# Toppling a Monument

**Kay Parley, R.P.N., B.A., B.Ed.1**

Our mental hospital was the pride of its founders, the people of our province. Local citizens loved to motor through the spacious grounds on a Sunday afternoon and brag to visitors about the broad, cool lawns, the happy flowerbeds, the acres and acres of hedge and trees, all cultivated and raked meticulously clean. Gangs of patient workers had planted and maintained those grounds, and patients had literally furnished the hospital. The mattresses on which they slept were made by patients. Hundreds of wicker chairs which lined the wards were made by patients. Patients had prepared rinks, ball diamonds, and tennis courts. The very paintings which hung on the walls had been done by a patient. Patients worked on the hospital farm which supplied much of their food, and patients did the laundry, scrubbed the corridors, and carried out the garbage. In short, it was a Protestant ethic hospital.

The main building, vintage the early 1920s, was fortunate in its architecture. Its long, low lines were in exquisite proportions, and it was graced by a pillared portico over the entrance. Above all that, it was domed, a touch which gave it some of the distinction of the Houses of Parliament. I once gazed at its golden brick facade through the rosy hips of a seeding rosebush, and the picture would have rivalled any of man's proud works!

It was not large, as mental hospitals go, and when the population peaked in the 1930s the count was only 2,500. It was gradually reduced until, in the late 1950s, it was 1,500, but since the building was planned to house 500 patients it was not undercrowded. The wards were large, housing up to 120 people, who slept bed-to-bed in dismal high-ceilinged dormitories which prevented suffocation, but permitted a disastrous noise level. The enormous diningrooms clattered their way through an endless series of meals which had to be eaten in shifts.

The hospital was said to have been a quiet, decent place in the 1920s, before the crowding, but it had had a bad reputation for two decades. In the pre-tranquilizer days there had been much violence, and much coercion. Hundreds of patients were on wards where the only furnishings were heavy wooden benches. They saw no color, no pictures, no mirrors, or curtains, or flowers. They had no access to their own clothes or

[1] **Ste. 9, 714 Dufferin Avenue, Saskatoon, Sask. S7N 1C6. This is a general introduction to an unpublished manuscript, by Kay Parley, entitled The Ones in the Long Pants are Men, and dedicated to Jane Brooks Lewis and Judith A. White. The hospital described is the former Saskatchewan Hospital at Weyburn, Saskatchewan.**

personal possessions. If they were considered dangerous, staff treated them with a mixture of militarism and fear, often with brutality. It was a human garbage heap, and professionals were doing their best to skim the most promising patients off the top of the heap, give them treatment, and get them out of the place before they, too, began to rot. The burden on the conscience was heavy, and staff morale depended, not on constructive effort and pride in accomplishment, but upon erratic bursts of fun. Staff broke rules, enjoyed a fair amount of immoral conduct, clowned on stage in concerts for the patients, made fun of any patient who might provoke a laugh, and tried to raise their spirits in other nonprofessional ways. The administration tried to curb these abuses, as insubordination is always curbed—with more rules to be broken.

Yet within that authoritarian milieu, in the midst of odors, ignorance, danger, and din, good people were working, learning to understand mental illness, to tolerate it, and to try to help. The training program for staff kept growing longer, until, in the late forties, it became a three-year course in psychiatric nursing, and psychiatric nursing became a separate and registered profession in Saskatchewan. The trainees gradually discovered hope and motivation, and a whole range of ideas about relating to the mentally ill. They removed psychiatric nursing from the stigma of "custodial care" or the role of prison guard, and pushed it to a new level. They believed that psychiatric nursing was a distinct profession and that no other could claim exact par with it; they discovered professional pride.

Then Dr. Humphry Osmond took over the superintendency of the hospital. He walked on to the wards to make his first official rounds and the staff stood to attention, .as they always did, and then hastened to unlock the doors for him.

"Please don't get up for me if you're talking to a patient," he said. "Your patient is the important person in this hospital. I can unlock my own doors."

Practically overnight, the ideals the staff had learned in lectures became possibilities. The hospital set about bringing itself out of the Middle Ages and into the 20th century. For a decade we watched remodelling, replacement of obsolete equipment, and a general facelifting, coupled by an awakening of attitudes and a strong emphasis on research. Dr. Osmond was not only humanitarian, he was creative, and the year finally arrived when our hospital was named the most progressive mental hospital in North America. It might not be the best, but it was improving by leaps and bounds.

The general public found it hard to adjust to our new administration, because housekeeping began to slip and the grounds, once a tourist attraction, were a mess. The new Superintendent believed that if a patient is put to labor for no pay it is correctly defined as "slave labor," which it is, and he could find no way to rationalize it, which there isn't, and so the grounds were allowed, deliberately, to lapse into disarray. It was amusing, in a bitter way, how interested the public could be in the mental hospital. Many knew that, despite the improvements, there were still far pleasanter places to be, and they shuddered at the thought of ever having to spend a night in it, but they were reluctant to see it changed. They wanted to keep that gold brick facade, surrounded by its lovely grounds, as a monument to something. They never seemed to think that, in erecting their monument, they had buried 1,500 people inside it!

The plan was flouted, at last, by the removal of the dome. It was determined that the old attic was a total waste of space, unheated, and useful only for storage and bats, so it came off to make way for a whole new modern floor. Try as they might, nobody could get very nostalgic about a monument with no dome! I found, personally, that I could live without the dome. What hurt me was that the hedges and flowerbeds which had made a charming garden at the front door were demolished in favor of a

parking lot. Not even a mental hospital was to furnish a retreat from the encroachment of the modern world, it seemed.

In March, 1958, I was almost finished two years of my training period, and my wing cap with rounded corners was brightened by a yellow ribbon to signify my status as a second-year student Psychiatric Nurse. Our uniforms were archaic. Our basic dress of medium blue had a fine white stripe, and over it we wore a bib starched to breastplate texture, a voluminous starched apron which had to reach a regulation seven inches below the knee, and a three-inch belt of white cotton starched to the consistency of iron, over and under which a key clip was intricately fastened. The "blues" were collared and cuffed in cotton porcelain which rubbed the throat and usually (on my uniform) gaped at the neck. I was forever parting my apron at the back and giving a tug to the tails of my bib in an attempt to overcome chronic gaposis. Our hair was not allowed to touch our collars so I, went about with mine shingled and looked bald under my cap. Pinning the collars and cuffs to the "blues" and pushing the pearl button studs through eyeholes in the belt were the biggest tasks connected with dressing. At first it took me 20 minutes to whip into uniform!

But oh that hefty belt made one feel small-waisted, protected, and light in the feet! The apron swished, the keys rattled, and the caps were breezy. The uniform did all it could to make us feel military and aloof from our patients. That is why, eventually, it went the way of the dome.

Morale can be very low in a mental hospital, but ours was fairly high. Our hands, in many wards where the aged and bedridden lived, were still in urine and feces, and our feet were very much on the ground, often plugging along beside groups of long-term patients who had been stored in the building for so long they had forgotten how to communicate, but our heads were swimming in a mystique. Among us were those who worked only for a paycheck, but their ranks were dwindling. Among us, too, were people' of knowledge and professional pride. We were proud of our training, determined to graduate, to win the right to wear the insignia of the Registered Psychiatric Nurse; maroon ties for the men, and for the women two maroon velvet bands.

We were paid to train—minimal wages to start and yearly increases—and in exchange we worked an eight-hour shift on wards. We then attended two hours of lectures each weekday, with homework and study time extra.* It was heaviest when we were on night shift for then we had to get up early each afternoon and go to the hospital to attend class, and a shift lasted four weeks. We were permitted a very small margin of absenteeism from ward work or class, and if we -exceeded it we could not graduate. Our passing mark was 60 and our passing average was high. This grind continued from September through May, and then we were free of class and merely did our regular work on wards, with a short vacation period. In third year they reduced our work day and allowed us time off for lectures. Third year also included a wonderful month when we were exempt from ward work altogether and spent full days in seminar with nine or 10 of our fellow students.

Such a comment suggests that I enjoyed class better than ward work, which may be correct. The challenge of ward work, in a large hospital, depended a great deal on the level, and though I found it rewarding I also found it heavy, physically. But I valued the opportunity to learn psychiatry in such a setting, and it was, to my mind, a superior educational experience to the isolated, academic work of university. It was, if we cared to use it so, an intensely growing experience. I have never felt closer to a group than I did to the students who went through seminar with me. We were spirited and unified, and it is a month

*** The training program, which began in 1936, was 500 hours (three years) in 1947, increased to over 600 hours in the 1950s, and finally evolved to 720 hours before the training school ceased in 1971.**

that stands out like a constellation in my memory.

Our hospital had a professional Occupational Therapist with a large staff, none of whom had less training than their psychiatric nursing, and the O.T. also supervised a Recreational Therapist and staff. Music and Art therapies supplemented crafts. There was a Ward Activities program to see that patients who did not participate in regular group activities had access to craft materials, instruction, and recreation right on their wards. The hospital also had a Social Therapist, whose job was to organize parties and to coordinate the work of visiting volunteers. We had a small bowling alley, assembly hall (with stage, balcony, and motion picture projector), and we had ball diamonds, bowling lawns, tennis courts, skating, and curling rinks. We had sports equipment ranging from medicine balls to bikes. To expand our facilities and help in the resocialization of patients, we had arrangements to take patients to a bowling alley, a movie theatre, and a public swimming pool downtown. To try to make up for a relative shortage of psychiatrists and psychologists, a number of our graduate nurses had taken clinical training, and these Clinical Nursing Officers were available for consultation and did psychotherapy with patients.

The "big" mental hospital was an impersonal horror of regimentation and authoritarianism, not to mention noise, unsanitary crowding, and neglect. It was bureaucratic at its best, inhumane and brutal at its frustrated worst. But it had something which small units will never be able to duplicate unless and until society makes tremendous adjustments in the way it is willing to spend money. The "big" mental hospital had a nucleus of professional specialists who are necessary to the best treatment of mental illness, and it had them all there in one place, available, and able to coordinate their use of facilities. Unfortunately, it also had too many patients.

When I look back at that hospital where I trained, 1956-1959, I am ashamed of some of our attitudes. We had a lot to learn about human rights. But when I think of what attitudes had been, what they were still in many hospitals, I know that we had taken giant steps. I recall some of the foundation stones of our training—the kind of things we were taught during our first week of orientation—and they are still the abc's and d's of psychiatric nursing:

1. A mental breakdown could happen to anyone. The mentally ill are not freaks or inferiors. No one is "immune."

2. A person is a whole; a physio-socio-psychological being, and it is the *whole* person who must be treated.

3. Every patient is an individual, with individual needs and differences.

4. *No* case of mental illness should be viewed as hopeless.

Those were our foundation stones. Upon them we were trying to build a therapeutic structure. The "big" hospital sometimes abetted the process and sometimes blocked it. There were so many polarities: the mechanical vs. the organic, the authoritarian vs. the democratic, the staff vs. the patients. In the old days, staff were guards, protecting the public from the insane and the insane from each other. We were trying to found a treatment situation in which patients and staff were in something together. Our teachers were devoted to helping us to understand. I remember the voice of a male supervisor, speaking to a newly admitted patient: "We'll work together, you and I, and we'll lick this thing!" I remember other voices, staff who thought of patients as another breed and referred to them as "them," who would not do so much as put a toe in the water. Fear of mental illness is the arch enemy of the Psychiatric Nurse.

The real issue, though it was too often covert, was historically based and much broader in scope than just our individual hospital. Often we floundered around in our own private arena, worrying about how to make the hospital environment both relaxing and stimulating, and thereby more therapeutic, or worrying about how to make our attitudes more

humane. Often the short-sighted individual skirmishes blinded us to the real problem—that the central goal and purpose of our hospital was being drastically changed and too many people were unaware of it. The general public had to be oriented to the new purpose, but so did the staff, and, believe it or not, so did the patients. "Mental hospital" still produced mental imagery of "Asylum," which was actually a synonym for "prison" or "punishment," or at best of "custodial care." For generations, the public had built these places to rid society of the mentally unstable, to protect society against them at all costs, with no regard for the comfort or well-being of the inmates. Our goal was to see to the well-being of the patients and, wherever possible, to return them to the society which had rejected them. Small wonder hundreds of people were confused. We had pulled a' gigantic switcheroo, and though the policy-makers were using caution and common sense, we could hardly expect to change centuries-old attitudes overnight.

Chief legacy inherited from the old regime was the value placed upon order. That's what mental hospitals had been about—the control and repression of deviance, the denial by force of any threat to middle-class conformity. Typical of our double dilemma, then, was the confusion of order with tolerance. Our training was weighted heavily in favor of tolerance. We were taught to understand, to question why, to try to put ourselves in the patient's place, to concentrate upon his special needs. To our great frustration, many of the nursing units were weighted heavily in favor of order, and some supervisors judged nurses more for their ability to get through the meals and medications and other routines with alacrity, and less for their ability to relate to patients. But the military discipline was fast disappearing. Staff no longer stood to attention when senior nurses or doctors entered the ward. The distance between beds no longer had to be measured, the spreads no longer had to be tight or the corners turned to an exact 45° angle. Everywhere, nurses and patients could be seen working and playing together. Nurses could sit at the breakfast table chatting with the patients over a cup of coffee, and yet it was rare to see a nurse drinking from the "patients' cups." Most nurses would unlock a special cupboard and get a "staff cup" before they would join the patients at breakfast. Of such incongruities our daily lives were constructed.

The hospital was burdened with rules and regulations, and the smallest transaction required paper work. Every item purchased for or by a patient had to be recorded, every item lost or destroyed had to be checked off. Every sign of problem or of improvement, of course, had to be reported. Countless restraints were supposed to keep the staff in line: no "visiting" from ward to ward, no reading on night duty, no this, no that. Most of us treated minor regulations with almost boisterous disregard, but major ones, like the 20-minute meal period, we had to accept. Every ward supervisor differed, and we all knew who was "fussy," who severe, and who lax. On some wards you counted the dirty laundry before you went off duty, if you broke your back to do it. On other wards, if emergencies kept you from finishing such tasks, you were allowed to leave them for the oncoming shift. Female supervisors had the reputation of being far more rigid about such regulations than male supervisors. Staff members could be "turned in" for insubordination and various kinds of rule-breaking, but it was rarely done. There was a strong norm against brutality toward patients, and yet there was an even stronger norm against "squealing."

Fortunately, we had enough constructive goals to fill up a lot of our time. It taxed our creative initiative to find activities to interest our patients and to motivate our patients to participate. Withdrawal is the chief symptom of schizophrenia, and we waged war against it constantly. If we succeeded in getting two usually mute schizophrenic patients

to speak to each other, or even to exchange smiles, it might be greeted as a triumph. Since many of our patients had been ill for years and seemed to have forgotten how to communicate, stimulating communication had high priority. The nurse saw herself as a bridge, over which the patient might be encouraged to pass on a journey from the "other world" in which he had been living back to the "world of reality" where the rest of us were living. In order to assist someone to make such a passage, it is essential to establish trust. Our interpersonal relationships with our patients were the key to our success in psychiatric nursing, and they called for understanding, not only of the patient, but of ourselves. We learned to keep a searchlight sweeping continually over our inner motivations, as we sought to know our patients.

The task was complicated by our staff-patient ratio. On better units, during the day shift, the ratio might be as low as five or eight patients to one nurse, but on evenings it might well be 50 to one. Partly in an attempt to overcome this problem, group therapy was popular, and when a nurse was assigned to a group she had the same patients for a four-week shift, possibly longer. It meant that the task of relating to patients was multiplied by the number in the group, and that one's self-searching was also intensified. It also meant that patients could be employed in helping each other. A good group nurse tried to be alert to every incident, every mood, every exchange between the patients in her group, for every moment in a social setting is fuel for the therapeutic fires. No one knows what really helps a patient to get well, but we have few doubts that his basic psychological needs must be met. He must feel that he is worthy as an individual—that he belongs somewhere, that he is accepted by his group. In some cases, group therapy did manage to answer these needs.

When this book was written, I was leading a group, and at the time I had quite a few negative things to say against group therapy, because I felt that patients were being thrown together jn groups without enough regard for their compatibility, and that their individual needs were taking second place. I still feel the same way about groups—that they are one of the best methods of treatment, and one of the worst.