 115 | 65.7 | 14 | 8.0 |
| 8. Can be treated best by manipulating environment | 174 | 1 | .6 | 17 | 9.8 | 111 | 63.8 | 45 | 25.8 |

With respect to statement 8, 95.7 percent of the agency heads and 89.6 percent of the hospital administrators agreed that the treatment of choice for older patients should be environmental manipulation rather than the more time-consuming personality probing or redirection techniques.

It may again be of interest to compare directly the usable responses of those agency heads and hospital administrators from the same States. Table 4 presents these comparative data, combining the four possible responses into two categories (agree and disagree) for easier handling.

The data in table 4 reveal a sometimes more and sometimes less complete agreement between the two groups about most of the statements. As in table 3 there is substantial concordance on two of the items (statements 2 and 8). A large majority in both respondent groups substantially disagree with statement 2 and agree with statement 8.

## Respondents' Comments

Since items in both sections of the questionnaire were intentionally negative and necessarily general in form, not permitting detailed shadings of the considerations involved, the respondents were encouraged to comment freely on each issue. As we had hoped, a wide divergence of opinion was noted among the respondents' comments.

While many comments were often lengthy and quite specific in support or in qualification of their responses to various items, a number of respondents were also more general in their remarks, pre-

**Table 4. Comparison of perceptions among heads of mental hygiene agencies and administrators of public hospitals about therapeutic climate of elderly patients, by source and response**

| Source and response | Eight negative statements (see text on page 464) | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Agency-only responses: [1] | | | | | | | | |
| Agency disagreed | 3 | 3 | 3 | 3 | 2 | 3 | 2 | 1 |
| Agency agreed | 1 | 1 | 1 | 1 | 2 | 1 | 2 | 3 |
| No hospital responses: | | | | | | | | |
| Agency disagreed | 2 | 5 | 3 | 4 | 4 | 3 | 3 | 0 |
| Agency agreed | 3 | 0 | 2 | 1 | 1 | 2 | 2 | 6 |
| Hospital-only responses: [2] | | | | | | | | |
| Hospital disagreed—median | 2 | 4 | 4 | 4 | 1 | 5 | 1 | 0 |
| Hospital agreed—median | 3 | 1 | 1 | 1 | 4 | 0 | 6 | 5 |
| No agency or hospital responded for the State | 2 | 2 | 2 | 2 | 2 | 2 | 2 | 2 |
| Agency and hospital medians both disagreed: | | | | | | | | |
| Number | 18 | 31 | 18 | 19 | 12 | 18 | 2 | 0 |
| Percent | *48.7* | *83.8* | *48.6* | *51.3* | *32.4* | *48.7* | *5.7* | ... |
| Agency and hospital medians both agreed: | | | | | | | | |
| Number | 3 | 1 | 7 | 6 | 7 | 6 | 14 | 34 |
| Percent | *8.1* | *2.6* | *18.9* | *16.2* | *18.9* | *16.2* | *40.0* | *94.4* |
| Median responses of agencies disagreed, of hospitals agreed: | | | | | | | | |
| Number | 8 | 5 | 5 | 5 | 7 | 6 | 9 | 1 |
| Percent | *21.6* | *13.6* | *13.6* | *13.6* | *18.9* | *16.2* | *25.7* | *2.8* |
| Median responses of agencies disagreed, of hospitals disagreed: | | | | | | | | |
| Number | 8 | 0 | 7 | 7 | 11 | 7 | 10 | 1 |
| Percent | *21.6* | --- | *18.9* | *18.9* | *29.8* | *18.9* | *28.6* | *2.8* |
| Total possible intrastate comparisons | 37 | 37 | 37 | 37 | 37 | 37 | 35 | 36 |
| Percent of 53 agencies responding to statement | 86.9 | 86.9 | 86.9 | 86.9 | 86.9 | 86.9 | 83.0 | 86.9 |
| Percent of 269 hospitals responding to statement | 65.1 | 65.1 | 65.1 | 65.1 | 65.1 | 64.7 | 65.1 | 64.7 |
| Percent of 178 usable responses from hospitals | 98.3 | 98.3 | 98.3 | 98.3 | 98.3 | 97.8 | 98.3 | 97.8 |

[1] No hospitals listed by the American Hospital Association.
[2] Agency did not respond.

ferring to focus on the geriatric problem as a whole rather than upon specific items in the questionnaire. These more generalized observations reflected two major types of response orientations.

1. Lack of confidence that sufficient funds and adequate (and interested) personnel would ever be available to cope successfully with the problem of mental illness among the elderly.

2. Conviction that the solution to the problem must rest in the combined efforts of individual mental hospitals and their respective local communities to meet the needs of geriatric patients. As we had expected, a few respondents commented that the intentional vagueness of the questionnaire items restricted rather than stimulated insight in their responses.

## Discussion

As indicated in the literature, for many of the general public and most of the professionals in mental health, the old conception of mental illness has been somewhat eroded under the new mental hygiene ideology. Instead of being considered hopeless, dangerous, and incurably irrational, the mentally ill patient now is viewed as capable of at least some growth, some development, and some rehabilitation. As a consequence of this more positive viewpoint, treatment programs have aided many mentally ill persons in returning to their communities as functioning persons.

So far as the mentally ill elderly patient is concerned, however, the literature contends that most of the general public and many of the professionals in mental health still retain the notion that older persons usually cannot improve measurably under psychotherapeutic management and, even if some few could be rehabilitated, these persons would generally have too little to offer to their communities to make the effort worthwhile. Nor do their respective families or communities appear to be especially interested in reassuming the responsibility for such supportive or supervisorial care as may be needed for the maintenance of discharged older patients.

According to the various respondents—some of whom were quoted twice in the following paragraphs but none of whose remarks on a specific item were interrupted—the older patient "has thus come to occupy the sociological niche once dominated by the so-called 'chronic' or 'burnt-out' schizophrenic"; that is, he is in a group for which "the recovery or salvage rate is low."

While the negative orientation of the questionnaire items may have appeared "too restrictive" or "too general" to some respondents, others generally frequently concurred with one respondent's observation that the prevailing therapeutic climate is reflective not only of the statements about the scope of the problem, but also of the total community attitudes about work with aged persons.

The editorial assumption that old and new concepts of mental hygiene ideology may in fact exist side by side in the same hospital system was supported by several agency directors. One comment to this point noted that, "It is difficult to give a true consensus since ideas vary so much by professional disciplines and knowledge of aging." However, a number of other respondents reported that, in their own hospital experience, they have noted "very little conviction among professional treatment personnel that elderly patients are rehabilitable" and that, "Professional people are not interested in the person over 65 as a challenging case." That such negativism may in fact prevail throughout certain whole State systems is indicated by these agencies' heads' remarks: "The level of enthusiasm for geriatric patient treatment is rather low hereabouts," and where the prevailing climate is described as "one of hopelessness and discouragement with respect to the effectual rehabilitation of the geriatric patient and his usefulness if rehabilitated."

This pessimistic attitude toward elderly patients also is reported as being compounded and abetted by the very real hospital problems related to coping with increased admissions concurrent with limited budgets and inadequately trained manpower. Hospital administrators and agency heads nevertheless often expressed mixed emotions about the apparent need to concentrate available treatment effort on helping the younger patient who may (or may not) have a better long-range prognosis: "Expedient, but not necessary or correct"; "Obviously but regrettably true"; or "Necessary, not 'expedient.' " As one administrator put it: "It's a matter of priority. With limited staff and increasing admissions, the younger patient with a better prognosis deserves the greater therapeutic effort. It's a matter of concentrating staff and doing a reasonably good job, or watering it down and helping no one."

On the other hand, many State agency directors and public mental hospital administrators expressed their strong convictions that rehabilitation

programs for elderly mental patients can be beneficial not only for these patients, but also perhaps for their communities. "Although presumably the younger person will interact with other human beings for longer than the geriatric patient, maybe you could say that the younger patient would offer it only over a more extended period," surmised one hospital administrator. Said another, "At issue here is our current set of values which stresses youth. . . . Yet society is gradually developing meaningful opportunities for these people —Vista Volunteers, Rotary Exchange Programs, and dozens of others." "When an aged person is rehabilitated, he shows more promise than one who has failed in early life and is apt to fail again," observed one agency head; and, "Obviously, the younger patient can be in the community for more years, but the older patient many times can offer 'more' for shorter periods of time," said an administrator.

Most of these latter respondents appeared to agree generally with the hospital administrator's comment that efforts to aid and thus to reduce the numbers of older patients should be "given a first priority even with limited funds. . . . Then we can develop more effective programs for the younger patients also."

A number of administrators and agency heads pointed out that their hospitals have special units and screening programs for admitting geriatric patients. It has been reported that, "When these units function well, major improvement in most elderly patients can be accomplished," and that ". . . unnecessary admissions can be greatly reduced, since few geriatric patients are really in need of hospitalization except for some supervision of acute episodes."

Respondents' opinions also varied considerably with respect to the psychiatric management of older patients. Observations were offered that "official diagnoses are often wrong," that "CBS and SBD are still used as waste-basket terms frequently diagnosed on basis of patients' age," and that "geriatric populations are not homogeneous." Many stressed that, "While the majority have strong organic elements in their disability, each case must be properly diagnosed," because " . . . some oldsters have a 'functional' disorder. Even in chronic brain syndromes, the superimposed behavioral, neurotic, or psychotic symptoms respond to treatment."

Three apparently contrasting viewpoints were expressed with regard to long-term therapy for older patients. For example. one point of view was that long-term psychotherapy could be beneficial: "All geriatric patients can benefit from psychotherapeutic treatment"; "It depends on the attitude of individual therapist; while individual therapy in institutional settings is difficult, but if possible, results are good"; and, "The majority of geriatric patients can benefit from routine psychotherapeutic treatment."

The counterview stressed that "Recognition, understanding and tender loving care means more to these people than any therapy we have been able to use"; and that "Everyone knows that the aged are never amenable to psychoanalytic techniques." The third position is that, "Few patients, old or young, can benefit from psychoanalysis or long-term psychotherapy." This last respondent, however, clarified further to the point that, "Where psychotherapy includes seeking to understand the life style of the individual, and aiding him to function at his maximum consistent with his life style, if it includes attention to the sources of emotional problems and seeking to ameliorate them, then almost all geriatric patients will benefit. Environmental support should be included in psychotherapy." In such context it is reasonable that another respondent might " . . . feel that both community and state hospital facilities should put more emphasis on psychotherapeutic treatment for the elderly."

Some respondents were more specific in stating their particularly preferred treatment modes. Supportive psychotherapy, that is, psychotropic drugs and good medical care, and the use of sheltered workshops were described as the most useful modes by one administrator, while another stated that, "Physical therapy and occupational therapy are essential." Environmental manipulation, defined as "a physical environment to provide maximum of living with a minimum of physical exertion plus emotional warmth" was recommended by one respondent. Another administrator suggested that older patients could benefit most under "group therapy, limited individual counseling, and a great deal of personalized attention by nonprofessional personnel." One respondent believed that, "The treatment most successful is usually chemotherapy"; while yet another stated that, "I think that the geriatric problem is not a psychiatric one basically. It needs psychiatric consultation, but it is basically a medical problem and one

which is best handled by a GP with some trained internists for special problems."

Perhaps the most concisely pragmatic view of the geriatric problem was expressed by one State agency head: "The elderly are of three classes: (1) definite organic pathology; (2) functional pathology; (3) mixed. With category (1) nursing care is all we can offer. With (2) the same things apply as to younger patients, and many times they fit better on return to society. And (3) completes the spectrum."

It would appear that directors of individual public mental hospitals may have to decide for themselves where best to expend their treatment time and skills, since these care problems necessarily may be secondary to problems of budget and availability of adequately trained manpower. Therapeutic hospital management of the geriatric mental patient need not be "a case of for or against." While it has been stressed frequently that there is a great need for more community facilities and resources to care for older patients, the usefulness and willingness of existing community facilities and resources should not be discounted. In several instances the hospital administrators emphasized that community facilities and resources responded quite well to constructive hospital offers of leadership, guidance, and support.

Perhaps these last optimistic viewpoints have major importance because they have grown out of the actual clinical experiences of the hospital personnel who are closely associated with the care of older patients. To paraphrase one respondent, the prevailing therapeutic climate for the aged in mental hospitals is reflected, to some extent, in the estimated dimensions or scope of the geriatric problem. The dimensions of the problem also reflect the total community attitudes toward working with the mentally ill aged. As this same hospital the administrator concluded, "Efforts to intensify work with the aged involves leadership and commitment to an optimistic outlook, both within the community and in the state hospital."

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An overview of the gerontopsychiatric literature reveals that a number of confusions and conflicts exist among psychiatrists and other professional personnel with respect to the management of elderly mentally ill patients. This survey was an attempt to examine the subject by obtaining from 50 State official mental hygiene agencies and the administration of 269 public mental hospitals their estimates of the dimensions of the geriatric psychiatric problem in their respective States and of the prevailing therapeutic climate for the mentally ill aged in their hospitals. The survey instrument was a two-section questionnaire. Responses were received from 48 agencies and 216 hospitals, although only those from 43 agencies and 178 hospitals were in usable form.

A summary of the findings indicated that while there was considerable variation among the States with respect to estimated proportions of older patients in public mental hospital resident populations, there was a substantial amount of agreement in these estimates between official mental hygiene agencies and hospital administrators within their respective States. When there was a within-State disagreement, it could often be attributed to factors such as either inadequacy of

official or State records or poor communication between the official agencies and their system hospitals or both.

On the other hand, in only about one-third of the States did the hospital administrators agree with their respective mental hygiene agencies about the number of unnecessary admissions, the possible benefits of therapy, and the conceivable hospital discharge rates for patients in the older age groups. In the remaining States, hospital administrators were about evenly divided in presenting larger or smaller estimates for these proportions than their State agencies. Again, there was considerable variation in these estimates among the individual States.

Regarding the therapeutic climate, only two premises elicited nearly unanimous responses among the mental hygiene agencies and within their States.

1. The importance of adequate diagnosis in the management of older patients.

2. The undesirability of long-term therapy programs for such patients.

All other "climate" items elicited a wide divergence of opinions. For example, respondents in both groups were about evenly divided concerning their views about the potential for rehabilitation and the cooperativeness in therapeutic activities among geriatric patients.

Based on the comments from both respondent groups, it might be concluded that currently rehabilitation programs for older mental patients are being emphasized in some State hospitals (probably a minority) and with gratifying results. Both old and new concepts of mental illness and its therapeutic management in elderly patients may exist side by side within the same hospital system, possibly leading to inconsistencies and inefficiencies in the total State rehabilitation program.

There is great variability in the existence and the expected usefulness of community facilities and resources across the country. Where the State hospitals have assumed the leadership to provide guidance and support to community facilities, a large number of aged patients have been appropriately discharged and adequately cared for. Emphasis by hospital administrators and agency heads on support of screening programs has resulted not only in reducing the number of admissions to State mental hospitals through more proper placement of geriatric patients in nursing homes and other community facilities, but also in the return of many adequately functioning older patients to their own homes.