IN THE NAVY II

A Therapeutic Community at the
U.S. Naval Hospital,
Yokosuka, Japan.

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It’s now been 44 years since I was discharged from the Navy. As I look back at my experiences with the therapeutic community I can see how my involvement there changed the direction of my life. I was initially selected for duty on the psychiatric service because of my size. I was assigned to the “brig ward,” where a strange collection of Navy and Marine Corps personnel were sent largely because they couldn’t be managed elsewhere. Later I attended the psychiatric technician’s school and had a placement on Ward 55 which was being run as a therapeutic community, and from there to Yokosuka.

I’ve been able to use many of the skills I learned from those experiences in the classroom with children who come from disruptive homes and a variety of ethnic backgrounds, each with their own lifestyles and customs. Although retired, I continue to do substitute teaching, my fondness due in large part to the “people skills” I learned from this program.

Rodney Odgers

Fred Holle, Professor Emeritus of Art, Cañada College, California, was a staff psychiatric technician at the U.S. Naval Hospital, Oakland, California, where the original experiment was conducted by Captain Harry A. Wilmer, MC, USNR. Viewers of PETT’s online publication, “In the Navy,” will recognize his illustrations.

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IN THE NAVY II:

Therapeutic Community Program at the U.S. Naval Hospital, Yokosuka, Japan. 1956-58

This document summarizes the experiences of a program carried out at the Yokosuka Naval Hospital begun by a team who had been trained during the experiment at the Oakland California, Naval Hospital in 1955-1956. This experiment was described in a previous Online Document (In the Navy). There, a therapeutic community was introduced on the admissions ward by Captain Harry A. Wilmer, MC, USNR. Patients remained for a maximum of 10 days for diagnostic purposes, to begin to become acculturated to the hospital, and start a course of treatment. Rather startling results were seen in this brief period of time; physical and mechanical restraints, and seclusion were eliminated. Daily community meetings followed by a staff review, set the tone for the ward’s activities and became a forum where staff as well as patients could learn to deal with their anxieties productively and begin to a course of treatment.

A large percentage of the patients received in Oakland were evacuated by air from Yokosuka; many arrived in disturbed conditions aggravated by prior treatment at that hospital and during the long evacuation from the Far East in restraint and under heavy sedation. A team consisting of a psychiatric nurse, three neuropsychiatric technicians, and the writer, a clinical psychologist, volunteered to be transferred to Yokosuka. We wanted to see what could be done to humanize conditions on the psychiatric wards where emotional disturbances were first recognized, to help patients exert greater self-control of their behavior, and begin to take responsibility for modifying it. We thus were basically concerned with the process of acculturation.
Noted ethnologist Gregory Bateson, who served as a consultant to the Oakland project wrote:

Essentially, the problem for any repetition of this experiment would be a problem in personnel selection—to choose as commander of the experiment somebody for whom the forms of Navy respect have both pragmatic and esthetic value but for whom these forms are not necessary to alleviate anxiety.

All this does not mean that the experiment could only be repeated with “another Dr. Wilmer.” Somebody entirely different might play the catalytic role. The minimum requirement is affective integrity and a belief that this integrity will permit the identification of self in others. Lacking these characteristics, it is doubtful whether any psychiatrist can help the psychotic. With them, probably any individual automatically helps.

Here then, is an account of the replication of that experiment with the necessary modifications due to staff, mission and location of the hospital. The catalytic agent for this program was the team through its absorption and training of the existing psychiatric staff.

PAST EVENTS

I could feel myself getting more anxious as the PanAm flight left the runway at Honolulu’s airstrip; the next stop would be Tokyo’s Haneda airport. Now baring an aircraft accident, there was no turning back. Just a few hours previously, I had been “poured” aboard the flight leaving from San Francisco’s International Airport after an extended party with my Navy friends. Earlier, Oakland’s new Chief of Psychiatry, Captain Marion Roudebush, MC, USN, and his lovely wife, Nina, had treated me to dinner at San Francisco’s fabulous “Ernie’s” restaurant. The assistant chief and my friend, Captain Robert Deen, MC, USN, had presented both Harry Wilmer and me with handsome leather briefcases (the only one I’ve ever owned).

As I saw the last of the Hawaiian Islands disappear and nothing but the blue of the sea and sky of the Pacific on the horizon, I wondered what was going to happen. Many questions ran through my mind now that I was more sober. Had I bitten off more than I could handle? What if the others who were to join me as a team, didn’t show up? At the time I left none of the others had received orders—psychiatric nurse Lieutenant Commander Marion Wardell, NC, USN, and three psychiatric technicians, Hospital Corpsmen Second Class Rodney Odgers, William Hall, and Clyde Maxwell.

The Navy is run very much on variations of the “old boy” system centering on who you know and where they lie in the chain of command. Secondly, you soon learn to put nothing in writing or you might get courtsmartialed! I had just returned from spending a month in England with Maxwell Jones and others, accompanied by my colleague and friend, Lieutenant Commander Lina Stearns, NC, USN, the chief psychiatric nurse at the Oakland Naval Hospital.
We had stopped off in Washington, D.C. for a few days to finalize the visionary project. We had met with the Navy’s Director of the Nurse Corps, Captain Leona Jackson, NC, USN, Lina’s friend. At her home over dinner one evening, we had discussed the possibility of Marion Wardell’s transfer from Oakland to Yokosuka. Ms. Jackson assured me that this was no problem (in due time), however, she could not guarantee that once there, the hospital’s nursing chief would assign Marion to the psychiatric unit. I would have to convince the chief nurse of that detail. I had met with Captain George Raines, MC, USN, the Navy’s Chief of Psychiatry and discussed the proposal in some detail. He was in general agreement but reminded me that he could not assure me that Yokosuka’s psychiatry chief, Captain Ira C. Nichols, MC, USN, would be receptive to the idea. He was getting along in the years, was known to be a rather reasonable but independent psychiatrist with Board certifications. And because of his seniority, he was in addition, the executive officer of the hospital, which placed him number two in the power structure. I would have to “sell” him on the idea.

I went over the plan with Rear Admiral Bruce Bradley, MC, USN, my former commanding officer at the Oakland Naval Hospital, now the Navy’s Deputy Surgeon General who was enthusiastic about the idea; as we parted he told me not to hesitate to get in touch with him if there was anything he could do personally. He made an appointment for me with the head of the Navy’s hospital corpsmen division to get the psychiatric technicians from Oakland transferred to make up the team. Those assignments, however, I found out were not made in Washington, but rather from the medical command for the Pacific located in Honolulu, at the office of Commander M.P. Huber, MSC, USN. But, I would first have to get the corpsmen transferred from the West Coast’s medical command located in San Francisco. The hospital corps commander gave me the names of the two key players for the transfers. I’d followed through with the requests, and was assured the matter would be handled “in due time.”

I had found the pieces, now would they all fit together? And I was beginning to wonder when “due time” would commence.

This was also a new situation for me as I knew no one personally at the Naval hospital or no one in Japan. The clinical psychologist who I was to replace had left. I had nothing to go back to; previous assignments on submarine patrols, or aircraft carriers had been temporary ones, but they were specific and authorized—furthermore, I had had a home base to return to with people I knew and worked with. Now I was on my own to enter a rather ambiguous situation, with so many unknowns. What would lie ahead for the next two years? The worst scenario was that all the plans would fall through and I’d be relegated to doing psychological testing, which I didn’t especially relish. But I’d resigned myself to that fate and should it occur, I would take as much time off to get to know the Japanese culture as I could.

At best, the scheme would come off: how, I wasn’t sure. After all, I was not a medical officer, or an MD, or a psychiatrist.
I arrived in Japan one morning on a day just between late spring and early summer of 1956. When I inquired at the air port’s military desk how to get to the hospital, the sergeant said that there was a bus in the afternoon that made the rounds of the military bases in the area, mainly the army’s at Yokohama and the Navy’s at Yokosuka. I can still recall the sights, the sounds, and the smells of that two hour bus ride through rice paddies, here and there villages with narrow and crowded streets; the binjo ditches on each side which carried raw sewage; the bombed out buildings, and the colorful costumes of the Japanese. This was after all less than ten years following the surrender and the nation was struggling enough to rebuild itself, let alone modernize. There were few motorized vehicles, most of them were three-wheeled. People walked great distances, took trains and busses to their destinations. And they wore white masks when they had colds.

The bus was not airconditioned and it soon became hot and humid; a gentle but persistent shower raised the humidity. The bus made numerous stops as the road was being repaired and there were crowds of people and animals blocking it. There were few in Western clothing; women wore dark blue baggy pants, the men tightly fitting trousers (“thigh pullers”), loosely fitting cotton jackets, strange shoes of black canvas tops shaped around their large toe, and wore colorful sweatbands to absorb perspiration.

THE YOKOSUKA NAVAL HOSPITAL.

Eventually the bus arrived at the gate of the Naval Base where a large blue and gold sign read: Commander, Naval Forces, Far East; there the environment changed abruptly. The base was well kept with manicured lawns and trees; there was an abundance of flowers; azaleas were in bloom surrounding the hospital. Small Japanese gardeners with bamboo ladders trimmed the trees with tiny scissors. The hospital which had been a Japanese military one, had wards on two stories emanating from a long corridor that ran the entire length of the hospital in the traditional telephone pole architecture. I was duly signed in and given two small rooms and a bath at the adjoining hospital’s bachelor officers quarters.

Timidly the next day I reported to Captain Nichols who greeted me very cordially and we exchanged pleasantries of where we’d been stationed, who we knew in common and so on. He didn’t seem to be at all aware of this great undertaking that was to take place
on his watch! He was a large man with a commanding appearance. He had snow white hair in a crew cut, receding at the temples, wore glasses that enlarged his eye balls and two of his front teeth were slightly parted. He had, as I was to learn over the next few months, a short attention span. While he appeared to be listening to you, he reached a point where he would interrupt and change the subject. It was no personal offense, just his manner. He wore the long white coat of physician and carried a little pad in his pockets which he would frequently get out and unobtrusively sketch people’s faces. I was also to find out he had a temper that could be activated without notice and I believed he struggled to keep it in control.

His next in command was Commander Al Fraser, MC, USNR, a well qualified psychiatrist who had been recalled to active duty for two years obligatory service. He seemed to be in charge of outpatient services for military dependents and civil service employees; he kept a low profile seeing them for diagnostic purposes and brief supportive therapy. There was an open ward just outside Captain Nichols’ office and a young medical officer was in charge of it.

On the floor below beneath the adjacent ward, was the locked ward that we’d heard so much about at Oakland. There, I soon found an ally and colleague, a young medical officer, also doing his obligatory service, Lieutenant Frank Rundle, MC, USNR, who was in charge. He’d recently been assigned there following a three months’ basic course in psychiatry at the National Naval Medical Center in Bethesda, Maryland. These medical officers were commonly referred to as “90-day wonders” in Navy circles. This was the man I would have to get to know and who would be the vital player of the team.

I can’t recall those first few days, but I was determined to get things going, to do something about these horrible conditions and the way patients were treated. There were no group meetings on either ward and no staff meetings. There wasn’t much I could do until the team arrived and I had no idea when that would occur. I was more than a little anxious and eager to get moving on the new project. But for now, two of the key people I needed to get to know were the chief nurse and the medical service corps officer who assigned the hospital corpsmen. I called on the chief nurse, Commander Ellen Dolloff, NC, USN, who seemed personable enough and soon found that she had not assigned a nurse specifically to the psychiatric service because there was none at the hospital with psychiatric training and quite frankly, she said that the psychiatry service didn’t want one. A nurse on an adjacent orthopedics ward came to the two psychiatric wards to give out medications but was not allowed to have a key to the locked ward as the hospital corpsmen did.

I became acquainted with the hospital’s medical administrator as he oriented me to Officer-of-the Day duties which would take place about once a month. I cautiously inquired how he assigned hospital corpsmen to the psychiatric service and he quickly told me that he chose most of them because of their size! None had had any psychiatric training.
One day Commander Dolloff told me she had a surprise for me: she’d received copies of orders that a nurse with psychiatric training would be arriving that I perhaps knew as she was coming from the Oakland Naval Hospital. Jokingly, Ms. Dolloff asked me if I could arrange to give the new arrival a key to the locked ward—if she did indeed, assign her to the NP service. After visiting her mother on the East coast, Marion Wardell arrived at the hospital.

And then I heard that our key NP technician, Rodney Odgers, had arrived, but mistakenly had been sent to the Navy’s infirmary at Sasebo, in Southern Japan. How could I get him transferred to Yokosuka? This took a call to Commander Huber in Honolulu, who said it could be arranged “in due time.” Rod finally arrived and then Clyde Maxwell and Bill Hall, the other two NP Technicians from Oakland appeared. Now the core of the team was assembled. I believe it was Marion Wardell who convinced Frank Rundle to designate Rod Odgers as senior corpsman for the closed ward which could be done due to his seniority and that he was a qualified NP Technician.

Electroshock and insulin were used and many of the patients were highly sedated. New admissions were sent to the closed ward, about 70 each month, who arrived from other parts of Japan, Okinawa, Formosa, Korea and ships operating in the Far East. They usually were checked in without having been seen by a psychiatrist; most had been seen by a medical officer who ordered them to the hospital, “for psychiatric observation.” Some had been sent from the brig as management problems. The hospital was designated as a United Nations activity and so personnel from other countries were sometimes admitted, for example from the Greek Navy, who spoke no English. Often patients were admitted in quite disturbed states, having hallucinations, having made suicidal attempts, or were combative. Most had not been told they were being sent to a psychiatric ward. Patients from other wards of the hospital and military personnel from the Naval base who became intoxicated while off the base were placed on the closed ward overnight due to lack of other facilities at the base to contain them. Sailors and Marines involved in administrative and legal action due to alleged homosexuality were admitted for evaluation. The closed ward had a capacity of 33 beds and there were three seclusion or quiet rooms which were lined with padded canvas. Patients wore pajamas, were not allowed to have matches or cigarette lighters, razor blades or breakable objects, knives or forks; only spoons were allowed to eat with.

The ward medical officer interviewed patients who had been admitted during the previous night at 7:45 the following morning and then held traditional medical sick call with patients standing at the foot of their beds. There was a small fenced-in recreational area outside where patients could shoot basketballs when corpsmen could be spared to supervise them. A movie was usually shown on the ward in the afternoon. The ward was not airconditioned, poorly ventilated, and became uncomfortable when the season was hot and humid.
THE NEW PROGRAM BEGINS

Goals.

The initial goals of this program, in addition to evaluating techniques developed in the Oakland project at an overseas hospital were: (1) to improve management on the wards by dealing openly with staff-patient tensions in the adjustment of patients to the hospital, (2) to prepare patients for continued treatment and hospitalization both here and elsewhere if they could not be restored to duty, (3) to encourage patients to begin to take an active part in their own and other’s treatment, (4) to eventually return more patients to duty from this hospital, and (5) to decrease the number of patients evacuated to the United States in restraints and to improve the clinical condition of those sent via air evacuation to other hospitals by developing greater self control.

When we began to talk about the experiment at Oak Knoll, the staff (three psychiatrists and 22 hospital corpsmen) were very skeptical. Frank Rundle was also but he listened and asked for details. Marion Wardell immediately made her presence felt on the closed ward by spending a good deal of her time there, talking with the hospital corpsmen, the patients, and participating in a meeting which was introduced mornings for them to become acquainted with patients who had arrived over night.

It was partly a matter of where “fools rush in,” and we were soon able to convince Frank to try having daily meetings on the closed ward, followed by a staff review. There was not enough space on the small ward to have a meeting of the patients and staff, so we double-decked the beds to clear an area which we also hoped could be used for some recreation.

We told the hospital corpsmen that we were going to change the ward management and place as much responsibility as possible on the patients themselves with the help of the staff and that we would begin to have a 45 minute daily ward meeting each morning followed by a 20 minute staff meeting. We expected all patients and the staff who were on duty to attend the meeting. At the first meeting, there were 26 patients on the ward, some had just been admitted the previous night, one had been there for six months. Twelve patients had been diagnosed as having schizophrenic reactions, three as having neurotic depression, one as anxiety reaction, and the remaining 10 as having character and behavior disorders.
OFF TO A GOOD START

Twenty-three patients, the ward medical officer, the nurse, six hospital corpsmen, the Master at Arms (hospital corpsmen supervisor) two Red Cross workers and I, gathered in the newly cleared area at the back of the ward. Three patients refused to attend and stayed on their beds. Dr. Rundle said the meeting was to talk about how the ward was run, to ask questions, and to bring up any personal problems anyone wanted help with.

The first patient to speak was the one who had been on the ward the longest (six months) and who was tacitly recognized as the leader by most of the patients. This patient asked why the radio couldn’t be located near the rear of the ward rather than at the nurses’s station and why the corpsmen considered it dangerous to have it in the recreation area. One patient, half sarcastically and with insight into some of the staff’s attitudes remarked, “We are all emotionally unstable and can’t be expected to control ourselves,” and then got up and nervously paced the floor for the remainder of the meeting. Another patient declared to the group that now that a nurse would be regularly assigned to the ward, the patients would have to watch their language. At another time a patient asked if a quiet hour could be observed, and after considerable discussion by the group it was decided that due to weekday activities such a quiet hour could be observed only on Sundays.

The general tone of the meeting was lively and at times several persons spoke at once. In addition, there was laughter and sarcasm, and some patients held private conversations with other patients and with staff members. The Ward Medical Officer interceded to encourage order and recognition of a single speaker. Throughout the meeting there was a display of real interest in improving ward conditions, but revealing personal feelings and problems was minimal.

At the first staff meeting, the hospital corpsmen said they felt that their authority on the ward and their means of controlling the patients was in jeopardy; the other staff were encouraged at the beginnings.

In the days to follow, the meetings grew in their openness. Talking about the restrictive conditions on the ward gave way to interpersonal relationships between the hospital corpsmen and the patients and between patients; finally personal problems of the patients began to be discussed. As at Oakland, the patients were initially more concerned with what was to happen to them administratively. Many were intent on getting out of the military which meant convincing the doctors that they should be transferred back to the U.S., the Oakland Naval Hospital specifically. A few wanted to return to duty, but hoped to get a new assignment which would be less stressful than the conditions that led to their hospitalization. Some patients, especially Marines were facing rather serious legal difficulties and hoped, with a psychiatric disorder, to get charges dropped or at least their sentences reduced. Many patients were frightened to be on a locked psychiatric ward.
and wanted to be transferred to the open ward as soon as possible. Officers who were seriously disturbed were sent to the closed ward until an evaluation could be made as to where they should be housed. For most of them that meant on a medical ward and Captain Nichols usually handled their cases personally. There were few female patients at that time and when one was admitted, she was housed on a medical ward and was not part of the community.

About six weeks after the community meetings had begun on the closed ward, we began similar meetings on the open ward which could accommodate 40 patients, and then we combined the two, bringing the patients from the locked ward to the open ward to meet together. We didn’t have enough chairs to seat the sometimes 100 or more patients and staff, so used blankets and sat on the floor Japanese style. The patients from the locked ward could get a glimpse of what it would be like for them on the open ward (patients wore uniforms or civilian clothing and most could leave the hospital grounds) and open ward patients could get to know those who would be moving to their ward. The staff reviews included those from both wards. The chief of nursing service, Commander Dolloff, attended the community meetings on a regular basis and when she was transferred to a new command, her replacement followed her lead. The chief nurse encouraged other nurses to visit the meetings, especially those on night duty on adjacent wards who had contact with the psychiatric wards. Red Cross staff and volunteer “Gray Ladies” became a regular part of the community. So now from an exclusively male culture, we had women in attendance which contributed a great deal to normal socialization.

Dr. Rundle was greatly impressed with the progress and after discussion in the staff meetings, instituted a number of changes. He announced that the quiet rooms would no longer be used and the staff converted them into space for other use. Shock therapy was discontinued and sedatives were reduced to an insignificant amount. Dr. Rundle introduced knives and forks on the ward and permitted the patients to shave unattended.

The hospital corpsmen who had been there the longest were terribly threatened even when they saw the effectiveness of the new program and the skill of the three NP technicians. Much of their anxiety was dispersed when off duty and at a Japanese bar named the “Skoshi” (Japanese for small) where they had for years congregated; many were involved with Japanese girls who worked there or frequented it. They had traditionally carried their tales to the bar and continued the practice rather than bring them into the staff meetings. Some were involved in black market activities with the Japanese.
Behavior of some of this group of hospital corpsmen when off duty was as disturbed as that of the patients.

We had a series of disturbances on the closed ward with patients who exhibited character and behavior disorders; one Marine made repeated suicidal gestures each time he was scheduled to return to duty to stand a courtsmartial. Several patients escaped by scaling the fence in the courtyard. The chief of psychiatry ordered the fence be made taller and in the meantime discontinue the practice of bringing the patients to the open ward for the combined meeting. By this time the patients had become reasonably integrated; many of the open ward patients showed great tolerance for some of the more disturbed ones, especially those with hallucinations. They asked if they could go to the closed ward during the day to be with them. I don’t remember how it started, but I ended up with a small group of eight to 10 of the patients who were causing the most difficulties in terms of “acting out” behavior and met with them daily in a small group with one of the corpsmen. They eventually became known as my “bad boys” by other staff in the hospital. Some of the doctors and nursing staff would inform me of their actions mornings at breakfast. In a few weeks after the disturbances on the closed ward ceased, we resumed the practice of combining the two wards and for the remainder of the next two years the practice was continued without interruption.

COMMUNITY MEETINGS: FORM, STRUCTURE AND CONTENT

The community meetings resembled those of the Oakland experiment, except that none of the staff had the psychoanalytic background of Dr. Wilmer. We provided a minimum of structure in the meetings whereby patients could evolve their own themes and content. Simple elements of form were introduced and maintained such as attendance, seating, consistency of time (length, opening and closing), minimizing distractions, and a summary at the close of the meeting.

We opened the group meetings with silence except when someone introduced new patients or a visitor. Barring an emergency, which was rare, we urged the staff not to open the meetings, but instead to reserve any matters that they wanted covered, for the last 15 minutes of the meeting; chances were that whatever they wanted brought out would have
already been covered. Sometimes there were prolonged silences and a few meetings when not a word was spoken. In those instances, one of us might comment at the close that it was unusual for so many people (120 at one time) to sit together without talking and that perhaps silence itself was helpful for it gave us a chance to be together and to think. We closed the meetings by one of the staff, sometimes a patient, summarizing what he or she thought had happened in the meeting and making some broad interpretation or underscoring matters that needed further attention and some where further questions were raised. There were a very few meetings when the time was extended to enable the community to deal with a crisis.

Movement in the community meetings followed a similar course to that of the Oakland experiment, in that it began with forming a structure in which patients and staff could communicate more freely and openly about their anxieties and interpersonal relationships. In the early phases of community building, a frequent theme was denial of emotional problems, especially by those who were seen as having behavioral and personality “disorders.” Their defense against looking at their own behavior was commonly projection onto authorities, to situations peculiar to the military (such as going AWOL or being involved in homosexual activity) or onto their comrades. Much of their acting-out behavior (assaults, theft, suicidal attempts) was hastened by getting intoxicated while not on duty. Liquor and narcotics were cheap, readily available, and congregating at bars was the norm. There were occasions when patients had been sent to the hospital when other means could have been used to resolve difficulties. Sometimes authorities wanted to get rid of them as they either didn’t fit into their Unit where they were seen as “strange,” or others were seen as “trouble-makers.”

Even when events were clarified and the patient began to understand his own role in his predicament, he might resist speaking or having his behavior discussed in the community meeting. The hospital’s ethos was that it would take the skill of a doctor to help him. At that point, Dr. Rundle might address a specific patient to point out that he was present in the group and asked what he could do to assist him? The issue of privacy and privileged communication was often raised in the early phases of the meetings. The expectation was constantly laid that all members of the staff could help patients, either directly or by referral. Patients who had been in the community longer were quick to address the issue and reassure newer ones that help was forthcoming from the group—patients as well as staff—if members could become candid and honest. One career sailor, for example, who had made a serious suicidal gesture showed the effects of a combined effort:

On the closed ward, under the unobtrusive supervision of the staff, the patients stood “special watches” over him and aided in his nursing care. Later, when this patient was ready for transfer to the open ward, he requested that he be allowed to remain on the closed ward in order that he might share in the treatment of the more seriously ill patients and thus discharge his “debt” to the community and show his gratitude to the group. Following extensive surgical repairs and physical therapy, this patient was restored to full duty.
On the other hand, the expectation had been developed in the community that all patients had this responsibility. It was accentuated when a patient went AWOL, took an overdose of narcotics and was found dead. In subsequent community meetings, patients revealed that some not only knew of his plans to go AWOL and had not alerted anyone, but had assisted him in carrying out his venture. The episode became a part of the communities’ history and was recounted at times when privileged communication became an issue.

Legal issues nevertheless were realistic and often difficult to deal with in the community due to its military setting. The staff did not officially have privileged communication. The issue was made more complicated in the second year of the community when the commanding officer, upon the recommendation of the chief of psychiatry, appointed me as the summary court martial officer for the hospital. This was the lowest court martial where the officer is prosecutor, defense, judge and jury over cases referred by the commanding officer. Many of the offenders referred were psychiatric patients. There were times when I would be in the community meeting where patients were attempting to deal with their problems and later, sometimes the same day, I would have to formally hear them and make legal decisions on their behalf.

And so there were occasions when “confessions” could have a deleterious effect on a serviceman’s career and, at times, were not encouraged in the community meetings. It was interesting that:

Often patients would seek private interviews to reveal their own infractions of rules, knowing full well that to do so was to invite legal action. In the community, it was emphasized that members must face their social responsibilities to the group, and that they should not seek to escape punishment by private revelation of guilt. Sometimes patients on the eve of their departure from the hospital would confess to having committed some illegal act, stating that they just could not leave without “getting it off their chest.” On occasion they offered suggestions as to how we could help other patients who engaged in such behavior, usually indicating that they believed the staff’s attitudes were too lenient.

Patients initially were concerned that even when they did begin to ask questions in the meetings the staff were reluctant to give them specific answers or referred their inquiries to the various groups. Here, we found Maxwell Jones’s experiences at Mill Hill useful:

Sometimes it was necessary to answer a question directly and concretely. This was so especially with questions concerning psychiatric illnesses, diagnoses, theories, and treatment. In such a case a simple, honest, direct answer was useful in educating patients, in clarifying misconceptions, in allaying anxiety, and in removing the shroud of mystery that so often surrounds such matters.
There were times when tempers flared and patients verbally attacked the staff or other patients. Once a patient tried to physically attack another patient but others quickly intervened. We hoped patients would assist one another when outbursts or withdrawal from the group happened; if none did, then a staff member would. One time a very angry, aggressive patient made loud attacks on the group and then left it. While the group was debating what to do, a young nurse who had been on duty nights for the ward and those adjacent and often attended the group the next morning, quietly got up, went after the patient and brought him arm in arm back to the meeting; she got him a seat beside her and held his hand gently for the remainder of the meeting while the group discussed his behavior. Previously it had taken several corpsmen to help him control his abusive temper when it erupted.

Aside from day to day issues involved in examining and perfecting relationships, there were meetings that took on mystical dimensions. Patients sometimes recounted their dreams, both current and from the past. A patient was admitted—I believe it was a Marine, who had been AWOL for a period of something like six months—with a diagnosis of “schizophrenic reaction.” As his story unfolded in the community meetings, he had gotten to know a Japanese family, probably through one of the daughters, and had disappeared from his Company. He had lived with the family in a remote mountain village and taken on Japanese customs, dress, food, and learned a great deal of the language. He was living in a centuries old environment totally isolated from present day civilization. I don’t recall how he came to the attention of military authorities, but his tale gripped the community and the question of him being courtmartialed for desertion seemed rather preposterous. And the more we learned of his former existence, the more difficult it was to put a label on his behavior. I remembered the dream similar in content to this patient’s reality, that a patient had told in a community meeting one day at Oakland which revealed his desire to return to a Japanese village as a potter.
It was about this same time that the chief of psychiatry referred a young Marine from the elite Tokyo Honor Guard to me for psychological testing and brief supportive therapy. As he told me about his difficulties with his assignment, it became apparent that he was on the verge of desertion; he too had become involved with a Japanese family as part of an affair with a daughter. “Madama Butterfly” was still very much alive.

STAFF REVIEW

The staff met to review the community meeting, and, in a similar manner to those at Oakland, began by constructing a seating chart, noting who opened the meeting, the predominant themes, the principal players, the tone, how it ended; and made forecasts or predictions.

Hospital Corpsman Rodney Odgers then met with the patients on the closed ward separately where they discussed how the ward was run and made plans for the rest of the day as to activities both on and off the ward. Sometimes other corpsmen and Marion Wardell or Frank Rundle joined the meetings.

We were concerned about the hospital corpsmen and their behavior and so began meetings for them one afternoon a week which Marion Wardell held with some of the rest of us attending on a sporadic basis. In time, these meetings resembled the tutorials for social therapists at Henderson. These meetings eventually became highly specialized training sessions and several of the hospital corpsmen were eventually certified as NP Technicians.

STAFF ROLES AND FUNCTIONING

As I look back on these experiences, if I had it to do over again, I doubt that I would have had the courage to assemble a team and attempt to make the changes that we set out to do. It was the kind of braveness that youth are blessed with. And also there was faith that it would work. But the conditions that we were beset with were more serious than any of us had foreseen. We did, however, have the model Harry Wilmer had built to begin with along with Max’s experiences both with military personnel at Mill Hill and at Dartford. At the same time I often wish that I could repeat the program knowing what I do now!

We were fortunate in every respect, nonetheless, no matter how precarious the situation was at any one time: the most crucial new factor was the presence of Frank Rundle who was goaded into being the leader of our team and learned on the job. He was basically dissatisfied with the way psychiatry was practiced and only had a basic introduction before being sent to this outpost. None of the other psychiatrists had experience in group methods. He was fully committed to the new program and many times placed himself in considerable jeopardy when he used his position to implement it.

The chief of service was an experienced and qualified neuropsychiatrist who had been an administrator for some years and was currently executive officer of the hospital. He did attend the community meetings on occasion and was readily available for individual consultation. The next psychiatrist in command was an experienced individual psychotherapist who attended to outpatients and

Corpsmen in a Naval hospital can function as variously as any crew of any ship. Under adverse conditions, when they are rebellious or their morale is low, they can consciously or unconsciously sabotage the best-intentioned program by the effect that their attitude has on the patients’ behavior and illnesses. Under other conditions they can have an amazing espirit de corps exceeding all expectations.

Harry A. Wilmer
diagnosis for special cases and did not attend our meetings. There were other young psychiatrists who were with us for shorter periods of time. Some entered into the program, others remained on the periphery. The community at times humorously referred to Frank and me respectively as the “cardinal” and the “bishop!”

The active support and presence of the chief of nursing service and her successor contributed a great deal to the team’s morale. In addition to her support, she was in close contact with the commanding officer and was able to interpret our program to him in general and at those times when we were working through difficult situations. The assistant chief also attended the community meetings often and sent other nurses to visit. Marion Wardell became an inspiration to all the staff, even the most recalcitrant of the older corpsmen who previously had no contact with nurses. The extent to which roles were blurred was apparent one day when a patient asked why Ms. Wardell didn’t see the female out-patients they’d seen waiting to see the assistant chief psychiatrist. He thought it might be easier for one woman to talk to another about her problems. During the second year of the program, Lina Stearns, then retired as the head of psychiatric nursing at Oakland, paid us a visit which contributed a great deal to sanctioning what we were doing. She boosted our morale considerably by telling us how the program was showing its effects on the improved condition of the patients who arrived there after being evacuated.

The hospital corpsmen were the cornerstones of the program—in time they became the equivalent of the social therapists that I’d met and seen in operation on my first visit with Maxwell Jones at Henderson. The three from Oakland became the models for the others. Rod Odgers had the greatest impact. After his meeting with the closed ward patients, he could frequently be seen on the ward, barefoot, with his pants legs rolled up, swabbing the deck with his “crew” of patients. And I had seen him eating with a paranoid patient who thought the food was poisoned; Rod would take a bite of the food and then offer another to the patient.

Along with Frank Rundle, we had acquired two sturdy and influential members in Hospital Corpsmen Second Class, Ben Geiger and Eugene Full. Ben was the Master at Arms for the psychiatric service which meant that as the senior corpsman, he was the administrator for the 20 or so corpsmen assigned to the service. Eugene was his assistant. Although both of them had no training in psychiatric nursing, they seemed to instinctively know what we intended and entered into the
program with commitment. They attended all the meetings and were influential in bringing some of the other corpsmen into the program, which was no easy task.

About midway in the program we suddenly received a number of corpsmen just out of hospital corps school who were conscientious objectors thus serving alternative service to combat. They were bright, devoted, creative individuals, some with college backgrounds, who entered the program with great enthusiasm and energy, which sometimes posed a grave threat to the older corpsmen—and to the hospital administration when they got carried away with their “creativity.” They were a “curiosity” to many of the patients who had never questioned their own values of military service or alternative “patriotism.” Here they were among us, these young men who would refuse to be placed in combat, yet were almost on the front lines, picking up the casualties.

Hospital Corpsman third class, Douglas Hicks, one of these corpsmen wrote:

[T]he role of the staff corpsmen as well as that of the patient has undergone many fundamental changes. Formerly, the corpsmen were primarily responsible for the security of the psychiatric wards. Now the emphasis has shifted, and a corpsman is more a friend and a model with whom the patient can identify and from whom he can learn technics of interpersonal relationships. The staff is encouraged to develop interests of their own which they may share with the patients, and in working together in activities that are mutually enjoyable, the role of the corpsman assumes a more therapeutic nature.

Along with the often frustrating and uncertainties of working in the program, there were external factors that couldn’t be discarded as they affected our personal lives. Some we could talk about in our sessions, others were best kept private. There were frequent “witch hunts” for example, by naval intelligence to locate military personnel who were involved in homosexuality. Undercover investigators commonly surreptitiously would “catch” one person and then hold him hostage to reveal others. There was one investigation in which the commanding officer of a ship was named and another close to home, centered on the hospital corpsmen’s barracks. Suspects would often be sent to us for “referral” which might determine whether a person would be courtmartialed or given a dishonorable discharge. Some made suicidal attempts when apprehended. One day the chief of service phoned me to come to his office to get a young Navy pilot “who likes to take penises in his mouth,” and test him to find out what was wrong with him. There were times when Frank and I had to be expert
In addition to the staff sessions, there was considerable socializing off duty. The staff needed little reason to throw a party, some were small, intimate affairs, others involved families and girl friends. Some were on the naval base, others were in restaurants and recreational places. There were also incredibly beautiful R&R resorts near by operated by the Japanese for retreats. General MacArthur’s former yacht had been given to the naval base and for a minimal cost, groups could engage it for a day to cruise the area and have food catered.

The hospital corpsmen were to become the prototype of the social therapists, a role that the correctional officers would later assume in the prison transitional therapeutic communities in California; the practice of patients in that role was in the embryo stages at Yokosuka; later prisoners would take on that role.

There were unexpected collateral duties. One day the commanding officer’s secretary informed me that I was to report to the commander of the Japanese Maritime Self Defense Forces office located in Yokohama. I found I was to be a consultant to them on psychological factors in morale, something I knew a little about, but not of another culture that was apparently so different; however, it was an interesting assignment as it brought me in direct contact with Japanese officialdom.

We had “inherited” Dr. Fukui, a Japanese psychiatrist from a nearby mental hospital who had been coming to the hospital once a week to learn about American methods of psychiatric treatment. He attended the newly inaugurated community and staff meetings, and although there were large gaps for him due to translation difficulties, entered into the new project with enthusiasm. When he invited me to visit his hospital I was frankly aghast when I saw semi-darkened ward after ward of patients “asleep” under narcosis as the major treatment along with Morita therapy that was widely used at that time. Both procedures were in direct opposition to what we were trying to accomplish.

Little did I know that only a few miles away, the great Zen master, Daisetz Suzuki, was practicing at his monastery in Kamakura. Furthermore when I found that little cottage to retreat to in the countryside, I was within cycling distance. This is one of the things I now would have done differently had I known of him—I’d have made my way to his doorstep!

EXPANSION OF THE PROGRAM

As patients remained longer than at the admissions ward experiment at Oakland, other groups and activities spawned. Most patients were eventually in small groups led by Frank Rundle, Marion Wardell, the three NP Technicians or me. A new patients’ group appeared from those who had been on the open ward longer where, over coffee, they oriented the patients on the closed ward as they arrived. Work groups were formed led by some of the hospital corpsmen and long-time patients. Creativity blossomed: a writer’s group put out a weekly newsheet and an orientation booklet. A Japanese language

As soon as words are used, they express meaning, reasoning; they represent something not belonging to themselves; they have no direct connection with life, except being a faint echo or image of something that is no longer here.

D.T. Suzuki, Essays in Zen Buddhism.
group was formed. One of the corpsmen organized an art group that met two evenings a week; the participants held an exhibition for the hospital. A drama group acted out skits and staged a rather dramatic play at Christmas. Patients kept liaison with those transferred to Oakland through their newsheet and encouraged some friendly competition with them to form their own.

Corpsman Douglas Hicks, who’d majored in fine arts at a professional school, organized the art group attended by both patients and staff, wrote:

Gentle persistent persuasion often brings rewarding results. On one occasion, one of the staff officers half-jokingly ordered two Marine patients to attend the meeting, as he noticed they were unoccupied on the ward. They apparently took this seriously and attended a meeting. These two patients were able to “save face” and join in the activities. Throughout their stay in the hospital they attended more regularly than many others and produced some very interesting art work... Most of the patients find the group extremely rewarding and purchase sketch pads to practice at other times.

Doug Hicks gave five illustrations of art work from patients and related their productions to their conditions. He called attention to the social function that the group served:

[A]n art exhibition was held in the Red Cross lounge, complete with refreshments and a judges’ committee composed of a professional artist, a patient, and a staff psychiatrist. Prizes were awarded and over 100 visitors, including patients from other parts of the hospital, attended the showing. All the psychiatric patients from the closed and open wards were allowed to attend the exhibit. This provided them with an opportunity to mix with others in a social setting, which was considered important in their treatment.
I don’t remember how it started, but on November 1, 1956, a four page dittoed news sheet appeared on each patient’s bed. Called ‘The Gomen Asai,(Japanese for an apology), It opened with a salute: “Attention on Deck: Greetings to this newspaper, on this, the day of it’s birth. May it grow fat and healthy on a diet of newsworthy items, hearty in humor, and pleasant anecdotes.” Signed, with a great flourish: Ira Nichols. The first issue contained a feature article by one of the patients, “Personality of the week,” another “Staff of the week;” a roving reporter column asking patients and staff if men would vote for a woman president (the national elections were a few days hence); jokes, a gossip column, a humorous advice-giving column, some cartoons, and a prize for the final name for the weekly, to be chosen among submissions. Later editions added a “Medical Corner” article by a staff member, an editorial, letters to the editor, an article on some phase of Japanese customs and culture, original articles and short stories, poems, a run down on activities for each ward and the newspaper was now mimeographed. The final name chosen was “At Ease,” with a logo showing two hands shaking, one with the sleeve of a medical officer, the other of an enlisted man; beneath was a Buddha and a Japanese torii . Although some of the corpsmen participated in the production, the patients edited and prepared the paper each week.

The Christmas season was approaching which was a lonely time for patients so far from home, being hospitalized, and in a foreign non-Christian culture. Although the administration of the hospital would provide the traditional meal and the Red Cross had added gifts and decorations, a group of the patients who were interested in drama, decided they would do a play. They spent many hours deciding the theme, writing and re-writing the script, and then rehearsals began, held in great secrecy. On the day that the play was to be given, one of the patients who had taken the lead in production, opened the community meeting:

Listen, I’d like to say something! When I suggested the idea of a play for this ward, I didn’t know things would turn out the way they did. Ever since the committee started meeting, there has been nothing but dissension and arguments among all of us. Nobody co-operated and we can’t get anywhere. I’ll tell you the truth, I’m sorry that I mentioned the idea in the first place. And now as if it were all my fault they told me it’s my job to break the news that there will be no play. All right, that’s the announcement. There will be no play! But that’s the thing I’m to say and I don’t care if you doctors lock me up in 8A in the quiet room or even if you send me to duty for the rest of my life!

The patient then stood up, got more excited and pointed an accusing finger and said: “It’s all your fault! You, Mr. Briggs stamped out all the good suggestions anyone had! You criticized everybody and made all of us miserable!”

At that point the editor of the newspaper, as if he had not been listening, said in a calm manner, “Never mind that. Doctor Arnoff, we need a new name for the ward paper and I’d like to know if you have any suggestions?”

Corpsman Odgers, stood up and shouted: “No, No, I can’t stand that any
longer!“ and made a break toward the entrance to the ward. “I can’t stand it! I can’t stand it,” he shouted as he left the group. Two patients left to try to convince Rod to return to the group and called for help. Two other patients and corpsman subdued Rod and had him on the floor. A patient appeared dressed in a corpsman’s uniform, and attempted to put pajamas over Rod’s uniform. Rod continued: “No, No, let me go, let me go I say. I’ll call my lawyer. No! better yet, I’ll call my mother if you don’t let me go! “ Meanwhile, unobtrusively, the newspaper editor had left the group, and returned with Captain Nichols coat on and had a sketch pad and pencil. Calmly, he asked, “Is something the matter around here? What’s going on? He went over to where the action emanated around Rod, who was calmed down, lying on the floor, and someone had given him a pillow to rest his head.

By now, most of the community realized this was the play and that they were all participants in a kind of theater in the round. The remainder, in two acts, humorously satirized aspects of the program and individual members. The cast summoned additional players from the audience. The mimeographed script appeared. It was interesting how the players had kept the dramatic presentation under wraps. They had even arranged to have Captain Nichols at the meeting, someone had gotten the coat of his dress uniform as a prop, and most all of the staff were present, even the deputy chief, who almost never attended meetings. The caricatures of the staff gave us all some idea of how we were viewed by the patients. In the end, the hero, “patient” Rod, was finally diagnosed, taken before a staff meeting, and asked what he preferred: a discharge or return to duty. Ironically instead, he chose to become a Marine!

MISSION ACCOMPLISHED: RESULTS OF THE PROGRAM

To recap, the objectives of the program, were: (1) To reproduce aspects of the Oakland experiment at another Naval hospital for a group of Navy and Marine patients many of whom were experiencing an early, usually their first, emotional or mental breakdown. (2) To improve management conditions of psychiatric patients on the closed and open wards. (3) To lay the groundwork for continued treatment for those patients for whom it seemed appropriate, both at this hospital or elsewhere. (4) To promote the practice of patients helping one another by taking an active part in the rehabilitation process. (5) to return more patients to duty from this hospital. (6) To change the conditions under which patients were air evacuated to the U.S. by developing greater self-control.

Although there were no means to do systematic research, in general, we found that most of these goals were largely achieved. At the end of the first eight months, no patient had been put in seclusion rooms by the staff. At one instant, a patient was admitted to a seclusion room overnight by Marine guard on orders of a higher authority. Before this program they were in constant use to control disturbed patients. Mechanical restraints were totally eliminated. In the 10 months prior to the new program, 10 electroshock and 174 sub-insulin coma treatments were administered to patients while on the closed ward. No shock treatments were given after the new program was introduced. The use of ataractic drugs was used cautiously, perhaps two to three patients out of 70-80 were on temporary doses of chlorpromazine at any one time. Its
use was mainly for newly admitted patients who were acutely disturbed and
given intramuscularly for 1 or 2 days, then orally if indicated until the patient
had become accustomed to the closed ward. Knives and forks became in reg-
ular use on the ward.

We were able to move patients off the closed ward sooner thus keeping
fewer patients on the ward at any one time and reduce the number of beds on
the ward. See Table 1.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Bed Capacity and Beds Filled for 8 Months Preceding and 8 Months Following Establishment of Therapeutic Community, U.S. Naval Hospital, Yokosuka, Japan.</th>
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</thead>
<tbody>
<tr>
<td>Bed Capacity</td>
<td>Average Patient Load for Month</td>
</tr>
<tr>
<td>Range</td>
<td>Average</td>
</tr>
<tr>
<td>Closed Ward</td>
<td></td>
</tr>
<tr>
<td>8 Months prior</td>
<td>28-50</td>
</tr>
<tr>
<td>8 Months later</td>
<td>25.33</td>
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<tr>
<td>Open Ward</td>
<td></td>
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<tr>
<td>8 Months prior</td>
<td>60-88</td>
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<tr>
<td>8 Months later</td>
<td>82-88</td>
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But we were not able to get a significantly greater number of patients back
to duty, as we had hoped to do, with the exception of a 10 per cent increase for
those with character and behavior disorders.

Looking at diagnoses, (at the point of evacuation by the U.S. Air Force)
and comparing the first eight months of the new program with the eight months
preceding it. (admitting diagnoses remained relatively the same for the two
periods):

- the number of patients with psychotic diagnoses decreased by more
  than one-half (70.7% compared with 32.5%),
- the number with character and behavior diagnoses increased: 13.3% to 46.1%.
- patients being sent under restraint and sedation (that is confined to
  stretchers) decreased as well as those sent in pajamas and under
  some sedation; the most significant finding was the sharp increase
  in those patients who made the evacuation in their uniforms and
  with no sedation. Often several patients were evacuated on the
  same flight and offered comfort and support to one another. Flights
  were composed of medical and surgical patients as well as psychi-
  atric and received patients from Guam and Tripler Hospitals along
  the route of the evacuation. See Table 2

The changes brought about by the new program were revealed in a study by
the School of Aviation Medicine of the U.S. Air Force University on the effects
of using ataractic drugs during evacuation of the patients from the Far East.
The Naval Hospital at Yokosuka had a rather high locked ward census and appeared to exact a heavy demand on a small staff. Staff patient ratio was less than half that of either . . . hospital or the . . . hospital. Despite this staffing disadvantage a highly individualized philosophy was manifest toward each patient. In classification there was quite a liberal view with the choice lying between 1B [pajamas and mild sedation], and 1C [uniform and no sedation], and patients thought to be able to travel only under conditions of 1A [restraint and heavy sedation] were held on for further on-ward care prior to evacuation. There was no classification by diagnosis. Thorazine was rather infrequently used but in major acute disturbances was given as the drug of choice.

As I’ve said, we had been concerned at Oakland of the condition of patients arriving from Yokosuka (21.4% of admissions). We thought too many were arriving in restraint and under heavy sedation from the trip which took between three and five days and could be longer with patients laying over at Tripler Army Hospital in Honolulu depending on flight conditions. Flight officials often indiscriminately enforced the regulations of original flight classifications (1A or 1B) for the whole trip. For patients who were already distressed, these flight conditions further threatened their delicate hold on reality. It would appear that the self-control witnessed in the program did hold up in time. I was able to spend two weeks at Oakland a year after the new program in Yokosuka. I met with 40 former patients and found that 90% were functioning on open

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**Table 2**

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<th>9 Mos. Before</th>
<th>9 Mos. After</th>
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<tr>
<td>Restained</td>
<td>80</td>
<td>60</td>
</tr>
<tr>
<td>Sedated</td>
<td>70</td>
<td>50</td>
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<tr>
<td>Uniform</td>
<td>10</td>
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**Graph showing air evacuation of patients from U.S. Naval Hospital, Yokosuka, Japan preceding and following establishment of Therapeutic Community program.**
wards. The staff furthermore, commented on how the condition of the patients arriving from Yokosuka had notably changed and were impressed with the leadership positions many of them took in the meetings and ward activities.

SAYONARA

After two years, many of us were to complete our assignments in Yokosuka, some to be transferred to other bases, others to leave the Navy. The chief of service was transferred to California for his last duty before retirement. Frank Rundle was to leave for a residency in psychiatry. Marion Wardell was transferred back to Oakland, for her last two years before retirement where she was put in charge of training nurses and hospital corpsmen. Rod Odgers’ enlistment had expired. He left the Navy, decided to become a teacher, took a teacher’s training course and post graduate degree, and in 1999, retired after 35 years of teaching elementary grades in San Francisco. Ronald Lee, a NP technician from Oakland who later joined us, entered the University of California’s School of Social Work for post graduate work and eventually headed San Francisco’s outpatient mental health service. He also graduated from the Theological Union and became a Friar Brother of the Franciscan order. There were also sadnesses when we heard that one of the psychiatrists and one of the nurses later suicided and Ira Nichols and his wife were both killed in an automobile accident.

We were assured that the new program would continue when we learned that Captain Marion Roudebush, from Oakland, would become the new chief of psychiatry. He’d spread Harry Wilmer’s work to all of the other wards there which now had daily community meetings and a staff review. And then a year later, Maxwell Jones visited Yokosuka as part of his assignment for the World Health Organization to study rehabilitation programs worldwide.

The advent of new leaders, trained not only in psychodynamics and empirical methods of treatment, but also in social learning and social organization, will hopefully lead to the reevaluation of the whole concept of the psychiatric hospital and the role of the psychiatrist.

Maxwell Jones.
Midway through the program, Harry Wilmer arranged for me to come to Bethesda to contribute to a military monograph he was preparing on his experiment at Oakland. While in Washington, I learned that my next possible assignment was to be with the Marines at their Camp Pendleton, California base. I had ambivalences about this possibility; it sounded like a great opportunity to get involved in a form of “prevention” of the kinds of mental breakdowns we’d been seeing over the past six years, and it was 15 miles from Laguna Beach, an area I’d wanted to live in for some time. On the other hand, I was leery about moving into a totally new area and without a “Team!”

I discussed my future with Rear Admiral Bradley; a long range possibility would be to head up the Navy’s hospital corpsman division, but at that time I was too junior as an officer and hadn’t had the experience with the whole field of military nursing. He suggested for my next assignment that I go to the hospital corps school in San Diego and teach the human relations kinds of things as we’d done at Oakland as part of the hospital corpsmen’s curriculum; that experience would better prepare me for that eventual job. We spoke to Captain Raines, who agreed to release me from the psychiatry division (which included clinical psychologists) if a new billet could be arranged.

I needed time to think about these ideas and to discuss them with others. I was beginning to question what I was eventually to do with my life. I had drifted into some incredible experiences in the Navy and there was the financial security. I was now nearly at the midpoint of an early retirement and was turning 31; I had published more articles and read papers at meetings than any officer in my Corps. I didn’t especially want to continue to “pioneer” projects in psychiatric settings and yet I wanted new experiences. I had left a nearly completed PhD when I went into the Navy. Did I want to return to graduate school and finish it? Where did I want to live?

Those kinds of questions were going through my mind as I returned to Yokosuka to finish up my tour there. But as my time was coming to a close, I learned that I was to be transferred to Bethesda, Maryland to attend a nine months course in hospital administration which I didn’t want for it would inevitably lead to an administration assignment. I was also notified that although I had not taken the required correspondence courses, I had been selected for promotion to the next rank. That eventual job I’d wanted was getting closer: did I really want it?
I awakened early one morning and took a walk to the village outside the hospital. The mist was rising and people were scurrying off to work; the plaintiff sound of the tofu man’s horn came from the alley. I suddenly thought of tossing everything aside, resigning from the Navy and retreating to my cottage; to live out the fantasy that had come so close to reality. I did resign from the Navy; when it came time to say sayonara to Japan, I compromised when I took on a new challenge; this time it put me “in prison” for the next five years and after that there was to be a “Koko-tei II.”

KUDOS

There were no commendations, no medals for bravery, for good conduct or performance of duty during this program; satisfaction was realized in a job well-done. I hope proper credit is self-evident as to those who participated in this program as far as memory has allowed. As I’ve attempted to convey in these pages, the two years of this exploration were exciting and fulfilling ones for all of us.

The nurses and hospital corpsmen entered into the undertaking with good faith and made their own unique contributions, even though some of the latter came on board begrudgingly. The momentum became irresistible.

The patients eagerly joined forces as participants in the psychosocial adventure. As they were struggling to understand and cope with their “illnesses,” they were contributing to the ongoing operation of the program. I don’t believe many of them realized that in the nature of their participation their own attitudes and behavior were beginning to change.

The administration was interesting especially in view that the program was carried out within the confines of the military where orders are passed down. Here direction seemed to be reversed and came from the bottom up. I don’t believe either of the two commanding officers (both physicians) we had during the program had a clue as to what was going on except when there was a crisis that was not contained within our own perimeters. Neither, to my knowledge, ever visited the program except perhaps on an official military inspection with the patients standing at the foot of their beds.

Our chief of service, having collateral duties of being the executive officer of the hospital, no doubt kept his superior informed of what he thought he should know and defended us when need be. Looking back, I don’t really know how much the chief of service himself knew or understood what we were about. I believed that at times he merely tolerated what we were doing with the good faith that we knew what we were about, and at other times, he was curious about what was happening; he got numerous comments as his office was
on the corridor to the open ward where the patients from the closed ward passed by each morning for the community meeting. His door was usually open and sometimes he would greet patients who would stop and chat with him. He attended the meetings on a casual basis. I was constantly amazed at how much freedom he unintentionally gave to the program even when I thought what we were doing did not adhere to his own beliefs and practices. There were times when we felt he restricted us but we usually found a way to compromise so that we could continue.

The team was an exceptionally close one. We worked hard and played hard together. There was a minimum of traditional military protocol between officers and enlisted ranks. Respect was built on results regardless of who initiated the efforts.

As to the lasting effects, we will never know; nevertheless on a day to day basis there were significant changes in the direction of self-control and socialization not likely to have occurred without the combined forces of this Navy community. There were natural factors to draw on: the positive parts of military *esprit* where morale was high. There was comradeship in the friendly rivalry between Navy and Marine Corps personnel; the respect for one another transcended traditional military protocol. And there was a great amount of affection.

But then we were making peace, not war!
NOTES AND REFERENCES


4. I had very little experience in dealing with “acting-out” behavior and so was learning along with these patients. I had a paperback copy of Aichhorn’s *Wayward Youth* which I carried in my pocket and from which I read selections each morning at breakfast to try to get a better understanding of their dynamics and how they should be treated. Little did I know that I would be spending the better part of five years in their company after I left the Navy.


6. While I didn’t initially want this appointment and requested that it be rescinded, I found over time that it had some advantages and proved to be very interesting. The commanding officer expected swift and concrete punishment for offenders he referred from his “Captain’s Mast,” the Navy’s lowest form of punishment which all commanding officers perform. I found that most of the “offenders” (hospital patients) were merely reacting to stressful situations both from their assignments in the Navy or from the physical treatments they were receiving at the hospital—many were anxious as they had not been told much about their illness and treatment. There were many patients from the orthopedic service who were worried about future functioning of their limbs and had gone out drinking, became intoxicated and caused disturbances in local bars or back on their wards. Some patients had been “disrespectful” to doctors or nurses. All in all, they seemed to be a bewildered lot and when I’d heard their accounts, would assure them that their behavior was not in the best interest of the Navy—which they’d already been told many times. I’m put most of them on probation, dismiss some of the charges for some, and for those where it seemed appropriate, would “sentence” them usually for six weeks to attend a small weekly group meeting which I formed. About half of these were patients from our psychiatric community. And at the end of the “sentence” I would reconvene the courtmartial to review their case and dismiss their charges. It interested me that nearly all of the men who were in the group continued to attend the meetings even when they were no longer “required” to do so, as long as they were in the vicinity of the hospital and some visited it at a later time when their ships were in port.

The commanding officer was not overjoyed with my procedures, as he wanted them to be punished. I had consulted with the senior legal officer for the Far East Naval Command to insure that what I was doing was indeed legal and he showed an interest in how military justice could be so applied. It was ironical or a fantastic bit of synchronicity that years later when I’d left the Navy, and the commanding officer (a pediatrician) had retired, we met once more. I was doing staff training for a new narcotics treatment institution for the...
California Department of Corrections and among the group for a one month’s course which included sensitivity training, was my former commanding officer as a “trainee” having been hired as a medical officer for Corrections. 7. Reference # 5. 1342-3. 8. Ibid., 1344 9. Dennie Briggs, In The Navy: Therapeutic Community Experiment at the U.S. Naval Hospital, Oakland, California. PETT Archive Occasional Paper number 2 2000. p 19

10. I nearly succumbed to these fantasies myself. I had become interested in the Japanese culture early on in graduate school by befriend a Japanese-American fellow student whose parents had been interned during World War II. He indoctrinated me into the Japanese community of Los Angeles and eventually I studied the effects of internment on a group of children. When I met social anthropologist Bill Caudill at Yale, my interest was re-kindled from his studies of Japanese acculturation and preparation for going to Japan to conduct field studies. One of the hospital corpsmen who was involved with a Japanese girl arranged for me to meet her family, who in turn found me a thatched-roofed cottage on top of a hill in nearby Zushi with a view of the sea.

The cottage had been deserted for some time for around its summit was the local cemetery and villagers believed the cottage was haunted by the ghosts of the dead. “Koko-tei” became a retreat for me along with some of the staff for those two years.


13. Tragically, the U.S. military still has not satisfactorily settled the matter of homosexuals serving among their ranks. Unfortunately the issue has become politicized. The American Psychiatric Association removed homosexuality from its list of mental disorders in 1973. Twenty years later, both houses of the American Congress held extensive hearings on the armed forces’ policy of discharging personnel known or suspected to be homosexual. The current Secretary of State, Colin Powell, then Chairman of the Joint Chiefs of Staff of the Department of Defense, DOD, testified that “. . .the presence of open homosexuality would have an unacceptable detrimental and disruptive impact on the cohesion, morale, and esprit of the Armed Forces. . . . open homosexuality in units is not just the acceptance of benign characteristics such as color or race or background. It involves matters of privacy and human sexuality that, in our judgement, if allowed to exist in the force would affect the cohesion and well-being of the force.” (Policy Concerning Homosexuality in the Armed Forces: Hearings Before the committee on Armed Services United States Senate. Washington, D.C. U.S. Government Printing Office, 1994. 708) General Powell, commenting on the “don’t ask, don’t tell” policy, promulgated by President Clinton, said, “. . .permits gay and lesbian Americans to serve if they are willing to keep their orientation a private matter. . . We will not ask, we will not witch hunt, we will not seek to learn orientation.” (Ibid. 709). Yet studies have shown that more service personnel have been discharged from the military services since the policy than before it was implemented.

Major General Norman Schwarzkopf, commander of the Desert Storm operation in his testimony before the Senate, said, “Allowing homosexuals to serve would damage the image of the Army in the eyes of the American people and demean its national role. . . homosexuals, by definition, are individuals who have an established predilection for violating the Uniform Code of Military Justice through commission of sodomy. Exclusion of homosexuals from military service is a means of precluding military service by a group of individuals who have a natural proclivity to commit criminal acts.” (Ibid. 599)

It is interesting that in the same hearings before the House of Representatives, it was pointed out that Congress’s own General Accounting Office had concluded that they “. . .do not agree with the position that professional military judgment is a sufficient basis for the policy. Nor do we agree with the DOD’s position that the policy is not capable of being evaluated by social and behavioral scientific evidence.” Policy Implications of Lifting the Ban on Homosexuals in the Military: Hearings Before the Committee on Armed Services, House of Representatives. Washington, D.C. U.S. Government Printing Office, (1993). 248-9.


“Therapeutic intervention is not confined only to the patients,” declared Dr. Alekos Kokkinidis from the four years he operated a therapeutic community at Salamina Naval Hospital for personnel of the Greek Navy. Writing in the *International Journal of Therapeutic Communities* (1988), he said, “My first step was to sensitise and train the existing staff of the clinic, who decided to work voluntarily in the direction of creating new operating conditions.” (p.301). He went on to say that most of the operational problems in the community “. . .originated in tension in the relationships between the staff of the community. . .The junior nursing staff. . .who had been working in the same place for many years, expressed more hesitation and fear, but this reaction, too, was eliminated in the second phase when groups were set up for them.” (Ibid., 303). . . New community staff are selected and appointed in line with the views of the community, and clear criteria for this process have been worked out. (Ibid., 302).

In another therapeutic community at a U.S. Naval Hospital (1965-1967), psychiatrists Arthur Schwartz and Richard Farmer found “The major barrier to the development of the therapeutic community was the attitude of the corpsmen. They were reluctant to change their old patterns of interaction, perhaps because they feared they would not understand how to function under the new conditions. As neuropsychiatric technicians, they had been taught certain ways of conducting themselves, and they found it hard to abandon them. . . They continually complained that we were not treating the patients as patients. . . They feared that if a modicum of control was given to the patients, the service would turn into veritable madhouse.” (“Providing Milieu Treatment in a Military Setting” in Jean Rossi and William Filstead, eds, *The Therapeutic Community: A Sourcebook of Readings,* New York, Behavioral publications, (1973) 265. The psychiatrists began meetings for “re-educating” the hospital corpsmen assigned to their two wards. “They had to learn to act to catalyze and foster group interaction, and not to dominate the group or control the decisions.” (Ibid.,264) As with our experience, “At first the corpsmen complained that they felt powerless because the usual methods of control were no longer available to them.”(Ibid., 266).

15. “Morita therapy has been successfully used for. . . a type of neurosis manifesting either neurasthenic, obsessive compulsive, hypochondrical, or anxiety states. . . [It] consists of two phases: Gajoku, an absolutely solitary rest therapy phase, and a work therapy phase. Morita therapy is thought to be most beneficial to [these types of] patients when they remain in the clinic setting for a minimum of one month.” (Takashi Yamaguchi, “Group psychotherapy in Japan today,” *International Journal of Group Psychotherapy.* 36:568.
Dr. Fukui’s questions and comments gave us some ideas to ponder based on differences between American and Japanese culture. Silence in the groups, for example, which we never understood as having a single meaning, could be seen in another context. “Americans are likely to take silence as consent whereas Japanese often use a polite silence to convey refusal or disagreement. . . the safest way is not to express yourself overtly; if you assert yourself you may get into trouble because you may become a target for the hostility and jealousy of other people.” (Takashi Yamaguchi. 574, 576.) Likewise, in Japanese culture, arguments and disagreements were discouraged as well as expression of negative attitudes. We found in the simple request of seeking directions, if you asked a Japanese if Mt. Fuji, for example, was in a certain direction, he would agree, even if it was not, to save you from possibly losing face. “. . Japanese value silent understanding and indirect communications and that both men and women are early socialized to sense other people’s feelings and to meet their needs without being asked.” (Takashi Yamaguchi. Ibid. 573.) This two part “structure” is seen as a basic cultural ingredient of the personality. (see L. Takeo Doi, “Omote and Ura: Concepts derived from the Japanese 2-fold structure of consciousness,” Journal of Nervous and Mental Disease. 157. (1973).,258-261. 


17. See reference # 12. 189-190. 

18. ibid., 193. 

19. I am indebted to Mr. Rodney Odgers who made available a copy of the original script of the play from his papers. RdOgrs@aol.com. 

20. See reference # 2; Dennie Briggs and Marion Wardell. “A locked ward was opened: Interesting results were obtained when a therapeutic community was instituted in the psychiatric unit of a naval hospital overseas” American Journal of Nursing. 61:102-105 (September, 1961). 