Psychiatric Quarterly, Vol. 75, No. 3, Fall 2004 (© 2004)

THE EVOLUTION OF THE THERAPEUTIC COMMUNITY

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The creation of Therapeutic Communities in the Military Hospitals of the UK for the treatment of psychological casualties of war during the Second World War is described. The personnel and the methods utilised are discussed and the lessons learned are summarised. It is argued that this was not an entirely new phenomenon. The author describes previous usage of similar methods in residential communities for disadvantaged or delinquent youth in the period between the two world wars and, prior to this, the eighteenth century "era of moral treatment" in mental hospitals in the UK and USA.

KEY WORDS: therapeutic community; moral treatment; psychiatric history.

SOME ANTECEDENTS OF THE THERAPEUTIC COMMUNITY

Moral Treatment of the Mentally Ill

In France, in 1792, Phillipe Pinel, Superintendent of the Bicêtre and Salpétrière Asylums in Paris is reported to have struck the chains off some of the inmates of these places and set them free and is commonly regarded as a pioneer of a more humanitarian treatment of the insane.

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0033-2720/04/0900-0233/0 © 2004 Human Sciences Press, Inc.

In this same year, a revolution in the treatment of the mentally ill was about to take place in England. The Tuke family of merchants, resident in York, dismayed by the unfeeling treatment and ultimate death of a mentally ill fellow-Quaker set out to build a hospital for the insane which would be run on humanitarian principles. Due respect would be given to the patient and the comforts of good living and friendly relationships would be provided (1). The name of this method was finally settled upon as *moral treatment,* which was taken by Tuke from a translation of a treatise written by Pinel. However, K. Jones points out that Pinel's *traitement morale* does not translate strictly as the *moral treatment* which was at that time being established at The Retreat, the Quaker foundation of the Tuke family which was eventually opened in 1796. The Pinel phrase refers to a treatment through the emotional self whilst the moral management of the Tukes refers to the attitude of respect for human rights and the values of relationships (2). The first American doctor to visit the Retreat was John Francis of New York who wrote in the Visitors Book in 1815 that *"The New World cannot do better than imitate the old so far as concerns the management of those who labour under mental derangement"* (3).

In the first half of the nineteenth century many other asylums for the mentally ill, both in England and America, followed the system commenced at The Retreat. Towards the close of the nineteenth century, David Hack Tuke, a descendant of Samuel Tuke, the founder of The Retreat, advocated occupation as a part of treatment saying that *"the immediate object is not the value of the labour but the benefit to the patient."* In his *Dictionary of Psychological Medicine* (4) he also notes that *"nursing their fellow patients is a valuable occupation for both sexes."*

Charles Dickens, the nineteenth century author, was a social commentator as well as a novelist. In his book, *American Notes*, (5) he describes how he observed the Superintendent of the Boston State Hospital sitting down to dinner with the patients and how *"moral influence alone restrains the more violent,"* thus doing away with restricting devices. Samuel Woodward, of the Worcester State Hospital, wrote that, *"if the physician could manipulate the environment he could thereby provide the patient with new and different stimuli, thus older and undesirable patterns and associations could be broken or modified and new and more desirable ones could be substituted in their place"* (6).

In Germany in 1803, Reil, of the University of Halle, advocated that each asylum should have its own theatre with the *"roles in the plays distributed according to individual therapeutic needs. The fool, for instance, would be given a role making him aware of the foolishness of*

his way of behaving." He, too, saw work as an essential aspect of therapy progressing from the requirements to maintain physical health, through artistic creativity, to mental activity (7).

In summarising the nineteenth century experiences throughout Europe, we find many basic truths concerning the social psychology of large residential groups in hospitals which have been "rediscovered" by more recent sociological observation, namely: 1) That when the leader interacts at the level of the group his power can be magnified rather than dissipated; 2) That it is not so much the occupation of the group but the participation in the group activity which is the curative factor; 3) That responsibility-sharing and mutual self-help leads to a decrease in passivity and dependence and to abandonment of the sick role; 4) That when the aetiology of the illness is placed outside the influence of the patient a state of hopelessness is engendered in both therapists and patients; 5) That the mental hospital is a microcosm of society with mental symptoms being no more than exaggerations or acted-out representations of so-called normal social behaviour; 6) That role playing experiences can lead to insight into the individual's abnormal behaviour; 7) That negative sanctions are less effective than positive reward in changing behaviour.

Living and Learning Communities for Disadvantaged Youth

In the period between the two world wars there were a number of well-known "*living-and-learning* experiments" with adolescents and young adults throughout the world, which have been extensively reviewed by Bridgeland (8). Examples of such well-known projects are Homer Lane and the Little Commonwealth (9) in England, and which itself emanated from Lane's experience in Father Flanagan's Boys Town in USA; Aichorn in Austria and Makarenko and the Gorki Republics in post-First World War Russia and the Q Camps in England. These latter were short-term, residential communities, which were called Q Camps where Q stood for Query or Quest, and the philosophy on which they were based was Planned Environment Therapy. This latter approach was initiated in the nineteen thirties by Marjorie Franklin, a psychoanalyst working with children. Planned Environment Therapy (10) was based upon identifying the remaining "healthy" aspects of the personality in the subjects studied and utilising such in an attempt to restructure the individual's attitudes and function within a social and community environment. David Wills became an important figure in the Camps and later set up Hawkspur Camp (11), which was based on the Planned Environment principles.

The participants in these diverse and internationally generated residential communities were, for the most part, offenders, homeless, or otherwise socially handicapped young people. However, the concepts of *shared responsibility* for the physical maintenance of the living space, *participation* and *democratic decision-making* in the governance of the project, were common to all of these projects. All seem to have arisen relatively independently of each other and at the inspiration of some interested individual which suggests a philanthropic philosophy common to the human race.

Although not directly linked to the Northfield or Mill Hill developments during World War II, described below, there are some associations which have been brought to recent light by the diligent work of Craig Fees, Archivist to the Planned Environment Therapy Trust and to the Association of Therapeutic Communities (12). At a joint conference of the ATC and PETT in the 1950's, a participant listening to Maxwell Jones' account of his own practice, remarked with some indignation at the nonreference to the earlier work, that "it's just Hawkspur all over again." Similarly, a Commanding Officer at Northfield, in the early war years, having just read a small monograph published in 1943, entitled *Q Camp: An Experiment in Group Living with Maladjusted and Anti-Social Young Men,* commented to the officer in charge of the Psychiatric Unit, *"that's what we ought to do here."* He was quite unaware that Dr. Denis Carroll, the officer in charge of the Psychiatric Unit, had been the Chairman of the Q Camps Selection and Treatment Committee and had himself suggested that the monograph quoted be published! (12).

THE MISFORTUNES OF WAR

In the foreword to a recent book on the Northfield Experiments (13) Hinshelwood writes, *"The legend of Northfield is one of those myths of creation."* The specialist units in the United Kingdom for the treatment of psychiatric casualties of the Second World War are repeatedly cited as the originators of the Therapeutic Community, but perhaps the true seeds of the Therapeutic Community were already dormant in our society. The fortunes (or misfortunes) of war had thrown together personnel from many different professional backgrounds and schools of thought. In addition to the varied clinical approaches that these diverse professionals brought with them, these latter were also the bearers of the decades of moral, cultural and social attitudes, which have contributed to the development of our civilised society. In the early years of the war,

the need was established to find methods to cope with the psychiatric casualties of war that had led to the masses of so-called "shell-shock" victims of the First World War and their mishandling by the authorities; varying from punitive excesses to long-standing invalidism. Two hospitals were set up primarily for this task, at Northfield in Birmingham and Mill Hill in London.

Northfield

The medical staff at Northfield were largely psychoanalysts with a Tavistock Clinic background. The hospital came into being in 1942 when an old Victorian Asylum was taken over for Military Psychiatric Casualties. Only patients who had a reasonable chance of return to military service were admitted and the conduit for return to the army was the Training Wing, of which the psychoanalyst Wilfred Bion was appointed Director at the end of 1942. Bion, had witnessed the traumas of war when he had served with distinction as a tank commander in the First World War (14).

Together with Rickman, he instituted a disciplined programme of daily parades, a period of which was spent in group discussion. Rickman was a psychoanalyst who had had some experience of a psychoanalytic approach to war trauma at the smaller Wharncliffe Hospital, in Sheffield, where a feature had been to use military drill as a form of "occupational therapy" and as a reintroduction to the "normal" work of a soldier. He was also a former colleague and analysand of W. H. Rivers (15), the psychiatrist who had pioneered the humane and psychotherapeutic treatment of some of the psychological casualties of the First World War. What was an innovation, in this First Northfield Experiment, were the discussion groups which Bion initiated. The task of the group was to *study its own internal tensions*, which stood in the way of the individuals performing their military duties. Although this may seem a common therapeutic task to us today, it was not a procedure which was familiar to the more traditional doctors in the hospital nor was it what the military authorities expected of the Training Wing. Bion and his colleague Rickman were soon in conflict with both the medical and the military hierarchy and they were dismissed from their posts after six weeks despite an improvement in behaviour and morale in the Training Wing.

A few weeks after Bion left, Foulkes arrived at Northfield and instituted ward-based sessions of group therapy according to the model that he had been developing in his civilian practice. He had been influenced by the teachings of the American psychoanalyst, Trigant Burrow, who

first used what he termed *group-analytic* methods during the 1920's. Burrow's viewpoint was that disorders in human behaviour were essentially social or interrelational and demanded observation and study in a dynamic group setting (16). Drawing also upon the theories of Lewin (17), Foulkes came to view the whole hospital as the current "social field" and the behaviour of the individuals within it as being subject to the forces inherent in that field. In his first book, Foulkes, (18) diagrammatically illustrated the relationship between traditional individual *Psychoanalysis*, formal *Group Analysis* and what he calls *Open-Air Psychiatry*, or working in the *Life-Space* of the patient. *Psychoanalysis* is at the centre of the circle and the other areas are the successive enveloping layers; firstly *Group Analysis* and then a covering layer devoted to *Open-Air Psychiatry* or dealing with the issues of everyday life in a social setting. De Mare, who was at Northfield in a junior medical officer capacity and was later to pioneer the practice of therapy in the large group, has commented that what Foulkes did not do was to bring the small groups in the various hospital wards and departments into face to face contact and discussion with each other (19). Such a community meeting, bringing together all involved in the project, is an essential component of any Therapeutic Community today.

With the arrival of Harold Bridger at Northfield, a few months after Foulkes, the concept of the *hospital-as-a-whole* became more manifest. The differentiation between the Training Wing and the Hospital Wing was discarded. Activities were introduced, both in the hospital and in external projects, not as a means of occupational therapy but as a means of *studying, and increasing the opportunities for, participation in group interaction*. Bridger was drawing upon his awareness of the Peckham Experiment, which was an experiment in social cohesion carried out at Peckham, in working-class London, just before the Second World War. By giving free access to a swimming pool, local residents were encouraged to participate in a number of neighbourhood schemes and discussion groups affecting daily life in the area (20). Additionally, he drew upon his experience before the war as a teacher of mathematics when he introduced real and practical tasks (such as following the fluctuations of the Stock Market) into the classroom as a way of learning, rather than relying solely on didactic lectures. He was also utilising the methods to which he had been introduced in the *leaderless groups*, which were a wartime feature of officer selection. In these latter, a group of soldiers would be given a task—such as construction of a bridge over a stream—and would be observed as to the way they worked co-operatively, by whom leadership was undertaken, and how others responded to whatever form of leadership emerged.

Main arrived towards the end of the war, having had experience in the early treatment of 'battle exhaustion' and also of the resolution of a threatened mutiny by a battle-weary battalion on the Italian front. He supported the concept of the hospital-as-a-whole and encouraged Foulkes to act as a kind of roving organisational consultant who visited various departments in the hospital where problems were arising, in order to study the situation in a group setting and facilitate the emergence of a group resolution. The major contribution of Main was perhaps to acknowledge the wider concept of the *interrelated systems* at work in this setting, and which needed clarification of the issues involved, and then resolution of the conflict through negotiation. Thus, rather than coming into confrontation with the existing order in the hospital, as Bion had done, he recognised the needs and expectations of the military system and the *status quo* of the conventional psychiatric treatment system as well as facilitating the newer psychoanalytic way of working with the group. Nevertheless, he made the *primary task* the restoration of the soldier patients to military service. He was somewhat critical of Foulkes and some others on the staff, whom he designated as 'treaters', in a situation which he clearly regarded as secondary to the real task in this time of war (21).

Mill Hill

During the war years, Maxwell Jones, was at the other Hospital for military personnel at Mill Hill, in London, and which was staffed primarily from the Maudsley Hospital, the premier psychiatric teaching hospital in UK, with a tradition of a multidimensional approach of organic, social and genetically-based psychiatry.

The Mill Hill hospital was located in the public school of that name, from which the pupils had been evacuated. It was like a civilian mental hospital in its range of psychiatric treatments; from the currently utilised physical treatments to occupational therapy and social activities. Jones was in charge of the *Effort Syndrome Unit* and began by lecturing to his patients on the aetiology of neurotic symptoms through neural pathways; but his audience was less concerned with physiology than with their "here and now" situation in the hospital and being drafted into military service. Gradually, the lectures became group discussions—in a large-group setting—of the current situations which faced these soldier-patients and from this experience he developed his ideas for the future task of the psychiatric hospital as a Therapeutic Community and the place within such for a community meeting.

THE LESSONS LEARNED FROM NORTHFIELD AND MILL HILL

Northfield

Under the leadership of Main, the Second Northfield Experiment flourished.

It drew the attention of a visiting group of distinguished American psychiatrists in 1945, which resulted in the well-known collection of original papers being published in the *Bulletin of the Menninger Clinic* (22). These Northfield papers were reproduced with comments from contemporary sources in a special edition of the journal *Therapeutic Communities* in 1996 (23). The American visitors were impressed by their visit to Northfield and the extent of group therapy in the UK. However, Karl Menninger comments in a foreword to the original edition that, *(group therapy) "is not as yet the preoccupation or method of preference in the leading psychiatric hospitals of America whereas it actually is in England."* In the Menninger papers, Main had set out a vision for the psychiatric hospital of the future in which the hospital *"will be run as a community with the immediate aim of full participation of all its members in its daily life . . . there must be no barriers between the hospital and the rest of society. . . . the anarchical rights of the doctor must be exchanged for the more sincere role as a community member."* Whilst Main is regarded as the originator of the term Therapeutic Community, Harrison (24) points out that the term was previously used by Harry Stack Sullivan in 1939. According to Main, an aim of treatment in such a hospital would be *"the socialisation of neurotic drives, their modification by social demands within a real setting, and ego-strengthening. The increased capacity for sincere and easy social relationships and the socialisation of super-ego demands provide the individual with a capacity and a technique for a stable life in a real role in a real world."*

Mill Hill

Maxwell Jones postulated for the mental hospital of the future the establishment of *open communication*, with *flattening of the staff hierarchy*, and in order to facilitate such, *role blurring*, whereby the therapeutic input would not be restricted to the professional staff, daily large group *community meeting*s to discuss the real issues of the moment,

democratic decision making and *"a single therapeutic goal, namely the adjustment to social and work conditions outside without any ambitious psychotherapy"* (25).

It was a further visit to a Therapeutic Community in England in the early 1950s by a senior U.S. Naval Psychiatrist, Harry Wilmer, which inspired the visitor to establish a similar group-oriented approach in the Naval Hospital at Oakland, California. This time, a visit was made to Maxwell Jones at Belmont Hospital in Sutton, where the postwar Therapeutic Community, later to be renamed as Henderson Hospital, was located. On his return to USA Wilmer set about establishing a similar community in the Oakland base. Dennie Briggs, who was then a clinical psychologist in the Naval service and had joined Wilmer's team, believes the Oakland unit to be the first Therapeutic Community in the USA. He has deposited an account of the working of the Oakland Naval Therapeutic Community with the Planned Environment Therapy Trust Archive (26). After his Naval service, Wilmer continued to utilise the Therapeutic Community approach in many different projects and with varied client groups in the USA and taught and wrote extensively about the method (27). On the advice of his senior, Briggs had made a visit to Belmont in 1956, following which he was to become a friend and collaborator with Maxwell Jones on many projects in the USA, which included extending the Therapeutic Community ethos into schools and into Penal Institutions (28).

On the whole, however, what emerged from these two innovative experiences at Northfield and Mill Hill was very similar in terms of the concentration on the functioning and well-being of the hospital community, with less emphasis on the individual as the primary therapeutic target. Out of Northfield came a *philosophy* of the Therapeutic Community and from Mill Hill a *method*. Strange as it may seem, in a professional activity where communication is regarded as paramount, there was little or no exchange of ideas between the protagonists, Main and Jones, in these two wartime experiments. Bridger alone, (the nonpsychiatrist), seems to have visited other units concerned with the rehabilitation of service personnel before taking up his duties.

POSTWAR DEVELOPMENTS OF THE THERAPEUTIC COMMUNITY ETHOS

After the war, Main was appointed as Director of the Cassel Hospital, where there was a tradition of psychoanalytic treatment (29), and

here he established his model of the Therapeutic Community, which might be called a *psychotherapeutic* community. Patients were treated in individual and analytic group sessions as well as being involved in community activities, which latter were largely directed by specially trained and often psychoanalytically experienced, nursing staff.

Maxwell Jones continued to develop his more *sociotherapeutic* community methods at Henderson Hospital in Sutton (30), where the patients upon whom the method was primarily utilised were young personality disordered clients. He interested an American social anthropologist, Robert Rapoport, in exploring the community. Rapoport had just returned from an investigation of tribal life with the Navajo Indians and he and his team took on a participant-observer role to explore life in the Belmont Therapeutic Community. The experiences of the Rapoport team were reported in the book *Community as Doctor* (31). Initially, the book had a mixed reception from the psychiatric profession, who were perhaps beginning to tire of the Therapeutic Community saga, and Max himself was disappointed with the findings. Rapoport pointed out a number of contradictory or negative factors in the therapeutic community process as it then was. For example: a) it could be *damaging to those with poor ego-functioning*; b) there seemed to be a *conflict of aims* between staff with a *rehabilitative aim* (assisting the damaged patient to survive life's traumas) and those with a *curative aim* (eradicating the psychological symptoms); c) despite the assertions that "we are all equal here" there was a prominent *dependency on the professional staff*, who continued to see patients for individual sessions, and Rapoport pointed out that those patients who had the better outcome were those who had formed close relationships with key staff figures.

Maxwell Jones later came to terms with the Rapoport findings and was to write, *"for me to discover the discrepancy between what I thought I was doing as a leader and what trained observers saw me doing was frequently a painful—but almost always a rich learning experience"* (32). Most well known from the Rapoport report, are the four ideological themes he extracted from his observations, namely, *permissiveness, communalism, democracy and reality confrontation.* These often-quoted principles have been critically scrutinised by many authors; Morrice (33), Haigh, (34) Birch et al, (35) among others. They are frequently taken as being the essential ingredients of the Therapeutic Community and for many who seek to create a Therapeutic Community the assumption is that, once added, the true Therapeutic Community will inevitably result. This, of course, is not the assured outcome.

Curative Factors in the Therapeutic Community

An understanding of what is contained within these ideological principles of Rapoport is necessary so that they can be applied or facilitated to develop productively. In an investigation at Henderson Hospital (36) we explored the relevance of the generally agreed *curative factors in group psychotherapy* (37) as applied to the Therapeutic Community. In summary, we asked patients to denote what had been for them the most important factor in the previous week in terms of advancing their therapy. Looking at when such factors occurred, we found that in the early stages of treatment the new patient looked first for *acceptance* and the *instillation of hope*. Later came *learning from interpersonal actions* and *self-understanding*. The Rapoport principles are not in themselves the curative factors in the therapeutic community process. They are either therapeutic techniques or conditions in which change can occur, but they probably contain within them certain more discrete curative factors. Thus, *permissiveness* allows for catharsis, self-disclosure and the assumption of self-responsibility. *Reality confrontation* can promote self-awareness and the development of identity and self-concept and learning through interpersonal actions. *Democracy* allows self-management to emerge and altruism to flourish as a patient is allowed to contribute meaningfully to the treatment of others. *Communalism* promotes interaction with others, responsibility-sharing, the abandonment of fixed social roles and attitudes, and the development of new relationships. When we asked patients to say where these important events occurred we found that, although they could arise in any of the group therapy structures in the treatment day, slightly more of these important and beneficial incidents took place within the community boundaries but outside the formal therapy groups.

Attachment Theory and the Therapeutic Community

Although Maxwell Jones appeared to exclude any *"ambitious psychotherapeutic programme,"* evidence that psychodynamic factors were present in his concept were illustrated by Rapoport's finding that those patients who responded best were those who formed strong relationships with key staff figures. Indeed, a feature of the Therapeutic Community is the attachments that patients are enabled to make within the community. Often it will be the first successful attachment that a patient will have made after repeated failed attachments in his earlier personal development. He will test out, act-out, but finally take the

risk of attaching to the community as a whole, to the staff and to other patients (38).

In this respect the Therapeutic Community has something of the features of Winnicott's *Potential Space* (39) . The term *Potential Space* was used by Winnicott to describe the metaphorical space between mother and child in which both experimented in an interactive way with closeness and distance, separation and togetherness, boundary setting and boundary keeping. It was a learning experience for both, but particularly for the child who was venturing out into the new experience of independence. Similarly, the *Potential Space* of the Therapeutic Community recreates a learning experience for both patients and staff. The daily community meeting is a primary focus of interaction for observation of, and intervention within, the field of sociotherapy. Such meetings are the very heart of the Therapeutic Community process. This is the *Open-air Psychiatry* of Foulkes.

Peter v. der Linden, writing of a Therapeutic Community in the Netherlands, has commented *"this setting* (i.e. the Therapeutic Community) *possesses its own creative value, it's own educational moments, that have no counterparts in ambulant therapy. The therapeutic community is both a physical space with working, eating, sleeping, leisure, and creative areas such as the art room or gym and also, through its rules, customs, and expectations, it is a psychic space."* (40).

THE UTILISATION OF THE THERAPEUTIC COMMUNITY IN GENERAL PSYCHIATRY

In the immediate years following the Second World War and the awareness of the Northfield and Mill Hill experiences, the concepts of the Therapeutic Community were enthusiastically taken up by psychiatrists returning from the war and impressed by the success of war-time psychiatric interventions, whether in the above specialist Therapeutic Communities or in the early-treatment "group" interventions for Battle Exhaustion, set up in the combat areas and avoiding the necessity for transfer back to base hospitals. However, the principles of the Therapeutic Community that were developing in the postwar years, were not readily transferable to civilian mental hospitals, with the diversity of psychiatric diagnoses within such, and so the take-up was limited.

Clark (41) distinguished between the Therapeutic Community *Proper*, such as at Belmont Hospital (Maxwell Jones), the Cassel Hospital (Main) and a very few smaller units treating personality and neurotic disorders, and the Therapeutic Community *Approach*, which

embodied some of the more generalised "living and learning" techniques of psycho-social therapies. Such latter hospitals utilised group discussions on the daily life of the hospital community and limited participation in ward management.

On the whole, these were embodied in the "Open Door" hospitals which followed a tradition of not locking all the wards and providing a free access to social and occupational amenities within the hospital and grounds. This less controlling approach was also named "the return to moral treatment" and echoed the traditions of some of the mid-nineteenth century asylums already alluded to above. It is interesting to note that Dingleton Hospital, in Scotland, was one of the pioneers of the first (nineteenth century) Open Door policy and a hundred years later was the hospital to which Maxwell Jones was appointed as Medical Director in 1962. At Dingleton he developed a system which spread outside the hospital community itself and incorporated local authority social workers, general practitioners and members of the wider public (42).

The further development of the Therapeutic Community *Proper* has included the establishment of the Association of Therapeutic Communities (ATC) in 1970 and its expansion into an international membership, the Journal of Therapeutic Communities, and an internet-based discussion group. There is now a specialist library of Therapeutic Community publications produced by Jessica Kingsley Publications in London. Therapeutic Community Training courses and Conferences are regularly held, notably the annual Windsor Conference, which has become an international meeting point. The ATC and PETT (Planned Environment Therapy Trust) have moved administratively and professionally, closer together, with the latter largely concentrating upon residential communities for children but utilising similar techniques to the Therapeutic Communities for adults.

CONCLUSIONS

The Therapeutic Community is more than just a specialist method of psychiatric treatment and I would like to feel that the issues explored in this overview of the evolution of the Therapeutic Community give us some evidence of a *democratic tendency* in the human race, as Winnicott described (43) or building upon that, of a *therapeutic community impulse* as Kennard has postulated (44). In the 1st Maxwell Jones Memorial Lecture, in 1997, Professor John Cox, President of the Royal College of Psychiatrist spoke of an inherent *community obligation* to support

and assist our fellow men and support and maintain the society in which we live (45).

The Therapeutic Community is the resource through which such drives can find expression.

A POSTSCRIPT: MACONOCHIE'S EXPERIMENT

In 1836, Alexander Maconochie, a former naval officer, the first secretary of the Geographical Society and the foundation Professor of Geography at the University of London, took up the post of secretary to the Governor of Van Diemen's Land (later Tasmania). He was a prodigious pamphleteer and writer of reports to Parliament and for learned Journals and during his appointment to the colony he was invited to prepare a report for *The Society for the Improvement of Prison Discipline.*

He was disturbed by the negative and punitive conditions under which the transportees from England, who had been sentenced to terms of imprisonment in Van Diemen's Land, were held. Drawing upon the experiences of man-management that he had utilised in the Navy, in which he involved all concerned in the resolution of conflicts that arose below decks, he campaigned for a new philosophy of rehabilitation to be applied within the Penal Colonies. He was given the opportunity to put his words into action by being appointed as Prison Governor on Norfolk Island, a notorious settlement for the "scum of the prisons."

First of all he did away with the instruments of harsh punishments such as the gallows and the flogging racks and encouraged the prisoners to look to their future as free men. His system of rehabilitation was based on four stages in which the convict first worked in the prison or on the land and earned marks which could be exchanged for food and other comforts. When the subject had shown that he could budget satisfactorily, he was paired with a fellow convict and they worked together for the same benefits. Thirdly, the individual joined a group, which now had to look primarily to the welfare and sustenance of the group as a whole. Last of all, a successful outcome would be to leave the prison and live and work within the colony as a (relatively) free man until his sentence was expired.

Contemporary mores regarding the punishment of offenders did not agree with this innovative and spirited attempt at "moral education," despite its apparent success in the rehabilitation of many convicts. Maconochie was dismissed from his post and recalled to England. A similar project, which he set up at Birmingham Prison, also fell foul of the powers that be and once again was terminated.

With hindsight, we could see *Maconochie's Experiment* as an early example of an inspiration to make the community therapeutic. Regrettably, the innovator's enthusiastic reforming zeal set him up *against* the ruling establishment rather than seeking to work *within* such. The fascinating and detailed account of *Maconochie's Experiment* is given in the book of that title written by John Clay, a former staff member of a Therapeutic Community for adolescents (46).

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