Hospital Stressors Experienced By Elderly Psychiatric Inpatients

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ABSTRACT

Purpose: The aim of this study was to identify the hospital related stressors experienced by elderly psychiatric inpatients during hospitalization.

Method: Fifty voluntary consecutive patients diagnosed as non-psychotic filled out a questionnaire. This descriptive study was conducted over a six month period.

Results: Stressors related to illness and treatments were frequently reported, as were stressors related to environmental issues. The stressors faced by patients that were related to their hospitalization were found to be having a psychiatric illness, knowledge deficit about the illness/treatment, mandatory inpatient treatment and changes in social relationships and having too much free time in the hospital.

Discussion: Our findings suggest that people who are psychiatric inpatients experience at least one stressor. Stressors related to having a mental disease and its treatment have been frequently reported.

We can say that hospitalization often remains stressful for psychiatric patients. These findings are applicable in clinical settings where psychiatric inpatients experience hospital stressors.

Keywords: elderly, hospitalization, hospital stressors, psychiatric inpatients

ÖZET

Hastânede Yatan Yaşlı Psikiyatrik Hastalarda Hastâne Stresörleri

Giriş: Bu çalışmada, hospitalizasyon süresince yaşlı psikiyatrik hastaların hastâneyle ilgili stresörlerinin aydınlatılması amaçlanmıştır.

Yöntem: Non-psikotik 50 gönüllü hasta bir anketi cevaplamışlardır. Bu tasvirî çalışma 6 ay sürmüştür.

Bulgular: Gerek muhitî, gerekse hastalıklar ve tedavilerle ilgili stresörler sıklıkla bildirilmiştir. Hastâneye yatırılmalarının bir psikiyatrik hastalığa sâhip olmaları, bu hastalık ve tedavisi hakkında bilgi sâhibi olmamaları, yatan hasta olmanın güçlükleri, sosyal ilişkilerindeki değişiklikler ve hastânede çok fazla boş vakitlerinin olması bu stresörlere yol açmıştır.

Tartışma: Bulgularımız, hastânede yatan psikiyatrik hastalar en azından bir stresöre mâruz kalmaktadırlar. Bir akıl hastalığına sâhip olmak ve bunun tedavisi sıklıkla bildirilmiştir.

Psikiyatrik hastalarda hospitalizasyonun sıklıkla stres yaratıcı olduğu görülmektedir. Bulgularımız hastânede yatan psikiyatrik hastaların hastâne stresörlerinin önemine dikkat çekmektedir.

Anahtar Kelimeler: yaşlılar, hospitalizasyon, hastâne stresörleri, yatan psikiyatrik hastalar

OBJECTIVE

When outpatient treatment is not effective the alternative for psychiatric patients is to be treated in a hospital. The basic purposes for hospitalization are to prevent the patient from harming him/herself or others, to stabilize a crisis situation, to implement medical treatment and specific problem solving methods, to develop a rapid plan for outpatient treatment, and to help the individual achieve effective functioning in society (Shives and Isaacs 2002, Varcarolis 1998, Videbeck 2001). Psychiatric disorders are characterized by repeated hospitalizations. Individuals may be hospitalized for a day or several days, depending on how rapidly progress is made. Inpatient treatment is accompanied by many difficulties for

the psychiatric patient and his/her family. The patient experiences feelings of loneliness, hopelessness, worry and anger and may become passive and dependent because of the hospitalization. In addition to this the patient may face problems such as being isolated from daily life, activities and society, a decrease in self-confidence, loss of abilities, disturbances in relationships, and lack of self care, inability to carry out marital and family roles, job loss and economic difficulties (Gardner et al 1999, Lieberman et al 1998).

Other studies that have been conducted have shown that psychiatric patients experience difficulties related to seeking help from team members, being forced to receive inpatient treatment, not feeling well, receiving information about their treatment, hospital food, being able to verbalize complaints and lack of self-confidence (Greenwood et al 1999), difficulties with side effects from the treatment, changes in lifestyle, relationships with team members, disease related symptoms, family's behaviors, and problems related to the physical environment (Koenig et al 1995) and problems with being admitted against their will, pressure in treatment, and difficulties from intensive procedures (Gardner et al 1999). According to Leavey et al (1997), patients are not satisfied with their situations, they do not receive information about their illnesses, there are not appropriate activities for patients, confidentiality is not maintained, and nurses and doctors do not set aside enough time to talk with the patients. It is recognized that the days after admission are a high-stress period but there is a lack of information about the stressors that individuals who are psychiatric inpatients experience during this period. Observations have been made in our country that the time when patients are admitted for inpatient psychiatric treatment is stressful, but it is known that there is insufficient information about what the stressors are that affect patients during hospitalization. This descriptive research was conducted for the purpose of identifying the stressors that are faced by non-psychotic patients who are admitted to a psychiatric ward.

METHODS

The research was conducted between 01.09.2002 – 28.02.2003 on the Psychiatric Ward at Akdeniz University Hospital. The psychiatric ward is on the 8th floor of the hospital, and is an open (unlocked) 12 beds capacity unit. There are 2 doctor's rooms, one interview and one treatment room, a shared bathroom, and a multipurpose room used for eating and watching television; there is also a room outside the ward but on the same floor that is used for interventions. There are 13 physicians, three nurses and three assistant personnel employed on the ward. During the time the research was conducted there was one nurse during the week working on each shift between 08.00 and 24.00. During the remaining time there was one research physician, one intern physician and one assistant personnel.

The criteria for inclusion were that patients were between the ages of 18-65 years old, at least a primary school graduate, having been in the hospital for at least three days so that a clinical diagnosis would have been made and some adaptation would have occurred, not to have a communication problem, not to have Alzheimer's disease, dementia or a psychotic disorder according to DSM-IV-TR (Diagnostic And Statistical Manual Of Mental Disorders, 4th Edition). Fifty consecutive patients met inclusion criteria and all agreed to participate. Patients gave written informed consent to participate after hearing a complete description of the study.

A two-section questionnaire was developed for the purpose of collecting basic research data. In the first section there were questions about the patient's descriptive characteristics. The second section asked questions about hospital-related stressors. In the first step in the development of this section fifteen patients were asked an open ended question exploring what they found most stressful about being in the hospital. Then we reviewed the literature for information about experiences during hospitalization perceived as being stressful by elderly patients (Greenwood et al 1999, Koenig et al 1995, Videbeck 2001). 25 item lists of stressors was the result.

Stressors were assessed by asking participants to indicate from these 25 the most stressful issues they were facing at the time of hospitalization. Patients responded by using 2-point scales of "not difficult" (1), or "difficult" (2). A reliability test was conducted for the reliability of the form's determination of stressors and Cronbach alpha= 82.07% was found.

The frequency and percentage of data was calculated using SPSS packet program. Groups were determined by evaluating the percentages of descriptive characteristics (Table 1). The percentage of patients answering "difficult" was calculated and to determine the most difficult stressors a lower limit of 50% was accepted. According to this the 5 stressors that the patients found to be the most difficult were determined. These were *"having a psychiatric illness," "knowledge deficit about the illness/treatment," "mandatory inpatient treatment," "changes in social relationships" and "having too much free time in the hospita*l." The other stressors that were stated but not considered the greatest stressors because they were less than 50% were related to fa-

mily, economic, environmental, work, education, hospital food, another physical illness, and presence of visitors on the ward. The 5 greatest stressors in the study were compared with descriptive characteristics for statistical significance (Table 2) using Chi square test and accepting $p<0.05$ for statistical significance.

RESULTS

In the examination of the patients' descriptive characteristics it was determined that 48% of the patients were male, 52% female, 64% married, and 60% currently employed. The age mean was 41.0±11.9. Only 68% of the patients knew their diagnosis and 50% had had this diagnosis for six years or more. When the patients' hospitalization related information was examined it was determined that 54% had been hospitalized 4-5 days, 52% had been hospitalized more than once and 68% had been hospitalized voluntarily. In the evaluation of the patients' diagnoses it was seen that 74% had depression and anxiety disorders and 26% had addiction to alcohol/medication (Table 1).

The greatest stressors faced by patients related to their hospitalization were having a psychiatric illness (90%), knowledge deficit about the illness/treatment (74%), mandatory inpatient treatment (73%), and changes in social relationships (63%) and having too much free time in the hospital (58%). The distribution of some sociodemographic and disorder related characteristics according to the stressors are shown in Table 2. The female patients had significant difficulty with *"having too much free time in the hospital,"* married patients with *"mandatory inpatient treatment"* and "changes in social relationships," employed patients with *"changes in social relationships"* and *"having too much free time in the hospital"* and these results were found to be statistically significant ($p<0.05$). A significantly high percentage of patients with a diagnosis of depression and anxiety disorder were found to have difficulty with all the stressors except *"changes in social relationships"* ($p=0.001$, $p<0.05$).

Patients with unknown diagnoses had significantly high levels of difficulty with *"knowledge deficit about the illness/treatment"* and *"changes in social relationships,"* patients who had been ill for more than six years with *"changes in social relationships,"* patients who had been hospitalized 4-5 days with *"knowledge deficit about the illness/treatment"* and *"changes in social relationships,"* those admitted more than once with *"having a psychiatric illness," "knowledge deficit about the illness/treatment"* and *"mandatory inpatient treatment,"* patients admitted against their will with *"mandatory inpatient treatment"* and *"changes in social relationships"* ($p<0.05$).

Table 1: Some Sociodemographic and Disorder Related Characteristics (n=50)

Characteristics	n	%
Diagnosis (DSM-IV-TR)		
Depression and anxiety disorders	37	74
Addiction to alcohol/medication	13	26
Sex		
Male	24	48
Female	26	52
Age		
19-35 years	17	34
36-65 years	33	66
Marital status		
Married	32	64
Unmarried	18	36
Employment		
Employed	30	60
Unemployed	20	40
Knowing diagnosis		
Known	34	68
Unknown	16	32
Time to illness		
0-5 years	25	50
>6 years	25	50
Day of hospitalization		
4-5 days	27	54
6-12 days	23	46
Number of hospitalization		
Once	24	48
More than once	26	52
Type of hospitalization		
Voluntary	34	68
Involuntary	16	32

DISCUSSION

Our findings suggest that people who are psychiatric inpatients experience at least one stressor. Stressors related to having a mental disease and its treatment have been frequently reported. This finding is similar to those of previous studies about stressors faced by patients (Kimhy et al 2004, Koenig et al 1995). We can say that hospitalization often remains stressful for psychiatric patients.

Having a psychiatric illness: All patients, without separating them by demographic or illness related characteristics, who participated in the research identified having a psychiatric illness as causing the greatest stress. Based on this it is interesting that the greatest difficulty experienced by the patients was not related to their hospitalization but related to their illness. This

Table 2: The distribution of sociodemographic and disorder related characteristics according to the stressors.

Characteristics		Stressors														
		Having a psychiatric ilness (%90)			Knowledge deficit about the illness/treatment (%74)			Mandatory inpatient treatment (%73)			Changes in social relationships (%63)			Having too much free time in the hospital (%58)		
		Difficult (%)	x2	p	Difficult (%)	x2	p	Difficult (%)	x2	p	Difficult (%)	x2	p	Difficult (%)	x2	p
Sex	**Male**	91.7	0.142	0.706	75.0	1.532	0.216	62.5	0.005	0.944	79.2	0.009	0.924	**37.5**	**7.962**	**0.005**
	Female	88.5			88.5			61.5			65.4			**76.9**		
Age	*19-35years*	88.2	0.089	0.765	76.5	1.534	0.465	64.7	0.080	0.777	70.6	1.957	0.162	70.6	1.676	0.196
	36-65years	90.9			84.8			60.6			72.7			51.5		
Marital status	*Married*	93.8	1.389	0.239	84.4	0.340	0.560	**93.8**	**6.287**	**0.012**	**78.1**	**5.824**	**0.016**	56.3	0.112	0.738
	Unmarried	83.3			77.8			**66.7**			**44.4**			61.1		
Employment	*Employed*	93.3	0.926	0.336	80.0	0.203	0.652	60.0	0.127	0.721	**73.3**	**5.516**	**0.018**	**46.7**	**3.955**	**0.047**
	Unemployed	85.0			85.0			65.0			**40.0**			**75.0**		
Diagnosis	*Depression/anxiety disorders*	**97.3**	**8.420**	**0.004**	83.8	0.307	0.580	**91.9**	**6.595**	**0.001**	**75.7**	**5.937**	**0.015**	**73.0**	**13.097**	**0.001**
	Addiction to alcohol/medication	**69.2**			76.9			**61.5**			**38.5**			**15.4**		
Knowing diagnosis	*Known*	88.2	0.368	0.544	61.8	**3.431**	**0.044**	61.8	0.002	0.960	**44.1**	**11.167**	**0.001**	61.8	0.618	0.432
	Unknown	93.8			87.5			62.5			**93.8**			50.0		
Time to illness	*0-5 years*	84.0	2.000	0.157	84.0	0.136	0.713	80.0	0.595	0.440	**80.0**	**4.367**	**0.037**	66.7	0.739	0.390
	>6 years	96.0			80.0			88.0			**52.0**			47.8		
Day of hospitalization	*4-5 days*	85.2	1.512	0.219	**59.3**	3.024	**0.047**	63.0	0.023	0.879	**81.5**	**5.062**	**0.012**	66.7	1.810	0.179
	6-12 days	96.7			**82.6**			60.9			**47.8**			47.8		
Number of hospitalization	*Once*	**79.2**	**6.019**	**0.014**	**54.2**	5.510	**0.019**	**70.8**	**2.821**	**0.015**	66.7	0.651	0.420	54.2	0.278	0.0598
	More than once	**100.0**			**84.6**			**96.2**			76.9			61.5		
Type of hospitalization	*Voluntary*	85.3	2.614	0.106	82.4	0.009	0.925	**76.5**	**4.482**	**0.034**	**47.1**	**3.957**	**0.048**	52.9	1.116	0.291
	Involuntary	100.0			81.3			**100.0**			**75.0**			68.8		

was an expected result because of the negative approach of society against psychiatric patients, the long-term therapy for the illness, and the problems associated with side effects of the medications they use (Boyd 2001, Shives and Isaacs 2002).

The patients who had been hospitalized more than once had the most difficulty with *"having a psychiatric illness"* ($p<0.05$). This result may be from the chronic nature of the patients' illnesses, losses from extended length of hospitalization and repeated hospitalizations, being ostracized and experiencing hopelessness with the treatment. In the same manner those hospitalized against their will experienced the most difficulty with this stressor, an expected result because of their lack of acceptance of their illness and treatment. Patients who do not accept that they have an illness may experience stressors that are faced in general at the hospital differently and more intensely. In the same way, when admitted against their will, negative results are loss of autonomy, freedom, and self-respect and these may be more difficult for patients and be the reason for resistance to treatment (Roe et al 2002) and it has been shown that those who are voluntarily admitted believe more in the necessity of hospitalization (Hoge et al 1997).

Another important finding in the research was that those with the diagnosis of depression and anxiety disorder had more difficulty with *"having a psychiatric illness"* than those with diagnoses of substance addiction ($p<0.05$). According to Raingruber (2002) patients with the diagnosis of depression are blamed and ostracized more by society and this situation may make their hospitalization more difficult. In our country society's opinion of psychiatric patients is not different. Negative attitudes and rejection that has developed against patients makes it more difficult for psychiatric patients to receive treatment (Kocadere et al 2001, Sağduyu et al 2001, Taşkın et al 2002). It has been determined that society has the most negative feelings against patients with substance addition in studies conducted in our country (Sağduyu et al 2001, Taşkın et al 2002) as well as in other countries (Crisp et al 2000). However the patients who participated in our study stated that they did not consider themselves psychiatric patients. For this reason nearly all of the patients in this group, who were receiving treatment for alcohol addiction, did not consider themselves as having a psychiatric problem.

Knowledge deficit about the illness/treatment: Psychiatric patients have a greater need for counseling, support, encouragement and information than other patients. These needs need to be met by health care members in the most appropriate manner (Mac Haffie 2002, Uyer 2000). A large percentage (75%) of other patients gave similar statements about the stressor *"knowledge deficit about the illness/treatment."* Similarly, Llewellyn-Jones et al. (2001) found that most patients want to know when their medication could be reduced or stopped, and some patients asked for more medication. In studies about patient satisfaction the illness and treatment dimensions are the primary issues for psychiatric patients. One study found that the most effective element in the satisfaction of patients hospitalized on a psychiatric ward was the explanation of medication treatment, psychotherapy, ECT and other interventions and for information to be provided (Williams and Wilkinson 1995).

In addition to this the other important factors in patient satisfaction are communication, adequately informing the patient, showing interest in the patient and setting aside time for the patient (Yılmaz 2001). Psychiatric patients cannot make the first attempt at establishing communication and they expect the health care team members to take the first step. In a study by Greenwood et al. (1999) it was determined that psychiatric patients have difficulty asking for help from team members. In another study psychiatric patients stated that their satisfaction with hospitalization was affected by the attitudes of team members (Leavey et al 1997). During data collection our patients also stated that they were not able to get necessary information about their illness and treatment from physicians and when they had a problem they were not able to find a nurse or physician, particularly their own physician, to solve their problems. A study identified features of professional hierarchy and organizational complexity that further restricted patients' access to information from staff (Pollock et al 2004). In a study by Yemez et al. (2002) patients spending time with their physicians in psychiatric treatment and approaches using effective models of physician patient communication were shown to have a positive effect on patient's adaptation to treatment and prognosis.

Mandatory inpatient treatment: For patients who participated in the research *"mandatory inpatient treatment"* was one of the significant stressors (Table 2). In a study by Greenwood et al. (1999), being forced to be hospitalized was found to be difficult for patients. In other studies patients have found hospitalization to cause different problems. In particular patients experience difficulty with hospitalization because of society's opinion of and ostracizing patients and the illnesses (Crisp et al 2000, George 2002, Magyary 2002, Montgomery and

Kirkpatrick 2002, Ostman and Kjellin 2002, Raingruber 2002) because of losses such as role, job, financial, that occur with hospitalization and difficulty adapting to the hospital (Roe and Ronen 2003), and because of the increased cost of treatment (Flaskerud and Wuerker 1999, Horvitz-Lennon et al 2001).

Patients in our study who were admitted against their will had more difficulty with *"mandatory inpatient treatment"* than those who were willingly admitted. In studies about this topic when patients are admitted against their will they experience losses of autonomy, freedom and self-respect, which they find more difficult, and these can make them resistant to treatment (Roe et al 2002), although the majority of psychiatric patients considered that their hospitalization was necessary, their anxiety experienced from being hospitalized could be decreased with the condition that their hospitalization is voluntary and of short duration Garner et al (1999) and that voluntarily admitted patients believe more that their hospitalization was necessary (Hoge et al 1997). Similarly it has been determined that short hospitalizations or part-time (half-way) hospitalization can facilitate socialization and provide economic benefits (Flaskerud and Wuerker 1999, Horvitz-Lennon et al 2001).

In our country there is no option for psychiatric patients other than being followed as an outpatient or inpatient. If the patient cannot be monitored as an outpatient the only option is 24 hour continuous monitoring on a hospital ward. The characteristics of these wards are not any different from any other hospital ward. For example, the beds are always open, the rooms have 2-6 patients, and most wards are on the upper floors of multi-floored hospitals. The findings cannot be generalized to all countries and it would not be wrong to conclude that our results were affected by the characteristics of the ward where the study was conducted and the conditions of psychiatric wards and lack of alternatives in our country.

Changes in social relationships: The fourth most frequently cited statement was *"changes in social relationships"* for a stressor that our patients were determined to have significant difficulty with for all demographic and patient-related characteristics except gender, age and number of hospitalizations. It is known that decrease in or changes in interpersonal relationships can be at the foundation of psychiatric disorders. Commonly seen problems are being withdrawn, difficulty expressing oneself and social isolation (Boyd 2001, Shives and Isaacs 2002, Varcarolis 1998). When examined in light of this we can consider that changes in social relationships are a natural part of psychiatric illnesses and not just related to being hospitalized. However we need to consider some characteristics of the patients who participated in our study because half of our patients had had a psychiatric illness for more than 6 years, it was not their first hospitalization and they had been hospitalized for 4-12 days (Table 1). It is known that long term hospitalization is associated with negative behaviors such as difficulty adapting to life in society, aggression, weakness in self care activities, social relationships and in adapting to home life, and withdrawal (Dilonardo et al 1996, Trieman and Leff 2002).

Having too much free time in the hospital: Another stress factor identified by our patients was *"having too much free time in the hospital."* In particular high percentages of the female patients, those with the diagnosis of depression and anxiety disorder and unemployed patients had difficulty with *"having too much free time in the hospital"*. Leavey et al. (1997) had results similar to ours and found a relationship between lack of appropriate activities on the ward and psychiatric patients' lack of satisfaction.

It has been stated in the literature that the psychiatric ward environment needs to be natural, it needs to increase the patients' ego strength and help them achieve autonomy, and it should decrease their stress levels, be therapeutic and provide for the establishment of therapeutic relationships with patients (Liebermen et al 1998, Thomas et al 2002, Varcarolis 1998, Videbeck 2001). It is necessary for individuals to feel useful and productive for them to have feelings of self-worth (Boyd 2001, Shives and Isaacs 2002, Varcarolis 1998). To meet this need on psychiatric wards they need to be maintained in the most appropriate way, well-planned and organized. However on the ward where the research was conducted there were no planned activities and there were no therapists who could ensure active participation of the patients. For this reason the result is quite meaningful for emphasizing the importance of activities and not being inactive for the patients.

CONCLUSION

In this study, that was conducted for the purpose of determining the hospitalization-related stressors, all of the patients who participated in the study faced one or more stressors, which were primarily related to their illness and treatment and by environment stressors the least. Based on these results it is recommended that:

- individual and group meetings be organized to meet the psychiatric patients' needs for information and diagnosis of illnesses and to be able to verbalize

their perceptions, experiences and difficulties related to their psychiatric illness,

- learning, developmental and controlled change related activities be planned and continued throughout the time of hospitalization that would prevent patients' feelings of loneliness and isolation by increasing their interactions with other patients and team members,

- that patients be taught educational and cultural structures that they could using before or after discharge from the hospital and to increase their coping with stress and anxiety and that they be taught practical coping strategies,

- that similar studies be conducted with outpatient psychiatric patients to identify similar and different stressors in the two groups.

The short periods of time and small sample size were the major drawbacks of our study. There was no control group in this study; therefore a comparison couldn't be made. This situation is the main limitation of this study. Implications for treatment include identifying hospital related stressors for individual patients and providing interventions to enhance coping. Future research focuses on linking subjective experiences of stress with more objective measures of stress will be important. When stressors are identified at hospitalization, intervention to help individuals manage and cope with spesific stressors can be incorporated into admission plan.

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