

Response to The Northfield Experiments—a reappraisal 70 years on

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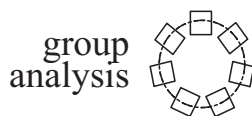
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Response



Response to The Northfield Experiments—a reappraisal 70 years on

Tom Harrison 

That the Northfield Experiments continue to interest those working in group therapy and therapeutic communities is testament to their importance. One of the problems of their legendary status is tracing their influence on subsequent practice. Unlike the work of Maxwell Jones at Mill Hill and later at Belmont (Henderson) Hospital which led to a ‘recipe’ for establishing therapeutic communities, Wilfred Bion, Tom Main, John Rickman, Sigmund Foulkes, Harold Bridger and others ‘created a feast of new ideas’ of which many have only been half-digested (Kennard and Roberts, 1983: 50). Dr Coombe has made an important contribution in describing something of their legacy. His personal account allows us to see something of the real impact that the work of those pioneers made.

In recounting the events of three-quarters of a century ago, derived from secondary sources, succinct contemporary accounts and reminiscences, inaccuracies are liable to creep in, and I am as guilty of this as others. It is difficult, as a civilian clinician, to place oneself in an environment where the exigencies of war dictate one’s practice. As a historian of the Northfield Experiments I can only comment marginally on issues relating to the practice of psychotherapy and related fields subsequently, so this response is largely confined to the history of that unit.

First it is important to emphasize that the hospital was a military hospital and describing how Bion (Bion and Rickman, 1943: 678) ‘quickly instituted a group focus in the Training Wing’ is misleading.



Recognizing that the army was already constituted of groups, he saw the task as persuading the men to 'tackle neurotic disability as a communal problem'. It is important to acknowledge the importance of his use of military language. He was acting as an officer in command of a 'rather scallywag battalion' and from this stance considered how best to raise the morale of the men so that they could function effectively and usefully. He employed military techniques, the mid-day parade of 'some hundred men', to achieve this, reminding all concerned that, although they were in a hospital, they were also part of the British Army. He (Bion, 1946: 79) used structures that were already in place, supplemented by short lived groups which he utilised to 'rally' those troops, who 'were not too far gone to be steadied' to face the enemy: neurosis. He employed military discipline in the form of a rest room for those individuals who felt that they could not take part in the activities of the training room. The effect of this was to make any person using this 'respite' feel very uncomfortable as he would feel 'frozen out' by his colleagues (de Maré quoted in Harrison, 2000: 189). As a result order was re-established, to the extent that the Commanding Officer remarked on the 'big change in cleanliness that had taken place' (Bion and Rickman, 1943: 679). Bion learnt about group dynamics from these experiences, but did not set out to create groups, or be a group therapist. This is the fundamental difference between him and Foulkes. The latter had previously treated people in groups and he continued to see his role in this way during his time at Northfield.

Dr Coombe comments on the various individuals involved being 'rather ambitious and self-focussed, believing strongly in their abilities and making strong claims for their superiority. Humility was not their strong point' (Coombe, 2020: 172). I think this misinterprets the collegiate confidence of those later identified as the Tavistock Group. They shared a vision of how psychological methods could be used in the social setting of an army at war. They had to fight for these ideas in the face of opposition from traditional attitudes, both within the army and outside. The antagonism extended as far as the Prime Minister Winston Churchill (Winston Churchill quoted in Ahrenfeldt, 1958: 26), whose comment when setting up an enquiry into their effectiveness was 'it would be sensible to restrict the work of these gentlemen, who are capable doing an immense amount of harm'. Incidentally, although the subsequent report vindicated their work he never acknowledged this. Their 'ambitiousness' in the light of this was not that of self-promotion, but of their joint commitment to

maximize the functional efficacy of the British Army in the face of traditional reservations. There clearly was some intolerance of those who did not understand their viewpoint, and Tom Main's (Main, 1945a: 1) irritation with Foulkes related to the latter continuing to promote 'the development of personal insight into pathological affairs, rather [*than*] with using group treatment to get insight into the difficulties of the inter-personal relationships'. They were also products of their officer class, where subordinates were expected to salute them at all times. However, Patrick de Maré (de Maré, 2000: 111) makes it clear that found John Rickman 'enormously consoling' and watching him participate in a film about the War Office Selection Board (Anon, 1944) leaves one acutely aware of how humane and considerate he was to his colleagues. Bion, on the other hand, de Maré found to be 'extremely shy'.

Elsewhere, Dr Coombe hints at a shibboleth that was raised at the conference in 2018 which he mentions, and that is that the soldiers being treated at Northfield were returned to the front line. As Bion (Bion and Rickman, 1943: 678) related, doctors treating soldiers who had faced active service always ran the risk of making 'that hideous blunder of thinking that patients are potential cannon-fodder, to be returned as such to their units'. This reflects the 'non-combatant guilt' that medical men faced when confronted by those who had endured extreme threats to life and limb and which, perhaps, continues to affect subsequent commentators. There are a number of issues that arise from this. First is the likely impact of soldiers with a known history of mental health problems joining a fighting unit, where each man relies on his fellows for his safety. Secondly, Northfield was a secondary service to a system known as 'Forward Psychiatry' where distressed personnel were treated close to the battle-field with the intention of returning them to their own units as rapidly as possible. Once the individual had made it to Northfield the intention was to assess them in order to identify whether they could still serve in other capacities, such as ward orderlies, office staff and the like. Thirdly, there is no evidence that any soldier was returned to front line duties from the hospital.

Dr Coombe's statement that the 'almost universal view of these matters since is that Bion and Rickman were not able or willing to bring the administrative part of the hospital or the army into an understanding of their ideas' (Coombe, 2020: 165) perhaps overstates the case leading up to their dismissal, particularly in the light of Harold Bridger's observation that Bion was 'ill at ease with open systems'

which better describes the situation. My own observations, (Harrison, 2000), perhaps failed to emphasize the fact that Rickman was deeply involved in training other psychiatrists at the hospital and organizing psychiatric conferences, which were much appreciated by those attending them (de Maré, 2000: 111). The events that led to his, Bion's and the commanding officers' removal from the hospital remain largely a mystery, and speculation in the absence of documentary evidence tends to be deceptive.

The description of how Bridger worked with psychiatrists in Australia is invaluable. As I have argued elsewhere (Harrison, 2018: 449–450), his insights into the operation of 'open systems' have largely been neglected by the therapeutic community movement in the United Kingdom. He sometimes implies that he had developed the phrase 'the double task' at Northfield (e.g. Bridger, 1982: 242). However, none of his contemporary writings employ this term (e.g. Bridger, 1945, 1946). Despite this, the phrase aptly describes his setting up of the social club which apparently served the function of a recreational area for the soldiers, but had the underlying intention of enabling everyone to see themselves as part of the larger system of the 'hospital-as-a-whole'. His conceptualization of the 'transitional space', in which people in an organization could take 'time-out' to reflect on the challenges facing them, of course relied on Donald Winnicott's formulation of the 'transitional object' in 1951, well after Northfield had reverted to its original purpose as a civilian psychiatric hospital.

I will now address a few specific inaccuracies. John Rickman arrived at Northfield in July 1942 according to his daughter, rather than late in that year (Harrison, 2000: 184). Sergeant Bradbury (Bradbury, 1990) would not have enjoyed being called an 'occupational therapist'. He did not like his work being referred to as 'art therapy' ('hateful term'), arguing that art *was* therapy of itself. He also made it clear that he left it to others, such as Foulkes to carry out therapeutic interpretations. As he himself reported (Bradbury, 1990) 'if there be therapeutic help gained from painting it most certainly comes from the "doing", not from the smart interference from the likes of me'.

It is important to remain as close to the intentions and perceptions of the original participants, rather than re-interpreting them in the light of present day understanding. This brings me to Bob Hinshelwood's interpretation of Foulkes' work as a 'third' Northfield Experiment. The suggestion that there were two comes from a letter by John Rickman (Rickman, 1945) to Major A. T. M. (Tommy) Wilson in

1945 and, as Dr Coombe has described, refers to the work by Bion and Rickman, and then that of Main, Bridger and Foulkes. Once one starts on elaborating on this, present-day biases start to distort the picture. Should we also include the work of Joshua Bierer as the 'fourth' experiment? He gained an international reputation after the war, in many ways as much as Foulkes or Main. Should the work of Drs Backus and Mansell (Backus and Mansell, 1944) with patients suffering from enuresis be categorised as the 'fifth' and so on?

The excitement of Northfield and discovering the richness of the 'feast of ideas' is best served by exploring the original source material. For instance there is a collection of papers describing probably the first ever peer group discussions of group therapy, now held at the Wellcome Contemporary Medical Archives. In this, on the 5th of September 1945, Tom Main (Main, 1945b: 4) asks a question that perhaps has never been answered, 'If a man is socially well adapted, would you dare to say his neurosis was?'. This is central, as Coombe points out, work at Northfield 'meant working towards soldiers being able to put aside their neuroses and personal matters and function'. As Main (Main, 1945b: 5) stated it, it was not just to help the person get healthy in himself, but also to 'make him healthy with regard to society, to the particular society that he is living in', which in this particular case was the army. If one subscribes to the concept that we exist within our relationships, then it is possible to argue that functioning well in interactions with others means that we are resolving our neuroses and personal difficulties. According to Main and Bridger's colleague, the psychoanalyst Jock Sutherland,

man's sensitivity to his place in society, his status in the eyes of other men, is central to the problem of stress. When his own ends are submerged to the common end, or within a group ideal, he is often at his best'. (Sutherland, 1966: 71)

Has this matter received less attention in the psycho-analytic press than it deserves and is it possibly one of the central aspects of how the therapeutic community approach achieves success?

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