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Group Analysis 1977 10: S2

DOI: 10.1177/053331647701000212

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THE CONCEPT of the THERAPEUTIC COMMUNITY :
VARIATIONS and VICISSITUDES

Tom Main

When you honoured me with your invitation to give this, the first, S. H. Foulkes Memorial Lecture, I did not hesitate to accept. I knew Michael Foulkes for over 30 years and I decided that it would be forgivable to allow myself certain reminiscences evoked by memory of him; but not so much about him as about the first years when we worked together, ate together and talked much before taking our separate ways in friendship.

My title was offered impulsively and I shall not confine myself strictly to it. The vicissitudes occurred before as well as after the birth of the concept: the variations later. I should also make clear that whilst this lecture is offered to the memory of Michael Foulkes it is not primarily about him.

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Some time in 1940 when Britain was fighting for sheer survival a phobic infantry soldier was sent to a psychiatrist by his Medical Officer at the request of his Company Commander. The psychiatrist reported back as follows: "This soldier should be excused from handling a rifle, should be allowed to wear carpet slippers and should be given duties within a two-mile radius of his home in Bradford."

This putting the patient first and above all else ("le malade, toujours le malade") is in the medical tradition we all hope to find in our doctors when we are ill, and it is in this tradition that the great studies of man's organs, his bodily systems and their pathology have been made. This medical model has brought great benefits to mankind and it would be folly not to value and pursue it always. But we must also respect its limitations. My example shows how it can be inappropriate sometimes to the point of being ridiculous, even harmful for the welfare of the patient's fellows and for his own dignity. The idea of a soldier contributing to a desperate war effort by marching about a suburb of Bradford, wearing carpet slippers and having no rifle is not easy to contemplate without amusement. Our psychiatrist was ridiculous but only because he had been half educated, taught to think in terms only of a single order of system - the individual - and therefore unable to respect other levels of human systems. Even a passing acquaintance with general systems theory would have helped him.

Every individual can be conceived of as a system of interacting sub-systems - such as the circulatory or muscular or respiratory systems; and in bodily illness it is a matter for diagnosis which of the sub-systems is disordered and needs treatment. The individual is however something more than the sum of his parts, and indeed every human system is more than the sum of its parts. This is because human systems and their sub-systems are in active relations with each other, and react dynamically in complex ways to create larger systems, be it a cardiac system, a whole human system, a family system or a hospital system. In each case an understanding of the system is not to be achieved by serial study of the isolated parts.

Each human system, no matter how complex, may thus be viewed on its own, or as an interacting element in a higher-order system which itself can be studied as

a whole, but which in turn will be an element in a yet higher-order system. In the hierarchy of systems each level of sub-systems, systems and higher-order systems has its own legitimacy, its own unique laws and dynamics and pathology and its own claims on us for singular concepts designed specifically for that particular level. Once we have chosen one system for study - say an individual, or a work-group - we should be clear that it will not be well understood nor usefully treated by techniques or insights derived from work with systems of a different order in the hierarchy. An expert on the renal system is not thereby equipped to treat a whole person's unhappiness, nor is a psychoanalyst automatically equipped to treat a family nor a family therapist a disturbed work-force; nor, to reverse the direction, is a social anthropologist automatically equipped to understand the nature of a single person. Each expert is competent only with his own level of system.

It will be clear that sometimes the disorder inside one system will secondarily disturb one or more of the systems with which it is dynamically related, perhaps of a lower order, or a similar order or a higher order. In diagnosis we therefore need to distinguish those disturbances which arise from inside a system from those which are merely reactive to the strains created by other related systems, and to be capable of locating our diagnosis accurately at the appropriate level of system and in the key system of that level. Put in more human terms the individual may be disordered because of matters inside himself, or his disturbance may be essentially reactive to another person's disturbance - let us say that of his wife. His own disorder, whether internal or reactive, may create strains for nobody but himself or it may affect other family members. He may again create strains for a higher-order system, let us say his employers, or be under strains from that. And so on. Our neurotic soldier was disordered within himself as a system, and this had led to him being under further strains from his relations within the higher-order system. Our psychiatrist proposed to alter only the latter, whether it liked it or not, in the interest of his patient. Hence the slippers and no rifle. He was however utterly blind to the intolerable strains in the higher-order system which this soldier's illness created and which were expressed by the Company Commander's referring him. Indeed he invited the higher-order system to accept even further strains and to alter its life and death aims to suit his patient. As you can imagine this invitation to the Army to alter its aims was declined and the soldier was discharged, no doubt to everybody's satisfaction.

In the scientific hierarchy of human systems, none has any particular merit over another. Each has its own right to recognition. But to make unconfused and appropriate observations about human distress we need some awareness of the different orders of system as well as observational instruments, concepts and tools of intervention singular and appropriate for each order; and now we may avoid sterile prejudgements and lofty generalisations about the singular importance of one particular preferred system for every kind of distress. And we might come to discriminate and value and cease to preach about the superior or inferior merits, for instance, of individual treatment or marital or family or group or social treatment in various circumstances. We can indeed grow the hope of respecting each level of diagnosis and treatment for what it can and cannot do, and of deciding when one level of treatment would be more appropriate than another in a given situation. But if we can make diagnoses only at one level then we shall only have one shot in the locker, and one automatic prescription no matter what the human trouble.

My army anecdote was from 1940, and concerned the relentless use of the

medical model with which all doctors entered the Army. But we learned. By 1945 there were few Army psychiatrists who thought only in terms of personal systems, even those who worked only in hospital. Many psychiatrists were now thinking, somewhat confusedly it is true, in terms of lower- and higher-order systems - although they did not use these words. Psychiatrists working with units in the field were all aware of certain battalions in which individual breakdown was common and of others in which it was rare. A few psychiatrists, of whom I was one, tried to find out what made this difference and began to think in terms of larger social wholes, to recognise their several identities and to study the ways management systems in various battalions improved, maintained or damaged the morale of battalions as wholes as well as the mental health of the individuals who comprised them. We had easy access to such matters as the rates of sick bay attendances, absence without leave, drunkenness, minor indiscipline, severe military delinquencies, venereal disease, breakdowns and various psychosomatic illness. It was not difficult to notice how these figures rose and fell more or less together, and collectively were reliable indices of unit morale. In addition it was possible to get informed opinion at various levels about which units were in bad shape. In the field one met well-run units of high group morale which carried significant numbers of men with manifest personal breakdown who refused to report sick, and who would soldier on effectively; and other units who combined to make an unhappy and inefficient whole with generalised reactive miseries, complaints, delinquencies and psychosomatic disturbances, even among men with records of stable personal health. Such facts alone revealed the limitations of the medical model of individual illness and personal treatment, and almost all field psychiatrists added to concern for the individual a concern for various social systems of the Army. This was a new world. The facts were there, the demand urgent, and we doctors were ill-trained for helping in these problems. Social science was in its infancy - was psychiatry then to become more a social psychiatry and less a medical one? We were ignorant but willing. The concept of social systems had yet to be devised and we had to be content with vague ideas such as social wholes, group morale, social climate, corporate identity, although we were much helped by the generously offered concepts of social psychologists like Eric Trist and later by social anthropologists like Adam Curle.

I worked chiefly with the infantry's common fantasies and soon it was possible to ask questions, one of which is relevant for this occasion. What was it about the various battalions which made the difference in promoting or failing to promote the health of the individuals within them? It had nothing to do with social structure nor with the width or height of the administrative hierarchy. These were inescapably identical in all units. Nor had it anything to do with roles; these, and the powers and responsibilities they carried, were defined precisely and without blurring by the Army and were the same in each battalion. Nor had it to do with role relations; these too were also laid down. Thus it was not the type of social hierarchy, nor role-rigidity, nor the role relations which explained why a particular battalion was therapeutic or anti-therapeutic. It seemed to be something both more vague and more important than these; it was the culture, the human folk ways by which the systems were operated, the quality of human relations inside the social structure. These differed widely and clearly made the difference to the humans in the several units. I shall return to this matter of culture later.

Our rather vague concepts, such as group-morale and group dynamics concerned higher-order systems, and this change of system was new and far from easy for us doctors. It is difficult today to remember that at the time it involved

effortful major conceptual shifts in a psychiatry which had hitherto ignored groups except as the sum of personal states. Not all psychiatrists were able to make these conceptual shifts, but those who did were rewarded by a new exciting viewpoint - the possibility of a social psychiatry concerned with the study and treatment of social entities and their effects on individuals as their sub-systems. This viewpoint did not require the abandoning of interest in the inner life of individuals; rather it led to an additional new major interest for those who were already committed to a psychoanalytic interest in the inner life of man. But this did not arrive suddenly. It grew slowly out of the urgent demands of the situation and the facts in the new field before us. In the Army the individual was cared for, trained, and valued highly, but only as a contributor to group purposes, and for the survival of his group as a whole he must be risked, perhaps even to lose his life. There were also economic pressures on psychiatrists to recognise groups. Soldiers were many and psychiatrists few. In addition the existence of groups was inescapable and insistent; sections, platoons, batteries, squadrons, companies and so on. Every man belonged to a group and derived some of his identity from it. Every time a psychiatrist saw an individual he knew - unless he was blinkered like the 1940 psychiatrist in my anecdote - that he was seeing a member of a group of singular skills and purpose. It was not surprising that under the pressures from such facts various psychiatrists began to observe and think about and to experiment with groups and to grasp at the scant available knowledge about groups. In the clinical field a little-known foreign psychoanalyst, Michael Foulkes, now highlighted as a pre-war pioneer of small-group treatment, was posted to a hospital - Northfield - and given his majority and full facilities to apply and develop his studies into the unconscious life of groups and to teach. Joshua Bierer was similarly employed for a time at Northfield. And in diverse non-clinical work with groups there were more. John Rickman, the distinguished psychoanalyst, had begun his interest in group unconscious functioning decades before at the leaderless meetings of the Society of Friends, and even during the 1918 revolution had studied the effects of group discipline systems in a Russian village. Familiar with Trigant Burrows' psychoanalytic work of the 20s on group therapy, he had become vastly experienced in the study and resolution of unconscious tensions in the leaderless small-group activities and group discussions devised for officer selection by his distinguished psychoanalytic pupil Wilfred Bion. Rickman generously taught and inspired others, especially that small band of workers who after the war founded the Tavistock Institute of Human Relations and became applied psychoanalysts. Henry Dicks studied the Psychological Foundations of the Wehrmacht and Nazi culture; John Kelnar later did similar although lesser work about the Japanese. A.T.M. Wilson undertook operational research into field problems and then brilliantly devised and supervised a country-wide network of units as transitional communities, imaginatively using small groups in the reculturation of thirty thousand socially dislocated soldiers - the returned prisoners of war. It quickly became clear to all involved that to be effective in the desperately urgent matter of war, we needed deeper understanding of unconscious motives, fantasies and object-need in groups as well as in individuals, and we drew heavily on psychoanalytic thought, even developed it. We had to be practical, and as J. D. Sutherland later remarked, there is nothing so practical as a good theory. He and a score of others took part in this change towards a social psychiatry simply because the work was there demanding to be done, but I will mention only a few more. Sutherland himself worked thoughtfully and intensively alongside Ferguson Roger with small groups in Officer Selection; and H. E. Bridger, a mathematician and educationist experienced in field command, was energetic as a military observer of groups in Officer Selection. He was posted to

Northfield in 1945 after Foulkes, and about the same time as I was. By 1945, outside the Army, British psychiatry went on, as it does today, in proper pursuit of the medical model and largely untouched by interest in higher-order human systems or the unconscious life of man. But there were a few kindred spirits. T. P. Rees of Warlingham Park was seeking for a social approach to avoid the anti-therapeutic and maximise the therapeutic effects of mental hospital life. Major Elliot Jaques, a psychiatrist of the Canadian Army, was eager to join his thinking and his future with ours. Maxwell Jones, a civilian inundated with neurotic patients at Mill Hill Emergency Hospital was experimenting with psychodramatic portrayals of selected patients' individual problems followed by large-group discussion of these. And at the centre of the movement was Ronald Hargreaves, a brilliant imaginative stimulator and military administrator of this higher-order psychiatry.

In passing, most of the sixteen I have mentioned were called by Henry Dicks "Members of the Invisible College." Four are dead, five later became heads of Institutes concerned with groups, seven took academic chairs in psychiatry or an allied social science, and eight were or became psychoanalysts.

But now to Northfield, where the concept of the therapeutic community was born. It was a large military psychiatric hospital in Birmingham commanded, when I arrived, by a regular army medical colonel who was not a psychiatrist. The administrative staff, the clerks, orderlies, cooks, sentries, educational staff, physical trainers, paymaster, quartermaster were all soldiers of various ranks, while the Matron and her nurses were all of officer rank as Army nurses. I was sent there in early 1945 when our armies were at the gates of Germany and it was at last clear that the war was to end in victory for us. My relevant Army experience had involved studies of group morale and discipline during battle, especially of infantry in the western Desert, and I had had experience of arranging the systems of care of psychiatric breakdown in the British and Canadian armies in the battles of Western Europe. My instructions were to help the development of group studies at Northfield and I was to take charge of one of the two divisions in the hospital. The social structure of my division was clear. As a Lieutenant-Colonel I was responsible to the Commanding Officer, a full Colonel, not only for overall treatment of patients but also for promoting and directing the morale, discipline and work of all - patients and staff - in my division. I had several Majors - senior psychiatrists - in turn responsible to me in the same way for their medical and nursing officers and men and patients and in turn their Captains and Lieutenants were responsible to them. Each Major cared for one or two wards and the nurses were in military hierarchy and responsible to him. His ward patients were responsible, through their medical officers, to him. Proper saluting occurred all round, although it was not always of a kind a Guards sergeant-major would have been proud about, especially when offered or returned by unusual soldiers like Major Foulkes. Inside this clear hierarchy, as in all military units, the officers and soldiers were also people and of course variously enjoyed or disliked each other. The hierarchy was an indestructible ordered container with a prime medical purpose and what went on in it was human life, some of it psychotic, much of it severely neurotic, which could variously be stimulated, enjoyed, tolerated, disciplined or treated. When I got there I found the usual hospital convention of regarding all the staff as being totally healthy, and if wayward to be overridden, reprovved or disciplined; and all patients as being totally ill, and if wayward to be tolerated as not real people and treated with charity, drugs or psychotherapy - that is to say social splitting and the projection of health and illness were part of the social order. Group-treatment abounded, based on and inspired by Foulkes' teaching.

There was much indiscipline in the patients. Their psychiatrists tolerated this and excused it on grounds of illness, but my non-psychiatrist commanding officer and his non-psychiatric military staff throughout the hospital were far from content with the psychiatrists' tolerance and sought to have soldiers who got drunk or got out at night or were violent or mutinous or had untidy wards to be put on charges and sent to the orderly room. I had a difficult time with my (superior) commanding officer over such cases almost every morning. I also had a difficult time with my (inferior) officers who were most resistant to my idea that they also should study indiscipline as a psycho-social problem. Rather they wished to tolerate it and study it only at a lower-order of system, that of individual pathology which they treated individually and in small groups. As a senior doctor I should protect the patients from the insensitive mind of the military so that my psychiatrists could get on with their important therapeutic work. After a few weeks of this heavy going I began to feel misjudged by all and grew ill-tempered.

Then I heard that a disorder in the higher-order system of the hospital had preceded my arrival. It had been treated by discipline and had been hushed up as shameful but it had not been studied as an intra-system problem; yet once I heard about it I understood both my commanding officer's need for me to ensure more discipline and my psychiatrists' contempt for mere administrators. I report it now for it is no longer a painful matter of anger and scandal but an interesting event from which a lesson - important for the therapeutic community concept - is to be learned.

The first Northfield Experiment had already been conducted by Bion and reported in the Lancet. Faced with a wardful of neurotic soldiers, who in Army terms were slovenly, undisciplined, idle and dirty in ways that were outside the medical model of illness, Bion had viewed their behaviour not as the result of massed personal illnesses but as a collusion by a group with the staff requirements of the hospital where the staff are to be well and self-disciplined and patients are to be ill and disordered. He told his soldier patients at a daily ward parade that he was fed up with them, and henceforth refused to be responsible for caring about, treating or disciplining delinquent behaviour which was theirs and not his, created by them and not him. He would not punish them but would no longer visit them or their ward. He would be available for discussion in his office every morning but only for soldiers who presented themselves clean and properly dressed. In the next weeks they severely tested out his resolve. The ward became filthy, beds were not made for days, absence without leave and drunkenness increased and the whole hospital staff was alarmed and angry. It was chaotic, but Bion plainly did not get his D.S.O. in the first world war for nothing and he stood firm. As the days passed a slowly increasing number of properly dressed soldiers began to attend his office and some N.C.O. patients soon begged him to intervene in the chaos. He refused to take over their indignation and military ideals but discussed these with them as their property and so freed them to own the conflict between fecklessness and efficiency inside them. They slowly grew responsible for themselves and their ward comrades and now formed their own discussion groups and rotas and disciplinary systems. Cleanliness and order, no longer imposed from above, grew inside the ward group. The military super-ego, no longer projected onto higher authority, had returned to the lower-order system and Bion's ward became the most efficient in the hospital. This was a bold imaginative innovative experiment, not in permissiveness about illness but in the delegation of health and responsibility to patients. But now for the secret, the part that was not written up, but which I regard as of equal importance to that which was. The unpublished secret is that Bion was sacked from

Northfield. Neither the commanding officer nor his staff was able to tolerate the early weeks of chaos and both were condemning and rancorous about Bion's refusal to own total responsibility for the disorder of others. The resultant rows in the commanding officer's office came to the notice of higher authority and after Bion had left the commanding officer of the hospital, then a psychiatrist, was also sacked, to his great indignation. Once I heard about these rows I was tempted to hold partisan views about them, but then realised that my very job was to study such higher-system tensions and that at the level of the higher hospital system this first experiment had been a technical failure although a brilliant success at the lower ward system. Bion had been therapeutic for his ward but anti-therapeutic for the military staff, successful in his ward, a lower-order system, but highly disturbing to the hospital, the higher-order system. To put it another way he had failed to work at and get and maintain social sanction for his deeds. Thus anti-social in the wider sense, he had been the author of his own social downfall.

Both abroad and in this country I have often been asked by an enthusiastic doctor, sometimes eminent, to use my authority to help him maintain his "good" therapeutic community, in a ward or a hospital wing or a whole hospital, and to throw my weight behind him and his progressive staff in a fight with the "bad" reactionary others in the larger whole, either inside or outside the hospital, who cannot stand the strains and want the work stopped or modified. Always the doctor has failed to get and maintain sanction for what he is doing. Usually he and his staff simply feel innocent, righteous and wronged. Sometimes the patients will join them in projecting all evil outside the community and now in idealisation of the community, all will proselytise about its benefits. There is now no hope of owning and examining the destructiveness or other negative matters inside the community - for these have been projected outside, lost to group ownership and examination and treatment. This failure to gain sanction is in the end not only destructive of wide-eyed awareness and treatment of group problems, but self-destructive for the very existence of the lower-order system; because it is anti-therapeutic for the higher-system. It needs emphasis, and is to be neglected at peril, that every higher-order system is related hierarchically to the lower-order system and has to be studied and helped in its own right if it is to understand and support the work of the lower-order system. David Clark, author of "Administrative Therapy" and of the phrase "Therapeutic community approach" made this very point in his first essay about educative duties of the senior psychiatric administrator who is squeezed by those both above and below him.

At Northfield I now knew that my commanding officer was aware that his psychiatrist predecessor had been sacked. I began to understand his anxieties about the therapeutic goings-on in his hospital, in which soldiers discussed things in an undisciplined way as equals with their officers in groups, questioned openly the way things were and were permitted ill-discipline by their psychiatrists. And I began to think that this was why he did not check his military staff's plain disapproval at the way psychiatrists did not stamp out their soldier patients' indiscipline. In this I was wrong and later realised it.

At this time Northfield was not a therapeutic community, only a community in which therapy was occurring, mainly in groups. I was still concerned however only to further the innovative group treatment of patients and naively hoped that if I could educate my commanding officer he might persuade his staff to be more tolerant of therapy for patients' ill discipline. I spoke now more freely to him of the technical problems we were tackling and shared more of

my uncertainties with him. At my invitation he manfully sat in on certain groups but remained sceptical and still sometimes raged at me over events in my division and at the failure of my officers adequately to discipline their men.

In both divisions of the hospital many groupy things were however happening. Psychodrama was in enthusiastic general experimental use; for it was new and had to be tested. Sociometry was used to measure and arrange groups of patients for work-tasks. Michael Foulkes, the outstanding therapist and teacher in my division went on treating the patients of his wards in small groups. He knew much more than any of us about treatment and we leaned heavily on him and he taught us, in small staff groups. His remarkable capacity for requiring others to puzzle with him, his calm, his patience and his ability to tolerate uncertainty and confusion and to think his way through small group events drew all the Northfield psychiatrists to learn from him. Martin James, Susannah Davidson, Mildred Creak, Stewart Prince, James Anthony, Pat de Maré, Armstrong Harris, F.R.C. Casson, Millicent Dewar and many others now distinguished and well known workers sat at his feet as I did whenever possible. He was inexhaustible. Simple but important questions were settled. Was this not several individual treatments done in a group? Was it treatment by the group? Or was it rather treatment of the group as a whole? What did he mean by a group identity? Or a group theme? It was difficult to understand that he could think about two systems at once, the small group as a sensitive whole and its interacting human sub-systems, that could study the dynamic group matrix and also listen to the unconscious content, or follow the development of a group and also of the individuals in it. Because of Foulkes group treatment was used for the majority of patients in every ward. In this memorial lecture I would like to emphasise that before and during and after Northfield he was blazing a trail that opened up a whole new order of human system for therapy - the small group. It was new then, indeed revolutionary. There were other trail-blazers - for instance Slavson - but it was Foulkes more than anybody in Europe (Bion never had pretensions about group therapy) who was steadily developing it as a proper clinical study. Foulkes had a later benign interest in other systems, of lower order (for instance in studies of families) and of higher order (for instance ward groups) but he did not seek to become expert in these. He knew about small groups and marvelled about them and could not understand why anyone should miss such a good thing. At Northfield he came only slowly to the idea and was not excited at first that a whole community might become therapeutic. Indeed he teased me and described my first efforts as "highly organised chaos", but soon after the idea was promulgated he leapt at the thought that small-group discussion could be a basic tool for promoting it.

The work of Harold Bridger gave him further opportunity. Fresh from cool studies of the way leaderless groups tackle work problems and create their own leaders, Major Bridger with a small staff was posted to Northfield to help develop group activities. The word spontaneity as used by Moreno in his reports of children's play-groups was in vogue, part of an end-of-the-war climate which accorded Bridger freedom to facilitate the emergence of spontaneously formed action-groups of patients. I have to remind myself now that at that time of dependence on leadership it was daring to do so. Bridger however was skillful and confident about the hidden unused capacities in people. For instance he sat alone and waited for days in a large room with a new notice over the door announcing it as The Club and when soldiers came in and asked him what club it was he asked them what club they hoped it was and then offered to work with them to make it so. And soon because there were many hopes there were many activities. There had been staff-organised occupational

therapy but now, with Bridger, patient-organised group projects began to flourish. Hobby-groups formed, a newspaper group, a chess group, a drama group, a printing group, a typing group and so on; a painting group advised by Sergeant Bradbury, now lecturer at the Tate Gallery. Bridger also explored work ambitions and discontents and facilitated spontaneous work-groups for specific projects. Real work for the hospital and the neighbourhood began. Groups for carpentry, bricklaying, metalwork, glazing, decorating, catering, the first industrial therapy groups (at the nearby Austin Motor Works at Longbridge) now began and carried along each member; while job-trials for desired but untested jobs in civilian life were arranged through the local labour exchange.

Not all went well; because the groups contained human beings troubles abounded. These troubles were at various levels of system. Some inefficient individuals were recognisably preoccupied with intra-personal problems, such as personal mourning for multiple comrade-loss, and other such intra-systemic problems which were not primarily disturbances of relations with their present objects. They could be respected and supported by groups but only slightly aided by examination of their present relations with groups and individual treatment was offered to them alongside the continuing total programme. Then in some work-groups, as in therapy-groups, inefficiencies, quarrels, arguments, sulks and walk-outs occurred, and now Foulkes gladly accepted my invitation to become an ad-hoc trouble-shooting consultant whenever crises or inefficiencies appeared in work-groups large or small. Sometimes he needed to do major group-therapy to help groups carry disturbed individuals, but sometimes only the group-system was disturbed. I will always remember his pride at resolving before lunch a morning's lightning strike in the stage group (of painters and scene shifters), which threatened to wreck an evening's vaudeville. With Bridger he had moved on from therapy groups to the treatment of action-groups.

But now we began to use groups for a third purpose - the examination of other crises and inefficiencies, whether clinical or administrative and whether these involved staff or patients or both. Once a problem was discovered an ad-hoc group was called of all concerned and affected, to seek out what had gone wrong. Almost always we would find that interpersonal tensions inside the group were hidden behind a so-called material event: (and often projected on to some superior in the military hierarchy). Thus we slowly replaced blind hierarchical discipline of un-understood annoyances by the discipline of informed common-sense.

Northfield was now, by 1946, a hospital of a new kind, in which both patients and therapeutic staff sought to explore in a way never attempted before the unconscious tensions which pain the lives of individuals and of the small groups they find themselves living in. It looked - as Foulkes teased me - highly chaotic, but both hospital divisions were in fact busy, efficient and relatively free from unresolvable internal tensions. It was also innovative and exciting. Yet in the larger hospital there were strains. Something was not right.

In the larger community many of the non-therapeutic military staff, administrative, domestic, maintenance and to a lesser extent secretarial were of low morale. Some openly resented patients taking the right of action or decision over matters of work or equipment and it was true that patients would organise group discussions and activities which regularly overlapped or contradicted or interfered with the military staff's wishes, duties or expectations. The staff was being ignored and after all they, not the

patients, were there to run things. Treatment was treatment: fair enough; patients should be treated kindly because they were ill but they should do what they were told; when things went wrong staff should step in and correct things and show the way; it should not be left to patients to sort out troubles; things had gone too far; it was the psychiatrists. My commanding officer made it plain that his tolerance was now at an end, and I began to think about Bion's fate. I had resolved however not to share it, however noble that would be, and wondered how to preserve the tottering sanctions for our work. I tried not to feel either too guilty or too righteous and wronged - without great success - and to free myself to think about my commanding officer's plight. Why could he not control his staff and support our work? Why had this otherwise pleasant, intelligent man become regularly stupid, angry and threatening? Why did he feel himself threatened by events? With some difficulty I ceased to be so self centred and began to see that he had troubles of his own. He was responsible to his seniors and he was also the inevitable repository for all the grumbles and discontents of his military, administrative and artisan staff which I and others, safe in our military rank and medical authority, had ignored or brushed aside as reactionary. Yet he was being fed by his military juniors with these discontents as their head of the administrative and domestic hierarchy of the hospital which was separate and distinct from the therapeutic hierarchy which I represented. I then realised that the almost daily rows he and I conducted were about unresolved tensions, not between him and me as individuals but between the lower-order systems of military and therapeutic staff fed upwards and into us. These tensions between the administrative and medical sub-systems had been regarded by all in the sub-systems as nuisances, issues not for open study or scientific scrutiny but for noisy argument or silent power struggles. He and I were thus being unconsciously required by our own staffs to be their champions and to conduct these struggles on their behalf; and we had been unconscious of this. So now there was a new set of problems. How to ensure that the tensions could be examined, perhaps resolved, where they began - between people in the lower hospital systems? How to put the lower-order military staff in touch with the needs of the lower-order therapeutic staff and patients? And vice versa. What were the unconscious fantasies each system grew about the other? How much blind mutual projection of evil was going on and distorting perceptions of each other?

One evening I suddenly realised the whole community, all staff as well as all patients, needed to be viewed as a troubled larger system which needed treatment. Could all people in it move to consideration of each other's plight and benefit from opportunities to examine the conscious and unconscious uses each was making of others? Could the total institution become therapeutic for all? Clearly we would need a total culture of enquiry if we were regularly to examine, understand and perhaps resolve the tensions and defensive use of roles which are inevitable in any total system. Today the concept is well-worn, and the term I coined for it - The Therapeutic Community - is now in use so widespread that the coinage is somewhat debased; but then it was new and for me at least it was a sudden insight, a major conceptual shift, a new way of viewing events in a hospital. It also demanded appropriate viewing instruments. At this level of system - a whole community - techniques of investigation and intervention had yet to be devised; indeed today argument about them still seems wholly proper. But now at Northfield inter-staff relations and staff-patient relations began to be seen as legitimate matters for regular, indeed essential, study, whereas hitherto only patient-staff, patient-doctor and patient inter-relations had been. This attempt to create an atmosphere of respect for all and the examination of all difficulties would be a long way from the medical model,

whereby disease is skillfully treated in anonymised people under blanket medical compassion and served by a clinically aloof and separate administration.

I would like to have been able to report great things at Northfield as the result of this new concept, for the time and the climate were right. Foulkes and his numerous trainees had often had nurses sit in on therapy groups - although only as healthy beings - and Bridger had always had certain non-therapy staff sit in on task-group discussions. But I was posted to other work a few months after arriving at the notion of the Therapeutic Community and I was able to gather only its first fruits, although I had other opportunities later in civilian life; and in 1946 I published the idea tentatively at the request of Karl Meninger who was a fascinated visitor to Northfield. In the few more months I was there military staff began to participate in examining tension systems. They slowly but increasingly joined crisis-groups and ward discussions, and now task-groups and hobby-groups with patients. It became ordinary for orderly room clerks, staff sergeants, Matron's staff, secretaries, military cooks and orderlies and night staff, yes, and sometimes my commanding officer and his adjutant, to be seen in groups alongside patients and psychiatrists. Many were raising personal issues or plans or complaints relevant for their work and discussing how they were affected by others, and were being listened to. I held two on-going staff training groups to examine current work-tensions, one for nurses and one for orderly room and catering and artisan staff. The Rehabilitation Officer from the labour exchange (for now the war was over and demobilisation would soon begin) also sat in on a special interest group. The military staff's grumbles and ideas and problems were given equal status to everybody else's and they themselves were seen increasingly as people working in legitimate and inescapable roles and inevitably contributing to constraints and freedoms in the whole system. They now argued and discussed with patients and others and came to recognise their own total usefulness. People of individual style and potential and work needs were better recognised where stereotypes of the sensitive sick and the insensitive staff had tended to exist.

The higher - order system as a whole began to examine its tensions and became better able to understand and therefore to sanction the activities of its various sub-systems. My regular Army commanding officer began to accept his proper kudos from psychiatrists who visited Northfield, but I would be exaggerating if I said he became fully at ease. Of course there were always problems to examine. When I left Northfield not all military staff were able to tolerate discussion of tensions that involved them; but, more importantly, there were similar resistances in some psychiatrists about regarding the woes of the staff as being not only inevitable but legitimate even though these had major effects on the unconscious roles accorded to their patients. It would be pleasant to think that had we worked further on this traditional split between therapeutic and non-therapeutic staff it might have been narrowed, but such a belief would also be foolish and, yes, grandiose. Every community requires and in subtle ways gets certain people to act as containers for its conservative wishes on the one hand and its progressive wishes on the other and tends to require, create and maintain various split off sectors of itself into which it can variously project evil, disorder, financial discipline, illness, inefficiency, health and insensitivity and to encourage these in subtle fashion to create trouble. Thus internal personal conflicts are socially externalised. Indeed resolving such social splits, especially insofar as patients may be used as containers of childishness and helplessness or staff as containers of all brains and ideas is inevitably an essential

never-ending task in any hospital community aiming to be therapeutic. But Northfield went quite far with this task and now I shall leave it with an anecdote about how one small split was resolved. I remember with gratitude that in a group met to discuss a crisis over food a staff corporal-cook patiently explained to an irate private soldier that I had no choice, as a senior officer, about doing a weekly inspection of my patients' kits and personal cutlery, nor about criticising his favourite ward sister for neglect of her military duty of seeing that his own missing cutlery was replaced. After hearing the corporal, the soldier turned to me sympathetically and asked if I liked the job of inspecting kits. When I said "No, but I have to do it", he went on, "And you've got to do it well or you're in trouble, aren't you? And if you do it well we hate you, don't we? What a rotten job you've got."

Certain obvious lessons from this, the second Northfield Experiment, were clear. Psychiatric patients are sick as people, but not sick all through. Their skills and healthy parts need not be ignored in daily life in hospital as in the medical model which concentrates only on their sick parts. Delinquencies, fecklessness, clinical crises, dependence and irresponsibility in patients are forms of participation in hospital systems. Informed patient participation in organising and running the ways of a hospital is possible. Staff-based discipline is mostly unthinking but will be used whenever staff anxieties are unbearable. Staff anxieties are inevitable in psychiatry and staff defences against these tend to take rigid forms. Staff anxieties are legitimate and need regular exploration and treatment. Patients and staff tend to require and become entrapped in collusive splitting and projective defences against pain; health and illness, good and evil, strength and weakness, activity and helplessness, leader and led. Heads of organisations are liable to be unconsciously required to own or act on the tensions of their staff. Groups and sub-groups and whole communities tend to project ownership of hostility outwards and so lose the hope of insight. Using group discussion a culture of enquiry can be promoted for the better recognition of the humanness of all and better understanding and resolution by all of clinical crises and social upsets. A whole hospital community can be anti-therapeutic for the people in it even though the medical model is well pursued and their diseases are well treated. By altering the relations sought by staff and patients a hospital can become less anti-therapeutic and more therapeutic for all the people of the hospital, and yet can still allow room for the appropriate practice of the medical model. So much for the lessons.

Since Northfield many more experiments with therapeutic communities have been made. A sizeable literature has grown up, and in preparing this lecture I have much appreciated an appraisal of it by Richard Thompson which I hope will soon be published. He points out, as have others, that the term "therapeutic community" is in such widespread and diverse use as to be almost meaningless; and has been used for many situations of which a few he quotes are: a West African Yoruba Village, the school, the church, the prison, centres for drug addicts, community care programmes, general hospitals, admissions units, geriatric hospital care, the world and, by allusion, corrective camps. So the term is now a bandwagon, and I cannot clear up the resultant confusion.

Thirty years after Northfield the term "therapeutic community" owes most of its meaning to Maxwell Jones whose innovative work, especially with psychopaths at the Social Rehabilitation Unit of Belmont Hospital, and voluminous writings about his own precepts and practices have much influenced others. His personal skill as head of that and other units, together with

his publications, have earned him deserved status and if I have some important reservations about some matters he holds dear, I must record my admiration of his pioneer efforts. The work in the U.S.A. of Goffman and then Caudill, both social scientists, have also been powerfully influential in getting doctors to accept the propriety of viewing higher human systems as wholes with properties and laws of their own; Stanton and Schwarz have demonstrated in detail that staff relations can have massive effects on patients' syndromes and that these cannot be noticed by a non-psychological staff seeking to pursue only the medical model. In this country R. N. Rapoport, another social scientist, has also illustrated how the study of social systems can illumine many phenomena that would otherwise be regarded as due to the patients' illnesses. Yet the work of social scientists in surveying hospitals as social systems has not always been fundamental; some of it has been essentially only indignant or impatient and reformist about superficial behavioural phenomena, not truly compassionately investigative of deeper unconscious needs and conflicts. One ill-effect is that here and there one may find psychiatrists attempting to explain away interpersonal conflicts as due to defects in the social structure, rather than setting about the more painful task of examining the multipersonal origins of conflicts which often hide behind the blaming of the social structure. Criticising the structure seems often to be merely a seductive avoidance of the problem, a projective defence against studying more painful interpersonal conflicts in depth. The blurring of staff roles, which Maxwell Jones advocates, seems to me another device for avoidance of conflict studies to allow the illusion of staff innocence and the disownment of responsibilities when the going gets rough. Is it not an example of the defence of appeasement against persecutory anxiety, the fear of being attacked for being active and clear? Persecutory anxiety is inevitable in group life, especially in executives, as Elliott Jaques has shown; indeed this and other anxieties are inevitable in all human relations, but they cannot be resolved by appeasement, only acted out. Better if the staff fears about pursuing a role which is essential but unpopular are brought to light, discussed openly and studied in depth by all as human equals. Of course unconscious fantasy roles are always sought and offered both up and down the hierarchies of all human systems and of course they bedevil recognition of real people in real roles and thus hinder realistic relations. But they need analysis not appeasement by role-abdication. In General Hospitals defences against staff anxieties, of appeasement and of role avoidance or diminution may not much matter (although the work of Isobel Menzies suggests that they do), but in psychiatric hospitals where emotional matters are the essence of the work, where the strains can be overbearing and where staff acting out of anxieties is liable to be a daily event, the regular scrutiny and resolution of prevailing projective fantasy systems within groups seems essential for promoting the health of both patients and staff. Altering social structures and roles under flags of permissiveness or democracy to appease projections is liable to endanger study of the problems which arise in attempts at real adult relations between people in essential functional roles.

I agree heartily with Maxwell Jones about the need to avoid authoritarianism but again this is not, as is commonly suggested, related to social structure. Authoritarianism is a specific way of relating to people, an attitude towards them, a personal characterological or cultural but not an organisational matter. It is not produced by any particular hierarchical structure, but can operate in any. (Authority is of a different order of fact, a matter of special skill or knowledge as recognised by others. It can lead to pride or the fear of being envied, and to apology, but it is not, like authoritarianism,

primarily an attitude towards others.) Responsibility downwards for tasks (that may involve care of subordinates) and upwards to people is however an organisational matter, and in my opinion tasks should be carefully and clearly designed in several linked roles at necessary hierarchical levels to suit the overall purpose required by an organisation so that the resultant social structure will both make sense and be clear to all. Whether the responsibilities in such a clear system will or will not be discharged in an authoritarian or a humane manner will not be the result of the structure's clarity but will depend on the character of people and the culture, the folk-ways of the organisation. Clarity of structure and of roles actually enhances efficiency and minimises conflicts between roles and about responsibility and allows the examination of remote manoeuvre. I join the inability of Raskin to regard role blurring as therapeutic, for a community.

My own conclusions, from the early studies of different battalions to later experiences with different hospitals is that it is not the structure but the culture which is decisive for the human relations on offer. A clear known structure and appropriate roles with inescapable responsibilities is needed for efficiently operating any task; of repressing of prisoners or rehabilitating them, caring for sick children or healthy ones, of distributing food parcels or bombs, of saving lives or running an extermination camp. Efficiency requires clear unshakeable roles for all. Efficiency is relevant but insufficient for a therapeutic community. Over and above efficiency and social structure, the culture - the ways people in the structure relate to each other - is decisive for whether the people in the structure treat each other's roles with distance or warmth, enmity or friendliness, respect or contempt, concern or coldness. Not the structure but the culture will decide, for instance, how far, when the various orders of staff and patients meet together in role but in joint consultation, they will truly respect and be interested in each other's work and listen to all ideas as personal equals; and how far they will truly discuss doubts and resistances and enlist and evoke each other's talents and invite participation in various tasks and how far not. The culture will greatly influence how far delegation of powers and responsibilities is or is not adequate, and how far people trust each other and how far they watch each other suspiciously. In my observation, culture, the folk-ways of operating an organisation including the informal ways people relate to each other, is decisively influenced by the way the organisational heads relate to others. As they relate to their immediate sub-heads, so will these relate to their staffs and their staffs to their juniors. In a therapeutic community where a culture of patient honest enquiry into difficulty is needed, with interest in understanding in depth the personal systems, the systems, group systems and the community system, it seems essential that the culture be initiated by the heads of the community organisation. They are thus required to practise true personal respect and professional concern for each other and for their immediate subordinates. They will be ready to recognise and investigate their own and their immediate staffs' successes and failures with dispassionate interest but not blame, to share with them their own uncertainties and problems, to demand their participation in facing problems and fashioning plans and to require that their team think with them about the work to be done. The word charisma does scant justice to such an orientation of self-conscious responsibilities. I am glad to say I have met several such heads and cultures.

And now to end. The term "Therapeutic Community" has become used so variously that it is almost meaningless today. Nonetheless, just as it was a conceptual breakthrough when Freud through free association conceived of studying a whole human experience and not simply the parts which interest a questioner; so

treatment of groups in free discussion is the extension to a higher order system of this very breakthrough. The therapeutic community concept is, I believe, yet another extension of Freud's breakthrough, for it also rests on the study of unconscious matters. Its hallmark is not a particular form of social structure but a culture of enquiry. It both requires and sanctions instruments of enquiry into personal and interpersonal and inter-system problems and the study of impulses, defences and relations as these are expressed and arranged socially. It is good to remember that one essential instrument for it - group treatment - was fostered and nourished and defended by Michael Foulkes, in whose memory I gratefully offer these remarks.

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