



Oregon Historical Quarterly C. L. Brown article with interview of Dr. Joe Treleaven

Oregon State Hospital During the 1960s

A Patient's Memories and Recent Interview of her Doctor

by C.L. Brown
with and interview of Joseph H. Treleaven

THE THREE-STORIED, SPIRED building stretched for a full block along Center Street in Salem, Oregon, just a few blocks from my childhood home. On weekend walks, my mother would sometimes take us past the seemingly endless structure, and, when I asked about it, she explained that crazy people lived in the building and that the bars and screens over some of the narrow windows were there to keep them from getting out. Little did I know that, by the time I turned sixteen, I would be a patient at Oregon State Hospital (OSH). 1

A 1952 brochure published by the hospital for visitors indicates that patients were not allowed onto the 180 acre campus without an escort.¹ When I arrived at the hospital in 1965, however, the sidewalks crisscrossing the park-like expanse, landscaped to bloom in the spring and summer, bustled with patients, student nurses, and young interns passing each other on their way to various destinations. Ground privileges were earned by patients. In return for devoting a few hours a day to an Industrial Therapy (IT) assignment, patients were rewarded with a "number 2 card," which allowed them to come and go from the buildings at will during certain hours. 2

For a time, I was allowed the card as a result of my efforts in two separate assignments. In the first, I helped feed by hand the disabled and wheelchair-bound patients on a geriatric ward. In the second, I donned a shower cap and cape, then soaped and rinsed patients who responded to me with vacant stares and passive cooperation. Other patients accepted IT assignments in the main kitchen, warehouses, landscaping crews, greenhouses, beauty or barber shop, and sewing room. 3



Views of the beautiful grounds of the Oregon State Hospital could be seen from the third floor windows of the day room of Ward 81.

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In nice weather, I walked outside on the southeast corner of the campus and saw numerous greenhouses. I was told they provided starts for vegetables grown to feed patients and for the flowers that lined the walkways. Near the greenhouses, long-shuttered structures with attached loading docks bordered the several acres of arable land between the hospital grounds and the Oregon State Prison walls. I thought the buildings looked like the remnants of a farm. I later learned that, at one time, the hospital — a largely self-contained community when I was a patient there, having its own library, fire trucks, morgue, and religious services, for example — had depended on patient workers to produce and harvest all of the agricultural products consumed at the institution. In 1893, the hospital actually produced enough to feed not only themselves but also the institutions for the deaf and for the blind.²

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When I was a patient at the hospital, the fields appeared unused, although the tracks of a narrow gauge railway remained, leading from the fields and into the entrance of a tunnel. The system — still in use in 1965 — allowed for the transportation of all kinds of goods to different sections of the hospital, even in bad weather. As a new patient, I had been escorted into the tunnel system to have my picture taken and to get tested for tuberculosis. Men pushing hot-food carts passed us, headed for the elevator that took them into the building above. Other carts were heaped with laundry, which I later learned was sent to the prison for processing.

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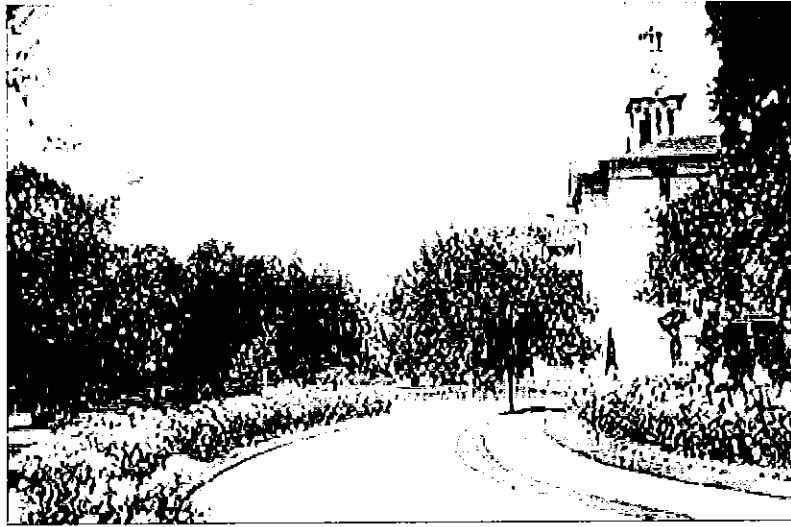
Patients could work on the Oregon State Hospital farm, pictured here during its operational days before the author arrived at the hospital.

OHS neg. OrHi 17941

Once, another patient and I ducked into the tunnels to wait out a sudden rainstorm. She asked me if I wanted to see something. When I said yes, she took me to an area where the tunnel opened up into an alcove beneath the oldest part of the hospital. She pointed to what appeared to be concrete benches, each embedded with an iron ring, and told me that patients had been chained to those rings long ago.

In 1965, the hospital operated an outpatient department in addition to its inpatient services, and it was through the outpatient portion of the Marion County Unit that I was admitted as an inpatient. The Marion County Unit was one of several buildings that were erected decades after the original 1883 complex opened on Center Street. As such, it seemed a modern part of this second generation in hospital structures. The construction of additional units ceased after 1955, perhaps an early indication of trends away from public institutions.³

As an inpatient, I noted that some female patients wore floral-patterned, cotton smocks issued by the hospital while others wore their own clothing from home and also that certain individuals exhibited a concavity above the eye, reportedly the result of a lobotomy. These latter persons were introverted, placid, and often mute. Eventually, I realized that they represented a kind of "previous generation" of patients who had lived at the hospital for years or decades. Still, they patrolled the halls with other patients, enigmatic reminders of another time.



This photograph from about 1905 shows the paved, curving lane that wound up the hill toward the original "J" building complex. Patients could earn ground privileges by working on landscaping crews.

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Others of that generation maintained long-term positions on various work assignments, and their daily treks to and from their work were part of the predictable clockwork of the institution. One man appeared to be of Asian heritage, and he always walked with his hands clasped behind his back, all the while talking to himself in a language other than English. When other patients greeted him, he would always respond with, "Very good, very good." One tiny lady, who was known for her large talent, visited other wards to share her piano pieces, some of which were soothing and some of which inspired people to get up and dance. 9

No matter when they came to the hospital, almost every patient needed new shoes. One day, there was a delivery; in the alcove by the nurse's station, stacks of boxes were being opened as women searched for their sizes. Other patients told me that these brand new shoes were due to the efforts of Dr. Dean Brooks, the superintendent of the hospital from 1955 to 1982.⁴ He had arranged for businesses to donate their surpluses when they could. 10

The Marion County Unit offered puzzles, board games, and library books for those so inclined and also employed recreational therapists who rounded up the able-bodied for games of volleyball and softball during the summer or for ping-pong tournaments during the winter. The World War II-style Quonset hut in the center of campus offered weekly dances or movies and, occasionally, small groups of patients were taken on camping and hiking trips. 11

Feeling awkward and clumsy in group activities, I usually shied away from them. Having experienced the tranquility of the woods in the past, however, I jumped at the chance to be included in one of the camping trips. The hike lasted several days and took us high in the mountains. Escorted by doctors and staff and removed from the environment of the hospital, we patients were encouraged to attempt new challenges. At one point, we traversed a swaying rope bridge over a deep canyon. Even the most unlikely among us made the crossing, and the effort of success forged us into a cohesive group. A turbulent stream tumbled over the boulders at the bottom of the canyon and, before dinner, we were invited to try our luck at fishing. "Impossible," I thought, but someone put the rod in my hands and told me to cast the line into a pool far below. Unbelievably, the rod jerked down when a fish struck, and I pulled and reeled until I thought the pole 12

would break. Although I do not remember the death of the fish, I do remember the group's approval at dinner.

There was a joke on campus that took many forms, but the essence was, "you can't tell the staff from the 13 patients." Instead of wearing uniforms, as personnel in a general hospital might do, the staff and doctors — for the most part — wore street attire. The effect was to diminish the differences between staff and patients and to encourage getting well.

Therapy included one-on-one with the psychiatrist, as needed, group therapy around various themes, 14 and psychodrama. In the large day room on the men's ward, all ambulatory patients were invited to attend psychodrama sessions. Patients gathered around the perimeter and watched as the psychiatrist and staff worked with families on their various issues. The family would act out a scene that portrayed how they normally dealt with a problem, and then the staff would role-play an alternative. Finally, the family members again became the actors in the scene but were "coached" by staff positioned behind them.

Treatment also included drugs. Chlorpromazine hydrochloride, marketed in 1954 by Smith, Kline and 15 French as Thorazine and Stelazine, a related drug of the same class, were two treatments used to decrease the symptoms of psychosis.⁵ Sometimes, patients were given an intramuscular injection of the drug in addition to their usual regimen. I was the recipient of such painful shots in the gluteus maximus after running away or becoming upset. On a couple of occasions, young women who refused to willingly accept the shot were taken to the floor and given the injection in front of other patients. Thus, some of us believed that the drugs were used as punishment or as a means to control a person.



Known as the "50" building in 1965, this more recent structure housed mostly geriatric and physically disabled patients, many of whom needed to be fed by hand.

Courtesy of Salem, Oregon, Public Library Historic Photograph Collection

The increased dosage from a shot often led to noticeable side effects, one being an almost unbearable 16 restlessness in the legs. I found that I needed to walk incessantly to diminish the feeling. At times, only stamping my foot on the ground helped. Some referred to this as the Stelazine Stomp. Another side effect caused muscle spasms that pulled my head toward one shoulder so that I walked bent over to one side. People sometimes developed a constriction of their mobility referred to as the Thorazine Shuffle.

Occasionally, patients were transferred to a more secure unit on the campus — that building along 17

Center Street with the bars on the windows. I woke up there one day and was terrified that I might never be released. If there had any been any "back wards" at OSH in the past, the women's security ward on Center Street, also known as Ward 81, surely would have been one of them. By comparison, the Marion County Unit had been modern and airy. Ward 81 was a long, dark corridor with small rooms on either side. Open a door to a room, and the first thing you saw was the window with the screen on it. A single bulb hung from a long cord attached to the ceiling, and a metal nightstand stood next to the enameled cast-iron pipes at the head and foot of the bed.

A back ward would have been a ward where nothing much was going on in the way of treatment, and the people would not be expected to recover any time soon, if ever. Ward 81 was old, from the original radiators between every two rooms to skeletonkey locks in the doors to claw-legged bathtubs standing on classic black and white tile to the heavy, leather-covered furniture. There, the nurses and aides still wore white uniforms, giving the place a distinctly medical aura.

No matches, glass containers, or razors were allowed in the possession of patients, and even the silverware was counted after meals. It was the staff who waxed and buffed the floor while patients languished in their private worlds. About once a week, a white-haired doctor who spoke with a thick accent came by to meet with a long-term patient who did not speak English. One dark-skinned woman never left her locked room, except to bathe. But, like the daylight flooding the dayrooms at either end of the long corridor, therapeutic changes were about to reinvigorate the ward.

Perhaps one of the last to benefit from the changes sweeping the hospital, Ward 81 became the project of Clinical Director, Dr. Joseph H. Treleaven. Younger patients began arriving, social workers conducted group therapy, occupational therapists offered craft projects, and patients began taking over the ward chores. The nurses and aides spent more time with the patients, making casual conversation that gradually opened up opportunities for deeper sharing. Staff became reliable sources of help for individual patients at those times during the evenings or on weekends when no doctors or social workers were coming onto the ward.

The old furniture disappeared and, in its place, new and brightly-colored chairs and settees appeared. The ceiling was lowered and the lighting was improved. Patients were trusted with an electric lighter for their cigarettes and were allowed a voice in their own rehabilitation by way of a patient council.

During the summer of 1967, I turned eighteen and, after seven months on Ward 81, I was discharged to the Upward Bound Program (for disadvantaged, low-income students) at the University of Oregon. As a successful "graduate" of OSH, I was dismayed years later when I read about the neglect of the buildings and the criticism of the institution. Reflecting on my own experiences at OSH, I wanted to document its transformation in the 1960s, and, in 2007, I interviewed Dr. Treleaven twice, once in January and again in June.⁶

In the following interview excerpts, Dr. Treleaven discusses the training and philosophies that led to the changes I experienced. He worked to prevent the development of an "us and them" mentality between staff and patients, for example, and he encouraged a systematic approach to patient disturbances, included staff in conversations regarding the treatment plan for each patient, and invited staff to share their insights and frustrations so that no one felt they faced a problem alone. He discusses the importance of providing patients with opportunities for independent action, decisionmaking, and responsibility, as well as the importance of opening up the institution to create a teaching and learning community.

January 2007 interview C.L. Brown: You were born in Saskatchewan, Canada, and raised on a farm. What interested you in a career in psychiatry?

Joseph H. Treleaven: That's a question I've asked myself many times. When I was in high school, besides reading what I had to read, which I didn't do all the time, I spent time in the library reading different science books and some on medicine. I had an interest in medicine. I think my mother had a wish that I become a physician like her brother and that had something to do with it, so that got me into medical school. At medical school, I thought I'd like to learn to do a little surgery and become a general practitioner in a little town somewhere. I got to internship and decided I couldn't stand to work with surgeons. I didn't like them as people. I realized you should get a lot of training in surgery before you did it and so that was out.... I became interested in mental health a little bit in medical school because I worked in a mental hospital one year. My girlfriend was working in a small town in Saskatchewan and about the only good job there was to work at the mental hospital. So I spent the summer doing that, getting to know patients and listening to them talk.

The other factor is my mother had some sort of emotional illness when I was an adolescent. She was never treated for it or hospitalized but she was obviously in distress a lot and it was very troubling to me as a child. So I think that had something to do with it. And when I was through with my internship, psychiatric

residency was the only thing that paid a living wage. I was married and had a child on the way and I just couldn't afford most residencies, without borrowing a lot of money.... I tried general practice and I saw so much psychiatric problems in general practice that I thought, well, there's a real need here, so I went to start my training at the clinic in Topeka, Kansas.

So, after your training at the Menninger Clinic [in Kansas], you became a staff psychiatrist at Oregon State Hospital in 1953? 27

I was only at the Menninger Clinic for one year.... The first job I landed was at Oregon State Hospital.... I had 28 qualified for licenses in all the provinces in Canada, but I didn't have any here [in the United States] so it was difficult to get a job, but they were so hard up for physicians I landed a job here. They were also accredited for two years of training in psychiatry so I could get accredited training here and at the same time make enough to live on.

In 1953, when you first were a staff psychiatrist, which building were you in? 29

The "J" building. The admission building was a fairly new building. It was only about five years old in 1953, 30 and it was set up as an admissions/ treatment facility, something special and new. Admissions came in — men on the bottom floor and the women on the top floor. If they had a recent illness and if it looked treatable, [then we sent them to the treatment wards, where] the treatments we had were electroshock treatment and insulin-coma treatment and hydrotherapy and occupational therapy, which was woodworking and crafts.⁷ That was it.



Joseph Treleaven posed for this picture at the request of the Salem newspaper when he became clinical director at Oregon State Hospital in 1966.

Courtesy of J.H. Treleaven

The hydrotherapy was keeping in cold towels ...

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Sometimes cold packs, sometimes continuous warm tubs because it had a soothing effect. Before we had antipsychotic drugs, people would come in extremely disturbed, and we could lose people. They would die from exhaustion or dehydration because they went 24-7, exhausted themselves, and we didn't have effective medication. One of our techniques was to put them in cold packs or hot tub, which would be soothing. The other was to give them a lot of electro-shock therapy. Sometimes that would control it.

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JUNE 27, 2007 INTERVIEW

I'd like to ask you about the transformation of Oregon State Hospital from a primarily custodial institution of

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the 1950s to a dynamic learning community and therapeutic institution of the 1960s.... In 1953, when you began as a staff psychiatrist, the hospital was already grossly overcrowded. Here we have an institution which was so philosophically oriented to treatment that its name was changed from Oregon State Asylum to Oregon State Hospital in 1907 and, yet, as late as 1953, it is bulging at the seams. In your view, what accounted for the logjam?

I think there were many factors. A lot of patients were admitted who weren't very treatable, given the state of the art at the time and the nature of their conditions. There were many people who had what we used to call Chronic Brain Syndrome; it might be Alzheimer's, it might be multiple strokes, it might be anything that damaged the brain, and it was usually older people. I would say at least a third of the admissions would be for that. They were people who would now be in nursing homes, but they were admitted to the hospital in those days. That was one factor.

A third of schizophrenic people went into remission with treatment or without it. A third went back and forth [between illness and remission], and a third never really recovered. At one time, I had occasion to review the charts of a lot of patients who had been at Eastern Oregon State Hospital for twenty years or more, and the thing that struck me was that the person was admitted to the hospital and they had a severe mental disorder, [but] you could see from the notes — which were very sparse — that they gradually improved but nobody paid any attention. Nobody worked to get them out. Nobody worked to set up a situation where they could leave the hospital. Nobody worked with the family to find an alternative place to live, so they just became institutionalized. They lost — through illness and through being incarcerated — the necessary skills to live in the community or in their own home, so they became chronic that way.

I think those are the major factors. Now, I must say that, in 1953, when I came there, Oregon State Hospital was not just a custodial institution.... But there was only one treatment ward [each for women and men] in the whole hospital. There were thirty or forty wards altogether.

The one treatment ward was the admissions ward?

No, I turned that [admissions] ward into a quasi-treatment ward, because I wanted to treat people and learn — through observation — the natural course of some of the illnesses we dealt with. So I had a few people that were in treatment in this milieu program — and maybe in individual or group therapy — who didn't go on to the "treatment" ward where the modalities were coma-insulin and electro-shock.⁸ The treatment was sort of minimal when you look at all the patients we had.

If there were so many chronic patients, how was it decided what ward they'd go to?

Well, that was my job on the admissions ward. I had this influx of patients, a thousand a year; I suppose they averaged three a day or more. I had to keep people moving along, so I'd negotiate with the other physicians. If a person had a new illness or a recurring illness that would maybe respond to electro-shock or coma treatment, I'd send them to the "treatment" ward. If not, then they'd go to one of the other wards in the hospital, depending on their physical disability, how amenable they were to supervision. Whether or not they were hard to handle — violent — determined where they went. There were some wards where they took older people with senility, Alzheimer's, Chronic Brain Syndrome.... They called them back wards.... There wasn't much going on there.

It was kind of a dead-end for people?

Pretty much. Sometimes there would be a ward that was built to house thirty people. I had two wards with eighty people on each ward, mostly elderly women with Chronic Brain Syndrome, and no prospects of treating these people. All I could do was treat acute medical illnesses. Even that was very limited, because I still had the responsibility of evaluating half of the female patients admitted to the hospital. There wasn't any assisting staff to help with that.... There were only about 16 physicians for over 3,000 patients.... It was totally unreasonable. I felt very bad about it as a young doctor, because I could not attend to the needs of those patients at all.... Oh, they'd be restrained to water pipes or the bed or something like that. It was a bad scene.... It was typical of mental hospitals. I think OSH was one of the better ones. They had better care and less neglect, but it was a bad situation. The hospital had absolutely no control over who came, except the voluntary patients and, even then, they were just usually signed in. They weren't even interviewed by a physician before they were admitted to the ward.

The problem, too, was that in the state there weren't any other resources. There were ten psychiatrists in

Portland and one in Salem. When I first came, I don't think there were any others in the state, so if you came from Medford or Grants Pass or some place like that, there's no help. Either a general practitioner treated them or nobody.... So that was the situation and ... what made me very interested in developing community programs, was that a lot of voluntary patients that came to the hospital didn't really need to be in the hospital, but they couldn't find any treatment anywhere else.

What kind of cases would those be?

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Emotional problems, mild depression. A large number of people, especially on the male wards, were alcoholic. There were some attempts at some programs for alcoholics, but they were minimal. We'd have people who were admitted umpteen times for chronic alcoholism.... Sometimes they'd keep people longer and longer but that didn't do any good either. It just took up another bed.

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Before 1965, Medicare and Medicaid did not exist to pay for indigent persons, so who paid for treatment?⁹

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The state paid for treatment. Now, in the [19]50s, it became apparent that some of these elderly people were eligible for social security of some sort and they could be transferred to a nursing home or a group home in the community. There was a big push on to get these elderly people out of the hospital into group homes and nursing homes. There was sort of a feud between the Board of Control, which ran the institutions, and the local welfare commissions.¹⁰ Local welfare was not under the state then; it was under local commissions.... But there was a movement, on the part of the Board of Control, pushing hospitals to really get working to get people out to community facilities under this federally-assisted funding.

So in the 1950s, local communities tended to resist that because they weren't getting paid to take their people back?

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They had to pay some of the cost of care. The federal government paid some of it. I just remember this initial situation, as clinical director at the hospital, the Board of Control was always checking up to see how many you got out, pushing the superintendent to get these people moving to cut down on the state expenditure. There wasn't anything where they thought community care was better; they would just shift the financial burden. At least, that was my interpretation.

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In 1956, you wrote a paper about a fifth modality. You entitled it "Experience With Milieu Therapy in a State Hospital Setting." ... "Milieu" refers to what?

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Well, it's a term developed at Topeka, I think, by the Menningers.¹¹ It was based on sociological and psychiatric studies that were conducted, I suppose at many places, but the main place that I knew about was Chestnut Lodge — a private mental hospital in Maryland.

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When I first arrived as a resident at Topeka State Hospital, I had a stack of papers on my desk by a couple of researchers, Stanton and Schwartz, a psychiatrist and a sociologist. They'd studied — by sitting on the ward and observing — the interaction between patients and staff that demonstrated that staff conflict resulted in patient deterioration and other things ... living in a hospital where all the decisions were made for the patients and they were kept in a very dependent position caused them to lose a lot of their social functioning.

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So the Menningers developed what they called, at times, attitude therapy. The gist of it was that how you set up the social interactions between staff and patients, and [among] patients on the ward, and the attitude you take toward patients, is a form of treatment. What I tried to do was break down to some extent this barrier between staff and patients, us and them.

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Can you give me an example where staff were making inappropriate decisions for the patients?

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I wouldn't say it was inappropriate. They thought it was necessary, that patients didn't have the ability to decide what to wear, what to eat. Dr. Dean Brooks wrote in his paper "A Bushel Of Shoes" where — in another hospital — [patients] didn't have their own shoes or their own clothes.... There was just a bucket where they all dove in and pulled out some shoes in the morning. Or the lights were left on all night, and people were trying to sleep with a light in their face. Patients were not trusted to do anything.

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... When a patient was disturbed, it was just that the patient is disturbed. Nobody looked at what caused

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the disturbance in the patient-staff interaction. Staff would get into conflict with other patients, and that would interfere with their relationship with one another and with the patient.

What I tried to do is evaluate a patient and make a prescription to the staff about how that patient should be handled, whether you took an attitude of what was called "firm kindness" — which worked very well for a depressed person — or the kind where you gave a specific task and told them they had to do it ... because it was part of their treatment.... The theory was — true or not — depression is often internalized anger. If you get the anger directed outward, the depression cools down.... No matter how pressed we were, we'd take half an hour to an hour every day to review patients' progress, so the staff would report to me on how the patient was doing and if there were any problems. I encouraged staff to speak up about things that needed to be changed on the ward or conflicts they had with one another or with patients. We'd discuss it and try to find some resolution.

So, on a daily basis things were reviewed and adjusted as necessary? 58

Yes, and it helped me keep tabs on what was happening with all the patients, what the staff attitudes were towards the patients; and the attitudes were not always good. We tried to help a person take a different view of patients. 59

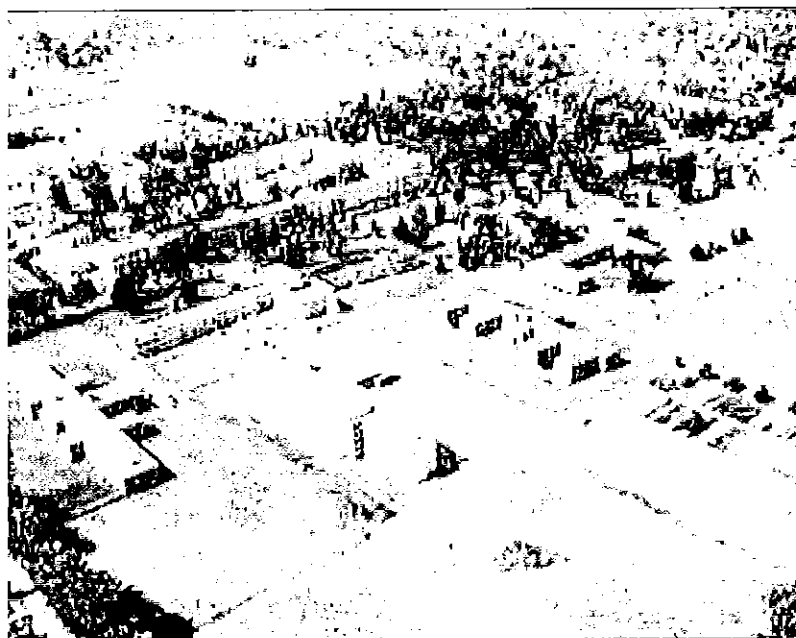
One lady came in. She was very suspicious and withdrawn, and angry and the staff all thought she was terrible. We had a meeting with the patient and with staff. I encouraged the staff to talk to me about how they felt about it, to express their anger and work it out. All of a sudden the staff came to me and said, "Well, she's not such a bad lady after all." ... I'd try and provide a model for how you help people resolve conflict instead of judging them, which is a usual thing for a lay person. People were very judgmental about patients. Instead of judging them, you can try to understand what is going on and how you can intervene to change it.... We supported one another. A person didn't feel they were stuck with the problem by themselves. 60

You wrote that one goal of milieu therapy was to combat the "custodial" milieu which promoted passivity, dependence, and regression and to replace it with a "flexible milieu ... able to promote personality growth or reconstitution by providing opportunities for independent action, freedom, decision-making and responsibility." How could something so entrenched be changed? Did OSH as a whole move in the directions you were attempting to take the women's admission ward in the [19]50s? If so, when and what do you think caused the changes? 61

On that ward, not everybody got in step right at first. There were people who had been around a long time and thought this was a lot of nonsense. We'd work with them. I'd work with them to try to help them understand. Some people, maybe ask[ed] for another assignment in the hospital. Most of the time, people came around, saw there was something in that, and then they felt better about their work. 62

In terms of the effect on the whole hospital, it was a continuous effort. If you didn't tend to that milieu, tend to the social situation and work with the people constantly, it will deteriorate. We talked before about the famous experiment at Stanford where they divided the people up into jailers and jailed and, after awhile, the jailers became very brutal.¹² If you don't deal — in any institution — with that tendency to develop that "us and them," people get into conflict, and it's detrimental to patient care. 63

... That natural tendency, if you're not focusing on patient needs, is to get more and more restrictive. You don't let them use scissors or you take away all utensils because someone might stab somebody with a fork. A very famous example: a fellow was trying to work this way with patients at a hospital in the East; he put in a big plate-glass window on the ward of disturbed patients. Everybody thought he was crazy, that it would be broken in no time. It was never broken. If you deprive people of the amenities of life in a severe way, they are going to be angry, and they are going to break things.... Dorothea Dix, in the mid-nineteenth century, was crusading all over the United States to develop state hospitals because people were cared for in attics, jails, poorhouses, and they were being abused and neglected.¹³ So, the state hospital was part of a reform movement, and the first hospitals were often quite good.... They would get a top physician — they didn't have psychiatrists in those days in the community — [who worked] in the spirit of providing the patient with healthy surroundings and healthy activities and supervision, but in a kindly and caring manner. 64



By 1955, the Oregon State Hospital included the original "J" building, topped by a tall, thin spire (upper center), as well as newer structures, including (left to right, bordering open space on bottom of photograph): the medical building, the "50" building, Marion County Unit, nurses dormitory, and Griffith Hall.

Courtesy of Salem, Oregon, Public Library Historic Photograph Collection

What was called "moral therapy"?

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[Yes, they had] the expectation that they'd get better, and the results were pretty good. But what happened was with the increased immigration, more and more poor people, the inevitable politics of state government, the mentally ill do not have a significant constituency. If you know how the goodies of state government are passed out — it's the squeaky wheel that gets the dough — that and the Civil War and everything led to not enough funds coming in and the institutions gradually going downhill in the last half of the nineteenth century....

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I think World War II was the beginning of the change because it was a shock to the military establishment how many recruits were impaired by some form of mental problems. That was shock number one. A lot of doctors were shanghaied by the military into going into psychiatry because they needed someone to treat these people. Bill Menninger ... was head of psychiatry in the U.S. Army during WWII, [and], with his initiative, he and [his brother] Karl established a big training center in Topeka to meet the need for psychiatrists. It became apparent to a lot of people that there needed to be a lot more mental health workers in this country.... In the [19]40s, there were many public investigations and reporting about bad conditions in state hospitals in this country. It created a new reform movement. The social climate after the war was one of optimism — we can do anything, we won the war, let's take care of the problem. The move was to upgrade the hospitals and get more psychiatrists functioning in private practice. The National Institute of Mental Health in the [19]50s — and especially in the [19]60s, before community mental health programs — did a lot

of training of mental health professionals and investigating different aspects of mental health in the community and studying different, promising programs.¹⁴

... When I came to Oregon in 1953, Dr. John Waterman, working under the Board of Health, was developing and promoting child guidance clinics throughout the state.... He tried to get a group of interested citizens together to promote the development of local child guidance programs. His goal was to get one social worker located in the community and a team of specialists. His wife was a psychiatric social worker and he was a child psychiatrist, and they had, at the Board of Health, a psychologist. They'd go around and ride the circuit, you know, and consult at these places. So, as a resident when I came here, I started working under his supervision doing consultant work in some of the local communities. 68

When I got into private practice in Tacoma, I was a consultant at the local mental health program. In the first months I was there, the state director brought in a fellow to give a one-week seminar in community psychiatry. His name was Gerald Kaplan from Harvard. Kaplan was a very impressive man and he — in one week — opened my eyes to the possibilities of a public health approach to psychiatry, [one] based on the public health model that you don't just wait to get people into treatment. You go out and find what's producing it and try to do something about it. 69

... One of the problems is that people who have a serious mental disorder, they can be a real pain in the butt.... The family does everything they can think of to help the person and finally the minister, the physician, or friends say, "There is nothing you can do; you have to commit them to the state hospital." And people resisted that because that was "putting them away." ... Once they did it — with a lot of guilt — a lot of people sort of withdrew from the patient after a few months and sort of built a life without them; and the idea of asking these people to take this person back, this person that they've had all this distress with, when they've adjusted to life without them, and the fact that the person has been away for a long time ... it's a very difficult situation. It's very difficult to get the person back in. 70

... That was one of the reasons many of us thought you really need to treat the person with the family, [to] have the family involved all along so there is not this rupture in the relationship, not this fear. As the person gets well, the family can see it and you support the family and work with them as well as with the patient. So that was another reason the treatment needed ... to be as close to home as possible, because it is just not practical for people to drive up from Medford or Grants Pass to Salem. Most people can't afford that, and they don't have the time; they have to work. 71

... [I] had an opportunity that sort of dropped in my lap to be the first administrator of the Mental Health Division.¹⁵ My job was to help get this community program, which was passed by the legislature, to set up community mental health programs in the counties and to coordinate that with the state hospital. It sort of came natural to me ... to do that job.... A big change was in January 1955, when we got a new superintendent, Dr. Dean Brooks. Dr. Brooks is a very intelligent, very sensitive man ... very patient-oriented. 72

So, in 1955, Dr. Brooks came to the hospital as superintendent ... 73

... He actually came in 1947. He didn't have the authority to make big changes but, when he became superintendent, he had vision but more than that, he was open to ideas. He created a climate at the hospital, one of participation. He didn't just dictate to staff, he involved staff on committees, in making decisions about the administration of the hospital. He recruited people who he thought would be pro-patient care, [who were] open to ideas and interested in developing programs. 74

... He brought Maxwell Jones in to shake up the hospital. Maxwell Jones came in like a tornado and really changed the culture in that place.... He was a very persuasive and forceful man. He would challenge what everyone was doing, like wearing uniforms.... All the staff wore uniforms, except the physicians. One doctor always wore a white coat. That was like his badge, like the stethoscope is the badge of the doctor, all these symbols. The nurses wore uniforms, the aides wore uniforms.... Max challenged the hierarchical system of the hospital, where all the decisions had flowed down from the top: there was the superintendent, there was the head nurse, there was the charge attendants, and they ran their separate little areas. The patients didn't have much say about anything. 75

So, Maxwell Jones challenged the hierarchy. 76

With Dr. Brooks' permission. Sometimes it was a little hard on Dr. Brooks, too, but he was that sort of guy, that he would open up the place to new ideals. He always had a patient council — I don't know if you were aware of that. He always had a meeting with patients. A representative of each ward would come, and he'd ask them to talk about their gripes — not their personal gripes, but their gripes about the food, the clothing, the policies that affected everybody in the hospital. That way, he had access. If something was going on that 77

was a little strange, he'd do something about it.

You asked me how it changed. I think the main reason it changed was because of Dr. Brooks. Also, the times were changing. People were talking about therapeutic communities all over the country. Maxwell Jones was a good publicist. It was in the air.

Dr. Brooks developed a relationship with the University of Oregon.

Yes, that's true. He also developed the residency training program. Actually, I got here under that.... After the war, when there was a need for more psychiatrists, the federal government would give grants to different institutions to train psychiatrists, so that a person could leave his practice and live on a stipend for three years to learn to be a psychiatrist. Most people think that if you have a teaching hospital, you have a better hospital than one where you don't do teaching. If you have to teach people, you keep your learning up to date.... You have a bunch of students. They are enquiring and that keeps the place alive.... There were always people circulating through from other disciplines, too. The student nurses all came here for three months of psychiatry from all the different hospitals in Oregon. Clinical psychologists came. More and more of these disciplines did part of the training in the state hospital. Again, that opens it up, creates a learning climate.

At that time, through the 1950s and 1960s, there was a lot of concern about patients becoming dependent on the hospital.

You take away a person's ability to make decisions, you provide them with the clothes they wear, you provide them with their meals, they don't go out and deal with community any more, they don't know how to get a job, they don't know how to use public transportation or how to live in an apartment.... One very enterprising social worker at Eastern Oregon State Hospital, on his own, developed what I thought was one of the best programs I ever saw for countering that.

From people who had been in the hospital many years, he would select a group of people from the chronic ward and bring them into a part of the hospital that was set up like an apartment and then teach them to live together, to feed themselves, clothe themselves, look after their clothing. When they got to a certain level of proficiency, he'd move them out into a facility in the community, a rented house where they'd move as a group — as a social unit — and, with support from a worker for problems that came up, they could usually make it.

It sounds like the Rehabilitation and Social Living Unit that Dr. Brooks started.

[Yes.] ... Even in the 1950s, they got money from the legislature to have outpatient treatment. There was an outpatient department at the hospital that got started in 1955, maybe 1954. What they would do is see people on a voluntary basis. Often, people from the community — a psychologist, a social worker, and a psychiatrist — all working together with these people.

But just certain people in the immediate vicinity of Salem benefited. It wasn't limited to that, but, practically, people couldn't commute from all over. It was a step in the right direction.



Dean Brooks became superintendent in 1955 and, along with Treleaven, transformed the institution from having primarily a custodial focus to being a therapeutic and learning community.

Courtesy of Salem, Oregon Public Library Historic Photograph Collection

So having an outpatient unit at the hospital showed that it was something that was needed?

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Yeah, but it couldn't be there for the whole state. The other thing is that Dr. Brooks would take some of his staff — like me when I was clinical director — and the social workers and go down and consult with communities all over about the relationship between the hospital and the community, the problems they were having with the hospital and the problems the hospital was having with them, and solve some of the problems that created friction between the hospital and the community.

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So who would you talk to about the problems?

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The health department, because they had a lot to do with commitments, the sheriffs, the schools to some extent. It was usually sponsored at the health department. The juvenile department [would] bring in the community people who were involved in hospital patients coming and going.

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... The other big thing the hospital did in 1965 or 1966 was they created the community units. That created a major shuffle in the hospital and that was planned out very carefully, involving all the staff working on committees and planning this out.... The big day was March 5, 1965, the same day Dammasch State Hospital opened.... It was [meant] to improve the coordination between hospital care and community care, of getting people into the hospital and, especially, following them up afterwards.... Instead of being spread all over the hospital, [patients] were in a group of wards under a treatment team. That treatment team would go and visit the county and discuss patients who had been released, or who were going to be released, and help them develop follow-up programs.

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Not only would the patient be on a ward that represented their county, or group of counties, but also the staff wouldn't be shifted all around the hospital, so there would be consistency.

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Right, so they could function more as a team, so they had a community orientation. It was a big step, an important step, a very radical step, and they brought it off pretty well. In this process, you see, this was group planning, it created esprit de corps among those people, and they functioned as a clinical team. Instead of each discipline being separate and responsible to some hierarchical office, they were responsible to the director of that unit.... [We] weren't just [told], "Well, you're assigned to this ward" as a social worker or a psychologist or the doctor, and they might yank you and put somewhere else another day. You had a concept that we are a team to work with patients from this area of the state and we're also responsible to liaison with community people, especially the community health nurse who did a lot of the follow-up care and the sheriff and the other community leaders that got involved.

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How was Governor Hatfield involved in Community Mental Health Programs [CMHP]?

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Governor Hatfield had a lot to do with community mental health in this state. He was a progressive, young legislator who knew what was going on and had a personal interest in developing mental health services. As soon as he was elected governor in 1959, he appointed a commission to study what needed to be done in Oregon's mental health program. They came up with this report, which basically outlined the program he took to the legislature in 1961.

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[Hatfield's program] was enacted to create the Mental Health Division, which brought together the institutions under the Board of Control, the child guidance programs, the Board of Health. The alcohol and drug treatment programs were under the Liquor Commission; he brought that into the Mental Health Division, along with the institutions for the retarded.... The purpose, initially, was to develop CMHPs for prevention and early treatment and, theoretically, it had to do with the discharged patient. The idea was that maybe they could treat some of these people before they came to the hospital. The idea was they'd help people to re-settle, but that wasn't too explicit. It was aimed at setting up a program that would deal with early intervention, prevention, community education. That was the main focus. They grew out of child guidance clinics and they were rolled into this.... So, child guidance clinics and family therapy were the orientation, and that's what the people were trained in. They weren't, I think, too keen on working with the severely mentally-ill people. That was the hospital's job. Unless they had some training and experience, it was too much for them. Anyway, the community had a mental health board of directors. The county commission was the authority, and the county could hire someone to run their mental health program or they could delegate it to a non-profit agency. Usually, they ran their own show. They had specific functions to carry out and a 50/50 grant to do it.

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My job was to help communities get this organized. I talked to all kinds of groups, [such as] rotary clubs, about what the law was, how they went about this, and what the objectives of it were. I went all around the state talking about this. I pitched to the legislature about what this program was and what the funding needs were. There was quite a growth of funds the first four to five years.... My first official day on the job was July 1962.

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At what point did the expectations change to include aftercare for chronically ill, discharged patients?

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I think there was some expectation from the beginning, but it wasn't very much. Originally, the hospital teams

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would work with the public health nurses — who did a lot of the follow-up work for the mentally-ill people and, so, they were the outreach team, and I don't think they got folded into the local mental health program very much. If there were any programs specifically for people being discharged from the hospital, they were few and far between, and I don't remember them.

The problem became apparent after several years that they were dealing with a new population, by and large.... People would be discharged, and there wouldn't be any follow-up care, except what was provided by the county teams, from the hospital, and that was very limited.... The model of office mental health work was not sufficient. We found that out when we did a study in 1977,'78 ... [of] what was needed to take care of chronically mentally-ill people outside of the institutions. So it was a gradual, developing awareness on the part of — not just us — the whole nation.

What happened with de-institutionalization — a lot of us professionals felt that there were too many people coming to the hospital who didn't need to be there. We needed — for their sake — to get them out of there, or not have them there, to have better programs near their homes. That was our big push as professionals....

The community programs, they've got their needs now. Once you set up an office — I don't care what it is — then within months, weeks, or even days, they have their own needs. Part of it is self-preservation; part of it is to find a competent leader. So they have their own agendas, and the needs of the chronically mentally-ill and the discharged patients weren't high on the agenda.... When we finally became aware that the job wasn't really getting done, we had people coming back that shouldn't have had to come back, and it was not good for them; it was not good for the communities, not good for anybody.

We began to see what the tools were that we needed to put into the community, through these studies we did nationally. The literature about chronic mental illness [CMI] and how you treat it — there was a whole knowledge base that increased during the 1970's. At least in Oregon, what we did is develop a program for the CMI in the community. My predecessor, Dr. Don Bray, and then I, would go to the legislature and say, "We want some money ear-marked for this job. We will grant funds to the community on a slot basis." ...

How would you sum up what you have learned from observing, for over half a century, the response of mental health professionals and society to the issues of mental health and illness?

... One is that in any human program — especially mental health — one needs to always keep in mind the humanity of what you're doing. By that I mean, you're dealing with an individual, unique human being. It isn't "that gallbladder in room 210" or it isn't "that schizophrenic on the back ward." You're dealing with a unique human being with a past, a family, and that needs to be addressed whatever the condition is.

Another point is there's all schools of thought about what mental illness is and how you treat it, whether it is hereditary, organic, psychosocial or what-not. The answer is all of the above. Learn about them, address them, and find out as much as you can about how the thing functions and where you can intervene. What I've seen, somewhat to my sorrow, in the training of psychiatrists — and I think it is being corrected now a little bit — they go into being prescribers of medication and they didn't learn about human beings, who they are, how they function, how you relate to people and how that relationship is important in whether you're helpful or not helpful.

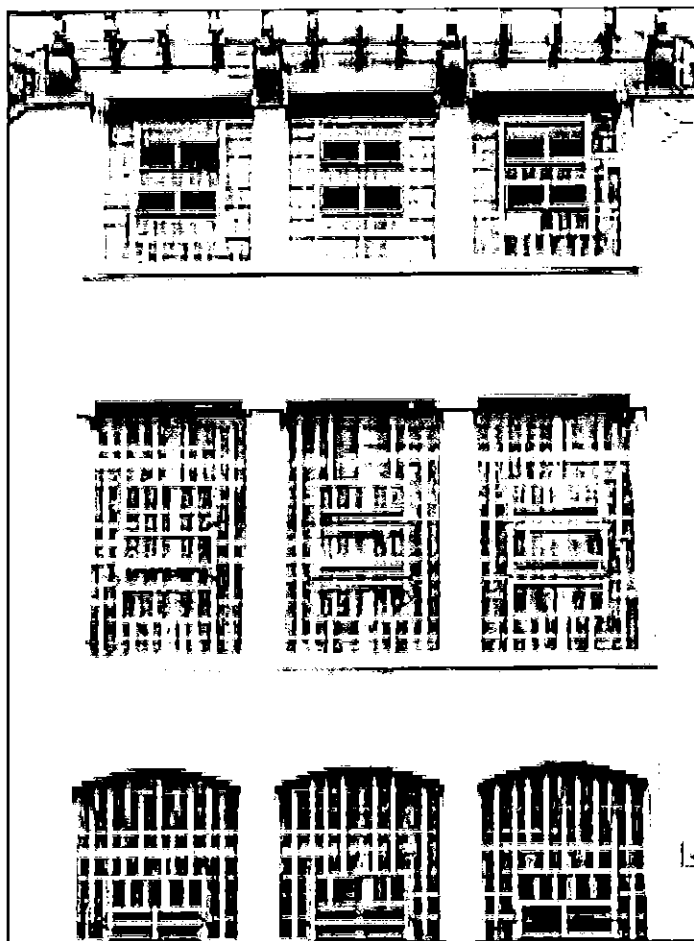
The other thing I've learned to my sorrow is that things are cyclic. You'll work on something to bring it up to a certain level; it'll deteriorate, and then ten years later you're back starting all over again [laughs].... The other thing is, I've felt, as I've watched younger generations come along, that they have much more sophistication than we did in my generation. I think every year, understanding about human personality has improved in the general public — not everybody, but people are much more sophisticated about what goes on in human beings and what their needs are and what sort of things can help them or harm them. While there were a few mental health workers fifty years ago, there is an army of them in all sorts of species — some maybe more capable than others but each making a contribution....

NOTES

1. The pamphlet "Information for You About Oregon State Hospital" was published in the mid-1950s by an unnamed superintendent. It is available at the University of Oregon Knight Library, Eugene.

2. See Ronald Rudy Higgins-Evenson, "Parties, Patronage, Professionals, and the State: A History of Oregon Institutions, 1859–1900" (M.A. Thesis, University of Oregon, 1995).

- ^{3.} On the architectural history and structure of the Oregon State Hospital, including some background on mental health care in the United States and in Oregon, see the National Register of Historical Places nomination for the Oregon State Hospital Historic District, available at http://www.oregonheritage.org/OPRD/HCD/NATREG/docs/national_register_recent/marion_salem_oregonstatehospitalhistoricdistrictnomination.pdf (accessed March 26, 2008).
- ^{4.} Personal communication with Joseph Treleaven, June 1007.
- ^{5.} See Gerald N. Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill*, (New York: Free Press, 1994).
- ^{6.} Transcripts and tapes of the interview are archived at the Oregon Historical Society Research Library, Portland.
- ^{7.} On electro-shock treatment and Insulin shock therapy, see Peter A. Magaro et al., *The Mental Health Industry: A Cultural Phenomenon* (New York: John Wiley & Sons, 1978), 52–53; and G. Tournay, "Psychiatric Therapies: 1800–1968," in *Changing Patterns of Psychiatric Care*, ed. T. Rothman (New York: Crown Publishers, 1970).
- ^{8.} Milieu Therapy refers to a social psychiatry movement, popular during the early 1960s, that pushed for patient involvement in modifying the physical environment and staff structures of their treatment. See Peter A. Magaro et al., *The Mental Health Industry: A Cultural Phenomenon* (New York: John Wiley & Sons, 1978), 68–99.
- ^{9.} On the effects of Medicare and Medicaid on the mental health profession, see Steven M. Gillon, "The Politics of Deinstitutionalization: The Community Mental Health Act of 1963," in *That's Not What We Meant To Do* (New York: W.W. Norton & Company, 2000), 102.
- ^{10.} See Oregon State Board of Control Records Guide, "Agency History," Oregon State Archives, <http://www.sos.state.or.us/archives/state/control/controlhist.htm> (accessed March 12, 2008).
- ^{11.} Drs. C.F., Karl, and William Menninger founded the Menninger Clinic in Topeka, Kansas, in 1925. C.F. was the father of Karl and William. The Menninger Clinic, "History," <http://www.menningerclinic.com> (accessed March 9, 2008). See also Lawrence Friedman, *Menninger: The Family and the Clinic* (Lawrence: University Press of Kansas, 1992); and Karl A. Menninger, *The Human Mind* (Garden City, N.Y.: Garden City Publishing, 1930).
- ^{12.} The experiment was conducted by Stanford psychology Professor Philip Zimbardo in 1971. See Philip Zimbardo, *The Lucifer Effect: Understanding How Good People Turn Evil* (New York: Random House, 2007).
- ^{13.} See David Gollaher, *Voice for the Mad: The Life of Dorothea Dix* (New York: The Free Press, 1995).
- ^{14.} On the National Institute of Mental Health (NIHM), see Donna R. Kemp, *Mental Health in America: A Reference Handbook* (Santa Barbara, Calif.: Contemporary World Issues, 2007), 277–78.
- ^{15.} In 1961, Governor Mark Hatfield created the Mental Health Division to promote the development of a system of community mental health programs. In 1963, President Kennedy signed the Community Mental Health Centers Act (Public Law 88–164), calling for the emptying of state mental health institutions in favor of preventative community clinics; however, many of communities were not capable or not willing to match the government's contribution toward the project, and mental health patients were released from State hospitals, often with little or no outpatient or follow up services, and left with few resources in their community. Murry Levine, *The History and Politics of Community Mental Health* (New York: Oxford University Press, 1981), 50–77.



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