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# THE WASHINGTON COUNTY MENTAL HEALTH SURVEY A FOLLOW-UP OF PATIENTS ADMITTED TO THE ARKANSAS STATE HOSPITAL, 1930-48\*

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This paper is a progress report on the findings to date in one phase of the Arkansas Mental Health Survey. The survey is a joint undertaking of the Arkansas State Hospital, the Arkansas State Board of Health, and the University of Arkansas. The research upon which this paper has been based is the product of the University's Institute of Science and Technology, done with the advice of psychiatrists on the Staff of the State Hospital and of an Advisory Committee, composed of specialists in psychology, sociology, rural sociology, and social welfare, from the University faculty. The projected program of the Arkansas Mental Health Survey includes: (1) a follow-up study on a sampling basis of former patients of the Arkansas State Hospital, to discover how they have readjusted to their communities, (2) a statistical analysis of the material in the Hospital records for the 33,000 patients admitted from 1930 to 1948, (3) a survey on a sampling basis of the extent of mental disability in the general population. It is expected that the findings of this survey will represent a scientific contribution as well as form the basis for a mental health program in Arkansas.

The particular aspect of the study on which this is a report is the follow-up of former patients of the State Hospital made in Washington County, Arkansas, in the summer of 1949. This study was conceived of as a pilot study for a state-wide survey, and a similar pilot study is now in progress in Jefferson County. It was felt that these two counties would provide experience with most of the segments of population to be encountered in Arkansas. One of the main functions of the Washington County Pilot Study was to make a preliminary test of some aspects of the study design for the statewide survey; among these were schedule construction, interviewing technique, case-finding procedure, and the utility of mailed questionnaires. Due to limitations of time, this paper will not be concerned with the methodological findings, but will be limited to the substantive findings of the Study as they have been revealed to date.

Washington County is an Ozark County containing two cities of over 2500 persons. It has some very isolated rural areas, but has a higher than average income for the State. Its average annual admission rate to the State Hospital for the period was about 8 per 10,000 population in 1940. This is somewhat lower than the State average but falls within the middle third of the counties' admission rates.

The sample for the Washington County Study consists of 502 patients who were admitted to the State Hospital between January 1, 1930, and Decem-

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ber 31, 1948. The sample represents all kinds of disabilities which are accepted for Hospital admission: the psychoses, the psychoneuroses, psychopathic personality, alcoholism, and epilepsy, as well as patients who were admitted and found upon diagnosis to be without psychoses or without mental disability unless these admissions were for a legal test of sanity. For all cases for whom an informant in Washington County could be located, an intensive interview was obtained. In every case the attempt was made to interview a close relative who was intimately acquainted with the patient. Information for those cases for whom no informant in the sample area could be found was obtained by a mailed questionnaire when this was possible. The four interviewers were college graduates in psychology, social work, or sociology; had previous interviewing or related experience; had done, with one exception, graduate work; and were intensively briefed before field work started.

The survey obtained some information on all but six percent of the cases. Thirty-two percent of all the cases admitted to the State Hospital had died while there. An additional thirteen percent had died since their release. Eighteen percent of the patients admitted in the period were in a mental hospital at the time of the survey, all but five cases being in the State Hospital. The remaining 31 percent, those who were living and not in a mental hospital are those to whom the remainder of this paper will primarily be devoted.

Analysis of the Washington County data is by no means complete and many of the findings are at the present time tentative and inconclusive. The material to be presented is primarily descriptive; many of the questions concerning relationships among the data must await further analysis and some must await the larger sample of the statewide survey.

Inquiry was made into four major areas of the patient's adjustment: first, his recovery from the symptoms of his mental disability, second, his adjustment to the economic world, third, his participation in the social activities of his community, and fourth, his adjustment in marriage and family life. The informant's judgement as to recovery level and the interviewer's rating were both employed for the first area. As a means of rating each patient with regard to the last three areas of adjustment, a Guttman Scale was constructed for each area.<sup>1</sup> This scale classifies cases into types possessing rank order, but does not assume that adjustment can be measured in terms of some quantitative unit.

#### THE EXTENT OF RECOVERY FROM MENTAL ILLNESS

According to the informants' responses to a question specifically asking about the mental condition of the living patients, three out of ten have recovered and one-third of these is said to have achieved a better personality adjustment than they possessed before the onset of their difficulty. Another

<sup>1</sup>Louis Guttman, "The Cornell Technique for Scale and Intensity Analysis," a paper presented to the Conference on Measurement of Consumer Interest, University of Pennsylvania, May 17-18, 1946.

three still possess symptoms of their mental disturbance, but not symptoms so severe as to require hospitalization, while almost 4 out of 10 are presently hospitalized because of their mental condition. The informants' responses to this question also seem to indicate that no total gain in recovery level was registered between the time of release and the time of the study among those patients who are not now hospitalized. While some patients recovered beyond their condition at release, others became worse so that the total picture remains the same.

While the history of the patient's disorder since release is not investigated as thoroughly as it might be, readmissions give some indication of the amount of recurrence. Of the former patients who were not in the Hospital at the time of the study, 1 out of every 4 had returned to the State Hospital at least once. The meaning of this rate of readmission for the Hospital is made clearer by observing that over one-half of the Washington County patients in the State Hospital now have been there at least once before. It is also interesting to note that eight percent of the cases when admitted to the State Hospital for the first time were known to have been admitted previously to some other mental hospital.

With the exception of present age, the same factors were correlated to number of readmissions as to recovery level, readmission rates being lower for women, for white-collar workers, and for those who were admitted to the Hospital more quickly after the illness was recognized. More readmissions were found for those whose age at first admission was under 30.

#### OCCUPATIONAL ADJUSTMENT

The capacity to carry on one's appointed task is the *sine qua non* of satisfactory personal adjustment. For most adult males this means some kind of gainful employment and for adult women it generally means either homemaking or a gainful occupation. For this reason, considerable attention was given to these aspects of adjustment in the follow-up of released patients.

At the time of the follow-up, 46 per cent of the released patients for whom information was available were gainfully employed. While there is no exact measure of the amount of employment in Washington County, the best estimates available indicate that this figure is comparable with that for the general population of Washington County. Apparently until they are sufficiently ill to necessitate hospitalization, these persons are able to keep up a semblance of useful employment in the same proportion as the rest of the population.

In order to obtain some estimate of the regularity of employment and whether or not work was full or part time, it was asked how much of the time in the six months prior to interview the patient had worked for pay. For those for whom information was available, this question revealed that a little less than one in four had been fully employed during the entire period. An additional twelve per cent had been employed more than half the time. Nine per cent had been employed, but worked less than half the

time. It appears then that while the former patients of the State Hospital are employed in about the same proportion as the general population, they are probably less regular in their employment history.

At the time of the interview, 54 per cent of the cases were reported as "not gainfully employed." Included among these are 26 per cent reported to have home duties; the remainder were reported as "not doing anything" (28 per cent of all known cases).

As might be expected there were differences by sex and marital status. Women were reported to be gainfully employed much less frequently than men. Persons of both sexes who did not live with a husband or wife at the time of the study were reported to be "doing nothing" in considerably larger proportion than those who were living in a married state. This is probably related to the fact that the married person has more responsibility to support his family or to take care of her home than does an unmarried person. There is also probably a tendency for the more fit persons to marry or remain married; such a selective factor would operate to produce these findings. In addition fewer elderly persons would be living in a married state.

Practically all of the women classified as having home duties were found, when further inquiry was made, to be doing either all of their housework or nearly all household tasks. The great discrepancy between the proportion of married women reported as "not doing anything" and the rest of the sample may possibly be accounted for by greater pressure on them to perform their tasks combined with laxer standards of performance. As has already been pointed out, however, there is also evidence that women living with their husbands have on the whole made the best recoveries.

The great majority of the persons who were not employed, including home makers, were supported by their families; however, 15 per cent were dependent on some other source, primarily Public or Old Age Assistance. Thirteen per cent were self-supporting through savings, pensions, or other forms of income. Among the unemployed patients who had at some time been gainfully occupied the median length of time since their last jobs was five years. Almost one-fourth had been unemployed less than one year and the same proportion had been unemployed for 20 years or more.

Not all of the unemployment found among the former patients was attributed to mental illness. The following are the causes to which any lack of employment in the six months prior to the interview was primarily attributed by the informant:

family duties	29
mental or physical condition	27
inability to find work	20
physical condition	12
age	7
unwillingness to work	7
other reasons	18
	<hr/>
	120



It is apparent that there is a great deal of over-lapping among these categories. "Age," for example may be associated with either mental or physical disability. "Unwillingness" to work may well be part of the patient's syndrome, and the fact that an individual cannot find work may also be an indication of mental or physical disability.

For those patients who were employed a favorable picture of adjustment on the job was presented by the informants. Practically all cases were reported as having a job that was "very suitable" or "adequate" to the patient; that he liked his job "very well" or "pretty well," that he got along "very well" or "pretty well" with his fellow workers, and that he was fatigued by his job only "seldom, never, or sometimes."

An interesting question is how the experiences of mental illness and hospitalization affected the patient's occupational adjustment. If the period of six months before the patient's first hospitalization is used as a basis for comparison, no significant differences in the proportion of patients in each occupational group, in the regularity of employment, or in employment status are observed. Since half of the cases for whom these data were available, suffered the onset of their disorder by the beginning of this six months period and another six per cent were experiencing their difficulty during at least half the period, the mental illness can be presumed to have already had its effect on the majority of patients during this period. Thus it would seem that hospitalization was not successful in raising the occupational adjustment of the patients as a group beyond the level they were at during their illness. It would be desirable in the statewide survey to include a comparison of present occupational adjustment with adjustment prior to onset as well as with adjustment just prior to hospitalization.

#### MARRIAGE AND FAMILY ADJUSTMENT

The expected pattern of behavior in our society, especially in an area as bound by tradition as the Ozarks, is that adults marry and bear children, preserving a permanent union between the marriage partners. To what extent have the former patients been able to conform to these minimum essentials?

A comparison with the total population of the United States 14 years and over in 1948,<sup>2</sup> shows that while 64 per cent of the U. S. population are married, only 41 per cent of the released patients are married, and that a large amount of this difference is accounted for by higher proportion of divorced and separated persons among former patients. Despite the fact that there are more divorces among the patients, approximately the same proportion of patients have been married more than once as is found in the general population. This probably implies the existence of an unmarriageable residual. A slightly larger proportion of single persons is also reported for the former patients.

<sup>2</sup>"Current Population Reports: Population Characteristics," Series P-20, No. 23 (Washington D.C.: March 4, 1949).

The quality of the social relationships between the former patient and other members of his family represents another facet of family and marriage adjustment. At the lower level of adjustment are those cases whose mental disabilities present special problems for their families. The families of one-fourth of the patients had to take their mental disabilities into account and make allowances for them; for part of the patients this was only necessary occasionally and for a similar number it was more or less usual. For one-tenth of the patients the responsibilities of the family went beyond this to include special care of appearance, and in a few cases feeding.

About four out of ten patients were reported to be hardships to their families in some respect: frequently mentioned were that the patient made extra work and responsibility for other family members and that he caused additional expense. The economic burden generally consisted in supporting an adult who would under normal circumstances be financially independent or himself contribute to the family's support. Few patients were under the care of a physician for their mental condition. A sizable proportion of the families complained that the unsocial behavior of the patient or the care given to him disturbed family life. Three per cent complained that the patient's illness injured the family's status in the community.

Another aspect of family adjustment is the extent to which patients were able to get along with other family members without coming into conflict with them. Naturally the extent to which the patient is able to do this partially depends on the attitude of the others, a factor which present data does not permit control of. One out of five patients were reported not to get along well with the family in which they lived. Fifteen per cent of the patients who were married and living with their husband or wife at the time of the interview were considered by the informant to be less happy than "average." Exactly half were reported to be "average," and the remainder happier than "average." This was somewhat a more favorable picture than that reported for patients living in other than a conjugal family. Half of these patients were reported to be less happy than average.

When the present happiness of marriages is compared with the situation prior to onset it is found that for the great majority it is reported to be the same as before the onset of illness, and about the same proportion have become more happy as have become less happy. But for the patients who live in other family groups, the situation has become less happy for somewhat more than it has become better, though again it remains the same for the majority.

In summary, at the present state of analysis it seems that a larger proportion of these patients are living in an unmarried state than one would find in the general population and this is primarily the result of a disproportionately large number of divorces and separations although further analysis may show that more have never married. A significant proportion require special consideration and often considerable sacrifice from other members of the family, and a smaller proportion were living in a family where they did not get along and were unhappy. Persons living with their

husband or wife were somewhat happier than those living in other kinds of family groups.

#### SOCIAL ADJUSTMENT

Membership in organized groups and especially attendance at meetings can be said to indicate to some extent, the amount of recovery achieved by the patient. It indicates that his mental condition is good enough to enable him to associate with others and that his symptoms are sufficiently reduced that he is to this extent acceptable to his associates; his participation also measures in some degree his contribution to the community's activities. By "organized groups" is meant groups in which relationships between members are to some extent formalized, such as churches, lodges, farmers' organizations, women's clubs, unions, luncheon clubs, and so on.

Of the former patients about whom we have information on this point, two-thirds had not attended any meeting of any organization in the month immediately prior to the interview, and one-fourth had attended from one to four meetings only. A little over one-half of the former patients about whom we had information belonged to no organization, while 37 per cent belonged to only one organization. None of the former patients belonged to more than three organizations.

While we have no data by which to compare these former patients with the general population of Washington County, comparison with other populations indicates somewhat less participation on their part, though the difference is not striking and could be accounted for in some instances as easily by other differences between the samples as by differences between former patients and a non-hospitalized population. Thirty-five per cent of the former patients were church members as compared to 38 per cent of the population of a sample of 130 village-centered southern communities in 1936.<sup>3</sup> In Boone County, a somewhat more isolated and rural Ozark county than Washington County, 58 per cent of the farmers and their wives were church members as against a little less than 50 per cent of the former patients living on farms.

When the patients living in Fayetteville and Springdale are compared with the general population of Boulder, Colorado, it is found that the proportion of patients who belong to no organization is not greatly different from that in Boulder; however the proportion belonging to more than one organization is smaller.<sup>5</sup> Since in the vast majority of cases, persons who belong to only one organization belong to a church, this means that the town-dwellers among the Washington County patients participate in the church as frequently as do the citizens in Boulder, but participate less in other organizations.

<sup>3</sup>J. H. Kolb and E. de S. Brunner, *A Study of Rural Society* (Houghton Mifflin Company, 1940) p. 500.

<sup>4</sup>J. L. Charlton, "Social Aspects of Farm Ownership and Tenancy in the Arkansas Ozarks" (Fayetteville, Arkansas: Agricultural Experiment Station, University of Arkansas College of Agriculture, Bulletin 471, September 1947) pp. 40, 41.

<sup>5</sup>F. A. Bushee, "Social Organization in a Small City," *American Journal of Sociology*, Volume 51, November 1945, pp. 217-226.



In answer to the question, "Does he attend more or fewer meetings than he did before his illness?", informants who were able to answer the question reported that about one-third of the patients attend fewer meetings, 52 per cent attend about the same number, and 14 per cent attend more.

In the Washington County study, amount of visiting was taken as indicative of the extent of informal social participation. Information on amount of visiting was obtained for 80 per cent of the former patients. Separate questions were asked concerning visits from others and visits made by the former patients themselves, but the over all picture indicated that visiting was reciprocal: the persons in the sample were visited as frequently as they visited, although, of course, individual exceptions appear. Almost 60 per cent of the patients received at least one visit and made one visit a month. The frequency distribution is bimodal, one falling in the class interval of less than one visit a day but at least once a week, in which about one-third of the cases fell, and the other mode falling in the class interval of less than one visit a month, in which one-fifth of the cases fell. Many of these cases were reported never to receive or make visits.

Only very fragmentary data on visiting for general populations are available, but the evidence we have seems to show that the patients as a whole do not differ strikingly from other populations for whom data are available.<sup>6</sup> Nevertheless only 12 percent visited more than the rest of their families while 29 percent visited less. Although there may be some variation in the amount of visiting considered as normal for persons in different family roles, by and large this group of cases does not visit as often as persons in their communities, social classes, and families are expected to, and thus represent a poorer than average level of social adjustment in this respect.

When the informant was asked to compare the amount of the patient's visiting with his visiting before the onset of his difficulty, the picture is almost identical to that presented when the comparison is with other members of the family. If the patients' visiting behavior were about like that of other family members before the onset of their mental difficulties, this would be the expected outcome of this question.

Another measure of social adjustment is the extent to which patients have so far over-stepped the boundaries of acceptable behavior that they have come into conflict with the agencies of law enforcement. Seventeen percent of these cases were known to have either been arrested or "had trouble with the law." In about half the cases, these difficulties with the law occurred at the time of Hospital admission or at subsequent readmissions. It is the usual procedure for the sheriff to drive patients to the State Hospital, but these cases were those in which the symptoms of the disorder caused the patient to be apprehended as a law violator or he was considered to be so by his family or other members of his community, who called a law enforcement officer out of fear or helplessness. In view of the fact that there are

<sup>6</sup>See J. L. Charlton, *op. cit.*, pp. 40, 41 and J. L. Hypes, *Social Participation in a Rural New England Town* (New York Bureau of Publications, Teachers College, Columbia University, 1927) p. 29.

no facilities or personnel for the care or treatment of psychiatric cases in the County other than those provided in the veteran's hospital, it is not surprising that the sheriff and police become custodians of the mentally ill and that the jails frequently house them until their removal to the hospital.

Of the cases for whom legal difficulties were reported, one-half reported fewer since their hospitalization. For some patients at least, this is probably an indication that they have not experienced the return of violent or acutely aggressive behavior which originally precipitated their admission to the Hospital. One-fourth reported more legal difficulties and one-fourth the same number.

#### CONCLUSIONS

An over-all picture of the adjustment level achieved by the former patients of the Arkansas State Hospital can be obtained from the total adjustment scale constructed according to the Guttman technique. Since cultural expectations are different for persons of different sex and marital status, four scales were constructed each using as scale components the interviewer's rating of the former patient's personality adjustment, and the occupation, social, and family adjustment scale scores. The scale types of the central categories of the four scales are not the same, but the highest and lowest scale types are identical. For those patients for whom sufficient information was available to construct the scale it was found that nine percent fell in the highest scale type. Former patients in this scale type have made above average personality adjustment, are employed and have good occupational adjustment, high social participation, and good family adjustment. If women who scored high on personality adjustment, social participation, and family adjustment, though they are not employed, are included in the highest adjustment level, a course which is probably justified by the traditional female role in our society, we find 19 per cent or almost one out of every five former patients in the "well-adjusted" category.

Twenty-four per cent fell in the lowest scale type in which personality adjustment is below average, patients are not employed or have poor occupational adjustment, have little or no social participation, and make poor family adjustments. Few of these cases were obviously in need of hospitalization, but the need for some kind of clinical guidance to help them achieve better adjustment is self-evident.

One practical conclusion which may be drawn from this study to date is that Arkansas must make available to citizens in all parts of the State psychiatric services for prevention, diagnosis, and follow-up care. This may be done through general hospitals located throughout the State or through mobile clinic units or perhaps a combination of both.

