

Some Problems of Feeding Mental Patients

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THE need for developing adequate food services in state mental hospitals has been well recognized.¹ In order to assess current practices, the State of Oklahoma made a study of the food purchased for state institutions in the fiscal year, 1952.² A committee of the Oklahoma Dietetic Association studied the basic ration plans of some ten states with a view to adopting a standard for Oklahoma. The plan finally established was an adaptation of the U. S. Department of Agriculture *Master food plan at moderate cost*.³ Table I shows the results of a survey. Column B and C in this table present the standard and the percentages found in 1952 for a typical hospital. At the time of the original study there was no practical way to eliminate data relating to food used in the employee's cafeteria or distributed to some 60 or more families living on the hospital grounds. Information that has become available recently discloses that approximately 12 per cent of the total food budget was spent for employees. The percentages are grossly adjusted in Column D. It can be presumed that the higher-cost foods such as citrus fruits, fresh vegetables, eggs and meats were issued in greater quantities to the employees, thus depleting the patients' supply.

During the past three years a comprehensive treatment program for the mentally ill, including better food service, has been developed in Oklahoma. It involved the placement of qualified dietitians, training of employees, and other improvements. The division of biometrics of the Oklahoma State Department of Mental Health, developed monthly reports on

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the percentage of each food group currently being used, based on actual store issues for patients only. The standard has been simplified and revised in some food groups. Inspection of the report for October 1955 for the same hospital (Table I) reveals several improvements, the most significant of which are in groups II (citrus and tomatoes), V (other fruits), VI (meats), VII (milk and cheese), and VIII (eggs). The standard for milk has been revised to one quart daily. Groups IX (legumes and nuts) and XII (sugars) have been reduced substantially. It is expected that the high percentage of "other fruits" will compensate somewhat for "other vegetables" in nutrients. Fruits seem to have a better acceptance than the poor quality canned vegetables that are being used. Specifications and methods of purchasing will need to be revised to improve the consumption of vegetables. Group XII (sugars) was reduced by omitting the practice of serving syrup every day for breakfast and jellies at other meals for the sweet or dessert.

The increased percentage of meat represents a much greater amount of edible lean meat. The original study of purchases included carcass beef and pork, whereas the October 1955 study represents trimmed and fabricated cuts ready for cooking. All excess bones, suet and fat are now sold instead of being served as "bony stew" to the patients. Government commodity dried beans and rice are used as potato substitutes, so that the potato level is realistically down. The standard for legumes was revised upward due to their high acceptance. Bread consumption dropped when other foods were offered to the patients. Group XIII shows that a stronger brew of coffee is being made but also indicates that coffee is being served only once daily. Other miscellaneous items in this group are reduced due to accounting procedures of charging other departments for the use of salt, soda, and vine-



gar. Less catsup and pickles are being used, whereas the use of spices and condiments has increased. Government commodity dried beans, rice, beef, dry milk, cheese, and butter affect the October 1955 percentages in a favorable way.

When a new food was to be used or a food not served for years was to be reintroduced, a sufficient quantity was purchased to serve the entire population adequately. To cite an example: the serving of bananas means very little if they are cut into bits and put into a pudding. It may be important to the patients to see and feel a whole banana again. One old man was so impressed that he was moved to tears as he remarked that he didn't know that bananas still grew, then, jokingly, went on to ask whether bananas still grow on trees. When ice cream was re-introduced, the patients ate it in relatively large quantities. Now the consumption has leveled off to a normal serving.

Consumption has been affected by the elimination of greatly disliked and monotonous foods. The high percentage of dried fruits in the original study was principally due to dried black figs. These are no longer purchased. Oatmeal had been served every morning (with the syrup) for years, as far back as menus can be located. Both foods can contribute nutrients to a diet but not when they end in the garbage can.

Thoughtful practices in purchasing and in planning were found to increase food acceptance. Yet, dietary factors are not the whole story. Neither the satisfaction of the food service personnel working with the patients nor the response of these mental patients to good food can be shown on statistical reports. Fights in the dining room, for example, are now extremely rare whereas formerly they occurred during almost every meal. Night cries and screaming have also diminished. Dry skin,

TABLE I
Amounts of Foods Used in a Mental Hospital, Oklahoma Department of Mental Health

A	Food group	Food purchased, fiscal year, 1952			Patient food issued, month of October 1955		
		B Standard lb per person daily; unless otherwise specified	C Percentage of original standard (unadjusted)	D Adjusted percentage (column C less 12% to employees)	E Percentage of original standard	F Revised standard lb per person daily	G Percentage of revised standard
I	Green and Yellow Vegetables	0.45	70	62	68	0.45	68
II	Citrus and Tomatoes	0.40	33	29	58	0.40	58
III	Potatoes	0.55	57	50	50	0.55	50
IV	Other Vegetables	0.35	84	74	75	0.35	75
	Other Fruits	0.22	61	62	206	0.25	185
V	Dried Fruits	0.03	111		112		
VI	Beef	0.28	39	44	61	0.65	58
	Fish	0.043	61		58		
	Fowl	0.121	39		21		
	Pork	0.186	43		57		
	Other	0.021	258		232		
VII	Milk	1.4	112	99	159	2.15	103
	Cheese	0.025	84	74	102	0.025	102
VIII	Eggs	0.71 each	16	14	108	0.125	77
IX	Legumes and Nuts	0.6 az	300	266	193	0.075	97
X	Flour	0.4	97	84	83	0.55	82
	Cereals	1.0 oz	68		73		
	Cornmeal and Crackers	0.3 oz	128		62		
	Other	1.1 oz	98		137		
XI	Butter	0.075	38	88	281	0.15	155
	Bacon and Salt Pork	0.025	391		88		
	Other	0.050	51		88		
XII	Sugar	0.125	284	250	158	0.18	110
XIII	Coffee, Cocoa, Tea	0.05	21	91	62	0.125	76
	Misc. (Spices, etc.)	0.025	270		119		

red, swollen joints, dull and lifeless hair, diarrhea, and constipation are not as great problems as formerly. All of these changes cannot be attributed solely to better diet but probably also reflect better medical and nursing care which are a part of the improved treatment program for the mentally ill.

The emotional significance of food is deeply rooted. The infant is first and primarily an orally-motivated being, and eating represents the child's first contact with the reality of the external world.⁴ Food which satisfies the pains of hunger also brings awareness of love and security or rejection and hostility, and food retains strong emotional values throughout life.⁵ It can and should become one of the important forces in the treatment and resocialization of the patient. Many of the patients are admitted to a psychiatric hospital in a depleted nutritional state, sometimes of long duration. The burden of their problems has interfered with their habits of living and in many cases has decreased their incomes. Several of the psychotic illnesses involve withdrawal from reality, with the result that appetite is greatly affected. Fantasies involving food may produce bizarre eating patterns and attitudes, such as the belief of a paranoid patient that the food is poisoned.

The effect of the increased tensions and anxieties of the mentally ill on their metabolism and utilization of food has not been sufficiently investigated. Crawfis⁶ corroborates this by saying: "In addition to alteration of appetite in mental disturbance, it has been suggested that there may be changes in digestion and absorption of food. It is to be hoped that in the near future we will have more research in this field." The following quotations from recent papers indicate the growing interest and recognition of the role of a good food-service program in the mental hospital: "Food is one therapy in a mental hospital that is available for all patients three times a day. As such it becomes an important instrument for the treatment and rehabilitation of the mentally ill."⁷ "Food and the manner in which it is served strongly influence the mental and emotional status of the hospital patients. The well fed patient is one to whom psychotherapy can be applied with the

best results."⁸ "Mental illness is bad enough in itself, it should not be overlaid by nutritional deficiencies."⁹

Food plays an important role in the patient's life. His acceptance of the food and the value his body derives from it is not determined solely by the preparation, appearance and nutrient quality of the food. Patients appreciate new foods, better quality and better prepared foods, and adequate quantities of well-liked foods. They will respond favorably to a wider choice of foods through cafeteria service, to having attractive dishes, as well as to comfortable and attractive dining rooms.⁷ However, the emotional setting, which involves the attitudes of the persons feeding the patient, also plays a dominant role.

SUMMARY

Every meal should be recognized as an opportunity for the socialization of the patient. Every personal contact with the patient should represent a positive step in his rehabilitation.¹ Through the use of dietary standards we have effected substantial general improvements in the diet. However, the needs of special groups can not be overlooked. The more closely acquainted the food-service supervisor becomes with these groups, such as the geriatric, orthopsychiatric, and other special patients, the more adequately will she meet their needs. Fundamentally, food service programs should aim to meet the needs of each individual patient.

REFERENCES

1. BENGTS, H. A.: The dietitian's contribution in the care of the mental patient. *J. Am. Dietet. A.* 31: 491, 1955.
2. Executive Department, Oklahoma Division of the Budget: *A Survey of the Cost of Food in the Penal and Eleemosynary Institutions of the State of Oklahoma During the Fiscal Year 1952.*
3. LIFQUIST, R. C., and TATE, E. B.: *Planning Food for Institutions.* Agric. Handbook No. 16, U.S.D.A., Bull. Human Nutrition Home Econ. 1951.
4. RICHMOND, J. B., and POLLOCK, G. H.: Psychologic aspect of infant feeding. *J. Am. Dietet. A.* 29: 656, 1953.
5. PUMPIAN-MINDLIN, E.: The meanings of food. *J. Am. Dietet. A.* 30: 576, 1954.



6. CRAWFIS, E. H.: The dietitian in the mental hospital. *J. Am. Dietet. A.* 30: 464, 1954.
7. OWENS, L., and WHITE, G. S.: Observations on food acceptance during mental illness. *J. Am. Dietet. A.* 30: 1110, 1954.
8. CHAMBERS, B. M.: Food service should be a medical responsibility. *Mental Hosp.*, 5: 17, 1954.
9. HEABERLIN, E.: Nutrition programs in state institutions. *J. Home Econ.* 11: 669, 1955.

