A SURVEY OF 100 FEMALE SENILE ADMISSIONS TO A MENTAL HOSPITAL

By

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AN investigation was undertaken to determine the fate of 100 consecutive female admissions over 65 to a mental hospital. The patients were admitted to Kingsway Hospital, Derby, between October 1958 and December 1959 and were each followed up for a year or until death. These 100 patients formed 24% of the total female admissions for the period. The catchment area from which they came includes the County Borough of Derby (a heavy-industrial town) with a total of over-65 female population of 8,724; Shardlow Urban District (a rather rambling and mainly country area) with 5,633; and Long Eaton Urban District (a light-engineering town) with 1,934. Thus the total over-65 female population was 16,311. Working from these figures the expected admissions from these areas would be (in %): 53 : 35 : 12, whereas the actual figures were (in %): 62 : 30 : 8. This shows, as one would expect, a proportionately higher admission rate from the industrial areas.

REASONS FOR ADMISSION

The main symptoms which led to admission were depression in 29 cases, including 9 suicidal attempts; confusion and agitation in 20; aggressive behaviour in 15; restlessness in 14; delusions of persecution in 12.

Eleven patients showed no florid symptoms, but were unable to care for themselves or their homes.

TYPES OF MENTAL ILLNESS

The patients were classified into three groups according to their illness, namely degenerative, affective and schizoid.

The degenerative group, containing 62 cases, was the largest and included 48 cases of senile dementia, 10 cases of arteriosclerotic dementia, 3 cases of confusional state (2 due to cardiac failure and 1 to diabetes), and 1 case of organic dementia due to secondary cerebral neoplasm.

The affective group contained 30 cases of endogenous depression and 1 case of reactive depression.

The schizoid group contained 7 cases of late paraphrenia.

Of the total series, 30% had a history of previous mental hospital admissions.

AGES

The ages on admission varied from 66 years to 88 years, the average being 73 years and the standard deviation 5·9.

PHYSICAL ILLNESSES ON ADMISSION

Hypertension (greater than 200/110) (11 cases); cataract (8 cases); cardiac failure (6 cases); cerebral thrombosis (6 cases); arthritis (5 cases); bronchitis (3 cases); pernicious anaemia (2 cases); diabetes (2 cases); deafness (2 cases); and 1 case each of: gastric ulcer; asthma; psoriasis; subacute combined degeneration of the cord; syphilis; angina pectoris; mitral disease; peripheral neuritis; cerebral tumour; and vaginal prolapse.

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Home and Marital State

Thirty-two per cent of the patients in the series lived alone, compared with the national figure for women over 65 of 14%.

Nine of the 32 patients in this group were discharged, and of these 7 went to live with a relative, only 2 being able to return to a solitary existence.

The marital state of the patients called for little comment, the distribution of married, widowed and single showing no significant variation from the national figures.

Disposal and Duration of Stay

Of the 100 patients admitted, 17 died and 46 were discharged during the year of follow up. 27 patients (87%) of the affective group, 17 patients (27%) of the degenerative group and 2 patients (28%) of the schizoid group were discharged.

The average duration of stay of the various groups was as follows: affective —66 days; degenerative—70 days; schizoid—107 days.

Causes of Death

Compared with the local figures for women over 65, there was an increased overall death rate (17% : 7·4%). The causes of death in the series with the corresponding local figures in brackets were: cerebral vascular lesions 24% (16%); cardiovascular disease (excluding the above) 24% (45%); chest diseases 40% (16%); accidents 12% (2·8%).

Treatment

Thirty-one of the patients were given electroplexy modified by pentothal and brevidil, whilst the remainder had tranquillizers only. The main tranquillizer used was sparine, which was usually given as the suspension.

Occupational therapy was undertaken by all patients except those who were physically ill. No leucotomies were performed and psychotherapy was limited to discussion of the patients' problems, mainly of a social and welfare nature. The local mental health officers and the hospital social workers were helpful in maintaining contact with the home and tried to ensure that the patients' former accommodation would be available on discharge.

Discussion

The following points have emerged from the survey:

(1) Amongst the patients living alone there was a higher proportion of senile and arteriosclerotic dementia than in the whole series (66%: 58%). Many of these patients were unable to do their own shopping, cooking and housework, and would have benefited greatly if sympathetic help had been given by their families. In this way admission might have been avoided, or at least delayed. Whilst the Welfare Services provided meal tickets and occasional visits, these were inadequate for the patients' requirements. In several cases widowhood and slum clearance schemes led to re-housing and this had a detrimental effect. Old ladies who had friends in the centre of the town were moved to very nice bungalows on the outskirts, where their friends had difficulty in visiting, because of the distance involved and expense of the bus fares. The resultant isolation, combined with some confusion in the new surroundings, was sufficient to precipitate the necessity for admission. In some cases admission to hospital led the families to realize their responsibilities, and to assist with the accommodation of their parents on discharge.

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(2) In many cases the hospital admission was due basically to a physical ageing process. Thus the 11 patients who died in the first two months might well have been treated at home if the relatives had been more co-operative. Incontinence was a large factor in determining whether relatives were able to cope with the patient, and the suggestion is put forward that the more extensive use of disposable drawsheets might be useful in this connection.

(3) The list of physical illnesses which were found in patients on admission points to the need for the psychiatrist to be a good general physician, in addition to having a specialized knowledge of mental illness. This has also been borne out recently by Herridge (1960) in his investigations of physical illness in a psychiatric ward.

(4) The discharge rate (41 %) and the duration of stay (77 days) gives the lie to the idea that elderly people with mental illness who enter the mental hospital will never emerge again. This attitude of hopelessness is quite common in the community, and even in some practitioners. Whilst most of the recent propaganda for mental health stresses the curability of younger mental patients, little is said of the older patients. Though the demented patient cannot be returned to sanity, she can often be habit-trained and tranquillized, so that she is no longer out of place in a home setting with tolerant relatives.

Reference

Herridge, C. F. (1960). *Lancet*, *ii*, 949.

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