Dynamic Chiropractic

REHAB / RECOVERY / PHYSIOTHERAPY

Clear View Sanitarium -- Part 6

DEVELOPMENT OF THE TREATMENT PROGRAM

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In the early years, Clear View's treatment program could be described by the simple equation: chiropractic adjustments + custodial care + humane concern. Early in the 1930s, Dr. Herbert Hender's appointment to the staff added the beginnings of psychotherapeutic counseling to the program. This service became critically helpful to those patients starting to realize the problem was with themselves, not with the rest of the world.

There was no one single factor solely responsible for the reform of mental patient care, but the time was ripe. Concerns for human welfare seemed to escalate after WW II. Perhaps the exposure of so many Americans to the plight of less fortunate millions touched off a wave of conscience. It was no secret that mental patients were treated poorly in most state institutions, funding provided the barest essentials and salary for the staff discouraged all but the incompetent or highly dedicated.

Psychiatrists, psychologists, and other mental health workers all began to speak concordantly. Movies such as "The Sake Pit" depicted patients and doctors whom one could like and admire, and built growing resentment against a system which doomed treatment to failure and patients to a lifetime of imprisonment in a mental hospital. Pressures reached Washington and here too were receptive minds. Congress formed a Joint Commission on Mental Health and Illness charged with the responsibility to study the problem in depth and to provide quidelines to improve the nation's mental health care. As it turned out, the commission was not a mere political ploy. Funds were made available and a dramatic change was felt across the nation and in its mental hospital.

Clear View had no federal funding, only those funds generated by patient fees. But when the sanitarium changed hands in 1951, we were ready and eager to create a new kind of environment, an environment which would favor and support a convalescent patient. For example, television was installed on both upper wards. It was done with the belief it would bring the patient into closer contact with the outside world. I learned from patients that they were interested in the news, movies and, like their counterparts in the outside world, many of the women became soap opera fans. These were important and significant changes because arousing and maintaining interest in a mental institution is very difficult but is one of the major weapons to prevent institutionalization, which is a condition created in prison-like environments where staff strives to maintain a static state and hope is regularly quenched.

Gradually, the staff was expanded, occupational therapists initiated constructive programs to stimulate the apathetic schizophrenics and again instill some sense of worth in personalities who had some time ago decided they had very little, if any, real worth.

Group therapy sessions were scheduled on a regular basis because they stimulated interpatient relationships. Patients who spent day-after-day without speaking to another patient would be asked to pass around cigarettes to the others. A really good session was one in which an essentially silent

patient felt compelled to speak and express his feelings. Many of these efforts were highly delusional and difficult to follow. I recall one session in which a stout young woman got up to talk about "her secret." She would not say what it was but clearly it was a problem for her. After many meetings, to our surprise she blurted out her secret. She said, "I'm fat!"

I believe the most unpredictable responses from patients occurred when we arranged dances. The excitement among the patients was intense, a rare and wonderful phenomenon. They pressed against the windows waiting for the four-piece band to appear. Earlier in the day, my wife would usually supervise the attendants to shampoo and dress the ladies' hair in preparation for the festive evening.

Some patients were shy and a few would not participate at all, but a remarkably high percentage did. The band would begin and the floor filled at once. Roy Owens, one of our most unforgettable personalities, danced, as might be expected, with a distinctive style. He took charge of his partner, sweeping her about the floor, giving a very rapid flutter to whichever foot was off the floor at the moment. My wife's judgement, after dancing with him, was that he danced exceptionally well despite his bizarre flourishes.

One dance night, the excitement was running high as usual. Eight o'clock came but the band did not. We called the leader. He was in bed with the flu and he had forgotten all about it. I dreaded telling the patients there would be no dance. When I did, their expressions made me feel like a guilty failure. One of our student interns who had volunteered to help at the dance, asked if he could go home and bring his records and player. When the music started this time the success was no different than when the band played. I felt the most meaningful event was the intense look of disappointment on so many faces when the band did not show and the relief when the dance began, signifying they could care so much about a social event. That more than justified all of our efforts.

We instituted an intern program for senior students who had either completed psychiatry 411 or were currently enrolled in it. The program lasted three months, concomitant with the college's quarter. Senior students had several options (1) intern in the B.J. Palmer Clinic and, (2), intern in the spinograph department, (3) intern in the student clinic in advisory roles to less advanced students or, (4) intern at Clear View.

In the beginning interns were assigned for a period of three months. They reported to the sanitarium at 10:00 a.m., and were free after 3:15 p.m. After a week's orientation in which they learned what was expected of them and what they were not to do, each intern was assigned a small group of patients. They then had access to their patients' files in order to become thoroughly familiar with the details of each patient's history. I discussed each case with each intern and then gave them a written assignment to be completed at the end of the internship. The assignment would usually ask the intern to evaluate the patient's progress during the three months, to suggest possible activities which might be helpful, to evaluate the progress of his relationship with the patient, and to relate that to his own feelings about the patient.

Interns nearly always developed a strong interest in their patients during their tour of duty. They would frequently take the patient to their homes and involve them to whatever degree possible with family members. Sometimes they would take their charge to the movies and occasionally to a sports event.

Intern meetings were conducted once a week to discuss the problems and questions they might have. There were many questions, especially questions regarding chiropractic and mental disorders. Each

day the patients were examined with the neurocalograph and subject to the best judgement of Dr. Evan Boardman, who was the treating chiropractor. The intern was required to be present during these daily procedures. Adjustments were not limited to the upper cervical spine; full spine adjusting on a Hylo table was widely employed. Although the intern participated in nearly all phases of care, he did not adjust any of the patients.

Much was happening to psychiatry across the nation. A reactionary response to the traditional confinement of mental patients to their wards resulted in the re-emergence of the "open ward" philosophy. Mental hospital theorists insisted that patients recovered in greater number and more rapidly if they were not imprisoned. Locked wards began to open. The extent and type of wards unlocked were the decision of the superintendent or hospital board. Patients were free to roam the grounds of a hospital or even the buildings but generally were required to remain on the grounds.

I had been reading and pondering these radical changes and it seemed these new modes of treating patients were consistent with our philosophy of care at Clear View. Accordingly, against the advice of older heads, I opened the two upper wards. Those patients who had been there a long time did not respond at first to an invitation to use the privilege. It seemed to be perceived as more of a threat than a privilege. We held our breath for a time but nothing untoward happened. Over the next six months there were some elopements but not as many as before. We, the staff and patients, found ourselves increasingly comfortable with this progressive practice, and in my opinion my relationships with patients were improved because I was no longer their chief jailer.

The next phase of the open-ward policy was to allow improving patients to go to downtown Davenport on their own. Occasionally, a patient caused a problem when away. A 70-year-old, paranoid woman made a weekly trip to the city, usually with another female patient. She was an angry, sharp-tongued lady who, each time, visited a fruit and vegetable store. One of the male clerks caught her attention. She never left the store without berating this man mercilessly. He, in turn, threatened to have her arrested and told the lady's companion that if we didn't stop her, he would. Faced with this threat I refused to allow her to make her weekly visit. Two weeks later the clerk called, concern evident in his voice, asking if something had happened to the lady. I told him she was all right, but I had reacted to his threats to have her arrested. He said, "Oh." After a pause he said, "Well, I guess it is okay for her to come into the store. She really doesn't hurt anyone." So, the next week she returned to the store to continue her ritual of abuse.

In 1955, I had been invited to enroll Clear View in the American Psychiatric Hospital Association which I did and was looking forward to attending the association's annual meeting in Washington. The most prestigious psychiatrists would be there, and I wanted very much to know what these leading lights would say. I arrived the night before which gave me time to browse through the exhibits and pick up my identification badge. There were already a number of attendees with badges. Most of them read, John Jones, "MD," which was not surprising, but all of a sudden I saw a number of "DCs." These were names I didn't recognize and I didn't understand it at all. Then I picked up my ID at the registration desk and it read, W. Heath Quigley, I.A. The mystery was solved, but I felt embarrassingly foolish not to have recognized the abbreviation for Maryland.

Open-ward policy was a very real issue at the symposium. Most of the discussions centered around how much liberty should be allowed. A number of superintendents related successes of the policy, a few told of major failures. I had the impression that the degree of success was closely related to the enthusiasm and depth of the superintendent's conviction. After the program's close, I felt I had learned

a great deal at the symposium and returned home with ideas I believed would make us a better institution.

Sweeping changes also brought us new problems. One of the major topics at the symposium was discussion and the report of a number of hospitals concerning the new neuroleptics -- the tranquilizing drugs.

At that time, there were only a few such drugs -- Thorazine, Reserpine (Rauwolfia), and Mellaril. I heard a dozen stories of hallucinating schizophrenics whose hallucinations stopped within a week or two after taking Thorazine. Reserpine and Mellaril were praised by others. Reserpine is no longer used and Mellaril is sometimes used by veterinarians. In rapid succession, a series of tranquilizing drugs appeared on the market. Few patients in mental hospitals were not given these substances. That they had a profound effect could not be challenged. Thorazine and its relatives had an anti-hallucinating effect that became dramatically evident when the drug was withdrawn, plaguing the patient with the "voices." The standard procedure with violent patients was to place them in restraints. If moderately violent, cuffs; if severely violent, straight-jackets. The tranquilizing drugs were just that. Violent patients became quieter, interacted with others more serenely, which meant a great many more patients could be trusted on open wards. The problem we now faced was this: Patients were being transferred by loved ones to Clear View with the hope they could be cured or at least greatly improved. These patients were arriving after months of major tranquilizing medication. The sudden deprivation of their medication precipitated extremely agitated behavior, often violent, with the recurrence of hallucinations. Patients who had been walking freely about hospital grounds and participating reasonably well in group activities were now on the violent ward in restraints as the effect of the medication wore off.

It was evident that we were being forced into the use of psychotropic drugs. The policy that evolved was this: If a patient was admitted who had been treated with neuroleptics for any significant period of time, we would supply that drug, slowly withdrawing it as his treatment progressed. Sometimes the procedure worked and sometimes it didn't. In these cases, it was not just a case of inconvenience if a patient's behavior deteriorated, it could be a matter of life and death. Experience had taught us that prolonged agitation leads to the exhaustion syndrome which is usually fatal.

Through the services of two osteopathic physicians on the staff who were familiar with the medical history of the patients, the transition from medical care to chiropractic care was achieved. It would, however, be deceptive to suggest that all patients made that transition.

Next month will conclude the series on Clear View.

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