The Ingrebourne Centre (1954-2005)

Vicissitudes in the Life of a Therapeutic Community

by

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TABLE OF CONTENTS

Chapter 1

Living in Groups: Introduction to the Rationale and Methodology of the Research

> We talked it out in the group, an' I guess the actual patients became part of the therapy (ex-resident of the Ingrebourne Centre commenting in 2015)[1]

1. Introduction: Therapeutic Communities and the Social Human

That man is a social animal is a truism that has worn thin with repetition, yet its extensive implications are rarely fully understood. George Mead, the American philosopher and psychologist, argued that 'I' exists only in relationships to another, albeit the 'other' might be the repository of memories, experiences and sensations that constitutes 'me'.[2] This counter-intuitive understanding places relationships at the heart of consciousness and argues that it cannot exist in their absence. Variations on this theme have been postulated by numerous others from the psychoanalyst Fairbairn to the French philosopher Merleau-Ponty.[3]

From a biological point of view Dr Ian McGilchrist, a psychiatrist writing on neuroscience, adopts a similar stance, asserting that there is no need to create a link between each of us, 'because although individual we are not initially separated, but intersubjective in our consciousness.[4]

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[1] This comment reflects the experience of one interviewee INGCE24, interview,2015, 4. All quotes heading up chapters are from interviews carried out with people who were at Ingrebourne or associated with it.

[2] G. H. Mead, "The Social Self," *Journal of Philosophy, Psychology, and Scientific Methods* vol. 10 (1913): 374–80 and G. H. Mead and C. W. Morris, *Mind, Self, & Society; from the Standpoint of a Social Behaviourist* (Chicago, Ill.; London: University of Chicago Press, 1967), 173–78.;

[3] Fairbairn, the independent Scottish psycho-analyst, saw psychological development as the dynamic interplay between the self and other people, otherwise described as object-relations, thus rejecting Freud's reliance on instinctual mechanisms (W. R. D. Fairbairn, 'Object Relations and Dynamic Structure', in *Psycho-Analytic Studies of the Personality* (London: Tavistock, 1952), 137–61.). Maurice Merleau-Ponty stated that 'There is no inner man, man is in the world, and only in the world does he know himself'. M. Merleau-Ponty, *Phenomenology of Perception* (London: Routledge Classics, 2010), xii.

[4] Iain McGilchrist, *The Master and His Emissary : The Divided Brain and the Making of the Western World* (New Haven: Yale University Press, 2010), 144–45.

Most practitioners of medical care including psychiatrists, however, treat the individual as a separate identity in isolation from their social environment.[5] This reflects a deepening divide between the practice of psychiatry and sociological understanding of mental disorder.[6] Those involved in the therapeutic community (TC) movement contested this perspective.[7] In centres adopting these methods the group setting and interactions with all participants, including between those attending for treatment, take precedence over the dyadic doctor-patient relationship. This approach reaching back to the early twentieth century has always courted controversy.[8] Its deepest roots have been counter-cultural from Socrates through Quakerism to military psychiatry in the Second World War. Despite this it continues in various forms as a method of working with prisoners, people addicted to alcohol and drugs, and children to the present day.[9]

2. The Project and Rationale

i. Aims of the Research

This project examines the Ingrebourne psycho-therapeutic community that operated in South West Essex from 1957 to 2005. It aims to contribute to the few historical studies of relationships between staff and between them and those in their care in therapeutic communities. This gap in examining the interrelationships was adumbrated in 2001 by historian Kerry Davies.[10] In her study, of post-Second World War mental health patients' narratives in Oxfordshire, she argues for the value of people's narratives of their psychiatric

[5] Joan Busfield in her sociological review of managing mental illness points out the sole exception to this being the therapeutic community. Joan Busfield, *Managing Madness: Changing Ideas and Practice* (London: U. Hyman, 1989), 343. Kathleen Jones another sociologist and historian of mental health services also refers to the abandonment of the social perspective of mental disorders by psychiatrists in favour of a 'strictly medical stance'. Kathleen Jones, *Experience in Mental Health* (London: Sage, 1988), 83.

[6] David Pilgrim and Anne Rogers, 'Social Psychiatry and Sociology', *Journal of Mental Health* vol. 14, no. 4 (2005): 317–320.

[7] See: W. R. Bion, *Experiences in Groups and Other Papers* (London: Tavistock, 1961), 53–54, M. Pines, 'The Contribution of S. H. Foulkes to Group Therapy', in *The Evolution of Group Analysis*, ed. M. Pines (London: Routledge & Kegan Paul, 1983), 267. For brevity the phrase therapeutic community will in most cases be condensed to TC throughout the rest of this thesis.

[8] The earliest community for children in the United Kingdom, established by Homer Lane as the *Little Commonwealth* in 1914, was closed in 1918 following his supposed misbehaviour with the female children in his care (W D Wills, *Homer Lane: A Biography* (London: George Allen and Unwin, 1964), 156–95.

[9] For forensic units see Michael Parker, ed., *Dynamic Security: The Democratic Therapeutic Community in Prison*, Community, Culture and Change 17 (London ; Philadelphia: Jessica Kingsley Publishers, 2007). For addiction treatments see Ilse Goethals et al., 'Core Characteristics, Treatment Process and Retention in Therapeutic Communities for Addictions: A Summary of Four Studies', *Therapeutic Communities: The International Journal of Therapeutic Communities*, vol. 36, no. 2 (2015): 89–102. For children in the UK: Adrian Ward, *Therapeutic Communities for Children and Young People* (London; New York: Jessica Kingsley, 2003).

[10] Kerry Davies, '"Silent and Censured Travellers"? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948', *Social History of Medicine*, vol. 14, no. 2 (2001): 267–92.

care, rather than their internal world. She also states that more work is needed to understand the relationships between staff and patients in group therapy, TCs and ward meetings.[11] In turn Nicolas Henckes, the French historian of psychiatry, has argued that the history of clinical thinking has to 'integrate the dynamics and issues of daily practice' at a local level, as this is where scientific and technical knowledge have their roots.[12] The Ingrebourne Centre was where a particular technology of social therapy was prescribed and enacted.

The research records the history of the Centre paying particular attention to the internal social dynamics, and relationships with the social, political and cultural environment beyond its walls. It aims to elucidate the factors that sustained its operation for nearly half a century and the dynamics that led to its eventual closure. The relevance of this task is to contribute to the literature concerning the processes that sustain, or contribute to the demise of, such an institution, particularly in the field of social psychiatry.[13] The importance of highlighting such issues is emphasised by the recent publication of *The Theory and Practice of Democratic Therapeutic Community Treatment* (2017) by two eminent practitioners in the field.[14] Whilst describing much of the theoretical and historical background, as well as the therapeutic approaches, little attention is given to issues relating to how such communities collapse, or persist, despite their tendency to transience. The discussion of leadership take less than two pages of a total of over three hundred and relations with the external world, vital to the existence of any organisation, add a further six. Sociologist Nick Manning on the other hand, in a volume ignored by these two authors, reviews the sociological processes affecting such organisations in depth.[15] He is sceptical about their effectiveness and sustainability in the present cultural and political environment and is a significant influence on this present research.

As the study progressed the issue of compassion emerged. Staff in a number of British hospitals were criticised for their deficiency in this respect, rather than questioning the culture that enabled its absence to flourish.[16] Advocates of the TC approach consider that listening, and responding 'kindly', to, those in their charge is their primary concern. Tom

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[11] Davies, 287, footnote 77.

[12] Nicolas Henckes, 'Narratives of Change and Reform Processes: Global and Local Transactions in French Psychiatric Hospital Reform after the Second World War', *Social Science & Medicine*, vol. 68, no. 3 (2009): 511.

[13] In a personal communication, medical historian Jonathan Reinarz has commented that this is in contrast to typical medical histories that celebrate successes rather than failures. The history of psychiatry in contrast is riven with narratives demonstrating its inadequacies in assisting the subjects of its care.

[14] Steve Pearce and Rex Haigh, *The Theory and Practice of Democratic Therapeutic Community Therapy* (London ; Philadelphia: Jessica Kingsley Publishers, 2017).

[15] N. P. Manning, *The Therapeutic Community Movement : Charisma and Routinization.* (London: Routledge, 1989).

[16] E.g. 'Nurses lack compassion NHS admits', *The Telegraph*, 6th March 2015. See also Health Service Commissioner for Great Britain and Parliamentary and Health Service Ombudsman, *Care and Compassion: Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People* (London: HMSO, 2011); Robert Francis, *The Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. Presented to Parliament Pursuant to Section 26 of the Inquiries Act 2005* (London: HMSO, 2013), 4.

Main, a psychiatrist who used the term 'Therapeutic Community' for the first time in British practice in 1946, passionately advocated that all staff have to be 'sincere' members 'in a real community responsible not only to themselves and their superiors but to the community as a whole'.[17] He argued that through

> group discussion a culture of enquiry can be promoted for the better recognition of the humanness of all and better understanding and resolution by all of clinical crises and social upsets.[18]

His colleague, Harold Bridger, amplified this stating that

> the individual can only experience full freedom and satisfaction in a society that recognises his worth, and gives him the opportunity to develop in a spirit of warm human relationships.[19]

In this thesis, the complex interrelationship of kindness, trust, humanity and empathy are subsumed under the single term 'compassion' and issues surrounding this will be discussed at greater depth in the final chapter.

The nature of the difficulties experienced by those seeking help at the Centre is not considered here. This is because these would distract from the exploration of a therapeutic approach that embeds the understanding of relationships as a central focus for concern, rather than the traditional dyadic approach of the therapist/patient relationship. Further, it avoids the protean and potentially overwhelming discourses that surround the nature of mental disorders, particularly as the diagnoses attached to those who attended the Ingrebourne were relatively non-specific and wide-ranging. Dr Richard Crocket, who established the Centre considered that it always had a number of patients that were 'hard to classify'.[20] There is always a problem about relating past diagnoses to present day phenomena. Whilst the time frame here is shorter than that of historian Mark Micale's study of hysteria, his caveats about the difficulties of reinterpreting earlier diagnoses in present day terms still hold true.[21] Psychiatrist and historian David Healy illustrates this within the time scale of this thesis. In his view, before the existence of anti-depressants, which began to be used in the late 1950s, depression 'as we now understand it did not

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[17] T. F. Main, 'The Hospital as a Therapeutic Institution', *The Bulletin of the Menninger Clinic*, vol. 10, no. 9 (1946): 67. The term had its antecedents in the work of Harry Stack Sullivan who coined it in 1939 when he referred to his work as a 'therapeutic camp or community'. H S Sullivan, *Conceptions of Modern Psychiatry* (London: Tavistock, 1955), 232.

[18] T F Main, 'The Concept of the Therapeutic Community: Variations and Vicissitudes', in *The Ailment and Other Psychoanalytical Essays* (London: Free Association Books, 1989), 138.

[19] H. Bridger, 'The Northfield Experiment', *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 76.

[20] R. W. Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', *Proceedings of the Third World Congress of Psychiatry*, Toronto: University of Toronto Press, 1961, 270.

[21] Mark S. Micale, *Hysterical Men: The Hidden History of Male Nervous Illness* (Cambridge, Mass.: Harvard University Press, 2008), xiv.

exist'.[22] Its frequency has seemingly increased over this time from one in a thousand of the population to one in four, according to some estimates.[23] Finally, the TC is an approach to working with people that has been applied to an array of relationship difficulties that children and adults face including: addictions, learning difficulties, emotional upheavals and criminal behaviours.

ii. The Concept of the Therapeutic Community

An issue that arose when considering this research is the lack of awareness of the term 'therapeutic community'. On discussion with doctors, historians, lawyers, and psychologists, it was clear that very few had any concept of the term.[24] Unlike other care institutions, such as hospitals, residential care homes and day centres, it has necessitated considerable explanation. It can be a Humpty Dumpty phrase in that its meaning changes at the whim of whoever is employing it.[25] This was reflected by many who came across the Ingrebourne for the first time. The discomfort of members of the Regional Hospital Board visiting the nascent community in late 1958 was palpable in their short memorandum. As they reported, 'It was extremely difficult for us to appreciate the purpose or effectiveness of this treatment'. [26]

Ten years after the concept was introduced, sociologist Robert Rapoport complained in 1956 that despite being adopted with enthusiasm, it did not 'betoken a well-defined and validated set of rational procedures.[27] Four years later Maxwell Jones, an early pioneer in

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[22] David Healy, *The Creation of Psychopharmacology* (Cambridge, MA: Harvard University Press, 2002), 57. Two psychiatrists, Callan and Berrios, also argue that depression has changed definition during this time, becoming too deterministic. In consequence the responses have been largely limited to pharmaceutical intervention rather than considering broader social and economic aspects. Christopher M. Callahan and G. E. Berrios, *Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940-2004* (Oxford; New York: Oxford University Press, 2005), viii–xi.

[23] Healy, *The Creation of Psychopharmacology*, 57.

[24] This research project has been the subject of discussion with a wide group of professional colleagues, supervisors and annual assessors. The uncertainty of some listeners was expressed by someone who likened what she had heard to *The Lord of the Flies*. This is a novel by William Golding in which a group of unsupervised school boys are cast away on an island and in the end their relationships deteriorate to the level of killing one of their fellows. William Golding, *Lord of the Flies* (London: Faber and Faber, 2012).

[25] 'When *I* use a word' Humpty Dumpty said, in a rather scornful tone, 'it means just what I choose it to mean – neither more nor less.' L. Carroll, *Alice's Adventures in Wonderland, and Through the Looking-Glass.* (London: Book Club Associates, 1973), 190.

[26] North Eastern Metropolitan Regional Hospital Board, 'Ingrebourne Centre (Report of a Visit)', 1958, Planned Environment Therapy Trust.

[27] R. N. Rapoport, "Oscillations and Sociotherapy," *Human Relations* vol. 9, no. 3 (1956): 357. Tom Main claimed to be the first person to coin the term in 1946 in a paper published in the *Bulletin of the Menninger Clinic*. However, the first known use goes back to 1929 when the American psychiatrist applied it to his work with people suffering from schizophrenia. T. F. Main, "The Hospital as a Therapeutic Institution," *The Bulletin of the Menninger Clinic*, vol. 10, no. 9 (1946): 66–70; H S Sullivan, *Conceptions of Modern Psychiatry* (London: Tavistock, 1955), 232.

the field at the Belmont Hospital in Surrey, considered that it 'tended to be used in so many ways that its meaning has become vague and confused'.[28] Soon after David Clark, who instituted TC approaches at Fulbourn Hospital near Cambridge, stated that the phrase had had 'so much currency that it has been almost rubbed smooth of meaning'.[29] At Ingrebourne the idea was described as being 'the facilitation of patients to assist each other, and also for the staff to be there to help that process and relationships along'.[30]

In an attempt to bring some coherence to the situation, psychologist David Kennard identified four usages:

1. The transformation of traditional mental hospitals into more active, caring institutions during the 1950s to 70s.

2. The democratic community, espoused by Maxwell Jones, that takes place in small units, where therapeutic decisions and functions are shared by all participants and differences in status are minimised.

3. Small cohesive communities with a continuous hierarchy or chain of command. Staff are recruited from people previously availing themselves of the service provided.

4. A variety of units which evolved following dissatisfaction with conventional psychiatry. These are marked out by a strong commitment to a particular faith or philosophy of life and an emphasis on the equal status of all members.[31]

Here the primary focus is on the second form. Furthermore, attention will only be paid to those therapeutic communities established in National Health Service mental hospitals in the United Kingdom. This limitation ignores the widespread achievements in other fields, such as children's residential homes, schools, prisons and addiction centres.

Their theoretical purpose and method is neatly summed up by Clark as employing 'the contributions of *all* – especially the less highly trained staff and the other patients – in an attempt to help the sick individual'[32]. Amplifying this succinct statement, Crocket argues that the community meeting 'made up of all the patients and staff in the unit' was the hallmark.[33] This gathering was central to treatment and particularly served to integrate all the activities in the centre.[34] It was usually held daily and acted as a forum for discussing all

[28] M Jones, 'Introduction', in *Community as Doctor: New Perspectives on a Therapeutic Community*, by R.N. Rapoport (London: Tavistock, 1960), 1.
[29] D. H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, Mind and Medicine Monographs 9 (London: Tavistock, 1964), 42.
[30] INGCE29, interview, 24.
[31] D. Kennard and J. Roberts, *An Introduction to Therapeutic Communities* (London; Boston: Routledge & Kegan Paul, 1983), 6–7. Jeff Roberts was the consultant psychiatrist at the Ingrebourne Centre from 1975 to 1984.
[32] Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 43.
[33] R. Crocket, 'Lecture: Changes and Choice in Group Psychotherapy, Prospects for the Therapeutic Community', Undated, post 1970, 2, Planned Environment Therapy Trust.
[34] Crocket, 5.

aspects of the unit and events that took place within it.[35] Manning emphasises, as does Crocket, the importance of all social relationships being used in the 'pursuit of therapy' and the large group is where this is expressed most clearly.[36]

The generally accepted philosophy of such centres is encapsulated by Rapoport in his study of Belmont Hospital Social Rehabilitation Unit, later known as the Henderson Hospital, in 1953 to 1957.[37] He identifies four major principles: permissiveness, reality confrontation, democratisation and communalism. In practice, these mesh together to provide a milieu in which a homely atmosphere enables the participants to discuss in groups their difficulties, explore ways of overcoming them and reach a deeper understanding of them.

These terms, particularly democratisation, will be seen to have been highly misleading in practice. Issues of power and control are rarely confronted by staff who subscribe to a psychotherapeutic treatment strategy in TCs. Some sociological studies demonstrate that in such environments social control is fundamental to the way that they work. Victor Sharp, a participant observer in an Australian Richmond Fellowship TC, found that, by applying a 'sickness' model to those receiving care, the staff took on an authoritative role as knowledge producers and mediators'.[38] People who rebelled against the prevailing rules and sanctions were seen as reacting 'pathologically', whilst those who conformed were held to be 'examples of reasonable behaviour'.[39] He argued that staff acted as agents of social control 'whose concern is with the resocialisation of members for a non-egalitarian society which is geared to the efficient functioning of individuals in the work force and reproductive systems'.[40] Those people who could not accept this 'failed' and were discharged either to other services or expelled.[41] Sociologist Michael Bloor, also acting as a participant observer, contested these findings in a later study of another TC run by the same organisation.[42] Whilst acknowledging that similar mechanisms were at work, he found that dissent was actively tolerated and resident autonomy encouraged. Residents were encouraged to reflect on their understanding of their social world and learned to recognise that perception is ambiguous and contingent on different circumstances.[43] Hearing different viewpoints offers

[35] Kennard and Roberts, *An Introduction to Therapeutic Communities*, 8.
[36] N. Manning, 'Therapeutic Communities - a Problem or a Solution for Psychiatry? A Sociological View.', *British Journal of Psychotherapy*, vol. 26, no. 4 (2010): 434.
[37] Robert, N. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, London: Tavistock, 1960), 54.
[38] Victor Sharp, *Social Control in the Therapeutic Community* (Farnborough, Hants.; Lexington, Mass.: Saxon House ; Lexington Books, 1975).
[39] Sharp, 167, 169.
[40] Victor Sharp, 'The Research Act in Sociology and the Limits of Meaning: The Understanding of Crisis, Care and Control in a Therapeutic Community', *Australia and New Zealand Journal of Sociology*, vol. 13 (1977): 240.
[41] Sharp, *Social Control in the Therapeutic Community*, 197.
[42] Michael Bloor, 'Social Control in the Therapeutic Community: Re-Examination of a Critical Case', *Sociology of Health and Illness*, vol. 8, no. 4 (1986): 302–24.
[43] M. J. Bloor and J. D. Fonkert, 'Reality Construction, Reality Exploration and Treatment in Two Therapeutic Communities', *Sociology of Health and Illness*, vol. 4, no. 2 (1982): 125–26.

alternative explanations for any situation. This social learning enables movement from a fixed construction of reality to a more flexible, adaptive one.

In trying to explain the experience of Therapeutic Communities one is made profoundly aware of the inadequacies of language, a theme well expressed by sociologist Norbert Elias. He argued that language reduces dynamic processes to static, mechanical conditions.[44] A central aspect of sharing emotions with others is the intensity of 'being in the world' that it brings with it. This intensity often precludes anything but the most superficial recollection subsequently. The American psychotherapist Carl Rogers, on emerging from a session he had just conducted, remembered that characteristically he could not recall more than one or two events or statements. He only knew 'that I was very much present in the relationship, that I lived it in the moment of its occurrence'.[45] Although the whole session had been conducted through the medium of conversation, the words, the gestures, the atmosphere, all combined to make a largely ineffable, lived time. The TC is an arena where such interactions ebb and flow throughout the waking hours.

The intensity of such experiences is accompanied very often by a passionate defence of the practices. The social scientist Nick Crossley employing Bourdieu's concept of *illusio* explores this commitment of the participants in what he describes as 'working utopias'.[46] Whilst his examples were significantly more 'radical' than the Ingrebourne, the same 'belief in the game' is evident in many people who have worked in TCs.[47] They often describe their experience as life changing and life enhancing.

A psychiatrist from the Ingrebourne elaborated on the complexity of understanding such an environment, arguing that they 'are multi-layered structures and the temptation is to choose one of a number of models in order to describe a phenomenon'.[48] It is in response to

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[44] N. Elias, *What Is Sociology?* (New York: Columbia University Press, 1978), 111–12.

[45] http://psychology-forum.com/counselling-and-psychotherapy-forum/video-of-carl-rogers-person-centred-counselling-the-gloria-tapes/ accessed 14/3/2014

[46] N Crossley, 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain', *Sociology*, vol. 33, no. 4 (1999): 809–830. Bourdieu uses the word to indicate the complicity between the person's view of the world and the environment they are in that leads them to be unquestioningly 'caught up' in the latter's mores and culture. Pierre Bourdieu, *In Other Words : Essays towards a Reflexive Sociology* (Oxford: Polity, 1990), 194–95.

[47] Nurse Bill Murray was convinced of the 'great work' was done at the Ingrebourne and that the 'place seemed to shine'. Bill Murray, 'Thank You', *Joint Newsletter of the Planned Environment Therapy Trust, the Charterhouse Group of Therapeutic Communities and the Association of Therapeutic Communities, with the Community of Communities*, no. 10 (2004): 80–81. Chris Nicholson described being in the community group at a children's unit as being 'incredibly moving and finally vivifying'. Chris Nicholson, 'Between You and Me', *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 10 (2004): 32–37. A resident of the Mulberry Bush School reflected on her time there: 'I will never forget the life there and the profound impact it had on my life'. Ex-pupil Mulberry Bush School, '"I Have Been Waiting to Say That for a Long Time....''"', *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 12 (2004): 31.

[48] Jeff Roberts, 'Destructive Processes in a Therapeutic Community', *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 160.

this statement that this research fuses a variety of sources and perspectives in order to create a 'discursive formation', in the words of the philosopher Michel Foucault, which will reveal a 'descriptive possibility and outline the domain of which it is capable, define its limits and its autonomy'.[49] Ingrebourne was the nexus of a number of discourses. These included the nature of the power relationship between the roles of the doctor and the person in his or her care, social and medical perspectives on therapy, and democratic versus leadership models of management.

iii. The Ingrebourne Centre

The Ingrebourne was chosen as a subject for research as a 'case study' of the TC movement in Britain following the Second World War. An earlier study examined the origins of the approach in a military hospital during that conflict called the Northfield Experiments.[50] These events have a near mythological status within the TC world, but there is little direct evidence of their influence. This research provided an opportunity to explore this further.

The Centre was a small, self-contained unit with up to sixty-five people in it at any one time. Forty would be attending for therapy and fifteen or so provided it. Of the former, up to twenty might be residential whilst the rest attended on a daily basis. It was a discrete two-story building within the grounds of a much larger hospital for the elderly near Hornchurch on the border between North East London and South West Essex and five miles from its parent Hospital, Warley, a traditional large Victorian asylum. Ingrebourne opened in 1951 as a rehabilitation unit for adult patients. With the arrival of Crocket as the consultant psychiatrist it evolved into a TC by the late 1950s. It continued operating in that way until its eventual closure in 2003.[51] This length of practice made it one of the longest lasting of such services in the United Kingdom, only exceeded by the Cassel and the Belmont/Henderson hospitals. This, with its less well known history, suggested an ideal opportunity to examine the vicissitudes of such a unit throughout the rise and demise of this approach in the National Health Service.

It was an environment in which emotions were foregrounded particularly in relation to any associated behaviours. The aspiration was to provide a trusting and safe environment within which people's behaviour could be reflected on by themselves in concert with other participants. The staff members were open to challenge and could be called upon to answer for any behaviour, both in open meetings with those they were treating and also amongst colleagues. This reflexivity was an essential element of practice. These activities were typical

[49] Michel Foucault, *Archaeology of Knowledge*, Routledge Classics (London ; New York: Routledge, 2002), 121.
[50] T. M. Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments : Advancing on a Different Front* (London; Philadelphia: J. Kingsley, 2000).
[51] There is some uncertainty about its final closure as a therapeutic community. Psychotherapy services continued on the site until 2005.

of most TCs operating in the sphere of adult mental disorders in the United Kingdom over this period, although the actual culture varied through the expertise of the staff and the nature of the people selected to attend.

iv. Other Research in the Field

A comprehensive history of therapeutic communities for adults in the United Kingdom has yet to be written. Significant difficulties for such an enterprise arise from three inter-digitating causes. First are the controversies that continue to rage over what is and what is not a TC. A second issue is their range, spread and transience. Finally, most have been poorly chronicled and any existing records have often been dispersed in amongst the archives of larger parent organisations.

Therapeutic communities only figure in passing in more generalist histories of psychiatric care during the twentieth century.[52] Social historian Joan Busfield rightly points out that they made little impact against the sceptical opposition of nursing staff and medical management in most mental hospitals.[53] The historian of science, Catherine Fussinger, suggests that there were greater parallels between the radicalism of the anti-psychiatric and the TC movement than has been given credit.[54] She argues that in their rejection of mainstream psychiatric treatments and mental hospital care, their empowerment of staff and patients as therapists and confrontation with reality, they paved the way for people like R. D. Laing and David Cooper to set up their establishments outside of formal health services. Certainly Franco Basaglia, whose work eventually led to the dramatic reform of Italian mental health law, was initially heavily influenced by the TC run by Maxwell Jones at Dingleton Hospital in Scotland.[55]

Most existing historical accounts concentrate on the major centres such as the Belmont/Henderson, Fulbourn and Claybury Hospitals.[56] These were primarily initiated by

[52] Fussinger in 2011 could find cursory attention paid to them. C. Fussinger, '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War II', *History of Psychiatry*, vol. 22, no. 2 (2011): 147.
[53] Busfield, *Managing Madness*, 336. For a more detailed description of this resistance to change by nursing staff before the war see Niall McCrae, 'Resilience of Institutional Culture: Mental Nursing in a Decade of Radical Change', *History of Psychiatry*, vol. 25, no. 1 (2014): 70–86.
[54] Fussinger, '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists'.
[55] John Foot, *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care* (London ; Brooklyn, NY: Verso, 2015), 109–13.
[56] E.g. D. H. Clark, *The Story of a Mental Hospital : Fulbourn, 1858-1983* (London: Process Press, 1996). D. V. Martin, *Adventure in Psychiatry*, Second (Oxford: Bruno Cassirer, 1974), M. Jones, *Social Psychiatry in Practice*,

psychiatrists who then published personal narratives of their work. There is scant reference to the contemporary social environment, little of the psychological/philosophical underpinnings and virtually no sense of analysis. How and why they ceased operation rarely figures. Most fall foul of Manning's critique that they are 'internal' histories largely ignoring the social context within which they were operating.[57] In particular, this refers to the hierarchical world of the National Health Service, the local social environment, the existence of other relatively successful treatment methods, differences between staff and residents understandings and the previous experience of staff. Beyond this they take no account of critiques of the TC that place them within the remit of the 'psy' sciences to control and regulate individuals.[58] These include Nikolas Rose's statement that 'all aspects of the regime sought to manage the individual from a pathology seen as social maladjustment to normality to a normality construed in terms of functional efficiency', which is complemented by Robert Castel's argument that they 'have in their own way reinvented the old principles of moral treatment on which traditional psychiatry is based'.[59]

One of the more reflective examples of this genre is that provided by David Clark relating to his work at Fulbourn Hospital.[60] He was appointed as the medical superintendent in 1953, at the age of 32, and spent the next thirty years as the senior doctor there. He achieved an international status as a pioneer of British social psychiatry and published a number of papers and books on 'administrative therapy', his initial term for the changes he encouraged at the institution, later altered to 'social therapy'.[61] He reserved the term 'therapeutic community' for wards in the hospital which took up the practices described earlier rather than applying it to the whole institution.

His account of the process of implementing these changes was published as *The Story of a Mental Hospital: Fulbourn 1858-1983*.[62] Following a brief introduction to the early history of the place the main body of the book is taken up with his own experiences. The foreword by historian Roy Porter welcomes Clark's contribution and hopes that it would provoke others

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First (Harmondsworth: Penguin, 1968), M.M. Glatt, K.F. Weeks, and J. S. Whiteley, "Experiences of the Community Treatment of Neurosis in a Mental Hospital Unit," *International Journal of Social Psychiatry*, vol. 3, no. 3 (1957): 203–10,

[57] R. D. Hinshelwood and N.P. Manning, *Therapeutic Communities : Reflections and Progress* (London; Boston: Routledge and K. Paul, 1979), 186–87.

[58] Helen Spandler, *Asylum to Action: Paddington Day Hospital, Therapeutic Communities, and Beyond*, Community, Culture, and Change 16 (London ; Philadelphia: Jessica Kingsley Publishers, 2006), 15.

[59] Nikolas S Rose, 'Psychiatry: The Discipline of Mental Health', in *The Power of Psychiatry*, eds. Peter Miller and Nikolas S. Rose, (Oxford: Blackwell, 1986), 73; R Castel, F Castel, and A Lovell, *The Psychiatric Society* (Columbia University Press, 1982), 194–95.

[60] Clark, *The Story of a Mental Hospital*, 1996.

[61] Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 1964. D. H. Clark, *Social Therapy in Psychiatry* (Edinburgh; New York: Churchill Livingstone, 1981).

[62] Clark, *The Story of a Mental Hospital*, 1996.

to record their experiences for posterity.[63] Unfortunately no other medical superintendent has responded to this encouragement.

After visiting the long-stay wards where he found that 'the vast mass of human hopelessness became apparent', Clark introduced ideas which he had seen in practice at other hospitals.[64] His introduction to TC approaches was from Maxwell Jones at the Belmont Hospital in 1953. Here he found the 'atmosphere of free and open discussion to be stimulating' at the community meetings and he hoped to institute the approach at Fulbourn.[65] He was also impressed by visits to other hospitals such as Warlingham Park, where Dr T.P. Rees had opened the doors and introduced group therapies.[66] A further source of inspiration was the social studies by American authors such as Stanton and Schwartz, who examined the life of a private mental hospital in America in a book published contemporaneously by the Tavistock Clinic in the UK.[67] These stimuli will be enlarged on in a later chapter. Here it is sufficient to recognise that they were all significant aspects of the post-Second World War upheaval that was taking place in psychiatric thinking, as practitioners looked for sociological approaches to understanding the repressive relationships existing in mental hospitals.

Clark describes the internecine battles with different members of the senior staff whilst recruiting allies at all levels. The approach was *ad hoc* and carried out piece-meal. First was the opening of the doors of all the wards, despite his initial scepticism.[68] Eventually, many of them became therapeutic communities and the hospital came to be seen as 'progressive', with staff learning together about themselves as well as good practice. As his nursing colleague John Adams points out, there is a sense that Clark's commentary ends with a sense of '*après moi le deluge*', with the taking over of the institution by more traditional medical senior academic staff attached to Cambridge University in 1977.[69] He expected the social changes to be reversed in favour of a more hierarchical and biological approach.[70]

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[63] R Porter, 'Foreword', in *The Story of a Mental Hospital: Fulbourn 1858-1983*, (London: Process Press, 1996), x.
[64] Clark, *The Story of a Mental Hospital*, 33.
[65] Clark, 41.
[66] Clark, *The Story of a Mental Hospital*, 89. He states that he was introduced to Warlingham by an article in the *The Lancet* - Anon, 'Freedom in Mental Hospitals: The End and the Means', *The Lancet*, vol. 264 (1954) 964–66.
[67] Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in the Treatment of Psychiatric Illness* (London: Tavistock Publications, 1954). John Adams in his interview with David Clark learned that he also was influenced by other similar studies such as that by Ivan Belknap. John Adams, '"Challenge and Change in a Cinderella Service": a History of Fulbourn Hospital Cambridgeshire, 1953-1995.' (PhD Thesis, Open University, 2009), 102, https://www2.rcn.org.uk/__data/assets/pdf_file/0005/414644/Adams_John_complete_PhD.pdf; Ivan Belknap, *Human Problems of a State Mental Hospital* (New York: McGraw-Hill, 1956).
[68] D. H. Clark, 'Letter: The Open Door', *The Lancet*, vol. 280 (1962): 881.
[69] Adams, '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.', 10.
[70] Clark, *The Story of a Mental Hospital*, 217.

Inevitably, as a personal account, it figures Clark's own activities as being central, although he attributes the 'true achievements' to those members of staff, 'who had the courage to change the hospital and remake their lives after many years of defeat and stigma'.[71] Indeed the mechanism of this was elaborated upon by one charge nurse who reported that Dr Clark was 'good to work for. He gave us more or less free reign'.[72] Dr Ross Mitchell, a consultant who worked with him, however, elaborated on the competing roles of such a position, stating

> David was the medical superintendent, very much in charge. So there was a paradox. Here he was trying to flatten the authority pyramid – but … he is a very authoritarian person.[73]

Immediately this confronts the problem of the 'hero-innovator' with whom particular endeavours are identified. Leadership is a critical issue in such enterprises and recurs as a theme throughout this thesis. At the Ingrebourne, Dr Richard Crocket took this role and yet without the support and active participation of both the staff and the patients, who largely remain anonymous, nothing would have been achieved. One consequence has been a recent tendency for members of other professions in mental health services, such as nurses and psychologists, to create independent narratives of their occupation resulting in largely monocular views of their progress.[74] The current research attempts to address this by looking at the inter-relating roles of staff members and those who were being treated within the Ingrebourne Centre.

Whilst mostly autobiographical, the value lies in Clark's description of the day-to-day struggles that were necessary to reform a large psychiatric hospital. His account has been extended by John Adams, whose PhD thesis explores the history of the hospital from 1953 to 1995, applying methods similar to those employed in the present project.[75] He interviewed twenty-seven members of staff at all levels and two patients, with the aim of exploring 'subjective perceptions of the hospital regime in all its complexity'.[76] He was particularly concerned with the consequences of the changes in practice on the nursing staff in the hospital and their roles in effecting changes. He narrates the story of Clark's tenure as the senior psychiatrist, amplified by oral histories from members of staff. Clark's drive and vision is recognised as energising a 'spirit of change' in the hospital, but is seen within the context of wider changes occurring in mental hospitals nationally. Adams' record of the first decade is remarkable in the lack of evidence of the nursing contribution to changes; indeed,

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[71] Clark, xii.
[72] Adams, '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.', 196. (Quote from Pat Lambert)
[73] Adams, 179. (Quote from Dr Ross Mitchell)
[74] John Hall, *Clinical Psychology in Britain.*, 2015; P. Nolan et al., 'Mental Health Nursing in the 1950s and 1960s Revisited', *Journal of Psychiatric and Mental Health Nursing*, vol. 4, no. 5 (1997): 333–338.
[75] Adams, '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.'
[76] Adams, 73.

he argues that 'old routines … proved resistant to reform'.[77] His interviewees also revealed that changes were not always as 'progressive' as they sounded. Opening the doors of a ward could lead to some patients being nursed in pyjamas to prevent them from absconding.[78] Physical treatments such as leucotomy, deep insulin coma therapy and electro-convulsive treatment continued to be used, somewhat undermining Clark's public promotion of the social reforms.[79]

Initial moves toward a more social orientation began with the appointment of a junior doctor in 1958.[80] Taking over responsibility for a women's convalescent ward, he asked Clark whether he might run it as a TC. The latter was somewhat apprehensive about this, but the new doctor gained the support of the matron and the sister in charge of the ward and the experiment took place. Gradually, variations on these practices spread through the hospital.[81]

Adams explores the functioning of these wards using the principles of permissiveness, democratisation, reality confrontation and communalism, illustrating them with accounts from his interviewees. It is clear that, whilst there was the usual degree of resistance, tensions and bewilderment, many of the participants, doctors and nurses, found the experience interesting and beneficial. Patients became willing to support each other, for instance taking each other shopping or assisting in cleaning the ward.[82]

Risk was a central concern for nurses and Clark's crucial role was to emphasise that he would support them if things went wrong. The concept of 'risk' and its management has loomed large in mental health nursing.[83] However, this facilitating approach was challenged by the arrival of Sir Martin Roth as the Professor of Psychiatry in Cambridge University. With an international reputation as a 'biomedical' psychiatrist, having made discoveries about the physical basis of Alzheimer's disease amongst other achievements, he opposed the 'social' psychiatry of Clark from the outset.[84] His was a 'strictly hierarchical view of staff working' and he slowly 'deleted' community meetings from the wards he was working on.[85] Critics of social therapy had a greater opportunity to decry the former regime and the 'laissez-faire, airy-fairy kind of thing' they found there, associated with accusations of poor standards of physical care.[86] This was connected to

[77] Adams, 153.
[78] Adams, 110. (Quote from Judith Atkinson)
[79] Adams, 154–55.
[80] Clark, *The Story of a Mental Hospital*, 165.
[81] Adams, '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.', 209.
[82] Adams, 214. (quote from Jimmy Loh)
[83] Adams, 235.
[84] Adams, 271–79.
[85] Ibid., 277, 292.
[86] Adams, '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.' (Quote from Interviewee 05)

> unclear boundaries, unclear leadership, unclear expectations. Lots and lots of therapy, but the basics that I'd been brought up to understand were required didn't seem to be there.[87]

However, in an important finding relevant to Ingrebourne, the retirement of Clark did not lead to the eradication of the TC approach at Fulbourn. Many of the wards continued under the leadership of the nurses maintaining the social therapeutic approach.[88]

The Paddington Day Hospital provides a counterpoint to this story of relative stability. Two reports by external scholars stand out as attempts to understand the social dynamics of this controversial institution.[89] It had similarities to the Ingrebourne Centre in that it was a relatively small stand-alone unit in West London catering for 45 day-patients and remote from its parent hospital (Horton Hospital in Surrey).[90] Situated in the basement, it remained sequestered from the services in the building above.[91] Its importance lies in the contentious practices that developed there, contributing to its eventual closure in 1979. It became within the TC movement a case study illustrating the pitfalls of bad therapeutic practice.[92]

Paddington started life in 1962 as a unit resettling patients from the parent hospital.[93] Those attending remained briefly before being discharged and, whilst there, received mainstream psychiatric treatments including medication and behaviour therapy.[94] The consultant tried to introduce group-based therapies, but this was resisted by the nursing staff until new appointments were made, including some who had worked in the Henderson Hospital.[95] After this doctor left, he was replaced by Dr Julian Goodburn. This innovator alongside the other staff began to 'democratise' the unit so that a *laissez-faire* atmosphere began to develop in which everyone would take part in lengthy discussions about personal, social and political issues.[96]

In 1971, it was proposed by the local hospital management group that the service should be transferred to a more traditional site at St Mary's Hospital, which lacked the resources and the inclination to continue it as a centre for psychotherapy.[97] In response to this threat, both staff and patients formed a joint action committee which lobbied the press, local Members of Parliament and general practitioners. As a result of the publicity, 22 MPs signed a petition

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[87] Adams, 286. (quote from Neil Chell)
[88] Adams, 302.
[89] C. Baron, *Asylum to Anarchy* (London: Free Association Books, 1987), Spandler, *Asylum to Action*, 2006.
[90] Helen Spandler, 'Spaces of Psychiatric Contention: A Case Study of a Therapeutic Community', *Health & Place*, vol. 15, no. 3 (2009): 672.
[91] Baron, *Asylum to Anarchy*, 27.
[92] Spandler, *Asylum to Action*, 25.
[93] Baron, *Asylum to Anarchy*, 27,33.
[94] Spandler, *Asylum to Action*, 30; C. Baron, 'The Paddington Day Hospital: Crisis and Control in a Therapeutic Institution', *International Journal of Therapeutic Communities* 5, no. 3 (1984): 158..
[95] Spandler, *Asylum to Action*, 30.
[96] Spandler, 32.
[97] Spandler, 39.

to the Secretary of State for Health. Eighty local general practitioners also wrote requesting its continuation, as it served a group of patients that they found difficult to manage.[98] Boosted by the success of the campaign, in which he had played a prominent part, the consultant gained an idealised 'saviour' role.[99] In thrall of this, he felt able to promote a form of psychotherapy that became the sole theoretical basis on which the unit functioned.[100] Every activity was subjugated to the dominant creed to the extent that simple practical tasks ceased, including social activities, keeping records and employing a cleaner.[101] Admission procedures were suspended, so that people joined without assessment.[102] An anti-authoritarian ideology that espoused 'democratisation' and was antagonistic to any form of bureaucracy developed.[103]

When Goodburn proposed to stop free meals and the repayment of travelling expenses, the patients rebelled and complained to the Area Health Authority.[104] Pursuing his anti-bureaucratic stance, he declined to implement their suggestions and, consequently, was suspended from duty in 1976. Crocket was seconded from the Ingrebourne to replace him until it closed in 1979.

There are a number of accounts of this series of events, of which two were conducted by external researchers. Claire Baron conducted the first as a participant-observer ethnographer for three years during the 1970s.[105] She emphasises the experience of being in the unit and the effect the innovations had on staff relationships and the oppressive, though covert, use of power by the consultant. She draws on Goffman's analysis of institutionalisation in which the patient has to conform to the staff's vision of psychiatric disorder and its therapy.[106] In her view, his use of 'reductive psychological explanations' led to a sense of degradation 'of having every statement reduced to a psychopathological symptom'.[107] Increasingly, this led to defensive behaviour by staff and patients resulting in the eventual splits that led to the suspension of Dr Goodburn.

Helen Spandler, on the other hand, sets the day hospital in a broader cultural context, emphasising that it was something of a pioneer within the TC movement.[108] She disputes what she sees as the over-simplified version that Baron provides, arguing that there were

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[98] Baron, *Asylum to Anarchy*, 39.
[99] Ibid., 24, 76; M. Lemlij, S. Mulvany, and C. J. Nagle, 'A Therapeutic Community Is Terminated', *Group Analysis*, vol. 19, no. 3 (1981): 217.
[100] Baron, *Asylum to Anarchy*, 56.
[101] Baron, 46, 56, 97.
[102] Ibid., 45, 85.
[103] Baron, 'The Paddington Day Hospital: Crisis and Control in a Therapeutic Institution', 58.
[104] Lemlij, Mulvany, and Nagle, 'A Therapeutic Community Is Terminated', 217.
[105] Baron, *Asylum to Anarchy*.
[106] Baron makes it clear that it would be an exaggeration to see the process as entirely a Goffman-type process of self-degradation. C. Baron, *Asylum to Anarchy* (London: Free Association Books, 1987), 244; Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth: Penguin, 1968), 32–33.
[107] Baron, *Asylum to Anarchy*, 178–79.
[108] Spandler, *Asylum to Action*, 38.

important possibilities of innovation and social change that were revealed by the events.[109] Firstly, some people receiving treatment there were inspired to become active participants in the formation of the Mental Patients' Union, which organised and campaigned against psychiatric treatment and incarceration and has been seen by many commentators as being a pivotal organisation in the development of the organised psychiatric service survivor movement in Britain.[110] Andrew Roberts, who had been a patient at Ingrebourne and whose views have significantly influenced the present research, was another founder member. Spndler further points out that many TCs relied on charismatic leaders for their existence and survival, and she invokes the concept of the 'trickster' to describe such innovators.[111] These people, whilst acting in 'unpleasant and shocking' ways, raise issues that challenge pre-conceptions. Her conclusion is that simplistic narratives of 'asylum to anarchy' do not elaborate on the radical impulse to change social relationships.

In understanding the events at Ingrebourne, the reports of these two institutions highlight a number of important issues. First is the relationship of leaders and followers, second is the adherence to doctrines in the face of practicality, third the difference between what is espoused publicly and the reality of day-to-day life of TC work and, finally, the impact of the external world on units that operate in isolation.

3. Theoretical Background

i. Psychiatric History in the Twenty First Century

Historian Barbara Rosenwein contends that people live in emotional groups.[112] Each has its own systems of feelings which the researcher must uncover. She elaborates by arguing that each person moves between communities, adjusting their presentation of self accordingly. This offers a model that both fits the nature of the Ingrebourne and is also compatible with the social constructionist perspective offered at the outset of this chapter. In her review of *History in Practice*, Ludmilla Jordanova, reclaiming the broader aspects of a social approach, suggests that historians should take a 'holistic' perspective.[113] This she argues should be connected with the lives of ordinary people and that weight should be given to lived experience, incorporating the complex relationships between people. She goes on to argue that more attention should be paid to the *longue durée*, acknowledging broader and deeper

[109] Spandler, 94.
[110] Spandler, 52.
[111] Spandler, 96. She takes this phrase from Daniel Burston's biography of R. D. Laing Daniel Burston, *The Wing of Madness: The Life and Work of R.D. Laing.* (Cambridge, Mass.; London: Harvard University Press, 1998).
[112] Barbara H. Rosenwein, 'Worrying about Emotions in History', *The American Historical Review*, vol. 107, no. 3 (2002): 842.
[113] L. J. Jordanova, *History in Practice*, 2nd ed (London: Hodder Arnold, 2006), 43–47.

social currents that take decades to work out. These include the impact of cultural and political changes on the activity within the unit, whilst also acknowledging the relevance of the responses of the participants to the broader TC movement. It might be argued that a careful study of such a counter-cultural institution has a broader relevance for the success of dissenting organisations within the present neo-liberal consensus.

Henckes contends that changing the way psychiatric institutions operate is a complex process involving many actors with differing expectations.[114] For many practitioners, the actual process of reform became '*a way of doing psychiatry*', which was certainly true for those involved in TCs.[115] He develops a framework that examines the conditions within which the changes became a project for the participants and how they achieved these ends. He expects that carrying this analysis out will result in a better understanding of the popularity of these reforms and their 'far-reaching political and social implications'.[116]

In exploring history that has occurred within this researcher's lifetime, and in a field in which he was active, a number of issues have to be contended with. Whilst the Ingrebourne was unknown to the author, the practice of therapeutic community work is familiar both experientially and academically. Jordanova warns against emotional over-involvement and this holds true when investigating a field in which there has been a deep attachment previously.[117] Looking for more objective ways of interpreting the evidence necessitated a wide ranging exploration of different vantage points including the standard grand narratives such as Marxism, post-modernism and psychoanalysis. Clearly, throughout there have been issues of power within relationships, despite the espousal of democratisation by the participants. The Paddington Day Hospital illustrates one extreme expression of this. Similarly, market forces as expressed by the pharmaceutical companies, have distorted the therapeutic field within which the Ingrebourne operated.[118] Psychotherapies have come to dominate the theoretical framework of TCs for adults and it is argued here that this is at the expense of both a sociological perception of their operation, understanding the impact of compassion and recognising the capacity of interpersonal relationships to promote resilience.

Any history of a TC, in the latter half of the twentieth century, has to acknowledge the influence of 'anti-psychiatry' as a social phenomenon that shook up the complacency of mainstream psychiatric practice. At Ingrebourne, there was some contact with protagonists of this school of thought, but relatively little actual impact. Similarly, the parallel critiques of the post-modernist observers, in particular Michel Foucault and Nikolas Rose and the Marxist perspective of Andrew Scull, have to be recognised as part of the historiographic

[114] Nicolas Henckes, 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis', *History of Psychiatry*, vol. 22, no. 2 (2011): 164–81.
[115] Italics as in original. Henckes, 164.
[116] Henckes, 166.
[117] Jordanova, *History in Practice*, 55.
[118] David Healy, *The Antidepressant Era* (Cambridge, Mass.: Harvard University Press, 1997).

background. Responding to these is unavoidable in any historical study relating to psychiatric practice after 1980. Each sought to critique psychiatric practice as a form of social control and was successful in identifying issues of power and repression that were deployed to subjugate those people identified as suffering from mental disorder throughout the past. However, as the historian of twentieth-century, mental health counter- cultures Nick Crossley points out, the concentration on power and dominant discourses has been to the detriment of understanding social movements that have introduced plurality, dynamism and the potential for change into the field.[119]

Historians Volker Hess and Benoît Majerus argue that, unlike these histories of practices in the eighteenth and nineteenth centuries, there is no narrative that offers 'a comparable, reliable framework for interpretation' for the twentieth century.[120] They go on to argue that the subject is attempting to free itself from its Manichean anti-psychiatric genealogy by producing more nuanced interpretations that examine the overlap between the social and scientific arenas.[121] Elsewhere, Majerus considers that the historiography of mental disorder needs to renew its approaches and proposes that the study of the materials involved in psychiatric care, such as walls, beds and pills, offers an alternative by integrating actors and themes largely ignored previously.[122] Certainly, the participants have dramatically increased in their diversity and increasing visibility.[123]

Pursuing this line of thought, a group of academics and clinicians involved in the practice and the history of psychiatry argue for the complexity of provision of care to be acknowledged rather than perpetuating 'single-issue mythologies' that have dominated institution-based accounts.[124] The proliferation of ways of mediating care through community-based services has resulted in the changing roles of the different professions. The significance of the psychiatrist's role has declined, whilst psychologists and nurses take increasing responsibility for the management of patients.[125] External factors, such as political and managerial intrusions, have manifestly changed the power structure. They conclude that the breadth of historical narrative has expanded and in particular needs to include the experience of people who have used the services both individually and as a social and political movement. This echoes historian Roy Porter's emphasis on the

[119] N. Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', *Social Science & Medicine*, vol. 47, no. 7 (1998): 877.
[120] V. Hess and B. Majerus, 'Writing the History of Psychiatry in the 20th Century', *History of Psychiatry*, vol. 22, no. 2 (2011): 139–40.
[121] Hess and Majerus, 141–42.
[122] B. Majerus, 'Material Objects in Twentieth Century History of Psychiatry', *Low Countries Historical Review* vol. 132, no. 1 (2017): 150.
[123] See also G. Eghigian, 'Deinstitutionalizing the History of Contemporary Psychiatry', *History of Psychiatry*, vol. 22, no. 2 (2011): 201–214'.
[124] John Turner et al., 'The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research', *Medical History*, vol. 59, no. 04 (2015): 599.
[125] Turner et al., 622.

importance of doing 'medical history from below'.[126] They go on to propose that further historical accounts should include the broader issues of the health economy and the organisational development of the NHS and other relevant authorities.

Crossley, examining the early development of the National Association for Mental Health, also takes the Foucauldian perspective to task in its vagueness about how the technologies of control, governance and self are contested.[127] This particularly relates to Nikolas Rose's condemnation of the TC regime referred to earlier. That clinicians might also be involved in contesting social control has been little explored, except by a small group of practitioners under the rubric of 'critical psychiatry'.[128]

ii. Emotional Narratives of a Transitional Space

This thesis is not a history of emotions, but it is entangled with emotions. The emphasis is on the dynamics of the relationships of the participants with each other and the external world. The Ingrebourne was a transitional emotional space in which affectual expression was encouraged and reflected on, at times heatedly. The passionate adherence by those involved to a particular form of working contributed to the bewilderment and frustration of those outside who were not necessarily antagonistic, but who had to implement changes to the service. Oral history is riven with feeling from the decision to carry out this form of research, through the anticipation of the meeting and then the roller-coaster of the actual interview itself.[129] Some oral historians and historians of emotions engage their readers with personalised accounts of both their own lives and their feelings. For instance, historian Thomas Dixon describes his own feelings and reflections whilst researching the story of Margery Kempe, and oral historian Andreas Portelli describes his anger at inconsiderate statements in a conference[130] Whilst this approach is entirely consistent with this author's own predispositions, the more traditional approach of writing in the third person has been

[126] R Porter, 'The Patient's View: Doing Medical History from Below.', *Theory and Society*, vol. 14, no. 2 (1985): 175–98.
[127] N. Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health.', *Sociology of Health and Illness*, vol. 20, no. 4 (1998): 462.
[128] D.B. Double, 'The Limits of Psychiatry', *British Medical Journal*, vol. 324, no. 7342 (2002): 900–904.
[129] The American *Oral History Manual* refers to emotions solely in the context of the victims of traumatic events. Barbara Sommer W. and Mary Kay Quinlan, *The Oral History Manual*, 2nd ed. (Lanham, New York, Toronto, Plymouth UK: AltaMira Press, 20090, 63. Recent articles in the journal *Oral History* however contend with the issues raised by emotions in interviews. Joanna Bornat, 'Remembering and Reworking Emotions: The Reanalysis of Emotion in an Interview', *Oral History*, vol. 38, no. 2 (2010): 43–52; Carrie Hamilton, 'On Being a "good" Interviewer: Ethics and the Politics of Oral History', *Oral History*, vol. 36, no. 2 (2008): 35–43; Jenny Harding, 'Talk about Care: Emotions, Culture and Oral History', *Oral History*, vol. 38, no. 2 (2010); Michael Roper, 'Analysing the Analysed: Transference and Counter-Transference in the Oral History Encounter', *Oral History*, vol. 31, no. 2 (2003): 20--32.
[130] Thomas Dixon, *Weeping Britannia: Portrait of a Nation in Tears*, (Oxford: Oxford University Press, 2015), 16; Alessandro Portelli, *The Battle of Valle Giulia: Oral History and the Art of Dialogue* (Madison, Wis: University of Wisconsin Press, 1997), 51.

maintained, both to foreground the contributions of those who gave evidence and to enable the necessary distancing from a familiar subject.

How the nature and expression of emotions have evolved over history is a hotly contested subject.[131] The approach taken here is that core emotions are expressions of the body's interactions with the external world.[132] How these are expressed is modified continuously through the gestural or verbal language applied and thus their expression is under permanent re-construction.[133] Whilst the events described here occurred within the author's own life time the relationship of British people with tears, anxiety and happiness has undergone marked changes, including an increasing tendency to medicalise distress.[134] The Ingrebourne Centre was in itself a facilitator of the move from reticence to freer expression of feeling that marked the third quarter of the twentieth century in the United Kingdom.[135]

Harold Bridger, one of the transformative figures at Northfield Military Hospital, described in the third chapter, went on to work at the Tavistock Institute of Human Relations as a management consultant where he was a colleague of Crocket's friend, Dr Jock Sutherland. Central to his theoretical position were the concepts of 'transitional space' and 'transitional process', derived from the work of the child psychoanalyst Donald Winnicott.[136] The former provides an opportunity for participants to step outside the normal day-to-day activities of everyday working life to reflect as a group on the changes occurring in their social environment and how to respond to them. The process is a threefold one of letting go of dysfunctional, although deeply held and valued, ideas and practices, discovering new ways of thinking and acting whilst coping with the insecurity engendered by changing conditions. This exactly fits the intentions behind the Ingrebourne. Bridger emphasises the nature of this work as engaging in a 'double task'. Exploring the realities of any particular situation goes hand in hand with understanding and managing the emotional and psychosocial issues arising.

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[131] Jan Plamper, *The History of Emotions: An Introduction*, Emotions in History (Oxford: Oxford University Press, 2015), 9–39.

[132] Barbara Rosenwein in an interview argues that emotions have a universal biological reality, but are expressed differently. Jan Plamper, 'History of Emotions: An Interview with William Reddy, Barbara Rosenwein, and Peter Stearns', *History and Theory*, vol. 49 (2010): 260. Peter and Carol Stearns remark on the 'curious' fact that many historians ignore biological factors in their studies of emotion. Peter N. Stearns and Carol Z. Stearns, 'Clarifying the History of Emotions and Emotional Standards', *The American Historical Review*, vol. 90, no. 4 (1985): 824.

[133] James M Wilce, *Language and Emotion* (Cambridge: New York: Cambridge University Press, 2009), 183.

[134] E.g. Dixon, *Weeping Britannia*, 231–216; Wilce, *Language and Emotion*, 153–54; Rhodri Hayward, *Transformation of the Psyche in British Primary Care, 1880-1970.* (London: Bloomsbury Academic, 2015), 124–30.

[135] Dixon, *Weeping Britannia*, 2–5, 263-278.

[136] This and the following is taken from Anthony Ambrose's introduction to the concepts of Transitional Thinking. Bridger himself wrote few easily accessible descriptions of his work. Anthony Ambrose, 'An Introduction to Transitional Thinking', in *The Transitional Approach to Change*, by Gilles Amado, Anthony Ambrose, and Rachel Amato (London: Karnac, 2001).

Another strand of conceiving space in psychiatric institutions stems from the work of social geographers such as Chris Philo. He states that '"spatial relations" have been central to the very functioning of past mad-businesses'.[137] However, in general, his and other's emphasis is largely on institutions designed to influence the behaviour of the inmates.[138] With the medical historian John Pickstone, he recognises the multitude of different settings that now populate the psychiatric landscape and is cognisant of the fact that 'many of our previous conceptual and methodological tools are simply not up to the job'.[139] In discussing these newer developments occurring 'off the beaten track' of mainstream psychiatry, they suggest that these spaces provide '*hopeful*' opportunities for innovation. This would fit the profile of the Ingrebourne. The implications of such a local geography are that the emotional and imaginary phenomenological space begins to impose itself on the researcher, especially when much of the evidence is assembled from interviews.

As the humanistic geographer Yi-Fu Tuan reports, language is crucial to the creation of place.[140] He illustrates how changes in attitude can appear to alter an environment. This process was continuously at work at the Ingrebourne, where the initial bewilderment and even fear could be replaced by a sense of family and trust. The naming of rooms demarcated specific activities so one would become an office, or a bedroom and another the art therapy room. As Andrew Roberts expressed it:

> The big group meeting was important and it had a kind of symbolism of that in its location. I showed you those stairs. Well we all went up to it. Can you see the symbolism? It is a special event. Everybody goes up to it. It is in this room we do not usually use. It had its kind of aura about it.[141]

There are two levels of this imagined transitional space: the ideal and the experienced. The former was determined by the theoretical underpinnings of the practices and expressed in the 'guidelines' or rules laid out at different stages. The latter is the emotionally charged, day-to-day experience of the interactions within the place now accessed through the memories of participants complemented by a few contemporary accounts.

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[137] Chris Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity* (Lewiston, New York: Edward Mellen Press, 2004), 33.

[138] For instance the collection of essays, edited by Topp et al., describe varying forms of institutions designed to improve patient care and Sarah Curtis' review of post-asylum geographies of mental health care. Leslie Elizabeth Topp, James E. Moran, and Jonathan Andrews, eds., *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, Routledge Studies in the Social History of Medicine 27 (New York: Routledge, 2007); Sarah Curtis, *Space, Place and Mental Health*, Geographies of Health (Farnham, Surrey, England ; Burlington, VT: Ashgate Pub, 2010), 185–202.

[139] Chris Philo and John Pickstone, 'Unpromising Configurations: Towards Local Historical Geographies of Psychiatry', *Health and Place*, vol. 15, no. 3 (2009): 654.

[140] Yi-Fu Tuan, 'Language and the Making of Place: A Narrative-Descriptive Approach', *Annals of the Association of American Geographers*, vol. 81, no. 4 (1991): 684.

[141] Andrew Roberts, 'Reflections on Ingrebourne: Developed from the Transcript of an Interview of Andrew Roberts by Tom Harrison on 18.2.2011' (Personal communication, 2011), 11, Personal.

Phenomenologically, Yi-Fu Tuan considers that 'space' and 'place' are interdependent.[142] 'Place' provides the stable platform from which the dynamic, unlimited freedom of 'space' can be considered. Through their evolving relationships at the Ingrebourne, people created an emotional 'transitional space', which expanded far beyond the confines of the physical location. It is the boundaries of this mutually imagined, 'agreed domestic territory' that form the basis of this discussion. The 'place' will be explored in Chapter Three and the 'transitional emotional space' forms the core of Chapter Four, which details the activities carried out within it.

4. Methodological Issues

i. Collecting Evidence: Documentation

Five forms of data were collected: archives, published documents, oral histories, a film and a site visit. At the outset, Crocket's extensive archive provided an invaluable introduction to the first twenty years of the Ingrebourne Centre. It includes personal reflections, letters, articles both published and unpublished, notes of meetings and a collection of interviews conducted with him. The correspondence contained a number of letters shuttled between himself and senior administrators at a local and regional level up until 1977. Unfortunately, other official documents relating to the Ingrebourne Centre have been lost or destroyed. On opening the door to the cellar of the administration block in the 1990s, staff found water was lapping at the threshold, destroying the records kept there.[143] Warley Hospital had also been subjected to flooding as well as fire, and records were in the process of being catalogued, where possible, at the Essex County Records Office.[144] No trace could be found of the North Eastern Metropolitan Regional Hospital/Health Authority records.

Fortunately, a number of interviewees were able to provide some documentary evidence covering the final thirty years. Evidence, even more scanty, was obtained from the London Metropolitan Archives and the Essex County Archives. A few members of staff published articles describing the practices at the unit. Andrew Roberts has committed a significant amount of relevant material describing his experiences in the Centre on to a website providing a valuable counter-narrative to that of the staff.[145]

Published material was collected through a number of different methods. First, the Crocket archive contained his publications and referenced some by other members of staff. The

[142] Yi-Fu Tuan, *Space and Place: The Perspective of Experience*, (Minneapolis, Minn.: Univ. of Minnesota Press, 2011), 6.
[143] INGCE27, Telephone conversation, October 2014.
[144] http://seax.essexcc.gov.uk/Result_Details.aspx?DocID=810048
[145] http://www.studymore.org.uk/ingrebou.htm

Planned Environment Therapy Trust Archive also contains an extensive library of relevant interviews, documents, journals and books.[146] Searches were made on-line through the University of Birmingham and Google using the search term 'Ingrebourne'. Relevant journals were hand searched.[147] People who contributed their narratives also gave information about publications that they were involved in or were aware of. Finally, this author owns an extensive collection of articles and books collected over half a century on the subject of therapeutic communities.

ii. Collecting Evidence: Oral History

Three groups of narratives were collected. The first consisted of interviews with fifteen members of staff and three patients at the Ingrebourne.[148] Three senior managers of the local mental health services also contributed. A nursing officer from St George's Hospital provided some brief evidence during a telephone conversation. A group of staff who had worked in psychiatric hospitals during the 1960s to 1980s were interviewed, consisting of seven nurses, a historian of mental health nursing and three consultant psychiatrists. These provided accounts of conditions in the main-stream hospitals and some indications of the cultural climate of the National Health Service during the time that the Ingrebourne was operating.

The narrators were collected through word of mouth, professional contacts and internet searches.[149] One ex-patient was contacted through a staff member who had remained in touch and another made contact through a website advertising the project.[150] This provided a range of people who had worked at the unit throughout its existence apart from the late 1960s and early 1970s.

Clearly, this could not be considered to be a 'representative' sample as they were all self-selected and tended to be supportive of the Centre's work. Historian Trevor Lummis outlines two issues to do with the validation of oral evidence: reliability and the

[146] http://www.pettrust.org.uk/

[147] These included *International Journal of Therapeutic Communities, Therapeutic Communities*, and *The Joint Newsletter of the Association of Therapeutic Communities.* The *British Medical Journal* and the *The Lancet* were searched for articles on hospital reforms in the 1950s through to the 1970s.

[148] The staff included two social workers, two art therapists, a psychologist, four doctors and six nurses.

[149] A number of names were found through archive documents and then these were searched on the internet adding relevant descriptors such as psychotherapist, doctor, etc.. Not all responded. One individual had emigrated to Australia and although his name was still associated with a psychotherapeutic institution, it became apparent that he had actually died some years earlier. Andrew Roberts, who had been a resident, was discovered by entering the words 'Ingrebourne Centre' as a search term.

[150] A second ex-patient made contact through the same route but expected to be paid for the interview. In view of the lack of funds for such an event and uncertainties associated with the manner of the approach, this opportunity was turned down. An attempt to stimulate interest through offering an article to a local newspaper proved fruitless.

representative nature of interviewees.[151] He suggests comparing different cohorts to identify omissions and silences. Structuring interviews to identify commonalities assists in identifying episodes that have been suppressed either for inter-personal reasons or for wider 'political' ones. The problem for the present research is that there is little significant overlapping of interviews chronologically. The main group of narrators were those who were active in promoting the work of the unit. Less wholehearted participants, who were not interviewed, may have held very different views. However, as one respondent described their understanding,

> I, I think pretty much most of us were quite enthusiastic about the therapeutic community approach, and they could have easily gone elsewhere if they wanted. So, so yeah, I, I would say … I'm trying to think whether there were any exceptions. No, I would say most people were very enthusiastic. I can still remember some people who came from abroad, even, and came to work with us, even. You know, they were very enthused.[152]

Another narrator acknowledged that while

> there were other people that didn't… I think subscribe in the same way to, to the whole group process. Others came in and embraced it, and were very good and always came to the large group', apart from a couple who 'didn't kind of see it as their role … I'm trying to think ... most of th', most other people did.[153]

A particular member of staff stood out in the memory of another contributor. This individual, acting as 'a bit of a disruptive, undermining presence', through 'simple facial expressions' and casting 'disdain on this idea or submission or that', stating 'of course we tried that once. Didn't work!'.[154] A few members of staff who found the transition from the traditional hierarchical psychiatric nursing role difficult to manage did not stay long.[155] In general, this suggests that the majority of staff were 'signed up' to the approach. Some incidents were revealed of a very personal nature which helped to establish the authenticity of the accounts, but clearly could not be referred to in this thesis. The 'group-think' that arose from this situation is discussed in the penultimate chapter.

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[151] T. Lummis, 'Structure and Validity in Oral Evidence', in *The Oral History Reader*, eds. R. Perks and A. Thomson, Second (London: Routledge, 1998), 255.

[152] INGCE17, interview, 17. Most excerpts from interviews have been 'tidied up', removing extraneous utterances and repetitions. A few are left as in this case to give some indication of the hesitancy with which the evidence was given as in this and the following quotation. All interviews, unless otherwise stated, were carried out by the author and will be archived at the Planned Environment Therapy Trust.

[153] INGCE29, interview, 29.

[154] INGCE27, interview, 9.

[155] INGCE19, interview,25.

In all but one case, interviews were carried out in people's own homes.[156] They mainly lasted between one and a half to two hours. Each interview was conducted using a semi-structured questionnaire that evolved as new evidence emerged. For instance in an early interview with Andrew Roberts, it became clear that patient-to-patient interactions were significant and this aspect was included in subsequent sessions. The emphasis in these questions was not on the individual's life history or, in the case of those who had received treatment, on their difficulties, but on their experience of the Centre and the social interactions within it.

All interviews were transcribed by the researcher and then these were sent to the narrators for corrections.[157] Some were followed up by email correspondence seeking clarification and asking new questions. All sources have been anonymised except where the narrators explicitly wished their names to be used.[158] Andrew Roberts, in particular, made it clear that:

> I tend to think that if I am being interviewed it is as me. Just as if I gave an interview to a magazine and that anything I say will be traceable back to me. I can see that there might be circumstances where anonymity might be desirable but it is well past the time to be anonymous about my psychiatric history.[159]

Oral histories held at the Planned Environment Therapy Trust Archive were also consulted, particularly those conducted by Craig Fees, the archivist, with Richard Crocket.

iii. Collecting the Evidence: Film and Site visit

Two other forms of data collection became available. The first was a Channel 4 documentary, *A Change of Mind – The Narrow Line* (1986), and some unused rushes from that recording in the possession of a member of staff.[160] This illustrated the daily life and treatments of the unit with a commentary by the senior consultant and an introduction by Crocket's friend, Sutherland. The rushes gave extra footage of a drama group and other activities. The overall effect of the film is to present the Ingrebourne Centre as a large, well run family with all participants engaged in the enterprise of 'getting better'.[161] The senior

[156] The exception was with a manager who was able to make time between two other appointments and took place in what was expected to be the quiet room of a public house. Unfortunately the use of a recorder was precluded because of the noise and this led to only notes being taken.
[157] They were also sent a questionnaire asking for their agreement to the interviews being archived at the Planned Environment Therapy Trust once the research was completed.
[158] The coding used was INGCEXX where XX was the number of the interviewee.
[159] A. Roberts, personal communication, 5th December 2014
[160] Andy Metcalfe and Paul Morrison, *A Change of Mind: A Narrow Line*, DVD, Television Documentary (Channel 4; Concord Media, 1986); Andy Metcalfe and Paul Morrison, *A Change of Mind: A Narrow Line 2 & 3 Rushes and Psychodrama Group*, DVD, Television Documentary (Channel 4; Concord Media, 1986).
[161] This contrasted with such documentaries as that made of Borocourt and St Lawrence's hospitals in 1981 for ATV which illustrated the appalling conditions in which people with learning difficulties were being kept. Nigel Evans, 'Silent Minority' (ATV, 1981). The documentary producer R. M. Young commented on the difficulties of

doctor gave a commentary on the various aspects that were being illustrated in her parental, expert role. She even appears in the kitchen commenting on how to bake a cake. Her presentation was characteristic of contemporary British documentaries, although it was unusual for it to be a woman in that role.[162] It shows nothing of the underlying tensions between the varying approaches of different staff, and the patients on view are clearly 'signed up' to the values of the unit. However, it gave an opportunity for the people receiving treatment to describe their experiences and also for genuine moments of group tension to be illustrated.

The researcher also visited the abandoned St George's Hospital and gained access to the Ingrebourne building. This gave both experience of the 'place' and a sense of its anachronistic setting in a hospital for older people. Photographs from this visit were sent out to narrators to act as a prompt in the interviews and to illustrate this thesis.

iv. Working with the Evidence

There is a significant trend to dissect narratives into their constituent textual parts in order to discern their meaning.[163] The oral historian Alessandro Portelli makes the point that 'it is unnecessary to give excessive attention to the quest for new and closer methods of transcription' when working with oral history.[164] Not only does this fail to capture anything of the original emotional flavour, it appears to be an effort to apply a linear, sequential logic that aims to pin things down and make them clear and precise. Iain McGilchrist, drawing from the lessons of modern neuroscience, attributes this form of rational utilitarianism to thinking generated by the brain's left hemisphere.[165] He argues that this attitude is increasingly predominant in Western philosophy and culture and emphasises abstracted, decontextualized, disembodied reasoning.[166] As another oral historian, Michael Roper, states: 'Too much significance can be given to methods that organise and categorise the words in an interview'.[167] On the other hand, the right hemisphere is concerned with

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making a series of science programmes for Channel 4 in the same year. The team started out making 'an avowedly radical series', but it was made clear that it should 'balance' opposing views, and, consequently, the attempt to critique the subject was constantly undermined. He argued that existing coverage at the time was of the 'gee whiz' variety aiming to explain, entertain and celebrate the subject. The Ingrebourne film fits this description perfectly. R. M. Young, 'The Dense Medium: Television as Technology', *Political Papers No 13. Special Issue on Science and Technology* 13 (1986), http://human-nature.com/rmyoung/papers/paper96.html.

[162] C. A. Johnson and B. E. Johnson, 'Medicine on British Television: A Content Analysis', *Journal of Community Health*, vol. 18, no. 1 (1993): 30.

[163] Norman Fairclough, *Analysing Discourse: Textual Analysis for Social Research* (London ; New York: Routledge, 2003).

[164] Alessandro Portelli, 'What Makes Oral History Different', in *The Oral History Reader*, eds. Robert Perks and Alistair Thomson, Third (London ; New York: Routledge Taylor & Francis Group, 2016), 50.

[165] McGilchrist, *The Master and His Emissary*, 2010.

[166] McGilchrist, 137.

[167] Roper, 'Analysing the Analysed: Transference and Counter-Transference in the Oral History Encounter', 23.

context, the relational aspects of experience, emotion and the nuances of expression, including empathy and inter-subjectivity. McGilchrist summarises his argument, stating that the left hemisphere is concerned with 'what' and the right 'how'.[168] He then goes on to argue that it is not possible to attain understanding by '*grasping*' it, it 'has to be already in us, and the task is to awaken it, or perhaps to unfold it'.[169]

It was important to suspend preconceived ideas whilst listening to the interviews and to modify theories in the light of new evidence, but it was not appropriate to abandon all previous knowledge. Indeed, critiques such as that of Manning assisted in seeing 'below the surface' of the largely benign recollections of the participants. Bourdieu's concept of reflexivity, constantly reviewing conclusions reached and prejudices overlooked, seemed to be both how this researcher naturally operated and appropriate to the task.[170] The outcome is that themes have arisen through continual reflection on reading and listening to a wide variety of sources over a period of eight years.[171]

Throughout the thesis, quotations from primary sources have been used extensively in order to illustrate the observations and descriptions being offered. The oral historian Anna Karpf, echoing many others, challenges the hegemony of the written word over that spoken by the narrator arguing that much of their authentic voice is lost in transcription.[172] Whilst this is self-evident, the telling of stories helps to bridge that gap. Recreating incidents such as watching student nurses throw cigarettes on the floor for patients to pick up, as related in Chapter Three, still reflect the disgust evoked in the informant. Some of the stories tell of more than can be elucidated in the rest of the text and will arouse responses in the reader over and above the specific point being made. This all hopefully contributes to a sense of place and space beyond the formal account being given.

The historian is continually confronted with the problematic nature of oral history as evidence. Joan Scott, the American historian, argues that

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[168] Iain McGilchrist, *The Master and His Emissary : The Divided Brain and the Making of the Western World* (New Haven: Yale University Press, 2010), 93.

[169] McGilchrist, 155. In considering how to manage the considerable mass of oral history collected, alongside the written material a number of strategies were considered. An initial foray into detailed studies of the narratives, such as *Critical Discourse Analysis* and *Narrative Analysis*, was rapidly abandoned as being inappropriate to the disparity of sources both in time and context. Margaret Scotford Archer, ed., *Critical Realism: Essential Readings*, Critical Realism--Interventions (London ; New York: Routledge, 1998); Roberto Franzosi, 'Narrative Analysis-Or Why (And How) Sociologists Should Be Interested in Narrative', *Annual Review of Sociology*, vol. 24 (1998): 517–554. Grounded Theory although more suitable was complicated by the variety of methods encompassed under this term A. Bryant and K. Charmaz, 'Introduction', in *The SAGE Handbook of Grounded Theory*, ed. A. Bryant and K. Charmaz (London: Sage, 2010), 11

[170] Pierre Bourdieu and Loïc J. D Wacquant, *An Invitation to Reflexive Sociology* (Chicago: University of Chicago Press, 1992).

[171] Glaser and Strauss, the originators of Grounded Theory, advised their students that the essential information would surface and 'stick in the investigator's mind. Phyllis Stern N., 'On Solid Ground: Essential Properties for Growing Grounded Theory', in *The SAGE Handbook of Grounded Theory*, eds. A. Bryant and K. Charmaz (London: Sage, 2010), 118.

[172] Anne Karpf, 'The Human Voice and the Texture of Experience', *Oral History*, vol. 42, no. 2 (2014): 50–55. See also Portelli, 'What Makes Oral History Different'.

> When experience is taken as the origin of knowledge, the vision of the individual subject (the person who had the experience or the historian who recounts it) becomes the bedrock of evidence on which explanation is built. Questions about the constructed nature of experience … are left aside.[173]

Whilst this statement may now be seen as outdated, as it was made in 1991, it is still being employed as a rationale for ignoring oral testimony and so the issues it raises have to be addressed.[174] It is usually contrasted with documentary evidence such as archival material or 'scholarly' research articles.[175] Their apparent objectivity is relative, even illusory, depending on how and why they were generated and the status of the author. Both have difficulties in interpretation as accurate records of events within the Centre. Published accounts were mainly written by the senior medical staff. The material presented is selective, simplifying the processes whilst advocating the approach. Archival material reveals more complexity, but is patchy and absent for much of the period covered in this research. The narratives given orally are coloured memories and have severe restrictions in terms of their chronological accuracy. However, it has been possible to build up a complex picture that can be seen to have parallels in other organisations. From this some conclusions about the TC approach are drawn in the final chapter, both relevant to other similar organisations and also as a counterpoint to the dominant medico-psychiatric agenda of the early twenty-first century.

5. Framework of the Thesis

In the following chapter, the nature of mainstream psychiatric care in the United Kingdom is described, followed by introducing some of the attempts made to ameliorate the situation. Where the evidence is available, the situation at Warley Hospital is highlighted. Conditions in most hospitals were clearly appalling and efforts at reform largely relied on individual entrepreneurial efforts. The next three chapters describe stages in the life of the Ingrebourne. Chapter Three explores its evolution and Chapter Five examines its demise. Each of the phases in its development is prefaced by descriptions of the political or cultural setting locally and nationally. The cultural setting of the 1950s and '60s was clearly conducive to the introduction of a more humanistic approach and collective solutions to problems. However, the *ad hoc* nature of this evolution at the Centre was not easy going as Crocket and his colleagues faced bewilderment from managers and other outsiders. The latter part of the story is marked by increasing economic pressures as the neo-liberal agenda takes hold and is set in the context of greater political control over clinical practice.

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[173] Joan W. Scott, 'The Evidence of Experience', *Critical Enquiry*, vol. 17, no. 1 (1991): 777.
[174] Chris Millard, *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing*, Mental Health in Historical Perspective (Houndmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan, 2015), 199.
[175] Millard, 198.

How staff reacted to these increasing restrictions paradoxically led both to it continuing unchanged for longer than other similar units, but also to their exclusion from planning psychological services that might have continued its work in a modified form for longer still.

The intervening Chapter Four looks more closely at the functioning of the transitional emotional space at the Ingrebourne. This is introduced by a brief history of group and TC theory and practice drawing attention to those influences that can be seen as acting on participants at the Centre. Questioning perceived reality in the Western World has origins that at least go back to the elenchtic discourses of Socrates. By the 1940s, this approach, along with Quaker practices, had combined with group work developed in the United States and psychoanalysis to trigger a novel way of treating soldiers emotionally affected by their life in the Army. This subsequently triggered a burgeoning of centres in the National Health Service that described themselves as TCs. The programme at the Ingrebourne changed in detail, but not in essentials, for nearly half a century. Thus it became possible to explore some of the tensions and relationships that both allowed it to continue for so long and also contributed to its decline.

The final chapter aims to draw out some of the underlying themes and consequences of this research, in particular the complex issues around compassion and kindness. Some will be relevant to the TC approach, whilst others have a broader resonance in caring for others.

It is hoped that the following pages bring an institution and its setting alive. The narratives and passion of those involved are as much part of the social and cultural perspectives as any overarching themes that may be discerned. Indeed, the very complexity of compassion is in itself a theme that is too often extruded from historical studies in which those receiving care are reified as the 'mad'.[176] The necessity to desiccate histories in order to 'clarify' one's vision is to oversimplify and to miss out the 'messiness' that is part of ordinary human existence.[177] Commitment, such as expressed by most of the participants quoted here, enables innovation and action and, without it, the transitional emotional space described here would neither have been created, nor sustained.

[176] Andrew Scull, *Museums of Madness : The Social Organization of Insanity in Nineteenth-Century England* (Harmondsworth: Penguin, 1982).
[177] Millard, *A History of Self-Harm in Britain*, 199.

Chapter 2

'Strange Therapeutics': Reform in British Mental Health Services 1950-1970 [1]

> You have to be a saint or an idiot to ignore the fact that life in a mental hospital, as a nurse or patient, has more ugly aspects than beautiful or inspiring ones.[2]
>
> We have to make what we can with what resources are made available to us and with what humanity we can find.[3]

1. Stasis and Reform in Post-Second World War Psychiatric Hospitals

Nick Manning contends that 'powerful forces other than the rational application of knowledge to an area of human needs' shaped the therapeutic community approach.[4] A primary driver was to escape from the stultifying institutionalism of the traditional mental hospital. As one member of staff described it, 'when I saw the Ingrebourne Centre, and what they were doing, I was really struck at how they were doing something different from the main stream'. [5] It suited him 'very well' compared to Warley Hospital.[6] Elsewhere nurse Heber Mattis moved from a psychiatric hospital 'which I found quite depressing' to the Uffculme TC and 'it was a revelation really for me. Because people did listen to the patients, and the whole approach was infinitely more dignified'.[7] Crocket rejected the stranglehold that he perceived the Medical Superintendent had over psychiatric hospitals and was keen to reform both 'out of existence'.[8] Fussinger agrees that 'reformist psychiatrists' in the 1950s condemned the rigid hierarchy in mental hospitals, arguing that they both wanted to

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[1] The title is taken from an account by a patient of a psychiatric hospital in 1954. It refers to the wide range of experimental treatments that were carried out at this time, ranging from deep insulin treatment and neurosurgery, to group therapy. Anon, 'Strange Therapeutics', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds, (London: Christopher Johnson, 1957), 66–80.

[2] Paul Warr, *Brother Lunatic*, (London: Neville Spearman, 1957), 42.

[3] Dr Taylor, a psychiatrist, commenting on the paucity of appropriate care for a particularly disabled young man in 1972, Quoted in House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital.* (London: HMSO, 1974), 80.

[4] Manning, *The Therapeutic Community Movement*, 183.

[5] INGCE17, interview, 1&2.

[6] Warley Hospital is referred to throughout this chapter as it was the 'parent' hospital to the Ingrebourne Centre and thus illustrates the conditions locally.

[7] Heber Mattis, interview, 2.

[8] R. W. Crocket, 'Our Mental Hospitals Can We Reform Them out of Existence?', *The Observer*, 21st October 1956, 6.

overcome their separation from patients and to offer the latter greater opportunities to express their points of view.[9]

Post-war psychiatric service reform in the United Kingdom consisted of two inter-digitated phases. Until the 1959 Mental Health Act, pressure for change was largely 'in house'. Afterwards, activity gradually snowballed, spreading beyond the walls of the mental hospitals and culminating in their eventual abandonment. The first section of this chapter describes the conditions in these institutions and the second the activities of those attempting to amend the situation. The establishment of TCs was amongst the most dynamic approaches to overturning the traditional order and the history of their development is deferred to Chapter Four. The final section traces events from the 1959 Mental Health Act to the start of Margaret Thatcher's premiership. This elaborates on the increasing state intervention in psychiatric services. Alongside was the rising public awareness of the institutional problems of mental hospitals and the swelling volume of critical voices concerning psychiatric practice.

With the establishment of the National Health Service in 1948 the political emphasis was on the provision of general medical and surgical care. The psychiatric services earned the epithet of being a 'Cinderella Service, which applies to the present day.[10] There were few resources forthcoming to improve the hospitals' physical condition, and management remained in the hands of the medical superintendents.[11] They remained for the most part little changed until their closure, with large groups of people catered for in open wards that denied any form of privacy. Many staff members were resistant to change and the management often repressed those who tried to unsettle the status quo.[12] The move to 'community care' was piece meal and lethargic, hampered by the necessary funding to make alternative arrangements for the large numbers of people involved and the

[9] C. Fussinger, '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War II', *History of Psychiatry*, vol. 22, no. 2 (2011): 149.

[10] House of Lords, 'Media Notice: Is the NHS Staffed for the Future? Is Mental Health Still a Cinderella Service? The House of Lords Committee on the Sustainability of the NHS Investigation into NHS Workforce and Mental Health Services', 2016, https://www.parliament.uk/business/lords/media-centre/house-of-lords-media-notices/2016/october-2016/is-the-nhs-staffed-for-the-future-is-mental-health-still-a-cinderella-service-lords-to-ask-experts/. Accessed 14/01/2017.

[11] Kenneth Robinson, in presenting a private member's bill, reported that the 42% of beds in the health service that accounted for mental health, received 16% of the overall NHS funding. Hansard, 'Debate: Mentally Sick (Care and Accommodation)', vol. 523 (London: HMSO, 1954), 2293–2379, http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation#column_2299. See also John Welshman, 'Rhetoric and Reality: Community Care in England and Wales, 1948-74', in *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000*, eds. Peter Bartlett and David Wright (London and New Brunswick, NJ.: Athlone Press, 1999), 208–9.

[12] In 1957 H. Maddox, a lecturer in psychology summarising a study on mental nurses, found that innovation was inhibited by older nurses who were more likely to recommend coercive or disciplinary measures than psychological ones. H. Maddox, 'The Work of Mental Nurses', *Nursing Mirror*, 19th April 1957, 190. See also for the period between the wars: Niall McCrae, 'Resilience of Institutional Culture: Mental Nursing in a Decade of Radical Change', *History of Psychiatry*, vol. 25, no. 1 (2014): 70–86; Diana Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997* (London; New York: Routledge, 1998), 64.

concentration of services on those with 'less serious, shorter term problems'.[13] As sociologist Elizabeth Bott commented in 1976, 'the old custodial function of the hospital has continued, but a new short-stay function has been added'.[14]

i. 'Are they Heaven or are they Hell?' :[15] The Psychiatric Hospital in Mid-Twentieth-Century Britain

The year Dr Crocket joined the staff of St George's Hospital marked a watershed in British institutional psychiatric care.[16] The numbers of people incarcerated peaked at over 150,000 in 1954 and waned thereafter.[17] The local mental hospital, Warley, shared this trend, declining from 1,996 patients in 1954 to 1,760 in 1960.[18] The asylum water towers, dominating their landscapes, appeared to be in as little danger of being washed away as the ground that they stood on. Most patients, particularly longer term residents and the elderly, were to experience little change in their circumstances for another two to three decades. The first fifteen years following the Second World War was a time of alarm for a few, but little general public disquiet concerning the state of services for people with mental disorders.[19] This was accompanied by lack of resources, 'always meagre', that could result in a few, mostly untrained staff, attending large numbers of patients in bleak and crumbling buildings.[20] 'So much is stagnant and yet nothing dies' mused a bored poet in a ward dayroom in 1963, echoing *The Stagnant Society,* Michael Shanks' description of the

[13] Busfield, *Managing Madness*, 240.
[14] Elizabeth Bott, 'Hospital and Society', *British Journal of Medical Psychology*, vol. 49 (1976): 97.
[15] Donald M. Johnson and Norman Dodds, *The Plea for the Silent*, (London: Christopher Johnson, 1957), 8.
[16] In this chapter, and those following, hospitals will be referred to by their name only, avoiding endless repetition of the word 'hospital'.
[17] G. C. Tooth and Eileen, M. Brooke, 'Trends in Mental Hospital Population and Their Effect on Future Planning', *The Lancet*, vol. 277 (1961): 710–13. The official figures notified to the Board of Control were 151,378, Great Britain House of Commons, 'Annual Report of the Board of Control to the Lord Chancellor for the Year 1953' (HMSO, 1954), 3.
[18] G. S. Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953.*, Second ed. (Brentwood: Warley Hospital, 1969), 31, http://www.simoncornwell.com/urbex/projects/w/docs/fhy1.htm.
[19] As Mr Bernard Braine M.P. submitted to the Houses of Parliament in 1954: "Frankly, where mental illness or mental deficiency is concerned, the public have hitherto preferred not to think about it but to thrust it into the background as though it was something rather shameful, certainly something which they could not understand and which they would prefer not to be bothered with'. http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation#column_2347 (Accessed 28/10/12). The leading sociologist of the time, Richard Titmuss, in a polemical diatribe against political prevarication argued that there had been significant campaigning about closing '*bad*' institutions, but his evidence largely focussed on professional opinion and Parliamentary debates. Richard Titmuss, 'Community Care as Challenge', *The Times*, no. 54458 (12 May 1959): 11.
[20] Kathleen Jones and Roy Sidebotham, *Mental Hospitals at Work*, The International Library of Sociology and Social Reconstruction (London: Routledge and Kegan Paul, 1962), 2. See also J. P Martin and Debbie Evans, *Hospitals in trouble* (Oxford: B. Blackwell, 1984), 92, 117.

contemporary political, economic and social state of the United Kingdom.[21] However, British society evolved more rapidly than these secretive, 'marooned in time' institutions.[22]

In describing the mental hospital of the 1950s to 1980s, there are a limited number of contemporary first-hand accounts.[23] People were reticent about describing what they saw and heard. Those who did faced a 'conspiracy of silence'.[24] Alysia Wingfield learnt that when she 'tried to tell people Outside about the atmosphere which permeated Heartbreak House through and through, they found it hard to believe'.[25] Those who were in authority were largely unaware of, or oblivious to, the physical and emotional violence being visited on their charges. As a consequence, the picture that emerges is overwhelmingly and potentially inaccurately critical, particularly as most published reports were written as exposés. This has to be balanced with the observation that many contemporary critics were silenced by those with whom they were working and that oral histories have revealed much unrecorded emotional and physical abuse, as well as acts of compassion.

Those incarcerated tend to emphasise the callousness and powerlessness rather than outright cruelty.[26] As one veteran observed, 'it was very, very disciplined … everything was done without any explanation. You weren't told *why* you'd got to do it. You were just told you've *got* to do it'.[27]

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[21] Elizabeth Jennings, 'In a Mental Hospital Sitting-Room', *The Listener*, vol. 70, no. 1808 (1963): 826; Michael Shanks, *The Stagnant Society* (Harmondsworth: Penguin, 1961).

[22] The quotation comes from a nurse working in the 1940s. Peter Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thornes, 1998), 109.

[23] R Porter, 'Foreword', in *The Story of a Mental Hospital: Fulbourn 1858-1983*, (London: Process Press, 1996).

[24] Johnson and Dodds, *The Plea for the Silent*, 8.

[25] This is the pseudonym of a woman who was a patient in the mid-1950s and Heartbreak House was the name she gave to the hospital in which she was confined. Alysia Wingfield, *The Inside of the Cup* (London: Angus and Robertson, 1958), 125.

[26] This was something found repeatedly in the first of the Inquiries into mental hospitals in 1969. They reported 'Once again we found no evidence of deliberate mistreatment in this ward. But low standards of patient care' were evidenced by the 'unduly causal attitude' towards the deaths of two patients and the 'passive acceptance of a life of virtually complete inactivity'. (National Health Service, *Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.* (London: HMSO, 1970), 21) After this the Welsh Hospital Board surveyed every long-stay hospital in the principality and found that similar conditions affected all of them. (J. P Martin and Debbie Evans, *Hospitals in Trouble* (Oxford: B. Blackwell, 1984), 68) The Normansfield Hospital Report, published in 1978, reported only one incident of violence, the overall concern was the low standard of nursing care with a consequent poor quality of life for the inmates. (National Health Service, *Report of the Committee of Inquiry into Normansfield Hospital.*, Cmnd 7357 (London: HMSO, 1978), 9. It was also the main refrain of the interviews carried out by this author. See also Cherry, *Mental Health Care in Modern England*, 264; Kathleen Jones and Roy Sidebotham, *Mental Hospitals at Work*, The International Library of Sociology and Social Reconstruction (London: Routledge and Kegan Paul, 1962), 202; Eric H. Pryor, *Claybury: A Century of Caring* (Lavenham: Lavenham Press, 1993), 108.

[27] Anonymous male patient in Diana Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997* (London; New York: Routledge, 1998), 170.

The sense of control by the staff was exemplified by the locked doors and the keys that opened them.[28]

> There were the jingling keys! One could go through no door, without the humiliation of asking and perhaps waiting for someone to open it for you.[29]

This contributed, with the possibility of being transferred to more 'secure' wards or padded cells, to the pervading sense of fear.[30] Behind any compassion shown by staff lay the long-stay locked wards, which were regarded as places of punishment to which those who did not conform were sent. This inhibited criticism and initiative on any inmate's part in case they might be 'transferred to the refractory ward about which he has frightening fantasies'.[31]

Staff often acted as if the people in their care were less than human, openly expressing such sentiments as though they would not understand, stating 'Where there is no sense there is no feeling'.[32] The attitude was to regard patients as 'unmitigated nuisances and undeserving malcontents' or to infantilise them.[33] As late as the 1970s, a student nurse observed nurses throwing cigarettes on to the floor for patients to 'scrabble for'.[34]

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[28] The keys were highly visible symbols of power expressed as direct control. 'Always the doors were locked. One could tell when nurses passed by the jingle of the keys at their waists' and patients were 'not being allowed to emerge beyond the door at the end of the passage without special permission and the appropriate clanking of keys'. Even laundry maids carried them, in a large bunch around the waist, 'because every door in the corridors and the wards was locked'. (Anon, 'Strange Therapeutics', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds, (London: Christopher Johnson, 1957), 71; Donald M. Johnson, *A Doctor Returns* (London: Christopher Johnson, 1956), 29.; Diana Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997* (London; New York: Routledge, 1998), 147). David Clark recalled: 'The crashing of keys was an essential part of asylum life'. (Greg Wilkinson, ed., *Talking About Psychiatry* (London; Washington, D.C.]: Gaskell, 1993), 78) See also: Jones and Sidebotham, *Mental Hospitals at Work*, 58.; Pryor, *Claybury: A Century of Caring*, 105–6.; Nolan, *A History of Mental Health Nursing*, 1998, 109.

[29] Anon, 'Fear Gripped Me', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 116.

[30] J. Custance, 'Mental Hospitals and Mental Treatment', *International Journal of Social Psychiatry*, vol. 1, no. 1 (1955): 67.

[31] Denis V. Martin, 'Institutionalisation', *The Lancet*, Vol. 266 (1955) 1188-1190, 1189.

[32] One of John Hopton's interviewees emphasised how the patients were treated as 'an underclass' and conversations would be held in front of them 'as if they didn't exist or had no sense of understanding'. John Hopton, "Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care," *History of Psychiatry*, vol. 10, no. 3 (1999): 359. See also Enid Mills, *Living with Mental Illness: A Study in East London*, (London: Routledge & Kegan Paul, 1962), 51; Virginia Beardshaw, Thorold, and Social Audit Ltd, *Conscientious objectors at work*, 20-21; Anon, 'A Broken Window', in *The Plea for the Silent*, ed. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 51

[33] Anon, 'An Unnecessary Stigma', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 39; W. A. L. Bowen, 'Need for Inspection (or Survey) of Psychiatric Hospital Services', in *Psychiatric Hospital Care*, ed. Hugh Freeman (London: Balliére, Tindall, & Cassell, 1965), 16. Enid Mills makes the same point in her study of the effects of hospitalisation. Mills, *Living with Mental Illness: A Study in East London*, 52.

[34] INGCE10, 2011, 2. Mocking and teasing patients as a form of 'fun' is reported widely: One of Beardshaw's respondents reported that even the doctors "'mocked' and 'laughed' at some confused patients, in front and behind them". Another saw staff teasing often in a "hurtful manner". Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 18. At St. Augustine's, patients would be called "Dumbo" to their faces.

Even with good care, Morag Coates found that in fourteen years of being a patient she was kept in ignorance of which hospital or ward she was in and even 'the name and status of the doctor looking after me'.[35]

This loss of control began before admission. Mrs Thornton explained how three men came to her house and took her to hospital without explanation.[36] After being admitted 'without being either informed or consulted', a doctor only realised his predicament on hearing the ward door being locked behind him, and it took months before he learnt that he had been certified.[37] Elsewhere a patient recalled, 'It felt as though I was kidnapped. … I thought it was a concentration camp at first'.[38]

The 'mortifying process' of admission involved being 'made to strip and surrender all personal belongings in my pockets – cash, diary, glasses – and so forth'.[39] Everything was then taken away. In the late 1960s during the first week of admission, the day was spent in a locked sitting room alongside the student nurses.

> And you just had to sit in with them in this confined space. I mean it was a sizeable sitting room. When you go there at seven-thirty, you knew that you were going to be sat there. So God knows what the poor patients thought of it all. And you're just sort of staring at each other.[40]

Powerlessness went hand in hand with idleness.[41] 'Dull, dull, dull!' exclaimed Alyson Wingfield.[42] Activities were highly regimented.[43] A nurse recalled feeling sorry for the male

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South East Thames Regional Health Authority, 'Report of a Committee of Enquiry St. Augustine's Hospital, Chatham, Canterbury.' (Croydon: South East Thames Health Authority, 1976), 159. This could get particularly bizarre as when nurses set fire to patient clothing whilst they were wearing it at Whittingham Hospital. Lancashire Evening Post 28 April 1971, quoted in Martin and Evans, *Hospitals in Trouble*, 1984, 101.

[35] Morag Coates, *Beyond All Reason*, (London: Constable, 1964), 167.

[36] Pathé News, *M.P.s Win Mental Patient's Freedom* (Pathé News Films, 1956), http://www.britishpathe.com/video/mps-win-mental-patients-freedom.

[37] Anon., 'A Doctor's Story', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 132. Certification was the process by which any person could be forced to become a patient in a psychiatric hospital. In the 1950s, the procedures were still those legally framed in the 1890 Lunacy Act, and it usually involved a relative making a statement before a justice of the peace, supported by two doctors. Kathleen Jones, *A History of the Mental Health Services* (London; Boston: Routledge and Kegan Paul, 1972), 177.

[38] Mills, *Living with Mental Illness: A Study in East London*, 52.

[39] Goffman uses this phrase to summarise these processes of "abasements, degradations, humiliations and profanations" during the process of admission. Erving Goffman, 'Characteristics of Total Institutions', in *The Mental Patient: Studies in the Sociology of Deviance*, eds. Stephan P. Spitzer and Norman K. Denzin (New York: McGraw-Hill, 1968), 313. Anon, 'No Benefit of Jury', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 14.

[40] INGCE9, interview, 2.

[41] David Clark in Wilkinson, ed., *Talking about Psychiatry*, 1993, 79; Cherry, *Mental Health Care in Modern England*, 259; Jones and Sidebotham, *Mental Hospitals at Work*, 60, 202.

[42] Wingfield, *The Inside of the Cup*, 43.

[43] At Claybury during the 1950s, if the weather was clement, outdoor activity was initiated by the Charge Nurse bellowing thoughout the ward 'Boots on, all outside' and ended by the order 'All inside'. The whole process was repeated for a further two hours in the afternoon. (Eric H. Pryor, Claybury: A Century of Caring (Lavenham:

patients who after breakfast had to go out into the yard where they would walk around until dinner time. It did not matter what the weather conditions were like they were out 'in the snow, the rain, whatever'. [44]

At Warley attempts were made to ameliorate the situation. In 1955, the range of occupations was deliberately varied in order to promote rehabilitation. The Medical Superintendent reported on 'Occupational Gangs' of male patients who assisted 'magnificently' in removing railings, opening up the gardens, widening the roads and clearing away old farmyard buildings.[45] In the occupational therapy department, people made chess sets out of old aluminium teapots, wooden boxes for the laboratory, toys for a local children's residential school, and renovated furniture and binding books for the library.[46]

Important decisions could be made after the most cursory of interviews by the doctors.[47] In the 1950s, one man complained to the doctor about the effects of the insulin therapy he was receiving. His concerns were summarily dismissed as irrelevant'.[48] Elsewhere for another patient, 'News leaked out that I was booked to go forward for a deep insulin course'.[49] Miss Wills never found out what electro-convulsive therapy was because they 'made her unconscious' before administering it to her.[50]

There was serious cruelty. The inquiries into psychiatric hospitals over the following two decades give ample evidence of this.[51] The psychiatrist at Severals, Russell Barton, realised

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Lavenham Press, 1993), 112-113). The regimentation was ubiquitous. A nurse at Tooting Bec in the early 1960s reported that 'I did find, when I was on the wards, I found it heavily regimented', and elsewhere a research worker 'got the impression that the patients were simply fitted into the daily routine'. (INGCE4, interview by T. Harrison, 2010, 8, Personal.Kathleen Jones and Roy Sidebotham, *Mental Hospitals at Work*, The International Library of Sociology and Social Reconstruction (London: Routledge and Kegan Paul, 1962), 204). John Hopton interviewed a number of members of staff at Prestwich Hospital in 1993, and they similarly reported the emphasis of inflexible discipline, associated with denigration of the patients' humanity, extending from the 1930s to the 1970s. John Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care': 353. See also Clark, *The Story of a Mental Hospital*, 34.

[44] INGCE6, 2010, 4.

[45] London Metropolitan Archive: G. S. Nightingale, 'Medical Superintendent's Report and Statistics for the Year 1956. Warley Hospital Brentwood.', Annual Report to Hospital Management Committee (Brentwood, Essex: Warley Hospital, 1956), 2, A/KE/C/02/06/582.

[46] Nightingale, 3.

[47] E.g. Cherry, *Mental Health Care in Modern England*, 268.

[48] Anon, 'Schizophrenia from Within', in *Schizophrenia from Within*, ed. J. K. Wing (Surbiton, Surrey: National Schizophrenia Fellowship, 1975), 29–44; 31-32.

[49] Anon, 'No Benefit of Jury', in *The Plea for the Silent*, eds. Donald M. Johnson and Norman Dodds (London: Christopher Johnson, 1957), 22.

[50] Barbara Robb, 'Diary of a Nobody', in *Sans Everything: A Case to Answer*, ed. Barbara Robb, (London: Nelson, 1967), 69.

[51] Martin and Evans listed 22 between the years of 1969 – 1981. Martin and Evans, *Hospitals in Trouble*, 1984. 256-257. Beardshaw however believed that that this was an underestimate. Her research team was refused access to at least three other inquiries. She also found that a fifth of student nurses who responded to a questionnaire (albeit from a very low overall response rate) reported incidents of patient abuse that they had witnessed Beardshaw, Thorold, and Social Audit Ltd, *Conscientious objectors at work*, 89, 18.

in hindsight that 'In most institutions a minority of unenlightened staff secretly assault patients who are not compliant' and he vehemently contended that to presume that it did not happen was 'naïve and fatuous'.[52] John Custance reported on his being 'beaten up' on several occasions in one month and felt that such treatment was endemic.[53] Even in the 1970s some staff appeared to revel 'in the violent and aggressive nature of some parts of the work' and for the nurse who witnessed it, this 'came as a bit of a surprise'.[54] Derek McCarthy's first day in a psychiatric hospital was marked by the charge nurse clouting an elderly blind man on the back of the head 'so fiercely that he flew across the room and hit the wall' accompanied by the explanation that 'if you live amongst shit, you become shit!'.[55] This was known as 'thump therapy'.[56]

This catalogue of abuse and neglect is amplified and extended through personal accounts given by staff and the published reports of committees of inquiry.[57] It includes stealing by staff, over-sedation and the use of treatments as punishment.[58] Two students in the 1970s were witness to the charge nurse's wife taking home a shopping trolley filled with provisions meant for the patients.[59]

Care has to be expressed in how these accounts are interpreted. Erving Goffman's concatenation of prisons, concentration camps and psychiatric hospitals overstates the barbarity of the latter situation.[60] Whilst the cruelty was present, it was usually carried out

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[52] Barton, *Institutional Neurosis*, 10-11.
[53] J. Custance, 'Mental Hospitals and Mental Treatment', *International Journal of Social Psychiatry*: 67.
[54] INGCE3, 2010, 10.
[55] Interview McCarthy, Derek interviewed by Chris Boulding, in *Mental: A History of the Madhouse* (British Broadcasting Corporation, 2009), http://www.youtube.com/watch?v=qxE9I_8fhe8.
[56] Niall McCrae and Peter Nolan, two nursing historians, also give similar accounts of violence from their interviews of nurses. Niall McCrae and Peter Nolan, *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors*, Routledge Key Themes in Health and Society (Abingdon, Oxon; New York, NY: Routledge, Taylor & Francis Group, 2016), 192–94.
[57] Whilst most of the official reports on the hospitals carried out over the two decades 1960-1980 are titled **I**nquiries, that pertaining to St Augustine's was called an **E**nquiry. South East Thames Regional Health Authority, *Report of a Committee of Enquiry St. Augustine's Hospital, Chatham, Canterbury.* (Croydon: South East Thames Health Authority, 1976).
[58] Stealing: National Health Service, 'Report of a Committee of Inquiry into Whittingham Hospital' (London: HMSO, 1972), 14–16, 60–64; Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 16.; South East Thames Regional Health Authority, 'Report of a Committee of Enquiry St. Augustine's Hospital, Chatham, Canterbury.', 76. Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 1998, 50. Cruel treatments: House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital.* (London: HMSO, 1974), 49–51; National Health Service, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.' (London: HMSO, 1970), 76; National Health Service, 'Report of a Committee of Inquiry into Whittingham Hospital', 58.
[59] INGCE11a & INGCE11b, interview.
[60] Even where he is explicitly describing events in psychiatric hospitals, in his chapter on the *Underlife of a Public Institution*, apart from the single institution he examined in detail, most of Goffman's examples are taken from concentration camps, prisons, and even slavery. However this does not completely invalidate his arguments. It was a significant text in providing arguments for reforming hospitals in the UK during the 1970s and later. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, (Harmondsworth: Penguin, 1968). Scull similarly takes issue with Goffman's hyperbolic comparison of the

covertly in defiance of policy. The Committee of Inquiry investigating allegations of brutality and mistreatment at South Ockenden found that the enormous majority of the staff worked 'very hard to care for their patients'. [61] Eric Pryor was very aware of the regular 'acts of great kindness' performed by his colleagues.[62]

The experienced critics quoted above could also draw attention to the humanity of many members of staff. One 'found four out of six doctors kind and helpful. I rapidly made friends with most of the staff'.[63] Alysia Wingfield found 'that very few of the nurses ever seemed to be wilfully sadistic. Generally, they were wonderfully detached and good humoured, in spite of their difficult patients'.[64] Andrew Roberts had to escort a friend of his to another 'old bin' where the nurse welcomed her with open arms and 'she was treated as a human being'.[65]

Staff would have to manage violence whilst retaining compassion. A patient could recall that 'there were kind nurses and I even grew to like some of those with whom I had waged the fiercest battles'.[66] Another at Severalls recognised that the better nurses would be with her for twenty-four hours a day and get to know her. They would understand that 'when I was absolutely fighting mad if they could tickle my sense of humour' or 'if they gave me a cuddle or gave me some little sign that they considered me a person' they could 'get through' to her.[67]

But the 'good' nurses would not 'bear witness against the bad ones', although abusive staff members were in the minority.[68] If they did, the likelihood was that they would be ignored, threatened with violence, moved to other parts of the hospital, or even dismissed.[69] As one nurse expressed it, 'you learnt not to tell tales and not to say anything'.[70] Even in the 1980s, less than a quarter of nursing students felt that they could report malpractice without fear of reprisal and only half felt that any notice would be taken.[71]

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hospitals and concentration camps. Andrew Scull, *Social Order/Mental Disorder : Anglo-American Psychiatry in Historical Perspective.* (Berkeley: University Of California Press, 1989), 310.

[61] House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital*, 3.

[62] Pryor, *Claybury: A Century of Caring*, 111.

[63] Anon, 'No Benefit of Jury', 28.

[64] Alysia Wingfield, *The Inside of the Cup*, 34.

[65] Andrew Roberts, 2011, 21, Personal.

[66] Anon, 'Strange Therapeutics', , 79.

[67] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 145.

[68] Jimmy Laing and Dermot McQuarrie, *Fifty Years in the System* (London: Corgi, 1992), 47. Paul Warr, as a nurse, berated himself: 'I had seen patients badly maltreated by bullies, I had seen them kicked and subjected to all kinds of cruelty, mental and physical, and I had done nothing'. Warr, *Brother Lunatic*, 42; National Health Service, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.', 124. See also Barton, *Institutional Neurosis*, 13.; Pryor, *Claybury: A Century of Caring*, 110.

[69] Virginia Beardshaw has comprehensively evidenced the reactions to which conscientious objectors were subject. Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*. See also Pryor, *Claybury: A Century of Caring*, 106.

[70] Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 24.

[71] Beardshaw, Thorold, and Social Audit Ltd, 21.

For some the institution acted as the asylum it was supposed to be, although the sense of benign neglect accompanying this is evident when one patient reported in the 1950s at Severalls that she was quite happy there. She did not have to do anything she did not want to. She could go anywhere she pleased and 'walk round, sit in the sun, go in what you call the tea bar, have a cup of tea or do the work that I did there'. [72] Some actually sought out the asylum, 'In the end I asked to go away… I needed somewhere to be safe, but I put myself behind bars to do it.[73] The medical superintendent of Claybury, Denis Martin, was alert to the dangers of the patient 'settling in'.[74] For some people, this was very attractive. Recreation, including cinema, television, cricket, musical evenings, and debates were all laid, on making hospital more pleasurable than the life they had outside.

However, more independent patients such as Alyson Wingfield experienced it as the 'nursery atmosphere', echoing the findings of Elizabeth Bott, a social researcher, who found that a culture of reliance on the 'kindly' nurses promoted a 'curiously peaceful but unreal atmosphere' on the wards.[75] David Towell, examining nursing practice at Fulbourn, found nurses were 'doing for' the patients such as getting them up in the morning, making their beds, and organising their day, leaving them in a passive and dependent role.[76] For Goffman, these behaviours were implicit in the processes of institutional care.[77] They have not yet been eradicated, as is evidenced by the recent scandals in the care of people with learning difficulties at Winterbourne View near Bristol in 2011, apparently recurring following their relocation.[78] The elderly continue to be vulnerable.[79]

Whether staff was caring, or not, the real issue lay in their control of patients. Reflecting on his nursing experience in the 1970s, Heber Mattis outlined the nature of this:

> And they mostly managed because they knew the patient inside out and backwards. The good bit was they knew them very well and were often quite paternal and supportive. The bad bit was they knew them very well and were quite paternal and supportive. It was all restrictive. There was no liberty, no choices. I mean you were

[72] Anonymous report in Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 129.
[73] Quoted in Mills, *Living with Mental Illness: A Study in East London*, 57.
[74] Martin, 'Institutionalisation', 1189.
[75] Wingfield, *The Inside of the Cup*, 23.; Bott, 'Hospital and Society', 134.
[76] David Towell, *Understanding Psychiatric Nursing*, (London: Royal College of Nursing, 1975), 54. The same behaviour was remarked upon by the Health Advisory Service, who found it strange that nurses who were understaffed should be carrying out activities, such as shaving, or dressing, that the patients could do for themselves. National Health Service, 'Annual Report of the Hospital Advisory Service to the Secretary of State for Social Services and Secretary of State for Wales for the Year 1973' (London: HMSO, 1974), 5.
[77] Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 1968.
[78] Holl, Alison. 'Winterbourne View patients in new care safety alerts', http://www.bbc.co.uk/news/uk-20070437. Accessed 20/01/2015
[79] The U.K. Care Quality Commission inspected the hospital care of elderly patients, under the care of National Health Service Hospitals in 2011, and found problems with many of them being treated with little dignity, poor hygiene, and being deprived of food through lack of attention. http://www.cqc.org.uk/public/reports-surveys-and-reviews/themes-inspections/dignity-and-nutrition-older-people. Accessed 20/01/2015.

> fixed in time and space from day one and you weren't allowed to come out of it. Because if you did you couldn't be managed.[80]

Reaction to this drove many to espouse the TC approach. They argued for a regime that enabled the person receiving care to be listened to and to have some say in the running of the community that they were part of. This required a process that engendered trust and a sense of safety. The detailed account given here reflects the continuing nature of traditional psychiatric hospital care with its tendency to incapacitate the person rather than enabling them to become active participants in their treatment.

ii. "Sixes and Sevens":[81] the Locations of Incarceration

Many accounts detail how the twentieth-century psychiatric hospital originated in the humanitarian aspirations of the early nineteenth century, and how they eventually became repositories for society's misfits.[82] What little spark of reform that was lit in the years between the two World Wars was all but extinguished as doctors and experienced male nurses went off to join the military in their droves after 1939.[83] Many women also left to work in munitions factories. Some hospitals were requisitioned for other purposes, emptied, and their inmates moved to overcrowded institutions elsewhere.[84] Those continuing to function faced the restrictions of a wartime economy: shortages of clothing, heating and food.[85]

Incorporating psychiatric units into the National Health Service in 1948 nominally gave them equal status to general medical hospitals. This signalled that the aim was to treat and cure,

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[80] Mattis, interview, 5. Hopton found that kindness and compassion were exhibited to patients within the confines of the regime. Attempts to change it were not welcomed by most nurses. Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 361.

[81] "Sixes and Sevens" refers to the combined ward on which Alysia Wingfield was kept in 1954. Wingfield, *The Inside of the Cup*, 15. A quirk of a number of mental hospitals was to pluralise the numbers of the wards such as 'twenties' for ward 20 at Hollymoor Hospital.

[82] Amongst others: Andrew T Scull, *Museums of Madness : The Social Organization of Insanity in Nineteenth-Century England* (Harmondsworth: Penguin, 1982).; Andrew T Scull, *Madhouses, Mad-Doctors, and Madmen : The Social History of Psychiatry in the Victorian Era* (London: Athlone Press, 1981).; James Gardner, *Sweet Bells Jangled out of Tune : A History of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath* (Brighton: The Author, 1999), 264.

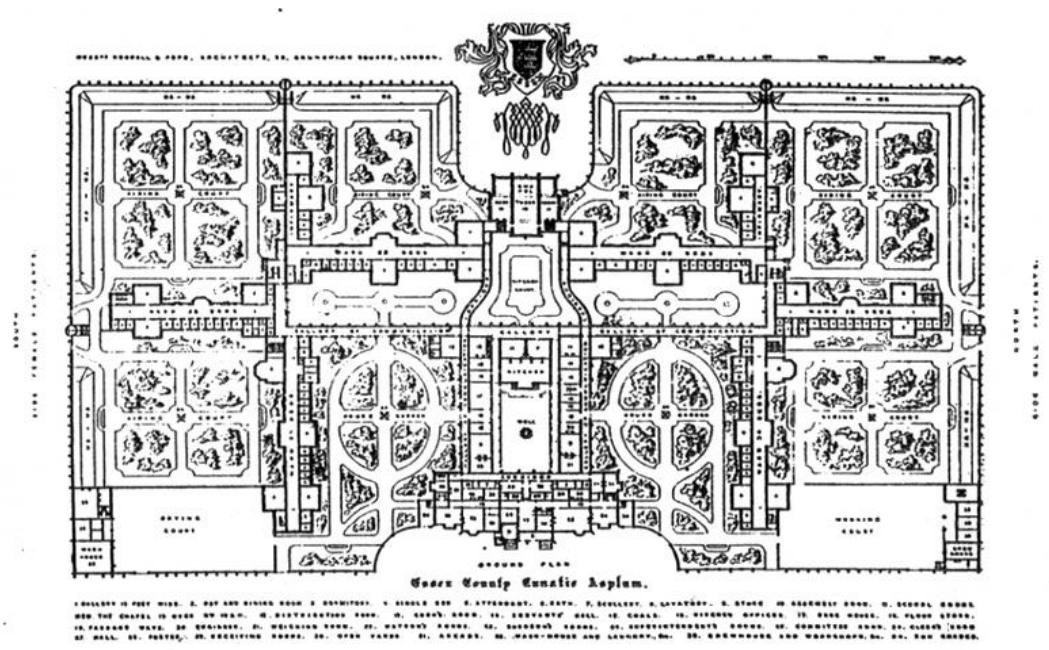
[83] Jones, *A History of the Mental Health Services*, 270.; Ministry of Health and Central Health Services Council, *Psychiatric Nursing: Today and Tomorrow: Report of the Joint Sub-Committee of the Standing Mental Health and the Standing Nursing Advisory Committees* (London: HMSO, 1968). 9; Clark, *The Story of a Mental Hospital*, 29.

[84] E.g. Hollymoor Hospital in Birmingham. Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 154–55.

[85] At St Francis' Hospital 70% of male patients lost 7lbs in weight, and 55% of the females lost 9lbs. Gardner, *Sweet Bells Jangled out of Tune*, 264. There were similar concerns at Fulbourne, see Clark, *The Story of a Mental Hospital*, 29.

rather than continuing as warehouses. Little changed in practice, mental hospitals were dilapidated and carceral. [86] They had to accommodate increasing pressures on bed availability, as voluntary admissions swelled the workload.[87] Buildings were unfit for purpose and, in the decade following 1948, there was little or no new accommodation.[88] One superintendent stated in 1955 that many 'of our mental hospitals are depressing, inconvenient, ill equipped, and understaffed'.[89] In 1969, the newly formed Hospital Advisory Service reported that many of the hospitals they visited were 'excessively large' and wards were overcrowded.[90] As a result, it was impossible for the few nurses on duty to develop effective therapeutic relationships and care deteriorated. Padded rooms and locked wards remained in use. In wards containing fifty or more of the most difficult patients, chronic disturbance, aggression and violence were inevitable.

Figure 2.1 Plan of the original buildings of Warley Hospital



(From Nightingale 1969, 23)

[86] At Claybury, "Becoming part of the NHS was hardly noticeable at shop-floor level". Pryor, *Claybury: A Century of Caring*, 104.
[87] Hugh Freeman, 'Psychiatry and the State in Britain', in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century*, ed. Marijka Gijswijt-Hofstra et al. (Amsterdam: Amsterdam University Press, 2005), 124.
[88] Freeman, 124.
[89] J.A.R. Bickford, 'The Forgotten Patient II One Solution', *The Lancet*, vol. 266 (1955): 971.
[90] Department of Health and Social Security, 'National Health Service Hospital Advisory Service: Annual Report for 1969-70' (London: HMSO, 1971), 21.

Figure 2.2 Warley Hospital c. 1960

(from Nightingale 1969, 23)

Warley was 'an epitome' of the typical mental hospital. Built in the mid-nineteenth century and consisting of a central building with the wards budding off interminable corridors, exercise yards through which patients could 'be seen sitting about behind heavy iron bars' it was a 'grim' place.[91] It was opened in 1853 as the Essex County Lunatic Asylum when it consisted of a range of two-story, brick buildings divided into male and female sides surrounded by well kempt gardens. [92] The original structures from 1853 (fig. 2.1) were added to over the following century, expanding from 300 beds initially to 2,035 in 1946.[93] After the Second World War, it suffered from the endemic problems affecting similar hospitals concerning the lack of staff and poorly maintained buildings.[94] The nursing shortage continued into the 1970s.[95] Wards had poor or no central heating and the sanitary arrangements needed 'bringing up to modern standards'.[96] In 1953, it was chronically overcrowded and whilst the overall bed numbers began to fall, the admission rate increased from 848 people in 1953 to 1,405 in 1963.[97]

[91] London Metropolitan Archive, A. G. L. Ives and Edwards, 'Notes on Visit to Warley Hospital Management Committee', Notes on a visit (Warley Hospital, March 1954), 3, A/KE/C/02/06/582.
[92] G. S. Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953.*, Second ed. (Brentwood: Warley Hospital, 1969), 31–32, http://www.simoncornwell.com/urbex/projects/w/docs/fhy1.htm..
[93] Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953,* 25.
[94] Nightingale, 31-32.
[95] Nightingale, 38.
[96] Nightingale, 36.
[97] Nightingale, 35.

Elsewhere, in 1967, a nurse worked on large wards with beds very close together and even the corridors were being used as dormitories.[98] Another found 'there wasn't even room for lockers in between, and this was still the same when I left in the early seventies'.[99] In Edinburgh in 1958, the patients from one ward had so little space that they took their meals in the bathroom of another.[100]

The physical conditions of the hospital buildings were a perpetual concern.[101] Most were up to a century old and presented an austere picture partially relieved by the immaculate gardens maintained by working parties of the patients.[102] Some had new villas for the acute patients or those suffering from neurosis, but the conditions for the longer-term residents were often marked by extreme neglect.[103] The maintenance could be so poor that the blankets of sleeping patients might be covered in frost or soaked by rain.[104]

Perhaps nowhere was the humiliation more evident than the bathing arrangements.[105] Because of the shortage the same hot, going on tepid, water was used for large groups of patients.[106] As a patient reported, twenty-five people of all ages, sizes or conditions were rushed in and out of five baths by the staff, accompanied by a 'stench of dirty linen, unwashed bodies and the humid atmosphere was appalling'.[107]

At the time of Crocket's appointment to the twenty beds at St George's Hospital, Warley had just over 2,000 patients, served by 13 medical officers, of whom three were fellow consultants.[108] Whilst investment in facilities and reduction of numbers in wards proceeded

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[98] INGCE9, interview, 1. Similar conditions were recorded at St Francis' Hospital as late as 1969. James Gardner, *Sweet bells jangled out of tune : a history of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath* (Brighton: The Author, 1999), 274-275. A Granada World in Action film of 1968 showed similar scenes at Powick Hospital in Worcestershire to a wider audience. https://www.youtube.com/watch?v=UzjeBaBFWqw

[99] INGCE6, interview, 3. See also National Health Service, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.', 21.85

[100] Audrey John, *A Study of the Psychiatric Nurse*, (Edinburgh: Livingstone, 1961), 49.

[101] Three fifths of the elderly wards, in a survey of 168, "provided dismal surroundings" comparing unfavourably with local authority provision for a similar group. Peter Townsend, 'A National Survey of Old People in Psychiatric and Non-Psychiatric Hospitals, Residential Homes, and Nursing Homes', in *Psychiatric Hospital Care*, ed. Hugh Freeman, (London: Balliére, Tindall, & Cassell, 1965), 231. See also:. Gardner, *Sweet Bells Jangled out of Tune*, 1999, 272.; Cherry, *Mental Health Care in Modern England*, 245–48.

[102] E.g. Jones and Sidebotham, *Mental Hospitals at Work*, 55, 57.Gittins, *Madness in its place narratives of Severalls Hospital, 1913-1997*, 48, 157.; Pryor, *Claybury: A Century of Caring*, 105.

[103] Cherry, *Mental Health Care in Modern England*, 247. See also Jones and Sidebotham, *Mental Hospitals at Work*, 56,61.Gardner, *Sweet Bells Jangled out of Tune*, 272; David Clark in Wilkinson, *Talking About Psychiatry*, 79; Martin and Evans, *Hospitals in trouble*, 117; J.A.R. Bickford, 'Treatment of the Chronic Mental Patient', *The The Lancet,* vol. 263 (1954): 924.

[104] John, *A Study of the Psychiatric Nurse*, 54.; National Health Service, *Report of the Committee of Inquiry into Normansfield Hospital.*, 10.

[105] One ward at St Francis' Hospital had one bath for 96 female patients. Gardner, *Sweet Bells Jangled out of Tune*, 273.

[106] John, *A Study of the Psychiatric Nurse*, 90.; Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 1964, 33.

[107] Anon, 'Strange Therapeutics', 75.

[108] Three Consultants, Four Senior Hospital Medical Officers, a Senior Registrar and five Juniors These figures are taken from Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953.*, 1969, 9.

slowly over the half century between the Second World War and the final closure, conditions were ameliorated rather than transformed. In 1981, the hospital still had 954 beds. Nationally, one and half people per thousand were resident in psychiatric hospitals and, although the length of stay was reducing, admissions rates were increasing.[109] In 1986, the Audit Commission complained that 'unfortunately progress to community care has been slow'.[110] By 1993, 81 of the 130 psychiatric hospitals that were open in England in 1953 had shut down.[111] Warley was one of the last to close, and, in 1998, still had 482 beds open.[112] The last of the original buildings was abandoned in 2001, and a newer unit built in the grounds was closed in 2011.[113]

The wards that replaced them were often no improvement. In 2007, Janey Antoniou echoed those who went before in describing the boredom of sitting on a ward, with the frustration of having no way to deal with the hours stretching away in front of her.[114] Kevin Norwood found the environment of the new unit, with its narrow corridors, low ceilings, drab lifeless walls and close proximity with other patients who were disturbed, compared poorly with the old asylum, with its 'wide open spacious grounds with lovely quiet spots where a person in a depressed state could be taken out for a walk'.[115] Nearly half the patients in acute wards in 1998 felt they had not received enough information about their illnesses and possible treatments. This was compounded by the lack of contact with staff, boredom, and fears of violence.[116] The Healthcare Commission reported in 2003 that, in some services, bed occupancy was 150% with service users returning from visits home to find their beds were taken by others.[117]

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[109] Admission rates increased from 374 per 100,000 to 396 per 100,000 in the twelve years from 1970 to 1981 Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England* (London: HMSO, 1984), 22, 3.

[110] Audit Commission for Local Authorities in England and Wales, ed., *Making a Reality of Community Care: A Report* (London: HMSO, 1986), 15.

[111] Freeman, 'Psychiatry and the State in Britain', 137.

[112] Paul McCrone et al., 'Service Use and Costs of Supporting the Most Socially Disabled Patients in a Hospital Reprovision Programme: A Two-Hospital Comparison', *Social Psychiatry and Psychiatric Epidemiology*, vol. 41, no. 8 (2006): 657.

[113] Romford Recorder: http://www.romfordrecorder.co.uk/news/heritage/the-final-curtain-for-153-year-old-mental-health-hospital-serving-havering-1-763194

[114] Janey Antoniou, 'Bored on the Ward', in *Experiences of Mental Health In-Patient Care.*, ed. Mark Hardcastle et al. (London ; New York: Routledge, 2007), 34. See also Len Bowers, 'Runaway Patients':, *Mental Health Practice*, vol. 7, no. 1 (2003): 10–12. Commission for Health Improvement, 'What CHI Has Found in: Mental Health Trusts. Sector Report' (London: Commission for Health Improvement, 2003), 21; Sainsbury Centre for Mental Health, *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards.* (London: Sainsbury Centre for Mental Health, 2001), 5.

[115] Norwood, 'Feeling out of Control', in *Experiences of Mental Health In-Patient Care*, eds. Mark Hardcastle et al. (London ; New York: Routledge, 2007), 42.

[116] Sainsbury Centre for Mental Health, *Acute Problems*, 5; Commission for Health Improvement, 'What CHI Has Found in: Mental Health Trusts. Sector Report', 21. For wards being locked, see Bowers, 'Runaway Patients'; Inés García et al., *Acute Care 2004: A National Survey of Psychiatric Wards in England* (London: Sainsbury Centre for Mental Health, 2005), 83–85.

[117] Commission for Health Improvement, 'What CHI Has Found in: Mental Health Trusts. Sector Report', 21.

Throughout this period, the Ingrebourne continued with one and a half doctors, five nurses and three nursing assistants, a psychiatric social worker, a social therapist and a part-time psychologist serving up to forty patients.[118] This apparent 'richness' of staff would not have gone unremarked by Crocket's clinical colleagues at Warley and it is clear that he fought his battles with senior management without their support.

iii. 'Plus ça change …'[119]: Power in the Mental Hospital.

This section describes how relationships within and without these institutions sustained these conditions. After describing the role of the medical superintendent, the overt and covert mechanisms that undermined his authority are explored.

Officially, the medical superintendent was the senior officer in the hospital hierarchy.[120] This position had nearly a century and a half of tradition behind it, and, in many cases, continued until the 1970s.[121] Sociologist Kathleen Jones and Roy Sidebotham, an accountant, investigating a mental hospital in 1960, described the superintendent as a 'constitutional monarch'.[122] The management at Severalls Hospital was a hierarchy over which the medical superintendent ruled 'like a feudal lord'.[123] These descriptions characterise the prevailing perceptions of this role, and for the few medical staff under his authority it was a reality.[124] His main powers over other staff lay in his authority to dismiss them and his ability to block changes. At one Midland hospital, the superintendent dismissed a nurse for leaning a bike against a wall in the wrong place after having let the air out of her tyres.[125] More creative activities required negotiation. By 1962, his power was waning.[126] The power to admit and discharge all the patients in the hospital was a particular bone of contention with their medical colleagues until the 1959 Mental Health Act.[127]

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[118] R. W. Crocket, 'Memorandum: Ingrebourne Centre Staffing and Activity November 1955', 1955, Planned Environment Therapy Trust.

[119] Quote from Dr Nightingale on his perception of the early 1950s at Warley. Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953*, 33.

[120] Kathleen Jones in her history of Mental Health Services in the United Kingdom reported that 'hospitals had been freed from the obligation to appoint a medical superintendent in 1959'. This did not go uncontested and many retained their position for some decades afterwards. Dr David Clark retained this position at Fulbourn until 1971. Clark, *The Story of a Mental Hospital*, 225. The termination of Dr Russell Barton's tenure in this post, in 1969, was particularly acrimonious. Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 88–89.

[121] Jones, *A History of the Mental Health Services*, 90.

[122] Jones and Sidebotham, *Mental Hospitals at Work*, 65.

[123] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 31.

[124] Consultant Psychiatrist, 'Letter: Mental Health Bill', *The Lancet*, vol. 263 (1959): 471–72.; Another Consultant Psychiatrist, 'Letter: The Medical Superintendent', *The Lancet*, vol. 264 (1959): 183.

[125] INGCE31, 2016, 22.

[126] Jones and Sidebotham, *Mental Hospitals at Work*, 44.

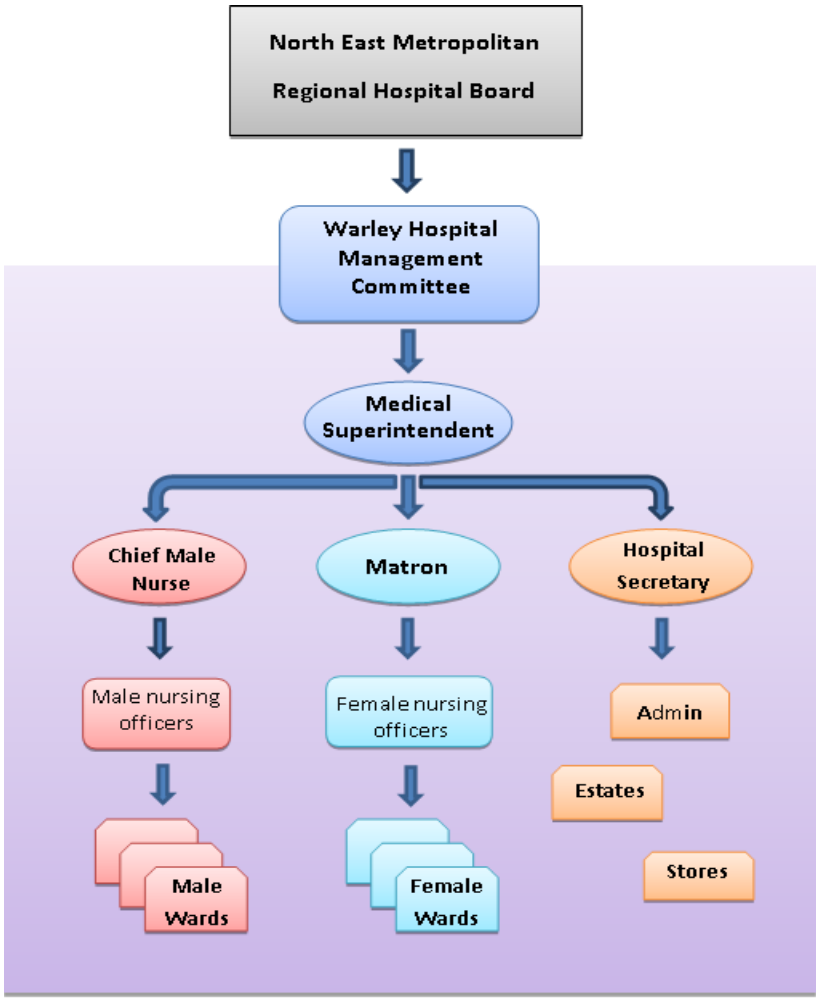
[127] John G. Howells, 'The Establishment of the Royal College of Psychiatrists', in *150 Years of British Psychiatry 1841-1991*, eds. German. E. Berrios and Hugh Freeman, vol. 1 (London: Gaskell, 1991), 119.

However, he had other actors to contend with and, as historian Greg Eghigian suggests, it is perhaps time to 'deinstitutionalise' the history of psychiatry and get rid of the idea that 'psychiatry and psychiatrists have an autonomy and authority akin to the nineteenth-century superintendent or *Anstaltsvater*'.[128] It was not a popular job.[129] As will be demonstrated, they were accountable to external authority, and nurses had the ability to routinely undermine their authority.

During the early years of the National Health Service, 14 Regional Hospital Boards formed the upper tier of the local NHS structure.[130] They administered all the Health Service provision in their area 'on behalf of' the Minister for Health.[131] The duties of these Boards and the Hospital Management Committees were not explicitly laid out in the National Health Service Act of 1946.[132] However, their remit was to monitor the running of the hospitals and ensure 'that the patients were properly cared for in the light of contemporary knowledge within the framework of any policy laid down by the Department (*of Health*) or the Board'.[133] Overall control of finances was held at regional level, and it was they who approved bids for resources. They were only able to distribute funds allocated to them by government and, as the authors of the *Inquiry to South Ockenden Hospital* commented even as late as 1974, 'nobody can doubt that the money allocated by Parliament has been inadequate'. [134] They also took responsibility for the appointments and contracts of consultant psychiatrists, a fact that would cause difficulties for superintendents wishing to assert their hegemony.[135]

[128] G. Eghigian, "Deinstitutionalizing the History of Contemporary Psychiatry," *History of Psychiatry*, vol. 22, no. 2 (2011): 204.
[129] J.C. Sawle Thomas, 'Administration in Psychiatry and Its Therapeutic Implications', *International Journal of Social Psychiatry*, vol. 2, no. 3 (1956): 186; Richard Fox, 'Point of View: On Managers', *The Lancet*, vol. 324 (15 September 1984): 628–29.; Hutton, G. 'Management in a Changing Mental Hospital'. *Human Relations*, vol. 15, no. 4 (1962): 286.
[130] Each served a number of counties and local authorities.
[131] Parliament, Great Britain, *National Health Service Act*, Geo. VI c. 81, 9 and 10 (London: HMSO, 1946), para. 12 (1).
[132] There were 14 Regional Hospital Boards in England and Wales.
[133] House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital*, 128.
[134] House of Commons. Great Britain. Parliament, 128. Kenneth Robinson, the future Minister of Health, in 1954 was driven to emphasise the under-investment in the mental health services. He pointed out that they had been starved of capital since 1948, and that they received only 16% of the total NHS budget of £40 million capital expenditure, despite the fact they catered for almost half the beds. http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation#column., column 2307
[135] Ministry of Health, Central Services Council. 'Report of the Committee on the Internal Administration of Hospitals' (London: HMSO, 1954), 12.

Figure 2.3 Warley Hospital Management 1948-1957.



See note[136]

The members of the Hospital Management Committees were appointed by the Regional Hospital Boards to administer individual hospitals or groups of hospitals.[137] Despite this, there sometimes appeared to be 'a gap' existing between these two levels, leading to conflict over national policy and ownership of particular hospitals.[138] They did not employ the consultant medical staff, neither did they have jurisdiction over their extra-mural work such as out-patients and domiciliary visits.[139] Dr Bickford, the medical superintendent at De La Pole Hospital, found that they rarely visited, and those who did were outspoken in

[136] This diagram has been created using data from Nightingale 1967; Jones, *A History of the Mental Health Services*, 285–86; Parliament, Great Britain, *National Health Service Act*, para 11.
[137] Ian Skottowe, *A Mental Health Handbook* (London: Edward Arnold, 1957), 7; Parliament, Great Britain, *National Health Service Act*, para. 11. At 'Northtown' the HMC consisted of 19 members, 4 medical practitioners, 6 justices of the peace, 6 trade union representatives, and 2 businessmen. Jones and Sidebotham, *Mental Hospitals at Work*, 63–64.
[138] Bowen, 'Need for Inspection (or Survey) of Psychiatric Hospital Services', 19.
[139] Hutton, 'Management in a Changing Mental Hospital', 300.

opposing improvements.[140] Their ability effectively to monitor patient care was compromised by their 'remoteness, ignorance, complacency and political impotence'.[141]

The relationship between these committees, the board and the medical staff at the hospital was open to many interpretations. In 1960, Kathleen Jones found it was difficult to clarify where the 'sphere of authority' of the medical superintendent ended and that of the Hospital Management Committee began in one hospital.[142] Personalities played a significant part. At Hollymoor Hospital, in the late 1950s, the Chairman of the Hospital Management Committee, David Rhydderch, was a forceful local councillor who fought long and hard for improvements. He ran foul of the medical superintendent, who led the medical staff in rebellion against him. The resulting conflict finished up being debated in the Houses of Parliament, and, although he was largely exonerated, he soon retired through ill-health whilst the doctor remained in post. [143]

In many cases, the Hospital Secretary acted both as secretary to the Hospital Management Committee and as a subordinate to the Medical Superintendent in the hospital.[144] Thus he was both the senior executive officer of a committee overseeing his medical colleague and subject to his authority in the hospital, opening endless opportunities for confusing the 'chain of command'. It was possible for the hospital secretary's subordinates to be suspended for executing business of the committee if it conflicted with the wishes of the senior doctor.[145] Psychiatrist Dr Russell Barton found that administrators 'can wage war against clinical staff and vice versa'.[146] Alternatively, at a Midlands hospital, it was clear that the Hospital Secretary was indispensable to the Superintendent: 'he was good. And Dr Xxxx leaned fairly heavily on him'.[147] At Farleigh Hospital on the other hand, the relationship was clearly acrimonious, 'as happened not infrequently throughout the country', commented the Committee of Inquiry.[148]

The superintendent also had to contend with the senior nurses. As illustrated in Figure 2.3, there were during the 1950s, two separate nursing hierarchies covering the male and female sides of the hospital. At Farleigh, it was asserted that the Chief Nursing Officer 'was in complete control'. [149] Through his energy and commitment and buoyed up by support

[140] J.A.R. Bickford, 'The Forgotten Patient', *The Lancet*, vol. 266 (1955), 918. See also Clark, *The Story of a Mental Hospital*, 72; Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 64.
[141] Martin and Evans, *Hospitals in Trouble*, 248.
[142] Jones and Sidebotham, *Mental Hospitals at Work*, 64.
[143] Hansard, ed., 'Birmingham Mental Hospital Committee (Former Chairman)', in *Birmingham Mental Hospital Committee (Former Chairman)*, vol. 664, 155 (London: HMSO, 1962), 94–170.
[144] Hutton, 'Management in a Changing Mental Hospital', 286.
[145] B. M. C. Gilsenan, 'Administration of Psychiatric Hospitals', in *New Aspects of the Mental Health Services*, eds. Hugh Freeman and James Farndale, vol. 7, The Westminster Series (Oxford: Pergamon Press, 1967), 498.
[146] Barton, *Institutional Neurosis*, 55.' between the medical superintendent and the administrative staff. Jones and Sidebotham, *Mental Hospitals at Work*, 88.
[147] INGCE5, interview, 3.
[148] National Health Service, 'Report of the Farleigh Hospital Committee of Inquiry' (London: HMSO, 1971), 12.
[149] National Health Service, *Report of the Farleigh Hospital Committee of Inquiry*, 16-20.

from the longer-established nurses, he effectively had more influence than the superintendent. But he was overworked, 'unable to adequately supervise' and appeared to be unaware of the abuses that were happening.[150] At Ely Hospital, this officer was 'a kind, conscientious, self-effacing and co-operative man, who had never taken any initiative or made any representations about the conditions, establishment and organisation of the nursing staff on the male side'. [151] At Napsbury, ward nurses aligned themselves with the consultants, with the result that their professional seniors were ignored.[152] Peter Dawson, Chairman of the Society of Registered Male Nurses, publicly confronted the hegemony of the superintendents, whom he saw as thwarting nurses' innovative practice and independence of thought.[153] Challenges to the superintendent's position also came from their medical colleagues, and Crocket was a significant critic. In his *Observer* article, he described them as 'conservative' figures, who were 'far too occupied in preserving the *status quo*'.[154]

The managerial roles of both the doctors and the nurses were evolving. The Bradbeer Report of 1954 fired the first shot across the bows of traditional mental hospital management, recommending a tripartite leadership of senior nurse, senior doctor and hospital administrator.[155] This was largely ignored until implementation of the Salmon Report on senior nursing structure in 1966 and the Cogwheel Report on medical management in 1967.[156] The former recommended replacement of the male/female split in the hospital with a single principle nursing officer. Its implementation took years in some hospitals such as South Ockenden.[157] Historian of psychiatric nursing Peter Nolan reported that it did not receive universal approval as it was intended to reward ability rather than years spent in the lower grades.[158] Certainly, at St Andrew's Hospital in Norfolk, it caused a fair amount of consternation as senior staff had to reapply for the new posts.[159]

The Cogwheel Report advised the replacement of the medical superintendent with a medical division in which the medical staff was to meet and discuss hospital policy. From this committee a chairman was appointed by Regional Boards in consultation with Hospital

[150] National Health Service, 23.
[151] National Health Service, 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.', 74.
[152] Bott, 'Hospital and Society', 135.
[153] P. Nolan and others, 'Mental Health Nursing in the 1950s and 1960s Revisited', *Journal of Psychiatric and Mental Health Nursing*, vol. 4, no. 5 (1997): 335.
[154] Crocket, 'Our Mental Hospitals Can We Reform Them out of Existence?', October 1956.
[155] Ministry of Health, 'Report of the Committee on the Internal Administration of Hospitals'.
[156] Ministry of Health, 'First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals.' (London: HMSO, 1967).
[157] House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital.*, 137.
[158] Nolan, *A History of Mental Health Nursing*, 134.
[159] Cherry, *Mental Health Care in Modern England*, 298.

Management Committees and the consultant staff.[160] Psychiatrists, however still frequently maintained an authoritarian approach. An occupational therapist at Prestwich Hospital recalled starting a drama group in the 1960s, only to be called in by the consultant who 'screamed… "Who the hell are you to organise drama with my patients. I decide what happens to the patients in this hospital"'.[161] At the same hospital in the 1970s, nurses were expected to stand to attention when the doctor came onto the ward.[162] Whilst such overt expressions of medical dominance have waned, it is evident that the culture has largely been modified rather than overturned.[163]

Underpinning this hierarchy were the nursing staff, constituting the largest professional group. Overall, their numbers were increasing.[164] A typical ward in the 1950s was managed by a charge nurse or sister and sometimes supported by a deputy.[165] There might be one other qualified staff nurse, rarely more. Other staff could include students, nursing cadets, or rarely a ward orderly or maid. In many places, nursing assistants were employed to replace the lack of qualified female nurses.[166] In Edinburgh in 1958, half the wards surveyed had no domestic staff, requiring either patients or nurses to carry out these duties.[167] It was usual to work 12-13 hour shifts from 7.00am, for a total of 96 hours in a fortnight.[168] These hours gradually fell to 84 a fortnight by 1968.[169]

In spite of the official hierarchy, the senior ward nurses (charge nurses in particular) exercised significant power.[170] Their influence was largely conservative, creating 'little fiefdoms' of the wards they worked on. This continued until the 1980s and beyond in some cases. In his evidence to the Committee of Inquiry into Normansfield Hospital in 1977, one

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[160] Ministry of Health, 'First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals', 57–58.
[161] Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 358.
[162] Hopton, 358–59.
[163] Neil R. Brimblecombe, 'The Changing Relationship between Mental Health Nurses and Psychiatrists in the United Kingdom', *Journal of Advanced Nursing*, vol. 49, no. 4 (2005): 344–53.
[164] Nationally their numbers increased from 19,000 whole timers in 1949 to 27,000 in 1966 supplemented by an increase in part-time staff from 6,000 to 9,000. Ministry of Health and Central Health Services Council, 'Psychiatric Nursing: Today and Tomorrow: Report of the Joint Sub-Committee of the Standing Mental Health and the Standing Nursing Advisory Committees', 9. By 1973, Warley's 1,358 occupied beds were served by 277 qualified nursing staff, supported by another 247 unqualified nursing staff. Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England and Wales 1973* (London: HMSO, 1976), 31, 50.
[165] H. A. Goddard, *The Work of the Mental Nurse*, (Manchester: Manchester University Press, 1955), 56–57.
[166] Goddard, 57.
[167] John, *A Study of the Psychiatric Nurse*, 37.
[168] Goddard, *The Work of the Mental Nurse*, 102; Ministry of Health and Central Health Services Council, 'Psychiatric Nursing: Today and Tomorrow: Report of the Joint Sub-Committee of the Standing Mental Health and the Standing Nursing Advisory Committees', 9; John, *A Study of the Psychiatric Nurse*, 46.
[169] Ministry of Health and Central Health Services Council, 'Psychiatric Nursing: Today and Tomorrow: Report of the Joint Sub-Committee of the Standing Mental Health and the Standing Nursing Advisory Committees', 9.
[170] As illustrated in the interviews carried out by Gittins. Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 180. Pryor hints at this disparity when he describes the doctors as being "ostensibly in charge". Pryor, *Claybury: A Century of Caring*, 109.

trenchantly asserted his position stating that, although his views might be considered outdated and 'not in keeping with modern management', he was 'resistant to outside peering and prying eyes'. [171] This approach, in his opinion, had worked well and was proven to be effective. The attitude to patients that often accompanied this was 'You've got to keep on top of these people. You have to show them who is master'.[172]

It was clear to a young doctor in the 1960s that the nurses were in charge of the wards; 'certainly they ran the wards that I was on'.[173] The power of the charge nurse has largely been ignored by historians and contemporary observers alike.[174] Goffman speaks of the 'doctors being in control of the institution'.[175] Crocket echoed this view when describing the traditional approach stating that 'all psychiatric activity is doctor centred'.[176] When nursing researcher Virginia Beardshaw argued that psychiatric nursing hierarchies were 'powerful', she undermined her observation by giving two examples illustrating the ability of the charge nurse to nullify any threat from his seniors whilst intimidating the complainants.[177] As one of her respondent's explained, the nursing officers 'sit in the office miles from the wards and see nothing. Everyone knows they are coming so they see only perfection in the wards'.[178] At Claybury and Fulbourn, there was a system of 'pipe tapping' that would warn the next ward to be visited when a senior nurse or doctor was on their way.[179] The doctors rarely visited and were usually only allowed to see what the charge nurse wished.[180] Arguing that 'the staff ran the show, not the doctors', Jimmy Laing recalled telling a doctor about an incident of brutality, to which the reply was 'I know, but they'll deny it'.[181]

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[171] House of Commons. Great Britain. Parliament, *Report of the Committee of Inquiry into South Ockendon Hospital*, 110.

[172] Mental nurse quoted in Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 23.Not infrequently ex-soldiers turned nurses would express this physically. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 35.; Peter Nolan, *A history of mental health nursing* (Cheltenham: Stanley Thornes, 1998), 111-112.

[173] INGCE5, interview, 2.

[174] Most of the commentaries on 'the power of psychiatry' have concentrated on the controlling relationship between the psychiatric profession and those they are treating, rather than the relationships within the psychiatric hospitals. An exception to this is the study by Baruch and Treacher, in the 1970s, which found doctors making decisions about patients that were based on very little contact with them. The result was that junior staff members often acted on their own initiative going against decisions that they saw as arbitrary and unhelpful to their patients. Geoff Baruch and Andrew Treacher, *Psychiatry Observed* (London ; Boston: Routledge & K. Paul, 1978), 223.

[175] Of course he particularly referred to the American situation, but some of his evidence came from the UK. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 321.

[176] Richard Crocket, 'The Therapeutic Community Approach in a Neurosis Unit' (November 1957), 5, Planned Environment Therapy Archive.

[177] Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 31.

[178] Beardshaw, Thorold, and Social Audit Ltd, 34. See also Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 359.

[179] Pryor, *Claybury: A Century of Caring*, 107.; David Clark in Wilkinson, *Talking about Psychiatry*, 81.

[180] Russell Barton, as a psychiatrist, was particularly distressed that he was unaware of the brutality that occurred. Barton, *Institutional Neurosis*, 7.

[181] Laing and McQuarrie, *Fifty Years in the System*, 104.

Visitors, such as inspectors from the General Nursing Council, would have little chance of seeing the real situation, as they gave warning of their arrival weeks ahead.[182] Internal critics were stifled. As one nurse remembered, 'if you raised your eyebrows, and said something about it, word got around that you could be bit of a troublemaker'.[183] He was hauled up in front of the nursing tutor to be told, 'I hear you've been giving Mr so and so a bit of a rough time and don't you realise that he's been here in this hospital for a long time. He's a well-respected member of staff'. Peter Nolan interviewed 20 nurses who started their careers in the 1940s and found that the majority of the men considered that mental hospitals were places 'run for the convenience and enjoyment of the staff'.[184] They experienced the charge nurses wielding 'a sometimes tyrannical sword' to run their wards.[185]

This localised power could be put to good purpose. As one commentator stated, 'the whole purpose and vocation of mental nursing becomes clear in one small act of affection by the nurse, which is entirely spontaneous'.[186] Their compassion would create an atmosphere that both improved the situation of the patients and the staff.[187] A young doctor's overwhelming impression on arriving at Bexley Hospital was the devotion of the male nurses to their patients and their skill in managing them.[188] A number of reports emphasise the attempts of nurses to alleviate the conditions in which they found their patients.[189] In another hospital, a charge nurse and his staff helped to stop the indiscriminate, and ineffectual, use of insulin therapy, in the process rebuffing the doctor who had prescribed it.[190] At De La Pole Hospital, it was they who demanded that the doors were opened.[191] These humanitarian efforts, however, relied on the initiative of the nurse employing them rather than a systematic approach to patient care.[192] They, like those who were deliberately abusive, were probably in the minority. Most responded to the conditions that they found by adapting, as did those they were looking after, and by becoming institutionalised.

This power was maintained precariously. The mutual aim of the nursing hierarchy and their subordinates was to keep things quiet in a state of 'order, quietness and tidiness'.[193] There was always the fear for junior staff that if they rocked the boat their promotion prospects would be jeopardised, stifling innovation. Nurses who opposed this culture could be

[182] Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 61.
[183] INGCE3, interview, 7.
[184] Nolan, *A History of Mental Health Nursing*, 107.
[185] Nolan, 133.
[186] Goddard, *The Work of the Mental Nurse*, 119.
[187] Nolan, *A History of Mental Health Nursing*, 112.
[188] Dr Peter Sainsbury in Wilkinson, *Talking about Psychiatry*, 137.
[189] Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 359.
[190] Nolan, *A History of Mental Health Nursing*, 132.
[191] Bickford, 'The Forgotten Patient II One Solution', 970.
[192] Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 361.
[193] Denis V. Martin, *Adventure in Psychiatry*, Second (Oxford: Bruno Cassirer, 1974), 9.

ostracised or made the subject of 'very spiteful and derogatory remarks'.[194] Any enquiry by doctors into how patients were behaving that reflected on nursing practice was viewed with suspicion and hostility.[195]

Senior nurses often colluded with those running the wards, tolerating them being 'firmly in control at ward level' and 'effectively in charge'.[196] Psychiatric hospitals were frequently the largest local employer, absorbing husbands, wives and children from the same families.[197] As Diana Gittins found at Severalls Hospital, it was a 'way of life'.[198] One informant described how family members were preferred for promotions and how they formed cliques running an 'internal Mafia'.[199]

The sway of this group of staff was enhanced by their trade unions, as observed by the inquiries into abuse at mental hospitals.[200] The recruitment was helped by the fact that, until 1958, all male mental nurses and those females without general nursing qualifications were excluded from membership of the Royal College of Nursing.[201] Sociologist J. P. Martin argues that, although they were set up to negotiate pay and conditions of service, their ambit extended to reviewing hospital policy and administration and anything that affected their members' work.[202] They tended to be more concerned with 'union solidarity than with professional criteria'.[203] Nursing researcher Audrey John found that joining the main union (COHSE) was part of this defensiveness.[204] At Severalls Hospital, in defiance of the policy of the Regional Hospital Board, local union agreements ensured that all promotions for male nurses were internal.[205] Elsewhere, the union was seen to collude with management in suppressing complaints.[206] Where the nurse who was carrying out the abusive behaviour was an officer of the union, they were almost untouchable.[207] At Warley in the 1970s, the union held sway, with recurrent strikes emulating the nearby Ford car works at Dagenham, abuse of overtime working by nurses and a general intent to maintain the status quo.[208] It was not until new management was appointed that their influence was curtailed at the

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[194] Martin, 34.
[195] Martin, 11.
[196] National Health Service, 'Report of the Farleigh Hospital Committee of Inquiry', 19.see also Martin and Evans, *Hospitals in Trouble*, 109.; Gittins, *Madness in its place narratives of Severalls Hospital, 1913-1997*, 57, 183–184.; National Health Service, 'Report of the Farleigh Hospital Committee of Inquiry', 19.; Beardshaw, Thorold, and Social Audit Ltd, *Conscientious Objectors at Work*, 32.
[197] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 50.
[198] Gittins, 47.
[199] Gittins, 184.
[200] Gittins, 63.; Jones and Sidebotham, *Mental Hospitals at Work*, 68.National Health Service, *Report of the Committee of Inquiry into Normansfield Hospital.*, 12.
[201] John, *A Study of the Psychiatric Nurse*, 119.
[202] Martin and Evans, *Hospitals in Trouble*, 141.
[203] Ibid., 94, 192–195.
[204] John, *A Study of the Psychiatric Nurse*, 119.
[205] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 181.
[206] Beardshaw, Thorold, and Social Audit Ltd, *Conscientious objectors at work*, 34, 42,50.
[207] Beardshaw, Thorold, and Social Audit Ltd, 50.
[208] INGCE31, interview, 31.

expense of threats being made to the nursing officer. Again, the story is complex, in at least two hospitals trade unions were set up in opposition to the management in order to effect changes for the better, both for patients and the staff.[209]

At Warlingham Park Hospital, the long-serving 'hard core' of male nurses, artisans, senior female nurses, and senior doctors maintained the traditions and determined the culture.[210] At Severalls, the split between the male and female halves of the hospital arguably led to, and maintained, the patriarchal domination within the hospital.[211]

The nurse-patient relationship was the fulcrum around which the rest of the hospital functioned and yet the former were largely confused about their task.[212] Caught in the transition between the traditional custodial role and the much publicised, but little evidenced, therapeutic revolution that was alleged to be taking place, their status could be little more than jailors, farm labourers or 'skivvies', cleaning the ward floors and bathing their charges.[213] They had little identifiable perspective, beyond that of 'common sense', of how patients should be treated.[214] In David Clark's view, their main role was to 'watch the patients to see that they didn't escape or harm one another'.[215]

The custodial approach was hard to sustain. The level of tension and anxiety could be extremely high, particularly prior to the introduction of psychotropic drugs in the mid-1950s.[216] The neglected patients were frustrated, often expressing aggression defying the

[209] Mattis, interview, 7; INGCE31, interview, 27.
[210] T. P. Rees, 'Back to Moral Treatment and Community Care', *The British Journal of Psychiatry*, vol. 103, no. 431 (1957): 310.
[211] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 127.
[212] John, *A Study of the Psychiatric Nurse*, 123.
[213] For transition see: Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 37–38; Kathleen Jones, 'The Role and Function of the Mental Hospital', in *Trends in the Mental Health Services*, ed. Hugh Freeman and James Farndale, (Oxford: Pergamon Press, 1963), 60–66; A. R. May, 'Observations on Training the Psychiatric Nurse', in *Psychiatric Hospital Care*, ed. Hugh Freeman, (London: Balliére, Tindall, & Cassell, 1965), 28.; J. K. Wing and G. W. Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960 - 1968.*, (Cambridge: Cambridge University Press, 1970), 4.; Towell, *Understanding Psychiatric Nursing*, 13. For lack of evidence of therapeutic improvements see: Simon Goodwin, "Community Care for the Mentally Ill in England and Wales: Myths, Assumptions and Reality," *Journal of Social Policy*, vol. 18, no. 1 (2009): 29,; For working practices see: John, *A Study of the Psychiatric Nurse*, 37–40; Richard A. Hunter, 'The Rise and Fall of Mental Nursing', *The Lancet*, vol. 267 (1956): 99.
[214] Annie T. Altschul, *Patient-Nurse Interaction; a Study of Interaction Patterns in Acute Psychiatric Wards*, University of Edinburgh. Dept. of Nursing Studies. Monograph No. 3 (Edinburgh: Churchill Livingstone, 1972), 191.; Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 360.; Martin, 'Institutionalisation', 1190.
[215] Wilkinson, *Talking about Psychiatry*, 80.
[216] Dermot J. Ward, 'The Central Function of the Mental Nurse', *International Journal of Nursing Studies*, vol. 4 (1967): 180. Forty years later this custodial aspect of ward care continued to be a source of conflict and stress for nurses. Jocelyn Handy, 'Stress in Mental Health Nursing: A Sociopolitical Analysis', in *Stress and Coping in Mental Health Nursing*, ed. J. Carson, L. Fagin, and S. Ritter, (London: Chapman and Hall, 1995), 55–56. See also Alex Baker in Wilkinson, *Talking about Psychiatry*, 197.

onerous restrictions.[217] David Clark experienced on some wards, at Fulbourn Hospital in 1953, 'an air of tremendous tension. You felt frightened the whole time, and watched your back. You knew there was a very real chance that somebody would try and hit you with something'.[218] The senior ward nurse faced conflicting responsibilities emanating from the ward doctor, the consultant, the nursing hierarchy and the administrator.[219] This role confusion was heightened by the aspirations expressed in their training that conflicted with the realities of ward life, and the expectations of observation rather than therapy.[220]

Stress-inducing decisions are avoided by carrying out ritual tasks.[221] Sociologist Isabel Menzies found that general nurses managed by carrying out routinized work for patient groups doing paperwork, housekeeping and routine chores, thereby restricting their contact with individuals.[222] This was reinforced by depersonalising, categorising and denying the significance of patients' feelings.[223] Mental hospital inspections concentrated on the physical status of the wards. Maintaining cleanliness often had a higher priority than patient care.[224] Customs such as spending the morning cleaning the floors were remarked upon by many nurses.[225] As one recalled, 'there was an obsession with polished floors. There were these lovely wooden floors. They had to be polished every day'.[226] In the absence of domestic staff, the nurses and the patients carried out the cleaning, with 'them big 'bumper machines'.[227] By the end of a twelve-hour shift, they would be physically exhausted, short tempered and bored.[228]

When Audrey John observed that the lack of communication led to 'something of a battlefield, with the patients as the prize over which medical and nursing professions fought', she omitted the endemic warfare between staff and their charges.[229] The struggle to establish control was central. 'Institutionalisation' was seen as beneficial. The patient

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[217] Goffman, 'Characteristics of Total Institutions', 313–14; T. P. Rees and M. M. Glatt, 'The Organization of a Mental Hospital on the Basis of Group Participation', *International Journal of Group Psychotherapy*, vol. 5 (1955): 157.
[218] Wilkinson, *Talking about Psychiatry*, 79.
[219] Barton, *Institutional Neurosis*, 16.
[220] Desmond Cormack, *Psychiatric Nursing Observed*, (London: Royal College of Nursing, 1976), 88.
[221] Isabel Menzies, 'The Function of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital.', in *Containing Anxiety in Institutions: Selected Essays*, ed. Isabel Menzies Lyth (London: Free Association Books, 1988), 54–55.
[222] Menzies, 51.
[223] Menzies, 52–53.
[224] At Prestwich in the early 1970s the matron would visit the ward and check that the beds were all in line, the wheels turned all to the same angle and she would measure the turn down of the bedclothes. Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 359. See also: John, *A Study of the Psychiatric Nurse*, 75–77, 97.; Nolan, *A History of Mental Health Nursing*, 109.
[225] INGCE6, interview, 2. See also Cherry, *Mental Health Care in Modern England*, 260; Pryor, *Claybury: A Century of Caring*, 108.
[226] INGCE9, interview, 4–5.
[227] INGCE6, interview, 2.
[228] John, *A Study of the Psychiatric Nurse*, 108.
[229] John, 74–75.

settling into the rhythms and restrictions of institutional life was expressed as: 'He gives no trouble, doctor, he is very cooperative'.[230] Once established, however, it proved frustrating 'because everything you do is useless… you are trying so hard and you don't get any response from them'.[231]

iv. The 'Corruption of Care'[232]

Four themes emerge from the forgoing account. The first is the pervasiveness of abusive practice, and the endemic denigration of those incarcerated. Second is the accompanying pervasive fear, particularly affecting patients, but not unknown to staff. This was sustained by ambivalence at every level, from the hospital to government, towards improving the situation. Finally, there was evidently compassion expressed by staff in wide ranging situations, but the system neither facilitated it, nor recognised its value. This was left to the reformers whose passion for change is well expressed by Dr T.P. Rees, in his presidential address to the Royal Medico-Psychological Association in 1957, when he emphasised the values of trust, kindness and the importance of the patient's happiness and self-respect.[233]

How could such 'corruption of care' arise, and how could it pervade mental hospitals throughout the United Kingdom? Possible explanations provide an embarrassment of riches. Professor J. P. Martin provides a list of causes categorised under seventeen headings ranging from policy issues to personal failings.[234] Certainly, diverse factors in dissimilar situations led to homologous outcomes, to which the 22 inquiries in to conditions at different hospitals carried out between 1969 and 1980 testify.[235]

Rival groups jockeyed to make sense of their roles in institutions isolated from, and largely neglected by, the world outside. It is a common feature of critiques of the medical profession to employ the term 'power', as in *The Power of Psychiatry*.[236] This deterministic approach suggests that a particular action executed by someone in possession of knowledge, authority or other social lever has predictable consequences. It implies the capacity to direct the behaviour of others to pursue a particular course. However it is much easier to use power to stop an activity than to make individuals do something else, and certainly this form of negative power was exercised widely by different groups of people.

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[230] John, 92; see also Martin, 'Institutionalisation', 1188.
[231] A nurse describing her experience in Sholom Glouberman, *Keepers : Inside Stories from Total Institutions* (London: King Edward's Hospital Fund for London, 1990), 92.
[232] A term used by Martin and Evans, *Hospitals in Trouble*, 108.
[233] Rees, 'Back to Moral Treatment and Community Care', 303–6.
[234] Martin and Evans, *Hospitals in Trouble*.
[235] J. P. Martin helpfully lists these at the end of his book: Martin and Evans, 256–57.
[236] Miller, P., and Rose, N. *The Power of Psychiatry* (Cambridge [Cambridgeshire] : New York, NY, USA: Polity Press ; Blackwell, 1986).

Denis Martin found that these tensions led to the creation of a 'vicious cycle': as peoples' freedom of expression ossified, the superintendent learnt less and less of what was happening.[237] His anxieties would increase and he would respond by 'tightening up control'. His isolation would increase, whilst the staff became dissatisfied and resentful. This iterated down the hierarchy to the patients who would respond by either being subdued and institutional, or express their frustration in violence. In turn, staff became alienated from the people they were expected to care for and consequently maintained a determinedly rigid, regimented and aggressive attempt to control their 'fiefdoms'.

The outcome was the estrangement of those providing care from the experience of those receiving it. This was exemplified by how the Hospital Management Committee at Farleigh Hospital, on their regular visits of inspection, confined their comments to the 'usual high standard of hygiene and physical care', whilst remaining unaware of, or ignoring, the on-going violence towards patients in one of the wards.[238] This attitude is reflected in the account by Dr G.S. Nightingale, the medical superintendent of Warley from 1945 to 1969. In his history of his period of office, the few times he mentions those in his care they are reified figures, such as 'senile but harmless patients' or 'adolescent drug addicts'.[239] He concentrates on the architectural and staffing changes made in the hospital, with occasional asides mentioning a visit of the Duchess of Kent or an epidemic of tuberculosis.

At ward level, it was the philosophy by which unit functioning was maintained. Any patient behaviour that interrupted this was objectified as either pathological or delinquent.[240] Elizabeth Bott viewed the social task of the hospital at this time as being to confirm the sanity of the patients' relatives, and by extension the external community through isolating those deemed mad.[241]

When a member of staff arrived at Ingrebourne, they were 'totally surprised that I was treated as a person and that anything I said in the staff meetings, for example, was considered as important as anybody else's'. [242] Unsurprisingly, this was far preferable to the 'big loony bin' which was not a 'terribly inspiring environment', where, as a junior staff member, 'you can pipe up and nobody hears you'. Not only did the Centre represent a greater freedom and respect for those receiving treatment, this applied to the staff as well.

[237] Martin, *Adventure in Psychiatry*, 105–6.
[238] National Health Service, 'Report of the Farleigh Hospital Committee of Inquiry', 7.
[239] Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953*, 26, 29.
[240] David Towell gives a detailed description of how nurses handled the behaviour of two patients who were identified in this way. Towell, *Understanding Psychiatric Nursing*, 57–81.
[241] Bott, 'Hospital and Society', 125.
[242] INGCE20, 2014, 1&2.

2. Emerging from Despondency: Reform in British Mental Health Services 1950-1970

Without understanding the ambivalences, paradoxes and variety of experiences, it is easy to make simplistic assertions like that made by the lecturer in mental health Liam Clarke, who states that 'change came about through a small group of enthusiastic medical superintendents and despite sustained opposition from mental nurses'.[243] This succinct summary culled from the pages of professional journals ignores the role of the many staff who were involved, and the influence of external organisations which could enable, or stifle, innovation.[244] As an instance, the matron appointed to Severalls in 1957 pointed out that Dr Barton took 'the credit for all the open wards', whereas in fact they had started the process before he arrived.[245] Further, the board that appointed him 'broke with tradition' to do so, rather than appointing the deputy superintendent.[246] Dr Bickford, at De La Pole Hospital, made it clear that he was indebted to support of the chief male nurse, Peter Archer, in instituting the reforms there.[247] In many instances, nursing staff were prevented from initiating changes.[248] Clarke also neglects the role of 'whistle blowing' nurses who triggered a number of the inquiries carried out later on.[249] The complexity is deepened when it is recognised that these descriptions largely relate to the longer-term wards where patients would stay for years, even decades. The acute admission wards often had been upgraded to being relatively attractive places to stay at the expense of those incarcerated for longer.[250]

With this proviso, the following will make reference to those people whose names are attached to various reforms largely because they had the time and motivation to publish accounts of the events described here.[251]

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[243] Liam Clarke, 'The Opening of Doors in British Mental Hospitals in the 1950s', *History of Psychiatry*, vol. 4, no. 4 (1993): 527.

[244] The National Health Service Hospital Advisory Service report for 1969 – 1970 drew attention to the variation in Regional Boards and Hospital Management Committees in supporting modernisation of mental handicap and mental illness services. Department of Health and Social Security, *National Health Service Advisory Service: Annual Report for 1969-70* (HMSO, 1971), 15, 20,26.; Se also Nolan and others, 'Mental Health Nursing in the 1950s and 1960s Revisited', 335.

[245] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 152.

[246] Gittins, 67.

[247] Bickford, 'The Forgotten Patient II One Solution', 971.

[248] Nolan, *A History of Mental Health Nursing*, 132.; Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', 358.

[249] E.g. at Ely and Farleigh hospitals for many years suppressed efforts by student nurses to do something about ill-treatment of patients. J. P. Martin and Debbie Evans, *Hospitals in Trouble* (Oxford: B. Blackwell, 1984), 13.

[250] Stanley Smith, 'The Role of the Admission Unit in Mental Hospital Work', in *Psychiatric Hospital Care*, ed. Hugh Freeman (London: Balliére, Tindall, & Cassell, 1965), 43–49.

[251] Archivist Craig Fees points out that this is where oral histories would prove valuable. Personal communication.

i. 'Shadow and Substance': Social Reforms in British Psychiatric Services in the 1950s and 1960s

Any account of reform in British psychiatric hospitals must acknowledge that attempts to achieve better conditions for their residents has a history extending back for over two centuries.[252] It also has to be recognised that such challenges did not just emanate from professionals. People who had been incarcerated also expressed their opinions more or less successfully, such as the Alleged Lunatics' Friend Society in the nineteenth century.[253] This account commences in the period between the two World Wars. Some activists began their work during this time and many others were influenced by the events of the second conflict. Then, the protagonists of reform and their motivations will be portrayed before giving a description of the nature of some of those changes. The development of the therapeutic community approach is deferred to Chapter Four.

ii. Between the Wars

At Warley Hospital, the intention to indicate 'a more hopeful outlook in the care and treatment of the insane' was effected by dropping the word 'Asylum' and renaming it the 'Brentwood Mental Hospital' in 1920.[254] The medical emphasis was given particular impetus through publication of the findings of the Royal Commission on Lunacy and Mental Disorder in 1926, which stated 'there is no clear line of distinction between mental and physical illness'.[255] This was exemplified at Warley by the inclusion of 'clinical rooms' on each ward and the establishment of a laboratory, x-ray unit and operating theatre. New treatments such as malarial therapy, prolonged narcosis and chemical convulsant therapy were introduced.[256]

Occupation for the patients was also catered for with the conversion of an older building into workshops, a 'needle room' and an 'occupational centre'.[257] Separation of the 'chronic'

[252] Kathleen Jones, *A History of the Mental Health Services* (London; Boston: Routledge and Kegan Paul, 1972).
[253] Nicholas Hervey, 'Advocacy or Folly: The Alleged Lunatics' Friend Society, 1845-1863', *Medical History*, vol. 30 (1986): 245–75.
[254] The details in this paragraph are all from Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953*, 27.
[255] Houses of Parliament, *Report of the Royal Commission on Lunacy and Mental Disorder* (London: HMSO, 1926), 15.
[256] These were part of a battery of physical treatments that were 'new' discoveries during this period. Some of them were still being used in the 1950s. Malarial therapy involved infecting the patient through the bite of specially kept mosquitoes. The apparent benefit was derived from the accompanying fever. Continuous narcosis required the administration of strong sedatives to induce the patient to sleep for twenty hours out of twenty four. Chemical convulsant therapy required the induction of epileptic fits through administering Cardiazol or similar drugs. All taken from William Sargant and Eliot Slater, *Physical Methods of Treatment in Psychiatry*, (Edinburgh: Livingstone E.S. Ltd, 1944).
[257] Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953*, 27.

wards from the more active acute wards was accomplished by the establishment of a separate 'Admission Unit' for men.[258]

The reality that lay beneath this platitudinous narrative by Warley's medical superintendent was exposed when Dr Montague Lomax revealed deep-seated concerns about the physical abuse endured by patients at Prestwich Hospital.[259] He criticised the gloomy, dilapidated and dirty state of the buildings, the poor diet and clothing of the patients and the unjust and tyrannical behaviour of those looking after them.[260] This aroused a great deal of publicity, leading to questions being raised in the House of Commons. The subsequent enquiry concluded that, whilst patients were poorly fed and clothed and there was a lack of trained staff, there was no evidence of cruelty or abuse.[261] Despite failing to vindicate Lomax's claims, public disquiet led to the establishment of a Royal Commission on Lunacy and Mental Disorder, which in turn led to the Mental Treatment Act of 1930.[262] This made provisions for voluntary treatment of patients rather than the previous system of formal detention and also encouraged less restrictive approaches to therapy.[263] Dr Humphrey Kidd, a psychiatrist writing in 1967, saw the reforms in mental hospitals following the Second World War as originating in the provisions of this Act, as it enabled people to be treated of their own free will.[264] At Warley, this encouraged the development of out-patient clinics, extending the 'parole' system that allowed patients to spend time outside the hospital and the unlocking of some ward doors, presaging the 'open door' movement after the war.[265]

Other innovations of the period included the opening of psychiatric observation wards in general hospitals to serve as 'sorting houses' for emergency admissions prior to disposal to relevant services. [266] These were the precursors to the unit at St George's hospital to which Dr Crocket was appointed in 1954.

One practitioner whose work straddled the Second World War was Dr Thomas Percy Rees. His first act on becoming the Medical Superintendent of the 900-bed Warlingham Park Hospital in 1935 was to 'throw open' the hospital gates, intending that they should never be closed again.[267] This was the opening salvo of the 'open-door' movement that took as its

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[258] A similar women's unit was deferred due the interruption of the Second World War.
[259] Montague Lomax, *The Experiences of an Asylum Doctor: With Suggestions for Asylum and Lunacy Law Reform.* (London: George Allen and Unwin, 1921), http://ia601506.us.archive.org/14/items/39002041606220.med.yale.edu/39002041606220.med.yale.edu.pdf.
[260] John Hopton, 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care', *History of Psychiatry*, vol. 10, no. 3 (1999): 351.
[261] Jones, *A History of the Mental Health Services*, 233.
[262] Jones, 237–46.
[263] Jones, 249–50.
[264] Humphrey Kidd, 'The Modern Role of the Mental Hospital', in *New Aspects of the Mental Health Services*, ed. Hugh Freeman and James Farndale, (London: Pergamon Press, 1967), 481.
[265] Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953,* 28.
[266] J. Hoenig and M. W. Hamilton, *The De-Segregation of the Mentally Ill*, The International Library of Sociology and Social Reconstruction (London: Routledge & Kegan Paul, 1969), 7–8.
[267] Anon, 'Obituary: Thomas Percy Rees', *The Lancet*, vol. 281(15 June 1963): 1331.

model a romanticised notion of the Moral Treatment of the nineteenth century.[268] Seven years later only two of twenty-two wards were closed, and by 1954 all were open.[269] The inspiration for these reforms came from a visit to some Dutch and German hospitals in 1928 where the patients were fully occupied and the hospitals were a 'hive of activity'.[270]

Medical historians Chris Lawrence and George Weisz argue that between the two World Wars many in the medical field were pursuing the idea of holistic medicine.[271] Outside of the mental hospital, there was a rising tide of interest in psychology.[272] This included the psychologist, William McDougall, whose 'purposive' and group psychology theories were familiar to many of the psychiatrists referred to here.[273] Indeed, it would be possible to argue that 'group-mindedness' and a holistic stance to psychiatry were inseparable. Joshua Bierer, the founding psychiatrist of the Marlborough Day Hospital and a group therapist, was explicit in his embracing of a 'universal' approach to patients using physical, social or psychological methods according to their needs.[274]

In particular, there was an increasing interest in psychoanalytical ideas amongst many doctors, although they were not universally popular amongst psychiatrists.[275] Dr James Crichton-Browne, whilst not unsympathetic to psychological approaches, found the sexual nature of the purported internal world offensive.[276]

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[268] Rees, 'Back to Moral Treatment and Community Care'.
[269] Anon, 'Freedom in Mental Hospitals', *The Lancet*, vol. 264 (1954): 964.
[270] Rees, 'Back to Moral Treatment and Community Care', 309.
[271] *Greater than the Parts: Holism in Biomedicine, 1920-1950* (New York: Oxford University Press, 1998), 1–18. Albeit, as Lawrence points out in another essay this was associated in the medical profession with an elitist sceptism of the reductionism implicit in laboratory sciences and a requirement of an education in 'higher' culture. They feared for their status in the face of 'mass' culture. Christopher Lawrence, 'Still Incommunicable: Clinical Holists and Medical Knowledge in Interwar Britain', in *Greater Than the Parts: Holism in Biomedicine 1920-1950*, eds. Christopher Lawrence and George Weisz (New York, Oxford: Oxford University Press, 1998), 94–111.
[272] Mathew Thomson has exhaustively catalogued the fields in which this area of interest was developing. These included intelligence testing, industrial psychology, children's education and welfare, shellshock and war neuroses, as well as popular approaches to self-improvement. Mathew Thomson, *Psychological Subjects : Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006). The rise of psychoanalysis has also been well documented. E.g. Paul Roazen, *Freud and His Followers*, (Harmondsworth, Middlesex: Penguin Books, 1979).; Eli Zaretsky, *Secrets of the Soul: A Social and Cultural History of Psychoanalysis*, (New York: Vintage, 2005).
[273] His book, *The Riddle of Life,* explicitly argues against mechanistic models of human interaction, based on purely physical systems. W McDougall, *The Riddle of Life*, (London: Methuen & Co., 1938).
[274] J. Bierer and R. I. Evans, *Innovations in Social Psychiatry: A Social Psychological Perspective through Dialogue* (London: The Avenue Publishing Co., 1969), 27.
[275] Thomson, *Psychological Subjects*, 95.
[276] Trevor Turner, 'James Crichton-Browne and the Anti-Psychoanalysts', in *150 Years of British Psychiatry: Volume II The Aftermath*, eds. Hugh Freeman and German. E Berrios (London: Athlone Press, 1996), 147.

iii. The Second World War and its Aftermath

For most hospitals, the Second World War was a period of stasis and often regression. Some were closed for war duties and their patients transferred to other already overcrowded mental hospitals.[277] All lost staff to the services. Amongst these were a number of psychiatrists and other professionals recruited from the Tavistock Clinic.[278] They formed a group who melded their psychoanalytic leanings with a pragmatic outlook, critically reviewing traditional military practice and introducing an evidence-based approach to organisation. This had a profound effect on military recruitment, officer selection, an understanding of morale and management of psychiatric casualties.[279] In particular, their emphasis was on intelligence and technical skill in soldiers.[280] They believed that these men needed to understand the nature of the war and the enemy they were fighting, rather than blindly submitting to orders.[281] The Adjutant-General to the Forces, General Sir Ronald Adams, was appalled at the lack of comprehension in those he met early in the war and actively promoted weekly discussion groups about current affairs.[282] It was widely thought that the work of the Army Bureau of Current Affairs, that produced the educational material for these meetings, was significantly responsible for the success of the Labour Party in winning the post-war election.[283] Whilst this is unlikely to be true, it reflected a broader approach to public education pursued by the Labour press in presenting the Beveridge Plan. This laid out the basis for the Welfare State and its promised sense of security and health for the post-war world that recent historians have argued promoted a positive enthusiasm for socialist ideas.[284] It conceived of a society in which the state made provision to tackle the

[277] Patients from Hollymoor Hospital in Birmingham were transferred to other hospitals in the city when it was taken over by the Emergency Medical Services. Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 155. Parts of Warley Hospital were evacuated in order for general medical and surgical services from the London Hospital to move in. Members of staff, including four doctors, were called up and joined the forces. Forty patients from Severalls Hospital also had to be accommodated following the bombing of that unit. Nightingale, *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953*, 30. See also Jones, *A History of the Mental Health Services.*, 1972, 270.

[278] R. H. Ahrenfeldt, *Psychiatry in the British Army in the Second World War* (London: Routledge and Kegan Paul, 1958); Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*; B Shephard, *A War of Nerves: Soldiers and Psychiatrists 1914 - 1994* (London: Jonathon Cape, 2000); Henry Victor Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge & K. Paul, 1970), 102–10.

[279] Privy Council Office, *Report of an Expert Committee on the Work of Psychologists and Psychiatrists in the Services* (London: HMSO, 1947).

[280] Shephard, *A War of Nerves: Soldiers and Psychiatrists 1914 - 1994*, 189.

[281] Roger Broad, *The Radical General: Sir Ronald Adam and Britain's New Model Army 1941-1946* (Stroud: History, 2013), 13.

[282] Broad, 126.

[283] S. P. Mackenzie, *Politics and Military Morale: Current-Affairs and Citizenship Education in the British Army, 1914-1950*, Oxford Historical Monographs (Oxford : New York: Clarendon Press ; Oxford University Press, 1992), 174–177. Actually in June 1945 there were 4,531,300 men and women serving in the Armed Forces of whom only 1,710,000 voted out of a total of 25 million total votes cast. Angus Calder, *The People's War: Britain 1939 - 1945* (London: Pimlico, 1992), 581–83.

[284] Geoffrey G. Field, *Blood, Sweat, and Toil: Remaking the British Working Class, 1939-1945* (Oxford: Oxford University Press, 2013), 335–42; Peter Sloman, 'Rethinking a Progressive Moment: The Liberal and Labour Parties in the 1945 General Election: The Liberal and Labour Parties in the 1945 General Election', *Historical*

giants of *Want, Disease, Ignorance, Squalor and Idleness*.[285] It was actively promoted by left-wing papers, such as the *Picture Post*, the *Daily Mirror* and the *Daily Herald*, which provided simple, clear and graphical explanations of its proposals.[286]

How much experience in the services influenced psychiatrists in general is not clear. David Clark's involvement demonstrated to him how men's psychological health could be 'influenced by the way in which they were led' and, similarly, a 'lively, vigorous and hopeful leadership' would result in improvements in the hospital residents.[287] He explained that military service had torn psychiatrists from the enclosed world of their mental hospitals and consulting rooms and 'plunged them into the turmoil of army training camps, tented hospitals and combatant units and made them forcibly aware of the tremendous power of social factors for affecting men's thinking and feeling'.[288] On the other hand, there is little evidence that Crocket experiences in the Royal Air Force influenced his practice, and few appear to have come to the same conclusions as Clark.[289] Many accounts of how military service influenced psychiatric practice after the war rely heavily on extrapolating from two specialist units at Northfield and Mill Hill.[290] Most serving psychiatrists came nowhere near these institutions and were thinly spread across the globe in different arenas of action, often working as general medical officers.[291]

Research, vol. 84, no. 226 (2011): 722–44. The politics of those involved with the Tavistock Clinic have never been spelt out. However, the psychiatrist, Dr John Rickman, received a letter from his friend, Arthur Heard, celebrating the Labour victory stating 'which you and I took a humble part in'. Arthur Heard, 'Letter to John Rickman, 14/8/1945', 1945, British Psychoanalytic Society.

[285] Sir William Beveridge, *Report on Social Insurance and Allied Services*, Cmd. 6404 (London: HMSO, 1942), 6.

[286] Field, *Blood, Sweat, and Toil*, 339.

[287] Clark, *The Story of a Mental Hospital*, 40.

[288] D. H. Clark, 'The Therapeutic Community - Concept, Practice and Future', *British Journal of Psychiatry*, vol. 111 (1965): 947.

[289] There are a number of interviews with psychiatrists in *Talking about psychiatry*. Whilst some of them were psychiatrists or medical officers in the Army, and had a range of extraordinary experiences, none of them referred to the impact that this experience had on their subsequent practice. Wilkinson, *Talking about Psychiatry*, 1993.

[290] S. Ramon, *Psychiatry in Britain: Meaning and Policy* (London: Croom Helm, 1985), 152.

[291] Of the senior psychiatrists whose careers were deemed worthy of record in the *British Journal of Psychiatry*, Dr John Howells, Dr. Max Hamilton, Sir William Trethowan and Dr Peter Sainsbury all worked as general medical officers. Drs Hare and Rawnsley missed active service because of physical conditions. Dr Alex Baker, who was active in reforming Banstead Hospital, became the Area Military Psychiatrist for Aldershot and learned a great deal about family psychiatry, running an out-patient clinic and organising his time. Interviews in Wilkinson, *Talking about Psychiatry*, 1993.

iv. Influences on Reform: Social Psychiatry

Historian Nick Crossley makes it clear that the shift to provide alternatives to mental hospital care at this time is not easily explained.[292] He argues that the mental health field was evolving through its own internal dynamics and this is especially true of the 1950s when there was scant public or political interest.[293] A leading article in *The Lancet* in 1956 stated 'change has arisen not from deliberate policy but from the internal needs of the hospital itself'.[294] Another historian, Nicolas Henckes, suggests that, whilst there were clearly entrepreneurial figures involved and that reforming 'the psychiatric institution was a project with diverse meanings for many different actors', there were underlying factors that enabled them.[295] These included the discourse about social factors in operation in institutions and new career opportunities available to psychiatrists. In Britain, this was particularly exemplified by the expanding numbers and influence of consultant medical staff. Two contemporary researchers considered that the 'changing balance of opinion in psychiatric practice… is the resultant of current social, economic, and even political theories, and not merely of strictly clinical considerations'.[296]

Social psychiatry was actively promoted through the relationship of some British psychiatrists and their American counterparts.[297] A major import to the UK was a sequence of textbooks on social psychiatry during the 1950s. A central generator of this interaction was the Tavistock Institute of Human Relations, both through its joint production of the

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[292] N. Crossley, *Contesting Psychiatry* (London: Routledge, 2006), 65. He refers to the competing explanations of such people as Andrew Scull, Nikolas Rose, Kathleen Jones and Joan Busfield. In particular, commenting on the economic drivers, he relates this to the later 1970s, rather than the immediate post-war period.

[293] Houses of Parliament, *Report: Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957*, Cmnd 169 (London: HMSO, 1957), 22 paras 67-68.

[294] Anon, 'Leading Article: Preventive Psychiatry', *The Lancet*, vol. 267 (1956): 1087.

[295] Nicolas Henckes, 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis', *History of Psychiatry*, vol. 22, no. 2 (2011): 173.

[296] G. M. Carstairs and A. Heron, 'The Social Environment of Mental Hospital Patients: A Measure of Staff Attitudes', in *The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behaviour*, eds. Milton Greenblatt, Daniel J Levinson, and Richard J Williams (Glencoe, Illinois: The Free Press, 1957), 226.

[297] Professor Ronald Hargreaves, of Leeds, presented a paper on British psychiatry at the same conference in which Erving Goffman gave his first account of *The Characteristics of Total Institutions* the precursor to his book on *Asylums.* Hargreaves, G. R. 'Current Developments in Social Psychiatry in Britain. In eds. David McK. Rioch, *Symposium on Preventive and Social Psychiatry 15-17 April 1957*, 401-408. (Washington D. C.: Walter Reed Army Institute of Research, Walter Reed Army Medical Centre, 1957). In addition, other British psychiatrists presented papers at a 1957 American conference at which research on the sociological aspects of mental hospital care was presented. Milton Greenblatt, Daniel J Levinson, and Richard J Williams, *The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behaviour* (Glencoe, Illinois: The Free Press, 1957). In 1957, the Royal Medical Psychological Association and the Royal Society of Medicine organised a joint Anglo-American symposium where distinguished American psychiatrists shared their views on teaching, mechanisms of mental illness and treatments. Anon, "Joint Meeting of the Royal Society of Medicine (Section of Psychiatry and the Royal Medico-Psychological Association (Maudsley Bequest)," *The British Journal of Psychiatry* 104, no. 435 (1958): 491–491. .[297] Psychiatrist Joshua Bierer established the *International Journal of Social Psychiatry*, which aimed at a global audience, but particularly carried both British and American articles. See for instance the first issue *International Journal of Social Psychiatry,* vol. 1, no 1 (1955).

journal, *Human Relations,* with the Research Centre for Group Dynamics at MIT in Massachusetts and its book publishing arm which acquired the British publishing rights for a number of American academic publishers.[298] This resulted in the publication simultaneously in both countries of the seminal study of therapeutic community hospital culture, *The Mental Hospital*, by Alfred Stanton and Morris Schwartz.[299] The significance of this study is that it links disparate accounts of how people react within differing sociological spaces and concludes that the result of traditional institutional treatment is 'apathy and withdrawal' of the patients and the 'stultification and boredom or withdrawal' of the staff.[300] They contrast this with the interpersonal relationships developed in units run by Harry Stack Sullivan for young men with psychosis and a 'Therapeutic Milieu' for children described by Bruno Bettelheim and Emmy Sylvester.[301] They also refer to Tom Main's and Maxwell Jones' work during the Second World War (see Chapter Four). David Clark learned from it that the animosities and collusions of the staff could result in disruptive behaviour in their patients.[302] These approaches shifted the focus of disturbed behaviour from pathology in the patient to disturbed relationships in the staff team. It was followed a year later by *From Custodial to Therapeutic Care in Mental Hospitals*, a study of the transformation of a traditional hospital milieu to one based around social treatment.[303] The impact of these is indicated by the fact that they were reviewed in the *Journal of Mental Science* and were regularly cited in British publications on social psychiatry.[304] This stream peaked with the seminal *Asylums* (1961) by the sociologist, Erving Goffman.[305] That this work was taken seriously by practising psychiatrists is evidenced by Dr Douglas Bennett and his colleagues

[298] The TIHR was itself set up through American money in the form of the Rockefeller Foundation. Henry Victor Dicks, *Fifty Years of the Tavistock Clinic* (London: Routledge & K. Paul, 1970), 207-208; Diana Burfield, "Tavistock Publications: a Partial History.," *Management and Organizational History*, vol. 4, no. 2 (2009): 208-209.

[299] Alfred H. Stanton and Morris S. Schwartz, *The Mental Hospital: A Study of Institutional Participation in the Treatment of Psychiatric Illness*, (London: Tavistock Publications, 1954). David Clark considered that it was the study that had the greatest impact on social psychiatrists. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 8.

[300] D. C. Watt, Review: 'The Mental Hospital: By Alfred J. Stanton, M.D. and Morris S. Schwarz, Ph.D. Tavistock Publications, Ltd., London, 1954. Pp 492+xx. Price 35s', *Journal of Mental Science*, vol. 102, no. 428 (1956): 341.

[301] Sullivan, *Conceptions of Modern Psychiatry*, 1955; Bruno Bettelheim and Emmy Sylvester, 'A Therapeutic Milieu', *American Journal of Orthopsychiatry* 18 (1948): 191–206.

[302] Clark, *The Story of a Mental Hospital*, 40.

[303] This time not through Tavistock Publications Milton Greenblatt, Richard H. York, and Esther Lucille Brown, *From Custodial Care to Therapeutic Patient Care in Mental Hospitals.* (New York: Russell Sage Foundation, 1955).

[304] D. C. Watt, Review: "The Mental Hospital: By Alfred, H. Stanton, and Morris S. Schwartz, Tavistock Publications, Ltd., London, 1954", *Journal of Mental Science*, vol. 102, no. 428 (1956): 624; D. C. Watt, Review: 'From Custodial to Therapeutic Patient Care in Mental Hospitals: By Milton Greenblatt, M.D., Richard, H. York, Ph.D., and Esther S. Brown, Ph.D. Russel Sage Foundation, New York, 1955, *The British Journal of Psychiatry*, vol. 103, no. 431 (1957): 418. Citations e.g. M. Jones, *Social Psychiatry: In the Community, in Hospitals, and in Prisons*, (Springfield: Charles C Thomas, 1962), 125-126; D. H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, Mind and Medicine Monographs 9 (London: Tavistock, 1964), 152; Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 6.

[305] And continues in print to the present day. Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 1968.

employing the term 'total institution' in their article on developing a resettlement unit at Netherne Hospital in 1961.[306] Two contemporary researchers considered that the 'changing balance of opinion in psychiatric practice… is the resultant of current social, economic, and even political theories, and not merely of strictly clinical considerations'.[307]

The reforms were part of an international movement. Dr Ronald Hargreaves, a member of the Tavistock group during the Second World War, established the Mental Health Section of the World Health Organisation.[308] In this role, he organised a series of Expert Committees on Mental Health that included contributors from China, India, Thailand, Chile, Brazil, the USA and Europe.[309] They produced a programme that Henckes describes as 'utopian', but which reflected the drive to provide better care of people with mental health problems.[310] One strand was the establishment of community mental hospitals in association with out-patient services, psychotherapy, social clubs and day hospitals, reported on in 1953.[311] This document was endorsed by Clark, who agreed that 'the most important single factor in the efficacy' of treatment in hospital was the 'atmosphere'.[312] The elements of this were that the patient's individuality should be preserved, they should be assumed to be trustworthy, capable of responsibility and initiative, good behaviour should be encouraged and there should be a programme of planned, purposeful activity. Henckes argues that the vision promoted by this organisation provided both terms of reference for the debates on mental health in France, as well as ammunition for particular groups to achieve their own goals.[313]

Historian, Michael Staub, argues that this move to a social model of politics and personality offered a more optimistic view of human nature.[314] Derived from the work of the American sociologist, Kurt Lewin, it was found that through practical experience social attitudes could be modified. He argues that this was the forerunner of approaches adopted by the New

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[306] This was before the publication of *Asylums* and referred to his earlier paper given in 1957. Erving Goffman, 'The Characteristics of Total Institutions', in David McK. Rioch, ed., *Symposium on Preventive and Social Psychiatry: 15-17 April 1957* (Washington D. C.: Walter Reed Army Institute of Research, Walter Reed Army Medical Centre, 1957); Douglas Bennett, Steven Folkard, and Audrey K. Nicholson, 'Resettlement in a Mental Hospital Unit', *The Lancet*, vol. 278 (1961): 539.

[307] Carstairs and Heron, 'The Social Environment of Mental Hospital Patients: A Measure of Staff Attitudes', 226.

[308] Anon., 'Obituary: G. R. Hargreaves', *British Medical Journal*, vol. 1, no. 5323 (1963): 62–63.

[309] Expert Committee on Mental Health, 'Report on the First Session', Technical Report (Geneva: World Health Organization, 1950), http://apps.who.int/iris/bitstream/10665/37979/1/WHO_TRS_9.pdf.; Expert Committee on Mental Health, 'Report on the Second Session', Technical Report (Geneva: World Health Organization, 1951), http://apps.who.int/iris/bitstream/10665/37982/1/WHO_TRS_31.pdf; Expert Committee on Mental Health, 'Third Report: The Community Mental Hospital', Technical Report (Geneva: World Health Organization, 1953), http://apps.who.int/iris/bitstream/10665/37982/1/WHO_TRS_73.pdf.

[310] Henckes, 'Narratives of Change and Reform Processes', 512.

[311] Expert Committee on Mental Health, 'Third Report: The Community Mental Hospital'.

[312] Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 26; Expert Committee on Mental Health, 'Third Report: The Community Mental Hospital', 17–19.

[313] Henckes, 'Narratives of Change and Reform Processes', 512.

[314] Michael E. Staub, *Madness Is Civilization: When the Diagnosis Was Social, 1948 -1980* (Chicago: University of Chicago Press, 2011), 30.

Left. This political shift is less easy to identify in the UK, although much of the rhetoric in the different papers by social reformers would have been consistent with a socialist agenda.[315]

No account of social change in post-war Britain can ignore the impact of American culture, ideology and technology. Culturally, music, film and increasingly television all served to continue and expand on the effects of United States military personnel stationed in the UK during the war and the increasing influence of the entertainment industry prior to it.[316] Economic dependence on the US influenced, and at times determined, government policy.[317] Their technology, business practices and industrial strength all served to provide a barrage of challenges to British commercial life.[318] This dominance over the United Kingdom led to cultivating the 'Special Relationship' during 1945-1951 being a matter of necessity rather than choice.[319] Indeed the effort put into 'modernising' British industry was part of a deliberate offensive to 'stabilise' Europe against the communist menace posed by Russia.[320] It is beyond the scope of this essay to identify more than a few of the more immediate channels by which this trans-Atlantic inundation affected psychiatric practice in the United Kingdom, but it is worth remembering that it also served to energise significant conflicts as well.[321]

The Anglo-American relationship in medicine was part of the wider trans-global ascendance of the English language as a medium for communication.[322] In an era when travel to America was expensive and relatively rare, psychiatrists often crossed the Atlantic in both directions

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[315] It is difficult to identify any specific political alliances by those involved in reform. However the comments by Heard to Rickman have already been referenced in an earlier footnote (281), and Richard Crocket's choice of the *Observer*, a left-leaning newspaper, to present his attack on the 'conservative' medical superintendents is also perhaps indicative.

[316] Angus Calder, *The People's War : Britain 1939 - 1945* (London: Pimlico, 1992), 306–11. This influence is captured by Harry Hopkins' describing the 'rapturous welcome' of the 'endless procession of American stars of 'stage, screen and radio'', who 'marched into the spotlight'. Harry Hopkins, *The New Look: A Social History of the Forties and Fifties in Britain*, 1st American Ed. (Boston: Houghton Mifflin, 1964), 109.

[317] Brian Howard Harrison, *Seeking a Role: The United Kingdom, 1951-1970*, New Oxford History of England (Oxford : New York: Clarendon Press ; Oxford University Press, 2009), 100.

[318] Anthony Sampson described the impact of American business practices in the take-over of British Aluminium, in 1958, that led to the undermining of 'the old boy network' in British banking. Anthony Sampson, *Anatomy of Britain* (London: Hodder and Stoughton, 1962), 387–92.

[319] Succinctly expressed by Prime Minister Harold Wilson when questioned about his reluctance to criticize the American war in Vietnam, he responded 'because we can't kick our creditors in the balls'. Quoted in Harrison, *Seeking a Role*, 10.

[320] Nick Tiratsoo, 'Limits of Americanisation: The United States Productivity Gospel in Britain', in *Moments of Modernity: Reconstructing Britain 1945-1964*, eds. Betty Conekin, Frank Mort, and Chris Waters (London; New York: Rivers Oram Press, 1999), 97.

[321] Scientology, founded by American entrepreneur Ron Hubbard, started their campaign against psychiatry in the 1960s. As a result of their attack on the National Association for Mental Health this organisation changed its name to become MIND installing an American lawyer, Larry Gostin as their director of Legal and Welfare Rights department. He went on to campaign for reform in the law, and to attack the conditions present in psychiatric hospitals. N. Crossley, *Contesting Psychiatry* (London: Routledge, 2006), 134–139; Larry O. Gostin, *A Human Condition*, vol. 1&2, 2 vols (London: MIND, 1975).

[322] John C. Burnham, 'Transnational History of Medicine after 1950: Framing and Interrogation from Psychiatric Journals', *Medical History*, vol. 55 (2011): 3–26.

to share ideas and experiences.[323] Dr Edward Mapother, the Medical Superintendent of the Maudsley Hospital, went on an exploratory mission in 1930, and found much to admire, as well as hospital overcrowding everywhere. The Second World War saw an increasing collaboration both in the civilian and the military.[324] In 1950 Dr Harry Wilmer spent time working with Maxwell Jones and met with Joshua Bierer, T. P. Rees and Tom Main before returning to establish a therapeutic community in Oakland, California.[325] David Clark was invited to spend a year at Stanford University in California after spending six weeks lecturing throughout the country in 1961.[326] Maxwell Jones was Common Wealth Visiting Professor in Psychiatry at the University of Stanford from 1959 to 1960, where he gave a series of lectures later to be published in book form, following two years working at Oregon State Hospital.[327] In 1957, the Royal Medical Psychological Association and the Royal Society of Medicine organised a joint Anglo-American symposium where distinguished American psychiatrists shared their views on teaching, mechanisms of mental illness and treatments.[328] The psychiatrist, Joshua Bierer, established the *International Journal of Social Psychiatry*, which aimed at a global audience, but particularly carried both British and American articles.[329] Crocket attended a lecture in London given by Dr Moreno the American 'father' of Psychodrama in 1954 and later went on a lecture and 'discovery' tour to the US himself.[330]

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[323] For travel to America: Andrew Rosen, *The transformation of British life, 1950-2000 : a social history* (Manchester, UK; New York; New York: Manchester University Press, 2003), 151. There were 6 British speakers at the conference in America that led to the publication of *The Patient and the Mental Hospital* in 1957. Milton Greenblatt, Daniel J Levinson, and Richard J. Williams, eds. *The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behaviour* (Glencoe, Illinois: The Free Press, 1957). In the case of Dr John Hamilton, the physician superintendent of the Bethlem Hospital, he was sent to America, ostensibly to study psychiatric practice there, whilst the medical director at the Maudsley Hospital manoeuvred to take his hospital over, and abolish his post. Keir Waddington, 'Enemies Within', in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, eds. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam-Atlanta, GA: Rodopi, 1998), 194.

[324] Stephen Casper, 'The Origins of the Anglo-American Research Alliance and the Incidence of Civilian Neuroses in Second World War Britain.', *Medical History*, vol. 52 (2008): 327–46. The evidence for the latter is less well researched, however John Rickman organised a number of joint conferences of British psychiatrists at which American practitioners attended. (I have in my possession a photograph of one such, at which a Lt Kelly of the USA army is present). The senior staff of the Menninger Clinic visited services in 1946 and this resulted in the staff of the Northfield Experiment having their papers published in the Bulletin of that organisation. Karl Menninger, 'Foreword', *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (May 1946): 65.

[325] Harry A. Wilmer, *Social Psychiatry in Action: A Therapeutic Community.* (Springfield Illinois: Charles C Thomas, 1958).

[326] Clark, *The Story of a Mental Hospital*, 1996, 181–83.

[327] M. Jones, *Social Psychiatry in the Community, in Hospitals, and in Prisons.* (Springfield: Charles C Thomas, 1962), xix.

[328] Anon., 'Joint Meeting of the Royal Society of Medicine (Section of Psychiatry and the Royal Medico-Psychological Association (Maudsley Bequest)', *Journal of Mental Science,* vol. 104, no. 435 (1958): 491.

[329] See for instance the first issue *International Journal of Social Psychiatry,* vol. 1, no 1 (June 1955).

[330] R. F. Marineau, *Jacob Levy Moreno 1889-1974: Father of Psychodrama, Sociometry, and Group Psychotherapy* (Tavistock/Routledge, 1989). Crocket was not impressed finding this 'apostle of psychodrama … 'worked up feeling by vibrant self-expression'. R. W. Crocket, 'Diary 9: 1954 - 1975', 17th May 1954, Planned Environment Therapy Trust. R. W. Crocket, 'Memorandum: Dates of American Trip 14th May 1968 to 15th June 1968', 1968, Planned Environment Therapy Trust.

v. Influences on Reform: The Psychiatrists

Most of the expressed concern about the state of psychiatric hospitals came from the psychiatrists until the later 1950s.[331] As the century progressed, economic arguments began to take the foreground. Andrew Scull argues that the increasing range of welfare programs enabled the cheaper option of community care to replace the more expensive asylum treatment.[332] On the other hand, historian Joan Busfield argues that the delay in closing the mental hospitals was due to the financial stringencies of the 1970s.[333] But initially the energy for reform appears to have stemmed from the activities of a relatively limited number of doctors. Sociologist Shulamit Ramon argues that although they acted in an unco-ordinated manner, they were cognisant of each other's activities.[334] This is particularly evidenced through the articles and correspondence published in the pages of the medical journal, *The Lancet*.[335]

The influence of the bodies overseeing the mental disorder services in Britain was mainly handicapped by their ignorance, conservatism, or their pre-occupation with broader medical services.[336] The sole Regional Hospital Board to develop a clear plan was in Manchester and even this relied on doctors to initiate and implement it.[337] As has been described earlier, nursing staff were poorly educated, defensive, demoralised and trapped into cycles of denial. Those recruited from outside of the hospital 'mafias' and who might have had different ideas, rarely entered the profession with any clear idea of how to proceed and were rapidly enmeshed into the prevailing practices. A few stood out to oppose this such as Annie Altschul, who as principle nursing tutor at the Maudsley Hospital promoted a professional approach.[338] She published a practical, theoretically-based textbook in 1957

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[331] E.g. J. A. R. Bickford, 'The Forgotten Patient', *The Lancet*, 917–919; T. P. Rees and M. M. Glatt, 'Mental Hospitals', in *The Fields of Group Psychotherapy*, ed. S. R. Slavson, (New York: International Universities Press, 1956), 17–39.; Denis V. Martin, 'Institutionalisation', *The Lancet*, Vol. 266 (1955): 1188.; Alexander Watt, 'Overcrowding in Mental Hospitals, Relief from the Outpatient Clinic', *The Lancet*, vol. 268 (1956): 1096–1098.

[332] Andrew Scull, *Decarceration : Community Treatment and the Deviant : A Radical View* (Cambridge: Polity Press, 1984), 135.

[333] Busfield, *Managing Madness*, 348–49.

[334] Ramon, *Psychiatry in Britain: Meaning and Policy*, 154.

[335] The overwhelming number of articles concerning the conditions in and the management of mental hospitals and correspondence related to it consulted in this thesis came from the *The Lancet*. A few were published in the *International Journal of Social Psychiatry* and there were occasional ones in the *British Journal of Psychiatry* (incl. its forebear the *Journal of Mental Science*) and the *British Medical Journal*. The reason for this bias is unclear. It is likely that the Maudsley-dominated editorial board of the *British Journal of Psychiatry* would have been reluctant to publish such material, especially if it was not 'scientific'.

[336] As recorded earlier, the only member of a Hospital Management Committee known to have a significant influence on the services under his chairmanship, David Rhydderch, eventually was defeated by the intransigence of the medical superintendent.

[337] S. Smith, 'Psychiatry in General Hospitals: Manchester's Integrated Scheme.', *The Lancet*, vol. 277 (1961): 1158.

[338] Robert Howard, 'Psychiatry in Pictures: Annie Alschul Teaching Psychiatric Nurses, 1950s, Bethlem Hospital', *British Journal of Psychiatry*, vol. 183 (2003): A22.

that emphasised an active, holistic psychosocial approach.[339] Her influence took many more years to have any impact.

Only the medical profession had the necessary knowledge, social position, and statutory authority available to energise change. As importantly, they had networks, stretching beyond the confines of the hospital or region, through which they both shared intelligence and influenced national policy. The Royal Medico-Psychological Association served these functions through its house journal, conferences and providing members of the Royal Commission into Mental Health Law.[340] Their impact included their involvement in the National Association for Mental Health until its transformation into MIND in 1971.[341] Those practitioners who were skilled enough to combine these resources effectively were rapidly promoted as 'hero-innovators' and have embodied this mythical role to the present day, excluding their many collaborators from received history.[342]

Marxist historian Andrew Scull is particularly critical of humanitarian impulses, arguing that historiography should move away from such 'rhetoric of intentions'.[343] In the face of this form of critique, it has to be recognised that reforming hospital practice was not to be undertaken lightly. As one doctor expressed it, 'The psychiatrist often feels that he is expected to undertake an arduous and exacting task without reasonably adequate equipment and help'.[344] Clark recalled, 'one of the heaviest burdens to bear' at this time 'was the sense of isolation'.[345] Medical historian Vicky Long argues that disparate reformers shared a view that the care of psychiatric patients needed transforming.[346] She finds that their accounts offer only a partial and distorted insight into their states of mind.[347] Whilst clearly their narratives are selective, it is difficult to ignore the evident compassion. Sir William Sargant, a passionate adherent of the physiological approach to mental disorder, expressed his anger about the state of chronically-untreated patients in the mental hospital where he was himself under treatment.[348] Clark recalled feeling at that time 'guilty

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[339] A. Altschul, *Aids to Psychiatric Nursing*, (London: Balliére, Tindall, & Cox, 1964).

[340] At least two of the four medical members were psychiatrists T. P. Rees, and D. H. H. Thomas. There were 11 members all told and no other psychiatric professionals were represented. House of Commons, 'Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957.' (London: HMSO, 1957), iii.

[341] Dr Kenneth Soddy, a child psychiatrist, was 'medical director' and Dr R.F. Tredgold, an adult psychiatrist, edited the journal. Nick Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health', *Sociology of Health and Illness*, vol. 20, no. 4 (1998): 475.

[342] Peter Nolan, *A history of mental health nursing* (Cheltenham: Stanley Thornes, 1998), 113. For evidence of the necessity for collaboration see also Martin, *Adventure in Psychiatry*, 1974, 35.

[343] Scull, *Museums of Madness*, 15.

[344] 'The Forgotten Patient II One Solution', 971.

[345] D. H. Clark, 'Letter', *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 3 (2001): 6.

[346] Vicky Long, 'Adventures in Psychiatry: Narrating and Enacting Reform in Post-War Mental Healthcare', *Studies in Literary Imagination*, vol. 48, no. 1 (2015): 113.

[347] Long, 124.

[348] Ann Dally, his psychiatric colleague and biographer, argued that he was 'probably the only prominent psychiatrist in the twentieth century to express concern about the suffering of chronically mentally ill people'.

whenever I went out to a mental hospital and saw the neglected hundreds'.[349] Later, he was buoyed up by the 'enthusiasm for new solutions based on social restructuring and social engineering' that accompanied the inauguration of the welfare state.[350] Dr G. M. Bell at Dingleton, a pioneer of the open door movement, railed against the barbarities of mechanical restraint, seclusion and tube feeding, arguing that these 'barbarities are degrading to the nurse and the doctor, as well as the patient'.[351] Bickford fulminated about the patients he saw,

> clad in the shapeless garments so familiar to us; and if they are up they never wear shoes. Too often they are regarded as objects of disgust and even ridicule, and sometimes it seems that the attention paid to them is less than that accorded to the hospital's pigs.[352]

Their actions often emphasised the passivity of patients, but even this could change. Clark revised his views when forms of self-government were introduced to Fulbourn, acknowledging the importance of everyone in the community having an active part to play.[353] The TC movement would go furthest in undermining the one-way street of 'treatment flowing from the doctor downward'.[354]

A particular inspiration for a number of reformers stemmed from their association with Scottish psychiatrist David Kennedy Henderson. He reflected the Anglo-American relationship described above, and had close relationship with Adolf Meyer at the John Hopkins Medical School in Baltimore, Maryland.[355] The latter promoted a 'biopsychosocial' model of mental disorder, that acknowledges that there may be physical underpinnings, but recognises the influence of social and psychological factors that modify its expression and mechanism.[356] It emphasises the interplay of different factors in a way that allows for an approach that can be 'both scientific and humanistic' and engendered 'the possibility of genuine inter-disciplinary cooperation'.[357] This more 'optimistic' approach was promoted by

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Certainly this would be true of his colleagues at the Maudsley Hospital, but whether or not the psychiatrists described here were 'prominent' or not is open to interpretation. Ann Dally, 'Sargant, William Walters (1907-1988)', in *The Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004), http://www.oxforddnb.com; accessed 06/09/2018.

[349] Clark, *The Story of a Mental Hospital*, 40.

[350] D. H. Clark, 'The Therapeutic Community', *British Journal of Psychiatry*, vol. 131 (1977): 560.

[351] G. M. Bell, 'A Mental Hospital with Open Doors', *International Journal of Social Psychiatry* 1, no. 1 (1955): 42.

[352] Bickford, 'The Forgotten Patient', 919.

[353] Clark, 'The Therapeutic Community - Concept, Practice and Future', 950.

[354] Clark, 949.

[355] Hazel Morrison, 'Henderson and Meyer in Correspondence: A Transatlantic History of Dynamic Psychiatry, 1908–29', *History of Psychiatry*, vol. 28, no. 1 (2017): 72–86.; Jonathan Andrews and Iain Smith, 'The Evolution of Psychiatry in Glasgow during the Nineteenth and Twentieth Centuries', in *150 Years of British Psychiatry 1841-1991*, eds. German E. Berrios and Hugh Freeman (London: Gaskell, 1991), 328–29.

[356] David Pilgrim, 'The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future?', *Journal of Mental Health*, vol. 11, no. 6 (2002): 585–94.

[357] Pilgrim, 589, 593.

Henderson in the United Kingdom through his popular textbook on psychiatry, written in collaboration with W.H. Gillespie, which went through a number of editions between 1927 and the late 1970s.[358] His book on *Psychopathic States* particularly emphasises the social aetiology and symptomatology of disorders previously considered as organic in origin.[359] A number of the people involved in the therapeutic community approach were students of his, including Crocket and David Clark.[360] Another, Maxwell Jones, named the Henderson Hospital in his honour.[361]

Returning to the status of psychiatrists, Henckes argues that there were new career opportunities for psychiatrists in France and this also played a part in energising the reforms.[362] In the United Kingdom, the consultants were employed by the Regional Hospital Board, placing their career prospects largely outside the control of the medical superintendent. Encouraged by the Bradbeer Report, they increasingly felt able to operate independently.[363] The relaxing of this supervisory restraint enabled entrepreneurial activity in initiating changes in the parts of the hospital for which they were responsible. Crocket reminisced: 'I was pretty free. I was revelling in my ability to innovate and I was ready to go ahead without much… What was constraining me were internal traditional things that I'd acquired in my academic psychiatry'.[364] Henckes adds that this was also promoted as senior psychiatrists were replaced by younger colleagues.[365]

As the 1950s progressed, dissatisfaction with the provision of care in psychiatric hospitals became more a matter of public concern. A number of publications described the horrific experiences of those who had been incarcerated.[366] In the early years of the decade, an exception to public apathy was the activity of two Members of Parliament, Dr Donald Johnson and Mr Norman Dodds, who doggedly raised issues in the House of Commons and published a collection of people's experiences in hospitals.[367] This was supplemented by the increasing interest of Kenneth Robinson, Labour Member of Parliament, who led the first

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[358] M Gelder, 'Adolf Meyer and His Influence in British Psychiatry', in *150 Years of British Psychiatry 1841-1991*, eds. German E. Berrios and Hugh Freeman (London: Gaskell, 1991), 431.
[359] J. S. Whiteley, 'Guest Editorial: Maxwell Jones CBE MD FRCPsych FRCP(Ed)', *International Journal of Therapeutic Communities*, vol. 12, no. 2&3 (1991): 77; D. K. Henderson, *Psychopathic States* (New York: Norton, 1939).
[360] David Clark reported being deeply impressed by his 'interest in people'. Interview David Clark with Brian Barraclough Wilkinson, *Talking about Psychiatry*, 1993, 74. D. W. Millard, 'Richard Wilfred Crocket', *Psychiatric Bulletin*, vol. 31, no. 7 (2007): 278–278. Laing was also clearly influenced by his textbook. Allan Beveridge, *Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing, 1927-1960* (New York: Oxford University Press, 2011), 200–201.
[361] Whiteley, 'Guest Editorial: Maxwell Jones CBE MD FRCPsych FRCP(Ed)'.
[362] Henckes, 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis', 174.
[363] Ministry of Health, 'Report of the Committee on the Internal Administration of Hospitals'.
[364] R Crocket, 'PETT Interview (T) CF 272', 23 November 1998, 17, Planned Environment Therapy Trust.
[365] Henckes, 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis', 175.
[366] Johnson, *A Doctor Returns*; Jane Simpson, *The Lost Days of My Life* (London: George Allen and Unwin, 1958); Warr, *Brother Lunatic*; Wingfield, *The Inside of the Cup*.
[367] There is a sequence of questions asked by these two throughout the middle to later 1950s e.g. Hansard http://hansard.millbanksystems.com; Johnson and Dodds, *The Plea for the Silent*.

debate on the subject in the House of Commons for over quarter of a century, in 1954.[368] However, government action remained largely placatory with piecemeal funding made available until the publication of the *Hospital Ten-year Plan for England and Wales* in 1962.[369] The pressure for reform gained momentum with the publication of the Royal Commission report on mental health law which promoted voluntary treatment and laid the groundwork for the 1959 Mental Health Act.[370]

The pre-war mental hygiene movement continued to exert its influence, albeit divested of most of its eugenic trappings.[371] This was particularly evident in the preventative focus of the National Association for Mental Health.[372] Dominated by psychiatrists, its fundamental vision was that of a 'meritocratic social order founded on mental "ability" and emotional maturity', promoted through its journal, *Mental Health*.[373] From its post-war Medical Director, Kenneth Soddy, through to the reforming psychiatrist, T. P. Rees, runs the thread of 'solving the problem of the misfit' in 'virile and highly developed societies'.[374] Historian Jonathan Toms finds that, in spite of this, psychiatrists in the Association began to move away from seeing the mental patient as autonomous, to an approach that emphasised 'free communications between staff and between staff and patients'.[375]

There were also, during this decade, a number of local and national attempts to educate the public about mental disorders focussing on their 'curability'.[376]

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[368] Kenneth Robinson, Minister of Health in the mid-1960s, took a particular interest, and, through his chairmanship of the North West Metropolitan Regional Hospital Board Mental Health Committee, gained a great deal of first-hand knowledge. In this role, he repeatedly visited the hospitals responsible to the Board. Hugh Freeman, 'In Conversation with Kenneth Robinson (Minister of Health, October 1964-October 1968)', *Psychiatric Bulletin*, vol. 12, no. 7 (1988): 258. See also Jones, *A History of the Mental Health Services.*, 289; http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation

[369] In 1954 a "mental million" was made available to increase the number of beds in mental and 'mental deficiency' hospitals by 4,500. Hansard, "Debate: Mental Hospitals (staffing)," vol. 520 (London: HMSO, 1953), 1273, Nurses pay was regularly discussed. http://hansard.millbanksystems.com/commons/1953/nov/12/mental-hospitals-staffing. House of Commons, *A Hospital Plan for England and Wales*, Cmnd 1604 (London: HMSO, 1962).

[370] House of Commons, 'Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957.', 3–4.

[371] Jonathan Toms, *Mental Hygiene and Psychiatry in Modern Britain*, (Houndmills, Basingstoke: Palgrave Macmillan, 2013).

[372] Crossley, 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health.', 478.

[373] Toms, *Mental Hygiene and Psychiatry in Modern Britain*, 142.

[374] Soddy reviewed what he saw as the successes of military psychiatry in managing the problem of the unfit, and described how these lessons could be applied to civilian life. Kenneth Soddy, 'Some Lessons of Wartime Psychiatry, Pt 2', *Mental Health*, vol. 6, no. 3 (1946): 69. Sandison worked at Warlingham Park, under T.P. Rees, and described how the hospital 're-socialized' the patients in groups from those containing 'the most deteriorated and faulty' to the 'more advanced' in a clearly hierarchical system. R. A. Sandison, 'The Re-Socialization of the Psychiatric Case', *Mental Health*, vol. 10, no. 4 (1951): 88, 90.

[375] Toms, *Mental Hygiene and Psychiatry in Modern Britain*, 160. The quote comes from Emanuel Lewis, 'Book Review: Adventure in Psychiatry: Social Change in a Mental Hospital', *Mental Health*, vol. 23, no. 1 (1964): 26.

[376] In 1957 the BBC showed a sequence of five documentaries under the title of *The Hurt Mind*. These included films on psychological treatments, physical treatments and admission to hospital.

vi. The Nature of the Reforms

That most psychiatrists were wedded to a purely physical 'medical model' is unsurprising, trained, as they were, in fundamental biological sciences of anatomy, physiology, pharmacology and pathology. They had little exposure to psychology and even less to social sciences.[377] Their further education in psychiatry relied on journals and standard textbooks.[378] These predominantly followed the 'faulty machine' model of disease, mirroring other medical specialties.[379] The integration of mental health services with other branches of medicine, as a result of the implementation of the NHS, again promoted the application of physical and drug treatments. On the other hand, it resulted in most psychiatrists working together in the hospitals, rather than in private practice, as in other countries.[380] This burgeoning sense of professional identity led to the Royal Medico-Psychological Association reforming as the Royal College of Psychiatrists in 1972.[381]

Vicky Long argues that there was little consensus on how progress in treating patients was to be achieved.[382] She contrasts the physiological stance of Sir William Sargant with the social psychiatric approach of Denis Martin and David Clark. In 1958, these competing methodologies in psychiatry were illustrated by Crocket's friend, Jock Sutherland, addressing a conference on the subject of 'Stress and Psychiatric Disorder'. At this meeting, senior figures in the fields of physiology and psychiatry attempted to find a way to navigate the perplexity of different models of human reactions to environmental challenges. His contribution followed that of Dr Linford Rees, who took a physiological and pharmacological perspective and lauded the 'promising and fruitful field' of psychotropic drugs, such as chlorpromazine.[383] Sutherland, on the other hand, after describing the field as confusing because of the 'number and complexity of inter-related open systems contributing to

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https://www.bfi.org.uk/films-tv-people/4f4b999ee7395, accessed 20/06/2015. See also G. M. Carstairs and J. K. Wing, 'Attitudes of the General Public to Mental Illness', *British Medical Journal*, vol. 2, no. 5096 (1958): 594. Some hospitals made promotional films to attract new nursing recruits, such as the York Retreat's *Light Through the Clouds*. player.bfi.org.uk/film/watch-a-light-through-the-clouds-1955/

[377] Interview Robert Cawley with Greg Wilkinson, ed., *Talking about Psychiatry* (London : [Washington, D.C.]: Gaskell ; Distributed in North America by American Psychiatric Press, 1993). See also, for emphasis on physical treatments Michael Balint, *The Doctor, His Patient and the Illness*, 2nd ed., revised & enlarged, reprinted (London: Pitman Paperbacks, 1968), 282.

[378] Baruch and Treacher, in their trenchant critique of a general hospital unit, analysed the contents of the most popular textbooks on psychiatry, and the standard *British Psychiatric Journal* and found that organic models of mental disorder predominated. Geoff Baruch and Andrew Treacher, *Psychiatry Observed* (London; Boston: Routledge & K. Paul, 1978), 32–33.

[379] D. Russell Davis, 'Depression as an Adaptation to Crisis', *British Journal of Medical Psychology*, vol. 43 (1970): 109–116.

[380] Freeman, 'Psychiatry and the State in Britain', 126.

[381] Thomas Bewley, *Madness to Mental Illness: A History of the Royal College of Psychiatrists* (London: RCPsych Publications; 2008), 71–73.

[382] Long, 'Adventures in Psychiatry: Narrating and Enacting Reform in Post-War Mental Healthcare', 109.

[383] W. Linford Rees, 'Prevention and Treatment of Psychiatric Reactions to Stress by Physiological and Pharmacological Means.', in *Stress and Psychiatric Disorder*, ed. J. M. Tanner, (Oxford: Blackwell, 1960), 97–103: 103.

behaviour', took a psycho-social view.[384] Referring indirectly to the Ingrebourne and similar units, he described them as striving 'to become more open systems with much greater communication in the community and with more explicit handling of the patient's difficulties as psychosocial problems'. He discussed the difficulties of measurement in such systems and described some attempts to overcome these at the Tavistock Clinic, signifying the pressures to demonstrate discernible outcomes, an issue that was to dog therapeutic communities for the next half century.

For most psychiatrists, alignment with the 'medical model' was partial, with varying degrees of acknowledgement of psychological and social aspects. The influential psychiatrist, Dr Frank Fish, in 1965 explored the relationships in a sophisticated argument for balance.[385] Reminding his audience of the definition of medicine given by Henry Sigerist, the medical historian, he made it clear that psychiatry was not a natural science, but the application of science to enable individuals to fulfil their social role.[386] He recognised that a number of his colleagues were 'known to neglect' the importance of a social or psychological causation in many disorders. As 'Olympian clinicians' or 'medical technocrats', they were ill-equipped to handle the emotional and social problems and, instead, endeavoured to demonstrate their respectability through adopting the attitudes and techniques of their specialist medical colleagues.[387] Nevertheless, he welcomed the introduction of TC approaches in hospitals, but warned against simplistic reactions against their more organically-orientated contemporaries. This tendency was illustrated by Dr Richard Hunter vehemently weighing in against the use of physical treatments by doctors, 'jealous perhaps of the therapeutic advances in general medicine', who used 'instruments of restraint under the guise of treatment: hypoglycaemic, electrical and neurosurgical'.[388] This demonstrated a clear bifurcation in understanding between those who espoused a predominantly physical view of mental disorder and those who recognised the greater influence of the social.[389] In general, however, there was a spectrum of views, heavily weighted to the physical end, as Desmond

[384] J. D. Sutherland, 'Prevention and Treatment of Psychiatric Reactions to Stress by Psycho-Social Means.', in *Stress and Psychiatric Disorder*, ed. J. M. Tanner, (Oxford: Blackwell, 1960), 104–15.

[385] He published three standard textbooks on psychiatric disorder, All went into reprints, with other authors revising them. The most recent was *Clinical Psychopathology* in 2007. Frank Fish, *Schizophrenia*, (Bristol: John Wright and Sons, 1962); Frank Fish, *An Outline of Psychiatry for Students and Practitioners*, (Bristol: John Wright and Sons, 1964); Frank Fish, *Clinical Psychopathology: Signs and Symptoms in Psychiatry*, (Bristol: John Wright and Sons, 1967).

[386] Frank Fish, 'Psychiatry as a Medical Specialty', *The Lancet*, vol. 285 (1965): 565.

[387] Doroshow emphasises how the use of insulin therapy made psychiatry a more legitimate medical field in her historical review. D. B. Doroshow, 'Performing a Cure for Schizophrenia: Insulin Coma Therapy on the Wards', *Journal of the History of Medicine and Allied Sciences*, vol. 62, no. 2 (2006): 220.

[388] Hunter, 'The Rise and Fall of Mental Nursing', 99.

[389] Professor Michael Shepherd agreed with this distinction, on the one hand the general physicians/neurologists and, on the other, the general practitioner/community doctors. In Wilkinson, *Talking about Psychiatry*, 231.

Cormack found in the 1970s whilst researching psychiatric nursing.[390] He also noted that nursing staff tended to reflect the same views as the doctors they were working with.

The use of physical treatments at Warley included the use of electro-convulsive treatment, prefrontal leucotomies and an increasing 'consumption' of chlorpromazine.[391] In 1957, 650,000 tablets of this medication had been dispensed along with 250 gallons of the syrup, as well as injections and suppositories.[392] The difficulties arising for the pharmacy department in storing and dispensing a broadening variety of medications resulted in 'anything but tranquillity' for the pharmacist.[393] Nonetheless, experiments with new medications at the hospital were carried out with some judiciousness. A trial of a new American drug called Frenquel found that those patients on 'dummy' tablets also improved socially due to the increased attention being paid to them by staff.[394] These medical treatments were supplemented by escalating use of social therapies, work and occupational therapy, which necessitated major expansions of the departments involved.[395]

Despite their real and apparent antagonism, the two approaches to psychiatry were generally synergistic, at least in terms of influencing the wider public.[396] They gave hope to the more optimistic staff, for they were engaged in a '*furor therapeuticus*', as David Clark described it.[397] Doors were opened alongside the use of physical treatments and they were found to result in social change, enabling the nurses to feel more confident about relaxing their control.[398] In Scotland, the psychotherapeutically-orientated psychiatrist, Dr Thomas Freeman, saw nothing contradictory in administering insulin coma or electro-shock therapy alongside his psychoanalytic work.[399] Beside the increasing use of psychotherapies, there

[390] Crossley, *Contesting Psychiatry*, 64; Cormack, *Psychiatric Nursing Observed*, 87.
[391] London Metropolitan Archive, G. S. Nightingale, *Medical Superintendent's Report and Statistics for the Year 1955. Warley Hospital Brentwood*, Annual Report to Hospital Management Committee (Brentwood, Essex: Warley Hospital, 1955), 2, 12.
[392] London Metropolitan Archive, G. S. Nightingale, 'Medical Superintendent's Report and Statistics for the Year 1957. Warley Hospital Brentwood.', Annual Report to Hospital Management Committee (Brentwood, Essex: Warley Hospital, 1957), 11.
[393] Nightingale, 'Medical Superintendent's Report and Statistics for the Year 1956. Warley Hospital Brentwood.', 11.
[394] Nightingale, 'Medical Superintendent's Report and Statistics for the Year 1957. Warley Hospital Brentwood.', 2.
[395] London Metropolitan Archive, E. H. Pooley and A. G. L. Ives, 'Report to Warley Hospital Management Committee' (Warley Hospital, January 1956), 1.
[396] William Sargant was the main consultant to the documentary series *The Hurt Mind*, yet despite his strong antipathy to talking treatments the films cover a wide range of approaches including psychotherapy. Long, 'Adventures in Psychiatry: Narrating and Enacting Reform in Post-War Mental Healthcare', 111.
[397] Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 5.
[398] Clark illustrated how the apparent benefits of insulin therapy could be ascribed to the intense 'camaraderie' of the therapeutic team working with the patients. Apart from receiving the treatment which necessitated a great deal of vigilance by the staff because of its potential dangers, the recipients were subject to personal attention, called by their first names and encouraged to participate in games in which all took part. Clark, 6–7.
[399] T. Freeman, 'Perspective: An Occasional Series in Which Contributors Reflect on Their Careers and Interests in Psychiatry', *Psychiatric Bulletin*, vol. 12, no. 8 (1988): 307.

was a sense of 'something being done', and of hopefulness that echoed the broader enthusiasm for new technologies.[400]

Experimentation with different forms of treatment was accompanied by increasing attention to measuring their effects. The psychiatrists and psychologists pioneering social reforms in the British Army in the Second World War considered their approach to be scientific.[401] A central pillar was the increasing use of statistics to demonstrate outcomes.[402] Dr 'Jack' Rees, consulting psychiatrist to the British Army, argued that the techniques of scientifically-controlled studies they had learned in the war should be applied in civilian psychiatric practice, ensuring a 'new realism'.[403] In 1946, statistician L. S. Penrose lectured the Royal Medico-Psychological Society on the 'Social Aspects of Psychiatry: The Importance of Statistics', firmly allying practice with quantitative social research and equally firmly disassociating it from the influence of pre-war eugenic theory.[404]

These re-framings of 'psychiatric spaces' shifted them in two dimensions. The first was to change the geography, transposing the wards to new environments. The second was to increase their social permeability both internally and externally, enabling greater freedom of movement and ideation of patients and staff. Those at the Ingrebourne Centre attained both of these by being removed from the parent hospital and maintaining an 'open' ward. Transposition overtly carried with it aspirations of de-segregation, integration into 'the community' and de-stigmatisation. Behind these notions lay more complex aims concerning the professional aspirations of those involved in providing care. Alongside the doctors, the nurses, psychologists, social workers, administrators and occupational therapists also gained increasing confidence in promoting their professional standing, albeit at a slower pace.

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[400] Keir Waddington outlines the conflicting interests that led to the merger of the Bethlem Hospital and the Maudsley at this time. These were between interests that all subscribed to the idea that psychiatry was progressing, although in different ways. Keir Waddington, "Enemies Within," in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, eds. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam-Atlanta, GA: Rodopi, 1998): 192.

[401] Best expressed by Brigadier James, Consultant in Psychiatry to the Army at Home in 1945: 'The Officers of our Corps will one day recall with pride the courageous way in which the Army has used the sciences as aids to the Medical Service in war, and none has been more necessary or more widely applied than the lusty youth among the medical sciences that is known as psychiatry'. Brig. G. W. B. James, 'The Future of Psychiatry in the Army Medical Service.', *Journal of the Royal Army Medical Corps*, vol. 84 (1945): 51–53.

[402] Brigadier Rosie's summary of psychiatry during the conflict is replete with statistical evidence for their work. R. J. Rosie, 'Psychiatry in the Army', in *Medicine and Pathology*, ed. V. Zachary Cope, History of the Second World War (London: HMSO, 1952), 357–371. The summary of their work with psychologists published in 1947, is punctuated with percentages and figures, and includes a specific section that discusses the research and statistics used by the psychologists which they shared with their colleagues.Privy Council Office, 'Report of an Expert Committee on the Work of Psychologists and Psychiatrists i the Services' (London: His Majesty's Stationary Office, 1947), incl. 46. This attitude was carried through in the Tavistock Clinic where the mantra 'no research without therapy, no therapy without research' was current. Bill Cooke, 'The Tavistock's Everyday Use of Benzedrine, and More: On the Multiple Significances of DB, Scholar-Publisher', *Management and Organizational History* 4, no. 2 (2009): 203.

[403] J. R. Rees, *The Shaping of Psychiatry by War*, (New York: W.W. Norton, 1945), 151.

[404] L. S. Penrose, 'Social Aspects of Psychiatry: The Importance of Statistics', *Journal of Mental Science*, vol. 92, no. 389 (1946): 713–18.

One aim was to see people before their admission to hospital. Previously, this could only be carried out in the person's own home or in private rooms. The 1930 Mental Treatment Act authorised the establishment of psychiatric out-patient clinics in general hospitals.[405] There had been a scattering of clinics before this, but the Act created the conditions for their exponential expansion.[406] Dr Duncan Macmillan, a psychiatrist in Nottingham, rapidly took advantage of this and, during 1933, saw 85 patients referred by general practitioners for diagnostic and psychotherapeutic work in a room at the local general hospital.[407] This was augmented by the establishment of an out-patient department, clinics at other hospitals and, after 1952, increasing domiciliary work. The 1948 NHS Act opened the doors to general practitioners requesting home visits which, in Bristol, became unsustainable, and out-patient clinics were opened in order to solve this difficulty.[408] The numbers treated in this manner increased from 85 in 1933 to 3,100 in 1947 and then 15 years later to nearly 17,000.[409] By 1957, there were over 800 clinics where most psychiatrists would spend between 8 and 12 hours a week.[410] Such out-patient work was seen as a means to reduce the number of in-patients and thereby tackling the overcrowding in mental hospitals.[411] A significant proportion of Crocket's and his medical team's time was spent in seeing out-patients.[412]

Another approach was for people to attend day hospitals where they could spend various lengths of time during the day and return home for the evening and night. Joshua Bierer is credited with establishing the first British version in 1946.[413] This rapidly achieved fame as the Marlborough Day Hospital, having evolved into a TC.[414] A gradual trickle followed either attempting a full replacement for the in-patient service or serving a specific group of individuals. By 1961, the researcher James Farndale was able to visit a total of 42 and found that many more were planned.[415] By 1972, this increased to 145 units, alongside 177

[405] Jones, *A History of the Mental Health Services*, 250.
[406] In 1946 Dr Blacker carried out a survey of psychiatric out-patient clinics and found that, before 1929, there were 29 countrywide, following the passing of the 1930 Act, another 148 were established. Before 1919, there were only 7 in total. C. P. Blacker, *Neurosis and the Mental Health Services*, (Oxford: Humphrey Milford, 1946), 136–37.
[407] Duncan Macmillan, 'Requirements of an Integrated Mental Health Service (Psychiatric Out-Patient Needs Etc.)', in *Psychiatric Hospital Care*, ed. Hugh Freeman (London: Balliére, Tindall, & Cassell, 1965), 125.
[408] Donal F. Early, Glenside Hospital Museum, and Friends, *'The Lunatic Pauper Palace': Glenside Hospital Bristol, 1861-1994 : Its Birth, Development and Demise* (Bristol: Friends of Glenside Hospital Museum, 2003), 90.
[409] Macmillan, 'Requirements of an Integrated Mental Health Service (Psychiatric Out-Patient Needs Etc.)', 127.
[410] Jones, *A History of the Mental Health Services*, 298.
[411] Watt, 'Overcrowding in Mental Hospitals, Relief from the Outpatient Clinic'.
[412] R. W. Crocket, 'Memorandum: The Ingrebourne Centre: St George's Hospital, Hornchurch, 1955-1958', 1958, 1,4, Planned Environment Therapy Trust.
[413] J. Bierer, 'Letter: Day Hospitals', *The Lancet*, vol. 269 (1957): 888.
[414] R. D. Hinshelwood, 'The Seeds of Disaster', *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 181–88.
[415] James Farndale, *The Day Hospital Movement in Great Britain* (London: Pergamon Press, 1961), 2–4.

hospitals which also catered for day attendances, providing over 13,000 places in total.[416] Ingrebourne was one of the earliest, having established 20 day places in 1955.[417] It was unusual in that these were provided alongside the 20 in-patient beds.

A more radical form of translocation was to site the beds in a general medical hospital. In Manchester, the psychiatrists pressed for the development of general hospital units to prevent people being admitted to the mental hospitals.[418] By 1961, there were 12 such units in the region.[419] Elsewhere, the development of such units was unusual. Some observation wards were instituted after the 1930 Mental Treatment Act, but these largely were circumscribed in their function and did not provide a comprehensive service.[420] Dr Sands started treating psychiatric patients in a general hospital neuropsychiatric ward at Sutton Hospital in 1943, but there is no evidence that this continued after the war.[421] Despite a great deal of medical enthusiasm, their expansion was limited and, by 1971, less than four per cent of all psychiatric beds were in such units.[422] People, whose behaviour was too difficult or who were resident for over a year, were usually transferred to the mental hospital.[423] The numbers of those relocated could be very low, as in Bolton where only five people a year were moved.[424]

Attempts were made to instruct local authorities to provide services, particularly after the implementation of the 1959 Mental Health Act. The Chief Medical Officer, in the following year, proclaimed the benefits of joint working with local voluntary and statutory services and psychiatric hospitals, the provision of hostels, the establishment of 'half-way' houses to enable the transition from hospital care to work and help for old people in their homes.[425] The absence of financial assistance, or compulsion, curtailed any significant movement in

[416] Department of Health and Social Security Welsh Office, *Censuses of A. Patients in Mental Illness Hospitals and Units in England and Wales at the End of 1971: B. Mental Illness Day Patients in England and Wales at April 1972*, Statistical and Research Report Series ; No. 10 (London: HMSO, 1975), 40–41.
[417] Evelyn Tiley, 'Ingrebourne Centre: A Therapeutic Community', *Nursing Times*, 21st October (1966): 1399–1401. See also Crocket, 'Memorandum: The Ingrebourne Centre: St George's Hospital, Hornchurch, 1955-1958', 1.
[418] J. T. Leyberg, "A District Psychiatric Service: Bolton Pattern," *The Lancet*, vol 275 (1959): 282; Hugh Freeman, 'Oldham and District Psychiatric Service', *The Lancet*, vol. 275 (1960): 218.
[419] Smith, 'Psychiatry in General Hospitals: Manchester's Integrated Scheme.'
[420] Hoenig and Hamilton, *The De-Segregation of the Mentally Ill*, 7–8.
[421] E. Sands, 'Treatment of Psychiatric Patients in General Hospitals: A Social Experiment.', *British Medical Journal*, vol. 1, no. 4298 (1943): 628–30.
[422] Department of Health and Social Security Welsh Office, *Censuses of A. Patients in Mental Illness Hospitals and Units in England and Wales at the End of 1971*, 6. The British medical press, in particular *The Lancet*, carried a significant number of papers written by doctors lauding the benefits of their particular unit. This author has collected in excess of 30 such papers published between 1943 and 1969
[423] H. S. Capoore and J. W. G. Nixon, "Short-stay Psychiatric Unit in a General Hospital," *The Lancet*, vol. 278 (1961): 1351–1352; J. Hoenig and I. M. Crotty, "Psychiatric Patients in General Hospitals," *The Lancet*, vol. 274 (1959): 22–23; C. P. B. Brook, 'Psychiatric Units in General Hospitals', *The Lancet*, vol. 284 (1964): 684–86.
[424] Leyberg, 'A District Psychiatric Service: Bolton Pattern', 282.
[425] Chief Medical Officer, 'Report of the Ministry of Health for the Year 1960, Part II: On the State of the Public Health.' (London: HMSO, 1961), 98–99.

this direction.[426] The Seebohm Report in 1968 stated that community care 'is, for many parts of the country still a sad illusion and judging by published plans will remain so for years ahead'.[427] This conclusion was confirmed seven years later by the White Paper, *Better Services for the Mentally Ill*, which lamented the fact that 'supportive services in a non-medical, non-hospital setting are still a comparative rarity.[428] Thirty-one local authorities had no residential accommodation and sixty-three no day-care facilities. By 1979, 'care in the community' remained a political promise rather than a reality.

Alternatively, the patients' living space could be modified. In the spirit of Tom Main's 1948 dictum that, 'man is primarily a social animal, in whom satisfaction or frustration results largely from his relations with others', the social environment became the object of change.[429] This flew in the face of the still influential eugenics movement. Lt-Col. Petrie stated in his inaugural presidential address to the Royal Medico-Psychological Association in 1945 that the 'intricate subject of heredity has two aspects - the positive one of producing efficient citizens, and the negative one of preventing the unnecessary spread of bad and unstable stocks'.[430]

Following in the wake of Dr Rees at Warlingham, Dr Bell at Dingleton Hospital had all the doors opened by 1949.[431] Dr Duncan Macmillan achieved a similar result three years later at Mapperley Hospital in Nottingham.[432] At Claybury Hospital, with 53 wards, by 1955 all but two of the male wards were open. However, on the female side, 14 remained closed.[433] At Warley by 1957, 11 of the 16 male wards were opened, and 13 of the 23 female wards.[434] The reason for this delay was the anxiety raised by the proximity to busy main roads and the railway.

Another approach was configured under the heading of 'rehabilitation'. Most hospitals had patients who worked in the sewing room, laundry, kitchen, gardens or on the wards. These were *ad hoc* arrangements to help reduce hospital costs and to provide occupation.[435] There

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[426] Busfield, *Managing Madness*, 346–49.
[427] Houses of Parliament, 'Report of the Committee on Local Authority and Allied Personal Social Services' (Londoo: HMSO, 1968), 107.
[428] Department of Health and Social Security, *Better Services for the Mentally Ill*, Cmnd 6233 (London: HMSO, 1975), ii.
[429] T. F. Main, 'Rehabilitation and the Individual', in *Modern Trends in Psychological Medicine*, ed. N. Harris, (London: Butterworth, 1948), 387.
[430] A. A. W. Petrie, 'Psychiatric Developments: The Presidential Address Delivered at the One Hundred and Third Annual Meeting of the Association on Wednesday, November 29, 1944', *Journal of Mental Science*, vol. 91, no. 384 (1945): 270.
[431] G. M. Bell, 'A Mental Hospital with Open Doors', *International Journal of Social Psychiatry*, vol. 1, no. 1 (1955): 42.
[432] Anon, 'Freedom in Mental Hospitals', 965.
[433] Martin, *Adventure in Psychiatry*, 18.
[434] Nightingale, 'Medical Superintendent's Report and Statistics for the Year 1957. Warley Hospital Brentwood', 3.
[435] E.g. Clark, *The Story of a Mental Hospital*, 49.; Early, Glenside Hospital Museum, and Friends, *'The Lunatic Pauper Palace'*, 97; Jones and Sidebotham, *Mental Hospitals at Work*, 89–91; Wing and Brown, *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960 - 1968.*, 91.;

were occupational therapy departments in most hospitals, but these were often poorly staffed and insufficient to cope with the demand.[436] Whilst the term 'rehabilitation' had been applied to wounded soldiers after the World Wars it was a late-comer to psychiatry. Industrial rehabilitation units largely concentrated on providing work training for people with physical difficulties in a time of a labour shortage with a small minority suffering from mental difficulties.[437] An exception to this was the establishment of the Industrial Neurosis Unit at Belmont Hospital under the leadership of Maxwell Jones in April 1947.[438]

It is evident that conditions within these hospitals improved for those enforced to live in them, but only by degrees. M. P. Christopher Mayhew visited Warlingham Park in 1957 and, though it was a 'good' hospital, it had grossly overcrowded, grimy wards and conditions were grim.[439] He realised that some of the patients' 'minds are elsewhere - quite outside our world'. Denis Martin was sceptical about the nature of these spatial reforms, making it clear that opening doors did not fundamentally change the relationships of authority of the staff and submission by the patients.[440]

3. Utopian ideals and Mundane Reality: Mental Hospitals in the Era of Anti-psychiatric Critiques 1959 to 1979

The 1959 Mental Health Act for Richard Crocket was another nail in the coffin of the medical superintendent and it was 'scarcely possible to over-estimate' its significance for therapy.[441] The rest of this chapter traces the changes in psychiatric practice following this legislation until the election of the Thatcherite Conservative government in 1979. This was a period of evolution marked by increasing public disquiet about the 'medical' model of mental disorder, but little actual change, despite the increasing pressure to close the hospitals and replace them with 'community care'.

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[436] E.g. Charles Gore and Kathleen Jones, 'Survey of a Long-Stay Mental Hospital Population', *The Lancet*, vol. 278 (1961): 544. One hospital was 'so large and the patients so numerous' that most were only able to attend for one day or less in a week. Jones and Sidebotham, *Mental Hospitals at Work*, 73

[437] Vicky Long, 'Work Is Therapy? The Function of Employment in British Psychiatric Care after 1959', in *Work, Psychiatry and Society, c. 1750-2015*, ed. Waltraud Ernst (Manchester: Manchester University Press, 2016), 337–38.

[438] M. Jones, *Social Psychiatry* (London: Tavistock, 1952), xiii.

[439] Andrew Miller Jones, *The Hurt Mind: Put Away*, Transcript, Documentary (BBC, 1957), http://ftvdb.bfi.org.uk/sift/title/10718. The document is not paginated.

[440] Martin, *Adventure in Psychiatry*, 8.

[441] R. W. Crocket, 'The Therapeutic Team in Ancient Hospitals with Modern Boundaries', 1961, Planned Environment Therapy Trust, 11; Richard Crocket, 'Community Therapy and the Boundaries of Group and Individual Hospital Treatment', 1962, 11, Planned Environment Therapy Trust.

i. The State Begins to Intervene

The 1959 Mental Health Act began to define what mental illness was, stipulated where it should be treated and categorised forms of compulsory admission.[442] Although making no change in the powers of the local authority it did clarify them and it 'followed in the spirit' the trends towards community care through enabling the treatment of patients voluntarily, informally and outside of the hospital.[443] Final authority for the management of patients passed from the medical superintendent to the treating consultant. It was this change that Crocket so welcomed, allowing him to take full responsibility for the patients in his care.

The next twenty years saw gradual, increasing politicisation of psychiatric practice with the medical hegemony being challenged by politicians, other members of staff, patients and most publicly a disparate group of radical thinkers grouped under the unsatisfactory title of 'anti-psychiatry'. Up until 1961, the push towards community care was carried through by psychiatrists in the mental hospitals, encouraged by the Chief Medical Officer in his annual reports.[444] The first major shot across their bows was fired by Enoch Powell, Minister for Health, when he announced in the same year that hospital beds would be reduced by half over the following fifteen years.[445] This was bolstered by a statistical analysis published the following month, which demonstrated that the number of occupied beds had fallen by 8,000 between 1954 and 1960 and predicted that this trend would continue.[446] This marked the political adoption of community care and was reaffirmed by the publication in 1963 of *Health and Welfare: The Development of Community Care*, which in sociologist Kathleen Jones' view provided little in the way of a rationale.[447] After recognition by Barbara Castle, Secretary of State for Social Services, that all was not well, this was followed in 1975 by *Better Services for the Mentally Ill*.[448] This provided a platitudinous account of 'the underlying theme of development still holds good', despite the series of reports on the appalling conditions at a number of mental hospitals that continued to appear and the

[442] Jones, *A History of the Mental Health Services.*, 312–18.
[443] Chief Medical Officer, 'Report of the Ministry of Health for the Year 1959, Part II: On the State of the Public Health' (London: HMSO, 1960), 128.; Derek Walker-Smith, 'Mental Health Bill: Second Reading 26th January 1959' (London: Houses of Parliament, 1959), http://hansard.millbanksystems.com/commons/1959/jan/26/mental-health-bill#S5CV0598P0_19590126_HOC_230.
[444] Each year during the 1950s, the Chief Medical Officer in his annual report to the Houses of Parliament would comment on the development of mental health services. Most of these contained favourable references to the development of out-patients, rehabilitation and after-care services outside of hospital. E.g. Chief Medical Officer, 'Mental Health' in *Report of the Ministry of Health for the Year 1954. Part II: On the State of the Public Health,* 104–10 (London: HMSO, 1955); Chief Medical Officer, *Report of the Ministry of Health for the Year 1957. Part II: On the State of the Public Health*, 122–29 (London: HMSO, 1958).
[445] Kathleen Jones, *Asylums and after: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London; Atlantic Highlands, N.J: Athlone Press, 1993), 159.
[446] Tooth and Brooke, 'Trends in Mental Hospital Population and Their Effect on Future Planning'.
[447] Jones, *Asylums and After*, 183.
[448] Department of Health and Social Security, *Better Services for the Mentally Ill*, 17.

severe financial restrictions.[449] A leading article in the *British Medical Journal* was almost celebratory in asserting that nothing 'more than limited progress' had been made, declaring that psychiatric hospitals were still necessary, and arguing that, in some, over 60% of patients were unlikely to be discharged.[450]

Thus 'community care' remained largely in suspended animation for the next quarter of a century. Bed numbers decreased by 1981, with 73,000 in-patients occupying 85,000 beds, in line with Enoch Powell's prediction, but this was not balanced by facilities being developed in the community.[451] Andrew Scull, in 1984, found the British experience 'dismal' and 'a sham', with a mere £6.5 million spent on residential and day care services away from hospitals, whilst institutional care absorbed £300 million.[452] In 1993, NHS manager Tom Butler described it as the 'mythical alternative' to institutional care.[453] The 1984 report of the House of Commons Social Services Committee stated that the 'pace of removal of hospital facilities for mental illness has far outrun the provision of services in the community to replace them'.[454] They further reported that 'no major hospital has closed', although some were in the process of doing so by the 'end of the decade'.[455]

ii. Expanding Psychiatric Practice

The only real moves toward treating patients in the community were the expansion of out-patient treatments, the establishment of day hospitals and the move of a few psychiatric nurses to work in people's homes and in general practices. Out-patient treatment expanded from half a million in 1950 to over one and half million in 1981.[456] Day hospitals, although increasing, provided an insignificant number of places.[457] Community nursing was pioneered at Warlingham in the mid-1950s by a nurse who supported recently discharged patients.[458]

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[449] Martin and Evans, *Hospitals in Trouble*.
[450] Anon, 'Leading Article: Asylums Are Still Needed', *British Medical Journal*, vol. 1, no. 6002 (1976): 111.
[451] Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England*, 20.
[452] Scull, *Decarceration*.
[453] Tom Butler, *Changing Mental Health Services: The Politics and Policy*, (London: Chapman & Hall, 1993), 43.
[454] House of Commons, 'Second Report from the Social Services Committee. Session 1984-5. Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. Volume 1. Report Together with the Proceedings of the Committee' (London: House of Commons, 1985), xviii.
[455] House of Commons, xix.
[456] Chief Medical Officer, 'Mental Health' in *Report of the Ministry of Health for the Year 1954, Part II: On the State of the Public Health*', 104–10. (London: HMSO, 1955), 108; Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England*, 32.
[457] Farndale, *The Day Hospital Movement in Great Britain*, 2–4. In 1959 the few day care services catered for 1,500 adult psychiatric patients weekly, about 1% of all psychiatric patients. These increased to 12,390 by 1981, making about 12% of the total. Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England*, 59.
[458] McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*, 150.

Then five were employed in Plymouth by the early 1960s, but elsewhere growth was slow.[459] Many were attracted to this role as it allowed them to escape the control of psychiatrists and the stigma of mental hospitals.[460] This was despite the fact that they worked longer hours to support patients discharged into the local neighbourhood, apparently for no extra reward.[461] In 1966 there was the equivalent of 225 community nurses employed by 42 hospitals, increasing to between 3500 and 4500 in 1984.[462]

The local authorities employed mental welfare officers, some of whom were ex-nurses, who had a number of roles.[463] First, they had the duty of making applications for formal admission to mental hospitals.[464] Apart from this, they had 'a significant, though fluctuating, role in community care', which varied in different areas, often struggling with a lack of resources, poor training and indifference.[465] The few psychiatric social workers had a variety of functions 'characterized by considerable flexibility and variation according to the interests of individual workers and the needs of particular localities'.[466] Both were abolished by the Social Services Act 1970, subsuming them within the new model of 'generic social workers'.[467]

The psychiatric profession in contrast was doing better, with their numbers steadily increasing.[468] When Richard Crocket first took up post in 1954, he looked after children, as

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[459] McCrae and Nolan, 199–200.

[460] Peter Nolan, 'The History of Community Mental Health Nursing', in *The Handbook of Community Mental Health Nursing*, eds. Ben Hannington and Michael Coffey (London ; New York: Routledge, 2003), 15.

[461] Nolan, 12.

[462] The Royal College of Nursing was unclear about the actual figures. House of Commons, 'Second Report from the Social Services Committee. Session 1984-5. Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. Volume 1. Report Together with the Proceedings of the Committee.' Minutes of Evidence, Wednesday, 4 July 1984, Royal College of Nursing, p.395

[463] Mental Welfare Officers were based in local authority community teams. Psychiatric Social workers were based in psychiatric hospitals and Child Guidance Clinics. By 1970, there were 1,443 mental welfare officers, of whom 365 had qualified as social workers. E. Younghusband, *Social Work in Britain: 1950-1975. A Follow-up Study. Vols 1 & 2.* (London: George Allen and Unwin, 1978), 167.

[464] Jones, *A History of the Mental Health Services*, 310.

[465] Sheena Rolph, Dorothy Atkinson, and Jan Walmsley, '"A Pair of Stout Shoes and an Umbrella": The Role of Mental Welfare Officer in East Anglia: 1946-1970.', *British Journal of Social Work*, vol. 33, no. 3 (2003): 341, 347, 356.

[466] Noel Timms, *Psychiatric Social Work in Great Britain (1939-1962)* (London: Routledge & Kegan Paul, 1964), 124. In 1970 there were 365 nationally. Younghusband, *Social Work in Britain: 1950-1975. A Follow-up Study. Vols 1 & 2*, 167.

[467] Jones, *A History of the Mental Health Services*, 332–33. It has been argued that community nurses replaced the mental welfare officers, transferring the role from local authorities to the mental health services. Personal communication: Leonard Smith.

[468] In 1951, there was an 'approximate' membership of the Royal Medico-Psychological Association (the forerunner of the Royal College of Psychiatrists that included the whole of the United Kingdom) of 1,250. This had increased by 1971 to 'almost' 4,000 Bewley, *Madness to Mental Illness*, 57. Official statistics of English psychiatrists indicate that by 1976 there were 1,039 consultant psychiatrists and 3,014 other grades (psychiatrists in training and other non-psychiatric staff) in England alone, increasing by 1981 to 1,230 consultants and 3,542 other grades. Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England and Wales 1973*; Department of Health and Social Security, *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England*.

well as adults, in his out-patients clinic at the Ingrebourne Centre.[469] Psychiatrists were beginning to specialise, and, by 1973, the Royal College of Psychiatrists had recognised the sub-specialities of child, forensic, psychotherapy and mental subnormality.[470] In 1975, 835 full-time consultant psychiatrists served 250,000 adult in-patients and 1.5 million out-patients.[471] Crocket was a founding member of the Society of Clinical Psychiatrists, which was active in promoting the creation of the Royal College of Psychiatrists.[472] This was seen as their 'coming of age' in establishing equal standing of the profession with their surgical and medical colleagues.[473] It provided the platform to organise a separate training and qualification for new recruits. The Royal Charter emphasised their intention to remain an influential force by explicitly stating that it was to act as a consultative body on 'matters of public and professional interest concerning psychiatry and mental disorder'.[474]

In comparison, the nursing profession was finding it more difficult to institute changes. Between 1960 and 1970, the number of qualified male nurses fell and, although trained females increased, this was mostly with the lesser qualification of enrolled nurse.[475] The training was only gradually weaned away from *The Handbook for Mental Nurses*, the 'Red Handbook' produced by the Royal Medico-Psychological Association, to studies more fitted to working with patients.[476] The handbook was written mainly by psychiatrists and, in the final edition of 1964, continued to emphasise the physical care of the patients and was devoid of any sociological, or philosophical, critique of psychiatry. It went through a number of editions and remained in print until 1978, when the Royal College of Psychiatrists, who were still publishing it, declared that it was out of date. Its dominance restricted the utilisation of other nurse-authored manuals, which emphasised the social and environmental aspects of psychiatric care.[477]

During the 1960s and 1970s, there were a series of studies researching psychiatric nursing practice. Audrey John, in 1961, found that nurses had poor technical skills, low self-esteem and were largely ill-fitted for a truly clinical role.[478] David Towell, another nurse, found that many relied on the medical staff for instruction rather than enacting their own therapeutic

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[469] Crocket, 'Memorandum: The Ingrebourne Centre: St George's Hospital, Hornchurch, 1955-1958', 2.
[470] Bewley, *Madness to Mental Illness*, 97.
[471] This did not include the number of part-time psychiatrists, who had private practice work as well. Department of Health and Social Security, *Better Services for the Mentally Ill*, ii.
[472] Howells, 'The Establishment of the Royal College of Psychiatrists', 119; Society of Clinical Psychiatrists, 'Home Page of the Society of Clinical Psychiatrists Recording That Richard Crocket Was a Founding Member', accessed 6 March 2018, https://scpnet.co.uk/.
[473] Bewley, *Madness to Mental Illness*, 71. See also Howells, 'The Establishment of the Royal College of Psychiatrists', 133.
[474] Bewley, *Madness to Mental Illness*, 73.
[475] McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*, 196.
[476] Henry R Rollin, 'The Red Handbook: An Historic Centenary', *Bulletin of the Royal College of Psychiatrists*, vol. 10, no. 10 (1986): 279–80.;Peter Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thornes, 1998), 64. McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*, 177.
[477] Altschul, *Aids to Psychiatric Nursing*; McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*, 177.
[478] John, *A Study of the Psychiatric Nurse*.

skills.[479] Where a critical stance was taken, this tended to be an unsophisticated application of anti-psychiatric ideology. The most important of these studies was the only one undertaken by a psychiatric nurse, Annie Altschul, in 1972.[480] She explored nurse-patient interactions and found the staff had little common therapeutic ideology on which to base their therapeutic relationship, relying instead on 'common sense'.[481] Eventually, her views were influential in designing the General Nursing Council psychiatric nurse training in 1982.[482]

The predominance of the medical profession in directing psychiatric care during this period was reflected through the increasing role that the major tranquillisers and the anti-depressants played. Chlorpromazine was introduced in the mid-1950s.[483] Dr Anton-Stephens, at Warley in 1953, was a pioneering researcher in its use.[484] He observed that it produced a state of 'psychic indifference', which lessened the 'disturbed behaviour of schizophrenia' and brought about 'a decrease in distress'.[485] It was not widely used elsewhere until the later 1950s.[486] Its 'success' heralded the use of a spate of similar drugs over the next two decades, which has been credited with significantly contributing to the reduction of psychiatric beds, though it is probable that the causes for this are more complex.[487]

The anti-depressants have also assisted in the 'reframing' of mental disorders. Following the introduction of imipramine, in 1958, their use increased exponentially. In the United Kingdom, the historian of psychopharmacology, Professor David Healy, argues that, in the 1950s, less than 0.5% of the population was diagnosed as having a depressive disorder. By the 1990s, this had risen to 10% and thus hundreds of thousands more were expected to 'benefit' from their use.[488] Their effectiveness was lauded by the government White Paper on *Better Services for the Mentally Ill* in 1975.[489] The apparent success of this medical treatment, a 'cornucopia' of 'bounty' according to the psychiatric historian Edward Shorter,

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[479] Towell, *Understanding Psychiatric Nursing*.
[480] Altschul, *Patient-Nurse Interaction; a Study of Interaction Patterns in Acute Psychiatric Wards*.
[481] Altschul, 192.
[482] McCrae and Nolan, *The Story of Nursing in British Mental Hospitals*, 239.
[483] Healy, *The Creation of Psychopharmacology*, 101.
[484] D. Anton-Stephens, 'Preliminary Observations on the Psychiatric Uses of Chlorpromazine (Largactil)', *Journal of Mental Science*, vol. 100, no. 419 (1954): 543–57.
[485] Anton-Stephens, 557.
[486] Healy, *The Creation of Psychopharmacology*, 101.
[487] This is an argument that has raged for the past half century. Scull, *Decarceration*, 79–94. Busfield's more considered approach argues that it was one of four contributions to de-instutionalisation, the other three were the emergence of new medical ideas about the causes and treatment of mental disorder, the development of other facilities and the sense that psychiatry was becoming more of a medical discipline all undermined the commitment to the large mental hospital as a suitable place for treatment. Busfield, *Managing Madness*, 345–46.
[488] Healy, *The Creation of Psychopharmacology*, 309.
[489] Department of Health and Social Security, *Better Services for the Mentally Ill*, 11, 13.

led to psychiatrists' increased confidence in their 'medical' status.[490] Healy, on the other hand, contends that this led to the 'evisceration of the science of psychiatric therapeutics' by the pharmaceutical companies.[491]

iii. Anti-psychiatry

In essence, the changes at the Ingrebourne Centre in the first half of its existence were less influenced by politics and policy, than the cultural and social changes in broader society. Many of the staff had some sympathy with the anti-psychiatric movement. Indeed, Dr Ronnie Laing was twice invited to speak at the unit, although Crocket's main memory of these occasions was the lecturer's drunkenness.[492]

Anti-psychiatry, a term coined by Dr David Cooper in 1967, was adopted to cover a disparate group of critics of mainstream medical practice in mental health, not all of whom agreed with the term being applied to them.[493] It tends to be used as a catch-all phrase to capture the varying strands of radical criticism of Western psychiatric practice.[494] The psychiatrist Digby Tantam opined that its influence on psychiatry was more cultural than direct, and this is explored here rather than detailing its history.[495] Many practitioners acknowledged the

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[490] Edward Shorter, *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac* (New York: Wiley, 1997), 261.

[491] Healy, *The Creation of Psychopharmacology*, 312.

[492] R. W. Crocket, PETT Interview 17th November 1999 (T)CF 330, interview by Craig Fees and Helen Spandler, Transcription, 1999, 8, Planned Environment Therapy Trust. This observation is confirmed by an interview on Irish television in which the interviewer, Gary Byrne, confronts Laing with the fact that he is drunk. https://www.youtube.com/watch?v=N5XkFPYWkq4, accessed 06/09/2018.

[493] David Cooper, *Psychiatry and Anti-Psychiatry* (London: Tavistock, 1967). Those who eschewed the title included Thomas Szasz and Ronnie Laing himself. T Szasz, *Anti-Psychiatry: Quackery Squared* (Syracuse: New York: Syracuse University Press, 2009) https://ebookcentral.proquest.com/lib/bham/reader.action?docID=3410037; Beveridge, *Portrait of the Psychiatrist as a Young Man*, 317.

[494] Digby Tantam lists R. D. Laing, David Cooper, Joseph Berke in the UK, Thomas Szasz in the USA, and Franco Basaglia in Italy. He even includes Michel Foucault by association, p. 344. Digby Tantam, 'The Anti-Psychiatry Movement', in *150 Years of British Psychiatry: 1841-1991*, eds. German. E Berrios and Hugh Freeman (London: Gaskell, 1991), 333–47. Colin Jones adds in Jan Foudraine in Holland, and Sherry Turkle contributes Gilles Deleuze and Félix Guattari. Sherry Turkle, 'French Anti-Psychiatry', in *Critical Psychiatry*, ed. D Ingleby (Harmondsworh: Penguin Books, 1981), 150–83. For good measure Michael Staub adds Erving Goffman, although he antedated the others by about a decade. Staub, *Madness Is Civilization*, 3.

[495] A number of authors have outlined aspects of the history from different points of view, but there is no comprehensive account. John Clay, *R. D. Laing: A Divided Self : A Biography* (London: Hodder & Stoughton, 1996); Nick Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', *Social Science & Medicine*, vol. 47, no. 7 (1998): 877–89; Nick Crossley, 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain', *Sociology*, vol. 33, no. 4 (1999): 809–30.; Tantam, 'The Anti-Psychiatry Movement'. Michael Staub presents an American view point. Staub, *Madness Is Civilization*. Thomas Szasz is withering in his criticism of Tantam's association of him with the anti-psychiatric movement. Szasz, *Anti-Psychiatry: Quackery Squared*, 1–2. Duncan Double dislikes his view that it was a 'passing phase'. D. B. Double, 'The History of Anti-Psychiatry: An Essay Review', *History of Psychiatry*, vol. 13 (2002): 231.

validity of several moral and sociological insights without accepting the philosophy that denied the existence of mental disorder.[496]

In Britain, the person most associated with the movement, Dr Ronnie Laing, achieved the status of a heroic cult figure, 'the most famous psychiatrist in the world'.[497] His mythological status as a 'high priest', preaching against the cruel suppression of people diagnosed as having mental illness contributed to a youth movement in which all social conventions and authority were being questioned.[498] At a time when psychiatric hospitals were being compared to concentration camps and mental illness was dismissed as a myth, he set up Kingsley Hall, a community in which all barriers between staff and residents were apparently dismantled.[499] He, and his associates David Cooper, Clancy Sigal and Joseph Berke, published a number of best sellers about their involvement and philosophy.[500] This was supplemented by a vivid account given by Mary Barnes of her treatment there, later dramatized by playwright David Edgar in 1979.[501] Their stance was explicitly anti-establishment. Dr Joseph Berke argued that 'we're up against a whole society that is systematically driving its members mad'.[502] Laing, Cooper, Berke and Leon Redler organised a *Congress on the Dialectics of Liberation* in London in 1967, at which the Black Panther, Stokeley Carmichael, inveighed against 'the system of white supremacy coupled with international capitalism', and John Gerassi promoted revolution in America.[503] Their ideas were taken up

[496] A 1998 text-book on psychiatric nursing, that had significant influence on practice, refers repeatedly to the work of R. D. Laing and mourns the fact that his 'memory is sadly vilified'. It includes a chapter by his colleague, Joseph Berke. Phil Barker and Ben Davidson, *Psychiatric Nursing: Ethical Strife* (London: Arnold, 1998), 11, 66–75. Radical psychologists ran a journal *Red Rat* during the early 1970s, that highlighted the problems of traditional psychiatric practice at the time, including the reactionary nature of labelling. David Pilgrim and Andrew Treacher, *Clinical Psychology Observed* (London ; New York: Routledge, 1992), 35. The present-day Critical Psychiatry Group which includes psychiatrists and other disciplines, traces its roots back to anti-psychiatry. D.B. Double, 'Critical Psychiatry: Challenging the Biomedical Dominance of Psychiatry', in *Critical Psychiatry: The Limits of Madness*, by D.B. Double (Basingstoke: Palgrave Macmillan, 2006), 3–15.

[497] Beveridge, *Portrait of the Psychiatrist as a Young Man*, xiii.

[498] Colin Jones, 'Raising the Anti: Jan Foudraine, Ronald Laing and Anti-Psychiatry', in *Cultures of Psychiatry*, eds. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), 284–85.

[499] This unit is discussed further in Chapter 4. John Clay, *R. D. Laing: A Divided Self : A Biography* (London: Hodder & Stoughton, 1996), 131; Cheryl McGeachan, '"The World Is Full of Big Bad Wolves": Investigating the Experimental Therapeutic Spaces of R.D. Laing and Aaron Esterson', *History of Psychiatry*, vol. 25, no. 3 (2014): 29.. See also an interview with R.D. Laing. , accessed 06/09/2018.

[500] Cooper, *Psychiatry and Anti-Psychiatry*; R. D. Laing, *Self and Others*, (Harmondsworth: Penguin, 1971); Ronald D Laing, *The Divided Self: An Existential Study in Sanity and Madness* (Harmondsworth, Middlesex: Penguin Books, 1987)

[501] Mary Barnes and Joseph Berke, *Mary Barnes: Two Accounts of a Journey through Madness* (Harmondsworth, Middlesex: Penguin, 1982); David Edgar, Mary Barnes, and Joseph Berke, *Mary Barnes: Based on 'Mary Barnes: Two Accounts of a Journey through Madness' by Mary Barnes and Joseph Berke*, Post-production ed, A Methuen Paperback Methuen Modern Plays (London: Methuen, 1984).

[502] Andrew Rossabi, '"Anti-Psychiatry": An Interview with Dr Joseph Berke', in *Laing and Anti-Psychiatry*, ed. Robert Boyers and Robert Orrill (Harmondsworth, Middlesex: Penguin Books, 1972), 215.

[503] David Cooper, ed., *The Dialectics of Liberation* (Harmondsworth, Middlesex: Penguin Books, 1968), 7, 72–94, 150–74. The archives and recordings of this event are held at the Planned Environment Therapy Trust Archive.

sympathetically by the socialist, humanist, left-wing activists in the United Kingdom and influenced many people's views on psychiatry.[504]

This amalgam of psychological theorising and rebelliousness appealed to many working in psychiatry and articulated their discontent with the traditional mental hospitals. It did, however, puzzle others. One psychiatrist reported that, in 1962, he took up a new post in a mental hospital;

> I arrived at rather a fortunate time. It was a rather optimistic time, because the new drugs were becoming known. Largactil being the first one, I think, that had a dramatic effect. ... And the anti-depressants were getting better and better. And there was an air of tremendous optimism really. A lot of patients who'd been ill for a long time were actually getting better and able to go out. We all felt we were doing something really quite unusual and almost heroic. … And it became a bit of a shock later on in the sixties and the seventies when we started being reviled for the things we were doing. A very strange roundabout.[505]

The disagreements with mainstream psychiatrists became rancorous. Psychologist, David Ingleby, sums up the central issue as being one of the 'biological' psychiatrists failing 'to recognise the patient as a fellow human being'.[506] He continues by arguing that the blanket use of psychiatric labelling effectively invalidates and marginalises the whole person. This led to vehement opposition from the British psychiatric establishment. After celebrating the psychiatric profession's move to closer relationships with their medical colleagues, Professor Sir Martin Roth, President of the Royal College of Psychiatrists, in 1973 launched into a bitter attack on the contemporary 'anti-medical' critique.[507] Threatened by the 'popularity of their books', he set out the stall for the 'scientific' approach, which he believed might 'ultimately prove to be both illuminating and practically useful'.[508] Ignoring the appalling conditions in many mental hospitals, becoming public through recent inquiries, he castigates their contention that psychiatry constitutes 'something of a threat to human liberty'. He condemns their moralistic attitude, 'self-righteous, aggressive and denunciatory tone', ignoring the evidence that his own approach was hardly conciliatory.[509] The implicit splits between the medical and social approaches that were evident in the 1950s had, by this time, become an implacable divide with neither party wishing to concede any ground to the other.

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[504] P. Sedgwick, *Psychopolitics* (London: Pluto Press, 1982), 6–7.
[505] INGCE7, interview 2.
[506] D. Ingleby, 'Transcultural Mental Health Care: The Challenge of Positivist Psychiatry', in *Critical Psychiatry: The Limits of Madness*, by D.B. Double, (Basingstoke: Palgrave Macmillan, 2006), 66.
[507] Martin Roth, 'Psychiatry and Its Critics', *The British Journal of Psychiatry*, vol. 122 (1973): 373.
[508] Roth, 373.
[509] Roth, 378.

4. Stasis and Change

This chapter illustrates the psychiatric landscape in which the Ingrebourne Centre was established. Whilst it was launched in almost complete isolation, both from the community it served and the mental hospital to which it was nominally attached, it traced a course that was echoed in a variety of ways elsewhere. The aim was to break away from traditional psychiatric practice and enable a greater dialogue between the staff and those people they looked after. This was not a pre-planned endeavour, but evolved in fits and starts in synchrony both with the reforms outlined above and the cultural changes taking place from the 1950s to the 1970s.

Dr Henderson found that 'what disturbed him' about his junior colleague, Richard Crocket, in Edinburgh was that he 'swithered so much' and that he was 'so changeable'.[510] This is evident in the latter's recurrent wish to apply for different posts even whilst at the Ingrebourne, but also left him open to accepting initiatives from others such as his junior staff, an important characteristic of a leader in a unit that enabled greater transparency between levels of authority. He was also sensitive to the changes in culture in British society. The parallels between his *Observer* article and the publication by C.P. Snow berating the 'Two Cultures' three weeks earlier, described in the next chapter, illustrates this.

The Ingrebourne and similar units aimed to find ways to enable those receiving treatment, and those providing it, to have a greater sense of agency in an environment that felt safe and in which their difficulties were considered empathically. A number of participants described the Centre as having a 'family' atmosphere, illustrating the sense of warmth and trust that they experienced. Traditional forms of psychiatric treatment did enable some staff to express compassion. However, this was in a setting where the safety of the staff relied on codes of practice that managed and controlled patients' behaviour rather than investigating the reasons for it. Those taking the TC approach attempted to understand such behaviour and to explore different ways of expressing its underlying emotional drivers.

[510] To 'swither' means to be uncertain which course of action to choose. R. W. Crocket, 'Diary 7: 6th Dec. 1947 to 1st Jan. 1950', Planned Environment Therapy Trust, 9th November 1949.

Chapter 3

Oily Rags in the Corridor: Permissiveness and the Evolution of the Therapeutic Community at Ingrebourne

> The matron was a traditionalist. The floor shone with wax polish, and cleanliness was absolute. I went in this particular morning, and I found one of the patients with his motor bike dismantled in the corridor outside his bedroom, oily rags around, nuts and bolts lying loose. And I had to decide what to do about it, so I walked past, said 'Good morning,' and said nothing more, just left it.[1]

1. Changing the Culture: Introduction

There was no plan. The Ingrebourne Centre initially evolved by fits and starts. As Crocket himself reflected:

> One likes to think that innovation and change are the result of intelligent and purposeful planning … What really happened was that we went through a process of clinical adaptation to administrative factors; and then found that the empirical experiences which resulted were rewarding and appeared to be effective.[2]

He considered himself in 1954 to be a 'traditional and proper person' and 'orthodox'.[3] This chapter describes how the service evolved from a unit run along traditional mental hospital lines to one in which all medications were proscribed and treatment relied on group work. Whilst Crocket is central, he acknowledged his debt to others who instituted changes. His 'permissive' approach enabled others to experiment and innovate.[4] This was a significant word first publicly used by him in relation to his own practice in November 1957.[5] This coherence between the emerging cultural upheaval in society and the events at Ingrebourne is allusive but recurring.

This chapter first intimates the connection between evolving British culture and that of the Ingrebourne during the 1950s, before describing the physical environment and relating its

[1] R. W. Crocket, PETT Interview 23rd November 1998 (T)CF272, interview by Craig Fees, Transcription, 1998, 14, Planned Environment Therapy Trust.
[2] Crocket, R. W. 'Notes for a Presentation on Ingrebourne given in the United States of America', 1968. Planned Environment Therapy Trust.
[3] Crocket, PETT Interview, 23rd November 1998 (T)CF272, 8.
[4] Crocket, 14.
[5] R. W. Crocket, 'The Therapeutic Community Approach in a Neurosis Unit. Address to the Runwell Hospital Medical Society' (November 1957), Planned Environment Therapy Archive, 4.

development into a TC. Then the different stages of its development until the late 1970s are prefaced by descriptions of its contemporary cultural background. These influences were more significant at this time than the political and economic drivers of later years.

2. The First Years: 1954 to 1960

i. Stagnancy and Counter-Culture: Emerging Dissent in the British Way of Life 1950 to 1960.

Unsuccessful in his bid for a Senior Lectureship in Leeds in 1953, Crocket wished to be nearer London where the 'action was' psychiatrically.[6] He was appointed as a consultant psychiatrist at St George's Hospital in May 1954, the same week that the runner Roger Bannister broke the four minute mile in Oxford. More portentously, the French lost the battle of Dien Bien Phu in Vietnam, a harbinger of upheavals to come.[7]

The historian, Joanna Bourke, observes that working-class adolescents after the Second World War became both more affluent and further alienated from their elders.[8] The chaplain and youth worker, Kenneth Leech, described the 1950s as 'supremely the decade of the teenager'.[9] They were increasingly spending their money on music, the cinema and fashion. This was the age of Bill Haley rocking the dance halls and 'Teddy Boys', whose dandified clothes and outbreaks of violence caused anxiety well in excess of their limited numbers.[10] As Alan Sillitoe portrayed in his novel of working-class life, *Saturday Night and Sunday Morning*, this prosperity did not lead to happiness. The regular employment and wages of a factory worker meant you could save up for a 'motor bike or even an old car', but it was a 'mug's game' because of inflation and the Americans doing 'something daft like dropping the H-Bomb'.[11] In Bourke's view, it was not until the later 1960s that middle-class youth became an equally significant social force.[12] There were stirrings amongst the more articulate as the 'angry young men', Colin Wilson, Kingsley Amis and John Osborne aimed to

[6] R. W. Crocket, PETT Interview (T) CF 271, 23 November 1998, Planned Environment Therapy Trust, 8
[7] Four days later, John Foster Dulles, the US Secretary of State, ruled out the possibility of American intervention in Indochina!
[8] Joanna Bourke, *Working Class Cultures in Britain, 1890-1960: Gender, Class, and Ethnicity* (London; New York: Routledge, 1994), 46.
[9] Kenneth Leech, *Youthquake: The Growth of a Counter-Culture through Two Decades* (London: Sheldon Press, 1973), 1.
[10] Andrew Rosen, *The Transformation of British Life, 1950-2000: A Social History* (Manchester, UK; New York; New York: Manchester University Press ; Distributed exclusively in the USA by Palgrave, 2003), 109, 143; David Kynaston, *Family Britain, 1951-1957 : Tales of a New Jerusalem* (Bloomsbury, 2010), 379–81; Alan Sinfield, *Literature, Politics and Culture in Postwar Britain*, 2. ed., Classic Criticism Series (London: Continuum, 2007), 173–77.
[11] Sillitoe, *Saturday Night and Sunday Morning* (London: Pan Books, 1960), 21.
[12] Bourke, *Working Class Cultures in Britain, 1890-1960*, 46.

roll over cultural complacency.[13] These were the most public of a range of middle-class intellectuals who espoused jazz and existentialism, and railed against the 'degeneracy' and the perceived triviality of rock and roll.[14]

Others also expressed discontent. In the wake of the government's intention to build the hydrogen bomb, the Campaign for Nuclear Disarmament took to the streets in 1958, drawing together disaffected young people with an effective and distinguished, middle-aged leadership.[15] This unrest compounded the effects of the failure of British military ambitions in Egypt during the Suez Crisis in 1956, which terminated any imperial pretensions.[16] Even the cosy world of British capitalism, an old boys' club of mutual admiration, was being shaken by the 'cut and thrust' of the American take-over of British Aluminium, eventually concluded in 1958.[17] All these events were relayed to the increasing number of televisions invading people's homes.[18] The 'uneasy combination of complacency and insularity' of the mid-1950s was beginning to fracture.[19]

A similarly frustrated outsider, Crocket was both restless and uneasy. As a psychiatrist, he was unloved by the medical mainstream and viewed with suspicion by the general populace. A newspaper critic avowed psychiatry was 'that deservedly unpopular profession'.[20] His post at Ingrebourne intensified this. The isolation of the Centre from the main psychiatric hospital, Warley, was accentuated by the delegation of its management to the medical superintendent at St George's, a hospital for elderly people.

Paradoxically, he preferred this role, as he 'thought it essential to be separate'.[21] He later commented, 'I was known as a rebel by my former colleagues in various settings. I quite enjoyed it'.[22] Writing as 'A Consulting Psychiatrist' in the *Observer* in 1955, he expressed his growing anti-establishmentarianism in an attack on psychiatric hierarchy.[23] He inveighed

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[13] Colin Wilson's book *The Outsider*, and John Osborne's play, *Look Back in Anger*, first staged in 1956, signalled the arrival of those whom the media dubbed the 'Angry Young Men'. Another identified as a core member was Kingsley Amis who had published *Lucky Jim* two years earlier, seen by some 'as a shower of brickbats hurled by a half-educated hooligan at the holiest and most fragile shrines of art and letters'. A Powell, *The Strangers Are All Gone: Vol. IV of To Keep the Ball Rolling: The Memoirs of Anthony Powell*, 1st ed. (London: Heinemann, 1982), 159.

[14] Sinfield, *Literature, Politics and Culture in Postwar Britain*, 175–77.

[15] David Edgerton, *Warfare State Britain, 1920-1970* (Cambridge: Cambridge University Press, 2006), 231. Bertrand Russell, the philosopher, was a figurehead of CND, supported by Michael Foot MP, Canon John Collins of St Paul's Cathedral, and Kingsley Martin editor of the *New Statesman*.

[16] Morgan, *The People's Peace*, 156.

[17] Sampson, *Anatomy of Britain,* 387-391

[18] By 1956 48% of households had a television set. Kynaston, *Family Britain, 1951-1957*. 670.

[19] The quote comes from Morgan, *The People's Peace*. 137.

[20] Quoted in H. Pozner, 'Common Sense and Military Psychiatry', *Journal of the Royal Army Medical Corps*, vol. 107 (1961): 155–64, 155.

[21] R. St Blaize Molony, 'Letter to T Harrison 6th October 2010', 2010, Personal.

[22] R. W. Crocket, 'PETT Interview (T) CF 272', 23 November 1998, Planned Environment Therapy Trust. 10

[23] The article is anonymous, but the PETT archive has letters containing drafts, and correspondence from the paper to Crocket. R. W. Crocket, 'Our Mental Hospitals Can We Reform Them out of Existence?', *The Observer*, 21st October 1956, 6.

against the traditionalism of mental hospitals, describing the medical superintendent as 'a conservative figure … conforming to practices of management handed on by tradition'. Promoting the cause of younger doctors, for whom administration was merely a 'technical means by which to gain a clinical end', he argued that there should be 'full responsibility for each consultant, in place of the present compulsion to conform with the habits of a large, clumsy, and often frustrated organisation'.

Three weeks earlier the scientist, C.P. Snow, published his inaccurate, celebrated attack on the 'Two Cultures', in which he promoted the cause of 'the young English scientists', who were fretting 'about the ossification of the traditional culture'.[24] In his view, society needed their energetic 'moral health'. Both commentators stressed the vigour and innovative energy of youth, allied with science and technology. Both also ignored the evidence that young and energetic people were making inroads whilst part of the traditional hierarchy. The synchronicity of these parallel arguments reveals a common attitude later promoted by the Wilson government.

ii. 'D' Block at St George's Hospital: The Building and its Environment

Crocket's unit was known as 'D Block', in St George's, a 375-bedded hospital where Dr Miles was the medical superintendent, in the North Eastern suburbs of London.[25] Initially, it served as an outlying assessment unit for Warley Hospital, but because of its small size and distance from the parent asylum, it was seen as a 'problem child'.[26] The unit was situated behind the administration building (*Figs. 3.1 & 3.2*). As the only service for younger people, it was, and continued to be, an alien culture intruding into the sedate, traditional and somewhat sombre environment of geriatric medicine. Later commentators found this situation 'puzzling'.[27]

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[24] Subsequently his arguments were shown to lack evidence or support. Historian Kenneth Morgan disputes his conclusions, whilst David Edgerton, another historian, dismantled them. Morgan, *The People's Peace*, 144; Edgerton, *Warfare State Britain, 1920-1970*, 196–210.

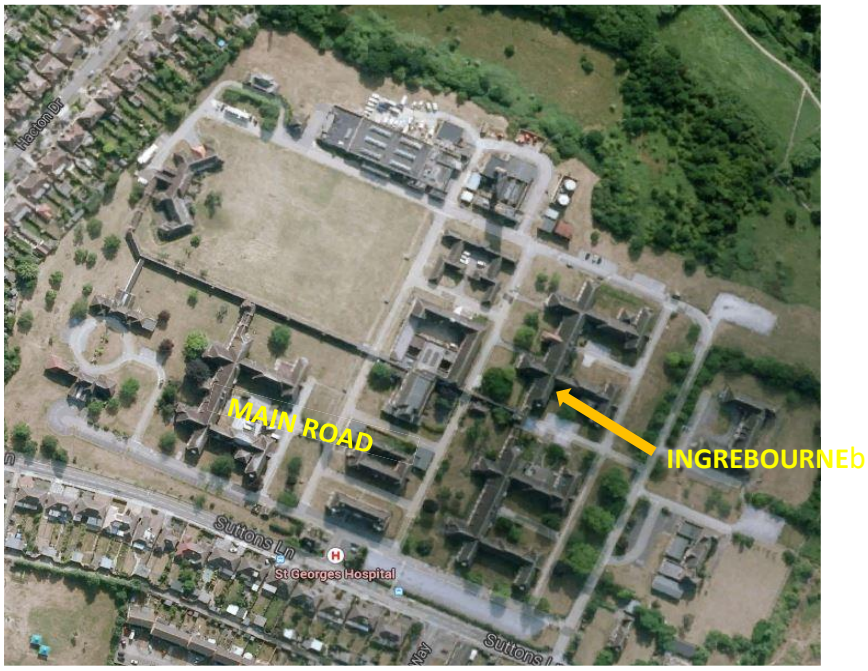
[25] R. W. Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch, 1955 – 1958'. (Unpublished, 1958), Planned Environment Therapy Trust. Elsewhere it is reported as being 'G Block'. Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process' (Tavistock Institute of Human Relations, 1975), 19. Crocket recalled it as G3 in later years. Crocket, PETT Interview (T) CF 271. 10. Given the fact that the memorandum was closer in time to the event of name, changing it is has been taken as being more accurate.
Strictly speaking, it is South West Essex, but it lies within the M25 motorway and has more attachment to the capital than a rural shire. Bed numbers are for 1962 and include the Ingrebourne Centre. They are abstracted from National Health Service, 'A Hospital Plan for England and Wales' (HMSO, 1962), 113.

[26] R. W. Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Crocket's own copy annotated by Anderson, H.' *International Journal of Group Psychotherapy*, vol. 12 (1962): 180-93, Planned Environment Therapy Trust, PP/RC/26/10/04/03.

[27] Ibid., 18.

The conditions in the main hospital can be inferred from the fact that they were debated in Parliament in 1963, four years before the publication of *Sans Everything*.[28] The buildings were seen as inappropriate for the elderly, many of whom were 80 years or older, doubly incontinent and 'confused in their minds'.[29] The layout caused 'the nurses to have to do a great deal of running about'.[30] There were too few, poorly trained staff who had 'too much to do, too much of a kind of work that can be exceptionally trying and unpleasant, demanding a real sense of vocation in those who undertake it'.[31] The patients' lockers were 'alive with ants and mice'.[32]

Figure 3.1: St George's Hospital showing the whole site.



(c. 2010 Courtesy Google Earth)

There are two dimensions of the Ingrebourne's geography: space and place. The emotional geographer, Yi-Fu Tuan, describes the former as allowing movement and the latter as providing a pause.[33] Another geographer, Tim Cresswell, expands on this, stating that naming place is a mechanism by which space becomes tangible and identifiable.[34] In 1974, the staff considered the geography of the building to be very important, as did Andrew

[28] Hansard, 'Debate: St George's Hospital, Hornchurch', vol. 674 (London: HMSO, 1963), 1669–82. See also The Guardian, 27th August 1962, Inquiry likely into hospital complaints.
[29] Hansard, 1678.
[30] Hansard, 1678-1679.
[31] Hansard, 1674
[32] Hansard, 1672
[33] Tuan, *Space and Place*, 6.
[34] Tim Cresswell, *Place: A Short Introduction*, Short Introductions to Geography (Malden, MA: Blackwell Pub., 2004), 9.

Roberts earlier.[35] Significantly, apart from Roberts, they referred to the internal architecture rather than that surrounding it. He, as someone using the Centre and the local community, was much more aware of its setting. For him

> the image of Ingrebourne is a seamless one of the building, the community and the environment. Grass is as significant as rooms. The Hornchurch theatre as important (for me) as our own theatrical productions. Ingrebourne was semi-detached geographically as well as in the NHS. In some ways it was bit of a fantasy world of its own. You belonged immediately to the world of nature (grass contexts), but with a civilised base, and to the world of the suburbs, the city and the rural countryside (as distinct from the immediate grasslands), but at a convenient distance. Hornchurch was a walk away, the city and rural countryside were train rides away (in opposite directions).[36]

The nature of it as an emotional and imaginary transitional space is discussed in Chapter Four. Here, the physical place is described, stripped of its experiential dimension.

The four sides of 'D' Block surrounded a rectangular courtyard (*Fig. 3.4*). On the Western long side, it was two stories high confronting a single story across the courtyard (*Fig.3.3*). Two single storey, wooden extensions on the South East and North East corners appear to have been added after the main construction (*Fig. 3.5*).

[35] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process', 7; Roberts, interview, 6.
[36] Andrew Roberts, 2018 personal communication.

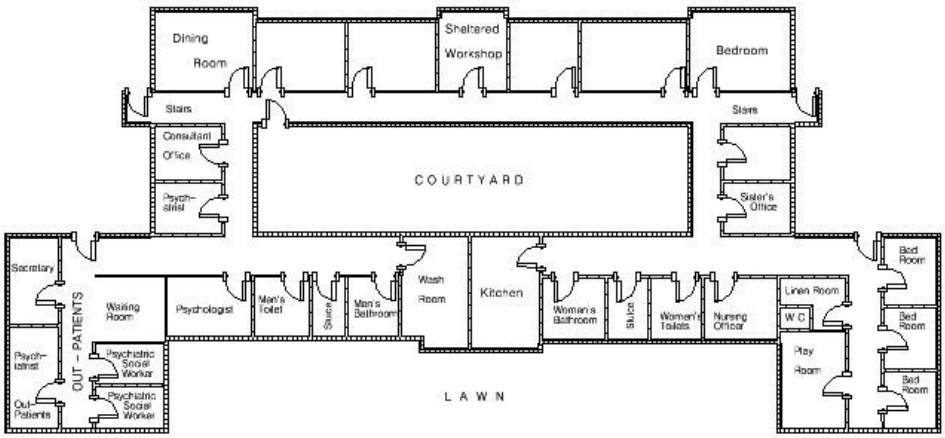
Figure 3.2: The Ingrebourne Centre in relation to the hospital entrance and administration block.

(c. 2010 Courtesy Google Earth)

Figure 3.3: The Ingrebourne Centre from the South West showing the second floor.

(TMH 2013)

Figure 3.4: Diagram of the Ingrebourne Centre (1975).



(Footnote) [37]

Figure 3.5: The Ingrebourne Centre from the North East, showing the wooden extensions.

(TMH 2013)

[37] Modified from diagram in Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process'.

Visitors, in 1959, found that the 'buildings and interior décor are modern and the centre is surrounded by pleasant gardens'.[38] However, by 1974, the flower bed was overgrown with weeds, contrasting with the carefully tended main hospital.[39] The central courtyard also 'presented something of an eyesore', with weeds breaking through its crumbling asphalt surface (*Fig. 3.6*). The impression of another arrival in 1981 was 'What a dingy building. What a dump!'.[40] However narrators, present at other times, have remarked on how the residents and staff looked after the grounds by the unit and that neglect was not an issue.[41]

Figure 3.6: The central courtyard as seen from the North Corridor.

(TMH 2013)

In 1954, the staff consisted of a psychiatrist, an assistant matron, a sister, five staff nurses, five nursing assistants and two domestic assistants. As Crocket made clear, this provided a generous staff-to-patient ratio enabling a more active therapeutic milieu.[42] Its separation avoided the associated stigma of Warley, although it continued contemporary mental hospital practice by keeping separate male and female sections, with a door that was locked

[38] Farndale, *The Day Hospital Movement in Great Britain*.274
[39] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process'. 8
[40] INGCE27, interview, 2.
[41] INGCE15, INGCE17 & INGCE18.
[42] R. W. Crocket, 'Memorandum on Ingrebourne Centre for North Eastern Metropolitan Regional Hospital Board' (Ingrebourne Centre, January 1955), Planned Environment Therapy Archive, 5.

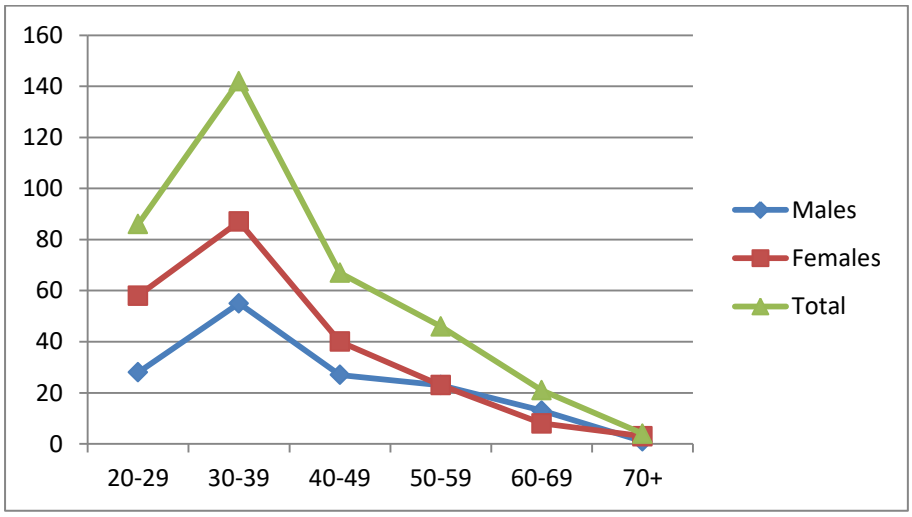
at night.[43] The regime was organised to reduce the risk of 'anything administratively untoward happening'.[44]

iii. 'D' Block at St George's Hospital: The Initial Work

The patients were drawn from the surrounding areas of Romford (pop. 106,000), Brentwood (33,400), Hornchurch (105,000) and Dagenham (113,000).[45] The first three were largely 'commuter' suburbs with many of the population working in London. Dagenham was dominated by the Ford car factory which employed 40,000 workers in 1953, many of whom lived in Hornchurch.[46] The area was predominantly suburban working class, rapidly 'beginning to get caught up with the city type of development'.[47]

[43] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process' (Unpublished, 1975), 19, Personal Collection.
[44] R. W. Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', *International Journal of Group Psychotherapy*, vol. 12, no. 1 (1962): 184.
[45] R. W. Crocket, 'Neurosis Unit: St. George's Hospital' (Unpublished, 1955), Planned Environment Therapy Trust.6; J. Farndale, 'British Day Hospitals', in *Trends in the Mental Health Services*, eds. H. Freeman and J. Farndale (London: Pergamon Press, 1963), 275.
[46] http://www.ford.co.uk/experience-ford/AboutFord/News/CompanyNews/2009/Dagenham80. Accessed 16/8/2014.
[47] R. W. Crocket, 'Notes for a Presentation on Ingrebourne given in the United States of America', 2.

Table 3.1: Ages of patients attending the Ingrebourne Centre 1 April 1957 to 31 March 1959.



(Footnote) [48]

Those using the Centre were largely under the age of 50 (*Table 3.1*), reflecting Crocket's assertion that they were 'young or middle-aged'.[49] This is relevant in that they were more likely to have been attuned to contemporary cultural changes. Indeed, inspectors from the Regional Hospital Board, in 1959, were upset to meet 'a group of young people of both sexes in a day room, listening to dance music from an amplifier'.[50]

Debating his treatment approach, Crocket reviewed a range of psychotherapeutic and socio-therapeutic approaches, and considered physical treatments, such as electro-convulsive therapy and insulin treatments.[51] He had no pre-conceived plan. He contemplated group therapy, but still as part of a traditional dyadic doctor-patient relationship. Once in post, from 1954 to 1957, individual psychotherapy was 'supplemented by E.C.T., drugs, abreaction, and other physical methods of treatment, depending on the judgement of the doctor clinically concerned'.[52] He used hypnotherapy on some out-patients and tried amphetamines on others.[53]

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[48] R. W. Crocket, 'The Results of Treatment in a Psychotherapeutic Community' (Glasgow, 1965), Planned Environment Therapy Trust (Library). 27. Unfortunately figures for the in-patients and for the earlier years are not available. However, there is no reason to consider that the age range of referrals should have changed, though the overall numbers will have increased. The in-patients were mainly drawn from the younger population up to the age of 45 years old during the following decade. Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process', 38.

[49] R. W. Crocket, 'Letter to Dr Miles 18 January 1955', 18 January 1955, Planned Environment Therapy Trust.

[50] North Eastern Metropolitan Regional Hospital Board, 'Ingrebourne Centre (Report of a Visit)'.

[51] R. W. Crocket, Diary 9, 25 February 1954

[52] R. W. Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958.' (Unpublished, 1958), Planned Environment Therapy Trust. 3

[53] R. W. Crocket, PETT Interview (T) CF 329, interview by Craig Fees, Transcript, 3 November 1999, Planned Environment Therapy Archive. 9, Crocket, PETT Interview (T) CF 271.11

At Fulbourn, David Clark expressed a clearer philosophy when applying for the superintendent post in 1953. He had 'a deep distaste for locking anybody up'.[54] He also responded to the World Health Organisation invocation to create hospitals as 'therapeutic communities' in which 'the main emphasis fell on activity, open wards, and improved public relations'.[55] Otherwise, he also was ambivalent about what he wanted to do, wondering whether after a year or two he could get back to London.[56] In the first months of his appointment, he 'often felt daunted by the task of altering and moving things and feared that I might be utterly defeated', sinking 'without trace in the mud of the Fens'.[57] He was also unclear about how to make changes. It was through resolving some *ad hoc* incidents in group discussion he began to gain confidence. It took another four years to open the last ward door in September 1958.[58]

At Claybury, Denis Martin had a similarly clear aim, which was 'to find ways and means of creating a community within which existing treatments might operate more effectively'.[59] How to achieve this was not so apparent. He initially experimented by opening up 'new opportunities for the freest possible communication between staff and patients' and between staff members, in order to create a milieu in which disturbed behaviour was understood, rather than controlled by 'arbitrary authority and rule'.[60] Staff meetings were inaugurated where all attending were encouraged to express their views. Ward meetings, where the patients were enabled to do the same, were commenced on one ward in 1955, eventually spreading to others over the following years. At Crocket's invitation, Denis Martin shared his views at Ingrebourne in 1954, indicating the former's early awareness of developments elsewhere.[61].

Maxwell Jones, on the other hand, had been refining his ideas for some years and he published a collaborative review of the work at Belmont Hospital in 1952, which he described as a 'therapeutic community'.[62] This included daily community meetings, a weekly conference, a number of instructional sessions, individual psychotherapy and a

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[54] Clark, *The Story of a Mental Hospital*, 1996.39

[55] The term Therapeutic Community in this context did not share the same specific definition as has been adopted in this dissertation. It referred to an environment where the patient was to be considered as an individual rather than as someone to be managed. D. H. Clark, "Reform in the Mental Hospital: A Critical Study of a Programme," *International Journal of Social Psychiatry*, vol. 3, no. 3 (1957): 211–23,23, World Health Organisation, *The Community Mental Hospital. Third Report of the Expert Committee on Mental Health.* (Geneva: World Health Organization, 1953).18.

[56] Clark, *The Story of a Mental Hospital*, 1996.42.

[57] Clark.57

[58] Clark.113

[59] Martin, *Adventure in Psychiatry*, 25.

[60] Martin, *Adventure in Psychiatry*, 25-26.

[61] Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958.' Appendix B.

[62] Maxwell Jones' seminal contributions to the development of the therapeutic community movement will be given in greater detail in the next chapter. M Jones, *Social Psychiatry* (London: Tavistock, 1952).

psychodrama group. His colleague, Dr Stallard presented their work to Ingrebourne staff in 1955.[63]

Initially, Crocket left another doctor, Maclay, to 'run St George's' and it appears that he had no intention to intervene, but, by May, he was sharing the use of the beds.[64] The latter was a senior doctor with some significant experience and Crocket considered it best to offer advice, but not supervision.[65] Soon Maclay, after retraining in child psychiatry, left to take up another post in 1955.[66] Crocket's increased involvement in the unit led him to ponder on how it should be run. He contemplated setting up a staff discussion group, similar to Denis Martin, and establishing 'a regime' of patient reviews.[67] He started a monthly training meeting with external speakers.[68] He toyed with the 'grandiose idea' of an *Ingrebourne Centre for Psychological Medicine*, providing nurse training and group therapy training, as well as research in Sociometry and social therapy.[69]

Initially, the unit was 'organised on the pattern of a mental hospital ward', with a mixture of individual psychotherapy with the psychiatrist twice a week, and proven physical methods of treatment'.[70] The patients otherwise spent their time in 'social therapy', a supportive measure provided by the occupational therapist. Despite the fact that it was designated as a 'neurosis unit', only half of those attending had this diagnosis.[71]

A day hospital was established in 1955, 'as the prime method of bridging the gap between the emotionally regressive climate which is inclined to develop inside hospital and the basic external social environment', and, by 1957 this accommodated twenty additional patients.[72]. He instituted a 'night hospital' approach in which patients could request an over-night admission in order to ride out an emotional crisis. It was one of the first units to provide day-hospital care in the country as an integral element of the centre, an inter-

[63] Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958. 'Appendix B.
[64] R. W. Crocket, 'Diary 9', 11 May 1954.
[65] Probably a Senior Hospital Medical Officer as his successor Dr H. Anderson was later. Crocket, 11 May 1954.
[66] Crocket, 'Neurosis Unit: St. George's Hospital'. 6; R Crocket, 'Notes on Chronology of Developments at Ingrebourne, Handwritten Note Undated', 1957, PETT.
[67] Crocket, 'Diary 9', 18 May 1954.
[68] Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958.'Appendix B.
[69] Crocket, 'Diary 9', 20 June 1954. Sociometry was an approach to measuring interpersonal relationships and was pioneered by Jakob Moreno, who edited a journal of the same name.Marineau, *Jacob Levy Moreno 1889-1974: Father of Psychodrama, Sociometry, and Group Psychotherapy*, 110, 118.
[70] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 184.
[71] Crocket reported in 1958 that of 150 consecutive admissions 16 had a psychosis, at least one had a cerebral tumour and another pre-senile dementia, two had epilepsy and five were addicted to drugs or alcohol. Of the rest he considered that 75 suffered from neurosis and others were depressed, had personality disorders or psychosomatic conditions. R. W. Crocket, 'Memorandum: The Ingrebourne Centre: St George's Hospital, Hornchurch, 1955-1958', 1958, 4, Planned Environment Therapy Trust.
[72] R. W. Crocket, 'The Results of Treatment in a Psychotherapeutic Community' (Glasgow, 1965), Planned Environment Therapy Trust (Library), 14-15

relationship that continued thereafter.[73]. The integration between day- and in-patient care was unique and emphasised the continuum between the community networks inside and outside the Centre.[74] Inspiration for this came from Crocket's knowledge of the day hospital in Leeds, run by the occupational therapy department, where both groups would mix.[75] Halliwick Hospital which fostered similar integration between the two sides, was opened three years later in 1958.[76]

Crocket recalled that 'I thought of the Ingrebourne Centre' after everyone in the unit, including patients, was asked how it should be named in 1955.[77] The democratic nature of this decision is open to question. He then had to pacify the Regional Psychiatrist, Dr Sawle Thomas, who was upset as Crocket had not 'put it through the committees, I just did it… I didn't think much about the impact on the Regional Board'.[78]

These initial years were marked by frustration with Dr Miles, who unusually was both medical superintendent and secretary to the Group Management Committee. After writing a series of letters, Crocket found him 'confused about the different requests' or unable to recall them.[79] One complaint was that no information about staff recruitment was forthcoming and Crocket wrote again stating 'I have heard nothing, at any time, of any substance about these appointments. My only information has come from puzzled applicants'.[80] He slept badly, having 'spasms of ineffective rage', angered by Miles' inefficiency, failure to answer letters and being 'too busy to see me'.[81] This clash clearly informed and energised his complaints about medical superintendents in the *Observer* article.

[73] Farndale, *The Day Hospital Movement in Great Britain*.6. In 1956, a night hospital was opened at the Maudsley Hospital. The inspiration for this was a unit in Montreal where patient's stayed overnight after their day's work. Arthur Harris, 'Day Hospitals and Night Hospitals in Psychiatry', *The Lancet*, vol. 269 (1957): 729–780.

[74] A search through contemporary references revealed no other unit that operated in a similar fashion. Farndale's review of day-hospitals recognised that some units contained day patients and in-patients, but the Ingrebourne was the only one that integrated the care of both sets together. Farndale, *The Day Hospital Movement in Great Britain*, 37.

[75] Farndale, 277.

[76] Farndale, 260.

[77] Crocket, PETT Interview (T) CF 271. 13; Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958', 2.

[78] R. W. Crocket, PETT Interview (T) CF 293, 30 June 1999, Planned Environment Therapy Trust, 3.

[79] R. W. Crocket, 'Letter to Dr Miles 28th January 1956', 28 January 1956, Planned Environment Therapy Archive.

[80] R. W. Crocket, 'Letter to Dr Miles 25th November 1955', 25 November 1955, Planned Environment Therapy Archive.

[81] R Crocket, 'Diary 9', Oct 15 1955; 'Diary 9', Oct 22 1955 Crocket.

iv. Large Groups and Modifying the Milieu: Initiating the Therapeutic Community

The appointment of Dr Hamish Anderson in 1957 marked the first significant changes.[82] He was 'very consciously Scots' with a 'solid heavy presence' and had a 'gift for toing and froing with the patients'.[83] He had previously worked with Dr Bell at Dingleton Hospital in Northumberland, where he had gained experience of group working methods.[84] Reflecting on this time, Crocket commented:

> for me it was entirely new, although people like Hamish Anderson, who weren't very good at expounding it, were perhaps doing things like this. I knew about Bell at Dingleton, but only as a kind of distant observer.[85]

Keen to apply his expertise, Anderson instituted a daily large group meeting in which all those in the Centre were to meet.[86] Initially, it was unsuccessful due to the inconsistent staff attendance and Crocket's reluctance to join in. Anderson was constantly being called to carry out duties elsewhere and so unable to provide the necessary leadership. Once arrangements were made so that he could attend regularly, it was 'dramatically successful' in changing the outlook of the staff and patients, and improving the emotional atmosphere.[87]

Crocket decided to be 'permissive about all this'.[88] The ward was still being run by a traditionalist matron who insisted on the floors being waxed and shone daily. His response on finding one man taking his motorcycle apart in the corridor was to hesitate before greeting him and then deciding to ignore the mess.[89] The substantial shift in the patient role, from passive recipient to someone able to impose themselves on the environment, converted Crocket and convinced him that he had to participate.

A timetable of meetings was drawn up with a daily large group, involving all patients and staff present, as its core constituent.[90] At this, 'any aspect of life in the Community, or a patient's problem, could be brought out and discussed'.[91] If something needed discussion, participants were told 'take it to the Large Group'. This arrangement remained fundamental

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[82] Unfortunately, there is little trace left of this doctor. David Millard, Crocket's obituarist, also failed to disinter any information about him, except that he became a general practitioner in Scotland. Personal communication.
[83] INGCE1, interview, 11.
[84] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process', 20.
[85] Crocket, PETT Interview 23 November 1998 (T)CF272, 18.
[86] R. W. Crocket, PETT Interview, interview by Craig Fees, 1998, 13, Planned Environment Therapy Trust.
[87] Crocket, PETT Interview (T) CF 271, 14.
[88] Crocket, 14.
[89] Crocket, 15.
[90] R. W. Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', *Proceedings of the Third World Congress of Psychiatry*, 269–74, 270-274.
[91] Crocket, 272.

thereafter. A separate 'Community' meeting, involving the same participants, was held three times a week to deal with the day-to-day running of the unit. This was formally constituted with a chair person, secretary and minutes. In practice, treatment issues cropped up and were often dealt with as in the large group, making distinction between the two difficult. It was later integrated into the large group meeting.[92] Other activities involved small groups, day-patient meetings and a patients' committee.

The conceptual shift was that the patients should relate to the whole 'artificially contrived group' of people for therapeutic purposes, rather than to any one individual.[93] To achieve this, Crocket recognised that 'freedom of communication amongst the therapeutic team probably has to come first'.[94] The aim was that the community as a whole should organise the social structure, but, because staff remained for longer than the residents, they were mainly responsible for executing this.[95] Crocket took the view that whilst staff might not be entirely 'emotionally balanced', they should be 'well enough adjusted within the culture of the community to be able to function therapeutically'.[96] He contended that in this form of treatment 'the therapist's concern extends to the whole of the patient's time while under treatment' and 'empathy and rapport of a psychotherapeutic kind is essential'.[97] Having to manage emotionally labile patients, without the safety-net of traditional authoritarian approaches, is stressful and he considered the use of meetings in which to discuss the feelings aroused to be especially necessary. However, apart from stressing how important it was that nurses needed 'good understanding of their roles', he was vague about how to achieve this.[98] It is in these 'sensitivity' meetings that the culture of the therapeutic community is created and sustained. There is, however, little published literature on how they operate, their effectiveness and their theoretical underpinnings.

His later assertion that the 'realisation that we were not alone came gradually, first when Maxwell Jones' post-war activities reached us' is contradicted by the evidence that he had arranged lectures by Martin and a representative from Belmont early in his sojourn at Ingrebourne.[99] He also recalled visiting Jones' unit at Mill Hill during the Second World War and later visited Jones again at Belmont Hospital.[100] Furthermore, two members of his staff came from units with similar aspirations. What it perhaps does suggest is that the implications of these other activities were not immediately apparent to him, and it reflects

[92] Hereafter called the community meeting.
[93] R. W. Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', *Proceedings of the Third World Congress of Psychiatry*, 270.
[94] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 182.
[95] Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', 270.
[96] Ibid.
[97] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 186.
[98] R. W. Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957.', Unknown, Planned Environment Therapy Trust, 4.
[99] R. W. Crocket, 'Early Experience at Ingrebourne. Paper Read at Windsor Conference of the Association of Therapeutic Communities The Therapeutic Community: Progress and Prospects, July 1987', 1987, Planned Environment Therapy Trust.
[100] Crocket, PETT Interview (T) CF 271, 14.

Henckes' point that reforming psychiatry was riven with varying meanings for the different professionals involved.[101] Although they sought support from their colleagues, each went about it in their own manner.

By the end of 1957, inspired by Anderson's enthusiasm, he gained enough confidence in the changes to give an enthusiastic account of the events to the medical staff of a neighbouring mental hospital, Runwell, on 'The Therapeutic Community Approach in a Neurosis Centre'.[102] In this, he acknowledged his debt to Maxwell Jones, particularly to that author's 1952 publication on *Social Psychiatry*.[103] From this Crocket gleaned six guiding principles:

1. Provision of a relatively ordinary and familiar social environment for the patient. This means minimizing factors in hospitalization or treatment which emphasises differences from social life outside.

2. Making the person aware of the effect of his behaviour on other people, and enhancing their social insight.

3. Ensuring that the process embraces the whole population of the unit.

4. Bringing trained staff into as many as possible of the diverse and fluctuating group situations, including informal as well as formal social groups.

5. Modifying the structure of the Unit so as to allow all patients and staff members to share authority and responsibility. This process appears to involve blurring of staff roles from the patient's point of view, but which requires staff to clearly understand their responsibilities.

6. Creating the freest possible channels of communication between all in the community.[104]

He also emphasised another dictum of Jones', that 'in a therapeutic community the whole of the patient's time spent in hospital is thought of as treatment'.[105]

Implicitly, he acknowledged the work of the Tavistock Institute of Human Relations. Employing the term 'tensions' in relation to participant interactions makes reference to a seminal paper, 'Intra-group Tensions in Therapy', by Wilfred Bion and John Rickman which reported on their work at the Northfield Military Hospital in 1942.[106] This was reinforced by his referencing another influential paper by Tom Main, 'The Ailment', which examined

[101] Henckes, 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis', 164.
[102] Crocket, 'The Therapeutic Community Approach in a Neurosis Unit'.
[103] Jones, *Social Psychiatry*.
[104] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 2–3.
[105] Jones, *Social Psychiatry*, 1952, 53
[106] W. R. Bion and J. Rickman, 'Intra-Group Tensions in Therapy: Their Study as the Task of the Group', *The Lancet* ii, 1943, 678–81.

group dynamics resulting from staff interactions with patients labelled as 'difficult' and the results of failing to share information.[107] All groups at the Ingrebourne reported back to the main community meetings specifically to counter this tendency. He emphasised that this open communication was an essential element in maintaining the coherence of the therapeutic approach.[108] Throughout, he stressed the importance of 'permissiveness', arguing that the 'doctor especially has to be able to set an example in surrendering overt authority and in accepting comment from patients'.[109]

Anderson expressed reservations. After Crocket described the change from a formal, and largely coercive regime of attendance, at the Occupational Therapy Department to one where the patients had more say in what they got involved in, he declared that 'No problems relating to occupation of patients have presented themselves now for many months'.[110] Anderson retorted 'Perhaps it would be wise – certainly more accurate – not to make ideal statements like this. There are still plenty of problems over occupations'.[111] They were no longer used to pass the time but had a constructive role in 'developing personal aptitudes which may fulfil the individual, as well as contributing to his social consciousness'.

Anderson's comments also indicate how he used techniques of 'persuading' the patient, stating 'it's a sort of social blackmail that commits him in front of his community'.[112] The description of him 'toing and froing with patients' is suggestive of someone who liked to argue his point.[113] This is amplified by how he saw the process of patient change. There were difficulties in getting the hospital authorities to supply reading lamps for the patients. After repeated requests were made by staff, they suggested that the patients might do so themselves, which they did. As he described it, there was

> 'a sort of sequence there of patient inertia → staff inertia → increased communications →staff activity →patient activity. There is another lesson about structure of communities there too. The impetus comes from leaders, i.e. staff'.[114]

Implicitly, he saw himself as the energising influence in this. The group meeting clearly was an opportunity for patients to express their feelings, but democratic processes were still

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[107] This paper is described in greater detail in the next chapter T F Main, 'The Ailment', *British Journal of Medical Psychology*, vol. 30 (1957), 124–45.
[108] Farndale, *The Day Hospital Movement in Great Britain*, 275.
[109] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 4.
[110] Crocket, 16
[111] In a later version of the lecture, Hamish Anderson is identified as the author of the notes by Crocket. (Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Author's Own Copy Annotated by Anderson, H.'), Crocket, 16 (reverse side).
[112] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 17 (reverse).
[113] R. St. Blaize-Molony, Interview, 11.
[114] The arrows are as in the original. Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 17 (reverse).

nascent. As one patient expressed it with regards to limiting the use of night sedation; 'Well, if that's the way the doctors want it we'll just do without'.[115]

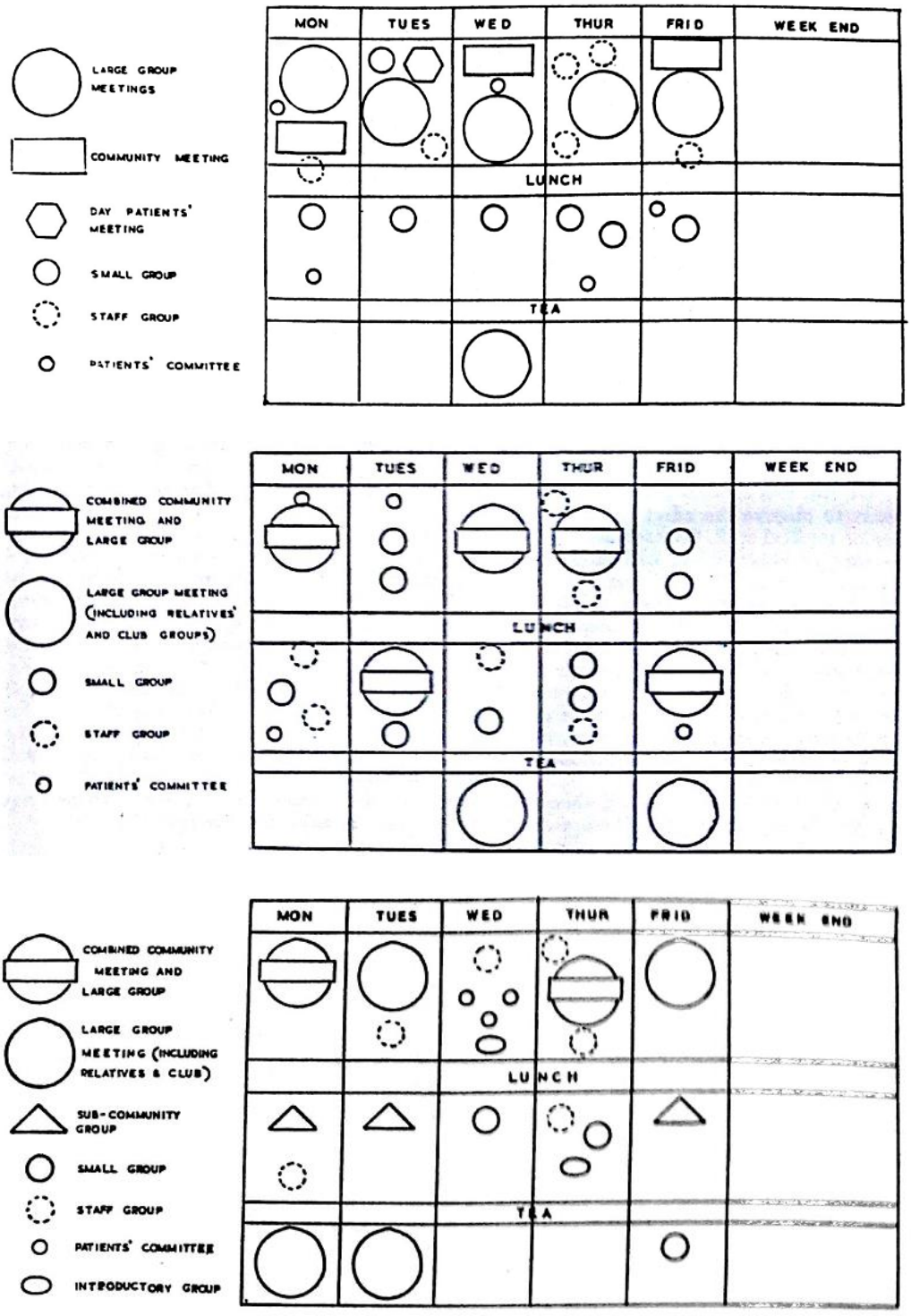
Anderson was more interested in changing people's behaviour than exploring difficulties. In another commentary, he considered that the aim was to feed-back real situations, 'so that the patient's habitual patterns of reaction may be shown in their uselessness to him, and new ones developed and reality-tested within the unit – then taken out for testing over week-ends etc'.[116]

This was a social approach, rather than a psychodynamic one, supplemented by efforts to devolve responsibilities. The reception of new patients was delegated to those who had been there longer, leading the staff to be 'constantly surprised by the capacity shown by patients to discharge duties', which were usually their own prerogative.[117]

It was a time of learning and change, illustrated by the evolution of the weekly timetable. Figure 3.7 demonstrates three of the five changes between the years 1957 to 1961.[118] The second and third show a trial of amalgamating the Community Meeting with the Large Group, which was later abandoned. The staff meetings were very flexible in their timing. At one point the two full-time doctors carried out separate meetings. This led to dissension and group fragmentation with staff and patients being split in their loyalties between the two regimes. Eventually, the therapeutic leadership reverted to the senior doctor and the unit was run as a single enterprise.

[115] Crocket, 17.
[116] H. A. Anderson, 'Commentary Footnotes on Initiation of a Therapeutic Community by Crocket R.', 1962, 15, Copy in possession of author.
[117] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 9.
[118] This paragraph and the diagrams are from Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', 1961.

Figure 3.7: Diagrams illustrating three out of five phases of the Timetable at Ingrebourne, 1957-1961.



(**Footnote**[119])

[119] Crocket. 272-274.

By 1958, Crocket was able to state that since 'February, 1957, the Centre has changed over to a Therapeutic Community approach'.[120] Other treatments were still being used, but now the emphasis was on forming a 'special type of relationship' with the patient, 'together with, in many cases, a greater or lesser degree of modification of the environment milieu within which he lives'.[121]

Rumblings reached the ears of the North Eastern Metropolitan Regional Hospital Board. Two members, visiting in 1958, were disturbed by what they found. After commenting that most of the patients 'would not normally be regarded as appropriate for a mental hospital', they were bemused by the group therapy and reported that it 'was extremely difficult for us to appreciate the purpose or effectiveness of this treatment'. [122] Characteristically, they then recounted that some of 'the bedrooms used by the patients were extremely untidy, and even dirty'. The fact that this form of antisocial behaviour was 'dealt with in the group discussions, and that only in extreme cases would action be taken against the offenders' only served to confuse them more. Despite the fact that the Centre was 'experimental', they were concerned that considerable resources were being diverted 'for the purpose of giving relief to patients (most of whom appear to be quite young) who have difficulty in adjusting themselves to the normal hurly-burly of life'. Having delivered themselves of this verdict, they took refuge in the fact that they were laymen and the 'final conclusion' on the value of the work should be reviewed by the appropriate specialists. These concerns about the nature of the patients, the methods of treatment and the costs, would escalate throughout the existence of the Centre and encapsulate persistent attitudes expressed by funding authorities about TCs.

Crocket was incensed and quick to respond in detail. His ire was further stoked by the fact that Dr Miles had failed to inform him of the outcome of the visit and also had not told him about a further visit by members of the Regional Hospital Board in January 1959.[123] He attempted to respond to each point made, accusing his detractors of disingenuousness. It has to be said that some of his responses were equally unconvincing. Arguing that 12% of the patients previously and 14% subsequently had been admitted to mental hospital leaves at least three quarters who had not. He questioned the high staffing ratio and consequent costliness without acknowledging the meagre staffing of wards in other mental hospitals. However, his arguments appear to have been successful, and he was able to continue and indeed raise issues about the paucity of his secretarial staffing.[124] Concurrently, he had to justify his work to Dr Nightingale, Medical Superintendent at Warley.[125] He was not going

[120] Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch. 1955 - 1958', 3.
[121] R. W. Crocket, 'Ingrebourne Centre, St George's Hospital, Hornchurch, Essex, Clinical Results, 1957 - 1959', 1962, Planned Environment Therapy Trust, 2.
[122] North Eastern Metropolitan Regional Hospital Board, 'Ingrebourne Centre (Report of a Visit)'.
[123] R. W. Crocket, 'Letter to Dr Miles, Responding to RHB Visit 1959', 30 January 1959, Planned Environment Therapy Trust.
[124] R. W. Crocket, 'Letter to Dr Graham 4th Feb 1959', 1959, Planned Environment Therapy Trust.
[125] Crocket, PETT Interview (T) CF 271. 15

about things as the latter had intended. By May 1959, he felt assured enough to tell Dr Miles that the methods used at Ingrebourne 'were increasingly being used elsewhere'.[126] Whilst partially true, the approach had not become widespread. His difficulties with the local hospital management continued on into the 1970s. One interviewee recalled that 'Crocket said to me, he says "would you mind talking with the finance people for me" saying "I've been trying for years, and I can't get any money"'.[127]

Having set the ball rolling, Anderson left on 31 July 1959.[128] The following decade ushered in new ideas and an increasing confidence.

Establishing the TC at Ingrebourne occurred piecemeal. Despite discussions with Sutherland and others in the field, Crocket was not confident enough to initiate the programme himself. It took the arrival of a more relevantly experienced and confident doctor to set things going. Once he had experienced the approach in action, Crocket could then formulate the practice in his first paper. The method was established and would continue with minor modifications for the next forty years. The next evolution relied on Anderson's replacement in the early 1960s. However, there was disquiet amongst senior managers around its effectiveness and costs, and although for the next three decades this critique was largely quiescent, by 2003 the same arguments led to the unit's closure.

3. From 'a Golden Age' to Despondency: The Ingrebourne Centre 1960 to 1975.[129]

Whilst there was a 'pervasive sense in the psychiatric literature that the therapeutic communities fad was on the wane' in the 1960s, the Ingrebourne Centre consolidated the processes that carried it through the next forty years.[130] The key figure at this stage was Dr St. Blaize-Molony, Dr Anderson's replacement. He brought his psycho-analytical expertise and, as the senior full-time doctor, was a significant support to and influence upon, his senior colleague. A paper written jointly by them in 1963 exploring the issues of authority

[126] R. W. Crocket, 'Letter to Dr Miles 14th May 1959', 1959, Planned Environment Therapy Trust.
[127] INGCE15, interview, 6.
[128] R. W. Crocket, 'Treatment and Results at the Ingrebourne Centre, St George's Hospital, Hornchurch, Essex. April 1st 1957 to March 31st 1959', 1962, Section 2, 4, Planned Environment Therapy Trust.
[129] Crocket made this observation in retrospect about the period in a note referring to a paper written at that time with his colleague St. Blaize-Molony. R. W. Crocket, 'Explanatory Notes on Crocket, R. and St. Blaize-Molony, R., Social Ramifications of the Therapeutic Approach in Psychotherapy, *British Journal of Medical Psychology*. 1964, vol. 37, 153', undated c 2000, Planned Environment Therapy Trust, PP/RC/30/02/05/02.
[130] Manning, *The Therapeutic Community Movement*, 47.

and permissiveness being worked out concurrently in the unit, illustrates the closeness of their professional relationship.[131]

This evolution was being played out against a backdrop of increasing confidence in 'progress' and broadening of 'youth culture' through music. Aspects of these cultural, social and political events throughout the 1960s are described before embarking on an account of developments at the Centre. The unit continued to be affected more by the broader social environment than by any national or local political interventions. After 1965, there appears to have been a decline in the morale. Crocket reports a sense of despondency and, by 1975, researchers found it run down and lacking staff. This section thus looks at the two periods consecutively, introducing each era with a brief review of the socio-political environment and the practice of psychiatry.

i. 'So much wonder floated free, so much hope was generated': The 1960s[132]

Prime Minister Macmillan's statement 'most of our people have never had it so good', delivered in 1957, reflected an era in which science appeared to promise limitless progress. His successor, Harold Wilson, continued to promote this belief in technology. In 1963 and in the spirit of C.P. Snow, due to be his Minister of Technology, he argued that the 'Britain that is going to be forged in the white heat of this revolution will be no place for restrictive practices or outdated methods on either side of industry'.[133] As the historian Paul Addison states, during this period Britain was ruled by 'the assumption that the new was always better than the old'.[134] Hire-purchase arrangements enabled everyone to take part by spreading the cost of buying cars, washing machines and new cookers.[135]

As the Beatles pleaded *Please, Please Me*, restrictions were being lifted and the 'permissive society' was born. At the Ingrebourne, the cultural freedoms of the 'sixties' encouraged social innovation. Signalling this, Crocket remarked on 'the appearance of Beatles' posters on bedroom walls (and any poster or picture on the wall was in itself a violation of hospital custom at the time) was one of the early signs that things were different'.[136] The concept of

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[131] R. W. Crocket and R. St. Blaize-Molony, 'Social Ramifications of the Therapeutic Community Approach in Psychotherapy', *British Journal of Medical Psychology*, vol. 37 (1964): 153–56.

[132] This is how St. Blaize-Molony recalled the era during which he was at Ingrebourne. R. St. Blaize-Molony, 'A La Recherche Du Temps Perdu: A Memoir of Richard Crocket after His 90th Birthday', *The Joint Newsletter of the Charterhouse Group of Therapeutic Communities, the Association of Therapeutic Communities , and the Planned Environment Therapy Trust*, no. 11 (August 2004): 44.

[133] See Harold Wilson, https://www.youtube.com/watch?v=oTnf3TNwc-E for a recreation of the speech and http://news.bbc.co.uk/player/nol/newsid_7000000/newsid_7004400/7004431.stm#, accessed 24/9/2014, for filmed excerpt.

[134] P. Addison, *No Turning Back: The Peacetime Revolutions of Post-War Britain* (Oxford; New York: Oxford University Press, 2010). 170.

[135] Dominic Sandbrook, *Never Had It so Good: A History of Britain from Suez to the Beatles* (London: Abacus, 2006), 114.

[136] R. W. Crocket, 'Introduction to Therapeutic and Psychotherapeutic Community Procedures: A Handbook.' (Typescript, 2000), 2, Planned Environment Therapy Archive.

patients developing a personal space would have been anathema to the 'orderliness' of the large asylums.

The cultural changes were described at the time as a 'relaxation of standards, a greater permissiveness, a raising of the demands a man may make on life and a lowering of the demands life can make on him'.[137] Historian Arthur Marwick argued that the '60s were a time of social upheaval as great as the Second World War.[138] Conscription to the Armed Forces came to an end in 1963. Capital punishment for murder ceased in 1965. The contraceptive Pill was introduced into Britain in 1961, and by 1964, half a million women were taking it.[139] The Abortion Act (1967), the decriminalisation of Homosexuality (1967), the abolition of censorship in the theatre (1969) and the liberalisation of the publishing industry following the failed prosecution of Penguin Press over publication of *Lady Chatterley's Lover* (1960) all contributed to a sense of new sexual freedoms. The associated pleasure was, perhaps semi-consciously, emphasised by the increasing use of the word 'gay' to reference homosexuality, first employed publicly by the comedian Benny Hill in the film *Light up the Sky* in 1960.[140]

The issue of homosexuality was one that concerned Crocket at Ingrebourne. A number of the patients would have discussed their sexual orientation and this exposed him to the question of how to manage when someone confessed to what was still a criminal act. His comment in 2001 was 'we had to live within the limits of accommodating homosexual patients. Their lot had to include acknowledgement that all, as it stood, was not one would want it to be'.[141]

Satire boomed, goosing the establishment. *Beyond the Fringe* (1960 to 1966), in which Peter Cook impersonated the Prime Minister doddering through a meaningless electoral broadcast, was ably buttressed by *Private Eye* (1961 to present) and *That Was the Week That Was* (1962 to 1963).[142] The latter was reflected in the Ingrebourne magazine, *Incentive* (June 1963), by an article headed '*That Was the Group That Was*: Songs for Swinging Neurotics'.[143]

How the term 'permissive' took on its public life and whether its usage in TCs during the 1950s and 1960s influenced its passage into popular culture is not clear. As we have seen Crocket used it in his initial address on therapeutic community practice.[144] The sociologist, Rapoport, included it as one of the four distinctive elements of the Belmont Hospital Social

[137] C.H. Whiteley and W.M. Whiteley, *The Permissive Society Morality* (London: Methuen, 1964), 21.
[138] Arthur Marwick, *British Society since 1945*, (London ; New York: Penguin Books, 2003), x.
[139] Hera Cook, *The Long Sexual Revolution English Women, Sex, and Contraception, 1800-1975* (Oxford; New York: Oxford University Press, 2004), 278-281.
[140] Benny Hill, Film: *Light up the Sky*, http://en.wikipedia.org/wiki/Gay, accessed 07/09/2018.
[141] R. W. Crocket, PETT Interview 23rd May 2001, Planned Environment Therapy Trust, 12.
[142] Sandbrook, *Never Had It so Good*. 572-588. See also YouTube: https://www.youtube.com/watch?v=qPCm6pRCSmQ, accessed 24/9/14.
[143] *Incentive*, Editor 'Jenny', June 1963, in possession of author, 3.
[144] Crocket, 'The Therapeutic Community Approach in a Neurosis Unit'. 4.

Rehabilitation Unit ideology.[145] As a consequence, it became one of the central tenets of TC practice.[146] It is uncertain whether the use of the word at Belmont preceded that of Crocket. However, it led to disquiet. The doctor in charge of the unit, Maxwell Jones, recalled that it caused 'a great deal of social disapproval' that jeopardised the very existence of his unit.[147]

By 1966, Crocket had come to define it as 'the capacity to relate to individuals or social groups without reactive anxiety which derives its strength from subjective fantasy rather than reality'.[148] This is one interpretation of a word that characterised the belief system of protagonists of the TC movement.[149] In the Rapoport study, the staff interpreted it as relating to pursuit of the understanding of problematic behaviour rather than taking punitive action.[150] How much the staff could tolerate of such difficulties would be a fluctuating limit, as was acknowledged by both authors. Similar constraints existed in general, and societal boundaries were continuously under pressure throughout the sixties and seventies. The expression became so pervasive that in 1969 the Home Secretary called for 'a halt in the advancing tide of so-called permissiveness'.[151]

On the other hand, the Rolling Stones heard every mother say 'life's just much too hard today' and then seek shelter with her little helpers: the tranquillisers.[152] The new technologies were seen as threatening people's stability. The historian, Mark Jackson,

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[145] The others were 'democratization', 'communalism' and 'reality confrontation'.Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 54.

[146] Morrice advised that, although encumbered by cliché and ritual, they provided the core concepts of the therapeutic community. J. K. W. Morrice, 'Basic Concepts: A Critical Review', in *Therapeutic Communities: Reflections and Progress*, eds. R. D. Hinshelwood and N. P. Manning (London: Routledge & Kegan Paul, 1979), 49. See other examples: A. Stevens, 'Introducing Forensic Democratic Therapeutic Communities', in *Grendon and the Emergence of Forensic Therapeutic Communities*, eds. R Shuker and E Sullivan (Chichester: Wiley-Blackwell, 2010), 11–12; J. Kipp, 'The American Contribution to Therapeutic Community for People with Psychosis and a Reflection on Current Milieu Treatment in the United States', in *Therapeutic Communities for Psychosis: Philosophy, History and Clinical Practice*, eds. J. Gale, A. Realpe, and E. Pedriali (Hove & New York: Routledge, 2008), 18–19; R. Byrt, 'Nursing: The Importance of the Psychosocial Environment', in *Therapeutic Communities: Past, Present and Future*, eds. P. Campling and R Haigh (London: Jessica Kingsley, 1999), 65.

[147] Jones, 'Introduction', 3.

[148] R. W. Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives.', *American Journal of Psychotherapy*, vol. 20, no. 4 (1966), 674.

[149] C. Fussinger, '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War II', *History of Psychiatry*, vol. 22, no. 2 (2011): 154–55; J. K. W. Morrice, 'Permissiveness', *British Journal of Medical Psychology*, vol. 38 (1965): 247–51.

[150] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 58.

[151] Callaghan, J., 1969, House of Commons debate on the Wootton Report, http://hansard.millbanksystems.com/commons/1969/jan/27/cannabis-wootton-report, c. 959, accessed 31/10/2014.

[152] Jagger, M. and Richards, K. 1966, 'Mother's Little Helper' lyrics © ABKCO Music Inc. The historian Ali Haggett has explored the background to this and indicated that the excess of use of tranquillisers by women as opposed to men is a complex issue that did not necessarily mean that the experience of distress and neurosis necessarily was significantly different between the sexes. She also reveals the complexity of causation, which was not necessarily related to the domestic role. Ali Haggett, *Desperate Housewives, Neuroses and the Domestic Environment 1945-1970,* (Routledge, 2016).

detects an increasing anxiety about stress and alienation.[153] In 1970, *The Times* carried an article headed 'One in nine has a nervous breakdown', arguing that they are brought on by stress, strain, overwork, shock, exhaustion and other causes.[154] This echoed psychiatrist Arthur Crisp's observation that many people blamed modern society for their mental ill-health.[155] At the same time, Jock Sutherland argued that when a man's 'own ends are submerged to the common end, or within a group ideal, he is often at his best and conversely, when he does not "belong" serious trouble and even death can ensue'.[156]According to the historian, Fred Cooper, the concern that communal networks were disintegrating led to a pre-occupation with loneliness that was endemic in the late 1950s and early 1960s.[157] Part of the effectiveness of the TC approach is the recognition people gain that they are 'not alone'.

The introduction of the Benzodiazepine anxiolytics, Valium and Librium, had not yet led to widespread concerns about their overuse by women as chemical solutions to the apparently rising tide of neurosis.[158] However, the publication of *The Feminine Mystique* (1963), by Betty Friedan, signalled a new perception of their role in society.[159] As Jagger and Richards recorded, the 'pursuit of happiness just seems a bore' and women were engaged in seeking new freedoms and rights beyond those bestowed by the Pill.[160] Historian Ali Haggett points to the lack of evidence supporting the idea that the domestic environment was a cause of 'desperate housewives' resorting to chemicals to relieve boredom and neurosis.[161] Instead, many women welcomed domesticity and joined organizations and groups that fostered friendship and intellectual stimulation to compensate.

Non-prescription drugs were of increasing concern. Whilst the use of heroin and similar narcotics was largely under control at the beginning of the decade, the situation was 'balanced precariously on a knife edge'.[162] The number of addicts rose six-fold to nearly 3,000 by 1972.[163] More significant was the increasing use of 'soft' drugs such as cannabis,

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[153] Mark Jackson, *The Age of Stress: Science and the Search for Stability*, (Oxford: Oxford University Press, 2013), particularly chapter 5, pp. 181-223.
[154] S. King, 'Coming through a Crisis: One in Nine Has a Nervous Breakdown', *The Times*, 23 November 1970, 5.
[155] Arthur Crisp, 'Introduction', *Journal of Psychosomatic Research*, vol. 10 (1966): 1.
[156] J. D. Sutherland, 'Session 4. Industry and "Stress Disorder"', *Journal of Psychosomatic Research*, vol. 10 (1966): 71–72.
[157] Fred Cooper, '"Cut It out at Last like the Cancer Which It Is": Prevention and Responsibility in the Loneliness Epidemic of the Late 1950s and Early 1960s.' (2016).
[158] In the West Midlands between May 1967 and April 1968, 13.6% of the female population were taking some form of psychotropic drug, as opposed to 6.65% of the male population. P. Parish, 'Supplement: The Prescribing of Psychotropic Drugs in General Practice', *The Journal of the Royal College of General Practitioners*, vol. 21, no. 92 (1971), 21.
[159] Friedan, *The Feminine Mystique* (New York: W. W. Norton, 1963). See Haggett, *Desperate Housewives, Neuroses and the Domestic Environment 1945-1970*, 11–15.
[160] Jagger, M., Richards, K., 1966, op.cit.
[161] Haggett, *Desperate Housewives, Neuroses and the Domestic Environment 1945-1970*, 175.
[162] Christie Davies, *Permissive Britain: Social Change in the Sixties and Seventies* (London: Pitman, 1975), 142.
[163] Davies, 153.

which, by 1968, was estimated as being used by between 30,000 and 300,000 people in the UK, most of whom resided in London.[164]

Lysergic Acid Diethylamide (LSD) was being used to treat mental disorder.[165] In the United Kingdom, a passionate advocate for its use in treating mental illness was Dr Sandison, at Powick Hospital, near Worcester.[166] One of his colleagues published a paper on 'Permissive group therapy with LSD'.[167] Both attended and presented papers at a conference organised by Crocket in 1961, where its role in treatment and the subjective experience it generated were discussed.[168] Crocket and Sandison subsequently co-edited the papers from this meeting. LSD later became a recreational, 'psychedelic' drug manufactured by amateur 'acid freaks'.[169] The terms 'permissive' and 'psychedelic' became particular signifiers of the 'hippy' culture of the late 1960s and early 1970s.[170]

This all went on to the drum beat of the Cold War. The discovery of Russian nuclear weapons on the island of Cuba in 1962 appeared to threaten outright conflict.[171] Earlier concerns about nuclear annihilation attached themselves to the American involvement in the Vietnam War and discontent became increasingly political as the 1960s progressed. [172]

Despite the positive rhetoric of politicians, the era began with the economy faltering. Exports fell alongside the balance of payments crises in 1961 and 1964.[173] The Ford works at

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[164] Home Office, 'Cannabis: Report by the Advisory Council on Drug Dependence' (London: Home Office, 1968). Para. 36;J Davis, 'The London Drug Scene and the Making of Drug Policy 1965-73', *Twentieth Century British History*, vol. 17, no. 1 (2006): 26–49.

[165] Synthesised by Albert Hoffman, a Swiss biochemist, in 1943, LSD's potential as a treatment for mental illness was examined by a number during the 1950s. Osmond, in Canada, coined the term 'psychedelic' by amalgamating two Greek words *psyche* (mind) and *delis* (manifest), which later was taken up enthusiastically by both people experimenting with it, and the press. E. Dyck, *Psychedelic Psychiatry: LSD from Clinic to Campus* (Baltimore, Md: Johns Hopkins University Press, 2008).

[166] R. A. Sandison, A. M. Spencer, and J. D. A. Whitelaw, 'The Therapeutic Value of Lysergic Acid Diethylamide in Mental Illness', *Journal of Mental Science* 100 (1954): 491–507.R. A. Sandison, 'Letter: A Role for Psychedelics in Psychiatry', *British Journal of Psychiatry*, vol. 187 (2005): 483.

[167] A. M. Spencer, 'Permissive Group Therapy with Lysergic Acid Diethylamide', *The British Journal of Psychiatry: The Journal of Mental Science*, vol. 109 (1963): 37–45.

[168] Crocket, PETT Interview (T) CF 271, 9. R. W. Crocket, R. A. Sandison and A. Walk, eds., *Hallucinogenic Drugs and Their Psychotherapeutic Use: Proceedings of the Quarterly Meeting of the Royal Medico-Psychological Association in London February 1961* (London: H.K. Lewis and Co., 1963).

[169] Davis, 'The London Drug Scene and the Making of Drug Policy 1965-73', 41; Sandison, 'Letter: A Role for Psychedelics in Psychiatry'.

[170] Adrian Mitchell opened his article for the *Guardian* in 1967 with the words 'Let's open with three rousing psychedelic ho-hums for the Permissive Society'. A Mitchell, 'Adrian Mitchell' Guide to the Underground', *The Guardian*, 12 October 1967, 9. Ronald Sandison also linked the two in an article for the *Practitioner* in 1968; 'we are on the fringe of the so-called permissive society, and a look at some aspects of this society may help us to see the future prospects for LSD more clearly'. R. A. Sandison, 'The Hallucinogenic Drugs', *The Practitioner*, vol. 200 (1968): 249.

[171] E. J. Hobsbawm, *Age of Extremes: The Short Twentieth Century, 1914-1991* (London : New York: Michael Joseph ; Viking Penguin, 1994), 228, 230.

[172] Nick Thomas, 'Challenging Myths of the 1960s: The Case of Student Protest in Britain', *Twentieth Century British History*, vol. 13, no. 3 (2002), 277–97.

[173] Morgan, *The People's Peace*, 209-211.

Dagenham was at the sharp end of worker militancy, with the Prime Minister ruing the control of the 'Communist shop stewards' there.[174] The factory again figured in 1968 when the women sewing machinists went on strike for equal pay, a momentous action that led to the introduction of the Equal Pay Act of 1970.[175]

ii. Psychiatry in the Sixties.

Public disquiet about mental hospitals gained momentum. Erving Goffman's critique of *Asylums* (1961) was published the same year that the British Minister for Health, Enoch Powell, announced the intended dissolution of mental hospitals.[176] The first rumblings of a gathering storm came with the publication, in 1967, of *Sans Everything: A Case to Answer*, which castigated the care of older people.[177] Whilst the sociologist Kathleen Jones found that the evidence presented was less than convincing, she acknowledged that the arguments for reform were 'well-reasoned'.[178] The book triggered a 'wave of suspicion and excitement' in the national press, which was followed by the sequence of enquiries into mental hospitals that marked the 1970s.[179]

When Crocket wrote that the methods employed at the Ingrebourne were 'being increasingly used elsewhere', others were less sanguine, reporting that there was actually a decline during the 1960s and the 'fad' was waning.[180] David Clark argued that it was a 'relatively defined technique' by 1960, but not widely practised.[181] Stuart Whiteley, medical director of the Henderson Hospital from 1966, considered that they faded from prominence during the decade, and 'smouldered on' until the 1970s, neither dying out altogether, nor becoming widely established.[182]

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[174] Quoted in David Kynaston, *Modernity Britain. Book 2,* 2014, 124.
[175] Sheila Cohen, 'Equal Pay – or What? Economics, Politics and the 1968 Ford Sewing Machinists' Strike', *Labour History*, vol. 53, no. 1 (2012): 51–68; Hastings, S., 2007, The story of the Ford sewing machinists: A TUC oral history project on equal pay in association with the Wainwright Trust. TUC accessed at file:///G:/Toms%20Downloads/1%252F090%252Fsewing+machinists+4pp-1.pdf, on 02/10/2014.
[176] The original was published by Anchor Doubleday in New York. The popular British edition came out with Penguin Books in 1968. Erving Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates* (Harmondsworth: Penguin, 1968); Kathleen Jones, *Asylums and after: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s* (London; Atlantic Highlands, N.J: Athlone Press, 1993), 159
[177] Barbara Robb, *Sans Everything: A Case to Answer* (London: Nelson, 1967).
[178] Kathleen Jones and A. J. Fowles, *Ideas on Institutions: Analysing the Literature on Long-Term Care and Custody* (London ; Boston: Routledge & Kegan Paul, 1984), 105–7.
[179] Jones, *Asylums and After*, 188–89.
[180] Crocket, 'Letter to Dr Miles 14th May 1959'; Manning, *The Therapeutic Community Movement*, 47.
[181] Clark, 'The Therapeutic Community', 555.
[182] J. S. Whiteley, 'Progress and Reflection', in *Therapeutic Communities: Reflections and Progress*, eds. R. D. Hinshelwood and N. P. Manning (London: Routledge & Kegan Paul, 1979), 16.

This perceived decline was seen as being due to a number of factors.[183] The over-optimism and idealism of many protagonists threatened to obscure their achievements and the concept had become muddled and the process confused.[184] As a result, the 'omnipotent needs' of the staff could result in practices that were detrimental. This was amply illustrated by the novelist Ken Kesey in *One Flew Over the Cuckoo's Nest*, (1962) and made into a popular film in 1975. In this, group therapy is portrayed as a particularly vicious method of 'mind control' by the 'Big Nurse' in charge of the ward.[185]

Institutional care was under attack and combined with the anti-psychiatry critique increasingly led to greater cautiousness by those who held the purse strings. Research findings into effectiveness were not helpful. In an authoritative account published in 1961, known as the 'three hospitals study', sociologist George Brown and his colleagues, including the highly respected social psychiatrist, Dr John Wing, found that a systematic rehabilitative approach produced significantly better outcomes for people with longer term schizophrenia than other methods, which included a therapeutic community.[186] Other research was ambiguous, both in identifying which patients benefited and whether it was effective.[187]

This was set against the background of an increasing array of alternative treatments. Work-therapy units were being developed, often aping factory conditions with lower pay.[188] By 1965, a quarter of psychiatric hospitals were employing between twenty and fifty per cent of their patients in this manner.[189] Some hospitals, such as Cheadle Royal, Glenside, St Wulstan's and Netherne, were leaders in their field offering methodical appraisal of the participants with a clear vision of how the approach meshed with employment opportunities outside of the hospital.[190] There was an increased interest in behavioural therapies, exemplified by the token economy system, in which tokens were given for worthy

[183] It is not clear how real this decline was. Papers were still being published indicating the institution of therapeutic community techniques in wards, and the John Conolly Hospital in Birmingham was opened specifically as a therapeutic community in 1965. Mary Lightbody and S. Jacobson, 'A Therapeutic Community in an Acute Admission Unit of a Mental Hospital', *British Medical Journal*, vol. 1, no. 5426 (1965): 47–49; Fay Crofts, *History of Hollymoor Hospital* (Studley, England: Brewin, 1998), 100.

[184] B. B. Zeitlyn, 'The Therapeutic Community - Fact or Fantasy?', *British Journal of Psychiatry*, vol. 113 (1967): 1084.

[185] Ken Kesey, *One Flew Over the Cuckoo's Nest* (London: Methuen, 1962); Ephraim Katz, *The Macmillan International Film Encyclopedia* (London: Macmillan, 1994), 474.

[186] J. K. Wing and G. W. Brown, 'Social Treatment of Chronic Schizophrenia: A Comparative Survey of Three Mental Hospitals', *The British Journal of Psychiatry*, vol. 107, no. 450 (1961): 847–61.

[187] Whiteley, 'Progress and Reflection', 17–18.

[188] The better units, such as at Netherne and Bristol, had a clearly defined progression through which the patients could graduate to more appropriate and interesting jobs.

[189] H. B. Kidd, 'Industrial Units in Psychiatric Hospitals', *The British Journal of Psychiatry*, vol. 111, no. 481 (1965): 1207.

[190] D. H. Bennett, 'The Historical Development of Rehabilitation Services', in *Theory and Practice of Psychiatric Rehabilitation*, eds. F. N. Watts and D. H. Bennett (Chichester: John Wiley & Sons, 1983), 27–29.

behaviour that could be exchanged for goods and privileges.[191] Other units were using behavioural techniques, including electric shocks, to 'cure' homosexuality.[192]

Rehabilitation served the ideals of community care. From 1960 onwards, there was increasing pressure from government to close down the psychiatric hospitals.[193] Methods of reducing the numbers through systematic programmes of reskilling hitherto disabled people fitted this prerogative well. Therapeutic communities, like the Ingrebourne, on the other hand were increasing the number of hospital patients by working with those whom the mental hospitals would not have cared for in the first place. With limited funding, services with demonstrable, and apparently logical, outcomes were likely to be at the front of the queue.

Medication continued its unstoppable rise. As historian of psychopharmacology David Healy expressed it, the 1960s was a world 'in which Librium and Valium triumphed'.[194] In the hospitals, the 'success' of chlorpromazine had stimulated the pharmaceutical industry to develop a raft of other antipsychotic drugs.[195] Depression began its seemingly inexorable increase as a diagnosis, secondary to the introduction of imipramine and amitriptyline.[196] The battle over whether misery and unhappiness were medical or psycho-social disorders had commenced in earnest. The evident efficacy of medication in alleviating some people's difficulties weighed heavily in favour of the former viewpoint.

It was clear that Ingrebourne was going to remain outside of mainstream psychiatry. How it survived for the next forty years is a question that will continue to be examined throughout this thesis.

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[191] S. Pilling, *Rehabilitation and Community Care* (London: Routledge, 1991), 76. The heyday of this approach was the 1960s. It could be used to attempt to modify every aspect of the patient's waking day, including toileting, and required a very controlled environment occluding any opportunity for the person to access alternatives.

[192] J. Bancroft and I. Marks, 'Electric Aversion Therapy of Sexual Deviation', *Proceedings of the Royal Society of Medicine* 61 (1968): 796–99.M. King and A. Bartlett, 'British Psychiatry and Homosexuality', *The British Journal of Psychiatry*, vol. 175, no. 2 (1999): 109–110.

[193] Jones, *A History of the Mental Health Services*, 321–40.

[194] David Healy, *The Antidepressant Era* (Cambridge, Mass.: Harvard University Press, 1997), 76.

[195] David Healy, *The Creation of Psychopharmacology* (Cambridge, MA: Harvard University Press, 2002), 124; Wilfrid Llewelyn Jones, *Ministering to Minds Diseased: A History of Psychiatric Treatment* (London: W. Heinemann Medical Books, 1983), 44, 45.

[196] Healy, *The Antidepressant Era*, 1997, 74–75. Healy has argued that the manufacture of the antidepressants, and contingent profits of the companies involved, has significantly influenced the increasing diagnosis of depression, and other conditions, by the medical profession. Ibid., 180-206.

iii. 'The Culture that Prevails', not Rules: 1960 to 1965 at Ingrebourne[197]

The following narrates the developments in the Centre over the next five years, which covers the time that St. Blaize-Molony was the full-time doctor working there. He had a significant influence over his senior colleague and, in retrospect, Crocket saw these years as 'something of a golden age'.[198] In his view, the unit was acting as a fully-fledged Psychotherapeutic Community. There was little outside interference and the community was left to get on with what it saw as its task uninterrupted. Practices established during this period at the centre varied little in the following years, although their nature gradually transmuted.

The passage of the 1959 Mental Health Act into law was highly significant for Crocket, who argued that it was the 'event which has brought community therapy forward for our attention'.[199] It established consultant psychiatrists as equals with their general medical colleagues as it removed the overview of the medical superintendent from their clinical practice.[200]

After a short interregnum, again requiring protracted discussions with the Regional Hospital Board, St. Blaize-Molony was appointed in Anderson's stead in 1960.[201] The new doctor was sensitive to the liberalising spirit of the times declaring that 'things were opening up in general'.[202] He had run therapeutic groups in Sheffield, influenced by the psycho-analytic approach of Foulkes and Anthony articulated in their landmark book on group therapy (1957).[203] Crocket later acknowledged the importance of this psychodynamic input, stating that his colleague 'successfully transferred to the community many of the insights and reality-based understandings he was concerned with in his training as a psychoanalyst'.[204] St.

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[197] In the introduction, to what was essentially a guide to conduct, St. Blaize-Molony made it clear that what he intended to offer the community was an attempt to summarise the 'mores and customs which facilitate' its aims'. The word 'rule' does not appear in the document. R. St. Blaize-Molony, 'Ingrebourne Centre: Guidelines for the Community', 1961, Planned Environment Therapy Trust.

[198] Crocket, R. W., Undated, Notes accompanying article 'Social Ramifications of the Therapeutic Approach in Psychotherapy', Planned Environment Therapy Trust.

[199] R. W. Crocket, 'Lecture Notes: Community Therapy and the Boundaries of Group and Individual Hospital Treatment. Chairman's Address to the Psychotherapy Section of the Royal Medico-Psychological Association, May 1962', 1962, 1, Planned Environment Therapy Trust.

[200] Crocket, 'Lecture Notes: Community Therapy and the Boundaries of Group and Individual Hospital Treatment. Chairman's Address to the Psychotherapy Section of the Royal Medico-Psychological Association, May 1962', 11.

[201] St. Blaize-Molony, 'A La Recherche Du Temps Perdu: A Memoir of Richard Crocket after His 90th Birthday', 44.

[202] R. St. Blaize-Molony, Interview, 1.

[203] S. H. Foulkes, after working at Northfield Military Hospital, developed his own brand of group therapy which he popularised in a series of publications. His contribution to group therapy will be discussed in the next chapter. S. H. Foulkes and E. J. Anthony, *Group Psychotherapy: The Psychoanalytic Approach*, (Harmondsworth: Penguin, 1965). St. Blaize-Molony, Interview: St. Blaize-Molony 1st October 2010 (TMH), 2.

[204] Crocket, R, Undated, Notes accompanying article 'Social Ramifications of the Therapeutic Approach in Psychotherapy'.

Blaize-Molony continued to hone his psychotherapeutic skills, attending Jock Sutherland's clinics at the Tavistock Clinic on a weekly basis, and later training as a psychoanalyst.[205] In practice, this meant a shift from Anderson's persuasive techniques to an interpretive approach based on understanding the motives for people's behaviour. Following Foulkes, he identified individual behaviour as being reflective of events occurring in the group as a whole. As he expressed his approach:

> if I gave an interpretation to an individual it was to indicate the community state of being. If I gave an interpretation to the community it was meant to hit the person who was most actively concerned, who was expressing the anxiety or tension in the group or the community at the time.[206]

This understanding of the interwoven nature of individual psychic events and the wider social network was central to both Foulkes' Group Analytic approach, and that of the Tavistock Institute of Human Relations. Its origins lay in the Northfield Experiments and the theoretical perceptions of Kurt Lewin described in the next chapter. Its importance is that it moves away from the individual as an isolated object of treatment to an understanding of him, or her, as an active node in a network of relationships. Evelyn Tiley, the senior nurse at the unit in 1966, emphasised that patients 'recover through the community rather than through any one person'.[207] The approach was summed up as utilising 'patient-patient relationships and staff-patient relationships for twenty-four hours a day, rather than working through doctor-patient sessional relationships'.[208]

This was not immediately obvious to newcomers. Typical of people arriving there with no previous experience of the therapeutic community approach, and despite his earlier familiarity with group work, St. Blaize-Molony found the initial experience bewildering. He discovered that 'various meetings always seemed very unintelligible really to me'.[209]

As with his predecessor, much of the day-to-day running of the unit was left to him. His senior, Crocket, remained in the background of the life of the community, acting as a sort of father figure.[210] In an attempt to instil some order to the unit, and perhaps to gain a sense of control over his bewilderment, St. Blaize-Molony drew up *Guidelines for the Community*.[211] The preamble stated that: 'The following is an attempt to summarize the salient features of culture that is followed in Ingrebourne Centre'. The first piece of advice referred to the expectations of the external world, in particular the wider hospital and its management

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[205] St. Blaize-Molony, Interview: St Blaize Molony 1st October 2010 (TMH), 2, 12.
[206] St. Blaize-Molony, Interview: St. Blaize-Molony 1st October 2010 (TMH), 6.
[207] Evelyn Tiley, 'Ingrebourne Centre: A Therapeutic Community', *Nursing Times*, October 21st (1966): 1399.
[208] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Author's Own Copy Annotated by Anderson, H.', 1.
[209] St. Blaize-Molony, Interview: St. Blaize-Molony 1st October 2010 (TMH), 1.
[210] St. Blaize-Molony, Interview: St. Blaize-Molony 1st October 2010 (TMH), 4.
[211] R. St. Blaize-Molony, 'Ingrebourne Centre: Guidelines for the Community', 1961, Planned Environment Therapy Trust.

committee, and dealt with smoking in bedrooms and the restriction of telephone calls to the hours of 6.15 to 10.15 p.m.. The second, and longest, addressed the issue of drugs, both prescribed and social, in particular alcohol. In general, they were to be avoided. The importance of parties and dances as therapy was stressed, but within reasonable limitations:

> social occasions form much of the treatment processes and alcohol in moderation plays a part in facilitating the development of such occasions. So the community has undertaken to serve a pre-selected amount when dances are held in the Centre. Each participant is served with and restricted to two alcoholic drinks and the community accepts the responsibility of seeing that these limits are observed.[212]

Subsequent sections dealt with visiting hours, attendance at groups, quietness, mealtimes, newspapers and the use of the treatment room.

The recommendations on medication addressed a particular problem that remained endemic throughout the lifetime of the community, as well as in others.[213] Anderson, commenting on how night sedation ceased to be prescribed, described how the 'formality of doling out sedatives' had been used by patients 'as a means of playing up the night staff'.[214] Tiley reported that the philosophy of the unit was that the 'drugs prevented the patients from presenting themselves as they really are', although they could help in moments of acute emotional crisis.[215] The crux of the matter for Crocket was the issue of responsibility. If the doctor prescribed 'a drug, or E.C.T., we were very definitely saying that he or she (*the patient*) was <u>not</u> responsible, and that the doctor knew best, knew the answers, and had some magic power to deal with the problem'.[216]

The day started with breakfast at 8 o'clock. Afterwards the residents would carry out domestic chores around the Centre.[217] This responsibility was fundamental, making the residents active participants in the daily running of their environment, rather than relying on others.

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[212] St. Blaize-Molony, 1.

[213] J. Hartman, 'Medication: A Necessary Evil?,' *International Journal of Therapeutic Communities*, vol. 1, no. 2 (1980): 121–24; M. Chiesa, M. Wright, and L. Delphine, 'Psychotropic Medication and the Therapeutic Community: A Survey of Prescribing Practices for Severe Personality Disorder', *Therapeutic Communities*, vol. 25, no. 2 (2004): 131–44; H. A. Wilmer, *Social Psychiatry in Action: A Therapeutic Community* (Springfield, Illinois: Charles C. Thomas, 1948), 91–118. See also an excellent description of how medication was used as a lever to manipulate power in the doctor-patient relationship at Villa 21 when the doctor confronted a 'leader of the patients' over his night medication at his bedside in full view of the other patients of the unit. Oisin Wall, 'The Birth and Death of Villa 21', *History of Psychiatry*, vol. 24, no. 3 (2013), 336–37.

[214] Anderson, 'Commentary Footnotes on Initiation of a Therapeutic Community by Crocket R.', 14, footnote 15.

[215] Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1399.

[216] R. W. Crocket, 'Notes for a Presentation on Ingrebourne to be given in America', 1968, Planned Environment Therapy Trust, 2.

[217] Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1400.

The Large Group was the first meeting of the day. At the beginning of the decade, this ran three times a week, but by 1963 it was daily.[218] It was held in the Centre's largest room upstairs and was attended by both day and resident patients, as well as all staff who were present in the unit.[219] Andrew Roberts recounts his experience of this meeting:

> About forty is a good size group. The chairs are mixed armchairs and hardbacks and arranged around the walls facing inwards. One sits where one likes. Two girls were particular about their seats and pushed the pads up, sometime before group, as a sign that they were reserved. Doctors, nurses and social workers also sit where they like. There are about four occasional tables in the room with ash trays on, which are pulled by patients into positions where the largest number can reach the ash trays.[220]

When St. Blaize-Molony took up his post, it was held at midday. He took early advantage of his superior's permissive attitude to move it to earlier in the morning, where it remained for the rest of the life of the Centre.[221] Its purpose by this time was to discuss events that were happening in the Centre and in people's lives, acting as a 'kind of "feed-back" situation for the community as a whole'.[222] As Andrew Roberts saw it, people 'talked about personal relations, family squabbles, how they felt about one another. It was all interesting and vital to a coordinated life, but wildly irrelevant to the question of god and the universe.[223]

The stance adopted by St. Blaize-Molony was to allow any issues to be aired openly, before offering some form of interpretation, enabling an alternative understanding. Such interventions were not the sole purview of the doctor, indeed insights from other members of staff and patients were encouraged, which was 'a much more frequent happening than might be expected'.[224] The 'interpretations' by staff were not always seen as accurate or relevant by the recipients. Andrew Roberts recorded his disagreement with one intervention; 'Dr Barker wanted to know, when he saw me next, why I needed to help lame dogs over stiles'. In Roberts' view, the question was 'a mis-conception'. On another

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[218] Anon, 'Ingrebourne Centre Timetable c. 1960-1964', n.d., Planned Environment Therapy Trust. Roberts' recollection is that it was daily when he attended the unit. A. Roberts, 'Ingrebourne Centre', studymore.org.uk/ingrebou.htm, accessed 07/11/2014; Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1399.

[219] The room is denoted as the Games Room in Figure 3.4 above. Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Author's Own Copy Annotated by Anderson, H.', 7.

[220] Andrew Roberts, was a patient at the Centre in 1963, and has posted his experiences on his website, presenting a detailed account of life there at that time. Roberts, 'Ingrebourne Centre'. Roberts was later a founding member, along with his partner, Valerie, of the Mental Patients Union.

[221] St. Blaize-Molony, Interview, 2.

[222] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Author's Own Copy Annotated by Anderson, H.', 7.

[223] Roberts, 'Ingrebourne Centre'.

[224] R. W. Crocket, 'Crossing the Therapeutic Rubicon, Draft' (29 January 1974), Planned Environment Therapy Archive, 5.

occasion, a doctor spoke dismissively about the intensity of one woman's expression of distress.[225]

The 'modelling' aspects that Anderson practiced were not entirely abandoned. Crocket explained that 'supportive' aspects of psychotherapy would include 'selective reinforcement of existing personality traits in patients'.[226] Nevertheless, the primary aspect of therapy involved the 'provision of 'good' relationships…, so that the patient's experience of what may be described as 'loving', 'tolerating', or 'accepting' behaviour, as against 'hostile', 'aggressive', 'destructive' or 'hating' behaviour, is increased'.[227]

Crocket envisioned the process as educative, through observing how others dealt with crises, and acquiring social and personal insights. In his view, it was necessary to sustain a sensitive balance between the supportive and interpretive elements of therapy because the majority of people coming to the unit were unable to 'make use of conceptual thinking and discussion as would allow for personality change'.[228]

Therapy groups, or activities such as cooking or gardening, made up the rest of the programme.[229] The therapy groups were explicitly psychotherapeutic and small allowing the revelation of more personal matters.[230] Figure 3.8 shows how the week was organised in 1961. Psychiatrists A and B were St. Blaize-Molony and a trainee registrar who was present for a limited period of time, usually six months. This timetable became the template for the next forty years, only being modified in detail.

[225] Roberts, 'Ingrebourne Centre'.
[226] Crocket, 'Crossing the Therapeutic Rubicon, Draft', 6.
[227] Crocket, 6.
[228] R H. Crocket, 'The "Therapeutic Community" Approach to Neuroses', in *Neuroses: I. Congressus Psychiatricus Bohemoslovenicus Cum Participatione Internationale 1959* (Prague: Státní zdravotnické nalkadatelství, 1961), 271–78, 274.
[229] Figure 4 gives a more comprehensive list under 'other activities'.
[230] Consisting of 6-10 patients and 1 or 2 staff members. Roberts, 'Ingrebourne Centre'.

Figure 3.8: Timetable of activities at Ingrebourne, 1961.

TABLE I. INGREBOURNE CENTRE

Breakfast: 8:00–8:30 a.m. *Dinner*: 12:15 p.m. *Supper*: 6:15 p.m.

Monday	Tuesday	Wednesday	Thursday	Friday	Other activities
9:30–11:00 a.m. Community Meeting and Large Group. All Patients. Psychiatrist A.	*9:30–11:00 a.m.* Large Group. All Patients. Psychiatrist A.	*9:45–10:45 a.m.* Nurses' Meeting. Psychiatrist B.	*9:00–10:00 a.m.* Nurses' Meeting. Psychiatrist C.	*9:30–11:00 a.m.* Large Group. All Patients. Psychiatrist A.	Community Chores, Painting, Crafts, Clay Modelling, Dressmaking, Baby-sitting for Day-patients' children, Sports (table tennis tournaments, swimming, walks), Cooking for social evening, Canteen, Dramatics, Dancing, T.V., etc.
11:00 a.m. Coffee	*9:30–12:00 Noon* Sheltered Work. Social Therapist.	*10:00 a.m.* Coffee	*9:30 a.m.* Coffee	*10:00 a.m.* ECT. Psychiatrist B.	
9:00–1:00 p.m. Oldchurch Hospital O.P. Psychiatrist B.	*10:00 a.m.* ECT. Psychiatrist B.	House Committee. Magazine Committee. Sports and Social Committee. Occupation Projects Committee.	*10:00–11:30 a.m.* Community Meeting and Large Group. All Patients. Psychiatrist A.	*11:00 a.m.* Coffee	
9:30–12:00 Noon Sheltered Work. Social Therapist.	*11:00 a.m.* Coffee	Introductory Group.	*11:45–1:00 p.m.* Case Conference. Psychiatrist C.	*9:00–1:00 p.m.* Oldchurch Hospital O.P. Psychiatrist C.	
2:45–4:00 p.m. Subcommunity Group. Psychiatrist A.	*11:15–1:00 p.m.* Staff Meeting.	*9:30–12:00 Noon* Sheltered Work. Social Therapist.	*p.m.* Introductory Group.	*2:00–4:30 p.m.* Ardleigh Green Club. Social Therapist.	
4:00 p.m. Tea.	*1:30–3:00 p.m.* Sheltered Work. Social Therapist.	*2:00–5:00 p.m.* Oldchurch Hospital O.P. Psychiatrist A.	Drama Group. Social Therapist.	*2:30–3:45 p.m.* Subcommunity Group. Psychiatrist B.	
4:15–5:30 p.m. Clergymen's Probation Group and Officers' Group. Alternate weeks.	*2:30–3:45 p.m.* Subcommunity Group. Psychiatrist B.	*2:00–4:00 p.m.* Small Group. Psychiatrist B.	*3:15 p.m.* Tea.	*3:15 or 4:00 p.m.* Tea.	
7:30–10:30 p.m. Romford Social Therapeutic Club. Psychiatrist A.	*2:00–4:30 p.m.* Ardleigh Green Club. P.S.W.			*5:45–7:15 p.m.* Small Group. Psychiatrist A.	
	3:15 or 4:00 p.m. Tea.				
	8:00–9:30 p.m. Relatives' Group. P.S.W.				

(Footnote [231])

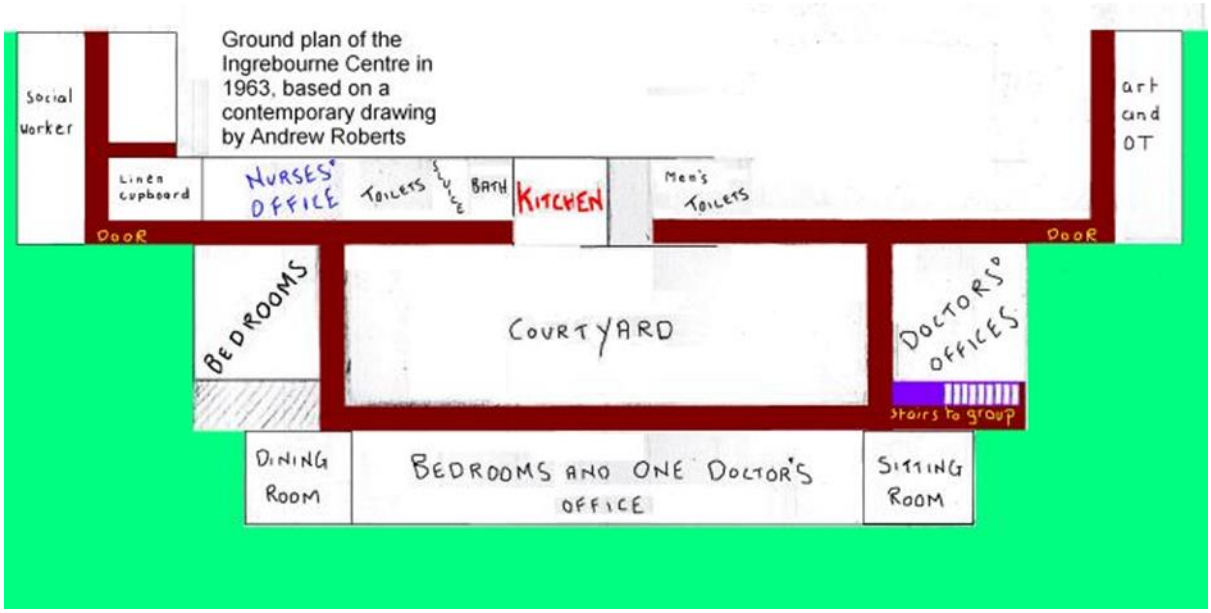
The daily *modus operandi* is discussed in greater detail in the next chapter, but some descriptions of the milieu are given here. The increasing confidence of people undergoing treatment to help each other is illustrated by Andrew Robert's experiences. Un-allocated time for the patients was often spent in the kitchen. Most congregated 'sitting around on hard chairs, or on the stoves and draining board, and brewing tea and coffee'.[232] Evelyn Tiley considered it to be the 'natural centre' of the community, and illustrated this with a photograph showing patients and their children occupying it.[233] Prospective patients were invited to meet community members there over a cup of tea as well.[234] Its importance as a 'really crucial area' is further emphasised by siting it centrally and titling it in red, in the drawing by Roberts (*Fig 3.9*).[235]

Evelyn Tiley was keen to emphasise the unit's difference from the traditional mental hospital, stating that there were 'no locked doors', and the patients were 'free to come and go'.[236] She emphasised that they 'like to keep the Centre as much like 'outside' as is possible', and the staff did not wear uniforms.[237] Emphasising the expectations that patients

[231] Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', 271.
[232] Roberts, 'Ingrebourne Centre'.
[233] Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1401.
[234] Tiley, 1399.
[235] Roberts, interview, 8.
[236] Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1399.
[237] Tiley, 1399–1400.

were no longer passive recipients of therapy, she illustrated the article with a picture of one 'amusing the children who were often admitted with their mothers' by demonstrating his footballing skills in the courtyard.[238]

Figure 3.9: Drawing of the Ingrebourne Centre illustrating the important areas relevant to the patients (1960s).



(Footnote) [239]

As Roberts recalls, 'I can remember very little that any of the doctors ever did' and asserts that the most important care and therapy came from the other patients.[240] On one occasion, whilst contemplating killing himself, he started talking to another person who was also considering suicide.

> That wheel of pain and the only thing you could do was to, you know, defy the universe and kill yourself. And so I explained this to XXX. She said the one thing that was going to smash into my feelings, which was: "you know that's how I feel". And she was goin' to try and kill herself, you see. But my response to XXX was "No you mustn't". I mean that just smashed through the logic of …
>
> Her life mattered to me. So everything started churning up and a few days later I changed my mind. You know, not like that, but I mean this really turned me upside down. If that hadn't happened I don't know that the groups would have broken through into me or anything like that. You know it could have happened anyway couldn't it? I mean it's unlikely to have happened somewhere else. But it wasn't part of the therapy in the sense of … It was perfectly normal interaction, yeah? It's

[238] Tiley, 1401.
[239] Roberts, 'Ingrebourne Centre'.
[240] Roberts, interview, 5.

> unlikely that I would have met somebody who I'd have explained it to like that in those circumstances. It wasn't part of a therapy session we were just sitting down there having a cup of tea and Ingrebourne had brought us as patients together.[241]

Further insights into the patient experience are provided by the magazine, authored by patients, and started in 1962. Most articles do not relate to the centre, but some do. One person described a new nurse who sat next to her in a morning group four years earlier:

> what a queer character. I'm not kidding, I mean just that; she looked very pale and very nervous and honestly, her hairdo was out of this world. She sat down next to me and I felt rather annoyed with her as she was causing me to take my mind off my man of that year. … Well, as I say, the character was very peculiar to me, lots of mornings she would sit with a large sheet of paper drawing the group circle, with each member in his or her seat. In the end I began to wonder if she was going to annihilate us one by one, then I realised she was just getting into the gist of things. As you all know, it's hard enough for us neurotics to understand what group therapy is, let alone the psychiatrists themselves.
>
> I wonder if you've guessed who I am talking about. She is a completely changed personality and I sincerely mean it when I say I think she gives herself constantly into helping others: So Miss XXX, I can only say thanks for walking in that morning.[242]

The description of the new nurse's confusion and uncertainty fitted many who entered their first community meeting. Goffman criticises asylum magazines ('the house organ') as being an 'institutional ceremony' largely under the control of the staff.[243] In these, the inmates are able to gently criticise the staff, but within limits. They are censored by their keepers and the journals act as an attempt to ameliorate the conditions in, and to justify the nature of the institution. The contribution above does this, but carries with it a sense of humorous conviction that suggests authenticity.

Another contribution listed songs and their interpretation in the community.[244] For instance St. Blaize-Molony came in for some stick: '*Misty*' was identified with 'Molony's summing-up', '*Smooth operator*' – 'Dr.Molony', '*Bewitched, buggered and bewildered*' – 'Rosemary - Blaize encounter' and '*Me and my shadow*' – 'Molony and [Dr.] Barker'.[245] Group therapy earned a number: '*These foolish things*' – 'Groups?', '*Answer me*' – 'No boomerangs, please'

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[241] Roberts, 7–8.
[242] R. Chamberlain, 'Strange Character', *Incentive*, (November 1963), 6.
[243] Goffman, *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*, 90–92.
[244] Anon, 'That Was the Group That Was - Songs for Swinging Neurotics.', *Incentive*, (June 1963), 3.
[245] This and the following all come from Anon. *Incentive*, (June 1963), 3.

and '*How about you?*' – 'The Boomerang'. [246] The devolution of responsibility avidly pursued by the doctors resulted in '*Do it yourself*' being countered by 'Build your own psychiatry kit'. The psychological approach being paramount gave rise to '*They didn't believe me*' – 'My purple spots were PHYSICAL!'.

Whilst the tenor was humorous, the underlying issues were real for those experiencing them. The psychotherapeutic zeal of the staff was not always understood, and perhaps was not always relevant to the patients, who saw things rather differently.

Commenting on Crocket's approach with the staff, St. Blaize-Molony colourfully recalled that

> Under gentle probing and the genius of a warm accepting rapprochement, individuals could search the missed opportunities in group for intervention by apt comment, or the moment for an interpretation which would have swung the group from Pinteresque desultory to the therapeutic flights of insight and meaning.[247]

Given that St. Blaize-Molony on another occasion described how he would have to interpret Crocket's rather 'gnomic' comments in groups, this may contain more hyperbole than accurate recall.[248] However it is clear that these groups, later called 'sensitivity groups', shared ideas about how to manage the feelings that were aroused by a closer relationship with the patients, and Crocket acted as a 'father' figure in supporting this.[249]

Staff meetings became more uncomfortable later in the 1960s and early 1970s, reflecting a period during which Crocket felt that the unit was operating less well. Describing this from the scant materials available forms the basis of the next section.

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[246] The 'Boomerang' refers to the tendency of many therapists to reflect a question back to the interlocutor. For instance 'Doctor why does everybody hate me?' and the doctor would reply 'Why do you think everybody hates you?' or slightly less aggressively, 'What makes you think everybody hates you?'.

[247] St. Blaize-Molony, 'A La Recherche Du Temps Perdu: A Memoir of Richard Crocket after His 90th Birthday', 45.

[248] St. Blaize-Molony, Interview, 3. In his diaries, he records being rather fed up with his wife's interruptions of his statements in social gatherings. She would do so, stating "What Richard really means to say is…".Crocket, 'Diary 9: 1954 - 1962', 24th Jan. 1952.

[249] St. Blaize-Molony, 'A La Recherche Du Temps Perdu: A Memoir of Richard Crocket after His 90th Birthday', 44.

iv.. The Permissive Society and Fighting in the Streets: From the late 1960s to 1975.

Unlike in the earlier and later periods the social and political changes occurring during the period 1965 to 1975 had a more complex impact on life at the Ingrebourne. In common with other TCs, many staff were attracted to the Centre precisely because the approach suited their counter-cultural attitudes. The period saw a tumult of ideas and questioning of the established order that was in tune with how the Ingrebourne staff saw themselves, *vis a vis* the traditional mental hospital. In 1972, at a meeting of members from different TCs, including the Ingrebourne, David Clark recalled how 'people were, as they did in those days, leaping to their feet making impassioned speeches, citing Chairman Mao and other figures like that, as the way to organise things'.[250]

Beyond the confines of the psychiatric world, the post-war political consensus was breaking up.[251] External pressures began to have an increasing impact on life inside the mental hospital. Practices were being questioned and the cost of these services began to be scrutinised. As a consequence, the complex changes occurring in British society were becoming of increasing relevance to the Ingrebourne Centre and its participants, as well as other therapeutic community pioneers, such as David Clark.[252] Authority was being ever more subject to challenge. Whether by the increasing militancy of the trade unions, university students, women or gay and anti-racist activists there was a determination that the *status quo* was no longer acceptable. Britain was seen by many as waning economically, even as being in a 'State of Emergency' by the early 1970s.[253] This pessimistic, declinist picture is disputed. Modern British historians Lawrence Black and Hugh Pemberton argue that the difficulties that Britain faced were part of an international economic crisis and that it served the political agenda of subsequent governments to distance themselves from the apparent errors of their forerunners in office.[254]

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[250] David Clark quoted in David Kennard, 'An Incomplete History of the Association of Therapeutic Communities', *Therapeutic Communities*, vol. 32, no. 2 (2011): 98.

[251] In their review of British politics, political academics Leach et al. report that the term 'political consensus' in relation to the post-war British political system is disputed. However, the late 1960s and early 1970s laid the foundations for the rejection of the predominant Keynes/Beveridge economic/social model led by the incoming Prime Minister Margaret Thatcher in 1979. Robert Leach, W. N. Coxall, and L. J. Robins, *British Politics*, (Houndmills, Basingstoke, Hampshire; New York: Palgrave Macmillan, 2011), 23-24.

[252] D. H. Clark, *'The Early Days of the ATC': The Peter van Der Linden Lecture, 1999* (Cambridge, 1999), http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=1201:the-early-days-of-the-atc-dr-david-h-clark-the-peter-van-der-linden-lecture-1999&catid=284&Itemid=408, accessed 07/09/2018.

[253] W. D. Rubinstein, *Twentieth-Century Britain: A Political History* (Houndmills, Basingstoke, Hampshire; New York: Palgrave Macmillan, 2003), 281. The phrase in italics was the title of populist historian Dominic Sandbrook's book on the early 1970s. Dominic Sandbrook, *State of Emergency: The Way We Were: Britain, 1970-1974* (London: Penguin, 2011).

[254] Lawrence Black and Hugh Pemberton, 'Introduction: The Benighted Decade? Reassessing the 1970s', in *Reassessing 1970s Britain*, eds. Lawrence Black, Hugh Pemberton, and Pat Thane (Manchester: Manchester University Press, 2016), 1–24.

Industrial action was a persistent threat to government and industry. The coal miners' work-to-rule, combined with an international shortage of oil contributed potently to the downfall of Heath's Conservative government in 1974.[255] This demonstrable power of organised labour is open to more sympathetic interpretations than reflected in the subsequent recantations by later Labour politicians.[256] By 1979, over half the total British workforce was unionised, with membership being actively promoted in the NHS.[257] In 1972, nearly a 100,000 ancillary workers were involved in the first major strike ever held by health service employees.[258] Trade union activity was particularly extensive at Warley, with nurses effectively bullying the hospital management during the first part of the 1970s, perhaps taking their cue from the workers at the nearby Ford Factory in Dagenham.[259] As one manager recalled, there was 'a lot of industrial action, as you know, during the seventies, and Warley Hospital in particular had, had some quite nasty action'.[260]

The scene was set throughout the 1960s, as Britain's share of world trade declined and there were recurrent crises in the national balance of payments.[261] The Labour Government's inability to address these issues though a 'national plan' to boost industrial efficiency and exports led to devaluation of the pound in 1967.[262] This, in combination with the country's entry into the European Economic Community, was widely seen as indicative of its fading global importance.[263] The health service was relatively sheltered from these constraints, but this only stored up problems for later governments to solve.[264] Instead, the late '60s and '70s were a period of turmoil in policy terms, as successive governments attempted to tackle the financial and administrative structures of the NHS.[265] The first task, budgeting for 'more economical and desirable services', was a continuing concern as rising costs threatened to spiral out of control.[266] These were almost entirely due to the increasing costs of technology in physical medicine, increased staff numbers and wages, and the impact of demographic change. In 1973, the Arab oil-producing countries introduced a

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[255] Peter Hennessy, *The Prime Minister: The Office and Its Holders since 1945* (London; New York: Allen Lane/Penguin Press, 2000), 352–54.
[256] John McIlroy, Alan Campbell, and Nina Fishman, 'Introduction: Approaching Post-War Trade Unionism', in *British Trade Unions and Industrial Politics: The High Tide of Trade Unionism 1964-79*, eds. John McIlroy, Alan Campbell, and Nina Fishman (Adershot: Ashgate, 1999), 1–19.
[257] Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Radcliffe Pub., 2010), 81.
[258] Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS* (London: King's Fund, 1998), 262.
[259] This will be described in greater detail in chapter 5. INGCE31, interview, 30–31.
[260] INGCE28, 2016, 1.
[261] B. W. E. Alford, *British Economic Performance, 1945-1975*, (Cambridge; New York, NY, USA: Cambridge University Press, 1995), 68–70.
[262] Brian Howard Harrison, *Seeking a Role: The United Kingdom, 1951-1970*, (Oxford : New York: Clarendon Press; Oxford University Press, 2009), 308–10; Alford, *British Economic Performance, 1945-1975*, 70.
[263] Black and Pemberton, 'Introduction: The Benighted Decade? Reassessing the 1970s', 3.
[264] Klein, *The New Politics of the NHS*, 78–79.
[265] Charles Webster, *The National Health Service: A Political History*, (Oxford: Oxford Univ. Press, 1998), 65–139.
[266] Webster, 111-115.

partial embargo on oil exports to the West, increasing fuel costs sharply.[267] Combined with one-day rail strikes and all-out miners' strikes, this exposed the fundamental weakness of the British economy.[268] The preceding optimism of never-ending growth was brutally aborted when the government imposed special measures to reduce fuel consumption by curtailing power supply to factories to only three days a week. The increasing assertiveness of different health staff groupings, in negotiating better pay and conditions, placed further pressure on the dwindling resources.[269] As a result, the NHS 'relapsed into a state of siege' as its constituent parts came to terms with the exigencies of cash limits and altered priorities.[270]

An attempt to redistribute funds from well-funded London services to more deprived provincial regions was relatively unsuccessful, as were efforts to move expensive hospital services into more 'community' based ones.[271] The North Eastern Metropolitan Region of London, under whose aegis both Warley and the Ingrebourne came, demonstrated this failure by actually increasing its share of the budget, but the mental health services did not benefit.[272] The greater part of the bounty was swallowed up by the prestigious London teaching hospitals.[273]

The same period saw the rise of the 'counterculture' and its evolution into political activism as the initial idealistic dreams faded, or faced the difficulties of practical implementation. The rise of the 'permissive' society, whilst apparently 'liberating' sexual behaviour, perhaps merely made activities engaged in for decades more public.[274] However, this openness resulted in the proliferation of flamboyant dress and music festivals in Hyde Park and the Isle of Wight, drawing attendances of up to half a million young people, supported by a plethora of 'underground' magazines that uninhibitedly discussed and illustrated sex, radical politics and relationships.[275] Many of the staff joining the Ingrebourne during the 1970s had explored alternatives to established society, including Buddhism, veganism, Green Peace

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[267] Trevor Owen Lloyd, *Empire, Welfare State, Europe: English History 1906-1992*, (Oxford; New York: Oxford University Press, 1993), 443.
[268] Rubinstein, *Twentieth-Century Britain*, 305.
[269] Klein, *The New Politics of the NHS*, 76.
[270] Webster, *The National Health Service*, 138.
[271] The re-allocation of money was decided through a formula known as RAWP (Resource Allocation Working Party), Webster, 86–87.
[272] In 1963 it received 5.14% above the national average, by 1975 this was 18.75% and, in 1988, this had 'dropped' to 9.01%, Webster, 86.
[273] INGCE28, interview, 4.
[274] Harrison, *Seeking a Role*, 481–82.
[275] Jonathon Green, *Days in the Life: Voices from the English Underground 1961 - 1971*, (London: Pimlico, 1998), ix–x. See also Anon, 'Isle of Wight Festival History', *The Daily Telegraph*, 6 October 2011, http://www.telegraph.co.uk/culture/music/music-festivals/8567648/Isle-Of-Wight-Festival-history.html; Ed Vulliamy, Peter Beaumont, and Tess Reidy, 'Hyde Park, 1969: The Counterculture's Greatest Day. And the Rolling Stones Came Too.', *The Observer*, 4 July 2013, https://www.theguardian.com/music/2013/apr/07/stones-park-first-time-around. Copies of contemporary magazines and newspapers such as *Oz* (http://ro.uow.edu.au/ozlondon/) and the *International Times* (http://www.internationaltimes.it/archive/) are available on line.

and marijuana as they sought a way of relating to others sympathetic to their egalitarian leanings.[276] As one expressed it, 'I was a bit of an anti-establishment type person in the sense that I was, for instance, into veganism. I was into Green Peace and everything that was just a bit different'.[277]

Reactions against the permissive society were beginning to set in, and, by 1975, punk had eclipsed psychedelia. Optimism transmuted into more focussed political action. Elucidating the increasingly direct challenges against the 'establishment', historian and pioneer Women's Liberationist Sheila Rowbotham argues that a 'crucial element in women's liberation writing has challenged the way people are defined and categorized by the state and understanding is denied to those without power, many of whom are of course women'.[278] This reflected how university students increasingly perceived themselves and others they considered to be disadvantaged.[279] Building on the activities of the Campaign for Nuclear Disarmament, the New Left and earlier demonstrations against government intervention in other countries, students brought a wide range of contentious issues to public attention, challenging the accepted order of things.[280] The women's liberation movement militantly promoted their rights both amongst their peers and publicly in a manner unseen since the suffragettes in the 1920s. According to historian Hera Cook, from 1965 to 1969 there was a 'transformation of sexual mores' as a result of the effectiveness of oral contraceptives introduced in 1961.[281] This enabled a wide-spread debate about the role of women in society particularly articulated by successors to Betty Friedan, such as Germaine Greer, the women's liberation movement and the journals *Spare Rib*, *Shrew* and *Women's Voice*.[282]

Punitive responses by the authorities only broadened the protests. Increasing violence in Northern Ireland, apartheid in South Africa and gay liberation all provided foci for more political activity. On occasion, this erupted into street fighting, such as at Grosvenor Square in March 1968, where 117 police were injured.[283] Unlike the earlier CND marches, this was 'a huge and violent confrontation with massed police', unequalled since the Cable Street riots of the 1930s.[284]

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[276] INGCE16, interview; INGCE17, interview; INGCE19, interview.
[277] INGCE17, interview, 1.
[278] Sheila Rowbotham, *The Past Is before Us: Feminism in Action since the 1960s*, (London: Penguin, 1990), 156.
[279] Caroline Hoefferle, *British Student Activism in the Long Sixties* (New York and London: Taylor & Francis, 2017).Hoefferle describes how the student protests began with complaints about conditions at different universities, but then evolved to encompass a range of other issues including Women's Liberation, apartheid and gay activism during the period from the late 1950s to the 1970s.
[280] Thomas, 'Challenging Myths of the 1960s: The Case of Student Protest in Britain', 278.
[281] Cook, *The Long Sexual Revolution English Women, Sex, and Contraception, 1800-1975*, 295.
[282] Laurel Forster, 'Spreading the Word: Feminist Print Cultures and the Women's Liberation Movement', *Women's History Review*, vol. 25, no. 5 (2016): 812–31.
[283] See British Pathé film http://www.britishpathe.com/video/grosvenor-square-anti-vietnam-riots, accessed 08/01/2015.
[284] Morgan, *The People's Peace*, 294.

Historian Brian Harrison reports that 'attitudes to death were changing kaleidoscopically in the 1950s and 1960s'.[285] Suicide was decriminalised in 1961 and capital punishment for murder was suspended in 1965 and finally ended in 1969.[286] However, the right to abortions under particular circumstances was won by women in 1967.[287] Simultaneously, as 'cultural barriers tumbled,' so did the emotional ones.[288] Confirming this, historian Thomas Dixon illustrates how attitudes towards death were changing away from a culture of denial to the open expression of grief.[289] He argues that, in the 1970s, 'men were moved to tears by all sorts of things' such as accidentally killing a hedgehog with their lawn mower, or, more regularly, as a spectator at a football match.[290] Expressing emotion was central to the work that the Ingrebourne Centre was engaged in as participants faced their inner demons.

v. Psychiatry Under Siege

Issues of death impacted on psychiatric practice through the perceived 'epidemic' of self-harm and suicide attempts through the 1950s to the late 1970s.[291] The Ingrebourne psychiatrists assessed people, in the local general hospitals, who had ingested poisons or otherwise harmed themselves and took some of them on for treatment at the Centre.

Historian Mathew Thomson identifies the late 1960s and 1970s as a period when the post-war consensus between professional and popular perceptions of psychological culture came under attack by radical thinkers.[292] Integral to the rising 'permissive' society were reflections on the nature of mental disorder, ranging from the idea that schizophrenia was 'a kind of passport to a world of insight' to the complete dismissal of the concept of mental illness.[293] Ronnie Laing developed the Kingsley Hall community in response to his observations that schizophrenia was a sane response to the insane environment of a pathogenic family and that all conventional psychiatric services were oppressive.[294] His aim was to remove the distinction between patient and staff treating them and the institution was as much as

[285] Harrison, *Seeking a Role*, 291.
[286] Houses of Parliament, 'Suicide Act 1961', c. 60 (Regnal. 9 and 10 Elix 2) § (1961), http://www.legislation.gov.uk/ukpga/1965/71/contents/enacted; Houses of Parliament, 'Murder (Abolition of Death Penalty) Act', 1965 c. 71 § (1965), http://www.legislation.gov.uk/ukpga/1965/71.
[287] Houses of Parliament, 'Abortion Act 1967', 1967 c.87 § (1967), https://www.legislation.gov.uk/ukpga/1967/87/introduction/enacted.
[288] Green, *Days in the Life*, ix.
[289] Dixon, *Weeping Britannia*, 260.
[290] Dixon, 263.
[291] Millard, *A History of Self-Harm in Britain*, 2.
[292] Thomson, *Psychological Subjects*, 266.
[293] Thomson, 271; T. Szasz, *The Myth of Mental Illness* (Paladin, 1972).
[294] R. D. Laing and A. Esterson, *Sanity, Madness and the Family* (Harmondsworth: Penguin, 1970); R. D. Laing, 'The Obvious', in *The Dialectics of Liberation*, ed. David Cooper (Harmondsworth: Penguin, 1968), 18–19.The following chapter will provide some more detail of the development of the Philadelphia Association and Kingsley Hall as part of the history of the therapeutic community movement. Here, it is only relevant to note the popularity of his anti-establishment ideas and its relation to the Ingrebourne Centre.

anything else an educational platform with lectures, experimental dramas, poetry readings, music and dance all creating a 'paradigm of psychiatric revolt… against the old order'.[295] Clearly, these ideas appealed to Crocket. He suggested in a staff meeting that he wished the Ingrebourne to move in the same direction and, whilst this was dismissed as 'facetious', he returned to the subject again approvingly in a later session.[296] He had also invited Laing on two occasions to speak at the Centre. Other staff members also read Laing's work with interest.[297] Elsewhere within the field of psychiatry he had a wide influence. Professor Anthony Clare observed that he 'influenced a whole generation of young men and women in their choice of psychiatry as a career' and 'everyone in contemporary psychiatry owes something to R. D. Laing' because of his insistence that the plight of the mentally ill should be taken seriously.[298] Professor Jenner attempted to set up a therapeutic community based on Kingsley Hall in Sheffield.[299] Peter Sedgwick, a political commentator of the period, reported that 'virtually the entire left and an enormous proportion of the liberal-arts and social-studies reading public' believed that Laing and his colleagues had accurately conveyed the significance of the psychotic experience.[300] As a result, they achieved a 'cultural and political dominance' amongst those with pretensions to progressive thinking.

Hospital care also came under intense scrutiny. Following the limited impact of *Sans Everything*, there was an increasing number of enquiries into conditions in psychiatric hospitals from 1969 onwards until the 1980s.[301] A consequence of one of the earliest scandals, at Ely Hospital, was the establishment of the Hospital Advisory Service in 1969 by the Minister of Health Richard Crossman.[302] Its remit was to inspect conditions in all psychiatric and mental-handicap hospitals.[303] Visits lasting a week were carried out by a multi-disciplinary team of practising professionals, seconded from their posts in the NHS, who then reported on their findings.[304] This surveillance raised awareness of professional staff that their activities were increasingly being monitored. During the 1960s, despite predictions of hospital closures, they were absorbing more finance than ever before.

[295] N Crossley, *Contesting Psychiatry* (London: Routledge, 2006), 100; Adrian Laing, *R.D. Laing: A Life* (London: Harper Collins, 1997), 108.
[296] Ingrebourne Staff, 'Summary of Staff Meetings 24.1.67, 31.1.67, 6.2.67, 14.2.67, 21.2.67.', 1967, pts 24.1.67 & 14.2.67, Planned Environment Therapy Trust.
[297] INGCE16, interview, 12.
[298] Anthony Clare, *In the Psychiatrist's Chair*, (London: Heinemann, 1992), 204.
[299] From an interview with Professor Jenner carried out by Nick Crossley in 1997. Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', 879.
[300] P. Sedgwick, *Psychopolitics* (Pluto Press, 1982), 6.
[301] J. P. Martin and Debbie Evans, *Hospitals in Trouble* (Oxford: B. Blackwell, 1984).
[302] Klein, *The New Politics of the NHS*, 59.
[303] Martin and Evans, *Hospitals in Trouble*, 141. Almost certainly there would have been at least one visit to the Ingrebourne Centre conducted by the HAS, however, attempts to trace any reports have been unsuccessful.
[304] Martin and Evans, 141.

Psychiatric nurses and psychiatrists increased by a third in the early 1970s, although the number of in-patient admissions changed very little.[305]

The 'definitive' White Paper, *Better Services for the Mentally Ill*, was published in 1975, confirming the government's commitment to community-based services.[306] It carried the proviso, nevertheless, that it would take 'a long-term programme to achieve in all parts of the country the kind of change'.[307] Furthermore, in the contemporary 'state of financial stringency', there was 'little or no scope for substantial additional expenditure on health and personal social services'. Thus Warley had to rely on its own resources to make changes in the face of severe challenges from the trade unions. Ingrebourne was left alone to do 'its own thing', whilst the hospital management tackled these other issues.

In parallel, the therapeutic community movement lost its initial anarchic energy and its emergent leadership began to consider how to organise to sustain the approach for the longer term.

4. Ingrebourne, 1965-1975

This period is illustrated by pieces of evidence gained from archival material, some oral histories and published reports. The structure set up at the beginning of the 1960s continued, despite some suggestions that alternative forms of therapy could be tried. The details are unclear, but the period appears to have been a less happy time. Crocket contrasted it with the previous 'golden age' and explained that 'the initial excitement had passed'.[308] He recalled that in the Centre itself there was an 'element of ennui', in particular the changes in the National Health Service seemed to stifle innovation or action research.[309] A new staff member was struck in the mid-1970s by a

> feeling that some people were there for long periods of time. You know, the patients, and there didn't seem to be very, any limits put on, at that time, whereas it was at the Henderson. And there didn't seem to be a great deal of transition in what people were talking about in small groups, going into the large group, and there was a sense of almost like a clique that was going on. New people, it was very hard for new people to come in.[310]

[305] Hugh Freeman, 'Mental Health Policy and Practice in the NHS: 1948-79', *Journal of Mental Health*, vol. 7, no. 3 (1998): 231, 234.
[306] Freeman, 232.
[307] Department of Health and Social Security, *Better Services for the Mentally Ill*, iii.
[308] Crocket, 'Explanatory Notes on Crocket, R. W. and St. Blaize-Molony, R., 'Social Ramifications of the Therapeutic Approach in Psychotherapy', *British Journal of Medical Psychology*, vol. 37, 153 (1964); R. W. Crocket, 'Explanatory Notes on Two Papers by Tollinton H.J.', undated, Planned Environment Therapy Trust.
[309] Crocket, 'Explanatory Notes on Two Papers by Tollinton H.J.'
[310] INGCE15, interview, 4.

Furthermore there 'were those sort of things that were going on I think that made it, at times, quite a cauldron of confusion and conflict'.[311] An ex-patient returning for further treatment commented, 'when I was last here as a patient, I felt I was a privileged guest at a five star restaurant; and now I feel as if I've come to a soup kitchen!'[312]

Reflective staff group sessions, or sensitivity groups, in a TC serve the function of examining and easing the relational dynamics in the unit.[313] It is a challenging process fraught with emotional turmoil. It is unusual to record them as this inhibits openness of expression and undermines confidentiality.[314] Despite this, there are extant verbatim reports of five sessions held at the beginning of 1967.[315] This record provides an insight into some of the tensions affecting the unit at this time and their very existence suggests a need to bring order to a situation which was not 'under control'. In reviewing these discussions, one has to be aware that they are only partial records, filtered through whosoever wrote them up. Beyond this, the sense of disorder may not be quite as serious, in terms of how the unit was running, as the intensity of expressed emotion suggests. However, they are important as they provide some clues as to the difficulties that unit staff were facing.

The exit of significant individuals can markedly destabilise the social dynamics of a unit such as Ingrebourne.[316] Following St. Blaize-Molony's departure, the task was now to establish a practice that did not rely on the enthusiasm of pioneers, but could continue with staff who needed to acquire the skills and understanding of the processes involved.[317] He was someone whom Crocket had relied on to innovate and sustain the practice of the unit, and through this had developed a partnership which was difficult to replace. Whoever stepped into this role was faced with a steep learning curve, even if that person was sympathetic to the philosophy.[318] There was no training, and little established literature, on how to work in such an innovative environment.

The first recorded meeting in early 1967 gives a sense of significant distress and conflict. The latter was particularly between a doctor and the consultant, although another nurse was described as 'splitting' the staff group. The non-medical staff felt unable to express their views, with one stating that they had had nine months of 'sheer hell' before being able to

[311] INGCE15, 5.
[312] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 26.
[313] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 187.
[314] In view of this, the evidence from these sessions reported here is entirely anonymised.
[315] Ingrebourne Staff, 'Summary of Staff Meetings 24.1.67, 31.1.67, 6.2.67, 14.2.67, 21.2.67.'
[316] R. N. Rapoport, 'Oscillations and Sociotherapy', *Human Relations*, vol. 9, no. 3 (1956): 263–64.
[317] This period of instability caused by the change of senior staff was also commented on by the researchers from the Tavistock Clinic. Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 26.
[318] Looking at the bibliography of Dr Tollinton's two papers he appears to have had a distinctly different theoretical bent with references to leadership, organisational and social systems theory. H. J. Tollinton, 'The Organisation of the Psychotherapeutic Community', *British Journal of Medical Psychology*, vol. 42 (1969): 271–75; H. J. Tollinton, 'Authority and the Psychotherapeutic Community', *British Journal of Medical Psychology*, vol. 42 (1969): 341–45.

speak in groups. During the meeting, a suggestion was made to introduce behaviour therapy as a treatment. This was provocative as it is a rigid and formalised approach that treats the individual as a 'black box', ignoring their psychic life, and is completely antithetical to a psychotherapeutic relationship. Despite this, it also might have been an expression of the wish to bring order to a chaotic situation. The session was also marked by questions being directed at individuals, rather than addressing the group as a whole, which might have explored the underlying structural difficulties.

These concerns continued into the next meeting with the leadership being questioned. Members were unsure of what the senior doctor was thinking. This anxiety about leadership was also the central concern of two contemporaneous publications, from doctors at the Centre, which explored the issues of authority.[319] There was a sense of bewilderment about what was going on emotionally. This experience of personal vulnerability led to the conclusion that activities needed to be made more concrete and orderly by recording, analysing, being more detached, and 'having more control over what I say'.

The need for control was expressed more articulately in the following meeting when it was contended that there was 'the need to be tidy and have a more orderly routine in the Unit'. The task of the meeting itself was also unclear to some, although the view was expressed that it should be 'to find out how we function as a team and our (*staff*) role in the community'. The focus then shifted to therapeutic interventions, particularly the issues of 'mothering' versus treatment with needy patients. The meeting then got tangled up in theory, leading the senior doctor to acknowledge that he 'went off into intellectualisations', which might have accounted for other members' sense of bewilderment. This self-reflexivity by the consultant seems to have shifted the emotional dynamics, as the subsequent meeting moved on to more task based issues.

The following session revolved around the visit of the Chairman of the Hospital Management Committee, a businessman. Again, the medical leader expressed his uncertainty about how to manage this. There was anxiety expressed about whether the visitor would understand what was going on, and whether he would bring standards of 'what it's like outside'. There was unease about whether they would be held responsible for, and 'made to feel guilty' about, what happened in the community meeting, which he was due to attend. The discussion then moved to whether special arrangements should be made to help him understand the situation. Laing's arrangements at Kingsley Hall, where such visitors were refused access 'because they upset them all', was referred to.

Following an apparently successful visit by the Chairman the final gathering tackled the issues raised in 'The Ailment'. This seminal paper, familiar to the staff, was relevant because of its description of the anti-therapeutic effects of failing to communicate issues about

[319] R. W. Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives', *The American Journal of Psychotherapy*, vol. 20, no. 4 (1966): 669–76; Tollinton, 'Authority and the Psychotherapeutic Community'.

patients between members of staff.[320] The session became more 'trusting' and orientated towards the task of working with the patients. The successful presentation of the unit to a potentially threatening visitor led on to a serious discussion of its primary task: treating patients.

Routinisation is an inevitable development in the establishment of any longer-term social organisation, such as a therapeutic community, if it is not to collapse.[321] The American psychiatrist, George De Leon, ameliorates this by suggesting that the 'essential curative elements' of the therapeutic community can survive this process through transmission by committed staff of the sense of community, self-help, role modelling and social learning.[322] This is maintained by the 'attitude, conduct, values and vision of people involved in the process rather than its institutional framework'. The evidence for this at the Ingrebourne Centre will be demonstrated in later chapters. From these five sessions it is possible to see that, through reflection and admission of leadership vulnerability, staff took on more responsibility. The potential dependency on a charismatic leader was lessened.

Alongside this the impingement of the external world and the experienced wish for some form of orderliness led to a reformulation in 1969 of St. Blaize-Molony's original discursive guidelines to the community, described earlier, into a terser set of 'Understandings about treatment at the Ingrebourne Centre' which expected the patients to agree to eight undertakings.[323] These were prescriptive and were clearly driven by psychotherapeutic, rather than social, principles. For instance, the sixth required the patient to 'seek to achieve maximum insight and understanding of subjective feelings, and of behaviour, on behalf both of oneself and others'. Another, after stating that the participant should take part in the chores around the Centre, demanded that the person should 'minimise individual relationships, except in personal commitments away from the Centre, and outside treatment'. This of course encouraged isolation from the surrounding community and also separation from the social realities of that person's living situation.

This sequence of discussions reflects sociologist Robert Rapoport's seminal description of the oscillations in group behaviour that occur in therapeutic communities.[324] He identified four phases. The first often follows 'constructive' participants leaving, being replaced by people with 'predispositions to disrupt'. It is marked by increased distrust, reduced openness of communication and a lessening of the unit acting as a coherent 'whole'. Then the 'crescendo of tension' leads to calls to 'bring the situation under control', clearly echoed in these sessions. This results in more authoritarian approaches being invoked. As the

[320] Main, 'The Ailment'. This is described in greater detail in Chapter Four.
[321] Manning, *The Therapeutic Community Movement*, 211–22.
[322] George De Leon, 'The Therapeutic Community: Status and Evolution', *International Journal of Addictions*, vol. 20 (1985): 841–42.
[323] Anon, 'Understandings about Treatment at the Ingrebourne Centre 24.10.69', 1969, Planned Environment Therapy Trust.
[324] Rapoport, 'Oscillations and Sociotherapy'.

situation begins to settle, 'reparative forces come into play' and, ultimately, the unit moves into greater integration with people acting therapeutically. These cycles repeat themselves throughout the life of the therapeutic community and are periods of learning and adjustment, although they cause great anxiety and there is a tendency to prevent them happening by establishing stricter boundaries. This becomes evident in the later periods of the Ingrebourne Centre, as is illustrated in the penultimate chapter. Surprisingly there is no evidence of the staff acknowledging that they were experiencing such a cycle, despite the likelihood that most of them would have been aware of Rapoport's paper. This indicates the overwhelming experience that such emotional disturbances imbue, with rational consideration being difficult either to contemplate, or accredit.

The oscillations continued throughout the life of the unit, but may have been more problematic during the period under consideration, giving rise to Crocket's senses of unease and of loss of a 'golden' age. Routine appears to have replaced creativity, adventure and even warmth. A brief anonymous report from 1976 describes the super-ego as being 'dominant' and 'allowing only occasionally the luxury of the invasion of the warmer elements.[325]

The need for orderliness is reflected in an unpublished paper written by a social worker, A.J. Carroll, in 1970, in which he argued that the 'primary aim' of the unit was the 'transformation of the patient in the direction of greater psychological and social value'.[326] This of course supports the critique that TCs are part of the 'psy' industry increasing individual conformity with social 'governance'.[327]

The final piece of evidence concerning this period of time is a study carried out by the Tavistock Institute of Human Relations.[328] This was a pilot study into the staff roles and treatment at the Centre, carried out by two researchers in 1974. The study had been requested by Crocket and possibly reflected his ongoing concerns about how the unit was functioning. Certainly the situation appeared grim. There was a shortage of referrals to the unit, low numbers attending and 'staff disagreements about who should be admitted'.[329] Also there was a concurrent staff shortage which resulted in the full study not being carried out. Indeed, the senior psychiatrist acknowledged that it was 'not functioning as a psychotherapeutic community'.[330] The general air of despondency was reflected in a statement by one member of staff, who said 'I felt stable when I left home this morning but

[325] Anon., 'The Centre as an Entity 1/6/76', 1976, Planned Environment Therapy Trust.
[326] A.J. Carroll, 'The Ingrebourne as a Going Concern', 1970, 2, Planned Environment Therapy Trust.
[327] Rose, 'Psychiatry: The Discipline of Mental Health', 77.
[328] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process'.
[329] Tavistock Institute of Human Relations, 7 (footnote).
[330] Tavistock Institute of Human Relations, 9.

I began to feel very confused very soon after I came in through the door (*to the unit*)'.[331] Even the physical state of the unit was remarked upon as being 'deplorable'.

5. The First Twenty Years: a Brief Reflection.

During the later period described, Richard Crocket wrote a number of papers on the practice of TCs and had gained a significant reputation as an expert. As a result, it was he who was invited to 'sort out' the problems of the Paddington Day Hospital and he took up the post of senior doctor there in 1976, on secondment from the Ingrebourne Centre.[332] He and other members of staff were active in the formation of the Association of Therapeutic Communities in 1972. The Centre gained something of an international reputation, with him being invited to go on a lecture tour of the United States, and the unit being included in a French review of British therapeutic communities.[333] However, it never achieved the status and fame of the Cassel or Henderson Hospitals.

There was a disjunction between this public image and how the unit operated after the heady days when Crocket had the support of a knowledgeable and committed senior doctor, St. Blaize-Molony. Unsurprisingly, his successors found it difficult to fill his role, as they had to learn 'on the job', a process that would take months. As the researchers from the Tavistock found, 'particular areas of tension seemed to exist within the doctors' group', reflecting staff meetings seven years earlier.[334] Interestingly, confirming De Leon's observations referred to above, the same researchers found that the 'nursing group seemed more cohesive and settled' on the arrival of a new senior nurse.[335] It will be seen that, later in the life of the unit, it was the nurses and other non-medical staff who maintained the TC approach more actively than the doctors.

Clearly, this reflected a low period for the unit. It is unclear how the situation changed, but the secondment of Crocket to 'rescue' the Paddington Day Hospital and the appointment of Jeff Roberts coincided with a new group of committed staff members during the second half of the 1970s. The reports from this later period, as evidenced by first-hand accounts from the participants, contrast strongly with the evident doldrums of the middle of the decade.

The life of the Centre over these two decades traced a course from innovation, through disillusionment, to recovery with the appointment of a new consultant. An important

[331] Tavistock Institute of Human Relations, 13.
[332] Helen Spandler, *Asylum to Action: Paddington Day Hospital, Therapeutic Communities, and Beyond*, Community, Culture, and Change, vol. 16 (London; Philadelphia: Jessica Kingsley Publishers, 2006), 84–85.
[333] G. Bléandonu, 'A La Recherche de La Communauté Thérapeutique (á Propos d'une Bourse Du Conseil de l'Europe)', *L'Information Psychiatrique*, vol. 44, no. 8 (1968): 739–51.
[334] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 130.
[335] Tavistock Institute of Human Relations, 130.

principle was laid down that loving, tolerating, or accepting behaviour, which might be described as compassionate, was promoted, as against hostile, aggressive, destructive or hating conduct.[336] Despite the evident 'low' times, it continued to function. The difficulties in justifying the resources employed without demonstrating outcomes remained in the background.

[336] Crocket, 'Crossing the Therapeutic Rubicon, Draft', 6.

Chapter 4

'Anybody spoke': Transitional Emotional Spaces

> It was one of those things with long awkward silences … I can remember sitting saying nothing for several…, nothing...[1]
>
> We'd sit round a circle in this big room and we could just talk about anything. And that usually there was about twenty minutes silence first of all, before anybody spoke.[2]

1. The Evolution of Transitional Spaces and Ingrebourne

In understanding the Ingrebourne Centre as a transitional emotional space, two aspects are considered. The first is epistemological, tracing the accumulating knowledge that both enabled its creation and sustained it. Second is the management of boundaries taxed by the practice of these ideas. The rigid social structure of the mental hospital was replaced by an environment in which hierarchies were open to question and problematic behaviour was discussed rather than punitively curtailed. Testing out what was permissible enacted social learning. Here a description of the intellectual foundations and evolution of adult TCs in the United Kingdom is followed by a description of how the Ingrebourne functioned on a daily basis, paying attention to its conceptual boundaries as a socially-constructed, transitional space. The emphasis is on how the participants created an imaginary place called Ingrebourne and what shape it took.

2. Silence and Spontaneity: The evolution of the therapeutic community concept

The Northfield Experiments and Maxwell Jones were foremost in the evolution of adult TCs in the United Kingdom.[3] David Kennard, historian of the TC movement, summarises their influence: 'If Bion, Foulkes and Main had created a feast of new ideas at Northfield, it was

[1] Both these quotations are from people attending groups at the Ingrebourne Centre. INGCE25, interview, 2015, 2,.
[2] A. Roberts, interview 2011, 4.
[3] The Northfield Experiments were an early application of many TC principles during the Second World War. A more detailed description of the activities there will be provided later in this chapter, as will the work of Maxwell Jones.

Jones that sat down and produced a recipe that others could follow'.[4] The first has an almost legendary status, but its impact is less easy to trace than that of Jones. Although aware of the Northfield Experiments, Crocket referred extensively to the latter's work. Both approaches challenged the authoritarian asylum mentality, offering a space where the psychiatrist has to adopt a 'more sincere role of member in a real community', in which patients are no longer 'his captive children', but have 'sincere adult roles to play'.[5]

The 'rich feast of ideas' at Northfield derived from varied sources which had in common considerations of human relationships in groups. Primarily, the task was to establish an environment in which trust and openness enabled reflexivity both within and between the participants, leading to the mutual questioning of accepted truths, both about the functioning of the participants and of the community.

The history of group therapies and TCs presented here is skewed towards those aspects that influenced staff at the Ingrebourne. Later in its life, the consultant, Jeff Roberts, and many staff trained at the Institute of Group Analysis established by SH Foulkes.[6] There was also continuing contact with the Henderson Hospital and the ideas of Maxwell Jones. Even the radical notions of R. D. Laing, although never adopted, continued to interest many staff members. The underlying theories behind the different approaches are only discussed in outline. The emphasis is on how different sources of influence came to bear on the development of the Centre.

The first section outlines the evolution of group therapies. Understanding how group meetings operate, and how to intervene in a considered manner, were essential skills. The silence, described in the quotations at the head of this chapter, was the equivalent of the surgeon's knife in cutting through to deeper layers of feeling and could be just as painful for the novice. Strategies for surviving the experience and making it meaningful were explored throughout the twentieth century. The recognition that people in these gatherings behaved in a communal manner, sharing emotions, perceptions and phantasies, was fundamental.[7] This communality both provided a sense of belonging, and safety, whilst enabling threatening tensions to arise and be explored.

After referring to the work of psychiatrists working in the British Army during the Second World War, the evolution of TCs in the NHS is described leading up to the establishment of

[4] Kennard and Roberts, *An Introduction to Therapeutic Communities*, 50..
[5] Main, 'The Hospital as a Therapeutic Institution', 67.
[6] Foulkes is variously addressed as Michael, Sigmund and SH. His wife elected to call him SH, without the punctuation, as was his own preference, and I shall follow her lead in this. E Foulkes, 'S.H. Foulkes: A Brief Memoir' (Karnac, 1990), 4.
[7] The use of the term 'phantasy', as opposed to the word 'fantasy', is deliberate. It refers to the psychoanalytic concept of the unconscious mental expression of instinctual urges that underlie all thought and feeling. The work of psychoanalysis is to enable the individual to articulate them and thereby understand their influence on his or her daily life. It is distinct from the conscious day dreaming aspect of the more common term 'fantasy'. Susan Isaacs, *The Psychological Aspects of Child Development* (London: Evans Brothers Limited with University of London Institute of Education, 1963), 33.

the Association of Therapeutic Communities in the early 1970s. Therapeutic communities existed for nearly a century. In concentrating on the development of this approach for adults, it is easy to overlook the pioneering role of similar methods of working with children. These stretch back to the work of August Aichhorn in Austria and Homer Lane in the U.K. during the immediate aftermath of the First World War.[8] However, there is no evidence of their influence on the Ingrebourne, and, as a result, they will not be discussed here despite their relevance to the therapeutic community movement as a whole. Instead, following reference to the early work of psychiatrists working for the British Army during the Second World War, their evolution in the NHS will be described leading up to the establishment of the Association of Therapeutic Communities in the early 1970s.

i. From Socrates to Transference: Groups and Group therapies

The earliest evidence of a discursive approach to examining accepted beliefs is Socrates' elenchtic discourse.[9] His enquiries were conducted in informal spontaneous gatherings in which all were encouraged to make their views known.[10] He would then challenge their assumptions, prompting them to examine their pre-conceptions. As a student at Cambridge John Rickman, a progenitor of the TC movement, experienced a similar peripatetic group.[11] Dr W. H. Rivers, appointed as Praelector of Natural Science Studies, organised a club, the '*Socratics*', around informal discussions held in his rooms. The poet Siegfried Sassoon, another participant, captured the flavour of these:

> and soon they floated
> Through dessicated forests, mangled myths;
> And argued easily round megaliths.[12]

Rickman also introduced another tradition, that of the Society of Friends. For four hundred years, the Quakers have refined the art of the democratic community meeting. In a paper, *A study of Quaker beliefs*, he explored their 'group psychology' in the light of psychoanalysis.[13] Their manner of worship is 'to meet in the silence of flesh, and to watch for the stirrings of

[8] August Aichhorn, *Wayward Youth* (London: Imago Publishing, 1951); W D Wills, *Homer Lane: A Biography* (London: George Allen and Unwin, 1964).
[9] M. Ettin, *Foundations and Applications of Group Psychotherapy: A Sphere of Influence* (Jessica Kingsley, 1999), 31–55.
[10] Plato, 'The Banquet', in *Five Dialogues of Plato Bearing on Poetic Inspiration*, trans. P. B. Shelley, Everyman's Library 456 (London: J. M. Dent, 1924), 17; Plato, 'Lysis', in *Socratic Discourse by Plato and Xenophon*, trans. J. Wright, Everyman's Library 457 (London: J. M. Dent, 1925), 205.
[11] Richard Slobodin, *W.H.R. Rivers: Pioneer Anthropologist, Psychiatrist of The Ghost Road* (Stroud: Sutton, 1997), 69–70; T. M. Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments : Advancing on a Different Front* (London; Philadelphia: J. Kingsley, 2000), 33–34.
[12] A copy of the handwritten original of the poem "An Early Chronology" is available at http://www.oucs.ox.ac.uk/ww1lit/collections/item/9824?CISOBOX=1&REC=1, accessed 01/04/2015
[13] J. Rickman, *A Study of Quaker Beliefs* (Karnac, 2003).

his (*the Lord's*) life', out of which arises a sense of 'mutual aid'.[14] This milieu enables an 'atmosphere of tolerance' in which thoughts can be expressed, irrespective of their effect.[15] The historian of children's therapeutic communities, Maurice Bridgeland, expressed it in a manner that accords closely with the therapeutic group, when he explained that this gathering is

> in theory, a collection of people to get together with open minds waiting to get some sort of feeling about something that might be worth communicating to other people.[16]

That this expertise contributed to the development of group psychotherapy is evidenced by notes of a lecture given by Rickman at Northfield Military Hospital during World War Two. These were taken by Major Harold Bridger, who recorded that the Quaker meetings had no elite clergy, no leadership and they were a 'kind of therapeutic session'.[17] His colleague at Northfield, Main, was also aware of Rickman's recognition of the value of waiting in silence for emotional spontaneous utterances to emerge.[18] Whilst this connection with the Friends has rarely been made explicit, the parallels were evident to Rapoport, who commented that the community meetings had the quality 'sometimes found in congregations of religious sects like the Buchmanites (Oxford Group), Quakers, and others that stress leaderless public-confessionals'.[19]

Formal group therapy has its origins in the United States in the early twentieth century. Dr Joseph Pratt gave a series of didactic lectures to groups of his tubercular patients. He was startled, and delighted, by the consequent 'fine spirit of camaraderie' that emerged.[20] Not everybody was enthusiastic about this spontaneous group élan. A contemporary, Dr Low, took the role of commander, promoting trusted patients to positions of authority. The meetings were educational, but also used to administer admonitions.[21] This potential of groups to release challenging attitudes continues to raise anxieties and influence public perceptions of therapeutic communities.

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[14] I. Pennington, *A Brief Account Concerning Silent Meetings 1680* (Quaker Heritage Press, 1996), 47; Rickman, *A Study of Quaker Beliefs*, 287.
[15] Rickman, *A Study of Quaker Beliefs*, 287.
[16] Maurice Bridgeland, interview by E. B. Boyling, transcript, 2008, The 'McGregor Hall' Therapeutic Community Archives, Planned Environment Therapy Trust.
[17] H. Bridger, 'Notes of a Lecture by John Rickman on Creativity and Leadership', undated, Harold Bridger Archive, Planned Environment Therapy Trust. These are undated handwritten notes, but internal evidence points to them being notes of a lecture that John Rickman gave during a visit to Northfield Military Hospital in 1945.
[18] T. F. Main, *The Concept of the Therapeutic Community: Variations and Vicissitudes* (Free Association Books, 1989), 128.
[19] N. Rapoport Robert, *Community as Doctor: New Perspectives on a Therapeutic Community* (London: Tavistock, 1960), 92.
[20] J. H. Pratt, 'The Principles of Class Treatment and Their Application to Various Chronic Diseases', *Hospital Social Service Quarterly*, vol. 6 (1922): 403.
[21] S. R. Slavson, *The Dynamics of Group Psychotherapy* (New York: Jason Aronson, 1979), 149–50.

From these didactic origins practice evolved to explore group processes. Psychoanalytic theory became increasingly dominant. Freud's *Group Psychology and the Analysis of the Ego*, which examined group behaviour from a psychodynamic viewpoint, was his only contribution on the subject.[22] In this, he reviewed the work of Gustave Le Bon, Wilfred Trotter and William McDougall, before deriving his own conclusions. The latter two were particularly influential in Britain.[23] Historian Mathew Thomson recognised McDougall as the 'most celebrated psychologist of the first half of the [*twentieth*] century'.[24] Wilfred Trotter, a surgeon, wrote the widely read *The Instincts of the Herd in Peace and War* in response to the issues of morale in the First World War.[25]

After announcing at the outset that 'from the very first individual psychology … is at the same time a social psychology as well', Freud applied his insights to large social groups such as the crowd, army or church.[26] He disagreed with French sociologist Le Bon's contention, that members of a mob manufacture new characteristics, reasoning instead that they express repressed manifestations of their unconscious.[27] The barbarity of crowds results from the repression of intellect and heightening of emotions.[28] Le Bon's evident distaste for mobs has echoes in outsider's views of TCs. The potential for anarchy was clearly in the minds of members of the Regional Hospital Board when they visited Ingrebourne in 1959 (described earlier).[29]

Freud rejected psychologist McDougal's thesis that increased organisation raises the collective mental life to a higher level of functioning, arguing that unconscious mechanisms

[22] S. Freud, *Group Psychology and the Analysis of the Ego* (Boni and Liveright, 1922).

[23] Crocket had a number of books by McDougall in his collection including a first edition of *The Group Mind* (1920), *An Outline of Psychology* (1923), a second copy of *An Outline of Psychology* (1933) (inscribed 'With Best Wishes, W.S. Syme, January 1936, RW Crocket Prize in Ear, throat and Nose', indicating that he was reading this as a medical student), and *Body and Mind: a Defence of Animism* (1920), Crocket archives: Planned Environment Therapy Trust. For McDougal's influence see M. A. Boden, 'Purpose, Personality, Creativity' in *Psychology in Britain: Historical Essays and Personal Reflections*, eds. G. C. Bunn, A. D. Lovie, and G. D. Richards (Leicester: British Psychological Society, 2001), 355; and G. C. Bunn, 'Introduction', in *Psychology in Britain: Historical Essays and Personal Reflections*, eds. G. C. Bunn, A. D. Lovie, and G. D. Richards (Leicester: British Psychological Society, 2001), 20.

[24] Mathew Thomson, *Psychological Subjects : Identity, Culture, and Health in Twentieth-Century Britain* (Oxford: Oxford University Press, 2006), 55.

[25] W. Trotter, *The Instincts of the Herd in Peace and War* (T Fisher Unwin, 1926); Thomson, *Psychological Subjects*, 213. Nearly forty years after its publication the popular British politician, Aneurin Bevan, referred to the 'primitive herd instinct' in his exposition of political philosophy *In Place of Fear* (1952). A. Bevan, *In Place of Fear* (Weybridge: Aneurin Bevan Society, 2008), 48.

[26] S. Freud, 'Group Psychology and the Analysis of the Ego', in *Civilization, Society and Religion*, ed. A. Dickson, trans. J. Strachey, vol. 12, The Penguin Freud Library (Harmondsworth: Penguin, 1991), 95.

[27] Freud, 100–101.

[28] Freud, 106.

[29] On being given a description of therapeutic communities, as part of an annual review for this thesis, a medically-qualified assessor remarked that it reminded her of William Golding's book, *The Lord of the Flies*, in which children left to their own devices run riot and commit murder.

have greater potency.[30] He contended that libidinal ties, evolved through early emotional experience, were transferred from group members to leaders who, in turn, are similarly tied to the group. The earliest emotional bond with another is identification with the parent.[31] When a particular quality of this relationship recurs between group members, it establishes a bond, the intensity of which is determined by the perceived importance of the common element. A doctor, with a medically-qualified parent, may have a tendency to engage socially with others in the same profession. The group ideals, embodied in the leader, replace those of the individual.

Many group theorists and practitioners were influenced by Freud. Three Americans - Paul Schilder, Louis Wender and Samuel Slavson - are referenced by Maxwell Jones as relevant to his work at Mill Hill. [32] Each modified the psychoanalytic approach. Wender argued that the sense of fellowship gained by losing the sense of being an 'individual sufferer' was therapeutic.[33] He found that the patients discussed their problems with 'greater candor' with each other than with their physician.[34] Relationships established between patients tended to lead to 'normal socialization'. He was the first to make reference to the manifestations of the psychoanalytic concept of transference in groups.[35] In particular, he argued that the therapist relates to the group as a 'father-to-the-whole-family'.[36] Schilder, a colleague of Wender, introduced the psychoanalytic practice of 'free-association', in which the participants were encouraged to articulate whatever was going through their minds.[37] He argued that group therapy replicated society more constructively than individual therapy, and that hostility and aggression could be diverted into co-operative efforts through the common bonding of individuals.[38]

Slavson also recognised that groups encourage 'less caution and greater abandon where members find support in each other', with the result that they become less fearful of talking about their problems.[39] He employed 'activity groups' with children, in which they were

[30] W. McDougall, *The Group Mind: A Sketch of the Principles of Collective Psychology with Some Attempt to Apply Them to the Interpretation of National Life and Character* (Cambridge: Cambridge University Press, 1921); Freud, 'Group Psychology and the Analysis of the Ego', 1991, 112–15.
[31] Freud, 'Group Psychology and the Analysis of the Ego', 134.
[32] M. Jones, 'Group Treatment, with Particular Reference to Group Projection Methods', *American Journal of Psychiatry*, vol. 101 (1944): 292–299; M. Jones, 'Acting as an Aid to Therapy in a Neurosis Centre', *British Medical Journal*, vol. 1, no. 4608 (1949): 756–59.
[33] L. Wender, 'Group Psychotherapy: A Study of Its Application', *Psychiatric Quarterly*, vol. 14 (1940): 710.
[34] L. Wender, 'The Dynamics of Group Psychotherapy and It Application', *Journal of Nervous and Mental Diseases*, vol. 84, no. 1 (1936): 55.
[35] S. Scheidlinger, 'The Group Psychotherapy Movement at the Millenium: Some Historical Perspectives', *International Journal of Group Psychotherapy*, vol. 50, no. 3 (2000): 318.
[36] Wender, 'Group Psychotherapy: A Study of Its Application', 708.
[37] P. Schilder, 'Results and Problems of Group Psychotherapy in Severe Neurosis', *Mental Hygiene*, vol. 23 (1939): 89; P. Schilder, *Psychotherapy* (London: Kegan Paul, Trench, Trubner, 1938), 113.
[38] Ettin, *Foundations and Applications of Group Psychotherapy: A Sphere of Influence*, 84.
[39] S. R. Slavson, 'General Principles and Dynamics', in *The Practice of Group Therapy*, ed. S R Slavson (New York: International Universities Press, 1947), 23–24.

allowed to interact freely, even leading to quarrelling and fighting.[40] The aim was to 'strengthen the autonomous trends in children rather than to feed their dependence'.[41] Later, he adopted more traditional methods of psychoanalysis and, in contradistinction to Foulkes and Bion, concentrated on working with the individual in the group setting.[42]

Wilfred Bion and SH Foulkes stand out as applying psychoanalytic ideas to groups in Britain in the mid- twentieth century. Both developed their early ideas at the Northfield Military Hospital and together played a significant role in the development of TC theory. Although there is continuing dissension between followers of either individual, there are some significant conceptual agreements, in particular their pioneering emphasis on working with the group as the focus of therapy, rather than treating individuals within it. Both were psychoanalysts, the former having his personal analysis with Melanie Klein in the 1940s, and the latter having trained in Vienna in the late 1920s.[43]

Following Freud's death in 1939, there was a 'falling out' between two streams of psychoanalytic thought.[44] The first continued the now traditional theories of the founder, particularly as articulated by his daughter, Anna, whilst many younger analysts espoused the ideas of Melanie Klein. This led to the 'controversial discussions' which lasted from 1941-1945, and resulted in the British psychoanalytic movement separating into three groups, albeit remaining under the umbrella of the Institute of Psycho-Analysis. There clearly was animosity expressed between the two main factions, and *The Freud-Klein Controversies 1941-1945*, which records the debates in detail, sometimes reads like a soap opera. [45] Bion (Kleinian) and Foulkes (Freudian) were on opposite sides of this debate, and their different approaches continue to dominate group therapy to the present day.[46]

Bion's legacy was promulgated through his early work with the Tavistock Institute of Human Relations.[47] During his brief stay there, he developed his understanding of groups and stabilised the staff team which was reforming after the war. In particular, he shared his thinking with Sutherland, who attended group meetings that he presided over.[48] His views

[40] S. R. Slavson, 'Group Psychotherapy', *Mental Hygiene*, vol. 24 (1940): 39.
[41] S. R. Slavson, 'Some Elements in Activity Group Therapy', *American Journal of Orthopsychiatry*, vol. 14 (1944): 581.
[42] Slavson, 'General Principles and Dynamics', 28.
[43] G. Bléandonu, *Wilfred Bion: His Life and Works 1897-1979*, trans. Pajaczkowska (London: Free Association Books, 1994), 47, 93, Foulkes, 'S.H. Foulkes: A Brief Memoir', 9.
[44] Pearl King and Riccardo Steiner, eds., *The Freud-Klein Controversies 1941-45*, The New Library of Psychoanalysis 11 (London: Tavistock/Routledge, 1992).
[45] King and Steiner.
[46] Recent email correspondence between this author and other speakers leading up to the Winter Workshop of the Group Analytic Society International in 2018 referred to this debate.
[47] E. Trist, 'Working with Bion in the 1940s; The Group Decade', in *Bion and Group Psychotherapy*, ed. M. Pines (London: Routledge and Kegan Paul, 1985), 36–38.
[48] J. D. Sutherland, 'Bion Revisited: Group Dynamics and Group Psychotherapy', in *Bion and Group Psychotherapy*, ed. M. Pines (London: Routledge and Kegan Paul, 1985), 52–53.

were seminal in Sutherland's understanding and he would have passed these on to Crocket. Bion's ideas are explored in more detail later in this chapter.

Bion had a ready-made audience in the 'Tavistock' group and was held in great regard by them.[49] On the other hand, Foulkes was initially more isolated. He promoted his ideas through books which gained wide circulation.[50] Although he was in contact with a number of people who admired his writings, he had to found his own Group Analytic Society in 1952. In turn, members of this set up the Institute of Group Analysis, which became responsible for training in 1971, attended by a number of the Ingrebourne staff subsequently.[51]

Foulkes summed up the differences between his approach and that of the Tavistock as one more of nuance than fundamental disagreement. He believed that group members should play more of an active role than was apparent in the Clinic's approach, which tended to rely on the therapist to relay interpretations in a traditional psychoanalytic manner.[52] He also adopted Lewin's idea of 'belongingness', which was absent in Bion's more analytic stance.[53]

Psychodrama was regularly used at the Ingrebourne Centre from the 1970s through to the 1990s.[54] Its American originator, Jacob Moreno, was a charismatic figure and many responded to him negatively.[55] His contribution to a conference in London, in 1954, evinced little enthusiasm from Crocket, who reported 'I didn't like him'.[56] Despite this, Crocket considered developing a research institute that would employ Sociometry, Moreno's term for the measurement of interpersonal relationships.[57] In psychodrama, Moreno's practice was to select an 'actor' from a group who was instructed to 'portray his own private world'.[58] Other participants would act as members of the cast and, or, comment on the roles of the main protagonist, or the director. The leader varied his approach, at times 'attacking and shocking' and, at others, being 'indirect and passive'.[59] The aim was to enable spontaneity and catharsis.[60] The former encouraged the individual to develop novel responses to old dilemmas, arising from the serendipity of the performance and discussion. The latter arose from the performer being 'off-balance' during the performance and was an emotional resolution of the conflict affecting him, or her.

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[49] Sutherland, 'Bion Revisited: Group Dynamics and Group Psychotherapy'.
[50] His book, co-authored with E. J. Anthony, *Group Psychotherapy* was published by Penguin Books and went through four editions between 1957 and 1973, and remains in print through the Karnac Press.
[51] Foulkes, 'S.H Foulkes: A Brief Memoir', 16.
[52] Foulkes and Anthony, *Group Psychotherapy: The Psychoanalytic Approach*, 20.
[53] Foulkes and Anthony, 71.
[54] INGCE13, interview, 13; INGCE17, interview, 19; INGCE20, interview, 33; Pat Conneely, 'Ingrebourne Centre Link: Brief History and Groups in Action at the Ingrebourne Centre' (Typescript, 1994), 3.
[55] R. F. Marineau, *Jacob Levy Moreno 1889-1974: Father of Psychodrama, Sociometry, and Group Psychotherapy* (Tavistock/Routledge, 1989), xii.
[56] Crocket, 'Diary 9: 1954 - 1962', 17th May 1954.
[57] Crocket, 'Diary 9: 1954 - 1962', 20th June 1954.
[58] J. L. Moreno, *Who Shall Survive?* (Beacon House, 1953), 82.
[59] Moreno, 83.
[60] Moreno, 42.

Psychodrama was practiced at Northfield, but later was largely abandoned in Britain until the 1970s.[61] Maxwell Jones was an early convert, who introduced Moreno's ideas to Belmont in 1949, employing rehearsed plays, which led to discussion and spontaneous acting within therapeutic groups.[62] Staff at Ingrebourne would appear to have been early participants in the later renaissance.[63]

Kurt Lewin was adopted as a disciple by Moreno, but later contemptuously dismissed, as his work was seen as avoiding 'real encounter'.[64] Through the lens of Northfield, his ideas had a profound impact on British TCs.[65] After the war, the Tavistock Institute of Human Relations established formal links with his Research Centre for Group Dynamics.[66]

Lewin highlights the dynamic intermeshing of the individual with his social environment or 'field'. People are understood in terms of their relation to the social field and the possible events within it. He explores the 'psychological life space', contending that the investigator has to develop constructive concepts relating to discernible laws and processes.[67] The group should thus be considered as a whole, because its structural properties are different to the separate parts.[68] At Northfield, Major Bridger began to reflect on how the 'hospital-as-a-whole' could operate therapeutically, rather than leaving wards to run independently.[69] Similarly, Crocket argued that day-patients and in-patients were one entity and should be integrated.[70] In developing a model of social networks he adopted Lewin's ideas of the 'life space', integrating it with the anthropological notion of kinship networks.[71]

Lewin's rejection of the 'Aristotlean' dichotomisation of the individual and the crowd was shared by the two pioneers in group therapy at Northfield: Rickman and Bion.[72] They argued

[61] Anon (British Psychodrama Association), 'A Brief History of Psychodrama', 2007, http://www.psychodrama.org.uk/view_document.php?id=84, accessed 08/04/2015; M H Davies, 'Psychodrama Group Therapy', in *Group Therapy in Britain*, eds. M. Aveline and W. Dryden, Psychotherapy in Britain (Milton Keynes: Open University Press, 1988), 89.
[62] Jones, 'Acting as an Aid to Therapy in a Neurosis Centre'.
[63] INGCE13, interview, 13; INGCE17, interview, 18. Both record the practice to have been in operation during the mid-1970s.
[64] Moreno, *Who Shall Survive?*, lxiv.
[65] Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 2000.
[66] S. G. Gray, 'The Tavistock Institute of Human Relations', in *Fifty Years of the Tavistock Clinic*, by H. V. Dicks (London: Routledge and Kegan Paul, 1970), 208.
[67] K. Lewin, *The Principles of Topological Psychology* (McGraw Hill, 1936), 3–17.
[68] K. Lewin, 'Frontiers in Group Dynamics: I. Concept, Method, and Reality in Social Sciences; Social Equilibria and Social Change', *Human Relations*, vol. 1 (1947): 5–41.
[69] H. Bridger, 'Northfield Revisited', in *Bion and Group Psychotherapy*, ed. M. Pines (London: Routledge and Kegan Paul, 1985), 101.
[70] R. W. Crocket, 'The Results of Treatment in a Psychotherapeutic Community' (Glasgow, 1965), 14–15, Planned Environment Therapy Trust (Library), 14-15.
[71] Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives', 675.
[72] K. Lewin, 'The Conflict between Aristotlean and Galilean Modes of Thought in Contemporary Psychology', in *A Dynamic Theory of Personality*, trans. D. K. Adams and K. E. Zener (New York; London: McGraw-Hill, 1935), 1–42.

that 'psychology and psycho-pathology have focussed attention on the individual often to the exclusion of the social field in which he is part'.[73]

Lewin applied the analogy of physical vectors to social fields. What forces are acting that influence individuals to behave in a particular way?[74] This implies that, by altering social dynamics, it is possible to influence people's behaviour. Thus one can alter the responses of individuals restricted by neurosis by modifying the way the hospital operates. His colleague, J. F. Brown, found that, in any situation, people's aims are constantly shifting. Barriers, successfully overcome, can raise the person's expectations of themselves and enable them to achieve tasks in 'such a way that the personality is enriched'.[75] Lewin and Lipitt compared two groups of school children.[76] The first was run in an authoritarian manner, with all decisions being made by an impersonal, remote leader. In the other, members of the group determined all policies through discussion, with the leader offering advice and proffering alternatives. The democratic group demonstrated greater cooperation and creativity, the students were more objective in outlook and the sense of 'belongingness' was heightened.

Another innovation was reflective practice, in which group members were encouraged to discuss their day-to-day interactions.[77] Known originally as T-groups (training groups) they were implemented in many TCs, including Ingrebourne, as 'sensitivity' groups.[78] Thus, through a number of filters, including the Institute of Group Analysis and the Tavistock Institute of Human Relations, Lewin's work was both implicit and explicit in much of the practice at Ingrebourne.

Of the American workers in this field, Crocket was particularly interested in the work of Trigant Burrow. He found that the latter's work at the Lyfwynn Camp in the Adirondacks had many parallels with his own at Ingrebourne.[79] It is clear from his private reviews of Burrow's book *The Structure of Insanity* (1932) that their views were aligned, stating that 'this book is of considerable interest. Burrow is putting into quite complicated terms the sort of thoughts that have been in my mind'.[80] He elaborated further, 'Trigant Burrow is the first person I

[73] W. R. Bion and J. Rickman, "Intra-group tensions in therapy: their study as the task of the group," *The Lancet*, vol. 242 (1943): 678–81, 681.
[74] J. F. Brown, *Psychology and the Social Order* (New York; London: McGraw-Hill, 1936), 44–45.
[75] Brown, vi, 294.
[76] K. Lewin and Lippitt, R., 'An Experimental Approach to the Study of Autocracy and Democracy: A Preliminary Note', *Sociometry*, vol. 1, no. 3&4 (1938): 292–300.
[77] A. J. Marrow, *The Practical Theorist: The Life and Work of Kurt Lewin* (Annapolis, Maryland: BDR Learning Associates, 1969), 210–14.
[78] INGCE15, interview, 34.
[79] R. W. Crocket and D. W. Millard, Interview MP1, interview by M. Pines, Transcript, 1999, 1, Planned Environment Therapy Trust.
[80] T. Burrow, *The Structure of Insanity* (London: Kegan Paul, Trench and Trubner, 1932); R. W. Crocket, 'Notes on The Structure of Insanity by Trigant Burrow', undated, Planned Environment Therapy Trust, PP/RC/26/07/01.

have come across who attempts to put into words exactly the pre-occupations which are my concern at this time'.[81]

Burrow's written output was prolific. He published five books, sixty eight articles and numerous unpublished papers until his death in 1950. Despite this, his wider influence is not clear.[82] Group analyst, Foulkes, was very uncertain, but acknowledged that reading some of his papers written in the 1920s 'must have made a deep impression on me'.[83] He certainly took over the phrase 'Group Analysis', whilst the originator instead coined another term, 'phyloanalysis'.[84] Two researchers and group analysts Edi and Giorgio Pertegato have explored his work exhaustively and express their concern that he was an 'eminent unknown man' who has been censored out of history.[85] In particular, they assert that Foulkes was significantly indebted to his work, whilst ambivalent about acknowledging it.[86] Perhaps one clue to his neglect is revealed by Crocket's comment that his 'terminology is rather difficult' and in reference to the term 'phylic coordination', he remarked 'whatever this may mean'.[87] Unfortunately, he added to the confusion by referring to the influence Burrow's 'systematizations' had on him without further explanation.

In his early career Burrow, from 1909 to 1910, after meeting with Sigmund Freud, became an analysand of Carl Jung.[88] He later abandoned classical psychoanalysis because of its overemphasis on the individual, being persuaded of the primary nature of human interdependence.[89] Instead, he began to expound on the importance of the 'group as a whole', in which therapy was 'a daily test of an actual living experience'.[90] Burrow's concepts of psychodynamics also veered away from the historicity of psychoanalysis, arguing for a more direct effect of society blindly bullying 'the so-called neurotic into inviolable concealment and isolation' rather than being due to infantile repression in the face of emotional conflict with the parents.[91] His therapy employed the patient as an 'observer' and

[81] Crocket, 'Notes on The Structure of Insanity by Trigant Burrow', 6.
[82] M. Ettin, *Foundations and Applications of Group Psychotherapy: A Sphere of Influence* (Jessica Kingsley, 1999), 69. See also the 'Introductory Essay' in Trigant Burrow, Edi Gatti Pertegato, and Giorgio Orghe Pertegato, *From Psychoanalysis to Group Analysis: The Pioneering Work of Trigant Burrow*, New International Library of Group Analysis (London: Karnac, 2013), xxxi–xxxii.
[83] S. H. Foulkes, *Therapeutic Group Analysis* (George Allen and Unwin, 1964), 13.
[84] S. H. Foulkes and Malcolm Pines, *Selected Papers of S.H. Foulkes: Psychoanalysis and Group Analysis*, ed. Elizabeth Foulkes (London: Karnac Books, 1990), 147.
[85] Burrow, Pertegato, and Pertegato, *From Psychoanalysis to Group Analysis*, xxxii.
[86] Burrow, Pertegato, and Pertegato, xcii–xciv.
[87] R. Crocket, 'The Ingrebourne Centre and Trigant Burrow: A Personal Perspective', *Group Analysis* 32, no. 2 (1999): 287.
[88] Ettin, *Foundations and Applications of Group Psychotherapy: A Sphere of Influence*, 67–68, Pertegato and Pertegato, 'Introductory Essay', xl.
[89] T Burrow, 'Biological Foundations and Mental Methods', *British Journal of Medical Psychology*, vol. 8 (1928): 49–63.
[90] T Burrow, *The Social Basis of Consciousness: A Study in Organic Psychology* (Kegan Paul, Trench and Trubner, 1927), 223.
[91] T Burrow, 'The Group Method of Analysis', *Psychoanalytic Review*, vol. 14 (1928): 271.

a 'responsible student of our common human problems'.[92] This engagement of those in treatment as active therapists both in their own difficulties as well as others, anticipated the therapeutic community approach.

Much of Crocket's reading of Burrow appears to have confirmed practices that had already been instituted at the Ingrebourne. He reported that he 'started on the trail' of the latter's work in 1964 when the main elements of the timetable there had already been established.[93] Amongst these was the practice of transferring the observations made in small everyday social groups to a daily community meeting, which was central to the work at Ingrebourne and he had already written about.[94] Again his practice was confirmed by the latter's study and review of what was happening 'here and now' in any group. This emphasis on present behaviour and inter-relationships was central to the work of Bion and Rickman at Northfield, though how relevant Burrow was to them reaching this viewpoint is open to question.[95]

Group theory was an essential element in the development of adult therapeutic communities, although often the process had to be re-discovered because of the *ad hoc* nature of their evolution. Once established, practitioners turned to being trained in one or other of the techniques.

ii. Utilizing Socio-Psychodynamic Factors: The Evolution of Adult Therapeutic Communities in the United Kingdom

Crocket collected a number of works by Harry Stack Sullivan.[96] This American psychiatrist was first to coin the term 'therapeutic community', referring to his social milieu approach to the treatment of schizophrenia in 1929.[97] He lauded the effect of 'utilizing socio-psychiatric factors' in treating his patients, stating that their social intelligence was increased '*sufficient to abolish the schizophrenic situation*'.[98] His six-bedded unit for men was run deliberately without nurses.[99] Side-stepping hide-bound attitudes, he 'hand-picked' only male, lower-paid assistants, believing that they would relate to patients in a genuine, more egalitarian

[92] Burrow, 276.
[93] Crocket, 'The Ingrebourne Centre and Trigant Burrow', 285. See also Chapter 4, Table 3.8.
[94] T Burrow, 'The Basis of Group-Analysis or the Analysis of the Reactions of Normal and Neurotic Individuals', *British Journal of Medical Psychology*, vol. 8 (1928): 198.
[95] As editor of the *British Journal of Medical Psychology*, Rickman was aware of Burrows' papers referred to in the footnotes above.
[96] Including *The Psychiatric Interview* (1954)*, Conceptions of Modern Psychiatry* (1955)*, and Clinical Studies in Psychopathology* (1953)*.* All were marked on the inside 'R. Crocket '54 or '55', and the last included a separate obituary from 29/1/49. Crocket archive, Planned Environment Therapy Trust.
[97] Sullivan, *Conceptions of Modern Psychiatry*, 232. In this he refers to 'a therapeutic camp or community'.
[98] Italics as in the original. H. S. Sullivan, *Schizophrenia as a Human Process*, ed. Helen Swick Perry, The Norton Library N721 (New York: Norton, 1974), 266.
[99] H. S. Perry, 'Introduction', in *Schizophrenia as a Social Process*, ed. H. S. Perry (New York: Norton, 1974), xvi.

manner.[100] He was at pains to distinguish the informal 'rough-and-ready' discussions that he held with his staff, which considered the 'data of living on the wards with the patients', from the more academic psycho-analytically orientated staff meetings held in the main hospital.[101] Sensitivity meetings held at Ingrebourne similarly discussed the emotional experiences of professionals working on the unit.

Ingrebourne, being in a ward away from Warley, echoed Sullivan's unit, which was 'uniquely cut off from various usual hierarchical structures that exist in any hospital'.[102] Sullivan asserted that behaviour needs to be verbalised. One problem for TCs is the physical expression of distress, described as 'acting out'. Discussing, and understanding, the underlying psychodynamics he believed 'usually permits the suppression of the dramatization'.[103] In his view, the patient was 'a *person* striving to live among persons', not someone to be managed as incurable.[104] The nursing assistants at Shephard and Enoch Pratt were low in the hospital hierarchy, received poor pay, but in spite of this, 'came to have high morale and to operate in a truly professional manner'.[105] Nurses in the mental hospitals in the 1950s and '60s were better paid, but largely ignored by medical staff, and, in a similar manner at the Ingrebourne, many of them 'blossomed', gaining much greater confidence in their abilities.[106] Crocket makes no reference to Sullivan in his early publications on his work at Ingrebourne, but the parallels are hard to miss.[107]

The Northfield Experiments have an almost legendary status in the history of adult TCs in Britain and abroad.[108] In 1942, Hollymoor Hospital was taken over by the British Army to treat soldiers who were experiencing problems with the exigencies of military service.[109] During the next six years, there were two periods, described at the time as 'Experiments', that worked towards creating a milieu where soldiers were encouraged to review their

[100] Perry, xvii. He considered that professionally trained nurses would find it difficult to 'unlearn' their ingrained nursing attitudes of 'my Profession, right or wrong, but always my Profession'. He also was nervous of them becoming the 'prototype of the high-status female in an inferior male society'.
[101] Perry, 'Introduction', xvi.
[102] Perry, xvi.
[103] Sullivan, *Conceptions of Modern Psychiatry*, 222.
[104] Sullivan, *Schizophrenia as a Human Process*, 255.
[105] Perry, xvi.
[106] A number of staff attributed their advancement in later life to their experiences at the Ingrebourne. E.g. Bill Murray, 'Thank You', *Joint Newsletter of the Planned Environment Therapy Trust, the Charterhouse Group of Therapeutic Communities and the Association of Therapeutic Communities, with the Community of Communities*, no. 10 (2004): 81.
[107] Crocket had three books by Sullivan in his collection dating from 1953 to 1955, one of which contained a copy of Sullivan's obituary. Sullivan, *Schizophrenia as a Human Process*; Sullivan, *Conceptions of Modern Psychiatry*; H. S. Sullivan, *The Psychiatric Interview* (London: Tavistock Publications, 1955).
[108] R. D. Hinshelwood, 'Foreword', in *Bion, Rickman, Foulkes and the Northfield Experiment: Advancing on a Different Front*, by T. M. Harrison (London: Jessica Kingsley, 2000), 7. See also D. H. Clark, 'Fifty Years on - Some Personal Reflections', *Therapeutic Communities*, vol. 17, no. 3 (1996): 156; B. Mandlebrote, 'The Northfield Experiment: Its Contribution to Developments in Psychiatry', *Therapeutic Communities*, vol. 17, no. 3 (1996): 149–53.
[109] The following is taken mainly from this author's previous work on Northfield, Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 2000.

behaviour in the light of the social requirements of a state at war.[110] The first was a short-lived attempt to inculcate a sense of self-discipline through a daily large group. Major Wilfred Bion used the mid-day parade to consider with them the behaviours they were exhibiting 'here and now'. His colleague, Major John Rickman, ran reflective groups on the ward for six months previously.[111] Together, they wrote the influential *Intra-Group Tensions in Therapy* (1943), which argued that the participants' principle task was to examine the internal tensions operating in the unit and the effects of neurotic behaviour.[112] Discussion and remedies were only employed once the difficulties were clear to everyone. Fundamentally, the task was to grasp the method being used, 'developing the forces that lead to smoothly running cooperative activity', so that it could be applied by the soldiers in other situations.[113] The focus was switched from the individual, to the social field within which they were operating, in line with Lewin's conceptualisation.[114]

After leaving the hospital, Bion and Rickman worked for the War Office Selection Board (WOSB), which ran three-day assessments of men applying for officer training.[115] The former had been instrumental in setting this institution up, particularly initiating the concept of the leaderless group exercise.[116] In this, a group of candidates were given a task, such as building a bridge, without identifying a leader or a method.[117] The assessors then were encouraged to consider what evolved and how any individual coped. The key capability that Bion considered essential was the ability to maintain relationships with his fellows, whilst under stress himself. As he expressed it, the method was 'so simple and so obvious', and was to provide a parallel situation to that which a potential officer might find himself on the field of battle, albeit less intensely.[118] This examination of the real life and 'here and now' situation was central to their way of working.

Subsequently, Bion joined many of his ex-army colleagues, including Rickman and Sutherland, in setting up the Tavistock Institute of Human Relations.[119] He ran groups there, in 1948, that enabled the participants to explore the dynamics of their relationships.[120] His

[110] Rickman can probably be credited with the use of this title, recorded in two letters in 1945. J. Rickman, 'Letter to Tom Main 31st August', 1945, British Psycho-Analytical Society; J. Rickman, 'Letter to Tommy Wilson 1st September', 1945, British Psycho-Analytical Society.
[111] Both were doctors who were deeply involved in psychoanalysis and psychological work in the Army as a whole.
[112] Bion and Rickman, 'Intra-Group Tensions in Therapy: Their Study as the Task of the Group'. Its immediate impact was recorded by their senior officer at the War Office, Ronald Hargreaves, who commented that it put forward fundamental ideas about group therapy that have never previously been emphasised. R. Hargreaves, 'Letter to John Rickman 4th October', 1943, British Psycho-Analytical Society.
[113] Bion and Rickman, 'Intra-Group Tensions in Therapy: Their Study as the Task of the Group', 678.
[114] Bion and Rickman, 681.
[115] E. Trist, *Working with Bion in the 1940s; The Group Decade* (Routledge and Kegan Paul, 1985), 16.
[116] Trist, 7.
[117] W. R. Bion, 'The Leaderless Group Project', *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 77–81.
[118] Bion, 77-78.
[119] Sutherland, 'Bion Revisited: Group Dynamics and Group Psychotherapy', 56–57.
[120] Bion, *Experiences in Groups and Other Papers*, 29.

passivity and limited interventions rapidly evoked tensions, which he would then interpret once they had become overt.

In *Experiences in Groups*, Bion describes how group members oscillate between a rational task-orientated approach and three basic assumptions: fight/flight, pairing and dependency.[121] These unconscious belief systems become emotionally powerful, overriding attempts to achieve the prime objective. Group members might feel that the emotions are too difficult to face and experience the wish to run away, or battle with the group leader. Alternatively, two may hold a conversation that is watched by the others who perceive a sexual liaison in progress. Dependency on one person is of considerable concern in TCs, from which can arise all the problems associated with charismatic leadership. Keller and Roberts, two later members of staff at Ingrebourne, referred to this in understanding the behaviour of a staff team in 1983.[122]

Major Foulkes arrived at Northfield shortly after Bion and Rickman's departure. Initially concentrating on developing group therapy on his ward, he eventually became part of the team that worked with Bridger. He had previously 'discovered' the group 'collective unconscious' whilst working in civilian practice in Devon.[123] By allowing the participants to talk in a free-flowing manner it became clear to him that the group reacted as one, rather than as individuals. This enabled interpretation of such things as a group silence, rather than addressing each individual about their particular problem. In addition, he considered that such therapy allowed patients to share their experiences and to show understanding of those of others, enabling them to be 'on equal terms '.[124] Their realisation that others also had similar emotional difficulties came as a relief and enabled them to examine their own problems more objectively, accepting understandings provided by other members more easily than from the therapist.

At Northfield he took the opportunity to develop these theories further, initially pursuing a specifically therapeutic attitude. This later was castigated by Tom Main who complained bitterly about therapists at Northfield who

> 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.[125]

Gradually, however, encouraged by a colleague, Harold Bridger, his approach became better orientated to the needs of the hospital as a military unit. He began to 'wander about' and

[121] The following is taken from Bion, *Experiences in Groups and Other Papers*, 1961.
[122] A. Keller and J. Roberts, 'The A.T.C. Supervisors' Group: An Experiment in the Supervision of Therapeutic Communities', *International Journal of Therapeutic Communities*, vol. 4, no. 1 (1983): 16.
[123] S. H. Foulkes and E. Lewis, 'Group Analysis; a Study in the Treatment of Groups on Psycho-Analytical Lines', *Journal of Medical Psychology*, vol. 20 (1945): 175–84.
[124] Foulkes and Lewis, 183.
[125] T. F. Main, interview by T. M. Harrison, 1984.

hold spontaneous groups in different situations, such as the Art Hut, and with the hospital band.[126]

After the war, Foulkes promoted his approach in a series of books. The most widely available, *Group Psychotherapy* (1957), was referred to by St. Blaize-Molony as a particular influence.[127] This establishes some basic precepts. Group members are invited to talk about whatever comes to mind (free association) then to 'analyse' their actions and interactions.[128] It is essential for all to be involved in the study of the dynamics, not just the lead therapist.[129] This discussion includes the unconscious elements as in psychoanalysis, but, unlike that approach, the emphasis is on the 'here and now', rather than the psychogenetic past.[130]

Major Harold Bridger arrived at Northfield in 1944 and this signalled the beginning of the second Experiment. Informed by the work of Bion and Rickman, and similarly influenced by Kurt Lewin, his first decision was to consider the 'hospital-as-a-whole' and the role of his 'social therapy' unit in achieving this. [131] This attempt to integrate the social system of the hospital into one organism, serving the task of returning the soldier-patients back to active service, aimed to remove the social barriers erected between the various wards and departments.[132] Each ward elected a committee from its residents and representatives from these formed a hospital-wide committee, organising activities such as work opportunities, the hospital newspaper and social events, creating a form of hospital self-government.[133]

Lt. Col. Tom Main joined eight months later and worked alongside Bridger to promote the reforms. His article, 'The Hospital as a Therapeutic Institution' published in 1946, both established the term 'Therapeutic Community' and laid out some fundamental principles underlying it.[134] Referenced by Crocket in 1964, it was still being used as training material at Ingrebourne thirty years later and remains one of the seminal papers of the TC movement.[135] Reflecting its author's personality, it reads with the passionate intensity of a manifesto. He condemns the traditional hospital as robbing the patients 'of their status as responsible human beings', and goes on to remind us that 'they are called "good" or "bad"

[126] Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 237–39.
[127] This was written in collaboration with E. J. Anthony and first published in 1957. Foulkes and Anthony, *Group Psychotherapy: The Psychoanalytic Approach*. Now published by Karnac under the Maresfield Library imprint; INGCE1, 2010, 2.
[128] Foulkes and Anthony, 37.
[129] Foulkes and Anthony, 37.
[130] Foulkes and Anthony, 41.
[131] Bridger, 'The Northfield Experiment', 1946, 75.
[132] Bridger, 75.
[133] Bridger, 74.
[134] Main, 'The Hospital as a Therapeutic Institution', 1946.
[135] R. W. Crocket and R. St. Blaize-Molony, 'Social Ramifications of the Therapeutic Community Approach in Psychotherapy', *British Journal of Medical Psychology,* vol. 37 (1964): 153. It was one of the papers contained in Conneely, 'Ingrebourne Centre Link: Brief History and Groups in Action at the Ingrebourne Centre'. For evidence of the latter statement, see D. Kennard, 'The Therapeutic Community', in *Group Therapy in Britain*, eds. M. Aveline and W. Dryden, Psychotherapy in Britain (Milton Keynes: Open University Press, 1988), 154.

only according to the degree of their passivity in the face of the hospital demand for their obedience, dependency and gratitude'.[136] He delineates the issues of institutionalisation: 'So, isolated and dominated, the patient tends to remain gripped by the hospital machine' and 'health and stability are too often bought at the excessive price of desocialisation'. In its place, he proposes that the hospital should become a 'therapeutic setting with a spontaneous and emotionally structured (rather than medically dictated) organization in which all staff and patients engage'.[137] The daily life of such a unit should be related to 'real tasks' both relevant to the needs of the institution and the larger society in which it is set. The therapeutic task is to understand and engage with the interpersonal barriers preventing the individual from participating in a full community life. In this environment, the doctor, and by implication other staff, has to abrogate any *ex cathedra* status, encouraging the members of the community to tackle disorder and dissension as problems of group life, rather than passing judgement.[138] He warned that doctors would find abrogating their 'grandiose' medical role difficult. [139] He rounds off the paper with a generalised quote from the soldiers who participated. When asked why they were better, they tended to reply 'with a vague "I don't know why. I found something that suited me. Then I met some nice people. I think that helped."'.[140] For many working in mental hospitals this was a clarion call for change.

In 1958, Crocket corresponded with another Northfieldian, Dr Joshua Bierer, about the latter's use of night beds which he planned to institute at Ingrebourne.[141] After the war, Bierer continued work at the Marlborough Day Hospital, begun previously at Runwell Hospital.[142] His relevance to the future of similar approaches is summed up by Sutherland's review of his book. [143] Sutherland praises him for setting up with 'slender resources'. Nevertheless he finds vaguely conceived principles of 'social psychiatry and syntho-analytical psychotherapy' disconcerting, and expresses scepticism about his capacity to treat adequately as many patients as he claimed. Crocket noted in his diary in 1955 that 'I do not respect Bierer or his associates'.[144]

The Second Northfield Experiment lasted about 18 months and never really engaged the whole hospital. It never was a truly therapeutic community as indicated by Main and Bridger, but it aspired to achieve a significant re-appraisal of the role of staff and patients within the mental hospital setting. Through the medium of Jock Sutherland, Crocket would

[136] Main, 'The Hospital as a Therapeutic Institution', 66.
[137] Main, 67.
[138] Main, 68.
[139] Main, 68.
[140] Main, 70.
[141] R. W. Crocket, 'Letter to Dr Joshua Bierer 10th January', 1958, Planned Environment Therapy Trust.
[142] J. Bierer, 'Group Psychotherapy', *British Medical Journal*, vol. 1, no. 4232 (1942): 214–16; J. Bierer, 'Day Hospitals: Further Developments', *International Journal of Social Psychiatry*, vol. 7 (1961): 148–51.
[143] J. D. Sutherland, 'Review: Day Hospitals by Joshua Bierer', *British Medical Journal*, vol. 2, no. 4728 (1951): 404.
[144] Crocket, 'Diary: 1954 - 1962', 15th June 1955.

have been very aware of the events that occurred there. Later, in 1968, he visited Eric Trist, a psychologist and professor at U.C.L.A., who had worked alongside Bion and Rickman during the war and was also acquainted with Main. Crocket was able to spend some time discussing Northfield and confirming his previous knowledge of it.[145] The art therapist at Ingrebourne from 1975 – 1986, Gerry McNeilly, considered that the Centre had been influenced by these events.[146]

Crocket's relationship with Sutherland was complemented by St. Blaize-Molony observing his work in groups. Commenting later, the latter found Sutherland to be 'very down to earth'.[147] Sutherland became medical director of the Tavistock Clinic in 1947, and was considered to be crucial in conveying British comprehension of group processes to the United States.[148] He introduced the ideas of Bion and Foulkes to the Menninger Clinic and other institutions in Topeka and Washington during the 1960s. He also supported other psychotherapists, including R.D. Laing who established the Kingsley Hall TC.

In 1946 Main was appointed as medical director of the Cassel Hospital in Richmond, which he transformed into a psychotherapeutic institution. Incorporated into the NHS in 1948, it is the only remaining TC still operating within its auspices. Through publications and personal contacts Main continued to be a highly influential figure. In 1957, in a seminal paper, called 'The Ailment', he explores the problems concerning the 'special' patient in psychiatry. He focusses attention on a group of people who, by taking individual nurses aside and giving them confidential information with the proviso that they should not share it with other staff, effectively isolates the professional from the rest of the therapeutic team.[149] This arouses conflict amongst staff, leading to them splitting into an 'inner' sympathetic group and an 'outer' critical one. A common consequence is that the patient is evicted as being 'too difficult'. Main advises that 'sincerity' is essential, requiring staff to communicate openly with each other and avoid being trapped into such confidences alone. This explanation of a process, without criticism of the participants, allows such difficult emotional encounters to be faced and managed. Its influence is reflected in the fact that the

[145] R. W. Crocket, 'Journal of Visit to America 13th May to 15th June 1968', 4, http://pettrust.org.uk/index.php?option=com_content&view=article&id=610:week-4-4-june-1968-to-10-june-1968&catid=201&Itemid=335, accessed 20/08/2018.
[146] Gerry McNeilly, *Group Analytic Art Therapy* (London; Philadelphia: J. Kingsley Publishers, 2006), 40.
[147] INGCE1, Interview, 2.
[148] P. O'Farrell, 'Obituary: John D. Sutherland (1905-1991)', *The International Journal of Psycho-Analysis*, vol. 73, no. 3 (1992): 579.
[149] Main, 'The Ailment'.

psychiatrist, Dr Spielman, re-reviewed the paper forty years later.[150] As stated previously, Crocket found it relevant to his work.[151]

Main wrote in 1983 that 'the term "therapeutic community" owes much of its meaning to Maxwell Jones, whose innovative work … and voluminous writings … have much influenced others'.[152] Contemporaneously, Kennard stated that although Main coined the term, 'it was Maxwell Jones whose name came to symbolise the movement'.[153] Through his writings and work at Belmont Hospital, Jones played a significant role in promoting TC concepts throughout the 1950s and 1960s. Rapaport's study of the unit helped to secure its international reputation.[154] Crocket invited him to speak at the Ingrebourne in 1957, thus establishing a long-standing relationship with the Henderson Hospital that continued through to the 1980s.[155] He had been aware of the work at the Belmont for some time, adopting features from Jones' first book as being characteristic of his own unit's work.[156] After reading an article in *The Times* describing the unit, he sat in on groups there. Following this experience, he was keen to distinguish his own management of groups in an egalitarian circle, from his perception that Jones conducted the patients in 'serried rows, like a lecturer'.[157]

in his first book published in 1952, Jones makes scant reference to his intellectual predecessors.[158] He does, however, acknowledge that his wartime group talks at Mill Hill, owed a great deal to Joseph Pratt.[159] These thrice weekly lectures to the patients covered various aspects of neurology, physiology and psychology.[160] Like Pratt, he found that they

[150] R. Spielman, '"The Ailment" by T F Main - 40 Years On', *Therapeutic Communities*, vol. 19, no. 8 (1998): 221–26. In 2005, another team of psychiatric staff considered that its importance lay in the fact that it was still being referred to and quoted from. Peter Hayward et al., '"The Ailment" Revisited: Are "manipulative" Patients Really the Most Difficult?', *Journal of Mental Health*, vol. 14, no. 3 (2005): 291.
[151] R. W. Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Center', *International Journal of Group Psychotherapy*, vol. 12, no. 1 (1962): 189.
[152] Main, 'The Concept of the Therapeutic Community: Variations and Vicissitudes', 1989, 139.
[153] D. Kennard and J. Roberts, *An Introduction to Therapeutic Communities* (London; Boston: Routledge & Kegan Paul, 1983), 50.
[154] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 1960.
[155] The Belmont Hospital was later renamed as the Henderson Hospital. R Crocket, 'Memorandum: The Ingrebourne Centre. St George's Hospital, Hornchurch.1955 - 1958', (Unpublished, 1958), 9, Planned Environment Therapy Trust.
[156] R. W. Crocket, 'The "Therapeutic Community" Approach to Neuroses', in *Neuroses: I. Congressus Psychiatricus Bohemoslovenicus Cum Participatione Internationali 1959* (Prague: Státnízdravotnickénalkadatelství, 1961), 272–3.
[157] Crocket, PETT Interview (T) CF 271, 14.
[158] Jones, *Social Psychiatry*, 1952.
[159] Jones, 'Group Treatment, with Particular Reference to Group Projection Methods', 292–93.
[160] Effort Syndrome prior to the Second World War was a diagnosis ascribed to soldiers who exhibited varying symptoms including breathlessness, fatigue, left thoracic pain and dizziness. Dr Paul Wood studied 300 patients in 1940 and concluded that it was a form of anxiety neurosis rather than physical in origin as previously thought. J.S. Whiteley, 'Guest Editorial: Maxwell Jones CBE MD FRCPsych FRCP(Ed)', *International Journal of Therapeutic Communities*, vol. 12, no. 2&3 (1991): 77; P Wood, 'Da Costa's Syndrome (or Effort Syndrome)', *British Medical Journal*, vol. 1, no. 4194 (1941): 767; M. Jones, 'Physiological and Psychological Responses to Stress in Neurotic Patients', *Journal of Mental Science*, vol. 44 (1948): 392.

became more than didactic, the patients began to raise difficulties that they were facing in ward life.[161] This led on to holding dramatizations of actual case histories or social problems, initially in ignorance of Moreno's work, but, by 1946 Jones was borrowing freely. In these psychodramas the doctor played the role of father representing 'normality', a particularly literal interpretation of Wender's advice about the therapist acting in the role of 'father-to-the-whole-family'.[162] He shared the American's view that communal discussion of problems may 'rob them of their painful significance'.[163] The participants realised that other people's problems resonated with their own and that, by 'pooling solutions', there were alternative ways of handling difficulties.[164]

Following his work during the Second World War, Jones moved to Dartford where he organised and ran a rehabilitation unit for returning prisoners of war suffering from neurosis.[165] Here, he extended the work developed at Mill Hill by including a disablement resettlement officer to assist with the mens' return to work. In 1947 he took over an industrial neurosis unit at Belmont Hospital where 100 beds were used to 'study the problem of the chronic unemployed neurotic'.[166] Crocket made frequent reference to this work in his earlier papers.[167] As Jones became more interested in people with relationship difficulties, the emphasis shifted to the therapeutic value of the social milieu.[168] In Kennard's view, Jones created a format which others could follow by establishing three key ingredients: the community meeting, staff review meetings and enabling a 'living-learning' environment.[169] The latter recognised that crises needed understanding and 'the whole of a patient's time spent in hospital is thought of as treatment'.[170] The crux of this process was the daily community meeting where everyone present attended and problematic incidents were discussed.[171] Here, people could learn about the consequences of behaviour and discuss alternative approaches. Anderson and Crocket developed their approach independently, but quickly recognised the similarities when they learnt more of Jones' work.[172]

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[161] Jones, *Social Psychiatry*, 1952, 13.
[162] Jones, 'Group Treatment, with Particular Reference to Group Projection Methods', 294; Wender, 'Group Psychotherapy: A Study of Its Application', 708.
[163] Jones, 'Group Treatment, with Particular Reference to Group Projection Methods', 298.
[164] Jones, 298.
[165] M. Jones, 'Rehabilitation of Forces Neurosis Patients to Civilian Life', *British Medical Journal*, vol. 1, no. 4448 (1946): 533.
[166] Jones, *Social Psychiatry*, 1952, 25.
[167] Crocket, 'The "Therapeutic Community" Approach to Neuroses'; Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Center'; Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', 1961.
[168] Jones, *Social Psychiatry*, 1952, 53.
[169] Kennard and Roberts, *An Introduction to Therapeutic Communities*, 50.
[170] Jones, *Social Psychiatry*, 1952, 53.
[171] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 93.
[172] Crocket, PETT Interview (T) CF 271, 14.

The staff review meetings, held immediately after the community meeting, served two main functions. The first was to understand the interactions occurring in the preceding gathering and, second, to enable new staff to understand the processes of the unit.[173] This was well established at Ingrebourne.[174]

During the 1950s, British psychiatrists were increasingly conscious of the experimentation and research into the social aspects of hospital-based psychiatry being carried out in the United States of America. In particular, Crocket was aware of the work of Harry Wilmer and Macdonald and Daniels. He references the latter on a number of occasions, but, apart from a single published paper it is difficult to find anything else about this couple.[175] In this article, a nurse and a psychiatrist describe the difficulties encountered in setting up a therapeutic community in a four-ward hospital in Colorado.[176] They provide a text-book account of implementing innovation in the face of traditional mental hospital attitudes amongst staff. Characteristically, there was a small group of innovators challenged by others who rigidly stuck to hospital routines. A third mutely indecisive group were 'swayed by the dominant faction of the moment'. The authors then proceed to detail how group discussions, rather than lectures, were more effective in aiding acceptance of the changes. Increasingly, the nurses became more adept at handling the emotional turmoil of their patients in a non-pejorative manner. Their increased confidence in expressing their opinions, concurrently with that of the patients, led at times to uncomfortable confrontations with the medical staff. However, this was part and parcel of the necessary freeing up of communication between all members of the therapeutic team. Crocket took from the paper the challenge presented by nurses finding it difficult to face the expression of difficult emotions by the patients, and the necessity of prolonged support for them by the medical staff.[177]

Another American psychiatrist, Harry Wilmer, was also referenced by Crocket in 1961.[178] During the latter's trip to the United States in 1968, he visited the Youth Drug Study Unit at the Langley-Porter Neuropsychiatric Institute, where Wilmer was working. He spent the day taking part in the unit, attending the groups held there, and clearly was less impressed than he expected, although he considered that it was the one unit that he visited in America that was closest to in style to Ingrebourne.[179] Wilmer had been inspired by his visits to the Cassel Hospital and Belmont, where he met Main and Jones in the early 1950s and set up a therapeutic community ward in the Naval Hospital at Oakland California.[180] He also was

[173] Kennard and Roberts, *An Introduction to Therapeutic Communities*, 51.
[174] Conneely, 'Ingrebourne Centre Link: Brief History and Groups in Action at the Ingrebourne Centre', 7; INGCE17, interview, 9; INGCE20, interview, 20.
[175] E.g. Crocket, 'The "Therapeutic Community" Approach to Neuroses', 278; Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 193.
[176] J. M. Macdonald and M. L. Daniels, 'The Psychiatric Ward as a Therapeutic Community', *Journal of Nervous and Mental Diseases*, vol. 124 (1956): 148–55.
[177] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Center', 182–83.
[178] Crocket, 'The "Therapeutic Community" Approach to Neuroses', 272.
[179] Crocket, 'Journal of Visit to America 13th May to 15th June 1968', 4-5.
[180] Wilmer, *Social Psychiatry in Action: A Therapeutic Community*, 5.

aware of the events at Northfield.[181] Whilst Crocket felt that he learnt little from the visit, he would have gained an increasing sense of confidence from reading Wilmer's book. This described the practical details of setting up a busy, locked, 34-bedded, admission ward as a therapeutic community. It had

> previously been managed by conventional hospital practices employing restraints, large amounts of sedation, and seclusion as methods of control. Such methods were discontinued. Yet behaviour improved dramatically. Serious violence disappeared entirely. This does not mean that no blows were struck by any patient in the therapeutic community, for sometimes it became temporarily impossible for a disturbed patient to control himself.[182]

He reflected Crocket's own considerations of the 'all important' need for staff support. If the staff could be helped to cope with their own tumultuous emotions without feeling guilty or contemptuous, they would not 'project their own feelings of internal disorder, allied with guilt and contempt, onto the patients'.[183] As a consequence the patients found an '*esprit de corps*' and a sense of belonging in a mental hospital ward.[184]

Historian and psychiatrist Hugh Freeman stated that, as in the 1950s, there was no clear direction nationally throughout the 1960s and therapeutic innovations continued to rely on the 'efforts of individual clinicians'.[185] Exemplifying this, Drs Martin, Glatt and Weeks, in 1952, selected a group of 'some seven or eight male patients' to spend their day in a small, neglected, isolation block at Warlingham Park Hospital'.[186] The men were 'given no guidance as to what they should do', but were able to 'discuss the situation in a twice weekly group with one of the doctors'. The initial fortnight rendered them completely helpless, but eventually they began to care for their environment, re-decorating the building and renovating the garden. Subsequently, they began cooking for themselves. Cameron et al., reporting in 1955, carried out a similar experiment in Scotland.[187] They invited eleven socially isolated women to a room called the 'Rumpus Room'. Again, few instructions were given, except that the doctors visited daily. After a while, the women began to relax, participate in activities and become more sociable. R. D. Laing, one of those involved, subsequently referred to these events as being central to his understanding of schizophrenia.

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[181] Wilmer, 9.
[182] Wilmer, 17–18.
[183] Wilmer, 11–12.
[184] Wilmer, 26.
[185] Freeman, 'Mental Health Policy and Practice in the NHS', 233,237.
[186] D. V. Martin, M. M. Glatt, and K. F. Weeks, 'An Experimental Unit for the Community Treatment of Neurosis', *The British Journal of Psychiatry*, vol. 100, no. 421 (1954): 983–89.
[187] J. L. Cameron, R. D. Laing, and A. McGhie, 'Patient and Nurse: Effects of Environmental Changes in the Care of Chronic Schizophrenics', *The Lancet*, vol. 266 (1955): 1384–86.

Until the early 1970s, TCs operated independently of each other. Table 4.1 lists some of those established by this time. The main communication was through informal discussions, visits, staff movement, articles in the medical press and occasional lectures given by senior psychiatrists. Denis Martin, reforming Claybury, referred to the many conversations he had with 'colleagues experimenting in community therapy and the visits to the units and hospitals in which they work'.[188] David Clark recalled

> that we began to visit one another and talk about what we were doing. And share with one another the pains of doing something which was seen as so irregular, unprofessional, shabby, lamentable, dangerous, revolutionary, by all our colleagues in the medical, in the nursing profession and our management committees.[189]

At the time, he considered that only six units in the late sixties were 'proper' TCs.[190] However, in the early 1970s, Crocket surveyed thirty-five units that were running community meetings, and concluded that there was 'a much wider interest in the methods of social psychiatry than had been realised'.[191]

Only four have survived to the present day: the Arbours Association, Grendon Prison, Richmond Fellowship and the Cassel Hospital. This list, as stated earlier, is not exhaustive and there were other units that were established that quite quickly disappeared again. As an example, Drs Lightbody and Jacobson resolved in 1963 to run an acute admission ward at St Francis' Hospital in Sussex as a therapeutic community.[192] They described their experiment as it stood eighteen months later in an article in the prestigious *British Medical Journal*, however, no mention is made of them in the history of the hospital published in 1999, suggesting that it had little impact on the hospital as a whole.[193] It did not feature in other surveys of therapeutic communities and the assumption can be made that it did not last for long.

The historian Catherine Fussinger identifies three phases in the development of TCs in Britain.[194] The first consisted of the experiments in the British Army already alluded to. The next concerned experimenting with different forms of practice both in the United Kingdom and North America during the 1950s and early 1960s. The final stage began in the middle of the 1960s and continued until the late 1970s and was made up of two distinct movements. One was the diffusion of the model more broadly in the West, and the other was the

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[188] Denis V. Martin, *Adventure in Psychiatry*, (Oxford: Bruno Cassirer, 1974), viii.
[189] *'The Early Days of the ATC': The Peter van Der Linden Lecture, 1999*.
[190] Mandlebrote, 'The Northfield Experiment: Its Contribution to Developments in Psychiatry', 151.
[191] R. W. Crocket, 'Report: Therapeutic Communities in Britain and Other European Countries', 1972, 7, Planned Environment Therapy Trust. He suggested that there was a much wider range of units, in 'almost every region', than he was able to visit.
[192] Lightbody and Jacobson, 'A Therapeutic Community in an Acute Admission Unit of a Mental Hospital'.
[193] James Gardner, *Sweet Bells Jangled out of Tune : A History of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath* (Brighton: The Author, 1999).
[194] C. Fussinger, 'Eléments Pour Une Histoire de La Communauté Thérapeutique Dans La Psychiatrie Occidentale de La Seconde Moitié Du 20e Siécle', *Gesnerus*, vol. 67, no. 2 (2010): 220.

unacknowledged expropriation of this approach by the British anti-psychiatrists.[195] She maintains that, whilst engaged in this adoption of TC ideas, they vociferously rejected their more traditional psychiatric colleagues.[196]

[195] Fussinger, 220.
[196] Fussinger, '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists', 149.

Table 4.1: Therapeutic Communities for adults with mental health disorders, 1946-1972.

Name	Year Est.	Comments
Marlborough Day Hospital	1946	Day Hospital.[197]
Belmont/Henderson	1947	In-patient unit: Developed from work at Mill Hill during WWII.[198]
Cassell Hospital	1948	In-patient Unit: Described in text.[199]
Claybury	1955	Hospital: First ward opened as TC in 1955, later whole hospital.[200]
Uffculme Clinic	1955	In-patient and day patient:.[201]
Littlemore Hospital	1956	Hospital: introduced TC methods, by 1959 spread to half the wards.[202]
Ingrebourne	1957	Single ward.[203]
Fulbourne	1958	Hospital: One ward initially, eventually involved the whole hospital.[204]
Richmond Fellowship	1959	Residential Unit: Charity catering for Schizophrenia.[205]
Villa 21, Shenley Hospital	1962-6	Ward: for people with psychosis.[206]
Dingleton Hospital.	1963	Hospital: Further development of an open door hospital.[207]
Grendon Prison	1963-	Prison service: 250 individuals.[208] Continues to present day
Kingsley Hall (Philadelphia Association)	1965	Private residential unit: Laing at al. independent for psychosis.[209]
John Conolly Hospital,	1965	Hospital: a catchment area practice, closed c. 1984.[210]
Paddington Day Hospital	1965	Day Hospital: closed 1979 following major difficulties.[211]
Halliwick Hospital	1966-72	Whole hospital of 4 wards as therapeutic community[212]
The Arbours	1970	Private residential unit: continues to present day.[213]
Bethlem Hospital	c. 1960	Ward: Tyson West Two collapsed from Messianic pretensions[214]

[197] J. Bierer, 'Theory and Practice of Psychiatric Day Hospitals', *The Lancet*, vol 274 (1959): 901.
[198] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 2.
[199] Jennifer Johns, 'Historical Background', in *The Ailment and Other Psychoanalytical Essays*, by T. F. Main, (London: Free Association Books, 1989), 2–3.
[200] Martin, *Adventure in Psychiatry*, 25.
[201] J. A. Harrington and W. Mayer-Gross, 'A Day Hospital for Neurotics in an Industrial Community'. *The British Journal of Psychiatry*, vol. 105, no. 438 (1959): 224–34; M Pines, 'Therapeutic Communities in Teaching Hospitals', in *Therapeutic Communities: Reflections and Progress*, eds. R. D. Hinshelwood and N. Manning (London: Routledge & Kegan Paul, 1979), 29.
[202] Pines, 'Therapeutic Communities in Teaching Hospitals', 28–29; M. Gelder, 'Bertram Mandelbrote', *The Psychiatrist*, vol. 35, no. 4 (2011): 158.
[203] Farndale, *The Day Hospital Movement in Great Britain*, 274.
[204] Clark, *The Story of a Mental Hospital*, 197.
[205] Elly Jansen, *The Therapeutic Community: Outside the Hospital* (London: Croom Helm, 1980), 7.
[206] O. Wall, 'The Birth and Death of Villa 21', *History of Psychiatry*, vol. 24, no. 3 (2013): 326–40.
[207] K Millar, *The Story of a Community: Dingleton Hospital Melrose* (Melrose: Chiefswood, 2000), 105–26.
[208] T. Newell and B. Healey, 'The Historical Development of the UK Democratic Therapeutic Community', in *Dynamic Security: The Democratic Therapeutic Community in Prison*, ed. M. Parker (London: Jessica Kingsley, 2007), 67.
[209] J. Clay, *R.D. Laing: A Divided Self* (London: Hodder and Stoughton, 1996), 122.
[210] Pines, 'Therapeutic Communities in Teaching Hospitals', 29.
[211] C. Baron, *Asylum to Anarchy* (London: Free Association Books, 1987), 35, 273.
[212] Lionel Kreeger, 'Introduction', in *The Large Group: Dynamics and Therapy*, ed. Lionel Kreeger (London: Constable, 1974), 13.
[213] J. Berke, 'Reflections on Arbours', *International Journal of Therapeutic Communities*, vol. 11, no. 4 (1990): 191.

Amongst these 'rebels' one figure stands out: Ronnie Laing.[215] He and his colleagues took the idealism of the therapeutic community to its extreme at Kingsley Hall. Here there were no patients, no doctors, no white coats, and no mental illness, 'there was no 'schizophrenia', and therefore no 'schizophrenics' – just people living together'.[216] Through his many popular publications, lecture tours and television appearances, he became a celebrity.[217] He was a signifier of the radical left wing spirit of the age described in the previous chapter. His role, having been treated dismissively by historians, such as Edward Shorter and Roy Porter, is now being re-evaluated.[218]

He and his colleague, David Cooper, had previous experience of developing therapeutic milieus in psychiatric hospitals. As a trainee psychiatrist from 1953 to 1955, he worked at Gartnavel Hospital where he was involved in the 'Rumpus Room' (described above).[219] It was here that he learnt from the patients through sitting and conversing with them.[220]

David Cooper led the transformation of a ward, Villa 21, at Shenley Hospital from 1962 to 1966.[221] Here, the staff 'felt their way' into working with 19 young men. As Cooper expressed it 'after some months … it was decided to hold daily community meetings' in which problems that affected the whole ward were discussed.[222] These were supplemented by two more 'formal *therapeutic groups*' and the programme emulated the 'classical' TC. Gradually, staff roles and routines were abandoned, to the extent that nurses withdrew from their directive supervisory function altogether.[223] Unsurprisingly, the ward became filthy, windows were broken and some patients remained in bed for days. Eventually, the staff took back some control by supervising eating and cleaning arrangements, and insisting

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[214] R. F. Hobson, 'The Messianic Community', in *Therapeutic Communities: Reflections and Progress*, ed. R. D. Hinshelwood and N. Manning (London: Routledge & Kegan Paul, 1979), 231–44.
[215] Whilst there were others Laing was the 'star' as the historian Nick Crossley described it. Crossley, *Contesting Psychiatry*, 101.
[216] Laing, *R.D. Laing: A Life*, 100.
[217] Crossley, *Contesting Psychiatry*, 101.
[218] Rhodri Hayward, 'Book Review: Recovering R. D. Laing', *Metascience*, vol. 16 (2007): 525–27; Roy Porter, *A Social History of Madness: Stories of the Insane*, (London: Phoenix Giant, 1999), 120–24; Roy Porter, 'Anti-Psychiatry and the Family: Taking the Long View', in *Cultures of Psychiatry*, eds. Marijka Gijswijt-Hofstra and Roy Porter (Amsterdam-Atlanta, GA: Rodopi, 1998), 257–81; Shorter, *A History of Psychiatry*, 276.
[219] Allan Beveridge, *Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing, 1927-1960* (New York: Oxford University Press, 2011), 199–223; Cameron, Laing, and McGhie, 'Patient and Nurse: Effects of Environmental Changes in the Care of Chronic Schizophrenics'. There is some controversy over how much he was involved in setting up the experiment. In his own personal accounts, he tends to downplay the involvement of other significant individuals. David Abrahamson, 'R. D. Laing and Long-Stay Patients: Discrepant Accounts of the Refractory Ward and `Rumpus Room' at Gartnavel Royal Hospital', *History of Psychiatry*, Vol. 18, no. 2 (June 2007): 203–15; Jonathan Andrews, 'R. D. Laing in Scotland: Fact and Fictions of the "Rumpus Room" and Interpersonal Psychiatry', in *Cultures of Psychiatry*, eds. Marijka Gijswijt-Hofstra and Roy Porter (Amsterdam: Rodopi, 1998), 121–50.
[220] Beveridge, *Portrait of the Psychiatrist as a Young Man*, 210–17.
[221] Wall, 'The Birth and Death of Villa 21', 326.
[222] Cooper, *Psychiatry and Anti-Psychiatry*, 99.
[223] Cooper, 103–110.

on attendance at the community meeting. This process, of moving from authority maintained by 'conformism to the rigid, stereotyped dictates of authority persons' to taking responsibility for a safe environment within which both the patients and the staff could discover 'real sources of authority in themselves', was, he believed, to be a move to 'authentic leadership'.[224]

In 1963, Laing, Cooper and five others set up Kingsley Hall to develop an ideal community for working with people suffering from schizophrenia.[225] The centre ran for five years and had an influence that spread well beyond the few residents there. Here, a nursing sister, Mary Barnes, 'regressed' as part of her therapy to the stage where she was being cared for as a baby, covering herself in 'shit', or lying rocking and thumb-sucking in a large painted box.[226] Others joined to escape the punitive care in their local mental hospitals and to 'be themselves'. The therapists lived on the site and shared the tasks of the community cooking and cleaning.[227] It became a Mecca for visitors, sharing the utopian ideals, led by the 'sun, moon and guiding star' of the counter-cultural guru, Laing.[228] Amongst those who took an interest was Crocket. Laing, however, was dismissive of his psychiatric colleagues and more interested in changing the world.[229] He repudiated any distinction between madness and sanity and criticised psychiatry's attempt to control and 'cure' those that were deemed unwell.[230]

Whilst, according to Fussinger, the TC was diffusing through the Western World, Dr Stuart Whiteley, successor to Maxwell Jones at the Henderson Hospital, found that 'on the whole the therapeutic community idea began to fade in the mid-sixties in the U.K.'.[231] He convened a conference, in July 1970 to discuss the gloomy situation, where a dozen interested psychologists, nurses, psychiatrists and social workers 'fanned into flame the smouldering embers'.[232] David Clark recalled that they needed an environment in which the difficulties they were facing in running a TC could be discussed.[233] They forged links between different services, inaugurating the Association of Therapeutic Communities in 1972.[234] Crocket and

[224] Cooper, 108.
[225] Laing, *R.D. Laing: A Life*, 93–97.
[226] Clay, *R.D. Laing: A Divided Self*, 124–25.
[227] Clay, 127–28.
[228] Clancy Sigal, *Zone of the Interior* (Hebden Bridge: Pomona, 2005), 183; Laing, *R.D. Laing: A Life*, 108. Franco Basaglia, the psychiatrist who became a central figure in the reform of the Italian psychiatric system, was amongst those visiting. Crossley, 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain', 810.
[229] D. Ingleby, 'The View from the North Sea', in *Cultures of Psychiatry*, eds. Marijke Gijswijt-Hofstra and Roy Porter (Amsterdam-Atlanta, GA: Rodopi, 1998), 297.
[230] Crossley, 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis', 878.
[231] J. S. Whiteley, 'The Henderson Hospital: A Community Study', *International Journal of Therapeutic Communities*, vol. 1, no. 1 (1980): 48.
[232] Whiteley, 'Progress and Reflection', 16.
[233] D. H. Clark, *'The Early Days of the ATC': The Peter van Der Linden Lecture, 1999*.
[234] D. Kennard, 'An Incomplete History of the Association of Therapeutic Communities', *Therapeutic Communities*, vol. 32, no. 2 (2011): 98.

the Ingrebourne were early members and hosted the second meeting in November 1970.[235] The initial meeting, intended to be between the senior staff at each centre, was hijacked by groups of other staff insisting that they should be present at the initial meeting.[236] This resulted in subsequent meetings, held in different hospitals, stimulating enthusiasm, and the sharing of ideas between all levels of staff members. The Association consolidated its co-ordinating position by publishing a newsletter in 1972, augmented by the *International Journal of Therapeutic Communities* in 1980. The first five years were marked by wide ranging debate as to whether it should be looking for professional and scientific respectability or, congruent with the period, starting a social revolution.[237] It was not until 1996 that Kennard considers that it became a professional organisation.[238] Crocket regretted its formalisation, remarking that, in becoming orthodox 'it lost this ability to be the opposite, unformed, incandescent, the capacity to go in different directions at different times'.[239] Reflecting his relationship with the spirit of the period, he argued that it lost the ability to act permissively. Members of the staff at Ingrebourne remained closely associated with the ATC for many years, attending meetings and contributing to the newsletter and journal.[240]

Ingrebourne shared many similarities with the development of other units in the United Kingdom. Whilst its early days was marked by an *ad hoc* approach, it gradually gained a sense of direction and purpose as Crocket and his colleagues became aware of the epistemological background to group processes and TC practice.

3. A Mish-Mash of Relationships: Therapeutic Spaces at Ingrebourne

Two years prior to the election of Thatcher's Conservative government in 1977, Jeff Roberts was appointed as the lead doctor at Ingrebourne to replace Crocket.[241] His tenure lasted until December 1982. Following the despondent and insecure period described at the end of the last chapter, his appointment coincided with the recruitment of a group of enthusiastic new staff.[242] His lack of experience and permissive approach enabled them to shoulder responsibility.[243] Many of this new group trained at the Institute of Group Analysis, giving

[235] D. H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community* (London: Tavistock, 1964).
[236] D. H. Clark, *'The Early Days of the ATC': The Peter van Der Linden Lecture, 1999*.
[237] Kennard, 'An Incomplete History of the Association of Therapeutic Communities', 99.
[238] Kennard, 102.
[239] Crocket, PETT Interview 23rd November 1998 (T)CF 272, 16.
[240] E.g. Murray, 'Thank You'; Roberts, 'Destructive Processes in a Therapeutic Community'.
[241] Richard Crocket was appointed as an interim consultant to replace Julian Goodburn at the Paddington Day Centre.
[242] INGCE15, interview, 2013; INGCE16, interview, 2013; INGCE20, interview, 2014; INGCE29, interview.
[243] INGCE20, interview, 9.

them a shared theoretical background.[244] Previously, new staff had to learn new techniques 'on the job, by modelling themselves on the staff more skilled and experienced in group techniques – usually the doctors'.[245] He was replaced by a locum consultant until 1984 when the permanent post was taken by Dr Margaret Williamson. She had previously been in psycho-analysis with Sutherland in Edinburgh and was pre-eminently an individual psychotherapist.[246] She remained until the unit closed in 2005.

The organisation of the unit remained relatively stable throughout this period (1977-2005), and the evidence from interviews allows an opportunity to examine its internal social dynamics and to some extent its relationship with the external world. Towards the end, discussed in the next chapter, the service was gradually whittled away through bed closures and reductions in the numbers of patients.

Despite the relative longevity of the Ingrebourne functioning as a TC, it is argued here that some of its internal contradictions contributed to its demise in the face of increasing external pressures. It was a contested space with rivalries, many not articulated, between different sets of expectations. As one staff member remembered the tensions, 'Because, in that kind of heat of relationships, who was gone to most, who was seen as the most important, who was seeing somebody individually, who was doing that, who was doing… I mean all that was going on.[247]

Researchers from the Tavistock Institute of Human Relations in 1974 aimed to study the 'structure and methodology of the Centre, evaluate its effectiveness and consider whether it could be applied in other settings'.[248] Their report provides a snapshot of the functioning of the unit at a time when it lacked staff, beds, whilst the building was rewired, and direction. The staff was divided and it was 'not functioning as a psychotherapeutic community'.[249] This source reveals more dysfunctional features than the later interviews and as such, counterbalances their relatively upbeat memories.

The following section aims to identify elements which sustained, or were potentially disruptive of, the unit's survival. In line with Lewin's thesis, it concentrates on the social and cultural dynamics rather than being concerned with individual behaviour.[250] The legacy from

[244] They have maintained this regard for each other to the present day. A number of the contacts made by this researcher were made through their still active social network.
[245] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 28,69-77, 87.
[246] INGCE30, interview, 2016, 2–3.
[247] INGCE29, interview, 21.
[248] Hereafter, when referred to in the text, it will be designated by the phrase TIHR study. Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 2.
[249] Tavistock Institute of Human Relations, 16.
[250] After some consideration, it has been decided to name the senior consultants who were the leaders at particular times. Inevitably, their styles of working were perceived by those who were working with them as more or less conducive to the ideas of the therapeutic community approach, but it would be consistent with

the first twenty years included: providing a caring and supportive social environment, a programme of group activities, openness of communication, inclusion of all participants into the process, a greater say in the running of the unit for all, and guidelines for behaviour.[251] At its core was the dictum that the 'whole of the patient's time spent in hospital is thought of as treatment'.[252]

Enabling greater interaction between patients and therapists results in greater overt emotional upheaval. Managing the expression of distress verbally, whilst finding means to curtail its inappropriate physical expression, is a central challenge for any TC. The task is to maintain appropriate boundaries to enable a safe transitional space in which trust can develop in order to explore new possibilities in relationships.[253]

i. The Boundaries of the Therapeutic Transitional Space

There are a number of dimensions to a TC such as the Ingrebourne. First is the nature of space and place. As stated in the opening chapter, the TC has been reframed by Bridger as a transitional space. This viewpoint is explored before embarking on examining the different boundaries that contained this dynamic environment. Then the malleability of interpretation of different physical spaces is described before exploring the more abstract limits such as those applied to behaviour.

a. The Relevance of Boundaries

Understanding and maintaining boundaries is central.[254] Maxwell Jones told his colleague Dennie Briggs that a TC is a more or less self-contained environment which has 'a periphery within which it is relatively safe to let one's guard down, to be one's true self within limits of that special setting'.[255] Crocket asserted that TC theory 'directs attention to boundaries', and

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the naming of Crocket as the initiator, and also the individuals would be easily recognisable anyway to those who were involved. There is no intention to attribute any value judgement to their actions.

[251] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957.' 2-3.

[252] Jones, *Social Psychiatry*. 53

[253] A. Foster, 'The Management of Boundary Crossing', in *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N Manning (London: Routledge & Kegan Paul, 1979).

[254] Penelope Campling, 'Boundaries: Discussion of a Difficult Transition', in *Therapeutic Communities: Past, Present and Future*, eds. Penelope Campling and Rex Haigh (London: Jessica Kingsley Publishers, 1999); Foster, 'The Management of Boundary Crossing'; Morrice, 'Permissiveness'.

[255] Maxwell Jones quoted in Dennie Briggs, 'Reflections on an Incident at Dingleton', *International Journal of Therapeutic Communities*, vol. 12, no. 2&3 (1991): 147.

everything that happens within the boundaries of the network 'can be used for treatment'.[256] In 1962, he elaborated on the nature of structural boundaries:

> The boundaries to the hospital community are geographical, in membership and in time. The most obvious boundary is the geographical one. Treatment communities have a location, a territory which is theirs, a geographical space with boundaries to the outside world. They function in buildings which generally 'belong' to them in a conceptual sense.[257]

Campling considers that boundary issues are the primary struggle for disturbed patients.[258] She emphasises that the management of boundaries 'have the power to directly effect and change the personality structure' of all those participating.[259] In stating that the 'concept of boundary is central', John Whitwell describes how the task is twofold and paradoxical.[260] The 'negotiated space' of the therapeutic encounter with a disturbed individual has to be closely bounded whilst enabling that person to experience separateness and develop their personal identity. The resulting testing of limits is necessary for growth, but they have to be discernible and resilient, although not rigid.

This spatial interpretation of the inner and outer aspects of psychotherapy has its genesis in psychoanalysis. Adherence to limitations concerning time, place and conduct are central to a psychotherapeutic session, ensuring the safety of the patient and enabling them to have fixed boundaries within which to express themselves freely.[261] Bridger's concept of the *transitional space*, originating in his work at Northfield Military Hospital, has been referred to in Chapter One.[262] It is a concept applicable to different situations, including TCs.[263] Transposing child psychoanalyst Donald Winnicott's theory of the transitional object, he contends that 'we are creating space-time experiences which will allow for learning and relinquishment to go on'.[264] The opportunity to '"suspend business" and explore what is

[256] R. W. Crocket, 'Some Aspects of Theory Associated with Therapeutic and Psychotherapeutic Community Work', undated, 41, Planned Environment Therapy Trust.
[257] R. W. Crocket, 'Changes and Choice in Group Therapy: Prospects for the Therapeutic Community' (unpublished, 1968), 10, Planned Environment Therapy Trust.
[258] Penelope Campling, 'Boundaries: Discussion of a Difficult Transition', in *Therapeutic Communities: Past, Present and Future*, eds. Penelope Campling and Rex Haigh (London: Jessica Kingsley Publishers, 1999), 90;
[259] Campling, 91.
[260] John Whitwell, 'Management Issues in Milieu Therapy: Boundaries and Parameters', *Therapeutic Communities*, vol. 19, no. 2 (1998): 101.
[261] Glenn O. Gabbard, 'Patient-Therapist Boundary Issues', *Psychiatric Times*, vol. 22, no. 12 (2005): 28–32.
[262] As he stated in 1987 'my thinking … has been much influenced by my experience, during the war, as a social therapist at Northfield Military Hospital'. H. Bridger, 'Courses and Working Conferences as Transitional Learning Institutions', in *Training, Theory and Practice*, eds. W. Brendan-Reddy and C. C. Henderson (Washington D.C.: NTL University/University Associates, 1987), 222.
[263] Bridger, 'Groups in Open and Closed Systems', 3.
[264] Bridger, 3. A transitional object is an article, such as a piece of cloth or teddy bear, that is adopted by the infant as he or she negotiates the early months of recognising what is 'me' and what is 'not-me'. It facilitates the emotional development from the primary narcissistic state to one in which others are experienced as separate. It represents an 'intermediate state between a baby's inability and growing ability to recognize and accept reality'. D. W. Winnicott, *Playing and Reality* (Penguin, 1971), 1–30

going on' allows a 'here and now' review of unconscious motives and emotional blockages, in order to move to a less partial appreciation of the difficulties facing any group or organisation.[265] The TC is an 'open system' in which members have to 'share more closely in the management of the internal system', contrasting with traditional authoritarian patterns of control.[266] It is a 'living organism which has to find a balance between maintaining an existing state, culture and structure while endeavouring to be creative in fulfilling its purpose, growth and development'.[267] Management of its internal and external boundaries, seen as porous and variable, is fundamental. This model, he contends, is adaptable and thus capable of managing in an age of 'accelerating social, international and economic changes' and the 'increasing array of specialism and functions', including the technological and information explosion. It is a system that requires hard work, as the exploration of alternatives to preconceived beliefs 'can arouse pain, stress or impatience and result in more simplistic but more comfortable rationalisation'. Bridger's conceptualisation of the *transitional space* has largely been ignored in British TCs, although it has been met with more enthusiasm abroad.[268]

b. Malleable Geography: The Lived in Space.

Historical geographer Chris Philo's approach to the geography of institutional provision for those experiencing mental disorder mainly considers their segregation, arguing that 'the human society of a given period and place does commonly produce a space, or rather a series of spaces, to be occupied, or at least utilised frequently' by those deemed as mentally ill.[269] This aspect is less applicable to the Ingrebourne, because the building was 'commandeered' for its purpose, rather than specifically designed.[270] The Centre developed despite the political and managerial environment and largely continued in a similar vein. In the next chapter, some external perceptions are presented that illustrate this sense of an impermeable cocoon.

Diana Gittins, in her study of Severalls Hospital, remarks that 'social interaction itself can subtly alter and change the uses of buildings'.[271] This reflects a sense that environment is an

[265] Underlining as in original, Bridger, 2.
[266] Bridger, 11–12.
[267] Bridger, 5.
[268] The paper from which much of the foregoing is taken was delivered to an international conference in Italy. He also worked in Australia with group analysts, Paul Coombe personal communication 11/02/2018.
[269] Philo, *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity*, 3.
[270] There is no record of how the local community saw the Centre. A search was carried out of the online records of local newspapers and no mention of the unit was found. St George's Hospital itself figures rarely
[271] Gittins, *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*, 21.

intractable influence over human relations.[272] The term 'subtly' underplays the profundity of the role of Ingrebourne's inhabitants in reconstructing the use of the building. Every room took on a new function from its original purpose. Many of the spaces were subject to re-interpretation through unit-wide discussions, as one researcher found: the 'use of the community room waxes and wanes'.[273] When art therapy moved to a larger room, it increased its influence in the life of the unit.[274] Throughout the Centre's lifetime other services encroached. Initially, there was a workshop for people with longer-term mental health disorders, and, latterly, parts of the building were taken over for other uses.[275]

The boundary wall of the building did not contain the Ingrebourne. All meals were taken in the St George's hospital canteen.[276] A number of staff/patient holidays, or trips out, were organised, including camping weekends.[277] As one narrator put it, 'A network is not just the group of patients who were in the Centre. It was a network of patients that extended beyond the centre. People linked via that Centre'. [278] It was thus a continuously evolving notion, accreting and discarding memories, rituals and interpretations throughout its history.

In one sense, the Ingrebourne continues the history of the geographical separation of the people identified as mentally disturbed from the community in which they lived.[279] It was an isolated unit, this distinction being further emphasised by its placement in a hospital for older people. Crocket described it as 'a part of the global human network which has been hived off, as it were, from the rest of the social network for treatment purposes'.[280] Its sometimes unkempt state of repair would have contributed to this sequestration.

When Crocket emphasised the provision of 'a relatively ordinary and familiar social environment' at the Ingrebourne, he was probably unaware of how this phraseology was redolent of a 'discourse of domesticity that psychiatrists skilfully weaved' from the York

[272] For example Sarah Curtis in her study of the interactions of *Space, Place and Mental Health*, makes a fairly brief reference to the 'benefits of participation in community organisations', the overall tenor is of people's passivity in face of the environment. Curtis, *Space, Place and Mental Health*, 117–19.
[273] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 8.
[274] INGCE15, interview, 6.
[275] Bertram A. Miller, 'Sheltered Workers', *Incentive*, June (1963): 19; Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 24; John James Clayton, 'Letters from Grendon Underwood, C Wing, after the Peer Review Visit to Ingrebourne, 2', *Joint Newsletter of the Planned Environment Therapy Trust, the Charterhouse Group of Therapeutic Communities and the Association of Therapeutic Communities, with the Community of Communities*, no. 6 (2002): 17.
[276] ING17, interview, 29; INGCE21, interview, 2014, 6–7.
[277] ING21, interview, 13.
[278] Roberts, 'Reflections on Ingrebourne: Developed from the Transcript of an Interview of Andrew Roberts by Tom Harrison on 18.2.2011', 16.
[279] James E. Moran and Leslie Topp, 'Introduction: Interpreting Psychiatric Spaces', in *Madness, Architecture and the Built Environment*, eds. Leslie Topp, James E. Moran, and Jonathan Andrews (London: Routledge Taylor & Francis Group, 2011), 1.
[280] Crocket, 'Changes and Choice in Group Therapy: Prospects for the Therapeutic Community', 11.

Retreat, through the 'villa' system of hospital provision to the present day.[281] In referring to the therapeutic space as an 'agreed shared domestic territory', his imagery was concerned with the experiential rather than the physical.[282] The building had little in common with domestic architecture. Others shared this perception. Carroll contrasted the unit with the traditional hospital, arguing that most of the 'activity within the community closely resembles the patient's previous daily life at work and in the home'.[283] He described 'a committee of elected officers which takes many of the decisions affecting the internal activities of the community and which relates to outside bodies'. Whilst clearly different from the mental hospital routine, this democratic approach was perhaps only achieved in the most radical of workers' co-operatives. Hardly domestic or commonplace! Nevertheless, these were significant attempts to achieve a more informal atmosphere and the analogy of a family was commonly used. Andrew Roberts identified the kitchen as a 'really crucial communal area'. For him and his colleagues, it 'was the hub'. [284] The patients were expected to help in the daily domestic routines of the Centre.[285] Many mothers could bring their younger children with them, who would then be looked after when necessary by a children's nurse.[286] This, at times, extended to them staying overnight in the same room as their parent.[287] The staff gave up the wearing of uniforms in 1965.[288]

Thus, as Yi-Fu Tuan explains, language makes place.[289] Adopting a 'narrative-descriptive' approach, he demonstrates how people transform their environment into something familiar, and explicable, through naming and storytelling.[290] By so doing, they create a bond with the place and also exercise power over it. The oral histories collected about the Ingrebourne reiterate this process and demonstrate that the psychic establishment will last a great deal longer than the physical building.[291]

[281] Moran and Topp, 'Introduction: Interpreting Psychiatric Spaces', 6.
[282] Crocket, 'The Theory of the Therapeutic Community - an Approach to Structural Psychiatry and the Use of Intensive Social Treatment Networks' Ch. 7. Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Adapted from a Lecture given to the Runwell Hospital Medical Society 21/11/1957', 2; Moran and Topp, 'Introduction: Interpreting Psychiatric Spaces', 6.
[283] Carroll, 'The Ingrebourne as a Going Concern', 5.
[284] Roberts, Interview, 8–9.
[285] Carroll, 'The Ingrebourne as a Going Concern', 4; Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1400.
[286] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 115.
[287] Tiley, 'Ingrebourne Centre: A Therapeutic Community', 1400.
[288] Tiley, 1400.
[289] Tuan, 'Language and the Making of Place', 684.
[290] Tuan, 686.
[291] Which was due for demolition in 2015.

c. Places of the Ingrebourne Imagination: Internal

Illustrating two levels of the imagined space at Ingrebourne, the ideal and the experienced, Andrew Roberts' friends redesigned the Centre in fantasy, increasing the size of the kitchen and making it 'even more the hub'.[292] This was evidently different from the abstract ideas of the staff about the ideal form of therapy, but the intentions were the same, to improve its therapeutic potential.[293]

Staff conceptions of the ideal therapeutic space were dominated by two aspects: the purpose and the principles of a therapeutic community. The therapeutic intent remained consistent, albeit, by the 1990s, restrictions on the severity of disturbed behaviour increased as resources diminished. Crocket's summary of the principles, referred to in the previous chapter, by 1994 had been telescoped. In an introductory booklet for new staff, it was stated that patients should become 'active participants in their own therapy and that of other patients' and there was to be 'free expression of feeling [*and*] democratic rather than traditional hierarchical social organisation'.[294] Each person was 'expected to play their part in the continued maintenance and development of the therapeutic community'.[295] Whilst the emphasis on participation remained, the concern that 'In a therapeutic community the whole of the patient's time spent in hospital is thought of as treatment' was no longer explicit. [296]

For some participants, this transitional space was the ground work for more radical expectations. Whilst Andrew Roberts and his friends were engaged in designing a model of the ideal centre, Crocket's own publications promoted a similar zeal and the staff aimed at perfecting their 'in loco parentis' role.[297] The Tavistock Clinic researchers observed that there was a discrepancy between Crocket's 'highly sophisticated methods of treatment' and their observations of a 'staff group struggling with dissatisfaction, complaints and uncertainties'.[298] This is not unusual in TCs. Rapoport noted the divergence between Jones'

[292] Roberts, Interview, 9.
[293] A third strata of the imagined space that is not explored here, but that is receiving attention amongst geographers, is that of the unconscious psychic relation to the environment. It is beyond the scope of a historical study such as this one to speculate on material that requires study in the 'here and now'. Joyce Davidson and Hester Parr, 'Geographies of Psychic Life', in *Psychoanalytic Geographies*, eds. Paul Kingsbury and Steve Pile (Farnham: Ashgate Publishing, 2014)
[294] Pat Conneely, 'Brief History and Groups in Action at the Ingrebourne Centre' (Unpublished, 1994), 3, Personal. The additions in brackets are not original.
[295] Conneely, 14.
[296] The introductory booklet, by Conneely, emphasised the range of therapeutic options available before adding a brief outline of what a therapeutic community was. As will become clearer later in this chapter the senior staff became increasingly involved in individual therapy, which was their preferred therapeutic approach. Jones, *Social Psychiatry*, 53
[297] Monica Meinrath and Jeff Roberts, 'On Being a Good Enough Staff Member', *International Journal of Therapeutic Communities*, vol. 3, no. 1 (1982): 7.
[298] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 121.

ideology and what was actually happening at Belmont.[299] Ingrebourne staff were made uncomfortable by the difficulties of meeting Crocket's standards:

> So if you'd taken up everything that came your way in Richard's idealistic world, that you were able to, you know, be therapeutically enabling in every situation, you'd have gone mad. And nobody could do it.[300]

Boundaries, and the debates over them, provided the connection between the idealised and the experienced spaces. At Ingrebourne, they extended to include behaviours that had led to exclusion elsewhere. The geographer, Hester Parr, studied a drop-in day centre for people with longer-term mental health disorders in Nottingham.[301] She found there new 'norms' of allowable behaviour were established, but over and above that these extended boundaries were monitored by the attendees as much as the staff. At Ingrebourne, maintaining and monitoring these limits was open to continual debate. Exemplifying this, instead of laying down rules, St. Blaize-Molony devised *Guidelines to the Community* in the early sixties.[302] He explained that the community had developed mores and 'customs which facilitate the aims of the community' and these were an attempt to summarise the 'salient features of the culture that is followed'. These were couched in explanatory terms, emphasising consideration for others and/or the effects on therapy.

Tavistock Clinic researchers were concerned that with 'no clear boundaries it is easier for participants to tread on each other's toes'.[303] During a staff discussion where the need for 'tighter boundaries' was discussed, the consultant appeared to be at logger-heads with the staff who he felt were imposing a structure from above, rather than allowing it to emerge from the changing needs of the patients.[304] By the mid-1990s, the *Guidelines* had become *The Therapeutic Agreement*, in which the discursive nature gave way to dogmatic statements such as 'no violence to yourself or others at any time' and no exclusive or sexual relationships should take place between patients'.[305] These admonitions were followed up by the declaration that any breaches could result in suspension or dismissal. Thus, over the years, the cultural space experienced by participants gradually moved from one in which the boundaries were to some extent negotiated to a more authoritarian approach, albeit still very much less so than in traditional mental hospitals.

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[299] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 269–73.
[300] INGCE29, interview, 27.
[301] Hester Parr, 'Interpreting the "hidden Social Geographies" of Mental Health: Ethnographies of Inclusion and Exclusion in Semi-Institutional Places', *Health and Place*, vol. 6 (2000): 225–37.
[302] Ronald St. Blaize-Molony, 'Guidelines to the Community about 1961-1962', 1962, 1, Planned Environment Therapy Trust.
[303] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 69.
[304] Tavistock Institute of Human Relations, 110.
[305] Anon., 'Ingrebourne Centre: Patients' Handbook', 1996, Personal.

Unlike the findings of Kerry Davies in her study of patients' experiences of Oxford asylums, the narrators in this research rarely mentioned the physical geography of the building, except when stimulated to do so.[306] The exception was the kitchen which was consistently referred to as a hub and social gathering place, rather than as a physical room. Andrew Roberts reported:

> when patients would talk, the kitchen was always given enormous amount of importance. Yes it was where food was made. Where we work', yes? did together. I don't think it was the way the doctors saw it. But it was always the way we saw it. There was a very strong feeling that the kitchen was the centre.[307]

A nurse started up an informal therapeutic group in the kitchen, and the doctor observed 'that some of the most important therapeutic transactions occur in the kitchen'.[308] Staff would have cups of tea there before going into groups, though they weren't always welcome.[309] In 1974, when a nurse entered, 'the previously relaxed conversation' dried up, but soon the social worker was able to 'swap jokes with patients'.[310] Other places that were redolent with meaning were the courtyard, which became a badminton court, and the garden. These intermittently became centres of social interaction, particularly during the summer. Interest in the latter waxed and waned according to the willingness of the staff to be involved.

Other physical barriers were more rigid. Offices for the doctors and some other professionals, and the out-patients were inviolable.[311] For many members of staff, there were 'no closed off spaces'.[312] The nursing office 'was a constant hubbub of people in and out and patients sitting in there chatting to people'.[313] It did mean that there was little opportunity for those staff to have time to themselves. On the other hand, nurses did not enter patients' rooms without knocking.[314]

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[306] One exception, Andrew Roberts, was very helpful providing a lot of detail about the different rooms and the meanings that they held for him and his fellow participants. (Roberts, interview). For some of the later informants, this researcher shared some photographs taken on the site before its demolition. Kerry Davies, '"A Small Corner That's for Myself": Space, Place and Patients' Experiences of Mental Health Care 1948-98', in *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, eds. Leslie Topp, James E. Moran, and Jonathan Andrews (London: Routledge Taylor & Francis Group [distributor], 2011).
[307] Roberts, interview, 9.
[308] Quoted in Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 76.
[309] INGCE17, interview, 8.
[310] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 86.
[311] INGCE17, interview, 24.
[312] INGCE29, interview, 31.
[313] INGCE29, 31.
[314] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 7–8.

Kerry Davies was informed by one of her narrators: 'spaces need to be occupied by people for 'some time' in order to absorb meaning and identity'.[315] The interviews for this research are redolent with this understanding. Referring to the small garden, one person recalled:

> outside there would have been vegetable beds, and we would have barbeques and stuff out there during the summer. It would have been a focal, one of the focal points of the building during the summertime. People would sit out there, relax.[316]

The 'therapeutic landscape' was actively malleable. Crocket was taken aback, as described earlier, to find a patient dismantling a motor bike in the corridor. This breaking of traditional boundaries led to his readjustment to what was permitted.[317] Some patients took on the hierarchy of St George's Hospital, organising a house meeting, which 'started making decisions' and sending these to the hospital matron. [318] She 'wasn't going to have decisions sent to her from patients about fixing bulbs and things like that', but eventually she had to back down. From being passive recipients of care, the patients instigated a process that gave them some authority to intervene in the running of the Centre. Particularly intense moments of 'reality confrontation' in the community meeting when incidents of transgressive behaviour were discussed, such as the incident of the whisky bottle described later, could lead to reconstruction of personal boundaries.

This relaxing of traditional boundaries imposed on patients broadened the socially constructed space within which all participants could operate. For someone more used to the fixed boundaries of more formal organisations, this fluidity could be stressful, as one new arrival explained 'it's taxing to me in a much less structured environment'. [319] The fact that the staff hierarchy appeared unclear was unsettling. Campling, in another setting, described how some ex-prisoners preferred the safety of gaol to the 'torture' of a TC; the lack of obvious boundaries was too much for them.[320]

d. Places of the Ingrebourne Imagination: Relations with the Outside

The physical boundary for those joining was more permeable than most mental hospitals. After a short period as an in-patent, the individual would attend as a day-patient and subsequently as an out-patient for some years if necessary.

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[315] Davies, '"A Small Corner That's for Myself": Space, Place and Patients' Experiences of Mental Health Care 1948-98', 306.
[316] INGCE17, interview, 8.
[317] Crocket, PETT Interview 23rd November 1998 (T)CF272, 13.
[318] Roberts, interview, 10.
[319] INGCE16, interview, 6.
[320] Penelope Campling, 'Containment: From Cruelty to Kindness', *Therapeutic Communities: The International Journal of Therapeutic Communities*, vol. 36, no. 1 (2015): 21. A search of the literature to provide more examples of this issue was unsuccessful. People who leave TCs early are rarely researched or easily contacted.

Unlike the Paddington Day Hospital where all barriers to inclusion were lifted, the Ingrebourne conducted an assessment process prior to the acceptance of new patients.[321] This consisted of an interview with a doctor who would then present the case to an admissions group.[322] During the 1980s, a joint staff and patients' admissions panel made the final decision about who should and should not be admitted.[323] In the 1960s, reception of the new patient was organised by a committee made up of longer-term residents.[324] Inclusion as a process was a point of contention between the Ingrebourne and potential customers. General practitioners were deterred from making referrals because of the long process involved and the uncertain outcome.[325] By 1997, it was commented that the Centre did not 'cater for as many people as it could' and that it 'should seek to extend the range of people who it can help'.[326]

Despite Crocket's wishes to integrate the unit with the external world, this was rarely successful and remained a continuing problem. The health service management was rarely 'in tune' with what was happening there. In 1974, he was frustrated by the hospital administration, who would neither release money for improvements to be made to the dilapidated central courtyard nor allow the patients to do any of the work themselves. [327] In his view, any constructive discussions were met with a 'rigid and stereotyped response': maintenance was the administration's business and infantilising passivity was the appropriate role for patients. This was a two-way process. In the early 1980s, a senior nurse manager 'found it more and more difficult to get anywhere near the Ingrebourne'.[328] Difficulties with these formal relationships were an on-going feature of the Centre and contributed to its final difficulties.

The staff 'didn't have much to do with the rest of St George's' for much of the time, and the Centre was 'ignored, or tolerated at best' by the hospital.[329] Occasionally, there was friction, as hospital staff were 'bemused' and 'wondered what we were about'.[330] Relationships were not helped by some mildly disinhibited patients. A young woman sun-bathing topless in the back garden gave rise to 'all sorts of complaints', and caused embarrassment to the male nurse who felt responsible for stopping her.[331] A senior manager remembered the unit as 'a

[321] Spandler, *Asylum to Action*, 35.
[322] INGCE15, interview, 35; Conneely, 'Brief History and Groups in Action at the Ingrebourne Centre', 4.
[323] INGCE25, interview, 2015, 20.
[324] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 187.
[325] INGCE31, interview, 6–7.
[326] Health Advisory Service, 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 1997, 18, CCJ archive, Planned Environment Therapy Trust.
[327] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 71–72.
[328] INGCE31, interview, 3.
[329] INGCE17, interview, 29; INGCE16, interview, 17.
[330] INGCE19, interview, 21; INGCE29, interview, 32.
[331] INGCE19, 21.

bit of a cuckoo in the nest', but acknowledged that it caused little trouble apart from the odd overt 'kiss and a cuddle type of thing' between patients.[332]

Attempts were made to integrate through games of football and cricket, painting murals, running a cake stall on open days and putting on a concert for the whole hospital.[333] One staff member became active in the trade union for the whole hospital and thought he did 'a little to put a dent' in the prejudices.[334]

Crocket attempted to integrate the unit with the wider community. In 1957, he set up a 'psychotherapeutic club', which, at its peak, had 107 people attending, including patients' relatives.[335] A group was formed a year later, with four local clergymen, to discuss 'professional questions common to psychiatry and the Churches'.[336] Links were established with marriage guidance, probation officers and general practitioners.[337] These fell into abeyance by 1975. Crocket, following the initiative of some patients in 1965, set up the Ingrebourne Society in 1972 to achieve wider links with the local community.[338] The aim of this weekly meeting outside of the hospital, was to provide a forum for the general public to discuss psychiatric issues. Typically, Crocket's ideals ran ahead of the practice. One assistant found that 'my heart sank at the thought of another evening with three people trying to discuss things'.[339]

There was little formal contact with Warley, although both Jeff Roberts and Margaret Williamson attended medical management meetings there.[340] Some student nurses from the main hospital spent some of their training at Ingrebourne.[341] Hospital management was pre-occupied with the difficulties with the trade unions at the main institution. As a result, the Ingrebourne community operated in an isolated bubble experienced as both mysterious and difficult by outsiders.

e. Who's in and Who's Out? The Ubiquitous Boundary

The psychotherapist Angela Foster characterises the community meeting as the concrete manifestation of the TC's boundary, for only members could attend.[342] However, this

[332] INGCE28, interview, 15.
[333] ING18, interview, 18; ING 19, interview, 21.
[334] INGCE19, interview, 21.
[335] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 24.
[336] Tavistock Institute of Human Relations, 23.
[337] Tavistock Institute of Human Relations, 26.
[338] Anon., 'What Is the Ingrebourne Society? Probably by Crocket R. W.', undated c. 1975, Planned Environment Therapy Trust.
[339] INGCE29, interview, 3.
[340] ING13, interview, 28; INGCE31, interview, 3.
[341] ING17, interview, 1-2; INGCE18, interview, 4.
[342] Foster, 'The Management of Boundary Crossing', 273.

frontier was permeable. Being included in the Ingrebourne only resulted in partial separation from the person's social network. Residents usually only stayed for a short period of time and returned home at the weekends.[343] Additionally, the person's kin were encouraged to join a discussion group with other families.[344] Communication was 'facilitated especially in the relatives group'.[345] The greatest part of therapy was as day-patients attending between two and five days a week.[346]

It was in the community meeting that limitations to behaviour were discussed. Community spaces have entrances and exits. Passing through these was always a subject for contemplation. For instance, the meeting itself, bounded as it was by the room it was in and the time allocated to it, could exhibit this practically: 'this patient, she just got up and ran out, in great distress. I ran out and followed her and tried to get her back'.[347] On the other hand the transition from patient to citizen was often less well considered,

> I don't think that we paid enough attention to the end purpose of admission to the TC. At the Ingrebourne, being able to make good relationships inside the Unit would be no good if they didn't transfer to the outside and I don't think we paid enough attention to that.[348]

Once recognised, boundaries are ubiquitous. There were those for staff that delineated between 'domestic privacy and professional commitment'.[349] It was difficult because

> You see, in a community you have to relate differently as a therapist, because you have to be there as a person, but also you're always there as a therapist. And people found that boundary enormously difficult. You know, I had the same difficulties, but you have to learn. Have to be able to be involved with people in a natural real way, and yet not be self-disclosing, and certainly not bringing any of your issues … it's always putting their needs first and not letting your needs interfere with it.[350]

Nurses from mental hospitals were used to substituting physical activity, such as playing games, to defuse crises.[351] Instead, they were to confront difficulties and through discussion enable those in their care to reflect on their behaviour. This, of course, had consequences

[343] INGCE17, interview, 5.
[344] Anon, 'Ingrebourne Centre: Patients' Handbook', 13; Conneely, 'Brief History and Groups in Action at the Ingrebourne Centre', 5; Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 187.
[345] Carroll, 'The Ingrebourne as a Going Concern', 4.
[346] INGCE17, interview, 5.
[347] INGCE20, interview, 19.
[348] INGCE20, email correspondence.
[349] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 26.
[350] INGCE20, interview, 13; INGCE27, interview, 38.
[351] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 182.

on their own emotional well-being, leading them to feel 'embarrassed and ill at ease' when the patient began to reveal their thoughts and feelings.[352]

Woven into the fabric were meetings for the staff, the 'sensitivity group', or 'role group', where this balance was maintained.[353] Here, everyone 'was on the same level' and if you didn't agree with what someone else 'was doing, or what they said, or how they spoke to a patient, or how they were treating, we would say so'.[354] From the outset, Crocket saw them as providing 'empathy and support of a therapeutic kind as an essential element'.[355] Recognising that nurses were the largest group, and had the closest contact with the patients, he was particularly conscious that they needed to unlearn activities which avoided emotional stress. They needed to be 'flexible, less dependent on rules and regulations', and willing to make much closer relationships with patients.[356] Much of the discussion in the earliest sessions related to the understanding of roles within the community.[357] They were forced to consider the value of their practice, and whether their own boundaries fitted with those of the service. In one meeting, the subject of access to books on psychotherapy came up, leading to concerns about the possibility of patients 'intellectualising' their therapy.[358] This broadened to a debate on whether they should attend staff meetings, and if so how many, or if not, why not.

There were times when some staff transgressed these limits. One doctor had to confront a therapist who was beginning to 'seduce' a patient.[359] On some outings, less grounded staff might 'act out' themselves when drinking with the patients.[360] One therapist later commented that,

> I think that acting out is something which all staff had to go through and learn about for themselves, probably becoming more sophisticated of their understanding of it as time went on. After all, the sort of relationships you have to have with patients is not replicated in any other setting and it's hard to talk about, outside of therapy, unless it's one member of staff disapproving of the actions of another and this does not facilitate learning.[361]

[352] Crocket, 182.
[353] The name changed throughout the lifetime of the Ingrebourne. Badly led, these could deteriorate into 'insensitivity groups', 'sometimes it could be quite brutal'. INGCE19, interview, 16.
[354] INGCE18, interview, 3.
[355] Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 182.
[356] Macdonald and Daniels, 'The Psychiatric Ward as a Therapeutic Community', 148.
[357] Ingrebourne Staff, 'Summary of Staff Meetings 24.1.67, 31.1.67, 6.2.67, 14.2.67, 21.2.67.'
[358] R. Crocket, 'Note on the Patient's Role: Record of a Staff Meeting 1961', 17 July 1961, Planned Environment Therapy Trust.
[359] INGCE22, interview, 2014, 9.
[360] INGCE18, interview, 9.
[361] INGCE20, email correspondence.

Staff members were aware that the practice in some other services was to hold staff meetings with the patients sitting in attendance, but this was never carried out at the Ingrebourne because it was felt that the staff needed space of their own.[362]

The limitations of confidentiality were also contentious. There was always a tension between what was revealed in psychotherapy and the discussions in the Community Meeting. Responding to the issues raised in Main's paper, 'The Ailment', insisting that all information should be shared, was a difficult lesson for new members of staff to learn, having been used to keeping what the patients disclosed confidential.[363] However, in the latter stages of the Centre's existence, the pre-eminence of the Community Meeting was undermined by an increasing emphasis on individual psychotherapy, rather than the social and communal aspects of the regimen.

There were also issues of behaviour, either verbal or physical. A member of one group discussion argued, 'look we gotta keep this down, because it upsets people outside.' … 'you don't do this kind of … you don't do too much energetic talking outside'.[364] Verbalisation was frequently 'used for acting out'. Words were used to channel aggression or other feelings, rather than for communication.[365] Where this remained intransigent, the question arose that 'in the interests of the community such a patient is discharged'.[366] This equivocal statement exposes the dilemma that problematic behaviour posed. There was always a tension between continuing to cope with, and trying to understand, on-going difficulties that provoked stressful, even unbearable, feelings in the staff, and ejecting the individual.[367]

One nurse was confronted with a patient wielding a knife:

> I remember my exact words that day was "Put that fucking knife down or I'm gonna deck you." Partly because I knew the guy fairly well an' I think I knew what was going to work. He was threatening someone else with a knife and it had to be dealt with.[368]

An emergency unit meeting was held, involving all those present, and things were talked through. The patient was warned that, if anything else like that happened, he would be discharged.

Tensions could arise between day and night staff. One of the latter wrote concerning a patient's particularly demanding behaviour. At a joint meeting the next day, a day staff

[362] INGCE29, interview, 35; INGCE17, interview, 21–22.
[363] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 74.
[364] Roberts, interview, 18.
[365] Carroll, 'The Ingrebourne as a Going Concern', 4–5.
[366] Carroll, 5.
[367] Crocket was aware of the tendency to take on people whose behaviour was uncontainable at the Ingrebourne. Crocket, 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre', 190.
[368] INGCE19, interview, 26.

member responded that their colleague was improperly critical and rejecting, which then led to an acrimonious exchange of views.[369] This was not typical. An experienced night nurse informed a new member of staff that if she suspected 'anything, like drugs, drink, perhaps they sneaked in, or a woman, or anything' she was 'to knock on the door and go in and confront the situation'. [370] Then their behaviour would be discussed with all those involved. After being reported to the day staff, it would be taken up in group discussion. As the novice reported, 'So we actually worked quite well in that respect'.

Boundaries were an issue between residents as well. One patient was 'acting out', letting a lighted cigarette to burn 'away on the floor beneath his chair'.[371] Another responded to this by complaining that 'a minority do the dirty work while the majority irresponsibly make a mess and leave it'. The subsequent discussion turned on issues of parenting difficult children. An outside observer was impressed that, although the week had started with an overall theme of helplessness, by the Friday there was 'some degree of reparation and constructive interaction'.[372]

The term 'acting out' is significant and refers to the physical expression of emotional conflicts. Psychoanalyst Bob Hinshelwood illustrates how this behaviour causes difficulties for staff.[373] One woman, who used drugs, cut her arms, took overdoses and sniffed gas, tested out the ability of the staff working with her to contain her. These activities increased whilst she was in the TC, resulting in the nurse working with her despairing and recommending that she should be transferred to another hospital. The psycho-therapist disagreed, leading to conflict between the two staff members. This sort of scenario was rehearsed frequently at Ingrebourne. Crocket gave a list that included threatening with a sheath knife, breaking cups and crockery, turning up the wireless and putting dead cats on the therapeutic couch illustrative of the challenges facing staff in unravelling the underlying social/psychological dynamics at play.[374] Staff could also act in a similar manner, turning up late, talking dismissively about patients and missing groups.[375]

The use of drugs, both legal and illegal, and alcohol caused on-going concern. As part of creating a 'normal' environment, there were parties. One member of staff recalled

[369] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 113-14.
[370] INGCE18, interview, 2.
[371] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 114-114A.
[372] Tavistock Institute of Human Relations, 119.
[373] R. D. Hinshelwood, *Thinking about Institutions: Milieux and Madness* (London; Philadelphia: J. Kingsley, 2001), 95–101.
[374] R. W. Crocket, 'Acting out as a Mode of Communication in a Psychotherapeutic Community.', *British Journal of Psychiatry*, vol. 112 (1966): 386.
[375] Crocket, 386.

> A bit like in a family. And a bit like with adolescent children. You choose your battles. I am sure that there were people doing stuff, I remember… you know we would have parties there and we would be allowed to have 'some' alcohol. But judging this was absolutely a nightmare. I hated the parties. We would have 'some' alcohol. And you can bet your life that there'd be bottles of gin in the room and god knows what. And also I remember once, really smelling dope on somebody, and just thinking "It's in the middle of a leaving party, you know, just let it go. What are you going to do about it?" So if you'd taken up everything that came your way in Richard's [*Crocket*] idealistic world, that you were able to, you know, be therapeutically enabling in every situation, you'd have gone mad. And nobody could do it.[376]

Prescribed drugs could also be an issue. It was not until the patients themselves decided to stop night sedation that this stopped, although sometimes they would pass on drugs to each other.[377]

Boundaries were particularly important, as some people 'needed somewhere safe, to express what they were going through'.[378] Campling argues that psychotherapy is 'working at the boundary of our inner and outer worlds, where it is all muddled up, where past and present are muddled up together'.[379] In the TC, the culture of safety, with the emphasis on building trust and a strong therapeutic relationship, allows primitive feelings to be understood and destructive behaviour to be minimised. The recurrent theme of family that runs through many narrators' accounts testifies to the fact that at Ingrebourne, this was achieved to a significant extent.

ii. Camaraderie, Caring and Crisis: The Emotional Environment

Those arriving at the Centre for treatment had usually been given diagnoses that ranged from anxiety and depression to 'character' disorder.[380] Crocket stated that the 'only limitation on treatment is whether or not a patient is sufficiently responsible not to require close supervision'.[381] Common to all were disruption in relationships, stemming from their manner of interacting. Common behaviours included: overdoses or other acts of self-harm, aggression towards others, anorexia or actions that appeared inexplicable to those around them. Referrals came from general practitioners, other psychiatrists, or through being seen

[376] INGCE29, interview, 27.
[377] R. W. Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Presentation given at Runwell Hospital, 21st Nov 1959. With Additional Notes by Dr Hamish Anderson' (1959), 27, Planned Environment Therapy Trust.
[378] INGCE18, interview, 3.
[379] Campling, 'Containment', 22.
[380] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process',65.
[381] Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives', 669.

at the local general hospital by the medical staff of the Centre. The long and tedious process of being accepted into the unit led some to 'drop out' before entering.[382]

Those accepted were expected to spend between two to twenty weeks as in-patients.[383] Thereafter, they attended as day-patients up to four days a week. The slight majority of patients in 1970 were women.[384] There were never more than a total of forty patients in the community at any one time. Twenty were in-patients and the rest attended on a daily basis. The numbers of in-patients declined as cost-saving pressures were applied by management from the late 1980s onward.

Initially the patients were often seeking a 'haven' or for their problems to be solved, and when this did not happen their first reaction was negative.[385] The first days at the Centre could be challenging: 'I arrived and was terrified. And I was asked to relinquish any medication that I was on, very mild tranquilisers, and that scared me a bit'.[386] This was especially so in the groups. One person found it 'was strange – really strange – I just couldn't grasp what it was all about', and another 'was frightened by the degree of disturbance which other patients manifested'.[387]

Staff members were also subject to similar qualms. [388]

> I can still remember sitting in a large group and being, being almost like scared out of my wits at the prospect of all these patients, as I would have thought of them, could turn around and question me, quite openly and *en masse*, you know, they could have as a group turned on me and questioned what I was up to.[389]

The emotional challenges for staff could be quite extreme and tested their ability to respond in a constructive manner:

> I mean I certainly can remember residents having a real go at me. Especially early on, you know, I was naïve and saying some remarkably stupid things looking back, and being ripped apart. On one, or two, occasions quite deservedly. But you wouldn't have tolerated it in a psychiatric hospital.[390]

[382] INGCE31, interview, 6.
[383] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 43.
[384] Tavistock Institute of Human Relations, 37–38.
[385] Tavistock Institute of Human Relations, 99.
[386] INGCE24, interview, 1.
[387] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 99.
[388] Tavistock Institute of Human Relations, 86.
[389] INGCE17, interview, 4.
[390] INGCE19, interview, 27.

Terry Burridge became ill as a result of sustained verbal attacks from a female patient.[391]

The stresses for some were not immediately apparent:

> It was much easier to start with than it got, as things went on. Because it was one of those things with long awkward silences, and nobody saying anything and I was young and foolish and very mouthy and quite happy to fill the gaps with comments on what other people were saying.' … 'But then you're required to work as well. I can remember sitting saying nothing for several, nothing really of any note, about myself in small group. And then Xxxx saying, you know, "If you don't say anything about yourself, you're not helping anybody else here either".[392]

Whilst the environment was clearly not familiar, or ordinary, it undoubtedly allowed for greater interaction between all those participating than the typical mental hospital. Indeed, for some it 'was very much like a family'.[393] A patient echoed this:

> I think that was what was so new, unique about that set up. In many ways it was a family. It was a family of people. … and I can only speak for myself and I thought that they were very interested in us. They were very caring towards us.[394]

The friendliness was particularly noted: 'there was camaraderie, yeah they were a bit disorganised'.[395] It contributed to the therapeutic nature of the Centre: 'there was some very real healing going on, almost despite these other things. You know, there was a real sense of people caring for each other I think' and 'people were looking after each other'.[396] Another emphasised the difference in the way that patients related to him: 'you heard people talking in a way you wouldn't hear when I was working in a psychiatric hospital. And they'd be opening their souls'.[397]

The patients also experienced this. One, in a therapy group, reported on her experiences at another mental hospital:

> I couldn't understand why I was there. It was nothing, just drugs and left you by yourself. I was even more alone. It was awful. Put on Lithium. … zombie like state of no feelings. In there for four months. And he (*the doctor*) said to me "Why don't you

[391] Terry Burridge, 'On Joining a Therapeutic Community', *Therapeutic Communities*, vol. 18, no. 2 (1997): 145–47.
[392] INGCE25, interview, 5.
[393] INGCE22, interview, 4.
[394] INGCE24, interview, 4.
[395] INGCE30, interview, 17.
[396] INGCE29, interview, 24.
[397] INGCE19, interview, 16.

> stop fighting. You have to accept that this is your life". Couldn't accept that I was on drugs for life, I just couldn't.[398]

In contrast, she found that the Ingrebourne 'was one place where you're allowed to be yourself'. Another reported that it was 'what I liked about that. Everybody was equal. And you could say anything and it wouldn't go anywhere else. They were all trustworthy. You know'.[399]

After initial qualms about group therapy, people would discover 'what my problems were about' and realise that they were not 'alone any more'.[400] One activity that promoted the 'family' atmosphere was the Friday afternoon community tea. The cookery group in the morning would have made food, such as cakes, for the staff and residents to share before going home for the weekend.

> We all sat down in the lounge and had some of the cake, had a chat, and said our good-byes then. You know, it was kind of winding up the week sort of time, with the produce of a group that took place in the middle of the day.[401]

As in any family, or other social group, not everybody felt at home:

> Sometimes there were relationships that everybody got worried about, that were unhelpful. Sometimes there were people that were very left out of those relationships, and very frustrated and unhappy'.
>
> *Q. We talking about staff or patients? Or both?*
>
> I think probably both, in different times.[402]

The situation was never static. There were fluctuations in the emotional status of the unit. These are well recognised within the TC movement and were first described by Robert Rapoport and are known as 'Rapoport cycles'.[403] One staff member recalled 'sometimes it was great working there, and sometimes it was very difficult'.[404]

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[398] Quoted from a Channel 4 television documentary made about the Ingrebourne in 1983 Andy Metcalfe and Paul Morrison, *A Change of Mind: A Narrow Line*, DVD, Television Documentary (Channel 4; Concord Media, 1986).
[399] INGCE25, interview, 6.
[400] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 100.
[401] INGCE17, interview, 31.
[402] INGCE29, interview, 24.
[403] R. N. Rapoport, 'Oscillations and Sociotherapy', *Human Relations*, vol. 9, no. 3 (1956): 357–74. E.g. quoted in Nick Manning, *The Therapeutic Community Movement : Charisma and Routinization.* (London: Routledge, 1989), 223.

> I mean how on earth that mish-mash of relationships which at times … worked better than others. I mean there were times when it was functional, times when it was dysfunctional, you know….[405]

These fluctuations could be exacerbated when new members of staff arrived and had to face the emotional reactions of people to the loss of those who had left.[406] This would be complicated by their naivety in coping with the anger and resentment engendered.[407] On top of this was the tendency of longer serving staff to 'suggest previous solutions based on their past experience', which inhibited newer staff from working it out for themselves, and increasing their sense of insecurity.[408]

Despite the sense of uncertainty, one person recalled that the 'Centre manifested its Rapoport cycles quite well, and the cycle would amount at times to occasions when there was a very high level of so-called 'acting out'.[409]

iii. Holding it all together: Managing the boundaries

Central to the work of a TC is the therapeutic exploitation of challenges to a person's construction of their sense of self in relation to others. This applies primarily to those who are seeking help, but it also applies to staff who embark on a voyage of increased self-awareness. Responding to the resultant out-pouring of emotion and behaviours provides the central task of the staff in preserving the space as therapeutic, trustworthy and safe. The management of boundaries is pivotal, whilst always being open to question about their nature and purpose. Such interfaces include the difference between acceptable and unacceptable behaviour, contact with the external social environment, the nature of leadership, democratisation and the relationship of idealism and pragmatism. Given the fluid nature of human interactions, none of these are fixed and will vary given different situations and once they become 'fossilised', the beneficial effect of reviewing them is lost.

There were a number of mechanisms for managing this freer interplay of emotions. The mutual support that participants gave to each other was highly significant. The timetable

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[404] INGCE21, interview, 5.
[405] INGCE29, interview, 34.
[406] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 28.
[407] This was described by psychiatrist Martin Bhurruth when taking over the running of a TC in Leicester. He experienced hostility, bullying and anger, directed at him and other members of the community. Martin K. Bhurruth, 'Some Impressions on Taking on the Leadership of a Therapeutic Community', *Therapeutic Communities*, vol. 36, no. 4 (2015): 219–28.
[408] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 28.
[409] INGCE13, interview, 10.

offered a sense of stability and routine within which there were regular and frequent opportunities to sit back and reflect on what was happening. The central event was the community meeting in which all those involved could review events. The task of the staff was to provide an enabling container, and the stresses that this imposed also required periods of reflection in the 'sensitivity' group. Behind it all stood the leadership role.

a. Mutual Aid [410]

The companionship enabled the expression of compassion. From the early days of group working, as Dr Pratt found in his education groups for tuberculosis where a 'fine spirit of camaraderie' developed, participants formed mutual-aid networks independently of the formal therapy.[411] A staff member at Ingrebourne enlarged on this: 'that was the whole concept of a therapeutic community. It wasn't just about the formal groups, it was about the experience of living in a containing environment'.[412] Peter van der Linden, a Dutch practitioner, points out that another interpretation of the 'community meeting' is that of the informal patient network within any therapeutic community.[413] Patients, both in his unit and at the Henderson Hospital, found that nearly half of the most helpful interventions came from other residents outside of formal therapy groups. This is supported by Andrew Roberts' description of sharing his thoughts about suicide with another patient described in the previous chapter. He found that his colleagues formed 'a really active patient body, and they were the people who had the effect on me'.[414] Another reported:

> you know we started going … having a meal together or you know copping home together, or calling round or "Come and do my hair at home". You know there was friendships made there … It, it very much was because even when we were outside we would talk about things and we would discuss how we felt about the place.[415]

This extended to practical support:

> No one understood why I had panic attacks … but it didn't really matter. They'd say "Do you want me to walk you to the station, or get the bus?" I'd say "Xxxx will you come with me?" you know, it kind of, they were all kind of in there rooting with you. And I think that, I think that's what we were doing in a way.[416]

[410] Rickman, *A Study of Quaker Beliefs*, 287.
[411] See chapter 2 for a discussion of Dr Pratt's work.
[412] INGCE19, interview, 13.
[413] Peter van der Linden, 'How Does the Large Group Change the Individual?', *International Journal of Therapeutic Communities*, vol. 9, no. 1 (1988): 31–39.
[414] Roberts, interview, 5.
[415] INGCE24, interview, 4.
[416] INGCE24, 10.

It could even lead to successfully challenging staff decisions, as in one case where 'strong minded' patients refused to allow the doctors to evict someone who, emerging from an 'absence', had attacked another.[417]

Staff saw it as their role to promote this. As one explained 'It's very much the people in the group who count, and the therapist is almost a peripheral figure. And he or she is responsible for really husbanding the group rather than anything else'.[418] Another added, echoing Main, that 'the job isn't for us to be God-like and to provide all the answers. People often expect that of you. What the job is basically to help people in a group to find out things for themselves.'[419] A nurse recalled that there might be conflict over whose turn it was to carry out a particular chore. [420] As a consequence one might get angry and leave to self-harm, or get depressed or get drunk. But other group members would share their experience of similar problems and offer suggestions about other ways of dealing with the situation and 'this became our kind of playing ground for working out a different way of dealing with things'.

Maxwell Jones stresses that the task is to 'set up a structure whereby the patient contribution can be maximised'.[421] This is achieved by enabling a culture in which new patients are able to disclose the difficulties facing them early in their treatment, encouraging a sense that the task is both to receive and offer therapeutic interventions and providing an environment in which discussion of emotional problems is safe and widespread. The effect was to 'build up in each individual a more integrated picture of himself, firstly as seen by others, and, finally, when accepted by him as part of his own self-evaluation'.[422]

This ranged from sharing experiences, commenting on each other's behaviour or statements, emotional support and even following distressed people out of groups to encourage them to return. At times, staff would make interpretations in groups that were not easily understood. It was not uncommon to find patients translating for the benefit of others. A member of staff recalled, 'we were trying to talk about the underlying significance of ordinary daily things that you do' and 'suddenly it clicked' with a few of the patients who then good-naturedly tried to explain to those that had not understood using day-to-day examples.[423]

The staff were more concerned with the unconscious 'or what we thought was really being said', whilst the residents found the sharing of common experiences much more powerful. They reported that finding 'I'm not the only one that has this shit going on in my head. Oh!

[417] Andrew Roberts, (2018) Personal communication.
[418] Metcalfe and Morrison, *A Change of Mind: A Narrow Line*.
[419] Metcalfe and Morrison.
[420] INGCE17, interview, 6.
[421] Jones, *Social Psychiatry in the Community, in Hospitals, and in Prisons*, 65.
[422] Jones, 68.
[423] INGCE20, interview, 20.

So and so has. God how did they deal with it? You know that person's still alive so that maybe I can be'.[424] When the Centre was undergoing difficulties, the distinction between staff and patients became blurred, with the latter making interpretations and staff sometimes being overtly troubled, to the extent that visitors would 'inappropriately identify a patient as the psychiatrist'.[425] Even then, the patients found 'relief in finding that others had problems too', which reduced their sense of loneliness.[426]

It is not clear whether staff were always aware of this mutual aid. Crocket himself tended to a paternalistic idea of 'permissiveness' by the staff, rather than acknowledging the activity of the patients in assisting each other.[427] The Patients' Handbook of 1996 makes no mention of the mutual support by patients for each other.[428] However, the sense of safety enabled acts of compassion.

b. The Timetable

Asked what kept the institution ticking over, one individual replied 'Well, the programme'.[429] It was a major stabilising influence: 'that was a good thing about it. The structure of the day… it gave a sense of security, in what was a situation hugely in flux'.[430] Another staff member compared it to another therapeutic community:

> The timetable gave it some safety. So you knew where you were going to be and what you were going to do next. You knew when the tea break, you knew when the lunch was going to be. And you knew where you were going to be after lunch. So the timetable was a kind of a container. You don't get that timetable at the Arbours.[431]

Whilst timings of groups varied over the period studied, there was consistency in that the Community Meeting was held daily, and this was supported by small psychotherapy groups, the art therapy group and activity groups. This is illustrated by the two examples given in Tables 4.1 and 4.2. These, 35 years apart, demonstrate the relative stability of the

[424] Survey results. INGCE19, interview, 30.
[425] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 68.
[426] Tavistock Institute of Human Relations, 129.
[427] For example in his unpublished thesis, he states that the patient should be made aware of the effect of his behaviour on others, and that channels of communication should be as free as possible. Later, he discusses the fact that people need each other, without mentioning that this includes patient-to-patient relationships. Crocket, 'The Theory of the Therapeutic Community - an Approach to Structural Psychiatry and the Use of Intensive Social Treatment Networks', ch. 1, p. 3; Ch. 5, p. 1.
[428] Anon., 'Ingrebourne Centre: Patients' Handbook'.
[429] INGCE20, interview, 5.
[430] INGCE29, interview, 34–35.
[431] The Arbours is a therapeutic community network of houses set up by R.D. Laing's colleagues Morton Schatzman and Joseph Berke in 1970 that has 'live in' therapists. Each house has about 2-3 residents who have a diagnosis of schizophrenia. INGCE14, interview, 2014, 14; Berke, 'Reflections on Arbours'.

programme. As one member of staff recalled, 'I don't recall making any radical changes in the programme, but there were often small changes which were discussed with the whole [community]'.[432]

[432] INGCE19, interview, 8.

Table 4.1: Timetable at Ingrebourne, 1961

TABLE I. INGREBOURNE CENTRE

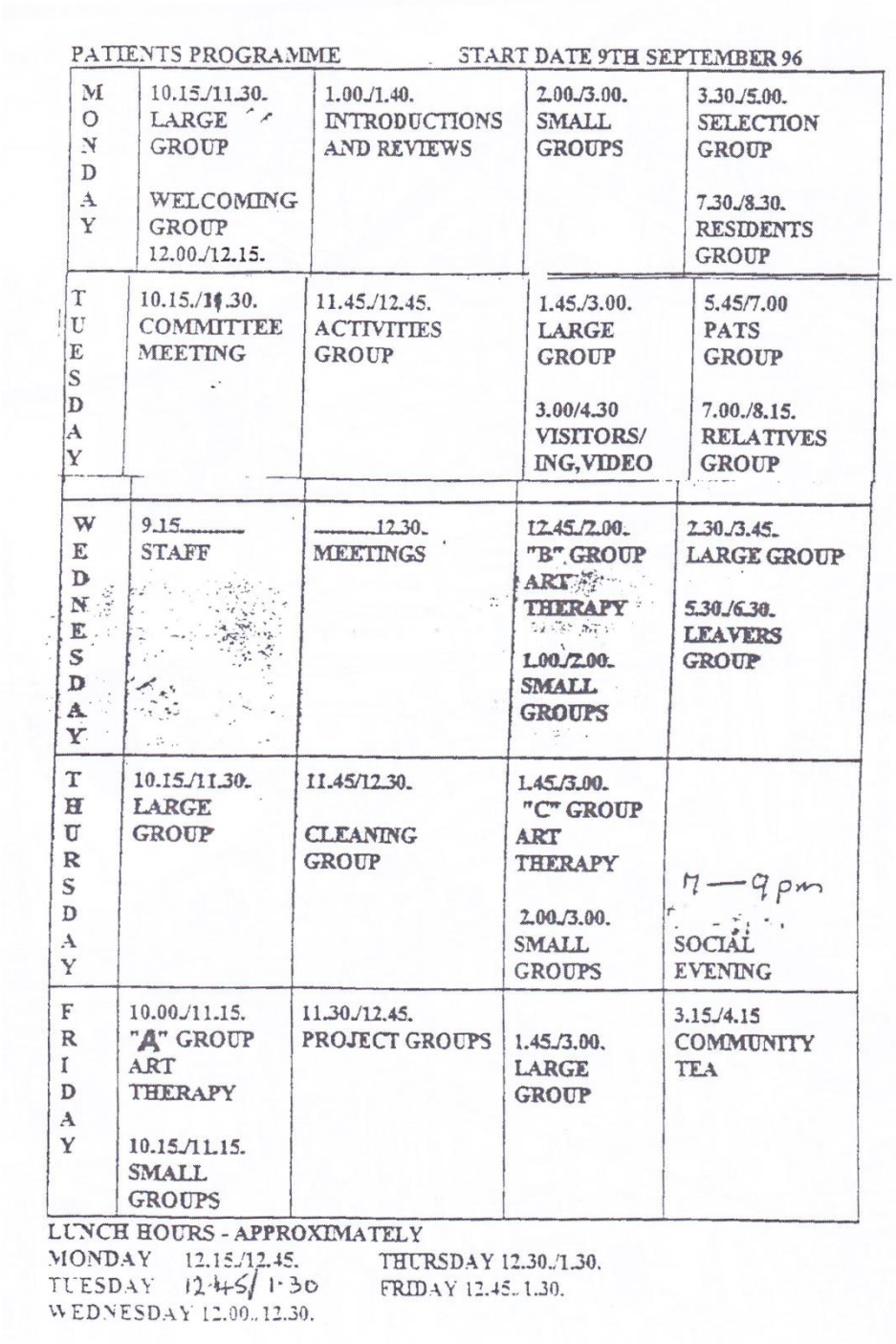
Breakfast: 8:00–8:30 a.m. *Dinner*: 12:15 p.m. *Supper*: 6:15 p.m.

Monday	Tuesday	Wednesday	Thursday	Friday	Other activities
9:30–11:00 a.m. Community Meeting and Large Group. All Patients. Psychiatrist A.	*9:30–11:00 a.m.* Large Group. All Patients. Psychiatrist A.	*9:45–10:45 a.m.* Nurses' Meeting. Psychiatrist B.	*9:00–10:00 a.m.* Nurses' Meeting. Psychiatrist C.	*9:30–11:00 a.m.* Large Group. All Patients. Psychiatrist A.	Community Chores, Painting, Crafts, Clay Modelling, Dressmaking, Baby-sitting for Day-patients' children, Sports (table tennis tournaments, swimming, walks), Cooking for social evening, Canteen, Dramatics, Dancing, T.V., etc.
11:00 a.m. Coffee	*9:30–12:00 Noon* Sheltered Work. Social Therapist.	*10:00 a.m.* Coffee	*9:30 a.m.* Coffee	*10:00 a.m.* ECT. Psychiatrist B.	
9:00–1:00 p.m. Oldchurch Hospital O.P. Psychiatrist B.	*10:00 a.m.* ECT. Psychiatrist B.	House Committee. Magazine Committee. Sports and Social Committee. Occupation Projects Committee.	*10:00–11:30 a.m.* Community Meeting and Large Group. All Patients. Psychiatrist A.	*11:00 a.m.* Coffee	
9:30–12:00 Noon Sheltered Work. Social Therapist.	*11:00 a.m.* Coffee *11:15–1:00 p.m.* Staff Meeting.	Introductory Group.	*11:45–1:00 p.m.* Case Conference. Psychiatrist C.	*9:00–1:00 p.m.* Oldchurch Hospital O.P. Psychiatrist C.	
2:45–4:00 p.m. Subcommunity Group. Psychiatrist A.	*1:30–3:00 p.m.* Sheltered Work. Social Therapist.	*9:30–12:00 Noon* Sheltered Work. Social Therapist.	*p.m.* Introductory Group.	*2:00–4:30 p.m.* Ardleigh Green Club. Social Therapist.	
4:00 p.m. Tea.	*2:30–3:45 p.m.* Subcommunity Group. Psychiatrist B.	*2:00–5:00 p.m.* Oldchurch Hospital O.P. Psychiatrist A.	Drama Group. Social Therapist.	*2:30–3:45 p.m.* Subcommunity Group. Psychiatrist B.	
4:15–5:30 p.m. Clergymen's Probation Group and Officers' Group. Alternate weeks.	*2:00–4:30 p.m.* Ardleigh Green Club. P.S.W.	*2:00–4:00 p.m.* Small Group. Psychiatrist B.	*3:15 p.m.* Tea.	*3:15 or 4:00 p.m.* Tea.	
7:30–10:30 p.m. Romford Social Therapeutic Club. Psychiatrist A.	*3:15 or 4:00 p.m.* Tea.			*5:45–7:15 p.m.* Small Group. Psychiatrist A.	
	8:00–9:30 p.m. Relatives' Group. P.S.W.				

Footnote[433]

[433]Crocket, 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy', 1961. 271

Table 4.2: Timetable at Ingrebourne, 1996.



PATIENTS PROGRAMME START DATE 9TH SEPTEMBER 96

MONDAY	10.15./11.30. LARGE GROUP WELCOMING GROUP 12.00./12.15.	1.00./1.40. INTRODUCTIONS AND REVIEWS	2.00./3.00. SMALL GROUPS	3.30./5.00. SELECTION GROUP 7.30./8.30. RESIDENTS GROUP
TUESDAY	10.15./11.30. COMMITTEE MEETING	11.45./12.45. ACTIVITIES GROUP	1.45./3.00. LARGE GROUP 3.00/4.30 VISITORS/ ING,VIDEO	5.45/7.00 PATS GROUP 7.00./8.15. RELATIVES GROUP
WEDNESDAY	9.15 STAFF	12.30. MEETINGS	12.45./2.00. "B" GROUP ART THERAPY 1.00./2.00. SMALL GROUPS	2.30./3.45. LARGE GROUP 5.30./6.30. LEAVERS GROUP
THURSDAY	10.15./11.30. LARGE GROUP	11.45/12.30. CLEANING GROUP	1.45./3.00. "C" GROUP ART THERAPY 2.00./3.00. SMALL GROUPS	7—9 pm SOCIAL EVENING
FRIDAY	10.00./11.15. "A" GROUP ART THERAPY 10.15./11.15. SMALL GROUPS	11.30./12.45. PROJECT GROUPS	1.45./3.00. LARGE GROUP	3.15./4.15 COMMUNITY TEA

LUNCH HOURS - APPROXIMATELY
MONDAY 12.15./12.45. THURSDAY 12.30./1.30.
TUESDAY 12.45/ 1.30 FRIDAY 12.45./1.30.
WEDNESDAY 12.00./12.30.

Footnote[434]

[434] Anon, 'Ingrebourne Centre: Patients' Handbook', 5.

c. The Community Meeting[435]

The importance of the community meeting was 'greater than the sum of its parts'.[436] Its strength lay in its consistency. It had many functions.[437] Primarily, it aimed to integrate and explore activities occurring throughout the unit. Crocket emphasised that the 'community is an entity' and 'staff and patients are expected to look to the relationship with the community as a whole'.[438] The approach emphasised social experience rather than psychological introspection; providing opportunities for 'testing-out' new ways of relating to others, rather than 'sharing interpretative understandings'.[439] Crocket was at pains to explain that this distinction was not entirely valid in practice and that in a TC social- and psycho- therapies were inextricably interwoven.[440]. This was illustrated by the example of a patient who, as part of a gardening group, planted some potatoes. When the time came to harvest them this individual believed that they 'had gone to crap' as a result of their intervention, and so refused to dig them up. Following discussion of these emotions in their psychotherapy group, they were then able to harvest them and cook them as part of a meal shared with others.[441]

The role of the community meeting role evolved throughout the life of the Centre, with a psychotherapeutic slant predominating towards the end. It took place in a room on the upper floor of the building, 'where we all sat around the edge'.[442] With up to forty or fifty people in attendance, it could be very crowded.[443] It could be 'quite daunting, speaking in the large group. And there's a particular kind of madness I think that can happen in large groups'.[444] People experienced intense feelings in it. Crocket remarked, 'if a patient carries a burden of aggression and hostility the tension and threat in a silent brooding Community meeting can become intolerable'.[445] Echoing this, Main described the 'long uneasy silences with even the most resourceful apparently lacking the capacity for contributing usefully'.[446] Participants seem to lose the ability to think. Their 'mental vigour' is split off and projected

[435] The term Community Meeting will be used to cover what is otherwise sometimes described as the Large Group. Whilst, at times, there was a distinction drawn between the two, the term 'Community Meeting' covers the nature of the forum where all members met on a daily basis to discuss events that were current.
[436] J. Lomax-Simpson, 'The Value of the Large Group for Community Psychiatry: Is My Large Group an Orange Balloon?', *International Journal of Therapeutic Communities*, vol. 6, no. 1 (1985): 45.
[437] Crocket, 'Memorandum: Dates of American Trip 14th May 1968 to 15th June 1968'.
[438] Crocket, 'Changes and Choice in Group Therapy: Prospects for the Therapeutic Community', 5.
[439] Crocket, 3.
[440] R. W. Crocket, 'Appendix A: Features of Different Types of Therapeutic Communities' (Unpublished, 1978), 73, Planned Environment Therapy Trust.
[441] INGCE17, interview, 7.
[442] INGCE24, interview, 3.
[443] INGCE19, interview, 2.
[444] INGCE29, interview, 11–12.
[445] Crocket, 'Changes and Choice in Group Therapy: Prospects for the Therapeutic Community', 5.
[446] T. F. Main, 'Some Psychodynamics of Large Groups', in *The Large Group: Dynamics and Therapy*, Ed. L. Kreeger (London: Constable, 1975), 60.

onto ‘a vague non-personal creation’ which is both mysterious and powerful called ‘the group’, in the presence of which they feel ‘stupid, helpless and afraid’.

At other times at the Ingrebourne:

> People got quite heated. You know, over things, frustrated and they would be jumping up an’ storming out and ... But every time somebody got up and stormed out somebody went after them, and inevitably would talk them into coming back in. There was a kind of safeness really about being able to do that for people.[447]

Some staff found this emotional tension and drama very engaging: ‘I mean the most exciting bit was the large group’, which was the ‘most potentially therapeutic element of the programme’.[448]

The Large Group was the forum where the social dynamics of the unit could be revealed, investigated and understood. On one occasion this was illustrated by the actions of a senior member of staff walking in and putting a rum, or whisky, bottle ‘smack in the middle of the floor’ and then sitting down. It was the focus of attention and everyone realised that someone had been drinking on the premises. It became ‘very tense, and he said that there really was an issue here and clearly someone was taking part in the community but not abiding by the rules’.[449]

This community meeting was the norm in contemporary TCs.[450] Stuart Whiteley at the Henderson explained that the staff’s role was to ‘work in collaboration with the residents to ensure that information from all the areas is brought to common knowledge’.[451] They were to feedback when any incident occurred, how they felt and ‘to identify the issues of conflict, … clarify them and facilitate their resolution’.

At Ingrebourne, a patient turned a carpet in a small group room upside down because she could not stand the bright colours. Other people did not know why, but tolerated the arrangement for several days. Eventually, the reasons filtered through and were explored in the community meeting and the carpet was put right.[452] This way, the meeting served as the opportunity to explore the intra-group dynamics present in the unit. When it worked well, conflicts, which in other more traditional settings would have remained covert and obstructive, could be understood and resolved.

This meeting was followed by a staff group in which those who had attended would review both their own behaviour and interventions, whilst noting issues that had arisen which

[447] INGCE24, interview, 3.
[448] INGCE13, interview, 2–3.
[449] INGCE16, interview, 4.
[450] J. S. Whiteley, *The Large Group as a Medium for Sociotherapy* (Constable, 1975).
[451] Whiteley, 209.
[452] Tavistock Institute of Human Relations, ‘Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process’, 9.

could be the focus of work over the next day.[453] Maxwell Jones explained that the staff should conduct a 'post mortem' in which the reactions and perceptions of those present at the community meeting could be discussed. [454] This acted as a valuable form of training. In practice, at the Ingrebourne, the focus tended to be less clear cut. 'We would basically talk through what had happened in that particular group and try and understand it'.[455]

An on-going issue was the language used by therapists. At times, the staff themselves did not understand it, especially when first starting. One thought, 'What the hell is happening? What the hell do they mean?' He had to go away to look up the words and, as he remarked, 'what chance' did the group members have.[456] The pressure to seem knowledgeable could lead to confusion:

> I remember a chastening moment when I'd been practicing in my mind what I wanted to say in the large group. And I sort of strung this thing together, this comment, and somebody said "Well that's all very well. What the hell does that mean?" And it was quite right. Because we could all spout some kind of psychobabble.[457]

The patients in turn would learn to mimic the language and use it as a screen. When challenged, it was clear that they did not always know what they meant.[458] This tendency to psychotherapeutic formulation had the possibility of redefining day-to-day events in a manner that drained them of humanity and compassion. As one staff member reported, there was 'intense intellectualism leading to all sorts of acting-outs, e.g. suicidal gestures'.[459]

By 1994, there were other therapeutic approaches: individual psychotherapy, couples and family therapy, psychodrama, and project groups. The latter included photography, cooking, gardening and running a magazine.[460] In addition they were involved in the new patient selection group, a residents' group to sort out day-to-day issues in living in the Centre, a review group to assess each individual's progress and a leaver's group for those about to leave the community.

The small psychotherapy groups gave the patients the chance to discuss more personal issues in the context of their individual histories and were usually run on Group Analytic lines. They were also seen as a 'stepping stone' to enabling people to gain the confidence to speak more openly in the larger community meeting.[461]

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[453] ING17, interview, 8; INGCE19, interview, 11.
[454] Jones, *Social Psychiatry in the Community, in Hospitals, and in Prisons*, 60–65.
[455] INGCE19, interview, 9.
[456] The phrase in brackets was implied in the interview. INGCE18, interview, 16.
[457] INGCE29, interview, 23.
[458] INGCE18, interview, 17.
[459] INGCE22, personal communication, 2018.
[460] Conneely, 'Brief History and Groups in Action at the Ingrebourne Centre'.
[461] Conneely, 3.

The community meeting offered the space to engage in Bridger's 'double task'. This process involves letting go of dysfunctional, although deeply held and valued, ideas and practices, discovering new ways of thinking and acting whilst coping with the insecurity engendered by changing conditions. The 'letting go' of deeply held convictions in the face of challenging external demands did not sit easily with the Ingrebourne staff towards the end of its lifetime.

d. Leadership

The fulcrum around which the boundary issues of any therapeutic community turn is that of the leadership.[462] This issue is addressed here as it relates to the internal functioning of the Centre. How it functions is a 'critical facet' of the relationship between the community and the outside world.[463] In the next chapter, the concentration is on external relationships. Despite Maxwell Jones emphasising its 'paramount importance', anxieties arising from this term have led to relatively little discussion of it in TC publications.[464] David Clark expressed this ambivalence when he stated that the 'word "leader" has gradually acquired certain unfortunate connotations'.[465] Psychotherapists are also often reluctant to take on a position of authority because it entails moving away from clinical work.[466] Crocket briefly tackled the issue early on, stating that surrendering 'overt authority does not mean that authority is lost'.[467] He observed that the community itself very quickly establishes boundaries of what is acceptable and what is not.

Dr J. K.W. Morrice, a consultant psychiatrist, unpicks some of the myths implied by 'democratisation'.[468] He finds that, in the 1970s, reflecting the permissive society, there was a tendency to argue that 'everyone is equal' without considering their abilities. This reaction to the authoritarianism and oppressive hierarchies of mental hospitals requires examination of what leadership implies, but not its abandonment. Paradoxically, democracy 'can only be sustained from a position of power'.[469] Doctors have to be aware that other professions

[462] Matti Isohanni, 'Leadership and Problem Solving in the Psychiatric Organization', *International Journal of Therapeutic Communities*, vol. 10, no. 3 (1989): 146.
[463] N. P. Manning, 'Collective Disturbance in Institutions: A Sociological View of Crisis and Collapse', *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 151.
[464] M. Jones, *Maturation of the Therapeutic Community : An Organic Approach to Health and Mental Health* (New York; London: Human Sciences Press): xxviii.
[465] D. H. Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community,* Mind and Medicine Monographs 9 (London: Tavistock, 1964), 63.
[466] M. P. Bolten, 'Training for Leadership: Administration in a Psychotherapeutic Community', *International Journal of Therapeutic Communities*, vol. 12, no. 1 (1991): 35.
[467] R. W. Crocket, 'The "Therapeutic Community" Approach to Neurosis', in *Neurosis.* (I Congressus Psychiatricus Bohemoslovenicus cum Participatione Internationali 1959, Prague, 1961), 276.
[468] J.K.W. Morrice, 'Myth and the Democratic Process', *British Journal of Medical Psychology*, vol. 45 (1972): 327–31.
[469] Morrice, 328.

were now 'kicking over the traces' after years of labouring under the 'medical yoke'. Quoting Maxwell Jones' concept of multiple leadership, he considers that diverse situations require different leaders.[470]

Bridger rejects the spurious opposition of 'democracy' and hierarchy; the former is a way of life, whilst the latter is a structural issue.[471] He argued that the reverse of democratic is authoritarianism. Ignoring hierarchy leads to confusion, and failure to address the necessary responsibilities incumbent on running an organisation. The ensuing conflict tends to be seen as 'a clash of personalities', rather than stemming from the underlying structural problems.

Crocket examined the issue of 'authority and permissiveness' from a psychodynamic perspective in 1966[472] Employing the sociologist Max Weber's distinctions between charismatic, traditional and rational-legal authority, he argued that traditional authority, derived from infantile relationships with their parents, is a central aspect of therapy.[473] According to his colleague, St. Blaize-Molony, it is this 'authentic' authority that is looked for, or challenged by patients.[474]

The British TC movement tends to rely on bluff 'common sense', analogies with parenting and psycho-analytic and/or sociological theory for their understanding of leadership, with little acknowledgement of the vast managerial literature.[475] The trait school of leadership is often in evidence, implying either that some people are 'born' managers or that leaders have different inbuilt styles.[476] Richard Rollinson, Regional Director for the Peper Harow group of TCs for children, was concerned about the overwhelming number of papers on leadership promoting 'complicated and largely abstract ideas about theories, styles, strategies and skills'.[477]

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[470] M. Jones, *Beyond the Therapeutic Community* (New Haven and London: Yale University Press, 1968).
[471] Bridger, 'Groups in Open and Closed Systems', 240.
[472] Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives'.
[473] Max Weber, *Basic Concepts in Sociology* (London: Peter Owen, 1962).
[474] Crocket, 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives', 674.
[475] An instance of the 'common sense' approach is given by Matti Isohanni, who argues that 'Leaders should prefer a democratic style, but keep the whole organizational context firmly in their hands. A formal leader must be able to create and maintain team work'. Isohanni, 'Leadership and Problem Solving in the Psychiatric Organization', 149. On the other hand, John Diamond has more of a sense of the psychodynamic aspects of managing a community. John Diamond, 'Who's in Charge Here? - Managing the Mess', *International Journal of Therapeutic Communities*, vol. 24, no. 1 (2003): 11. Parenting, even going as far as describing the emergent TC as the 'new baby', is a particular theme of Jan Birtle, and her colleagues, when considering setting up a new TC in Birmingham. Jan Birtle et al., 'Leadership in a New Therapeutic Community: Learning to Regulate the Temperature', *Therapeutic Communities*, vol. 25, no. 2 (2004): 86–87.
[476] For the 'born' school see Hans Eykman, 'The Loneliness of the Leader: Reflections on Psychotherapeutic Leadership', *International Journal of Therapeutic Communities*, vol. 12, no. 1 (1991): 30.
[477] Richard Rollinson, 'Leadership in a Therapeutic Environment "What a Long Strange Trip It Is"', *Therapeutic Communities*, vol. 24, no. 1 (2003): 23.

Despite the much vaunted 'democratization' ideal, doctors have always led NHS TCs.[478] At Ingrebourne, whilst the centre was run by a full-time doctor, it was his consultant, who was designated the leader, even though they spent a significant portion of the week elsewhere.[479] The Tavistock researchers remarked on the paradox that, in this 'flattened' hierarchy, the leadership role was more important than in a traditional hierarchical setting.[480]

The term 'democratization' continues to preoccupy the British TC movement.[481] Disseminated through Rapoport's seminal study of Belmont in 1960, it has become part of the TC theoretical framework thereafter.[482] However, he found that there was the belief that 'each member of the community should share equally in the exercise of power in decision-making about community affairs'. In practice, staff were aware of professional responsibilities that superseded this ideal. Particular situations, such as a medical emergency or severely unacceptable behaviour, called for decisive leadership. The 'flattening of the hierarchy' enables those being treated to exercise some degree of influence within the unit and learn from the consequences of their decisions. In particular, it promotes their ability to discuss each other's difficulties and approaches. In such an atmosphere, 'the expectation is that each person [*including staff*] will feel free to make mistakes, discover himself, grow and learn'.[483] At Ingrebourne, one practitioner considered that it 'is dissolving hierarchies. It's moving towards democratisation far more. So, I would view it as that there's far more, it's not exactly consensus decision making, but far more participation in decision making, was my experience'.[484]

However, 'democracy' is sometimes substituted for democratisation. As a result, the anti-authoritarian emotions of the staff and patients can lead to 'killing off of father' and denying the necessity for leadership.[485] At Ingrebourne this tendency led to people not 'carrying their responsibilities enough', rather like an adolescent 'wanting all the advantages of living in your parents' house, but not wanting to take your responsibilities that go along with it'.[486]

[478] Interestingly, no one interviewed for this research disputed the legitimacy of this, perhaps because of the previous status of the interviewer himself.
[479] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 73.
[480] Tavistock Institute of Human Relations, 29 footnote.
[481] This fixation is illustrated by the most recent textbook on 'Democratic' TCs. Pearce and Haigh, *The Theory and Practice of Democratic Therapeutic Community Therapy*.
[482] Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 55–58.
[483] J.K.W. Morrice, 'Basic Concepts: A Critical Review', in *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N Manning (London: Routledge & Kegan Paul, 1979), 49.
[484] INGCE16, interview, 3.
[485] Morrice, 'Basic Concepts: A Critical Review', 52.
[486] INGCE16, interview, 8.

Rather than creating an open forum that enables all to speak, democracy can give voice to the most dominant characters.[487] Campling gives a potent illustration of this. She observed a staff team standing by as the residents voted for someone to leave, following them tipping over a coffee table. The woman had been describing sexual abuse she had undergone. Although the staff agreed that the wrong decision was made, and was one which had actually re-inflicted abuse similar to that which she was recounting, the decision held. Therapeutically, the community was damaged, as well as the patient. The staff disowned their 'real power and responsibility' in 'the name of flattened hierarchies and democracy'.[488]

Leadership requires the appropriate balance between acting authoritatively when necessary and enabling free expression, purposefulness and a sense of influence. None of the doctors at the Ingrebourne had any management qualifications.[489] It was their first consultant post for all of them. None had previously worked in a TC, in contrast to some of the other staff. One applied for the post because they were 'quite intrigued, interested' and wanted to 'find out about therapeutic communities'.[490]

Clark, at Fulbourn, considered that doctors were the 'best and worst prepared of all the hospital's professionals' for this role'.[491] Their education, medical expertise and the 'entrenched power of the medical profession behind them' is counterbalanced by the social conditioning that leads them to operate in an authoritarian manner.[492] For each, it was a case of working out their practice whilst 'on the job' and having to unlearn much of their habituation. For Crocket, this was a case of trial and error, as new insights from members of his team were experimented with.

The anxiety about leadership in the TC movement runs hand in hand with concerns about charismatic leadership and the development of cults.[493] Psychiatrist Bob Hobson describes the *Messianic Community* in which the 'Leader and his colleagues colluded in an idealization of himself and of the UNIT' to the bewilderment of those outside with responsibilities to

[487] Anne Crozier, 'Attempts at Democracy', in *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N Manning (London: Routledge & Kegan Paul, 1979), 263.
[488] Penelope Campling, 'Maxwell Jones Lecture 2001 - Response to Jane Knowles', *Therapeutic Communities*, vol. 22, no. 4 (2001): 289.
[489] This was typical for consultant medical staff, who had little or no training in leadership or management. T. M. Harrison and Alison J. Gray, 'Leadership, Complexity and the Mental Health Professional. A Report on Some Approaches to Leadership Training', *Journal of Mental Health*, vol. 12, no. 2 (2003): 153–59,153; J. Reed, 'Leadership in the Mental Health Service: What Role for Doctors?', *Psychiatric Bulletin*, vol. 19 (1995): 67–72.
[490] INGCE13, interview, 1.
[491] Clark, *Social Therapy in Psychiatry*, 93.
[492] An editorial in the *British Medical Journal* referred to the tendency of consultants to be 'headstrong' and 'to make a bloody nuisance' of themselves until they got what they want. Tom Treasure, 'Redefining Leadership in Health Care. Leadership Is Not the Same as Browbeating', *British Medical Journal*, vol. 323, no. 7324 (2001): 1263–64.
[493] E.g. Morrice, 'Basic Concepts: A Critical Review', 51–52. The issue of 'charismatic leadership' was discussed by staff at the Ingrebourne, 'I remember when I was at the Ingrebourne, and in the ATC groups, we used to talk a lot about it and there was always an anxiety about when a charismatic leader retired or moved on, how the TC would survive it – and I think some didn't. I think this is what was behind the move to democratisation, as a way of helping a TC over that gulf after a charismatic leader had left'. INGCE20 email correspondence.

manage the unit alongside 'normal' services.[494] The 'exhilarating sense of cohesion' and an increasingly esoteric mutual language, leads to a psychic split developing between the 'good' unit and the 'bad' external world.[495] The debates amongst staff about power relations and group psychodynamics then result in rivalries and their splitting into destructive alliances, leading to the collapse of the community. Innovative leaders such as Maxwell Jones, against whom the charge of charismatic leadership is often laid, bear the anxieties of the staff group who are dealing face-to-face with their own bewilderment, and the often disturbed behaviour of those they are working with.[496]

At the Ingrebourne, Crocket became the 'wise old man of the Centre', with the staff at times looking to him for 'profound or oracular communications'. [497] Whilst acknowledged as the most experienced and knowledgeable person, the staff gave strikingly contradictory views about him. Some found that he gave generously of his time and knowledge and was 'very facilitating'. Others accused him of being too academic or that there was 'implicit criticism and subtle manipulation' in his relationship with them.[498] There was a contradiction between his idealism and the reality of what could be achieved. He found it difficult to acknowledge the tension involved in thinking about every activity as a therapeutic intervention, even making a cup of tea.[499]

This situation was complicated by the fact that Crocket only worked part-time at the unit and was dependent on the senior doctor who had to apply the theory and practice whilst still learning them.[500] When that person left there was a period of disorganisation that would remain unresolved until after the induction of his or her replacement. They, in turn, might leave before they had fully comprehended what was expected of them. The result was that the highly sophisticated and abstract theory developed around Crocket was 'often an abstract ideal rather than a current actuality'.[501]

When Jeff Roberts and Margaret Williams arrived, they were faced with a unit that had established traditions and practices, with a staff and patients who were keen to conserve these. Senior doctor appointments were made by outsiders, few of whom understood the nature of the therapeutic community way of working, and who were liable to appoint that individual who was best qualified 'psychiatrically', rather than taking account of how the

[494] Robert F. Hobson, 'The Messianic Community', in *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N. P. Manning (London: Routledge & Kegan Paul, 1979), 233.
[495] Hobson, 234.
[496] Manning, *The Therapeutic Community Movement*, 25.
[497] INGCE20, interview, 5.
[498] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 70–71.
[499] INGCE29, interview, 6.
[500] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 28.
[501] Tavistock Institute of Human Relations, 28.

unit was to be run.[502] There was consequently immediate tension between the staff and the new leader imposed upon them, who knew much less about the unit's *modus operandi*. Inevitably the result was to attempt to 'convert' the new arrival and frustration if this was unsuccessful. It took a while for the new consultant to 'get the hang' of it.[503] And there was conflict as staff was trying to 'make him more like us and he was trying to make us more like him'.[504]

4. Boundaries and Compassion

Bridger, reflecting on the TC as an 'open system', argues that

> it provides a transitional space and time and a variety of endeavours designed to enable one kind of population to enter, then to have the opportunity of reflecting, rethinking, testing themselves out, working through many different struggles and inner tensions, and hopefully regaining MORE OF THEMSELVES in the process of building on painful learning and unlearning experiences.[505]

He points out that the experience of boundaries in such a system adjusts with time. Initially, the community feels restrictive, and, indeed, the necessity for learning the 'rules of the game' may require curtailment of ways of responding to stress that affect others adversely. However, as 'time goes on and hopefully inner strengths and potential resources are developed', the range of choice and responsibilities open up, and new ways of adjusting to relationships enable a successful passage out of the institution. Bridger reframes the discourse about the therapeutic community approach, discarding the shibboleths surrounding such words as 'democratisation' and introducing the importance of leadership and the task.

This chapter explored the historical and theoretical underpinnings of practice at the Ingrebourne. Theory and practice were often at loggerheads, but the former acted as a touchstone to assist in understanding the emotional turmoil. Casting it as a 'transitional space' allows the delineation of its boundaries, and ties it into a task-orientated framework. These limits enabled the development of trust and the enactment of compassionate care. The Centre offered an alternative way of working to the autocratic stability of the mental hospital, but carried with it tensions and potential for conflict, both internally and with the

[502] All these appointments would have been arranged through the Regional Hospital (later Health) Boards, who held the consultant contract. The selection panel would have been appointed by the Regional Board, and while there would have been one consultant from the hospital, all other members would have had no connection with the Ingrebourne Centre. House of Commons, 'The National Health Service (Appointment of Consultants) Regulations 1982', 1982, http://www.legislation.gov.uk/uksi/1982?page=47.
[503] INGCE20, interview, 9.
[504] INGCE20, 9.
[505] Emphasis as in the original Bridger, 'Groups in Open and Closed Systems', 7.

external environment. The next chapter looks at how this interaction with the outside world led to its eventual demise.

Chapter 5

'And then some splitting started appearing'[1]: Later years at the Ingrebourne Centre

> The Ingrebourne was quite a tenacious sort of organisation. You had to be very brave to criticise it.[2] (NHS manager, 2016)

> The Ingrebourne Centre, originally a therapeutic community model, providing long term therapy to people who were experiencing complex difficulties, has over the last number of years "lost its way".[3] (NHS Manager, 2003)

1. The Rise of the Economic Patient and the Decline of Trust

After relating the political and cultural changes within the NHS during the last quarter of the twentieth century, this chapter explores factors that led to the closure of the Ingrebourne Centre. The material for this later period is mainly derived from interviews with members of staff and people who had been treated there. The documentary evidence is otherwise thin on the ground. As a result, the chronology is tendentious, relying as it does on memories. Attempts have been made to 'triangulate' between different sources, but this has been necessarily approximate in many cases.

The story is one of a gradual 'chipping away' of the service, both in terms of resources and also of the central ideas of the TC. This process was enabled by both internal and external dynamics. The perspective taken here is that government policy and medical practice has increasingly reframed the patient as a 'market consumer', similar to the model of *homo economicus* that dominates mainstream neo-classical economic theory.[4] This has necessitated a lengthy introduction to the background environment in which the Ingrebourne was operating, as it is necessary to delineate how the standardised patient was being created.

Little historical research has been carried out on the failure and collapse of small organisations. The emphasis has been on whole societies.[5] The major studies of

[1] INGCE22, interview, 24.
[2] INGCE31, interview, 16.
[3] Steve Marsh, 'Briefing Paper: Eastern Operations Division. Reconfiguration of Psychological Therapies in Havering 15th October 2003', 2003, CCJ archive, Planned Environment Therapy Trust.
[4] Richard Bronk, *The Romantic Economist: Imagination in Economics* (Cambridge, UK; New York: Cambridge University Press, 2009), 226.
[5] For instance 'declinism' in British History has been specifically related to the apparent decline of the United Kingdom as a global power. David Edgerton, 'The Decline of Declinism', *The Business History Review*, vol. 71,

organisational decline have been carried out by researchers into commercial businesses, supplemented by some investigations into hospitals. The collapse of the Paddington Day Hospital is partially relevant, but for the fact that the intensity of the internal dynamics were exceptional, rather than typical of similar therapeutic communities. A useful summary of performance decline in public sector organisations is provided by two public policy academics, Pauline Jas and Chris Skelcher, who examined fifteen poorly performing English local authorities.[6] They find that these organisations are different from commercial ones in that they continue to operate until the relevant source of authority decides to close them. Profit-oriented businesses are dominated by their ability to meet the demands of the market and are susceptible to the requirements of its customers. There is greater difficulty in measuring the performance of public sector organisations as they fulfil less clear conditions, and there are also social constraints that enable poorly performing centres to persist. Both these mechanisms can be seen to operate in the case of the Ingrebourne, particularly where other priorities pre-occupied senior management in charge of the broader service. In common with other businesses studies, Jas and Skelcher argue that causes of failure stem from internal and external sources.[7] Those outside the organization include fundamental changes that undermine the unit's rationale for existence and changes in customer preferences. Manning also recognised that both internal and external factors played a part in the failure of a community to thrive. The sub-title of his book, *Charisma and Routinization* (1989), accords with their model that belief in an overarching paradigm leads to inflexibility and an inability of the organisation to respond to changing demands.[8] Each of these will be seen to be operative in the present case, particularly when it is recognised that the 'customer' is not the patient but those who employ the service on that person's behalf. These were other psychiatrists and general practitioners in the days before 'commissioning', and bodies described as 'purchasers' after the NHS reforms instituted in the 1980s.

Internally, a number of processes lead to decline. Jas and Skelcher hold the view that 'at a particular point a paradigm associated with the organization's leadership becomes dominant'.[9] This provides a blueprint which is adopted by those working in the unit and establishes its *modus operandi* and values. This can blind those working there as to the changing circumstances in which they are operating, leading in turn to a rigid 'group think' that prevents adaptation. At the Ingrebourne, it will be seen that the idea of a socially orientated therapeutic community was gradually replaced by a more rigid psychoanalytic

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no. 2 (1997): 201–6; J. Tomlinson, 'Thrice Denied: "Declinism" as a Recurrent Theme in British History in the Long Twentieth Century', *Twentieth Century British History*, vol. 20, no. 2 (2009): 227–51,

[6] Pauline Jas and Chris Skelcher, 'Performance Decline and Turnaround in Public Organizations: A Theoretical and Empirical Analysis', *British Journal of Management*, vol. 16, no. 3 (2005): 195–210.

[7] David A. Whetten, 'Organizational Growth and Decline Processes', in *Readings in Organizational Decline: Frameworks, Research, and Prescriptions*, eds. Kim S. Cameron, Robert I. Sutton, and David A. Whetten (Cambridge Massachusetts: Ballinger Publishing Company, 1988), 27–44; Cheryl A. Trahms, Hermann Achidi Ndofor, and David G. Sirmon, 'Organizational Decline and Turnaround: A Review and Agenda for Future Research', *Journal of Management*, vol. 39, no. 5 (2013): 1277–1307.

[8] Manning, *The Therapeutic Community Movement*.

[9] Jas and Skelcher, 'Performance Decline and Turnaround in Public Organizations', 200.

ideology held by the leadership. However, the initial orientation never completely faded away, being maintained by other staff members and those receiving treatment. Neither approach was flexible enough to respond to the changing demands from the external environment.

i. No Such Thing as Society[10]

After 1979 the political climate of the country changed, and government intervention in the NHS had a delayed, but increasing impact on the Ingrebourne Centre. As a consequence, the broader cultural environment described in Chapter Three had less specific influence and attention here is turned to the effects of this shift in economic policy.

Thatcher's government seemed to many a much needed antidote to the apparent economic and political chaos of the previous decade.[11] Whilst the previous administration, under James Callaghan, had begun to bring the disastrous inflation of 27% in 1975 under control, the 'Winter of Discontent' undermined any electoral advantage he may have gained from this. Following the ending of wage restraint introduced in 1976, over the winter of 1978 to 1979, workers in many industries sought to catch up on lost time.[12] These were led by the Ford workers at Dagenham who turned down a 5% offer in September and through withdrawing their labour achieved a 17% pay increase.[13] This heralded a storm of other strikes, including many by NHS workers. Early in 1979, military ambulances were deployed to replace those withdrawn following the absence of their crews.[14] Nurses worked to rule. At Warley Hospital there was active trade union participation in this unrest, although there are no reports of the staff at Ingrebourne participating.[15] As a consequence of this turmoil, the Tory promises of curbing trade union power were welcomed by many.[16]

The first watershed for the NHS came with the Griffiths Report of 1983, which proposed a 'coherent management process' to replace the previous consensual administrative

[10] This statement was made in an interview on 'AIDS education and the year 2000', in Woman's Own 31st October 1987 quoted from Andy McSmith, *No Such Thing as Society* (London: Constable, 2011), 5.
[11] C. Hay, 'Chronicles of a Death Foretold: The Winter of Discontent and Construction of the Crisis of British Keynesianism', *Parliamentary Affairs*, vol. 63, no. 3 (2010): 446..
[12] Robert Leach, W. N. Coxall, and L. J. Robins, *British Politics*, 2nd ed, Palgrave Foundations (Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan, 2011), 361; Hay, 'Chronicles of a Death Foretold', 450.
[13] As related in the previous chapter Dagenham was one of the areas from which patients at Ingrebourne would have come from. Lloyd, *Empire, Welfare State, Europe*, 471.; Hay, 'Chronicles of a Death Foretold', 453.
[14] Rivett, *From Cradle to Grave*, 348.
[15] INGCE28, interview, 2016; INGCE31, interview.
[16] Christopher Booker, *The Seventies: Portrait of a Decade* (Harmondsworth: Penguin, 1980), 20–21.

approach.[17] It was illustrated by the observation that 'if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge'.[18] The report inaugurated the trend towards a 'value for money' approach to health service provision, which the TC approach was singularly ill-suited to meet.[19] The key objective was to improve the efficiency of providers of health services, and, to implement this, general managers replaced the previous consensual tripartite system of manager, senior doctor and senior nurse.[20] The patient as the 'supermarket customer' began to emerge in government policy, significantly shifting the focus from collective consumerism to individual responsibility.[21]

With the *NHS and Community Care Act* of 1990, the government ratcheted up the commodification of medicine through the development of an 'internal market'.[22] Purchasing health care was separated from providing it. General practitioners were to become fund-holding practices and procure the care, which they believed their patients needed, from whomsoever they considered to provide the best option. The Health Authorities took responsibility for buying services for the remaining health care needs. This apparent clarity was not exhibited in practice. The government's own aims and predictions were abstract. One commentator described it as 'a political process driven by clearly-stated ends', but which required those implementing it to work out how to do it 'on the hoof'.[23] As a result, policy makers and managers 'adapted the outlines which they had been presented with and muddled through'.[24]

The Act legislated for local authorities to be the brokers and care managers of social care, absolving the NHS from any further responsibility in this direction.[25] Rather than providing services, they were to contract out to other organisations, mostly in the independent, private and charitable, sector.[26] The three purchasing agencies, health authorities, local

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[17] Sir Roy Griffiths was the managing director of the supermarket chain Sainsbury's. Rudolf Klein, *The New Politics of the NHS: From Creation to Reinvention* (Oxford: Radcliffe Pub., 2010), 117; R. Griffiths, *Report of the NHS Management Enquiry* (London, 1983), 18

[18] R. Griffiths, *Report of the NHS Management Enquiry* (London, 1983), 9.

[19] Rudolf Klein, *The New Politics of the National Health Service*, 3rd ed. (London; New York: Longman, 1995), 131–69.

[20] Adam Oliver, 'The English National Health Service: 1979-2005', *Health Economics*, vol. 14, no. S1 (2005): 575,577.

[21] Alex Mold, *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain* (Manchester: Manchester University Press, 2015), 61.

[22] Klein, *The New Politics of the National Health Service*, 176; Geoffrey Rivett, *From Cradle to Grave: Fifty Years of the NHS*, (London: King's Fund, 1998), 420; Secretaries of State for Health, Wales, Northern Ireland and Scotland, *Working for Patients*, CM555 (London: HMSO, 1989); Parliament, *National Health Service and Community Care Act 1990* (London, 1990), http://www.legislation.gov.uk/ukpga/1990/.

[23] Butler, *Changing Mental Health Services*, 64.

[24] Julian Le Grand, Nicholas Mays, and Jennifer Dixon, 'The Reforms Success or Failure or Neither', in *Learning from the NHS Internal Market: A Review of the Evidence*, eds. Julian Le Grand, Nicholas Mays, and Jo-Ann Mulligan (London: King's Fund, 1998), 118.

[25] Parliament, *National Health Service and Community Care Act 1990,* part III.

[26] D. Mechanic, 'The Americanization of the British National Health Service', *Health Affairs*, vol. 14, no. 2 (1995): 56.

authorities and general practice fund-holders, were to hammer out plans to promote care in the community, on the assumption that health and social needs are easily distinguished.[27] However, this partnership proved problematic because of contrasting priorities for the different agencies involved. General practice fund-holders were keen to claim some of the resources available for mental health care in order to get psychiatric staff into their surgeries to treat the less severely ill.[28] Local authorities inevitably wished for the resources to follow the patients, but relocating a patient from hospital rarely released funds from closures to go with him or her. Identifying where patients originally came from, anything up to 30 or 40 years previously, and where they wished to move to, was a major problem for Warley managers.[29]

Highlighting the role of patients initiated some movement towards listening to their voice directly, rather than through such organisations as the Community Health Councils, which had hitherto advocated on their behalf.[30] Over the next few years, there was an increasing involvement of individuals in committees deciding on the future of mental health services, and some 'user led' services were also set up. In concert with this, there has been a consistent political push to promote consumer 'choice'. This activity continued to contribute to the promotion of individualism consistent with the overall neo-liberal agenda.[31] Marianna Fotaki, Professor of Business Ethics, argues that the shift from trust to choice centres on the economic premise of patients being rational individuals, who, if given enough information, will be able to make the appropriate decisions.[32]

The 'business' model also included the necessity to make 3% efficiency savings year on year from 1990, forcing many Trusts to close services seen as non-essential.[33] These could include clinical services such as speech and language therapy, rehabilitation and dietetics. A doctor involved in making these decisions describes how choices had to be made between removing eggs and cutlery from the breakfast menu or axing a nursing post.[34] Staff at Ingrebourne felt these threats to their service continuously throughout this period.[35]

Hand in hand with this drive to marketization, medical epidemiologist, Archie Cochrane, began his crusade for evidence-based medicine in which the randomised controlled trial was

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[27] Butler, *Changing Mental Health Services*, 82; Klein, *The New Politics of the NHS*, 162.
[28] Edward Peck and Elizabeth Parker, 'Mental Health in the NHS: Policy and Practice 1979-98', *Journal of Mental Health*, vol. 7, no. 3 (1998): 248.
[29] INGCE28, interview, 16.
[30] Mold, *Making the Patient-Consumer*, 61.
[31] Shulamit Ramon, 'Neoliberalism and Its Implications for Mental Health in the UK', *International Journal of Law and Psychiatry*, vol. 31, no. 2 (2008): 121.
[32] Marianna Fotaki, 'Can Consumer Choice Replace Trust in the National Health Service in England? Towards Developing an Affective Psychosocial Conception of Trust in Health Care', *Sociology of Health & Illness*, vol. 36, no. 8 (2014): 1276.
[33] Allyson Pollock and Colin Leys, *NHS Plc: The Privatisation of Our Health Care* (London ; New York: Verso, 2004), 22,82.
[34] Pollock and Leys, 112.
[35] INGCE21, interview, 2014, 9; INGCE30, interview, 10.

established as the gold standard.[36] This inspired to the establishment of the Cochrane Collaboration in the early 1990s.[37] The Randomised Controlled Trial (RCT) is a methodology that compares two treatments, usually a placebo, and the active therapy, in order to establish the efficacy of the latter. The person undergoing treatment is randomly allocated to either the active or the placebo group. In order for it to meet agreed standards of practice both the experimenters, and the subjects of the trial, must be unaware, or 'blind', to which remedy is being administered to whom.[38] Ideally, the subjects should be suffering from a single condition, taking only the treatment under scrutiny and generally comparable whether they are in the active or passive group. Beyond this, the trials should be replicable and replicated. For the evidence to meet the standards set by Cochrane, all the research on a particular therapeutic intervention is collected and subjected to a meta-analysis which draws out the overall evidence for efficacy.[39] Apart from the inherent problems in psychiatry, such as using rating scales which give the illusion of objectivity but rely on observations by the clinicians or the subjects, the relatively limited effects of psychiatric medication and the difficulties in generalising results to the clinical situation, the ideal subjects for such a trial are homogenous.[40] The RCT promotes the idea of the 'standard' patient and ignores difference.

Evidence-based medicine became, with the establishment of Cochrane, 'a new gospel for government ministers and clinicians'.[41] This is despite the fact that there is considerable evidence that the statistical basis for much of the evidence of the effectiveness of psychiatric medication is profoundly suspect, and that it largely ignores any qualitative research.[42] The establishment of the RCT as central to evidence-based medicine has robustly promoted the hegemony of a single strand medical model of psychiatric disorder as opposed to a more multi-dimensional one.[43] It is immediately obvious that treatment at a therapeutic community is not amenable to the rigours of the RCT approach, not least because the preferred outcome is not always apparent at the outset of entering into the programme. Many practitioners indeed reject the idea of making the outcomes specific at

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[36] David L. Sackett et al., 'Evidence Based Medicine: What It Is and What It Isn't.', *British Medical Journal*, vol. 312, no. 7023 (1996): 72.; Raymond Tallis, *Hippocratic Oaths: Medicine and Its Discontents* (London: Atlantic Books, 2004), 30–34.

[37] I. Chalmers, K. Dickersin, and T. C. Chalmers, 'Getting to Grips with Archie Cochrane's Agenda.', *British Medical Journal,* vol. 305, no. 6857 (1992): 787; R. J. P. M. Scholten, M. Clarke, and J. Hetherington, 'The Cochrane Collaboration', *European Journal of Clinical Nutrition*, vol. 59 (2005): S147–49. Now the title has been shortened to Cochrane. https://uk.cochrane.org/

[38] B. Sibbald and M. Roland, 'Understanding Controlled Trials: Why Are Randomised Controlled Trials Important?', *British Medical Journal,* vol. 316, no. 7126 (1998): 201–201.

[39] Chalmers, Dickersin, and Chalmers, 'Getting to Grips with Archie Cochrane's Agenda.'

[40] Healy, *The Creation of Psychopharmacology*, 284, 350.

[41] Rivett, *From Cradle to Grave*, 382.

[42] David Healy, 'Trussed in Evidence? Ambiguities at the Interface between Clinical Evidence and Clinical Practice', *Transcultural Psychiatry*, vol. 46, no. 1 (2009): 16–37; D. D. R. Williams and Jane Garner, 'The Case against "the Evidence": A Different Perspective on Evidence-Based Medicine', *British Journal of Psychiatry*, vol. 180 (2002): 8–12.

[43] Healy, *The Antidepressant Era*, 103.

the outset of working with people, 'drawing on eclectic, ambiguous and potentially contradictory sources for their diffuse ends'.[44]

Despite these difficulties an international review of TC approaches was carried out and published in 1996.[45] This found that, of 181 studies in 38 countries, only 8 were RCTs 'of any sort' which included clear out-come criteria. Of these, only one was in any way similar to Ingrebourne as a democratic non-secure unit. This was a therapeutic community ward for 'subnormal' men with severe difficulties in relationships.[46] It did find that the approach led to greater acceptance of their fellow patients, and increased friendship formation in a group of young men whose ability to do so previously was severely compromised. However, the comparison group were left in 'the traditional hospital disciplinary regime' and, unsurprisingly, did not change in their behaviour.[47] Even had those in charge of the purse strings taken the time to examine this report, the outcome would have appeared particularly underwhelming considering the costs incurred in providing the service. They clearly took little notice of evidence presented to them by the Health Advisory Service in 1997. This demonstrated considerable longer-term savings through the TC approach at the Henderson Hospital.[48] Efforts to overcome the difficulties in carrying out RCT studies of TCs have been carried out more recently and have demonstrated improvements in problems with aggression and self-harm, as well as greater 'client satisfaction', compared with treatment as usual.[49]

Little research was carried out at the Centre, after Crocket's initial analysis in 1960, to demonstrate its efficacy, or otherwise. The sole exception was an attempt by researchers from the Tavistock Institute of Human Relations to analyse the progress of eleven patients in 1974.[50] This was done by reviewing the nursing and medical notes. They found that, where the person had been involved with the Centre over a long period of time, there were usually substantial improvements. Nevertheless, their conclusions were that, whilst most patients gained from their time at the Centre, there was no 'clear impression of distinctive

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[44] Maurice Punch, 'The Sociology of the Anti-Institution', *The British Journal of Sociology*, vol. 25, no. 3 (1974): 317.

[45] Jan Lees, Nick P Manning, and Barbara Rawlings, *Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders* (York: NHS Centre for Reviews and Dissemination, University of York, 1999).

[46] Agnes Miles, 'The Effects of a Therapeutic Community on the Interpersonal Relationships of a Group of Psychopaths', *British Journal of Criminology*, vol. 9 (1969): 22–38.

[47] Miles, 36.

[48] Health Advisory Service, 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 13. Twenty nine admissions to the Henderson Hospital had prior to admission, cost the NHS £14,000 a year each. The follow-up found this reduces to £1,038 a year. This would have recouped the cost of their stay at the Henderson within three years and considerable savings thereafter. B. M. Dolan et al., 'Cost-Offset Following Specialist Treatment of Severe Personality Disorders', *Psychiatric Bulletin*, vol. 20, no. 07 (1996): 413–17.

[49] Steve Pearce et al., 'Democratic Therapeutic Community Treatment for Personality Disorder: Randomised Controlled Trial', *British Journal of Psychiatry*, vol. 210, no. 02 (2017): 149–56.

[50] Tavistock Institute of Human Relations, 'Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of Treatment Process', 46–67.

improvements in patients reported, which would differentiate the Centre from other dynamically orientated treatment settings'.[51] This was not a resounding endorsement and their recommendations to follow this up with further research were never taken up.

The approach taken by Cochrane is central to clinical guidance given by the National Institute of Clinical Excellence (NICE), later designated the National Institute for Health and Clinical Excellence (still NICE) in 2005. [52] This organisation, since its institution in 1999, was an important element of the 'command and control' model of managing the NHS adopted by the Labour Government, alongside performance indicators.[53] Their charter emphasises their responsibility 'to ensure careful and targeted use of finite resources'.[54] In the 2007 scoping exercise, for their guidelines on borderline personality disorder, they excluded any treatments that were 'not normally available in the NHS', thus putting the Ingrebourne's work out of the reckoning.[55] Later guidance emphasises psychological approaches, but not social.[56]

With increasing attention paid to acts of violence committed by people with mental health problems, issues of 'risk' have come to dominate clinical practice. Sociologist and critic of the 'psy' sciences Nikolas Rose argues that, in parallel with this push towards rapid and measurable forms of treatment, the perceived failures of community psychiatry shifted from the neglect of vulnerable people to the 'supposed threat' posed by the mentally ill.[57] Clinical practice has been placed under the new socio-political demand to survey and control the mentally ill in order to protect the general public, resulting in a technology of risk registers, risk assessments, and risk management.[58]

A significant element of this approach was the introduction of the Care Programme Approach in 1990.[59] This was introduced to reduce the risk of people with severe mental health problems losing contact with services, ensuring that they do not 'slip through the safety-net of care'.[60] It involves a written plan that documents health and social care needs

[51] Tavistock Institute of Human Relations, 66.
[52] National Institute for Health and Clinical Excellence, 'Who We Are', https://www.nice.org.uk/about/who-we-are, accessed 09/09/2018.
[53] Rudolf Klein, 'Britain's National Health Service Revisited', *New England Journal of Medicine*, vol. 350, no. 9 (2004): 939.
[54] National Institute for Health and Clinical Excellence. 'Charter', https://www.nice.org.uk/Media/Default/About/Who-we-are/NICE_Charter.pdf, accessed 09/09/2018.
[55] National Institute for Health and Clinical Excellence, 'Scope', https://www.nice.org.uk/guidance/CG78/documents/personality-disorders-borderline-final-scope2.
[56] National Institute for Health and Clinical Excellence. 'Borderline personality disorder: recognition and management: 1.4 Inpatient services', https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services
[57] Nikolas S. Rose, 'Historical Changes in Mental Health Practice', in *Textbook of Community Psychiatry*, eds. Graham Thornicroft and George Szmukler (Oxford: Oxford University Press, 2001), 23–24.
[58] See also Ramon, 'Neoliberalism and Its Implications for Mental Health in the UK', 122–23.
[59] Department of Health, *Caring for People: The CPA for People with a Mental Illness Referred to Specialist Mental Health Services*, Joint Health/Social Services Circular C(90)23/LASSL(90)11 (London: Department of Health, 1990).
[60] David Kingdon, 'Care Programme Approach', *Psychiatric Bulletin*, vol. 18, no. 02 (1994): 68.

and the allocation of a key worker responsible for co-ordinating the care package. There should be regular reviews that assess the person's 'compliance'.[61] It courted controversy as being a mixture of 'good clinical sense' and 'administrative absurdity', or 'too blunt', too uni-axial and too all inclusive to be helpful'.[62] At the time when the Ingrebourne finally closed in 2005, nationally, nearly 400,000 people had been documented in this way.[63]

These changes have been summarised as tending towards 'a highly bureaucratic and rationalised state of modern mental health services'.[64] Integral to this is an increasing clinical reliance on a somatic understanding of psychiatric disorder, which ignores social aspects, and the adoption of simplistic psychological therapies, or medication, as the solution to these difficulties.[65] This increasing hegemony of a standardised 'medical model' has been sustained by the various iterations of the Diagnostic and Statistical Manual of the American Psychiatric Association, that has been categorising all forms of mental disorder under specific diagnostic labels since 1952.[66]

Part and parcel of this reductionist stance is the increasing scepticism concerning working with unconscious motivations.[67] Coining the phrase 'cosmetic psychopharmacology', psychiatrist Peter Kramer argues that creating new identities through pharmaceutical treatments is replacing the idea of righting past, repressed wrongs.[68] He suggests that Prozac, and its analogues, modifies human behaviour in order to fit in with our present high-tech capitalism.[69]

Perhaps as significant were the cultural changes, most aptly summarised by Thatcher's contention that there was 'no such thing as society'. Strictly speaking, she was correct, it is a social construct. Nonetheless, her underlying beliefs in 'self-reliance' and strident approach to relationships with colleagues that ignored 'mutual tolerance and mutual support' were the antithesis of the interdependence promoted by the TC approach and its associated 'virtues' of trust and compassion.[70]

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[61] Kingdon, 69.
[62] Tom Burns and Judy Leibowitz, 'The Care Programme Approach: Time for Frank Talking', *Psychiatric Bulletin*, vol. 21, no. 7 (1997): 427; L. Jane Knowles and Rex Haigh, 'Care Programme Approach', *Psychiatric Bulletin*, vol. 22, no. 03 (1998): 188.
[63] National Health Service: Information Centre. 'MHMDS 2003-07 data tables: Report 2: Number of inpatients detained in hospital', http://webarchive.nationalarchives.gov.uk/20081112213209/http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin/mhmds-2003-07-data-tables, accessed 09/09/2018.
[64] Double, 'Critical Psychiatry: Challenging the Biomedical Dominance of Psychiatry', 4.
[65] Double, 'The Limits of Psychiatry'.
[66] Ingleby, 'Transcultural Mental Health Care: The Challenge of Positivist Psychiatry', 68–69.
[67] Hayward, *Transformation of the Psyche in British Primary Care, 1880-1970.*, xiv.
[68] Peter D. Kramer, *Listening to Prozac* (New York, N.Y., U.S.A: Penguin Books, 1994), xvi.
[69] Kramer, 297.
[70] D. Hurd, 'Chairing from the Front (Book Review of The Downing Street Years by Margaret Thatcher)', *The Spectator*, 6 November 1993, 46.McSmith, *No Such Thing as Society*, 21–22.

Therapeutic communities were coming under greater scrutiny. In the period 1971 to 1972, hospital management authorities questioned the validity of the therapeutic approach of three London units, with a view to modify their work in such a way as to terminate their functioning in this way.[71] One of these was the Paddington Day Hospital, referred to in Chapter One. The second time that public attention was drawn to it, in 1976, was when a group of patients wrote to the Area Health Authority and the Minister for Health and Social Security complaining about conditions in the unit.[72] The ensuing debate and inquiry provoked further media coverage making it a '*cause celebre*', which continued to be debated by mental health professionals and their critics long afterwards.[73] Helen Spandler argues that the exaggerated criticisms of the unit were part and parcel of the retreat from left-wing politics and the counter-culture, which heralded the rise of Thatcherism.[74] Kennard pointed out that, by the mid-1970s, the 'therapeutic community movement had peaked' and the majority of psychiatrists were able to 'snuggle back into their nineteenth century identities and dismiss the therapeutic community as a fad that had passed'.[75]

ii. Trusts, the 'Internal Market' and Mental Health Services.

As referred to earlier, Warley was the 'parent' psychiatric hospital to the Ingrebourne, although the latter was managed through St George's Hospital until 1974. They both came under the auspices of the North East Metropolitan Hospital Board, which evolved into the North East Thames Regional Health Authority, also in 1974. At this time Community Health Councils were established in each district, ostensibly to 'represent the views of the consumer'.[76] One of their tasks was to visit local services to monitor practice. The Barking, Havering and Brentwood CHC visited Ingrebourne on two occasions, in 1984 and 1997.[77]

Table 5.1 outlines the various administrative structures affecting Warley and Ingrebourne. During the period 1974-1982, there were also District Management Teams in place. These acted as a third tier between the Department of Health and the hospital administration.[78] Locally, there were three: Barking, Havering and Brentwood. The first replaced the old Romford Hospital Management Committee and was responsible for St George's Hospital.[79]

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[71] Brian Haddon, 'Political Implications of Therapeutic Communities', in *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N Manning (London: Routledge & Kegan Paul, 1979), 39.
[72] Baron, *Asylum to Anarchy*, 184.
[73] Spandler, *Asylum to Action*, 98–115.
[74] Spandler, 112.
[75] David Kennard, 'Editorial', *International Journal of Therapeutic Communities*, vol. 7, no. 4 (1986): 208.
[76] Klein, *The New Politics of the NHS*, 69.
[77] Barking, Dagenham and Havering Community Health Council, 'Report No. 59. Visit by Team "B" to the Ingrebourne Centre, St George's Hospital, on Thursday, 6th September 1984', 1984, Essex Records Office.
[78] Klein, *The New Politics of the National Health Service*, 84.
[79] INGCE28, interview, 1.

Table 5.1: NHS administrative configurations relating to Warley and St George's Hospitals 1948-2002

Date	Organisational Level	New configuration
1947-1974	Regional Health Board	North East Metropolitan
1948-1974	Hospital Management Board	Warley Hospital St George's Hospital[80]
1974-1982	Area Health Authority	Barking, Havering and Brentwood[81]
1974-1994	Regional Health Authority	North East Thames
1982- 1993	District Health Authorities	Split - Barking and Havering, Greater London Brentwood in South Essex District
1993-1996	Reduction of DHA numbers	Barking, Dagenham & Havering, Greater London Brentwood in South Essex District
1993-2000	Mental Health Service Provider	BHB Mental Health Trust
2000-2008	Mental Health Service Provider	North East London Mental Health NHS Trust
1996-2002	Health Authority	Barking and Havering, London and South Essex
2000-	Purchasers: Primary Care Groups/Trusts	Barking and Dagenham PCT, Havering PCT, Redbridge PCT, Waltham Forest PCT[82]

Footnotes [83]

The table illustrates the increasing rate of managerial change imposed throughout the latter part of Ingrebourne's life. During the 1990s, the picture was complicated by the introduction of Hospital Trusts, with all the local psychiatric services being incorporated into the BHB (Brentwood, Havering and Barking) Trust in 1993.[84] This then merged into the North East London Mental Health NHS Trust in 2000. One of the effects of psychiatric services

[80] National Archives, The. Hospital Records Database: Warley Hospital Brentwood. http://www.nationalarchives.gov.uk/hospitalrecords/details.asp?id=2413, accessed 09/09/2018.
[81] http://www.nationalarchives.gov.uk/hospitalrecords/details.asp?id=2413; ING28, 2-3.
[82] Pratibha Datta, 'North East London Mental Health Trust Mental Health Needs Assessment: Summary Report. 7th Nov 2004', 2004, Planned Environment Therapy Trust, CCJ Archive.
[83] Most of this is derived from the WIKIDocs site in the absence of other sources. Where specific collateral information is available this is referenced separately. Wikidocs. 'Authorities in North East Thames Region', http://www.wikidoc.org/index.php/List_of_District_Health_Authorities_in_England_and_Wales#Authorities_In_North_East_Thames_Region, accessed 09/09/2018.
[84] INGCE28, interview, 1. The Trust was officially named the BHB Trust.

coming under the same management as general hospitals was that the former were seen as a sort of 'cash cow' from which to milk resources to feed the latter.[85] This resulted in both Warley Hospital and Ingrebourne being deprived of resources, particularly with regards to maintenance. When one manager arrived at the hospital in 1977, he enquired what the successes of one ward sister had been over the previous year:

> She answered "I have just got my toilets all privatised. And I got plaster on my walls. So I don't have just bare brick". And I, and I looked at her with open mouth'.[86]

Ingrebourne came under the same management as Warley in 1982, alongside the development of the general management structure described earlier.[87] Prior to that time, it remained as an isolated psychiatric unit within a general hospital management structure. It was little understood by senior management of St George's, and it was not even maintained to the same standard as the rest of the hospital. It was 'a shack' in one visitor's opinion.[88] One of the Centre's nursing officers, attending management meetings with staff from the rest of the hospital, found:

> Some of them pretended we weren't there… That's for sure. And some of them tried to just deal with the admin stuff, you know. Like staffing levels, and budgets and that sort of stuff. And others, I think my memory is one or two were distinctly unhappy about having mad people on the premises, really.[89]

The staff at Warley Hospital, on the other hand, argued that they

> were doing the hard work, dealing with the cutting edge of things, you know, the coal face, the acute episodes, the psychosis, all the sort that was difficult to deal with… Whereas we were being selective, we were taking who we wanted in. If you showed any signs of psychosis, you weren't going to be coming into the Ingrebourne Centre.[90]

As a result, Ingrebourne was left well alone, with little managerial oversight. Once it joined the rest of the mental health services, it continued in isolation. As a senior Trust manager explained, 'the closure of Warley Hospital completely dwarfed anything to do with the Ingrebourne Centre'.[91] The outcome of this was that, despite some attempts to encourage

[85] INGCE31, interview, 5.
[86] INGCE31, 5.
[87] It has not been possible to establish the exact timing. From the 1974 re-organisation. Ingrebourne remained with St George's in the Barking Health District, whilst Warley was under Havering. The date of 1982 fits with the information given in a number of interviews.
[88] INGCE31, interview, 5.
[89] INGCE16, interview, 16.
[90] INGCE17, interview, 17.
[91] INGCE28, interview, 18.

the Ingrebourne to look at how it could adapt its service in the changing financial and policy climate, it experienced very little real interference from outside until the late 1990s.[92]

2. 'If We Were to Fight for Survival'[93]: Decline and Fall.

Having explored some of the extra- and intra-unit dynamics at work it is now possible to look at how they played out over the last quarter century of the unit's existence. Nick Manning argues that British therapeutic communities 'live a precarious existence', being constantly concerned about survival. [94] In this the Ingrebourne Centre was no different to any other similar unit, except that it survived longer than most. In understanding the demise of such a unit, the external factors have been already described in some detail. The unit staff was to come under increasing pressure to justify its existence. Crucial to this negotiation was the role of the leadership. In discussing authority in the therapeutic community, it is well to remember the warning issued by American historian and political commentator James MacGregor Burns that 'leadership is one of the most observed and least understood phenomena on earth'.[95] However, the literature does provide evidence for some basic tasks of this role, which will be outlined before embarking on an examination of how these were approached in practice.

i. Responding to Change: Leadership and Routinisation

Most scholarly attention to leadership concentrates on success rather than failure, with the latter usually being seen as part of a natural process.[96] With regards to TCs, whilst their demise has led to publicly expressed anguish, only Manning has examined the process in detail.[97] An essential element for an organisation's survival is its ability to be flexible and innovate when external expectations are shifting, recognising new opportunities and adapting to embrace them.[98] There is evidence as well that risk aversion stifles efforts to

[92] INGCE31, interview, 10.
[93] Cecilia Clementel-Jones, 'The Community and the Community. The out-Patient Service and Training Function of an Established Therapeutic Community', undated c. 1982, 1, Planned Environment Therapy Trust/Personal.
[94] Manning, 'Collective Disturbance in Institutions: A Sociological View of Crisis and Collapse', 147.
[95] James MacGregor Burns, *Leadership*, (New York: Harper & Row, 1978), 2.
[96] Abraham Carmeli and Zachary Sheaffer, 'How Leadership Characteristics Affect Organizational Decline and Downsizing', *Journal of Business Ethics*, vol. 86, no. 3 (2009): 363; Gilbert Probst and Sebastian Raisch, 'Organizational Crisis: The Logic of Failure', *Academy of Management Executive*, vol. 19, no. 1 (2005): 90.
[97] The two studies of the Paddington Day Hospital are of an exceptional case. Clark, *The Story of a Mental Hospital*, 1996, 234–35; Jeremy Laurence, 'Mental Hospital Closure Is Condemned as Inhumane', *The Independent*, 18th December 2007; Victoria Spurgeon, 'The Closure of a Therapeutic Community in a Forensic Unit', *Nursing Times*, 16th February 2012, https://www.nursingtimes.net/students/the-closure-of-a-therapeutic-community-in-a-forensic-unit/5041621.article, accessed 09/09/2018; Manning, *The Therapeutic Community Movement*.
[98] David J. Teece, Gary Pisano, and Amy Shuen, 'Dynamic Capabilities and Strategic Management', *Strategic Management Journal*, vol. 18, no. 7 (1997): 509.

make the necessary changes to prevent decline.[99] Responding to an increasingly complex environment necessitates greater 'inclusivity, engagement and consultation with more varied stakeholders' than previously'.[100]

Sociologist Maurice Punch describes the sociology of the anti-institution as one in which there is a constant tendency for routinisation to set in.[101] The basis for his reflections was a study of Dartington School. Here, under the auspices of the headmaster Bill Curry, it 'apparently relinquished the safety and comfort of traditional authority' from 1931 to 1957.[102] Believing that children, in the right circumstances, would behave rationally and responsibly, he instituted a participatory democracy. However, when the lack of institutional restraints led to crises, it was he who 'exercised his considerable charisma' to regain control. Difficulties arose on the retirement of such a leader, who left the school 'on the verge of disintegration'.[103] In response to his 'laxity', his successors began to institute more authoritarian measures, such as abolishing mixed bathing, invoking the hostility of the pupils and splitting the staff group.

Manning has also found similar pressures exhibited towards routinisation in his study of TCs, stemming from the increasing necessity to conform to the demands of external authority.[104] He argues that the initial enthusiasm for TCs was almost revolutionary in aiming to alter the social structure of mental hospitals and to care for those in them in a more humane manner.[105] The approach subsequently evolved into a treatment approach in its own right, with the attendant requirements of psychotherapeutic training, research and accreditation, all aiming for standardisation.[106] Increasingly, the complexity of human relationships was ignored in favour of consistent therapeutic approaches and measurable outcomes.

Because of their vulnerability in the face of the increasing technology of evidence-based medicine, and value-for-money policies, TCs have moved towards 'becoming respectable' by attempting to demonstrate, 'in the language of the establishment', their effectiveness.[107] This process has increased the value placed on recognised therapeutic techniques, such as group psychotherapy, and relegated the social and interpersonal aspects. They are under increasing pressure to 'deliver the goods' in demonstrating therapeutic value. Many practitioners tend to ignore this pressure, by assuming the effectiveness of the approach and concentrating on improving the model.[108]

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[99] Carmeli and Sheaffer, 'How Leadership Characteristics Affect Organizational Decline and Downsizing', 364.
[100] Kleio Akrivou and Hilary Bradbury-Huang, 'Executive Catalysts: Predicting Sustainable Organizational Performance amid Complex Demands', *The Leadership Quarterly*, vol. 22, no. 5 (2011): 995.
[101] Punch, 'The Sociology of the Anti-Institution'.
[102] Punch, 313.
[103] Punch, 319.
[104] Manning, *The Therapeutic Community Movement*.
[105] Manning, 192.
[106] Manning, 213.
[107] Manning, 194.
[108] Manning, 196.

Concerns about routinisation are endemic to TCs. Maintaining a consistently compassionate and innovatory response to every crisis, such as window smashing, wrist cutting and overdosing, is difficult and stressful, and the tendency is to rely on previous experience: 'we have seen this before and know how to deal with it'.[109] One member of staff 'came to have an allergy to windows being smashed'.[110] A common method to avoid the tension is to rely on the 'leader' to provide the solution.[111] A doctor at Ingrebourne found 'that you are constantly on the telephone, there's constant expectations from them. Huge demands come, "Do this! Do that!", and you get vivid descriptions of all the acting out that's going on'.[112]

ii. 'Incompatibility … with the authoritarian, bureaucratic organisation which the National Health Service has become'?[113]: Working with the Outside

David Clark summarised the problems for any TC as, 'a unit where patients make decisions, where disorder is apparent and from which unacceptable demands may come, perplexes and angers tidy-minded and harassed managers'.[114] All of this is apparent with the Ingrebourne, but fortunately for its survival during the last three decades of the twentieth century, the administration was more pre-occupied with the problems besetting St George's Hospital. Later on, when the management of the Centre was taken over by Barking, Havering and Brentwood Health Authority, the emphasis shifted to the closure of Warley Hospital and its attendant difficulties. Indeed, for many years, the Ingrebourne existed in a management 'bubble', with health service managers not being sure what was happening within it, but content that it caused few problems. For the senior administration at Warley Hospital, it was for some while a 'feather in the cap' for the service, which otherwise had little to distinguish it from other large mental hospitals on the fringes of London.[115] Visitors from the Barking, Dagenham and Havering Community Health Council in 1984 was of the opinion that 'the 20 beds at the Ingrebourne Centre are to be regarded as extremely precious'.[116]

Whilst cuts to the service started in the 1980s with the unit being closed at the weekends, it was only towards the latter half of the 1950s and early 21st century that the accumulated

[109] Manning, 220.
[110] INGCE13, interview, 4.
[111] Manning, *The Therapeutic Community Movement*, 220.
[112] INGCE13, interview, 12.
[113] This quote is typical of how many in the TC movement perceive the demise of the approach in the NHS. It ignores the successes in other sectors, such as drug rehabilitation and prisons. Clark, *The Story of a Mental Hospital*, 235.
[114] Clark, 200.
[115] INGCE28, interview, 7.
[116] Barking, Dagenham and Havering Community Health Council, 'Report No. 59. Visit by Team "B" to the Ingrebourne Centre, St George's Hospital, on Thursday, 6th September 1984', 2.

effects of 'evidence-based medicine' and financial stringency began to take serious effect.[117] As late as 1997, thirty people were attending and twelve beds were available for in-patients, although they were not always being used. [118] A visit in the same year, by the Hospital Advisory Service, reported 'the powerful impression of the benefits that admission to the community can yield'.[119] The report overall, however, was critical, arguing that role confusion and conflict 'has stifled managerial change'. The Ingrebourne's 'rigid policy prohibiting medication' was a barrier to admission. There was scant information about a limited, and geographically restricted, range of psychological therapies. More effort was needed to liaise with other services, giving advice and training. In particular, the report insisted that 'psychotherapy patients become part of the Care Programme Approach'. This ignored the published advice that such an approach was inappropriate for this group of patients, as 'the slightest hint that someone else may be held responsible for their behaviour' could undermine the therapeutic relationship.[120] Overall, they asserted a 'radical rather than incremental change' was required.[121]

In 1992, a psychiatrist and a psychologist, Anna Higgitt and Peter Fonagy, contended that the national trend was away from long-term psychiatric hospital admissions, to favouring brief admissions and crisis management. They asserted that the lack of a significant evidence base to support this suggested that this change was driven primarily by economic, rather than clinical or scientific, considerations.[122] This scrutiny of any form of longer-term therapy led to a sense of dread of closure throughout the therapeutic community movement. At the Cassell Hospital in 2005, psychiatrist Marco Chiesa considered that the increasing trend towards privatisation of NHS provision would divert money from patients to company profits and salaries.[123] He believed the likelihood was that psychotherapy services would be commissioned from private practitioners and clinics, and as a result, less available to patients because of the costs. In 1999, Steve Kisely, an academic in Australia and previously a public health officer in Birmingham, also emphasised the paucity of evidence for TC practice giving little evidence to commissioners for their effectiveness.[124]

In 1995, one beleaguered psychiatrist working in another therapeutic community summed up his observations:

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[117] INGCE23, interview; INGCE28, interview; INGCE31, interview.
[118] Burridge, 'On Joining a Therapeutic Community', 145.
[119] Health Advisory Service, 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 9.
[120] Knowles and Haigh, 'Care Programme Approach'.
[121] Health Advisory Service, 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 1.
[122] Anna Higgitt and Peter Fonagy, 'Psychotherapy in Borderline and Narcissistic Personality Disorder', *British Journal of Psychiatry*, vol. 161, no. 1 (1992): 36.
[123] Marco Chiesa, 'Modernization or Privatization? The Future of the NHS and Implication of Governmental Reforms for Psychotherapy Services', *Psychoanalytic Psychotherapy*, vol. 19, no. 1 (2005): 71–85.
[124] Steve Kisely, 'Psychotherapy for Severe Personality Disorder: Exploring the Limits of Evidence Based Purchasing', *British Medical Journal*, vol. 318, no. 7195 (1999): 1410–12.

> TCs are threatened or closing, providers are separated from and vie for purchasers, trusts are in the ascendant (a state of trust is in limbo), and budget holding weights competitive tendering, referrals and waiting lists. A covert sibling rivalry, if not internecine warfare, prevails between, and often within, healthcare purchasing and providing authorities. This stems from the need to provide profit making clinical services, shed or downgrade others, and garner extra-contractual referrals.[125]

He went on to argue the threat was that, in order to keep the admission rate as high as possible, the quality of care would be compromised by taking in people who presented more problematic behaviours. At the Henderson, these issues became part of the community meeting agenda, with questions being raised about what therapy was worth in hard cash, and the distinction between short and longer term benefits.[126]

As Bridger emphasised, managing the boundaries of a TC requires consideration of the 'interplay of forces' between the service and its context'.[127] The open system entails a new form of 'boundary' leadership that embraces a participatory approach with the team. The increased intervention by external parties requires anticipation through engagement with the relevant purchasers and senior management in cases like the Ingrebourne.[128] It necessitates 'scouting' for information and staying abreast of events inside and outside of the unit, ensuring the staff recognises the factors that are at play and respond appropriately. The staff members themselves need to be empowered to participate in decision-making, becoming colleagues rather than subordinates.[129]

Crocket made little attempt to relate to his colleagues in Warley, or the hospital management. Indeed, he isolated himself from them as much as he could. He expended his energies on the more idealistic, and less successful, enterprise of trying to inform the local community about the unit and psychiatric practice in general. Subsequently, Jeff Roberts established relationships with his consultant colleagues at Warley Hospital, a relationship that Williamson, when threatened with closure, successfully built on.[130] But this engagement with the outside world was limited. Crocket was very active in the Association of Therapeutic Communities. This, however, whilst being a powerful support to members of staff and a valuable information exchange, could exercise little or no influence on policy, or local NHS management. A medical colleague of Roberts tried to suggest that there should be

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[125] David Fainman, 'Quo Vadis in the Therapeutic Community: Leadership and Training for What?', *Therapeutic Communities*, vol. 16, no. 2 (1995): 103.
[126] Fainman, 106.
[127] Bridger, 'Groups in Open and Closed Systems', 59.
[128] Vanessa U. Druskat and Jane V. Wheeler, 'Managing from the Boundary: The Effective Leadership of Self-Managing Work Teams', *Academy of Management Journal*, vol. 46, no. 4 (2003): 446.
[129] Bridger, 'Groups in Open and Closed Systems', 60; Druskat and Wheeler, 'Managing from the Boundary: The Effective Leadership of Self-Managing Work Teams', 447.
[130] INGCE13, interview, 7.

more visitors to the unit, but this was not encouraged and there was little 'exchange with the external world'.[131]

No Centre leader really set about systematically making relationships with, and informing, senior health service managers about the work being done in the unit. Even the nursing managers obliged to attend management meetings made little impact on their senior colleagues. As one nursing officer put it,

> They had to invite me really, because I was part of their nursing hierarchy, really. I tried to do a bit of ambassadorial work, that would be my way anyway, because of my sympathy with psychiatry and people who had emotional problems. I would have been thinking of myself as in that role of trying to help people understand what we were trying to do.
>
> **Q**: And you weren't aware of anybody there [*in St George's Hospital management*], at that time, who had any sympathy towards Ingrebourne?
>
> No. I wasn't really, to be honest.[132]

iii. Internal tensions

The external political and cultural environment of the Centre over this period is well documented, compared to the study of sociological processes taking place in small communities. The main therapeutic community journal reflected this when, in the absence of any other similar work, an issue in 2012 was given over to reprinting articles published between twenty and thirty-two years earlier.[133] Since then, there has been one paper on leadership from a personal perspective and another looking at the value of instability within the organisation.[134] Fine and Harrington, two social scientists, in 2000, also bemoaned the paucity of recent social research into, and theorisation about, small groups.[135]

Manning contends that the internal life of such a unit could provide at least as great a threat, and at times even more so, than the external pressures.[136] Jeff Roberts, whilst working at the Ingrebourne, reviewed the destructive forces at work within such an

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[131] INGCE22, interview, 4,6.
[132] INGCE16, interview, 16.
[133] *Therapeutic Communities: The International Journal of Therapeutic Communities*, 2012, vol. 33, iss. 2/3.
[134] Martin K. Bhurruth, 'Some Impressions on Taking on the Leadership of a Therapeutic Community', *Therapeutic Communities* vol. 36, no. 4 (2015): 219–28; Peter Holmes and Susan Williams, 'Consistency, Continuity and Stability - Organisational Virtues or Not?', *Therapeutic Communities*, vol. 33, no. 4 (2012): 166–74.
[135] B. Harrington and Gary Alan Fine, 'Where the Action Is: Small Groups and Recent Developments in Sociological Theory', *Small Group Research*, vol. 37, no. 1 (2006): 5.
[136] Manning, 'Collective Disturbance in Institutions: A Sociological View of Crisis and Collapse', 149.

environment.[137] He points out that damaging social processes occur in all human societies, often in a concealed manner. In the therapeutic community, these are brought into focus with frightening clarity. He described a number of mechanisms by which these exhibit themselves. Individuals can either behave harmfully towards themselves or others, or remain in the community long after they have any necessity to do so therapeutically. Either of these types of behaviour leads to pressure towards forcible ejection of the individual concerned, or cessation of wider therapeutic activity, while day-to-day disruptions are managed. Covert group processes may also be disruptive. Bion, as related in the previous chapter, described a number of unconscious, basic assumptions held by participants that divert members' attention from the central task of the group.[138] Jeff Roberts found these to be operating almost constantly in the community meeting every morning.[139]

On the other hand, splits may occur in groups, separating one imagined faction from another. Characteristically, this can occur between staff working on different shifts, or commonly there is the wish to protect the 'good' and ideal unit from the 'bad' and destructive depredations of the outside world.[140] The issues concerning charismatic leadership have already been referred to. One perennial split was between staff who were in constant contact with patients and those who had offices to escape to. All the nurses, including the senior nurse, the social therapist and the art therapist, had no private space and were continuously interacting throughout the working day. They were 'the eyes and ears of the staff team in the sense that they would pick up on stuff and bring it back to wider staff team then, in whatever forum'.[141] As one nurse expressed how he spent his day: 'before the groups started I would probably have gone into the kitchen and sat there with the residents and had a cup of tea. You know something normal like that'.[142] Another recalled, 'I would play badminton with the patients at lunchtime in the courtyard, and go for, do the walks'.[143] Other staff members, such as the psychologists and psychiatrists, had commitments outside of the unit, as well as their own offices in which they could isolate themselves from the hubbub of the community as a whole.

Nurses tended to work set shifts, whilst other members of staff worked nine to five. They had to attend to the practical issues, such as 'opening the place up on a Monday morning and locking the place up on a Friday evening. Making sure there was enough bed linen in the laundry room'.[144] They also tended to have less training.

After outlining a number of other processes, Jeff Roberts contends that, with good leadership, it is possible to learn from 'working through' these destructive impulses by open

[137] Roberts, 'Destructive Processes in a Therapeutic Community'.
[138] W. R. Bion, *Experiences in Groups and Other Papers* (Tavistock, 1961), 62–65.
[139] Roberts, 'Destructive Processes in a Therapeutic Community', 162–63.
[140] Hobson, 'The Messianic Community'.
[141] INGCE17, interview, 21.
[142] INGCE17, 8.
[143] INGCE21, interview, 19.
[144] INGCE17, interview, 20.

communication and reflective feedback. An essential element is staff learning to recognise these communal tensions and to understand the effects that they have on themselves and others. He agrees with Manning, that the main threat to therapeutic communities is from internal conflict, rather than the external Health Service management.[145]

Manning, starting with the observation that social disruption in a unit could be seen to reflect pathology in the institution rather than in the individual participants, identified a common sequence of events.[146] Staff and patients would stop talking to each other and there would be a breakdown in communications, accompanied by increased violence and rule-breaking. Absenteeism would increase, messages were forgotten or misinterpreted, decisions made 'on the hoof' and a general sense of imminent disaster would ensue. Eventually, there would be a collective disturbance amongst the patients, with one of them 'acting out' in particular.

Whilst this 'nightmare' scenario never developed at Ingrebourne, some of Manning's observations are pertinent to the situation there. First is the necessity to survive in the external society, relying on resources drawn from the community they are operating in, and requiring maintenance of some degree of approval in order to counter incipient hostility.[147] Thus the participants need to observe the law, and, to a significant degree, the political and moral norms of the culture in which they exist. Thus, when a female patient sun-bathed topless in the Centre's garden, it was likely to, and did, offend other people on St George's.[148] An important element in its survival was the lack of serious incidents bringing the unit to the attention of outsiders in a negative manner. Indeed, a nursing officer for St George's commented on how the unit caused him little or no difficulties when he was on duty at nights.[149] Others also commented on the relative infrequency and minor importance of such incidents.[150] Thus the relationships with the external world of the Ingrebourne were relatively untroubled for a considerable period. So the emphasis lay with those working at the Centre itself to maintain the culture and manage any splits that occurred internally.

Throughout the life of the community, there was always a tension between an individual psycho-analytically orientated model and socio-therapeutic approach that emphasised group interactions. One of the doctors in the early 1970s did not 'see the point' of excursions out for patients and refused to go with them.[151] Even when a number of members of staff were training in group analysis, which emphasised the nature of shared emotions amongst group members, the conflict was evident: 'you had quite a lot of competition between the staff, and who could actually come up with the smartest

[145] Roberts, 'Destructive Processes in a Therapeutic Community', 170.
[146] Manning, 'Collective Disturbance in Institutions: A Sociological View of Crisis and Collapse'.
[147] Manning, 149.
[148] INGCE19, interview, 20.
[149] INGCE33, Telephone Interview, 2015.
[150] ING23, interview, 2; ING28, interview, 14–15.
[151] INGCE29, interview, 64.

interpretation, but that often was built on individual psychotherapy, and analytic, psychoanalytic models as well'.[152]

As described earlier, Crocket's concept of the psychotherapeutic community was to emphasise the relationship of the patient to the community as a whole. Many members of staff found this bewildering, discordant with the increasing requirements to use 'evidence-based medicine' and the necessity to demonstrate the effectiveness of their interventions. The subjective experience of the emotional benefits of sharing painful and intense emotions, and others acknowledging them, had to be validated in some way. It is not clear how many members of staff really grasped Crocket's theoretical stance. It would appear that, during the latter period of the unit's existence, the nurses were more in tune with it than the medical staff. As one, present in the 1990s, explained, it was important to ensure that information was shared with the community:

> Now we were very careful about, about that sort of thing, that we wouldn't want people using X or Y member of staff as a confidante in the evening or whatever, and not bringing that stuff into groups. Or if there ever was discussions about stuff it was always, the understanding that, that either you brought it back to the group yourself, as the resident or, you know, the, the member of staff would eventually have to, to bring it in. And no kind of splitting off, with secrets and stuff like that. The nursing staff were, were the ones who were round all day. So they might be passing through the kitchen, they might be out in the courtyard, you know, playing tennis, or basketball, or whatever. They might be out doing the garden. So they would (*be*) quite visible, and they were also able to see the community and what relationships were taking place within it. What was going on for different people. So they were, I suppose, the eyes and ears of the staff team in the sense that they would pick up on stuff and bring it back to wider staff team then, in whatever forum.[153]

Increasing emphasis by successive senior medical staff on individual psychotherapy therapy worked against this.

Discussions in the 1970s concerned the balance between interpretive small groups and the community meeting. As one member of staff wrote at the time, the 'question as to whether the existence of such small groups conflicts with the community idea is frequently discussed'.[154]

The trend to individual psychotherapy was illustrated by a member of staff, following his experience of the Ingrebourne in the early 1980s. After stating 'I've become very unfavourable to groups, I have to say', he described his concerns: 'a lot of group interpretations seem to make, sometimes make a lot out of very little and kind of the

[152] INGCE15, interview, 4.
[153] INGCE17, interview, 21.
[154] Carroll, 'The Ingrebourne as a Going Concern', 3.

threads that they pull out are often a bit tenuous … I don't know that they were necessarily the most therapeutic things'.[155]

A senior doctor in the early 1980s was explicit that he 'was more keen to interpret a little bit more individually', as a consequence of the psychoanalytic training that he was undergoing.[156] This was in contrast to his predecessor who 'was much keener than me in interpreting on community lines, on group therapy lines'.[157]

The shift from socio- to psycho-therapy was a reflection of wider processes occurring within the TC movement, with the small group therapy 'becoming the symbolic heart of the modern therapeutic community', replacing the community meeting in this role.[158] A Centre social worker in 1992 was part of a team that in another day hospital was using 'solution-focussed therapy' as they were 'interested in pursuing the idea that complex problems do not always need complicated solutions'.[159] In 1994, a 'Brief Description of Psycho-dynamic Therapies' available at the Ingrebourne began with describing individual therapies, working through group and family treatments ending with the therapeutic community.[160] This indicated the reversal of priorities that had occurred since Crocket established his approach.

The period during which Jeff Roberts was the senior doctor has already been remarked upon as one in which other members of staff felt able to assert their opinions and skills. His 'laid back' style was not always to the taste of everybody. One doctor contrasted the Ingrebourne with his previous experience at Fulbourn working with David Clark, who, in his view, was talented at keeping the boundaries without being persecutory. At Ingrebourne, he found the leadership denied the need for boundaries at all.[161] Certainly by 1999, a staff member was led to believe that this period was 'a mess when everything was going a bit mad'.[162]

The appointment of Margaret Williamson brought to a head the rivalry between a sociological view of disorders in relationships and a more medico-psychological perspective.[163] She was a highly intelligent doctor, well trained in psychoanalytical psychotherapy, who was seen as a 'good' psychiatrist, but who had no experience in therapeutic community work.[164] Whilst she preferred individual psychotherapeutic work, the main programme of the community continued, and she participated in much of its social

[155] INGCE14, interview, 4.
[156] INGCE22, interview, 29.
[157] INGCE22, 29.
[158] Manning, *The Therapeutic Community Movement*, 69.
[159] Ron Wilgosh, David Hawkes, and Ian Marsh, 'Focussing on Solutions', *Nursing Times*, vol. 88, no. 31 (1992): 47.
[160] Conneely, 'Brief History and Groups in Action at the Ingrebourne Centre', unpublished paper.
[161] INGCE22, interview, 9.
[162] INGCE32, interview by John Hopton, Transcription, 1999, Personal copy.
[163] This researcher was unable to interview Dr Williamson, and thus unable to get her perspective on this period. It is hoped that her viewpoint is respected throughout this thesis.
[164] INGCE22, interview, 5.

life and was 'good fun' in these situations.[165] She was welcomed by some as being a necessary counterpoint to the previous 'liberalness' of Jeff Roberts. As one colleague stated, 'I must admit that Margaret was right on one thing, that when she came she found the place without boundaries, so to speak'.[166] Another commented on her 'good common sense' in comparison to his being a 'bit this and that'.[167]

As one member of the staff observed, for this new consultant arriving at the unit there was a sense that the community was a 'cauldron continuously waiting to erupt', with the result that a new inexperienced doctor would become very anxious and keen to remain in control.[168] This would have been compounded by the increasingly risk-averse environment that the Centre was operating in as described earlier. Another argued that 'when she came she found that everybody was doing whatever he liked. So she had a rough ride'[169] As a nurse commented, 'it's like when someone else comes in. It takes a while and you're a bit resentful of them'.[170]

Both her predecessors had relied on their junior medical staff, and senior nursing managers, to run the unit on a day-to-day basis, and to a large extent field the difficult choices. She, on the other hand, was more decisive and did not like to let problems persist and tended to resolve them in a more authoritarian manner.[171] Many staff felt that the family-like atmosphere changed to a more formal one.[172] She would have been acutely aware of the pressures building up on units like the Ingrebourne and the necessity to maintain a risk-free profile, whilst emphasising the unit's effectiveness. Her perspective was not shared by the rest of her staff and there were points of conflict. The atmosphere changed, the 'relationships were extremely good, up to the point that Xxxx (*the new consultant*) came and then some splitting started appearing'.[173] Eventually, things came to a head on one occasion, when the senior nurse was allocated to other work whilst complaints against her were investigated. The nurse was eventually exonerated and the dispute was clearly over the different approaches to therapy within the unit.[174] Some influential members of staff left soon after Williamson was appointed, contributing to a sense of turbulence, which would not have helped her settle in.

One member of staff felt he was being criticised for

[165] INGCE15, 2nd Interview, 1; INGCE30, interview, 18.
[166] INGCE22, interview, 11.
[167] INGCE30, interview, 7.
[168] INGCE15, 2nd Interview, 1.
[169] INGCE22, interview, 11.
[170] INGCE19, interview, 10.
[171] INGCE19, 10.
[172] INGCE22, interview, 5.
[173] INGCE22, 24. Whilst it is easy to identify who Xxxx was, the intention is to emphasise relationships rather than personalities.
[174] INGCE21, interview, 3.

being a bit too lacking in boundaries, but I don't think I was… Because the play that was created was pretty edgy. I mean it was about prostitution. That was one of the things that struck me. The girl who, I don't know, I think she kind of brought her… she actually had been a prostitute. She had sold herself. She couldn't talk about it. But she played this character. And I thought "Well there is... Why isn't she talking about it? Maybe she just, sometimes you can't, sometimes it is just too horrible. But if you can pretend to be someone else, something creative with it and, you know, the rest of the community's reaction to this play and her part". Yeh, that was really brilliant. They said to her "You played that brilliantly. That's wonderful". So she'd exposed a dark side of herself and turned it into a jewel. For me that's, that's what therapy's about. If you can detoxify the dark nasty stuff that's inside someone then their life's going to be a bit easier.[175]

Figure 5.1: Group Sculpture 1

[175] INGCE19, interview, 37.

Figure 5.2: Group Sculpture 2

(Footnote[176])

On another occasion a group built a sculpture (Figures 5.2 and 5.3), which entailed the group members going all over the unit collecting bits of material during the session and he remembers 'one or two staff thinking "Now you're running riot there"'[177].

The conflict was summarised accordingly:

> I think you know that the simplest way I can kind of think about it is one side was very much boundaries, very strict, and the other side was also boundaries and strict, but seemed in my mind to be more, more humanistic in terms of working with people, if they couldn't adhere to a strict boundary.[178]

A later member of staff, in contrast, found that 'there was great freedom' and 'you could try something out' and he was supported in this by nurse in charge of the unit.[179] So, creativity had not been completely stifled.

Despite these difficulties, the tensions were largely contained within the Centre and it was only on one occasion that senior management had to intervene.[180] It is also clear that, whilst boundaries were maintained in a less flexible manner than previously and psycho-analytically-orientated therapy predominated, the socio-therapeutic approach did not wither away. The implications of a television crew making a documentary of the unit were

[176] These two pictures are courtesy of John Gretton.
[177] INGCE19, 35.
[178] INGCE17, interview, 24–25.
[179] INGCE17, 18.
[180] To investigate the nursing officer as referred to earlier.

explored through a psycho-drama session in which people took various roles in making a documentary film. As Williamson made clear in her commentary,

> there has been a lot of talking about the filming and how it effects people, how it makes them feel. So that it's quite often helpful to be able to really set this up, and re-enact it and then work through some of the feelings.[181]

iv. 'Watching the House Being Destroyed':[182] The Final Days

The Ingrebourne became routinised and spontaneity decreased. This was associated with the intransigence remarked upon by senior management when trying to confront the staff with the effects of their long assessment process and lack of referrals and admissions.[183] It was clear that this stance in particular was maintained by the consultant, whereas other staff might have been more flexible privately, but not in public. Amongst the issues that were under debate was the issue of medication. In 1999, a member of staff considered that rather than instituting a blanket ban on its use, which prevented some individuals being admitted, it might be possible to work more flexibly with this group, but found that his suggestion was rejected. This was despite the fact that the Health Advisory Service had recommended it in 1997.[184] Similarly, there were absolute restrictions on violence and sexual relationships as a result of which 'far too many people' were discharged without discussion.[185]

Trahms et al. argue that the leadership of a declining organisation needs to be aware of its causes and severity.[186] This requires a change of attitude and increased flexibility in relation to both the internal and external factors, in order to take firm action to salvage the situation. Their options include either, retrenchment and reducing the service offered, or looking for new markets and seeking new resources. As noted above, in 1997, it was reported that outside the Centre there was a lack of knowledge about its work, and the consultant had 'minimal' links with psychiatric colleagues at Warley.[187] Attempts were made to rectify this, significantly when the senior doctor was on sick leave, by staff visiting referrers, and seeking their views about what was expected from the unit.[188] One senior

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[181] Metcalfe and Morrison, *A Change of Mind: A Narrow Line 2 & 3 Rushes and Psychodrama Group*.
[182] Cecilia Clementel-Jones, 'Comments on Havering's Financial Recovery Plan and Its Effect on Psychological Therapies', 2005, 2, Planned Environment Therapy Trust.
[183] INGCE31, interview, 11.
[184] Health Advisory Service, 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 19.
[185] INGCE32, interview, 3.
[186] Cheryl A. Trahms, Hermann Achidi Ndofor, and David G. Sirmon, 'Organizational Decline and Turnaround: A Review and Agenda for Future Research', *Journal of Management*, vol. 39, no. 5 (2013): 1288.
[187] National Health Service Health Advisory Service, 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 8, 29.
[188] INGCE32, interview, 2.

nurse made explicit attempts to explain the service to the local Health Authority in the mid-1990s. In their opinion there was a lot of money and resources going into a group of patients who were not the health authority's main concern. They were very concerned then about having emptied out the asylums and community, putting them into the community, and looking after them. And our patients were considered to be sort of like 'worried well' and depressed and housewives who took Valium.[189]

The nurse then related some of the patients' stories to explain the severity of their problems, with the result that 'we dropped off the top of the agenda' and avoided closure.[190] But despite arguments, cuts continued to be made. These efforts continued when the Community Health Council representatives visited in 1995 with the result that they concluded that 'the achievements and success of the service provided at the Ingrebourne Centre should be more widely publicised'.[191] They also noted the need for adequate staffing levels and the poor state of repair of much of the furniture.

However, the 'standard' treatment model was rigidly stuck to, despite the dwindling resources and admissions. The length of stay in the service in 1997 had reduced from three or four years to twelve months, and those admitted had to sign a contract.[192] If this was breached, they were sanctioned with warnings, suspension or dismissal.

As a senior manager from the BHB Trust attempted to explain to the Centre staff:

> And, I said 'I can't keep on doing this. You know, we've got to get some sort of agreement that if you can't fill thirty odd places in your unit, then we have to start thinking about what is the number that is a viable number and see whether we can start making a model around that'. Well! That was an anathema to them, you know, they saw the writing on the wall. And they were very, very opposed to anything like that.[193]

In 1997, the NHS Health Advisory Service reported that the staff had developed 'something of a siege mentality'.[194] Their isolation was heightened by the 'rather radical nature of the service', echoing Punch's observations on Dartington School, where internal 'ends had become paramount' and outsiders were considered with hostility.[195] The Report offered significant advice about how to resolve the difficulties facing the unit, but this was

[189] INGCE21, interview, 10.
[190] INGCE21, 11.
[191] Barking, Dagenhan and Havering Community Health Council, 'Report No. 412 - Visit to Ingrebourne Centre, Hornchurch by Community Care Services Working Group on July 10th 1995 at 2.00 p.m.', 1995, 3, London Metropolitan Archive, B04/044.
[192] National Health Service Health Advisory Service, 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 8.
[193] INGCE31, interview, 11.
[194] National Health Service Health Advisory Service, 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 7.
[195] Punch, 'The Sociology of the Anti-Institution', 321.

determinedly ignored. This resolute unwillingness to change has been identified as a major contribution to commercial decline. Two researchers investigating the deterioration of businesses found, in their study of 250 different firms, that risk-aversion and inflexibility were significantly associated with failure.[196]

Despite this, the consultant achieved, through rather different methods, a considerable stay in execution. She took her concerns to her medical colleagues at Warley Hospital, who were now under the same management, the BHB NHS Trust. Here, she successfully gained their support in resisting closure. As a senior manager explained, in spite of pushing for a more community based service to replace the appalling conditions at Warley Hospital, his arguments 'fell on stony ground'.[197] The doctors saw the way to maintain their professional status was through the number of beds under their control. It was this attitude that encouraged them to support their associate at Ingrebourne and to protect her. As one manager saw it:

> She had a certain degree of clout. Because the consultant psychiatrists would band round her and protect her. Because that's the way the consultants worked here. You weren't allowed ever to criticise a consultant. You criticise one and the rest of them would get round.[198]

The Division of Psychiatry, their representative body, had 20 to 30 consultant members and exercised considerable power over the management with their obstructive approach. This made tackling the issues concerning the Centre very difficult, particularly when the closure of Warley Hospital itself remained a priority. This attitude undoubtedly led to them being excluded from the planning of new psychological services. [199] Contemporaneously, a leader in the *British Medical Journal* was critical of medical staff attempting to 'browbeat' management and who were uncompromising in their approach, suggesting that many used their influence to 'obstruct progress and subvert change'.[200]

Further cuts to services at the Ingrebourne began to take hold towards the end of the 1990s, with in-patient services ceasing altogether and then day services reducing to half a day during the week by 1999.[201] In 1995, the Barking, Dagenham and Havering Community Health Council made a visit to the unit and found that funding for one and a half social workers had been withdrawn, the medical staff had reduced to one consultant psychotherapist and, in order to maintain a senior psychologist post, a senior nurse post had

[196] Carmeli and Sheaffer, 'How Leadership Characteristics Affect Organizational Decline and Downsizing', 371.
[197] INGCE31, interview, 13.
[198] INGCE31, 16.
[199] Peter Byrne and Jill Chaloner, 2003, CCJ archive, Planned Environment Therapy Trust.
[200] Tom Treasure, 'Redefining Leadership in Health Care. Leadership Is Not the Same as Browbeating', *British Medical Journal*, vol. 3223 no. 7324 (2001): 1263–64.
[201] INGCE32, interview, 2.

to be sacrificed.[202] There were still in-patient beds being used during the week. Other services began to take over rooms within the building, and Centre staff began to be 'farmed out', using their expertise to run groups in the main hospital at Warley.[203]

Increasingly, economic arguments were employed, stating that the unit was too expensive to run. However, as a senior staff member explained,

> But I think what was difficult was the time span people were there for. Though when you worked it out, and I did this exercise at some point. I can't remember the reason I did it, but I just did a basic maths exercise. Right, divide the number of people here, and the number of hours behind, and the number of staff. Actually this actually isn't as uneconomical as people are saying. It's actually quite economical.[204]

The issue with such services as TCs is that their outcomes are difficult to define and the 'package' of care that they provide is made up of many elements. In a climate in which simple, 'cost effective' and short-term solutions are being sought, such as Cognitive Behaviour Therapy which satisfies these criteria, clarifying the economics of the TC approach is complex and needs to be considered over the longer term. The impression was that 'a lot of money and resources were going into a group of patients who it was not the health authority's main concern'.[205] The testimony of users who in 1997 gave 'a powerful impression of the benefits that admission' had no weight in the balance compared to the 'gold standard' of the Randomised Controlled Trial.[206] This was despite the fact that they had experienced 'long-term conditions of a highly disabling nature, for whom nothing else had worked'.[207]

By 2005, the unit had finally closed, although the actual termination of the Therapeutic Community was earlier.[208] It has been difficult to determine the specific date although Clementel-Jones, who had been working at the Centre, reported in 2005 that there had been an attempt to close the unit in 'two weeks flat' in 2003.[209] Following this, the work was purely out-patient psychoanalytic psychotherapy, both individual and in groups.[210] The TC was not resurrected. Some effort had been made to spread the skills developed at the

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[202] Barking, Dagenham and Havering Community Health Council, 'Report No. 412 - Visit to Ingrebourne Centre, Hornchurch by Community Care Services Working Group on July 10th 1995 at 2.00 p.M.', 2.
[203] INGCE18, interview, 25; INGCE30, interview, 25.
[204] INGCE19, interview, 40.
[205] INGCE21, interview, 10.
[206] National Health Service Health Advisory Service, 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 9.
[207] National Health Service Health Advisory Service, 9.
[208] INGCE30, interview, 9.
[209] Clementel-Jones, 'Comments on Havering's Financial Recovery Plan and Its Effect on Psychological Therapies'.
[210] Cecilia Clementel-Jones, 'Letter Concerning Trust's Consultation Document 15th October 2003', 3 December 2003, Planned Environment Therapy Trust.

Ingrebourne. In November 2003, staff were running patient groups on wards in the main hospital and holding teaching sessions for the nursing staff there.[211]

Throughout the life of the Ingrebourne, the group of people worked with had included those categorised as having a personality disorder.[212] They had histories of 'habitual self-harm, repeated suicide attempts, extreme social isolation, frequent hospital admissions, and highly unsuccessful relationships with other services'.[213] In 2003, a draft document was produced, for the BHB Trust proposing an alternative arrangement of the North East London Mental Health Trust-wide Personality Disorder Service.[214] This drew together the conclusions of a number of local working parties that had been exploring the issue over the previous five years. This made explicit the necessity to look at 'rates of mortality as well as financial savings'.[215] Whilst the therapeutic community model was 'looked into', the conclusion was to provide services based on 'evidence-based-approaches'. These included Dialectical Behaviour Therapy (DBT), which was described as a variant of cognitive behaviour therapy, 'with an emphasis on gaining control of behavioural and emotional dysregulation'.[216] This lynch-pin was to be supported by other therapies of a more psychotherapeutic nature. All centred on the traditional therapist-patient dyad, where the expert imparts skills and knowledge to the person who does 'not have important interpersonal, self-regulation and distress tolerance skills'.[217] The financial argument was supported by a prediction that the new service would reduce the use of in-patient beds by half, and the rates of self-harm by over three quarters in the first year of treatment of any individual.[218]

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[211] Cecilia Clementel-Jones, 'To Jill Chaloner Re Psychotherapy Services 25/11/2003', 2003, Planned Environment Therapy Trust.

[212] By 1997, the description of those attending was 'those with severe personality disorder' and those with 'less severe psychological difficulties' who were thought suitable for an 'analytical approach'. Sixty percent had 'suffered physical and/or sexual abuse'. National Health Service Health Advisory Service, 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 8.

[213] National Health Service Health Advisory Service, 9.

[214] North East London Mental Health NHS Trust, 'Proposal for the Development of a Personality Disorder Service 22/9/2003' (NELMHT, 2003), PETT.

[215] North East London Mental Health NHS Trust, 1.

[216] North East London Mental Health NHS Trust, 2. Dialectical Behavioural Therapy was developed by an American psychologist Marsha Linehan in order to treat chronically suicidal patients and extended to treat people with difficulties in managing intense and painful emotional states. Marsha Linehan, 'Commentary on Innovations in Dialectical Behavioural Therapy', *Cognitive and Behavioural Practice*, vol. 7 (2000): 478.

[217] Klaus Lieb et al., 'Borderline Personality Disorder', *The Lancet*, vol. 364 (2004): 461.

[218] North East London Mental Health NHS Trust, 'Proposal for the Development of a Personality Disorder Service 22/9/2003', 2.

3. 'A Fight for Survival'[219]

A member of staff commented on his experience in the 1990s, 'we were less able to contain people. So it became an inevitable slippery slope, after that. We would gradually be able to offer less of a service than we would like to'. He elaborated, stating that they 'were a bit choosy, and a bit kind of over-analysing', 'but further up the food chain, the people holding the purse strings, I think the reality was that they saw us as being a waste of money'.[220] Whilst all the spontaneity had not been entirely stifled, this was maintained largely by the nursing staff and the art therapist, and centred on interactions with those attending the service. The boundaries that had become increasingly ossified related to those between the service and the external world. The isolation, lack of communication, belligerent defensiveness and apparent expense of the service resulted in decisions over its future being taken out of the hands of those running it. This is evidenced by a complaint made by the consultant who was distressed to read that 'details of the plan have been leaked' to her, referring to a document that outlined proposals for the service that she was running.[221] At the same time, the patients were not to be told about the closure plans and yet they were to be discharged back to the 'referrers' within five weeks.[222] Other psychiatrists were also concerned about their lack of involvement with the planning and argued that 'Not a single consultant supports the plan as it stands'.[223]

The Ingrebourne finally closed in 2005. The therapeutic community aspect had finished two years earlier. It was possible to visit the site in 2015 and all the buildings remained derelict and due for demolition. Few of the staff that worked there remained with the local Trust and a number of the contributors to this research have moved overseas.

The Ingrebourne's demise fits closely with the pattern outlined by Manning and other commentators on decline in institutions. The staff were isolated from the changes going on round them and remained largely inflexible in their approach. Central to this was the paradoxical effect of leadership. Whilst initially the support of the medical staff at Warley assisted the Ingrebourne to stay open, the obstructionist tactics of the profession led them to be excluded from the planning of future services.

Whether or not it would have been possible to negotiate a way for the therapeutic community aspect of the service to continue is questionable. The nature of the approach is that it does not fit with standardised treatment methods and modern health policy. The

[219] Taken from Clementel Jones discussing the role of the Ingrebourne Centre. Clementel-Jones, 'The Community and the Community. The out-Patient Service and Training Function of an Established Therapeutic Community', 1.
[220] INGCE17, interview, 15–16.
[221] Clementel-Jones, 'Comments on Havering's Financial Recovery Plan and Its Effect on Psychological Therapies'.
[222] Clementel-Jones.
[223] Byrne and Chaloner, 2003.

outcomes, whilst demonstrably beneficial in a significant number of cases, are not always predictable in detail. The preferred therapeutic attitude in the present health system is to target symptoms rather than taking a holistic approach to the person and their social network. As the consultation document for psychological services in Havering outlined, the 'intervention, goals and number of sessions … usually 8', would be agreed and documented before undertaking treatment.[224] Alex Mold contends that choice now drives health policy 'to an unprecedented extent' in England.[225] As Marianna Fotaki comments, trust is being replaced by 'consumer choice', which relies on the person being sufficiently informed to execute.[226] The shift to a market economy leads to an over-reliance on the patient being able to calculate the cost-benefit relationship of a particular intervention, at the 'expense of embodied, relational and social attributes'.[227] For people who have difficulties in making and sustaining relationships, and whose manner of interacting appears to be the only choice they have, part of the task is to assist them in broadening the options available to them. This requires a compassionate understanding of their difficulties, and trust in secure boundaries, so that their 'imaginary space' can expand. After reviewing the evidence that compassion improves health care outcomes, Fotaki argues that the imposition of 'impersonal surveillance systems' and cost-saving measures, imposed by managers who are distanced from the reality of day-to-day care, militates against its expression by staff.[228]

The final chapter enlarges on the issues of compassion and its role in mental health services.

[224] Caroline Mathisson, 'Reflections: A Consultation Document 27th May 2003', 2003, 8, CCJ Archive, Planned Environment Therapy Trust/Personal.
[225] Mold, *Making the Patient-Consumer*, 169.
[226] Fotaki, 'Can Consumer Choice Replace Trust in the National Health Service in England?', 1276.
[227] Fotaki, 1276.
[228] Marianna Fotaki, 'Why and How Is Compassion Necessary to Provide Good Quality Healthcare?', *International Journal of Health Policy and Management*, vol. 4, no. 4 (2015): 201.

Chapter 6.

A Transitional Therapeutic Community: Caring, Compassion and Containment in Psychiatric Care

> I wonder if you've guessed who I am talking about. She is a completely changed personality and I sincerely mean it when I say I think she gives herself constantly into helping others: So Xxxx, I can only say thanks for walking in that morning.[1]

1. 'Empathy and Rapport of a Therapeutic Kind'?[2]

Historian Ludmilla Jordanova contends that the most common methodology in writing history is to examine a particular instance in all its complexities, and then to construct a perspective that makes sense of the evidence.[3] The Ingrebourne was part of a movement that intended to reform the care of people enduring the rigours of mental disturbances in the latter half of the twentieth century in Britain. It endured for most of that period and thus reflected many of the issues that affected other concurrent endeavours of a similar nature. In unfolding this particular history, one issue increasingly took centre stage. This was the problematic nature of compassion in the care of people identified as having mental disorders. Implicit in this discussion is the dependence of human identity on relationships.

Commentators such as Andrew Scull would dismiss the evidence from the narratives given by members of staff, managers and people who had been in treatment, which reverberate with passion about the work of the Ingrebourne Centre. His argument would be that, as in the case of the York Retreat through the early nineteenth century, these motives obscure the underlying intention to '*transform* the lunatic, to remodel him into something approximating the bourgeois ideal of the rational individual'.[4] Foucauldian commentators are similarly sceptical. Professor of rhetoric and ex-social worker Leslie Margolin identifies kindness as camouflage to disguise the 'imposition of surveillance and control' in social

[1] This comes from a patient in the Ingrebourne magazine and reports her experience of how a new member of staff changed their attitude whilst in the unit. Chamberlain, 'Strange Character'.
[2] Crocket, 'The Therapeutic Community Approach in a Neurosis Centre. Presentation given at Runwell Hospital, 21st Nov 1959. With Additional Notes by Dr Hamish Anderson', 4.
[3] L. J. Jordanova, *History in Practice*, 2nd ed. (London: Hodder Arnold, 2006), 67.
[4] Andrew Scull, 'Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry', *Psychological Medicine*, vol. 9 (1979): 425.

work.[5] Examining an institution, such as the Ingrebourne, it is possible to identify aspects that fit this perspective, but to solely focus on this is to neglect the 'intelligent kindness' of those involved.[6] Crocket early on argued that the supportive nature of the therapy involved the 'provision of 'good' relationships…, so that the patient's experience of what may be described as 'loving', 'tolerating', or 'accepting' behaviour, as against 'hostile', 'aggressive', 'destructive' or 'hating' behaviour, is increased'. [7] He also stated that 'empathy and rapport of a therapeutic kind' was essential.

Compassion is problematic.[8] It is made up of constituent attitudes, including altruism, kindness, trust and empathy.[9] Whilst in etymological terms they are distinct, in practice they are inextricable.[10] They are facets of the same process. They take us to the 'heart of relationships' incurring the ability to identify another's state of mind and adjust one's response accordingly to their benefit.[11]

Compassion is both an obligation to others born of an understanding of our connectedness, and the natural expression of our attitudes and feelings arising from this connectedness.[12] In

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[5] Leslie Margolin, *Under the Cover of Kindness: The Invention of Social Work*, Knowledge, Disciplinarity and Beyond (Charlottesville: University Press of Virginia, 1997), 8.

[6] This is the title of a recent book by a psychiatrist involved in a therapeutic community and her colleague. John Ballatt and Penelope Campling, *Intelligent Kindness: Reforming the Culture of Healthcare* (London : [S.l.]: RCPsych Publications ; Distributed in North America by Publishers Storage and Shipping Co., 2011).

[7] R. W. Crocket, 'The Therapeutic Community Approach in a Neurosis Centre, 4.

[8] In researching the history and application of the term one faces the plethora of other words that are associated and substituted, such as charity, beneficence, benevolence, humaneness etc. Then there are the issues of motivation. For instance, in discussing altruism the psychoanalysts Seelig and Rosof identify five different types, including conflicted, generative, psychotic, pathological and proto-altruism. Beth Seelig and Lisa Rosof, 'Altruism', in *Good Feelings: Psychoanalytic Reflections on Positive Emotions and Attitudes*, ed. Salman Akhtar (London: Karnac Books, 2009), 63–91. Many psychoanalysts see altruism as a form of pathological masochism. Seelig, p. 68. In this thesis, it is the process of empathic kindness that is seen as central to maintaining creative and beneficial human relationships. The term itself is open to a multitude of interpretations, though the definition given here corresponds with that given by Goetz et al., who state that it is 'the feeling that arises in witnessing another's suffering and that motivates a subsequent desire to help. Jennifer L. Goetz, Dacher Keltner, and Emiliana Simon-Thomas, 'Compassion: An Evolutionary Analysis and Empirical Review.', *Psychological Bulletin*, vol. 136, no. 3 (2010): 351–74, 351.

[9] Ballatt and Campling, *Intelligent Kindness*, 4–6. Goetz et al. concur that there is a family of compassion related states that centre on concern for ameliorating the suffering of others. Goetz, Keltner, and Simon-Thomas, 'Compassion', 352.

[10] There is also the complication that even their meanings are contested. As the two philosophers, Amy Coplan and Peter Goldie, point out, there is little consensus over what counts as empathy, whilst altruism is seen as a 'twofold, overlapped, and confused concept' by the philosopher Raquel Weiss and the political philosopher Paulo Peres. Amy Coplan and Peter Goldie, eds., *Empathy: Philosophical and Psychological Perspectives*, Oxford: Oxford University Press, 2014), xxiii; Raquel Weiss and Paulo Peres, 'Beyond the Altruism-Egoism Dichotomy: A New Typology to Capture Morality as a Complex Phenomenon', in *The Palgrave Book of Altruism, Morality, and Social Solidarity. Formulating a Field of Study*, ed. Vincent Jeffries (Basingstoke: Palgrave Macmillan, 2014), 73.

[11] Ballatt and Campling, *Intelligent Kindness*, 9–10. All these complementary terms (kindness, empathy, altruism) are open to a wide range of interpretations and definitions. See C. Daniel Batson, *Altruism in Humans* (Oxford ; New York: Oxford University Press, 2011), 11–32 for a detailed discussion of the various interpretations of the words empathy and altruism. Here, is it is proposed to keep to this simple statement.

[12] Ballatt and Campling, *Intelligent Kindness*, 9.

a TC, it is distinguished from such emotions as pity, sympathy and consolation which promote passivity.[13] Psychotherapy entails the employment of empathy and compassion whilst maintaining a degree of emotional distance from the experience of the patient.[14] This practice is not easy. As John Ballatt, a sometime manager in the National Health Service, and Penny Campling, a psychiatrist, state; kindness 'implies … a *practice* that can be challenging, risky that requires *skill*' and is, 'deep down, frightening and hazardous'.[15]

Opening up a dialogue between those designated as patients and those taking the role of therapists is a problematic process, particularly where the former articulate their emotional life in physically and culturally unacceptable ways. Interwoven in this interaction are the complex power relationships at play, both in the external expectations placed upon the staff and their own wishes to benefit those they are working with. Alongside this is the task for the team in managing their own inherent social and psychological attitudes whilst under stress themselves. There is always the impulse to punish transgressive behaviour rather than making the attempt to understand and empathise.[16] Taking responsibility for an enterprise that runs counter to society's expectations is a challenging task, requiring management of both the interactions within the institution, as well as adapting to the exigencies of external agencies.

The following draws together some of these arguments through a discussion of compassion and containment, a partial history of its expression in British mental hospitals over the past two centuries and reflections on how the Ingrebourne and other TCs differed from previous attempts, and how they fared in maintaining the endeavour.

2. 'The Vigil and the Gift': Care, Compassion and Containment [17]

Bridger, in describing his work at Northfield, summed up the approach as one in which 'the individual can only experience full freedom and satisfaction in a society that recognises his worth, and gives him the opportunity to develop in a spirit of warm human relationships'.[18] His colleague, Main, added that the staff implementing this needed to be sincere, tolerant

[13] Miriam Brill and Nurit Nahmani, 'The Presence of Compassion in Therapy', *Clinical Social Work Journal*, vol 45, no. 1 (2017): 11. The distinction between sympathy and empathy is a disputed one. Here the former is considered as being the passive understanding of another's experience whilst the latter is to enter into that person's perceptions.

[14] Brill and Nahmani, 14.

[15] Ballatt and Campling, *Intelligent Kindness*, 11, 14.

[16] This tendency was reported two centuries earlier by the French reformer, Phillipe Pinel, who described the 'extreme harshness, blows and barbaric treatment' meted out by staff who see only 'cunning and well thought-out provocation' in their patients' disturbances. Philippe Pinel, *Medico-Philosophical Treatise on Mental Alienation* (Oxford, UK; Hoboken, NJ: Wiley-Blackwell, 2008), 98.

[17] Taken from the title of a paper by Nick Fox. Nick Fox, 'Postmodern Perspectives on Care: The Vigil and the Gift', *Critical Social Policy*, vol. 15 (1995): 107–25.

[18] H. Bridger, 'The Northfield Experiment', *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 76.

and ready to listen.[19] Their role had to shift from 'owning' the patients to participating as technicians able to discuss issues, avoiding an *ex cathedra* status from which to pontificate. To achieve this enabling role, the staff member has to tackle his or her own emotional needs, rather than responding to them when provoked. Congruently, Ballatt and Campling describe kindness as

> a condition in which people recognise their nature, know and feel that this is essentially one with that of their kin, understand and feel their interdependence, feel responsibility for their successors and express all this in attitudes and actions towards each other.[20]

In delving further into the history and practice of such emotions, different terms have currency. Kindness is a word that is rarely used, whilst compassion, altruism and empathy are more commonly employed.[21] The historian of psychiatric institutions, Leonard Smith, found that the 'rhetoric of kindness and humanity' was difficult to maintain in the custodial and spartan conditions of early nineteenth-century lunatic asylums.[22] Its use continues to be troubled. 'It is difficult to talk about kindness, an ordinary quality caught up in the technological claptrap', writes Tim Dartington from the Tavistock Clinic in the foreword to *Intelligent Kindness* (2011).[23] The book's authors go on to present it as a term in need of rescue.[24] In the eyes of the psychoanalyst Adam Phillips and the feminist historian Barbara Taylor many people see it as a 'virtue of losers' in our present capitalist society.[25] Under Thatcherism, it 'was downgraded into a minority motivation suitable only for parents (especially mothers), "care professionals" and assorted sandal-wearing do-gooders'.[26] Historian Tony Judt, along with many economists, argues that conventional economic reasoning bases its conclusions on the so-called 'rational man', who pursues his ends

[19] T. F. Main, 'The Hospital as a Therapeutic Institution', *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 66–70.
[20] Ballatt and Campling, *Intelligent Kindness*, 9.
[21] Discussion with one informant led to the issue of love, and the fact that this is even less acceptable in therapeutic discussion. INGCE15 email 21/07/2018.
[22] L. D. Smith, *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England* (London; New York: Leicester University Press, 1999), 191.
[23] Tim Dartington, 'Foreword', in *Intelligent Kindness*, by John Ballatt and Penelope Campling (London: RCPsych Publications, 2011), iv.
[24] Ballatt and Campling, *Intelligent Kindness*, 9–17.
[25] Adam Phillips and Barbara Taylor, *On Kindness* (London: Hamish Hamilton Ltd : [distributor] Penguin Books Ltd, 2009), 7. The identical issues hold in other areas of human interaction such as education, where it can suggest a 'sentimental and unrigorous approach' or 'indicate fanciful new-ageism'. Stephen Rowland, 'Kindness', *London Review of Education*, vol. 7, no. 3 (2009): 207.
[26] Phillips and Taylor, *On Kindness*, 104.

without reference to such things as altruism or self-denial.[27] Even in psychotherapy literature, the role of compassion is unclear and appears to have been side-lined.[28]

The experiments at Northfield and Mill Hill stemmed from a requirement to return soldiers back to functional military service. Whilst this never included re-engaging in the battlefield, it did require conforming to the exigencies of army life, usually in a supportive role, such as a medical orderly. For Bion, the task was to produce 'self-respecting men socially adjusted to the community and therefore willing to accept its responsibilities whether in peace or war'.[29] This appears to confirm those post-modern critics who characterise TCs as using techniques to 'drive home the stringent rules that are supposed to govern normal existence'.[30] Sociologist Nikolas Rose rejects humanitarian motives as mere window dressing for regimes that 'sought to manage the individual from a pathology conceived of as a social maladjustment to a normality construed in terms of functional efficiency'.[31] He elaborates; arguing that, far from being a threat to the 'psy' professions, TCs merely offer another way of re-socialising people who are otherwise outside the psychiatric remit.[32] By accentuating the independence of the 'normal', autonomous individual who is seen to have the 'freedom' to make personal choices, these disciplines, both consciously and unconsciously, engage in the subjectification of those they are working with, in the interests of governability in a liberal democracy.[33] Individual subjectivity enables the state to collect classifiable intelligence from which responses can be calculated.[34] The reification of human experience creates a 'describable individuality … a means of control and a method of domination'.[35] This critique clearly has resonance, particularly with the increasing industrialisation and regulation of the performance of health care.[36]

In offering a less sceptical view on the practice in TCs, two aspects need further consideration. First is to challenge the monocular view that is presented by this latter perspective and suggest other factors are in operation. The second is to suggest that

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[27] Tony Judt, *Ill Fares the Land - a Treatise on Our Present Discontents* (Harmondsworth: Penguin, 2011), 35–36; Bronk, *The Romantic Economist*; Joe Earle, Cahal Moran, and Zach Ward-Perkins, *The Econocracy: The Perils of Leaving Economics to the Experts*, Manchester Capitalism (Manchester: Manchester University Press, 2017).

[28] Brill and Nahmani, 'The Presence of Compassion in Therapy'.

[29] Bion and Rickman, 1943

[30] Françoise Castel, Robert Castel, and Anne Lovell, *The Psychiatric Society*, European Perspectives (New York: Columbia University Press, 1982), 194. The Synanon Movement founded by someone previously addicted to alcohol, Charles Dederich, in 1963 was based around a hierarchical structure and featured a regime considered by many as being 'too harsh to be socially acceptable in a modern context'. Pearce and Haigh, *The Theory and Practice of Democratic Therapeutic Community Therapy*, 26.

[31] Rose, 'Psychiatry: The Discipline of Mental Health', 73.

[32] Rose, 77.

[33] Nikolas S Rose, *Inventing Our Selves : Psychology, Power, and Personhood* (Cambridge, England; New York: Cambridge University Press, 1998), 10–17.

[34] Rose, 102–3. The parallels with this argument and the concept of '*homo economicus*' referred to in the previous chapter are evident.

[35] M Foucault, *Discipline and Punish: The Birth of the Prison* (Harmondsworth: Penguin, 1991), 191.

[36] Ballatt and Campling, *Intelligent Kindness*, 125–26.

enabling people to function better in relationships is asserting their interdependence rather than their individuality.

The difficulty with a dogmatic post-modernist perspective is the pursuit of one argument to the exclusion of all others.[37] The sociologist Nick Fox recognises that care is a discipline that entails a technology of surveillance in the service of power and control, but he argues that, alongside of this, millions of carers 'invest their efforts with love and generosity of spirit'.[38] Professionalism entails monitoring progress, recording and evaluation and moves the locus of power away from the recipient, a process which he identifies as the *Vigil*. Nonetheless, whilst acknowledging these Foucauldian insights, he points out that this is only a partial view and that 'care-as-gift' is another aspect. Drawing on the feminist writer Hélène Cixous' work on the *Propre* and the *Gift*, he illustrates the first approach by such closed controlling phrases as 'do this for me… I want you to be like this', whereas the latter is marked by enabling statements, such as 'what can I give you to help you achieve…'.[39] He goes on to argue that the second approach is disturbing because it threatens to upset the balance of power in the professional relationship.[40]

Foucault himself argues that, in resisting subjectivication, a 'practice of the self' is fundamental. He states that this implies 'an exercise of the self on the self by which one attempts to develop and transform oneself'.[41] Elaborating on classical Greek sources, he states that the aim of freedom from domination by power relationships within human relationships, including families, is to acknowledge a number of 'rules of acceptable conduct or of principles that are both truths and prescriptions'.[42] He goes on to make it clear that this ethos of freedom is also a way of caring for others. Perhaps Andrew Roberts' and his friends, setting up a house committee to challenge the hospital hierarchy over the light bulbs, demonstrates how the therapeutic community approach presents a challenge to 'subjectivication'. This is not to say that this was a continuous or even frequent process at Ingrebourne, but to argue that it provided an environment which could enable Foucault's prescription.

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[37] For instance as Jerome Wakefield, in reviewing Leslie Margolin's book on social work, *Under the Cover of Kindness*, states that the latter author 'seems to assume that people are capable of only one motive'. Jerome C. Wakefield, 'Foucauldian Fallacies: An Essay Review of Leslie Margolin's Under the Cover of *Kindness*', *Social Service Review*, vol. 72, no. 4, 555.

[38] Fox, 'Postmodern Perspectives on Care: The Vigil and the Gift', 110.

[39] Fox, 117. In Hélène Cixous' brilliant, almost poetic, voyage into femininity and masculinity, she argues that for *propre* giving there is always a return, whilst the *gift* is open-handed benevolence without self-interest. She identifies these as being socially gendered masculine and feminine performances that can be present in either sex. Hélène Cixous and Catherine Clément, *The Newly Born Woman* (Manchester: Manchester University Press, 1987), 86–87.

[40] Fox, 'Postmodern Perspectives on Care: The Vigil and the Gift', 118.

[41] Michel Foucault, 'The Ethics of the Concern for Self as a Practice of Freedom', in *Michel Foucault: Ethiics. Essential Works of Foucault 1954-1984.*, ed. Paul Rabinow, vol. 1 (Harmondsworth: Penguin, 1997), 282.

[42] Foucault, 285.

If one acknowledges that peoples' persona are significantly created through interaction with others, or as philosopher Judith Butler states 'there is no wishing away of our fundamental sociality', then working through group therapy has the potential of moving away from the emphasis on the individual to the importance of mutuality.[43] In discussing group psychology, Freud alludes to the philosopher Schopenhauer's analogy of the freezing porcupines when describing the ambivalence of human relationships.[44] Like the porcupines, people need to gain warmth from each other, but the spines make too much closeness unbearable. The incipient hostility in chimpanzee societies is mitigated by grooming and the evolutionary psychologist, Robin Dunbar, maintains that aggression in human groups is curtailed by similar affectionate verbal bonding.[45] Anthropologists R. Boyd and P.J. Richerson give evidence to support the contention that social evolution favours empathic altruism, particularly in small groups.[46] Humans require the skills of living together in order to survive contact with each other over and above any concessions made to broader societal demands, such as governability. Working through group therapy rather than in the more usual dyadic doctor-patient relationship enhances the opportunities of developing these abilities. The activities of the Friday cooking group at Ingrebourne emphasised the caring for others and the sociable and enjoyable aspects of the process. The film referred to in Chapter Four contains a sequence in which a man was making a cake to share, albeit inexpertly, and the story of the potatoes in which the person eventually shared them with the others are illustrations of activities that were less about governability than social ability.

However, the surveillance aspects were also in evidence. Largely imposed by external requirements, patients were examined, identified as to their suitability for the service, documented and 'unacceptable' behaviour was called to account. The incident of the whisky bottle in the community meeting illustrates how cultural boundaries were indicated and reinforced. The ultimate sanction was to be evicted and this was more rigorously enforced towards the latter years with little discussion. Similarly, the external surveillance of how the unit was operating increased. Its resistance to change eventually led to its closure in favour of more 'measurable' options such as limited sessions of cognitive behaviour therapy. The previous chapter has described something of how *aeger economicus* has come to dominate policy and even medical thinking.[47]

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[43] Judith Butler, *Giving an Account of Oneself*, (New York: Fordham University Press, 2005), 33.
[44] S. Freud, 'Group Psychology and the Analysis of the Ego', in *Sigmund Freud: Vol 12, Civilization, Society and Religion* (Harmondsworth: Penguin, 1991), 130–31.
[45] R. I. M. Dunbar, *Grooming, Gossip and the Evolution of Language* (London: Faber and Faber, 2004).
[46] R. Boyd and P. J. Richerson, 'Culture and the Evolution of the Human Social Instincts', in *Roots of Human Sociality*, eds. N.J. Enfield and Stephen C. Levinson (Oxford, New York: Berg, 2006), 453–77.
[47] The Latin word *aeger* can either means sick(adj.) or a sick person (n).

3. 'Great Tranquillity Was Everywhere Prevalent': Care, Compassion and Control in the History of British Mental Hospitals[48]

In exploring the historical issues of compassion, it is appropriate to take into account Barbara Rosenwein's proviso that, as a mediaeval historian, she has cause to worry about emotions.[49] People in the past experienced and expressed a range of feelings and 'these emotions had multiple meanings then (as they do today); they had their effects on others and were manipulated in turn (as ours do and are)'. There is a great temptation for TC practitioners to ignore the latter part of Rosenwein's pronouncement and lay claim to simplified accounts of the past. Clark, describing his work at Fulbourn, asserts that 'work very similar to ours was being done by Pinel, Tuke, Conolly'.[50] This is symptomatic of a tendency amongst TC apologists to allege that 'moral treatment' was a forerunner of their own work.[51] One American psychologist goes as far as claiming that the therapeutic community was the 'rebirth' of an environment in which patients were never punished and treated in a kindly, responsive and upright manner.[52]

Similarly, an argument for recurrence of earlier practices is put forward by the archivist of the Bethlem and Maudsley Hospitals, Patricia Alldridge, who posits the idea that the practice of psychiatry has 'been going round in circles for the past 750 years'.[53] She illustrates her case by reference to the fluctuations in the size of hospitals provided for the care of the insane. In her view, there are 'very few, if any, ideas on the public and institutional care of the mentally disordered which have not been round at least once before'.[54] This contention is only sustainable if the perspective taken is at the broadest level. Any comparisons between the management of those identified with severe mental disorders in different centuries can find similarities in the attempts to distance them from 'normal' society, and the nature of institution provided for them has been more or less carceral. In a similar manner, the repeated attempts to provide a more humanistic, compassionate approach to care in the mental hospital can be seen at a gross level to be cyclical. A more discriminatory perspective recognises significant distinctions and innovations.

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[48] Report of the Commissioners of Lunacy of Scotland, 1875, quoted in H.B. Wilbur, *A Report Relating to the Management of the Insane in Great Britain* (Albany: Weed, Parsons and Company, 1876), 21.
[49] Barbara H. Rosenwein, 'Worrying about Emotions in History', *The American Historical Review*, vol. 107, no. 3 (2002): 821.
[50] Clark, *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*, 119.
[51] Wilson Firth, 'Acute Psychiatric Wards: An Overview', in *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*, eds. Penelope Campling, Steffan Davies, and Graeme Farquharson (London: Gaskell, 2008), 177.
[52] Robert Sprafkin, 'The Rebirth of Moral Treatment', *Professional Psychology*, vol. 8, no. 2 (1977): 161–69.
[53] Patricia Alldridge, 'Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane', *British Journal of Psychiatry*, vol. 134 (1979): 321–34.
[54] Alldridge, 321.

Tracing the history of compassion in the history of treatment of those people identified as insane is problematic. Meaning evolves, as is illustrated in historian Thomas Dixon's tracing of the usage of the term altruism in Victorian Britain.[55] Even today, the meanings of empathy and sympathy are debated.[56] Whilst in the nineteenth century, in the United Kingdom, kindness was seen as part and parcel of 'moral treatment', this practice was open to a number of interpretations. The alienist, Henry Monro, queried whether insanity could be avoided by the 'wholesome use' of moral discipline (self-restraint), or whether it was a bodily disease.[57] The crusader for 'non-restraint', Dr John Conolly, on the other hand, was a passionate advocate for the tranquillising effect of kindness. His book, *The Treatment of the Insane Without Mechanical Restraints* (1856), is littered with phrases such as 'to remedy with kindness… so that the patients may be tranquillised', 'the patient was controlled by kindness' and 'a good asylum, where the only restraint was kindness'.[58] It is this latter appeal to the emotions that twentieth-century psychiatrists have taken to heart when reforming the asylums. Dr Thomas Rees, the reforming medical superintendent of Warlingham Park Hospital, reiterated the call to go 'back to moral treatment' in his presidential speech to the Royal Medico-Psychological Association in 1957.[59] He recounted idyllic descriptions of spacious buildings, surrounded by glorious grounds and gardens, where there was no compulsion and there were ladies playing the harp, or piano, in flowery dresses.

Histories of the TC movement in particular tend to identify the work of the Tuke family at the York Retreat as a progenitor.[60] This was an institution founded in 1796 by the Quaker William Tuke in response to the deplorable conditions in the asylum in the city.[61] It provided care for thirty inmates suffering from mental disorder in an environment that aimed to provide a 'surrogate home and family in which to resocialize the patient'.[62] Essential elements of the practice there were 'judicious kindness', encouragement of 'self-restraint' and 'mild treatment'.[63] However, the less commonly depicted elements of the therapy

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[55] Thomas Dixon, *The Invention of Altruism: Making Moral Meanings in Victorian Britain*, A British Academy Postdoctoral Fellowship Monograph (Oxford; New York: Published for the British Academy by Oxford University Press, 2008).
[56] Heather D. Battaly, 'Is Empathy a Virtue?', in *Empathy: Philosophical and Psychological Perspectives*, eds. Amy Coplan and Peter Goldie (Oxford: Oxford University Press, 2011), 277, 284.
[57] Henry Monro, *Remarks on Insanity Its Nature and Treatment* (London: John Churchill, 1851), iii.
[58] John Conolly, *Treatment of the Insane without Mechanical Restraints* (London: Smith, Elder and Co., 1856), 57, 120, 159.
[59] T. P. Rees, 'Back to Moral Treatment and Community Care', *The British Journal of Psychiatry*, vol. 103, no. 431 (1957): 303–313.
[60] David Kennard and Jeff Roberts, *An Introduction to Therapeutic Communities* (London; Boston: Routledge & Kegan Paul, 1983) 16-17. Manning, *The Therapeutic Community Movement*, 3; Pearce and Haigh, *The Theory and Practice of Democratic Therapeutic Community Therapy*, 19.
[61] Samuel Tuke, *Description of the Retreat; an Institution near York for Insane Persons of the Society of Friends*, eds. Richard Hunter and Ida Macalpine (London: Dawsons of Pall Mall, 1964), 22–23.
[62] Anne Digby, *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914*, Cambridge History of Medicine (Cambridge ; New York: Cambridge University Press, 1985), 34.
[63] Tuke, *Description of the Retreat; an Institution near York for Insane Persons of the Society of Friends*, 131–62.

included coercion, albeit 'only as a protecting and salutary restraint'.[64] This included a strong linen restraint to confine the patient to the bed, forced feeding and the use of the 'eye'.[65] This latter was the ability of the physician to catch the patient's eye and through will power to subjugate that individual's rebelliousness.[66]

Another of those quoted by Clark was Phillippe Pinel at the Bicêtre Hospital in Paris, who purportedly released those in his care from their chains in 1793, and later abolished them at the Salpêtrière in 1795.[67] His view was that treating people with mental illness with 'kindness, firmness and address, can throw but little light upon the moral management of insanity'. Despite removing the chains, he still had patients 'bound and closely confined', used 'intimidation without severity' and 'oppression without violence'.[68] As the sociologists Michael Bloor, Neil McKegancy and Dick Fonkert remark, the claim that therapeutic communities began with the social experiments of Pinel and Tuke 'is a bit of a fiction'.[69] This is not to underestimate the fact that these individuals recognised the humanity of those that they were working with, in a manner that was uncommon in contemporary practice. As Pinel expressed it, those affected by mental illness required their reason restored, rather than punishment.[70]. The superintendent 'must fathom the causes of any turbulent events which may arise', and the staff should react in a measured and appropriate manner rather than responding brutally. However, this did not prevent recourse to strait-jackets and other forms of restraint where deemed necessary.

Kindness continued to be promoted by psychiatrists throughout the nineteenth century. However, in the case of Dr James Cowles Prichard, it took a back seat to medications and the value of separating the afflicted person from their family. Furthermore, he argued that the physician should not inspire fear or dread in the patient, but leave that to attendants so that he be seen as 'protector of his patients, and the dispenser of kindnesses and indulgences'.[71] This dichotomy between the attitudes of those writing about kindness in treatment and those individuals who actually were purportedly dispensing it was present

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[64] John Haslam, *Observations on Insanity* (London: F. & C. Rivington, 1798), 126, https://ia600302.us.archive.org/12/items/observationsonin00hasl/observationsonin00hasl.pdf, accessed 03/08/2018.
[65] Tuke, *Description of the Retreat; an Institution near York for Insane Persons of the Society of Friends*, 163–76.
[66] Roy Porter, *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency* (London: Penguin Books, 1990), 209–11.
[67] Shorter, *A History of Psychiatry*, 11. Although, as Edward Shorter states, it was actually the hospital manager Jean-Baptiste Pussin who actually effected the removal in the Bicêtre. Rapoport also views PInel as a fore-runner, albeit in a more superficial way. Rapoport, *Community as Doctor: New Perspectives on a Therapeutic Community*, 1960, 15.
[68] Phillippe Pinel, *A Treatise on Insanity: In Which Are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders*, trans. D. D. Davis (Sheffield: W. Todd, 1806), 60, 68, https://archive.org/details/atreatiseoninsa00pinegoog.
[69] Michael Bloor, Neil P. McKeganey, and Dick Fonkert, *One Foot in Eden: A Sociological Study of the Range of Therapeutic Community Practice* (London: Routledge, 1988), 18.
[70] Pinel, *Medico-Philosophical Treatise on Mental Alienation*, 78.
[71] James Cowles Prichard, *A Treatise on Insanity and Other Disorders Affecting the Mind*, Reprint 2018 (Philadelphia: Haswell, Barrington and Haswell, 1837), 217.

throughout the nineteenth and twentieth centuries though rarely so explicitly stated. Dr Alfred Maddock, writing a few years later in 1854, advised that the treatment of 'all mental ailments was partly medical and partly moral'.[72] The latter included 'kind and friendly council' and 'gentle and conciliatory surveillance' in the cases that he described, but these were two brief observations in a treatise which largely dealt with the physical causes of mental disorder.[73]

Keepers, as the attendants were often called, remained a 'hidden dimension' of care in the asylums.[74] Ideally, the 'physician must be able to command the services of a staff of kind and conscientious attendants'.[75] How often this was achieved is questionable. There was little or no training for staff who had no previous experience in work that was unattractive to the general public and the rapid expansion of the asylums during the nineteenth century meant that there was always a shortage of suitable individuals.[76] Many were people who had previously been inmates, a practice that was questionable even at the time.[77] Pinel actively advocated such recruitment ostensibly because they were likely to be disposed to be kindly and humane having experienced the effects of cruelty, but also because they were 'habituated into obedience, and easy to be drilled'.[78] The likelihood in practice was that they were conveniently available at a time of shortage.[79]

Despite the increases in the size of asylums towards the end of the nineteenth century, the greater number of people incarcerated and the 'fashionable' vying between asylums as to 'which shall cost the less', some practitioners attempted to promote compassionate practices.[80] The Medical Superintendent of Winson Green Asylum in Birmingham, E.B. Whitcombe, was forced to defend his practice of letting between 200 and 400 patients 'walk beyond the Asylum grounds', arguing that the hospital was not a prison.[81] An American visitor in 1875, investigating the state of mental hospitals in Great Britain, Dr H. B. Wilbur,

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[72] Alfred Beaumont Maddock, *Practical Observations on Mental and Nervous Disorders* (London: Simpkin, Marshall and Co., 1854), 99.
[73] Maddock, 73,99.
[74] This is the chapter heading in Anne Digby's book on the York Asylum that refers to the attendants. Digby, *Madness, Morality, and Medicine,* 140-170.
[75] Conolly, *Treatment of the Insane without Mechanical Restraints*, 94.
[76] L. D. Smith, 'Behind Closed Doors; Lunatic Asylum Keepers 1800-1860', *Social History of Medicine*, vol. 1, no. 3 (1988): 305, 309.
[77] Smith, 308-309.
[78] Pinel, *A Treatise on Insanity: In Which Are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders*, 91.
[79] Smith, 'Behind Closed Doors; Lunatic Asylum Keepers 1800-1860', 308.
[80] E. B. Whitcombe, 'Winson Green. Superintendent's Report for the Year 1888', in *Report of the Committee of Visitors of the Lunatic Asylums for the Borough of Birmingham 1888* (Birmingham: Birmingham Town Hall, 1889), 23. Between 1855 and 1890 the numbers of people incarcerated rose from 30,993 to 86,067. Scull, *Museums of Madness*, 224.
[81] E. B. Whitcombe, 'Winson Green. Superintendent's Report for the Year 1883', in *Report of the Committee of Visitors of the Lunatic Asylums for the Borough of Birmingham 1883* (Birmingham: Birmingham Town Hall, 1884), 18.

commented on the 'kind-hearted' superintendent of a Scottish Asylum who had arranged for nearly all the doors of the hospital to be unlocked.[82]

Clearly these reports can be viewed with suspicion, because they come from doctors who had an investment in promoting their work in a society that was increasingly concerned with behaving altruistically, but they do appear to represent the attempts of people who aimed to ameliorate the conditions of their charges against the mainstream.[83] Chapter Two gave instances of compassion exhibited by staff in British hospitals during the second half of the twentieth century. These also occurred against the grain of institutional care. In the novel *Brother Lunatic*, Paul Warr gives an example, based on his own experience. He found a charge nurse, whose bullying and hectoring manner served to intimidate patients on his ward, sympathetically reading a post-card to one old man who was almost inarticulate. On recognising the meanness of the daughter who had sent it for his birthday, he paid, out of his own pocket, to 'get the old bastard some cakes for his tea'.[84] This example illustrates the paradox that lies at the heart of traditional mental hospital care. Control has to be established by whatever means possible, but once effected humanity could be expressed.

4. Care and Compassion in the Therapeutic Community

Set against these examples, a case can be made that the creation of the TC was an innovative technology in psychiatric care.[85] It had its antecedents in similar work with children and adolescents at the beginning of the twentieth century.[86] August Aichhorn, in Vienna in 1918, recognised the 'lack of love' in a group of aggressive adolescent boys and after some months of disturbed behaviour managed in a compassionate way they began to form positive emotional relationships to each other and the staff.[87] In Britain, Homer Lane had also 'discovered the need for affection' in emotionally deprived children, and through love, 'the highest form of compulsion', worked with a number of them in the 'Little Commonwealth'.[88] This was an institution run along democratic lines - each participant was a 'citizen' with voting rights - for young people who had been excluded from other schools because of their delinquent behaviour.[89] Throughout the twentieth century, a number of

[82] Wilbur, *A Report Relating to the Management of the Insane in Great Britain*, 24.
[83] Dixon, *The Invention of Altruism*.
[84] Paul Warr, *Brother Lunatic* (London: Neville Spearman, 1957), 36.
[85] N. P. Manning, 'What Happened to the Therapeutic Community', in *The Year Book of Social Policy in Britain 1975*, eds. Kathleen Jones and Sally Baldwin (London: Routledge & Kegan Paul, 1976), 141.
[86] David Kennard, 'The Therapeutic Community', in *Group Therapy in Britain*, eds. Mark Aveline and Windy Dryden (Milton Keynes: Open University Press, 1988), 153.
[87] Aichhorn, *Wayward Youth*, 170–78.
[88] Quoted in Wills, *Homer Lane: A Biography*, 137.
[89] Wills, 129–55.

pioneers embarked on similar work with 'delinquent' or otherwise disturbed children.[90] Amongst these were A.S. Neill whose work at Summerhill achieved international fame, where he believed that 'love means approving of children'.[91] It was an institution where he was 'no authority to be feared', but their equal. This did not mean that his responsibilities were avoided but authority, stemming from his abilities rather than his position, was executed as necessary. These institutions appear to have only had an indirect influence on the development of adult TCs. There is evidence that there was some awareness of them at Northfield, but they are not referenced by any of those working there.[92]

In establishing and sustaining such a counter-cultural enterprise and preserving such a nebulous attitude as compassion requires leadership. Chapter 3 looked at this role in the light of managing the ongoing concern and raised issues about charisma and democratisation. On the other hand, Chapter 4 considered leadership in a time of crisis and in particular the necessity to manage relationships outside of the Centre. The TC approach is entirely dependent on all participants to promote and carry it out, and this has been emphasised repeatedly through the employment of the term 'democratisation'. The importance of how this is co-ordinated is a neglected issue in the TC literature. Manning criticises Jones and Rapoport for failing to deal with leadership's 'special effect', asserting that the issue of charismatic leadership has hidden behind TC ideology 'for longer than it ought'.[93] It cannot be considered in isolation from the social environment, and how it is exercised is dependent on the co-worker group. The styles of the three successive consultants at Ingrebourne reflected the culture of the period they were working in to a remarkable degree. Crocket's permissiveness, associated with his wish to innovate, echoes that of his colleagues at Fulbourn and elsewhere. Jeff Roberts' enabling style had more than a passing resemblance to 'hippy' communalist attitudes, and Williamson's more authoritarian stance was a faint echo of Prime Minister Thatcher. Anthropologist Neil Armstrong asserts that the influence of external factors on medical practice is subtle, but he finds that it seems 'to resonate with widely discussed social and cultural processes'.[94] An attempt has been made in this study to outline some of these. It has to be remembered that they were appointed by committees that were seeking particular attitudes that suited the

[90] Maurice Bridgeland, *Pioneer Work with Maladjusted Children: A Study of the Development of Therapeutic Education* (London: Staples Press, 1971).
[91] A. S. Neill, *Summerhill* (London: Victor Gollancz, 1962), 8.
[92] Denis Carroll, Foulkes' commanding officer, and Bion were both involved in the Institute for the Scientific Treatment of Delinquency at the Tavistock Clinic. Harrison, *Bion, Rickman, Foulkes, and the Northfield Experiments*, 2000, 70. The former had oversight of the Hawkspur Experiments run by David Wills. W. D. Wills, *The Hawkspur Experiment* (George Allen and Unwin, 1941), 189–90. This was a milieu where 'juvenile delinquents' worked in a very similar manner to the Little Commonwealth. Wills, *The Hawkspur Experiment*. See also Craig Fees, http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=967:craig-fees-1997-2001-comment-denis-carroll-and-the-second-northfield-experiment&catid=266&Itemid=407, accessed 02/08/2018.
[93] This was in 1976, and the issue remains largely concealed to the present. Manning, 'What Happened to the Therapeutic Community', 146–47.
[94] Neil Armstrong, 'What Leads to Innovation in Mental Healthcare? Reflections on Clinical Expertise in a Bureaucratic Age', *BJPsych Bulletin*, 2 May 2018, 2.

purposes of the different organisations they represented. The Royal College of Psychiatrists had the remit to approve the standards of clinical ability, whilst the health service managers had policy and economic issues to consider. These leaders also did not operate in a vacuum. The ability of different members of staff to influence Crocket has been illustrated, whilst the sense that some sort of control was needed by staff remained a continuing theme and contributed to Williamson's ability to adopt this approach.

The fact that the internal culture of the Ingrebourne was sustained for nearly half a century largely relied on the nursing and therapy staff, as well as the patients themselves. Medical staff was largely naïve, at least initially, and it was their co-participants who in different ways maintained compassion, the centrality of the community meeting and the programme of therapeutic meetings, such as art therapy, psychodrama, activities and psychotherapeutic groups. Whilst emphasising the importance of balancing the internal issues of 'membership needs and individual purposes with and the objectives of the group', Bridger also drew attention to the importance of considering the wider picture and 'the world or society in which our team exists'. [95] Manning asserts that the participants' strong positive transference to the community can result in indifference to the outside world.[96] At the Henderson Hospital, as a consequence, relations with other organisations were 'poor and painful', especially with the health service environment. This pattern of relationships almost exactly fits the Ingrebourne, as described in Chapter Five, and, alongside inflexibility, would appear to have been a significant contributory factor in its demise.

5. Compassion, care and 'customers'

The question arises whether compassion can be sustained in modern psychiatric care, or as geographer Jeff Popke asks, how can people maintain high standards of 'ethics and responsibility in a world held together by an array of impersonal organizations, institutions, and forms of discursive power?'[97] Charles Darwin recognised 'sympathy' as being innate, but at the same time enhanced by the approbation of others.[98] Psychologists Goetz et al., reviewing recent research, concur with this, adding that individuals calculate the costs against the benefits of such an action.[99] The failings at the Mid-Staffordshire Hospital, England, where up to 1,200 patients died due to neglect, were attributed to 'a culture based

[95] H. Bridger, 'A Viewpoint on Organizational Behaviour', ed. G. Wostenholme and H. O'Connor (CIBA Foundation Symposium on 'Teamwork for World Health', Istanbul: Churchill J. & A., 1971), 1–2.
[96] Manning, 'What Happened to the Therapeutic Community', 148.
[97] Jeff Popke, 'Geography and Ethics: Everyday Mediations Through Care and Consumption', *Progress in Human Geography*, vol. 30, no. 4 (2006): 505.
[98] Charles Darwin, *The Descent of Man*, 2nd ed., Great Minds Series (Amherst, N.Y: Prometheus Books, 1871), 110, 125.
[99] Goetz, Keltner, and Simon-Thomas, 'Compassion', 355–56.

on doing the system's business - not that of the patients'.[100] Staff were more concerned with 'a target-driven management and reneged on their professional obligations', because they felt their jobs were at risk.[101] Campling, reflecting on these issues from the point of view of someone who had worked in a TC, finds a 'palpable sense of unsafety' in NHS staff 'across the country', a result of 'grossly over-spent budgets and high level examples of government duplicity'.[102]

In the light of this, Fotaki insists that policies and organisational structures can suppress, or reinforce, the innate compassion of healthcare professionals.[103] The issue arises as to how the latter might be achieved. From the stance of a political scientist, Joan Tronto, suggests that in a democratic society organisations might function democratically, taking into consideration 'the needs and perspectives of all within the institution'.[104] She has come to the conclusion that hierarchies should become 'flattened', and thereby the 'contradictory needs of institutions can more easily be organized', and argues that this requires a 'political' space for the needs-interpretation struggle to take place.[105] In practical terms, this entails an opportunity for those providing care to discuss together difficulties they are facing and to 'have some input in the ways that institutional controls above them are implemented'.[106] The importance of this is that, whilst reaching similar conclusions, the source of these ideas is entirely separate from that of the TC movement.

This thesis, in exploring the Ingrebourne Centre, has found that the therapeutic community approach implements a mechanism by which compassionate care can be delivered to people experiencing difficulties in relationships. Whilst attention has only recently been drawn to this particular aspect in care delivery, notably mainly by women authors, it is significant that similar conclusions, such as regular meetings of all those concerned and 'flattening of the hierarchy', are being drawn to ensure the delivery of kindly and considerate care.

The Ingrebourne, as have other similar communities and psychiatric practice in general, publicly undervalued the power of compassion in therapy.[107] Relatively little mention of it is

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[100] Robert Francis, *The Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. Presented to Parliament Pursuant to Section 26 of the Inquiries Act 2005* (London: HMSO, 2013), 4.
[101] Peter Nolan, 'The Francis Report: Implications and Consequences', *Nursing Ethics* 20, no. 7 (2013): 842
[102] Penelope Campling, 'Containment: From Cruelty to Kindness', *Therapeutic Communities: The International Journal of Therapeutic Communities*, 22.
[103] Marianna Fotaki, 'Why and How Is Compassion Necessary to Provide Good Quality Healthcare?', *International Journal of Health Policy and Management*, vol. 4, no. 4 (2015): 200.
[104] Joan C. Tronto, 'Creating Caring Institutions: Politics, Plurality, and Purpose', *Ethics and Social Welfare*, vol. 4, no. 2 (2010): 168.
[105] Tronto, 168.
[106] Tronto, 169.
[107] Sociologists Sara Carmel and Seymour Glick identify a number of the positive benefits of compassionate care in medicine including greater patient satisfaction, better recovery from surgery and traumatic impairment. Sara Carmel and Seymour M. Glick, 'Compassionate-Empathic Physicians: Personality Traits and Social-Organizational Factors That Enhance or Inhibit This Behaviour Pattern', *Social Science and Medicine*, vol. 45, no. 8 (1996): 1253. In addition, self-compassion is becoming recognised as an effective approach to

made in the professional press until recently, except when accounts from those people using the service are included.[108] The therapeutic impact of patients' social interactions has similarly been increasingly neglected until very recently. Instead, the concentration has been to demonstrate effectiveness according the criteria laid out by Cochrane.[109] This, coupled with adherence to a set of principles, rather than adopting a systematic understanding of organisational management, leadership and external relationships, such as that described by Bridger, has contributed to a rigidity of response to the demands of 'shifting values in healthcare under neoliberal ideology'.[110]

Main at Northfield asked 'If a man is socially well adapted would you dare to say that his neurosis was?'[111] This unanswered query implicitly questions this shift to a purely psychotherapeutic view. A researcher into addiction, Rowdy Yates argues that 'the framing of a TC methodology within a health intervention paradigm' ignores other aspects of a complex intervention, where 'not only the individual elements but the interplay of those elements are crucial to the value delivered'. [112] This suggests that the re-examination of the social aspects of how the TC works, in particular the part played by the 'mutual aid' of participants, is overdue. Referring back to the opening paragraph of this study, if it is accepted that consciousness is socially constructed, this opens up an alternative perspective from which to examine the functioning of therapeutic communities.

This study has attempted to lay bare some of the social constructs, or elements of *illusio*, that those at the Ingrebourne adhered to which led them into conflict with those outside who held alternative views.[113] An essential ingredient of exposing this has been the employment of oral history. This technique is often undervalued by 'mainstream' historians, however, it has proved in this research to have exposed the ambiance, and the social dynamics of the situation, in a way that no other source could have done.

Whether the increasing emphasis on compassionate care, and how to implement it, in the academic literature, can be transformed into practice is open to question. However, the

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treating depression, e.g. Alice Diedrich et al., 'Self-Compassion as an Emotion Regulation Strategy in Major Depressive Disorder', *Behaviour Research and Therapy*, vol. 58 (July 2014): 43–51.

[108] Although Manning has pointed out their ability to humanise prisons. Nick Manning, 'Therapeutic Communities: a Problem or a Solution for Psychiatry? A Sociological View.', *British Journal of Psychotherapy*, vol. 26, no. 4 (2010): 440. See also Campling, 'Containment';

[109] Not unsuccessful in providing the evidence of effectiveness, but unsuccessful in persuading purchasing authorities and other professionals. See Jan Lees, Nick Manning, and Barbara Rawlings, 'A Culture of Enquiry: Research Evidence and the Therapeutic Community', *Psychiatric Quarterly*, vol. 75, no. 3 (2004): 279–94.

[110] Marianna Fotaki, 'What Money Cannot Buy? Compassion in Healthcare: A Response to the Recent Commentaries', *International Journal of Health Policy and Management*, vol. 4, no. 12 (2015): 873.

[111] T. F. Main, 'Discussion on Group Therapy, Session 15, 12th Sept 1945', vol. PP/SHF/C.3/8 (Wellcome Contemporary Medical Archives Centre, 1945).

[112] Laura Aslan and Rowdy Yates, 'Exploring the "Black-Box" of Therapeutic Community (TC) Methodology and the Subjective Experiences of Residents within TC Structures', *Therapeutic Communities: The International Journal of Therapeutic Communities* 36, no. 2 (2015).

[113] Crossley, 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain'.

lessons learned from organisations such as the Ingrebourne, which successfully sustained such a culture for nearly half a century, may have a role to play in such a translation. Whether the acknowledgement by Matt Hancock, Secretary of State for Health in 2018, that 'People cannot be expected to deliver world class care when facing bullying and harassment on this scale. So the culture must change', remains rhetorical or beckons a culture change, only history will tell.[114]

[114] Matt Hancock, 'My Priorities for the Health and Social Care System' (2018), https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system?utm_source=3c152e23-0463-4533-8dd1-4028c059c976&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediat.

Bibliography

1. Primary Sources.

Archives:

Contemporary Medical Archives, Wellcome Trust Library for the History and Understanding of Medicine, London.

Main, T. F. 'Discussion on Group Therapy, Session 15, 12th Sept 1945', Wellcome Contemporary Medical Archives Centre, 1945, PP/SHF/C.3/8.

Essex County Records Office, Colchester.

Barking, Dagenham and Havering Community Health Council. 'Report No. 59. Visit by Team "B" to the Ingrebourne Centre, St George's Hospital, on Thursday, 6th September 1984', 1984. Essex Records Office, A10367, Box 60.

Institute of Psychoanalysis Archives, London.

John Rickman archive:

Hargreaves, G. R. 'Letter to John Rickman 4th October', 1943. British Psycho-Analytical Society, P03/C/B/03.

Heard, Arthur. 'Letter to John Rickman, 14/8/1945', 1945. British Psychoanalytic Society, P03/C/B/03.

Rickman, J. 'Letter to Tom Main 31st August', 1945. British Psycho-Analytical Society, P03/C/B/04.

Rickman, J. 'Letter to Tommy Wilson 1st September', 1945. British Psycho-Analytical Society, P03/C/B/05.

London Metropolitan Archive, London.

Barking, Dagenham and Havering Community Health Council. 'Report No. 412 - Visit to Ingrebourne Centre, Hornchurch by Community Care Services Working Group on July 10th 1995 at 2.00 p.m.', 1995, London Metropolitan Archive, uncatalogued accession B04/044.

Ives, A. G. L., and Edwards. 'Notes on Visit to Warley Hospital Management Committee'. Notes on a visit. Warley Hospital, March 1954. London Metropolitan Archive A/KE/C/02/06/582.

Pooley, E. H., and A. G. L. Ives. 'Report to Warley Hospital Management Committee'. Warley Hospital, January 1956. London Metropolitan Archive, A/KE/C/02/06/582 .

Nightingale, G. S. 'Medical Superintendent's Report and Statistics for the Year 1955. Warley Hospital Brentwood.' Annual report to Hospital Management Committee. Brentwood, Essex: Warley Hospital, 1955. London Metropolitan Archive, A/KE/C/02/06/582.

Nightingale, G. S. 'Medical Superintendent's Report and Statistics for the Year 1956. Warley Hospital Brentwood.' Annual report to Hospital Management Committee. Brentwood, Essex: Warley Hospital, 1956. London Metropolitan Archive, A/KE/C/02/06/582.

Nightingale, G. S. 'Medical Superintendent's Report and Statistics for the Year 1957. Warley Hospital Brentwood.' Annual report to Hospital Management Committee. Brentwood, Essex: Warley Hospital, 1957. London Metropolitan Archive, A/KE/C/02/06/582.

The National Archives, Kew.

National Archives, The. Hospital Records Database: Warley Hospital Brentwood. http://www.nationalarchives.gov.uk/hospitalrecords/details.asp?id=2413, accessed 03/10/2016.

Planned Environment Therapy Trust, Toddington, Gloucs. (http://www.pettrust.org.uk/)

i). Cecilia Clementel-Jones archive*:*

Byrne, Peter, and Jill Chaloner. 'Letter: Re Reflections.', 2003. CCJ archive. Planned Environment Therapy Trust.

Clementel-Jones, Cecilia. 'The Community and the Community. The out-Patient Service and Training Function of an Established Therapeutic Community.', undated c. 1982. Planned Environment Therapy Trust, CCJ archive.

Clementel-Jones, Cecilia. 'Letter Concerning Trust's Consultation Document 15th October 2003', 3 December 2003. Planned Environment Therapy Trust, CCJ Archive.

Clementel-Jones, Cecilia. 'To Jill Chaloner Re Psychotherapy Services 25/11/2003', 2003. Planned Environment Therapy Trust, CCJ Archive.

Clementel-Jones, Cecilia. 'Comments on Havering's Financial Recovery Plan and Its Effect on Psychological Therapies', 2005. Planned Environment Therapy Trust, CCJ Archive.

Datta, Pratibha. 'North East London Mental Health Trust Mental Health Needs Assessment: Summary Report. 7th Nov 2004', 2004, Planned Environment Therapy Trust, CCJ Archive.

Marsh, Steve. 'Briefing Paper: Eastern Operations Division. Reconfiguration of Psychological Therapies in Havering 15th October 2003', 2003. CCJ archive. Planned Environment Therapy Trust.

Mathisson, Caroline. 'Reflections: A Consultation Document 27th May 2003', 2003. CCJ Archive. Planned Environment Therapy Trust/Personal.

ii). Richard Crocket archive:

Anderson, H. A. 'Commentary Footnotes on Initiation of a Therapeutic Community by Crocket R.', 1962. Planned Environment Therapy Trust, PP/RC/26/10/04/03.

Anon. 'Ingrebourne Centre Timetable c. 1960-1964', n.d. Planned Environment Therapy Trust, PP/RC/26/09/03/01/05.

Anon. 'Understandings about Treatment at the Ingrebourne Centre 24.10.69', 1969. Planned Anon. Environment Therapy Trust, PP/RC/11/30/01.

Anon. 'What Is the Ingrebourne Society? Probably by Crocket R.', undated c 1975. Planned Environment Therapy Trust, PP/RC/25/02/45 .

Anon. 'The Centre as an Entity 1/6/76', 1976. Planned Environment Therapy Trust, PP/RC/11/31/06.

Carroll, A.J. 'The Ingrebourne as a Going Concern', 1970. Planned Environment Therapy Trust, RC/25/02/42/02.

Crocket, R. W. 'Diary 7: 6th Dec. 1947 to 1st Jan. 1950', Planned Environment Therapy Trust, PP/RC/10/01.

Crocket, R. W. 'Memorandum on Ingrebourne Centre for North Eastern Metropolitan Regional Hospital Board'. January 1955. 1955. Planned Environment Therapy Trust, PP/RC/26/14/02/107.

Crocket, R. W. 'Letter to Dr Miles 18 January 1955', 18 January 1955. Planned Environment Therapy Trust, PP/RC/26/14/02/77.

Crocket, R. W. ‘Memorandum: Ingrebourne Centre Staffing and Activity November 1955’, 1955. Planned Environment Therapy Trust, PP/RC/26/14/02/45.

Crocket, R. W. ‘Letter to Dr Miles, 25th November 1955’, 1955. Planned Environment Therapy Archive, PP/RC/26/14/02/37.

Crocket, R. W. ‘Letter to Dr Miles, 28th January 1956’, 1956. Planned Environment Therapy Archive, PP/RC/26/14/02/32.

Crocket, R. W. ‘Notes on Chronology of Developments at Ingrebourne, Handwritten Note Undated’, c. 1957. Planned Environment Therapy Trust, PP/RC/26/14/02/104.

Crocket, R. W. ‘Letter to Dr Joshua Bierer 10th January’, 1958. Planned Environment Therapy Trust, PP/RC/26/14/02/13/06.

Crocket, R. W. ‘Memorandum: The Ingrebourne Centre. St George’s Hospital, Hornchurch. 1955 - 1958.’, 1958. Planned Environment Therapy Trust, PP/RC/11/01/01/01.

Crocket, R. W. ‘Letter to Dr Graham 4th Feb 1959’, 1959. Planned Environment Therapy Trust, PP/RC/26/14/02/22.

Crocket, R. W. ‘Letter to Dr Miles 14th May 1959’, 1959. Planned Environment Therapy Trust, PP/RC/26/14/02/20.

Crocket, R. W. ‘Letter to Dr Miles, Responding to RHB Visit 1959’, 30 January 1959. Planned Environment Therapy Trust, PP/RC/26/14/02/05/01.

Crocket, R. W. ‘The Therapeutic Community Approach in a Neurosis Centre. Presentation given at Runwell Hospital, Medical Society, 21st Nov 1957. With additional hand written notes by Dr Hamish Anderson’, 1959. Planned Environment Therapy Trust, PP/RC/25/02/01.

Crocket, R. W. ‘The Therapeutic Team in Ancient Hospitals with Modern Boundaries: Address given to the King Edward Fund Centre, unpublished typescript, 1961. Planned Environment Therapy Trust, PP/RC/25/03/04.

Crocket, R. W. ‘Note on the Patient’s Role: Record of a Staff Meeting 1961’, 17 July 1961. Planned Environment Therapy Trust, PP/RC/11/60.

Crocket, R. W. ‘Diary 9: 1954 - 1962’. Planned Environment Therapy Trust, PP/RC/10/04.

Crocket, R. W. ‘Treatment and its Results at the Ingrebourne Centre, St George’s Hospital, Hornchurch, Essex. April 1st 1957 to March 31st 1959.’, 1962. Planned Environment Therapy Trust, PP/RC/26/01/01.

Crocket, R. W. 'Ingrebourne Centre, St George's Hospital, Hornchurch, Essex. Clinical Results 1957 - 1959', Pts 1 and 2, 1962. Planned Environment Therapy Trust, PP/RC/03/09.

Crocket, R. W. 'Lecture Notes: Community Therapy and the Boundaries of Group and Individual Hospital Treatment. Chairman's Address to the Psychotherapy Section of the Royal Medico-Psychological Association, May 1962', 1962. Planned Environment Therapy Trust, PP/RC/25/03/05.

Crocket, R. W. 'The Results of Treatment in a Psychotherapeutic Community'. Glasgow University, 1965. Planned Environment Therapy Trust (Library).

Crocket, R. W. 'Memorandum: Dates of American Trip 14th May 1968 to 15th June 1968', 1968. Planned Environment Therapy Trust, PP/RC/04/01.

Crocket, R. W. 'Journal of a Visit to America, 13th May to 15th June 1968', 4. http://pettrust.org.uk/index.php?option=com_content&view=article&id=610:week-4-4-june-1968-to-10-june-1968&catid=201&Itemid=335.

Crocket, R. W. 'Notes for a Presentation on Ingrebourne given in the United States of America', 1968. Planned Environment Therapy Trust, PP/RC/04/07/01/02.

Crocket, R. W. Lecture: 'Changes and Choice in Group Therapy: Prospects for the Therapeutic Community'. undated, post 1970. Planned Environment Therapy Trust, PP/RC/11/08.

Crocket, R. W. 'Report: Therapeutic Communities in Britain and Other European Countries', 1972. Planned Environment Therapy Trust, PP/RC/26/08/07/02.

Crocket, R. W. 'Crossing the Therapeutic Rubicon, Draft'. Ingrebourne, 29 January 1974. Planned Environment Therapy Archive, PP/RC/25/02/10.

Crocket, R. W. 'Appendix A: Features of Different Types of Therapeutic Communities'. Unpublished, 1978. Planned Environment Therapy Trust, PP/RC/26/01/17/01.

Crocket, R. W. 'Early Experience at Ingrebourne. Paper Read at Windsor Conference of the Association of Therapeutic Communities The Therapeutic Community: Progress and Prospects. July 1987', 1987. Planned Environment Therapy Trust, PP/RC/04/02/03.

Crocket, R. W. 'Introduction to Therapeutic and Psychotherapeutic Community Procedures: A Handbook.' Typescript, 2000. Planned Environment Therapy Archive, PP/RC/24/20/06/02.

Crocket, R. W. 'Explanatory Notes on Crocket, R. and St. Blaize-Molony, R., Social Ramifications of the Therapeutic Approach in Psychotherapy. *British Journal of Medical Psychology*, 1964, 37, 153', undated c 2000. Planned Environment Therapy Trust, PP/RC/30/02/05/02.

Crocket, R. W. 'Explanatory Notes on Two Papers by Tollinton H.J.', undated c.2000. Planned Environment Therapy Trust, PP/RC/26/09/16/01.

Crocket, R. W. 'The Theory of the Therapeutic Community - an Approach to Structural Psychiatry and the Use of Intensive Social Treatment Networks', undated. Planned Environment Therapy Trust, PP/RC/24/15/01.

Crocket, R. W., 'Notes on The Structure of Insanity by Trigant Burrow', undated, Planned Environment Therapy Trust, PP/RC/26/07/01.

Crocket, R. W. 'Some Aspects of Theory Associated with Therapeutic and Psychotherapeutic Work', undated, Planned Environment Therapy Trust, PP/RC/11/66/01.

Crocket, R. W. and D. Millard, 5th June 1998, MP1. Interview by Malcolm Pines, transcript. Planned Environment Therapy Trust.

Ingrebourne Staff. 'Summary of Staff Meetings 24.1.67, 31.1.67, 6.2.67, 14.2.67, 21.2.67.', 1967. Planned Environment Therapy Trust, PP/RC/11/31/01 - PP/RC/11/31/05.

St. Blaize-Molony, R. 'Guidelines to the Community about 1961-1962', 1962. Planned Environment Therapy Trust, PP/RC/25/02/03.

iii). Other:

Clark, D. H. Video recording: "The Early Days of the ATC": The Peter van der Linden Lecture, 1999, Planned Environment Therapy Trust, http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=1201:the-early-days-of-the-atc-dr-david-h-clark-the-peter-van-der-linden-lecture-1999&catid=284&Itemid=408, accessed 07/09/2018.

North East London Mental Health NHS Trust. 'Proposal for the Development of a Personality Disorder Service 22/9/2003'. NELMHT, 2003. Planned Environment Therapy Trust, CCJ archive.

North Eastern Metropolitan Regional Hospital Board. 'Ingrebourne Centre (Report of a Visit)', 1958. Planned Environment Therapy Trust, PP/RC/26/14/12/06.

Studymore online archive (http://www.studymore.org.uk/ingrebou.htm)

Roberts, A. 'Ingrebourne Centre'. studymore.org.uk/ingrebou.htm, accessed 07/11/2014.

Personal (papers donated by, or copied from, contributors).

Anon. 'That Was the Group That Was - Songs for Swinging Neurotics.' *Incentive*, June 1963, 3, Personal.

Anon. ‘Ingrebourne Centre: Patients’ Handbook’, 1996. Personal.

Chamberlain, R. ‘Strange Character’. Incentive, November 1963, 6. Personal.

Conneely, Pat. ‘Ingrebourne Centre Link: Brief History and Groups in Action at the Ingrebourne Centre’. Unpublished Typescript, 1994. Personal.

Tavistock Institute of Human Relations. ‘Pilot Study of a Long Established Therapeutic Community Focussing on Staff Roles and Aspects of the Treatment Process’. Tavistock Institute of Human Relations, 1975. Personal.

Official Sources: U.K.

Audit Commission for Local Authorities in England and Wales, ed. *Making a Reality of Community Care: A Report*. London: HMSO, 1986.

Beveridge, Sir William. *Report on Social Insurance and Allied Services*. Cmd. 6404. London: HMSO, 1942.

Callaghan, J, 1969, House of Commons debate on the Wootton Report, http://hansard.millbanksystems.com/commons/1969/jan/27/cannabis-wootton-report, c. 959. Accessed 31 Oct. 2014.

Chief Medical Officer. ‘Mental Health’ in *Report of the Ministry of Health for the Year 1954, Part II: On the State of the Public Health,* 104–10. London: HMSO 1955.

Chief Medical Officer. ‘Mental Health’ in *Report of the Ministry of Health for the Year 1957, Part II: On the State of the Public Health,* 122-130. London: HMSO, 1955.

Chief Medical Officer. ‘Mental Health’ in *Report of the Ministry of Health for the Year 1959, Part II: On the State of the Public Health*, 127-142. London: HMSO, 1960.

Chief Medical Officer. ‘Mental Health’ *Report of the Ministry of Health for the Year 1960, Part II: On the State of the Public Health*, 94-100. London: HMSO, 1961.

Commission for Health Improvement. ‘What CHI Has Found in: Mental Health Trusts. Sector Report’ (London, Commission for Health Improvement, 2003), 21.

Department of Health. *Caring for People: The CPA for People with a Mental Illness Referred to Specialist Mental Health Services*. Joint Health/Social Services Circular C(90)23/LASSL(90)11. London: Department of Health, 1990.

Department of Health and Social Security. ‘National Health Service Hospital Advisory Service: Annual Report for 1969-70’. London: HMSO, 1971.

Department of Health and Social Security Welsh Office. *Censuses of A. Patients in Mental Illness Hospitals and Units in England and Wales at the End of 1971: B. Mental Illness Day Patients in England and Wales at April 1972*. Statistical and Research Report Series ; No. 10. London: HMSO, 1975.

Department of Health and Social Security. *Better Services for the Mentally Ill*. Cmnd 6233. London: HMSO, 1975.

Department of Health and Social Security. *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England and Wales 1973*. London: HMSO, 1976.

Department of Health and Social Security. *The Facilities and Services of Mental Illness and Mental Handicap Hospitals in England*. London: Government Statistical Service, 1984.

Francis, Robert. *The Mid Staffordshire NHS Foundation Trust Public Inquiry: Executive Summary. Presented to Parliament Pursuant to Section 26 of the Inquiries Act 2005*. London: HMSO, 2013.

Hancock, Matt. 'My Priorities for the Health and Social Care System'. Oxford, 2018. https://www.gov.uk/government/speeches/matt-hancock-my-priorities-for-the-health-and-social-care-system?utm_source=3c152e23-0463-4533-8dd1-4028c059c976&utm_medium=email&utm_campaign=govuk-notifications&utm_content=immediat.

Hansard, 'Debate: Mental Hospitals (Staffing)', 520:1248–82. London: HMSO, 1953. http://hansard.millbanksystems.com/commons/1953/nov/12/mental-hospitals-staffing.

Hansard, 'Debate: Mentally Sick (Care and Accommodation)', 523:2293–2379. London: HMSO, 1954. http://hansard.millbanksystems.com/commons/1954/feb/19/mentally-sick-care-and-accommodation#column_2299.

Hansard, ed. 'Birmingham Mental Hospital Committee (Former Chairman)'. In *Birmingham Mental Hospital Committee (Former Chairman)*, 664:94–170. 155. London: HMSO, 1962.

Hansard, ed. 'Debate: St George's Hospital, Hornchurch', 674:1669–82. https://api.parliament.uk/historic-hansard/commons/1963/mar/28/st-georges-hospital-hornchurch.

Health Advisory Service. 'A Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 1997. CCJ archive. Planned Environment Therapy Trust.

Health Service Commissioner for Great Britain, and Parliamentary and Health Service Ombudsman. *Care and Compassion: Report of the Health Service Ombudsman on Ten Investigations into NHS Care of Older People*. London: HMSO, 2011.

Home Office. 'Cannabis: Report by the Advisory Council on Drug Dependence'. London: Home Office, 1968.

House of Commons, Great Britain. 'Annual Report of the Board of Control to the Lord Chancellor for the Year 1953'. HMSO, 1954.

House of Commons. 'Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957.' London: HMSO, 1957.

House of Commons. *A Hospital Plan for England and Wales*. Cmnd 1604. London: HMSO, 1962.

House of Commons. Great Britain. Parliament. *Report of the Committee of Inquiry into South Ockendon Hospital.* London: HMSO, 1974.

House of Commons. 'The National Health Service (Appointment of Consultants) Regulations 1982', 1982. http://www.legislation.gov.uk/uksi/1982?page=47.

House of Commons. 'Second Report from the Social Services Committee. Session 1984-5. Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. Volume 1. Report Together with the Proceedings of the Committee.' London: House of Commons, 1985.

House of Lords. 'Media Notice: Is the NHS Staffed for the Future? Is Mental Health Still a Cinderella Service? The House of Lords Committee on the Sustainability of the NHS Investigation into NHS Workforce and Mental Health Services', 2016. https://www.parliament.uk/business/lords/media-centre/house-of-lords-media-notices/2016/october-2016/is-the-nhs-staffed-for-the-future-is-mental-health-still-a-cinderella-service-lords-to-ask-experts/. Accessed 20/01/2017

Houses of Parliament. *Report of the Royal Commission on Lunacy and Mental DIsorder*. London: HMSO, 1926.

Houses of Parliament. *Report: Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 1954-1957*. Cmnd 169. London: HMSO, 1957.

Houses of Parliament. Suicide Act 1961, c. 60 (Regnal. 9 and 10 Elix 2) § (1961). http://www.legislation.gov.uk/ukpga/1965/71/contents/enacted.

Houses of Parliament. Murder (Abolition of Death Penalty) Act, 1965 c. 71 § (1965). http://www.legislation.gov.uk/ukpga/1965/71.

Houses of Parliament. Abortion Act 1967, 1967 c.87 § (1967). https://www.legislation.gov.uk/ukpga/1967/87/introduction/enacted.

Houses of Parliament. 'Report of the Committee on Local Authority and Allied Personal Social Services'. London: HMSO, 1968.

Ministry of Health, Central Services Council. 'Report of the Committee on the Internal Administration of Hospitals'. London: HMSO, 1954.

Ministry of Health. 'First Report of the Joint Working Party on the Organisation of Medical Work in Hospitals.' London: HMSO, 1967.

Ministry of Health, and Central Health Services Council. 'Psychiatric Nursing: Today and Tomorrow: Report of the Joint Sub-Committee of the Standing Mental Health and the Standing Nursing Advisory Committees'. London: HMSO, 1968.

National Health Service. 'A Hospital Plan for England and Wales'. HMSO, 1962.

National Health Service. 'Report of the Committee of Inquiry into Allegations of Ill-Treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff.' London: HMSO, 1970.

National Health Service. 'Report of the Farleigh Hospital Committee of Inquiry'. London: HMSO, 1971.

National Health Service. 'Report of a Committee of Inquiry into Whittingham Hospital'. London: HMSO, 1972.

National Health Service. 'Annual Report of the Hospital Advisory Service to the Secretary of State for Social Services and Secretary of State for Wales for the Year 1973'. London: HMSO, 1974.

National Health Service. *Report of the Committee of Inquiry into Normansfield Hospital.* Cmnd 7357. London: HMSO, 1978.

National Health Service Health Advisory Service. 'Review of Adult Psychotherapy Services in the BHB Community Health Care NHS Trust', 1997.

National Health Service: Information Centre. 'MHMDS 2003-07 data tables: Report 2: Number of inpatients detained in hospital', http://webarchive.nationalarchives.gov.uk/20081112213209/http://www.ic.nhs.uk/statistics-and-data-collections/supporting-information/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin/mhmds-2003-07-data-tables, accessed 03/07/2018.

National Institute for Health and Clinical Excellence, 'Who We Are', https://www.nice.org.uk/about/who-we-are, accessed 4/06/018.

National Institute for Health and Clinical Excellence. 'Charter', https://www.nice.org.uk/Media/Default/About/Who-we-are/NICE_Charter.pdf, accessed 14/06/2017.

National Institute for Health and Clinical Excellence. 'Scope', https://www.nice.org.uk/guidance/CG78/documents/personality-disorders-borderline-final-scope2, accessed 14/16/2017.

National Institute for Health and Clinical Excellence. 'Borderline personality disorder: recognition and management: 1.4 Inpatient services', https://www.nice.org.uk/guidance/cg78/chapter/1-Guidance#inpatient-services, accessed 14/06/2014.

Parliament, Great Britain. *National Health Service Act*. Geo VI c. 81, 9 and 10. London: HMSO, 1946.

Parliament. Great Britain. *National Health Service and Community Care Act 1990*. London, 1990. http://www.legislation.gov.uk/ukpga/1990/.

Privy Council Office. *Report of an Expert Committee on the Work of Psychologists and Psychiatrists in the Services*. London: HMSO, 1947.

Secretaries of State for Health, Wales, Northern Ireland and Scotland. *Working for Patients*. CM555. London: HMSO, 1989.

Walker-Smith, Derek. 'Mental Health Bill: Second Reading 26th January 1959'. London: Houses of Parliament, 1959. http://hansard.millbanksystems.com/commons/1959/jan/26/mental-health-bill#S5CV0598P0_19590126_HOC_230.

Wilson, H. Video: Speech to the Labour Party Conference, 1963. http://news.bbc.co.uk/player/nol/newsid_7000000/newsid_7004400/7004431.stm#, accessed 24/9/2014.

Wilson, H. Transcript: Speech to the Labour Party Conference 1963, https://www.youtube.com/watch?v=oTnf3TNwc-E, accessed 24/9/2014.

Whitcombe, E. B. 'Winson Green. Superintendent's Report for the Year 1883'. In *Report of the Committee of Visitors of the Lunatic Asylums for the Borough of Birmingham 1883*, 14–22. Birmingham: Birmingham Town Hall, 1884.

Official Sources: International.

World Health Organisation: Expert Committee on Mental Health. 'Report on the First Session'. Technical Report. Geneva: World Health Organization, 1950. http://apps.who.int/iris/bitstream/10665/37979/1/WHO_TRS_9.pdf.

World Health Organisation: Expert Committee on Mental Health. 'Report on the Second Session'. Technical Report. Geneva: World Health Organization, 1951. http://apps.who.int/iris/bitstream/10665/37982/1/WHO_TRS_31.pdf.

World Health Organisation: Expert Committee on Mental Health. 'Third Report: The Community Mental Hospital'. Technical Report. Geneva: World Health Organization, 1953. http://apps.who.int/iris/bitstream/10665/37982/1/WHO_TRS_73.pdf.

Interviews: unpublished

INGCE1. Interview by T. Harrison, 2010. Personal.

INGCE3. Interview by T. Harrison, 2010. Personal.

INGCE4. Interview by T. Harrison, 2010. Personal.

INGCE5. Interview by T. Harrison, 2010. Personal.

INGCE6. Interview by T. Harrison, 2010. Personal.

INGCE7. Interview by T. Harrison, 2010. Personal.

INGCE9. Interview by T. Harrison, 2011. Personal.

INGCE10. Interview by T. Harrison, 2011. Personal.

INGCE11a & INGCE11b. Interview by T. Harrison, 2014. Personal.

INGCE13. Interview by T. Harrison, 2013. Personal.

INGCE14. Interview by T. Harrison, 2014. Personal.

INGCE15. 2nd Interview. Interview by T. Harrison, 2014. Personal.

INGCE16. Interview by T. Harrison, 2013. Personal.

INGCE17. Interview by T. Harrison, 2014. Personal.

INGCE18. Interview by T. Harrison, 2014. Personal.

INGCE19. Interview by T. Harrison, 2014. Personal.

INGCE20. Interview by T. Harrison, 2014. Personal.

INGCE21. Interview by T. Harrison, 2014. Personal.

INGCE22. Interview by T. Harrison, 2014. Personal.

INGCE23. Interview by T. Harrison, 2015. Personal.

INGCE24. Interview by T. Harrison, 2015. Personal.

INGCE25. Interview by T. Harrison, 2015. Personal.

INGCE27. Interview by T. Harrison, 2014. Personal.

INGCE28. Interview by T. Harrison, 2016. Personal.

INGCE29. Interview by T. Harrison, 2016. Personal.

INGCE30. Interview by T. Harrison, 2016. Personal.

INGCE31. Interview by T. Harrison, 2016. Personal.

INGCE32. Interview by John Hopton. Transcription, 1999. Personal.

INGCE33. Telephone Interview. Interview by T. Harrison, 2015. Personal.

Crocket, R. W. PETT Interview 23rd November 1998 (T)CF 271. Interview by Craig Fees, transcript. Planned Environment Therapy Trust, PP/RC/01/23/01.

Crocket, R. W. PETT Interview 23rd November 1998 (T)CF 272. Interview by Craig Fees, transcript, 1998. Planned Environment Therapy Trust, PP/RC/01/30.

Crocket, R. W. PETT Interview 30th June 1999 (T)CF 293,. Interview by Craig Fees, transcript. Planned Environment Therapy Trust.

Crocket, R. W. PETT Interview 3rd November 1999 (T)CF 329. Interview by Craig Fees, transcript. Planned Environment Therapy Archive,.

Crocket, R. W. PETT Interview 17th November 1999 (T)CF 330. Interview by Craig Fees and Helen Spandler, transcript. Planned Environment Therapy Trust, PP/RC/01/37.

Main, T. F. Interview by T. Harrison, 1984. Personal.

Mattis, Heber. Interview by T. Harrison, 2011. Personal.

Roberts, A. Interview by T. Harrison, 2011. Personal.

Roberts, A. ‘Reflections on Ingrebourne: Developed from the Transcript of an Interview of Andrew Roberts by Tom Harrison on 18.2.2011’. Personal communication, 2011. Personal.

Roberts, A. Personal communication, 05/12/2014.

St. Blaize-Molony, R. Interview, 2010. Personal.

St. Blaize-Molony, R. 'Letter to T Harrison 6th October 2010', 2010. Personal.

Interviews and personal reports, published:

Antoniou, Janey. 'Bored on the Ward'. In *Experiences of Mental Health In-Patient Care.*, edited by Mark Hardcastle, David Kennard, Sheila Grandison, and Leonard Fagin, 33–40. London ; New York: Routledge, 2007.

Baker, Alex. . Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 192-205, London : Gaskell, 1993.

Hamilton, Max. . Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 13-27, London : Gaskell, 1993.

Hare, Edward. Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 59-72, London : Gaskell, 1993.

Howells, John. Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 207-229, London : Gaskell, 1993.

McCarthy, Derek. Interviewed by Chris Boulding in *Mental: A History of the Madhouse*. British Broadcasting Corporation, 2009. http://www.youtube.com/watch?v=qxE9I_8fhe8, accessed 10/05/2015. Now https://www.youtube.com/watch?v=oswUssXzFlY, accessed 10/09/2018.

Norwood. 'Feeling out of Control'. In *Experiences of Mental Health In-Patient Care*, edited by Mark Hardcastle, David Kennard, Sheila Grandison, and Leonard Fagin, 41–47. London ; New York: Routledge, 2007.

Rawnsley Kenneth. Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 98-133, London : Gaskell, 1993.

Sainsbury, Peter. Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 134-144, London : Gaskell, 1993.

Trethowan, Sir William. Interview in Wilkinson, Greg, ed. *Talking about Psychiatry*. 28-49, London : Gaskell, 1993.

Documentaries and News Reports:

Anon. 'Isle of Wight Festival History'. *The Daily Telegraph*, 6 October 2011. http://www.telegraph.co.uk/culture/music/music-festivals/8567648/Isle-Of-Wight-Festival-history.html, accessed 08/01/2015.

Crocket, R. W. 'Our Mental Hospitals Can We Reform Them out of Existence?' *The Observer*, 21 October 1956, 6.

Evans, Nigel. 'Silent Minority'. ATV, 1981. https://www.youtube.com/watch?v=5fdZ33Rryq4.

Holl, Alison. 'Winterbourne View patients in new care safety alerts', http://www.bbc.co.uk/news/uk-20070437, accessed 08/09/2018.

Jones, Andrew Miller. *The Hurt Mind: Put Away*. Transcript, Documentary. BBC, 1957. http://ftvdb.bfi.org.uk/sift/title/10718, accessed 20/06/2015.

Laing, R. D. Interview: R. D. Laing on Kingsley House, Mental Illness, 1970s . https://www.youtube.com/watch?v=nTEZ_eumRKI, accessed 07/09/2018.

Laurence, Jeremy. 'Mental Hospital Closure Is Condemned as Inhumane'. *The Independent*,18th December 2007 (2007). https://www.independent.co.uk/life-style/health-and-families/health-news/mental-hospital-closure-plan-is-condemned-as-inhumane-765690.html, accessed 08/09/2018.

Pathé News. *M.P.s Win Mental Patient's Freedom*. Pathé News Films, 1956. http://www.britishpathe.com/video/mps-win-mental-patients-freedom, accessed 08/09/2018.

Pathé News. *Grosvenor Square Anti-Vietnam Riots.* http://www.britishpathe.com/video/grosvenor-square-anti-vietnam-riots, accessed 08/01/2015.

Vulliamy, Ed, Peter Beaumont, and Tess Reidy. 'Hyde Park, 1969: The Counterculture's Greatest Day. And the Rolling Stones Came Too.' *The Observer*, 4 July 2013. https://www.theguardian.com/music/2013/apr/07/stones-park-first-time-around, accessed 08/01/2015.

2. Secondary Sources

Abrahamson, David. 'R. D. Laing and Long-Stay Patients: Discrepant Accounts of the Refractory Ward and `Rumpus Room' at Gartnavel Royal Hospital'. *History of Psychiatry*, vol. 18, no. 2 (June 2007): 203–15.

Adams, John. '"Challenge and Change in a Cinderella Service": A History of Fulbourn Hospital Cambridgeshire, 1953-1995.' Doctor of Philosophy, Open University, 2009. https://www2.rcn.org.uk/data/assets/pdf_file/0005/414644/Adams_John_complete_PhD.pdf.

Addison, P. *No Turning Back: The Peacetime Revolutions of Post-War Britain*. Oxford ; New York: Oxford University Press, 2010.

Ahrenfeldt, R. H. *Psychiatry in the British Army in the Second World War*. London: Routledge and Kegan Paul, 1958.

Aichhorn, August. *Wayward Youth*. London: Imago Publishing, 1951.

Akrivou, Kleio, and Hilary Bradbury-Huang. 'Executive Catalysts: Predicting Sustainable Organizational Performance amid Complex Demands'. *The Leadership Quarterly* 22, no. 5 (October 2011): 995–1009.

Alford, B. W. E. *British Economic Performance, 1945-1975*, Cambridge; New York, NY, USA: Cambridge University Press, 1995.

Alldridge, Patricia. 'Hospitals, Madhouses and Asylums: Cycles in the Care of the Insane'. *British Journal of Psychiatry*, vol. 134 (1979): 321–34.

Altschul, A.T. *Aids to Psychiatric Nursing*. Second. London: Balliére, Tindall, & Cox, 1964.

Altschul, A. T. *Patient-Nurse Interaction; a Study of Interaction Patterns in Acute Psychiatric Wards*. University of Edinburgh. Dept. of Nursing Studies. Monograph No. 3. Edinburgh: Churchill Livingstone, 1972.

Ambrose, Anthony. 'An Introduction to Transitional Thinking'. In *The Transitional Approach to Change*, by Gilles Amado, Anthony Ambrose, and Rachel Amato. London: Karnac, 2001.

Andrews, Jonathan. 'R. D. Laing in Scotland: Fact and Fictions of the "Rumpus Room" and Interpersonal Psychiatry'. In *Cultures of Psychiatry*, edited by Marijka Gijswijt-Hofstra and Roy Porter, 121–50. Amsterdam: Rodopi, 1998.

Andrews, Jonathan, and Iain Smith. 'The Evolution of Psychiatry in Glasgow during the Nineteenth and Twentieth Centuries'. In *150 Years of British Psychiatry 1841-1991*, edited by German E. Berrios and Hugh Freeman, 309–38. London: Gaskell, 1991.

Anon., ‘Freedom in Mental Hospitals: The End and the Means’. *The Lancet*, vol. 264 (1954): 964–66.

Anon., ‘Leading Article: Preventive Psychiatry’. *The Lancet*, vol. 267 (1956): 1087.

Anon., ‘No Benefit of Jury’. In *The Plea for the Silent*, edited by Donald M. Johnson and Norman Dodds, 11-31. London: Christopher Johnson, 1957.

Anon., ‘An Unnecessary Stigma’. In *The Plea for the Silent*, edited by Donald M. Johnson and Norman Dodds, 32–42. London: Christopher Johnson, 1957.

Anon., ‘Strange Therapeutics’. In *The Plea for the Silent*, edited by Donald M. Johnson and Norman Dodds, 66–80. London: Christopher Johnson, 1957.

Anon., ‘Fear Gripped Me’. In *The Plea for the Silent*, edited by Donald M. Johnson and Norman Dodds, 110–26. London: Christopher Johnson, 1957.

Anon., ‘A Doctor’s Story’, In *The Plea for the Silent*, edited by Donald M. Johnson and Norman Dodds, 127-134, London: Christopher Johnson, 1957.

Anon., ‘Joint Meeting of the Royal Society of Medicine (Section of Psychiatry and the Royal Medico-Psychological Association (Maudsley Bequest)’. *The British Journal of Psychiatry*, vol. 104, no. 435 (1958): 491–491.

Anon., ‘Obituary: G. R. Hargreaves’. *British Medical Journal*, vol. 1, no. 5323 (1963): 62–63.

Anon., ‘Obituary: Thomas Percy Rees’. *The Lancet*, vol. 281 (1963): 1331–32.

Anon., ‘Schizophrenia from Within’. In *Schizophrenia from Within*, edited by J. K. Wing, 29–44. Surbiton, Surrey: National Schizophrenia Fellowship, 1975.

Anon., ‘Leading Article: Asylums Are Still Needed’. *British Medical Journal*, vol. 1, no. 6002 (1976): 111–12.

Anon., (British Psychodrama Association). ‘A Brief History of Psychodrama’, 2007. http://www.psychodrama.org.uk/view_document.php?id=84, accessed 08/04/2015.

Anton-Stephens, D. ‘Preliminary Observations on the Psychiatric Uses of Chlorpromazine (Largactil)’. *Journal of Mental Science*, vol. 100, no. 419 (1954): 543–57.

Archer, Margaret Scotford, Roy Bhaskar, Andrew Collier, Tony Lawson, and Alan Norrie, ed., *Critical Realism: Essential Readings*, Critical Realism--Interventions (London ; New York: Routledge, 1998)

Armstrong, Neil. ‘What Leads to Innovation in Mental Healthcare? Reflections on Clinical Expertise in a Bureaucratic Age’. *British Journal of Psychiatry Bulletin*, 2 May 2018, 1–4.

Aslan, Laura, and Rowdy Yates. 'Exploring the "Black-Box" of Therapeutic Community (TC) Methodology and the Subjective Experiences of Residents within TC Structures'. *Therapeutic Communities: The International Journal of Therapeutic Communities* 36, no. 2 (2015)

.

Balint, Michael. *The Doctor, His Patient and the Illness*. 2nd ed., revised & enlarged, reprinted. London: Pitman Paperbacks, 1968.

Ballatt, John, and Penelope Campling. *Intelligent Kindness: Reforming the Culture of Healthcare*. London: RCPsych Publications, 2011.

Bancroft, J., and I. Marks. 'Electric Aversion Therapy of Sexual Deviation'. *Proceedings of the Royal Society of Medicine* 61 (1968): 796–99.

Barker, Phil, and Ben Davidson. *Psychiatric Nursing: Ethical Strife*. London: Arnold, 1998.

Barnes, Mary, and Joseph Berke. *Mary Barnes: Two Accounts of a Journey through Madness*. Harmondsworth: Penguin, 1982.

Baron, C. 'The Paddington Day Hospital: Crisis and Control in a Therapeutic Institution'. *International Journal of Therapeutic Communities* 5, no. 3 (1984): 157–70.

Baron, C. *Asylum to Anarchy*. London: Free Association Books, 1987.

Barton, Russell. *Institutional Neurosis*. Third. Bristol: John Wright and Sons, 1976.

Baruch, Geoff, and Andrew Treacher. *Psychiatry Observed*. London ; Boston: Routledge & K. Paul, 1978.

Batson, C. Daniel. *Altruism in Humans*. Oxford ; New York: Oxford University Press, 2011.

Battaly, Heather D. 'Is Empathy a Virtue?' In *Empathy: Philosophical and Psychological Perspectives*, edited by Amy Coplan and Peter Goldie, 277–301. Oxford: Oxford University Press, 2011.

Beardshaw, Virginia, Oliver Thorold, and Social Audit Ltd. *Conscientious Objectors at Work : Mental Hospital Nurses : A Case Study*. London: Social Audit, 1981.

Belknap, Ivan. *Human Problems of a State Mental Hospital*. New York: McGraw-Hill, 1956.

Bell, G. M. 'A Mental Hospital with Open Doors'. *International Journal of Social Psychiatry*, vol. 1, no. 1 (1955): 42–48.

Bennett, D. H. 'The Historical Development of Rehabilitation Services'. In *Theory and Practice of Psychiatric Rehabilitation*, edited by F. N. Watts and D. H. Bennett, 15–42. Chichester: John Wiley & Sons, 1983.

Bennett, D, H., Steven Folkard, and Audrey K. Nicholson. 'Resettlement in a Mental Hospital Unit'. *The Lancet*, vol. 278 (1961): 539–41.

Berke, J. 'Reflections on Arbours'. *International Journal of Therapeutic Communities*, vol. 11, no. 4 (1990): 191–95.

Bettelheim, Bruno, and Emmy Sylvester. 'A Therapeutic Milieu'. *American Journal of Orthopsychiatry* 18 (1948): 191–206.

Beveridge, Allan. *Portrait of the Psychiatrist as a Young Man: The Early Writing and Work of R.D. Laing, 1927-1960*. New York: Oxford University Press, 2011.

Bewley, Thomas. *Madness to Mental Illness: A History of the Royal College of Psychiatrists*. London: RCPsych Publications, 2008.

Bhurruth, Martin K. 'Some Impressions on Taking on the Leadership of a Therapeutic Community'. *Therapeutic Communities*, vol. 36, no. 4 (2015): 219–28.

Bickford, J.A.R. 'Treatment of the Chronic Mental Patient'. *The Lancet*, vol. 263 (1954): 924–27.

Bickford, J.A.R. 'The Forgotten Patient'. *The Lancet*, vol. 266 (1955), 917–919.

Bickford, J.A.R. 'The Forgotten Patient II One Solution'. *The Lancet*, vol. 266 (5 November 1955): 969–71.

Bierer, J. 'Group Psychotherapy'. *British Medical Journal*, vol. 1, no. 4232 (1942): 214–16.

Bierer, J. 'Letter: Day Hospitals'. *The Lancet*, vol. 269 (1957): 888.

Bierer, J. 'Theory and Practice of Psychiatric Day Hospitals'. *The Lancet*, vol. 274 (1959): 901–902.

Bierer, J. 'Day Hospitals: Further Developments'. *International Journal of Social Psychiatry* vol. 7 (1961): 148–151.

Bierer, J, and R. I. Evans. *Innovations in Social Psychiatry: A Social Psychological Perspective through Dialogue*. London: The Avenue Publishing Co., 1969.

Bion, W. R. 'The Leaderless Group Project'. *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 77–81.

Bion, W. R. *Experiences in Groups and Other Papers*. London: Tavistock, 1961.

Bion, W. R., and J Rickman. 'Intra-Group Tensions in Therapy: Their Study as the Task of the Group'. *The Lancet*, vol. 242 (1943): 678–81.

Birtle, Jan, Chris Newrith, Iona Brown, Bobby Mousse, Michael Bennett, and Graham Mackay. 'Leadership in a New Therapeutic Community: Learning to Regulate the Temperature'. *Therapeutic Communities*, vol. 25, no. 2 (2004): 85–99.

Black, Lawrence, and Hugh Pemberton. 'Introduction: The Benighted Decade? Reassessing the 1970s'. In *Reassessing 1970s Britain*, edited by Lawrence Black, Hugh Pemberton, and Pat Thane, 1–24. Manchester: Manchester University Press, 2016.

Blacker, C. P. *Neurosis and the Mental Health Services*. Oxford: Humphrey Milford, 1946.

Bléandonu, G. 'A La Recherche de La Communauté Thérapeutique (á Propos d'une Bourse Du Conseil de l'Europe)'. *L'Information Psychiatrique*, vol. 44, no. 8 (1968): 739–51.

Bléandonu, G. *Wilfred Bion: His Life and Works 1897-1979*. Translated by C. Pajaczkowska. London: Free Association Books, 1994.

Bloor, M. J. 'Social Control in the Therapeutic Community: Re-Examination of a Critical Case'. *Sociology of Health and Illness*, vol. 8, no. 4 (1986): 302–24.

Bloor, M. J., and J. D. Fonkert. 'Reality Construction, Reality Exploration and Treatment in Two Therapeutic Communities'. *Sociology of Health and Illness*, vol. 4, no. 2 (1982): 125–40.

Bloor, M. J., Neil P. McKeganey, and Dick Fonkert. *One Foot in Eden: A Sociological Study of the Range of Therapeutic Community Practice*. London: Routledge, 1988.

Boden, M. A. 'Purpose, Personality, Creativity'. In *Psychology in Britain: Historical Essays and Personal Reflections*, edited by G. C. Bunn, A. D. Lovie, and G. D. Richards, 353–63. Leicester: British Psychological Society, 2001.

Bolten, M. P. 'Training for Leadership: Administration in a Psychotherapeutic Community'. *International Journal of Therapeutic Communities*, vol. 12, no. 1 (1991).

Booker, Christopher. *The Seventies: Portrait of a Decade*. Harmondsworth: Penguin, 1980.

Bornat, Joanna. 'Remembering and Reworking Emotions: The Reanalysis of Emotion in an Interview'. *Oral History*, vol. 38, no. 2 (2010): 43–52.

Bott, Elizabeth. 'Hospital and Society'. *British Journal of Medical Psychology*, vol. 49 (1976): 97–140.

Bourdieu, Pierre. *In Other Words : Essays towards a Reflexive Sociology*. Oxford: Polity, 1990.

Bourdieu, Pierre, and Loïc J. D Wacquant. *An Invitation to Reflexive Sociology*. Chicago: University of Chicago Press, 1992.

Bourke, Joanna. *Working Class Cultures in Britain, 1890-1960 : Gender, Class, and Ethnicity*. London; New York: Routledge, 1994.

Bowen, W. A. L. 'Need for Inspection (or Survey) of Psychiatric Hospital Services'. In *Psychiatric Hospital Care*, edited by Hugh Freeman, 14–20. London: Balliére, Tindall, & Cassell, 1965.

Bowers, Len. 'Runaway Patients': *Mental Health Practice*, vol. 7, no. 1 (2003): 10–12.

Boyd, R., and P. J. Richerson. 'Culture and the Evolution of the Human Social Instincts'. In *Roots of Human Sociality*, edited by N.J. Enfield and Stephen C. Levinson, 453–77. Oxford, New York: Berg, 2006.

Bridgeland, Maurice. *Pioneer Work with Maladjusted Children: A Study of the Development of Therapeutic Education*. London: Staples Press, 1971.

Bridger, H. 'A Viewpoint on Organizational Behaviour'. edited by G. Wostenholme and H. O'Connor. Istanbul: Churchill J. & A., 1971.

Bridger, H. 'The Northfield Experiment'. *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 71–76.

Bridger, H. 'Groups in Open and Closed Systems'. In *The Therapeutic Community Today: A Moment of Reflection on Its Evolution. Proceedings of the First World Institute of Therapeutic Communities. Casstel Gandolfo, Italy, August 27-31, 1984.*, edited by World Federation of Therapeutic Communities. World Federation of Therapeutic Communities, 1984.

Bridger, H. 'Northfield Revisited'. In *Bion and Group Psychotherapy*, edited by M. Pines, 87–107. London: Routledge and Kegan Paul, 1985.

Bridger, H. 'Courses and Working Conferences as Transitional Learning Institutions'. In *Training, Theory and Practice*, edited by W. Brendan-Reddy and C. C. Henderson, 221–45. Washington D. C.: NTL University/University Associates, 1987.

Briggs, Dennie. 'Reflections on an Incident at Dingleton'. *International Journal of Therapeutic Communities*, vol. 12, no. 2&3 (1991): 145–54.

Brill, Miriam, and Nurit Nahmani. 'The Presence of Compassion in Therapy'. *Clinical Social Work Journal*, vol. 45, no. 1 (March 2017): 10–21.

Brimblecombe, Neil R. 'The Changing Relationship between Mental Health Nurses and Psychiatrists in the United Kingdom'. *Journal of Advanced Nursing*, vol. 49, no. 4 (2005): 344–53.

Broad, Roger. *The Radical General Sir Ronald Adam and Britain's New Model Army 1941-1946.* Stroud: History, 2013.

Bronk, Richard. *The Romantic Economist: Imagination in Economics*. Cambridge, UK ; New York: Cambridge University Press, 2009.

Brook, C. P. B. 'Psychiatric Units in General Hospitals'. *The Lancet*, vol. 284 (1964): 684–86.

Brown, J. F. *Psychology and the Social Order*. New York and London: McGraw-Hill, 1936.

Bryant, A., and K. Charmaz, 'Introduction', in *The SAGE Handbook of Grounded Theory*, ed. A. Bryant and K. Charmaz, 1-28. (London: Sage, 2010)

Bunn, G. C. 'Introduction'. In *Psychology in Britain: Historical Essays and Personal Reflections*, edited by G. C. Bunn, A. D. Lovie, and G. D. Richards, 1–29. Leicester: British Psychological Society, 2001.

Burfield, Diana. 'Tavistock Publications: A Partial History.' *Management and Organizational History*, vol. 4, no. 2 (2009): 207–22.

Burnham, John C. 'Transnational History of Medicine after 1950: Framing and Interrogation from Psychiatric Journals.' *Medical History*, vol. 55 (2011): 3–26.

Burns, James MacGregor. *Leadership*. 1st ed. New York: Harper & Row, 1978.

Burns, Tom, and Judy Leibowitz. 'The Care Programme Approach: Time for Frank Talking'. *Psychiatric Bulletin*, vol. 21, no. 7 (1997): 426–29.

Burridge, Terry. 'On Joining a Therapeutic Community'. *Therapeutic Communities*, vol. 18, no. 2 (1997): 145–47.

Burrow, T. *The Social Basis of Consciousness: A Study in Organic Psychology*. London: Kegan Paul, Trench and Trubner, 1927.

Burrow, T. 'Biological Foundations and Mental Methods'. *British Journal of Medical Psychology*, vol. 8 (1928): 49–63.

Burrow, T. 'The Basis of Group-Analysis or the Analysis of the Reactions of Normal and Neurotic Individuals'. *British Journal of Medical Psychology*, vol. 8 (1928): 198–206.

Burrow, T. 'The Group Method of Analysis'. *Psychoanalytic Review*, vol. 14 (1928): 268–280.

Burrow, T., Edi Gatti Pertegato and Giorgio Orghe Pertegato. *From Psychoanalysis to Group Analysis: The Pioneering Work of Trigant Burrow*. New International Library of Group Analysis. London: Karnac, 2013.

Burston, Daniel. *The Wing of Madness: The Life and Work of R.D. Laing.* Cambridge, Mass.; London: Harvard University Press, 1998.

Busfield, Joan. *Managing Madness: Changing Ideas and Practice*. London: U. Hyman, 1989.

Butler, Judith. *Giving an Account of Oneself*. 1st ed. New York: Fordham University Press, 2005.

Butler, Tom. *Changing Mental Health Services: The Politics and Policy*. 1. ed. London: Chapman & Hall, 1993.

Byrt, R. 'Nursing: The Importance of the Psychosocial Environment'. In *Therapeutic Communities: Past, Present and Future*, edited by P. Campling and R Haigh, 63–75. London: Jessica Kingsley, 1999.

Calder, Angus. *The People's War : Britain 1939 - 1945*. London: Pimlico, 1992.

Callahan, Christopher M., and G. E. Berrios. *Reinventing Depression: A History of the Treatment of Depression in Primary Care, 1940-2004*. Oxford ; New York: Oxford University Press, 2005

.

Cameron, J. L., R. D. Laing, and A. McGhie. 'Patient and Nurse: Effects of Environmental Changes in the Care of Chronic Schizophrenics'. *The Lancet*, vol. 266 (1955): 1384–86.

Campling, Penelope. 'Boundaries: Discussion of a Difficult Transition'. In *Therapeutic Communities: Past, Present and Future*, edited by Penelope Campling and Rex Haigh. London: Jessica Kingsley Publishers, 1999.

Campling, Penelope. 'Maxwell Jones Lecture 2001 - Response to Jane Knowles'. *Therapeutic Communities*, vol. 22, no. 4 (2001): 287–91.

Campling, Penelope. 'Containment: From Cruelty to Kindness'. *Therapeutic Communities: The International Journal of Therapeutic Communities*, vol. 36, no. 1 (2015): 21–28.

Capoore, H. S., and J. W. G. Nixon. 'Short-Stay Psychiatric Unit in a General Hospital'. *The Lancet*, vol. 278 (1961): 1351–52.

Carmel, Sara, and Seymour M. Glick. 'Compassionate-Empathic Physicians: Personality Traits and Social-Organizational Factors That Enhance or Inhibit This Behaviour Pattern'. *Social Science and Medicine*, vol. 45, no. 8 (1996): 1253–61.

Carmeli, Abraham, and Zachary Sheaffer. 'How Leadership Characteristics Affect Organizational Decline and Downsizing'. *Journal of Business Ethics*, vol. 86, no. 3 (2009): 363–78.

Carroll, L. *Alice's Adventures in Wonderland, and Through the Looking-Glass.* London: Book Club Associates, 1973.

Carstairs, G. M., and A Heron. 'The Social Environment of Mental Hospital Patients: A Measure of Staff Attitudes'. In *The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behaviour*, by Milton Greenblatt, Daniel J Levinson, and Richard J Williams, 218–30. Glencoe, Illinois: The Free Press, 1957.

Carstairs, G. M., and J. K. Wing. 'Attitudes of the General Public to Mental Illness'. *British Medical Journal*, vol. 2, no. 5096 (1958): 594–597.

Casper, Stephen. 'The Origins of the Anglo-American Research Alliance and the Incidence of Civilian Neuroses in Second World War Britain.' *Medical History*, vol. 52 (2008): 327–46.

Castel, Françoise, Robert Castel, and Anne Lovell. *The Psychiatric Society*. European Perspectives. New York: Columbia University Press, 1982.

Chalmers, I., K. Dickersin, and T. C. Chalmers. 'Getting to Grips with Archie Cochrane's Agenda.' *British Medical Journal*, vol. 305, no. 6857 (1992): 786–88.

Cherry, Steven. *Mental Health Care in Modern England : The Norfolk Lunatic Asylum/St. Andrew's Hospital, 1810-1998*. Woodbridge: Boydell, 2003.

Chiesa, M, M Wright, and L Delphine. 'Psychotropic Medication and the Therapeutic Community: A Survey of Prescribing Practices for Severe Personality Disorder.' *Therapeutic Communities*, vol. 25, no. 2 (2004): 131–44.

Chiesa, M. 'Modernization or Privatization? The Future of the NHS and Implication of Governmental Reforms for Psychotherapy Services'. *Psychoanalytic Psychotherapy*, vol. 19, no. 1 (2005): 71–85.

Cixous, Hélène, and Catherine Clément. *The Newly Born Woman*. Manchester: Manchester University Press, 1987.

Clare, Anthony. *In the Psychiatrist's Chair*. London: Heinemann, 1992.

Clark, D. H. 'Reform in the Mental Hospital: A Critical Study of a Programme'. *International Journal of Social Psychiatry*, vol. 3, no. 3 (1957): 211–23.

Clark, D. H. 'Letter: The Open Door'. *The Lancet,* vol. 280 (1962): 881.

Clark, D. H. *Administrative Therapy: The Role of the Doctor in the Therapeutic Community*. Mind and Medicine Monographs 9. London: Tavistock, 1964.

Clark, D. H. 'The Therapeutic Community - Concept, Practice and Future'. *British Journal of Psychiatry*, vol. 111 (1965): 947–54.

Clark, D. H. 'The Therapeutic Community'. *British Journal of Psychiatry*, vol. 131 (1977): 553–64.

Clark, D. H. *Social Therapy in Psychiatry*. Edinburgh; New York: Churchill Livingstone, 1981.

Clark, D. H. *The Story of a Mental Hospital : Fulbourn, 1858-1983*. London: Process Press, 1996.

Clark, D. H. 'Fifty Years on - Some Personal Reflections'. *Therapeutic Communities*, vol. 17, no. 3 (1996): 155–57.

Clark, D. H. 'Letter'. *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 3 (2001): 6.

Clarke, Liam. 'The Opening of Doors in British Mental Hospitals in the 1950s'. *History of Psychiatry*, vol. 4, no. 4 (1993): 527–51.

Clay, John. *R. D. Laing: A Divided Self : A Biography*. London: Hodder & Stoughton, 1996.

Clayton, John James. 'Letters from Grendon Underwood, C Wing, after the Peer Review Visit to Ingrebourne. 2'. *Joint Newsletter of the Planned Environment Therapy Trust, the Charterhouse Group of Therapeutic Communities and the Association of Therapeutic Communities, with the Community of Communities*, no. 6 (2002): 17.

Coates, Morag. *Beyond All Reason*. London: Constable, 1964.

Cohen, Sheila, 'Equal Pay – or What? Economics, Politics and the 1968 Ford Sewing Machinists' Strike', *Labour History*, vol. 53, no. 1 (February 2012), 51–68

Conolly, John. *Treatment of the Insane without Mechanical Restraints*. London: Smith, Elder and Co., 1856.

Cook, Hera. *The Long Sexual Revolution English Women, Sex, and Contraception, 1800-1975*. Oxford; New York: Oxford University Press, 2004.

Cooke, Bill. 'The Tavistock's Everyday Use of Benzedrine, and More: On the Multiple Significances of DB, Scholar-Publisher'. *Management and Organizational History* 4, no. 2 (2009): 203–6.

Cooper, David. *Psychiatry and Anti-Psychiatry*. London: Tavistock, 1967.

Cooper, David, ed. *The Dialectics of Liberation*. Harmondsworth: Penguin Books, 1968.

Cooper, Fred. '"Cut It out at Last like the Cancer Which It Is": Prevention and Responsibility in the Loneliness Epidemic of the Late 1950s and Early 1960s.' presented at the

Preventing Mental Illness: Past, Present and Future, Ross Priory, University of Strathclyde, 2016.

Coplan, Amy, and Peter Goldie, eds. *Empathy: Philosophical and Psychological Perspectives*. Oxford: Oxford University Press, 2014.

Cormack, Desmond. *Psychiatric Nursing Observed*. London: Royal College of Nursing, 1976.

Cresswell, Tim. *Place: A Short Introduction*. Short Introductions to Geography. Malden, MA: Blackwell Pub, 2004.

Crisp, Arthur. 'Introduction'. *Journal of Psychosomatic Research*, vol. 10 (1966): 1.

Crocket, R. W. 'Our Mental Hospitals: Can we Reform Them Out of Existence?', *The Observer*, 21st October 1956, 6.

Crocket, R. W. 'The "Therapeutic Community" Approach to Neuroses'. In *Neuroses: I. Congressus Psychiatricus Bohemoslovenicus Cum Participatione Internationali 1959*, 271–78. Prague: Státní zdravotnické nalkadatelství, 1961.

Crocket, R. W. 'Aspects of Communication in the Therapeutic Community Approach to Psychotherapy'. *Proceedings of the Third World Congress of Psychiatry*, Toronto: University of Toronto Press, 1961, 269–74.

Crocket, R. W. 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre'. *International Journal of Group Psychotherapy*, vol. 12, no. 1 (1962): 180–93.

Crocket, R. W. 'Initiation of the Therapeutic Community Approach to Treatment in a Neurosis Centre, Crocket's own copy annotated by Anderson, H.' *International Journal of Group Psychotherapy*, vol. 12 (1962): 180-93, PP/RC/26/10/04/03.

Crocket, R. W. 'Acting out as a Mode of Communication in a Psychotherapeutic Community.' *British Journal of Psychiatry*, vol. 112 (1966): 383–88.

Crocket, R. W. 'Authority and Permissiveness in the Psychotherapeutic Community: Theoretical Perspectives.' *American Journal of Psychotherapy*, vol. 20, no. 4 (1966): 669–76.

Crocket, R. W., and Ronald St. Blaize-Molony. 'Social Ramifications of the Therapeutic Community Approach in Psychotherapy'. *British Journal of Medical Psychology*, vol. 37 (1964): 153–56.

Crocket, R. W., R. A. Sandison, and A Walk, eds. *Hallucinogenic Drugs and Their Psychotherapeutic Use: Proceedings of the Quarterly Meeting of the Royal Medico-Psychological Association in London February 1961*. London: H.K. Lewis and Co., 1963.

Crofts, Fay. *History of Hollymoor Hospital*. Studley: Brewin, 1998.

Crossley, N. *Contesting Psychiatry*. London: Routledge, 2006.

Crossley, N. 'R. D. Laing and the British Anti-Psychiatry Movement: A Socio-Historical Analysis'. *Social Science & Medicine*, vol. 47, no. 7 (1998): 877–89.

Crossley, N. 'Transforming the Mental Health Field: The Early History of the National Association for Mental Health.' *Sociology of Health and Illness*, vol. 20, no. 4 (1998): 458–488.

Crossley, N. 'Working Utopias and Social Movements: An Investigation Using Case Study Materials from Radical Mental Health Movements in Britain'. *Sociology*, vol. 33, no. 4 (1999): 809–30.

Crozier, Anne. 'Attempts at Democracy'. In *Therapeutic Communities: Reflections and Progress*, by R. D Hinshelwood and N Manning, 263–71. London: Routledge & Kegan Paul, 1979.

Curtis, Sarah. *Space, Place and Mental Health*. Geographies of Health. Farnham, Surrey, England ; Burlington, VT: Ashgate Pub, 2010.

Custance, J. 'Mental Hospitals and Mental Treatment'. *International Journal of Social Psychiatry*, vol. 1, no. 1 (1955): 66–70.

Dally, Ann. 'Sargant, William Walters (1907-1988)'. In *The Oxford Dictionary of National Biography*. Oxford: Oxford University Press, 2004. http://www.oxforddnb.com, accessed 06/09/2018.

Dartington, Tim. 'Foreword'. In *Intelligent Kindness*, by John Ballatt and Penelope Campling, iv–vi. London: RCPsych Publications, 2011.

Darwin, Charles. *The Descent of Man*. 2nd ed. Great Minds Series. Amherst, N.Y: Prometheus Books, 1871.

Davidson, Joyce, and Hester Parr. 'Geographies of Psychic Life', in *Psychoanalytic Geographies,* ed. Paul Kingsbury and Steve Pile (Farnham: Ashley Publishing, 2014).

Davies, Christie. *Permissive Britain: Social Change in the Sixties and Seventies*. London: Pitman, 1975.

Davies, Kerry. '"A Small Corner That's for Myself". Space, Place and Patients' Experiences of Mental Health Care 1948-98'. In *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*, edited by Leslie Topp, James E. Moran, and Jonathan Andrews, 305–20. London: Routledge Taylor & Francis Group [distributor], 2011.

Davies, Kerry. '"Silent and Censured Travellers"? Patients' Narratives and Patients' Voices: Perspectives on the History of Mental Illness since 1948'. *Social History of Medicine*, vol. 14, no. 2 (2001): 267–92.

Davies, M H. 'Psychodrama Group Therapy'. In *Group Therapy in Britain*, edited by M. Aveline and W. Dryden. Psychotherapy in Britain. Milton Keynes: Open University Press, 1988.

Davis, J. 'The London Drug Scene and the Making of Drug Policy 1965-73'. *Twentieth Century British History*, vol. 17, no. 1 (2006): 26–49.

De Leon, George. 'The Therapeutic Community: Status and Evolution'. *International Journal of Addictions*, vol. 20 (1985): 823–244.

Diamond, John. 'Who's in Charge Here? - Managing the Mess'. *International Journal of Therapeutic Communities*, vol. 24, no. 1 (2003): 5–21.

Dicks, Henry Victor. *Fifty Years of the Tavistock Clinic*. London: Routledge & K. Paul, 1970.

Diedrich, Alice, Michaela Grant, Stefan G. Hofmann, Wolfgang Hiller, and Matthias Berking. 'Self-Compassion as an Emotion Regulation Strategy in Major Depressive Disorder'. *Behaviour Research and Therapy*, vol. 58 (2014): 43–51.

Digby, Anne. *Madness, Morality, and Medicine: A Study of the York Retreat, 1796-1914*. Cambridge History of Medicine. Cambridge ; New York: Cambridge University Press, 1985.

Dixon, Thomas. *The Invention of Altruism: Making Moral Meanings in Victorian Britain*. A British Academy Postdoctoral Fellowship Monograph. Oxford ; New York: Published for the British Academy by Oxford University Press, 2008.

Dixon, Thomas. *Weeping Britannia: Portrait of a Nation in Tears*. Oxford, United Kingdom: Oxford University Press, 2015.

Dolan, B. M., F. M. Warren, D. Menzies, and K. Norton. 'Cost-Offset Following Specialist Treatment of Severe Personality Disorders'. *Psychiatric Bulletin*, vol. 20, no. 07 (1996): 413–17.

Doroshow, D. B. 'Performing a Cure for Schizophrenia: Insulin Coma Therapy on the Wards'. *Journal of the History of Medicine and Allied Sciences*, vol. 62, no. 2 (2006): 213–43.

Double, D. B. 'The History of Anti-Psychiatry: An Essay Review'. *History of Psychiatry*, vol. 13 (2002): 231–36.

Double, D.B. 'The Limits of Psychiatry'. *British Medical Journal*, vol. 324, no. 7342 (2002): 900–904.

Double, D.B. 'Critical Psychiatry: Challenging the Biomedical Dominance of Psychiatry'. In *Critical Psychiatry: The Limits of Madness*, by D.B. Double, 3–15, Basingstoke: Palgrave Macmillan, 2006.

Druskat, Vanessa U., and Jane V. Wheeler. 'Managing from the Boundary: The Effective Leadership of Self-Managing Work Teams'. *Academy of Management Journal*, vol. 46, no. 4 (2003): 435–57.

Dunbar, R. I. M. *Grooming, Gossip and the Evolution of Language*. London: Faber and Faber, 2004.

Dyck, E. *Psychedelic Psychiatry: LSD from Clinic to Campus*. Baltimore, Md: Johns Hopkins University Press, 2008.

Earle, Joe, Cahal Moran, and Zach Ward-Perkins. *The Econocracy: The Perils of Leaving Economics to the Experts*. Manchester Capitalism. Manchester: Manchester University Press, 2017.

Early, Donal F, Glenside Hospital Museum, and Friends. *'The Lunatic Pauper Palace': Glenside Hospital Bristol, 1861-1994 : Its Birth, Development and Demise*. Bristol: Friends of Glenside Hospital Museum, 2003.

Edgerton, D. *Warfare State Britain, 1920-1970*. Cambridge: Cambridge University Press, 2006.

Eghigian, G. 'Deinstitutionalizing the History of Contemporary Psychiatry'. *History of Psychiatry*, vol. 22, no. 2 (2011): 201–214.

Elias, N. *What Is Sociology?* New York: Columbia University Press, 1978.

Ettin, M. *Foundations and Applications of Group Psychotherapy: A Sphere of Influence*. Jessica Kingsley, 1999.

Ex-pupil Mulberry Bush School. '"I Have Been Waiting to Say That for a Long Time....'"'. *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 12 (2004): 31.

Eykman, Hans. 'The Loneliness of the Leader: Reflections on Psychotherapeutic Leadership'. *International Journal of Therapeutic Communities*, vol. 12, no. 1 (1991): 29–34.

Fainman, David. 'Quo Vadis in the Therapeutic Community: Leadership and Training for What?' *Therapeutic Communities*, vol. 16, no. 2 (1995): 103–11.

Fairbairn, W. R. D. 'Object Relations and Dynamic Structure'. In *Psycho-Analytic Studies of the Personality*, 137–61. London: Tavistock, 1952.

Fairclough, Norman. *Analysing Discourse: Textual Analysis for Social Research*. London ; New York: Routledge, 2003.

Farndale, James. *The Day Hospital Movement in Great Britain*. London: Pergamon Press, 1961.

Farndale, James. 'British Day Hospitals'. In *Trends in the Mental Health Services*, edited by H. Freeman and J. Farndale, 177–86. London: Pergamon Press, 1963.

Fees, Craig
http://www.pettrust.org.uk/index.php?option=com_content&view=article&id=967:craig-fees-1997-2001-comment-denis-carroll-and-the-second-northfield-experiment&catid=266&Itemid=407, accessed 02/08/2018.

Field, Geoffrey G. *Blood, Sweat, and Toil: Remaking the British Working Class, 1939-1945*. Oxford: Oxford University Press, 2013.

Firth, Wilson. 'Acute Psychiatric Wards: An Overview'. In *From Toxic Institutions to Therapeutic Environments: Residential Settings in Mental Health Services*, edited by Penelope Campling, Steffan Davies, and Graeme Farquharson, 174–87. London: Gaskell, 2008.

Fish, Frank. *Schizophrenia*. Bristol: John Wright and Sons, 1962.

Fish, Frank. *An Outline of Psychiatry for Students and Practitioners*. Bristol: John Wright and Sons, 1964.

Fish, Frank. 'Psychiatry as a Medical Specialty'. *The Lancet*, vol. 285 (1965): 565–67.

Fish, Frank. *Clinical Psychopathology: Signs and Symptoms in Psychiatry*. Bristol: John Wright and Sons, 1967.

Foot, John. *The Man Who Closed the Asylums: Franco Basaglia and the Revolution in Mental Health Care*. London ; Brooklyn, NY: Verso, 2015.

Forster, Laurel. 'Spreading the Word: Feminist Print Cultures and the Women's Liberation Movement'. *Women's History Review*, vol. 25, no. 5 (2016): 812–31.

Foster, A. 'The Management of Boundary Crossing'. In *Therapeutic Communities: Reflections and Progress*, eds. R. D Hinshelwood and N Manning. London: Routledge & Kegan Paul, 1979.

Fotaki, Marianna. 'Can Consumer Choice Replace Trust in the National Health Service in England? Towards Developing an Affective Psychosocial Conception of Trust in Health Care'. *Sociology of Health & Illness*, vol. 36, no. 8 (2014): 1276–94.

Fotaki, Marianna. 'Why and How Is Compassion Necessary to Provide Good Quality Healthcare?' *International Journal of Health Policy and Management*, vol. 4, no. 4 (2015): 199–201.

Fotaki, Marianna. 'What Money Cannot Buy? Compassion in Healthcare: A Response to the Recent Commentaries'. *International Journal of Health Policy and Management*, vol. 4, no. 12 (2015): 873–74.

Foucault, Michel. *Discipline and Punish: The Birth of the Prison*. Harmondsworth: Penguin, 1991.

Foucault, Michel. 'The Ethics of the Concern for Self as a Practice of Freedom'. In *Michel Foucault: Ethics. Essential Works of Foucault 1954-1984.*, edited by Paul Rabinow, 1:281–301. Harmondsworth: Penguin, 1997.

Foucault, Michel. *Archaeology of Knowledge*. Routledge Classics. London ; New York: Routledge, 2002.

Foulkes, E. 'S.H Foulkes: A Brief Memoir'. In Foulkes, S. H. *Selected Papers: Psychoanalysis and Group Analysis*, Edited by Elizabeth Foulkes. London: Karnac Books, 1990. 3-20.

Foulkes, S. H. *Therapeutic Group Analysis*. George Allen and Unwin, 1964.

Foulkes, S. H. *Selected Papers of S.H. Foulkes: Psychoanalysis and Group Analysis*. Edited by Elizabeth Foulkes. London: Karnac Books, 1990.

Foulkes, S. H, and E J Anthony. *Group Psychotherapy: The Psychoanalytic Approach*. Second. Harmondsworth: Penguin, 1965.

Foulkes, S. H., and E. Lewis. 'Group Analysis; a Study in the Treatment of Groups on Psycho-Analytical Lines'. *Journal of Medical Psychology*, vol. 20 (1945): 175–84.

Fox, Nick. 'Postmodern Perspectives on Care: The Vigil and the Gift'. *Critical Social Policy*, vol. 15 (1995): 107–25.

Fox, Richard. 'Point of View: On Managers'. *The Lancet*, vol. 324 (1984): 628–29.

Franzosi, Roberto. 'Narrative Analysis-Or Why (And How) Sociologists Should Be Interested in Narrative', *Annual Review of Sociology*, vol. 24 (1998): 517–554

Freeman, Hugh. 'Oldham and District Psychiatric Service'. *The Lancet*, vol. 275 (1960): 218–21.

Freeman, Hugh. 'In Conversation with Kenneth Robinson (Minister of Health, October 1964-October 1968)'. *Psychiatric Bulletin*, vol. 12, no. 7 (1988): 258–62.

Freeman, Hugh. 'Mental Health Policy and Practice in the NHS: 1948-79'. *Journal of Mental Health*, vol. 7, no. 3 (1998): 225–39.

Freeman, Hugh. 'Psychiatry and the State in Britain'. In *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century*, edited by Marijka Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar, and Hugh Freeman, 116–40. Amsterdam: Amsterdam University Press, 2005.

Freeman, T. 'Perspective: An Occasional Series in Which Contributors Reflect on Their Careers and Interests in Psychiatry'. *Psychiatric Bulletin*, vol. 12, no. 8 (1988): 306–9.

Freud, S. *Group Psychology and the Analysis of the Ego*. Boni and Liveright, 1922.

Freud, S. 'Group Psychology and the Analysis of the Ego'. In *Civilization, Society and Religion*, edited by A. Dickson, translated by J. Strachey, 12:95–178. The Penguin Freud Library. Harmondsworth: Penguiin, 1991.

Frieden. *The Feminine Mystique*. New York: W. W. Norton, 1963.

Fussinger, C. 'Eléments Pour Une Histoire de La Communauté Thérapeutique Dans La Psychiatrie Occidentale de La Seconde Moitié Du 20e Siécle'. *Gesnerus*, vol. 67, no. 2 (2010): 217–40.

Fussinger, C. '"Therapeutic Community", Psychiatry's Reformers and Antipsychiatrists: Reconsidering Changes in the Field of Psychiatry after World War II'. *History of Psychiatry*, vol. 22, no. 2 (2011): 146–163.

Gabbard, Glenn O. 'Patient-Therapist Boundary Issues'. *Psychiatric Times*, vol. 22, no. 12 (2005): 28–32.

García, Inés, Claire Kennett, Mansur Quereshi, and Graham Durcan. *Acute Care 2004: A National Survey of Psychiatric Wards in England*. London: Sainsbury Centre for Mental Health, 2005.

Gardner, James. *Sweet Bells Jangled out of Tune : A History of the Sussex Lunatic Asylum (St Francis Hospital) Haywards Heath*. Brighton: The Author, 1999.

Gelder, M. 'Adolf Meyer and His Influence in British Psychiatry'. In *150 Years of British Psychiatry 1841-1991*, edited by German. E Berrios and Hugh Freeman, 419–35. London: Gaskell, 1991.

Gelder, M. 'Bertram Mandelbrote'. *The Psychiatrist*, vol. 35, no. 4 (2011): 158–158.

Gilsenan, B. M. C. 'Administration of Psychiatric Hospitals'. In *New Aspects of the Mental Health Services*, edited by Hugh Freeman and James Farndale, Vol. 7. The Westminster Series. Oxford: Pergamon Press, 1967.

Gittins, Diana. *Madness in Its Place Narratives of Severalls Hospital, 1913-1997*. London; New York: Routledge, 1998.

Glatt, M.M., K.F. Weeks, and J. S. Whiteley. 'Experiences of the Community Treatment of Neurosis in a Mental Hospital Unit'. *International Journal of Social Psychiatry*, vol. 3, no. 3 (1957): 203–10.

Glouberman, Sholom. *Keepers : Inside Stories from Total Institutions*. London: King Edward's Hospital Fund for London, 1990.

Goddard, H. A. *The Work of the Mental Nurse*. Manchester: Manchester University Press, 1955.

Goethals, Ilse, Wouter Vanderplasschen, Stijn Vandevelde and Eric Broekaert, 'Core Characteristics, Treatment Process and Retention in Therapeutic Communities for Addictions: A Summary of Four Studies.' *Therapeutic Communities: The International Journal of Therapeutic Communities*, vol. 36, no. 2 (2015): 89-102.

Goetz, Jennifer L., Dacher Keltner and Emiliana Simon-Thomas. 'Compassion: An Evolutionary Analysis and Empirical Review.' *Psychological Bulletin*, vol. 136, no. 3 (2010): 351–74.

Goffman, Erving. 'The Characteristics of Total Institutions'. In *Symposium on Preventive and Social Psychiatry: 15-17 April 1957*, edited by David McK. Rioch. Washington D. C.: Walter Reed Army Institute of Research, Walter Reed Army Medical Centre, 1957.

Goffman, Erving. *Asylums: Essays on the Social Situation of Mental Patients and Other Inmates*.. Harmondsworth: Penguin, 1968.

Golding, William, *Lord of the Flies*. London: Faber and Faber, 2012.

Goodwin, Simon. 'Community Care for the Mentally Ill in England and Wales: Myths, Assumptions and Reality'. *Journal of Social Policy*, vol. 18, no. 1 (2009): 27.

Gore, Charles, and Kathleen Jones. 'Survey of a Long-Stay Mental Hospital Population'. *The Lancet*, vol. 278 (1961): 544–46.

Gostin, Larry O. *A Human Condition*. Vol. 1&2. 2 vols. London: MIND, 1975.

Gray, S G. 'The Tavistock Institute of Human Relations'. In *Fifty Years of the Tavistock Clinic*, by H. V. Dicks, 206–27. London: Routledge and Kegan Paul, 1970.

Green, Jonathon. *Days in the Life: Voices from the English Underground 1961 - 1971*. Pimlico 291. London: Pimlico, 1998.

Greenblatt, Milton, Daniel J Levinson, and Richard J Williams. *The Patient and the Mental Hospital: Contributions of Research in the Science of Social Behaviour*. Glencoe, Illinois: The Free Press, 1957.

Greenblatt, Milton, Richard H. York, and Esther Lucille Brown. *From Custodial Care to Therapeutic Patient Care in Mental Hospitals.* New York: Russell Sage Foundation, 1955.

Griffiths, R. *Report of the NHS Management Enquiry*. London, 1983.

Haddon, Brian. 'Political Implications of Therapeutic Communities'. In *Therapeutic Communities: Reflections and Progress*, by R. D Hinshelwood and N Manning, 38–45. London: Routledge & Kegan Paul, 1979.

Haggett, Ali. *Desperate Housewives, Neuroses and the Domestic Environment 1945-1970.* Routledge, 2016.

Hall, John, David Pilgrim and Graham Turpin. *Clinical Psychology in Britain: Historical Perspectives.* Leicester: British Psychological Society, 2015.

Hamilton, Carrie. 'On Being a "good" Interviewer: Ethics and the Politics of Oral History'. *Oral History*, vol. 36, no. 2 (2008): 35–43.

Handy, Jocelyn. 'Stress in Mental Health Nursing: A Sociopolitical Analysis'. In *Stress and Coping in Mental Health Nursing*, edited by J. Carson, L. Fagin, and S. Ritter, 47–67. London: Chapman and Hall, 1995.

Harding, Jenny. 'Talk about Care: Emotions, Culture and Oral History'. *Oral History*, vol. 38, no. 2 (2010).

Hargreaves, G. R. 'Current Developments in Social Psychiatry in Britain. In David McK. Rioch, *Symposium on Preventive and Social Psychiatry 15-17 April 1957*, 401-408. (Washington D. C.: Walter Reed Army Institute of Research, Walter Reed Army Medical Centre, 1957).

Harrington, J. A., and W. Mayer-Gross. 'A Day Hospital for Neurotics in an Industrial Community'. *The British Journal of Psychiatry*, vol. 105, no. 438 (1959): 224–234.

Harris, Arthur. 'Day Hospitals and Night Hospitals in Psychiatry'. *The Lancet*, vol. 269 (1957): 729–780.

Harrison, Brian Howard. *Seeking a Role: The United Kingdom, 1951-1970*. New Oxford History of England. Oxford : New York: Clarendon Press ; Oxford University Press, 2009.

Harrison, T. M. *Bion, Rickman, Foulkes, and the Northfield Experiments : Advancing on a Different Front*. London; Philadelphia: J. Kingsley, 2000.

Harrison, T. M., and Alison J. Gray. 'Leadership, Complexity and the Mental Health Professional. A Report on Some Approaches to Leadership Training'. *Journal of Mental Health*, vol. 12, no. 2 (2003): 153–59.

Hartman, J. 'Medication: A Necessary Evil?' *International Journal of Therapeutic Communities*, vol. 1, no. 2 (1980): 121–24.

Haslam, John. *Observations on Insanity*. London: F. & C. Rivington, 1798. https://ia600302.us.archive.org/12/items/observationsonin00hasl/observationsonin00hasl.pdf, accessed 03/08/2018.

Hastings, S., 2007, The story of the Ford sewing machinists: A TUC oral history project on equal pay in association with the Wainwright Trust. TUC accessed at file:///G:/Toms%20Downloads/1%252F090%252Fsewing+machinists+4pp-1.pdf, accessed on 02/04/2014.

Hay, C. 'Chronicles of a Death Foretold: The Winter of Discontent and Construction of the Crisis of British Keynesianism'. *Parliamentary* Affairs, vol. 63, no. 3 (2010): 446–70.

Hayward, Peter; Fran Tilley; Catherine Derbyshire; Elizabeth Kuipers and Susan Grey, '"The Ailment" Revisited: Are "manipulative" Patients Really the Most Difficult?', *Journal of Mental Health*, vol. 14, no. 3 (2005): 291.

Hayward, Rhodri. 'Book Review: Recovering R. D. Laing'. *Metascience*, vol. 16 (2007): 525–27.

Hayward, Rhodri. *Transformation of the Psyche in British Primary Care, 1880-1970.* London: Bloomsbury Academic, 2015.

Healy, David. *The Antidepressant Era*. Cambridge, Mass.: Harvard University Press, 1997.

Healy, David. *The Creation of Psychopharmacology*. Cambridge, MA: Harvard University Press, 2002.

Healy, David. 'Trussed in Evidence? Ambiguities at the Interface between Clinical Evidence and Clinical Practice'. *Transcultural Psychiatry*, vol. 46, no. 1 (2009): 16–37.

Henckes, Nicolas. 'Narratives of Change and Reform Processes: Global and Local Transactions in French Psychiatric Hospital Reform after the Second World War'. *Social Science & Medicine*, vol. 68, no. 3 (2009): 511–18.

Henckes, Nicolas. 'Reforming Psychiatric Institutions in the Mid-Twentieth Century: A Framework for Analysis'. *History of Psychiatry*, vol. 22, no. 2 (2011): 164–81.

Henderson, D. K. *Psychopathic States*. New York: Norton, 1939.

Hennessy, Peter. *The Prime Minister: The Office and Its Holders since 1945*. London ; New York: Allen Lane/Penguin Press, 2000.

Hervey, Nicholas. 'Advocacy or Folly: The Alleged Lunatics' Friend Society, 1845-1863'. *Medical History*, vol. 30 (1986): 245–75.

Hess, V., and B. Majerus. 'Writing the History of Psychiatry in the 20th Century'. *History of Psychiatry*, vol. 22, no. 2 (2011): 139–45.

Higgitt, Anna, and Peter Fonagy. 'Psychotherapy in Borderline and Narcissistic Personality Disorder'. *British Journal of Psychiatry*, vol. 161, no. 1 (1992): 23–43.

Hinshelwood, R. D. 'The Seeds of Disaster'. *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 181–88.

Hinshelwood, R. D. 'Foreword'. In *Bion, Rickman, Foulkes and the Northfield Experiment: Advancing on a Different Front*, T. M. Harrison, 7–10. London: Jessica Kingsley, 2000.

Hinshelwood, R. D. *Thinking about Institutions : Milieux and Madness*. London; Philadelphia: J. Kingsley, 2001.

Hinshelwood, R. D., and N.P. Manning. *Therapeutic Communities : Reflections and Progress*. London; Boston: Routledge and K. Paul, 1979.

Hobsbawm, E. J. *Age of Extremes: The Short Twentieth Century, 1914-1991*. London : New York: Michael Joseph ; Viking Penguin, 1994.

Hobson, R. F. 'The Messianic Community'. In *Therapeutic Communities: Reflections and Progress*, edited by R. D. Hinshelwood and N. Manning, 231–44. London: Routledge & Kegan Paul, 1979.

Hoefferle, Caroline. *British Student Activism in the Long Sixties*. New York and London: Taylor & Francis, 2017.

Hoenig, J., and I. M. Crotty. 'Psychiatric Patients in General Hospitals'. *The Lancet*, vol. 274 (1959): 22–23.

Hoenig, J., and M. W. Hamilton. *The De-Segregation of the Mentally Ill*. The International Library of Sociology and Social Reconstruction. London: Routledge & Kegan Paul, 1969.

Holl, Alison. 'Winterbourne View patients in new care safety alerts', http://www.bbc.co.uk/news/uk-20070437. Accessed 20/01/2015.

Holmes, Peter, and Susan Williams. 'Consistency, Continuity and Stability - Organisational Virtues or Not?' *Therapeutic Communities*, vol. 33, no. 4 (2012): 166–74.

Hopkins, Harry. *The New Look: A Social History of the Forties and Fifties in Britain*. American. Boston: Houghton Mifflin, 1964.

Hopton, John. 'Prestwich Hospital in the Twentieth Century: A Case Study of Slow and Uneven Progress in the Development of Psychiatric Care'. *History of Psychiatry*, vol. 10, no. 3 (1999): 349–69.

Howard, Robert. 'Psychiatry in Pictures: Annie Alschul Teaching Psychiatric Nurses, 1950s, Bethlem Hospital'. *British Journal of Psychiatry*, vol. 183 (2003): A22.

Howells, John G. 'The Establishment of the Royal College of Psychiatrists'. In *150 Years of British Psychiatry 1841-1991*, edited by German. E. Berrios and Hugh Freeman, 1:117–34. London: Gaskell, 1991.

Hunter, Richard A. 'The Rise and Fall of Mental Nursing'. *The Lancet*, vol. 267 (1956): 98–99.

Hurd, D. 'Chairing from the Front (Book Review of The Downing Street Years by Margaret Thatcher)'. *The Spectator*, 6 November 1993, 46.

Hutton, G. 'Management in a Changing Mental Hospital'. *Human Relations*, vol. 15, no. 4 (1962): 283–310.

Ingleby, D. 'The View from the North Sea'. In *Cultures of Psychiatry*, edited by Marijke Gijswijt-Hofstra and Roy Porter, 295–314. Amsterdam-Atlanta, GA: Rodopi, 1998.

Ingleby, D. 'Transcultural Mental Health Care: The Challenge of Positivist Psychiatry'. In *Critical Psychiatry: The Limits of Madness*, edited by D. B. Double, 61–78, Basingstoke: Palgrave Macmillan, 2006.

Isaacs, Susan. *The Psychological Aspects of Child Development*. London: Evans Brothers Limited with the University of London Institute of Education, 1963.

Isohanni, Matti. 'Leadership and Problem Solving in the Psychiatric Organization'. *International Journal of Therapeutic Communities*, vol. 10, no. 3 (1989): 145–54.

Jackson, Mark. *The Age of Stress: Science and the Search for Stability*. 1st ed. Oxford: Oxford University Press, 2013.

Jagger, M. and Richards, K. 1966, Mother's Little Helper lyrics © ABKCO Music Inc.

James, Brig. G. W. B. 'The Future of Psychiatry in the Army Medical Service.' *Journal of the Royal Army Medical Corps*, vol. 84 (1945): 51–53.

Jansen, Elly. *The Therapeutic Community : Outside the Hospital*. London: Croom Helm, 1980.

Jas, Pauline, and Chris Skelcher. 'Performance Decline and Turnaround in Public Organizations: A Theoretical and Empirical Analysis'. *British Journal of Management*, vol. 16, no. 3 (2005): 195–210.

Jennings, Elizabeth. 'In a Mental Hospital Sitting-Room'. *The Listener*, vol. 70, no. 1808 (1963): 826.

John, Audrey. *A Study of the Psychiatric Nurse*. Edinburgh: Livingstone, 1961.

Johns, Jennifer. 'Historical Background'. In *The Ailment and Other Psychoanalytical Essays*, by T F Main, 1–4, London: Free Association Books, 1989.

Johnson, C. A., and B. E. Johnson. 'Medicine on British Television: A Content Analysis'. *Journal of Community Health*, vol. 18, no. 1 (1993): 25–35.

Johnson, Donald M. *A Doctor Returns*. London: Christopher Johnson, 1956.

Johnson, Donald M., and Norman Dodds. *The Plea for the Silent*. London: Christopher Johnson, 1957.

Jones, Colin. 'Raising the Anti: Jan Foudraine, Ronald Laing and Anti-Psychiatry'. In *Cultures of Psychiatry*, edited by Marijke Gijswijt-Hofstra and Roy Porter, 283–94. Amsterdam: Rodopi, 1998.

Jones, Kathleen. *A History of the Mental Health Services.* London; Boston: Routledge and Kegan Paul, 1972.

Jones, Kathleen. *Asylums and after: A Revised History of the Mental Health Services: From the Early 18th Century to the 1990s*. London ; Atlantic Highlands, N.J: Athlone Press, 1993.

Jones, Kathleen. *Experience in Mental Health*. London: Sage, 1988.

Jones, Kathleen. 'The Role and Function of the Mental Hospital'. In *Trends in the Mental Health Services*, edited by Hugh Freeman and James Farndale, 60–71. Oxford: Pergamon Press, 1963.

Jones, Kathleen, and A. J. Fowles. *Ideas on Institutions: Analysing the Literature on Long-Term Care and Custody*. London ; Boston: Routledge & Kegan Paul, 1984.

Jones, Kathleen, and Roy Sidebotham. *Mental Hospitals at Work*. The International Library of Sociology and Social Reconstruction. London: Routledge and Kegan Paul, 1962.

Jones, M. 'Group Treatment, with Particular Reference to Group Projection Methods'. *American Journal of Psychiatry*, vol. 101 (1944): 292–299.

Jones, M. ‘Rehabilitation of Forces Neurosis Patients to Civilian Life’. *British Medical Journal*, vol. 1, no. 4448 (1946): 533–535.

Jones, M. ‘Physiological and Psychological Responses to Stress in Neurotic Patients’. *Journal of Mental Science*, vol. 44 (1948): 392–427.

Jones, M. ‘Acting as an Aid to Therapy in a Neurosis Centre’. *British Medical Journal*, vol. 1, no. 4608 (1949): 756–59.

Jones, M. *Social Psychiatry*. London: Tavistock, 1952.

Jones, M. ‘Introduction’. In *Community as Doctor: New Perspectives on a Therapeutic Community*, by R.N. Rapoport, 1–6. London: Tavistock, 1960.

Jones, M. *Social Psychiatry: In the Community, in Hospitals, and in Prisons*. Springfield: Charles C Thomas, 1962.

Jones, M. *Beyond the Therapeutic Community*. New Haven and London: Yale University Press, 1968.

Jones, M. *Social Psychiatry in Practice*. Harmondsworth: Penguin, 1968.

Jones, M. *Maturation of the Therapeutic Community : An Organic Approach to Health and Mental Health*. New York; London: Human Sciences Press, 1978.

Jones, Wilfrid Llewelyn. *Ministering to Minds Diseased: A History of Psychiatric Treatment*. London: W. Heinemann Medical Books, 1983.

Jordanova, L. J. *History in Practice*. 2nd ed. London: Hodder Arnold, 2006.

Judt, Tony. *Ill Fares the Land - a Treatise on Our Present Discontents.*, Harmondsworth: Penguin, 2011.

Karpf, Anne. ‘The Human Voice and the Texture of Experience’. *Oral History*, vol. 42, no. 2 (2014): 50–55.

Katz, Ephraim. *The Macmillan International Film Encyclopedia*. London: Macmillan, 1994.

Keller, A., and J. Roberts. ‘The A.T.C. Supervisors’ Group: An Experiment in the Supervision of Therapeutic Communities’. *International Journal of Therapeutic Communities*, vol. 4, no. 1 (1983): 13–21.

Kennard, D. ‘Editorial’. *International Journal of Therapeutic Communities*, vol. 7, no. 4 (1986): 207–9.

Kennard, D. 'The Therapeutic Community'. In *Group Therapy in Britain*, eds. M. Aveline and W. Dryden, 153–84. Psychotherapy in Britain. Milton Keynes: Open University Press, 1988.

Kennard, D. 'An Incomplete History of the Association of Therapeutic Communities'. *Therapeutic Communities*, vol. 32, no. 2 (2011): 97–107.

Kennard, D., and J. Roberts. *An Introduction to Therapeutic Communities*. London; Boston: Routledge & Kegan Paul, 1983.

Kesey, Ken. *One Flew Over the Cuckoo's Nest*. London: Methuen, 1962.

Kidd, H. B. 'Industrial Units in Psychiatric Hospitals'. *The British Journal of Psychiatry*, vol. 111, no. 481 (1965): 1205–9.

Kidd, H.B. 'The Modern Role of the Mental Hospital.' In *New Aspects of the Mental Health Services*, edited by Hugh Freeman and James Farndale, 481–92. London: Pergamon Press, 1967.

King, M., and A. Bartlett. 'British Psychiatry and Homosexuality'. *The British Journal of Psychiatry*, vol. 175, no. 2 (1 August 1999): 106–13.

King, Pearl, and Riccardo Steiner, eds. *The Freud-Klein Controversies 1941-45*. The New Library of Psychoanalysis 11. London: Tavistock/Routledge, 1992.

King, S. 'Coming through a Crisis: One in Nine Has a Nervous Breakdown'. *The Times*, 23 November 1970, 5.

Kingdon, David. 'Care Programme Approach'. *Psychiatric Bulletin*, vol. 18, no. 02 (1994): 68–70.

Kipp, J. 'The American Contribution to Therapeutic Community for People with Psychosis and a Reflection on Current Milieu Treatment in the United States'. In *Therapeutic Communities for Psychosis: Philosophy, History and Clinical Practice*, edited by J. Gale, A. Realpe, and E. Pedriali, 16–27. Hove & New York: Routledge, 2008.

Kisely, Steve. 'Psychotherapy for Severe Personality Disorder: Exploring the Limits of Evidence Based Purchasing'. *British Medical Journal*, vol. 318, no. 7195 (1999): 1410–12.

Klein, Rudolf. *The New Politics of the National Health Service*. 3rd ed. London ; New York: Longman, 1995.

Klein, Rudolf. 'Britain's National Health Service Revisited'. *New England Journal of Medicine*, vol. 350, no. 9 (2004): 937–42.

Klein, Rudolf. *The New Politics of the NHS: From Creation to Reinvention*. Oxford: Radcliffe Pub., 2010.

Knowles, L. Jane, and Rex Haigh. 'Care Programme Approach'. *Psychiatric Bulletin*, vol. 22, no. 03 (1998): 188.

Kramer, Peter D. *Listening to Prozac*. New York, N.Y., U.S.A: Penguin Books, 1994.

Kreeger, Lionel. 'Introduction'. In *The Large Group: Dynamics and Therapy*, edited by Lionel Kreeger, 13–29. London: Constable, 1974.

Kynaston, David. *Family Britain, 1951-1957 : Tales of a New Jerusalem*. Bloomsbury, 2010.

Kynaston, David. *Modernity Britain. Book 2,* 2014.

Laing, Adrian. *R.D. Laing: A Life*. London: Harper Collins, 1997.

Laing, Jimmy, and Dermot McQuarrie. *Fifty Years in the System*. London: Corgi, 1992.

Laing, R. D. 'The Obvious'. In *The Dialectics of Liberation*, edited by David Cooper, 13–33. Harmondsworh: Penguin, 1968.

Laing, R. D., and A. Esterson. *Sanity, Madness and the Family*. Harmondsworth: Penguin, 1970.

Laing, R. D. *Self and Others*. Harmondsworth: Penguin, 1971.

Laing, R. D. *The Divided Self: An Existential Study in Sanity and Madness*. Harmondsworth: Penguin Books, 1987.

Laurence, Jeremy 'Mental Hospital Closure Is Condemned as Inhumane', *The Independent*, 18th December 2007.

Lawrence, Christopher. 'Still Incommunicable: Clinical Holists and Medical Knowledge in Interwar Britain'. In *Greater Than the Parts: Holism in Biomedicine 1920-1950*, edited by Christopher Lawrence and George Weisz, 94–111. New York, Oxford: Oxford University Press, 1998.

Le Grand, Julian, Nicholas Mays, and Jennifer Dixon. 'The Reforms Success or Failure or Neither'. In *Learning from the NHS Internal Market: A Review of the Evidence*, by Julian Le Grand, Nicholas Mays, and Jo-Ann Mulligan, 117–43. London: King's Fund, 1998.

Leach, Robert, W. N. Coxall, and L. J. Robins. *British Politics*. 2nd ed. Palgrave Foundations. Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan, 2011.

Leech, Kenneth. *Youthquake: The Growth of a Counter-Culture through Two Decades*. London: Sheldon Press, 1973.

Lees, Jan, Nick P Manning, and Barbara Rawlings. *Therapeutic Community Effectiveness: A Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders*. York: NHS Centre for Reviews and Dissemination, University of York, 1999.

Lees, Jan, Nick Manning, and Barbara Rawlings. 'A Culture of Enquiry: Research Evidence and the Therapeutic Community'. *Psychiatric Quarterly*, vol.75, no. 3 (2004): 279–94.

Lemlij, M., S. Mulvany, and C. J. Nagle. 'A Therapeutic Community Is Terminated'. *Group Analysis*, vol. 19, no. 3 (1981): 216–19.

Lewin, K. 'The Conflict between Aristotlean and Galilean Modes of Thought in Contemporary Psychology'. In *A Dynamic Theory of Personality*, translated by D. K. Adams and K. E. Zener, 1–42. New York; London: McGraw-Hill, 1935.

Lewin, K. *The Principles of Topological Psychology*. New York; London: McGraw Hill, 1936.

Lewin, K. 'Frontiers in Group Dynamics: I. Concept, Method, and Reality in Social Sciences; Social Equilibria and Social Change'. *Human Relations*, vol. 1 (1947): 5–41.

Lewin, K., and Lippitt. 'An Experimental Approach to the Study of Autocracy and Democracy: A Preliminary Note'. *Sociometry*, vol. 1, no. 3&4 (1938): 292–300.

Lewis, Emanuel. 'Book Review: Adventure in Psychiatry: Social Change in a Mental Hospital'. *Mental Health*, vol. 23, no. 1 (1964): 26.

Leyberg, J.T. 'A District Psychiatric Service: Bolton Pattern'. *The Lancet* , vol. 274 (1959): 282–84.

Lieb, Klaus, Christian Schmahl, Marsha Linehan, and Martin Bohus. 'Borderline Personality Disorder'. *The Lancet*, vol. 364 (2004): 453–61.

Lightbody, Mary, and S. Jacobson. 'A Therapeutic Community in an Acute Admission Unit of a Mental Hospital'. *British Medical Journal*, vol. 1, no. 5426 (1965): 47–49.

Linden, Peter van der. 'How Does the Large Group Change the Individual?' *International Journal of Therapeutic Communities*, vol. 9, no. 1 (1988): 31–39.

Linehan, Marsha. 'Commentary on Innovations in Dialectical Behavioural Therapy'. *Cognitive and Behavioural Practice*, vol. 7 (2000): 478–81.

Linford Rees, W. 'Prevention and Treatment of Psychiatric Reactions to Stress by Physiological and Pharmacological Means.' In *Stress and Psychiatric Disorder*, edited by J. M. Tanner, 97–103. Oxford: Blackwell, 1960.

Lloyd, Trevor Owen. *Empire, Welfare State, Europe: English History 1906-1992*. 4th ed. The Short Oxford History of the Modern World. Oxford ; New York: Oxford University Press, 1993.

Lomax, Montague. *The Experiences of an Asylum Doctor: With Suggestions for Asylum and Lunacy Law Reform.* London: George Allen and Unwin, 1921. http://ia601506.us.archive.org/14/items/39002041606220.med.yale.edu/39002041606220.med.yale.edu.pdf.

Lomax-Simpson, J. 'The Value of the Large Group for Community Psychiatry: Is My Large Group an Orange Balloon?' *International Journal of Therapeutic Communities*, vol. 6, no. 1 (1985): 45–53.

Long, Vicky. 'Adventures in Psychiatry: Narrating and Enacting Reform in Post-War Mental Healthcare'. *Studies in Literary Imagination*, vol. 48, no. 1 (2015): 109–48.

Long, Vicky. 'Work Is Therapy? The Function of Employment in British Psychiatric Care after 1959.' In *Work, Psychiatry and Society, c. 1750-2015*, edited by Waltraud Ernst, 334–50. Manchester: Manchester University Press, 2016.

Lummis, T. 'Structure and Validity in Oral Evidence'. In *The Oral History Reader*, edited by R. Perks and A. Thomson, Second., 255–60. London: Routledge, 1998.

Macdonald, J. M., and M. L. Daniels. 'The Psychiatric Ward as a Therapeutic Community'. *Journal of Nervous and Mental Diseases*, vol. 124 (1956): 148–55.

Mackenzie, S. P. *Politics and Military Morale: Current-Affairs and Citizenship Education in the British Army, 1914-1950*. Oxford Historical Monographs. Oxford : New York: Clarendon Press ; Oxford University Press, 1992.

Macmillan, Duncan. 'Requirements of an Integrated Mental Health Service (Psychiatric out-Patient Needs Etc.)'. In *Psychiatric Hospital Care*, edited by Hugh Freeman, 123–35. London: Balliére, Tindall, & Cassell, 1965.

Maddock, Alfred Beaumont. *Practical Observations on Mental and Nervous Disorders*. London: Simpkin, Marshall and Co., 1854.

Maddox, H. 'The Work of Mental Nurses'. *Nursing Mirror*, 19th April (1957): 189–90.

Main, T. F. 'The Hospital as a Therapeutic Institution'. *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 66–70.

Main, T. F. 'Rehabilitation and the Individual'. In *Modern Trends in Psychological Medicine*, edited by N. Harris, London: Butterworth, 1948.

Main, T. F. 'The Ailment'. *British Journal of Medical Psychology*, vol. 30 (1957): 124–45.

Main, T. F. 'Some Psychodynamics of Large Groups'. In *The Large Group: Dynamics and Therapy*, by L (Ed.) Kreeger, 57–86. London: Constable, 1975.

Main, T. F. 'The Concept of the Therapeutic Community: Variations and Vicissitudes'. In *The Ailment and Other Psychoanalytical Essays*, 123–41. London: Free Association Books, 1989.

Majerus, B. 'Material Objects in Twentieth Century History of Psychiatry'. *Low Countries Historical Review*, vol. 132, no. 1 (2017): 149–69.

Mandlebrote, B. 'The Northfield Experiment: Its Contribution to Developments in Psychiatry'. *Therapeutic Communities*, vol. 17, no. 3 (1996): 149–53.

Manning, N. P. 'What Happened to the Therapeutic Community'. In *The Year Book of Social Policy in Britain 1975*, edited by Kathleen Jones and Sally Baldwin, 141–54. London: Routledge & Kegan Paul, 1976.

Manning, N. P. 'Collective Disturbance in Institutions: A Sociological View of Crisis and Collapse'. *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 147–58.

Manning, N. P. *The Therapeutic Community Movement : Charisma and Routinization.* London: Routledge, 1989.

Manning, N. P. 'Therapeutic Communities: A Problem or a Solution for Psychiatry? A Sociological View.' *British Journal of Psychotherapy*, vol. 26, no. 4 (2010): 434–43.

Margolin, Leslie. *Under the Cover of Kindness: The Invention of Social Work*. Knowledge, Disciplinarity and Beyond. Charlottesville: University Press of Virginia, 1997.

Marineau, R. F. *Jacob Levy Moreno 1889-1974: Father of Psychodrama, Sociometry, and Group Psychotherapy*. Tavistock/Routledge, 1989.

Marrow, A.J. *The Practical Theorist: The Life and Work of Kurt Lewin*. Annapolis, Maryland: BDR Learning Associates, 1969.

Martin, D. V., M. M. Glatt, and K. F. Weeks. 'An Experimental Unit for the Community Treatment of Neurosis'. *The British Journal of Psychiatry*, vol. 100, no. 421 (1954): 983–89.

Martin, Denis V. 'Institutionalisation'. *The Lancet*, Vol. 266 (1955): 1188-1190.

Martin, Denis V. *Adventure in Psychiatry*. Second. Oxford: Bruno Cassirer, 1974.

Martin, J. P. and Debbie Evans. *Hospitals in Trouble*. Oxford: B. Blackwell, 1984.

Marwick, Arthur. *British Society since 1945*. 4th ed., New ed. The Penguin Social History of Britain. London ; New York: Penguin Books, 2003.

May, A. R. 'Observations on Training the Psychiatric Nurse'. In *Psychiatric Hospital Care*, edited by Hugh Freeman, 264–70. London: Balliére, Tindall, & Cassell, 1965.

McCrae, Niall. 'Resilience of Institutional Culture: Mental Nursing in a Decade of Radical Change'. *History of Psychiatry*, vol. 25, no. 1 (2014): 70–86.

McCrae, Niall, and Peter Nolan. *The Story of Nursing in British Mental Hospitals: Echoes from the Corridors*. Routledge Key Themes in Health and Society. Abingdon, Oxon ; New York, NY: Routledge, Taylor & Francis Group, 2016.

McCrone, Paul, Angela Hallam, Martin Knapp, Francis Swaray, Ana Nazir, Julian Leff, and Andrew Szmidla. 'Service Use and Costs of Supporting the Most Socially Disabled Patients in a Hospital Reprovision Programme: A Two-Hospital Comparison'. *Social Psychiatry and Psychiatric Epidemiology*, vol. 41, no. 8 (2006): 656–61.

McDougall, W. *The Group Mind: A Sketch of the Principles of Collective Psychology with Some Attempt to Apply Them to the Interpretation of National Life and Character*. Cambridge: Cambridge University Press, 1921.

McDougall, W. *The Riddle of Life*. London: Methuen & Co., 1938.

McGeachan, Cheryl. '"The World Is Full of Big Bad Wolves": Investigating the Experimental Therapeutic Spaces of R.D. Laing and Aaron Esterson'. *History of Psychiatry*, vol. 25, no. 3 (2014): 283–98.

McGilchrist, Iain. *The Master and His Emissary : The Divided Brain and the Making of the Western World*. New Haven: Yale University Press, 2010.

McIlroy, John, Alan Campbell, and Nina Fishman. 'Introduction: Approaching Post-War Trade Unionism'. In *British Trade Unions and Industrial Politics: The High Tide of Trade Unionism 1964-79*, edited by John McIlroy, Alan Campbell, and Nina Fishman, 1–19. Adershot: Ashgate, 1999.

McNeilly, Gerry. *Group Analytic Art Therapy*. London; Philadelphia: J. Kingsley Publishers, 2006.

McSmith, Andy. *No Such Thing as Society*. London: Constable, 2011.

Mead, G. H. 'The Social Self'. *Journal of Philosophy, Psychology, and Scientific Methods*, vol. 10 (1913): 374–80.

Mead, G. H., and C. W. Morris. *Mind, Self, & Society; from the Standpoint of a Social Behaviourist*. Chicago, Ill.; London: University of Chicago Press, 1967.

Mechanic, D. 'The Americanization of the British National Health Service'. *Health Affairs*, vol. 14, no. 2 (1995), 51-67

Meinrath, Monica, and Jeff Roberts. 'On Being a Good Enough Staff Member'. *International Journal of Therapeutic Communities*, vol. 3, no. 1 (1982): 7–14.

Menninger, Karl. 'Foreword'. *Bulletin of the Menninger Clinic*, vol. 10, no. 3 (1946): 65.

Menzies, Isabel. 'The Function of Social Systems as a Defence against Anxiety: A Report on a Study of the Nursing Service of a General Hospital.' In *Containing Anxiety in Institutions: Selected Essays*, edited by Isabel Menzies Lyth. London: Free Association Books, 1988.

Merleau-Ponty, M. *Phenomenology of Perception*. London: Routledge Classics, 2010.

Metcalfe, Andy, and Paul Morrison. *A Change of Mind: A Narrow Line*. DVD, Television Documentary. Channel 4; Concord Media, 1986.

Metcalfe, Andy, and Paul Morrison. *A Change of Mind: A Narrow Line 2 & 3 Rushes and Psychodrama Group*. DVD, Television Documentary. Channel 4; Concord Media, 1986.

Micale, Mark S. *Hysterical Men: The Hidden History of Male Nervous Illness*. Cambridge, Mass.: Harvard University Press, 2008.

Miles, Agnes. 'The Effects of a Therapeutic Community on the Interpersonal Relationships of a Group of Psychopaths'. *British Journal of Criminology*, vol. 9 (1969): 22–38.

Millar, K. *The Story of a Community: Dingleton Hospital Melrose*. Melrose: Chiefswood, 2000.

Millard, Chris. *A History of Self-Harm in Britain: A Genealogy of Cutting and Overdosing*. Mental Health in Historical Perspective. Houndmills, Basingstoke, Hampshire ; New York, NY: Palgrave Macmillan, 2015.

Millard, D. W. 'Richard Wilfred Crocket'. *Psychiatric Bulletin*, vol. 31, no. 7 (2007): 278–278.

Miller, Bertram A. 'Sheltered Workers'. *Incentive*, June (1963): 19.

Miller, P. and Rose, N. *The Power of Psychiatry*. Cambridge [Cambridgeshire] : New York, NY, USA: Polity Press ; Blackwell, 1986.

Mills, Enid. *Living with Mental Illness: A Study in East London*. London: Routledge & Kegan Paul, 1962.

Mitchell, A. 'Adrian Mitchell' Guide to the Underground'. *The Guardian*, 12 October 1967, 9.

Mold, Alex. *Making the Patient-Consumer: Patient Organisations and Health Consumerism in Britain*. Manchester: Manchester University Press, 2015.

Monro, Henry. *Remarks on Insanity Its Nature and Treatment*. London: John Churchill, 1851.

Moran, James E., and Leslie Topp. 'Introduction: Interpreting Psychiatric Spaces'. In *Madness, Architecture and the Built Environment*, edited by Leslie Topp, James E. Moran, and Jonathan Andrews. London: Routledge Taylor & Francis Group [distributor], 2011.

Moreno, J L. *Who Shall Survive?* Beacon House, 1953.

Morgan, Kenneth O. *The People's Peace: British History, 1945-1990*. Oxford ; New York: Oxford University Press, 1992.

Morrice, J.K.W. 'Permissiveness'. *British Journal of Medical Psychology*, vol. 38 (1965): 247–51.

Morrice, J.K.W. 'Myth and the Democratic Process'. *British Journal of Medical Psychology*, vol. 45 (1972): 327–31.

Morrice, J. K. W. 'Basic Concepts: A Critical Review'. In *Therapeutic Communities: Reflections and Progress*, edited by R. D. Hinshelwood and N. Manning, 49–58. London: Routledge & Kegan Paul, 1979.

Morrison, Hazel. 'Henderson and Meyer in Correspondence: A Transatlantic History of Dynamic Psychiatry, 1908–29'. *History of Psychiatry*, vol. 28, no. 1 (2017): 72–86.

Murray, Bill. 'Thank You'. *Joint Newsletter of the Planned Environment Therapy Trust, the Charterhouse Group of Therapeutic Communities and the Association of Therapeutic Communities, with the Community of Communities*, no. 10 (2004): 80–81.

Neill, A.S. *Summerhill*. London: Victor Gollancz, 1962.

Newell, T., and B. Healey. 'The Historical Development of the UK Democratic Therapeutic Community'. In *Dynamic Security: The Democratic Therapeutic Community in Prison*, edited by M. Parker, 41–68. London: Jessica Kingsley, 2007.

Nicholson, Chris. 'Between You and Me'. *The Joint Newsletter of the Association of Therapeutic Communities, the Charterhouse Group of Therapeutic Communities and the Planned Environment Therapy Trust*, no. 10 (2004): 32–37.

Nightingale, G. S. *Warley Hospital, Brentwood: The First Hundred Years 1853 - 1953.* Second. Brentwood: Warley Hospital, 1969. http://www.simoncornwell.com/urbex/projects/w/docs/fhy1.htm.

Nolan, P., and Hopper, B. 'Mental Health Nursing in the 1950s and 1960s Revisited'. *Journal of Psychiatric and Mental Health Nursing*, vol. 4, no. 5 (1997): 333–338.

Nolan, P. *A History of Mental Health Nursing*. Cheltenham: Stanley Thornes, 1998.

Nolan, P. 'The History of Community Mental Health Nursing'. In *The Handbook of Community Mental Health Nursing*, edited by Ben Hannington and Michael Coffey, 7–18. London ; New York: Routledge, 2003.

O'Farrell, P. 'Obituary: John D. Sutherland (1905-1991)'. *The International Journal of Psycho-Analysis*, vol. 73, no. 3 (1992): 577–80.

Oliver, Adam. 'The English National Health Service: 1979-2005'. *Health Economics*, vol. 14, no. S1 (2005): S75–99.

Parish, P. 'Supplement: The Prescribing of Psychotropic Drugs in General Practice'. *The Journal of the Royal College of General Practitioners*, vol. 21, no. 92 (1971).

Parker, Michael, ed. *Dynamic Security: The Democratic Therapeutic Community in Prison*. Community, Culture and Change 17. London ; Philadelphia: Jessica Kingsley Publishers, 2007.

Parr, Hester. 'Interpreting the "hidden Social Geographies" of Mental Health: Ethnographies of Inclusion and Exclusion in Semi-Institutional Places'. *Health and Place*, vol. 6 (2000): 225–37.

Pearce, Steve, and Rex Haigh. *The Theory and Practice of Democratic Therapeutic Community Therapy*. London ; Philadelphia: Jessica Kingsley Publishers, 2017.

Pearce, Steve, Lisle Scott, Gillian Attwood, Kate Saunders, Madeleine Dean, Ritz De Ridder, David Galea, Haroula Konstantinidou, and Mike Crawford. 'Democratic Therapeutic Community Treatment for Personality Disorder: Randomised Controlled Trial'. *British Journal of Psychiatry*, vol. 210, no. 2 (2017): 149–56.

Peck, Edward, and Elizabeth Parker. 'Mental Health in the NHS: Policy and Practice 1979-98'. *Journal of Mental Health*, vol. 7, no. 3 (1998): 241–59.

Pennington, I. *A Brief Account Concerning Silent Meetings 1680*. Quaker Heritage Press, 1996.

Penrose, L. S. 'Social Aspects of Psychiatry: The Importance of Statistics'. *The Journal of Mental Science*, vol. 92, no. 389 (1946): 713–18.

Perry, H. S. 'Introduction'. In *Schizophrenia as a Social Process*, edited by H. S. Perry, xi–xxxv. New York: Norton, 1974.

Petrie, A. A. W. ‘Psychiatric Developments: The Presidential Address Delivered at the One Hundred and Third Annual Meeting of the Association on Wednesday, November 29, 1944’,. *Journal of Mental Science*, vol. 91, no. 384 (1945): 267–80.

Phillips, Adam, and Barbara Taylor. *On Kindness*. London: Hamish Hamilton Ltd : [distributor] Penguin Books Ltd, 2009.

Philo, Chris. *A Geographical History of Institutional Provision for the Insane from Medieval Times to the 1860s in England and Wales: The Space Reserved for Insanity*. Lewiston, New York: Edward Mellen Press, 2004.

Philo, Chris, and John Pickstone. ‘Unpromising Configurations: Towards Local Historical Geographies of Psychiatry’. *Health and Place*, vol. 15, no. 3 (2009): 649–56.

Pilgrim, David. ‘The Biopsychosocial Model in Anglo-American Psychiatry: Past, Present and Future?’ *Journal of Mental Health*, vol. 11, no. 6 (2002): 585–94.

Pilgrim, David, and Anne Rogers. ‘Social Psychiatry and Sociology’. *Journal of Mental Health*, vol. 14, no. 4 (January 2005): 317–320.

Pilgrim, David, and Andrew Treacher. *Clinical Psychology Observed*. London ; New York: Routledge, 1992.

Pilling, S. *Rehabilitation and Community Care*. London: Routledge, 1991.

Pinel, Philippe. *Medico-Philosophical Treatise on Mental Alienation*. Oxford, UK; Hoboken, NJ: Wiley-Blackwell, 2008.

Pinel, Phillippe. *A Treatise on Insanity: In Which Are Contained the Principles of a New and More Practical Nosology of Maniacal Disorders*. Translated by D. D. Davis. Sheffield: W. Todd, 1806. https://archive.org/details/atreatiseoninsa00pinegoog.

Pines, M. ‘Therapeutic Communities in Teaching Hospitals’. In *Therapeutic Communities: Reflections and Progress*, edited by R. D. Hinshelwood and N. Manning, 23–30. London: Routledge & Kegan Paul, 1979.

Pines, M. ‘The Contribution of S. H. Foulkes to Group Therapy’. In *The Evolution of Group Analysis*, edited by M. Pines. London: Routledge & Kegan Paul, 1983.

Plamper, Jan. ‘History of Emotions: An Interview with William Reddy, Barbara Rosenwein, and Peter Stearns’. *History and Theory*, vol. 49 (2010): 237–65.

Plamper, Jan. *The History of Emotions: An Introduction*. Emotions in History. Oxford, United Kingdom: Oxford University Press, 2015.

Plato. ‘Lysis’. In *Socratic Discourse by Plato and Xenophon*, translated by J. Wright, 201–30. Everyman’s Library 457. London: J. M. Dent, 1925.

Plato. 'The Banquet'. In *Five Dialogues of Plato Bearing on Poetic Inspiration*, translated by P. B. Shelley, 17–71. Everyman's Library 456. London: J. M. Dent, 1924.

Pollock, Allyson, and Colin Leys. *NHS Plc: The Privatisation of Our Health Care*. London ; New York: Verso, 2004.

Popke, Jeff. 'Geography and Ethics: Everyday Mediations Through Care and Consumption'. *Progress in Human Geography*, vol. 30, no. 4 (2006): 504–12.

Portelli, Alessandro. *The Battle of Valle Giulia: Oral History and the Art of Dialogue*. Madison, Wis: University of Wisconsin Press, 1997.

Portelli, Alessandro. 'What Makes Oral History Different'. In *The Oral History Reader*, edited by Robert Perks and Alistair Thomson, Third., 48–58. London ; New York: Routledge Taylor & Francis Group, 2016.

Porter, R. 'The Patient's View: Doing Medical History from Below.' *Theory and Society*, vol. 14, no. 2 (1985): 175–98.

Porter, R. *Mind-Forg'd Manacles: A History of Madness in England from the Restoration to the Regency*. London: Penguin Books, 1990.

Porter, R. 'Foreword'. In *The Story of a Mental Hospital: Fulbourn 1858-1983*, London: Process Press, 1996.

Porter, R. 'Anti-Psychiatry and the Family: Taking the Long View'. In *Cultures of Psychiatry*, edited by Marijka Gijswijt-Hofstra and Roy Porter, 257–81. Amsterdam-Atlanta, GA: Rodopi, 1998.

Porter, Roy. *A Social History of Madness: Stories of the Insane*. London: A Phoenix Giant Paperback, 1999.

Powell, A. *The Strangers Are All Gone: Vol. IV of To Keep the Ball Rolling: The Memoirs of Anthony Powell.* 1st ed. London: Heinemann, 1982.

Pozner, H. 'Common Sense and Military Psychiatry'. *Journal of the Royal Army Medical Corps*, vol. 107 (1961): 155–64.

Pratt, J H. 'The Principles of Class Treatment and Their Application to Various Chronic Diseases'. *Hospital Social Service Quarterly*, vol. 6 (1922): 401–11.

Prichard, James Cowles. *A Treatise on Insanity and Other Disorders Affecting the Mind*. Reprint 2018. Philadelphia: Haswell, Barrington and Haswell, 1837.

Probst, Gilbert, and Sebastian Raisch, 'Organizational Crisis: The Logic of Failure', *Academy of Management Executive*, vol. 19, no. 1 (2005): 90.

Pryor, Eric H. *Claybury: A Century of Caring*. Lavenham: Lavenham Press, 1993.

Psychiatrist, Another Consultant. 'Letter: The Medical Superintendent'. *The Lancet*, vol. 274 (1959): 183.

Psychiatrist, Consultant. 'Letter: Mental Health Bill'. *The Lancet*, vol. 273 (1959): 471–72.

Punch, Maurice. 'The Sociology of the Anti-Institution'. *The British Journal of Sociology*, vol. 25, no. 3 (1974): 312–25.

Ramon, S. *Psychiatry in Britain: Meaning and Policy*. London: Croom Helm, 1985.

Ramon, Shulamit. 'Neoliberalism and Its Implications for Mental Health in the UK'. *International Journal of Law and Psychiatry*, vol. 31, no. 2 (2008): 116–25.

Rapoport, R. N. 'Oscillations and Sociotherapy'. *Human Relations*, vol. 9, no. 3 (1956): 357–74.

Rapoport, Robert, N. *Community as Doctor: New Perspectives on a Therapeutic Community*. London: Tavistock, 1960.

Reed, J. 'Leadership in the Mental Health Service: What Role for Doctors?' *Psychiatric Bulletin*, vol. 19 (1995): 67–72.

Rees, J. R. *The Shaping of Psychiatry by War.* New York: W.W. Norton, 1945.

Rees, T. P. 'Back to Moral Treatment and Community Care'. *The British Journal of Psychiatry*, vol. 103, no. 431 (1957): 303–313.

Rees, T. P., and M. M. Glatt. 'The Organization of a Mental Hospital on the Basis of Group Participation'. *International Journal of Group Psychotherapy*, vol. 5 (1955): 157–61.

Rees, T. P., and M. M. Glatt. 'Mental Hospitals'. In *The Fields of Group Psychotherapy*, edited by S R Slavson, 17–39. New York: International Universities Press, 1956.

Rickman, J. A Study of Quaker Beliefs. In Pearl King (Ed.) *No Ordinary Psychoanalyst: The Exceptional Contributions of John Rickman,* 269-293, London: Karnac, 2003.

Rioch, David McK. *Symposium on Preventive and Social Psychiatry 15-17 April 1957*. Washington D. C.: Walter Reed Army Institute of Research, Walter Reed Army Medical Centre, 1957.

Rivett, Geoffrey. *From Cradle to Grave: Fifty Years of the NHS*. London: King's Fund, 1998.

Roazen, Paul. *Freud and His Followers*. Peregrine Books. Harmondsworth, Middlesex: Penguin Books, 1979.

Robb, Barbara. 'Diary of a Nobody'. In *Sans Everything: A Case to Answer*, edited by Barbara Robb, 69–112. London: Nelson, 1967.

Robb, Barbara. *Sans Everything: A Case to Answer*. London: Nelson, 1967.

Roberts, Jeff. 'Destructive Processes in a Therapeutic Community'. *International Journal of Therapeutic Communities*, vol. 1, no. 3 (1980): 159–70.

Rogers, Carl. http://psychology-forum.com/counselling-and-psychotherapy-forum/video-of-carl-rogers-person-centred-counselling-the-gloria-tapes/ accessed 14/3/2014.

Rollin, Henry R. 'The Red Handbook: An Historic Centenary'. *Bulletin of the Royal College of Psychiatrists*, vol. 10, no. 10 (1986): 279–80.

Rollinson, Richard. 'Leadership in a Therapeutic Environment "What a Long Strange Trip It Is"'. *Therapeutic Communities*, vol. 24, no. 1 (2003): 23–36.

Rolph, Sheena, Dorothy Atkinson, and Jan Walmsley. '"A Pair of Stout Shoes and an Umbrella": The Role of Mental Welfare Officer in East Anglia: 1946-1970.' *British Journal of Social Work*, vol. 33, no. 3 (2003): 339–59.

Roper, Michael. 'Analysing the Analysed: Transference and Counter-Transference in the Oral History Encounter'. *Oral History*, vol. 31, no. 2 (2003): 20--32.

Rose, Nikolas S. 'Historical Changes in Mental Health Practice'. In *Textbook of Community Psychiatry*, by Graham Thornicroft and George Szmukler, 13–27. Oxford: Oxford University Press, 2001.

Rose, Nikolas S. 'Psychiatry: The Discipline of Mental Health'. In *The Power of Psychiatry*, edited by Peter Miller and Nikolas S. Rose, 43–84. Oxford: Blackwell, 1986.

Rose, Nikolas S. *Inventing Our Selves : Psychology, Power, and Personhood*. Cambridge, England; New York: Cambridge University Press, 1998.

Rosen, Andrew. *The Transformation of British Life, 1950-2000 : A Social History*. Manchester, UK; New York; New York: Manchester University Press ; Distributed exclusively in the USA by Palgrave, 2003.

Rosenwein, Barbara H. 'Worrying about Emotions in History'. *The American Historical Review*, vol. 107, no. 3 (2002): 821–45

Rosie, R. J. 'Psychiatry in the Army'. In *Medicine and Pathology*, edited by V. Zachary Cope, 357–71. History of the Second World War. London: HMSO, 1952.

Rossabi, Andrew. '"Anti-Psychiatry": An Interview with Dr Joseph Berke'. In *Laing and Anti-Psychiatry*, edited by Robert Boyers and Robert Orrill, 209–17. Harmondsworth: Penguin Books, 1972.

Roth, Martin. 'Psychiatry and Its Critics'. *The British Journal of Psychiatry* 122 (1973): 373–78.

Rowbotham, Sheila. *The Past Is before Us: Feminism in Action since the 1960s*. Penguin Women's Studies. London: Penguin, 1990.

Rowland, Stephen. 'Kindness'. *London Review of Education*, vol. 7, no. 3 (2009): 207–10.

Rubinstein, W. D. *Twentieth-Century Britain: A Political History*. Houndmills, Basingstoke, Hampshire ; New York: Palgrave Macmillan, 2003.

Russell Davis, D. 'Depression as an Adaptation to Crisis'. *British Journal of Medical Psychology*, vol. 43 (1970): 109–1116.

Sackett, David L., William M. C. Rosenberg, J. A. Muir Gray, R. Brian Haynes, and W. Scott Richardson. 'Evidence Based Medicine: What It Is and What It Isn't.' *British Medical Journal*, vol. 312, no. 7023 (1996): 71–72.

Sainsbury Centre for Mental Health. *Acute Problems: A Survey of the Quality of Care in Acute Psychiatric Wards.* London: Sainsbury Centre for Mental Health, 2001.

Sampson, Anthony. *Anatomy of Britain*. London: Hodder and Stoughton, 1962.

Sandbrook, Dominic. *Never Had It so Good: A History of Britain from Suez to the Beatles*. London: Abacus, 2006.

Sandbrook, Dominic. *State of Emergency: The Way We Were: Britain, 1970-1974*. London: Penguin, 2011.

Sandison, R. A. 'The Re-Socialization of the Psychiatric Case.' *Mental Health*, vol. 10, no. 4 (1951): 87–96.

Sandison, R. A. 'The Hallucinogenic Drugs'. *The Practitioner*, vol. 200 (1968): 244–150.

Sandison, R. A. 'Letter: A Role for Psychedelics in Psychiatry'. *British Journal of Psychiatry* 187 (2005): 483.

Sandison, R. A., A. M. Spencer, and J. D. A. Whitelaw. 'The Therapeutic Value of Lysergic Acid Diethylamide in Mental Illness'. *Journal of Mental Science*, vol. 100 (1954): 491–507.

Sands, E. 'Treatment of Psychiatric Patients in General Hospitals: A Social Experiment.' *British Medical Journal*, vol. 1, no. 4298 (1943): 628–30.

Sargant, William, and Eliot Slater. *Physical Methods of Treatment in Psychiatry*. Edinburgh: Livingstone E.S. Ltd, 1944.

Sawle Thomas, J.C. 'Administration in Psychiatry and Its Therapeutic Implications'. *International Journal of Social Psychiatry*, vol. 2, no. 3 (1956): 185–95.

Scheidlinger, S. 'The Group Psychotherapy Movement at the Millenium: Some Historical Perspectives'. *International Journal of Group Psychotherapy*, vol. 50, no. 3 (2000): 315–339.

Schilder, P. *Psychotherapy*. London: Kegan Paul, Trench, Trubner, 1938.

Schilder, P. 'Results and Problems of Group Psychotherapy in Severe Neurosis'. *Mental Hygiene*, vol. 23 (1939): 87–98.

Scholten, R. J. P. M., M. Clarke, and J Hetherington. 'The Cochrane Collaboration'. *European Journal of Clinical Nutrition* vol. 59 (August 2005): S147–49

.

Scott, Joan W. 'The Evidence of Experience'. *Critical Enquiry*, vol. 17, no. 1 (1991): 773–97.

Scull, Andrew. 'Moral Treatment Reconsidered: Some Sociological Comments on an Episode in the History of British Psychiatry'. *Psychological Medicine*, vol. 9 (1979): 421–28.

Scull, Andrew. *Madhouses, Mad-Doctors, and Madmen : The Social History of Psychiatry in the Victorian Era*. London: Athlone Press, 1981.

Scull, Andrew. *Museums of Madness : The Social Organization of Insanity in Nineteenth-Century England*. Harmondsworth: Penguin, 1982.

Scull, Andrew. *Decarceration : Community Treatment and the Deviant : A Radical View*. Cambridge: Polity Press, 1984.

Scull, Andrew. *Social Order/Mental Disorder : Anglo-American Psychiatry in Historical Perspective.* [Berkeley: University of California Press, 1989.

Sedgwick, P. *Psychopolitics*. London: Pluto Press, 1982.

Seelig, Beth, and Lisa Rosof. 'Altruism'. In *Good Feelings: Psychoanalytic Reflections on Positive Emotions and Attitudes*, edited by Salman Akhtar, 63–91. London: Karnac Books, 2009.

Shanks, Michael. *The Stagnant Society*. Harmondsworth: Penguin, 1961.

Sharp, Victor. *Social Control in the Therapeutic Community*. Farnborough, Hants.; Lexington, Mass.: Saxon House ; Lexington Books, 1975.

Sharp, Victor. 'The Research Act in Sociology and the Limits of Meaning: The Understanding of Crisis, Care and Control in a Therapeutic Community'. *Australia and New Zealand Journal of Sociology*, vol. 13 (1977): 236–47.

Shephard, B. *A War of Nerves: Soldiers and Psychiatrists 1914 - 1994*. London: Jonathon Cape, 2000.

Shorter, Edward. *A History of Psychiatry: From the Era of the Asylum to the Age of Prozac*. New York: Wiley, 1997.

Sibbald, B., and M. Roland. 'Understanding Controlled Trials: Why Are Randomised Controlled Trials Important?' *British Medical Journal,* vol. 316, no. 7126 (1998): 201–201.

Sigal, B., and Gary Alan Fine. 'Where the Action Is: Small Groups and Recent Developments in Sociological Theory'. *Small Group Research*, vol. 37, no. 1 (2006): 4–19.

Sigal, Clancy. *Zone of the Interior*. Hebden Bridge: Pomona, 2005.

Sillitoe. *Saturday Night and Sunday Morning*. London: Pan Books, 1960.

Simpson, Jane. *The Lost Days of My Life*. London: George Allen and Unwin, 1958.

Sinfield, Alan. *Literature, Politics and Culture in Postwar Britain*. 2. ed. Classic Criticism Series. London: Continuum, 2007.

Skottowe, Ian. *A Mental Health Handbook*. London: Edward Arnold, 1957.

Slavson, S. R. 'Group Psychotherapy'. *Mental Hygiene*, vol. 24 (1940): 36–49.

Slavson, S. R. 'Some Elements in Activity Group Therapy'. *American Journal of Orthopsychiatry* 14 (1944): 578–88.

Slavson, S. R. 'General Principles and Dynamics'. In *The Practice of Group Therapy*, edited by S. R. Slavson, 1919–39. New York: International Universities Press, 1947.

Slavson, S. R. *The Dynamics of Group Psychotherapy*. New York: Jason Aronson, 1979.

Slobodin, Richard. *W.H.R. Rivers: Pioneer Anthropologist, Psychiatrist of The Ghost Road*. Stroud: Sutton, 1997.

Sloman, Peter. 'Rethinking a Progressive Moment: The Liberal and Labour Parties in the 1945 General Election: The Liberal and Labour Parties in the 1945 General Election'. *Historical Research*, vol. 84, no. 226 (November 2011): 722–44.

Smith, L. D. 'Behind Closed Doors; Lunatic Asylum Keepers 1800-1860'. *Social History of Medicine*, vol. 1, no. 3 (1988): 301–27.

Smith, L. D. *Cure, Comfort, and Safe Custody: Public Lunatic Asylums in Early Nineteenth Century England*. London ; New York: Leicester University Press, 1999.

Smith, S. 'Psychiatry in General Hospitals: Manchester's Integrated Scheme.' *The Lancet*, vol. 277 (1961): 1158–59.

Smith, S. 'The Role of the Admission Unit in Mental Hospital Work'. In *Psychiatric Hospital Care*, edited by Hugh Freeman, 43–49. London: Balliére, Tindall, & Cassell, 1965.

Society of Clinical Psychiatrists. 'Home Page of the Society of Clinical Psychiatrists Recording That Richard Crocket Was a Founding Member'. Accessed 6 March 2018. https://scpnet.co.uk/.

Soddy, Kenneth. 'Some Lessons of Wartime Psychiatry, Pt 2'. *Mental Health* 6, no. 3 (1946): 66–70.

Sommer, Barbara, W., and Mary Kay Quinlan. *The Oral History Manual*. 2nd ed. Lanham, New York, Toronto, Plymouth UK: AltaMira Press, 2009.

South East Thames Regional Health Authority. 'Report of a Committee of Enquiry St. Augustine's Hospital, Chatham, Canterbury.' Croydon: South East Thames Health Authority, 1976.

Spandler, Helen. *Asylum to Action: Paddington Day Hospital, Therapeutic Communities, and Beyond*. Community, Culture, and Change 16. London ; Philadelphia: Jessica Kingsley Publishers, 2006.

Spandler, Helen. 'Spaces of Psychiatric Contention: A Case Study of a Therapeutic Community'. *Health & Place*, vol. 15, no. 3 (2009): 672–78.

Spencer, A. M. 'Permissive Group Therapy with Lysergic Acid Diethylamide'. *The British Journal of Psychiatry: The Journal of Mental Science*, vol. 109 (1963): 37–45.

Spielman, R. '"The Ailment" by T F Main - 40 Years On'. *Therapeutic Communities*, vol. 19, no. 8 (1998): 221–26.

Sprafkin, Robert. 'The Rebirth of Moral Treatment'. *Professional Psychology*, vol. 8, no. 2 (1977): 161–69.

Spurgeon, Victoria. 'The Closure of a Therapeutic Community in a Forensic Unit'. *Nursing Times*, 16th February 2012 (2012). https://www.nursingtimes.net/students/the-closure-of-a-therapeutic-community-in-a-forensic-unit/5041621.article, accessed 09/09/2018.

St. Blaize-Molony, R. 'A La Recherche Du Temps Perdu: A Memoir of Richard Crocket after His 90th Birthday'. *The Joint Newsletter of the Charterhouse Group of Therapeutic*

Communities, the Association of Therapeutic Communities , and the Planned Environment Therapy Trust, no. 11 (August 2004): 44–47.

Stanton, Alfred H., and Morris S. Schwartz. *The Mental Hospital: A Study of Institutional Participation in the Treatment of Psychiatric Illness.* London: Tavistock Publications, 1954.

Staub, Michael E. *Madness Is Civilization: When the Diagnosis Was Social, 1948 -1980*. Chicago: University of Chicago Press, 2011.

Stearns, Peter N., and Carol Z. Stearns. 'Clarifying the History of Emotions and Emotional Standards'. *The American Historical Review*, vol. 90, no. 4 (1985): 813–36.

Stern, Phyllis, N. 'On Solid Ground: Essential Properties for Growing Grounded Theory'. In *The SAGE Handbook of Grounded Theory*, edited by A. Bryant and K. Charmaz, 114–26. London: Sage, 2010.

Stevens, A. 'Introducing Forensic Democratic Therapeutic Communities'. In *Grendon and the Emergence of Forensic Therapeutic Communities*, edited by R Shuker and E Sullivan, 7–24. Chichester: Wiley-Blackwell, 2010.

Sullivan, H S. *Conceptions of Modern Psychiatry*. London: Tavistock, 1955.

Sullivan, H. S. *Schizophrenia as a Human Process*. Edited by Helen Swick Perry. The Norton Library N721. New York: Norton, 1974.

Sutherland, J. D. 'Review: Day Hospitals by Joshua Bierer'. *British Medical Journal*, vol. 2, no. 4728 (1951): 404.

Sutherland, J D. 'Prevention and Treatment of Psychiatric Reactions to Stress by Psycho-Social Means.' In *Stress and Psychiatric Disorder*, edited by J. M. Tanner, 104–15. Oxford: Blackwell, 1960.

Sutherland, J D. 'Session 4. Industry and "Stress Disorder"'. *Journal of Psychosomatic Research*, vol. 10 (1966): 71–72.

Sutherland, J. D. 'Bion Revisited: Group Dynamics and Group Psychotherapy'. In *Bion and Group Psychotherapy*, edited by M. Pines, 47–86. London: Routledge and Kegan Paul, 1985.

Szasz, T. *The Myth of Mental Illness*. Paladin, 1972.

Szasz, T. *Anti-Psychiatry: Quackery Squared*. Syracuse: New York: Syracuse University Press, 2009.

Tallis, Raymond. *Hippocratic Oaths: Medicine and Its Discontents*. London: Atlantic Books, 2004.

Tantam, Digby. 'The Anti-Psychiatry Movement'. In *150 Years of British Psychiatry: 1841-1991*, edited by German. E Berrios and Hugh Freeman, 333–47. London: Gaskell, 1991.

Teece, David J., Gary Pisano, and Amy Shuen. 'Dynamic Capabilities and Strategic Management'. *Strategic Management Journal*, vol. 18, no. 7 (1997): 509–33.

Thomas, Nick. 'Challenging Myths of the 1960s: The Case of Student Protest in Britain'. *Twentieth Century British History*, vol. 13, no. 3 (2002): 277–97.

Thomson, Mathew. *Psychological Subjects : Identity, Culture, and Health in Twentieth-Century Britain*. Oxford: Oxford university press, 2006.

Tiley, Evelyn. 'Ingrebourne Centre: A Therapeutic Community'. *Nursing Times*, October 21st (1966): 1399–1401.

Timms, Noel. *Psychiatric Social Work in Great Britain (1939-1962)*. London: Routledge & Kegan Paul, 1964.

Tiratsoo, Nick. 'Limits of Americanisation: The United States Productivity Gospel in Britain'. In *Moments of Modernity: Reconstructing Britain 1945-1964*, edited by Betty Conekin, Frank Mort, and Chris Waters, 96–113. London ; New York: Rivers Oram Press, 1999.

Titmuss, Richard. 'Community Care as Challenge'. *The Times*, no. 54458 (12 May 1959): 11.

Tollinton, H. J. 'Authority and the Psychotherapeutic Community'. *British Journal of Medical Psychology*, vol. 42 (1969): 341–45.

Tollinton, H. J. 'The Organisation of the Psychotherapeutic Community'. *British Journal of Medical Psychology*, vol. 42 (1969): 271–75.

Toms, Jonathan. *Mental Hygiene and Psychiatry in Modern Britain*. Science, Technology and Medicine in Modern History. Houndmills, Basingstoke: Palgrave Macmillan, 2013.

Tooth, G. C., and Eileen, M. Brooke. 'Trends in Mental Hospital Population and Their Effect on Future Planning'. *The Lancet*, vol. 277 (1961): 710–13.

Topp, Leslie Elizabeth, James E. Moran, and Jonathan Andrews, eds. *Madness, Architecture and the Built Environment: Psychiatric Spaces in Historical Context*. Routledge Studies in the Social History of Medicine 27. New York: Routledge, 2007.

Towell, David. *Understanding Psychiatric Nursing*. London: Royal College of Nursing, 1975.

Townsend, Peter. 'A National Survey of Old People in Psychiatric and Non-Psychiatric Hospitals, Residential Homes, and Nursing Homes'. In *Psychiatric Hospital Care*, edited by Hugh Freeman, 223–32. London: Balliére, Tindall, & Cassell, 1965.

Trahms, Cheryl A., Hermann Achidi Ndofor, and David G. Sirmon. 'Organizational Decline and Turnaround: A Review and Agenda for Future Research'. *Journal of Management* Vol. 39, no. 5 (2013): 1277–1307.

Treasure, Tom. 'Redefining Leadership in Health Care. Leadership Is Not the Same as Browbeating'. *British Medical Journal*, vol. 323, no 7324 (2001): 1263–64.

Trist, E. 'Working with Bion in the 1940s; The Group Decade'. In *Bion and Group Psychotherapy*, edited by M. Pines, 1–46. London: Routledge and Kegan Paul, 1985.

Tronto, Joan C. 'Creating Caring Institutions: Politics, Plurality, and Purpose'. *Ethics and Social Welfare*, vol. 4, no. 2 (2010): 158–71.

Trotter, W. *The Instincts of the Herd in Peace and War*. T Fisher Unwin, 1926.

Tuan, Yi-Fu. 'Language and the Making of Place: A Narrative-Descriptive Approach'. *Annals of the Association of American Geographers*, vol. 81, no. 4 (1991): 684–96.

Tuan, Yi-Fu. *Space and Place: The Perspective of Experience*. Minneapolis, Minn.: Univ. of Minnesota Press, 2011.

Tuke, Samuel. *Description of the Retreat; an Institution near York for Insane Persons of the Society of Friends*. Eds. Richard Hunter and Ida Macalpine. London: Dawsons of Pall Mall, 1964.

Turkle, Sherry. 'French Anti-Psychiatry'. In *Critical Psychiatry*, edited by D Ingleby, 150–83. Harmondsworth: Penguin Books, 1981.

Turner, John, Rhodri Hayward, Katherine Angel, Bill Fulford, John Hall, Chris Millard, and Mathew Thomson. 'The History of Mental Health Services in Modern England: Practitioner Memories and the Direction of Future Research'. *Medical History*, vol. 59, no. 04 (2015): 599–624.

Turner, Trevor. 'James Crichton-Browne and the Anti-Psychoanalysts'. In *150 Years of British Psychiatry: Volume II The Aftermath*, eds. Hugh Freeman and German E. Berrios, 144–55. London: Athlone Press, 1996.

Waddington, Keir. 'Enemies Within'. In *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands*, edited by Marijke Gijswijt-Hofstra and Roy Porter, 185–202. Amsterdam-Atlanta, GA: Rodopi, 1998.

Wakefield, Jerome C. 'Foucauldian Fallacies: An Essay Review of Leslie Margolin's Under the Cover of *Kindness*'. *Social Service Review*, vol. 72, no. 4 (1998): 545–87.

Wall, O. 'The Birth and Death of Villa 21'. *History of Psychiatry*, vol. 24, no. 3 (2013): 326–40.

Ward, Adrian. *Therapeutic Communities for Children and Young People*. London; New York: Jessica Kingsley, 2003.

Ward, Dermot J. 'The Central Function of the Mental Nurse'. *International Journal of Nursing Studies*, vol. 4 (1967): 179–91.

Warr, Paul. *Brother Lunatic*. London: Neville Spearman, 1957.

Watt, Alexander. 'Overcrowding in Mental Hospitals, Relief from the Outpatient Clinic'. *The Lancet*, vol. 268 (1956): 1096–1098.

Watt, D. C. Review: 'From Custodial to Therapeutic Patient Care in Mental Hospitals: Eds. Milton Greenblatt, M.D., Richard, H. York, Ph.D., and Esther S. Brown, Ph.D. Russell Sage Foundation, New York, 1955'. *The British Journal of Psychiatry,* vol. 103, no. 431 (1 April 1957): 418–418.

Watt, D. C. Review: 'The Mental Hospital: Eds. Alfred J. Stanton, M.D. and Morris S. Schwarz, Ph.D. Tavistock Publications, London, 1954.' *Journal of Mental Science*, vol. 102, no. 428 (July 1956): 624–624.

Weber, Max. *Basic Concepts in Sociology*. London: Peter Owen, 1962.

Webster, Charles. *The National Health Service: A Political History*. Oxford Paperbacks. Oxford: Oxford Univ. Press, 1998.

Weiss, Raquel, and Paulo Peres. 'Beyond the Altruism-Egoism Dichotomy: A New Typology to Capture Morality as a Complex Phenomenon'. In *The Palgrave Book of Altruism, Morality, and Social Solidarity. Formulating a Field of Study*, edited by Vincent Jeffries, 71–97. Basingstoke: Palgrave Macmillan, 2014.

Welshman, John. 'Rhetoric and Reality: Community Care in England and Wales, 1948-74'. In *Outside the Walls of the Asylum: The History of Care in the Community 1750-2000*, edited by Peter Bartlett and David Wright, 204–26. London and New Brunswick, NJ.: Athlone Press, 1999.

Wender, L. 'The Dynamics of Group Psychotherapy and It Application'. *Journal of Nervous and Mental Diseases*, vol. 84, no. 1 (1936): 54–60.

Wender, L. 'Group Psychotherapy: A Study of Its Application'. *Psychiatric Quarterly*, vol. 14 (1940): 708–718.

Whetten, David A. 'Organizational Growth and Decline Processes'. In *Readings in Organizational Decline: Frameworks, Research, and Prescriptions*, edited by Kim S.

Cameron, Robert I. Sutton, and David A. Whetten, 27–44. Cambridge Massachusetts: Ballinger Publishing Company, 1988.

Whiteley, C.H., and W.M. Whiteley. *The Permissive Society Morality*. London: Methuen, 1964.

Whiteley, J.Leach S. *The Large Group as a Medium for Sociotherapy*. Constable, 1975.

Whiteley, J. S. 'Progress and Reflection'. In *Therapeutic Communities: Reflections and Progress*, edited by R. D. Hinshelwood and N. Manning, 15–22. London: Routledge & Kegan Paul, 1979.

Whiteley, J. S. 'The Henderson Hospital: A Community Study'. *International Journal of Therapeutic Communities*, vol. 1, no. 1 (1980): 38–58.

Whiteley, J. S. 'Guest Editorial: Maxwell Jones CBE MD FRCPsych FRCP(Ed)'. *International Journal of Therapeutic Communities*, vol. 12, no. 2&3 (1991): 76–80.

Whitwell, John. 'Management Issues in Milieu Therapy: Boundaries and Parameters'. *Therapeutic Communities*, vol. 19, no. 2 (1998): 89–105.

Wilbur, H. B. *A Report Relating to the Management of the Insane in Great Britain*. Albany: Weed, Parsons and Company, 1876.

Wilce, James M. *Language and Emotion*. Cambridge, England; New York: Cambridge University Press, 2009.

Wilgosh, Ron, David Hawkes, and Ian Marsh. 'Focussing on Solutions'. *Nursing Times*, vol. 88, no. 31 (1992): 46–48.

Wilkinson, Greg, ed. *Talking about Psychiatry*. London : Gaskell, 1993.

Williams, D. D. R. and Jane Garner. 'The Case against "the Evidence": A Different Perspective on Evidence-Based Medicine'. *British Journal of Psychiatry*, vol. 180 (2002): 8–12.

Wills, W D. *The Hawkspur Experiment*. London: George Allen and Unwin, 1941.

Wills, W D. *Homer Lane: A Biography*. London: George Allen and Unwin, 1964.

Wilmer, H. A. *Social Psychiatry in Action: A Therapeutic Community*. Springfield, Illinois: Charles C. Thomas, 1948.

Wing, J. K., and G. W. Brown. *Institutionalism and Schizophrenia: A Comparative Study of Three Mental Hospitals 1960 - 1968.* Cambridge: Cambridge University Press, 1970.

Wing, J. K., and G. W. Brown. 'Social Treatment of Chronic Schizophrenia: A Comparative Survey of Three Mental Hospitals'. *The British Journal of Psychiatry*, vol. 107, no. 450 (1961): 847–61.

Wingfield, Alysia. *The Inside of the Cup*. London: Angus and Robertson, 1958.

Wood, P. 'Da Costa's Syndrome (or Effort Syndrome)'. *British Medical Journal*, vol. 1, no. 4194 (1941): 767-772.

Young, R. M. 'The Dense Medium: Television as Technology'. *Political Papers No 13. Special Issue on Science and Technology* 13 (1986). http://human-nature.com/rmyoung/papers/paper96.html.

Younghusband, E. *Social Work in Britain: 1950-1975. A Follow-up Study. Vols 1 & 2.* London: George Allen and Unwin, 1978.

Zaretsky, Eli. *Secrets of the Soul: A Social and Cultural History of Psychoanalysis*. 1. ed. New York: Vintage, 2005.

Zeitlyn, B. B. 'The Therapeutic Community - Fact or Fantasy?' *British Journal of Psychiatry*, vol. 113 (1967): 1083–86.

Other On-line Sources

Authorities in North East Thames Region, http://www.wikidoc.org/index.php/List_of_District_Health_Authorities_in_England_and_Wales#Authorities_In_North_East_Thames_Region. Accessed 3rd October 2016.

Hill, Benny, Film: *Light up the Sky*, http://en.wikipedia.org/wiki/Gay, accessed 07/09/2018.