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Study of the mental status of persons in care and nursing homes

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A STUDY OF THE MENTAL STATUS OF PERSONS IN CARE AND NURSING HOMES

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A Study of the Mental Status of Persons in Care and Nursing Homes

Introduction

In our society today, the plight of the aged is one that is causing more and more concern to the medical profession, especially to psychiatry and its associated fields. The 1960 census shows about 16 million citizens of the United States are 65 or over; for 1970, this figure is projected to be about 19 million. This group represents a small percentage of our total population, but its number is growing steadily.

It is inevitable that a great number of these aged persons will be residents in care or nursing home situations, where they will require more medical attention than will those who are not in an institutionalized situation. Psychiatric care will certainly have an important role in the medical care required to meet the needs of these people.

It is the purpose of this paper to attempt to establish the need of psychiatric care by determining the mental status of persons within the care and nursing home population. This work was carried out under the auspices of the Community Services Division of the Nebraska Psychiatric Institute. The function of this

group is to aid communities of the state to become acquainted with the field of psychiatry through educational activities and to develop improved services. A very integral part of this program concerns mental care for the aged. Thus, in an attempt to better understand the needs of the elderly, this study was carried out in hopes that more service can be made available.

Homes

A care home is defined as one which houses residents not requiring rigorous medical attention or the presence of a registered nurse. A nursing home is one in which facilities are available for complete medical care and employs registered nurses. Legally no separation of homes for the aged is made and in reality the terms care and nursing are interchangeable, the above definitions not being adhered to.

In the metropolitan Omaha area, where this study was carried out, there are 30 homes with a population of approximately 1,680 persons. For this study a total of 17 homes were visited with a total population of 692 residents. The other homes were either unlicensed or would not permit entrance by an interviewer and were therefore eliminated from the study.

By criteria established by the Omaha-Douglas County

Health Department the homes are rated as "good," "fair," and "poor." When visited, the "good" homes had a cheery atmosphere, were well staffed and provided excellent recreational facilities for the residents. The "fair" homes lacked in some of these areas, particularly recreation, sometimes in cleanliness and staff personnel. The "poor" homes presented a gloomy atmosphere, poor staff--in numbers and experience--and provided practically no recreation. Above all, in these homes there was no privacy for the residents and no separation of the confused from the well residents. Most of the "good" homes and some of the "fair" homes provided adequate separation.

Method

A 20 percent random sample of the population studied was obtained. This was done by arbitrarily interviewing every fifth person on the roster of the home. Precautions were taken to prevent the attendant from influencing the choice of residents to be interviewed and nothing was known about the person at the onset of the interview except his name.

To evaluate the mental status of those interviewed, a questionnaire was used and verbatim responses were recorded. Primarily these questions dealt with

the status of memory, recent and remote, and orientation as to time, person and place. Questions such as: "What is your name?", "When were you born?", "Where are you from?", "How old are you?", "What is the name of this place?", "What is the date today?", "What is the month?", "Who is the President of the United States?", and "Who was President before him?" were asked directly. These same questions were used by investigators in New York in mental status evaluations of persons over 65. Their results proved to be 92 percent accurate after full psychiatric evaluation was carried out on the same person to whom the questions were asked.

In addition to the above questions dealing with orientation, questions designed to find out more about the person were asked. "Why are you here?" was used not only to find its true answer, but also to determine the person's insight into his situation. "Does anyone come to visit you?" and "Is there anyone in particular with whom you would like to visit?" were designed to elicit emotional response and help determine the person's affect. Since elderly people in homes are away from their families and friends, it was hoped this might bring out some emotional feelings. To find out something about their inter-personal relationships the following questions were asked: "How do

you feel here?", "How do you like the other persons living here?" and "How do they like you?" were asked. "Is anything unusual happening to you at present?" and "Is this a problem with you?" could also be placed in this group, but were also intended to determine any anxieties the person might harbor. Finally, inquiries about health were made: "Do you have any illnesses now?", "What is the nature of the illness?", and "What kind of treatment do you receive for your illness?" were asked. These also served to gain better insight into the person and in some instances brought out things not elicited elsewhere.

The questions were asked in the following order:

What is your name?

When were you born?

Where are you from?

What is the name of this place?

Why are you here?

How long have you been here?

How do you feel here?

How do you like the other persons living here?

How do they like you?

What is the date today?

What is the month?

Who is the President of the United States?

Who was President before him?

Do you have any illness now?

What is the nature of the illness?

What kind of treatment do you receive for your illness?

Does anyone come to visit you?

Is there anyone in particular whom you would like to visit?

Is anything unusual happening to you at present?

Is this a problem for you?

This order was used to evaluate the person's ability to quickly change thought processes from one area to another.

During the interview, objective observations were made and recorded. These consisted of the person's general appearance and attitude, his ability to see and hear, his spontaneity of verbalization, the coherence of his speech, and the presence of any peculiar mannerisms.

After the interview, questions about the person were asked of the attendant in charge. These were:

Does this resident wander?

What does this resident talk about?

Is this resident confused?

Does this resident strike others?

Is this resident cooperative?

Does this resident cry?

Is this resident withdrawn?

Does this resident care about his personal appearance?

Do you think additional care is needed?

The resident's record was also checked to verify age, birthdate and where he or she was from.

With all this information available, each of the persons interviewed was categorized according to the standard nomenclature described below.

Classifications

Normal senescence - Persons placed in this category were found to be well oriented to time, place and person. They displayed alertness, continuity of thought, proper affect, good appearance, interest in others and apparent good adjustment to the home situation and those around them. They appeared to have no gross neurotic tendencies nor were they subject to obvious confusion states.

Psychoneurotic reactions - This disorder is described as being primarily manifested by anxiety which may be directly felt and expressed, or automatically

controlled by defenses and symptoms. These persons show no reality distortion or personality disorganization. They usually maintain symptoms to obtain a secondary goal, such as, advice or sympathy. In elderly people neurotic tendencies may become more profound, especially anxiety and depression. The latter, however, may sometimes be indistinguishable from chronic brain syndrome.

Persons placed in this category displayed quite gross evidence of an anxiety reaction. Many persons were found to exhibit depression, but were placed in the chronic brain syndrome category on the basis of other information obtained. No attempt was made to classify these people into the sub-types of psychoneurosis.

Psychosis - The pattern of this disorder consists of personality disintegration, inappropriate responses to reality, failure to relate to others, and may be characterized by severe depression, delusions, hallucinations and peculiar mannerisms.

Unless masked by the above symptoms a psychotic may or may not have a normal sensorium. In this study, the persons were placed in this category by knowledge of previous institutionalization for psychosis.

However, they did show the manifestations of psychosis clearly and, in most instances, the same conclusion could be reached after reviewing the questionnaire.

Chronic brain syndrome - This is described as a relatively permanent illness with impairment of intellectual functions such as comprehension, knowledge, memory and judgment.. Also, impairment of sensorium, emotions, physiologic functions and behavioral disorders are noted in varying degrees. Psychoneurosis and psychosis may also be present with the chronic brain syndrome, therefore the following breakdown was made:

Chronic brain syndrome without associated disorders.

Chronic brain syndrome with behavioral disorders.

Chronic brain syndrome with psychoneurosis.

Chronic brain syndrome with psychosis.

Evaluation was made primarily from the questionnaire response, but often final analysis was made only after reviewing the objective findings and the attendant's comments about the person.

The psychophysiologic disorders and the personality disorders were not considered in this classification.

Case Examples

No. 1 - This person is a 74-year-old resident of

a home rated as "fair" by the health department. She was found to be quite neat appearing, ambulatory, and able to see and hear well. However, she was two years off on her age and one year off on her birthdate. She did not know the exact date, but did know the month. She answered the other questions correctly, but needed several minutes to recall the correct answers. The attendant reported that she wanders occasionally, is somewhat confused, and crys frequently about her son who visits her regularly. The patient stated she was very worried about herself and that she was depressed. However, the attendant stated that she is a good mixer and gets along well with everyone. This lady displays some impairment of memory, occasional confusion states and mild depression. She was classified as chronic brain syndrome without associated disorders.

No. 2 - This resident is an 85-year-old female who lives in a home rated as "fair." She was noted to be neat appearing, ambulatory, and able to see and hear well. She was constantly wringing her hands, pulling at her clothing, and persistently talked about being old. She first gave her maiden name, but later remembered her married name. Her memory was very poor, as she did not know her age, birthdate, the date or

the month. She could not answer the questions about the President of the United States and had no idea where she was. The attendant reported she was confused most of the time, wandered away many times and that she fought with the other residents constantly. This resident was classified as chronic brain syndrome with behavioral disorder.

No. 3 - This man is 74 years old and is a resident in a home rated as "poor." He looked depressed and was very much in need of a bath. As the interview progressed, it was evident that he was very depressed with his situation. He stated he had lost all interest in his surroundings and the events of the day. He was well oriented as to place and person but did not know what month it was. He stated he hated his roommate and repeatedly said he wanted to leave the home. This man had had a CVA resulting in hemiplegia and he was confined to a wheelchair. He said he had no visitors and that this depressed him. He also talked about his present illnesses excessively. The attendant noted that he seems obsessed by his illness. She stated that this resident had no interest in improving himself. This resident displayed quite adequate sensorium, but was undoubtedly depressed. Because of his obvious brain damage and marked depression, he was classed as chronic

brain syndrome, with psychoneurosis.

No. 4 - This 80-year-old female was interviewed in a home rated as "fair." She was confined to a chair by restraints and had a frenzied appearance. She was constantly moving back and forth in the chair during the interview. In response to the questionnaire, she knew only her name. All other responses consisted of "Ace, King, Queen, Jack and Ten of Hearts." Occasionally, she would say other words, some profane, but nothing rational. The attendant stated that this resident constantly jabbered about "Hearts" and nothing else. She did not care about her personal appearance and was incontinent. It was reported that this woman was a prominent citizen of a rural community before coming to the home. She was classified as chronic brain syndrome, with psychosis.

No. 5 - This lady is 78 years old and lives in a home rated as "good." She answered the entire questionnaire accurately and displayed a quick memory. She was neat appearing but looked quite depressed. She was not friendly, but rather seemed to be withdrawn. She admitted being depressed and started to cry at that time. She stated she just could not make friends like she wanted to. The attendant

described her as being self-centered and always on the "outside" of things. She was classified as psychoneurotic on the basis of her depression.

No. 6 - This lady was seen in a home classified as "fair." Her true age was not known and she had been in a state hospital for many years before coming to the care home. She was a neat appearing woman who described herself as "the oil woman." She was well oriented as to time and place and displayed no abnormal mannerisms or physiological dysfunction. Twice during the interview she experienced auditory hallucinations, having to go to the window to see what "Uncle Saboo" was saying to her. Each time he had advised her to answer the questions, the answers being very bizarre. She also talked about bugs and insects on the floor that sang songs at night. The attendant stated that this patient was very withdrawn and that the state hospital diagnosis was schizophrenia. On the basis of that history and the obvious personality disintegration and hallucinations, this resident was classified as psychotic.

The above cases certainly are not typical of all the residents of the various classifications, but these are the most clear cut.

Results

A total of 138 interviews were conducted, 97 (70 percent) being with female residents. In addition to the determination of the mental status of the individuals interviewed in this study, it was possible to gain some added information from the questionnaire for statistical presentation. The two areas chosen for presentation are these: (1) social visits to the residents, and (2) their reason for being in the home. Homes for the aged have long carried the stigma of being full of people who were put away and forgotten by family and friends. In the questionnaire, the questions "Why are you here?" and "Does anyone come to visit you?" were asked of every person interviewed. Concerning social visits, a "yes" or "no" answer was usually obtained. The results, in Table 1, show that a total of 67 percent responded that they did have visitors, while 28 percent indicated they did not have visitors. The remainder was unable to respond. It is interesting to note the difference in statistics in the differently rated homes.

TABLE I

	Rating of Home		
Answer	Good	Fair	Poor
Yes	47	43	5
No	10	19	9
Unable to answer	0	5	0

The question "Why are you here?" brought various answers, but could be broken down into four basic reasons: previous illness, family reasons, nowhere else to go and, again, unable to answer. Those under "previous illness" gave answers such as "I was sick," "I came from the hospital," "I broke my hip," etc. Also, those from state institutions were put in this category. Family reasons included answers such as: "My children put me here," "My kids can't afford to put me up," "I don't like my relatives and didn't want to live with them," and "My children thought it would be best." Two persons interviewed came with their spouses and were placed in this category. The "nowhere else to go" group includes the following responses: "No place to go," "My husband died and I didn't want to be alone," "I couldn't keep up the house anymore, so I came here" and "I was lonely being by myself." Again, it is interesting to note the variations in the differently rated homes, as shown in Table II.

TABLE II

Reason	Rating of Home: Good	Fair	Poor	Total %
Illness	5	19	7	22.4
Family	10	10	0	14.4
Nowhere else to go	34	20	4	42.0
Unable to answer	8	18	3	21.2

In this study group, it seems apparent that these people are not neglected by friends and relatives, and the largest percentage entered the home voluntarily, not being "put away and forgotten."

The results of the mental status evaluation are given in Table III. Of the 138 interviews conducted, 57 were in "good" homes, 67 in "fair" homes and 14 in "poor" homes.

TABLE III

Classification	Rating of Home: Good	Fair	Poor	Total %
Normal senescence	30	17	3	36.2
Chronic brain syndrome	24	37	9	50.7
Psychoneurotic	3	1	1	3.6
Psychotic	0	10	0	7.2
Unclassified	0	2	1	2.3
Totals	57	67	14	100.0

These results show that, for this study, 50 percent suffered from chronic brain syndrome, with or without associated disorders. The next most prevalent

group was normal senescence, being 36.2 percent of the total. The psychoneurotic group was small, but many with neurotic tendencies were included in the chronic brain syndrome group. The 7.2 percent classified as psychotics all had histories of previous institutionalization and carried that diagnosis when they entered the home.

As noted earlier, the chronic brain syndrome group was further classified. The results are given below.

TABLE IV

Chronic Brain Syndrome	
without associated disorder	19
with behavioral disorder	23
with psychoneurosis	14
with psychosis	14
Total	70

These figures show a fairly even distribution of the variances of chronic brain syndrome. Those persons without associated disorders primarily displayed disorientation and memory loss. Those with behavioral disorders were belligerent, uncooperative, careless about appearance and displayed peculiar behavior, such as hiding things, etc. Those with psychoneurosis mainly showed depression. A few displayed frank

anxiety, but none of the other psychoneurotic disorders were noted. The psychotics displayed withdrawal, autism and hallucinations most frequently. Communication with many of these residents was impossible.

Discussion and Conclusions

A review of the literature shows a paucity of studies of this type. Only two studies of the mental status of persons in homes for the aged have been done in the United States. One involved the evaluation of 557 persons, 84 percent of whom were classed as chronic brain syndrome. No other classifications were made. The second study dealt only with the prevalence of psychoneurotic disorders, stating that 25 percent of those interviewed (no number was given) showed neurosis, depression and anxiety being most common.

A report from Denmark, where much work has been done concerning nursing and care homes, states that 37 percent of all residents are mentally ill, 50 percent of this group classed as chronic brain syndrome.

The results of the study reported here vary markedly from those reported in the literature. 61.5 percent of those interviewed were found to be mentally ill, 81 percent of these, or 50 percent of the total,

being in the chronic brain syndrome category. The incidence of psychoneurosis was 14 percent, about half that of the study cited above.

Many variables are present that may account for the discrepancies. The experience of the person making the evaluation is probably most important. The method and completeness of the interviews certainly would play a part. The background of the persons interviewed, including mores, past occupation, medical history and family history would enter in. Also, the practice of placing elderly people in homes may vary from place to place, thus presenting a different populace to study. Probably a long list could be made, but that is not our purpose here.

This study shows a high incidence of mental illness, but a striking feature is that the incidence is highest in the poorer homes. Although the sample was small in the "poor" rated homes, a 71 percent incidence of illness was found. The large sample, 67, taken from the "fair" rated homes showed 72 percent incidence of illness. However, of the 57 interviewed in "good" homes, only 47 percent were mentally ill. The conclusion might be made that the environment has something to do with the incidence of mental illness.

However, factors such as criteria for admission, cost, etc. are not known, so no definite conclusion can be made about this.

These definite conclusions can be made:

1. There is a high incidence of mental disease among residents in care and nursing homes.

2. Chronic brain syndrome is most prevalent.

3. These people are not exactly "put away and forgotten."

4. Women outnumber men about 2 to 1.

5. The need for psychiatric care is indicated.

Summary

1. The mental status of 138 persons in care and nursing homes in the Omaha area is presented with classifications of (a) normal senescence, (b) chronic brain syndrome, with and without associated disorders, (c) psychoneurosis, and (d) psychosis being described with case examples.

2. The method of direct interview and associated information gathering is described.

3. A literature review is presented, showing the paucity of work in this field.

4. Statistical results are listed and conclusions are drawn.

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