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Discussion
Notes for my file
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Transcript of Dr. Vail's talk on Dehumanization
presented at the Institutional Assembly at Glen
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As a way of making clear how the problem of dehumanization fits into the total Minnesota Mental Health Program, I should like to begin my discussion by drawing a distinction between the external and the internal goals of an organization. The external goal of an organization is its ultimate purpose or mission, usually defined as a certain product of state of affairs which the organization has been designed to bring into being. In our case, for example, the external goal is the prevention, control, and treatment of major mental illness. The internal goals of an organization are the specific obstacles it must overcome if it is to accomplish its mission. In our case one of the obvious internal goals is the efficient operation of public mental hospitals; which in turn ^{ENTAILS} involves the problem of the possible dehumanization of hospitalized patients. The advantage of discussing the problem of dehumanization in the context of external-internal goals is that it enables me to emphasize the problem without creating the impression that I consider it our only, or even our ultimate, goal. But it is a very important goal. The laws emphasize this fact. The basic mental health act of 1949 was, to my view, predominately concerned with the problem of dehumanization. The point emphasized by that act was that the state must bring its mental hospitals up to standards, particularly in the area of the humane treatment of patients. So the problem of dehumanization, while it is not the only internal problem with which we are concerned, seems clearly to be one of the most important ones.

Furthermore, I'd like to make this clear: dehumanization is not the exclusive property of mental institutions. As I hope my talk will make clear, dehumanization cuts across various wide areas of human activity and human affairs. I do not intend to point the finger of scorn or shame at mental institutions or at the people who operate them now or have operated them in the past. I want, instead, to do something much more basic. I want to show how dehumanization develops as the product of certain historical provisions, certain laws, and certain kinds of organizations.

First of all, what is dehumanization? I have defined it as the divestment of human capacities and functions, and the process of becoming or the state of being less than a man. We could debate considerably on the philosophical aspect of this definition, asking ourselves what we mean by the word human, or by human nature, and we could thereby add our voices to the many thousands and millions of words which have been spoken on this subject since man became aware of himself. Such philosophical questions are important, but they cannot be adequately treated in a short paper. All that I hope to do is to make my meaning clear by showing some instances or examples of dehumanization.

Where is dehumanization found? As I said, dehumanization is not the exclusive property of mental institutions. It can also occur in the work of county welfare workers when they deal with families for whom they must find proper homes or with children who must be placed with foster families, or with patients who must be placed in proper boarding and nursing homes. Dehumanization is a problem for the people who operate such nursing homes; it is a problem for the administration, medical, nursing and other staff in TB sanatoriums; it is a problem for correctional institutions; for Indian reservations; for urban planners and for those who work in slums. The much debated National Service Corps, or Domestic Peace Corps as it is sometimes called, addresses itself, I think, essentially to the problem of dehumanization. In short, this problem is of concern to anyone who manages or is responsible for a situation which involves the care, maintenance, support, or supervision of other people who are living essentially in a dependent situation. Dehumanization may occur in any situation where one person is responsible for making the day-by-day decisions regarding the comfort and welfare of other persons.

How does dehumanization come about? For information on this subject I have turned to a book entitled Asylums written by Erving Goffman, a sociologist. Goffman is not the only one who has studied this problem, but his contribution has been unique, it seems to me, because as a sociologist and as an outsider he has had no axe to grind with mental hospital personnel and so has been able to observe conditions in mental hospitals with complete detachment. Perhaps Goffman's candor can be traced

to the fact that he has approached this problem not to find out what is wrong with mental hospitals, but simply to describe what he sees. And what he sees is that mental hospitals have many features in common with what he calls "total institutions", which are organizations that seem to make a specialty of dehumanisation.

What are some of the features of the total institution according to Goffman? The check list which accompanies this paper is an abstraction of many of Goffman's specific observations of dehumanising practices in mental hospitals. But before discussing these specifics, I want to point out the general features which Goffman ascribes to all total institutions.

The first feature of total institutions is ~~that they are~~ all-encompassing. The individual's entire life is spent within one set of boundaries, usually specific geographical boundaries. He works, sleeps, breathes, plays, lives, in this one setting. Obviously this feature is to be found not only in mental hospitals but also in boarding schools, monasteries, ships at sea, jails and prisons, migrant labor camps, Indian reservations, and military establishments, just to name a few.

Another feature of total institutions is the fact that a small group controls a larger group. In a boarding school a small group of masters and teachers supposedly controls a much larger group of students; in a prison a small group of gaolers controls a much larger group of inmates; in a mental institution, a small group of staff personnel controls a much larger group of patients; and in an army, a small group of officers controls a much larger group. This centralisation of control partly accounts for the fact that total institutions dehumanise their inmates by severely limiting their capacity for self-determination.

The total institution has a rationale, there is some kind of ~~thesis~~ thesis or idea that becomes the working hypothesis for the institution, and this tends to have something to do with producing a career, with "making someone over". For example, the rationale of the boot camp is to take a group of nitwits off the streets, out of the bars and drugstores and the drag races and wherever they may be — colleges, maybe — and to make soldiers out of them. The rationale of the entire organisation is based on producing something different; producing — if I may anticipate my next

point — a unit of work, in this case a soldier. The monastery has the rationale of taking someone with worldly connections and making him into a true and complete servant of God. The boarding school has the rationale of taking adolescents and making gentlemen out of them. And so it goes.

This leads to the question, What is the rationale of the mental institution? We talk about treatment, about the fact that everything that goes on in a mental hospital is part of the treatment, as though to suggest that the hospital takes over the patient's particular mental illness and makes something better out of him. Sometimes I wonder whether, in a crazy way, the institution does not rather actually make the person into a mental patient, does not produce for him the career of being a mental patient. I think this is a very interesting idea — a disturbing one, of course — but I think a useful one if we are talking about what actually happens in mental hospitals and what is the end product. I think we now have reason to believe that a lot of the things we have done because we did not know any better or because we did not know how else to do it, tend to produce a career mental patient.

Another feature of the total institution is that the inmate's entire life is spent within its boundaries. This is in very sharp contrast to what we refer to as normal life. I live in one place and I work somewhere else and I may take my pleasures elsewhere. In the total institutions this is not the case; everything takes place in one setting. Furthermore, there is a kind of transferability; for example, if I goof at my work Mr. Hursh is not going to call my home and tell my wife, "Don't let him watch Ben Casey tonight", or "Don't give him his usual quota of martinis because he just cost the state a million dollars due to some stupid decision." He might fire me, but he would not think of phoning to my dwelling place and asking my custodian there to punish me or to continue the punishment into this other realm. But such a process does occur in a total institution. The patient who goofs at the laundry is still punished when he gets back to the ward. We'll talk more about the punishment and reward aspect of the total institution later on, but I want to note now that the punishment is transferable.

One of the aspects of Communism that is so repulsive to us is that Communism is a total institution. I think a beautiful example of this is that the public official in Communist Russia is rewarded or punished not by being fired from his job, although this may happen, but in other ways which would carry over into the living area. A perfect example is Yuri Gagarin who, when he returned from his first manned space flight, was rewarded by being moved to a larger and classier apartment. The government controls the housing as they do many other things. This would be really unthinkable in our country. We might give John Glenn a Congressional Medal and honor him with parties and with all kinds of gifts, but it would be inconceivable that the President would somehow arrange to have him moved to a better house. His commanding officer, I suppose, might do this in the total institutional context of the Army post where he lives, but as a nation we do not operate this way.

The next important feature of total institutions is what Goffman calls "people work". This again is related to the rationale, to the matter of producing a career, of taking a plowboy and making a soldier out of him, a unit, a cog in a machine. "People work" consists in processing units, applying grievous dehumanization in order to make good ultimate form. I think an outstanding example of this is what came to light in the Eichman trials, where this was actually the jargon that was used: "We processed so many units in the month of July, 1943." And I think we see many examples of this in our institutions when we talk about numbers, about categories. I indulge in this myself. We talk about having so many less patients or so many less units to care for than we had a month ago, or so many more, whatever the case may be.

Another feature is the process of mortification, and we can find many examples of this. It relates in part to the "people work" idea, because it is the process by which we mortify the individual until he becomes a unit. Mortification relates also to the rationale. The monastic system, whether we are talking about Christian monasteries or Buddhist, employs mortification to reduce individuality and to limit liberty. Boot camps do the same thing. At one Marine boot camp as the recruit got off the train, still in their civvies, one of the drill sergeants lined them up and

ordered them to stand at attention while he had his eight-year-old daughter rail at them in a most vile fashion, calling them all sorts of horrible and humiliating names. Mortification processes similar to this can be found in many total institutions. Fraternity hearings make a person a working unit of the organization by subjecting him to certain rituals which are mortifying in nature. In boarding schools this is not uncommon. The new boys wear silly hats, do silly errands, perhaps carry bricks around, all of this presumably designed to make them "good boys" in this particular institutional setting.

We have abundant examples of mortification taking place day by day in our mental institutions, things which maybe started because we didn't know any better, or because there were so few people at the time, but which now persist for no reason whatever. I think all of you have heard the complaints from patients who have come in from very good homes, perfectly trained, well-dressed, well-groomed, they don't smell, they don't appear to have lice, and yet they are forced to take a bath, to remove their clothing, and to put on state clothing. Just the other day a patient who had been transferred from one institution to another and wanted badly to go back, told me that one of his reasons was that when he had come to the second institution he had had to surrender his own clothes and had been given state clothes -- he had even had to give up his fountain pen. Perhaps because a patient hurt himself with a fountain pen back in 1919 we still take away all fountain pens; because once a patient hung himself with a belt, we remove all belts. One point to note is that these regulations get wound in with the rationale. When asked why we are doing this or that we can say, "Because it is part of the treatment program. It's something that you must do because this is the only way you can get better."

The next major feature of total institutions is the system of reward and punishment. I think in some ways the traditional process of moving patients from the more convalescent or treatment-oriented wards into the more regressed wards is in some ways related to punishment. We may use this deliberately, saying, "If you don't go to the movies or don't go to work, or if you don't participate in such and such an activity, you'll have to go back to the other ward." It's like sending a kid to

his room; it's a way of punishment. But we rationalize this by saying, "H is no longer able to benefit from the treatment program in this ward or in this building or in this hospital, and therefore he must go to this other building, or ward, or hospital." But, to translate, this often means that he goofed and that this is his punishment. The reward, of course, works in the other direction: long-term patients who have become pensioners in the institution somehow are allowed to gravitate to place where they will have certain special privileges. Maybe they get to be a messenger and they can roam the grounds; maybe they can earn a little money because they have the car washing concession. If the patient goofs, which we translate as "H becomes too ill to handle this responsibility," then he goes back. Now these examples no doubt are irritating. Hospital personnel might reply, "How else are we going to run it?" Maybe there aren't any other ways to run it, but I think that we want at least to examine these things, since they go on day by day in our institutions.

Finally, total institutions are self-perpetuating. Practices become fixed in the tradition, and the rationale of the organization develops around them and perpetuates them. Why are we questioning this process? Because even if we can't do anything else in this paper we can at least look at some of these things objectively and honestly.

I would like to recommend to you an essay by George Orwell which communicates clearly the subtle interaction of the rationale with the punishment and reward system in a total institution. As an 8-year-old, Orwell was sent to an English boarding school on a scholarship and placed in a very dependent situation since, as he tells it, it was made clear to him that he was there at the sufferance of the head master who had taken quite a financial loss at having him and who insisted that it was up to him to perform in his school work so that he could get a scholarship to the greater glorification of the school. This essay is a devastating thing to read. Orwell at one point was punished for wetting his bed which was interpreted as a deliberate act on his part and something to be punished. On his way out after the punishment he was heard to say, "Well, that didn't hurt very much", so the head

master called him back in and really gave it to him the second time. This punishment, which seems so obviously dehumanizing and pointless, was justified by the rationale of the school, according to which any tactics on the part of the head master were acceptable provided they could be interpreted as methods for converting youngsters into disciplined "gentlemen".

At this point I would like to refer to the list of Goffman's specific observations of dehumanizing practices in mental hospitals. This list deals with some of the things I have already mentioned. For example: Are the patients regarded as units for processing? Do we seem to indicate indifference to the physical integrity of the patient, including such things as restraint and seclusion? Do we subject the patient to the sickness-treatment rationale of the institution? Do we provoke a defensive response, then attack that response as a symptom of the illness? For example, do we tease or nag the patient until he reacts and then say "Aha! There's your mental illness again." Do we allow the patient face-saving reactive expressions? Do we interpret all actions, even those normally considered indifferent, as signs of

illness? (The psychiatrist, I think, has been primarily responsible for causing us to believe that everything we do is somehow a defense or a sign of neurosis, a sign of dementia.) Do we perpetuate the diagnosis as a permanent badge, so that once a patient is labeled schizophrenic he is always a schizophrenic? We have had some bitter experience in overcoming the problem of getting the patient back into the community as a result of this tendency of ours to attach a permanent diagnostic badge to the patient. The medical and psychiatric professions are mainly to blame for this practice. I can recall one state institution, not in this state, fortunately, where a whole discussion in a staff meeting was devoted to trying to determine whether a particular patient was an "old schizophrenic" or a "young schizophrenic". Once it was determined whether he was "old" or "young", he was given his badge and permanently labeled schizophrenic. Thereafter, presumably, he would not have to be thought of as person at all, but simply as a diagnostic type, as a thing bearing label.

In reading the papers the other day I was quite disturbed to notice the reference

to the fact that a patient who had recently escaped from Fergus Falls State Hospital was being considered as a suspect in connection with the disappearance of two little girls from that area. No one had any real evidence. But the patient was there, and the girls were last seen there, and, because according to the popular superstition mental patients are supposed to be irresponsible and dangerous, the inevitable and obviously unjust inference was drawn that the patient was involved in this felony.

Some sections of the check list deal with Goffman's observation of the process by which patients adapt to institutional life. Some of these processes are considered bad in terms of the privilege system: for instance, withdrawal or regression, that is, clamming up; another is intransigency, which means fighting the system, or bucking back. Reactions which are considered good in terms of the privilege system I think are more interesting and a little more subtle. Goffman mentions colonization, where the patient settles down in the institution, finds a home there, builds a little niche for himself with his collection of odds and ends, and succeeds in making some sort of free world for himself with the limited materials available. Another "good" adaptation is conversion, where the patient accepts the view that he is no good, and that it is therefore proper and only correct that he should be in this place and be subject to degrading disciplines. "Playing it cool" is the process of getting along while at the same time harboring underlying hostilities to the system. "Immunization" is an interesting process which occurs with persons who have been in this kind of setting for so many years — in orphanages, boarding homes, hospitals, schools for the retarded, or jails — that they have become immune to institutional life and do not mind how they are treated. "Identification" is the process through which the patient becomes the "company spy," the stoolie, the guy who rats on his associates.

I'd like now to quote some comments which patients themselves have written concerning dehumanizing influences in their hospitals. In March of this year a questionnaire was sent from my office to all patients asking how they felt about the treatment program and inviting them to communicate what they had to say directly to "the top", so to speak.

In some hospitals as few as 1½% of the total patient population made responses, whereas in another hospital something like 40% of the patients responded. Even this fact was significant, since one of the things we wanted to determine was the degree to which a two-way communication system was actually operating between our office and the patients. But our main interest was in finding out what the patient would tell us about what we in turn should tell the public regarding Minnesota's mental health program. You might be interested to know, for example, that the patients themselves are as passionately aware as we are of the need for more staff. Sometimes I think if the legislators could read these comments from patients they would really be convinced of the need. While we were not searching for complaints, nevertheless, as you might expect, we got them, since this was interpreted by many patients as their chance to say something. It is only fair to mention that I have quoted only the negative comments, and not the others, because the negative comments have more to do with the problem of dehumanization.

One patient talks about student nurses coming, and how this has made a great difference in the hospital. "The nurses help a great deal in drawing some of the patients out. They seem more like human beings and less like robots going through the day either sleeping or scared of making a mistake for lack of anything else to do." Another patient says, "It seems that when a patient like myself is brought to one of these hospitals in state of delusion or hallucination or what have you, the staff is oh so anxious to do something about it. First, observation; second, the shock treatment; plus all the attention of student nurses, doctors, registered nurses, aides, etc. Then, when the patient has reached a plateau and begins to get more self-sustaining, everything is dropped. He is put into one of the other cottages, given work, and damn near forgotten. He's supposed to do the rest all by his little ol' self." Perhaps that is merely the complaint of a crank, but reactions like this are sure to happen from time to time. Another patient says, "Dr. so-and-so gave me a tranquilizer without even glancing at me or seeing the condition I was in. I was told in a letter one day when I changed to such-and-such a ward for over three months before returning to this other cottage, that the hospital staff would contact me when the end of the transfer would occur. No one had contacted me after four months and I was under severe tension." This statement emphasizes

the dehumanizing effect of allowing a communication system to break down. Here is a statement that bothered me: "It concerns me that some of the patients who are handling food should not be working with infectious sores on their arms, etc."; and here's another one: "When they pass the medicine they don't use clean water glasses. Even if there is a little bit of water left in a glass the nurses order a patient to empty other glasses with a little water in them until their glass is filled. They don't change sheets in the sick room, instead they just remake the wet ones. At least when it was my chance to get a bed in there, that's what they did." I don't know whether this is true or not. It is of course impossible to check each specific complaint. But maybe in the press of business, or for other reasons, these things do happen. "Too many shock treatments." Shock treatments of any kind are a great shock to the patients. "My head was operated on without my consent or knowledge."

Here is a really interesting one pertaining to the use of seclusion and restraint. "I'd like to complain about our security. A little room where we're put when bad." Notice that this patient doesn't say "When we become disturbed mentally or are acting out our delusional systems," but only "When we are bad." The point is that he interprets the use of restraint and seclusion as a punishment and not in any sense a process of therapy. Another patient says, "I don't think our relatives realize all a patient has to go through. It seems they could do a lot more to help a patient get well if they could take an interest in them and treat them more like human beings. Many of the patients have not seen their relatives or heard from them in years. It's as though they're brought there and left for someone else to worry about, and forgotten there. It leaves the patients with a sense of insecurity and helplessness." Here is another one I thought was interesting: "There's no need for rash decisions regarding mental illness on the part of juries. Simple mental conditions after years of probing seem to improve. If a simple thing like hearing voices occurs, this is easily done away with with a few weeks of pills. These diseases are not serious unless a person is actually committed for long periods of time, when of a sudden, it is almost a duty to hear voices again. And then the question is, would the occasional hearing of voices that are not of the annoying type be very serious?" I think this is particularly interesting in that this patient is talking about the career of the

mental patient; after you're here a little while you become a career patient and you begin hearing voice . Now you can make of these complaint what you will. To me they mean that the kinds of things we are talking about are things that are experienced by the patients. The patients do in actual fact feel that they are being degraded; they have the sense of being handled as mere units in a batch.

Now, to wind this up, I want to say that we should be aware of, look for, and analyze the structure and the system in which dehumanization occurs. When we do, we can realize that this is a process which is taking place day by day, not necessarily because anyone has willed it or because we are bad people, but because somehow in the structure of the organization this is what has developed. I want to leave you with several questions: What can we do about dehumanization? Now, of course, the obvious answer is get more staff. Well, let's just assume we're not going to, (I think this may be a safe assumption); then our task is to do something about the problem with the facilities at hand. What programs or projects or methods might there be for handling or dealing with this problem? And last, I hope that each of you will apply this check list to your own institution, and will continue to study this problem with your staff at every department level so that everyone in the institution will have a chance to acquaint himself with the problem of dehumanization. Let me repeat that I think this is one of the key problems with which we have to deal.

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Transcription of tapes containing reports of the discussion leaders at the Institutional Assembly; it includes 9 separate reports and Dr. Vail's replies to each report.

Group I

We discussed the question of structure versus non-structure at our large institutions. It was the opinion of our group that it was not the structure of policy that dehumanized the patients, but rather the employees' attitudes in carrying out policy.

Dr. Vail: The attitude that should be changed is that there is only one good way to do a thing, that way being the way it has always been done, and that any proposal of change is disturbing or shocking. You may be familiar with the record of an English comedian which describes the experiences of a boy in a cannibal family who decides one day that he doesn't want to be a cannibal any more. His parents were very shocked because, they said, people have always eaten people, and their boy would be a disgrace to the family if he didn't eat people any more. When the boy insisted that he would not eat people any more, the cannibals thought he had turned communist, or subversive. Another attitude that needs changing is the attitude that staff is in some way different from the patients, that somehow hospital employees are fully human whereas patients are not. I agree with you that in combating dehumanization it is more important to change attitudes like these than it is to make any changes in administrative structure.

Group II

Our group discussed the question of whether responsibility for the personal action of the patient belonged with the hospital or with the patient himself. We felt, in general, that the patient should be given as much responsibility as possible. We also felt that the hospital staff itself was largely responsible for fostering patient dependency on the hospital, since staff often deprives the patient of all opportunity for exercising personal judgment and responsibility.

Dr. Vail: For various reasons the hospital staff is expected to assume responsibility for the patient, but we must be aware that one of the effects of our doing so may be to

deprive the patient of opportunities to maintain or develop his own capacities for responsible behavior. We must constantly guard against misusing the patient in the name of "treatment". Some steps have already been taken to insure maintenance of the patient's sense of responsibility, two of the most important being the open hospital and the patient councils.

Group III

We first tried to determine the difference between humanization and dehumanization. The right of self-determination seemed essential to the process of humanization. An analogy was drawn between hospital patients and children in a normal home, and it was pointed out that the child is given a great deal of leeway in the choice of with whom he will play, where he will play, etc., even though he must still conform to a certain accepted standard of rules, such as being home at a certain time. The problem of dehumanization thus seems to be the problem of determining the proper degree of conformity to group standards of conduct. It seems clear that hospital patients should at least be asked for their opinion regarding the rules they are asked to obey, and for suggestions as to how they would modify these rules. We also felt that the check list given us for discussion today should be used as the basis for continuing discussions with ward personnel in the hospitals, and that the check list should be given to those participating in the discussion two or three days in advance.

Dr. Vail: We deliberately did not hand out the check list in advance because we did not want to create any defensive attitudes which would interfere with an objective consideration of this problem. I suggest that before you give this check list to personnel in your hospitals you prepare them for the discussion. Otherwise the discussion is likely to become merely an opportunity for self defense or self laceration on the part of the staff. The other issue you bring up is harder to deal with. It is not easy to get agreement on the precise meaning of "human". That is why we have organized our discussion of dehumanization around the concept of dignity: any act of discipline is dehumanizing which destroys the dignity of the person being disciplined. For one thing, the person being disciplined must be given a choice of obeying or disobeying. A little

while ago, for instance, all of us ate lunch together in the same place, at the same time, and of the same kind ; but we've had at least the choice of whether we would eat under these conditions or not. For another thing, the manner of the person administering the rule can be either humanizing or dehumanizing, depending upon whether he addresses himself to the one being disciplined with respect or with contempt. A third factor is the motive that underlies the rule: if a physician tells a patient that he cannot go into town, this command may have a humanizing effect if it communicates to the patient the physician's concern for the patient's personal welfare, whereas it will have a dehumanizing effect if it conveys only the physician's contempt for the patient's capacity to take care of himself. In short, we are assuming that rules are good when they result in heightening the patient's sense of personal dignity, and bad when they destroy his dignity.

Group IV

We agreed that we are all victims of dehumanization at one time or another, both in and out of hospitals. As ways to avoid the dehumanization of the patient in hospitals, we agreed that the patient should be allowed to keep as many personal possessions as possible, given more responsibility for his own treatment and care than we have allowed in the past, and not separated from the staff by such devices as uniforms, titles, etc. We also felt that certain treatment areas should be re-evaluated, especially the area of industrial therapy. We felt that the idea of "professional relationship" might be responsible for some of the cleavage between patients and staff, and that this idea should be re-examined. We also raised the question of how to define in a sociological contract^{EXT} the role of the patient.

Dr. Vail: The role of the patient is certainly an important consideration. What Goffman makes clear is that the role of the patient is frequently determined by his environment, rather than by his needs. We should reverse this process, first by determining what are the patient's real needs, and then by constructing an environment which permits these needs to be met. The cleavage between patients and staff members is also an important matter, perhaps having its roots in the fact that each of them has a different role in the hospital. Somehow or other we must come to realize that a difference in function does not

mean a difference in value.

Group V

We asked the following questions: From the point of view of the reasons for dehumanization, is there any difference between hospitals for the mentally ill and schools and hospitals for the mentally retarded? Since any process of group living requires the imposition of rules, and presumably therefore produces dehumanization, can we say that dehumanization is truly bad? If there is a kind of rule or sensible standard of conduct which can be imposed without dehumanization, how can this rule be determined? How can we alert ourselves to some of the factors of dehumanization? In general our group seemed to feel that there was more to be gained from discussing hospital conditions in terms of individualizing treatment programs rather than in terms of dehumanization. We were able to define certain dehumanizing factors: bad staff-patient ratio; use of diagnostic labels; lack of variety in hospital procedures; lack of opportunities for free choice.

Dr. Vail: Dehumanization is truly bad by definition. If we can point to something that is not really bad, then by definition it is not dehumanizing. Ordinary rules of living are not dehumanizing if they are administered with concern for the dignity of the individual. The unthinking application of general rules is one major dehumanizing factor.

Group VI

We agreed on these points: that staff must develop maturity enough to recognize that rule should be changed when they are outdated; that the patients themselves should be consulted on this matter, particularly through patient councils; that the entire staff of the hospital, not just the treatment staff, should be trained in how to observe and avoid dehumanizing practices.

Group VII

Since man always creates institutions, and since institutions require rules, man

can never avoid the problem of living under rules. The rules, however, should not be statements of what has happened in the past, but of what makes sense for the present. We felt that the basic reason why rules are so difficult to change is that the administrators, that is ourselves, have a fear of introducing something new. We decided that our first job was to decide how to make ourselves fully human, and then how to apply to the patients the same treatment that we applied to ourselves.

Group VIII

Inter-personal contact between patients and staff members ~~are~~ the seat of dehumanization, and therefore our efforts at reform ~~are to be directed~~ to this area.

Group IX

Since individualization is almost synonymous with humanization we concluded that if rules are to be "human" they must be flexible and capable of adjustment to individual needs. The only hard and fast rule is that we should not have any hard and fast rules. We discussed ~~some~~ methods of avoiding dehumanization within our institutions: education of our personnel, including the patients; the use of off-ground independent privileges to avoid total institutionalization as much as possible; the use of patient councils and patient representative groups; the use of group ward meetings such as the conference unit meetings at Fergus Falls; the provision of educational programs for the community at large.

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