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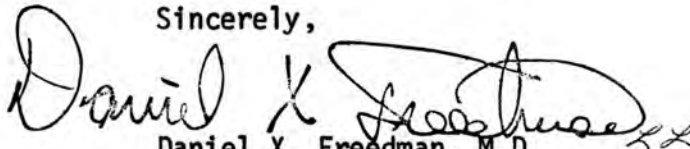
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Sincerely,


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P.S. Please return revised manuscript in triplicate (1 orig. + 2 copies)

PATIENT-PATIENT STAFF CONFERENCES

By Eric Berne, M.D.

This report tries to answer the question: "What is the best way, for curative purposes, to conduct a 90 minute meeting on a therapeutic community ward with a changing population of 15 to 30 patients?" A solution is offered which is the result of four years of trial and error. It is a systematic approach which is also an excellent teaching demonstration.

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PATIENT-PATIENT STAFF CONFERENCES

By Eric Berne, M.D.

For the past four years, the writer has been engaged in solving a specific clinical problem: What is the optimal method of conducting "therapeutic community" ward meetings? Such meetings are generally of three types. (1) Administrative discussions regarding the conduct of the ward, and individual privileges and restrictions. These may be called "ward meetings." (2) "Group process" confrontations, expressions, and reconciliations among patients and staff, and between the two categories. These may be called "process groups." (3) Meetings devoted to the alleviation of symptoms and the cure of psychopathology in individual patients. These may be called "treatment groups."

All three of these contribute to the welfare of the patient, and may therefore be called "therapy groups." There is a decisive difference, however, between the first two and the third. The ward may be compared to a beehive, where it is necessary to have a well-structured honeycomb in order to harvest the final product, which is honey. In the same way, it is necessary to have a well-run ward in order to get the maximum yield of the final product, which is therapeutic relief. Ward meetings and process groups are primarily to improve the milieu, morale, and ambience. But that is not enough. Within this matrix, it is still necessary to deal specifically with individual psychopathology. Otherwise the readmission rate will continue at a high level, and the ward ^{may} ~~will~~ be merely a superior country club or summer camp to which the patient can retreat again and again

in the winter of his or her discontent. Running a good ship may help to win the battle, but there is more to it than that, and the treatment group is the battle. This article deals with the treatment group, whose task is cure or permanent alleviation for each patient, so that he or she will not require nor request readmission.

Ward Populations

Therapeutic communities are of two kinds: stable, with a more or less fixed population, and unstable, with a largely floating or transient population. Fixed populations, in this sense, occur in state hospitals, veterans' hospitals, and correctional institutions, where patients or inmates stay (theoretically, at least) either for a fixed period or until they are well. This has the advantages that small closed groups can be set up, and the therapist can plan his treatment on a monthly, trimester, or even semester basis, with considerable assurance of bringing it to a successful conclusion and discharging most of his patients in suitable condition to carry on productively for the rest of their lives. If the therapist is well-trained and competent, this eliminates "making progress" in favor of "curing."

The unstable population is more of a challenge, and typically is found on the psychiatric wards of general hospitals, where discharge and readmission frequently occur because of extraneous factors irrelevant to the patient's recovery, such as finances or the insistence of relatives. In fact the patients themselves may become very skillful at arranging their discharges and readmissions, and learn the various behavior patterns required to be sent home, transferred to a state hospital, or readmitted. This is certainly not the most produc-

tive use of their intelligence and perceptiveness. (More about that later). In some cases, the patients on such wards are under the supervision of a referring physician, who can and often does discharge them with little or no notice to the hospital staff and the residents who are treating them. The net result of such influences is a special curve of distribution of the ward population, with daily and seasonal variations in number of patients, diagnostic categories, and length of stay: a few who stay for a long time (two to six months, for example); some who stay a shorter time (three to eight weeks); and others who flow or flit rapidly in and out (one day to three weeks).

This uncertainty poses very special treatment problems. The ward can be kept running smoothly enough by ward meetings and process groups, but planning psychotherapy for the individual patient is subject to a high degree of hazard. In fact, it makes each treatment group session a separate entity requiring its own closure, and calls for efficiency (doing as much as possible in a fixed period of time) rather than effectiveness (getting the job done no matter how long it takes)¹. By the same token, however, it makes each treatment session a well-circumscribed event, with more possibility of precision, incisiveness, and cogency. The main things to be avoided are vegetation and boredom on the part of either the patients, the therapist, or the staff.

Staff-Patient Staff Conferences

In a previous report² I recommended a policy of holding staff conferences in the presence of the patients. Subsequent experiences of others as well as myself confirm the therapeutic advantages of this.

(1) The patients feel like real people instead of second-class cit-

izens. (2) Even very disturbed people learn that they can sit still, listen alertly, and think clearly for an hour or so: a "small cure" which gives them back the feeling of what it is like to be well, and demonstrates that they are capable of returning to that state. (3) Instead of being observed silently by faceless authorities, and then talked about in secret behind their backs, they can listen to the staff members and form real judgments about them. They not only know what is planned for them, but understand why and by whom. The staff-patient relationship is reduced from a kind of paranoid nightmare, where the staff manipulates the patients (often while talking about the patients' "manipulativeness"), to a matter-of-fact professional situation with full disclosure. (4) The staff learns to speak in a way that can be understood by laymen. (5) The residents lose their fear that the patients will be damaged by straight talk. (6) Since this is a direct and real confrontation between staff and patients, rather than a performance by the patients for the benefit of the staff, and vice versa, boredom on both sides is almost abolished. "Almost," since some staff members may withdraw because their anxiety in such a situation begins to exceed that of the patients.

The Question

But this procedure still leaves unsolved one of the basic problems of ward meetings, where there may be 20 or 30 patients present. The first function of any clinician is observation, and in group treatment the rule is this: the therapist has the duty of observing every movement of every muscle of every patient at every moment during the group session. Experience shows that it ^{becomes increasingly difficult} ~~is almost impossible for anyone~~ to fulfill this requirement ^{as the number of} ~~if there are more than eight~~ patients in a

rises above eight.
 group. Whenever the therapist misses something, he is from that point on working with incomplete or even inadequate information, and so cannot do his job as well as he might. The more patients in his group, the more he has to compromise his standards. *The smaller the groups (down to eight) the better.*

Now let us restate the question in its most specific form. "What is the best strategy, for curative purposes, in holding a 90 minute meeting on a ward with an unstable population of 15 to 30 patients?" It seems likely that for the best results (1) the therapist should know exactly what he is doing, and (2) all the resources available should be used at each meeting as nearly as it is possible to do this. These resources include not only staff talent, but also patient talent, which should not be allowed to go to waste. Since the patients are speaking from first hand experience, we can assume that they have something valuable to say, and experience shows that they do indeed. The writer was given an opportunity to run an experimental group once a week over a period of several years with these considerations in mind, and believes that he has found the optimal answer to the question. This was the result of trying many different plans and approaches at the McAuley Neuropsychiatric Institute in San Francisco¹. True, the wards there enjoy a greater degree of stability than in many other places, since once a patient is placed there he is firmly under the control of a staff which is highly trained at all levels. But the approach selected and tested over a long period has also been found productive in other environments.

¹Michael Khlentzos, M.D., director.

The Solution

The procedure is as follows. The patients, whatever their number, are divided before each meeting into two equal groups by cutting the alphabetical roster at its median point. This ^{is one way of getting a} ~~tends to give a~~ clinically random selection of patients in ^{two "small"} ~~each~~ groups, and is better than sorting them by age or sex, which gives in effect two "homogeneous" groups with different interests. The aim is to keep each group as heterogeneous as possible, and a "random" sorting system bypasses homogeneities of diagnosis, length of stay, and other relevant factors.

There are three circles of chairs. Group I, the treatment

group, sits in the inner circle with the therapist. Group II, the patient observers, sit in the second circle. Group III, the staff members and visiting clinicians, if any, sit in the third or outer circle. The treatment group is, or should be, the most decisive for the welfare of the individual patient, of the three types of therapeutic community meetings, since it deals systematically with specific psychopathology. It should therefore be conducted by the most competent group therapist on the staff of the ward or institution. Hence it becomes a teaching instrument, for which it is admirably suited because of its necessary crispness. For that reason, other members of the staff and outside clinicians are likely to be sitting in. If they are (and we will assume that they are), their talents should also be fully and economically exploited. (The implication that treatment groups are a desirable matrix for dealing with specific psychopathology will not be dealt with here, since it is extensively discussed in the literature.³ We will beg the assumption that group treatment "is good.")

During the first 45 to 60 minutes, Group I is conducted as a regular treatment group, using a vocabulary that is understandable by both patients and staff. A good rule here is to use only words and sentence structures that should be understood by an eight year old, or even better, by a five year old. After that, Groups I and II change places, with or without a stretching break. But there must not be a coffee-break. No coffee or other food or beverage is allowed until the meeting is over, as that breaks the continuity and distracts the drinkers from the matter in hand. If the therapist himself needs coffee, something is wrong, and he is in the same position as a surgeon who needs coffee after excising one tonsil. Group II

then functions as a clinical conference, discussing the proceedings of the treatment group under the leadership of the therapist. Every patient in Group II is required to speak to the point. After that has taken place, each member of the staff (if any) in Group III is required to make some observations. This requires (a) a firm sense of timing, so that everything can be fitted into the allotted period and (b) considerable clinical skill and diplomacy to keep the observations pertinent and concise, and to "extract" statements from those reluctant to speak, who may range from depressed or sulky patients to shy and apprehensive student nurses.

INSTRUCTIONS →

The initial instructions, repeated at the beginning of each meeting for the benefit of newcomers, are: "I am Dr. X. The people in the inner circle are the patients, ~~and~~ They're going to have a group treatment meeting. The people in the other circles are not supposed to say anything until their turn comes. They're supposed to watch and listen to what happens, ~~and~~ When their turn comes later, they're supposed to say something that will help the patients in the inside group." Groups I and II, of course, switch positions at alternate meetings. *The therapist sits throughout in the circle of chairs between any two patients.*

During the treatment meeting, there are seldom any interruptions from Group II. If there are, the therapist says: "You're not supposed to talk now. Your turn will come later." So far, this has almost always accomplished its purpose. Even the most disturbed patients find that they can sit quietly for an hour, with the exception perhaps of someone with acute mania or senile agitation. Occasionally, a new patient in a state of screaming combativeness will be kept out of the meeting. Hysterical spasms and schizophrenic mut-

tering are acceptable. They are ignored at the time, to be dealt with at the next meeting, when Group II becomes Group I.

In order to produce the best results, the meeting must be conducted with maximum firmness of purpose. Far from upsetting the patients, this is appreciated by them, and many of them come up afterward and say "Thank you." For example, the first question which may be asked (by a new patient) is: "What's the difference between a therapy group and what you call a treatment group?" This question is welcomed by the therapist, since it puts matters on a proper footing right from the start. The answer given is: "A therapy group is where you make progress. A treatment group is where you get well." Usually one of the more experienced patients will give forth with this answer, and ~~that~~ is even better than the therapist saying it. For many patients, it is the first time that getting well instead of just making progress has been proposed to them, and the idea penetrates with considerable impact.

STRUCTURING
THE MEETING

→ So much for strategy. Tactically, the time is structured in a pragmatic way so as to produce visible and audible results. Anyone who wishes can begin to talk, and if the resulting transactions are sufficiently meaningful, the conversation is allowed to proceed until the therapist intervenes with a solidly based confrontation or interpretation. If the transactions are banal or spurious (Isn't it awful; I'm a lot better; Gee you're wonderful, doctor; Me too), the therapist interrupts at the first pause and turns to someone else to say: "What about you?" In doing this, he selects the patient who seems most ready to get better that day, and if occasion arises, he will so state. If, for example, a depressed patient is resentful because her reit-

erative complaints are interrupted, the therapist says: "Well, I don't think you're ready to get better to-day, and I think he is, so let's listen to him for a while instead." This has a strong positive effect, since it demonstrates to the depressed patient as well as to all the others, what readiness to get better looks like and sounds like.

Even "feelings," when they are banal or spurious, are interrupted if indicated, since the purpose of ~~the~~^{this} group is not abreaction or "self-expression," but cure, which is quite different, as Freud decided more than half a century ago. Genuine feelings, however, are treated with respect. When they occur, everyone present can see the contrast between them and the banal or spurious ones. In this connection, "banal" means feelings expressed as an act of compliance with the demands of the staff (Aha, so you really are angry underneath!), and "spurious" means feelings expressed as a demand for something from the staff (Are you just going to sit there while I'm suffering?)

THE INITIAL
PHASE →

If no one begins spontaneously, the therapist has two alternatives. He can ask: "Who wants to get well to-day?" He chooses the most likely candidate from among the volunteers. This is a self-selecting procedure, since the patients who don't volunteer aren't ready, otherwise they would volunteer. If after listening briefly he decides (not "feels") that the selected patient is really not ready to get better that day, he so states. "Well, I don't think you're really ready to get better to-day, so let's listen to what (another volunteer) has to say."

The other alternative is to pick out the most likely candidate by inspection. In either case, he first asks: "What's doing with you

to-day?" in order to get some perspective on the psychopathology.

Once he has that, he poses a more specific query: "How did you get in here?" This is an open question. If it is answered relevantly, he goes on to the next question, but if it is not, he interrupts to ask: "I mean what did you have to do to get in here?" The answer sought for is transactional and not descriptive (I was depressed) or procedural (The doctor sent me). In order to get an answer of the type desired, he may have to focus in with the third form of the question: "What did you do to make someone else (doctor, parents, etc.) nervous enough to send you to the hospital?" In this form, the question is thought-provoking and hence therapeutic for all but the most autistic or retarded patients. It is particularly appreciated by adolescents, who usually like "straight talk."

He then goes on to: "What ^{do you want to get cured of?} ~~is hurting in you?~~" ^{This is called "making the therapeutic contract,"} ~~After that comes~~
 After this has been set up in a workable form, he asks
 the crucial question for all hospitalized patients: "Do you want to get out of here, or do you want to get well?" Sometimes it is not necessary to ask this (with some new patients it may even be undesirable), as it may already be obvious to most of the people present -- staff and more sophisticated patients alike -- that the patient does not want to get well, but only wants to get out of the hospital. In such a case, ^{that} ~~the~~ patient is dropped in favor of someone else. The point may be hinted at without a direct confrontation by asking: "Haven't you been in here before? How long ago was that? If you go home now, where do you expect to be six months from now?" These questions can be asked in a way that will stimulate rather than alienate the patient, and may even make him change his mind by the next session.

THE GROUP → PROCESS

The transactions of the meeting are divided into two classes¹: major group process (between therapist and patient) and minor group process (between two or more patients). Minor group process is allowed to continue only so long as it can be generalized for the benefit of the other patients, or continues to be revealing about one of the speakers. E.g., "You see how she managed to get four of you angry in less than one minute," or "How come everybody rushes to your defence?" If indicated, the therapist may clarify this: "Oh, you don't see? Well, all of you heard what she said. Here's how she did it," etc. Major group process is preferred because with a patient who really wants to get well it can ^{nearly} always be generalized. ^{"Well, now she's told me the} ~~"You see how the~~ things her father said to her when she was ^{you can see how they} little, ^{making a contract with me} make her behave the way she does now." "So you're ~~going~~ to stop killing yourself even though your mother kept telling you to drop dead when you were little." Such observations will almost always elicit "workable" responses from others in the group.

Game-playing (e.g., Why don't you...Yes but) is allowed to proceed if it promises to lead to some insight. Otherwise it is interrupted. "Pastiming," as it is known colloquially to transactional analysts, is treated the same way. Pastiming means an irrelevant monologue or dialogue about some "theme:" an extraneous subject, or the past, or the future, with other people chiming in with Me too, I feel the same way, I saw that program too, etc. No doubt such third and fourth derivatives of the central problem of the patient can be interpreted by a clever therapist, but they are not the quickest route to symptomatic cure or permanent stability. What the therapist strives for in this situation are direct statements or first derivatives. The

interruption of games or pastimes, when deemed indicated, is worded as follows: "Talk about what's in your head, right here, not about what's outside." If the speaker appears dense, he is asked: "Are you on medication or shock treatment?" If he is evidently partially disabled temporarily by such treatments, he is very sympathetically dropped in favor of a better candidate.

At this point, the group has been set up so that productive treatment can proceed. In this first five to fifteen minutes, three important facts have been established (not "hopefully," but actually).

a. That the therapist is seriously committed to getting someone well, that in spite of his commitment he has a light and receptive touch, and that he is straight-talking but not "heavy" or threatening.

b. That there are some patients who are more interested in getting well than in just making enough "progress" to go home.

c. That straightness and self-concern will be reinforced, while crookedness or obtuseness will not. (More about obtuseness later).

THERAPEUTIC
OPERATIONS

→ The therapist now proceeds with his chosen method of therapy. The requirements are that everything he says must be understandable to all the patients, which means the elimination of polysyllables, while at the same time the vocabulary must be precise and technical enough so that the observers can make fruitful observations. To meet these requirements, he must use verbs and simple nouns and not adjectives and abstractions. Adjectives such as "hostile" and "masochistic" are accusatory, while abstractions such as "relationship" and "communication" are too vague to be of any value. That is, unless the patients understand what is a "non-relationship" or what is

"non-communication," they cannot grasp in a meaningful way the purport of the positives. In general, no words are used which cannot be defined by exclusion. Verbs are ideal for this. Thus "hit" excludes "not-hit," and "walk" excludes "stand still," "run," "fly," etc. ^{On the other hand,} "passive" excludes "active," but what if the patient is actively talking? "Dependent" excludes "independent," but what if the patient independently struck a nurse the previous day? Such ^{poorly defined} words may (or may not) mean something at a secret (sic) staff conference, but they are only confusing to a confused patient.

There are several psychotherapeutic approaches which meet these requirements. The most fruitful of these, in my experience, is transactional analysis³. One of the basic tenets of this system is that psychopathology in the neuroses and psychoses is largely the product of, or at least is enhanced by, parental programming. This gives an immediate therapeutic indication: find the antithesis to the specific parental programming and the patient will rapidly (e.g., today) make a therapeutic jump. If this approach is used, then the first specific intervention is a question: "What did your parents say to you when you were little?" If the patient gives an editorial answer, the therapist insists that he give a direct quotation instead. When he does, he is asked how old he was when his parents said that. If he was over eight, the therapist says: "That's OK, but I mean what did they say when you were real little?" Then he asks which parent said it, and most important, what the patient's response was. If the quotation is not directly relevant to the patient's attitude in the group or to his complaints, the question is rephrased: "What

did your parents tell you about life when you were little?" If a significant answer is still not forthcoming, it is rephrased again: "What did your mother say to you when she got angry?" or if necessary, "What names did your mother call you when she was angry?" E.g., "She said I was stupid (silly) (told me to drop dead)." "Oh, so that's why you were afraid you would sound stupid (silly) (you attempted suicide). You've still got a tape-recording of your mother saying that, in your head," etc. The interview then proceeds along the lines of transactional analysis as outlined in works on that subject³, with the other patients chiming in ad lib.

The therapist leads the patient boldly past his inhibitions, nostalgias, and anxieties, cutting forthrightly through the first lines of passive resistance until the patient is forced to take active measures in order to preserve his neurosis, psychosis, or non-adaptive behavior patterns such as violence or addiction. These active preservative measures will take the form of transactional games, heralded by "Yes but" and other resistive clichés. The therapist allows these to gain some momentum and then stops them in the most direct and economical way by asking matter-of-factly without any hint of rancor or exhortation: "Are you going to let me cure you?" He insists that the patient give an unqualified yes or no answer to this. If the answer is "Yes," then the momentum can be redirected to good advantage. If it is "No," the therapist asks: "Why not?" If the answer to this is "workable," he continues with that patient. If it is not, he switches abruptly to someone else, leaving the patient "leaning forward" as it were from an untenable position. In that case, the patient's need for closure can be exploited at some later individual or group session. These

aspects of the technique are a challenge to the therapist's education and skill.

This phase stops fifteen minutes before the hour. In the next stage, every patient in the treatment group who has not spoken so far is required to say something. Phrases such as: "Good morning," "Something," etc. are gravely accepted and the patient is then requested to say something else. The sequence of pressure here is: "Say something else." "Would you say something else?" "Would you please say something else?" "You have to say something else." The sequence is interrupted if the patient shows symptoms of weeping or rage, or if he says: "Please." ("Please, I'd rather not," or "Please don't make me.") If there is an absolute refusal, the therapist turns abruptly to the next patient.

THE OBSERVER
GROUP

→ This terminates the treatment group. If a patient starts to talk as this point, he is listened to politely until he pauses for breath and is then asked to save it for next time or to tell it to his own assigned therapist. The treatment group and the observer

group are now requested to change seats. The therapist does not repeat this request. Confused or reluctant patients are dealt with by other patients or by the ward nurses. The therapist remains where he is, and now says:

"You're the observer group. You're not supposed to talk about yourselves. You're supposed to say something that will help the people who were sitting here before."

He then requests one of the more experienced patients to lead off. The second speaker should also be an experienced patient. In this way, the inexperienced people can learn what is expected of them. Every one of the observers is required to talk. The willing ones are handled as follows: if they make a concrete suggestion in the third person (e.g., "He should move into a new apartment"), they are requested: "Tell it to him." They must then address the subject in the second person imperative, using his name. "John, move into a new apartment." If an observer begins "I think..." or "I feel..." he is cut off with: "That's talking about yourself, how you think or feel. Talk about him." "OK. John seemed to be angry at his room mate." "Did he seem to be angry, or was he angry?" "OK. John was angry at his room mate. The best thing would be for him to move out." "All right. Tell him that." "John, I think you should move out." "If that's what you think, then tell him straight out." "John, you should get your own apartment." (John): "Thank you." (Therapist): "Thank you." If an observer starts off with a pertinent discussion rather than a suggestion, the therapist listens carefully and then says: "Very good," adding any comments he deems

advisable. He goes on: "Now what do you have to say that will help him?" and the dialogue proceeds as before. An observer is permitted or encouraged to discuss as many of the patients as he wishes, as long as what he says is pertinent and ends with a concrete suggestion. There is often a tendency for all the observers to focus on the same patient, not necessarily the one the therapist spent the most time with. If this happens, the last few observers are requested to talk about some of the others.

GAMES AND
RESISTANCES

→ There are several common resistances or games which come up at this phase. Me Too and Doesn't Everybody are cut short. "Maybe you do feel the same way as John, but that's talking about yourself. Talk about him." "Maybe everybody has measles, but telling someone that doesn't cure him of it. Say something that will help John." Little Old Me and Gee You're Wonderful in all their variants are dealt with equally firmly. "Gee, I don't know anything about psychiatry!" -- "But you know something about human beings because you are one and you've been living with them all your life. Say something that will help John." "But I'm not a doctor!" -- "But you're a human being.." etc. The converses, "You know a lot more about it than I do, doctor," and "You're the doctor!" are turned off the same way, in each case ending with the very firm request: "Say something that will help John."

Obtuseness and its variations are likewise declined. "I wasn't really listening while they were talking." "Well, did you hear anything anybody said?" ("Well, yes." "Then say something about that.") ("No." "Aw, come on. You heard something." "Well, yes. John said...") "I don't know, doctor." "What is it you don't know?" "I don't know

what to say." "Well, tell me one thing you heard," etc. "No speak English." "This is the fourth time in a row you've said that, so by now you must have something to say." "No speak English." "Say it in Italian (Spanish, Greek, Polish)." (Shrug). "Aw, come on." "Well, John hee wus angry..." etc. In this way the observers are encouraged, coaxed, or pushed into using their intelligence for the benefit of their ward-mates.

Clichés offer the most interesting opportunity for doing therapy with the observers. This is particularly gratifying with older vegetating people who may never have expressed an autonomous thought since they were young children.

"I think John should shape up and get a job to keep him busy."

"That's something you heard from somebody else, it isn't something you thought of yourself. Where did you hear that kind of talk?"

"I don't know. Well, John needs to use will power."

"That's something you heard from somebody else too. Say something intelligent that you thought of all by yourself."

"John isn't using his full potential."

"That's something you heard on the ward or read in a book." Think of something you actually heard John say today that you yourself had an independent thought about. That's what I mean by something intelligent. Something that comes out of what you observed and not from your parents or out of a book."

"Well, John needs to get away from that guy that bugs him."

"That's it. That's something you thought of all by yourself by listening to what John said."

(Smile) "You mean I'm intelligent?"

"Yes, sir. You thought of that all by yourself, didn't you?"

Since this may be the first autonomous statement the patient has made since he came on the ward, everybody else may be pleased and smiling along with him.

Adolescents are usually much more aware of parental programming than older people are and can be confronted more quickly.

"Don't root around in the trash people put in your head to find something to say. Say it like it really was." "Crap" or "garbage" should never be used in this sentence, and "trash" should not be used if there are blacks or chicanos present, as this is a historically painful word for them to hear, however innocently it is used. In that case, "weeds" is appropriate, as suggested by an adolescent patient. Its double meaning ("grass") also encourages autonomy, free not only of parental programming but also of druggie reactions.

THE STAFF
MEMBERS →

By this time, 75 minutes have elapsed, and every patient in both groups has made some statement (with only rare exceptions). The comments and dialogues from the observers are often more informative about their own individual proclivities than even the proceedings of the treatment group. It is now the turn of the staff members, who discuss both the treatment group and the observer group. No one changes seats at this point. The junior people are called on first (student nurses, for example, or visiting medical students, etc.). Then follows the ancillary hospital personnel (social workers and psychologists, etc., and the ward secretary, if there is one, the ward technicians and nurses who know the patients well), the psychiatric residents, and finally the visiting staff or senior staff members. By following this "European system,"² the junior staff members will ^{usually} speak more freely than if the senior staff members or

the most aggressive talkers go first. Every staff member is required to say something. If anyone declines, the leader says: "Well, you heard each patient say something, and they should have the privilege of hearing you say something." Regular staff members may be excused, however, since they are known to all the patients, and their reasons for not talking on one or other occasion are probably legitimate.

THE CLOSING
PHASE →

The final phase is the summary by the group leader. He states the treatment plan for the next meeting, or for the long term, for each patient in the treatment group, openly and without fudging. In the course of this, he may comment on what the observers or the staff members said. He omits comment on the poor observers and reinforces the good ones. He synthesizes whatever is directly useful from what the staff says, but does not spend time deferring to each staff member. Then he gives his own brief synthesis as a general reward to all for participating, after which he rises to signify that the meeting is ended. If he has done his job well, some patients will come up to thank him or to ask a question. He has left ten minutes for that and for his break, with or without coffee, before he starts his next group or other task. He spends little time idling, since his job is to get patients well and there are many people who need his services. This is part of his commitment and will not go unnoticed by his patients, giving his well-selected words added weight. His response to the "Thank you's" is "What are you thanking me for?" because it is important for him to find the answer to that question, and some day he might.

Results

Because of the many therapeutic factors at work in a therapeutic community, it is hardly possible to isolate in a rigorous way the influence of a single procedure. The responses of the patients and nursing staff to the patient-patient staff conference is uniformly favorable because of its visible and audible therapeutic impact on both "patients" and "observers." Among psychiatric residents, some are very enthusiastic and pay careful attention, others show a skeptical and sporadic interest, and the remainder find other things to do. Some visiting clinicians have shown a sustained interest and have adopted a similar procedure as a regular feature of their own practices.

SUMMARY

There are three types of meetings commonly held on therapeutic community wards: administrative, group process, and group treatment. The first two improve the morale of the ward. The third is directed toward specific individual psychopathology. This appears to be the most decisive in establishing permanent stability in individual patients so that they will neither request nor require readmission to the pleasant ambience established by the other two.

During four years of trial and error, an optimal strategy was established by the writer for conducting his treatment sessions. This answers the specific question: "What is the best way, for both curative and teaching purposes, to conduct a 90 minute meeting on a ward with a changing population of 15 to 30 patients?" In such a situation, each meeting is set up in a well-planned way calculated from experience to produce maximal results in both connections. The

patients are divided into two groups: patients and observers. By using some of the patients as observers, the best use is made of their talents and intelligence, which are considerable. Even very disturbed patients will function as competent observers, much to their own edification and gratification. *The therapist has the advantage of dealing with smaller and more manageable groups.*

The proceedings are carried out in a systematic way where the therapist makes periodic choices between dichotomous possibilities on a decision tree. Transactional analysis is recommended, but is not essential, as a therapeutic approach. Each patient gets the benefit of multiplied multiple therapy, both from his own ward-mates who understand him well in one way, and from the staff members who understand him well in another way. Among other benefits, the patients learn to think autonomously and to use their intelligence.

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