
A New Social Psychiatry: A World War II Legacy

The papers under this Theme give accounts of three projects arising at different phases of the war that defined the nature of the new social psychiatry. Each led to innovations in practice and advances in theory. They all involved the building of new special purpose military institutions.

The Transformation of Selection Procedures. This is an overview of the War Office Selection Boards which constituted a major innovation. The solution to a crisis in officer selection that developed in 1941 was to build a residential institution in which groups of candidates were assessed by a group of judges—military and technical (psychiatrists and psychologists). The process through which this evolved as a collaborative undertaking between the military and technical teams is described by Murray as an exemplar of creating this type of relationship.

The candidates had come to compete for the privilege of going on to officer training. They were faced, however, with situations in which they had to cooperate. How they handled this dilemma was the key question in the “here-and-now” real-life situation they were in. The leaderless group method introduced by Bion (1946) showed that when formal structure was removed a group spontaneously developed structures of its own. A therapeutic element was built into assessment procedures which became a learning experience for all concerned.

As the war went on a large variety of selection projects was undertaken and far-reaching attempts were made to test the reliability and validity of the procedures. The follow-up in theaters of war was designed in a way that secured the full participation of commanding officers.

Murray gives the first overview to be published of this far-reaching multifaceted enterprise and its implications for the future.

The Discovery of the Therapeutic Community. At the height of the war all available manpower was needed. Too many soldiers were being invalidated out because of psychological illness. An attempt to reduce this outflow was made by Bion and Rickman (1943) at Northfield Military Hospital where they introduced for the first time the notion of a therapeutic community—a completely novel idea. In countervailing the conventional bureaucratic and authoritarian medical model this innovation produced so much anxiety in the staff that

it was stopped. Later it was reintroduced in a form developed by Harold Bridger, and elaborated still further by S.H. Foulkes (1946) who exercised a major influence on post-war developments. Bridger's overview, which evaluates the contributions of all the main actors, is the only such account to be published.

The experience of being at Northfield was an intense one for staff and patients alike. The therapeutic results were beyond expectations. Many of those involved felt they had been introduced into a world where far more was possible in human relationships than they had previously thought. They came to believe that the creativeness and cooperation released might, if replicated on a wide enough scale, provide a means of bringing into existence a more reparative society.

Transitional Communities and Social Reconnection. The beliefs that arose from Northfield were strengthened by experiences with the second therapeutic community which was designed for the civil resettlement of repatriated prisoners of war. Twenty of these units were brought into existence with some 200 repatriates in residence in each at any one time. This whole scheme was conceived by Wilson (1946). Follow-up showed it to be profoundly successful. It was not under medical auspices but run by regimental personnel with a handful of psychiatric and psychological advisers. It brought forward a new general concept—the function of transitional communities in establishing the “social reconnection” of those who, for a variety of reasons, may find themselves outside or alienated from the main society.

After agreements had been reached at ministerial level to use the experience gained in a number of post-war applications their implementation was prevented because of political interventions based on complete misunderstanding. Fortunately, the form of therapeutic community developed in parallel by Maxwell Jones (1968), which had medical protection, survived. In the mental hospital world therapeutic communities gained ground but reached certain limits not present in other settings. It is a tragedy that the war-time trans-medical versions did not spread; but the obstacles at that time were all but insuperable.

These war-time innovations need reassessment as regards their usefulness for addressing current problems and Bridger is testing out their relevance to AIDS and the drug problem in the United States and Italy. They have continuing potential as arenas for promoting personal growth and group cooperation in many settings. Their participative and democratic aspects have value for institution-building for the future.

References

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