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# The Northfield Experiments

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**The Northfield Experiments took place at Hollymoor Hospital, Northfield, Birmingham, during World War II. The first experiment was conducted by Bion & Rickman. The second evolved gradually; many people contributed to its success, including Foulkes, Main and Bridger. The experiments were an important landmark in the evolution of theory and practice in group psychotherapy and in the therapeutic community movement. They were not carried out solely as responses to the need for mass treatment of neurotic disorders among army personnel; antecedent factors, the theoretical orientation of the practitioners and the nature of army life were equally important. The two experiments differed in pace and in recognition of the needs of higher-order systems, particularly the military hierarchy. They shared many underlying concepts, including responsibility to society, the therapeutic use of groups (including the hospital community) and an emphasis on process. Lessons learned at Northfield remain relevant to the practice of psychiatry today.**

Between 1942 and 1948 Hollymoor Hospital, in Northfield, Birmingham, was a rehabilitation unit for soldiers suffering from neurosis. At Hollymoor, army psychiatrists pioneered psychological and social therapies in what became known as the Northfield Experiments. The conventional view of the experiments is well summarised by Bloch:

> "The Second World War was undoubtedly a great spur to the evolution of group therapy. The large patient population among the military could be more efficiently dealt with when treated in groups. . . . The Northfield Military Hospital in particular was a centre of innovation and there Bion and Foulkes instituted novel group methods. After the war Bion's work influenced therapists of the Tavistock School while Foulkes was the all important figure behind the establishment of the Institute of Group Analysis." (Bloch, 1986)

How did a military hospital come to generate advances in psychiatry which have been described as "a radical departure from the authoritarian regime where communication is essentially downwards" (Sainsbury, 1973)? Accounts written by those at Northfield, and interviews with staff and patients, reveal a complex series of innovations, influenced by many factors and people. The most successful initiatives utilised the therapeutic properties of groups including, ultimately, the hospital community. Important lessons were learned (and subsequently forgotten) about the role of psychiatry in society.

This paper examines some of the antecedents of this extraordinary series of events, broadens the conventional picture, and explores some of the less well-known initiatives. The various therapeutic approaches are described after outlining the tasks, the constraints, and the previous experiences of some of the key participants.

## The tasks

The tasks faced can be examined from the contemporary perspective of the patients, the psychiatrists or the army. Their priorities differed.

### Patients' views

Initially, patients at Northfield were soldiers from bases in the UK. As the second front opened up, soldiers arrived from active combat duty in France and Germany, eventually followed by prisoners of war. There were, however, other patients – from the RAF, from other theatres of war, German escapees, and men deemed to have 'disciplinary problems'. Major Bion who, with John Rickman, conducted the first Northfield experiment, was particularly aware of the latter group: "it must of course be remembered that in a psychiatric hospital there are collected all those men with whom ordinary military procedures have failed to cope" (Bion, 1946).

From December 1943, men were only admitted if it seemed probable that, after a short period of treatment, they would return to "high grade military duties (i.e. not merely simple administrative and domestic duties, or service in the pioneer corps)" (Ahrenfeldt, 1958). That this was not always so is revealed by the views of one sergeant in charge of the locked ward in 1946: "the whole essence was containment, not treatment". Many of his patients regarded beating the system as their main task: "if one got away with anything, the others took great pleasure in it". On one occasion he organised a football match in an attempt to dissipate some of his charges' aggression. Two men absconded within ten minutes of the match starting.



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Many men did not know why they were there. They often did not know where they had been sent, or what the hospital was, until the last moment. Foulkes, a key participant in the second experiment, recorded that "many of the patients at this time were unwilling soldiers with long-standing difficulties; their chief preoccupation was discharge from the Service" (Foulkes, 1948). Others have confirmed this: "most of us didn't want to stay here, we wanted to get back home. It seemed like a holding place before you were discharged . . . that's how most people felt" was one ex-patient's opinion. Bridger recorded other complaints: "I am browned off with everybody and everything . . . I am fed up with the Army . . . I seem to have lost confidence in myself . . . I hate being pitied" (Bridger, 1946). No soldier seems to have arrived with a clear idea of the purpose of their transfer, but many hoped for their discharge from the Army. Freeman (1988) noted that the patients at Northfield were "anything but forthcoming".

### The military perspective

Neurosis presented an immense problem of wastage of human resources. There were 118 000 discharges from the Army between September 1939 and July 1944 as a result of psychiatric disorder. Nearly two-thirds of these were as a result of neurosis (Cope, 1952). Anxiety and hysteria together constituted approximately a quarter of all discharges on medical grounds (Mayne, 1972).

Most psychiatric casualties were treated as near their unit as possible – a practice known as 'Forward Psychiatry' (Ahrenfeldt, 1968; Palmer *et al*, 1945). This provided a filter system, ensuring that only the most severe cases were referred back for hospital care. It is clear that the overall numbers reaching psychiatric hospitals increased during the war. In 1945 nearly one per cent of all military personnel were removed from active service for a significant period of time as a result of psychiatric disorder (Mayne, 1972).

### Psychiatric opinion

Throughout the war there were a number of nosologies of neurosis. These included hangovers from the 1914–18 conflict such as "shell shock" and "disorderly action of the heart", entirely new formulations like "wind up" (Palmer, 1945), and more traditional Army concepts such as "battle fatigue" and "lack of moral fibre". There was a move towards a phenomenological approach. Brigadier Rosie, Commanding Officer at Northfield between April 1943 and March 1944, described clinical presentations including simple terror states, anxiety states (mild and severe), stuporose states (with absence of anxiety), conversion hysteria, depressive states, and miscellaneous disorders (Rosie, 1952).

Many psychiatrists were struck by the pre-existing neurotic problems of those they were treating, and the mix of constitutional and environmental factors involved (Leigh, 1941; Slater, 1941; Slater, 1943; Palmer, 1945). The distinction between demoralisation and neurotic breakdown was clearly noted by many workers (e.g. Anderson *et al*, 1944).

They were often impressed by the marked courage of their patients. Bridger recalls that the men at Northfield were largely intelligent and articulate, and had more decorations for valour than was usual in the Army. At least one holder of the Victoria Cross was treated there. Edkins wrote of a similar group of patients:

> "It would be invidious to try and assess the military qualities of these subjects. It may be worth mentioning, however, that of the 21 Army Officers, six had the MC, and one other had been recommended for the VC and awarded the DCM when he was a Sergeant. There were two DFCs among the eight aircrew members of the Royal Airforce. These facts, and others, serve to show (if such proof were required) that military achievement need not be incompatible with bearing the burden of a neurosis." (Edkins, 1948)

These observations did not prevent some psychiatrists being over-protective of their patients. Tom Main gave an example:

> "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'." (Main, 1977)

The Northfield psychiatrists attempted to overcome this attitude. Bion's experience as a tank commander in World War I led him to be contemptuous of those who made the "hideous blunder of thinking that patients are potential cannon-fodder, to be returned as such to their units" (Bion & Rickman, 1943). Instead he attempted to recruit his patients into the 'battle' against neurosis, confident that once this enemy had been defeated they would tackle their other responsibilities with fresh vigour. Foulkes also "pointed out that we were not an experimental or research unit but a military hospital working under high pressure where the practical needs of the day had to be met" (de Maré, 1983).

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### Constraints

A number of difficulties faced those who attempted the task of psychiatric rehabilitation at Northfield. These included the hospital itself, the military regimen, the high turnover of staff and patients, and the endemic confusion, bewilderment and resentment.

### The hospital

Hollymoor Hospital sits on a hill in Birmingham, its copper-domed water tower acting as a landmark for miles around. It is a traditional mental hospital (with a matrix of two-storeyed wards surrounding the main hall and kitchens), opened in 1905 to accommodate long-stay psychiatric patients.

It functioned as a military hospital in both World Wars. In 1940 it was used to treat casualties resulting from air raids on Birmingham. It opened as a military psychiatric hospital in April 1942, when it was the largest such hospital in the UK (Crewe, 1955). Most service personnel suffering from neurotic disorders had previously been treated in Emergency Medical Service neurosis centres (Rosie, 1952). Hollymoor was described as "an entirely new type of unit", with 600 beds in a training wing, as well as 200 hospital beds (Rosie, 1952). The training wing was to re-establish military discipline among recovering soldiers. This was considered to be "carrying to its logical conclusion the conception of occupational therapy in the military sphere" (Rosie, 1952).

Foulkes described Hollymoor as viewed by new patients:

> "The patient arriving at the hospital . . . had a five-mile journey from Birmingham on a rickety tram before walking nearly a mile uphill with his kit . . . Standing at the end of the drive it presented a forbidding institutional appearance. Once inside, the hospital was as uncomfortable as the approach to it and its appearance would suggest – echoing stone corridors and enormous barely furnished wards, many of the doors locking. The remoteness of the hospital and the length of the drive are very much part of the picture, and were the constant subject of jokes by troops and staff alike." (Foulkes, 1948)

The long drive (among fields), and the long corridors, are some of the most vivid memories of those who were there, even today. One effect of this alienating environment was to discourage people from moving far from familiar surroundings. Many patients never left their ward or the canteen, except when they went on leave or to the local cafe.

### Military considerations

Northfield had a full military hierarchy, with a colonel as commanding officer. All the doctors were officers and most patients were not. Another contrast was emphasised when soldiers arrived from overseas: most had experienced combat, most of the staff had not (Foulkes, 1948). The ward sisters were from the Queen Alexandra's Imperial Nursing Service and their staff were Royal Army Medical Corps orderlies and women from the Auxilliary Territorial Service. The administrative staff were also military personnel.

Army discipline was observed, with saluting of officers by men. The hospital entrance (where leave passes were checked) was guarded by regimental police, who also initially manned the division between the hospital and rehabilitation wings (Foulkes, 1948). The corridors around the main hall were patrolled during dances, to discourage soldiers from entertaining their girlfriends in private.

Hospital-wing patients had to wear a special uniform (consisting of a blue jacket and trousers, white shirt and red tie). This made them conspicuous to the local civilians (many of whom regarded the patients as malingerers). As patients progressed towards discharge they wore khaki battle dress with a blue marker on the shoulder. This influenced the title of the first hospital newspaper: *Blues Flash*.

The training wing initially gave "modified military training under combatant officers and NCO instructors" (Ahrenfeldt, 1958). At times the training-wing staff were convinced that the hospital-wing medical staff were being hoodwinked by the soldiers and were overprotective. The administration did little to bridge the schism, arguing that each unit should carry out its own task without reference to the other (Foulkes, 1948).

### Turnover and overcrowding

Patient turnover at Northfield was very high. In October 1944, 1730 men were admitted, including 200 men on one day (War Office, 1944). The average length of stay was 6–8 weeks (Foulkes, 1946*a*). Between July 1943 and June 1944 there were up to 703 patients. The overcrowding was such that a tent was pitched in the grounds and when this was blown down patients were accommodated in the corridors. Huts had to be built to accommodate activities like art and leather work. Staff turnover was also rapid. Captain Abse spent only three months as a psychiatrist (War Office Diaries, 1944), and one sergeant did two administrative jobs in a similar period of time. These conditions made it difficult to be innovative, or to consolidate therapeutic advances.

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**Confusion, bewilderment and resentment**

Perhaps the most common experience for patients at Northfield was uncertainty, isolation and depression. One recalled "you felt a bit lost – unreal – after being hospitalised for such a long time . . . I didn't make any friends, most kept themselves to themselves. I did, certainly". Another, after spending two weeks in the guard room for going absent without leave (AWOL), "wasn't interested" about what was going on and disagreed with the diagnosis he was given (of anxiety neurosis). Scannell was placed in the refractory ward following desertion in 1947:

> ". . . almost everyone was imprisoned in the mesh of his own obsessions, fears and anxieties. There was something, too, in the very atmosphere of the ward, something enervating and depressing like a non-olfactory stink, a bad smell in the head, as if the air had been infected by the collective melancholy and morbidity of the men who lived in it." (Scannell, 1983)

Foulkes noted that during the early stages of his involvement:

> "as the bulk of the patients were in hospital because of the problems they presented in behaviour it is not surprising that in spite of the best efforts of the staff very many found their way, not to their duties but to Jones' café near by. There was little to occupy the new patient in between his interviews except to join the old hands at Jones' café or the NAAFI, and here there was opportunity to learn all manner of undesirable common knowledge, so that even the man of good morale stood a risk of deteriorating." (Foulkes, 1948)

This atmosphere affected some of the staff as well.

> "The psychiatrist in charge of the ward was a young Captain, overworked and sceptical about the value of anything that could be done for his patients at Northfield. I was briefly interviewed by him on my second day at the hospital but I did not see him again for almost a fortnight, during which I was beginning to feel that I would rot in the closed ward for months or even years. . . ." (Scannell, 1983)

Similar experiences formed the backdrop for every therapeutic approach used at Hollymoor. The atmosphere was maintained by the men's ignorance of the purpose of the hospital, the rapid turnover of patients (and some of the staff), and the institutional nature of the buildings.

## Antecedents and precedents

Of the many people who worked at Northfield, Bion, Bridger and Foulkes were among the most influential. Where did their ideas come from?

**Bion**

Wilfred Bion had been a tank officer in World War I and had first-hand experience of combat. This (and his bravery, demonstrated by the action for which he was awarded the DSO) meant he was respected by regular army officers. He had strongly held views about the purpose of rehabilitating neurotic soldiers. Between the wars he trained as a psychoanalyst after qualifying as a doctor.

He was influential in designing officer selection procedures. His particular contribution was the technique of direct observation of candidates performing a group task:

> "The man found he was not entered in a free-for-all competition with other candidates. Instead he found himself the member of a group and, apparently, all the tests were tests, not of himself, but of the group. In concrete terms, a group of eight or nine candidates, an 'eye-full' from the testing officer's point of view, was told to build, say, a bridge. No lead was given about organization or leadership; these were left to emerge and it was the duty of the observing officers to watch how any given man was reconciling his personal ambitions, hopes and fears with the requirements exacted by the group for its success. . . . It is not the artificial test, but the real life situation that has to be watched, that is, the way in which a man's capacity for personal relationships stand up under the strain of his own and other men's fear of failure and desires for personal success." (Bion, 1946)

This emphasis on process, rather than outcome, led to his success in using group structures to confront neurotic behaviour (Bion & Rickman, 1943). Bion acknowledged this influence and prefaced one account of the innovations at Northfield with a description of the thinking behind the War Office Leaderless Group Tests (Bion, 1946). Subsequently, he made it clear that a more important influence was the work he had previously carried out with John Rickman in Sheffield:

> "a memorandum I wrote in 1940 was the stimulus for an experiment, carried out by Dr John Rickman at Wharncliffe Emergency Hospital, which subsequently became known as the Wharncliffe Experiment. The experience he gained there was used by him and myself as the starting-point for a further experiment at Northfield Military Hospital. The fame, or notoriety, achieved by this experiment gave currency to the name 'Northfield Experiment'." (Bion, 1961)

**Bridger**

Harold Bridger, a major in the Royal Artillery, was by profession a mathematics teacher from Coventry. After working for the War Officer Selection Board he was posted to Northfield, and took charge of the rehabilitation wing in the late summer of 1944.

He was influenced by the concept of 'project teaching'. In Coventry, he had found that by

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concentrating on a practical task (such as running a school stock exchange) otherwise reluctant pupils became involved in mathematical concepts and processes. This proved more successful than the traditional methods of mastering concepts before applying them. Like Bion, he brought this emphasis on process to his work at Northfield.

Before taking up his post, he visited other military psychiatric hospitals. He was impressed at Dumfries Hospital by the active involvement of recovering patients in the rehabilitation of others and the sense of responsibility this engendered. He was less enthusiastic about some aspects of practice at Mill Hill:

> "Mill Hill Hospital, seemed to me a large hive housing a conglomerate of every type of treatment, physical (which seemed all too popular), psychotherapeutic (Ezriel) and psycho-social-therapeutic (Maxwell Jones). In his own small empire, Eysenck was developing approaches and methods about which he has long since published in various forms. Maxwell Jones's work at that time was the most interesting in what I considered to be a large 'therapy market place'. In general the patients seemed incidental . . . it was what I have referred to as a relatively closed system and centred on Maxwell Jones himself." (Bridger, 1985)

While on trains travelling between psychiatric hospitals, before taking up his appointment at Northfield, he read an account of the 'Peckham Experiment' (Pearse & Crocker, 1943). This long-term study of the residents of an area of London engaged subjects by the 'lure' of free use of a swimming pool. By this method the investigators managed to generate a sense of involvement among the people of Peckham, who willingly volunteered to take part in the experiment. The pool came to be a central feature of community life and ensured the success of the project. On arrival at Northfield, Bridger negotiated a role as 'Social Therapist' to the whole hospital. He developed this role through instituting a 'hospital club':

> "In particular I proposed a drastic reformulation in the hospital layout. Influenced by the Peckham experiment and recognizing the 'socio-psychological gap' in ward, professional and administrative relationships, I suggested . . . that the ward in the very centre of the hospital be cleared and named 'The Hospital Club'!
> "The Hospital Club, with its deliberate emptiness but allocated space for potential development, also represented the patient's own personality and social gaps within his 'life-space'." (Bridger, 1985)

The club, acting as a symbolic reflection of the 'hospital-as-a-whole-institution', came to be a central feature of the therapeutic community approach.

### Foulkes

Of the influences on Sigmund ('Michael') Foulkes's work at Northfield, de Maré (1983) observed:

> "Apart from gestalt, field and holistic theory, two papers in the mid 1920s by Trigant Burrow . . . two plays, one by Pirandello and the other by Gorki, the two psychoanalysts Wender and Schilder working in the USA, he had to rely on his own resources for inspiration, and he had no direct sources of information other than the situation at Northfield itself."

He had trained as a psychoanalyst in Frankfurt and had been in contact with the 'Frankfurt School' of Marxist sociologists, including Herbert Marcuse, who worked in the same building as housed the Institute of Psychoanalysis.

He had originally started group psychoanalytic treatment in his practice in Exeter in 1940, and subsequently published a paper on this with Eve Lewis (Foulkes & Lewis, 1944). This, rather than other work at Northfield, seems to have been the base from which Foulkes's methods evolved. Bridger has confirmed that Foulkes was at Northfield when Bion and Rickman carried out their experiment in 1943, although it was not until Rickman revisited Northfield in 1944 "that Foulkes became fully aware of the details of the first experiment" (de Maré, 1983).

### Psychoanalysis

Most active participants in the Northfield experiments were trained as psychoanalysts before the war or gained further training in the field afterwards. Psychoanalysis provided a theoretical structure, and many workers were particularly influenced by Melanie Klein; she was Bion's analyst (as was Rickman), and Rickman "had a period of analysis with her, although he never became a 'Kleinian'" (Sutherland, 1985). This was perhaps the first time such a large concentration of individuals devoted to looking at social applications of psychodynamic theory had ever been collected together.

## Therapeutic approaches

Despite the difficulties, many patients found their stay helpful. Nearly 50 years later, they remain enthusiastic about their experiences at Northfield and the insights they gained. These positive attitudes are associated with the group and social therapies which evolved in spite of the constraints. Other approaches were also used.

### Individual treatment

Bion trenchantly described what he found at Northfield when he arrived in 1943:

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"An observer with combatant experience could not help being struck by the great gulf that yawned between the life led by patients in a psychiatric hospital, even when supposed to be ready for discharge, and the military life from which their breakdown had released them. Time and again treatment appears to be, in the broadest sense, sedative; sedative for doctors and patients alike. Occupational therapy meant helping keep the patients occupied – usually on a kindergarten level. Some patients had individual interviews; a few, usually the more spectacular, were dosed with hypnotics. Sometimes a critic might be forgiven for wondering whether these were intended to enable the doctor to go to sleep." (Bion, 1946)

Even when social approaches to treatment were being emphasised, individual therapies (including individual psychotherapy and hypnotherapy) continued. One ward was set aside for narco-analysis.

Some therapies were decidedly unconventional. In an interview in 1984, Main described his technique of 'compulsory mourning' for tank commanders who had repeatedly lost their crews. They were often so numbed by the loss of their colleagues that they were unable to grieve. To break the deadlock, Main instructed them to be confined alone in a darkened room for three days, with one hour of daylight, one hour of electric light and a diet of bread and water. He ordered them to grieve, with blunt statements about their selfishness if they did not comply ("you're shits!") This draconian and apparently cruel technique successfully countered their over-controlled emotional state and released the pent up feelings that had been generating their neurotic behaviour.

## Groups

Soldiers had to rely on their comrades for survival in battle. Although individual effort could bring reward, it could not be at the expense of others. Brigadier Rees, the senior Army psychiatrist, emphasised that "The medical officer in the Army has to think in terms of groups and group welfare rather than of the individual patient" (Rees, 1943). Robinson enlarged on this:

"Military service enforces close relationship. There is no escape. It thus provides a setting which encourages and invites the trial of group psychotherapy. In the first place, military patients have a great deal in common as members of the military Services. They have lived, trained, played, travelled and in many cases fought together, while their presence in military hospitals for the purpose of psychiatric treatment indicates that they have developed their presenting symptoms as a sequel to, or concomitant with, their military experiences." (Robinson, 1948)

This was at least as powerful a motive for group work as the need to treat large numbers of soldiers *en masse*.

Bion distinguished between two meanings of the term 'group therapy':

"It can refer to the treatment of a number of individuals assembled for special therapeutic sessions, or it can refer to a planned endeavour to develop in a group the forces that lead to smoothly running cooperative activity." (Bion & Rickman, 1943)

Psychiatric practice reflected this dichotomy. Many psychiatrists concentrated on treating the individual; others, while using the group as a dynamic environment for people learning to work together, were always aware of the wider needs of a society at war.

Bion emphasised the latter, echoing Robinson's comments on army life. Cooperative working in groups could lead to success in treatment – particularly when the task was the shared endeavour to overcome neurosis (Bion & Rickman, 1943). But the main task was to enable men to take up their social responsibilities willingly.

In an interview in 1984, Main, who shared Bion's viewpoint, criticised Dennis Carroll (among others who adopted the first approach) as:

"one of the staid treater psychiatrists . . . he didn't show his adaptability in time of war. He wanted to go on analysing people. He was a treater. As Foulkes was. As George Day was. They wanted to go on treating people, but it was inappropriate in war. They wanted to pursue this selfish interest of theirs, when there were bloody great issues to be solved."

The experience of one soldier who underwent six months of intensive individual and group therapy with Foulkes at Northfield illustrates Main's point. He benefited a great deal personally, but was discharged in 1943 to become a school teacher, contributing nothing further to the Army.

Foulkes remained at Northfield for three years and later became enthusiastically committed to the 'hospital as a community' approach, and a major participant in the second Northfield experiment (as was Tom Main).

Groups were used throughout the hospital. Closed therapy sessions, open ward meetings, psychodrama, work groups, and leisure groups mushroomed. At times there would be meetings in the main hall to confront misbehaviour. Laurence Bradbury recalls Harold Bridger sitting on the stage crosslegged facing a large audience to discuss the problems of a group of soldiers who had been caught drinking in a local public house.

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**The therapeutic institution**

Apart from the development of theory and practice in group therapy, the major legacy of Northfield Military Hospital was an increased understanding of how a whole community can become involved in tackling a common problem. Foulkes noted the relationship between the psychotherapy group and the hospital community:

> "a group has boundaries like a membrane of variable permeability. If the hospital milieu is opposed to the spirit prevailing in the group, if the osmotic pressure is high, these boundaries harden and become more selective; if the spirit inside and outside is in harmony, they may almost or completely disappear . . . the more the hospital as a whole becomes a therapeutic field, the more it can become the main function of the psychotherapeutic group to activate and prepare the patient for the impact of the hospital community upon him and in turn to work out with him the stimuli thus received." (Foulkes, 1946*b*)

Main coined the term 'the therapeutic community' when he realised that the whole institution could be organised as a treatment environment for neurosis. The phrase has been widely used since with many and varied connotations, and so another term also used by Main (1946), 'the therapeutic institution', is used here.

## The first Northfield Experiment

Early in 1943, Bion was posted to join John Rickman, who was running a hospital-wing ward at Northfield. They determined to explore further the implications of their earlier work at Wharncliffe Hospital – an approach to treatment which involved a whole unit and moved away from the traditional individual model of care. There was an emphasis on the need for rehabilitation to follow treatment (Bion, 1961; King, 1989). At Northfield, both used the wider environment of their units as a therapeutic tool.

Bion commanded the rehabilitation wing. There are many accounts of the "slackness, indiscipline and untidiness of the Unit" when he took over. This, he recognised, was a demonstration of how inappropriate it was for the men to continue in the Army. He wrote: "No sooner was I seated before desk and papers than I was beset with urgent problems posed by importunate patients and others". He became convinced that "what was required was discipline" (Bion & Rickman, 1943).

He considered that the difficulties were symptomatic of the neurosis of the whole unit and the organisation of the hospital was a 'retreat' from neurosis.

> "In general all psychiatric hospitals have the same ailment and the same common aim – to escape from the batterings of neurotic disorder. Unfortunately the attempt to get this relief is nearly always by futile means – retreat. . . . Any psychiatrist who attempts to make groups study their own tensions, as a therapeutic occupation, is in today's conditions stopping a retreat and may as a result be shot at." (Bion, 1946)

He determined to tackle this as any officer would when commanding a unit facing the enemy. The dangers of neurosis had to be recognised, and then individuals could unite to fight it together. His military language reflected his determination to impose "the sort of discipline achieved in a theatre of war by an experienced officer in command of a rather scallywag battalion" (Bion & Rickman, 1943).

The soldiers were given opportunities to realise that the solutions were largely in their own hands. He achieved this by apparently relinquishing his responsibility for solving all the problems presented to him and forcing the group to fall back on their own resources. In practice, he paraded all the men and presented them with five regulations and an announcement that there would be a 30-minute daily parade "for making announcements and conducting other business". His covert intention was that the meeting would provide a framework for the men to gain insight into their activities and the progress of the unit as a whole: "the first step towards the elaboration of therapeutic seminars" (Bion & Rickman, 1943).

The next few weeks saw a marked change in the performance of the men and the unit. The Commanding Officer remarked on the improvements in cleanliness. The parades developed into constructive and active meetings. Men took part in activities well outside normal parade hours. "There was a subtle but unmistakable sense that the officers and men alike were engaged on a worth-while and important task" (Bion & Rickman, 1943).

At an early stage, when there were a large number of varied activity groups taking place, he accompanied two soldiers on a tour of the unit "Just to see how the rest of the world lives". They discovered that there was a wide range of activities going on, but that few men were engaged in each. He reported this back to the daily meeting, suggesting that the whole enterprise was a façade. Further, he referred to the men's previous complaints that much of what was going on in the Army was 'eyewash' and this was now present in the training wing itself. It is typical of his approach that this bold statement "left the audience looking as if they felt they were being 'got at'" (Bion & Rickman, 1943). He provided no further explanation and left them to work through the implications.

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In this manner he enabled the men to recognise that many of their perceptions of the Army were actually projections of their own internal conflicts. He reported that very quickly the men in the training wing became self-critical.

The sense of responsibility grew. Irrelevant and irresponsible suggestions could be developed into practical activity. A group of men, testing the new situation out, proposed that there should be a dancing class. After the suggestion was reflected back by getting them to make a concrete proposal, they decided that one should be held, outside parade hours, for men who lacked dancing skills. He reported: "a proposal, which had started as a quite unpractical idea, quite contrary to any apparently serious military aim, or sense of social responsibility to the nation at war, ended by being an inoffensive and serious study carried out at the end of a day's work" (Bion & Rickman, 1943).

Brigadier Rosie, a subsequent Commanding Officer at Northfield, wrote: "Bion and Rickman in 1943 endeavoured to bring the atmosphere of the hospital into closer relationship with the functions it ought to fill, and regarded training in the management of inter-personal relationships as valuable as a therapeutic approach" (Rosie, 1952).

Progress was terminated by Bion and Rickman being abruptly posted from Northfield. Many reasons have been advanced for this, but the most significant lesson carried over to the Second Experiment was the need to take account of the broader hospital system.

De Maré felt the First Experiment was terminated because of:

> "a cultural clash with the hospital military authorities. The fear that Rickman's and Bion's approach would lead to anarchy and chaos occasioned War Office Officials to pay a lightening visit at night. The chaos in the hospital cinema hall, with newspapers and condom-strewn floors, resulted in the immediate termination of the project." (de Maré, 1985)

Bridger (1985) wrote of a similar account given by Main (1977):

> "He omits, however, one key factor . . . which leads him to ascribe Bion's departure ('sacking') after only six weeks of work with his Unit to the inability of the Commanding Officer of the hospital and his professional administrative staff to tolerate the early weeks of chaos which accompanied the self-management and functional leadership responsibilities demanded of the Unit. . . . Main was only partially correct. Bion was essentially facing his Unit and the hospital professional staff with the task and responsibility for distinguishing between their existence and purpose as a military organization, and their individual inferences (in the majority of cases) that health entailed a return to civilian life. In addition, more fundamental issues were at stake."

These fundamental issues were a lack of appreciation by Bion of the effect of his approach on other psychiatrists and administrators (including the Commanding Officer), and that "he did not recognize, or perhaps not accept, that it was equally his business and part of his task to take these [wider] environments into account" (Bridger, 1985).

Trist advanced a further reason for the Experiment's abrupt ending:

> "What they were doing profoundly disturbed the rest of the organization. It queried the medical model. The opposition which Rickman had feared in 1940 began to gather, but not so much in an overt as in a covert form, and erupted in the symptom of an absurd incident. Bion, as messing officer, came to know that there was something wrong with the accounts. It was his duty to find a way of dealing with it. A person of rather high rank seemed to be implicated. Any public disclosure would have created a scandal that could have reacted badly against army psychiatry just as it was establishing itself. In the War Office, Brigadier Rees took no chances. He did not trust Bion, who was rather strict about regimental conduct, to handle the matter with the discretion he thought necessary. On his order Bion and Rickman were summarily posted back to WOSBs. . . . The matter of the accounts was smoothed over at the cost of stopping the Northfield experiment." (Trist, 1985)

Bion felt that the result of the Experiment was:

> "a powerful release of emotion which showed itself chiefly in heightened morale amongst the patients, acts of indiscipline by two warrant officers of the staff – *ex officio* stable personalities – and minor but persistent obstruction of obscure origin. The experiment was brought to a close by the authorities, and since it has not proved possible to investigate their state of mind I cannot suggest a cause of failure." (Bion, 1948)

### The second Northfield Experiment

The second, more prolonged, experiment evolved gradually. Its origins lay in the work that Foulkes had been doing in groups since his appointment in 1942; the lessons of the First Experiment were not incorporated until later.

Foulkes's work was initially confined to his hospital ward patients. The first step in the earliest phase of the Second Experiment was a series of organisational changes (probably initiated by the Commanding Officer, Dennis Carroll) which brought the hospital and training wings into closer contact with each other. Foulkes felt this "forced the hospital into a greater contact with realities" and produced "a better integration of its functions" (Foulkes, 1948).

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He thought they were facilitated by "the sense of emergency throughout the country created by the imminent Second Front", and later the change in the patients to "young, active soldiers who had seen battle" (Foulkes, 1948). This enabled him to extend his activities to men who had moved on to the rehabilitation wing. Bradbury, who had up to that point been providing educational activities on the wards, was able to set up his art hut along with other activities in the 'activities yard'. These included carpentry, leather work, modelling and pottery. This reduced the separation of men in their different wards and increased their contact with each other. Foulkes commented on the "breaking down of barriers throughout the hospital" (Foulkes, 1948).

Harold Bridger, an artillery officer, took up his appointment in charge of the rehabilitation wing in 1944. He immediately developed his role of 'Social Therapist' to have a hospital-wide function. He agreed with Bion that the only way to tackle group neurosis was to push responsibility back on to the members. He used the hospital social club to "create some identifiable equivalent of the hospital-as-a-whole-with-its-mission" (Bridger, 1985):

> "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." (Main, 1977)

After a few soldiers had idly wandered in and out, the challenge was taken up. Bridger was summoned to a meeting and confronted with arguments as to "why we were wasting public money and space in wartime – money and space that could be put to so many good uses!". He pointed out that they had the equipment, so far jealously guarded on each ward, and the ability to organise the club themselves. He later reported:

> "It is difficult to convey the tremendous energy and directive ability which can be generated when it is possible to find the transitional setting/experience through which the insights of therapy, derived from treatment, could be allied with social purpose and satisfaction in identifying with institutional forms, infra-structure and activities." (Bridger, 1985)

The hospital newspaper (now called *Mercury*) was developed, dances, theatre productions and other activities were organised, and the social club evolved.

In 1945, Tom Main was posted to replace Emmanuel Millar as officer in charge of a hospital wing. His enthusiastic commitment and understanding of what was happening linked the medical activities (under his command) more cogently with what was happening in the rehabilitation unit. Despite successes, group rivalries were creating difficulties for the Commanding Officer. Patient indiscipline was a particular problem. This was a result of his junior medical colleagues' tolerance, viewing the behaviour in terms of personal pathology. Main concluded that the difficulties were not just those of the lower-order systems of individuals (or even wards). The higher-order system of the hospital had to be addressed. Groups began to be used for a new purpose:

> "the examination of other crises and inefficiencies, whether clinical or administrative and whether these involved staff or patients or both. . . . Thus we slowly replaced blind hierarchical discipline of un-understood annoyances by the discipline of informed common sense." (Main, 1977)

From this came the idea that the whole institution should be therapeutic for all who were in it. The phrase 'The Therapeutic Community' was born. This phase lasted from Bridger's arrival to the departure of Foulkes, a period of 18 months. Although some innovations never became fully established (partly due to the rapidly changing personnel), some novel concepts were established and new ideas disseminated. Group therapy reached a wide audience of interested people. Physicians like Charles Lewsen, nurses, and art therapists learned about the new practices. Work became an active therapeutic tool, with men placed in the Austin Motor Company, local department stores, and Avoncroft Agricultural College. Activities such as bricklaying, toy repair, carpentry, metal work, leather work and glazing, were carried out on the campus. This was not viewed as 'work therapy', and art was not seen as 'art therapy'. Work and art were integral to the therapeutic process as methods of developing an individual's full potential and sense of purpose. In the later stages, men had the opportunity to explore alternatives in order to prepare for their future career, outside the Army. The seeds of the idea that the whole hospital could be reorganised to become therapeutic for all who were in it, had been sown. This led to the growth of the Therapeutic Community movement:

> "After the war, of course, Maxwell Jones had much more scope to develop hospital-wide activities of which he has written fully. 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 books." (Bridger, 1985)

### Comparisons and contrasts

In many ways the two experiments were similar. They differed from other contemporary practice because

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of the underlying concepts of responsibility to society, respect for patients (allied to a drive to encourage them to accept responsibility), use of groups and the hospital as therapeutic instruments, and an emphasis on process (rather than outcome).

Bion considered that the psychiatrist's task was "to produce self-respecting men socially adjusted to the community and therefore willing to accept its responsibilities whether in peace or war" (Bion & Rickman, 1943). The intention was not to force men to become 'cannon fodder' but to enable them to overcome their neurosis and then recognise and fulfil their social roles. These views, like Bion's comments about the need to avoid 'retreat' (Bion, 1946) probably had their roots in his own life experiences. He remarked on his award of the DSO in World War I, "I might with equal relevance have been recommended for a Court Martial. It depended on the direction one took when one ran away" (Day, 1983).

Main considered the aim of the hospital was to be "the resocialisation of the neurotic individual for life in ordinary society", achieved by ensuring that "The daily life of the community must be related to real tasks, truly relevant to the needs and aspirations of the small society of the hospital, and the larger society in which it is set". Success was that "there should be no regrets on leaving; rather an increased zest for life and confidence that the problems it presents can be met and faced without inefficiency or unhappiness" (Main, 1946).

Respect for the individual was allied to confronting the concept of sick patients being treated by well staff. This theme was constantly reiterated by Main (1946, 1977). Bion promoted personal responsibility by placing decisions about the running of the unit on the men's own shoulders. His confidence was based on his knowledge that "Once the rout is stopped even quite timid people can perform prodigies of valour" (Bion, 1946).

Bridger learned that "the individual can only experience full freedom and satisfaction in a society that recognizes his worth, and gives him the opportunity to develop in a spirit of warm human relationships" (Bridger, 1946). Rickman similarly stated:

> "The neurotic is commonly regarded as being self-centred and averse from cooperative endeavour; but perhaps this is because he is seldom put in an environment in which every member is on the same footing as regards interpersonal relationships." (Bion & Rickman, 1943)

Bion was in no doubt about the value of process in therapy: "It was more important that the method should be grasped, and its rationale, than that some solution of a problem of the wing should be achieved for all time" (Bion, 1946). This mirrors his experience with officer selection. Bridger also emphasised process, and believed that it should not be organised (except through the provision of resources). Taking responsibility for co-operative working and problem-solving, and confronting the consequences of actions, were seen as key therapeutic agents for both patients and staff.

The success of the second experiment lay in the greater attention paid to the wider community, the larger staff group involved, and the slower pace.

Bion and Rickman's experiment was centred firmly on the two instigators. The second experiment involved many staff at a number of levels. Bridger argues that Bion and Rickman failed to realise the effect their approach would have on other staff (Bridger, 1985). Instead of patiently explaining their aims, they were vehement in their condemnation of existing practice (as demonstrated by Bion's view of life in a psychiatric hospital) (Bion, 1946). Main, Bridger, Foulkes, Bradbury and others were concerned not to jeopardise their achievements. They communicated their purpose, and attempted to sanction approval for their initiatives. Foulkes, for example, invited Bion, Rickman and other staff to attend one of his groups.

Bion and Rickman initiated changes at breakneck speed: this probably contributed to the rapid termination of the first experiment. Practice evolved gradually during the second experiment. A factor behind this was the understanding of systems theory by the second group of workers. The needs of higher-order systems (such as the Army) were recognised, as well as those of individuals and groups. The Commanding Officer, while never completely at ease about the developments, was better informed, and his responsibilities were given more recognition.

The Northfield Experiments were a landmark in the evolution of group psychotherapy and the Therapeutic Community movement. After the war, Bion and Bridger went to the Tavistock Clinic. Foulkes became a consultant at the Maudsley Hospital. Main developed an analytically orientated therapeutic community at the Cassel Hospital (Hyde, 1988).

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