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Mental Patients' Attraction to the Hospital: Correlates of Living Preference

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ABSTRACT: Mental patients often show attraction to the hospital as a living alternative. In this study, 187 aftercare patients of an urban state hospital were examined for correlates of hospital attraction. Several variables, including background characteristics, psychosocial problems, psychiatric symptoms, substance abuse, and medication noncompliance, characterized the approximately 25% of the sample who showed hospital attraction. A logistic regression model for hospital attraction indicated that past hospital tenure, problems obtaining regular meals, positive symptoms of psychosis, and severe drug abuse contributed separately to the variance. The authors discuss the implications of these findings for treatment and public policy.

Observational studies have suggested that psychiatric hospitalization is a negative, demoralizing, even dehumanizing experience (Goffman, 1961; Goldman et al., 1970; Rosenhan, 1973). When patients themselves are assessed, however, they tend to report positive views of the mental hospital. Weinstein (1979) reviewed quantitative studies of patients' attitudes towards the mental hospital and found that favorable opinions predominated in 30 of 38 studies (79%). Homeless mentally ill people often seek refuge in the hospital (Drake et al., 1989b), but even before so many of the mentally ill became homeless, psychiatric pa-

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tients were likely to express positive attitudes about the hospital (Weinstein, 1979).

There are many explanations for why mental patients seek out hospitals. Homelessness and the relative lack of decent living alternatives in the community undoubtedly exacerbate the problem, but Weinstein's review (1979) indicated that patients, as opposed to mental hospital critics, clearly expressed favorable views of mental hospitals before the days of homelessness. A number of factors may well be implicated in explaining patients' attraction to the hospital: for example, psychopathology, hospitalization history, wishes for structure, hospital conditions, availability of basic amenities, community living alternatives, and quality of community treatment. These factors and others may be idiosyncratically weighted by the individual patient to determine living preference, and the patient in turn may be capable of acting on the preference thus formed. Viewing the hospital and the community through the patient's eyes could help us to avoid imposing our evaluation of these factors on the patient, could promote an empathic connection with the patient, and could lead us to an individualized treatment plan that makes sense to the patient (Drake and Wallach, 1988).

Many past studies found that patients' attitudes toward the hospital were uncorrelated with past or future hospital tenure, supporting thereby a tendency to ignore patients' phenomenology as unworthy of consideration. We believe, however, that the failure to find relationships was due to two problems. First, assessing general attitudes toward hospitalization identifies patients who value the hospital for treatment as well as those with an attraction for living in the hospital (Myers et al., 1990). Second, failure to take into account specific alternative behaviors, such as living in whatever situations are available outside the hospital compared to inside, generally leads to a lack of correlation between attitudes and behavior (Ajzen and Fishbein, 1977).

When attitudes toward the hospital are assessed as "living preference," which we define as comparative attraction to the hospital rather than the community as a living arrangement, they strongly predict future hospital tenure (Drake and Wallach, 1979; 1988). Living preferences of the chronically mentally ill can be ascertained for outpatients as well as inpatients, and these preferences predict hospital tenure in both settings. In our outpatient study (Drake and Wallach, 1988), hospital attraction predicted both rehospitalization and amount of hospitalization. In both inpatient and outpatient studies, relationships between

living preference and hospital tenure remained strong when past hospital history was controlled for.

Since living preference appears to be a robust determinant of hospital tenure, we inquire here as to which patients are attracted to the hospital. Are they more severely ill? Do they have fewer supports in the community? Are they simply comfortable with the hospital based on extensive past experience with hospitalization? The purpose of this report is to examine the correlates of living preference in an urban sample of chronically mentally ill outpatients discharged from a state mental hospital.

METHODS

Study Group

The study group, described in detail elsewhere (Drake and Wallach, 1988, 1989; Drake et al., 1989b), was drawn from chronically mentally ill patients discharged from Metropolitan State Hospital in Waltham, Massachusetts, to the Cambridge-Somerville Mental Health and Retardation Center. Subjects were followed by the ambulatory community services (ACS), an early version of the continuous treatment team approach.

The study group included 187 ACS outpatients with a DSM-III diagnosis of schizophrenia (n = 115), schizoaffective disorder (n = 18), bipolar disorder (n = 37), or personality disorder (n = 17). We excluded 71 ACS patients from the analyses: 10 with primary diagnoses of alcoholism, dementia, or mental retardation, 21 who were hospitalized during the evaluation, 9 who were lost during one-year follow-up, and 32 who were not known well by their primary clinician. A majority (54.5%) of the subjects in our study group were male. Nine percent were married, 63% were single, and 28% were separated, widowed, or divorced. Only 11% were competitively employed. Past hospital history (rounded to the nearest half year) ranged from six months to 30 years.

Measures

Primary clinicians rated subjects on a series of five-point scales that refer to psychosocial variables, psychiatric symptoms, alcohol and other drug use, and treatment compliance. These scales have been described elsewhere in terms of reliability and validity (Bartels et al., in press; Drake et al., 1990; Drake and Wallach, 1989; Drake et al., 1989a; Drake et al., 1989b; Drake et al., 1991). The specific variables are shown in Table 1. Primary clinicians also rated these subjects' living preference according to their attitudes and behaviors, as described elsewhere (Drake and Wallach, 1988), 143 subjects (76.5%) showed attraction to the community as a living alternative and 44 subjects (23.5%) showed attraction to the hospital as a living alternative. Clinician ratings of living preference were reliable and stable (Drake and Wallach, 1988) and were previously validated in a separate sample by comparing them with ratings made on the basis of semistructured interviews with patients themselves and with ratings made by hospital social workers who had tried to help the patients make discharge plans (Drake and Wallach, 1979).

TABLE 1
Correlates of Living Preference

Variable	*Correlation*	*p*	
Background Characteristics			
Age	−.02	0.408	
Gender (male)	.15	0.006	*
Marital status	.06	0.006	*
Education (high school or >)	−.09	0.089	
Employment (yes)	−.12	0.001	**
Past hospitalization	.39	<.001	***
Psychosocial Problems			
Food	.27	<.001	***
Finances	.16	0.019	
Housing	.24	<.001	**
Daily activities	.13	0.040	
Home environment	.16	0.008	
Social relationships	.16	0.009	
Psychiatric Symptoms			
Hostility	.27	<.001	***
Suicidal behavior	.16	0.011	
Bizarre behavior	.22	<.001	**
Hallucinations/delusions	.27	<.001	***
Suspiciousness/paranoia	.23	<.001	**
Depression	.20	0.002	*
Negative symptoms	.08	0.122	
Disorganized speech	.32	<.001	***
Substance Use			
Alcohol use	.20	0.002	**
Street drug use	.09	0.081	
Treatment			
Medication noncompliance	.21	<.001	**
Poor relationship with caregivers	.02	0.387	

* Significant at $p < .05$ after Bonferroni adjustment
** Significant at $p < .01$ after Bonferroni adjustment
*** Significant at $p < .001$ after Bonferroni adjustment
Note: All correlations were determined by Kendal's tau-c. Positive correlations indicate hospital attraction.

Analyses

We examined bivariate associations using Kendall's tau-c (Goodman and Kruskal, 1954) and adjusted alpha levels using the Bonferroni correction (Miller, 1981) when multiple tests were performed on a set of variables. We used logistic regression to model the multivariate prediction of living preference from all other variables.

RESULTS

Table 1 shows the bivariate correlations between living preference and background characteristics, psychosocial problems, psychiatric symptoms, substance use, and treatment noncompliance. After Bonferroni correction, male gender, single marital status, unemployment, past hospitalization, problems obtaining regular meals and stable housing, several psychotic symptoms and hostility, alcohol use, and medication noncompliance were significantly associated with hospital attraction.

Logistic regression analysis indicated that problems related to obtaining regular meals, more severe hallucinations/delusions, greater street drug use, and more past hospitalization contributed independently to the prediction of hospital attraction. As Table 2 illustrates, for each of these variables, the likelihood of hospital attraction increased with greater problem severity in an approximately linear fashion, although

TABLE 2
Logistic Regression Equation for Living Preference

Severity of Problem	*Food*	*Delusions*	*Drug use*	*Past Hosp Tenure*
1 (least severe)	.145	.119	.213	.048
2	.138	.180	.192	.091
3	.250	.214	.154	.231
4	.414	.375	.385	.419
5 (most severe)	.615	.500	.625	.516
Beta	.659	.462	.367	.141
Standard error	.165	.144	.156	.039
P-values	.000	.001	.019	.000

Note: Numbers in the upper half of the table refer to the proportion of subjects showing hospital attraction as a function of severity of problem for given variables. For example: 11.9% of subjects rated 1 for delusions showed attraction to living in the hospital, as opposed to 50.0% of subjects rated 5 for delusions. Computations for the regression equation are based on SAS PROC LOGIST.

street drug use appears to become an important factor only in the severe and extremely severe (ratings = 4 or 5) range.

DISCUSSION

Our data indicate that chronically mentally ill patients who are attracted to the mental hospital as a living alternative are multiply impaired. A combination of background characteristics, psychosocial problems, psychiatric symptoms, substance use, and treatment noncompliance correlated with hospital attraction; one variable from each of these domains, save the last, was included in the logistic regression equation.

Although past hospitalization was important, patients who exhibited hospital-seeking behaviors were not just older and more institutionalized. Age alone was uncorrelated with hospital attraction. Many attracted to the hospital were young patients dually diagnosed with severe psychotic illness and severe substance use disorder. This is suggested by the separate contributions of delusions and drug use in the logistic regression equation, together with our earlier demonstration for this sample of a strong link between younger age and substance abuse (Drake and Wallach, 1989). Although young adults such as these are frequently described as "treatment resistant" (Bassuk and Gerson, 1980; Schwartz and Goldfinger, 1981), many may actually seek out protection from drugs (Drake et al., 1991a). Creating safe and drug-free environments for these young people may be essential before treatment can be considered (Kline et al., 1991; Koegel and Burnam, 1988).

Our data are consistent with the view that hospital attraction is based on a desire for structure, support, and basic amenities rather than treatment. Many subjects who sought hospitalization were in fact significantly noncompliant with their medications. This finding again suggests that structure and protection may need to be separated from treatment considerations.

Findings from this study may generalize only to severely mentally ill patients served by the public hospital system in urban areas. Our own studies in rural New Hampshire indicate that people with severe mental illness in a rural area with available housing and intensive case management are rarely attracted to the mental hospital as a living alternative (Drake et al., 1991b). This contrast is exactly what would be expected if mental patients are rational judges of the situations they

face. At a time when mental health services and low-cost housing are in decline, and homelessness, violence, and drug abuse are on the increase, at least in urban areas and possibly elsewhere, more people with chronic mental illness can be expected to seek out the hospital as an attractive living alternative.

CONCLUSIONS

Patients who are attracted to the hospital can be readily identified, are highly likely to return to the hospital, and will spend more time in hospitals than other patients. Since attraction to the hospital is not just a function of previous hospital tenure, some young people with severe mental illnesses can be expected to migrate toward the hospital as a living alternative for the protection it offers. Attending to this inevitability will require not just better treatments for mental illness but, perhaps more importantly, attention to public health issues like the availability of decent, affordable, drug-free housing for the mentally disabled.

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