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JOHN RICKMAN, WILFRED RUPRECHT BION, AND THE ORIGINS OF THE THERAPEUTIC COMMUNITY

John A. Mills
University of Saskatchewan

Tom Harrison
South Birmingham Mental Health
NHS Trust

The history of psychiatric therapeutic communities is complex and obscure. Nevertheless, one can make a reasonable case for saying that the first true therapeutic community was created at Northfield Military Hospital, Birmingham, England, in 1945. That community had its origins in the thought and practice of two British psychoanalysts, John Rickman and Wilfred Ruprecht Bion. Accordingly, in the present article their careers and the social and intellectual influences bearing on them are discussed. The article then continues by describing Rickman's work as a military psychiatrist, Bion's prototype of a therapeutic community, and the therapeutic community that was eventually created at Northfield. It is hoped that the article will provide some of the groundwork for an adequate history of the therapeutic community.

Keywords: Bion, community psychiatry, Northfield, Rickman, therapeutic communities

Therapeutic communities represent one of the most significant innovations in the history of psychiatry. Very loosely, they can be described as institutions within which professional hierarchies are flattened, so that staff at the nursing or occupational therapy levels, in principle, plays as significant a role as psychiatrists. Such democratic responsibilities are also extended to those suffering from mental illness, who are also expected to take on a therapeutic role. The therapeutic community movement, like the community psychiatry movement of which it forms a part, can be interpreted as an attempt to accord everyone a place within the human community. Those suffering from mental illness, those afflicted by mental retardation, and those, like delinquent youth, "fallen women," drug addicts, and those suffering from alcoholism, who had, from the standpoint of 19th and early 20th century mores, excluded themselves from respectable society were all to be restored to the human fold. Community psychiatry, at its most fundamental level, came into being as a result of a shift in the nature and locus of social authority. From the 1850s to the 1950s, the advanced democracies had treated all those suffering from serious mental illness or mental deficiency, together with the socially delinquent, as wards of the state. The state (and its delegated institutions) had taken upon itself the duty of caring for the mentally ill and mentally retarded and of socializing, by punitive means, the socially delinquent.

John A. Mills, Department of Psychology, University of Saskatchewan; and Tom Harrison, South Birmingham Mental Health NHS Trust.

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Correspondence concerning this article should be addressed to John A. Mills, Rural Route 1, Hornby Island BC V0R 1Z0, Canada. E-mail: millsj@telus.net

Early in the 20th century we begin to see speculation about the individual origins of social control. For example, at a crude level, one can interpret the psychoanalytic view of society as one in which social forces are nothing other than projections of individual desires and wishes onto a collective canvas. Within social psychology, Kurt Lewin (1890–1947) is a key figure; a study in which he and his collaborators demonstrated the enhanced productivity of democratic as opposed to authoritarian and laissez-faire groups is especially noteworthy.¹ Certain beliefs underlay the work of Lewin and his collaborators, namely that people must understand their own motives and willingly cut back their own desires. That is, social control arises from within, it is cannot be effectively applied from without.²

Therapeutic communities arose from practices set within that matrix of speculation about the nature of social control. The history of those communities is complex and hard to elucidate, so complex that it cannot be presented within the bounds of a journal article. Nevertheless, one can say with certainty that a significant portion of its origins lies within certain developments within psychoanalytic theory in Britain in the 1920s and 1930s. Broadly speaking, several leading British psychoanalysts opened their minds to the work of some European and British social theorists, such as Jacob L. Moreno (1889–1974), Lewin, and William McDougall (1871–1938).³ As a consequence, they began to explore the social implications of psychoanalytic theory. It is crucial to note that their exploration lay within the broad and contested field of British psychoanalysis, not within the far narrower bounds of Viennese psychoanalysis, which was under the domination of Freud himself.⁴

John Rickman (1891–1951) and Wilfred Ruprecht Bion (1897–1979), even if they were not the most prominent British psychoanalytic theorists, certainly were the first to apply a socially oriented psychoanalytic theory to therapy, and hence had a decisive influence on therapeutic practice. In addition, both served as psychiatrists in the British army during World War II. They played a leading role in all aspects of the work of British army psychiatrists. Crucially, under Rickman's influence, Bion took the first steps toward creating a therapeutic community, and both Rickman and Bion helped to create the atmosphere within which the prototype of such communities actually came into being. Thus, an account of their careers must tell us a lot about the origins of the therapeutic community.

Community Psychiatry and the Therapeutic Community

Institutionally, therapeutic communities from an integral part of community psychiatry, the movement that arose within the profession in the 1950s, and became known as its “third revolution.”⁵ Community psychiatrists, unlike their colleagues, believed that psychiatry must focus its attention on the social manifestations of mental illness within social settings and that psychiatry's ultimate aim should be to help the mentally ill to function within society, albeit a society that had been trained to tolerate and to find a place for the mentally ill. Kennard describes the working principles of therapeutic communities as follows:

- What distinguishes a therapeutic community from other comparable treatment centers is the way in which the institution's total resources, staff,

patients, and their relatives, are self-consciously pooled in furthering treatment. That implies, above all, a change in the usual status of patients.

- The therapeutic community is a “living-learning situation” where everything that happens between members (staff and patients) in the course of living and working together, in particular when a crisis occurs, is used as a learning opportunity.
- Permissiveness in one of the four principles identified by [the sociologist Robert] Rapoport . . . and is perhaps the most central of the four: that all members should tolerate from one another a wide degree of behavior that might be distressing or seem deviant by ordinary standards.
- There is a “culture of enquiry,” a phrase that highlights the need not only for efficient structures but for a basic culture among the staff of “honest enquiry into difficulty,” and a conscious effort to identify and challenge dogmatic assertions or accepted wisdoms.
- The basic mechanism of change can be described as this: the therapeutic community provides a wide range of life-like situations in which the difficulties a member has experienced in their [*sic*] relations with others outside are reexperienced and reenacted, with regular opportunities—in groups, community relationships, everyday meetings and, in some communities, individual psychotherapy—to examine and learn from these difficulties. The daily life of the therapeutic community provides opportunities to try out new learning about ways of dealing with difficulties.⁶

We maintain that the therapeutic community should stand at the core of community psychiatry, both conceptually and in terms of practice. Therapeutic communities form a physical, social, and psychological space within which those suffering from mental illness can arrive at some understanding of their condition and learn to live both with it and their fellow human beings. Essentially, those who run therapeutic communities believe that there is an unbroken continuum in terms of therapeutic potential from those suffering from the most severe forms of mental illness to the most concerned and skillful psychiatrists.

It follows, then, that the staff of a therapeutic community attempts to recruit the therapeutic potential that lies within all of us rather than to impose diagnoses and associated therapies upon their charges. To put it another way, the locus of cure must lie within the community of patients, nursing staff, and psychiatrists, not within the therapist. Those suffering from mental illness have to learn that, in orderly societies, they bear a responsibility to live with others. Oddly enough, therapeutic communities place the greatest responsibility upon those people suffering from chronic mental disorders. Within therapeutic communities, such people must learn to accept that they are afflicted by madness and yet live within society.

It goes without saying that therapeutic communities place heavy demands on their staff, especially renunciatory demands. The medical superintendent of a therapeutic community must act as a mediator rather than as a leader. His or her subordinates must learn to operate in open democratic settings and to accept and to digest criticisms both from their colleagues and from those suffering from mental illness. To put the matter succinctly, the staff must function as living

embodiments of social norms. They must act as impalpable but forceful presences within the community, recognizing the first glimmerings of desirable outcomes whenever and in whatever form they emerge and gently pushing those suffering from mental illness toward ways of living that they have discovered for themselves.

The term “therapeutic community” in its contemporary sense was given form and meaning as a retrospective description of a mode of practice by the British psychiatrist, Tom Main, in an article written in 1946. Main, however, was not the first to use the term. Thus, in a lecture delivered in 1939, the American psychiatrist Harry Stack Sullivan had used the phrase “therapeutic camp or community.” The phrase occurred in the following passage:

[because] there are so many instances of hospitalization of young patients in episodes that might well be quickly remedied if so drastic a change of social situation as admission to the mental hospital were not experienced, I am greatly impressed with the desirability of an innovation in the shape of special communities in which some of the great advantages of the mental hospital could be made available, without incurring the necessary exposure to factors that now make for permanent institutional adaptation of many patients. Something at least remotely like what I have in mind has already been accomplished by the Civilian Conservation Corps, the various camps of which would be a rewarding field of study. It is desirable, during the developmental stage of a therapeutic camp or community, that it be in coöperative relationship with an accessible mental hospital. . . .⁷

Main wrote:

The transition of the patient from a passive recipient of care, regarded as “good” as long as they [*sic*] conformed to the dictates of the institution, into an active partner in therapy, making decisions about what form it was to take, challenging previous ideas, and taking power in the process of their recovery, was revolutionary.⁸

It would seem that both Main and Sullivan were echoing a style of practice that was beginning to emerge from outside psychiatry as it was practiced before World War II.⁹ The first psychiatric therapeutic communities had functional antecedents in certain residential schools for disturbed adolescents that came into being in Europe and the United States from the early 20th century and into the immediate post-World War II era.¹⁰ In two instances (Homer Lane’s *The Little Commonwealth* in England and institutions run by August Aichorn in Austria) the analogies are especially close.¹¹ Lane and Aichorn operated institutions in which, first, certain values were inculcated into the community as a whole. Second, both men oversaw a flattening of the hierarchy of authority so that all, even the superintendent, bowed to the overall values. Third, those values, succinctly, were: (a) a willingness to introspect about one’s motives; (b) forbearance; (c) a willingness to work for the good of the collective; (d) an acceptance of seeming chaos; and (e) a willingness, especially on the part of the superintendent, to improvise. Fourth, despite the flattening of the hierarchy of authority, Lane and Aichorn were both charismatic leaders, and it seems that charismatic leadership was essential to the success of at least the first therapeutic communities. Fifth, both Lane and Aichorn relied heavily on psychoanalytic doctrine even though it

was certainly not the case that Lane's practices emerged from psychoanalysis and that it is very difficult to see how much of Aichorn's practice was controlled by the doctrine, even though in his case, unlike Lane's, his acquaintance with psychoanalysis preceded his work with adolescents, while he was a prominent member of the Viennese psychoanalytic group.

The Influence of Psycho-Analytic Theory

The writings of two post-Freudians, W. R. D. Fairbairn and Melanie Klein, as interpreted and expanded by some of their British followers, had a determinate influence on community psychiatry.¹² In that regard, two features of Fairbairn's and Klein's theories were crucial. First, both supposed that, from its very birth onward, the child was a social animal, albeit an imperfect one in that it initially had relationships only with parts of human beings (e.g., the breast) and in that its relationships were strictly dichotomized into love or hate.¹³ Fairbairn and Klein thus opposed themselves to Freud's theory in which socialization supposedly arose as a consequence of libidinal drives. For Fairbairn, at least, the pleasure principle became a consequence of societal development, rather than its cause.

An abandonment of a linear theory of causation constituted Fairbairn's and Klein's second break with Freud. For both, then, the child became a part of a social field and was best understood as a part of and as a contributor to group life. Thus, Fairbairnian and Kleinian theory opened itself to influences from the social field theories of the 1930s. Instead of following a prescribed sequence, each child's development became an idiosyncratic interactive process in which there were both reactions to and actions upon significant objects in the social field.

Klein's doctrine of reparation constituted a marked difference between her theory and Freud's.¹⁴ She believed that aggression toward loved objects and the concomitant impulse to counteract that aggression gave rise, automatically, to a need to make good that harm (the reparative impulse) and that that impulse constituted the formative socializing influence in the child's life. As Klein wrote:

Side by side with the destructive impulses in the unconscious mind both of the child and of the adult, there exists a profound urge to make sacrifices, in order to help and to put right loved people who in fantasy have been harmed or destroyed. In the depths of the mind, the urge to make people happy is linked up with a strong feeling of responsibility and concern for them, which manifests itself in genuine sympathy with other people and in the ability to understand them, as they are and as they feel.¹⁵

Klein made a further break with Freud that was to have fruitful consequences for community psychiatry. At least within the confines of psychoanalytic theory, she dealt more successfully than Freud did with paranoia and with the self-enclosed world of those who suffer from delusions and hallucinations. In particular she demonstrated, at least to her own satisfaction and that of her followers, that, within the unconscious, psychotic tendencies were to be found in the early developmental stages of all children.¹⁶ Because she further suggested that a failure to resolve and overcome those tendencies led to a regression to those childhood phases in adulthood, she opened routes for the psychotherapeutic treatment of the chronically insane, routes that were to be followed enthusiastically by community psychiatrists.¹⁷

Early British Military Psychiatry and the Tavistock Clinic

World War II provided the matrix within which the prototypes of the therapeutic community appeared, while British army psychiatry provided the institutional setting. That setting is best referred to as the “invisible college,” the group of psychiatrists and other mental health personnel, which included Rickman and Bion among its members and which formed an identifiable but far from cohesive group within the psychiatric branch of the Royal Army Medical Corps (RAMC).¹⁸

There is an unbroken line from the work of people like W. H. R. Rivers on victims of so-called “shell shock” in World War I, so superbly portrayed by the novelist Pat Barker in her *Regeneration* trilogy, to the work of Rickman and Bion in World War II.¹⁹ Just as the members of the invisible college attempted to apply the lessons of wartime psychiatry to the postwar world, so did some of the World War I psychiatrists and those who worked as untrained psychiatrists. One of the latter, Hugh Crichton-Miller, founded London’s Tavistock Clinic in 1920 expressly to make available the insights of British wartime psychiatry to a peacetime population. Crucially, the Tavistock, conceptually and in terms of practice, was eclectic. It therefore provided a refuge for those in the growing British mental health movement who wished to escape the Scylla of the organicist Maudsley Hospital and Charybdis of Freudian psychoanalysis. At the same time, although the Tavistock set a course close to Charybdis, it did not support any particular psychoanalytic school. That lack of partisanship inspired trust in its work and enhanced its reputation.

The Tavistock’s ethos expressed the humane and practical concerns so characteristic of the best of the British middle and upper-middle classes during the late 19th and early 20th centuries. That humane concern for others was combined with an open-mindedness and optimism in a search for means of overcoming social problems, albeit with a strong authoritarian streak. As a consequence, the Tavistock was imbued with a spirit of inspired quasi-professional amateurism. That spirit manifested itself very strongly in the career of the clinic’s first medical director, Crichton-Miller, and in that of his successor, John Rawlings Rees. Although he worked under Rivers in World War I, Crichton-Miller had no psychiatric training. Rees, in his turn, acquired his training from Crichton-Miller and, of course, acquired experience in the course of his work.

Rees’s lack of formal qualifications proved to be of no hindrance to him when World War II began. He was appointed as consultant psychiatrist to the RAMC, with the rank of brigadier. His was an inspired appointment. Although his contribution to the events we will be describing was covert and indirect, it was nonetheless crucial. Rees had an unrivalled capacity to lead by example, to recognize promising developments, combined with the courage and self-assurance to delegate full powers to promising subordinates. He was also an urbane man who functioned easily in society. As a result, he won the respect and trust of those senior to him. Within the army proper, his crucial ally was Sir Ronald Adam, appointed Adjutant-General in 1941, and who remained in this post throughout the war. Adam shared Rees’s gifts for discerning and supporting innovation. Ronald Hargreaves, another Tavistock psychiatrist, forged a partnership with Adam in 1940 while working in Leeds on personnel selection. It was he who perhaps had most influence on setting up, and perpetuating, the events at North-

field. He kept abreast of all the developments, corresponding with all the main participants, and worked in the background recruiting psychiatrists to work there.

In September, 1939 Britain was conspicuously unprepared for war in a military sense. The same cannot be said of its state of readiness in the social or psychiatric realms. The government had begun to solicit expert advice in those areas well before the outbreak of war. Rees and his invisible college ensured that, with respect to military psychiatry and psychology, Britain was extremely well served. It is especially noteworthy that, in the early years of the war, the invisible college concentrated its efforts on morale building and on ensuring effective social relationships within the army rather than on psychotherapy. Those efforts were to form an essential prelude to the therapeutic innovations which were to come later. One should also note that those broad social commitments represented a continuation of the eclectic intellectual milieu of the Tavistock. Those working there were not open merely to prevailing currents of thought in psychoanalysis and psychiatry but to contemporary social theory, especially, as we have said already, the work of Moreno and Lewin.

A Summary Account of Rickman's Career

John Rickman was educated at a Quaker public school ("public school" in the specialized British sense) and at King's College, Cambridge, going on to obtain a medical degree in 1916.²⁰ He immediately left for Russia to work for the Friends' War Victims Relief Unit, where, in addition to his relief work, he engaged in innovative social practices, for example by training young Russian girls to act as medical orderlies and nurses. On his return to England, he specialized in psychiatry, taking up psychoanalysis as a result of meeting Rivers at Cambridge. Later, he worked with Freud, Sandor Ferenczi, Ernest Jones, and, especially, with Melanie Klein. He was in analysis with Klein from 1934 until 1941, was a founder member of the British Psycho-Analytical Society, and was also actively involved in promoting the work of the International Psycho-Analytical Press. He was also assistant editor of the *British Journal of Medical Psychology* from 1925 till 1934 and editor from 1935 till 1948, thereafter becoming editor of the *International Journal of Psycho-Analysis*.

Most of Rickman's career was devoted to administration. He died at the early age of 60 at the very point when he had abandoned his administrative work in order to start writing. However, despite his involvement in the administrative aspect of psychoanalysis, Rickman did find the time and energy to expand its theoretical domain. In the 1930s, he wrote several papers and gave lectures in which he applied Kleinian principles to social issues. Those papers and lectures are: editorials for *The Lancet* on the impact of air raids and other military disasters; "The Psychology of Crime" (1932); "Study of Quaker Beliefs" (1935); "Panic and Anxiety Reactions in Groups during Air Raids" (1938); "Uniformity and Diversity in Groups" (1938); and a lecture on "The Individual and the Group" (1939).

In that body of work, Rickman introduced innovations of his own. Thus, Harrison maintains that it was Rickman, rather than Klein, who, in the papers listed above, first introduced object relations oriented considerations into the field of group and social theory.²¹ In doing so, Rickman must have been influenced by

Fairbairn as well as by Klein. He knew of the former's work because of his editorial role in the *British Journal of Medical Psychology*.

The most succinct summary of Rickman's prewar views on groups is to be found in his notes for a lecture on the individual and the group. Rickman was concerned to demonstrate how the development of the individual psyche influenced group behavior. He was also eager to dissociate himself from contemporary psychologists and sociologists who were "preoccupied with conscious levels of mind," and who "tend to regard men as rational, acquisitive and [responding to] to conditioned reflex[es]." ²² According to him, the profound impact of psychoanalysis was to reveal that: "Man [is] disturbed by inner fantasy more than [the] real world." It is through understanding this world that groups had to be understood. Throughout his lecture, it is clear that he was trying to understand the mechanisms of the "group as a whole" rather than the functioning of the individuals within it. In addition, Rickman espoused a passive, nondirectional approach to the understanding of group processes.

Rickman derived that approach from his understanding of Klein's doctrine of reparation. He maintained that the need for reparation led to a reassuring search in the outer world for good things that have endured the malice of the self and others. Thus, curiosity, even in human beings, was not a simple impulse but was reinforced by the need for help against the forces of unconscious hate, while guilt, which is social as well as personal in origin, urges the mind to acquire more knowledge of the outer world. Guilt, reaction formation, and the reparative impulse provided explanations lacking in non-Kleinian theories, whereas Klein could give a theoretical account of the continuous, infiltrating, and ever-expanding drive to social action. Rickman advanced a further mechanism underlying the formation of groups, the diminution of guilt and anxiety whenever aggression was shared. The inevitable reparative impulse then led to a feeling of power if all (or at least most) members of a group focused their constructive energies on the solution of a shared problem.

Rickman treated the ego and its human and internalized acquisitions (the superego and all the internal objects acquired during early life) as a composite creature containing images and impulses leading to constructive and destructive actions. At the same time, that creature contained every variety of human type (that is, from very early in life, the infant was inescapably social). Having incorporated many kinds of human beings, each person felt many-sided, with many-sided interests and desires. That complexity of inner life was a reflection of the complexity of our outer environment. Should their relation to our primal love objects be good, people would enjoy and foster a many-sided development in themselves and others. Thus, cultural complexity tended to perpetuate itself, but with a concomitant crop of difficulties.

Rickman projected his ideas onto a broad social canvas. For example, his sojourn in Russia led him to make a penetrating analysis of the nature of its peasant society, later incorporated into his paper "Uniformity and Diversity in Groups."²³ In that paper, he embedded his observations into a theoretical analysis based both on his version of Kleinian theory and on his forays into current sociological theory. As Malcolm Pines points out, psychoanalysis, for Rickman, formed the bridge between psychology and sociology.²⁴ To use Rickman's formulation, psychological experiments were based on a one-body model.

A commentator on the article in which Rickman introduced the concept wrote that: "Rickman begins this symposium by dividing the field of psychology into areas of research according to the number of persons studied. One-Body Psychology (perception, learning). Two-Body (mother-child relationships), Three-Body (the Oedipus complex, two parents and a child), Four-Body (the Oedipus complex plus a sibling rival, and Multi-Body (groups))."²⁵ Although, nominally, psychoanalysis was a two-body discipline (involving analyst and analysand), theoretically it fell into the three-body category (the third body being the invisible social agent controlling transference and countertransference).

As a result of his acquaintance with Russian peasant communities, Rickman realized that isolated Russian villages acted as leaderless groups, in which all the members expressed the group ethos with identical force and in which the headman had neither the power nor the authority to impose his will. However, he also recognized that the satisfactions of group cohesiveness came at a heavy cost. Because none could excel group tasks were executed with a very low level of skill and even thoroughness, while no innovations were permissible. In bad crop years such a low level of practical expertise could cause starvation.²⁶ Rickman went on to speculate about social life in a broader sense, for example, the growing gulf between democratic and authoritarian societies in the 1920s and 1930s. Those speculations must have led him to turn his mind to the ethos of a democratic state's conscripted army. On the one hand, the personnel, especially the combat troops, must show high social cohesiveness. Unlike Russian peasants, however, soldiers must be both effective and innovative. Such qualities require leadership, but it must be a leadership acknowledged and recognized within a group as relevant and appropriate, rather than imposed without consideration for the members. Thus, the leader had to work for recognition, and his authority, through his actions which would include such things as concern for his men's welfare, explanation of orders, education about the war effort, and personal examples of proper behavior. This countered the "cannon fodder" approach of the traditional military leaders. Rickman wrote a pamphlet in which he presented his approach. He was also at pains not to overthrow the army system but to make it work. In his discussion of his role as an officer within the unit at Northfield Military Hospital, he made it clear that the task was to discuss an officer's role openly, not to obfuscate it. Thus, he wrote: "Such qualities require leadership; but it must be a leadership that the group recognizes and accepts willingly, rather than being autocratic."

On the outbreak of war, Rickman joined the Emergency Medical Service (EMS) as a civilian psychiatrist, later transferring to the RAMC, with the rank of major. While serving in the EMS, he worked at Haymeads Hospital in Bishops Stortford, Hertfordshire, and immediately took a radical approach. He may well have been the first person to advocate and to practice a set of procedures whereby, through focused activities in an occupational therapy department, those suffering from neurotic forms of mental illness were restored as rapidly as possible to normal social settings and normal social relationships. Organizationally, that meant that the work of the occupational therapy department became closely integrated with that of the psychiatric department. Even more to the point, it reduced the professional gap between psychiatrists and other mental health personnel. Rickman continued his work at Wharnccliffe in Sheffield, Yorkshire,

where he took the further step of converting the work of the occupational therapy department into a graded series of military exercises designed to return neurotic soldiers to combat. He therefore laid the groundwork for the methods of dealing with psychiatric battlefield casualties which were to be used throughout the British and American armies in World War II. Rickman wrote an account of his work in a document known as the Wharnccliffe Memorandum which is, unfortunately, lost.

In July 1942, Rickman was placed in charge of a Hospital Wing at Northfield Military Hospital (formerly Hollymoor Hospital) in Birmingham. Little is known of his early months there, especially with regard to group therapy. As far as we know, initially all the treatments at Haymeads and Wharnccliffe were of individuals. We do know that he began group treatments when Bion joined him at Northfield in late 1942, although, given his Quaker background, one can certainly surmise that he may have experimented with them earlier either at Wharnccliffe or when he was transferred to Northfield.

A Summary Account of Bion's Career

Bion, who was born in India in 1897, fought with distinction in World War I. After acquiring a degree in history from Oxford and working as a schoolmaster, he became a physician, specializing in psychiatry and eventually becoming a psychoanalyst. Grotstein comments that Bion was societally oriented very early in his career, writing that, under the influence of the surgeon and amateur sociologist Wilfred Trotter: "[Bion] was a 'social psychiatrist' prior to becoming a psychoanalyst. . . ."²⁷ As part of his psychoanalytic training, he underwent an analysis from Rickman, which appeared to have released his as yet pent-up creativity and which certainly fostered a close working relationship and intellectual affinity between the two men.²⁸ When World War II began, Bion joined the RAMC as a psychiatrist with the rank of major (retaining that rank throughout the war).

It appears that Bion conceived of Britain's WW II army as a citizen army to be commanded by field officers chosen by a method of democratic consensus. We suggest that Bion's conception of the role and nature of an officer corps influenced his invention, shortly after he became an army psychiatrist, of the leaderless group test, to be used by War Office Selection Boards (WOSBs) for the selection of military personnel for officer training. That test proved to be, in some people's opinion, the most successful and robust technique for the selection of army officers ever devised, even if its application to civilian use has been far less successful.²⁹ Bion denied that there was a connection between leaderless group tests and his later work with leaderless groups for therapeutic purposes.³⁰ Others, however, have seen such a connection. For example, Harold Bridger, a former mathematics teacher who had developed novel means of teaching his subject and who, as an army officer, had administered leaderless group tests, commented: "Real-life situations, that is, community and task-oriented groups involving self-management and self-study, were to be developed as a basic feature of original and community life."³¹ Another of Bion's war-time colleagues, J. D. Sutherland, quoted Bion himself, who wrote that the tests were designed to discover: "[a] man's capacity for maintaining

personal relationships in a situation of strain that tempted him to disregard the interests of his fellows for the sake of his own.”³²

The First Northfield Experiment

Following an administrative debacle, in which he was denied command of a unit that was to extend the application of leaderless group tests, Bion asked to be transferred to Northfield. He was placed in command of the Training Wing. It was there that he and Rickman set up a number of leaderless groups and carried out what has become known retrospectively as the First Northfield Experiment, which constitutes one of the most noteworthy events in the history of psychiatry.³³ Bion wrote only two very short papers on the experiment.³⁴ The more widely cited of those, “Intra-Group Tensions in Therapy,” jointly published with Rickman, makes for astounding reading. For one thing, it is very short (15 pages in the longer of its two versions). For another, it has no references. Furthermore, it reads like a memoir directed at the cognoscenti (the invisible college) rather than at a general academic or professional audience. Bion’s stance as an author is also striking. He wrote primarily as an officer and only secondarily as a therapist. Thus, he described mentally ill people as “psychologically underprivileged,” a phrase suggesting that they belonged to a lower social class than himself.³⁵ In his role as an officer, his aim at Northfield was to restore group morale and to prepare the men under his care (although one might want to say “under his command”) for effective military service.

Finally, one cannot say that, strictly speaking, “Intra-Group Tensions in Therapy” was a coauthored article in that Bion’s and Rickman’s contributions to the text are entirely separate. However, there is persuasive evidence that, as the article was originally conceived, Rickman would have been the senior author and the principal contributor of theoretical insights. In Rickman’s papers, there is a draft that reads like a possible introduction to Bion and Rickman’s article, together with a summary of its intended contents.³⁶ After discussing existing group techniques and describing the failure of exhortatory methods to restore morale to military psychiatric casualties, Rickman wrote:

The two experiments now to be described may be viewed as an attempt to develop “group membership” and to make it a part of a living experience that would assist the patient to adapt himself to new groups on discharge from the hospital, that is, to give him a better technique for handling the problems of group membership and make him more flexible in the acquisition of group membership characteristics. *Attention was focused not on what brings pain or happiness to the individual but what movement or action strengthens the group*—not our group, nor the Army’s group, nor a British, nor any other established group but first of all a group of their own making. Once group formation has started the patient can work his way back to the Army group: it is something, odd though it may sound, that he has to learn by experience, for when we do not ignore group relationships we tend to assume that this capacity is an immutable endowment—or if we do not make this assumption we have got to explain why medicine has paid comparatively little attention to the social relationships of individuals and the psychological structure of the field in which they move.³⁷

Since none of Rickman’s or Bion’s contemporaries knew of Rickman’s theoretical contributions, they must have been primarily influenced by the prac-

tical implications of the First Northfield Experiment. It was controlled by Bion's apparent belief in the symbiotic relationship between leader and led in military units. The men had to become worthy of command and ready to accept command. Conversely, officers had to identify themselves with their men's needs and interests (leadership had to come from within the unit and not be imposed upon it by members of a distinct caste). Bion was, evidently, enough of a democrat to believe that human beings had sufficient resources to realize when they were faced by problems and to devise means, perhaps with some help and guidance, to solve those problems. He allowed the situation to reveal the implicit complexity that was already there, and then aimed to enable the "men" to tackle this underlying anarchy. Then he waited for signs that those living in the chaotic conditions were prepared both to remedy the situation and to take the required steps themselves. By cooperating in shared tasks the psychiatric casualties at Northfield became ready to return to the battlefield.

In group therapy undertaken after World War II, Bion expanded the remit of psychoanalysis in ways that must have been influenced by the techniques he used in the Training Wing. Grotstein writes:

As an individual the person is one thing, but as a member of a group (s)he is another. In other words, each human being is defined by his or her group identity—in parallel with the fact that each group can be thought of as a single whole and as a group composed of individuals. This idea of reciprocity and balancing characterizes one of Bion's most profound ideas, that of *binocular vision* . . . an important part of normal reflective thinking.

Put another way, Bion created a paradigm change by adding this complementary dimension to the individual, one which can be summarized as follows: the individual is both the responsible agent for the initiation of his own will and at the same time is the unconscious medium through which the will of others passes and unconsciously affects him so that his subsequent behavior is comprehensible only by the consideration that he is behaving as if his will is now identical to the will of the group or a division within the group.³⁸

The First Northfield Experiment ended mainly because of an incident that had nothing to do with the operation of the Training Wing. Bion was mess officer at Northfield and became aware that someone was embezzling mess funds. It then became apparent that a senior officer had been misappropriating the money. Rees, knowing Bion's rigid sense of propriety, did not trust him to deal with the matter tactfully and transferred him. However, one also has to bear in mind that Northfield's Commanding Officer at the time, and many of the other senior personnel, had little understanding of, or sympathy for, Bion and Rickman's approach, a situation that was exacerbated by their failure to communicate with or confide in their colleagues. Bion and Rickman's successors at Northfield thus concluded that an experiment as radical as Northfield I had to have at least the concurrence of the Commanding Officer and at least a modicum of understanding and tolerance from those working in the hospital as a whole.³⁹

Even if Northfield I was abruptly terminated, its influence is undeniable. Bléandonnu comments:

What are we, with hindsight, to make of the experiment that Bion and Rickman set up at Northfield? It was undeniably a manifestation of creative genius. . . . It very often happens that real innovation is prematurely terminated; but the environment may slowly become more receptive to the original idea, and the innovation then gives way to more permanent changes and influences. Northfield Hospital became the birthplace of the "therapeutic community" which was to lead psychiatric practice in hospitals after the war, first in Britain and then in the United States.⁴⁰

The Second Northfield Experiment

If community psychiatry was born during the First Northfield Experiment, then it came of age during the Second Northfield Experiment because it was then (from the spring of 1944 until the autumn of 1945) that a full-blown therapeutic community was first put into effect. Although neither Rickman nor Bion were part of the medical staff at Northfield in 1945, both played an indirect role because of their membership of the "invisible college." Furthermore, Rickman had some direct involvement. He visited Northfield at least twice in order to assess progress at the unit and to discuss its work with the staff. He also corresponded with three of Northfield's psychiatrists, Foulkes, Hargreaves, and Main. Moreover, conceptually, there was a clear line of descent from the first experiment to the second, since the two experiments differed administratively rather than in terms of therapeutic aim or therapeutic method.

Northfield II became possible because a new commanding officer, Dennis Carroll, was appointed in March 1944 and laid the requisite administrative groundwork by bringing the hospital and the rehabilitation wings into a closer relationship than they had heretofore. Shortly after that change had come into effect, Harold Bridger was put in charge of the Training Wing. As a consequence of Carroll's administrative changes, Bridger had at his disposal educational materials, arts and crafts, recreational activities, and industrial trades. Furthermore, because he had worked with leaderless group tests, Bridger had become sensitized to and knowledgeable about group dynamics. Another highly significant person at Northfield at that time was Sergeant Laurence Bradbury, who, it is usually said, first introduced art therapy to England.⁴¹ Tom Main was the most senior of the psychiatrists to be involved in Northfield II and became well known because of his role in the therapeutic community movement.

It was during his stay at Northfield that Main first used the term "therapeutic institution." According to Main, such institutions had as their aim "the healthy socialization of patients." Harrison, in one of his footnotes, states that Bridger's concept of the "hospital-as-a-whole-with-its-mission" was analogous to Main's and continues: "There remains the suspicion that Main, in order to accept a new idea, had to reinvent it for himself, like so many pioneers."⁴² But Main certainly grasped his own idea with exemplary clarity.

The first soldiers to be treated at Northfield II consisted of psychiatric battlefield casualties from the Normandy invasions, to be followed by Chindits (men who had fought in Brigadier Orde Wingate's Special Forces in Burma). The Chindits were exceedingly physically ill. It would seem that the experiment proper began when Bridger, as part of an effort to weld the hospital into a cohesive unit, took over an empty ward and put up a notice saying: "The Hospital Club." Then he had meetings of ward representatives to discuss equipment and

organization. Harrison comments: "This emptiness acted like a silence in group therapy, leading the whole establishment to question its existence."⁴³ That questioning and the way it came into being constituted a very clear continuity between Northfield I and Northfield II.

Harrison continues:

The saga of the social club culminated in a meeting of patients to which Bridger was summoned. Here he was confronted by a group of soldiers wanting to know why he was wasting time and money in wartime. They were especially concerned about the waste of space . . . Bridger calmly agreed, and wondered what should be done about it. After the debate, the men began to realize that they could take responsibility and power, and organize things in the way that they wanted. The first Committee was thus formed as a result of the protest group. Once this energy had been released the patients' creativity knew no bounds. It was not a smooth path: at times the social club was vandalised, and even on occasion smashed up completely. However, progress was made. The Hospital Club acted as a therapeutic test bed. *It enabled individuals to place insights gained from their personal treatment into a social context and test out the consequences in a "here and now" community. It made it possible for them to ally their personal energy with a social purpose and come up with the organizational structures required to achieve it. This self-evidently paralleled their role in the army and society as a whole. . . .*⁴⁴

A mentoring system, in which those already in the hospital helped newcomers to orient themselves, as well as giving them information about hospital routines and services, was a crucial off-shoot of the Hospital Club. It prefigured the therapeutic role of inmates within later therapeutic communities. However, Northfield II did not become fully operational until the war had ended, by which time Northfield Hospital was one of the establishments preparing soldiers for return to civilian life; most of its intake consisted of returned prisoners of war.

Conclusion

Main left Northfield in 1946, going directly to the Cassell Hospital. Bridger left in September 1945, after which morale at the unit deteriorated. Fortunately, a group of American psychiatrists, led by Karl Menninger, toured the unit in June 1945, when it was still in full bloom. Menninger was so impressed that he devoted a complete issue of the *Bulletin of the Menninger Clinic* to group psychotherapy, thereby providing an irreplaceable record of the ground-breaking achievement of some of the psychiatrists and other personnel working in war-time Britain.⁴⁵

The issue of the continuity between that achievement and the development of the therapeutic community needs to be addressed. Very briefly, it seems that, in a very broad sense, we do see continuities between Northfield and later therapeutic communities. For example, Kräupl Taylor states, without elaboration, that: "The development of therapeutic group activities in Great Britain since the war can be largely traced back to the two 'Northfield Experiments'."⁴⁶ In a comment on Tom Main's career, Millard writes:

Within the therapeutic movement, Main emerged as by far the most powerful of the Northfield group, becoming Medical Director of the Cassell Hospital in 1946, immediately training as a psychoanalyst, and retaining the Directorship until his

retirement 30 years later. At the Cassell, he developed a distinctive version of the therapeutic community which retained within the treatment regime a more prominent place for individual and family psychotherapy or psychoanalysis. . . . there exists a network of institutions in the United States—Chestnut Lodge, the Austen Riggs Center, and the New York Hospital—adopting a very similar philosophy. . . .⁴⁷

In other respects, the link between Northfield and later therapeutic communities is indirect or even lacking, and that is especially true in terms of therapeutic practice. If one wants to argue that, theoretically, Rickman's and Bion's therapeutic practice was guided by modified Kleinian principles, then one has to demonstrate that such practices were widespread in therapeutic communities. Such, however, does not appear to be the case, even at the Cassell Hospital. For example, Brook, in his brief review of therapeutic practices there, states that Main and his colleagues frequently used individual therapy (i.e., that, unlike Bion and Rickman, they were not working with the "group-as-a-whole").⁴⁸ If we take the paradigm of such practices to be leaderless group therapy, then Bion was the almost sole practitioner of the method.⁴⁹ Certainly, the practice did not spread to America.⁵⁰

If we do take the position that there is a lack of continuity between Northfield and later therapeutic communities, we can offer very simple reasons for it. Although Bion engaged in leaderless group therapy after the war, he did so at the Tavistock Clinic, not in a therapeutic community. Rickman continued to devote himself to administrative work and did very little therapeutic work at all, while it is only now that the extent of his theoretical contributions is beginning to emerge. Bridger, the most innovative of those who worked at Northfield, was excluded from therapeutic work because he lacked medical qualifications and became involved in leaderless group work in the area of management, not of therapy.

Moreover, if we consider British therapeutic communities other than the Cassell Hospital it is by no means clear that their practices originated at Northfield. The most conspicuous example is Maxwell Jones's work at Belmont Hospital at Sutton in Surrey, near London.⁵¹ His work seems to be an example of inspired eclectic empiricism. Jones is especially important because his international influence, especially in North America, was much greater than that of any other figure in the therapeutic community movement. The same lack of a clear lineage appears to be true of the other major British therapeutic communities—Dennis V. Martin's at Claybury Hospital, near London, David H. Clark's at Fulbourn Hospital in Cambridge, and Duncan Macmillan's at Mapperley Mental Hospital in Nottingham.⁵²

A clear answer to the question of the intellectual lineage of those therapeutic communities cannot be obtained by examining the published literature. The answer lies within the relationships between the members of the "invisible college" and their relationships with those who were not members. Thus, Harold Bridger wrote of Maxwell Jones: "It is only sad that in private he has frequently acknowledged his debt for the ideas and dynamics he drew from Northfield I and Northfield II but has not, to my knowledge, done so publicly in his many works."⁵³ Clark, in several of his articles, acknowledges Northfield as the starting point for therapeutic communities but, by implication,

places Jones at the forefront of the therapeutic community movement. He certainly does not discuss any theoretical affinities between himself and the Northfield group. Martin portrays himself as the sole originator of his own ideas and the same is true, so far as we know, of Macmillan. In order to resolve those issues, one would have to know more about the post-World War II role of the invisible college, about the place of the Tavistock Clinic in the postwar British mental health movement, and of the place and role of psychoanalytically oriented psychiatrists in postwar Britain.

However, we can determine whether or not it is worthwhile to pursue the line of investigation we have outlined. We can ask: What are the crucial attributes of a therapeutic community?⁵⁴ First, assigning a primary role to group therapy. That is, individual therapy was practiced merely as an adjunct to group therapy. Second, a flattening of the professional hierarchy, especially with respect to the enhanced role given to nurses or medical orderlies and the assigning of senior psychiatrists to an advisory rather than a therapeutic role. Third, assigning a therapeutic role to occupational therapy departments and, within such departments, changing tasks from the merely palliative to projects oriented toward the world of work. Fourth, assigning a therapeutic role to those suffering from mental illness. That meant according respect to patients' therapeutic insights, whether regarding themselves or their fellow sufferers, and according respect to those suffering from mental illness and to their comments or criticisms regarding the operation of the unit to which they had been committed.

Fifth, the creation of a specific social atmosphere within therapeutic communities. Very briefly, we will characterize it as the maintenance, from an inward aspect, of tolerance and nurturance, combined, from an outward aspect, of the maintenance and fostering of pathways connecting to society outside the institution. The social atmospheres within therapeutic communities represented a decisive break with the autonomous worlds of traditional mental institutions. In the latter, the typical patient was chronically mentally ill and could be expected to spend a lifetime within the institution. In a therapeutic community, the typical patient was expecting (and was expected) to remain institutionalized for a very short time.

At Northfield II, all five attributes existed in a highly developed form. Moreover, their origins are to be found in Rickman's thought and practice during the pre-World War II and early war years. During his analysis with Klein, Rickman realized that analyst and analysand were, first and foremost, a social group, albeit merely a dyad, so that whatever happened in that dyad could, conceivably, occur in a multiperson group. Even before he became a psychoanalyst, Rickman had taught the untrained to take on a professional role. At Wharnccliffe, he began to train combat noncommissioned officers and occupational therapists to offer low-level military exercises in order to prepare men for a return to combat. At Northfield II, such practices were given a civilian aspect by assigning inmates to approved work situations outside the hospital. During both Northfield I and Northfield II, inmates were encouraged to take the primary responsibility for their own psychiatric conditions, to create workable social environments, and to at least act as aides in inducting new intake into the institution. The fifth attribute then automatically became a corollary of the preceding four.

We can see all five attributes in the practices of the institutions for delinquent children operating in Europe and the United States in the pre-World War II era and its immediate aftermath, institutions such as The Little Commonwealth, Aichorn's institutions, and Hawkspur in England. In those three instances, at least, we also see the deployment of psychoanalytic principles, always loosely and sometimes in a post hoc rather than a *propter hoc* sense. We suggest that Rickman and Bion, who were societally rather than medically or psychoanalytically directed in their early careers, imbibed the same sorts of principles underpinning the practices of the delinquent-youth institutions. Once they began their psychoanalytic training, then, both were attracted to the more liberal, socially oriented British psychoanalysis rather than to the classical Viennese variety. When World War II began, they were both, as military psychiatrists, primed to develop and use their nascent working principles. Given the complex history of the therapeutic community, which possibly extends as far back and as far afield as William Rush Duntton's work in occupational therapy at the Shepard-Enoch Pratt asylum in the United States in the 1890s, we cannot say that therapeutic communities had their sole origin in Northfield I and II. Nevertheless, the liberated Kleinian theory and the working practices of Rickman and Bion certainly deserve an honored place in that history.

Endnotes

1. See Kurt Lewin, R. Lippitt, and Robert K. White, "Patterns of Aggressive Behavior in Experimentally Created 'Social Climates'," *Journal of Social Psychology* 14 (1939): 229–256. Also see Lewin and Lippitt, "An Experimental Approach to the Study of Autocracy and Democracy: A Preliminary Note," *Sociometry* 1 (1938): 292–300. The studies revealed various differences between authoritarian and democratic groups, such as higher levels of intragroup aggression and of discontent in the former. We thank Hank Stam for providing us with the references cited.

2. Thus, writing of two of the earliest therapeutic communities, Maxwell Jones's unit at Mill Hill Hospital near London and Wilfred Bion's Training Wing at Northfield Military Hospital in Birmingham, England (both operating during World War II), Rex Haigh writes: "[both] made fundamental challenges to the nature of authority." (Rex Haigh, "The Quintessence of a Therapeutic Environment," in *Therapeutic Communities: Past, Present and Future* (London: Jessica Kingsley, 1999), 254.

3. See Tom Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments: Advancing on a Different Front* (London: Jennifer Kingsley, 2000), 24–37.

4. For accounts of British psychoanalysis, see Judith M. Hughes, *Reshaping the Psychoanalytic Domain: The Work of Melanie Klein, W. R. D. Fairbairn, and D. W. Winnicott* (Berkeley, Calif.: University of California Press, 1989) and Phyllis Grosskurth, *Melanie Klein: Her World and Her Work* (New York: Knopf, 1986).

5. The literature on community psychiatry is very large. The following bibliographic sources are useful: Robert N. Rapoport (1960), *Community as Doctor: New Perspectives on a Therapeutic Community* (London: Tavistock, 1960), Chapter 1, footnote 5; Milton Greenblatt et al., *Custodial to Therapeutic Patient Care in Mental Hospitals* (New York: Arno Press, 1955), 433–484 (especially 457–462; most of the bibliography lists background sources in areas such as empathy, attitudes, and group dynamics); Gerald Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton: Princeton University Press, 1991), 358–359, notes 4 and 5; Tom Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments* (London: Jessica Kingsley, 2000), 287–308.

6. David Kennard, "The Therapeutic Community as an Adaptable Treatment Modality across Different Settings," *Psychoanalytic Quarterly* 75 (2004): 296. Haigh in "The Quintessence of a Therapeutic Environment" puts forward five principles that differ from Kennard's but overlap with them. They are: 1. Attachment: A culture of belonging. "[c]ommunity members can clearly feel a sense of belonging—where membership is valued and where members themselves are valued." (247–248); 2. Containment: A culture of safety. Patients: "[have] the novel opportunity to have . . . powerful primitive feelings accepted and validated." (249); 3. Communication: A culture of openness, defined as the opportunity: "[to] make contact with others, enjoy mutual understanding of common problems and find meaning through this connection." (250); 4. Involvement: A culture of participation. Haigh comments: "Everything that happens in the community—from the washing up, to the board games, to the requests for leave—can be used to therapeutic effect." (252); 5. Agency: A culture of empowerment. Haigh comments: "[most] therapeutic impact comes from work the patient does, rather than the therapist." (254). In general, Haigh comments that only Principles 4 and 5 are truly specific to therapeutic communities.

7. Harry Stack Sullivan, *Conceptions of Modern Psychiatry: The First William Alanson White Memorial Lectures* (New York: Norton, 1940). Sullivan delivered the lectures in 1939, 232. We thank Craig Fees, who drew our attention to this passage. From other passages in Sullivan's writings, it seems that he was willing to extend a concept akin to the therapeutic community fairly broadly within mental hospitals. For example, he wrote: "The mental hospital is a community characterized by a strong interest in human behavior and an alertness to personality characteristics." (Sullivan, "Psychiatric Training as Prerequisite to Psychoanalytic Practice" in Sullivan, *Schizophrenia as a Human Process: The Early Work at Sheppard-Pratt*. [New York: Norton, 1962], 308–318 [a reprint of a paper Sullivan delivered in 1934]). Earlier, Sullivan had written passages suggesting even more strongly that he was thinking along the same lines as those who created the first therapeutic communities. For example, he had suggested that: "[the] locus of psychobiological events is in a nexus of persons and their relations . . ." and that: "[not] sick individuals but complex, peculiarly characterized situations were the subject-matter of research and therapy." With respect to therapeutic potential, he claimed that there was an interaction between ward personnel and patients, while, even in diagnosis, clinicians' propensities and nosological categories interact. Even more specifically, he had written: "I refer to experience in dealing with young male patients by deliberate and rather thoroughgoing modification of the personal social and cultural environment in and within which they continued their being during the earlier stages of hospitalization." In a further passage, he had written: "[it] dawned on me that in personal interaction—even though it occurs extraconsciously—there is a valid, even if recondite, field for observation, classification, and induction." (All passages quoted from Sullivan, "Socio-Psychiatric Research: Its Implications for the Schizophrenia Problem and for Mental Hygiene," *American Journal of Psychiatry* 87 [1931]: 982–983).

8. Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*, 215.

9. Craig Fees points out that the term "therapeutic community" also occurred in the title of an article by Elizabeth Eells ("From the Sunset Camp Service League: Camp as a Therapeutic Community" in the *Nervous Child*, 6 (1947) and suggests that: "[it] was in general circulation at an oral level among psychiatrists and other mental health professionals in 1930s and 1940s who were exploring and discovering the influence of environment and community on health, mental health and behaviour, and that [Sullivan's and Eells'] happen to be the first known settings into print." (Therapeutic Community Open Forum, posted on 16 January 2006). Fees also suggests that the term could have been in widespread casual use among the medical community from the early 20th century onward

and that Sullivan, Eells, and Main merely happened to be among those who first used it in published works.

10. For a list of some of those institutions see Kennard, "The Therapeutic Community as an Adaptable Treatment Modality across Different Settings," *Psychiatric Quarterly* 75 (2004): 297. For an overall account of such work in Britain, see Maurice Bridgeland, *Pioneer Work with Maladjusted Children: A Study of the Development of Therapeutic Education* (London: Staples Press, 1971).

11. For an account of Lane's work, see W. David Wills, *Homer Lane: A Biography* (London: Allen & Unwin, 1964). For an account of Aichorn's work, see August Aichorn, *Wayward Youth* (New York: Viking Press, 1935). This is a translation of *Verwahrloste Jugen*. 2nd. Ed. (Vienna: Internationaler Psychalytischer Verlag, 1931).

12. For accounts of Klein's and Fairbairn's theories, see Harrison, *idem*, 38–49 and Hughes, *Reshaping the Psychoanalytic Domain*. For an excellent treatment of Klein, see Grosskurth, *Melanie Klein*.

13. When speaking or writing of infants, Klein typically used the dichotomy "good breast" versus "bad breast." However, in that she believed that the phantasized dichotomy was the progenitor of later adult emotions she also, albeit more loosely, also spoke in terms of love and hate. See Grosskurth, *Melanie Klein*, 441 and 445 and various passages in Hughes, *Reshaping the Psychoanalytic Domain*, 44–88.

14. For a short review of her theory, see "Love, Guilt and Reparation" in Melanie Klein and Joan Riviere, *Love, Hate and Reparation* (New York: Norton, 1964), 57–119. Klein presented the theoretical and empirical basis for her position in her "A Contribution to the Psychogenesis of Manic-Depressive States" (especially on 305–310) and "Mourning and Its Relation to Manic-Depressive States," in Klein, *Contributions to Psycho-Analysis, 1921–1945* (London: The Hogarth Press, 1950), 282–310 and 311–338, respectively.

15. "Love, Guilt and Reparation," 65–66.

16. The belief that all children pass through psychotic stages is perhaps limited to those who follow Klein very strictly. Others would prefer to call such stages "infantile neuroses" or merely "bizarreness." See James S. Grotstein, *Building on Bion: Roots. Origins and Context of Bion's Contributions to Theory and Practice* (London: Jennifer Kingsley, 2003), 24, Note 7.

17. Bion was among those, such as Sullivan and Freda Fromm-Reichmann in the United States, who engaged in psychotherapy with psychotics. By the 1950s, he was giving long-term psychotherapy to such patients (a 5-year course of therapy to at least 10). His aim was not to cure conditions like schizophrenia but to enable schizophrenics to recognize for themselves the severity of their condition and thereby live some semblance of a normal life. He claimed that two thirds of his psychotic patients were earning a living. He rigorously eschewed any form of physical intervention, writing: "The analyst ought to expect concern for the patient's welfare to drive the family to intervene and he must be prepared to explain an alarming situation to them. He should strive to keep at bay surgeons and shock therapists alike while concentrating on not allowing the patient for a single moment to retreat either from his realization that he is insane or from his hatred of the analyst who has succeeded, after so many years, in bringing him to an emotional realization of the facts that he has spent his whole life trying to evade" (Bion, *Second Thoughts* (London: Heinemann, 1967), 34).

18. For a discussion of the "invisible college," see H. V. Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge and Kegan Paul, 1970), 107–109 and the numerous references to the group in Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*, especially 86–87.

19. For another fictional portrayal of psychiatric illness resulting from battlefield experience, see the account of the experiences and suicide of Septimus Warren Smith in

Virginia Woolf's *Mrs. Dalloway*. For a portrayal of someone who learned to live with battlefield neurosis, see Inspector Ian Rutledge in Charles Todd's series of mystery novels, starting with *Test of Wills*.

20. We are relying almost totally on Sylvia Payne's obituary in the *International Journal of Psychoanalysis*, republished as the Foreword to John Rickman, *Selected Contributions to Psychoanalysis* (London: Hogarth Press, 1957), 9–16.

21. See Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*, 38 and Harrison, "Northfield 50 Years On," (lecture, The Sutherland Trust, November 16, 2001).

22. Rickman, "The Individual and the Group," (lecture notes, Rickman Papers, Archives of the British Psycho-Analytic Society, Box 4, Folder 2, May 2, 1939). Inserts in square brackets added to create a grammatical sentence.

23. Rickman, "Uniformity or Diversity in Groups," (Paper based on two published lectures delivered in March of that year to the Institute of Psychoanalysis, 1958). We used an unpublished, transcribed copy in the possession of Pearl King and Tom Harrison.

24. Malcolm Pines, "The Influence of John Rickman and Melanie Klein on Wilfred Bion," (unpublished MS, 1998). We thank Dr. Pines for making it available to us.

25. From an abstract of Rickman's article in *Psychoanalytic Quarterly*, (1952): 21, 452. We thank John Forrester for bringing that quotation to our attention.

26. See Rickman, "Uniformity or Diversity in Groups."

27. James S. Grotstein, "Introduction: Early Bion," in *Building on Bion: Roots*, 9.

28. Eric Trist commented: In conjunction with [his analysis] he got out of his doldrums, entering on a late first marriage, publishing a late first paper (on psychological "asepsis") and beginning for the first time to reveal some of his immense powers of insight and intellect. Past the age of 40, he was beginning to find himself. (Eric Trist, "Working with Bion in the 1940s: The Group Decade," in M. Pines [ed.], *Bion and Group Psychotherapy*, [London: Routledge and Kegan Paul, 1958], 3).

29. See F. Kräupl Taylor, "A History of Group and Administrative Therapy in Great Britain," *British Journal of Medical Psychology* 31 (1958): 154–155, for an analysis of the degree of success and the validity of leaderless group tests. Kräupl Taylor maintains that the WOSB leaderless group tests owed their undoubted success to their indirect effects on morale rather than on their capacity to select the cognitive and personal characteristics required for leadership.

30. See Bion, *Experiences in Groups and Other Papers* (London: Tavistock, 1961), 83, Note.

31. Harold Bridger, "Northfield Revisited," in *Bion and Group Psychotherapy*, 92.

32. J. D. Sutherland, "Bion Revisited: Group Dynamics and Group Psychotherapy," *idem*, 49. Bion's beliefs in the socially based nature of personality and of human beings' openness to and awareness of the feelings of others appear, as suggested by one of the referees of this article, to bear some resemblance to Sullivan's. For example, in writing of the emergence of the capacity to love, Sullivan wrote: "Whereas previously, one may have learned to say the right things to one's companions, to do the right things, now those sayings and doings take on a very special significance. One's security is not imperiled by one's love object. One's satisfactions are facilitated by the love object. Therefore, naturally, for the first time one can begin to express oneself freely. If another person matters as much to you as you do to yourself, it is quite possible to talk to this person as you have never talked to anyone before." (Sullivan, *Conceptions of Modern Psychiatry: The First William Alanson White Memorial Lectures* [New York: Norton, 1940], 43.) We are not saying that Bion believed that officers should love those under their command, but we are saying that he believed that only those who had insight into and respect for their subordinates' feelings were worthy to command.

33. For a brief but sympathetic review of the First Northfield Experiment, see Kräupl Taylor, "A History of Group and Administrative Therapy in Great Britain," 153.

For a detailed analysis, see Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*.

34. Wilfred Bion and John Rickman, "Intragroup Tensions in Therapy," *Lancet* 2 (1943): 678–681 and Bion, "The Leaderless Group Project," *Bulletin of the Menninger Clinic* 10 (1946): 77–81. The first article was republished in Bion, *Experiences in Groups and Other Papers* (London: Tavistock, 1961).

35. Bion's phraseology is an instance of the downward imposition of democratic values so characteristic of his generation and the one preceding it. Thus, Beatrice Webb, a leading Fabian, combined pervasive snobbery with deeply felt and genuine socialism.

36. Rickman, "Group Therapy Applied to the Rehabilitation Wing of a Psychiatric Hospital and to Ward Treatment," (Rickman Papers, Archives of the British Psycho-Analytic Society, 1943).

37. Ibid, 3. Italics added.

38. Jason S. Grotstein, "Introduction: Early Bion," in *Building on Bion: Roots*, 13. Grotstein also wrote: "[Bion] states that there is such a thing as the psychology of the group but that the origins of the psychology lie solely with the individuals comprising the group, but he also seems to believe that the potential group-relating aspect within the individual is activated by the group. . ." (ibid, 14).

39. D. W. Millard comments: "[the] important lesson, taken over into the second Northfield Experiment, concerned failing to involve the wider environment (in this case the whole hospital community and its administration), which came to be seen as a necessity if an unconventional therapeutic regime was to become established and survive." (Millard, "Maxwell Jones and the Therapeutic Community", in *150 Years of British Psychiatry* [Vol. II], edited by George E. Berrios and Hugh Freeman [London: Athlone, 1996], 588.)

40. G. Bléandonnu (1994). *Wilfred Bion: His Life and Works, 1879 – 1979*. (London: Free Association Books), 63.

41. See Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*, 203. Bradbury himself refused to categorize his work as "art therapy."

42. Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments*, 215.

43. Idem, 208.

44. Idem, 209–210. Emphasis added.

45. *Bulletin of the Menninger Clinic*, 10 (Spring), 1946.

46. Kräupl Taylor, "A History of Group and Administrative Therapy in Great Britain," 153.

47. Millard, "Maxwell Jones and the Therapeutic Community," 590.

48. Alexis Brook, "The Impact of Tom Main," *Therapeutic Communities* 14 (1993): 205–212.

49. See Bion, *Experiences in Groups and Other Papers*.

50. See R. J. Corsini, *Methods of Group Psychotherapy* (New York: McGraw Hill, 1957), 77.

51. For an account of Jones's work, see Millard, "Maxwell Jones and the Therapeutic Community."

52. For accounts of their work see: Dennis V. Martin, *Adventure in Psychiatry: Social Change in a Mental Hospital* (Oxford: Bruno Cassirer, 1962); David H. Clark, *Social Therapy in Psychiatry*. (London: Churchill Livingstone, 1981), and "The Therapeutic Community," *British Journal of Psychiatry* 131 (1977): 553–64; and Duncan Macmillan, "An Integrated Mental Health Service: Nottingham's Experience," *The Lancet* November (1956): 1094–1095. In his "The Therapeutic Community – Concept, Practice and Future," *British Journal of Psychiatry* 111, 947–949, Clark (1965) gives a concise account of the origins of the therapeutic community. Although most of his discussion deals with

Northfield, he assigns Maxwell Jones a foundational role (but without discussing the theoretical origins of Jones's ideas or comparing his work with that done at Northfield).

53. Bridger, "Northfield Revisited," 100.

54. Our principles are similar to those listed by Kennard in "The Therapeutic Community as an Adaptable Treatment Modality across Different Settings," which we have quoted previously. Since we arrived at our principles independently of Kennard, we have chosen to use ours at this point in the article.

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