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## The Discovery of the Therapeutic Community

The Northfield Experiments\*

### *Introduction*

One of the most important achievements of social psychiatry during World War II was the discovery of the therapeutic community. The idea of using all the relationships and activities of a residential psychiatric center to aid the therapeutic task was first put forward by Wilfred Bion in 1940 in what became known as the Wharncliffe Memorandum, a paper to his former analyst, John Rickman, then at the Wharncliffe neurosis center of the war-time Emergency Medical Service (EMS). When he tried to put this idea into practice Rickman got virtually nowhere in face of severe resistance among medical and administrative staff. It entailed a radical change in staff/patient relations which produced a figure/ground reversal in the traditional authoritarian hospital. In order to achieve active patient participation in treatment, power was to be redistributed away from its monopolization by the doctor and shared by other staff and patients in appropriate ways.

An occasion to test the efficacy of the therapeutic community idea arose in the autumn of 1942 at Northfield Military Hospital in Birmingham when psychiatrists were invited to try out new forms of treatment which would enable as many neurotic casualties as possible to be returned to military duties rather than be discharged to civilian life. Rickman, now in the Royal Army Medical Corps, had been posted to this hospital for some weeks when Bion joined him from the War Office Selection Boards (WOSBs).

The therapeutic community created by Bion in the training wing (TW), of which he was in charge, existed only six weeks before it was stopped by the Directorate of Army Psychiatry. The scheme had begun to succeed, enabling a number of alienated individuals to re-engage with the soldier's role. The chaos created, however, was intolerable to the wider hospital staff who clung to the traditional medical model. This brief project became known as the First Northfield Experiment.

\*A new paper presenting the first comprehensive account of these developments.

A year or so later, after discussion between Bion and Ronald Hargreaves (the anchor man throughout the war in the Directorate of Army Psychiatry), the scheme was revived in a new form. It was decided to put the TW under non-medical direction. Having had relevant experience in the WOSB organization, I was chosen as the officer in charge. Thus came into being the Second Northfield Experiment which for the first time embodied the therapeutic community idea in a whole organization. The success of the scheme had a profound effect on the civil resettlement units for repatriated prisoners of war, which followed on from it, and on many post-war developments. A new paradigm had been born.

Out of a personal, historical description I will draw some key principles affecting the nature of therapeutic communities as open systems, considered as part of, and interacting with, the wider society. I shall distinguish such principles from those which govern a community endeavoring to operate as a relatively "closed system," that is, one regarded as sufficiently independent to allow most of its problems to be analyzed with reference to its internal structure and without reference to its external environment.

The experience to be revisited was the first attempt at creating a therapeutic community as an open-system by intention and not just by accident. It was conducted during World War II at a critical phase of the war as an integral part of army psychiatry. I shall be reviewing that endeavor with the insights, knowledge and experience of the more than 40 years which have followed that beginning.

The country-at-war emphasized an environment which, at one level, could not be denied by the professional staff and patients of a hospital. Yet returning people to health in that setting posed considerable problems and difficult decisions for both staff and patients. All were military personnel with the professional staff in various therapeutic roles. The issues arising were not dealt with explicitly but appeared in stressful and rationalized forms, as when decisions had to be made concerning the return of men to the armed forces or to civilian life. It is important to consider how far the professional staff member's own purposes, values and approach to treatment were affected by the war-time environment. In the community and organizational life of today such problems and choices may not appear so sharply, but they are just as real and critical.

## Northfield I

### *The Philosophy*

While Bion and his colleagues at the WOSBs (Bion, 1946) were coming forward with new ideas about groups, some serious problems were affecting

military psychiatric hospitals dealing with breakdowns in battle and in units. The withdrawal of psychiatric casualties back to base and then to hospital seemed to be associated with a growing proportion of patients being returned to civilian life. It was as if "getting one's ticket," as it was called, had replaced the objective of hospital treatment—to enable rehabilitated officers, NCOs and men to return to the army. Even at one of the largest hospitals with 800 beds, Northfield Hospital near Birmingham, where the military medical staff appointed to develop their own treatment methods were highly qualified psychoanalysts and psychiatrists, the TW to which patients were transferred for review before leaving for the army or "civvy street" had no better statistics than the rest.

Bion was appointed to the command of the TW to develop his own approach based not only on the experience gained in WOSBs but on the Wharnccliffe Memorandum in which he had adumbrated the idea of a therapeutic community. He undertook a double role as officer commanding the TW and as psychiatrist helping his men to face the working through of issues following their treatment and to make decisions about their immediate future. Returning to the army might include changes of role, unit and conditions of work; returning to civilian life might entail relocation or learning a new job. Either course meant confronting not only the conscious and unconscious attitudes and desires of individuals, but the values and norms that had been established in the TW and hospital as part of the war effort.

Bion has made two public statements about the First Northfield Experiment, one with Rickman (1943) and one (1946) in an issue of the *Bulletin of the Menninger Clinic* devoted to Northfield. The following extract from the latter sets out his objectives, his approach and his views on the meaning of his success/failure:

An observer with combatant experience could not help being struck by the great gulf that yawned between the life led by patients in a psychiatric hospital, even when supposed to be ready for discharge, and the military life from which their breakdown had released them. Time and again treatment appears to be, in the broadest sense, sedative; sedative for doctors and patients alike. Occupational therapy meant helping keep the patients occupied—usually on a kindergarten level. Some patients had individual interviews; a few, usually the more spectacular, were dosed with hypnotics. Sometimes a critic might be forgiven for wondering whether these were intended to enable the doctor to go to sleep.

It thus seemed necessary to bring the atmosphere of the psychiatric hospital into closer relationship with the functions it ought to fulfill. Unfortunately for the success of any attempt to do this, psychiatry has already accepted the doubtful analogy of physical maladies and treatments as if they were in fact similar to neurotic disorders. The apparatus of the psychiatric hospital, huge buildings,

doctors, nurses and the rest, together provide a magnificent smoke screen into which therapists and patients alike disappear when it becomes evident that someone may want to know what social function is being fulfilled, in the economy of a nation at war, by this aggregate of individuals.

It must of course be remembered that in a psychiatric hospital there are collected all those men with whom ordinary military procedures have failed to cope. Briefly, it was essential first to find out what was the ailment afflicting the community, as opposed to the individuals composing it, and next to give the community a common aim. In general all psychiatric hospitals have the same ailment and the same common aim—to escape from the batterings of neurotic disorder. Unfortunately the attempt to get this relief is nearly always by futile means—retreat. Without realizing it, doctors and patients alike are running away from the complaint.

The first thing then was to teach the community (in this case the TW) to seek a different method of release. The flight from neurotic disorder had to be stopped; as in a regiment, morale had to be raised to a point where the real enemy could be faced. The establishment of morale is of course hardly a prerequisite of treatment; it is treatment, or a part of it. The first thing was for the officer in charge not to be afraid of making a stand himself; the next to rally about him those patients who were not already too far gone to be steadied. To this end discussions were carried out with small groups. In these the same freedom was allowed as is permitted in any form of free association; it was not abused. These small groups were similar in organization and appearance to the leaderless group tests, known as group discussions, which had already been used, though for a different purpose, in the WOSBs.

As soon as a sufficient number of patients had in this way been persuaded to face their enemy instead of running away from it, a daily meeting of half-an-hour was arranged for the whole TW consisting of between 100 and 200 men. These meetings were ostensibly concerned only with the organization of the activities of the wing. The wing by now had been split up into a series of voluntary groups whose objects varied from learning dancing to studying the regulations governing army pay. In fact the problems of organization, of course, hinged on the problems of personal relationship. Lost tools in the handicraft section, defective cinema apparatus, permission to use the local swimming baths, the finding of a football pitch, all these matters came back to the same thing, the manipulation and harmonization of personal relationships. As a result almost immediately these big meetings as well as the small ones spontaneously became a study of the intra-group tensions and this study was established as the main task of the whole group and all smaller groups within it.

As a result the group began to think, and a deputation voiced the thought, that 80% of the members of the TW were “skrim-shankers,” “work-shys,” malingerers and the rest, and ought to be punished. A month before the TW had complained indignantly that inmates of a psychiatric hospital were regarded by

the rest of the community as just these things. It was disconcerting, but a revelation of what psychiatry could mean, when the psychiatrist refused to accept this wholesale diagnosis and simple proposal of punishment as the appropriate form of therapy, as a sound solution of a problem which has troubled society since its commencement. The therapeutic occupation had to be hard thinking and not the abreaction of moral indignation. Within a month of the start of this metier these patients began to bear at least a recognizable resemblance to soldiers.

Throughout the whole experiment certain basic principles were observed. In order of their importance they are set down here even though it involves repetition:

- The objective of the wing was the study of its own internal tensions, in a real life situation, with a view to laying bare the influence of neurotic behavior in producing frustration, waste of energy, and unhappiness in a group.
- No problem was tackled until its nature and extent had become clear at least to the greater part of the group.
- The remedy for any problem thus classified was only applied when the remedy itself had been scrutinized and understood by the group.
- Study of the problem of intra-group tensions never ceased—the day consisted of 24 hours.
- It was more important that the method should be grasped, and its rationale, than that some solution of a problem of the wing should be achieved for all time. It was not our object to produce an ideal training wing. It was our object to send men out with at least some understanding of the nature of intra-group tensions and, if possible, with some idea of how to set about harmonizing them.
- As in all group activities the study had to commend itself to the majority of the group as worth while and for this reason it had to be the study of a real life situation.

One of the difficulties facing a psychiatrist who is treating combatant soldiers is his feeling of guilt that he is trying to bring them to a state of mind in which they will have to face dangers, not excluding loss of life, that he himself is not called upon to face. A rare event, but one that does occur, is when an officer is called upon to stop a retreat which should not be taking place. His prominence at such a time will certainly mean that he will be shot at by the enemy; in extreme cases he may even be shot at by his own side. Outside Nazi Germany psychiatrists are not likely to be shot for doing their job, though of course they can be removed from their posts. Any psychiatrist who attempts to make groups study their own tensions, as a therapeutic occupation, is in today's conditions stopping a retreat and may as a result be shot at. But he will lose some of his feeling of guilt.

In conclusion it must be remembered that the study of intra-group tensions is a group job. Therefore, so long as the group survives, the psychiatrist must be prepared to take his own disappearance from the scene in not too tragic a sense. Once the rout is stopped even quite timid people can perform prodigies of valor so that there should be plenty of people to take his place.

*Abrupt Termination*

Within six weeks Bion had succeeded dramatically in getting the large majority of the men in the TW to re-engage with the soldier's role and to return to military duties. But there was a price. The disorder created on the way so disturbed the rest of the hospital that the experiment was abruptly terminated by War Office order. Patrick de Maré (1985) who was on the psychiatric staff at the time comments as follows:

Bion saw the large meeting of 100–200 people as the main trunk of the tree which could explore the tensions of the smaller activity groups—once he could persuade them to meet—which he arranged, partly by persuasion through small group meetings of chosen members, and partly by simply issuing an order to parade every day at 12:10 p.m. for announcements and other business of the TW. The result of this radical approach was that it produced a cultural clash with the hospital military authorities. The fear that Rickman's and Bion's approach would lead to anarchy and chaos occasioned War Office officials to pay a lightning visit at night. The chaos in the hospital cinema hall, with newspaper- and condom-strewn floors, resulted in the immediate termination of the project.

I personally helped Rickman and Bion to pack. Clearly, Bion was put out by these events. Rickman, on the other hand, merely exclaimed unrepentantly and unperturbedly: "Pon my soul!" in the high-pitched tone he sometimes adopted in mock surprise.

The notorious indiscipline, slackness and aggressive untidiness of the unit which Bion took over was one form of showing him and the review panel how unsuitable it was for returning any of its members to the army. Main (1983) among others ascribes Bion's premature departure to the inability of the commanding officer and his professional and administrative staff to tolerate the early weeks of chaos. He was only partially correct. Bion was facing the TW and the hospital professional staff with the responsibility for distinguishing between their existence and purpose as a military organization and their individual beliefs that in the majority of cases health entailed a return to civilian life.

The degree of success Bion achieved in that six weeks demonstrates not only the validity of the principles he and Rickman had evolved but says even more for the double professional approach he had employed: he was in uniform, an officer in the organization (i.e., the army) confronting his men with the state of their unit; he was also a professional psychiatrist consulting with these same men in assessing their condition and deciding with them their future in a nation at war.

*Lessons*

On succeeding Bion to the command of the TW and making my own analysis of the situation, there seemed to me to be critical lessons to be derived from his "sacking." While he had established his own approach, he had not appraised the effect this would have on the very different psychiatric and organizational approaches of his colleagues. In my discussions with him between the time of his leaving and my appointment, it became clear that his philosophy, value system, technical and organizational appreciations were poles apart from those of the other psychiatrists and medical administrators then at Northfield. This is not to say that it was Bion v. the rest. There were differences between the others' approaches too but, in general, they were consistent in their aim of assessing the present and future life needs of the individual regardless of hospital, army or war needs. As one of them said to his patients in a first group session, "I want you to look on me as you would the doctor in a white coat and not as someone in uniform." With this view Rickman and Bion voiced their total disagreement.

Foulkes, who came to Northfield later, began by using the small group setting as a way in which the problems of any one individual could be observed and reflected upon by other patients, so that an interactive group therapeutic process was created. I was able to enlist his full cooperation in working with activity groups where the strength and persistence of the forces operating towards the attainment, distortion or avoidance of group goals demonstrated to him their relevance for treatment in the military setting. He was to say later (Foulkes, 1964): "The changes which went on in both patients and staff were nothing short of revolutionary." His part in subsequent developments has been described by de Maré (1983). These experiences played an important part in forming his approach after the war which led to the establishment of the Institute for Group Analysis (Foulkes, 1964).

The introduction of change processes requires a search for a common understanding of purpose and methods. While only a few of the likely consequences may be predictable, it is important to explore the implications of any steps envisaged. A forum or "mini-scientific society" needs to be set up in which a collegiate climate allows these explorations to take place. What is needed are conditions and circumstances "good enough," to use Winnicott's (1965) term, to effect the transition.

Bion was fully aware in his organizational and professional roles of the central importance of the country at war as a critical environmental force which had implications for the internal worlds and defenses of his men. But he neglected—and was indeed somewhat disparaging of—the more immediate environment of the hospital-as-a-whole and the traditional reactions of the bureaucratic aspects of the military machine.

The commanding officer at that time was, by profession, a psychoanalyst who perceived his task as maintaining co-operation between the professional and administrative functions in the hospital. Bion, in contrast, demanded that the external organization, as the environment of his unit, should tolerate the forces and pressures which his efforts and ideas might release. He expected people to see for themselves that what was happening was a microcosm of the tasks and problems facing military hospitals as a whole. As a Major commanding tanks in the first world war and a psychiatrist in the second, he had shown a vast range of capabilities. But he could expect too much of his immediate environment. In addition, he did not recognize, or perhaps did not accept, that it was his task to take the hospital environment into account just as much as he had taken the army and the country at war so very seriously. Bion, in my view, was not at ease with the group as an open system. He was not at home with the implications of ecological change in groups, institutions and communities (Bridger, 1982).

## Northfield II

### *Orientation*

So far as I am aware, the term “therapeutic community” was first coined in connection with this second experiment which I initiated over the period 1944/45. A large number of people contributed to its development, not least the transient population of officers, NCOs and men who learned to take responsibility for their own return to health. In so doing, they found that the *process* of creating and developing the community enabled them to make full use of the resources it made available to them.

Following Bion’s departure, Ronald Hargreaves had approached me and discussed the possibility of my taking over command of the TW. I was not a psychiatrist or psychologist but had held a command, was an educationalist and teacher by profession and had extensive experience of the group approaches developed at the WOSBs. My remit was to understand the group and organizational processes that were going on. Although it was not remotely like the field command from which I had come, Northfield was a chance to test out the ideas I had gained in an organization with a very different mission. In one sense I welcomed the opportunity; in another I was quietly terrified, since I had no idea of what a mental hospital was like and felt as if I had suddenly been deskilled.

My posting was to take place only when the last commanding officer had been replaced by a medical CO, professionally a pathologist, but with regular

army command experience. In the culture of the army, when trouble in any form arises in a unit leading to the transfer of the central figure in the storm, it is almost invariably accompanied by the transfer of the accountable senior officer. I remember thinking that the hospital staff might also be wondering what was likely to happen when a regular officer and a field officer were replacing the psychiatric specialists who had occupied these roles before. As I discovered later, they had expected a law and order campaign!

In the meantime, I was to acclimatize myself by visiting other military psychiatric hospitals and neurosis centers in the EMS. I also read a book on the "Peckham Experiment" (Pearse and Crocker, 1943) which described an *unintentional* therapeutic community that had grown up in Peckham, South London, in the 1930s. It arose from an attempt by biologists, physiologists and others to monitor a number of health related factors over the long term. The subjects were local families prepared to volunteer, as families, to take part in a program of regular tests. Originally a swimming-pool was the main draw—only family units could join. While fulfilling its part of the bargain in relation to the tests, over time the community developed a life of its own. I was struck by the emphasis laid by the Peckham staff on working with those who are prepared to work with you—rather than on the use of some established form of sampling technique; and on using the swimming-pool, consciously or unconsciously, as a focus for the families who accepted. These families and the development process they set up represented the community as a whole at any one time.

My discussions with Bion encouraged me to build on my own capabilities and not to attempt a follow-on of his experiment in the restricted area of the TW. I decided to work in some dynamic form with the institution-as-a-whole, while also being prepared to consult with those parts of it which showed a readiness to take some responsibility on to themselves for creating an entity which could grow.

In teaching mathematics, that frequently unpopular subject, I had always searched for growing-points on which to build and had used various kinds of institution that could draw on real-life interests and yet have mathematical thinking inherent in them, e.g., a school Stock Exchange. Similarly in my battery command we had overcome the difficulty of getting men to read and digest battery orders by publishing them accompanied by "battery disorders." The latter were a set of cartoons prepared by a talented corporal, which could not be appreciated without reading the orders first. Only later did I come to learn how these transitional systems linked up with Winnicott's (1971) work on transitional objects in psychoanalytic theory and treatment.

Of the many experiences which contributed to my orientation I would like to compare two hospitals which influenced the strategy and practice I eventually formulated. The first, Mill Hill, a neurosis center in the EMS, seemed to me a

large hive housing a conglomerate of every type of treatment—physical, psychotherapeutic and psycho-socio-therapeutic, where the patients seemed incidental. In Maxwell Jones's ward everyone was taking part and shared in the various therapeutic tasks—but it was a relatively closed system and centered on Maxwell Jones himself. I was later to compare his approach to that of Joshua Bierer, who also used a dependency closed-system relationship in his ward at Northfield as the setting for his therapeutic work. After the war, of course, Maxwell Jones had much more scope to develop hospital-wide activities of which he has written fully (1968).

The second hospital, Dumfries in Scotland, was not as large but it seemed more like a well-managed workshop or depot. Although not the CO, the person at the center of things was Major Elizabeth Rosenberg, later better known as Elizabeth Zetzel, the psychoanalyst. She encouraged activities in every form, especially those which patients could run with the help of central resources—a hospital newspaper, for example. It was noticeable that care was taken to encourage what one might call the “recovering” patient to draw the newer ones into the various groups—when they were ready for it.

This experience reinforced my choice of the hospital-as-a-whole as the frame of reference for the work to come. I decided to adopt what I called the “double-task” approach, with one task located at the level of the hospital as an institution and the other at the level of those parts which showed leadership in developing relevant creative work. This leadership had to include a readiness to review the way the part was working.

### *Entry and Joint Planning*

I reported to the CO of Northfield with some trepidation, wondering whether my half-formulated ideas would ever take root. Two divisional psychiatrists, Emmanuel Miller and Alfred Torrie, gave me every support in getting the design started, as did Tom Main when he replaced them. The new CO and I had, together, to settle down, to meet the professional staff of the different disciplines and to learn about the hospital as a whole. Foulkes and others invited me to observe their group sessions. I had discussions with nurses, social workers, administrators, occupational therapists and indeed every section of the staff, including building and maintenance engineers. Learning about the various systems and the role of those who operated them, in whatever form or at whatever level, allowed me to appreciate the prevailing, and indeed conflicting, cultures. At this early stage I could not know how they all hung together, but it was important to experience the confusion of a newcomer and gain some sense of what the whole place was about. I learned, for example, that while devolution to wards, in almost every respect, had its advantages, the

atmosphere of live and let live was more apparent in some wards than others. Politics within and between the professional and administrative staffs left much to be desired.

While I would assume command of the TW it was agreed that I should also undertake a role involving special responsibility for the hospital-as-a-whole in a social process sense. This role would be that of social therapist thus distinguishing it from my unit command. The respective offices for myself and my two staffs would be distinct and separate. I proposed a drastic reformulation in the hospital layout. Influenced by the Peckham Experiment and recognizing the social gap in ward, professional and administrative relationships, I suggested that, without reducing the number of beds, the ward in the very center of the hospital be cleared and named the "Hospital Club." A meeting of representatives from each ward was held to explain the move. They were asked to discuss equipment and organizing methods. This was the only positive action regarding the club taken by the staff. My social therapy office was, however, close by and so were the offices of staff related to that role.

I explained to all staff groups and departments that I wished to create some identifiable equivalents of the hospital-as-a-whole with its mission and recommended the following steps:

- Staff seminars to explore what was intended by social therapy and what the implications might be.
- Independent professional discussions, e.g., psychiatrists, nurses.
- Ward meetings for exploring the implications of "external effects"—the impact of internal stresses on the wider environment.
- Greater emphasis by all activity supervisors on changing the pattern of relationships with patients from one of prescription to one of watching for initiatives on their part and responding to them.
- To make the hospital club with its deliberate emptiness, but space for potential development, into an arena which represented the patient's own personality and social gaps within his "life space."

When the various steps were agreed, a series of staff discussions was begun and gradually the empty hospital club made its presence felt. It took a little while for the representatives' meeting to be arranged—not because of finding appropriate people but because each ward would be asked to contribute from its recreational armory. Already talk and feelings were beginning to flow within and between wards. The various staffs ranged in their attitudes from highly skeptical to highly interested.

Things did not happen at once. Growth was "horticultural." The activity patterns across the hospital were more tree-like, with branches in all directions, than representing any tidy curriculum or program. Even when a rich array of

societal endeavors became established, many would fall into decline, be abandoned or wrecked and then rebuilt, depending on the population and the different needs or states or illness. There was never any chance to say, "Now we have arrived!" In this sense the therapeutic community became far healthier than many business organizations. The individuals comprising the former might be sick, mad or bad; those of the latter might be sane and physically healthy; but institutions are not the same as the sum of the individuals comprising them. We were continually learning and relearning this at Northfield.

Returning to the club, the cumulative awakening of interest led, not to a meeting of ward representatives to reach some mutually agreed business-like arrangement but to a protest meeting which I was summoned to attend. The protest, with full and prepared arguments, was to ask why we were wasting public money and space in wartime—money and space that could be put to so many good uses! I agreed and suggested that we work out what could best be done with the resources of the club and how, since they were ours to do with as we wished, we could use them for the war effort quite directly.

Without giving a blow-by-blow account it is difficult to convey the tremendous energy and directive ability that can be generated when it becomes possible to find a transitional setting through which insights from therapy can be allied with social purpose and satisfaction. One of the most critical boundaries crossed was when the ebb and flow of social change led towards serious patient/community efforts on the part of those "recovering." They began to share responsibility for those entering the admission ward and to care for those who might benefit from the empathy and the experience of those who had been through it. The growth of the hospital newspaper, the external schools' repair teams and many other activities not only facilitated the interaction between outer society and inner struggles but were themselves workshops for self-review of the forces and emotions affecting the life and work of the groups.

### *The Community After Eight Months*

After eight months I was able to make an overall assessment of the position reached. The large majority of men coming into Northfield say "I am browned off with everybody and everything," "I am fed up with the Army," "I seem to have lost confidence in myself," "I hate being pitied." Let us trace the progress of one such man. He enters the admission ward in the company of a few others. They are met by the nurse and a group of patients whose "selected activity" is to act as receptionists and guides. After the allotment of beds, they are joined by the ward psychiatrist. Each man is handed a program for his first three days and a copy of a magazine produced by the patients called "Introducing you to Northfield." He is requested to read it, discuss it and ask questions. The