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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 Wharncliffe 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.
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> 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.
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> 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

receptionist group then splits up to take the newcomers on a tour of the hospital, so that the contents of the magazine come alive.

They visit the hospital club—run entirely by patients who have selected this as their activity. They see patients working on the newspaper in their own offices; the band practicing for dances and socials; men painting scenery and arranging lights for stage shows; gardens and gardeners; a tennis court in use; the sports facilities; building construction and the selected activities yard, where painting, sculpture, handicrafts of all kinds, carpentry and radio construction are taking place. They see and enter the ever-open doors of contact officers, welfare workers, etc., who are there to help them at any time.

They see all these activities as contributing to a total pattern. They hear from patients that these are part of treatment. They see and hear that in the selected activities yard, while each patient is making something for his wife, child or himself, there is an overall project in which individuals and small groups are providing toys, accessories and fixtures for child guidance clinics and nursery schools. They learn that one can graduate to become a member of a small group which has its own circuit of nursery schools to maintain: mending toys, redecorating playrooms and occasionally helping the nurses bathe the babies!

"But," a man may say, "I'm not interested in any of this. I'm interested in engineering, farming, poultry-keeping, plumbing. . . ." His guide tells him that when he meets his psychiatrist and the activities officer he can arrange to conduct his activity at the Austin Motor Company, the Avoncroft Agricultural College or elsewhere, trying himself out and taking part in the life of these organizations.

The man returns to the admission ward with a sense of security in his surroundings. He then has a short individual interview with the senior psychiatrist and an initial interview with his own psychiatrist during which his activity is jointly selected (it can be changed later). Should it need special arrangements, the patient is passed on to a social therapy officer who makes the man a partner in achieving his particular objective. Many men select an activity as a test for the psychiatrist and social therapist; or they may use it to test themselves in a real or fantasy role. Particularly is this true of the returned prisoner of war who wishes to have a farm or a cottage in the country, or to help to look after horses.

Whereas eight months ago the new patient would say that he did not want to do anything while in the hospital, and the older patient would describe the limited range of activities as jobs to occupy the time between interviews, each now accepts the activity, selected by himself in conference with his psychiatrist, as a recognized part of his treatment. The term "occupational therapy" which had contributed to the earlier conception is no longer used. The extensive range of options and the principle of joint selection gives the man every opportunity to satisfy needs or test out fantasies. The soldier not infrequently

says, "I have always wanted to try my hand at . . . but I don't suppose you can do anything about that." Now he can experiment and test himself out.

That he is a real partner in achieving the opportunity is vital. This does not mean that all new patients immediately settle down to following their activities with enthusiasm. If a man wanders off for walks on his own or with a friend this is information for the psychiatrist, the nurse and the social therapy staff—and the men with whom he is working. The patient is not checked in the military sense; this can be left to the social and therapeutic forces at work. He will find his place and activity in a little while, even if he changes the latter several times.

For the rest of his stay in the admission ward the man spends a portion of his time being re-kitted, completing questionnaires and taking psychological tests. In the intervals and in the evenings he revisits one or more of the places he has found attractive. The notice-board in his ward tells him what is "on." His host-patient may also invite him to join a party going to a dance, theater or a social run by members of local firms, clubs or societies, where he can meet men and women who are themselves having fun, and not just giving him a good time. In some cases these are the first steps in an England which he may have left three, four or five years ago. The decision is at all times left to him.

On the afternoon of the third day he is introduced to his treatment ward, which is in the charge of his psychiatrist and nurse. The ward-workers' group (whose selected activity is to look after all domestic affairs in the ward) will "put him wise" to everything going on. He realizes that he will be a member of the ward for the rest of his stay in the hospital, and he can now embark on a secure but flexible program involving not only the life in his ward and his selected activity, but also the social opportunities inside and outside the hospital.

Every day his psychiatrist sees him during the morning round. Each week the commanding officer makes his inspection and is ready to hear requests and complaints. In addition, the ward holds its own weekly meeting attended by the psychiatrist and nurse. The men elect their own chairman who, together with two other elected representatives, attends a full meeting of ward committees each Friday. These meetings, on "constituency" and "House of Commons" levels, are extremely useful conductors by means of which domestic and hospital tensions can be transmitted and resolved. Matters affecting the ward are dealt with by the constituency; matters bearing on hospital affairs are referred to the House of Commons. The latter meeting is attended by the commanding officer and the senior officer of the social therapy staff, who act as links with all hospital departments, any member of which has a standing invitation to attend.

Despite a constantly changing patient population, committee meeting minutes make it possible to trace the trends of a society developing in almost direct

proportion to a growing sense of achievement and responsibility. At the beginning there was a collection of individuals, most of whom were self-appointed ward representatives, airing personal grievances and grumbles. Now the meeting of ward committees is a constitutional body conscious of its value and responsible to the hospital community as a whole.

Its work is not bound by the confines of the hospital. The links between Northfield and the city are becoming more numerous and more clearly defined, with plans being made for a total hospital project related to building an extension to the Crippled Children's Hospital in Birmingham. The growing contacts opened up by selected activities, sports and parties have brought large industrial concerns well within the hospital's consciousness, with the result that its psychological as well as geographical field has widened to an extent that tests both ward and overall committee meetings to the full.

In the frame of reference set up by the social life of the ward and hospital communities each psychiatrist has the opportunity of treating his patients, individually and in groups. He can see how the cohesive and disruptive social forces act on members of his ward. His observation of the patients' behavior has proved its value in treatment.

So far little has been said of other functional groups within the hospital. They each have their role not only in maintaining hospital services but in contributing to the total community. The women's auxiliary services take a full share in the social life of the hospital. It may be said that the social therapy staff is the whole staff together with the whole of the neighboring population. Unless this is so, treatment becomes restricted and may even be sterile. The treatment—one may call it an education in sincerity and tolerance—which the patients give to all related groups is no less important!

Although it is not possible here to trace in detail either the phenotypical picture of development or the process of "Lewinfiltration" (our term for describing the growth dynamics of a community) some conception of its progress may be gained by considering the field existing just prior to the beginning of the experiment. Entertainment, recreation, education and occupational therapy had been additional responsibilities for three different psychiatrists. Rehabilitation, which dealt only with patients in the last two or three weeks of their stay in the hospital, consisted mainly of para-military training and was in the hands of a para-military staff.

I have said little so far about the staff groups but they too developed many different directions of interest and inquiry. Previously, the nurses all worked according to the principles governing hospitals dealing with physical illnesses, despite the fact that there was only one medical ward. Now, there emerged the problem of discovering the role of the nurse in a therapeutic community where only a few patients were in the ward all day, let alone in bed! Their patients were out in Birmingham schools; repairing toys in a department store to raise

cash for charity or hospital activities; in the car factory opposite the hospital; in the club, etc.; and in many additional types of treatment sessions with psychiatrists. There was only one way—for the nurse to learn a different role—to be with the patients where *they* were.

The force-field of therapeutic functions had changed. The therapeutic task now involved far greater inter-disciplinary practice. Hospital and environmental endeavors involved collaboration between professional therapeutic staff and social practitioners from a variety of functions. A few months before the boundaries between them had been distinct and their tasks separate.

The Doctor in the Therapeutic Community

When Tom Main arrived, the psychiatric scene developed still further. He was the first to spell out explicitly the changed role of the psychiatrist in the therapeutic community (Main, 1946):

> These are not small requirements and they have demanded a review of our attitudes as psychiatrists towards our own status and responsibilities. The anarchical rights of the doctor in the traditional hospital society have to be exchanged for the more sincere role of member in a real community, responsible not only to himself and his superiors, but to the community as a whole, privileged and restricted only insofar as the community allows or demands. He no longer owns "his" patients. They are given up to the community which is to treat them, and which owns them and him. Patients are no longer his captive children, obedient in nursery-like activities, but have sincere adult roles to play, and are free to reach for responsibilities and opinions concerning the community of which they are a part. They, as well as he, must be free to discuss a rationale of daily hospital life, to identify and analyze the problems, formulate the conditions and forge the enthusiasms of group life.
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> . . . he does not seek ex cathedra status. Indeed he must refuse any platform offered to him, and abrogate his usual right to pass judgment on inter-group claims or problems. The psychiatrist has to tolerate disorder and tension up to the point when it is plain that the community itself must tackle these as problems of group life.
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> . . . It must be pointed out that the medical man, educated to play a grandiose role among the sick, finds it difficult to renounce his power and shoulder social responsibilities in a hospital and to grant sincerely to his patients independence and adulthood. But it is no easier for the rest of the staff. It is difficult to live in a field undergoing internal stress without wanting to trade upon authority and crush the spontaneity which gives rise to the stress, to demand dependence and to impose law and order from above. Such measures, however, do not solve the problem of neurosis in social life, but are a means of evading the issue.

The extent to which the therapeutic community idea had taken root among key psychiatric staff may be further illustrated by the following remarks of S.H. Foulkes (1946) concerning his relations with myself:

> Co-operation between us was perfect and there was not a single question of principle or detail in which we did not see eye to eye. Thus the relationship of the therapeutic group in the narrower sense towards the hospital changed, the smaller unit becoming more definitely oriented towards the larger community of the hospital. Neither of them is workable, or even thinkable, without the other. It never occurred to us to ask how much one or the other of them contributed to the therapeutic result, so fully did we look upon it as an integrated whole. Apart from this, the psychiatrist was (or should have been) operative in all the different groups in which his patients were engaged. To look upon this experiment otherwise is to misunderstand its basic ideas as well as that of the psycho-therapeutic group itself.

The Hospital at the War's End

When hostilities ended in Europe Foulkes took over my role of social therapist as the principal means of mobilizing the hospital behind its new mission of rehabilitation for civilian life. He writes (Foulkes, 1946):

> The war was now over, Bridger had left, the staff was depleted by demobilization. The hospital policy had changed semi-officially to one of rehabilitation for civil life. Everything was affected. The old division between khaki and blue had changed its meaning completely. A certain note of apathy had descended upon both staff and patients. The hospital life had become stale and incoherent, the activity side somewhat departmental and institutionalized. What was to be done? I had the good luck, on my own request, to be transferred to the activity department. It became quite clear that levers had to be used to bring about an effect on the hospital spirit as a whole. The situation suggested the remedy. Groups had to be formed whose task was directly related to the hospital itself and who, from their function, were forced into contact and co-operation with others.
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> . . . I founded one group called the Co-ordination Group who with new-found enthusiasm soon became a most active factor in the life of the hospital. Their influence was felt within a week or two throughout the hospital, from the CO to the last patient, orderly or office girl. New life blossomed from the ruins, brains trusts and quizzes between psychiatrists and patients, and similar events resulted, producing once more healthy and positive contact and co-operation.

He adds some general reflections on working with groups in the therapeutic community which merit being more widely known:

It will be seen that in the development described, the following shifts of emphasis emerged:

- From individual centred to leaving the lead to the group.
- From leader centred to group centred.
- From talking to acting and doing.
- From the still artificial setting of a group session to selected activities and to groups in life function.
- From content centred to behaviour in action.
- From the controlled and directed to the spontaneous.
- From the past to the present situation.

. . . The narrowest point of view will see in it merely a time saver perhaps, or a kind of substitute for other more individual forms of psychotherapy. Possibly it will concede that it might have special advantages, have its own indications, say, for instance, for the treatment of social difficulties. A wider view will see in it a new method of therapy, investigation, information and education. The widest view will look upon group therapy as an expression of a new attitude towards the study and improvement of human inter-relations in our time. It may see in it an instrument, perhaps the first adequate one, for a practicable approach to the key problem of our time: the strained relationship between the individual and the community. In this way its range is as far and as wide as these relationships go. Treatment of psychoneuroses, psychoses, crime, etc., rehabilitation problems, industrial management, education, in short, every aspect of life in communities, large and small. Perhaps someone taking this broad view will see in it the answer in the spirit of a democratic community to the mass and group handling of Totalitarian regimes.

Conclusions

The question of the renunciation of power and the sharing of responsibility with an interdisciplinary team had been at the bottom of the trouble stirred up by Northfield I. This issue is still with us, as Maxwell Jones's (1968) persistent struggles for forty years have demonstrated, especially when patients as well as staff are allowed a voice.

Several studies of substantial, as distinct from marginal, innovation (Chevalier and Burns, 1979) have shown that the first entry of a radically new model is usually arrested but that the learning acquired permits an extensive development when, after a delay, the environmental situation has become favorable for a second entry. The seed planted at Northfield I did not fall by the wayside. In another two years it flowered not only in Northfield II but in several forms in relation to the concluding phases of the war. As Bion observed in *Psychiatry in a Time of Crisis* (1948), a chain reaction had been started. Foulkes (1964) has traced further developments in the post-war period.

For innovative initiatives to persist in any of its parts sanction is needed from the highest levels of the organization. The whole in which the parts are embedded can then begin to change in a consonant direction. High level sanction is especially necessary when the initiatives are of a kind which create a discontinuity with what has gone before and are the harbingers of a paradigm shift.

As happens not infrequently, discoveries made within the protection of a therapeutic setting later find numerous applications in the wider society—until they become seen as general. Winnicott (1971) has talked of maturation and the facilitating environment regarding the child. Northfield showed that an unusually facilitating environment can lead to unusual maturation in adults. Approaches and methods first learnt in a specialized psychiatric setting may be adapted to bring into being degrees of commitment and levels of performance unreachable by conventional bureaucratic organizations in industry and other social sectors. The individual can grow through the life-enhancing experiences now provided which he himself, by his own participation, has helped to bring into existence. Most people doing organizational change projects, which have become such a vast enterprise since World War II, have little knowledge of where, how or under what circumstances the seminal work was done.

Northfield I was undertaken at the height of the war when the military outcome was still in doubt. There was a deep necessity for the work group concerned with the reality situation (*W* in Bion's sense) and his basic assumption fight (*baF*) to be constructively fused (Bion, 1961). What Bion and Rickman did reflected this situation and was congruent with it. Northfield II was undertaken when the military outcome was no longer in doubt. In this situation a need began to suffuse the society to restore those who had become "casualties" in any form through their part in the war effort. The therapeutic community that now came into existence as Northfield II created a reparative society. The profound healing effect of the need to make reparation had been explicitly stated by Melanie Klein (Klein and Riviere, 1937). Northfield II exemplified this effect at the social level and demonstrated the connection between personal and social healing.

Northfield II also created a democratic society. This showed that there was a link between participation and the release of creative forces. This link suggests also that democratic and reparative processes are connected at a deep psychological level. They mutually reinforce each other. These connections are still little appreciated and need to be taken into account in institution-building for the future.

Despite their promise, the war and immediate post-war developments of therapeutic communities reached a limit unexpected by their pioneers. They pose a persisting threat to authoritarian institutions and the prevailing bureaucratic culture. The resistances encountered by Bion and Rickman in one

hospital-as-a-whole, though worked through in Northfield II, reappeared in society-as-a-whole. In the course of the 40 years that have elapsed since these experiments manifested that there was a new way, only small progress has been made towards establishing a more democratic and more reparative social order. In making further progress towards this goal the experiences they yielded and the models they built provide a rich ground on which new efforts may be based.

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