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THE YOUNG ADULT CHRONIC PATIENT: A STUDY AT THE HELEN ROSS MCNABB CENTER IN KNOXVILLE, TENNESSEE

A Thesis

Presented for the

Master of Science in Social Work

Degree

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ABSTRACT

This research project studied the characteristics of a sample of the young adult chronic patient population at the Helen Ross McNabb Center, Inc., a private, non-profit community mental health center in Knoxville, Tennessee. Relevant demographic and clinical data were collected from computer listings and clinical records.

Four hypotheses were proposed that tested the relationship between age and primary psychiatric diagnosis with recidivism rate and clinician perceived adaptive functioning level. Statistical procedures utilized were chi-square and Pearson correlation coefficient tests.

The results exhibited descriptive data similar to population characteristics described in the literature. Hypotheses test results showed no significant statistical relationship between the variables of age and primary diagnosis with recidivism rate and adaptive functioning level. Results were discussed in regard to implications for treatment. Ideas for future research were suggested.

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CHAPTER I

INTRODUCTION

The label "young adult chronic patient" was conceived by Bert Pepper, M.D., and introduced into the professional vocabulary at a conference in Rockland County, New York, in 1980. The concept attempted to describe a new generation of young adult mental patients in the eighteen to thirty-five age group who exhibited impairment in social and psychological functioning, usually accompanied with a history of short-term hospitalizations. They were identified as our first generation of severely disabled patients to grow up in the community as a result of the deinstitutionalization movement that began in the mid 1950's.

Deinstitutionalization, the process of discharging mental health patients to the community instead of long-term residential care was a drastic shift in treatment philosophy and policy. By the late sixties and early seventies short-term treatment and routine discharges became standard procedure for state mental health hospitals. However, the community was unprepared to address the treatment and resource needs of these mentally ill individuals. As a result, there evolved a recidivist population who was unable to organize and maintain a support system for themselves in the community (Diamond and Winkler, 1985). By the late

seventies, the importance of the need for programs that provided effective community care and treatment for these uninstitutionalized patients was clearly evident to mental health practioners and administrators (Pepper et al. 1981).

Research studies in the area of the young adult chronic attempted to validate the population as a discrete clinical group, and identify characteristics that provided information in regard to service needs. Along with this research, there was an exposure of a variety of conceptual and methodological difficulties inherent in studying such a sizeable heterogenous population (Bachrach, 1984).

Conceptual research limitations included the process of defining the ever changing concept of chronicity. In the past, primary classification for establishing chronicity was long-term residence in a psychiatric facility. New definitions were necessary because of the mental health transition to a short-term residential treatment philosophy (Bachrach, 1988).

Methodological issues included the classic plight of the subjective nature of psychiatric research and measurement. In addition, it was noted that the researcher must be careful in generalizing results obtained from a sampling of a population that was reportedly highly mobile and unresponsive to treatment, as a whole (Bachrach, 1984).

With the above considerations in mind, this research proceeded to study the characteristics of a sample of the

young adult chronic patient population at the Helen Ross McNabb Center, Inc., a private non-profit community mental health center in Knoxville, Tennessee. Relevant demographic and clinical data were collected from computer listings and clinical records. This descriptive data was discussed in regard to implications for clinical programming and practice.

Four hypotheses were proposed and tested. These hypotheses explored the relationship between age and primary psychiatric diagnosis with recidivism rate and clinician perceived adaptive level of functioning. Finally, research limitations and implications for further research were discussed.

CHAPTER II

LITERATURE REVIEW

Developmental Theory

When attempting to initiate a literature review on the topic of the young adult chronic, it seemed logical to begin with a discussion of central developmental themes during this life period. Newman and Newman (1975) recognized in this discussion that rate of developmental progression varies chronologically among individuals.

Early psychoanalytic theory argued there were biologically pre-determined life stages. Freud (1905) proposed that psychological development was directly related to psychological states that involved sexuality as the primary driving force. This psychosexual developmental theory included the oral, anal, phallic, latent, and genital stages. Personality development was assumed to take place during these five stages which occurred in infancy through adolescence (Freud, 1933). While psychoanalytic theory identified the importance of childhood experiences as an influence in later adult life; psychoanalytic theory de-emphasized adulthood development and the corresponding possibility for learning and changing (Newman and Newman, 1975).

Modification of early Freudian theory served to re-emphasize the importance of the individual's development in the social system as an adult. For example, Harry Stack Sullivan (1946) emphasized the importance of peer relations and educational institutions on childhood development, noting that these influences can counter nuclear family experiences.

Later, Erik Erikson (1950) expanded traditional psychosexual theory to include central psychosocial crisis themes and developmental tasks. The role of societal cultural response in providing avenues for task achievement and crisis resolution was emphasized (Lidz, 1968). According to Lidz (1968), the first four of Erikson's eight life stages corresponded to Freud (1933) stages. In the Lidz (1968) comparative discussion, during the oral phase the infant concerned self with the acquisition of trust in self and others versus mistrust. The second year of life brought about a shift of emphasis in the anal stage on control issues which corresponded to a sense of autonomy versus shame. During the phallic period, the integration of the child into school prompted a focus on the need for initiative versus guilt. Latency brought about the realization that inferiority must be avoided by the acquisition of skills termed by society as industry. Erikson (1950) then diffused the idea of genital stage in adolescence as a purely sexual crisis and expanded it to

encompass the need for attainment of a strong sense of ego identity versus alienation (Lidz, 1968).

Erikson (1950) postulated that life stages continued through adulthood. Early adulthood was described as a time in life when the capacity for intimacy was realized. Middle adulthood was when a need for generativity versus stagnation emerged. Later life development was concerned with achieving a sense of integrity and viewing one's life as worthwhile as opposed to a state of despair.

Newman and Newman (1975) expanded Erikson's life stages from eight to ten, distinguishing between early adolescence and later adolescence. This division was relevant to this review of the young adult chronic since literature noted that this population commonly dealt with tasks included in this later adolescence life stage (Pepper, 1986). According to Newman and Newman (1975), the late adolescent strove to discover a sense of individual identity that lead to the task of making decisions which facilitated autonomous functioning apart from the nuclear family. Included in this breaking away process, the realization of the need for integration on some level in regard to the world of work was evident to most individuals (Pepper and Ryglewicz, 1987). Moral and personal values were further clarified and internalized during this later adolescence period (Newman and Newman, 1964). Kohlberg (1964) referred to this moral development as the process of post conventional morality.

This process involved the development of a level of reasoning which encompassed an internal sense of commitment to a set of moral principles. Failure to develop this reasoning process on some level resulted in a lack of respect for authority and an inability to exist productively in the existing societal structure. Pepper and Ryglewicz (1987) noted this inability to integrate into the societal order as a common element which the diverse population of young adult chronics shared. Curtis (1981) referred to this state of being during youth as social dyslexia and strongly recommended the need for services to provide assistance in re-educating these individuals in regard to socially accepted values. For Erikson (1950) and Newman and Newman (1975), the end of the adolescent life stage marked the end of childhood.

Lidz (1968) referred to the passage into young adulthood as the time when individuals completed physical maturation, obtained a strong perception of identity, and began the search to find a place in the framework of society. Schoenfeld (1988) pointed out the need for the role of social networking in the daily lives of young adults with mental disorders. The lack of meaningful relationships was cited as the life deficiency which contributed to a severe state of isolation. This individual condition was noted much earlier by Durkheim (1951) in his writings regarding alienation. The alienated person was defined as

one who was emotionally deprived and essentially separated from society, unable to achieve acceptance or rewards. The above citation appeared in agreement with Erikson (1950) philosophy of young adulthood as a life stage laden with the psychosocial crisis of intimacy versus isolation. Erickson (1950) identified tasks of this period as marriage, childbearing, work, and lifestyle. Lamb (1982) noted that the mental illness symptoms that the young adult chronic patient often experienced prevented acquisition of age appropriate tasks. As a result, the young chronic often became increasingly depressed and disheartened (Lamb, 1982).

Levinson (1986) defined the period of life between the ages of seventeen and forty years old in a more delineated framework. The period was categorized into four life stages. The Early Adult Transition, seventeen to twenty-two years, was defined as the period following pre-adulthood. The task was identification. Levinson's Entry Life structure, ages twenty-three to twenty-eight years, was defined as the stage of building an initial framework for adult living. The Age 30 Transition, age twenty-nine to thirty-four included life structure evaluation and modification. The Culminating Life Structure, age thirty-five to forty, was the period of time in which the integration of ego was achieved and realized. This internal breakdown of individuals in these approximate age groups appeared useful when attempting to delineate a young chronic

population that was reportedly heterogeneous in regard to level of life stage development (Sheets, et al., 1982).

Pepper (1986) noted that the use of developmental assessment and subsequent treatment modalities must be applied to the young adult chronic keeping in mind special considerations. The ability to be resolute in adolescent or young adult life stages was dependent on previous experiences. It was noted that no one progresses through stages fully resolved and unscarred emotionally (Lidz, 1968). In addition, resolution of psychosocial processes immediately before, during, or after onset of psychiatric illness was likely to be low (Blos, 1962). Lamb (1982) pointed out that while young chronics experienced the same stressors as others in their age group, the young chronic lacked ego strength. With this came the inability to withstand stress in a productive manner (Lamb, 1982).

Pepper (1986) called for a treatment approach that emphasized an assessment component in regard to the individual's life stage coupled with a treatment strategy appropriate to this developmental level. For example, attempts by the therapist to facilitate expansion of the patient's stress threshold were to be initiated only after clinician assessment of patient's rate of compensation (Pepper, 1986).

Historical Context

The central historical event in understanding the emergence of the young adult chronic population was deinstitutionalization (Borland and Higgins, 1980). Klein (1982) noted the importance of the development of medications as responsible for the deinstitutionalization movement. Three levels of patient recovery were noted as a result of the administration of these psychotropic medications to patients. The first level was described as complete recovery from mental illness with no social, cognitive or psychological deficits. This level of recovery was low in incident, with ranges estimated at eight to ten percent. The second level of recovery was the outcome of continued symptomatic complaints with moderate deficits. However, symptom relief was such that it allowed a compensation level conducive to staying out of the hospital for varying lengths of time. The third outcome was the patient who did not respond to medications and exhibited little or no progress toward recovery. This condition was usually accompanied with severe functioning deficits; the patient remaining in the hospital unable to function in the community. It was noted that the young adult chronic population was generally classified under the second level of compensatory recovery (Klein, 1982).

With the increased compensation level of a large group of mentally ill individuals, the mental health administration responded with a plan for a massive deinstitutionalization movement (Stein and Test, 1982). These authors stated that this process brought about "policies of admission diversion and short stay hospitalizations which were directed toward protecting patient's civil rights and allowing them to live in the least restrictive environment" (p. 58). Gorovitz (1982) summarized the ethical dilemma by noting that deinstitutionalization was not supported only by persons with the sole best interest of the patient in mind. It was also supported by business professionals concerned with lowering mental health operation costs (Gorovitz, 1982). Gilman and Diamond (1985) advocated for the system's realization that the chronically mentally ill were costly for society, no matter what kind of treatment they received. This literature also called for a change in the way resources were distributed so that current funding would be utilized more fully for community support.

Population Definition

Review of the research literature suggested two primary areas of focus. The first aimed at validating the concept of the young adult chronic as a discrete clinical

population. Secondly, efforts were directed in research to delineating the population in regard to demographic and clinical characteristics.

Young Chronics as a Discrete Clinical Population

Pepper et al. (1982) described the young chronic as a discrete population of mentally ill individuals, between the ages of eighteen and thirty-five, who have exhibited chronic symptoms of deficiency in functioning. In 1985 writings, Pepper and Ryglewicz provided a listing of characteristics that distinguished the young chronics from the older chronic patients. The data reported that diagnoses were more varied in the young adult chronic population, substance abuse higher, suicidal ideations and attempts higher, a higher frequency of sexual behavior, more numerous short term hospital stays, and a lower level of treatment compliance and acceptance accompanied with a higher level of unrealistic aspirations. It was also noted that the observed differences were associated with extreme age group variance and a changed service delivery pattern (Pepper and Ryglewicz, 1985).

McCreath's (1984) findings supported the hypothesis that the young adult chronic existed as a discrete clinical group. One hundred patients, of all ages, admitted to a partial hospitalization program at a community mental health center were studied. The stated purpose was to study the

idea that patients appeared to fit into the newly identified mental health category of young adult chronic. A total of seventy-eight percent fell into the young adult chronic category (McCreath, 1984).

Davis (1985) studied a group of younger subjects and attempted to compare characteristics of this group to the young adult chronics described in current literature. Results again generally supported the idea that the population was a discrete group based on quantity, age, and a noninstitutionalizing health system. Bachrach (1984) noted that the young adult chronic patient concept was "useful as an ideal construct by which current deficits in the psychiatric service system may be assessed" (p. 573). However, this author noted that such an ideal construct was always accompanied with limitations that must be recognized by the researcher. Examples of methodological limitations included the difficulty of relevant operationalization of the concept and the knowledge that the age range for this population must not be viewed as set.

Young Chronic Sub-groupings

Sheets et al. (1982) hypothesized three sub-groups according to the onset of the psychiatric debilitation and group characteristics. They were listed and briefly defined as follows:

1. **System Dependent Group** - These patients entered the mental health system at early adolescence. They were accepting of the role of "patient" and the need for treatment.
2. **High Energy - High Demand Group** - The onset of the illness was in the adolescent period. Issues with impulse control brought about frequent encounters with the law. There was a high risk for substance abuse. Unrealistic expectations were characteristics of this group and most felt they could not make it without treatment. Most were without community support and resources.
3. **High Functioning/High Aspiration Group** - These patients were newest to the mental health system and uncomfortable with the role of patient. Their goal was to integrate back into society after a short-term treatment contact. For many, these expectations were unrealistic. These individuals were usually from higher socio-economic backgrounds than the other groups and many entered the system following an extreme incident involving substance abuse.

Sheets et al. (1982) data suggested an association between these sub-groups and the variables of socio-economic status, functioning level and developmental level.

Egri and Canton (1982) noted that suicide potential, criminal background and experiences of individuals as children denoted sub-groups for clinical consideration within the young adult chronic population. Schacter and Goldberg (1982) categorized psychiatric sub-groups differentiated by the individual's capacity to problem solve, and separate from the family of origin. These factors were viewed as primary indicators of independent functioning level. The first group consisted of schizophrenics and borderline personality disorders. Separation from family and independent functioning issues were foremost and the ability to maintain some level of employment was common. A second group was dually diagnosed as mentally retarded and emotionally disturbed. The members of this group tended to live with families or group homes. When employment was obtained, it was most often in a sheltered setting. A third group consisted of young adults who were mentally ill and learning disabled. Similar to the second group in regard to living arrangement and employment status, these individuals differentiated themselves by exhibiting a higher level of insight capabilities. The common thread among all these groups was an impaired ability to form constructive peer relationships.

In summary, literature indicated that this young adult population constituted a conglomerate of individuals who differed in many aspects. Diagnoses, age at onset of

illness, level of premorbidity functioning, severity of psychological impairment, and environmental differences were examples of variables considered in the literature.

Treatment Services

The young adult chronic individual often utilized available treatment services in a revolving door manner. Robbins et al. (1978) described this population in a "state of disequilibrium because they cannot adapt in the community and cannot remain in the hospital (p. 440). Due to the heterogenous and complex nature of the population, need for specialized programming was expressed in two frameworks. First, literature described what is proposed to be model examples of effective strategies. Secondly, recommendations for programming was provided in terms of principles or guidelines.

Schacter and Goldberg (1982) discussed a Growth Advancement Program designed to feature group therapy services to facilitate skills in peer relations. Neffinger and Schiff (1982) described a program consisting of four services. Acute Stabilization was provided as the hospital alternative. The Intensive Day Treatment component provided transitional and supplemental services such as skills training. There were two follow-up components; Aftercare Day Treatment and Medication Clinic that provided

monitoring, and on-going assessment services. Treatment objectives were a result of mutual agreement between client and staff.

Stein and Test (1980) described a successful case management program called Training for Community Living in Wisconsin. A five person interdisciplinary team worked with the patients from morning to evening to assist patients with a variety of needs.

Unger (1987) presented two programs, each utilizing a non-stigmatizing, educational setting instead of a mental health setting that "addressed the student's educational, vocational, and social needs and encouraged a focus on health and strengths rather than weaknesses and pathology" (p. 2).

Bachrach (1982) noted the limitations of the inference of results of the model programs outside of the cultural context. Principles were presented that all stressed the assignment of professional priority to the quality care of the severely mentally impaired. Programs that realistically networked community resources and allowed programming tailored to individual needs was called for.

Pepper and Ryglewicz (1985) advocated for an assessment process that allowed for flexibility and the prioritization of needs. Teaching skills to patients in the areas of illness management techniques and drug education were viewed as high priority.

Lefley (1987) estimated that one third of the mentally ill young adults live with their families, in particular aging parents. Programming that included the family component in the structure was called for. Ryglewicz (1982) urged crisis intervention programs to involve the family as early as possible. Approach to issues were to be dealt with in a way that did not place blame. Initially, a positive, realistic approach that recognized the possible etiological explanations, prognosis, and management of the illness was recommended. Secondarily, as treatment progressed, the goal was often to assist the patient and the family in developing outside resources that allowed the separation process to begin.

Lamb (1982) noted that control issues of the patient were often the roadblock to treatment. The nature of the one-to-one relationship was emphasized along with control issues that were more pronounced in the young chronic. Control issues were of special concern with the young chronic substance abuser. Treatment approach needed to be a careful strategy of humanism, professionalism, and negotiation.

The literature called for the use of a variety of treatment modalities and approaches according to individual needs. However, there appeared to be minimal research in regard to association between noted characteristics and clinical programming.

CHAPTER III

METHOD

Purpose and Scope of Study

First, this study reported on a group of young adult chronic mental health patients in treatment at the Helen Ross McNabb Center, Inc., in Knoxville, Tennessee. The purpose of the study was to determine if patient characteristics could be delineated similar to those described in the literature. Secondly, this study explored the association of age and primary psychiatric diagnostic categories as related to the variables of number of reported hospitalizations within the past two years and reported adaptive level of functioning as reported by the primary case clinician.

Agency Description

The Helen Ross McNabb Center, Inc., located in Knoxville, Tennessee, was originally founded in 1948 as a non-profit organization. The group was formed under the leadership of Helen Ross McNabb, thus revealing the Center's namesake. Initially, primary interests were directed toward providing quality treatment services to children and their families. However, through the years the Helen Ross McNabb Center evolved into a non-profit,

comprehensive mental health center, providing a wide range of services and treatment modalities to adults and children.

The Helen Ross McNabb Center's primary service area was to Knoxville-Knox County community residents. The 1980 census estimated that 205,755 persons resided in that area. Geographic boundaries indicated that the people served were urban dwellers. Funding for center operation was received from Tennessee Department of Mental Health/Mental Retardation, United Way, The City of Knoxville, Knox County, as well as from patient fees and third party payments.

Statement of Problem

Serving such a heterogeneous population was considered problematic for the mental health professional at the Helen Ross McNabb Center. Resources were often limited and prudent programming was necessary to provide quality services to a large quantity of patients. It was hypothesized that a description of the above listed variables would provide relevant information inferring implications for programming clinical services at the Helen Ross McNabb Center.

In addition, the following hypotheses statements were made:

H_1: Age is related to the number of reported hospitalizations in the past two years.

H_0 : There is no relation between age and number of reported hospitalizations in the last two years.

H_2 : Age is related to the clinician reported level of adaptive functioning.

H_0 : There is no relation between age and clinician reported level of adaptive functioning.

H_3 : Primary diagnosis is related to the number of reported hospitalizations in last two years.

H_0 : There is no relation between primary diagnosis and number of reported hospitalizations in the last two years.

H_4 : Primary diagnosis is related to the clinician reported level of adaptive functioning.

H_0 : There is no relation between primary diagnosis and clinician reported level of adaptive functioning.

It was assumed that the variables of clinician reported level of adaptive functioning and number of reported psychiatric hospitalizations in the last two years were indicators of overall community functioning level (Davis, 1985).

Procedure of the Study

Population

A sample (n=255) of young adult chronic patients was

drawn from a population size numbering 685. Inclusion criterion for classification as a member of the young adult chronic population was stated as follows:

1. The patient had to be age eighteen to thirty-five years old.
2. The patient had to be diagnosed with a major psychiatric disorder as classified by the DSM-III. For the purpose of this study, disorders were further classified into the framework of schizophrenia, affective disorder, substance use, personality disorder, and organic or mental retardation.
3. The patient must have been in treatment for a minimum of thirty days. This stipulation was required so that at least minimum data was available to the researcher on a given patient.

Data Collection

A random systematic sampling technique was used to draw a sample (n=255) from the young adult chronic population. Permission was obtained from the Helen Ross McNabb Center to collect secondary data from existing computer files and clinical records. The computer listed files had been compiled to provide information listings required by the State of Tennessee Department of Mental Health/Mental Retardation. Existing clinical records were used to obtain

information on variable information not listed in the computer. Recording procedures allowed for the assurance of patient confidentiality.

Study Variables

Data were collected from Helen Ross McNabb Center clinical files and computer listings. The following variables were included in the research project:

1. Age
2. Sex
3. Race
4. Religion
5. Marital Status
6. Education Level
7. Income Status
8. Benefit Eligibility
9. Employment Status
10. Occupation Code
11. Referral Source
12. Living Arrangements
13. Clinician Reported Level of Adaptive Functioning
14. Primary Diagnosis
15. Secondary Diagnosis
16. Tertiary Diagnosis
17. Number of Reported Psychiatric Hospitalizations in Last two Years

18. Number of Reported Employment Changes in Last Year

19. Number of Reported Residence Changes in Last Year

Operationalization

Operational definitions of the variables were based on the clinical rationale and guidelines of the Diagnostic Statistical Manual III (1980). These definitions and groupings of variables were used in a consistent manner during the data analysis process.

Definition of Terms

Young Adult

Exact age boundaries were defined as age eighteen to thirty-five (Pepper, 1982; McCreath, 1984; Sheets et al. 1982).

Chronic

This concept was applied and defined as persons who had been identified as having a mental condition which would last indefinitely into the life span (Gruenberg, 1982; Bachrach, 1988).

Affective Disorders

This classification of psychiatric illnesses included disorders that described mood disturbances that impaired

the person's total psychological functioning. These disorders usually involved either one or both of the components of depression or mania (DSM-III, 1980).

Personality Disorder

These disorders denoted patterns of personality traits that were identified as inflexible and maladaptive. These traits caused impairment in social and psychological functioning (DSM-III, 1980).

Organic and Mental Retardation

This was defined as a disorder featuring behavioral or psychological abnormalities that were associated with transient or permanent brain damage or dysfunction (DSM-III, 1980).

Schizophrenia

This disorder was defined as presence of psychotic features during the active phases of illness that involved multiple brain processes. There was always a marked deterioration from the former level of functioning before onset of illness (DSM-III, 1980).

Substance Use

Condition where varying degrees of behavioral changes were identified as a result of substance use and abuse that affected the central nervous system (DSM-III, 1980).

Other Diagnostic Category

This diagnostic classification category consisted of all diagnoses not grouped in the other disorder groupings as defined by DSM-III (1980).

Clinician Reported Level of Adaptive Functioning

This was the clinician's assessment of the individual patient's level of adaptive functioning during the past year.

Primary Diagnosis

This was the first computer listed diagnosis and was considered to be the primary presenting mental health problem.

Secondary Diagnosis

This was the second computer listed diagnosis and was considered to be the secondary presenting mental health problem.

Tertiary Diagnosis

This was the third computer listed diagnosis and was considered to be the tertiary presenting mental health problem that was to be treated.

Non-recidivists

Persons in sample who had zero or one reported psychiatric hospitalization within the past two years.

Recidivists

Persons in sample who reported two psychiatric hospitalizations within the past two years.

Multiple Recidivists

Persons in sample who reported more than two psychiatric hospitalizations within the past two years.

Limitations

This research project was limited in regard to the nature of the secondary data available. Additional information in regard to the age of onset of illness, coupled with factor analysis statistical procedures, would have allowed sub-groups identification on a more complex level. Lack of accurate information in regard to overall length of time in treatment resulted in the inability to consider this crucial factor's association with data

collected. Accurate data was not available on the number of residence changes and employment changes in the past two years.

The homogenuity of the demographics of this population limited this study in regard to generalizability of data. This factor also limited the ability to comparatively discuss findings with other published research.

Data Analysis

Descriptive

Data collected on the demographic and clinical study variables were qualitatively analyzed. Frequency distributions of the sample were drawn up for the nineteen study variables. These descriptive tables were utilized to identify patterns that denoted implications for clinical programming.

Hypotheses Testing

Each of the four non-directional hypotheses statements involved one independent variable and one dependent variable. All four hypotheses were tested with chi-square. Chi-square was performed to make a determination if, in fact, there was statistically significant relationship between the stated independent and dependent variable in each hypotheses.

In addition, the level of data gathered to test the hypotheses of age with psychiatric hospitalizations and adaptive functioning allowed for the utilization of a parametric measure. Pearson correlation test was performed to further determine relationship between the variables of these two hypotheses.

CHAPTER IV

FINDINGS

Sample Characteristics

Demographic Study Variables

The demographic variable data collected on this sample was collected on this sample was displayed on Table IV.1. The sample was composed of 51.8 percent male and 48.2 percent female. Median age was 26.5 years. Age was categorized according to Levinson (1986). There were 14.1 percent of the sample who fell in the range of 18 to 22 years; 27.8 percent were in the age grouping of 23 to 28 years; and 58 percent of the subjects were between the ages of 29 and 35.

In regard to race, the group was 82.1 percent white; 17.1 percent black; and 0.8 percent other. Data on religion indicated that 71.4 percent were Protestant; 21.2 percent reported having no religious affiliation; 4.3 percent Catholic; and 2.4 percent other.

Marital status denoted 61.2 percent single persons; 30.2 percent reported divorced or separated; and 6.7 percent married. There was no information available on 3.0 percent of the sample.

Educationally, it was noted that 3.1 percent had less than a high school education; 43.9 percent had some high

TABLE IV.1

Demographic Study Variables Frequency and Percent Table

Item	Frequency (n=255)	Percent
Sex		
Male	132	51.8
Female	123	48.2
Age		
18-22	36	14.1
23-28	71	27.8
29-35	148	58.0
Race		
White	207	82.1
Black	43	17.1
Other	2	0.8
Religion		
Protestant	182	71.4
Catholic	11	4.3
No Affiliation	54	21.2
Other	6	2.4
Marital Status		
Single	156	61.2
Married	17	6.7
Divorced or Separated	77	30.2
Education Level		
Less than Ninth Grade	8	3.1
Some High School	112	43.9
High School Graduate	77	30.2
Post Graduate Training	58	22.8
Occupations		
Laborers	113	44.3
Professional/Technical	24	9.4
Sales	13	5.1
Housewife	33	12.9
Employment Status		
Employed (full or part-time)	19	7.5
Unable to Work	216	84.7

TABLE IV.1 (continued)

Item	Frequency (n=255)	Percent
Income (Monthly)		
*Less than $400		80.4
$400-$600 Month		6.4
$601-$799 Month		3.2
*51.9 percent reported SSI or SSDI		
Living Arrangement		
Alone	125	49.0
Children/Spouse	28	11.0
Parents	88	34.5
Others	14	5.5

school, but never graduated; 30.2 percent reported graduating from high school with no further training. 22.8 percent reported high school graduation plus some post graduate training. There was no further information available on the specifics of this post graduate training.

Occupations self-reported by this population was 44.3 percent laborers; 12.9 percent housewives; 9.4 percent professional technical workers; and 5.2 percent sales workers. The remaining did not report an occupation. Employment status did not reflect a high level of current activity in the job market. 84.7 percent reported themselves physically or mentally disabled and unable to work. Only 7.5 percent reported themselves as currently employed on a full or part-time basis.

Income reflected these occupational and employment demographic statistics. 80.4 percent reported income less than four hundred dollars per month; 6.4 percent reported income four to six hundred dollars per month; 3.2 percent reported income over six hundred dollars, but less than eight hundred dollars. It is also noted that 51.9 percent of the sample reported receiving benefits from Social Security Insurance or Disability Insurance programs.

Living arrangements for this sample consisted of 49 percent living alone; 11 percent living with children and spouse; 34.5 percent living with parents; and 5.5 percent with others.

Qualitative analysis suggested a homogeneous population in regard to demographic characteristics. The population had a relatively equal representation in regard to sex. It was noted that more than half of this population was between the ages of 29 and 35. The group was predominantly white, single and Protestant.

Data collected suggested that this population was predominantly lower socio-economic status. Educationally, almost half had never finished high school. The majority of the sample identified themselves as laborers which was a reflection of education statistics that revealed only a small proportion to have post-high school training. Incomes were uniformly low and over half of the sample reported receiving disability insurance benefits. The young adult chronic patient in this population was most likely to be living alone or with parents.

Clinical Study Variables

Table IV.2 exhibited the statistics collected on clinical variables. Primary, secondary, and tertiary diagnostic codes were collected for the sample. Primary diagnostic classification was 26.3 percent schizophrenic; 22.3 percent affective disordered; 7.1 percent organic/ mental retardation; 10.6 percent personality disordered; 11.0 percent substance use. Secondary diagnostic classification was 24.3 percent substance use; 18.4 percent

TABLE IV.2

Clinical Study Variables Frequency and Percent Table

Item	Frequency (n=255)	Percent
Primary Diagnosis		
Schizophrenic	67	26.3
Affective	57	22.3
Organic/Mental Retardation	18	7.1
Personality Disorder	27	10.6
Substance Use	28	11.0
Other	58	22.7
Secondary Diagnosis		
Schizophrenia	2	0.8
Affective	2	0.8
Organic/Mental Retardation	0	0.0
Personality Disorder	47	18.4
Substance Use	62	24.3
Other	142	55.7
Tertiary Diagnosis		
Schizophrenia	1	0.4
Affective Disorder	1	0.4
Organic/Mental Retardation	0	0.0
Personality Disorder	27	10.6
Substance Use	24	9.4
Other	202	79.2
Adaptive Functioning Level		
Good	7	2.7
Fair	30	11.8
Poor	178	69.8
Very Poor	35	13.7
Number of Hospitalizations		
Zero	46	18.0
One	75	29.5
Two	82	32.2
Three	38	14.9
Four	14	5.5

TABLE IV.2 (continued)

Item	Frequency (n=255)	Percent
Referral Source		
Mental Hospital	103	40.4
Self Referred	91	35.7
Correctional Authorities	39	15.3
Human Service Agency	22	8.7

personality disordered; 0.8 percent affective; and 0.8 percent schizophrenic. Tertiary classifications were 10.6 percent personality disordered; 9.4 percent substance use; 0.4 percent schizophrenic; and 0.4 percent affective disordered. The primary, secondary, and tertiary "other" percentages of 22.7 percent; 55.7 percent; and 79.2 percent respectively were explained. These percentages reflected heterogeneity of diagnoses classification that could not be traditionally labeled in one of the above mentioned categories. In addition, many of the young adult chronic patients did not receive secondary or tertiary diagnoses in addition to primary. Finally, DSM-III format required the listing of some mental illnesses on a certain primary or secondary level.

Adaptive functioning level assigned by the primary clinician for this sample was 14.5 percent good to fair; 83.5 percent poor to very poor.

In the sample, 18.0 percent reported no psychiatric hospitalizations in the last two years; 29.4 percent were hospitalized only once in the last two years; 32.2 percent were hospitalized twice; 14.9 percent three times; and 5.5 percent four times in the last two years. Mean number of hospitalizations was 1.6 percent. Median number of hospitalizations was 2.0 percent.

Information collected on referral source for this sample revealed 40.4 percent were referred from the local

state mental hospital, Lakeshore Mental Health Institute, in Knoxville, Tennessee. 35.7 percent were self-referred; 15.3 percent by correctional authorities; and 8.7 percent were referred by other human service agencies.

Data collected on number of residence and employment changes in the last year was considered invalid data. It was discovered that the computer collection coding method only allowed for a maximum range of two changes per year.

Qualitative analysis revealed that the frequency of primary, secondary, and tertiary diagnoses, indicated that almost half of the sample had been primarily diagnosed as schizophrenic or affectively disordered. Almost 40 percent had been diagnosed as personality disordered on either a primary, secondary, or tertiary basis. Over 44 percent had been labeled as a substance abuser on a primary, secondary, or tertiary level. A primary "other" category listing suggested a wide range of heterogeneity within this classification. Adjustment disorder was the modal diagnosis in this category. Other examples of diagnoses in this category was Pyromania, Cleptomania, and Conduct Disorder.

Hospitalization rates ranged from one to four with over half of the sample reported to be recidivists or multiple recidivists in the last two years. An overwhelming 85 percent of the sample was reported by the primary clinician to be in the poor to very poor adaptive functioning range.

Referral source was most likely to be the local state mental hospital or other mental health agency. The remaining were likely to be self or family referred. A significant 15 percent were referred by correctional authorities.

Hypotheses

H-1

This hypothesis tested the relationship between the age and number of reported psychiatric hospitalizations in the last two years. No direction was predicted.

Chi-square was performed on the variables of age group by psychiatric hospitalizations and was displayed on Table IV.3. Statistical significance was considered to be equal to or below the p=.05 level (n=255). A chi square value of .922 was received. Degree of freedom were four. Corresponding probability level was greater than p=.092. No statistically significant relationship was found.

Results of Pearson correlation testing was displayed on Table IV.4. The correlation between the independent variable of age groupings and the dependent variable of psychiatric hospitalizations was 0.002. The corresponding probability value was much greater than .05 which indicated no statistically significant correlation.

Therefore, the null hypothesis "There is no relation between age and number of hospitalizations" was accepted.

TABLE IV.3

Hypothesis Table of
Observed Frequencies and Percentages for
Age Group by Psychiatric Hospitalizations
in Last Two Years

	Psychiatric Hospitalizations			
Age Group	Non-Recidivist Percent	Recidivist Percent	Multiple Recidivist Percent	Total Percent
18-22	7.1 (18)	4.7 (12)	2.4 (6)	14.1 (13)
23-28	12.5 (32)	8.6 (22)	6.7 (17)	27.8 (71)
29-35	27.8 (71)	18.8 (48)	11.4 (29)	58.0 (148)
Totals ...	(121)	(82)	(52)	(255)

$x^2 = .922$, df = 4, p = .92 (direction not predicted)

TABLE IV.4

Display of Pearson Coefficient Correlation Results of Age Group by Psychiatric Hospitalizations and Adaptive Functioning Level

	Psychiatric Hospitalizations	Adaptive Functioning Level
Age Group	0.002	0.013

The hypothesis "Age is related to the number of hospitalizations" was rejected.

H-2

This hypothesis tested the relationship between age and clinician reported adaptive functioning level. No direction was predicted.

Chi square was performed on the variables of age group by psychiatric hospitalizations, and was displayed on Table IV.5. Statistical significance was considered to be equal to or below the p=.05 level (n=255). A chi-square value of 1.77 was received. Degrees of freedom were two. Corresponding probability value was greater than p=.44. No statistically significant relationship was found.

Pearson correlation test was performed and results were displayed on Table IV.4. The correlation of the independent variable of age and the dependent variable of adaptive functioning level was 0.013. The corresponding probability value was must greater than .05, which indicated no statistically significant correlation.

Therefore, the null hypothesis, "There is no relation between age and adaptive functioning level" was accepted. The hypothesis "Age is related to adaptive functioning level" was rejected.

TABLE IV.5

Hypothesis Table of
Observed Frequencies and Percentages for Age
Group by Adaptive Functioning Level

	Adaptive Functioning Level		
Age Group	Poor to Very Poor Percent	Good to Fair Percent	Total Percent
18-22	12.0 (30)	2.4 (6)	14.4 (36)
23-28	25.2 (63)	2.8 (7)	28.0 (70)
29-35	48.0 (120)	9.6 (24)	57.6 (144)
Total ...	(213)	(37)	(255)

$x^2 = 1.77$, df = 2, p. = .41 (direction not predicted)

H-3

This hypothesis explored the relationship between the primary psychiatric diagnosis and the number of psychiatric hospitalizations within the last two years. No direction was predicted.

Chi square was performed on the variables of primary diagnosis by psychiatric hospitalizations, and was displayed on Table IV.6. Statistical significance was considered to be equal to or below the p=.05 level (n=255). A chi square value of 10.61 was receive. Degrees of freedom were ten. Corresponding probability value was greater than p=.38. No statistical significant relationship was found.

Therefore, the null hypothesis "There is no relation between primary diagnosis and hospitalizations" was accepted. The hypothesis "Primary diagnosis will be related to hospitalizations was rejected."

H-4

This hypothesis explored the relationship between primary diagnosis and clinician reported adaptive functioning level. No direction was predicted.

Chi square was performed on the variables of primary diagnosis and adaptive functioning level. Results were displayed on Table IV.7. Statistical significance was considered to be equal to or below the p=.05 level (n=255). A chi square value of 10.73 was received. Degrees of

TABLE IV.6

Hypothesis Table of
Observed Frequencies and Percentages for
Primary Diagnosis by Psychiatric
Hospitalizations in Last Two Years

	Psychiatric Hospitalizations			
Primary Diagnosis	Non-Recidivist Percent	Recidivist Percent	Multiple Recidivist Percent	Total Percent
Organic and Mentally Retarded	3.9 (10)	0.8 (2)	2.4 (6)	7.1 (18)
Schizophrenic	14.1 (36)	9.0 (23)	5.9 (15)	29.0 (74)
Affective	3.9 (10)	5.1 (13)	2.4 (6)	11.4 (29)
Personality	5.5 (14)	5.5 (14)	1.6 (4)	12.6 (32)
Substance Use	5.9 (15)	4.7 (12)	2.4 (6)	12.9 (33)
Other	14.1 (36)	7.1 (18)	5.9 (15)	27.1 (69)
Total ...	(121)	(82)	(52)	(2)

$x^2 = 10.61$, df = 10, p. = .38 (direction not predicted)

TABLE IV.7

Hypothesis Table of
Observed Frequencies and Percentages for Primary
Diagnosis by Adaptive Functioning Level

	Adaptive Functioning Level		
Primary Diagnosis	Poor to Very Poor Percent	Good to Fair Percent	Total Percent
Organic and Mentally Retarded	6.4 (16)	0.4 (1)	6.8 (17)
Schizophrenic	22.0 (55)	6.4 (16)	28.4 (71)
Affective	9.2 (23)	2.0 (5)	11.2 (28)
Personality	10.0 (25)	2.8 (7)	12.8 (32)
Alcohol or Drugs	12.8 (32)	0.4 (1)	13.2 (33)
Other	24.8 (62)	2.8 (7)	27.6 (69)
Total ...	(213)	(37)	(250)

$x^2 = 10.73$, df = 5, p. = .057 (direction not predicted)

freedom were five. Corresponding probability value was an .057. This value was greater than the p=.05 level, and indicated that no statistically significant relationship was found.

Therefore, the null hypothesis "There is no relation between primary diagnosis and adaptive functioning level" was accepted. The hypothesis "Primary diagnosis is related to adaptive functioning level" was rejected.

CHAPTER V

DISCUSSION

Implications for Treatment

Demographic Study Variables

The demographic data suggested a population of young adult chronics at the Helen Ross McNabb Center who were characteristically similar to reports in the literature (Pepper, et al., 1982; Sheets, et al., 1982; Holcomb and Ahr, 1986; and Davis, 1985). One consistent variation was the slightly heavier representation of females in this population.

The data suggested a population of young chronic patients who were of similar ethnic background, and socioeconomic status. This homogeneity was considered an asset in terms of the treatment process. Treatment with a working knowledge of the patients frame of reference was necessary according to Pepper (1985).

Two further observations in regard to these data and treatment implications were noted. The first was the finding that this population tended to be at the older end of the age spectrum. Lamb (1982) noted that the older subjects in the young adult chronically disabled tended to have fewer goals and aspirations than younger subjects in this population. Estroff (1981) noted that at or around age

thirty, young adult mental patients were likely to accept defeat and resign themselves to permanent disability retirement after repeated failures in their lives. This implicated the need for programs that have mechanisms which ensure the highest likelihood of success in the hopes of countering the effects of past failures. One example of such programming was supportive vocational training programs that provided job coaches for the mentally impaired (Propst, 1988).

Secondly, two sub-groups of young adult chronics were noted in regard to living arrangements. The first sub-group consisted of individuals who lived independently and alone. For these patients, Stein and Diamond (1985) called for programs that facilitated the daily structure, skills training, and social support needs of the young adult mentally ill patient. Propst (1988) called for the non-punitive freedom of entry and exit in these programs. The second sub-group was the young adult chronic who was living with parents. Lefley (1987) suggested that these family members always be involved in the treatment process. Two common family issues in regard to the young adult chronic were noted by Lefley (1987). The first was the "breaking away" issue relevant to developmental processes and the young adult chronic. The second issue noted was the concern for an emerging discrete clinical group of aging patients

who were seeking treatment as a result of the stress of long-term caretaking of their mentally ill offspring.

Clinical Study Variables

The collection of clinical data generally confirmed the notion of heterogeneity within the young adult chronic population (Lamb, 1982; McCreath, 1984; Davis, 1985; and Bachrach, 1982). However, data collected suggested the possibility of sub-groupings within a program framework to target the specialized needs of this population.

Collins, et al. (1984) discussed the idea of specialized patient activities which targeted diagnostic groups. These specialized activities aimed to educate in regard to the specific nature of a given mental illness and the corresponding experienced symptoms. In addition, effective illness management techniques were taught. This concept could be easily applied to psychiatric sub-groupings of the young adult chronic patient at the Helen Ross McNabb Center. The substance abusers were especially included in this teaching approach since most mentally ill substance abusers were unable to receive full benefit from services offered in traditional alcohol and drug programs (Sciacco, 1984).

Data also revealed recidivism to be a prevailing issue among this population. Witheridge and Dincin (1985) described a "bridge" approach that had a significant

influence on one young chronic population's rate of recidivism. The philosophy was simple. Work was exclusively done in the "patient's world" or in the community. Problems of daily living were addressed with no issue being viewed as too mundane. After basic living needs had been met, treatment was geared toward issues of vocational training and aspirations. The modality of intensive case management in the community was recommended as the primary treatment modality for this population.

The population studied also revealed a small group of individuals referred from the correctional system. Lamb (1982) noted that jails were becoming a more frequent consequence of mental illness due to the deinstitutionalization era and a lack of hospital beds. Bloom, et al. (1988) suggested that offenders be divided into treatment sub-groups based on the natures of offenses. Examples given were alcohol abusers, sexual offenders, and persons who had successfully pleaded an insanity defense. The nature of the offenses determined the scope of the treatment.

The results of this hypotheses testing indicated that the clinician cannot use the variables of primary diagnosis or age to predict risk for hospitalization or adaptive functioning level for the young adult chronic patient at the Helen Ross McNabb Center. Stein and Diamond (1985) noted that grouping patients on dimensions such as willingness to

come in for services, medication compliance, daily structure, and ability to self-monitor may be useful as predictors for patient stability. Age may not be useful as an indicator due to the wide spectrum of developmental levels within this population. Extraneous variables such as time in treatment, nature of treatment modality involvement, and developmental level may have influenced the variable of primary diagnosis as a predictor of functioning level or risk for hospitalization.

Summary

This study has served to emphasize the importance of the assessment process when attempting to provide treatment services for the young adult chronic patient. This assessment process must have occurred on two levels. The first level involved efforts such as exemplified in this research project. An accurate description of the population as a whole was needed before efficient and effective programming decisions could be made in regard to resources allocation and corresponding clinical programming. The second level of assessment must have been initiated on an individual level so that treatment plans can be tailored to specific patient needs. It was also recognized that all young adult chronics were not able to tolerate groups at varying points in treatment and assessment of these dynamics

were needed. Further research was needed in regard to specific assessment scales development for this population.

This study implicated the need for a highly complex system of coordinated group treatment modalities for this young adult chronic population. The concept of group was recommended due to obvious characteristical sub-groupings within the population. The need for sophisticated program coordination was recommended due to the overlapping of patients within these sub-groups. Group was preferred to individual for two reasons. Group was a treatment modality recommended for addressing interpersonal issues that were foremost in this population. Secondly, group was favored due to the fact that it is often an extremely efficient means for providing services in terms of staff resources. Research was needed in regard to the effectiveness of such specialized groups in relation to varying group treatment contents and approaches.

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