

# A Bushel of Shoes

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ON THE NIGHT President Kennedy was buried, I was visiting a friend who is superintendent of one of the better mental hospitals on the East Coast. After watching a late television rehash of those tragic four days, my friend suggested that we make night rounds of his hospital.

The first several wards we visited—acute admission and treatment wards—were peaceful and the patients sound asleep. But in another building it was a different story. At 11:15 p.m. the lights were burning brightly. To keep out the light so they could sleep, some women had pillows over their faces, and others had pulled up the covers. Some were trying to sleep on their stomachs. Many were tossing about fitfully.

"When do you turn the lights out?" I asked the aide. "Oh, we don't, doctor," she responded. "Why not?" I asked. "It's the law," she said.

"You have to be kidding!" my friend said. "No, doctor, it's the law!" she replied.

I hardly need add that the "law" was changed then and there, and the lights were turned out for perhaps the first time in 25 to 50 years.

After the lights were turned off, my friend and I visited another women's ward in the same building. We almost stumbled over a couple of bushel baskets full of women's shoes. There were all sizes—some new, some old, some run over at the heels as though they'd been worn by feet four sizes too large. I asked about the baskets, and the night aide told us they were the "shoe baskets." Every night patients put their shoes in one of the baskets, and the following morning it was first come, first served.

Oregon State Hospital also is considered one of the better state mental hospitals. But I wondered how many lights were burning in our patients' faces and how many bushels of shoes could be found there. After I returned home, I made night rounds. I was pleased to find lights turned off. There were no shoe baskets. I failed to see, then, that some patients had no shoes.

In our hospital we have what is known as the

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Dr. Brooks spoke on this subject at a meeting of the Association of Medical Superintendents of Mental Hospitals September 15, 1969, in Houston.

superintendent's committee; elected patient-representatives from every ward meet with the superintendent for an hour each week to discuss any issue, with the exception of personal gripes. It was during one of those meetings that I found our bushel of shoes.

"Dr. Brooks," one of the patients asked, "how come we don't have any place to hang our towels in the bathroom?" I had been at the hospital 22 years, but only at that moment did I discover that there was not a rack or hook to hang a towel in any bathroom in the entire hospital. No one had ever raised the question before.

It was easy enough to supply the towel racks, but it seemed that was putting a Band-Aid where major surgery might be required. How many elements of dehumanization were present in our hospital? Just what is dehumanization? And how might we attack it?

Dehumanization can be defined as the divestment of human capacities and functions and the process of becoming or the state of being less than a man. It does not occur exclusively in mental institutions. It also occurs in nursing homes, correctional institutions, Indian reservations, colleges, the military—in any situation where one person is responsible for making day-to-day decisions about the comfort and welfare of others.

Erving Goffman, Ph.D., a sociologist, is one of the better-known students of institutions, and we used his book, *Asylums*, to learn more about institutions. Goffman described several features of what he called the total institution, a single setting in which an individual eats, sleeps, breathes, works, and lives. One feature is that it has a rationale. For example, a monastery tries to take a worldly man and produce a true and complete servant of God. Through recruitment or the draft, the Army may take high school dropouts, college graduates, or hippies and make soldiers of them.

What is the rationale of the mental hospital? We who work there like to think that everything that takes place is a part of treatment, suggesting that the hospital takes over the mentally ill person to make something better of him—a mentally healthy

person. But sometimes we make the person into a career mental patient. We do many things to help create such a state—sometimes because we don't know any better, sometimes because we just don't care.

**G**OFFMAN also listed mortification as a feature of the total institution. Mortification is the process, often humiliating, in which worldly comforts are taken away or given up voluntarily. Sometimes it involves inflicting painful severities on the body. The military uses mortification in boot camp and fraternities have used it in hazing. In monasteries mortification is used to eliminate the love of worldly possessions as rapidly as possible.

There are many examples of mortification taking place in our mental hospitals. All of us know of women who have just had their hair shampooed and styled at the beauty shop only to be subjected to the admission routine of being deloused, forced to shampoo their hair and to take a bath, whether needed or not, and made to wear state-issue clothing while their own is being marked for identification.

In December 1968, while we were talking of an attack on dehumanization, an incident jarred us into action. A supervising nurse, a psychologist, and a psychiatric aide came by my office to protest the awful garb patients were forced to wear. It was an embarrassing sight. They had dressed themselves in ill-fitting, state-issue clothes. To emphasize the situation, the psychologist chose to sit on the floor leaning against the wall. The aide had little to say. The nurse was obviously distressed, and following the 90-minute meeting I received a moving letter from her. I quote in part:

"The dress did not fit but then what matter? I was clean and decently covered. My God! We don't want dresses too short to show legs, girdles, and whatever awful things might be exposed. Yes, the dress was too long but I did wear it. . . . I went to see you, Dr. Brooks, to show you face to face the clothes our patients wear. Right off I was embarrassed and tried to cover it with rolling a cigarette; I had Bull Durham [tobacco] with me to roll my own. Nothing was really funny. I have even forgotten your jokes.

"I sat dumb and getting dumber as I wondered where to look and what to do with my hands. I felt so inadequate, and almost cried when I burst out to tell you how I felt. I could say no more or I would have wept.

"I wanted to leave so badly. What was missing, what did I need? Am I so shallow that I need my clothes to be me? And when I told about the aide who has the patients put on ward clothes after they

return from a visit home, then I understood what it means to be a patient."

Still wearing the same clothing, the nurse and the psychologist went to the canteen for lunch, to see how they would be treated. The nurse's letter tells what happened there:

" . . . I left him for a moment to use the phone. He said it made him feel very alone to have me leave. We both felt terrible when two employees behind us in the line were served first while we were ignored. I felt so blah and afraid that I hadn't noticed, until Loren asked why others had been served while we were still waiting. While he was paying for the food, I looked about to find a table. Took a step to go, then couldn't go alone. I waited for him.

"The more people recognized me and laughed, the sadder I became. It wasn't funny. When we sat down I moved closer to Loren, as close as possible. . . . By then I felt so 'nothing.' We almost ran back to the unit to take off the clothes. When I took off my dress, it was soaked under the arms, and Loren said his T-shirt was wet.

"I am writing this in my office, still feeling the effect. I feel empty and nil. It's taking awhile to be me again. . . ."

There was no question after that; we would begin our attack. We started with a massive fact-finding operation to uncover those elements of dehumanization that had become an accepted part of our institution. The hospital staff, convinced that they could raise the level of care significantly within the next few months, began to look critically at various aspects of patient care. Everyone was involved, patients and staff alike. The latter included stenographers, cooks, clerks, maintenance men, mechanics, and bookkeepers, as well as those involved in direct patient service. Interested people from the community were also invited to serve.

**W**E FIRST HAD to identify areas of concern. A task force, made up of patients, staff from the various disciplines, and people from the community, determined that the elements of physical care should be examined first. At least 25 areas of concern have been identified. They include clothing, dental hygiene, bathing, toileting, grooming, sleeping, recreation, eating, housekeeping, patients' money and personal possessions, maintenance, aesthetics, living space, and admission and discharge routines. As the study of each area is completed, carefully written standards for the quality of patient care are developed and distributed. We also plan to distribute at regular intervals, probably twice a year, a self-

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administered ward inventory questionnaire on the quality of care. It is our hope that all hospital practices will be constantly checked and questioned.

It may be of interest that the first study centered on one of the most important personal necessities— toilet paper. Continued complaints of shortages plus rumors of rationing and of patients' being forced to request their daily supply from aides invited immediate investigation. Five persons, one patient and four staff members, were directed to study the matter and report their findings in a week.

After two and a half days, the group had found the reasons for most of the complaints. Two areas were running out of their supply because a widely used recreational facility and a ward area housing 33 student nurses had not been figured in the normal issue. That was corrected immediately. In some areas the weekly issue was being divided equally between men and women, when the women should have been receiving two-thirds of the lot. Some wards lacked proper dispensers, and toilet tissue was kept in a shoe box placed on a small stand in the toilet area. Other wards had defective dispensers. Proper dispensers and adequate supplies of paper were placed on all wards. Problems with patients who hoard or flush or strew tissue are dealt with by ward staff and patients when they arise.

CLOTHING was our next area of study. It was a large task, because the committee had to study buying, requisitioning, issuing, marking, and giving patients some choices. They spent several weeks in intensive investigation before making their recommendations. The committee found that on admission many patients had their clothing taken from them and placed in central storage for safekeeping. Some of it had been there so long that it was no longer stylish. What were we thinking of to deny patients the use of their own clothing?

Patients who had no personal clothing or who were denied use of it dressed from a common supply of state issue. The men were outfitted in drab khaki. The women fared a little better by virtue of hospital-manufactured dresses. Clothing was reordered with little or no thought to updating style or upgrading quality. As a result we found a warehouseful of unusual items, some as many as 13 years old. There were hundreds of pairs of cotton hose, union suits, outsize shoes, and shelves of size-60 overalls. On the other hand, it was shocking to learn that very large men were without underwear because the state issue did not include their sizes. It was necessary to manufacture some shorts in sizes 52 to 56, which a few patients are now happily wearing.

Paradoxically, it was less than a generation ago that the state hospital furnished outsized clothes to the wards housing assaultive patients. The more obstreperous men patients, particularly those frequently involved in fights, were given trousers several sizes too large, but no belts. The theory was that the patients would be so busy trying to hold up their pants that they would have little or no time for fighting.

LAUNDRY also presents a problem. Clothing is laundered at an adjacent institution, and on return it is often torn, shrunken, faded, and misshapen. After only four washings, a new garment is no longer a good garment because of the extreme heat in both washer and dryer, too much bleach, and very poor ironing. For example, a freshly ironed dress looks as though it had been thrown into a sheet mangle with no effort whatsoever to straighten it.

However, little complaint can be registered about the laundry facilities until we have done something about providing proper storage for the patients' clothing. Laundry done with meticulous care would look as though it had been ironed by a steam roller once it was crammed into the tiny cubicles that constitute the present storage facilities. Most patients have no place to put personal belongings. The committee found clothing hanging from window sills, lying across beds, and draped across night stands.

In its study the committee first stated its aim and purpose. "We believe each individual achieves some self-definition through his name, memory, clothes, and associations. These aspects allow him to encounter, to feel, and to know his environment. At the same time, these very things allow him to be acknowledged, recognized, and known, in turn, by his environment. Clothing, then, becomes one of the most important constituents of personality. Deliberate attention must be given to using the facet of clothing as a means of helping the patient."

It was a fairly simple matter to make recommendations in keeping with those goals. Patients should use their own clothing whenever possible or be provided with personally fitted and assigned sets from hospital issue. The quantity purchasing of hospital clothing should be phased out, and all future purchases of clothing for needy patients should be made on an individual basis. Wardrobe lockers should be provided for each patient. Washers and dryers should be installed on each ward. Steps have been taken to implement each of those suggestions.

The handling of patients' trust accounts in a

mental hospital is a critical issue. Many states deduct maintenance charges from patients' money that has been deposited in the hospital business office. Often the deductions are made without notifying the patient. How would one of us feel if a department store where we had a charge account went directly to the bank, without letting us know, and deducted the amount due from our checking account? Don't we all feel just a little upset when our spouse forgets to enter a check on the appropriate stub?

To whom does the money in a patient's trust account belong, the patient or the state? Although it is recognized as belonging to the patient, the state invests the money and collects the interest. That may be entirely legal, but at the same time it is completely immoral. Steps have been taken to change the system of handling patients' money. The process is being made easier and quicker because the state treasurer is an interested and hard-working member of our task force.

**O**UR PRACTICES related to eating presented a study in contrasts. Some dining areas were clean, bright, and cheerful. There were tables for four with colored tablecloths and decorative flowers. Patients who needed assistance in eating were fed gently and slowly. Mealtime was truly a time of sociability.

In other ward areas, however, the food was cold; as long as 40 minutes elapsed from the time it was placed on the tray cart, uncovered, until it was served. Garbage cans were open in the dining areas. On one ward garbage was actually scraped at the end of the table while patients were still eating. Some of the patients who were food handlers were dirty, the tablecloths were sloppy, and the floors were filthy. In one area no napkins were available. Some patients who required feeding had food shoveled in so fast that they barely had time to swallow, let alone chew.

The aim of the committee on food was to make meals more pleasant and sociable by eliminating bad practices and underscoring good methods of food handling. The committee made 21 realistic and workable recommendations. Again, once the facts were known, the suggestions were easy. Food should be served hot from food carts when patients are ready to eat. Food for patients who are to be fed by others should not be dished up until they are ready to eat; if there is danger of patients' being fed too rapidly, one person should feed two patients, alternately. The committee also recommended that garbage disposal units be installed in all food service areas.

The hospital's hours for rising and retiring seem geared to the needs of the staff rather than the

patients. Lack of recreation during the evening hours plus the early-morning breakfast apparently dictate getting patients to bed at dusk and up at daybreak. We seem to be operating under an unwritten commandment: "Thou shalt not miss a meal." Elderly patients may be routed out of their beds at 5 a.m. so that they can be dressed and ready for breakfast. The night shift usually consists of one psychiatric aide, who until recently was expected to get patients up and dressed; thus those who had soiled themselves in the night were frequently put into their clothes without benefit of a bath. But they were not late to the morning meal! Why did we presume that only the night shift could get the patients up? As an indication of whether staff needs or patient needs were put first, consider the report that at shift change the day shift asked not "Is anyone ill?" but rather "Is everybody up?" It would be interesting to know what therapeutic benefit is available at 6 a.m. that the patient must be up to receive.

The committee on sleeping is in the middle of its study, and many elements contributing to dehumanization have been found. For example, several men were sleeping fully dressed. Why? Our survey showed many to have no night clothes whatsoever. If we were expecting men to sleep in underclothing, worse still was the finding that several men, particularly the outsized, did not have that either. Patients lucky enough to be provided with night clothes were given unbleached muslin gowns and slept on unbleached muslin sheets while employees living on campus slept on percale. Undersized wool blankets, shrunken from improper laundering, may have been another reason the men slept fully dressed; they simply had to keep warm. No recommendations have been made by the committee to date, but it is obvious that some changes will be made.

**A** COMMITTEE on housekeeping has made some very helpful suggestions in a detailed and sophisticated report. Committee members found conditions varying from too antiseptically clean to filthy. Some conditions existed because of confusion in administrative structure; cleaning supplies had to be requisitioned from four different departments, including the kitchen and pharmacy. There was confusion, too, about who was responsible for cleaning the wards. Some unit directors considered themselves personally responsible, others thought it was nursing's responsibility, and one thought housekeeping was purely a patient function. Although the study on housekeeping was limited in scope, its findings have implicated the total communication system within the hospital.

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Currently committees are at work on recreation, aesthetics, personal hygiene and grooming, and maintenance. The latter involves the study of minor construction, preventive maintenance, and repair as it relates to patient care. Because the priority system in the engineering department will come under critical review, some interesting questions may be raised. For example, which will be painted first, the living room in the superintendent's home (which is provided by the hospital), or the patients' recreation room on Unit II?

I have given only a sampling of what we are trying to do at our hospital. It is the barest beginning. Staff reactions to our attack on dehumanization are varied: enthusiastic, ambivalent, fearful,

resistant. Some talk it up, some talk it down, some joke about it, but the important thing is that we are talking. As for myself, I have not found a project as stimulating in my nearly 25 years of mental hospital work. All of us, who might never have acted at all, are looking at what we are doing and how we are doing it. We are making changes to bring about practices to fit our goal: preventing the dehumanization of people in our hospital.

Why didn't we start sooner? I don't know. Perhaps the issues seemed too simple, or perhaps too enormous. From what we see now, they are both. The task is simply enormous. If we adhere to the issues, and emphasize finding fact, not fault, all of us—patients and staff—can come out winners. •

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