TOMPKINS 1—*This ward of the Yale-New Haven Hospital has no locked doors, padded cells or barred windows, and yet it handles patients suffering acute psychiatric disturbances exclusively. Treatment is based on a revolutionary group-therapy concept in which "each patient's business is everyone's business . . . not just a group of doctors treating a group of patients, but also patients . . . treating one another." All day-to-day activities in the ward are regulated by an Advisory Board (composed of and elected by the patients); all decisions regarding problems or requests of individual patients are reached by open vote of the board. Above, the board in session.*

NEW HAVEN.

IT is a mild spring morning, and the patients' day room is warm with sunshine. Several of the tall windows are open, and their light plaid curtains stir in the breeze. From outside there comes the muffled noise of traffic, and the distant clatter of a pneumatic drill. Here, in chairs arranged in a large oval, the entire patient population and the staff—including psychiatrists, residents, nurses, social workers, psychologists—of "Tompkins 1" are gathered.

Tompkins 1, called T-1, is a small (30-bed) unit for the short-term treatment of acute psychiatric disturbance. It is located on the ground floor of the Yale-New Haven Hospital, a general hospital serving the city of New Haven, and affiliated with the Yale Medical School. Today's meeting, one of three weekly gatherings of the ward's patient-staff community, is being led by T-1's director, Dr. Gary Tucker.

Tucker, 34, rangy and brown-haired, slouches down relaxedly in his chair, one knee crossed over the other. He has just reopened the case of Susan, a 17-year-old girl who had been admitted to T-1 just prior to the weekend. Susan, diagnosed as pre-schizophrenic with thought disorder and possible hallucinations, attempted to walk off the unlocked ward on Saturday. Although a community meeting was called immediately after this incident to give the other patients a chance to express their own panic and concern, a sense of uneasiness has persisted. Now Susan sits rigidly in her chair, staring straight ahead.

Dr. Tucker: "I wonder what people in the community are thinking about Susan?"

Adolescent male patient: "I had her on patient special. She's very hard to special." ("Specialing" a patient

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MAGGIE SCARF is a freelance writer and the author of several children's books.

In the 'Therapeutic Community,' Patients Are Doctors

By **MAGGIE SCARF**

is accompanying him constantly during a designated time period.)

Older male patient: "I think Susan's having a hard time, trying to come to grips with the facts. Her illness."

Young female patient: "I think she seems slightly better this morning. Her eyes are open more of the time."

Same older male patient: "She seems to have a phenomenal need for sleep."

Middle-aged female patient: "I specialed her this morning. I asked her was she sleeping, and she said no. So I asked her: 'Are you thinking?' and she said yes. So I asked what about. But she just shut her eyes again, and acted like she'd gone to sleep."

Dr. Tucker: "Susan sounds a bit crazy and bizarre. Maybe that's her way to keep people off."

Same middle-aged female patient: "Maybe that's the way she protects herself from personal questions."

A male patient in his early 30's sits forward on his seat, looks around at the rest of the group tensely. "Look, I'm not sure what you mean by the word 'crazy.' I'm not sure what that word means."

Staff psychologist: "You don't know what crazy is? Well, just look at Susan for about five minutes. That's 'crazy.'"

There is a pause, then everyone bursts out laughing.

Same patient (angrily): "Do you think that's right, to call someone crazy?"

Young male patient: "Susan gets especially bizarre when she really wants someone to give her agitation medication."

Susan (looking at him): "What do you mean, bizarre?"

Male patient: "Well, the way you walk. The way you sit. You're so stiff. And even when you talk, it sounds flat, like a paid political announcement."

Dr. Tucker: "Apparently Susan isn't aware all the time when she's acting bizarre. She should have some feedback from the community."

Young female patient: "She came up and asked me yesterday if I thought she could be a nurse's aide."

Dr. Tucker: "Susan needs some reassurance. She needs to find out from the rest of us what is bizarre and what isn't." He reaches for a pipe in his jacket pocket, begins packing the bowl, glancing at the same time over the mimeographed list which sits on his lap. The room is filled with rustling noises: everyone is scanning his own copy of this paper. At its head, eight names are listed. Then, directly below:

PATIENT ADVISORY BOARD
May 13, 1969

1. Frank M. requests a Work Pass, May 15, from 9 A.M. until 3 P.M.
   Vote: 8 yes 0 no
2. Ann J. requests that she be placed on Independent Status.
   Vote: 7 yes 1 no
3. John R. requests that he be placed on 10-minute checks.
   Vote: 0 yes 8 no.

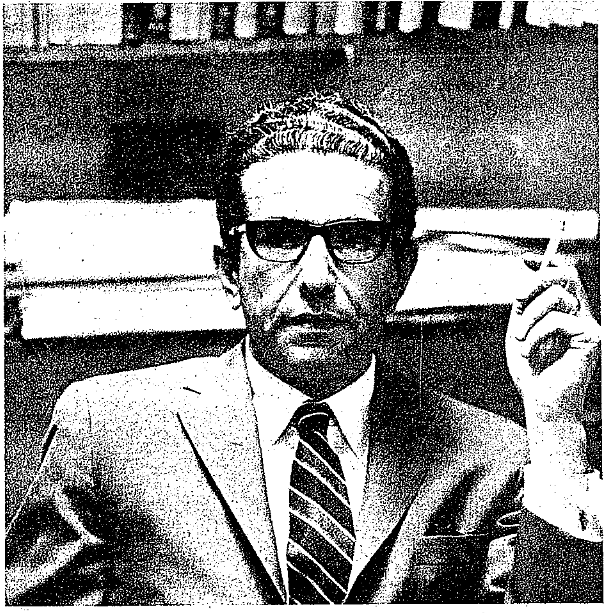
(There are over 20 items all together.)

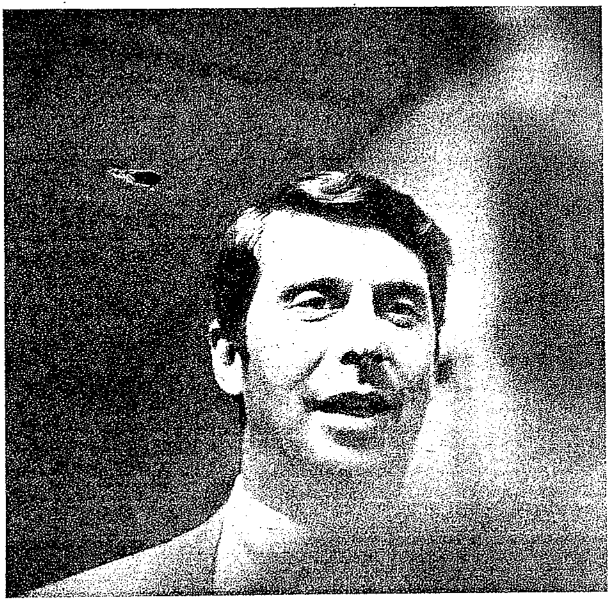
ONE of the young residents in psychiatry raises his hand: "On item 3, I notice that John wanted to be moved up from patient special to 10-minute checks. And that the Patient Advisory Board denied it unanimously."

Patient: "We don't trust John yet. When he came in here he kept saying he was a saint, and he was going to be martyred. Yesterday he started jumping around, telling the nurses he was turning into a grasshopper."

Everyone turns to look at John, a tall, cadaverous adolescent with blond, almost shoulder-length hair. He sits, a hand on each knee, staring downward. "I know I'm not a grass-

(Continued on Page 109)





FOUNDER & DIRECTOR—*Dr. Thomas Detre, at right above, established Tompkins 1 in 1960 and directed it for nine years. Dr. Gary Tucker, below right, took over last year. In the beginning the project had to weather controversy and criticism concerning its methods of treatment. Some argued that they achieved little more than "putting Band-Aids on deep wounds." Dr. Detre's answer: hospitals are not the place for dealing with a patient's long-term problems.*

Photographs by TIM KANTOR

Patients are doctors

(Continued From Page 33)

hopper. I know I'm not a saint. . . ."

Tucker (with a smile): "Good, we've had three already this year."

Young female patient: "John says he's physically ill. He says the medication he gets is making him sicker."

Tucker (looking around): "Who knows why John is here?"

Young female patient (with a laugh): "He's crazy!"

Susan (speaking up suddenly): "You mean you just look at him five minutes and you know it?"

Every face turns toward her in surprise; she smiles a droll smile; in a moment, everybody is rocking on his seat with laughter. Then Dr. Tucker turns back to the boy. "Perhaps, John, you could tell the community why you are here."

John (his voice low): "I was out of touch with reality. I took a mind drug. I was having trouble with my parents."

Tucker: "Well, I think we're all still quite concerned about you; and that the community is probably right in wanting to hold you back on patient special for awhile." He pauses, looks down at the list on his lap, then up again with a smile. "Anyhow, if you do turn into a grasshopper, we want to make sure someone is with you. . . . The rest of us wouldn't like missing it." John glances up at him, concedes the joke with a shrug and a self-mocking grin. Then this group therapy-*cum*-town meeting continues.

A pretty social worker raises her hand to ask how the community feels about items 6 and 7, two extended passes away from the hospital granted to Ezra, a male patient in his late 40's. A theoretical physicist, he was hospitalized six weeks ago during a severe depression. "Yes, I wonder if there was much discussion about those passes," asks Tucker, looking around. "And I'm wondering also what people think about Ezra's imminent discharge. Do you think he's being pushed out too soon, and that he's not really ready yet? We all know the problems he has with his wife. Is the community comfortable about his going, or do some of you think we're throwing him right back into the lion's den?"

Hand after hand goes up, as fellow patients and staff members contribute bits of information about Ezra—conversations they have had with him; what his recent moods and attitudes have been; how he has behaved during visits with his family; comments he has made during individual or group therapeutic sessions; how willing he has been to approach others in the community, and how often he has been isolating himself. There is nothing about Ezra's problems, his illness, his life situation, which is not known to the full patient-staff body, and which cannot be discussed openly in his presence. On Tompkins I, there are no secrets.

"Open communication and complete frankness are the 'party line' of this ward," explains Dr. Tucker. "In this sense you might say that each patient's business is everyone's business, which is just a harsher way of saying 'everyone's concern.' The whole therapeutic-community idea is predicated on the notion that everyone is involved; that it's not just a group of doctors treating a group of patients, but also patients who are treating one another. It is the social organization itself, and the intense interaction that it promotes, which is supposed to do the healing—the community is 'the doctor.'"

THE concept of the therapeutic or curative community was pioneered and developed, for the main part, in English psychiatric hospitals, shortly after World War II. It may be described as an arrangement in which all of a patient's time in the hospital—not just the time he spends in therapy—is thought of as treatment. The milieu in which he finds himself, i.e., the hospital, is seen as exerting a powerful influence upon his emotional life and behavior. Every contact, every casual conversation with a fellow patient, a nurse, even a kitchen helper, is regarded as potentially therapeutic. "Milieu therapy," as this approach is called, is an attempt to take into account what psychiatrists have called "the other 23 hours in the day"—to treat mental illness through a careful structuring of the social environment.

"What we see in the majority of our patients," says Tucker, "is that a period of great withdrawal has usually taken place just before hospitalization. They've become isolated from their families, their social setting; the very fact of needing hospitalization illustrates quite clearly that the person can't function any longer in his ordinary environment. His communications with those around him, if they exist, are distorted. And the dramatic symptoms we see on admission—delusions, hallucinations, excitement—are often being used by the patient to distance himself from terribly real, terribly painful problems."

One of the major efforts of the ward, therefore, is toward boldly forthright communication. A new arrival at T-1 may be startled at first by other patients coming up, asking, "Why were you brought here?" and then launching into explanations of their own illnesses, their situations, and their current problems.

But the new patient quickly learns that such behavior is not only accepted, but expected on the ward. Withholding information, maintaining privacy: these are viewed as antitherapeutic, both for the patient and the community as a whole. Secrets, be they between patients or between a staff member and a patient, are not tolerated; this even includes information which a patient may offer his therapist during individual treatment.

"Of course, we on the outside tell half-truths sometimes, don't go into details," explains Tucker. "We can tolerate ripples under the surface. But by the time a breakdown has occurred, the person is in need of a climate where communication is straightforward, simple and understandable. He needs to be able to say out loud the things that preoccupy him privately, to talk to others honestly and know that the responses he is getting are honest. For whatever bizarre actions or thought may have preceded his hospitalization, they've doubtless been confusing to those people who are close to him. And they, we often find, have begun responding in ways that are equally bizarre and irrational."

NEW patients on Tompkins 1, after initial evaluation, are generally placed on some form of medication—either a tranquilizer, such as Prolixin, or an antidepressant, or one of several experimental drugs now being tested on the ward. Drug therapy is widely used: approximately 80 per cent of the patients are treated with some type of psychopharmacological agent. "We usually start out with fairly low dosages and then increase according to need," explains Tucker. "Our guide is sleep; how much the patient needs in order to sleep." Occasionally, however, a new patient is placed on high dosages immediately. "It depends," Tucker admits, "on how scared we are."

A patient admitted to a mental hospital in the acute phase of disturbance, displaying such symptoms as hallucinations, excitement, delusions, is in such turmoil as to make him doubt the very existence of reality as he has previously conceived it. The experience of seeing or hearing things others do not see or hear, or of losing control, of being unable to think and communicate with others in an understandable way, has shattered his image of himself as someone capable of functioning within a normal society. The purpose of drug therapy is to reduce his discomfort during this intense stage of illness. "What people don't realize is how appallingly uncomfortable psychotic patients are," maintains Tucker. "There seems to be a popular idea that, once someone has gone around the bend, the rest is just picking up daisies. He's happy, you know, no responsibility, no cares. Actually that's not true; most psychotic patients are intensely unhappy and unhealthy."

During the first few weeks after arrival, as the patient's turmoil is lessening, the powerful social pressures of the ward begin to draw him in. Opposition to his symptoms or "craziness" is manifest, from the beginning. Although it is understood, he is told, that he may have crazy thoughts or ideas, he is not expected to act upon them. They are under his control: there are "appropriate" and "inappropriate" ways to handle them.

"'Appropriate' is a big word around here," smiles Julie Adams, a handsome blonde in her mid-30's, who is the ward's recreational therapist. "There is a lot of push toward suppressing and controlling symptoms, toward knowing when and to whom one may talk about them; in other words, when is it socially appropriate? . . . For instance, suppose you have a paranoid patient sitting in a room and suddenly he gets the idea that everyone is laughing at him, making fun of him. The thing he must learn is that he needn't go up and start a fight about it; that it can be handled in a more acceptable way if he gets someone who will understand, a staff member or even another patient, and talks these thoughts out . . . and this is something the patients do seem able to learn. People—even very sick people—respond amazingly to others' expectations of them."

Mrs. Adams, who has worked on Tompkins 1 for the past four years, had "no special training for the job. I'm not a regular occupational therapist; we don't stuff bunnies or make ashtrays; in fact, the patients are not encouraged to isolate themselves with 'things.' The main emphasis here is on the interactions—and they're quite intense—between members of the community, on taking responsibility, first for yourself, then for others. That is, getting on what we call 'the ladder,' and then moving up."

THE T-I ladder is a graduated series of social exercises which, because they are incorporated into the very structure of the system, force each individual patient into intense contact and extensive negotiation with the rest of the group. Such interaction—often painful for the ward newcomer—is, like the exercise of a wounded limb, oriented not only toward the work of repair but toward preserving those functions which remain unaffected. Each patient, at the time of admission, is assigned some position on the ladder. "It doesn't take very long for them to understand this," remarks Julie Adams, "or to begin feeling the pressure to move upward."

“Every contact, every casual conversation with a fellow patient, a nurse, even a kitchen helper, is regarded as therapeutic.”

At the lowest rung of the ladder are those patients who might possibly harm themselves, or who might lose control and injure someone else. They are on "staff special"; each such patient is accompanied by a nurse at all times. When discomfort and symptomology have lessened, however, the patient on "staff special" may prefer being accompanied by other patients, rather than by nurses. In order to gain this privilege, he must take his first step upward and achieve the next level, "patient special."

Movement upward is determined by the powerful patient Advisory Board, a group of eight elected patients who, according to the ward's written constitution, "manifest an awareness of responsibility." This board meets five times a week with the entire patient group to consider applications for changes in status, pass requests, for going out of the hospital, and disciplinary action for rule infractions.

Patients' requests are formally submitted to the Advisory Board in writing. Each item is read aloud by the board chairman before the assembled group; the petitioner is then expected to explain his request. If, for example, the patient had been hospitalized following a suicide attempt and were now requesting a move from staff special to patient special, he would have to persuade the rest of the group that he could handle the added measure of freedom. After the patient himself has spoken, discussion is thrown open to all patients present.

Finally, a vote of the eight-man board is taken by open show of hands.

The move from staff special up to patient special is a first, very small step toward independence. The next level for which a patient may apply is one at which he is "checked" at 10-minute intervals throughout the day. Beyond that, once his ability to assume responsibility for self-control is established, the patient may request "independent status." This is the mid-point of the ladder: at this point, the person is considered to require no special help whatsoever.

Nevertheless, patients are encouraged to move onward from independent status as soon as possible. "It's a level at which they're neither putting in nor taking out anything from the community," explains Mrs. Adams.

Once above independent status, the patient begins to take on responsibility for other, sicker patients. He may do this by volunteering for such duties as patient special, or by becoming a "checker" for those on 10-minute check status. Or, he may become a ward monitor. This job, which rotates daily, is shared by two

GOOD LISTENER—*Julie Adams, recreational therapist of Tompkins I, hears why a patient fled in tears from a group session ("They're picking on me"). Listening is an all-important part of T-1 technique.*

patients; it consists of overseeing patient activity in the community. Monitors are responsible for making sure that all specialers and checkers are performing their tasks, and that no inappropriate behavior is taking place. They also act as semiofficial assistants to the nurses, helping with morning blood pressures, etc. A monitor's day is arduous and involves handling a variety of complex situations; only a fairly well integrated patient can manage it.

Movement up the ladder has been geared thus far to assuming responsibility for the self, and after that, responsibility for others. At the top of this simple status hierarchy is the "buddy system" and the final responsibility—that of freedom. A patient admitted to the buddy system may, for the first time, be permitted to leave the ward. Initially, he will go out only in the company of similarly privileged "buddies"; and responsibility for one another will be shared and explicit. Once his ability to function outside the hospital has been demonstrated, however, the patient may apply for pleasure passes to visit home or friends, and/or work, school or outside-therapy passes.

Each of these pass requests, like movements upward along the status ladder, must be submitted for full discussion by the patient community and voted upon by the Advisory Board. In this way, responsibility for decisions involving each individual member is assumed by the group as a whole. "The patients here have real power," observes Mrs. Adams, who sits in on board meetings as liaison between patients and staff.

Although the staff retains the right to veto "unreasonable" Advisory-Board decisions, this prerogative is exercised with surprising infrequency.

TRADITIONALLY, since the great reforms in the care of the insane tury, the model of a mental hospital has been that one embodied in the Greek word "asylum"—an inviolable refuge. Situated, customarily, outside of city or community, the institution offered the suffering patient protection from the stress of daily social activity, and distance from whatever family pathology might be contributing to his illness. Within such hospitals no demands were or are placed upon the ill person; and he is not expected to make decisions, exercise judgment or function in any responsible way.

That such treatment might possibly have harmful effects has recently come to be recognized. While it would seem just and moral to remove a sick person from stress and responsibility, the prolonged helplessness and dependence caused by this type of hospitalization may actually prevent his return to ordinary life. Those social skills which he formerly had, and which may have remained intact during the period of acute illness, have often fallen into disuse: he no longer feels competent to face the demands of the outside world. At the same time, ties to family and friends have been seriously disrupted. Separated by physical distance from his former community, the patient may suspect that his place in it no longer exists, and concomitantly, he may be uncertain that he can function well enough to fulfill it if it does. The person who becomes "cured" in the hospital setting and then collapses on the front steps is a familiar one to most psychiatrists.

A unit such as Tompkins 1, within a general hospital, which is in turn in the midst of a busy community, is well situated for resisting the process of gradual estrangement which many psychiatric patients experience. As Dr. Thomas Detre, the ward's first director and its "founding father," pointed out in an article, published

“While it would seem just and moral to remove a sick person from stress, the prolonged helplessness caused by this type of hospitalization may actually prevent his return to ordinary life.”

tively the isolation to which . . . [patients] . . . are liable, our open doors should be doors that swing both ways. Families, friends and employers must be encouraged to visit the patients, maintain the patients' community contacts. A breakdown in interpersonal relationships cannot be mended by separating the patient from the community to which he must return.”

While it may be true, concedes Detre in the same article, that family members are often as disturbed as the patients themselves, “. . . we fail . . . if we do no more than blame them for patients' illnesses. If we consider relatives as participants in a disturbed transaction, they must become part of the over-all treatment program.” The much-increased knowledge of family dynamics, he adds, can help both patient and family to decode each other's distortions, while new drugs and drug therapies “afford the patient sufficient comfort to tolerate this decoding process.”

Detre, presently director of psychiatric services at Yale-New Haven Hospital, views the need for inpatient care not only as the culmination of an intrapsychic process, but, in its broader and more sociological sense, as dramatic demonstration that a certain individual can no longer exist within a certain setting. “As most administrators are aware, the majority of mental patients land in a hospital because they are annoying or frightening those around them,” says Detre. For this reason, the T-1 approach has been to focus not only upon the illness itself, but upon the social context in which it occurred: the patient's most intimate environment, his family.

There is in many mental hospitals a prevalent belief that patients' conditions deteriorate after visits with their families; frequently, it is recommended that relatives should be politely but firmly kept away during the first four weeks of hospitalization. T-1's position is the opposite: From the moment of admission, it is made clear to the patient's family that they are expected to play an important role in his treatment. In the early weeks of hospitalization, the patient's close relatives are seen by a ward social worker on a regular basis. These interviews, taking place once or twice weekly (or daily, if the family is very shaky), help family members to clarify their own feelings about the patient's hospitalization. They also serve to give the staff some insight into how the family functions; and what understanding they may have of the series of events which finally necessitated inpatient treatment.

At the same time, the patient is seeing his therapist in small-group therapy (in individual therapy also, if this seems indicated; most often it does not, for the ward view is that some patients use it to "isolate" themselves). And both patient and family get together regularly, not only during visiting hours, but at large patient-family gatherings, so-called "family meetings."

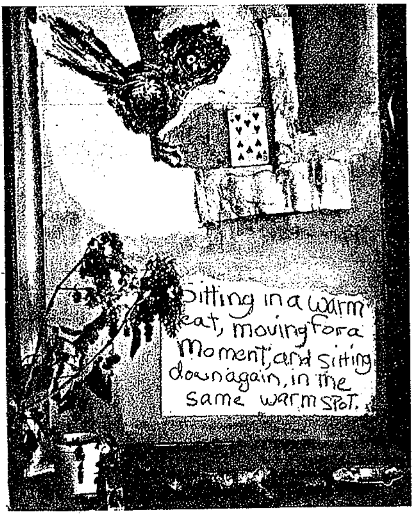
Family meetings take place twice weekly throughout the entire period of hospitalization. Led by a staff or resident psychiatrist, they are attended by patients, families, social workers, and generally a number of recently discharged patients, accompanied by their close relatives. Because the patient spectrum includes people in so many different phases of treatment, family meetings actually serve a variety of purposes. For the new family, the group is useful in providing orientation, in helping to draw them out and counter their feelings of isolation, and in offering reassurance that the acute phase of illness does subside. For families where the patient is further along in treatment, the group ideally serves as a sort of verbal reflector, pointing out to both family and patient the ways in which they interact, and what games they play. And finally, for the just-discharged patient making the difficult transition from hospital back to the community, the family meeting provides a safe place to return to, a place where the problems are known, and where one can talk out the early difficulties of readjustment. "Although the idea of these meetings often frightens relatives at first, they soon find them helpful," says Dr. Detre. "In fact, we've had cases where family members keep on coming back long after the patient himself has ceased attending."

MOST patients, after two or three weeks on the ward, have almost or completely suppressed symptomology; it is difficult to surmise what they might have been hospitalized for. (Indeed, visitors on T-1 are often under the impression that the ward only admits mildly ill people.) Once his symptoms are under control, and the patient seems generally able to communicate in a less agitated manner, meetings called "four-ways"—the "ways" being patient, family, psychiatrist and social worker—begin to take place.

The purpose of these meetings is to sort out the issues and difficulties associated with the onset of illness, to try to work out some of these difficulties and, if possible, to modify the way patient and family interact in attempting to handle them. "Of course, in the eight or ten weeks that a patient is hospitalized, we can't effect a major change in his family structure," allows Dr. Detre. "Nevertheless, the attempt is to return him to a somewhat more flexible environment, where at least some understanding of the problems has been gained."

Dr. Detre was director of Tomkins 1 for nine years: from the time of its establishment in 1960 until last June. (As the hospital's

SELF-EXPRESSION I—*A patient rehearses her skit for "The T-1 Follies," an entertainment scheduled for a "family meeting" of staff, patients and relatives to help "counter feelings of isolation."*


Sitting in a warm seat, moving for a moment, and sitting down again, in the same warm spot.

SELF-EXPRESSION II—*Collage, by a Tompkins 1 patient. "We don't stuff bunnies or make ashtrays."*

psychiatrist-in-chief, he still has the unit under his administrative charge.) In his early forties, of medium height, Detre is a man of immense personal force; a sociological study of the ward, carried out in 1961, described him as a "charismatic leader." ". . . And I've been called a number of other things," remarks Detre, with a perennial, amused half-smile.

"During the infant days of this ward, there was a great deal of criticism of our methods and our setup," he explains. "To many people, the mere idea of treating acute psychotics on a short-term basis, and in an open unit, seemed slightly preposterous. Then, there was opposition to the use of drugs —the drugs themselves were fairly new; the major tranquillizers had only come into use in 1954. Many psychiatrists, both in New Haven and at Yale, disliked them; they felt the drugs were a way of dealing with symptoms, and yet ignoring the long-term problems that existed."

Early objections to T-1 centered not only on drug usage, but on the demanding, pushy, behavior-oriented techniques of milieu therapy. Professionals in the area, more sympathetic to the goals of long-term intensive psychotherapy, disliked the intense social pressure brought upon patients in order to manipulate behavior and force them to suppress symptomology. Compelling someone to behave as if he were well, they argued, did not make him well in fact; and there was some feeling that the new ward was in effect, putting Band-Aids on deep wounds.

"Actually," points out Dr. Detre, fishing for a cigarette, "my own bias is that the hospital is not the place for dealing, at a fantastic cost, with the patient's long-term problems; I mean with the life history of his pathology. The only purpose of hospitalization, as I see it, is to end hospitalization, to restore the *status quo ante*, so to speak, the patient's level of functioning before the acute flare-up, so that it becomes possible for him at least to survive, to manage outside the hospital. And then to explore the long-term difficulties on an outpatient basis." For this reason, follow-up care is considered an integral part of the treatment scheme. Such care is arranged for every patient discharged from the inpatient service.

TODAY, almost 10 years after its establishment, Tompkins 1 wears a slightly more respectable, less radically experimental air. Drugs are, in general, no longer considered quite as objectionable: modified drug usage is practiced in many mental hospitals, as are a number of varying adaptations of the therapeutic-community approach. "Of course, we were by no means the first hospital to implement the methods of the therapeutic milieu," Dr. Detre says. "But ours was the earliest attempt to apply these methods to short-term treatment of acutely ill psychotic patients."

Unique in this country initially, T-1 is no longer the only unit of its kind in operation: hospitals such as Langley Porter in San Francisco, the Washington Psychiatric Institute, Fort Logan in Denver, Colo., have organized programs that are quite similar in orientation. Of the new hospital services opened during the past five years, a major proportion, according to Dr. Detre, "have been constructed along a model quite comparable to ours. I think this is part of a general shift which is taking place, a shift toward viewing the patient not only as an individual, but also as a part of a social system, a member of the society in which he lives."

Studies of Tompkins 1, and of its treatment methods, have been carried out with great frequency. Because the unit is a teaching and research ward affiliated with Yale Medical School, every aspect of its program is still subjected to constant scrutiny and re-evaluation. Aside from informal studies, there have been over 50 published investigations of the ward; these have included research on such questions as the relationship between sleep disorders and symptoms; how disputes among staff members affect the patient community, and even a paper on the tablemate choices of psychiatric patients as a guide for measuring social contacts.

During the past four years, Kenneth Keniston, associate professor of psychology at Yale and author of "The Young Radicals," and two young psychiatrists, Richard Almond and Sandra Boltax, have been engaged in a long investigation of the ward's social culture. Specifically, their questions have centered about the interesting notion that therapy on T-1 might be a process comparable to thought-reform or "brainwashing." Noting the application of intense social pressures to bring about changes in attitude and belief (so that "openness" becomes a more important value than that of maintaining confidentiality or privacy; "taking responsibility for others" becomes more highly prized than not interfering, etc.), Keniston and his associates devised a series of questionnaire studies that would attempt a measure of patients' values and beliefs at the time of admission, one week, one month, at discharge, and then 15 months later.

AT the end of one week on the ward, the researchers found, patients' values had already begun altering in the direction of the dominant ward culture. Agreement with such written statements as "each patient's major problems should be known to the staff and other patients" had grown considerably, while statements such as "patients shouldn't have to tell each other how they came to be on the ward" were increasingly rejected. This first week's swing toward the community value system was, for many patients, accompanied by the enormous discovery that with drugs, and the support of the milieu, it was possible to bring a good deal of bizarre behavior under control.

"We found that this trend, increasing acceptance of the ward's values —which revolve mainly around the themes of openness, taking responsibility, sharing problems and belief in the community — continued throughout the period of hospitalization," reports Keniston, whose questionnaire methods were supplemented by patient interviews and observations of the unit. "And this acculturation seemed to reach its peak, quite consistently, right around the time of discharge."

Fifteen months later, however, in a follow-up study of the same group, it was found that patients' attitudes had undergone changes in the reverse direction; they were now actually fairly similar to what they had been before admission. Thus, although some selective "brainwashing" or value change did seem to be taking place measurably during the course of therapy, it was, in Keniston's words; "relatively specific to the ward and the life within the therapeutic community."

Of the 59 patients contacted during the Keniston-Almond-Boltax follow-up study, none were in the hospital. (Neither were four other patients included in the original study, who had moved out of the area in the year-and-a-half interim.) "As a group," says Keniston, "we found them doing awfully well; they do feel improved. Out of the 59 people interviewed, 49 were working full-time, 7 weren't working, 3 were working part-time.

"Of course, T-1 tends to be a middle-class ward, which means in plain words that patients are likely to have a better stake in the outside community—better living conditions to return to, careers, schools. But still, when I look at some of these diagnoses, and at how short the period of hospitalization was, and then think what a really major accomplishment it was 20 years ago, just getting someone discharged from a mental hospital at all . . . Well," he smiles, gives a little shrug, "I'm impressed." ■

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