Age, Disability, and Rehabilitation

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IOWA REHABILITATION ASSOCIATION
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Institute of Gerontology,
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Iowa City, Iowa

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Foreword

For its second annual meeting, the Iowa Rehabilitation Association wished to have a program of substance in a current problem area of central concern to all of its members. From their own experiences, members of the program committee saw the need for focusing the attention of Association members and the community on the full range of rehabilitation needs of elderly citizens. In addition, the committee recognized the desirability of bringing to the meetings some newer concepts, program descriptions, and research reports developed in the last decade, an era of profound change and increased concern and activity regarding, "Age, Disability, and Rehabilitation."

In selecting its speakers, the IRA secured a trio whose work in gerontology and rehabilitation has not only been extensive at the grass-roots level, but has also pioneered research and program developments on this topic. Dr. Woodrow W. Morris' paper challenged his listeners to re-examine their conceptual frameworks and programs for the aged, as well as skillfully outlining the "Rehabilitation Needs of the Aged in Iowa." For my students and for me, Dr. Wilma Donahue's talk was the highlight of the meeting. She described the work she and her colleagues are doing with geriatric state mental hospital patients in a convincing and scholarly way and, in addition, reflected an inspiring sense of dedication and compassion. Dale Larson challenged IRA members to re-examine their views on both the rehabilitation and employment of the aged in a talk which flavored sharp criticism of present practices with pleasing humor.

The program committee for this meeting included: Dr. William deGravelles, Dr. Wilbur Layton, George Allen, William Herrick, and the writer. Harlan Watson, IRA president for 1962-63, also played an important role in planning this outstanding rehabilitation association meeting.

John E. Muthard
President (1963-64)
Iowa Rehabilitation Association

Rehabilitation Needs of the Aged in Iowa

Woodrow W. Morris, Ph.D.*

"Chronic disease is a problem whose scope is as great as the total population of the country. Each member of the population is a potential victim and, to the extent that control is possible, the key to individual control lies with the individual. While all are possible targets of chronic disease and the largest number of victims are under sixty-five years of age, older persons are more likely to be disabled by chronic conditions. In a population such as ours in which the proportion of older persons is growing, the chronic diseases, unless they are controlled, will become an increasing problem.

"In 1960, an estimated thirty million Americans were suffering from disabling and non-disabling chronic disease or impairment. There is no reason to think that this number has decreased."[1]

I open with this statement because it underscores two facts: first, that there is a great deal of chronic illness in the United States which is probably what led the late, great Dr. Walter Bierring to comment that the care of the chronically ill will become the general practice of the future; and second, that such illnesses are particularly prevalent among, and disabling to, the aged patient. As noted in the statement, the largest number of victims is under sixty-five. However, a larger proportion of the elderly are suffering from a disabling chronic illness (estimated at over 15 per cent of those over sixty-four) than any other age group. For example, the rate is almost three times that of patients in the age range forty-five to sixty-four.

A third reason for this emphasis on chronic disease is that these are the aged probably most in need of rehabilitative and restorative services. As noted in a paper by Steinberg and Frost:

Of the fifteen million persons in the United States more than sixty-five years old, 750,000 are in institutions. If our geriatric population increases as expected, and if no better preventive and restorative care is available, we shall have to provide

*Director, Institute of Gerontology, and Associate Dean, College of Medicine, State University of Iowa, Iowa City, Iowa.

[1] From Introduction to *Prevention of Chronic Illness, Chronic Illness in the United States, Vol. I,* published for the Commonwealth Fund, Harvard University Press, Cambridge, Mass., 1957.

350,000 more custodial beds within the next twenty years. Economically, this means a tremendous drain on our resources. Socially, it means the unnecessary removal of many old people into nursing homes where they will spend their last days in isolation and away from the communities in which they have lived active and useful lives.[2]

All the evidence we have suggests that as age increases, the impact of chronic illness becomes more severe. Of persons seventy-five and over, more than half are limited in their activities in varying degrees. As we all know, it is the disabled person who has generally lost his role in society. And as we also know, much disability can be reduced by early diagnosis, treatment, and rehabilitation.

Turning now to the situation in Iowa, we find that Iowans, in general, seem to be a fairly healthy lot. Like other people in the older age groups, they express the belief that their health is good—or, at least, as good as could be expected for their age, as they put it.

To quote from our 1960 survey of *Life After Sixty in Iowa*,[3] "Most Iowans over sixty regard their general state of health as 'good' to 'excellent.'" This is especially true of those living in urban counties, and particularly true of men. Conversely, higher percentages of folks from rural areas reported their health to be "poor" to "very poor." In any case, half or more thought their health was good. In extension of this it should be noted that there is a decline of such reports of good health with age. Now, despite the foregoing picture of generally good health, fully 36 per cent of our sample reported having some "major health difficulty," and this comprised almost 500 of the 1,359 respondents. This conservatively suggests that there are probably some 163,000 Iowans in the age range above sixty with major health difficulties (36 per cent of 452,000 over age sixty by the 1960 census reports).

Two features of everyday living tend to reflect the general state of health of Iowans and to sketch in the seriousness of the impact of health on daily life. These are the extent to which people may be confined to their homes and the degree to which they may need help in meeting their daily needs due to health factors.

Older Iowans are in large part free from confinement to home for health reasons (and it should be recalled here that our sample did not include any institutionalized persons). Only about 20 per cent were so confined (but even this suggests some 90,000 persons when 20 per cent is applied to the older age population). Partial and complete confinement begins to appear more frequently among women in their early seventies and among men who are seventy-five years old or over. In general, women are more subject to such restriction in activities than men.

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[2] Steinberg, F. U., and Frost, T. M., "Geriatric Rehabilitation in a General Hospital. A Follow-up of 43 Cases." *Geriatrics*, 18:2, 1963, pp. 158-164.

[3] *Life After Sixty in Iowa: A Report of the 1960 Survey*. Prepared by the Iowa Commission for Senior Citizens.

Similarly, about 15 per cent of older people report need for "help in getting around or to meet (their) daily needs." This need also shows a steadily and sharply rising increase with age among women; men report no remarkable increases with age until age seventy-five or over.

I believe the foregoing gives you a reasonably fair picture of the general status of the health of our aged population in Iowa and some indication of how their health is affecting their mobility.

Now, as I noted above, the 1960 study excluded institutionalized persons. I have no clear-cut statistics here. But again what can be pieced out is shockingly revealing.

For example, there are in Iowa some 412 licensed nursing homes and 329 licensed custodial homes caring mainly for the aged. These homes comprise some 16,000 beds, and two-thirds of the patients cared for therein are over the age of eighty. Sixty-eight additional projects are contemplated or are now under construction which will add almost 4,000 new beds.

In all public institutions there are about 8,000 patients over the age of sixty-five. Of the 6,000 patients in the several county homes, about 2,500 are over sixty-five. The biggest increase in county home populations has occurred in the last ten years, and these have been in mental patients who now comprise over 900 aged patients. Most of these county homes are unlicensed and seem to be providing mainly custodial care.

Iowa's mental health institutes comprise about 3,700 beds. These institutions have recently shown a decline in the number of patients over sixty-five from 1,200 in 1960 to 987 in 1961 to 908 in 1962. Since the number of in-patients in these hospitals has been declining, the percentages of 31 per cent, 29 per cent and 28 per cent, respectively, indicate that the proportion of aged is constant. These older patients, when released from the hospital, tend to return to the community setting. Others go to nursing homes, county homes, Veterans Administration hospitals, and to other institutions. Recently there has been a steady increase in the proportion going to nursing homes. This latter suggests the need for a careful study of the number of mentally ill in nursing homes and other situations and the kinds of therapeutic facilities provided in these institutions.

Other institutions caring for aged patients are:

Institution	*Number*	*Proportions of Aged*
Old Soldiers Home	413	48% over age 60
Oakdale Sanitarium	300	Most over age 45 10% over age 65
VA Domiciliary	550	58% over age 45 34% over age 65
VA Hospital (Knoxville)	1,450	73% over age 45 38% over age 65

It is not known exactly how many older patients are cared for in general hospitals, although some idea may be obtained from the utilization data furnished by Blue Cross which shows that in 1961 some 14,000 patients were over sixty-five; this is about 12 per cent of all in-patients.

Information is also needed regarding the care of mentally and emotionally ill patients by private physicians, general practitioners as well as specialists of all types.

The purpose of the foregoing has been to give you some idea of the relatively large numbers of aged Iowans who are ill enough to require some kind of institutional care and to suggest the magnitude of the rehabilitation problem we face if we are to improve the situation to any appreciable degree. It was also presented to give you some idea of the places in which care is being provided. That is, from private practitioners in the community through the whole gamut of institutions: nursing and custodial homes, county homes, general hospitals, state hospitals, VA hospitals and domiciliaries, the Old Soldiers Home, and University Hospitals.

Now, before even alluding to rehabilitative programs in these facilities, let me sketch out what I understand as the concept of comprehensive rehabilitation. As may have been perfectly clear in my introductory discussion of the chronic diseases and their impact on the aged, I believe we must take a broad view of the word handicapped as involving not only grossly crippling conditions, but also all illnesses and conditions which require treatment and/or adjustment to the illness and its sequelae. This conception, then, goes well beyond job-oriented rehabilitation and includes preparation for independency in contrast to dependency.

Much of this conception of comprehensive rehabilitation is in keeping with the principles recently formulated by the National Rehabilitation Association:[4]

Scope: Effective rehabilitation is comprehensive. It presupposes all the services necessary to enable impaired persons to function adequately as individuals, as family members, as citizens, and as economic contributors. It should be available to all disabled persons wherever they live and whatever their disability.

Joint Effort: Effective rehabilitation requires a rehabilitation emphasis in education, health, welfare, employment insurance, and recreation. It necessitates the coordination of the services of many public and voluntary organizations. It presupposes joint planning and action at local, state, and national levels.

Professional Coordination: Effective rehabilitation requires a combination of professional and technical skills. It presupposes conditions that enhance

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[4] National Rehabilitation Association Policy Committee. NRA Statement of Principles and Program, *Journal of Rehabilitation.* 1961 (January-February), 15.

professional coordination, that encourage effective communications among the various professions, foster equality of status among them, and facilitate cooperative effort.

Research: Effective rehabilitation requires constant self-analysis, stimulation, and evaluation. It uses research and advancing knowledge to evolve more effective methods of achieving rehabilitation goals.

Standards: Effective rehabilitation requires qualitative and quantitative standards which assure a sufficient number of well-trained persons, facilities adapted to special needs of impaired people, and effective application of services. It presupposes the availability of services when and where needed.

Public Understanding: Effective rehabilitation requires public understanding. Rehabilitation programming presupposes an understanding of disability, knowledge of rehabilitation objectives, and acceptance of disabled persons by the community.

Voluntary Effort: Effective rehabilitation requires united community action. The efforts of voluntary organizations and individuals provide needed services and supply vitality and new approaches to the rehabilitation movement.

Governmental Responsibility: Effective rehabilitation requires the assumption of major fiscal and program responsibilities by the federal government and states. This implies the appropriation of funds based upon needs and the progressive improvement of standards and goals in program development.

Administration: The satisfactory implementation of this function requires client-centered administrations that encourage the development of effective policy and enable administrators to deal effectively with other governmental and voluntary organizations.

In this connection I like the thoughts Professor Wendell Johnson expressed at a 1961 conference held at the State University of Iowa under the general heading Counseling the Older Disabled Worker:[5]

> In general, to me the most conspicuous common denominator that characterizes our rehabilitation programs is the fact that they are money and job oriented. It is almost as though unconsciously we have fallen into the habit of defending what we do in rehabilitation because 'it pays.' Every year the taxpayers and their representatives are told that so many people have been rehabilitated and that they will pay in income taxes the cost of their rehabilitation, or more, as though it were something that we were really doing for a profit, or as though its major justification is that it reduces our taxes. I think that we are not generally aware, certainly I wasn't and I have talked with many other persons who were not aware, of the degree to which we have taken on the habit of justifying what we do in rehabilitation on this basis. Because this tends to be the justification—the main justification, not the only one, of

[5] Muthard, J. E. and Morris, W. W., Eds., *Counseling the Older Disabled Worker*, proceedings of two conferences. Institute of Gerontology, November, 1961.

course—we tend to orient our rehabilitation efforts around the objective of preparing the client for paid work. And this has some pervasive and very important effects on our programs.

Effects of Money and Job Orientation

The economic orientation of our vocational rehabilitation programs tends, for one thing, to eliminate children from consideration, and so we waste a great deal of our effort because we get there relatively late in most cases. Somehow, we seem to feel that there is something natural about the legal or official distinction that has been made between persons below and above the age of sixteen years or thereabouts. There is nothing natural about this, of course; this is as arbitrary as anything could possibly be. And my own view of it is that it is one of the greatest anchors around our necks. The time to rehabilitate a person, if possible, is when he is very young. Now, while there is, of course, something done by some agency or by somebody for most children who have disabilities, it is not always well integrated with what is done later by some other agency, or some other set of persons.

Our basic orientation also tends to eliminate from major consideration persons who are very old. Anyone too young to work, or too old to work, tends not to be looked upon, in general, as a suitable client for rehabilitation, and we have come to take this pretty generally for granted.

Moreover, we tend to eliminate, in accordance with our established kind of justification and objective, those who are too disabled to be trained for paid employment. I think I detect—these things aren't as obvious after a great many looks at them as they are at first—I think I detect a general assumption on the part of most people that there is in this total picture some sort of a division of labor and responsibility. When we are having to deal with a person too old, too young, or too disabled to be prepared for a paid job, then this, we seem to feel, is the responsibility of somebody else.

Somebody Else

This term 'somebody else' is very vague. It isn't at all obvious in most cases who this 'somebody else' is. And it just about comes down to the fact that, from the point of view of the client as a person who is disabled, if he is too young, too old, or too disabled to work, there frequently isn't anybody else who's doing much of anything to serve his needs as a person. Many nursing homes, for example, don't provide a very satisfactory answer for people who are too old to work. Our society really neglects these people to a great extent.

To underscore the notion that the aged are neglected in many of our rehabilitation efforts, let me cite a special example which is applicable here. This is a quotation from a partial report on "Mental Illness Among Older Americans" prepared by the Special Committee on Aging of the United States Senate in 1961:[6]

Any survey of mental hospitals, nursing homes, county infirmaries, or other facilities where there are significant numbers of aged persons with psychologic disorders will reveal that this group, as a whole, fares badly. They are given up as hopeless, relegated to back wards euphemistically called 'continued treatment' but in actual practice 'discontinued treatment' situations, or are segregated in private and nonprofit homes away from the other patients, and

[6] *Mental Illness Among Older Americans.* Prepared for consideration by the Special Committee on Aging, United States Senate. U.S. Government Printing Office, Washington, D.C. 1961.

certainly where visitors will be least aware of their presence. This group of patients suffers the rejection not only because they are aged and useless in the eyes of our youth-oriented society, but also because they are mentally ill. The Joint Commission on Mental Illness in its monumental final report concludes that while—

> People do feel sorry for them, (the mentally ill) . . . in the balance, they do not feel as sorry as they do relieved to have out of the way persons whose behavior disturbs and offends them . . . . Rejection, as practiced against the psychotic patient, takes many forms, some tantamount to complete denial of his right to human existence.
>
> With the growth of urbanization, the care of the mentally ill took the form of removing social rejects through a disposal system isolating them well beyond the city limits in large 'asylums' functioning as human dumps.

Well, in my opinion, all of these people, including the aged, are deserving of our rehabilitative and restorative time, energy, and money.

Furthermore, I should like to mention a form of rehabilitation not often thought of as such. This is the simple recognition of an adjustment problem either to an illness or injury or to its sequelae. Let me illustrate this with an actual case. This involved a fifteen-year-old girl who had been found to have a hearing loss. After thorough study by physicians and audiologists, a hearing aid was prescribed and the case closed. This came to my attention as a psychologist when it was reported by the girl's parents and teachers that she was not using the prescribed aid. A few sessions of psychological counseling with this girl resulted in her better understanding of her own feelings about her hearing loss and the hearing aid which, in turn, resulted in her beginning to use it to the great improvement not only of her school work but also of her social relationships. *I call this rehabilitation.*

Another case was that of a twelve-year-old girl for whom it appeared that amputation of the right leg was necessary. The surgeons revealed great wisdom and insight in not performing this surgery until every known method of treatment had been tried, and also in their agreement that the loss of this limb would be a catastrophic psychological trauma to a girl of her age. The required operation was successfully delayed for two years, but at the age of fourteen the amputation had to be performed. Unfortunately, the predicted psychological reaction to the loss was forgotten with the result that less than six months later I saw the patient for psychological counseling because she was quite depressed, anxious, and showing signs of withdrawing from all social contacts. She was helped over this difficult adjustment period and was able to return to school and to almost normal, though limited, activities with her schoolmates. *I call this rehabilitation.*

Now let me turn to another area of interest which is particularly compelling in the case of the aged. This has to do with a generally held attitude toward senility and the implications of this attitude with respect to the rehabilitation of the aged. I have heard too many times statements to the effect that "due to the nature of senility, older people cannot be helped." The nature of senility referred to in such comments is well-illustrated in the following gloomy

description offered in a standard textbook of psychiatry: "The prognosis of the senile psychoses is manifestly hopeless. No well-defined remissions are to be expected. . . . The course is progressive, the patient gradually becoming more demented although life may continue for ten years or even longer before death supervenes."[7]

In large part this opinion about senility is conditioned by the fact of organic brain changes and their importance in the mental health of the patient. But as Aring has said: "The frequency with which our patients are said to be suffering from chronic brain syndrome these days leads me to wonder whether this elegant phrase isn't serving something besides diagnosis. House officers seem to be fond of it. It sounds so final. Chronic brain syndrome when combined with a diagnosis of cerebral arteriosclerosis represents senile dementia in modern dress. The indications usually are that an irrevocable mental state has set in."[8] Again, concerning treatment of these patients, Arling says, "As a young neuro-psychiatric house officer I had the usual introduction to the problem of taking care of many patients in a general hospital with what was then termed senile dementia. In the early 1930's, as today, these people were given the minimum of our time and were as rapidly as possible shunted to state hospitals and sanatoria for boarding the rest of their lives. As I try to recapture our thinking about these patients, we were as much embarrassed by them as any other feeling we may have had, a condition made tolerable for us by reason of the fact that they were soon to be gone. This state of affairs isn't much changed today; witness the frequency with which we move patients with chronic disorders out of the stream of medical consciousness, usually to somewhere in the suburbs or even more distant.

"It was only later that I became aware of some of the social and economic factors that brought many of these patients to us. The loosening of family ties with all that it implies, the relaxation of discipline with its depreciation of elders, the critical financial decade and the accompanying unemployment beginning in 1929, the urban shift of population, conscription, even the isolationism rampant after the first world war; these and many other factors played a part. However, a busy young physician earning clinical spurs had little time in those days for such concepts; it was only later that they entered my thinking about senile dementia."[9]

This conception of senility is, as you have already observed, quite at variance with the aforementioned textbook description. It posits environmental causative factors which may be important in the production of or in the hastening of the production of senile changes. These suggestions are in

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[7] Noyes, Arthur P. (M.D.), *Modern Clinical Psychiatry,* 2nd ed., 1939, Philadelphia: W. B. Saunders Co., p. 298.

[8] Aring, Charles, "Senility," *Archives of Internal Medicine,* Vol. 100, October, 1957, p. 520.

[9] *Ibid.,* page 52.

keeping with the thinking and research of Dr. Maurice Linden who has the following to say concerning the nature of senility: "The author is of the conviction . . . that senility as an isolable state is not an inevitable biologic stage in the human life cycle, but is rather a cultural artifact, a product of prevalent social attitudes. It is the logical culmination of the combined social rejection of the late mature person and the senescent person's self-rejection."[10]

The emphasis in these viewpoints is upon social and intrapersonal stresses which impinge upon older people, rather than inevitable, biological decline. If this be so, it should follow that such conditions might be alleviated if attention were paid to the proposed causative factors. This is exactly the approach Linden took in proposing to do group psychotherapy with female patients of this type. I am sure Linden met with some resistance from his colleagues who probably regarded this as something like "Linden's Folly."

The patients with whom he was concerned had a mean age of seventy, three being younger than 60 and one was eighty-nine. Time spent in the hospital before treatment ranged from one to 480 months. The mean was about 58 months. Thirty-one of the total of fifty-one had been hospitalized for two years or less; twelve had been in-patients for eight years or more.

Suffice it to say that after the course of group psychotherapy, which consisted essentially of resocialization, 45 per cent were able to leave the hospital for their own homes, county homes, or other placements. In contrast to this were the only 13 per cent of patients in the same building who did not participate in therapy who were able to leave the hospital. *Again, I call this rehabilitation.*

Now this next may sound odd to you, but I want to work it in. In my broad definition of comprehensive rehabilitation, I said "all illnesses and conditions which require adjustment to the illness and its sequelae." While retirement is not ordinarily thought of as an illness, it certainly is a social condition which may well require the individual so afflicted to adjust to it and its sequelae. We do not ordinarily think of retirement in just these terms, but it would seem to me to be well if we did. This is the great preventive virtue in such preparation for retirement programs as those offered by the University of Chicago and a few other universities. If the preventive approach is not taken, then it is to be predicted that many problems will follow, some of which will surely fall on the shoulders of those concerned with comprehensive rehabilitation. *And I would call work with such problems rehabilitation.*

I would like to make the point now that one hoping to effect rehabilitation of whatever kind must recognize that he cannot do this by himself. He must work in the context of a total community effort as Breen points out: "Maxwell Jones, when he argues for the development of the therapeutic community, the

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[10] Linden, M.D., "Group psychotherapy with institutionalized senile women: Study in gerontologic human relations." *Int. J. Group Psychotherapy,* 3, 1953, 150-170.

organization of all the services into a coordinated approach, is talking essentially about a closed environment. He wants to bring people for a period of time into a hospital where everybody has been trained to approach rehabilitation as a therapeutic community. Even the people who wash the floors would be sensitive to the emotional problems of the patients. But this concept of the therapeutic community needs to be carried farther. It must be applied to the communities in which people live. Thus, the community itself must be sensitive as to how it affects the individual and the way in which the individual in turn affects the community. This notion of the total therapeutic community is probably the most important concept we have in this whole field, and it is one toward which we should all direct our attention and efforts."[11]

Well, if you subscribe to the thoughts and ideas I have presented so far, it should be clear that comprehensive rehabilitation is not the sole province of the physiatrists or physical therapists, and, I suspect, they may be the first ones to agree with this. Rather, the workers in this vineyard must include, among others: *all* physicians of whatever persuasion, psychologists, social workers, vocational and rehabilitation counselors, specialists in education and retraining, speech therapists, audiologists, occupational therapists, nurses, dentists, and, as Wendell Johnson has suggested, any others in whatever fields who have given some thought to the idea and believe they have something to contribute—thus, economists, historians, artists, musicians, and so on.

The main question is: Are our aged in Iowa receiving these kinds of comprehensive rehabilitation services? Since we know of no such program in existence anywhere, of course they are not. What we need to do is decide if such a broadly conceived program is truly possible and worthwhile and, if so, to decide whether it is worth working toward.

I believe I am right in saying that there only about six physiatrists practicing in the whole state of Iowa, there are only about one hundred physical therapists, about thirty-five occupational therapists, few, if any, psychologists working in this area, and so on. Furthermore, I can find no evidence of a formal postgraduate course having been offered in Iowa in recent years to bring general practitioners and other physicians up to date on the latest concepts and methods of rehabilitation. Research in the field is sparse and narrowly conceived.

Furthermore, and I think unhappily, Iowa's aged are not receiving even the basic rudiments of rehabilitation in far too many of the facilities providing medical, nursing, or custodial care for them. All too often the care is only custodial, and I have even heard restorative services rejected by some because they would increase the problems and costs of the institution. Far too many institutions caring for the aged—and others, too—have no therapeutic or other restorative programs at all. There is a great and pressing need to survey all

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[11] Muthard, J. E., and Morris, W. W., *Op cit.*, p. 92.

of these facilities from this viewpoint. Having done this, changes should be implemented so as to provide the services which, even with our current incomplete know-how, our affluent society should provide, and which those in our care deserve to receive.

Such a cursory survey reveals three great needs: RESEARCH, TRAINING, SERVICE. Research is needed to further develop and elaborate some of these concepts of comprehensiveness and to develop techniques and methods, to say nothing of simply gaining knowledge and understanding. With such research in hand, it should be possible to modify and develop training programs so that they will be more nearly in keeping with the needs of the field. And with trained personnel, service may eventually be provided to those who need it.

Research on First-Admission Geriatric State Mental Hospital Patients

Wilma Donahue, Ph.D.*

Treatment for the rehabilitation of the geriatric mentally-ill patient has always been a scarce commodity in our society. Even now, when plans are under way nationally to revolutionize the treatment of mental illness and to do away with the large state mental hospitals and to substitute local facilities which will provide intensive programs of preventive, restorative, and after-care, many state legislatures and health officials are abrogating responsibility for the aged. They are requiring the discharge from state hospitals of all geriatric patients who are considered harmless. The result is that many mentally-ill old people are being placed in nursing homes, foster homes, county hospitals, and similar facilities where there is no one to care for them who is skilled in the techniques of rehabilitation of the mentally ill. Of course, the discharge is not for the purpose of securing more and better rehabilitative treatment for these patients, it is simply intended to release beds for the use of younger persons. In a sense it must be considered a gesture of social defeat when a stamp is placed on old people which reads "discard—not worth saving."

It is against this background that I shall discuss the problem of rehabilitating the mentally-ill aged. I shall do this under four headings. First, I shall review some of the circumstances which have engendered negative attitudes toward mental illness in old people and point out the results of recent studies which indicate that such attitudes are no longer tenable. Second, in support of a positive approach to the treatment of the mentally-ill aged, I shall outline the theoretical position we have established in our researches and review briefly some of the earlier studies out of which it has developed. Third, I shall discuss our current research-demonstration project in the rehabilitation of first-admission geriatric patients; and fourth, I shall raise some critical problems needing immediate action and solution if mentally-ill old people are to benefit maximally from their rehabilitation.

*Chairman, Division of Gerontology, Institute for Human Adjustment; Lecturer in Psychology, University of Michigan, Ann Arbor, Michigan.

The need for change in attitudes toward the treatment of the mentally-ill aged

None have a larger stake in mental health care and treatment than does the old age group in the population. Among adults, only this older group has shown a consistent increase throughout the century in age-specific rates for first admissions to public mental hospitals.[1]* Reaching a peak in 1953 of 240 per 100,000 of the population aged sixty-five and over, the rate declined to 232.7 in the 1956-1958 period, and is probably still declining. The decrease in admission cannot, however, be considered a reflection of improvement in mental health of older people because of a current trend toward placing the less disturbed persons in alternative facilities, especially nursing homes, rather than committing them to mental hospitals. In fact, while the decrease in rate of first admissions has been taking place, the residency rate of old people in mental hospitals has continued to increase, because the decline in rate has not been enough to offset the increase in the population of this age group.

Whether the geriatric patients are in the mental hospital or in some other care facility, they usually fare badly in competition with younger people for scarce professional services. In general, their care has been and still is largely custodial in type, the goal of which is to make the patients as comfortable as possible rather than to restore and remotivate them for return to an effective community life. The recent emphasis on bringing physical and social rehabilitation services into nursing homes and other long-stay care facilities, while a step in the right direction, is, in most instances, limited largely to minimal treatment by a nurse or nurse aide, who has been hastily and partially trained. Although there is no doubt that patient care is somewhat improved by these measures, it is not enough improved to bring about maximum restoration of the patients or to change the setting from a custodial- and illness-centered one to a rehabilitative milieu.

The fact that there is, however, a growing demand for the introduction of physical and mental restorative services in facilities which care for the chronically-ill aged reflects a growing acceptance of the findings of various studies which have contradicted the commonly-held belief that all mental illness in old people is organic in origin and thus hopelessly untreatable. A number of investigators have now demonstrated on autopsy that there is no one-to-one correlation between the extent of organic brain changes and the extent of behavioral pathology.[2, 3, 4, 5] Other studies have shown that a significant proportion of mental illness in later maturity is functional rather than organically based.[6, 7, 8] Further, certain sociological and psychological factors, typically present in later life, such as retirement, social isolation, physical illness, or loss of spouse by death, often seem related to mental illness.[9, 10, 11, 12] Since

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*For a complete list of references cited by Dr. Donahue see pages 22 and 23.

functional mental disorders and these precipitating situational factors are amenable to change, a new interest has been generated in the socio-psychological treatment of geriatric patients. The result has been a spate of demonstrations which have illustrated that a multi-disciplinary, total-push treatment program will increase the discharge rate of geriatric patients from mental hospitals.[13, 14, 15, 16, 17, 18, 19]

The theoretical background for the use of milieu therapy in the treatment of mentally-ill geriatric patients

Most of the total-push programs claim some use of milieu therapy, although few of them have used it with reference to a theoretical framework. In fact, it has been cogently pointed out that practically anything that is done for a patient is recorded as milieu therapy. Actually, in only a few instances has the milieu been used as a therapeutic agent in the sense it is defined by Cumming and Cumming,[20] that is, "a scientific manipulation of the environment aimed at producing changes in the personality of the patient" (p. 5). The dynamics implied in this definition are those of ego growth and reconstitution through crisis resolution. The theory assumed that when environmental demands exceed the ability of the individual to cope through use of his established patterns of response, a state of disequilibrium between the person and his environment is created and a crisis ensues which threatens his personality or ego organization. This crisis is resolved only when, through some new psychic growth process, the response repertoire of the individual is increased or adapted in such a way that he can re-establish a state of equilibrium. The Cummings suggest, therefore, that the milieu can be used as a therapeutic agent to induce psychic growth "by presenting the individual with a series of graded crises under circumstances that maximize his chances of resolving them" (p. 56). Such a formulation suggests that the individual will attain good mental health if his environment provides opportunity to assume instrumental roles which assist him to maintain his social equilibrium and if it makes possible his continued engagement with society, within the limits of his physical capacity.

The usual mental hospital environment accorded the geriatric patient cannot, by these criteria, be considered a therapeutic milieu. The newly admitted person is certainly in a crisis and, sooner or later, he will resolve it by assuming a patient role, the characteristics of which are those demanded by the hospital. In most instances, the expected role is a passive, semidependent one of subdued demeanor and minimal activity. The patient is expected to follow a prescribed sleeping, dressing, and eating routine with an occasional diversional activity, such as that provided by an occupational and recreational therapist or a kindly visitor. As a special dispensation, some patients may be allowed to work *for* the hospital (usually without financial compensation). The "best" patients, by staff standards, are those who accept the prescribed

patient role. In fact, the staff works hard to maintain a situation in which crises are minimized, because patients in personal turmoil are more demanding of staff time already greatly overburdened. Thus, in place of fostering rehabilitation of personality through new growth prompted by the stimulation of crisis resolution, the usual hospital milieu requires regression of personality to semidependence for the successful assumption of the custodial patient role.

It might be added that this is a particularly dangerous milieu for the geriatric patient because it may contain etiological factors leading to even greater personality damage and deterioration. At a time when the older mentally-ill person is undergoing the natural senescent processes of biological aging and the loss of socially significant roles, he needs support, new opportunity, and stimulation to help him maintain an ongoing orientation and motivation for independent living. He needs a hospital milieu which is therapeutic and which provides a system of values, roles, and status similar to those he has held in the past and similar to those he will entertain again if, when rehabilitated, he is to make a successful re-entry into the life of his community. And more, he needs a milieu which is community-oriented rather than hospital-centered.

From the inception of our first studies of aging at the University of Michigan, we have been concerned with the psycho-social rehabilitation of the institutionalized aged. The first study was done in 1949 at a local county hospital where an attempt was made to determine the effect of exercise of mental and social abilities upon personality integration of older patients. Results confirmed the basic hypothesis that use of function has beneficial effects.[21] In 1953 a second study was conducted, using experimental and control populations in matched old age homes and nursing homes, to measure the effects upon socialization of residents' participation in an intensive activities program. Sociometric data showed that residents living in the experimental facilities, where the activity programs were instituted, increased the amount, level, and complexity of their social interaction, while those in the control facilities, where there was no activity programs, became more isolated and withdrawn.[22] In 1957 a third and more elaborate study was undertaken, with financial assistance from the Office of Vocational Rehabilitation, to explore experimentally the extent and levels of rehabilitation that could be achieved with older patients in three county medical care facilities when a therapeutic milieu replaced a custodial type of care. The average age of the patients included in the study was in the late sixties. Approximately three-fourths of the patients in the experimental program achieved a higher level of self-care and independence, and nearly half were sufficiently improved to return to the community. This study tested the effectiveness of milieu therapy combined with intensive medical and physical rehabilitation measures. From observation, it appeared that among the most potent components of the therapy were

the orientation of all aspects of the program to the community and the opportunity of patients to pursue well-practiced roles and statuses.[23, 24, 25, 26]

A study of the rehabilitation of first-admission geriatric mentally-ill patients

With this background of demonstrations showing the rehabilitation potential of many older people when provided an active treatment program, it was natural that we should turn our attention next to the growing concern being expressed everywhere about the high commitment rate of old people to mental hospitals and their fate after commitment. Our theories and techniques were as applicable in the mental hospital as in any other long-stay type of facility. The Ypsilanti State Hospital, with a total patient census of 4,000, of which about one-third were in the older-age group, was conveniently near; and the hospital's administrative staff, made up of men committed to research on methods for improving treatment of mental illness, was cordial to a proposal for a cooperative study.

Accordingly, in 1961 a fourth research-demonstration was undertaken, again with financial support from the Office of Vocational Rehabilitation, which was designed to investigate whether it is possible to arrest or retard the manifestations and/or rate of senile changes in recent first-admission geriatric patients without previous psychiatric history, and to rehabilitate them for discharge through participation, within the hospital setting, in a "normalized" living situation, including retrainng in work experiences. In addition, we proposed to study a number of basic psychological questions in order to increase our scientific knowledge about factors contributing to psychiatric disability in later life. The hypothesis on which the study was designed was that, in contrast to the usual hospital regimen, a setting which can be manipulated scientifically to offer a psycho-social rehabilitation milieu will bring about changes in the patients' ward behavior, self-concepts, and social and occupational skills which will maximize their potential for successful re-entry into community life, or if discharge does not become feasible, they will be enabled to live as better-adjusted and more productive members of the hospital society.

The basic technique to be used was that of milieu therapy. The normalized community (the milieu) was to provide a set of controlled but meaningful life experiences, graded in difficulty to accommodate various levels of personality function, which patients could deal with through the practice of instrumental and social roles common to their past experience and which were compatible with the value systems and reward structure of the outside community rather than with those of a self-contained institutional society. If the milieu therapy was successful, ego growth would be fostered and the individual would resume normal behavior. It should be added that milieu therapy, as does physical rehabilitation, requires the total involvement of every staff member who interacts in any way with patients. Thus the staff, as well as programmed

activities, was considered an environmental factor to be experimentally evaluated.

To meet the requirements of a normalized community therapeutic milieu, a special experimental ward consisting of six rooms and ancillary space was established in one wing of the hospital. Components of this normalized ward included a mixed-sex patient population, the hospital and project staff, a scheduled activity program providing industrial therapy in a sheltered workshop offering paid jobs contracted for with outside employers, a craft training program leading to production of handicrafted articles of superior quality for sale in local art shops, and a variety of social, recreational, housekeeping, and storekeeping activities. Each of these offered a graded series of instrumental roles through which patients could advance as improvement made it possible for them to undertake the mastery of a new situation (resolution of a new crisis). In addition to the planned program, self-initiated activities were encouraged, and independence in the activities of daily living were made part of the total ward milieu. In order to insure that any differences between experimental and control patients were the result of the milieu therapy, the amount and type of social, medical, and psychiatric services were not increased over those customarily provided geriatric hospital patients.

An experimental and control group of patients, each containing an equal number of men and women, were selected at random from a roster of patients who met the following criteria:

1. Fifty-five years of age and over.
2. First-admission to a mental hospital within the past four years.
3. Evidence of psychiatric stability during earlier years of life.
4. Not permanently bedridden.
5. Accessible enough to be minimally testable.

The experimental patients were housed on the experimental mixed-sex ward, the control patients were distributed throughout twenty regular one-sex wards of the hospital. Characteristics of these two groups are reported in tables 1 through 9. Any differences which appear have not proven statistically significant; in fact, the random selection provided two well-matched groups. Altogether 127 patients were involved in the program long enough (at least six months) to be included as subjects in the study. Of these, seventy-five were in the experimental group and sixty-three in the control group. Average age of the patients was sixty-nine and one-half years, three-fourths belonged to the white race, and one-third was born outside the United States. The average number of years of schooling was slightly over seven. Only about one-fourth of the men and one-sixth of the women had a living spouse. The average patient had been in the hospital approximately fourteen months at the time he became a member of one of the project groups, although there was a wide variation from less than a month to over three years among the group. The overwhelming proportion of patients was diagnosed as suffering from chronic

brain syndrome, and while the average mental status of the group was between eight and nine points out of a possible thirteen on the mental status test, the range varied from very low to nearly perfect. In other words, no attempt was made to select patients most likely to be rehabilitated. We were interested in observing the extent to which we could provide a sufficiently flexible therapeutic milieu to accommodate the less intact patients, as well as those who were still able to function reasonably well.

The organization and pattern of living established on the experimental ward followed the lines of the theoretical conceptions of milieu therapy. It was a closed ward and all activities, except for patients who had ground privileges, were carried out on the ward. Accordingly, it was possible to structure the twenty-four-day to provide a stable framework for the ward society, but which, at the same time, allowed patients the latitude of choice and personal initiative. In general, the daily schedule was as follows, except that on Saturday and Sunday usually no scheduled activities were provided:

getting up and dressing
breakfast
making beds and cleaning
scheduled activities
  exercise and sing
  sheltered workshop
  personal pursuits
lunch and rest
scheduled activities
  sheltered workshop
  social-recreational
rest and dinner
no scheduled activities
retire

The schedule for patients on the control wards was similar except that they generally did not make their beds, care for their own sleeping area, shave themselves, or have scheduled activities, except an occasional one- or two-hour occupational or recreational therapy session per week.

The experimental ward did not immediately become a therapeutic community. In fact, the patients were confused at first by the new setting where the sexes lived on the same ward, sharing the dining and day rooms and working together in the workshop, and where they found that their learned attitudes of apathy and do-nothingness were inadequate. The changed situation was thus a frustrating one until they learned the expectancies and were able to utilize the available resources to regain a new equilibrium. When this happened, the ward began to take on the characteristics of an oriented community, and a complex pattern of interpersonal relationships developed between the staff and patients and among the patients. Described in terms of the observations of the activities program staff, the patients' behavior slowly changed from almost total disinterest, apathy, withdrawal, and inaction to one of awareness and active involvement. Receptiveness to new ideas increased; group discussion and action on ward problems were undertaken spontaneously by patients; standards of behavior in the various aspects of ward life, while not consciously stated, nevertheless became subtly enforced. Genuine interest in the concerns and needs of other patients and attitudes of mutual help-

fulness gradually emerged. Greater tolerance for the severely ill and overtly disturbed patients developed, but, on the other hand, intolerance for those who failed to perform in accordance with their ability increased. In short, the tone of the ward changed from one of disorganization, despair, and depression to the climate of a happy, sane, goal-directed community.

A good example of the therapeutic community in operation is the sheltered workshop program. The therapeutic value of paid work is well-established in the rehabilitation of the mentally-ill. Work occupies a central position in our social status system and its reward—pay—influences our self-esteem. It makes clear one's position in the hierarchy of instrumental social roles, and the possession of earned money fosters independence and security feelings. Therefore, the sheltered workshop program was one of the most important of the therapeutic tools used in the study. To make the earning of money fully meaningful, a store, operated by patients, was also established on the ward. Here the workers could spend their money for coffee (which was always available), candy, cigarettes, toilet articles, fruit, and so forth. (Parenthetically, I might add that the store became the focus for socialization among the patients, reminding one of the mores of the old-fashioned country store.)

The sheltered workshop was scheduled to take up from twenty-five to thirty hours per week, more if the patients wished to work outside the scheduled hours. Contracts with outside agencies provided an abundant amount of work and modest pay for all who wished to participate. Each job was broken down into smaller units, making it possible for patients at all functional levels to work, and, also, as their skill improved, permitted them to progress through a series of tasks graduated for difficulty. Knowledge of improvement and increased pay served as strong motivators. But perhaps even more important for self-esteem and meaningfulness of the person was the fact that the industrial contracts were with a company supplying parts to several major automobile companies. Not infrequently a late afternoon request for thousands of pieces to keep the Detroit assembly lines in operation the next day would set the workshop into a frenzy of somewhat joyful activity. Under these circumstances, the patients could have no doubt of their usefulness to society. Little wonder, then, that within a five-month period they sorted over two million letters for Buick cars, assembled 67,000 car panel knobs, and produced 200,000 items for the University Hospital. Initially, out of eighty-eight experimental patients, forty-three were rated as able, with training, to function at a relatively high level in the workshop, eight were able to work if brought to the workshop and given special and simple tasks, and thirty-seven were too confused to participate at all. By the end of several months in the rehabilitation milieu, however, thirteen of the thirty-seven poorest patients had moved to the top group, and two had moved to the intermediate group. Even among the twenty-five who remained too confused to take part systematically in the workshop, there were a number who showed marked improvement in func-

tion. Perhaps the best informal gauges of what work means to the patient is their oft-repeated statement that "I'd go crazy if I didn't have something to do," and the fact that many of them worked voluntarily and without supervision in the evenings and on weekends.

In order to measure changes in patient behavior and to insure that the changes, if any, were the result of the milieu therapy, a series of research studies were carried out coincidently with the treatment program. The experimental and control patients remained in the project an average of a little over ten months (Table X). During this time the same battery of tests* was administered to both groups at the beginning and at stated intervals during the treatment period. These tests gave measures of mental status; ward behavior; self-concept; type and amount of social, instrumental, and noninstrumental behavior in which patients engaged; and level and extent of performance in the workshop. Psychiatric ratings were obtained on all patients, and a special study was made of the visual status of patients in both groups. Discharge rates were not used as a criteria for success of the treatment program, because the legal requirement in Michigan that geriatric patients be discharged from the state mental hospitals at the rate of one thousand patients per year, regardless of whether recovered or not, makes the discharge rate a useless measure of the effectiveness of treatment programs.

Analysis of test data from the research studies is just now in process. A few results, however, can be reported which will indicate the nature of our findings. The mental status examination showed that there were essentially three levels of functionality. Table XI shows that while there was a slightly higher per cent of low mental status patients in the control group and a slightly lower proportion in the high group in comparison with the experimental group, the difference between the two groups is not statistically significant.

A factor analysis of the ward behavior scale produced seven major factors which account for 61 per cent of the total variance in the test. A comparison of the experimental and control groups on these seven factors shows (Table XII) that after being on the project for six or more months, more experimental than control patients are high in self-care; the experimental patients express more hostility which may only be a reflection of their greater activity in general; experimental patients show more interest in their surroundings, especially those patients who might otherwise have been expected to have only medium interest; while there is no statistically significant difference between the two groups in orientation, there is a trend for a larger proportion of experimental patients to be medium in orientation and control patients to be low; experimental patients were more helpful to one another, more sociable, and manifested fewer psychotic symptoms. When level of mental status is con-

*Modified Goldfarb Mental Status Test, Semantic Differential Scale, Gottesman Ward Rating Scale, Gottesman-Schneider Activities Time Sampling Scale, Psychiatric Rating Scale, and Workshop Evaluation Scale.

sidered, a positive correlation between high mental status and improvement is found. These and other studies not yet complete enough to report, indicate that, whatever the specific reason, the patients treated by milieu therapy improved in personality function more than a similar group of patients living on the regular hospital wards. It can be added that in many instances the experimental patients were rehabilitated to the point where they could return to the community and could carry on in paid work just as they had done in the hospital.

Some problems of rehabilitation

But in making this point, I am brought to the fourth part of this paper—that is, some unsolved problems associated with the rehabilitation of geriatric mentally-ill patients.

No problem appears more critical than that of the return of the patient to the community. Many discharged patients can return to their families or even live entirely independently. Many others, however, although no longer needing hospitalization in an intensive care setting, do continue to be somewhat frail mentally and physically. These patients require some degree of continuing aftercare, or at least oversight in an environmental setting which will continue the rehabilitation process or insure the maintenance of the level of ego function and physical health achieved through the treatment program. It is this need which gives rise to the critical problem because, while facilities exist in the community, such as nursing homes, family care, and long-stay hospitals, they generally offer an environment that propels the resident toward dependency and denies him the opportunity to continue in meaningful community-centered activities, such as paid work. It is a sad commentary when a mental hospital provides a richer life for many old people than they can have in the community at large. It is no satisfaction, and only creates an ethical dilemma for those who bring about the rehabilitation of patients, when the patients refuse discharge, saying as one did recently, "I won't leave. I like it here and the patients like me. I have something worthwhile to do, this is the best time of my life."

While aftercare is a community problem and must be solved at that level, it is also a responsibility of rehabilitation workers to take leadership in securing local action to bring about a solution. The half-way house is a partial answer, but it should be reserved for those patients who are enroute to their communities. Older people who need another type of arrangement are those who can live semi-independently only if they are permanently housed where some benign oversight and personal services are available. Such an environment should include the opportunity to carry out instrumental and social roles which insure the continued integration of the patient with the ongoing stream of life in his community. To achieve these ends, new living facilities and work opportunities outside competitive employment will have to be developed.

The second and last problem is an associated one. It deals with the need for the rehabilitation counselor to become better oriented with regard to older people, and thus to develop greater tolerance and understanding of their needs and greater appreciation that they have rehabilitation potential, that they have skills, and that they can be useful to themselves and society if roles and status can be assured them. The implication of this remark is that the average rehabilitation counselor and placement officer currently lacks these skills, and this has been our experience. It is a reflection of the newness of the field, the failure of training institutions to include this type of training in their teaching programs, and the residual of generally held stereotypes regarding the uselessness of older people. These are all aspects of the problem that are relatively easy to solve, it requires only becoming aware of the need and doing something about it.

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TABLE I

Number of Patients in Experimental and Control Groups by Sex

Group	*M*	*F*	*Both*
Experimental	37	38	75
Control	24	28	52
Both	61	66	127

TABLE II

Average Age (and s.d.) for Experimental and Control Groups by Sex

Group	*Age and s.d.*		
	M	*F*	*Both*
Experimental	68.1 (7.5)	70.9 (8.1)	69.5 (7.8)
Control	69.5 (7.6)	69.7 (7.6)	69.6 (7.6)

TABLE III

Percentage Distribution of White and Other Races for Experimental and Control Groups, by Sex

Group	*White Race*			*Other Race*		
	M	*F*	*Both*	*M*	*F*	*Both*
Experimental	73.0	81.6	77.3	27.0	18.4	22.7
Control	87.5	78.6	82.7	12.5	21.4	17.3

TABLE IV

Percentage Distribution of Experimental and Control Patients by Birthplace and Sex

Group	*U.S.*			*Other Countries*		
	M	*F*	*Both*	*M*	*F*	*Both*
Experimental	59.5	71	65.3	37.8	23.7	30.7
Control	58.3	64.3	61.5	37.5	28.6	32.7
Unknown	2.7	5.3	4.0	4.2	7.1	5.8

TABLE V

Average Number of Years in School

Group	*M*	*F*	*Both*
Experimental	7.0 (4.7)	8.2 (4.4)	7.7 (4.6)
Control	6.6 (4-1)	7.9 (3.8)	7.2 (4.0)

TABLE VI

Percentage Distribution of Marital Status by Sex for Experimental and Control Patients

Group	*Never Married*		*Married*		*Widowed*		*Divorced*		*Separated*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*	*M*	*F*
Experimental	24.0	13.0	27.0	15.8	21.6	55.3	16.2	7.9	10.8	7.9
Control	16.7	14.3	25.0	25.0	29.0	39.3	25.0	14.3	4.0	7.0

TABLE VII

Percentage Distribution of Diagnostic Categories by Sex for Experimental and Control Patients

Group	*CBS*		*Affective*		*Schizophrenia*		*Other*	
	M	*F*	*M*	*F*	*M*	*F*	*M*	*F*
Experimental	75.7	6.3	10.8	7.9	10.8	21.0	2.7	7.9
Control	66.7	8.2	12.5	3.6	12.5	10.7	8.3	3.6

TABLE VIII

Average Number of Months (and s.d.) Patients were in Hospital before Entering the Geriatric Rehabilitation Project, by Sex

Group	*M*	*F*	*Both*
Experimental	18.1 (17.37)	9.8 (13.78)	13.9 (15.58)
Control	15.1 (14.9)	13.6 (14.53)	14.4 (14.72)

TABLE IX

Average Mental Status Score (and s.d.) of Experimental and Control Patients upon Admission to the Project by Sex (Perfect Score = 13 points)

Group	*M*	*F*	*Both*
Experimental	9.0 (3.30)	7.95 (3.46)	8.48 (3.38)
Control	8.75 (3.32)	7.86 (3.67)	8.30 (3.50)

TABLE X

Average Number of Months (and s.d.) Patients Participated in the Project by Sex

Group	*M*	*F*	*Both*
Experimental	10.8 (1.7)	10.0 (1.9)	10.4 (1.8)
Control	10.9 (1.9)	10.8 (1.6)	10.8 (1.8)

TABLE XI

Comparison of Experimental and Control Groups on Mental Status Scores

Group	*Low (1-4)*		*Medium (5-10)*		*High (11-13)*	
	N	*Per Cent*	*N*	*Per Cent*	*N*	*Per Cent*
Experimental	12	16.7	31	43.0	29	40.3
Control	15	28.3	20	37.7	18	34.0

X^2 2.44 p = n.s.

TABLE XII

Per Cent of Patients in Experimental and Control Groups
Scoring High, Medium and Low on Ward Behavior Ratings

	I		II		III		IV		V		VI		VII	
Factor	*Self-care*		*Hostility*		*Interest*		*Orien-tation*		*Help-fulness*		*Socia-bility*		*Psychotic Symptoms*	
Adj. Score	*Exp.*	*Con.*	*Exp.*	*Con.*	*Exp.*	*Con.*	*Exp.*	*Con.*	*Exp.*	*Con.*	*Exp.*	*Con.*	*Exp.*	*Con.*
% High	41	24	51	57	41	17	25	28	36	13	53	36	79	55
% Medium	30	40	30	34	27	45	42	30	26	40	28	36	‡	
% Low	29	36	19	08	32	38	33	42	38	47	19	28	21	45
N	73	53	73	53	73	53	73	53	73	53	72	53	72	53
	p	.10	p	.05	p	.005	not sig.		p	.025	p	.025	p	.005

‡ Because of an unevenly skewed distribution, this factor was dichotomized.

Meeting the Challenge: Rehabilitation and Employment of the Older Worker

Dale C. Larson, M.S.*

Vocational rehabilitation, like the proverbial "damnyankee," has tended to become "all one word." Employment and rehabilitation have, in fact, united pragmatically in the thinking of many—almost to the point of impaction. With the constantly increasing number of older disabled persons capable of and wanting work opportunities, these definitions are undergoing significant philosophic revision. Leaders in the equivocal field of rehabilitation have sought to delimit their areas of concern, and the resultant maze of interpretations has obscured rather than clarified. Rarely do the explanations dealing with restoration concern themselves with time. Such is their concern with techniques and disabilities that they fail to include the concept of maintenance as opposed to, or implemented by, improvement.

Significantly, with a growing proportion of older persons in our society, there has grown an awareness that employment may represent improvement in condition rather than function. Rehabilitation in these terms implies employment only when a remunerative occupation is appropriate to the socioeconomic and psychologic needs of the individual. Let us recognize, however, that rehabilitation may be possible and opportune without insistence upon productive employment as a goal. An older person who, through the science of restorative medicine and the art of competent casework, is returned to community life able to care for his own personal needs certainly will consider himself both occupied and rehabilitated. If this be true, and certainly more and more programs are proving it to be, then the limited objective of *paid* employment may be inappropriate to the needs of the older person.

The sequential inference then is that employment should include in its definition service for which no pay is received as well as remunerative occupation. The social and economic implications here are worth considering. Paid

*Assistant Director in Charge of Special Services, Irene Walter Johnson Institute of Rehabilitation, Washington University School of Medicine, St. Louis, Missouri.

work is a long-established standard of social worth, and as such makes employment essential to the mental health of many. In a period when a substantial percentage of the nation's unemployed labor force is both younger and not disabled, are we not wise in urging a reformation of these Calvanist precepts? Is not the contribution which one makes to society a more valid mark of worth than a pay check? Does the projected increase of our gross national product envision a need for thousands of disabled older workers? The dollar standard applied to employment may now be inappropriate to our current social situation, and—in truth—already has been relinquished in the reality of many older persons.

Ample evidence of this new system of values is found in the increasing number of communities that are finding a welcome resource in the unpaid efforts of the older volunteer. Use of these persons in positions suited to their travel and endurance limitations has shown itself as a valuable means of releasing younger non-disabled volunteers for more active efforts. Here too, certainly, the law of expanding demand is operational, for the talents and interest of the mature men and women of good will have shown their worth and thereby created more opportunities for a larger segment of the retired population. On the other hand, we cannot realistically expect to find the millenium in the form of 16,000,000 volunteers over sixty-five!

In a society that has been taught to worship the virility of youth and camouflage the encroachments of age, we find that rehabilitation workers often feel that the reflection in the mirror of the future is appallingly clear. The problem of extending activity services and organization in this area is thus rendered at least as difficult as in the area of severely disabled. But like all of our colleagues in the other fields of service to society, we too look for "a way."

On careful analysis, however, the new way and the unique approach are likely to be conceived of as automatic devices or miraculous techniques. Rehabilitation workers eagerly buy the most recent publication if the publisher has been astute enough to describe it as "a revolutionary new method" in his prepublication advertisement. The worker wanders like a condemned soul in search of a do-it-yourself, four-step guaranteed plan for extending voluntary activity, direct services, and organization. None of these methods, of course, is effective for every circumstance, and disappointment and frustration often result—doubly sad in the life of those whose everyday occupation leads them through the gloomy ways of disappointment and frustration.

The tragedy is that the solution is within the province of every professional person—so simple that it is oftentimes completely overlooked. There is no "way," no method, no "gimmick" to extend voluntary activity and organization and services in social welfare and rehabilitation any more than there was a special "pitch" needed to convert millions to Buddhism, Mohammedanism, or Christianity. In all of these religions—and serving humanity is at least a cult

if not a faith—a leader or his disciples merely had a program that appealed to the average man and then sold it to him by personal contact.

The recognition of geriatrics as a part of the spectrum of rehabilitation has now brought the field of restoration to full circle. No longer does rehabilitation imply a special service provided in order to return war veterans to their homes and to the national economy. Since these early days—only thirty years past—special services for crippled children have been developed, and organizations have grown which give emphasis to specific disability types. During that time, however, the older age group has been served only in piecemeal fashion—dependent largely on considerations of employability or narrowly limited diagnostic entities. Older people have been eligible for rehabilitation services only if they were considered "employable" or if they suffered from a disability provided for by such specialized agencies as the Tuberculosis and Heart Associations—services which vary in type and availability in different geographic areas. Physicians, social workers, and society in general have been content to shelve these people without even a backward glance, or perhaps with the thin rationalization that "after all, they're old; what can one do for them?"

There are, in fact, many handicapped persons in the older working group for whom remunerative employment has become so symbolic of human worth that positive factors of mental health become inextricably involved in the attitude. Yet the older person with this frame of reference may become so severely disabled in later years as to make a paid vocation impossible or subject to qualifying alternatives—some less desirable than others.

First, the individual may be improved through rehabilitation to a measure of capacity for some types of employment. Most dramatic in this group are the stroke victims who more often than not—as former President Eisenhower so aptly demonstrated—do return to their jobs. One cannot but deplore the lot of one who suffers such an accident and—through professional ignorance or familial disinterest—is allowed to atrophy into a halfman.

Certainly, for others there is no complete return, and if their motivation is unswervingly directed toward re-employment, they may be taught a vocation commensurate with the limitations of disability. Here, however, is the opportunity for sweet reason to direct toward sublimated goals those who cannot work. No one can challenge the happy contentment of the octogenarian grandfather who, after retirement at seventy-two and severely limited by arthritis, has found both mental and physical therapy for his crippled hands in beautifully executed sculpture and skillfully designed tile mosaics. Does not the so-called *vocational* counselor have a vested responsibility for this type of occupational guidance? Is this sage sculptor not "gainfully" employed?

Of course, many such persons, with the submission which has guided their lives, resign themselves to the course set for them by the double-harnessed team of disability and age. For these, complacency and the comfort of the

status quo are shield and buckler against the battle of an active, competitive, and demanding world. Their protection lies in submissive acceptance, and rare is the relative, physician, or counselor who can change this. Both family and counselor have responsibility to exhaust their resources, however, before consigning such a one to the limbo of inevitability.

The final group finds itself in a true ring of Dante. Pity the old man who finds himself here, for he reacts to his handicap with a kaleidoscope of emotional responses ranging through frustration, despondency, and apathy to a complete rejection of his remaining life values. For him, fortunately, there is more hope than for his fatalistic predecessor. If his anger and his drive can be channeled and directed toward the goals of improvement and realistic activity, it is this person who often shows the most surprising gains.

In three of these four responses, there exists an implicit hope for return to some form of work activity. The emphasis has been, however, on the patient, his family, and the professional counselor. A coequal partner is the employer, if paid employment is to continue as a viable hope for this segment of our society. He must accept responsibility for finding solutions to the problems of work relocation and must do so in collaboration with the older worker. For the employer, this means an abandonment not only of the "no employees over sixty-five" rule, but, more importantly, of the attitude expressed in so many employment advertisements: "No one over forty need apply." Of the worker, it demands preparedness to cooperate by accepting training, other assignments, and even reduction in pay if he wishes to continue in employment.

In order to work these changes, we should consider current social concepts of rehabilitation and employment for the person over sixty-five. History and social attitudes have inferred a great decrease in activity and aptitude concomitant with aging. A study of the ages of world leaders today and within the past decade gives the lie to this; however, the construct continues unchallenged except by a few. The responsibility lies with Bismarck who proposed the first social security program as an unrealistic sop to a restless people. The wily chancellor proposed an aid program for German citizens over sixty-five, secure in the knowledge that the few who reached that age in the Nineteenth Century would cause little drain on the state treasury. Unfortunately, his arbitrary mark has persisted, and sixty-five continues to be regarded as the beginning of old age. In the United States, it is given further nurture by the anti-age doctrines of Hollywood and Madison Avenue that encourage the myth that a wrinkle or a gray hair is somehow un-American.

It is not surprising to find this social consensus reflected in the approach of medicine toward the rehabilitation potential of the older patient. Many physicians feel that time, effort, and money are wasted on the older patient. It is not too unusual, in fact, to hear the term "old crock" as a wry and convenient appellation delivered at the point of consigning some senior citizen to the human scrap heap. Medical schools have placed little emphasis on either

techniques or attitudes in dealing with the older patient. This, fortunately, may be a blessing in disguise, for geriatric exponents are now generally agreed that no disease or disability, either psychic or somatic, is directly attributable to the aging process; and that, in fact, as expressed by a recent president of the American Medical Association, "there is no such thing as geriatric medicine."

Experimental programs in rehabilitation and employment have, in recent years, shown the worth of a positive approach to these manifold problems. New York, Michigan, Illinois, Iowa, and California have demonstrated an assertive concern in the field of restoration. At least one pilot plan has shown conclusively that age is no barrier to the restoration of individuals suffering from a multiplicity of chronic disabling conditions. If a seventy-year-old can be restored to the simple human dignity inherent in the ability to care for his own needs, does this not justify the effort and forever lay the ghost of age as a barrier to restorative care? Progressive industries have recognized this growing need and have demonstrated the economic worth of older workers when the techniques of selective placement—the process of matching a man to a job in terms of his capacities and the demands of the position—and phased retirement—a gradual reduction of the work week over a period of a year or more—are utilized. Nor can one gainsay the unions for their growing recognition of the employment and leisure time needs of the arbitrarily retired or disabled worker. The tendency among these groups, quite naturally, has been toward an emphasis on activities rather than paid employment. Who would challenge this policy in the face of a large number of unemployed nonhandicapped younger workers? Was Bismarck, perhaps, born seventy-five years too soon?

Retirement compensations in the form of private pension plans and social security have certainly offered free-time funds which are irresistible to many. Compensated retirement, in fact, has generated a new concept of leisure time. The sunny beaches of California and the retirement villages of Florida and Arizona already may have established national patterns of recreation for those yet in grammar school. Of course, not all can share in this utopia; many retired persons still must augment their incomes for survival. Public assistance ranging from a munificent all-expense grant of less than $2.00 a day to more realistic allowances for food, clothing, shelter, and medical care provide help for many who would otherwise be subject to the vagaries of private charity. For others, a driving need for independence forces them to seek or continue employment long beyond the working years. Let us not gainsay them. Their daily re-creation may be the fruits of honest labor; their prize in the battle against time may be the pay check.

Conversely, to those earnest souls who constantly seek employment opportunities for older workers must come eventually the recognition that some simply accept with gratitude the opportunity of avoiding work. Their reward,

after nearly fifty years of labor, is the joy of discarding the incessant daily alarm clock.

Having produced the affluent society in which we can afford the yearly luxury of discarding a portion of ourselves, we must accept the dependency which this can foster. Such dependency must be dealt with through programs which meet *total* needs. The alternative is a heroic change in social attitude. It is, for example, sheerest nonsense to oppose governmental programming for the needs of older people without suggesting a workable alternate plan. In truth, the potentials for independence or support of minimal needs lie within the community—not in state and federal plans. If these potentials are not utilized to the fullest, the alternative is the acceptance of legislation generated by the pressure of unmet needs.

It is true that there is a growing recognition that compulsory retirement is less appropriate than it was in the thirties. Only 4 to 5 per cent retire voluntarily. Arguing against compulsory retirement are these facts:

1. *Productivity*—equal or superior to younger workers, according to a study by the National Association of Manufacturers.
2. *Absenteeism and turnover rates*—20 per cent better says the U.S. Department of Labor.
3. *Workmen's compensation rates*—2.5 per cent fewer accidents; 25 per cent fewer non-disabling injuries.
4. *Training costs in relation to work expectancy*—a U.S. Employment Service report shows a median of eight years of employment after training for workers in the fifty-five to sixty-four age group compared with 3.4 years for all retrained workers.

On the other side of the discussion, older workers lost-time accident rates are higher. They cause an increase in the cost of private pension plans (although a New York City committee on employment and retirement practices indicates there are ways of minimizing or even eliminating the differential). They are less suited to modern production methods (research by McGraw-Hill shows more than 50 per cent of the employers sampled felt older workers were harder to train). And finally, under certain conditions, older workers are less flexible.

In general then, the assets far outweigh the liabilities. Performance after training, the effect on labor relations, response to supervision, ability to get along with others, output, quality of workmanship, and overall performance are overwhelmingly in favor of the older worker. It is summed nicely by Dr. Robert Collier Page, past-president of the Industrial Medical Association: "It is well known that an experienced worker is better than an inexperienced one . . . and is bound to acquire a mellowness of judgment and a sense of dependability that are rare in the young."

The problem really is a simple one. Society has sought and science has pro-

duced more and more years of living; however, work-expectancy has not kept pace with life-expectancy. To make them comparable is the task.

The methods employed in providing rehabilitation services to the older or severely disabled patient are little different from those utilized by any rehabilitation agency; selection and motivation are the rudiments. Selection of potential candidates is basically a medical decision originating with the family physician in order to assure the maintenance of the patient-doctor relationship. Further screening may be done by the medical staff of a rehabilitation center. Motivation is an equally essential factor in considering any patient for rehabilitation, more so perhaps in the older patient who may have to rummage through a seemingly hopeless series of personal catastrophes to find sufficient emotional and physical strengths to try "just once more."

The goal of independence or the desire to avoid an institutional setting often is sufficient to stir the spark of hope, and to assure cooperation with a program of active therapy. On the other hand, those who have withdrawn into the complacent, effortless existence of supervised care may reject any attempt to disturb their placid lives. We need far more knowledge about how to stimulate a patient to master the courage to try again; it is difficult to persuade an oldster rejected by family, society, and friends that he *is* wanted and that he *does* have a place in the active life of the community.

Those who have had the joy of witnessing successful rehabilitation are constantly reminded of our own inadequacies in predicting success. A severely crippled child, an adult victim of an industrial accident, or an oldster who has been a long-term chronic patient all may be entered in the debit column at first observation; but we all have seen these persons, and others like them, demonstrate a depth of drive and an eagerness for life that supersedes all of the negative factors of emotional and physical disabilities. If we could but discover the secret of identifying—and even more of stimulating—that motivation, our record of successful rehabilitation in all phases would be unbelievable. Some might feel that a *measure* of motivation is essential to effective selection, and should therefore be included in a discussion of that problem. For our purpose, however, let us assume that motivation—at least in a large proportion of patients—can be developed and, to some extent, directed. If that assumption is not true, then geriatrics and, indeed, all of rehabilitation loses stature and significance.

The encompassing principle of rehabilitation as a "cradle-to-the-grave" approach must assume broad aims held in common by various disciplines which stem from a common background of professional knowledge and a mutual understanding of problems and their solutions. While we ordinarily consider primarily the three disciplines of medicine, social welfare administration, and psychology, it must be recognized that a great many others are inevitably concerned with, and related to, problems of habilitation and rehabilitation. The doctor, the psychologist, and the social worker are more

closely aligned, probably because of their common knowledge of human growth and development; this in spite of the fact that each has studied these aspects from a different point of view—the physician from the standpoint of biological growth, the psychologist from the viewpoint of emotional development and the norms which relate to it, and the social worker from the point of interpretation of observable facts and the manner in which the individual sees and reacts to these facts. The rehabilitation worker is usually the amalgamating force. They are all concerned, however, with the logical sequence of a total developmental pattern of the individual and ways in which human dynamics can affect human behavior or growth so that they may become more acceptable or satisfying to the individual or to society, or both.

The success of rehabilitation then depends on three complex and too-little-understood factors, all welded together by that most involved and misunderstood element—the human being. To achieve successful rehabilitation in any area, regardless of age or diagnosis, the basic process remains the same: good selection, adequate motivation, and sincere and interested follow-up. There is, however, a golden opportunity in the field of independent living rehabilitation to demonstrate the potentials which a "total-concept" approach toward using and understanding these factors can have for the advancement and the increase of effectiveness of the total field of rehabilitation.

This can be best summarized by a quote from Dr. Morris when he spoke here in 1961 at a conference on counseling the older disabled worker: "All of life is a developmental process with very few . . . sudden starts or stops. Thus, 'old age' is simply a relative phase along the continuum of this process. Our proper area of concern, then, should be with the whole process of adult development, rather than with the aging per se."