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The Affective Society: Loneliness and Community in Post-war Britain

By

Katharine Leigh Harper

A dissertation submitted in partial satisfaction of the

requirements for the degree of

Doctor of Philosophy

in

History

in the

Graduate Division

of the

University of California, Berkeley

Committee in charge:

Professor James Vernon, Chair
Professor Mark Bevir
Professor Thomas Laqueur

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Abstract

The Affective Society: Loneliness and Community in Post-war Britain

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Professor James Vernon, Chair

My dissertation is about loneliness as a social problem in Britain after the Second World War. I analyze four case studies in which various experts and care-taking professionals who identified loneliness as a problem among the populations with which they worked. Studying the period from 1945 to 1985, I show that the problem of loneliness challenged the social imaginary of the postwar settlement, in particular the sense of national community that underwrote British welfare state. I demonstrate that from this anxiety that modern Britons were lonely, new therapeutic cultures emerged in the fields of social work, psychiatry, and mental healthcare that emphasized the individual's capacity to create social bonds within a small group. These attempts to engineer community among strangers and neighbors undermined the very expertise that carried out the task.

Historians often attribute the rightward shift in British politics in the 1970s and 1980s to economic and political thought that enshrined a transcendent and market-oriented individual independent from state assistance. My research into the cultural and social dynamics of loneliness shows that rather than hyper-individualism, experts in social work and psychotherapy imposed a different ideal: small peer groups that could serve the function of self-help, and individuals who could forge meaningful relationships with others based on a culture of sharing. To show this trajectory, away from a regime of expertise and toward independent small groups, I use four case studies. The first is social workers in public housing in the 1950s and 1960s; second is the Group Analytic Society founded by Samuel Foulkes, a pioneer in group psychotherapy; third is the policy of community care and the growth of patients' rights; and finally I study Alcoholics Anonymous UK and support groups.

This project is based on original archival research conducted in the United Kingdom. For papers related to social work in British public housing, I visited the London Council of Social Service archives at the London Metropolitan Archives. The papers of the Group Analytic Society, Samuel Foulkes, and Mind were all found at the Wellcome Collection in London. The archives of Alcoholics Anonymous UK were located at the organization's headquarters in York, UK; and are in the process of being moved to the Borthwick Institute for Archives at the University of York. I also draw on published primary sources put out by the above organizations and related entities.

Dedicated to my parents, Jane and Jim.

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Graduate school has gifted me lifelong comrades. The first to come to mind is the original "Brit clique"—Jason Rozumalski, Sam Robinson, and Tehila Sasson—British history is the least of what we've shared. Every day for the last three years I've had the pleasure of eating lunch and plotting overthrow in the parking lot behind Dwinelle Hall with Chris Casey, Erica Lee, Danny Kelly, Tim Wright, Brendan Shanahan, Ari Edmundson, Julia Shatz, Joey Kellner, Sam Wetherell, and many more beautiful souls. To a person, every graduate student in the Berkeley history department has made my life better in one way or another. My tolerant friends in California who aren't in the history department, who have all fed me and housed me: Marina Kukso, Ariel Levine, Shannon Sellers, Jetti Allen, and Teddy Pozo. My friends in London, who invited me as a traveler into their circles during my research year: Lisa Renkin, Lorenzo Sabbadini, George Giannakopulos, Emma Greenwood, Lee Solomons, Jenny Imhoff, and Mak Judge. My girl gang and chosen sisters, who still have my back after 20 years: Kristin Goesel, Catie Disabato, Erica Tully, Nick Arrivo, Nikki Ulrich, and Bari Wolf. My (anything but) writing group: Serena Le, Trista Mallory, Anne Gross, and Carrie Ritter.

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This project was aided at every step by countless librarians and archivists at the London Metropolitan Archive, Wellcome Library, London Metropolitan University, the British Library, the Borthwick, and the UK National Archives. Special thanks to Stephen Sylvester, the archivist at Alcoholics Anonymous UK in York, for graciously allowing me access to their uncatalogued files.

Joey Kellner: your affection has been the most unexpected blessing. I love you very much.

Finally, my family. Mom, Dad, Sarah, Charlie, Amy, all the Harpers, and all the Marchittos: my love and gratitude is beyond words.

Thank you all for making me anything but lonely.

INTRODUCTION

Our capacity to share intimate details of our lives with strangers is a mundane expectation of everyday life, but this tethering of expressive social relationships with actualization is not linked to technological innovation. This project, titled "The Affective Society," is about loneliness as a social problem in postwar Britain. At the time I finished writing, in 2017, social isolation was being noticed by media and perennially declared a public health problem. That summer, a Harvard University study found that loneliness was linked to increased rates of heart attacks and strokes, leading some leading outlets to declare loneliness was deadlier than smoking.[1] Others compared loneliness to obesity, another stigmatized problem.[2] In between the British votes to leave the European Union and the American election of Donald Trump, George Monbiot wrote an opinion piece for *The Guardian* declaring that neoliberalism created loneliness, via "competitive self-interest and extreme individualism," providing a political dimension to a public mental health crisis.[3]

These laments about the fall from once organic communities and the danger of loneliness and isolation are not new. My dissertation traces how they have haunted us since at least the Second World War. Nowhere was this more evident than in Britain. Conducting my research I was immediately struck how as Britons set about constructing a new social democratic community, one able to unite a society shattered by capitalism and war, they were often haunted by the persistence of loneliness and isolation. As I discovered in my research this was especially evident among those social workers charged with building a sense of community on the ground. Social workers were the foot soldiers of the British welfare state, and avatars of new regimes of state-managed care, particularly for the postwar rehoused populations in cities and new towns. And yet in bundles of their files a series of issues kept cropping up: loneliness, isolation, anomie, and anxiety over the breakdown of traditional communities and kinship networks. As I quickly discovered, social workers were by no means alone in worrying about the atomization and loneliness of Britons. My dissertation then focuses on how loneliness became such a resonant social problem in postwar Britain not just for state actors but many more increasingly concerned about the relationship between the social isolation of Britons and their mental health.

“The Affective Society” explores the various therapeutic mechanisms and social formations that emerged around the quest to end loneliness by facilitating authentic relationships between strangers. It argues that social workers, psychologists, and NGOs concerned with questions of mental health sough to reimagine social community less as the technocratic product of the state and its experts than as best realized by decentralized networks and small familiar groups forged by individuals with reciprocal bonds. From this perspective the task of postwar reconstruction was not to engineer a new relationship between the market economy and the welfare state with experts charged to deliver a basket of social services. Instead it was to create a new model of community which had little to do with the state or its new welfare professionals and experts. While that sense of community drew on long currents of organicism in British

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[1] Sarah Knapton, "Having no friends could be as deadly as smoking, Harvard University finds," *The Telegraph* (24 August 2016), http://www.telegraph.co.uk/science/2016/08/24/having-no-friends-could-be-as-deadly-as-smoking-harvard-universi/

[2] Jessica Olien, "Loneliness is deadly," (23 August 2013), *Slate.com* http://www.slate.com/articles/health_and_science/medical_examiner/2013/08/dangers_of_loneliness_social_isolation_is_deadlier_than_obesity.html

[3] George Monbiot, "Neoliberalism is creating loneliness. That's what's wrenching society apart." *The Guardian* (12 October 2016), https://www.theguardian.com/commentisfree/2016/oct/12/neoliberalism-creating-loneliness-wrenching-society-apart

political thought it was also performative and tied to the creation of new social practices.[4] This dissertation then explores how the widespread *belief* that people were lonely—particularly those under the charge of care workers and medical experts—evolved into a critique of the welfare state for failing to live up to its own social imaginary. The erosion of consensus around the postwar settlement, therefore, was a complicated process that began at its conception. Ironically, as we shall see, myriad efforts to end loneliness and isolation by activating individuals to develop relationships within groups, led to a critique of the forms of much welfare state provision as well as possibly to the transcendent individualism that underwrote the political upheavals of the late twentieth century.

Why then, if loneliness and the new forms of social atomization were of such concern to welfare professionals, have historians of postwar Britain's welfare state had so little to say about it? For the most part historians of the British welfare state have focused their attentions on the construction, not the sense of erosion, of new forms of community. In contrast, the anxiety around loneliness and belonging, and ensuing attempts to engineer community by mental-health experts, illustrated uncertain belief in the national community that theoretically underwrote the postwar settlement. The story I tell is about exercises in engendering belonging among the citizenry in the assumption of its absence, real or imagined as that may have been. The British welfare state and its latter-day discontents have been largely (though not entirely) approached by historians politically, institutionally, and economically. Below, I will discuss the way the welfare state has been framed in these broad strokes, showing how each emphasizes integration and social democratic community formation. Each historical approach offers a different explanation for the rightward, neoliberal turn in British politics and culture in the 1970s and 1980s. My dissertation draws on each of these approaches, while ultimately telling the story of how the idea of loneliness threatened the idea of community.

Political historians of the second half of the twentieth century have often focused on the postwar settlement that seemingly emerged from the People's War and the Labour Party's electoral victory of 1945. These have included discussions of the degree to which the Conservative Party cohered to a new consensus around the mixed economy and welfare state. By these accounts, in order to retain working-class support, the Conservative Party expediently supported the fundamental economic arrangements put in place after 1945. These included full employment and the active role of unions, the national insurance systems of the welfare state, housing, and the nationalization of key industries. Some of these, such as housing programs, were carried out by Conservative governments. In many of these political accounts, the breakdown of the post-war consensus is described as a political response to economic shocks, culminating in public workers' strikes in 1978 and 1979. Global competition and the seemingly disproportionate power of public sector unions, for example, gave market-oriented, monetarist Conservative politicians an opportunity to win support for their views. Though beset by subterranean problems of economic infrastructure, the political narrative largely implies an initial period of harmony. These top-down histories may ignore the social dynamics of postwar Britain except as seen from the perspective of the state.[5]

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[4] Jose Harris, "Political Thought and the Welfare State, 1970-1940," *Past & Present* 135 (1992), pp. 116-141.
[5] Histories of the politics of welfare and postwar governance: Angus Calder, *The People's War* (London: Pimlico, 1992 [1969]); Stephen Brooke, *Labour's War: The Labour Party During the Second World War* (Oxford: Oxford University Press, 1992); Nick Thompson, *England Arise! The Labour Party and Popular Politics in 1940s Britain* (Manchester: Manchester University Press, 1995); David Edgerton, *Warfare State: Britain, 1920-1970* (Cambridge: Cambridge University Press, 2006); JCR Dow, *The Management of the British Economy, 1945-1960* (Cambridge: Cambridge University Press, 1964); Glen O'Hara, *Governing Post-War Britain: The Paradoxes of Progress, 1951-*

Another approach historians have taken to the postwar settlement examines policies or institutions responsible for building a new sense of social democratic community. Unlike the political historians' approach, these narratives allow for insight into the way ordinary citizens experienced reforms after 1945. These institutions include the National Health Service and national insurance programs, the restructured educational system, and housing programs, including New Towns. These histories illuminate the way daily life was restructured, as well as important continuities that endured from the pre-1945 period, as was the case with school-building infrastructure. My own work draws heavily on this approach, as the psychological and therapeutic experts at the center of this project were often tasked with administering care within these institutions. Those rehoused in inner-city London or living in New Towns were believed to be living entirely different lives than before the war, and experiencing care and the state in new ways. Finally, these institutions were not only there to alleviate want, but were believed to have the added effect of creating a national community around social democratic principles. Relevant to these institutional histories are the role experts played in managing and creating a sense of community. Expertise was itself a mixed economy, as the presence of voluntarism persisted into the postwar period evolving from nineteenth-century voluntary societies and social work to a constellation of NGOs in the twentieth century.[6]

In so far as historians have been interested in social fragmentation and the inadequate sense of social democratic community, it has been about the politics of difference. Welfare provisions, historians have shown, were gendered and racialized. They reinforced women's roles as mothers and as embedded in the family, for example, and were also formed in the context of post-colonial immigration from Asia and Africa. Historians have also discussed the new social movements of the 1960s and 1970s, in which Britons—particularly young ones—organized around new identities, and causes like feminism, racism, and gay rights. Finally, historians have discussed how British national identity fractured in the face of mass commonwealth immigration, challenging the idea of national community and laying the ground for a politics of exclusively white British identity that fractured the idea of the working classes. These histories of fragmentation can also be contextualized in the story of imperial decline and global relevance, the backdrop for both immigration and the economic shocks that disrupted the consensus around welfare in the 1970s.[7]

1973 (Basingstoke: Palgrave Macmillan, 2012); Lawrence Black and Neil Pemberton (eds.), *An Affluent Society? Britain's Postwar 'Golden Age' Revisited* (Aldershot: Ashgate, 2004); Peter Kerr, *Postwar British Politics: From Conflict to Consensus* (London: Routledge, 2005).

[6] Expertise in Britain has been discussed in: Matthew Hilton et al., *The Politics of Expertise: How NGOs Shaped Modern Britain* (Oxford: Oxford University Press, 2013); Roy McLeod (ed.), *Government and Expertise: Specialists, Administrators and Professionals, 1860-1919* (Cambridge: Cambridge University Press, 1988); . See also, Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 1998); Roberta E. Bivins, *Contagious Communities: Medicine, Migration and the NHS in Postwar Britain* (Oxford: Oxford University Press, 2005), Mark Clapson, *Invincible Green Suburbs, Brave New Towns: Social Change and Urban Dispersal in Postwar England* (Manchester: Manchester University Press, 1998); Anthony Alexander, *Britain's New Towns: Garden Cities to Sustainable Communities* (London: Routledge, 2009).

[7]For discussions of economic shocks and their ensuing domestic impact, see Andy Beckett, *When the Lights Went Out: Britain in the Seventies* (London: Faber and Faber, 2009); Niall Ferguson et. al. (eds.), *The Shock of the Global: The 1970s in Perspective* (Cambridge, MA: Harvard University Press, 2010); Catherine Schenk, *The Decline of Sterling: Managing the Retreat of an International Currency 1945-1992* (Cambridge: Cambridge University Press, 2010). Discussions of imperial decline include: Ellen Boucher, *Empire's Children: Child Emigration, Welfare and the Decline of the British World, 1869-1967* (Cambridge: Cambridge University Press, 2014); PJ Cain and AG Hopkins, *British Imperialism: Crisis and Deconstruction 1914-1990* (London: Longman, 1993); John Darwin, *The Empire Project: The Rise and Fall of the British World System, 1830-1970* (Cambridge:

One aim of this project is to use loneliness as a device that connects these historiographical focal points of social democracy with histories of British neoliberalism, understood as the end-point of social democratic breakdown. By and large, this has focused on the changing relationship between polity and economy, with austerity politics of the late-twentieth century drawing on free-market fundamentalism. Historians have also written cultural histories about the transcendent market-oriented individual at the heart of neoliberal philosophies. My work challenges this assumption, discussing how the twentieth century gave birth to a subject who was not an atomized individual, but one who could forge intimate relationships with others. The ultimate point remains similar: that the role of the state in everyday lives diminished and public life became privatized, but the ideal subject of the new regime was one attuned to small groups, not an island of himself. In short, self-help as opposed to state-help depended on a network of adaptable communities. Other than what has been described above, I draw on many historians to make this point. Among these are discussions of permissiveness in culture, which in a therapeutic setting allowed for free expression and sharing, encouraging personal independence through communal inter-dependence. Also, I locate the start of these changes (the permissive society, the critique of the welfare state, and the refashioning of individuality) in the 1950s rather than the 1960s or 1970s, in the so-called golden age of full employment and social democratic community.[8]

While "The Affective Society" is informed by these literatures it takes its cue from the new histories of emotion and affective life that are proliferating in the field of modern British history.[9] Of course, historians have long been aware of the importance of psychological, social psychological, and social research in the construction and maintenance of the welfare state.[10]

Cambridge University Press, 2009); Philippa Levine, *The British Empire: Sunrise to Sunset* (Harlow: Pearson Longman, 2007). Communal fragmentation in Britain, along the lines of new identity and social movements, including class, can be seen in: AH Halsey and Josephine Webb, *Twentieth-Century British Social Trends* (Basingstoke: Palgrave MacMillan, 2000); Mark Matera, *Black London: The Imperial Metropolis and Decolonization in the Twentieth* Century (Berkeley: University of California Press, 2015); Mike and Trevor Philips, *Windrush: The Irresistible Rise of Multicultural Britain* (London: Harper Collins, 1998); Mike Savage, *Identities and Social Change in Britain Since 1940: The Politics of Method* (Oxford: Oxford University Press, 2010); Elizabeth Roberts, *Women and Families: An Oral History, 1940-1970* (Oxford: Oxford University Press, 1995); Kathleen Paul, *Whitewashing Britain: Race and Citizenship in the Postwar Era* (Ithaca: Cornell University Press, 1997); Camilla Schofield, *Enoch Powell and the Making of Postcolonial Britain* (Cambridge: Cambridge University Press, 2013); Lucy Robinson, *Gay Men and the Left in Post-War Britain: How the Personal Got Political* (Manchester: Manchester University Press, 2007).

[8] For historical scholarship on the permissive society and breakdown of social mores in postwar Britain, for example as a component of youth culture, see: David Fowler, *Youth Culture in Modern Britain, 1920-1970: From Ivory Tower to Global Movement—A New History* (Basingstoke: Palgrave Macmillan, 2008); Frank Mort, *Capital Affairs: London and the Making of Permissive Society* (New Haven: Yale University Press, 2010); Jeffrey Weeks, *Sex, Politics and Society: The Regulation of Sexuality Since 1800* (London: Taylor and Francis, 1981); Claire Langhamer, *The English in Love: The Intimate Story of an Emotional Revolution* (Oxford: Oxford University Press, 2013). For British neoliberalism and Margaret Thatcher as a political phenomenon: Stuart Hall and Martin Jacques (eds.) *The Politics of Thatcherism* (London: Lawrence and Wishart, 1983); Andrew Gamble, *The Free Economy and the Strong State: The Politics of Thatcherism* (Durham, NC: Duke University Press, 1988). For neoliberalism and New Labour: Monica Prasad, *The Politics of Free Markets: The Rise of Neoliberal Economic Policies in Britain, France, Germany, and the United States* (Chicago: University of Chicago Press, 2006); John Clarke, *Changing Welfare, Changing States: New Directions in Social Policy* (London: Sage Publications, 2004).

[9] Much of this work has been about romantic love and familial affinity in the postwar period. See for example, Langhamer, *The English In Love*; Charlotte Greenhalgh, "Love in Later Life: Old Age, Marriage and Social Research in Mid-Twentieth-Century Britain" in A. Harris and T. Jones (eds.) *Love and Romance in Britain, 1918-*

My account of the importance of psychology and therapeutic practice in postwar British society and politics is highly indebted to the works of Nikolas Rose and Mathew Thomson. My ultimate findings, however, diverge somewhat from their accounts of growing expertise in the psychological field, and the immersion of that sphere with British politics and policy. Rose's *Governing the Soul* describes the proliferation of experts in the "psy" fields (psychiatry, counseling, human relations, and so forth) was linked to government and self-governance in advanced liberal democracies in the second half of the twentieth century. He includes wartime efforts to study the relationship between individual psychology for improving morale. This is followed by the institutionalized study of human relations (the Tavistock Institute for Human Relations) and workplace happiness (such as the National Institute of Industrial Psychology) and the creation of a psychological subjectivity. He also discusses the growth of a "therapeutic culture" in the 1970s, and the proliferation of therapeutic language to describe any host of individual and social problems. Central to this story is the development of a culture of expertise around psychology and worker subjectivity and its legitimation.[11] Mathew Thomson's *Psychological Subjects* eschews Rose's relatively top-down narrative of social control via psychological knowledge. Instead, Thomson focuses on the growth of a popular culture of psychology, and a deep integration of popularized psychology in society and everyday life, often at odds with official attempts to regulate populations (in schools, hospitals, or workplaces) via psychological knowledge. For Thomson, a popular knowledge of psychological subjectivity ran deep throughout British society and culture in the twentieth century.[12] This dissertation draws on Thomson and Rose's work in emphasizing the promiscuity of the popular psychologized self and "therapeutic culture" throughout British society. Yet rather than emphasizing the growing hegemony of 'psy' expertise upon the institutional forms of welfare state, my research reveals that attempts to end loneliness by enhancing the individuals capacity to form relationships and groups were explicitly at the expense of the authority of experts. I hope that this story of the critique and decline of expertise adds a new explanatory layer to our understanding of the challenges faced by the welfare state by the end of the twentieth century. [13]

In practice, the process of overcoming loneliness via creating interpersonal bonds with one's peers eschewed the role of experts in therapeutic practice. Explicitly, the aims of social group work and group analysis were to wean participants off dependence on professional intervention. The experiments this dissertation explores represented attempts to recast society as a networked collection of small groups. In addition, psychological professionals and experts aimed to reform individual behavior, and transform citizens into people who would easily and organically join such a small group for their own well-being. I argue, first, that this represented an updated version of Victorian self-help. Whereas nineteenth-century self-help literature emphasized individual morality and responsibility, the peer-driven antecedent of the postwar

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1970 (London: Palgrage Macmillan, 2015); Stephen Brooke, *Sexual Politics: Sexuality, Family Planning and the British Left from the 1880s to the Present Day* (Oxford: Oxford University Press, 2011).

[10] Daniel Ussishkin, "Morale: Social Citizenship and Democracy in Modern Britain" (Ph.D. dissertation, University of California Berkeley, 2007; monograph forthcoming); Nikolas Rose, *Governing the Soul* (Free Association Books, 1999); and *Inventing Our Selves: Psychology, Power, and Personhood* (Cambridge: Cambridge University Press, 1998).

[11] Nikolas Rose, *Governing the Soul* (Free Association Books, 1999).

[12] Mathew Thomson, *Psychological Subjects: Identity, Culture and Health in Twentieth-Century Britain* (New York: Oxford University Press, 2006).

[13] It is one that echoes Matthew Hilton, "Politics is Ordinary: Non-Governmental Organizations and Political Participation in Contemporary Britain," *Twentieth Century British Politics*, Vol. 22 (2011), pp. 230-268.

period emphasized the individual within a small group. The resources of the individual—hard work, resourcefulness, and morality—were the tenants of Victorian self-help, which some historians have argued were still embedded in twentieth-century British political economy and statecraft.[14] While not antithetical to the ethos of the welfare state, impressing a version of self-reliance showed that, from the beginning, the shortcomings of the welfare state needed to be supplemented by new types of social behavior and organization. Second, these projects that created group-minded individuals explicitly undermined expertise, and aimed to aggregate community resources toward psychological and emotional problems like loneliness.

Historians of Britain have long wrung their hands about the transcendent individualism that underwrote political upheavals of the late twentieth century, but I argue they were also dependent on a reimagining of society as decentralized networks feeling and reciprocal bonds, individuals forged by small familiar groups, and the noted absence of professionalized experts. This argument is developed in the following four chapters each of which focuses on a particular case-study. In each study, we can see similar trends emerging. I do not claim for these studies to be representative of British society as a whole, but instead the concern about loneliness was a trend that emerged in distinct political and social contexts where experts were engaging in psychological care work. What ties these studies together is inquiry into the relationship between social community and mental health that emerges from each discovered instance of loneliness. Loneliness is a slippery concept, that can mean several things. In the case studies that follow, I have chosen to focus on loneliness perceived from the outside. That is, I have not accessed memoirs or other primary texts from people who have experienced loneliness. I aim instead to ask why and how loneliness was perceived as a social problem, and to what effect. In each context that follows, the problem of loneliness generated a variety of ideas about how to reknit communities and make individuals more community-minded.

The first chapter concerns a social work organization in London from the end of the Second World War to the middle of the 1960s. My project begins with what I call the "discovery" of loneliness by social workers in London. This chapter looks specifically at the work of the London Council of Social Services, a branch of the National Council of Social Services, and an umbrella organization for voluntary and statutory social workers founded in 1919. Along with numerous social researchers, the LCSS identified loneliness as a critical problem for residents of reconstructed cities, culminating in a nation-wide study of loneliness in 1957. This chapter examines first, how these professionals came to see people living in London council estates (and elsewhere) as "lonely." Second, I look at the way the social work profession worked on itself, changing to become more emotionally responsive and psychologically aware. I look at how the LCSS intensified its interest in community associations, community centers, and tenants' associations on new estates, and other mechanisms by which social workers tried to teach residents to look after each other as neighbors. The chapter ends with a discussion of experimental endeavors meant to make cities less lonely: organizing informal networks such as neighbors and putting ex-convicts into family-like homes.

Following slum clearance and wartime bombing, by the end of the 1940s millions of Britons found themselves either in New Towns or rehoused in council estates within cities. These populations were a particular concern for social workers in London, as they were often living apart from their extended families, and therefore living without traditional informal care networks. In addition, social researchers found that more people—mostly very young adults and

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[14] Jose Harris, "Victorian Values and the Founders of the Welfare State," *Proceedings of the British Academy*, No. 78 (1992, originally read 14 December 1990), pp. 165-182.

the elderly—lived alone than they had before the war. LCSS social workers identified loneliness among people of all ages, though, and employed social research that linked urban isolation to suicide. The increased standard of living brought on by the welfare state—particularly when it came to housing—failed, in their eyes, to make people happier. These concerns cultivated in a nation-wide study of loneliness in 1957 conducted by the NCSS.

One way in which the LCSS tried to make new housing more personable was by intensifying their interest in community associations and group work. They recast the welfare state as requiring supplement from informal networks of spontaneous and organic social structures. This chapter covers the development of community work in council estates in the 1950s, and the way social workers with the LCSS cultivated group work amongst their charges. Here, I draw on an in-depth analysis of notes taken by one social worker about role-playing, as she struggled to teach members of her community association to work through their psychological and interpersonal problems with their neighbors and peers. Beyond their work in council estates, the LCSS also supported and carried out experimental community development projects for groups they believed to be particularly lonely—the elderly, and former convicts, for example. This chapter traces two such projects: a good-neighbor scheme for the elderly living alone, which recruited younger women to voluntarily do supplemental care work on estates; and a hostel for discharged prisoners that recreated a family atmosphere for residents.

What emerged from these practices was a critique of the welfare state (and specifically, planning) from a left-liberal position. On one hand the social workers of the LCSS utilized the idiom of the family when approaching the loneliness problem of London's rehoused. In this way they appeared to idealize organic social structures. The critique of social workers deployed against the welfare state echoed their contemporaries in social research, namely Michael Young and Peter Wilmott, whose *Family and Kinship in East London* chronicled the effects of postwar rehousing on tight-knit working-class communities.[15] However, their work went beyond critique. What also emerged was an ideal of democratic citizenship which called upon individuals to overcome their isolation in particular ways. Namely, by cultivating an inward capacity to create relationships with those *outside* of one's organic family unit or class, often a neighbor and stranger. Social workers in the LCSS, like most of the actors in this project, aimed to systematize and teach techniques of interaction to those they worked with. Finally, experiments in community work aimed to teach people to take care of each other without direction from either authority figures or the experts that underpinned the functioning of the welfare state. Starting with loneliness as a social problem, this chapter traces the way the authority of such experts was refashioned through the principles of community development in the 1950s and 1960s, by engineering psychological interdependence within new communities.

Chapter Two focuses on the concept of group work, an important component of social work in the previous chapter. Specifically, it is about one of the pioneers in group psychotherapy, psychoanalyst Samuel Foulkes. Foulkes was an Austrian-British psychoanalyst who in 1952 founded the Group Analytic Society (GAS) in London. Through Foulkes' thought and practice in group psychotherapy I discuss further how in the mid-twentieth century experts in psychology developed new expectations for how people ought to approach relationships and understand their place as individuals in society. First, throughout both his writing and work within the GAS, Foulkes equated isolation with mental disturbance, and this assumption was the basis for developing a practice in group psychotherapy. However, his perceived impact of group psychotherapy went beyond the therapeutic effect on the individual patient. For Foulkes and his

[15] Michael Young and Peter Wilmott, *Family and Kinship in East London* (New York: Routledge, 2013).

GAS compatriots, group therapy would have a widely ranging impact on the way people understood human psychology, and could have a transformative effect on society at large. In one of his first essays on the subject of group analysis, Foulkes wrote that group therapy was an important new instrument for approaching "The key problem of our time: the strained relationship between the individual and the community."[16] From its inception, Foulkesian group analysis was developed as a therapeutic practice alongside beliefs about its social and political impact. This chapter traces three developments. First, the development of group analysis as a relatively fringe psychoanalytic approach that understood itself also as an incubator for social democratic citizenship in the 1940s. This is followed by a discussion of the founding of the GAS and their practice in the 1950s, showing that group analysis increasingly focused not on the group, but the individual within the group. Finally, I show that by the 1960s, group analysis techniques had become somewhat mainstreamed, demonstrated by the work GAS members did with other professions (namely, social workers).

The chapter draws primarily on the personal papers of Foulkes and the archives of the Group Analytic Society (both located at the Wellcome Library), supplemented by published scholarly and medical articles by Foulkes and other GAS members. Foulkes was a prolific writer on group psychotherapy, and part of my task was an intellectual biography of Foulkes, to tease out the primary concepts in his writing about psychoanalysis, therapy, and social thought. This included analyzing work he did before the founding of the GAS, at the Clinic for Nervous Diseases in Exeter in 1940 and Northfield Military Hospital during the Second World War, along with other pioneers in group therapy and studies such as Eve Lewis and Walter Bion.

During the 1940s, Foulkes developed a theory of group analysis. Central to the efficacy of group analysis as a therapeutic process was the group's relationship to the group's conductor. Like social workers in the LCSS, the aim of group therapy was to wean the group—and by extension the individual patient—off the conductor's authority, so that he or she no longer required it. Other approaches to group psychotherapy that were contemporary to Foulkes—namely the human-relations school associated with Walter Bion and the Tavistock Institute—primarily aimed for high-functioning groups. While group harmony mattered to Foulkes and the GAS, their emphasis was instead on how the individual could learn to utilize the group toward his or her own therapeutic ends. Rather than focusing on optimizing group dynamics and psychology, Foulkes and the GAS aimed to teach individuals how to draw on their own personal powers of free expression to form productive bonds with strangers.

Following this pre-history of the GAS, I discuss its founding and the seminars that took place in the 1950s. Most of the members were mental health professionals, with specializations in psychoanalysis, psychiatry, medicine, social work, and education. At GAS seminars, these professionals would discuss their own practice implementing Foulkesian group analysis in these different fields. Along with discussions of their patients, members of the GAS discussed how principles of group analysis give insight to society at large. To do this, I use their own writings to position them in the context of mid-century theories of social psychology and communications. Finally, I discuss the outreach and education work they did in attempt to disseminate group analysis into other institutions and modes of care. There, I analyze the work members of the GAS did with hospitals, education professionals, and social workers. In the 1960s and 1970s, members of the GAS taught courses and led experimental group analysis sessions for members of these professions, often at the request of the latter.

[16] Samuel Foulkes, "On Group Analysis," *International Journal of Psycho-Analysis*, Vol. 27, 1936, p. 51.

The activities of Foulkes and the Group Analytic Society demonstrated how overcoming personal isolation was understood as both integral to mental health and ideal citizenship. Chapter Three returns to the practice of social work in Britain, tracing this trend through the implementation of community care as a policy and guiding principle of mental healthcare. Individual social workers saw loneliness as a mental health problem in British cities as early as the late 1940s. This connection between a lack of satisfying personal contact and mental disturbance was enshrined in policy as early in 1959 with the Mental Health Act. The primary thrust of the act was de-institutionalization. The goal was to return people living in mental institutions back to their communities, where their therapies could be maintained by local authorities, voluntary organizations, and informal networks such as their families. At its core was the belief that social belonging had curative effects for mental illness, extending piecemeal community development projects into national policy.

Chapter Three looks specifically at attempts to carry out community care policy on the local level for people with chronic mental illness. Here, I draw primarily on the records of MIND, Britain's largest mental health charity, as they monitored the progress and outcomes of many community care projects around the country. I discuss, first, the optimistic beginnings of community care and the way hostels and group homes were understood as successful projects to engineer community among those with mental illness. Many of these community care projects aimed to recreate the family home. Like the experimental group and neighborhood work conducted in the 1950s and 1960s by the LCSS, community care work after the Mental Health Act aimed to reform the way individuals opened themselves up to those in their proximity, overcoming mental disturbance by overcoming personal isolation.

As such projects faltered in the 1970s due to budget cuts and poor planning, MIND became advocates for people with chronic mental illness against both unnecessary institutionalization and the failures of community care. MIND's reports and criticisms of community care, however, usually shared its underlying philosophies, namely that social isolation was a primary factor in mental disturbance, and that the necessity of highly trained experts was an overstatement. By and large, MIND shared the assumption that for mental illness, care could be decentralized through local authorities and informal community networks. Their criticism of community care, I demonstrate, was that it failed to live up to these ideals.

MIND also served as a means for mental-health patients to self-organize around the failures of the state's care. Using their archive, I trace two related shifts in how people organized around and understood mental healthcare in the 1970s and 1980s. First, I show how community care projects, such as hostels and group homes, changed their emphasis from engineering a family-like atmosphere for residents, to teach them to build relationships, to encouraging independence. The second followed in the late 1970s and the 1980s and was the growth of a patients' right movement known as the user movement. The user movement demonstrated a departure from the original ethos of community care, in which those with chronic mental illness were understood to be isolated and poorly socialized. Instead, in the user movement, patients were conceived of as disempowered individuals. Patients' rights groups shared many qualities with community care projects and group therapy, but, unlike Foulkesian group therapy, collectivized individual discontent.

The final chapter in this project is based on the newly-opened and curated archives of Alcoholics Anonymous UK (AA UK). Most of the AA UK's organizational archives remain off-limits to researchers, but the organization's newsletters, dating from their formation in 1949 to the late 1980s, is available for limited access. My research is based largely on this monthly

newsletter, which in 1972 was given the name *SHARE*. *SHARE*'s articles were written by AA UK members, and also acted as a virtual meeting for people who lived in remote areas and could not attend a regular in-person meeting. From *SHARE*, we can learn about how AA UK functioned organizationally and as a therapeutic practice that utilized the group to assist the individual in overcoming mental distress—in this case, alcoholism.

The purpose of this chapter is to show how the problem of loneliness as the root of mental disturbance—and therefore social problems—was a concern beyond professionals in social work, psychology, and the state. In many ways, AA UK's methodology demonstrated the possibility that the interventions of the community development, community care, and group analysis movements had become common sense in a wider range of British society by the 1970s. While reading *SHARE*, I was most interested in the balance between freedom of expression and emotion and the unwritten rules of group work that constrained such expression.

In both *SHARE* and AA literature, self-inflicted loneliness was the foundation of what was referred to as "the alcoholic personality." Many contributor to *SHARE* described their drinking lives as aloof, as putting themselves on a pedestal, and of thinking of themselves as removed from the rest of society. Others described formative childhood trauma that caused them to develop emotional distance from their family members and friends. Finally, the social isolation of the unrecovered alcoholic was strong in the memories of many. In a meeting, overcoming this learned disconnection from others was done by talking about one's alcoholic past and life in general. Like community care, AA UK explicitly relied on the formation of informal networks of friendship and spontaneous contact (through both the group and the sponsorship system) to extend therapeutic care into the everyday lives of its members. Moreover, under AA UK's system, the role of medical or psychiatric experts was practically nil. AA UK's literature—including *SHARE*—newsletters, regional and national leadership, conferences, and local meetings were entirely conducted by lay meeting-attending recovering alcoholics. While in its early years numerous doctors and psychologists took an interest in AA UK's methods and success in enabling long-term sobriety for some, these professionals were not usually privy to meetings in their capacity as experts. Much like Foulkesian group analysis, the group was instrumental to individuals, whose interpersonal lives (the root of their emotional problems as well as their alcoholism) could be reprogrammed by how they learned to communicate the intimate details of their lives with strangers and acquaintances.

Many *SHARE* contributions were simply what the writer would say if they were able to attend a meeting, but could not due to geographic isolation. Others were recovering alcoholics who chronicled their personal experience going to AA UK meetings, with the hope that they could reach unrecovered alcoholics or recovered ones who had fallen off the wagon and convince them to attend a meeting. This latter group showed how despite the firmly held value of free expression, AA UK meetings did acculturate a set of unwritten rules and expectations about that expression. One such expectation was to only speak from one's own experience, rather than trying to make generalized insights about others, either from their past or others in the meeting. Moreover, guidelines about the relationship between the recovering alcoholic and his or her sponsor helped stabilize the emotional free-for-all implied in the meetings. Finally, in order to achieve full recovery, attendees were expected to do away with their own ego and resistance to being just part of the group. As a coda, I discuss the diffusion of AA UK into mental healthcare institutions, such as hospitals and prisons.

My research was conducted in London and York. For some of the archives I visited, I am either the first or one of few historians to use them. This was certainly the case for AA UK, and

possibly for Mind, which had only just given its papers to the Wellcome Collection a year before my visit in 2016. In the case of AA UK, their archives in York had not yet been catalogued when I visited, and were still in the process of meeting compliance with the UK's data protection laws for historical archives. I hope this project can serve as ground work for historians working on modern and contemporary British history who seek to access these untapped archives.

CHAPTER 1: LONELY PEOPLE AND THEIR GOOD NEIGHBORS: LONELINESS AND COMMUNITY IN POST-WAR LONDON

In the decades following the Second World War, concerns about emotional and psychological loneliness dogged the nascent welfare state. In this chapter, I discuss how loneliness was conceived as a social problem by a network of voluntary and statuary social workers, using the London branch of the National Council of Social Services (LCSS and NCSS, respectively) as a case study and the sociologists and social psychologists that entered their orbit in the 1950s and early 1960s. Specifically, I look at their work in council estates and their articulation of loneliness amongst rehoused populations in London in the 20 years following the Second World War. The NCSS was an umbrella organization for different voluntary social workers—pre-dated the advent of the welfare state and its members wrote cogently about how pre-existing social work institutions and practices would be integrated into new statutory services. For these onlookers, personally invested in the long-term outcomes of welfare provisions such as housing, loneliness challenged the democratic socialist ideal of the postwar settlement.

This chapter falls in line with historians of the Labour Party and British social democracy who have emphasized the persistence of ethical socialism in the immediate postwar period, rather than expertise-driven technocratic policy.[1] In particular, I focus on the ideal of "community," and the way loneliness—the absence of community—was identified as a social problem particular to the postwar settlement. This elaboration of the concept of community and fellowship was present in the work of Labour Party intellectuals like Michael Young and the Institute of Community Studies, for example, as well as among members of Labour's intellectual arms like the Political and Economic Planning group in the 1930s.[2] However, rather than looking at the intellectual buttresses of British democratic socialism, this chapter focuses on the attempted practical implementation of community among those believed to be lonely. Considering this ethical and communitarian strain in the architecture of British social democracy

New housing was a nursery room for social workers to evaluate the successes and failures of the welfare state from the ground up. After the war, the LCSS intensified its interest in community associations, community centers, and tenants' associations on new estates, as places where neighbors could come together and interact on non-political and non-sectarian grounds. Social work in turn needed to be more in tune with its emotional labor, to help residents of estates fill a deficit of interpersonal closeness. This chapter begins with a discussion of postwar housing reform, urban planning, and background information on the LCSS. Then, I discuss how the LCSS identified the problem of loneliness, and, while being informed by sociologists and researchers, the special attention they paid to housing conditions and work in estates. Then, I look at the work the LCSS did with community building efforts in housing estates. Finally, since loneliness seemed to disproportionately affect certain urban populations—the elderly, the disabled, and bed sit residents—I will end the chapter by looking at the LCSS's study on

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[1] Summarized in Martin Francis, "Economics and Ethics: The Nature of Labour's Socialism, 1945-1951," *Twentieth Century British History*, Vol. 6 No. 2 (1995), pp. 220-43.

[2] Francis; Lise Butler, "Michael Young, the Institute of Community Studies, and the Politics of Kinship," *Twentieth Century British History* Vol. 26 No. 2 (June 2015), p. 203

common lodging houses for single men, and specifically at the therapeutic practice of relationship building in a lodging house for discharged prisoners.

The London Council of Social Service, Foot Soldiers of British Peace

Founded in 1919, the National Council of Social Service was an umbrella group for voluntary and community organizations, and the LCSS their London chapter. From its foundation, the NCSS and LCSS were meant to bring the interests of voluntary groups into closer contact with the state.[3] After 1945, however, the line between the statutory and voluntary aspects of the LCSS became blurred. With the implementation of the welfare state, the London Council of Social Services was insistent in its usefulness as active participant, rather than relic. The state's care "from the cradle to the grave," stopped short, in Beveridge's own words, of understanding the "infinitely varied" needs of the individual. By the LCSS's own reading of Beveridge, their work functioned to "supplement the social provisions of the State in co-operation with other voluntary bodies." More than filling in the gaps of welfare, they were to be a source of information on "questions of social legislation or on matters having a bearing on any problem in the sphere of social work." In short, interpreters of welfare, and navigators of the local mechanisms of social services for citizens' needs. Along with coordinating and advising independent voluntary organizations, the LCSS had its own service apparatus: the London Citizens' Advice Bureau and the Old People's Welfare Committee, for example. In "Introducing the London Council of Social Service," a pamphlet produced in the 1950s for the purpose of collecting donations, the LCSS pointed to the over-100,000 people re-housed by the London County Council as a point of beginning for their work. Social problems were the consequences of families moving "miles from friends, relatives and work." In a sense, the LCSS aimed to humanize the postwar settlement, as exemplified by the language surrounding the Citizens' Advice Bureau: "friendly", and taking on enquiries "of a complicated personal character."[4]

The LCSS envisioned a unique place for itself in the postwar settlement. Pamphlets printed after the war asserted that voluntary organizations still had a "very important" place among state-run enterprises. The social work organization could act as ground-level guide for navigating new social services, but also was in the position to address the unique problems which arose from state intervention in peoples' lives. In one such pamphlet, the LCSS quoted William Beveridge, who said,

> State action must necessarily treat all citizens alike, but the needs of the individual are infinitely varied, and those needs are not only money. Informal education, help in the home, help in dealing with individual problems — these are matters best dealt with by voluntary agencies.[5]

Ambivalence toward social planning was embedded in the LCSS's post-war mission. Inserting themselves in the welfare state supplemented reforms by acting as interlocutor between individuals and the state. However, their practice also laid bare the potential disillusions with

[3] Margaret E. Brasnett, *Voluntary Social Action: A History of the National Council of Social Service, 1919-1969* (London: National Council of Social Service, 1969) and Jeremy Burchardt, "Reconstructing the Rural Community: Village Halls and the National Council of Social Service, 1919-1939," *Rural History* Vol. 10, No. 2 (1999)

[4] London Council of Social Service, "Introducing the London Council of Social Service," undated, c. 1959 based on archive information, London Metropolitan Archives (LMA) ACC/1888/010 fd. 3.

[5] The London Council of Social Service, "An Introduction to the London Council of Social Service," LMA ACC/1888/010 fd. 3. nd, 1950s

welfare as being counter to close social relationships, particularly amongst residents of urban estates and those who had moved away from their families and ancestral homes.

In the 1950s, the LCSS described their work as providing the connective tissue between citizens, statutory welfare, and voluntary organizations, a road map for navigating new state provisions and old charitable institutions. However, their institutional position was enhanced by their qualitative framing of their work. Rehousing, and mobilization and demobilization during the war led to what they called "problems of life" or "human or social problem[s]." For this, they had set up Citizens' Advice Bureaux all over the country, including 62 in London with 200,000 calls per year, with "many of the enquiries being of a complicated personal character." The Bureau's "approach to the citizen, bewildered by the intricacies and complexities of modern life is human and friendly", as they translated "official regulations" into plain language and gave modernity a human face. The LCSS made itself an arbiter of people's personal and interpersonal problems, filling the vacancies left by statutory bodies.[6] A report commissioned for the purpose of an appeals pamphlet noted that along with interpreting difficult legal information and directing people to the proper agency for their problems, the Citizens' Advice Bureau should: "[fill] the gaps in the social services and [deal] with personal problems; acting as a "safety valve" through the simple act of listening sympathetically; recognizing deep-seated and difficult social problems of which the enquirers themselves may not be aware."[7]

In the 1950s, the LCSS saw themselves as having a crucial role in ameliorating the unique social problems faced by relocated residents. Speaking of the "over 100,000 people" who had been rehoused by the London County Council, an appeals pamphlet noted that while these problems had received little public attention, the LCSS had been at work in uprooted communities for years. They wrote, "It has helped to form social groups in the new housing estates round [sic] London; it has given much help to family clubs which have been formed in blocks of flats, and it has encouraged the formation and growth of community associations." [8]

What follows divides the work of the LCSS from 1945 to the early1960s into two categories: the theoretical and the practical. A significant amount of the LCSS's operations was as a research body into social problems and their possible solutions. In the mid-1950s the LCSS encountered a constellation of sociologists—many based at the University of Birmingham, associated with the Mass Observation Movement, or affiliated with the burgeoning community studies and community sociology movements. These visitors and texts notably impacted the LCSS's agenda in the 1950s and 1960s, as evidenced by the commission of the *Loneliness* report in 1957, discussed below.

The second item has to do with the practical work of LCSS social workers in new housing estates, paying particular attention to the Standing Conference of Housing Estate Community Groups, formed by the LCSS's Office of Community Centres and Associations. This section will focus on the micro-strategies employed by the Office of Community Centres and Associations as they propagated and maintained Community Associations and other tenants' groups in new urban estates: essentially, how to form genuine relationships between tenants and social workers, and amongst tenants. This will also include the study of loneliness among so-

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[6] The London Council of Social Service, "An Introduction to the London Council of Social Service," LMA ACC/1888/010 fd. 3. nd, 1950s

[7] National Citizens' Advice Bureaux Committee in association with the National Council of Social Service, "The Citizens' Advice Bureau Service in London," nd, p. 3. LMA ACC/1888/010 fd. 3

[8] The London Council of Social Service, "An Introduction to the London Council of Social Service," LMA ACC/1888/010 fd. 3. nd, 1950s

called problem populations: the mentally ill, the elderly, and discharged prisoners. I will return to the specifics of the LCSS's postwar activities, after delving into the heart of the matter: the explicit addressing of loneliness as a significant social problem in London's postwar housing estates.

Rehousing and New Construction After the Second World War

New housing, whether postwar rebuilding in inner London or suburban New Towns, was a particular point of concern. The sheer number of new housing created new demands for social services, and also demanded a layer of social worker interlocutors to help ordinary people navigate welfare institutions. Rehousing and new construction in the three decades after the Second World War was extensive, and attempted to remedy housing shortages that existed before the war and those that were inflicted by it. It included added new housing units as well as replacing unsuitable slums with new housing. In 1944, the Ministry of Health's Design of Dwelling (also known as the Dudley) Report laid out the standards by which new housing would be built and potential slums identified. the Labour Party's six-year tenure after the war—1945 to 1951—over one million permanent dwellings were erected throughout the country.[9] Between 1951 and 1964 that number was 3.7 million, and 2.2 million between 1965 and 1970.[10]

While the mid-century saw extensive suburban and New-Town development, much of the rehousing and new construction in the country was urban, particularly in the 1950s. This was a combination of rebuilding from war damage and the clearance of slums. Slum-clearing had begun in the 1930s, when local authorities began collecting data about "unfit" residencies, but its progress was stalled by the war and remained so until 1953. Between 1955 and 1975, 1.3 million housing units were demolished.[11] Three million people were displaced and relocated. Rather than moving out to the suburbs, most of these people were rehoused in urban estates or close to urban areas.[12]

In the immediate post-war period, rebuilding subsidies provided to local authorities reflected the universalism of Labour government. The 1949 Housing Act, passed under Atlee, removed restrictions on local authorities to provide housing only for the working classes. This was an attempt, as then-Minister of Health Aneurin Bevan put it, to "meet the varied needs of the whole community" and recreate the "lovely feature of English and Welsh villages," with everyone on the same neighborhood a "living tapestry of a mixed community."[13] Social housing would become more removed from this organicist vision by subsequent governments returning to a subsidy system limited to needs-based housing for the working classes and a shift to reliance on private construction. In this context of shifting political underpinnings of housing provisions, social workers in urban Britain sought to engineer community amongst a freshly atomized and mobile rehoused population of various classes. This chapter looks at one such social-work organization—the London Council of Social Services (LCSS)—who from the end the Second World War through the 1950s were the interface between thousands of rehoused council-estate residents and the developing welfare state.

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[9] Peter Malpass, *Housing and the Welfare State: The Development of Housing Policy in Britain* (New York: Palgrave Macmillan, 2005), table, p. 68.
[10] Malpass, pp. 82, 84 (table), and 93 (table).
[11] AE Holmans, *Housing Policy in Britain: A History* (London: Croom Helm, 1987) p. 123-124.
[12] Patrick Dunleavy, *The Politics of Mass Housing in Britain, 1945-1975: A Study of Corporate Power and Professional Influence in the Welfare State* (New York: Oxford University Press, 1981), p. 1.
[13] Quoted in Jamileh Manoocherhri, *The Politics of Social Housing in Britain* (New York: Peter Lang, 2012) p. 27.

Rehousing, therefore, meant a variety of things. New towns and suburban developments, made possible by the 1946 New Towns Act, were one form of relocation. New towns were the target of *Family and Kinship in East London*, as well as the invention of "New Town Blues" and revived concerns about "suburban neuroses", originally conceived by psychiatrists in the 1930s. The lonely expanse of British suburbs was a cultural image that deserves recognition, though it is worth noting that most of these rehoused three million were not sent to New Towns, but to new developments in inner cities. Of those three million, over 440,000 were put in another symbol of modern industrial development: the high rise flat.[14] the sort of housing people were moved into was less important than the relocation and upheaval itself. The Abercrombie Report of 1943, the New Towns Act, the Greater London Plan of 1944, and the various postwar Housing Acts all created new avenues of state-directed relocation. In new housing estates and rehoused populations, the LCSS identified new patterns of everyday life as atomized aberrations of natural clusters of sociability. The problem of psychological loneliness was at times ascribed in nonspecific gestures to "modern times." But the social workers under examination also made very specific critiques of the welfare state, blaming the provisions they were entrusted with distributing for the creation of a lonely citizenry. Theirs was a reckoning with not only the welfare state, but also the myths of collective caring and security put forth during the Second World War. The social workers of the LCSS latched onto the writings of a circle of sociologists who confirmed their concerns about loneliness, culminating in a large-scale nationwide study of the problem in 1957. In the short-term, the problem of loneliness inspired the social workers of the LCSS to turn to their interpersonal techniques and emotional labor, as well as that amongst their clients.

The Pathological Loneliness of London's Rehoused

Rehousing in many cases led to a disintegration of family networks, observers believed. One effect of rehousing was a growing population of Britons—particularly young ones—living far away their families. Sociologists and other observers spoke to this particular type of loneliness, that of living outside of one's kinship network, particularly as young families and single people moved away from parents and grandparents. Suburbia's lengthened commutes also stretched families across space, as working fathers and stay-at-home mothers spent more time apart. Beyond that, though, more people actually were living alone and without family than had before the war. Between 1931 and 1951 the number of single-person households in England and Wales more than doubled, going from 689,000 to 1,403,000 living alone.[15]

In 1954, a psychiatrist named T.M. Ling, the Medical Director of Roffey Park Rehabilitation Centre, spoke for the LCSS's Women's Group on Public Welfare. He spoke on the problem of loneliness, and its "wide spread growth of which he described as a major social problem."[16] Though they did not print Ling's speech, it was likely similar to a talk he gave at the Town and Country Planning Association's Annual Summer School that same year. In his talk to town planners, Ling analyzed Peter Sainsbury's suicide epidemiology maps for London. The maps showed a geographic spread of suicide which seemed to skip over poorer neighborhoods such as Camberwell and Deptford. The difference, he argued, was significant. "Mathematically…poverty, overcrowding, and unemployment have little to do with suicide," the

[14] Dunleavy, pp. 1, 28.
[15] Holmans, p. 111 (table).
[16] Women's Group on Public Welfare, *Loneliness*. 1963 (first printing in 1957), p. 7. London Metropolitan Archives, LMA/4016/PA/C/01/111.

conference notes read. Rather, the determining variable was "a lonely mode of life." A second map illustrated a high "co-efficient correlation between the suicide rate and the isolation rate", measured by people living alone. Ling called on planners and architects to recognize the link between housing and mental health, as new developments with their uprooted communities, long commutes, and private dwellings were most prone to loneliness.[17]

By their own account, Ling galvanized the Women's Group to form the Social Aspects of Loneliness Working Group, who ran a three-year study on loneliness from 1955 to 1957.[18] The Women's Group was one of the most well established associates of the NCSS, and the most active after 1945.[19] They sent a questionnaire to 25 voluntary member organizations of the National Council of Social Service, including the social service councils of Bath, Exeter, London, Nottingham, Sheffield, and Woolwich; the Institute of Social Psychiatry, and the Association of Marriage Bureau.[20] The questionnaire determined the "size of the problem in [a] particular area, the age groups most affected, the causes to which loneliness was attributed by the organization, and what was being done about it."[21] The study's report sold 8,000 copies on its first printing, and according to its authors, received wide radio and television publicity.[22] The National Council of Social Service featured the study in their annual report for 1957.[23]

The Women's Group echoed a number of Ling's points, including Sainsbury's suicide maps as an indicator of social isolation and the relationship between higher standards of living, housing, and personal loneliness. They too noted that poorer boroughs in London, "with a more static population, greater warmth of life and intimacy between families, such as Battersea, Camberwell, Poplar and Bermondsey (all with a below-the-London average of people living alone) were among those with the lowest rate of suicide."[24] New housing patterns were a problem: over a million young people—moving from small communities to large towns—were living alone, almost twice as many as in 1931, and single person households increased by 104 per cent in England and Wales between 1931 and 1951.[25] At each life stage, the disruption of the intergenerational family unit was felt as loneliness: the young, unmoored from their villages, remained romantically single in their urban bedsits; young mothers were isolated at home while their husbands worked a long commute away; their young children suffered; and the old missed visitors and the company of family caretakers.

Switching from external conditions to personal shortcomings, the report argued that Britons suffered from a "deep-seated inability to make satisfactory human contacts"[26], and urban social life needed to be harmonized with the biological need for attachment as had been put forth by the likes of Dr. Spock and Dr. Rene Spitz.[27] Local authorities needed to encourage leisure activities which had little to no educational value—a clear rejection of Victorian rational recreation—but which prioritized a "friendly atmosphere."[28] The report made a strong case for

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[17] T.M. Ling, "Living in Town and Suburb," *Town and Country Planning Summer School: Report of the Proceedings* (London: The Town Planning Institute, 1954), pp. 50-53.
[18] *Loneliness*, p. 7.
[19] Brasnett, p. 144.
[20] *Loneliness,* p. 58.
[21] *Loneliness*, p. 8.
[22] *Loneliness*, p. 5.
[23] National Council of Social Services, 38th Annual Report, 1957, LMA ACC/1888/090, p. 7.
[24] *Loneliness*, p. 10.
[25] *Loneliness*, pp. 10, 43.
[26] *Loneliness*, p. 13.
[27] *Loneliness*, pp. 13-15.
[28] *Loneliness*, p. 29.

community associations on new estates, especially in the loneliest boroughs such as Westminster, Chelsea, and Kensington.[29] Community Associations—organized around nothing more than proximity and inclusive of men and women of all ages would, as the secretary of the National Federation of Community Associations put it, "'[restore] lonely people of the feeling of belonging,'" and would help people become, '"vital, creative, critical, and reflective beings, for whom loneliness [is] not to be dreaded but can provide a privacy to be enjoyed.'"[30] Community associations held the promise of teaching people to be more expressive with each other, both for social harmony but also as a critical step in psychological self-improvement.

The same summer Dr. Ling gave his talk, the LCSS annual meeting was addressed by Dr. John Spencer. Spencer was the director of the Bristol Social Project, a social research scheme funded by the Carnegie Trust, and which ran from 1953 to 1958. The Project was an experiment in "action-research," attempting to knit social research with professional action, in this case the action of social workers and psychiatric social workers engaged in social group work.[31] His talk was titled "Old and New Communities: Some Opportunities for Social Service," and described the special social problems posed by new housing. Spencer, along with fellow Bristol University researcher Peter Kuenstler was working to integrate social psychology into social work. Social group work, the employment of small, familiar groups to restore authenticity to social relations as a remedy for a host of social problems, was the result. In Kuenstler's collaborative anthology, *Social Group Work,* the authors noted the technocratic and material achievement of postwar housing, but that progress and privacy exacerbated social and psychological problems. Spencer's contribution to the volume, a history, put social group work at the pinnacle of a British heritage of settlements, Ragged Schools, Women's Institutes, and Friendly Societies, noting the "unplanned nature" of mutual aid societies from the nineteenth and early twentieth centuries as something for social group work to emulate.[32]

At the time of his talk to the LCSS, Spencer was conducting the Bristol Social Project, the progress of which the LCSS had been following. Originally an inquiry into juvenile delinquency in Bristol estates, Spencer's ultimate diagnosis was that crime was "the effect of social isolation on the family."[33] Small group work for him was both an object of study and held the greatest promise for changing patterns of crime and deprivation.[34] Spencer described the project as "action research", meant to initiate change in three orders: the first order was characterized by material improvements; the second, better education; and a third, more important than the first two, which was a complex, non-material process "focused primarily on feelings," and free expression in the context of familiar relationships. Change in the third sense could be achieved only through "learning about relationships." [35] Crucially, following the political victories of the welfare state, Britons were still poised antagonistically toward a withholding "common enemy" but now needed to learn to "work together harmoniously."[36]

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[29] *Loneliness*,p. 35.
[30] *Loneliness*, p. 36.
[31] George Goetschius and M. Joan Tash, *Working With Unattached Youth* (London: Routeledge, 2002), p. 358 (originally published in 1967 by YWCA of Great Britain); J. Tuxford and N. Dennis, "Research and Social Work." *Social Work,* Vol. 15, no. 2 (1958): 460-62. http://www.jstor.org/stable/43760349.
[32] John Spencer, "Historical Development" in Peter Kuenstler, *Social Group Work* (London: Faber and Faber, 1954) p. 41.
[33] John Spencer, *Stress and Release on an Urban Estate* (London: Tavistock Publications, 1961), p. 9.
[34] Spencer, p. 12.
[35] Spencer, *Stress and Release*, pp. 35-36.
[36] Spencer, *Stress and Release*, p. 52.

Spencer brought these sentiments to the LCSS's annual meeting in 1954, encouraging social workers to reassess their work in new communities. The meeting's recorder recounted:

> The intimate neighborliness and mutual aid of the nineteenth century were built up on a set of conditions which had now disappeared…Good houses had been built but a good community life would have to grow. He stressed that genuinely democratic methods were needed and warned us not to forget the lessons of the undreds [sic] of Coronation street parties which had been organised all over London without any central direction or administration…[37]

Spencer's logic highlighted a contradictory role for trained social workers in thinking about loneliness as a social problem and therapeutic potential of relationships. That is, social workers needed to take an active role in the work of community and their training needed to highlight the destructive impact of isolation, and they needed to learn to draw out a natural, necessary, but currently stunted instinct to bond. At the same time, their role was negated by such a natural and spontaneous sociability which resisted planning from above and outside intervention.

Practical Approaches to Loneliness: The Office of Community Centres and Associations

I now turn to the work the LCSS did on the ground, that of community associations. The history of community centers and associations is long, stemming from Victorian antecedents such as settlement houses.[38] However, during after the Second World War, due to the sheer scale of building and rebuilding, the LCSS heightened its interest in them. In 1949, thanks to a £1500 grant from the London County Council, the LCSS formed a loose association of housing estate groups, through which they offered advice and services to community groups on an individual basis. They also set about extensively surveying and counting the number of community centers and community associations.

The community center or association was understood in the simplest terms by the Cambridge House Corner Club in Camberwell as "a place where neighbours meet." However, it was "far more than that." A community center, they wrote "should arouse among its members the same pleasure, affection, and respect that they have for their own home, of which it is in truth

[37] Annual Meeting of the London Council of Social Services, 5 July 1954, LMA ACC/1888/011 fd. 2.

[38] For a discussion of tenant-driven association beginning in 1867, see John Grayson, "Campaigning Tenants: A Pre-History of Tenant Involvement to 1979," in Charlie Cooper and Murray Hawtin (eds.), *Housing, Community and Conflict: Understanding Resident "Involvement"* (Brookfield, VT: Ashgate Publishing, 1997), pp. 15-66. More internal studies of the community center and association movements include: Maurice Broady, et al., *Enterprising Neighbors: The Development of the Community Association Movement in Britain* (London: National Federation of Community Organizations, 1990); Alan C. Twelvetrees, *Community Associations and Centres: A Comparative Study* (New York: Pergamon Press, 1976); Mess, HA and King, H, "Community Centres and Community Associations" in HA Mess (ed.) *Voluntary Services Since 1918* (London: Kegan Paul, 1947). Self-organization in working-class and social housing, however, provides an incomplete history of tenant organization. The history of neighborhood-based organization by middle-class volunteers or professionals extends at least to Victorian settlement houses, home visitors, ragged schools, adult education, and other middle-class intervention in working-class and poor neighborhoods, and the social-work profession that emerged. The history of these voluntary and increasingly organized practices—conducted largely by women—are featured in Susan Pedersen's studies of the social origins of the British welfare state, such as *Family Dependence, and the Origins of the Welfare State: Britain and France, 1914-1945* (Cambridge: Cambridge University Press, 1993) and "Gender, Welfare, and Citizenship in Britain During the Great War," in *The American Historical Review*, Vol. 95 No. 4 (October 1990) pp. 983-1006 http://www.jstor.org/stable/pdf/2163475.

an extension."[39] Being a good neighbor or a good community member of an estate was not the same as being a well-socialized member of the public. Rather, community centers and associations were understood as an extension of private life, made bereft of intimacy by the evolving urban environment.

The LCSS and affiliated community centers argued that community centers and tenants' associations were integral provisions for modern life. In 1957, the annual report of the Churchill Gardens estate community association singled out the Westminster City Council for not fulfilling "the very great need" they had for a dedicated community center. The chairman J. Mills and secretary WBK Wilcockson wrote: "A Community Centre is NOT A LUXURY it is a NECESSITY." The demand continued:

> Many thousands of Council tenants, through the medium of their Associations are joining hands in a spirit of true democracy, where the main aims are fostering of neighbourliness and the social welfare of all. That this is possible, under constitution of non-party politics, must surely be approved and encouraged by all local governments.

Describing the utility of the community center connected democratic citizenship with neighborliness. The relationship between neighbors was a specific type of sociability not predicated by proximity, politics or identity. The report defined community association as a "Democratic fellowship of individuals and organization bound together by common purpose—the common good…[and] well-being of the individual or community." The local government needed to provide a community hall on every estate, a right they argued was "universally recognized." The reason for this was that, "Personal relationships play a major factor in our enjoyment of life, more so than ever in present times, which may be called 'the age of anxiety.'" In large urban housing blocks, "there is a great need for developing new social contacts and cultivating common interests and activities. Flat life is only soul destroying if the community is ignored."[40]

Despite these high-minded claims about democratic purpose, other documents from other estates indicate that engaging tenants' in participation was a struggle.[41] An undated report from the Cranston Tenants' Association from the 1950s. The writer celebrated the last meeting's large attendance, which they said "dealt a blow to the 'it's not worth missing the tele' section of the estate." Encouraging those who didn't show up: "The Association is YOURS – use it – support it…You are, WE REPEAT, 'YOU ARE' a member and thus bear part of the responsibility" that the association be kept up. This call was more practical than those for maintaining a democratic spirit among the citizenry. The writer of the report continued: "Remember also, it will be too late, when you wake up to realize that you are paying a substantial rental to live in a Hoxton slum, that you have made it so by a could not care less attitude," and that "No amount of complaining in the Laundry, or the Local [sic] will repair the broken windows."[42] Proponents of community and tenants' associations sought to redirect civic life into these neighborhood

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[39] "Confidential: The First Six Months of a Community Centre: The Cambridge House Corner Club," n.d., c. 1947, LMA AC/1888/067 fd. 5.
[40] J. Mills and WBK Wilcockson, Churchill Gardens Annual Report, 1957, LMA/1888/057 fd. 4.
[41] The difficulties faced in imposing an ethics of "community" and "fellowship" from above in the immediate postwar period, with particular mention of community associations is also discussed by Steven Fielding, et al., "Creating the 'Responsible Society' Part One: Building Community," in *England Arise! The Labour Party and Popular Politics in 1940s Britain* (New York: St. Martin's Press, 1995).
[42] Cranston Tenants' Association report, c. 1956, LMA ACC/1888/057 fd. 6.

organizations, encouraging people to organize around shared concerns with their neighbors. Moreover, being an active and good neighbor was framed as an important personal responsibility that was expected of residents in the estate.

Social workers aimed to facilitate this link between interpersonal harmony among neighbors living on estates and social progress. One social worker, Miss Becker, reported in 1958 on her "Neighbourhood Work" in the Dickens estate over the last five years. She described three levels of her work: case work (dealing with relationships between individuals), group work ("the inter-relation between individuals in groups with guidance of trained personnel but for their own individual development"), and community work ("the relationship between individuals in the community for a…specific purpose other than their own development"). Competent social work on estates required the worker to intervene on all three interrelated levels. Becker's reports reveal a belief that individual psychological well-being was tied up in individual relationships. Becker compared her work to that of a clinical hospital setting. While the techniques of community, case, and group work were similar, they were rooted in social cooperation and "the reconciliation of an individual through a relationship." Unlike a clinic, in which psychotherapeutic practice was "strictly circumscribed by the beginning of the illness and ended by the rehabilitation," the "community setting" was open-ended in timing and practice. The social worker was an important conduit for the psychological and relational lives of estate residents (Becker discussed the problems with which she referred clients to psychiatric social workers and counsellors), which were enmeshed. Groups and group work were essential linkages between the interpersonal and broad social harmony. A trained social worker "understands," Becker wrote, "what groups may mean to people, what type of mechanism actuates groups, and what the worker expects and what the client hopes to achieve through the group."[43] The community center, community association, and tenants' association were critical sites of intervention into the problems generated by isolation and social disconnect.

In 1949, Muriel Smith was appointed Officer of Community Centres and Associations for the LCSS. In 1957, the organization became the Standing Conference of Housing Estate Community Groups, who met yearly. By the mid-1960s, the LCSS estimated about 70 member estates, and counting.[44] Smith's job was to provide advice for community associations, advocate on their behalf to local authorities, help them write constitutions, by-laws and so forth. Her papers showed a close engagement with the personality management that went into estate work, and the sample constitutions she provided for new associations made "neighbourliness" their first and most prominent item.[45] The tenants she corresponded with saw community work as a right, and a necessary corrective to modern loneliness. Smith and others in the LCSS were also interested in the training of neighborhood workers and group social workers, fields which were still underdeveloped compared to their North American counterparts.

An undated stack of papers in Smith's files contained extensive training notes regarding techniques of "role playing and discussion," for community association meetings and conflict resolution. The files demonstrated an effort to codify and predict the behavior of small groups, to be more intelligible for the social worker. Role playing would help residents and social workers map the affective trajectories and motivations embedded in communities. Smith wrote a number

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[43] Becker, Time & Talents newsletter, March 1958 LMA ACC/1888/057 fd. 8.

[44] History of the Standing Conference, LCSS, Community Development Committee, "Minutes of meeting held on Monday, 18th July 1966", Appendix III, "Association of London Housing Estates". LMA ACC/1888/019 fd. 5.

[45] Sample constitution for community associations, as described by Smith to the Friary Estate, August 24, 1951, LMA ACC/1888/057, fd. 13.

of directives at the emotional register. All parties who engaged in role play for conflict resolution, for example, needed to "invest", not just act, and also "understand the feelings of the imaginary person" whose role they were imitating.[46] For discussion, practice was key, helping participants not only develop their opinions but "developing familiarity of members in the group" which "tends to make for more free expression."[47] Smith's devotion to the micro-strategies of living together served to create expectations for the emotional intelligence of neighborhood workers, and suggested that the management of the interpersonal deserved more attention from the social work establishment.

Emotional conduct was an important conduit for social harmony. All parties who engaged in role play for conflict resolution, for example, needed to "invest", not just act, and also "understand the feelings of the imaginary person" whose role they were imitating. Smith was clear that this was about inhabiting social roles outside of one's own, but that was familiar. She wrote: "It would be of no use to give me notes about a personality and a situation in which I was an employee in a factory and had to present my feelings about the foreman or shop steward." She could, however, "be a passenger on a bus or even a conductress because I have often observed the good and bad points of both persons and have been involved at least as a passenger." Participants could successfully role play in situations that were "real" to them. At the same time, they had to take care not to become too personal. On the question of whether or not "people's feelings get hurt," Smith said: "If I role play a scene before my mother, taking her personality on and with someone else, act out my problem with her, this would be very hurtful. It is too personal." She reminded readers that they were "acting out the relationship" not specific personalities, to experimentally inhabit their social position, not imitate their demeanor. So while role-playing was meant to smooth over potential interpersonal conflicts, the drama of acting out each other's roles did not include direct imitation of a certain personality. This suggested that Smith's understanding of social roles was abstract, and learning to inhabit others was not so much about the specific people involved, but understanding the point of view of these stylized roles. For discussion, practice was key, helping participants not only develop their opinions but "developing familiarity of members in the group" which "tends to make for more free expression."[48] Role playing could break down barriers of deference or misunderstanding, and Smith used it to advocate for freer expression between groups on estates and in society at large. Smith's devotion to the micro-strategies of living together served to create expectations for the emotional intelligence of neighborhood workers, and suggested that the management of the interpersonal deserved more attention from the social work establishment.

Smith also wrote about a lecture on "General Assessment and Discussion Group Techniques" which was about "general observations, the roles of leader and members, a description of the usual personalities found in a group,…and suggestions for meeting the more common problems facing a leader." The attendees were divided into groups, with one acting as a leader. They were given the question: "How can we help lonely people feel they are wanted?", showing further how deep this concern was among housing-estate social workers. As the participants spoke to each other, Smith said that everyone participated and "spoke freely" but the leader struggled to balance those who frequently contributed with those who were more shy. Elsewhere, she wrote: "Practice helps all participants…It is possible that the developing familiarity of members in the group tends to make for more free expression." Group work was a

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[46] Muriel Smith, "Notes on Role Playing," LMA ACC/1888/072, fd. 2
[47] Smith, "Conclusions", in "Notes".
[48] Smith, "Conclusions", in "Notes".

skill that could be learned with time, practice, and competent leadership. Smith wrote that with such practice, "The members of the group were evidently at ease and discussed freely. Although they cooperated with the leader, they did not appear to accept the responsibility for helping each other." This shortcoming demonstrated a lack of independence from the leader's authority and expertise, though the groups had succeeded in speaking freely and without inhibition with each other. Elsewhere, Smith lamented that there was "no noticeable development in mutual aid." Critically, the practice of role-playing in groups was only tenuously innate, and no inborn sociability could make up for the practice of "skills" that were required by "both membership and leadership." This shows that group work intended to be an extensive learning process for participants and social workers, as they learned how to lead without authority, how to participate in free discussion, and how to aid each other without the intervention of experts. Discussion groups had to balance the free flow of speech with restraining the tendency to become a "free for all." Participants needed to "listen as well as speak." Even if it meant a point was repeated, "there are others who wish to take part." Interpersonal closeness, the antidote to loneliness, could be taught and learned, and social workers like Smith saw it as an integral part of their job to facilitate this process. Smith's papers dealt not only with problems of leadership, but of shyness, silence, and overtalkers. [49]

The Common Lodging House Project and Returning Prisoners to Society

Thus far I have covered two aspects of the LCSS's work on loneliness: their research and their groundwork in housing estates. I now turn to the third element of their work in the 1950s and 1960s, their work with those they considered pathologically detached. The two examples elaborated upon are a good-neighbor scheme for the elderly and lodging houses for single men (most of them discharged prisoners). Both of these experiments refined practices of co-habitation and propagated the idiom of the "good neighbour" as a stop-gap for the shortcomings of state services, and a necessary informal component of welfare.

The "neighbourhood unit" was a feature of British and American urban planning in which the NCSS had taken an interest during the War as well as after it when it had ceased to be fashionable among professional urban planners. The neighborhood unit was part of the Greater London Plan of 1944. The Plan itself concerned the dispersal of London's overcrowded Victorian core into new suburban developments, for which the planners recommended the neighborhood unit as a guiding principle. Designated at (a seemingly un-neighborly) 5,000 to 10,000 people, the aim was to foster organic social wholes, analogous to the big national community myth which underwrote the postwar settlement.[50] Like many aspects of postwar urban planning, the neighborhood unit was indebted to pre-war experimentation with garden cities and village greens.[51]

The neighborhood unit was accepted as an official designation for the planning of suburban New Towns by the Reith (New Towns) Committee and the Ministry of Town and Country Planning in 1945. The Committee's final report in 1946 stated that the "guiding principles" for New Towns and developments should be that they ought to be "established and

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[49] Smith papers

[50] Angus Calder, *The Myth of the Blitz* (London: J. Cape, 1991); Sonya Rose, *Which People's War? National Identity and Citizenship in Wartime Britain, 1939-1945* (Oxford: Oxford University Press, 2003).

[51] Mark Clapson, *Invincible Green Suburbs, Brave New Towns: Social Change and Urban Dispersal in Postwar England* (Manchester: Manchester University Press, 1998) pp. 38-39.

developed as self-contained and balanced communities for work and living."[52] In the first New Town, Stevenage, the planners aimed to revive the social life of old English villages, structured around mixed-class and -status living: a society of neighbors, bound by location rather than strangers separated from each other by class, occupation, and status.[53] The neighborhood unit and the community-studies lens of social planning to which it contributed had its detractors, and was not the dominant approach to urban planning in the post-war period. Specifically, the Committee for Urban Studies at the University College of London—steered by Ruth Glass, Asa Briggs, and a number of American urban scholars—criticized the organic-community approach to urban planning as too localized, narrow, and qualitative; and pushed for a more structural and data-driven approach to urban studies.[54]

However, even in the face of these alternatives, the NCSS and LCSS leaned in the direction of community development throughout the 1950s and 1960s, and incorporated a vision of neighborliness into their work in urban estates. The NCSS advocated for the neighborhood unit as a guide to urban planning in their own literature, and testified in front of the Reith Committee on its behalf. During the Second World War, the NCSS's Community Centres and Associations Committee dedicated its research and study resources to bringing the Council's pre-war experience with community building into postwar planning. The report that came from these efforts, *The Size and Social Structure of a Town*, published in 1953, argued for the importance of self-contained neighborhoods, convincing town planners that the ideal population of a town was to be 50,000, and a neighborhood five to ten thousand each.[55]

The imposition of neighborliness by agents of the state and voluntary organizations had been treated as a matter of national necessity during the Second World War, and when the war ended social workers and volunteers sought to extend the comradery by proximity. Citizens' Clubs, in some places known as War Workers clubs, continued their life span after the war. One 1947 letter from the National Council of Social Services to the London branch inquired about the current state and future needs of Citizen's Clubs, particularly the London branch, known as the Middleton Workers' Club in Middlesex. The letter noted that the Hayed and Harlington Community Centre "grew out of the work of the War Workers' Club," and the NCSS suggested a similar trajectory for Middleton.[56] Attached was a pamphlet advertising the work of Citizens' Clubs: "Clubs for Citizens – A Wartime Experiment." The pamphlet described the functions of the Clubs, with an emphasis on their inclusion of men and women as well as people of different occupations and social classes. They encouraged "wide friendships." Most people, writer Mary Nicholson wrote, "go rather short of contacts in general." Institutions of modern public life, like pubs, churches, and unions, could help people "get enough company and make good friends," but did not offer a "wide choice of friends" or the opportunity to "lay oneself open to the stimulus of encountering unexpected characters and unfamiliar views." Such clubs, she argued were critical developing a "sense of responsibility" to the local community outside of one's family or other organic groups, which, "in a wider context" had "much to contribute to democratic society." The aim of such clubs was not only to bring people into friendship with each other, but to teach them self-management with the group. The pamphlet looked ahead to the

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[52] Final Report of the New Towns Committee, Cmd. 6875, quoted in Harold Orlans, *Utopia Ltd.: The Story of the English New Town of Stevenage* (New Haven: Yale University Press, 1953) p. 81.
[53] Orlans, p. 82.
[54] Clapson, p. 40.
[55] Brasnett, p. 121
[56] Letter to Miss. J Harbone, 11 February 1947, LMA ACC/1888/067 fd. 1.

period after the war and what may be made of this community spirit, and argued that community centers should be a critical part of demobilization and reconstruction.[57]

Being a good neighbor was not necessarily an inborn quality, but one social workers and community associations needed to teach and facilitate these skills to adapt to urban realities. In 1954, for example, the Morningside estate Tenants' Association wrote to the LCSS inquiring about a new two-story clubroom for the estate. They wrote:

> As communal life in London is now a fixed way of life, we have decided that steps must be taken to ensure this way of life be instilled in our children, that it be appreciated by our youth and that it be brought into better understanding of our neighbours.[58]

Social workers in the LCSS were encouraged to understand themselves as neighbors, as well. A pamphlet from 1949 titled "Discover Your Neighbour" reminded trainees and young social workers: "Satisfactory professionals are not dependent upon technical skill alone." Rather, their "knowledge" needed to be presented in a way to be "accepted and made use of by those whom you serve" by cultivating their "sense of social awareness." The pamphlet advertised a course to help social workers enhance that "important aspect of their career." Attendees were encouraged to both discuss with experts in the area to get a "complete picture of what a neighbourhood is and how it works," but also to "walk, talk, look, listen" at neighbors lives and homes.[59]

The idiom of neighborliness ran concurrent with developments in the psychology of attachment and relational approaches to rehabilitation. While the LCSS papers and publications listed here never mention him by name, the work of attachment-theory pioneer John Bowlby and attachment theory infuse their thinking on social harmony and rehabilitation. For these social workers, social connection was understood as a primal biological need. Attachment theory's primacy of the parent-child relationship in psychological development was reflected in an approach to rehabilitation that mimicked family structures, such as the Norman House discussed below. Rehabilitation of juveniles and adults could be achieved by repairing the individual's capacity to create and maintain social bonds.[60]

In 1957, the LCSS cooperated with the Gulbenkian Foundation—a private philanthropic foundation created in 1956 by the will of Portuguese-Armenian businessman Calouste Gulbenkian on his death in 1955—to oversee a study of twenty-five common lodging houses, containing all together 8000 beds, including 500 for women. The study included houses run by both local state authorities and voluntary groups.[61] Dr. Blyth Brooke, a London officer of medical health, suggested that a lodging house in Finsbury should appoint a social worker as an experiment. For two years, the social worker would "intensively" study the "material and mental needs of the residents," and discern what social services could be developed for this isolated

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[57] Mary Nicholson, "Clubs for Citizens: A Wartime Experiment," n.d., pp. 19-25. LMA/ACC/1888/067 fd. 1.

[58] Letter from Morningside Tenants' Association to LCSS, 6 December 1954, LMA ACC/1888/057 fd. 20.

[59] "Discover Your Neighbor", LMA ACC/1888/067 fd. 2., 1949

[60] Michael Rutter and Thomas G. O'Conner, "Implications of Attachment Theory for Child Care Policies," in Jude Cassidy and Phillip R. Shaver (eds.) *Handbook of Attachment: Theory Research and Clinical Applications* (New York: The Guildford Press, 1999) p. 824. Regarding Bowlby's direct influence on the postwar political settlement, Mathew Thomson discusses Bowlby's relationships and correspondence with Labour Party policymakers and writers (GDH Cole, Karl Mannheim, TH Marshall, Leonard Woolf, Michael Young, and various Labour MPs) at a weekend conference on the psychological problems of socialism in 1945: *Psychological Subjects: Identity , Culture, and Health in Twentieth-Century Britain* (New York: Oxford University Press, 2006) pp. 232-34.

[61] "Draft Foreward to Common Lodging House Study", 8 January 1960, LMA ACC/1888/012, fd. 2. The Gulbenkian Foundation funded numerous LCSS and other community-development projects in its early years, and continues to fund projects related to problems of social cohesion.

"floating" population.[62] In the narrative of individual rehabilitation, overcoming solitary ways was equated with overcoming other defects, such as criminal tendencies. In agreement with the wardens, the researchers concluded that individuated case work would be a poor use of social workers' time in places like this.

Norman House was a common lodging house founded in 1953. A home for discharged prisoners chaired by Peter Kuenstler (of *Social Group Work* and the editor of *Living in Towns*), "the group at the Home has a greater therapeutic value" than its wardens expected, more so than working one-on-one with a trained social worker. The Gulbenkian Foundation approached the LCSS regarding the employment of trained social workers in social reintegration. As part of the study, social worker Merfyn Turner was invited to settle in Norman House. Letters with the LCSS indicated he did the same at Rowton House, another hostel.[63] Turner was a school teacher by training but worked most of his life as a youth club leader and penal reformer in London. In 1945, he had succeeded Peter Kuenstler as youth leader at Oxford House in Bethnal Green, and also conducted social research on juvenile gangs in North-East London.[64] To study the house in general, the role social workers could play in rehabilitation, and what the social services needs of the residents would be, Turner became the warden of Norman House as part of his research. Unlike many of the charity organizations the LCSS coordinated, which were Victorian in origin, Norman House was founded in 1953, initially funded by the Trustees of the Parochial Charities of London.[65] Its first year in operation was 1955. In 1957, forty-three criminal offenders lived in the house, and the average length of stay for twenty-nine of them was three months. Of those, nineteen had not re-offended over the course of the year. However, of the seventy-four who lived in Norman House from 1955 to 1957, none returned to prison while living in the house.[66]

In the spirit of community-based action research, the experiment was designed to be open-ended and exploratory. Turner wrote to the LCSS that his plan was to "do no more for the first weeks than to settle in, as it were, getting myself accepted at the Hostel…I feel it is wiser to go in with no affiliations, as I did at Rowton House, and letting the pattern develop in its own time and way."[67] He described his research process as "unsystematic."[68] The LCSS and Turner—against Brooks—contended that the Ministry of Health should not take a "direct and active position in the enquiry."[69] The summer of 1958 saw a number of discussions among Brooks, Turner, and the LCSS over the method of inquiry into lodging houses, which could not be reduced to institutional turf war between statutory and voluntary workers. Rather, the dispatches from Norman House demonstrate an engagement with the observing social workers' uneasy position as a social actor within the lodging-house community. He facilitated but also took care not to disturb the family-like relationship building among his charges.

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[62] W.A. Sanderson, Secretary of the Gulbenkian Foundation, to Miss Proud, LCSS October 21, 1957. LMA ACC/1888/012 fd. 2.
[63] Merfyn Turner to Miss Proud of the LCSS, 12 July 1958, LMA ACC/1888/012, fd. 2.
[64] Merfyn Turner, "The Lessons of Norman House," *Annals of the American Academy of Political and Social Science*, Vol. 381, The Future of Corrections (Jan. 1969), p. 39.
[65] "Notes to Norman House Council", July 8, 1958, no author, but likely Turner or another LCSS researcher. p. 2 LMA ACC/1888/012 fd. 2
[66] "Third Annual Report: Norman House Scheme for Homeless Offenders", March 31, 1957 LMA ACC/1888/012 fd. 2
[67] Merfyn Turner to Miss Proud of the LCSS, 12 July 1958, LMA ACC/1888/012, fd. 2.
[68] Merfyn Turner to Miss Proud of the LCSS, 12 July 1958, LMA ACC/1888/012, fd. 2.
[69] LCSS, "Common Lodging House Discussions", 13 August 1958. LMA ACC/1888/012, fd. 2

Norman House was on the precipice of oncoming developments in penal reform and community care in providing communal after-care for prisoners. The initial report on Norman House in 1958 stated that the public was "becoming aware of the futility of introducing improved methods of treatment within the prisons if After-Care services are not able to continue the progress [prisons] already started."[70] As a narrative of individual rehabilitation, overcoming solitary ways was equated with overcoming other defects and criminal tendencies. Turner's primary insight into Norman House's potential as a method of penal after-care was that, "Although it is valuable to establish a relationship with an offender while he is still in prison, the group at the House has a greater therapeutic value than we had expected." The House did not discriminate based on the nature of criminal offense, though excluded homeless offenders who required "special [psychological] treatment." He described the residents' problems as more generally social than medical or psychiatric disorders: They were rooted primarily in "the inability to settle and to establish satisfactory relationships", followed by their problems "hold[ing] down a job" and meeting "the obligations that living in a community entails."[71] This inadequacy explained both their criminal tendencies and inability to live functionally outside of institutions. Integrating themselves with the wider world was made possible by learning to feel secure in the small group setting provided by the House.

According to Turner's notes, the solitary lodger who resisted friendship was not only a threat to group harmony, but was hindered in his own personal redemption, gained through interaction with others. Turner described successful lodging houses as being like a family home. The residents, he argued, were not men as they were seen by the outside world. Instead, "They are children with problems." Their problems did not easily fall on either side of a "sharp dividing line between sickness and health, normality and abnormality," and their problems demanded the collective participation of everyone in the House.[72] He also wrote that Wardens created a warm, familiar environment where house members were pushed into "discussion which so easily becomes argument" but which was how "people unconsciously started working out their own problems."[73] The House residents lived "as a family." Like a family, Turner wrote,

> We ask for behavior that is consistent with the privilege of belonging to one another. We are father and mother, big brothers and small brothers; and we have friends who call to see us, and who eat with us, as they do in other families. It makes no difference whether the friend is a judge or a builders' labourer. He sits at the same table, and if he is worthy of it he is accepting. Breaking into a family is seldom an easy achievement. With us it may be easier because we are a young family…and our response is more spontaneous.[74]

Like the work of many LCSS social workers in this time period, the Norman House under Turner operated under the assumption that familiar bonds were critical to social harmony, that they could be learned over time, and that social workers' participation should be that of a peer in a

[70] "Notes to Norman House Council", July 8, 1958, p. 2.
[71] "Second Annual Report: Norman House Scheme for Homeless Offenders", March 31, 1956, p. 2. LMA/ACC/1888/012 fd. 2
[72] "Third Annual Report: Norman House Scheme for Homeless Offenders", March 31, 1957, p. 2 LMA ACC/1888/012 fd. 2
[73] Norman House Report, Christmas 1957, LMA ACC/1888/012, fd. 2
[74] "Third Annual Report: Norman House Scheme for Homeless Offenders", March 31, 1957, p. 2 LMA ACC/1888/012 fd. 2

system of collective responsibility for one another. The aim of the House was to raise its children to leave the next as functional adults, and success in the world outside of the House required the ability to spontaneously generate friendships with proximate neighbors and co-workers. Like other LCSS projects in the 1950s, the Norman House put social work in an uneasy relationship with its own expertise. Describing the group behavior of the House, Turner wrote that it should not be "allowed to operate automatically," that is, without some type of intervention. He wrote, "Interaction that was not guided would often be harmful." For residents who had difficulty integrating, he suggested that "non-offenders with an insight into the individual's behavior" could manipulate the offenders' motivations and the group's attitude toward outsiders. The warden or social worker's expertise was needed to manage the group's emotions, particular suspicion directed toward new members, and turn "jealousy and resentment" into familiarity and security.[75]

Throughout the study, wardens and social workers advocated group therapy and an emphasis on the everyday work of trying to live together as being more transformative than individual case work with an expert in social work or psychology. To Turner, Norman House demonstrated the individuated case work could be replaced by giving members of groups the means to help themselves and each other, a process embedded in everyday interaction. In a special report on Christmas at Norman House, he wrote:

> We are a family, like countless others, needing urgently to learn to sit still, and to think, and hold a conversation…We apply ourselves to the workshop or the billiard table, or to discussion which so easily becomes argument where people unconsciously start working out their own problems.[76]

For residents of Norman House, the everyday was therapeutic, and they were served by developing relationships of trust and shared problem-solving. The solitary lodger who resisted friendship was not only a threat to social harmony, but was hindered in his own personal redemption.

Turner went on to write about his time at Norman House in a number of articles and a book called *Forgotten Men*, in cooperation with the LCSS's Common Lodging House Project.[77] The year of the Project's write-ups, 1960, saw the passage of the Mental Health Act, advocating forms of community care rather than institutional asylum care for the mentally disturbed. Communal living projects provided an alternative to de-institutionalization or re-housing with families. The Project's committee reported in 1960:

> It is the Committee's belief that this report is being issued at an appropriate time. Local authorities and some voluntary organisations are considering hostel accommodation for the mentally ill, discharged prisoners, physically handicapped people, the elderly, and homeless families.[78]

Looking ahead to community-based mental health care, LCSS social workers saw their methods of combating isolation as integral.

[75] "Third Annual Report: Norman House Scheme for Homeless Offenders", March 31, 1957, p. 2 LMA ACC/1888/012 fd. 2

[76] Norman House Report, Christmas 1957, p. 3. LMA ACC/1888/012, fd. 2

[77] LCSS General Secretary (George Mitchell) to Merfyn Turner, 28 September 1960. LMA ACC/1888/012 fd. 1.

[78] LCSS to "Mr Mitchell" re: report of the Common Lodging House Project. LMA ACC/1888/012 fd 1 (pdf 16)

Part of the Common Lodging House Project was to determine the role social workers could play in these new approaches to rehabilitation and re-entry into society. One committee member, NW Grant, a Senior Probation Officer, upon reading *Forgotten Men* concluded that individuated case-work was not the most optimal use of a highly-trained social worker or psychiatric social worker. Referring to Hope House, another home for homeless offenders, he suggested group therapy, with which the Prison Commission had been experimenting in prisons. He wrote, "Many of the men [in prison] are incapable of making relationships with other people, and therefore individual case work would be difficult or impossible, whereas treatment in a group might stand a better chance of success."[79] Group work addressed the problems of loneliness and social isolation that underpinned criminality, according to Grant.

The conclusions of the Common Lodging House Project shifted the authority of social workers in this specific rehabilitative context. Falling between the Younghusband Report and the Mental Health Act, the Project was in line with both the British government's increased focus on mental wellbeing, and the decentralization of care for the mentally ill. The Common Lodging House Project put emotional detachment and personal loneliness at the core of criminal tendencies, and the cultivation of relationships as a way of reeling criminals back into normal behavior. In doing so, they empowered the potential or peer groups to facilitate rehabilitation, and challenged the individuated case work model of social work. Social workers, as in community associations, were charged with facilitating authentic relationships between people rather than building them with their clients.

Good Neighbors for the Aged

Following the introduction of the first modern state pensions in 1908, and the incremental exit of old Britons from the labor force, state services repeatedly played catch-up to the needs of the non-working aged, with mixed success. The workhouses where impoverished elderly lived out their final days were gradually abolished and changed—if only in name—to Public Assistance Institutions (PAIs) organized by local authorities in 1929. Still, responsibility for keeping elderly people in their own home largely laid on their own families. The 1948 National Assistance Act stated that local authorities had a duty to maintain residents for the aged, and the PAIs were transformed into residential homes, sustained by state pensions. The first significant criticism of this system was launched by sociologist Peter Townsend in his 1962 study *The Last Refuge*, which accused residential homes of being painted-over workhouses, inadequate and punitive. He argued, ultimately, that the state failed to maintain people in their own communities, relying instead on institutional care. This changed gradually in the 1960s and 1970s, with the National Assistance (Amendment) Act of 1962 and the Health Services, Public Health Act of 1968, and National Health Services Act of 1977 giving local authorities more power and mandates to serve elderly people in their own homes.[80]

Social workers of the LCSS recognized both a deficit in state provisions as well as the impact social atomization and mobility had on elder care. They understood loneliness not only as a psychological problem, but as an alienation from society with detrimental physical and material effects. In an attempt to knit the elderly back into their communities, an experiment in "good neighbours" was launched in the late 1950s and early 1960s. One of the NCSS and LCSS's

[79] NW Grant, "Lodging House Project", to Miss Proud of LCSS 31st August 1959 LMA ACC/1888/012 fd. 1

[80] Robin Means, Sally Richards, and Randall Smith, *Community Care: Policy and Practice, Fourth Edition* (New York: Palgrave Macmillan, 2008) pp. 37-45; Peter Townsend, *The Last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales* (London: Routledge and Paul, 1962)

research-and-action components was the Old People's Welfare Association, managed by a Miss Proud. The material problems of the elderly were exacerbated by loneliness, and it was in elder care that the shortcomings of the welfare state were particularly stark. The problems faced by aged Britons surpassed the capacity of enhanced medical care and housing provisions, and were believed to be of a personal and psychological nature.

Like discharged prisoners, London's elderly seemed especially prone to loneliness, and many LCSS social workers saw isolation as a hurdle to effective elder care. Old people, particularly widows, were prone to loneliness, which highlighted the shortcomings of housing and welfare provisions to provide a good quality of life. In their writing about the elderly, social workers and charity groups often conflated the material and emotional needs fulfilled by community members. The "good neighbor" emerged as an important idiom, filling in the cracks left by material provision. It hearkened back to "good neighbor" schemes which served as public safety and morale monitors during the Second World War.[81] In postwar urban estates, it re-emerged as a model of social cohesion and bearer of a more fulfilling inner life for marginalized residents. Like many social work projects in the 1950s and 1960s, the LCSS experiments with old peoples' welfare served to facilitate the transformation of social workers' expertise, while bringing the everyday actions of neighbors under the purview of local government.

In or around 1956, Proud delivered a speech to the LCSS titled "The Care of the Aged in Great Britain" which echoed the community-studies paradigm in its anxiety over mobility and disconnect between generations, manifested in personal loneliness. While the old desired to remain independent within their communities, a desire made possible by statutory provisions, "They are at their best in familiar conditions and with those who are in sympathy with them." She continued: "The chief purpose" of social work with them "is to lift elderly men and women out of their loneliness." This could be done by giving them simple part-time jobs to prevent the feeling of disembodied uselessness that Proud said came with old age. But addressing loneliness in particular would be the most effective in improving their lives. Proud stated,

> We would all agree that every soul needs friendship. In our big cities at home, due to the postwar housing shortage and development of industry, we find it needs some organization to reduce the number of lonely old people. To link every old person with someone with whom a natural friendship may flower…[82]

Not simply relying upon community sociology or her own experience, Proud drew upon the works of Dr. AL Vischer, a Swiss psychiatrist who wrote an address titled, "The Old Person, His Peculiarities and His Problems." According to Vischer, the vital links of human society were felt only when they "lost their natural form," making them a "subject of discussion" and concern. Aging in the modern world generated this disconnect. "For countless people," he said at an address in Basel, "many experiences, feelings and thoughts achieve value only when communicated to other receptive people. The disappearance of such people is a grave loss." The welfare of the elderly depended primarily upon "loving, warm surroundings, for life in mutual understanding with one or more people." He advocated housing policies which mixed the elderly

[81] Good neighbor schemes discussed historically in the handbook National Council of Social Service, "Time to Care: A Handbook on Good Neighbour Schemes," (London, 1972), pp. 6-8. ACC 2201/M13/19.
[82] Proud, "The Care of the Aged in Great Britain" c. 1956, LMA ACC/1888/016 fd 1.

into corridors with young people and families, as well as "small discussion groups"—support groups for "near retirees" to bond over the social and psychological problems of retirement.[83]

The year after Vischer and Proud's addresses, the LCSS's Old People's Welfare Association experimented with the implementation of their ideas about personal loneliness among old people with a "good neighbour" scheme. A 1957 pamphlet on old people's welfare called for volunteers for friendly visitors for elderly neighbors. It read: "Our experience shows that many old people have doubts and worries which they are glad to discuss with a sympathetic listener" and that the varied problems they had could be sorted out with the help of such visitors, rather than a professional social worker or statutory body. Volunteers would be organized by the LCSS to offer "personal friendship and neighbourliness" while at the same time acting as the link between the lonely old person and more official sources of aid.[84]

In 1961, the LCSS's Standing Conference on Old People's Welfare participated in an experimental scheme titled "Day Care for the Aged and the Infirm" in St. Pancras. The LCSS cooperated in its operation with the St. Pancras Association for the Care of the Aged, the Borough of St. Pancras, the Geriatric Unit of St. Pancras Hospital, and various London County Council offices focused on the elderly and disabled.[85] Aimed at those either unwilling or too well to enter nursing homes, the experiment deployed residents' neighbors in their care. In a presentation to the Trustees of the City Parochial Foundation, the LCSS laid out their intents:

> The scheme was based on a belief that there was a considerable group of elderly people who because of mild confusion, forgetfulness, sickness or physical disability were unfit to be left alone for long periods; who did not wish or could not go into a Home; who could not be improved by treatment in a hospital.[86]

The experiment was aimed at a perceived shortcoming in welfare provisions. The deficit of a good life, from cradle to grave, by the state could be filled by cultivated informal ties between neighbors.

The elderly fell into this gap left by state services, and the good neighbor as a corrective alluded to organicist social structures, while at the same time was a bond created between strangers. The scheme's report stated:

> Old people, either living alone or left alone for long periods, need one person near them to visit frequently, and to help and see all is well. A 'Good Neighour' can befriend them, call frequently to see that they are all right and have not fallen for become ill, talk to them and cheer them up, and encourage them not to give up, but to help themselves as much as possible. Many old people live in one room, or in accommodation unsuitable for sitting in too long; and although it is nice to have someone to chat to, if they stay too long it can be exhausting and a burden to both. Short and frequent visits are better, and these can be managed if the 'Good Neighbour' lives nearby.

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[83] A.L. Vischer, "The Old Person, His Peculiarities and His Problems," Basel, 7 July 1956. LMA ACC/1888/016 fd. 1.

[84] LCSS Pamphlet, "Old People's Welfare" (1957) LMA ACC/1888/011 fd. 2.

[85] "Day Care for the Aged and the Infirm," LCSS Standing Conference on Old People's Welfare, Report covering period September 1, 1961 - March 1, 1962, p. 5. LMA ACC/1888/011 fd. 1

[86] "Day Care for the Aged and the Infirm," p. 1.

The good neighbor was necessarily a volunteer, and independent from the official social service apparatus. The LCSS report stated that neighbors living near the elderly "Have been encouraged to 'adopt' them, and to help them according to the need, and to visit as often as is deemed necessary."[87] Formalized neighbor networks would be knitted together by empathy rather than social service workers. Local Home Services workers had "many cases" and as such "they cannot feel the same responsibility, particularly if they are away sick." District Nurses could not "give the continuous overall friendship, supervision, help and care that such old people need and that they might get if they were cared for a by a relative."[88] Rather than employing professional care workers to help the aged, the ethos of social work could be extended to neighbors. Established "domiciliary services" and "centrally placed welfare worker[s] for the aged" did not have the time or resources to provide "regular care, unobtrusive supervision, and personal friendship" the way volunteers in the same estate might.[89]

At the same time, the Good Neighbour program was not meant to be entirely self-sufficient. Volunteers were to work "under a trained welfare worker, and reported regularly" and were meant to be "of great assistance to the trained worker, specially responsible for the welfare of the aged, and at the same time give the lonely sick old person the comfort and security of knowing that there is one person specially concerned for her, and on whom she can rely."[90] The "good neighbour" was autonomous, but also a purposeful construction of informal networks by local authorities. Social services needed to be able to rely on the existence of a flexible network of informal connections, and the LCSS's experiments around the aged and discharged prisoners demonstrate a deeply rooted anxiety about their absence. The Good Neighbour also acted as a man on the ground, able to be more flexible than a trained social worker, overburdened by case loads. The neighbor's tasks would vary "considerably case to case," but would include everything from shopping, assistance obtaining pensions, attending to stove fires, checking the electricity, and so forth. But they had an explicit emotional role, giving "the security of knowing that there is one person constantly in and out on whom they can rely, and to whom they can confide their worries and who is their main contact with the outside world."[91] The St. Pancras care-for-the-aged scheme showed a desire on behalf of social workers to extend the burden of their care-work to the populations with which they worked.

The experiment was meant to help the loneliness of not just the aged, but their neighbors. The role of the Good Neighbour was most likely to be held by a either a middle-aged woman whose children had grown up or a married housewife with young children. Not only would they have the time, they would also possess the proper "time, patience, understanding, commonsense, and sympathy." Moreover, their volunteer work could be easily folded into their normal household duties, and they too would desire the company.[92] It was important for the neighbor and her charge to "like each other," making it more likely that they would visit with each other multiple times per day.[93]

The Good Neighbour experiment suggested a meaningful precedent in the mythology of social cohesion London during the Second World War. This, along with the Common Lodging House studies and the propagation of community associations in estates, showed the LCSS's

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[87] "Day Care for the Aged and the Infirm," p. 5.
[88] "Day Care for the Aged and the Infirm," p. 4.
[89] "Day Care for the Aged and the Infirm," p. 5.
[90] "Day Care for the Aged and the Infirm," p. 5.
[91] "Day Care for the Aged and the Infirm," p. 5.
[92] "Day Care for the Aged and the Infirm," p. 6.
[93] "Day Care for the Aged and the Infirm," p. 10.

investment in engineering such cohesion amongst strangers living in proximity to each other. According to them, such projects could combat the loneliness and isolation engendered by rehousing and urban renewal. This cohesion and sense of community was mean to come about by training residents under their care to work within small groups and establish bonds with strangers in their neighborhood or estate, regardless of class, gender, political affiliation, or interests. Moreover, these social workers sought to both make their work more emotive while extending that training to their clients. In setting up these informal networks of care, LCSS social workers leaned heavily on non-professional women who were likely to be home during the day and already primed for care work.

Conclusion: Community Care Foreshadowed

The LCSS's work in merging the unattached through supposedly authentic relationships belied a concern about loneliness by social workers in urban Britain. Their research and work with certain problem groups showed the various ways social workers adapted to the perceived emotional and psychological problems, a transition which can be mapped onto mental health policy in the same period, particularly in the development of community care. The term community care was first used in a Royal Commission document in 1957, and was elaborated upon in the 1963 report *Health and Welfare: The Development of Community Care*. The report built upon the work of the Mental Health Act of 1959, pointing toward the potential of voluntary and community service as a supplement to state services. Crucially, mental illness and loneliness went hand in hand, stating that, "A normal person relies on those with whom he lives and works for understanding, sympathy and co-operation." The breakdown of this sympathy and co-operation was a result and cause of mental illness. The report continued:

> The mental health services therefore aim at strengthening [relationships] or constructing others in their place. Here the main need is an effective body of social workers, including mental welfare officers…By providing a personal service of advice and support of the mentally disordered and their families, the social worker can do much to prevent a breakdown…[94]

In this report the state made promises for the facilitation of voluntary and informal care networks for the elderly, mothers of young children, the disabled, and the unemployed, along with the "mentally disordered."

In the 1950s and 1960s, the LCSS's urban social work training turned increasingly to their responsibility over peoples' emotional and social lives, as a sphere of well-being detached from material prosperity. In doing so, they imported community development paradigms from the United States and Canada. Rather than putting these techniques in service of resource management, entitlements, or political engagement, affect and the interior fulfillment of relationships—especially that between neighbors—were elaborated as the missing piece of postwar prosperity and a desirable end in themselves. Their research, reports, correspondence, and work with housing estates suggested an internal narrative of material achievement giving way to collective discontent rooted in social isolation, in turn the root of all social problems. In subtle and not-so-subtle ways, LCSS social workers and their affiliates reinforced family support networks and organicist social visions. Finally, as self-appointed monitors of the postwar

[94] Ministry of Health, *Health and Welfare: The Development of Community Care* (London: HM Stationary Office, 1963), p. 24.; "Community Care: a chronology of policy development" (table), in Christina Victor, *Community Care and Older People* (Cheltenham: Stanley Thornes, 1997), p. 7.

settlement on the ground floor, social workers recast the welfare state as requiring supplement from an informal economy of spontaneous and authentic relationships which was both the purview of experts while by definition at the same time eluded their gaze.

CHAPTER 2: COMMUNITY AND EXPERTISE IN THE GROUP ANALYTIC SOCIETY, 1945-1975

"The key problem of our time: the strained relationship between the individual and the community." --Samuel Foulkes, 1946

In the 1950s and 1960s, isolation and loneliness were anathema to good mental health, and in turn to the well-being of British society. This chapter explores this relationship between isolation and neuroses from the perspective of practicing psychotherapists who pioneered group therapy. Working in the same time period, group psychotherapists engaged in many of the same practices as social workers (and occasionally worked with them), though more systematically and, in their eyes, scientifically. The subject of this chapter is the psychoanalyst Samuel Foulkes and the Group Analytic Society (GAS, founded in 1952), which sought to integrate psychoanalysis with principles from social psychology and therapeutic communities. As with community-oriented social work, the emphasis of group therapy could encompass both the functionality of the group; and the capacity of the individual patient to utilize the group for his or her own therapeutic ends. These two modes were not mutually exclusive. All forms of group therapy required the group to maintain a degree of interpersonal harmony, and all aimed to transform the individual member. Even so, the approach taken by Foulkes and the GAS centered on the individual's utilization of the group, primarily his or her developed ability to engage in a close therapeutic relationship with strangers, independent of directives from group conductors. Loneliness and isolation, for the GAS, were individuated conditions. While the breakdown of traditional communities inflicted loneliness on British society, the individual, through the depersonalized group, could be taught to overcome his isolation.

London social workers turned to loneliness as a social problem in new and reconstructed estates. Their modality of care adapted to the problem, and they turned both to their own emotional labor and increasingly to that which could be shouldered by their charges. Community development paradigms and community care of mental health institutionalized these practices on a larger, national scale. A similar mechanism was in place within some corners of the psychotherapeutic profession. This chapter examines the work of Samuel Foulkes, a pioneer of group psychotherapy, and the organization he founded, the Group Analytic Society (GAS). Building on his own and others' experimental work at the Northfield Military Hospital, Foulkes and the GAS also identified isolation as both a pressing psychological problem and the root of various though vaguely-defined social problems. Their version of psychotherapy had two distinct characteristics. First, the GAS and Foulkesian method saw to withdrawal of expertise from the group. Like their social worker counterparts, they sought to educate their charges to take on therapeutic care without the therapist, who could recede into the background. Second, they set out to help the modern individual overcome his isolation, to use the group for his own personal benefit, rather than treating the group as an entire unit. For Foulkes and the GAS, isolation exacerbated mental disturbance. The cure was not simply the presence of close relationships in one's life, such as a close family or co-workers, but the capacity to generate such closeness as an individual in various group settings. Like social workers in the previous chapter, the individual within the group, rather than the community or group itself, was the object of therapeutic practice.

The role of the conductor was discussed at length in GAS seminars. This distinguished them from the group-oriented type of human relations work advocated by the Tavistock Institute

and Foulkes's predecessor at Northfield, Wilfred Bion. Foulkes's version of group therapy put individual development at the center. The group could impact the way he or she interacted socially in his or her own life, acting as a surrogate for a family or workplace. Additionally, the group and its patterns of communication were projected onto the individual, facilitating his or her individual therapy. By the mid-1960s, GAS seminars seemed to place a greater emphasis on this latter function: The individual's development toward his or her best self happened via the siphoning of group energy. One's best self could easily share one's inner life with others like him. Moreover, the GAS inquired into the role of such an individual in society: an incoherent amalgam of his own life experience and existing in his relationships with others. This "in-between" space between people—what Foulkes called the group matrix—was what group analysts hoped to manipulate. Finally, their work with and through contemporaries in the social sciences—such as Gregory Bateson and Kurt Lewin—worked to define society at large as built by collectivity of small, familiar groups. In doing so, they challenged the expertise-driven nature of mental healthcare, putting the onus of care onto cooperative networks of patients.

This chapter traces, first, the development of the GAS and group analysis, both against individual psychoanalysis and other types of group therapy and therapeutic communities. This is done both by a study of the GAS's archives and seminars, Foulkes's scholarly work, and the published work of other GAS members. Through these materials, their particular group-oriented individual emerges, as does their social critique. Moreover, the release of inhibitions that characterized successful group analysis did not equal a breakdown of social mores or codes of conduct, but rather the development of new ones. I also discuss the ideas from outside the GAS and their broader impact on social thought. Finally, I end with a discussion of the GAS's outreach work into hospitals, schools, and social work training, ending with a discussion of their impact on therapeutic practices within and outside psychological practice.

Foulkes before the GAS: Exeter Clinic and Northfield Military Hospital

Born in Germany as Sigmund Fuchs, Samuel Foulkes trained in psychoanalysis in Vienna and then at the Frankfurt Psychoanalytic Institute in 1930 before moving to Britain during the Second World War. His began experimenting with group psychoanalytic treatment in Britain at his practice in Exeter at the Clinic for Nervous Diseases in 1940. [1] There, he co-authored his first paper with Eve Lewis, titled "A Study in the Treatment of Groups on Psycho-Analytic Lines," published in 1944. The paper reported the experience and successes of group analysis, arguing for its effectiveness as a therapeutic practice on part with individual psychoanalysis. Foulkes and Lewis discussed a September 1941 series of group analysis sessions with two men's group and two women's groups, one private and one done in the clinic. For part of the time, Foulkes led the men's group and Lewis the women's, though they principally conducted both groups together. The patients exhibited "all forms of psycho-neuroses; psychopathies; a good proportion of mild psychoses, but also more acute psychotic conditions," though diagnosis did not factor into selection of patients. In their report, they discussed at length the differences between individual analysis and group analysis, the role of the psychotherapist and their requisite qualifications, and the therapeutic effects in detail for individual case studies.

[1] Tom Harrison and David Clarke, "The Northfield Experiments," *British Journal of Psychiatry*, Vol. 160 (1992), p. 702.

They concluded that while group treatment was effective when paired with individual analysis, it also had its own unique therapeutic effects.[2]

From the outset, the authors made clear that improvisation and an aim to economize treatment instigated the expansion of their group therapeutic practice. "Group therapy," the first sentence read, "was inaugurated in the first instance for practical reasons. Foulkes had been interested in group analysis for years, and cited the American group treatment pioneer Paul Schilder as an influence. Group treatment, they argued, created "an economy of time for the therapist," while at the same time it "intensifies the effect and thus shortens the duration of treatment." Prior to group treatment, their Clinic patients, many with "severe and long-standing neuroses" were unable to get more than half an hour of individual treatment per week, often closer to twenty minutes. With group treatment, the authors were able to devote ninety minutes per week to groups of six to ten people, "and the results were incomparably better in every respect."[3] Group analysis economized individual's therapeutic needs; it also allowed patients to shoulder the burden of each other's treatment, and had other unique qualities that Foulkes and Lewis argued hastened analysis's therapeutic effects.

At the initiation of the group, the therapist gave instructions to the patients, all of whom had some experience in analysis and an understanding of the unconscious and free-association practice. Foulkes and Lewis communicated: "A complete analysis, which would be the ideal, is not within the range of your means or the time available." But that also "there is another and more essential side to it." They told their patients that they would find relief in both their common and differing problems ("human problems"). By reenacting, recognizing, and examining fundamental human anxieties and impulses with the group, patients could also interrogate the particular "requirements of them community in which we live, the various prohibitions and restrictions which are imposed on us from our earliest days and accompany us at every step and corner." Like individual analysis, patients were encouraged to speak freely and without inhibition, but to do so in the presence of their peers rather than by themselves with an analyst.[4]

The role of the therapist was different in group treatment than it was in individual analysis, and his or her role was a topic that would frequently come up in GAS seminars in the 1950s. In addition, group analysis trained participants to communicate with each other in certain ways without the help of their therapist, a theme that would reappear throughout the 1950s and 1960s. In some ways though, Foulkes and Lewis argued, the group analyst was far more active than an individual's analyst, and his or her role was different. In individual analysis the practitioners "remains totally in the background as an actual person." The patient's unconscious fantasies of parental images, then, were manifest by transference onto the analyst. But transference, they posited, operated differently in group analysis, hinging in part on the role of the therapist. In the "freer situation of the group," they argued, "the analyst comes in of necessity more definitely as a real person." This took "the edge off the transference phantasies as regards the deepest unconscious levels" and never quite became "fully conscious" in a group setting for analysis. The group moderated transference and kept it "nearer to the reality level" and good for "comparatively more superficial readjustment." Similarly, they described group analysts as more

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[2] SH Foulkes and Eve Lewis, "Group Analysis: A Study in the Treatment of Groups on Psycho-Analytic Lines," *British Journal of Medical Psychology*, Vol. 2 No. 2 (February 1945), DOI: 10.1111/j.2044-8341.1945.tb00751.x, pp. 175-184.
[3] SH Foulkes and Eve Lewis, p. 175.
[4] Foulkes and Lewis, p. 177.

active in their demeanor, more likely to offer smiles and nods, or “to quell there, bring out a theme more clearly or let another fall away,” not unlike the conductor of an orchestra. In fact, they suggested that an analyst may “behave like any member of the group,” relate “his own experiences,” or give “his own associations.” They cautioned against such behavior, suggesting that groups liked him to be in a “position of authority,” a caution that would be less important to the GAS.[5] While the group analyst was more active—or interventionist—than an individual analyst, he or she was also positioned more closely to the peer level of the group. As his or her distance diminished, so too did psychoanalytic specialized expertise and authority.

Foulkes and Lewis isolated the social “educational value” of group analysis for the patients in the experiment. Group analysis facilitated a “concrete realization of the part which social conditions play in their troublesome problems,” and “sets people thinking in a critical way and makes them experience the part they themselves are playing” with regards to these social conditions. They argued that group analysis presented its own unique processes, and intensified others, like identification and projection. Counter-identification, credited to Major Mark Burke of the RAMC, was the “process by which a person corrects his own attitude by way of contrast to another person.” By this process—a continuation of identification according to them—the group “brought the patient out of isolation into a social situation in which he can feel adequate and “express himself freely.”[6] Group analysis nurtured the social part of the patient’s being by targeting the isolated mind. It would eventually translate into “freer” social relations, nebulously defined as they may be. They also appealed to the wartime language of citizenship. Beyond aiding psychological problems, the pedagogical aspect of group analysis was a “contribution to their education as responsible citizens, in particular of a free and democratic community.”[7] The GAS would develop this line of thought, though to a different set of social concerns. Through group analysis, patients could learn to solve the problems of their peers, and let others shoulder the burden of their own analysis.

After Exeter and prior to the GAS, Foulkes experimented with group analysis at Northfield Military Hospital. Here, his clinical practice intersected with the concept of the therapeutic community. While providing additional background into Foulkes’s intellectual biography, his work at Northfield also illustrates the evolving relationship between group analysis (and therapeutic cultures in general) and an ideal of democratic citizenship in the immediate postwar period. While “the group” connotes collaboration and cooperation, the therapeutic practices at Northfield show neither a definitive loosening of social controls, but rather a shift to a new ideal of democratic personality and social relationships. As Nafsika Thalassis has demonstrated, while experiments in therapeutic communities and group therapy at military hospitals may be posed a fundamental challenge to military hierarchy and social deference, they adhered in equal measure to the importance to an “ideal of citizenship which combined liberal rights with military responsibility.”[8] As a therapeutic culture, group therapy may have flattened or liberalized interpersonal relationships, particularly by diminishing deference to the therapist’s expertise. The therapeutic community concept, experimented with at Northfield, did the same to the entire hospital community, attempting to make doctors, nurses, patients, and staff into a group of peers. At the same time, these experiments generated new

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[5] Foulkes and Lewis, pp. 178-79.
[6] Foulkes and Lewis, p. 183.
[7] Foulkes and Lewis, p. 176.
[8] Nafsika Thalassis, “Soldiers in Psychiatric Therapy: The Case of Northfield Military Hospital,1942–1946,” *Social History of Medicine*, (2007) 20 (2): 351-368 first published online July 10, 2007 doi:10.1093/shm/hkm040.

expectations for interpersonal behavior and for the role of the small group in self-help. Northfield also pulled at a central tension in the history of group therapy: treating individuals to make the group function better as a whole, versus using the group to treat the individual. In the post-war years, Foulkes and the GAS would privilege the individual's personal progress, making the object of care the individual rather than the group. The normative thrust of Foulkesian group analysis elaborated an ideal subject who psychologically benefitted from group membership and interaction in an inorganic group setting.

The Northfield experiments in group therapy consisted of two phases. The first was led by Wilfred Bion and John Rickman, beginning in 1942. Bion was removed after six weeks, however, due to an alleged failure to impose order to the military's standards, and Foulkes replaced him.[9] Broadly speaking, Bion, like Foulkes, was in step with the move away from medical and moral views of psychological disorder. Like the therapeutic-community pioneer Maxwell Jones at Mill Hill and others, they located both the cause and cure of psychological maladjustment in dysfunctional social relationships and isolation.

Wilfred Bion, by all accounts, worked with patient-soldiers in a way more in line with military interest than Foulkes would when he joined the staff at Northfield. His group-oriented approach with soldiers aligned with the expectations placed on civilians. The emphasis was on the individual soldier or civilian's duty toward the community, group, neighborhood, unit, or nation. Foulkes joined Northfield after Bion's dismissal after the so-called "first" Northfield experiment in 1942**.** He worked alongside Tom Main—who coined the phrase "therapeutic community"—and Harold Bridger, a major in the Royal Artillery Corps. Bridger was a teacher by training, and a proponent of progressive pedagogical methods such as "project teaching."[10] Like project teaching, their approach to group-based therapy was process-oriented and communal. As therapists, all emphasized process and social relationships. The many roles in the hospital taken as a whole was integral to the holistic mental well-being of patients and staff alike. At Northfield, Foulkes developed a holistic and systemic approach to therapy that represented the psyche as constructed by social networks and interpersonal relationships. His work was concurrent with pioneers in the therapeutic community movement, such as Tom Main and Maxwell Jones, the latter of whom would work with the GAS.

Following Northfield, Foulkes continued to work in group-oriented analysis. He published a series of articles and working papers in the late 1940s on the topic, including a working paper on communication for the 1948 International Congress on Mental Health. Following the Congress he participated in a study group on the topic of communication with the early members of the GAS.[11] That same year, he failed to receive NHS financial support to start a group psychology center.[12] In 1948 he also published an *Introduction to Group-Analytic Therapy*.

Prior to the establishment of the GAS and their seminars, Foulkes continued to utilize the language of wartime citizenship to propagate group analysis. The emphasis here, as it had been in Northfield and at Exeter, was to associate the individual with his membership in a collective. In 1946, he wrote that group therapy was "an expression of a new attitude towards the study and improvement of human inter-relations in our time." It was an instrument for approaching "the

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[9] Thalassis.
[10] Harrison and Clarke, p. 701.
[11] Foulkes and E. James Anthony, *Psychotherapy: The Psycho-Analytic Approach*, 1965 edition (London: Karnac Classics, 1984), p. 224.
[12] Elizabeth Foulkes, "Notes on the early days of the Group Analytic Society, London", 1977, Wellcome Trust SA/GAS/A/1

key problem of our time: the strained relationship between the individual and the community." Group work methods were not to be limited to therapy, but could be "the answer in the spirit of a democratic community to the mass and group handling of totalitarian regimes." Here, he also expressed an affinity with action research methods being developed by sociologists and social psychologists like Kurt Lewin.[13]

In 1947, he delivered a similar address to the first post-war Congress of European Psycho-Analysts in Amsterdam. Here, he discussed how mental disorder had social causes and interpersonal manifestations. Neurosis was associated with both individualism and (self-imposed and perpetuating) social isolation. The "neurotic position" he said, was "in its very nature highly individualistic." It was by nature "group disruptive" in that it was "genetically the result of an incompatibility between the individual and his original group"—the family. [14] Isolation was characterized by a lack of intimacy, privacy, secrecy, anxiety; but also "rivalry and competition," and a "superstitious imagination about other people's minds." Group therapy replaced this isolation with social contact on "deep levels", cooperation, and "genuine information based on testing in frank and mutual exploration." Individuality emerged, then, "not in contrast to that of others but as complementary to the group."[15] Group analysis worked on the interpersonal abilities of the individual, and his or her capacity to function within a group. He called this a shift from "group destructive" to "group constructive" behavior. [16] Again, therapeutic success was not evaluated by the group's overall functionality (as it would be in in a human-resources or organizational-psychology model of group work), but by the individual patient's capacity to turn himself or herself into a group-oriented communicator. Becoming group constructive meant becoming "compatible with the particular group in hand," would make them more "compatible with social life in general and…with the mode of life of the particular community which this group belongs." In short: "Adjustment in a therapeutic group means social adjustment." The individual naturally ("socially and biologically") felt pulled toward the norm of their immediate group, and learning to be group-constructive would have ramifications in their social life beyond the therapeutic group.[17] Specifically to overcome isolation and "individuality" the patient had to be compelled to reveal intimate, private secrets to strangers in order to make the same possible with their organic peer groups.

The group's functionality was a litmus test for the individual's mental health. Group analysis, he argued, had an edge over individual analysis in two ways. First, "The collective situation reduces the severity of censorship within the individual, and the Id becomes liberated." Foulkes associated the group element with freer individual expression and a relaxing of self-censorship. The group's own authority and boundaries of conduct, at the same time were "a good match for the ancient Superego." The "boundaries of the Ego", therefore, were in the group situation "under revision", and result was a "more free and stronger Ego structure."[18] The group analytical network played a key role in dismantling the stifling effect of self-censorship, and was a self-regulating social organism that spawned its own boundaries and expectations.

He continued to write and present his work on group analysis at various conferences,

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[13] SH Foulkes, "On Group Analysis," *International Journal of Psycho-Analysis*, Vol. 27 (1946), p. 51, quoted in *Psychotherapy*, p. 9.
[14] SH Foulkes, "Group Psychotherapy and Psycho-Analysis," Congress of European Psychoanalysts, Amsterdam 1947, p. 4. Wellcome Library Archives, PP/SHF/D/8/2
[15] SH Foulkes, "Group Psychotherapy and Psycho-Analysis," p. 3
[16] SH Foulkes, "Group Psychotherapy and Psycho-Analysis," p. 3.
[17] SH Foulkes, "Group Psychotherapy and Psycho-Analysis," p. 4.
[18] SH Foulkes, "Group Psychotherapy and Psycho-Analysis," p. 3.

developing his ideas about the therapeutic function of the group, and putting himself in dialogue with mainstream psychoanalysis. In one paper, presented to the International Congress for Psychotherapeutics in Leiden in 1951, he discussed the ideal social conduct of the group, in the context of a situation where "patients are not given any particular prescriptions as to how to behave, or what to discuss." Still, both conductor and patients engaged in a series of normative practices and statements in order to facilitate a "free and spontaneous expression," using verbal communication and words over nonverbal whenever possible. Successful group analysis required the learned practice of speaking without inhibition in "a form of spontaneous, shifting, undisciplined discussion as [the group's] medium of communication," where all feelings (including hatred of other members, criticisms and "emotional upsets" were "permissible and should be voiced"). [19] The GAS would frequently turn to this contradiction: that in order for people to speak freely with each other, with the "usual social censorship" removed, order had to be imposed from above by the therapist, all while negating and diminishing his own interventionist role in the therapeutic activity. Fittingly, the theme of the Congress where Foulkes presented the paper was "The Affective Contact," and there he dwelled upon the interpersonal dynamics of group therapy versus that of individual psychoanalysis.[20]

One way the conductor did this was to govern the group's relationship with time and narrative. With each session, the group and conductor had to set "every time afresh its own frames of reference." This meant that, contrary to classical psychoanalysis, both group members and the therapist were "far more concerned with the *here and now*, with the present situation, with interaction, relationships." Here, Foulkes looked to Jacob Moreno's psychodrama, a psychotherapeutic technique from the interwar period in which patients engaged in theatric role playing to therapeutic effect.[21] In this way, the group situation did not replicate the singular and insular social dynamic of individual analysis, which carved out in time its own narrative that included the patient's own past and his analytic history, including situations relating to the analyst himself like transference. This had no resemblance, Foulkes argued, to any ordinary real-world social situation. On the contrary, the group analytic situation was "also a special situation" but also put on display "basic processes which can be seen and observed afterwards in real life." Its dynamics operated "within the common matrix of this interpersonal situation" (bringing up the concept of the "group matrix" that was singular to Foulkes and would be revisited throughout his career). He described this quality of group therapy as a "half-way house to a social situation." The immediacy of the group-analytic situation made it a facsimile arena of real social life, and this perceived porousness between the group-analytic situation and the real world was reflected in the GAS's outward-looking tendencies to non-therapeutic social institutions.[22]

In keeping with its orientation in the present, Foulkes's vision of group analysis was process-focused, rather than goal-focused. The "process of communication," in keeping with the Congress's theme of "The Affective Contact," had a "key position in the dynamics of a therapeutic group." Naturally, human beings' inner suffering drew them "in the direction of integration," and "social and individual integration go hand in hand." This nature and "primary

[19] Foulkes, "Some Similarities and Differences Between Psycho-Analytic Principles and Group-Analytic Principles," *British Journal of Medical Psychology*, March, 1953, p. 30. 10.1111/j.2044-8341.1953.tb00805.x. Read to the International Congress for Psychotherapeutics in Leiden, Holland, 6 September 1951 while Foulkes was a consultant psychotherapist to Bethlem Royal Hospital and Maudsley Hospital.

[20] Foulkes, "Some Similarities," p. 32.

[21] Joseph Moreno, *First Book on Group Therapy* (Beacon House, 1932); *Psychodrama Vol. 1* (Beacon House, 1946).

[22] Foulkes, "Some Similarities," p. 31.

relief" found in communication needed to be cultivated in the therapeutic setting. The task for patients, then, was to "express eventually in articulate sociable language what is to begin with unconsciously and autistically expressed in the system." From this process, "other therapeutic agencies" would follow. And ultimately, the penetration of the individual psyche was the ultimate goal, to make changes in the individual "outlast the context of the group," separating Foulkes's concept of group analysis from group-limited types of group work, where the task or occupation at hand was paramount. The establishment of an "ever more powerful, flexible and adequate network of communicational channels" were not for the sake of such durable networks, but to produce an individual who could build and participate in such networks.[23]

GAS Seminars in the 1950s

Beginning in 1950, Foulkes began meeting with other analysts and psychological professionals at his home in London. In 1952 they had just seven members; but their ranks grew to 39 in 1955, and by 1977 had 272 members including 84 overseas.[24] Foulkes established the Group Analytic Society in London in 1952. The early membership included notable psychologists, psychoanalysts, and other scholars and therapeutic professionals. The Society included: Elizabeth Marx (who would become Foulkes's third wife, and wrote much of the biographical information available about him); psychoanalyst and child psychiatry specialist James Anthony; Patrick de Mare, who also worked with Rickman and Bion at Northfield; W.H.R. Iliffe; M.L.J. (Jane) Abercrombie, who applied her work in group analysis to research in education; and Norbert Elias, the German-British social theorist.[25] In 1971, they started the Institute of Group Analysis, which disseminated training materials and held courses in group analysis. In the 1950s, their activity was centered on seminars and study circles, covering different elements of group analysis and the members' studies. Topics included: theory and methodology, the role of the conductor or therapist, and the role of psychoanalytic concepts such as transference in group analysis.

From its foundation in 1952, the GAS tried to carve out a place for itself in both traditional psychoanalysis and the burgeoning independent field of group therapy. The role of the therapist was continuously fraught, and in many ways reflected the role LCSS social workers from Chapter One saw themselves inhabiting: active and educative but resolutely non-interventionist in the social networks of their communities. They refashioned their own expertise and authority, at once following the lead of their patients while teaching them how to take the lead of their own care and each other's. People could be—and needed to be—taught to rely on each other. The loosening of interpersonal inhibitions was as much a process generated from expertise and authority as it came from below.

The appearance of equality in the space of the room was an important component of group analysis. In a 1955 training seminar, the GAS emphasized that the group should sit in a circle, symbolizing that there was "no privileged position: everyone can talk to everyone else on equal terms." This equality was also demonstrated in such mundane details as the furniture, which would need to be relatively uniform. The size of the group was meant to be relatively small, though some group analysts went on to write and speak about the efficacy of group

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[23] Foulkes, "Some Similarities," pp. 32-33.

[24] Elizabeth Foulkes (Samuel's wife), "Notes on the early days of the Group Analytic Society, London", 1977, Wellcome Trust SA/GAS/A/1

[25] Samuel and Elizabeth Foulkes (ed.), *Selected Papers: Psychoanalysis and Group Analysis*, (London: H. Karnac Books, Ltd., 1990), p. 146.

psychotherapy in large groups. The ideal number, though, was between five and ten patients. If the group was too small, disagreement was more likely to create an isolated minority opinion. A group of seven or eight, they claimed, was "sufficiently representative of the community," reducing the likelihood of group hostility against a scapegoat.[26]

What was the role of the conductor? On this subject, the GAS delineated themselves from other group-analytic methods, notably Wilfred Bion and Freud. In a seminar led by Paul Senft, he compared the psychotherapeutic group to the classical Freudian group. The classical group, he argued, was "leader-centered." Discussing Freud's "Group Psychology and the Analysis of the Ego," Senft noted that in Freud's work, the group was hypothetical and an anthropological device meant to explain primal drives. Senft said that Freud's group dynamics were "based on those of the primal horde dominated by a powerful male." In this scenario, "Allegiance to the leader is based on ambivalence among the followers," and relationships between followers "depends on sublimated homo-sexuality." The group's "mutual identification" emerged from this ambivalence toward the leader. In contrast, the group-analytic group aimed to move away "from leader-centredness [sic] and towards group autonomy," though at first group members may be compelled to "force the conductor into an authoritative role." In the GAS, Freud's archetypical group formations—the horde, the church, the army—were replaced by the unique group unpredictably acting in the present. Senft argued that in their case: "The real relationship among members of the group based on the present situation is recognized as an important factor in treatment."[27]

The GAS also defined their work against contemporaries such as Wilfred Bion. The GAS's first study course seminar, held on 5 October 1953, was titled "Why a Group at All?" and was led by Patrick de Mare. The secretary noted that Foulkes's own method was characterized by "open-mindedness" instead of "close observation" on the part of the conductor. As a therapeutic method, they argued, Bion was less interested in therapy than in "making the study of group tensions a group task."[28] Taken as a whole, GAS seminars and Foulkes's own work suggested that, in contrast, the therapeutic emphasis was on the individual working through his own tensions with group members and the group as a whole. In Bion's groups, transference was a two-way operation, between the group as a whole and the therapist, while in the Foulkesian group it was multi-directional. According to the seminar's notes, Foulkes's group analyst "did not lead continually, he directed the group from behind the scenes, and used this influence to make himself superfluous: the 'ideal end' of therapy."[29] In this way, arguably, other methods of group therapy such as Bion's reproduced the Freudian leader-oriented group, in that the group's reactivity to the leader generated therapeutic growth en masse. For the GAS, the conductor's role was more complex and self-effacing, negotiating space between leader and peer.

Group analysis was similar to traditional psychoanalysis in that the analyst or conductor was present for and facilitated the patient's own self-discovery. At the same time, his or her expertise was diffused throughout the group. As was the case for community developers and social workers in London, the interpersonal care work between the expert and his or her charge was passed down to the patient's peers. Expertise in care work was not diminishing; it was refashioned. The experts made their role background to the networked society, capable and

[26] "Training Seminar," 12 December 1955 PP/SFH/D/6/7 GAS Notes on Training Seminars, pp. 1-4.
[27] "Summary of Seminar, 5.3.1956, Leader: Mr. P Senft," Wellcome Library Archives, PP/SHF/D/6/7
[28] "Notes on First Seminar, October 5th 1953," Wellcome Library Archives, PP/SHF/D/6/7
[29] "Notes on First Seminar, October 5th 1953," Wellcome Library Archives, PP/SHF/D/6/7

seemingly democratized. The individuals who made up these groups were guided through a set of practices designed to teach them to rely on their peers for psychological care, and to develop a personality which could engage in reciprocal, emotive interactions. People could be—and needed to be—taught to rely on each other. As such, psychoanalytic processes like transference were believed to be facilitated by other group members as much as by the analyst-patient relationship. In the 1950s, the first decade of its existence, the GAS inquired into the evolving role of the conductor in their therapeutic schematic. How actively verbal should the analyst be? How interventionist into group problems? Was the group autonomous? Ultimately, the answers to these questions pointed to a connection between emotional openness within a group and the psychological health of the individual.

The group's relationship with the analyst was a therapeutic process in itself. The GAS's seminars about group leadership showed that therapeutic progress was conjoined with how they responded or reacted to his or her authority. This could have wide-ranging impact, the GAS believed. According to a seminar led by De Mare in 1953, the successful group would have to learn to "work therapeutically." Citing Foulkes, he said, the successful therapeutic group used "authority in order to wean the group from such authority." De Mare emphasized the GAS's belief that they were embarking on new territory in psychotherapy, calling group analysis a "new development in history" that went beyond developments in that field. It could be part of a larger social process in which people's relationships with authority and leadership were transformed. "All other types of human conductors," such as the police, De Mare wrote, "struggle mightily to maintain their leadership roles." The anarchic-yet-stable state of the therapeutic group was "a state of affairs which has never yet been known except temporarily, with the possible exception of this recent development in psychiatry." The therapeutic group could learn to operate as a single mind, "in a relaxed and spontaneous fashion," lessening inhibitive personal barriers to free expression not only between members but "within the minds of individual members." The relaxation of authoritative leadership, and the acceptance of such diminished authority, was connected to this process of diminishing social constriction and inhibition. In a group, he continued, "Several people can far more simply take over the function of one large person than for instance the analyst in individual analysis," taking the therapeutic work out of the hands of expertise and spreading it amongst non-expert participants.[30] This was opposed to simply exploiting a group's inborn sociability

What was the therapist's role in facilitating something like atmosphere? At another 1953 seminar on the same topic, ML Abercrombie described her own personal experience with group therapy and a successful group: "There was a feeling of ease, things flowed, and were not isolated or departmentalised." She told the seminar that her group analyst had given her "a feeling of gentle reassurance" rather than being "provocative." Still, "She felt not actually soothed, but 'liberated.'" Abercrombie said that alongside her "personal need for therapy" was a "scientific interest in applying what she learned in the therapeutic group to 'active' forms of learning (or teaching)" as a primary interest. In this particular seminar, Abercrombie mainly discussed the "importance of physical arrangement in the group," like sitting in a circle and the quality of the room. This was tied into the environment or "atmosphere" the conductor was expected to create. At the same seminar, she emphasized "standardized conditions" or an "emphasis on external arrangements." Foulkes, however, stressed the "importance of standardisation for scientific purposes." Moreover, for the therapist, "standardised relationships

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[30] PB De Mare, "The Role of the Conductor," GAS Seminar 12 January 1953 PP/SFH/D/6/7 GAS Notes on Seminars 1952-57.

as a background helped the therapist to relate." He insisted that there was a "premium on relative standardisation" to facilitate discussion. Like the active or passive role of the conductor, group analysis also balanced control with openness. The analysts and others involved in propogating it sought to create standardized conditions in which personal expressive freedom could thrive.[31] Rather than exploiting any sort of inborn sociability, group psychotherapy was subtly pedagogical. As the locus of care rested on the patients, the individual had to both learn to communicate within a group and also re-evaluate his or her relationship with authority in the form of the therapist. The conductor, Paul Senft said in a seminar, was to "educate" the group for therapy by creating the right "atmosphere."[32] In other seminars and conferences, this atmosphere would be described as the "total culture" that group analysis sought to promote. In part, it was achieved by material conditions—circular seating; prohibiting drinking, eating, writing, and physical contact; promoting confidentiality. It was also found in the minimalism toward direction and guidance for the content of therapy, coupled with the carefully "supportive" or "constructive" aspects of leadership.[33]

The Group Matrix

At the intersection of the therapeutic practice of group analysis and the sociological theories used to justify that practice was Foulkes's idea of the "group matrix." This concept appeared frequently in Foulkes's work and in GAS seminars in the 1950s and 1960s. The group matrix—or alternatively, the group network—referred to the "interpersonal phenomena" that existed between two or more people, rather than within 'one person or in another." In describing and constructing the idea of the group matrix, Foulkes's language was strangely mathematical and imitative of physics and computational science. In this understanding of the group, the "matrix" was a discrete object that connected individuals in the group to each other. It described the "interpersonal phenomena", Foulkes wrote in 1957, that existed "literally in between two or more people," not within "one person or another." Mental disturbance, Foulkes claimed, was too often understand as a "function of the individual personality," rather than a disruption within relationships, or the web of interpretation, reception, and feeling that made up the group matrix.

The social or group matrix was a "network," he argued, not unlike the brain, in which a "network of fibers and cells…together form a complex unit." The objects under observation were not on the nodes that anchored the network, but the dynamic processes that took place in between them, like impulses and energy pathways in a neural network. In the group, these processed were "defined with regard to their meaning, their extension in time and space, and their intensity."[34] He also referred to this phenomenon as the "transpersonal network." The network's "lines of force," he said, could be "conceived as passing right through individual members." The individual patient, therefore, was both a "nodal point" in the network and "suspended in it." By situating the individual in a network, Foulkes posited that the personality was fragmented, and factors of mental disturbance were external to the individual, located in the network of the group.

The group matrix, social matrix, or communication matrix imagined an externalized process that the individual could experience and manipulate in a group analytic setting. The centrality of it to Foulkes's and the GAS's social thought shows how the relationships between

[31] Group Analytic Course 19 January 1953, PP/SHF/D/6/7, pp. 2-3.
[32] "Mr. Senft's Seminar," 4 June 1956, PP/SHF/D/6/7.
[33] PP/SHF/D/8/24 "On group analytic psychotherapy," Vienna 1968, p. 5.
[34] Foulkes and Anthony, p. 237.

patients or the functionality of the group was not as important as the individual's relationship with the group dynamics, rather than the other individuals in the group.

The GAS, Communication and Postwar Sociology

From its early years, the GAS looked to social psychology and sociology as much as it did to other psychoanalysts to theorize the group. At the first General Meeting of the Society in 1955, Foulkes spoke to this porousness when he said: "We admit our bias in favour of Freudian psychoanalysis, but do not rule out other schools of thought, as long as they are not incompatible with the group analytic approach." He noted by name Moreno, Kurt Lewin, and Norbert Elias. Other "compatible theorists" in psychoanalysis who were directly affiliated with the GAS were Drs. John Sutherland and Henry Ezriel of the Tavistock (Sutherland was the director) and Maxwell Jones, the therapeutic community pioneer who worked at Mill Hill during the war.[35] In 1966, when the GAS was setting up an international organization for its European and American members, the group insisted on establishing the "widest framework" possible for their work, to represent not only group psychoanalysis but "group work in all its forms," from various perspectives on group psychotherapy to "all sorts of group activities."[36] This approach was evident in their work with social workers and educators, described later, but also in their interaction with postwar sociology and philosophy.

The GAS delineated their practice from individual psychoanalysis, interactive as the latter may have been, by foregrounding the qualities of the group that made it most like a community or society at large. From group analysis, therapeutic techniques could emerge that could be applied to populations outside of the analytic circle. In a 1956 seminar, the Society discussed the "group-specific factors" of their work, drawing on the work of member SR Slavson, who authored *Re-Educating the Delinquent Through Group and Community Participation*. Discussion his work on the subject, the Society related it to Foulkes's statement that "the individual is carved out of the group," meaning that the therapeutic effects could not simply be scaled up from the relationships between two individuals (such as that between the patient and analyst), but that the group was a separate formation with its own behaviors and patterns. The seminar participants noted that the community was the "primary basis for conducting therapy, rather than the individual." Moreover, they said, "The cohesion of the group (community) and the currents moving within this are primary elements and cannot be explained in terms of interactions of individuals."[37] The multiple interactions that made up the group were more complex than a collection of individual relationships. The small group had its own patterns, which could be projected onto society at large, and vice versa.

One component of understanding the group was a studied understanding of communications as a field of study. In 1954, the GAS did a series of seminars on the subject of communication. Communication as a complex social process linked the patterns of group behavior to social behavior at large. Interventions into communicative behavior could therefore have wide-ranging effects. In one of these, M.J Abercrombie gave a seminar on "The Problem of Communication." A psychologist and researcher in group-centered education, Abercrombie

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[35] [35] Foulkes, "The Position of Group Analysis (Group Analytic Psychotherapy_ To-Day, With Particular Reference to the Role of the Society," read 31 January 1955 at the First General Meeting of the Society, Wellcome Trust, SA/GAS/B/1/13

[36] SH Foulkes, "Personal Report by Dr. SH Foulkes as Chairman Concerning our Meeting on the 2nd of October 1966 in Biel," pp. 2-4, Wellcome Trust, SA/GAS/B/1/18

[37] 11/6/1956 GA Seminar SHF, Group-Specific Factors, in PP/SFH/D/6/7 GAS Notes on Seminars 1952-57

noted that communication had “formed a fashionable topic at University College [London] and that the pundits there are doing research on the subject.” Her seminar asked: “Through what type of communication are therapy and democratic education linked? And how do they lead to good world citizenship?” In her paper, she discussed how, in verbal communication particularly, “something of the whole life experience and personality is communicated on a latent or implicit level,” describing the importance of subterranean perception in the group situation as an element of communication not present in, say, written communication. “Communication” as discussed in these seminars referred to the verbal, non-verbal, interpretative and symbolic. Reforming those behaviors and processes could be both individually therapeutic and socially transformative.[38]

The seminars on communication centered largely on the relationship between communication and neuroses. “Is it true,” one participant asked, “that the aim of therapy is to establish more accurate communication between people?” Or “to attempt to strive for a complete understanding between people?” And what did it mean to accomplish such therapeutic ends? Communication, according to Foulkes, could not be reduced to the mechanics of “transmitter and receiver” like a telegraph. Verbal communication in a group was a dynamic process, mutated by interpretation. Instead, Abercrombie noted, “it is essential to get clear” that a “piece of information [is changed] from the person expressing it to the recipient.” The role of the “intentional sender” in a communicative act needed to be diminished by those who studied group behavior, so that “one can no longer think in terms of discrepancy between what is intended and what is received.” Such discrepancies were not faults or necessarily deficiencies in communication, but appendages to the dynamic process of communication. Non-verbal communication, for example, accompanied and necessarily modified the verbal, influencing the process of interpretation by the receiver. One GAS member expressed anxiety about the inaccuracy of such implicit communication. The group responded that any “emotional disturbances” generated by misunderstanding were “often a more accurate index of group experiences or trends rather than the liberal [mechanical] understanding of a communication.” Communication was neither the utterance nor the actors who crafted and received message. Instead, it was a mutable object that changed shape en route to and from the participants in a group.[39]

To understand communication within groups and its therapeutic benefits, Foulkes and the GAS drew on Gregory Bateson and Jurgen Ruesch’s 1951 *Communication: The Social Matrix of Psychiatry*. In one of the communication seminars, Abercrombie discussed how Bateson and Ruesch dissected communication. First, there was the expressive act itself. This was followed by the “conscious or unconscious perception of the expressive acts” by others, and “the return observations that such expressive acts have been perceived.” In group psychotherapy, she continued, “the perception of having been perceived” was itself therapeutic. She asked: “Is it useful to think of psycho-therapy as being directed towards the establishment of more completely understanding of communication between people?” Doing so could repair the individual patient’s relationships.

Beyond the immediate therapeutics, Abercrombie also discussed Bateson and Ruesch’s notion of modern “anonymous communication.” This non-interactive communication, like

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[38] Mrs. Abercrombie, "The Problem of Communication," summarized by Dr. Donniger. PP/SFH/D/6/7 GAS Notes on Seminars 1952-57

[39] Mrs Abercrombie “On Comunication” GA Seminar Monday March 1 1954, PP/SFH/D/6/7 GAS Notes on Seminars 1952-57

government regulations and advertising, conveyed information that individuals could not respond to. Abercrombie circled this problem of mass communication back to the individual neurotic patient, further pushing the need for group-oriented therapy. When the individual, she said, "has no way of acting back to the communication in a personal way" they "become frightened and [feel] ineffective." Growing up in modern society, she said, one received a good deal of anonymous information, so much that "one can't really see it as different from anything else." Bates and Ruesch, she continued, "regard the understanding fo this mass (anonymous) communication as one of the tasks of therapy." The patient in analysis should be led to the "discovery that his usually inarticulate and unconscious assumptions about human relationship…are incorrect." Here, Abercrombie said that not only were mental disturbances a result of poor communication or social relationships, she also suggested that such disturbance was the widespread collateral psychic damage of modern mass communication and governance.[40]

Looking back on the foundation of the GAS in his own work on group psychotherapy, P.B. de Maré wrote of the conductor's role. Their understanding of it, he wrote, was determined as much by psychoanalysis as by their understanding of leadership from field theory and group dynamics in sociology, and in particular those theorized by Kurt Lewin and the microfunctionalists. They were also influenced by gestalt psychology, particular in the

> Adoption of the relative non-directive role of the conductor, in the focusing on free-floating discussion, in the molding of our understanding and interpretations, and in directing our attention to the total situation of the figure-background constellations.

De Maré attributed the development of the "non-directive" conductor to inevitable long-term trends in philosophy of mind and, in more recent times, cybernetics, communications, and general systems theory. The "revolutionary emphasis" in these latter fields being "information as distinct from energy (for example libido) flow."[41] (This will be expanded upon in the discussion that follows about Foulkes's notion of the group matrix.) He credited Foulkes with being the first to "recommend the free-floating discussion or 'group association', equivalent to the free association of psychoanalysis," as early as 1942. De Maré put Foulkes alongside what he called group dynamic theory, which was a focus of thinkers outside of psychotherapy.[42] Foulkes and his collaborators in the GAS aligned their work with what they saw as important currents in twentieth-century philosophy and social sciences.

German-American sociologist Kurt Lewin was an important influence on Foulkes and the GAS via his contributions to the study of group dynamics, social fields, and in the similarities between group analysis and Lewin's topological psychology. Foulkes looked to Lewin's "'field' theory" for a theoretical framework of group analysis. Foulkes's major and most comprehensive book on group analysis, *Group Psychotherapy: The Psycho-Analytic Approach* was published in 1957 and was written with British analyst Elwyn James Anthony. Here, Foulkes and Anthony discussed the diverse influences on their approach to group psychotherapy, including Lewin. They wrote that Lewin's social thought aligned with their own, particular concepts such as,

> The dynamic whole, of figure and background, of belongingness, of tension and conflict, of the various types of leadership and

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[40] Abercrombie, "On Communication."
[41] PB de Maré, *Perspectives in Group Psychotherapy: A Theoretical Background* (New York: Routledge, 2015; first edition 1972), p. 153.
[42] De Maré, p. 155.

"atmospheres", of the time perspective and the here and now.[43]

Their shared assumptions about group behavior and its imprint on the individual were similar to those which underwrote the therapeutic practice of the GAS.

Looking at how Foulkes and other members of the GAS read Lewin provides insight into group analysts' understanding of time and how each patient's individual biography interacted with group dynamics. To an extent, patients re-enacted infantile events and dysfunctional family relationships in the group, their pasts becoming present through their interpersonal behaviors and reactions. However, for Foulkes and the GAS, the way these personal narratives manifested in the group situation were an entirely new object of study, only existing in the present. The way the individual's narrative factored into group analysis (or did not), for example, was reflected in Lewin's distinction between the genetic and situational. In *Group Psychotherapy*, Foulkes and Anthony described Lewin's bearing on the idea of the "a-historic" group. Whereas traditional psychoanalysis operated "genetically," that is, accounting for determinants in the person's or group's infantile past, the situational:

> Postulates conduct determinants that confine themselves exclusively to the current situation or the 'here-and-now.' The individual reacts, according to this view, as if he had no childhood, or put differently, given two individuals—a normally matured adult and a hypothetical creation born into adult life—both would be expected to react to stress in a way explicable in terms of current field forces and valences. This challenging viewpoint has been called *a-historic*.[44]

The group, unlike the individual, "has no childhood." Hypothetically, an adult matured from childhood and a person born into adult could be "expected to react to stress in a way explicable in terms of current field forces."[45] In both Lewin's fields and the group analytic group, the past "ceases to exist in an operational sense."[46] While the group situation called for a "certain time depth", this was contained almost entirely within the short history of the group itself. The event was "mainly contemporary."

They incorporated Lewin's field theory into their schematic of group analysis. Rather than unspooling his or past in its intricacy, the patient carried their "life space" into the group, and collectively established the "group space" via these abbreviated versions of their life narrative, carried into the therapeutic circle and constituted the group's tensions and communication patterns.[47] This process, Foulkes and Anthony wrote, began inside the patient's personality, formed by his or her past, and

> Extrudes through perceptual antennae into the 'powerfields' of other group members. His needs give rise within him to 'tension systems', which endow the other members of a group with positive or negative valences. This concept valence in field theory is not unlike the concept of *cathexis* in psychoanalysis. Both are analogies derived from the physical sciences; both indicate a particular orientation of the subject to the object leading to a concentration of energy or force

[43] Foulkes and Anthony, p. 39

[44] Foulkes and Anthony, p. 32.

[45] Foulkes and Anthony, pp. 26-32.

[46] Foulkes and Anthony, p. 27.

[47] Foulkes and Anthony, p. 32.

> into a particular channel.[48]

Here, as elsewhere, Foulkes and his collaborators not only drew upon Lewin's Gestalt-influenced psychology and field theory, but used the physical language of invisible forces to describe the interpersonal operation of the group. This would be repeated in his allusion to the "group matrix," discussed elsewhere. This application of field theory to group analysis elaborated the specific social phenomenon that was the small group and made it subject to its own laws and order. It was, in Foulkes's vision, qualitatively different from both traditional individual psychoanalysis and organic social groupings, while retaining a similarity to both. Moreover, therapeutic benefits of group analysis could be gained by observing and intervening into intra-group events, rather than foregrounding each particular individual's personal past.

Foulkes also drew upon Lewin's notion of "time perspective" to discuss time, expectations, the here-and-now of group analysis; as well as the conductor's role in the group. While "time past" was of less concern, "time to come" was important. Group therapists were and should be concerned with time: how long to meet, how often, and when to stop. Open-endedness—group-association without direction or end-point—was distressing for patients, though not necessarily unproductive. Patients wanted time perspective, namely to know how long it would take to be "cured." The group analyst's management of the group, being "implicit rather than explicit," he tended, like "most psychotherapists," to avoid a time perspective. Lewin predicted "group demoralization" in the event the group could not be given such perspective or be otherwise "orientated in time." He insisted that needed a "programme", a "vision of the goal" and a "means or a purpose." However, to the group analyst, Foulkes contended, this is "a theoretical point of view that he has already transcended." In both individual and group analysis, he noted,

> The Freudian patient is confronted with 'interminable' treatment, and his urgent concern with a time perspective may be regarded as resistance to the analysis of the here and now.

This suggested that such an anxiety about time to come could be a therapeutic experience in itself. Group analysis, however, was slightly different from individual analysis in this sense. Being a "miniature life situation," group analysis more closely resembled the outer world and each patient's social reality. Their "future plans, therefore," Foulkes notes, "play a bigger part, and timing receives adequate consideration." The conductor needed to carve a middle way between maintaining the "here-and-now" perspective while accommodating the patients' needs for time perspective and orientation. For example, "The patient may be told that the group will last about two years, but he is told very little else." He was not told the "character" or "purpose" of treatment, and in doing so the "therapist remains non-directive and the course of therapy is formless." The relationship with time, Foulkes wrote, was significantly different in therapeutic groups than Lewin's own experimental groups and field work, because "the lack of a time perspective is a powerful therapeutic agent." Even Lewin, he noted, once "so well organized" a children's group where "interpersonal feeling and morale was immediately high," that the group continued in a self-organized way after their designated time, abandoning the need for time perspective. Ultimately, each group and each therapist needed to be "left to organize its own time."[49]

Lewin also gave Foulkes a way to make space for the conductor within the democratic formation of the small group, as he and Eve Lewis had done in the Exeter clinic experiments. *Group Psychotherapy* saw Foulkes working through field concepts from Lewin and related

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[48] Foulkes and Anthony, p. 33.
[49] Foulkes and Anthony, pp. 38-39.

sociologists of the "topological school", which suggested that conducted groups were more functional and democratic than leaderless ones. Drawing on Lewin's 1951 *Field Theory in Social Science*, Foulkes discussed how "The more organized and the more integrated a group was, the weaker were the boundaries that separated member from member, and the smoother did the channels of communication flow." A diagram illustrated a leaderless and randomly organized group of dots, each surrounding by a thick black line representing strong communication barriers. In comparison, an orderly circle of points surrounding a leader were depicted with light lines, with "tension spread more easily and…more evenly distributed."[50] Despite the importance of free association in therapy, group analysis was not a free-for-all. The group was anchored by organization and leadership.

Foulkes described how the therapist was to forge a new variation of expertise in his or her leadership. Again according to his reading of Lewin, groups could be "positive" or "negative." Positive groups were convened organically by "mutual feelings and common ends," like a family or a group of close friends. Negative groups were formed by an external artificiality, like in a workplace. The therapeutic group, Foulkes argued, was negative, an institutional construct convened by a hospital or clinic and a therapist. These types of groups were more prone than positive ones to direct collective aggression against their own members. Hostility, Foulkes concluded, "may reach disruptive levels unless skillfully managed by the conductor." At the same time, the conductor's status in the group generated a collective expectation for him to act as an expert, which was "hard to resist and deeply corrupting," and would make the group didactic, disrupting the pedagogical function of group therapy. Instead, "Once the 'atmosphere' is created the leader will find it a compelling force towards perpetuation." Beyond "atmosphere" the leader's role was varied. In part his or her job was to "symbolize [the group's] unity and integration", to "assume the place of the father", "act as arbiter in their conflicts", and "serve as an ideal model for 'rightness.'"[51] The small therapy group demanded a version of leadership compliant with both the therapeutic and democratic aims of group analysis. The leader was a teacher, imparting the social norms of group analysis, but not a didact. He or she led by example and subtle intervention. Anything too strong was considered an affront to the therapeutic process, and canceled out the learning process of speaking in the group.

The GAS's Work in Society

So far, I have looked primarily at how the GAS in London internally developed a theory and practice of group analysis, taking in ideas from outside their training and using them to adapt psychoanalysis to a group therapeutic model. Since its inception, however, individual members of the GAS worked outside of the society, helping workers in social services and psychiatric care implement group work in their own practices. This tendency extended back to Foulkes's statements about the social porousness of group analytic groups, and the potential of a therapeutic method that closely mirrored the real social world. For example, in 1953, ML Abercrombie at a GAS seminar compared group analysis to her own "Scientific interest in…'active' forms of learning (or teaching)" like group-work pedagogy.[52] The psychotherapists in the GAS had backgrounds in social work, pedagogy, and hospital administrations, and worked with those professions to extend the reach of group therapy methods. The ground was softened by concurrent interest by those professions in community care practice and the therapeutic

[50] Foulkes and Anthony, p. 34-35.
[51] Foulkes and Anthony, 36-38 fix other page numbers
[52] Group Analytic Course, 1952-1953, 19 January 1953, PP/SHF/D/6/7 GAS Notes on Seminars, 1952-57.

community model.

At the Sixth International Congress of Psychotherapy, held in London in 1964, GAS member Maxwell Jones—then the Medical Director of Dingleton Hospital in Melrose, Scotland and the chairman of the newly formed International Society for Social Psychiatry—called for more training work in group analysis for social psychiatry and affiliated professionals who were being called upon to do more psychotherapeutic work.[53] He said,

> Current trends in British psychiatry show the need for much keener awareness of the social dimensions and much closer familiarity with the work of welfare agencies and local authorities. Although the social sciences are bringing them into more frequent contact, there would appears [sic] to be a need for some standardisation of the training for medical officers, psychiatric social workers, and all other personnel engaged in social psychiatry.

In hospitals, he suggested, psychiatrists could be brought into "daily contact" with the rest of the ward team at a "daily ward meeting with all patients and staff present, followed by a staff meeting to discuss the interactions," which would "afford excellent opportunity for multidisciplinary training and for integrating the viewpoints of psychiatric social worker, nurse, occupational therapist, etc., with that of the psychiatrist."[54] Jones, like his compatriots in the GAS, hoped for the integration of group-analytic techniques into more conventional and wide-ranging settings like hospitals, schools, and social services.

GAS newsletters from the 1960s and 1970s showed its members working with institutions outside of the psychoanalytic practice. In 1964, for example, the Society reported that ML Abercrombie was working with the Bartlett School of Architecture in London on their education and training techniques. A member named HJ Home, a member of the Group-Analytic Practice, was holding courses at Open Way Clinic for about 20 students from "all forms of social service, including medicine." Mrs. Ilse Seglow, a psychotherapist at an LCC day school for troubled children, was conducting a psychodrama group for children and an analytic group for caseworkers in the Family Welfare Association. ACR Skynner, along with his work with psychiatric social workers discussed below, was reported to be working in family therapy with dislocated New Town families.[55]

This outreach work—often solicited from the outside, as it was by the psychiatric social workers—disseminated group analysis into new arenas of care, and into professions that were not primarily psychotherapeutic. Certain members of the GAS appeared to specialize in this type of outreach, and saw it as especially necessary in their day and age. In 1964, ACR Skynner, a consultant psychiatrist to St. Margaret's Hospital in Epping and the Harlow Child Guidance Clinic, and who conducted family group analysis and courses for psychiatric social workers, said that group analysis for families in his practice "seems unusually effective, particularly suited to New Town families who are separated from grandparents, who perhaps would normally assist in sorting out family difficulties."[56] Skynner became known for his work with the family, founding

[53] Group Analytic Society, ed. FRC Casson "Newsletter No. 3," February 1965, p. 4, Wellcome Trust SA/GAS/B/5/10.
[54] Maxwell Jones, "Training for Social Psychiatry," summarized in "Newsletter No. 3," February 1965, p. 10, Wellcome Trust SA/GAS/B/5/10.
[55] Newsletter No. 1, January 1964, SA/GAS/B.5/10
[56] Group Analytic Society, ed. FRC Casson, "Newsletter No. 1," January 1964, p. 4, Wellcome Trust SA/GAS/B/5/10

the Institute of Family Therapy in 1977.[57]

In 1965, Skynner gave a presentation to the GAS on "Group-analytic themes in training and case-discussion groups." As a leader of "several training groups for members of other services dealing with emotionally disturbed individuals", Skynner noted that in their discussions of their individual cases, case workers (such as social workers or nurses) were "not encouraged to reveal details of their personal experience." On the contrary, he argued, such practice could be beneficial, done "without danger," and "at a deeper level than that normally recommended and closer to the level of group analysis, as developed by S.H. Foulkes."[58] Care work in the social services, rather than resisting its emotive elements, should give into them, provided they did so along the lines of group analysis.

At the same meeting, the plenary speech was by GAS member DH Clark, the director of Fulbourn Hospital in Cambridge,[59] lauding the concept of the therapeutic community, a term coined by T.F. Main in 1946. Originally, he noted, the therapeutic community was intended to "help the entering patient's recovery" using positive social forces, rather than "negatively to increase his dependence," echoing the GAS's own ideas about a patient's independence from expertise via productive group work. Like group analysis, modern therapeutic communities, usually numbering between 30 and 100 members made up of staff and patients living and working together, "attempts to change the patients' faulty social functioning to a more satisfactory adjustment by various social techniques: regular community meetings, analysis of social events, role examination and restructuring and examination of communication." Not just a two-way relationship between patients and doctors or a horizontal-but-limited process amongst patients, the therapeutic community was promising in its inclusion of nurses and ancillary workers as well as patients. The concept, he argued had in the last two decades "transformed British mental hospitals from dreary, squalid abodes…into places of active rehabilitation, of social learning and enthusiasm where the severely crippled have the change to acquire social competence again."[60] Again, the GAS purported the cause of mental disturbance as being social in nature and curable via genuine, affective, and open interaction; the organization of institutions into familiar-sized groups; and the democratization of therapeutic practice. This final one was understood as both a flattening of institutional hierarchies and an increased flexibility of roles (such as that of "nurse," or "patient," who—participating in an identical practice—had the distinction between them blurred). Clark gave a lecture by the same title at the second Mental Health Research Fund annual lecture in London on February 1964.

In 1964, the GAS reported that in the winter of 1963 GAS member Isabel S. Jacobs had "conducted an experimental group of nine social workers concerned with adolescents." The aim was to see "how far group-analytic discussion would give the social workers better understanding of their clients' behaviour" and of their own reactions. Beginning in 1965, the Association of Psychiatric Social Workers began to provide a formal training course on psychoanalytic group work, using a programme developed by Dr. ACR Skynner of the GAS. Request for someone in the GAS to conduct such a supervision for psychiatric social workers

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[57] John Schlapobersky, "Obituary: Robin Skynner," *The Guardian* (28 September 2000), http://www.theguardian.com/news/2000/sep/28/guardianobituaries.booksonhealth

[58] ACR Skynner, "Group-analytic themes in training and case-discussion groups," summarized in "Newsletter No. 3," February 1965, p. 11, Wellcome Trust SA/GAS/B/5/10.

[59] June 1964 Newsletter, SA/GAS/B/5/10

[60] DH Clark, "The developing concept of the therapeutic community," summarized in "Newsletter No. 3," February 1965, p. 8, Wellcome Trust SA/GAS/B/5/10.

dated back to at least 1961.[61] Skynner proposed the training scheme in January of 1965, hoping to work with an eight- to twelve-person pilot group that coming September. The syllabus for the course began with general theories of group psychotherapy, grouped under "American approaches", "'Tavistock' theories (naming Wilfred Bion and Henry Ezriel), and the approach developed by Dr. Samuel Foulkes and the Group Analytic Society. From there, the course would discuss "general factors in Group Psychotherapy" as "based on the model of the small analytic group." This included traditional psychotherapeutic categories like transference and "free floating discussion" but group-specific issues such as "group rhythms, phases of resistance and activity", "sub-grouping, silences, meeting outside the group, scapegoat, saboteur," and other problematic personality types that would disrupt individual treatment by disrupting the group. The course also went over possible wider applications of "the techniques and principles developed in small groups to other groups." These included: therapeutic communities, social clubs, alcoholism and drug addiction, family therapy, and "training and case discussion groups."[62] By 1970 these courses were still in effect.[63]

Members of the GAS continued to holding training sessions, seminars, and conferences for social workers, hospital workers, and other professionals associated with mental health practice in the 1970s. In the 1974 and 1975 reporting year alone the GAS had received requests for supervision of their Qualifying Course in group analysis from Barnet Social Services, Barrow Hospital in Bristol, the National Marriage Guidance Council, St. Mary Abbots Hospital, Napsbury, a group of consultants in Coventry, the department of applied social sciences at Oxford University, and MIND, who asked for three tutors for a week-long course for hospital chaplains. While the MIND and Barnet requests fell through in the end, the others were taken on by GAS members, who reported on their work with Barrow Hospital and Oxford University.[64]

In 1974, Dr. DW Millard, a lecturer in Applied Social Sciences and Oxford University, and Malcolm Pines, discussed the "possibility of a member of the Group Analytic Society providing some group supervision in Oxford for social workers and perhaps others involved in various sorts of group work," and asked Jacobs to lead a course of seminars in 1974. Every two weeks from autumn 1974 to spring 1975, for one-and-a-half hours at a time, ten social workers from Oxfordshire, Berkshire, and Buckinghamshire attended seminars under Jacobs's guidance. The group consisted of four "generic" social workers, two psychiatric social workers, two workers in residential settings ("a boys' detention centre and a boys' hostel"), one adoption officer, and one trained probation officer. According to Jacobs's report, the aim was to develop group-work skills for social workers "already engaged in therapeutically oriented group work" or who hoped to be. Along with the classroom-like teaching of "concepts and techniques," participants would also "examine personal feelings aroused by working in a group (transference and counter-transference)." To teach the practice of group work, Jacobs followed Foulkes's method of supervisory groups for the training of registrars in group analysis at Maudsley Hospital."[65]

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[61] Group Analytic Society, "Minutes of Mtg of Cttee of Man [Management] of GAS 21 November 1961," Wellcome Trust, SA/GAS/B/1/14

[62] "Psychiatric Social Workers Training Scheme" January 1965, Wellcome Trust, PP/SHF/D/6/10

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[64] "Chairman's Report 1974/75," 3 July 1975, p. 4, Wellcome Trust, SA/GAS/B/1/17; Isabel S. Jacobs, "Report on Oxford Course," n.d., Wellcome Trust, SA/GAS/B/1/17; Date likely October 1975, according to "Minutes of the Committee Meeting of the Group Analytic Society, Held on Monday March 10th, 1975," Wellcome Trust, SA/GAS/B/1/11

[65] Isabel S. Jacobs, "Report on Oxford Course," c. 1975, Wellcome Trust SA/GAS/B/1/17

The Oxford seminar, like most GAS outreach, taught group analysis experientially, following traditional psychoanalysis in expecting practitioners to undergo the same treatment as their patients. According to her, it was a success. While only "two or three" members had previously engaged in group work before the course, "by the end 7 new groups had been started by members, some of them on an unstructured group-analytic model, others with more structure but making use of group analytic insights."[66]

Jacobs wrote an article on the course along with two of its participants, Dorothy Minett and Jacqueline Roberts, which shed additional light on the possible wider impact of the GAS's work with social workers. For instance, Jacobs recounted "heterogeneous" and "confused" notions about social workers' potential role as group therapy leaders. At the beginning of the workshop, the participants believed that group work should "help clients to practise social skills." As group conductor, Jacobs pushed participants to instead try "helping the members to analyse and work through whatever is said in the group." This open-endedness would ensure that group members being led by social workers did not only learn a set of behavioral social skills, but "also inner change and maturation."[67]

The social workers Jacobs worked with revealed frustration with the state of their own profession by way of their skepticism about group work. Social work agencies, they insisted, still saw group work as an "optional extra," and gave no reductions in case loads for conducting groups. Dorothy Minett lamented that her group for adolescent girls had been "impinged upon by a local headmaster, a doctor and a health visitor, all of whom had made determined efforts to find out everything that went on there."[68] The social workers' uncertainty, the report writers argued, was part of a larger anxiety (or "dependency needs", as they put it) about changes taking place in the social work profession, partially as a result of the reorganizations demanded by the1968 Seebohm Report.[69] This report and the implementations that followed over the next three years congealed social work departments and functions into all-purpose Social Services Departments under the purview of local authorities. The purpose was to provide a continuity of care that centered around the entire family and community, encouraging informal networks and neighborliness as supplements to statutory care. Social workers' discontent was largely emotional. Doing innovative, non-traditional work like group therapy was isolating and emotionally draining given the lack of institutional support. "'You need somebody to care for you if you've got to care for other people,'" one discussant lamented. There was "widespread insistence" in the group that social service agencies needed to reorganize their own administrative practices to include discussion groups as a decision-making engine "at all levels," from "grass-roots workers actually involved in doing therapeutic work" to the leaders of social services department. This would alleviate their isolation, and presumably make more room for personal feelings to be expressed and accommodated in the administration of social services. The report mentioned "two London social services departments" who had implemented workplace discussion groups, that dealt first with "problems within the hierarchy" in order to work with group workers' problems on the grass-roots level.[70] In its work with social workers, the GAS attempted to integrate the principles of group analysis into the practice of the caring professions,

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[66] Isabel S. Jacobs, "Report on Oxford Course," c. 1975, Wellcome Trust SA/GAS/B/1/17

[67] Isabel S. Jacobs, "Group Work Therapy – A Tool for Social Workers?," *Group Analysis*. July 1976, Vol. 9, No. 2, SAGE Journals, http://gaq.sagepub.com/content/9/2/151, p. 151.

[68] Isabel S. Jacobs, "Group Work Therapy – A Tool for Social Workers?," p. 153.

[69] Frederic Seebohm, "Report of the committee on local authority and allied social services. Cmnd 3703" (London: HMSO, 1968).

[70] Isabel S. Jacobs, "Group Work Therapy – A Tool for Social Workers?," p. 154-5.

as well as their entire institutional apparatus.

The discussion also focused on how social workers could conduct group therapy sessions in “psychiatrically impure settings.” The report suggested that in the long term, community and group therapy could lessen the necessity of social workers for certain clients. “Deprived clients in a group can themselves do quite a lot for one another,” they wrote, “and in so doing they discover they have something in themselves.”[71] This statement echoed other economizing arguments for group therapy and community group work, as well as the repeated narrative of the group analytic group learning to conduct itself without the authoritative presence of the analyst.

That same academic year, at Barrow Hospital in Bristol, Dr. Johanna Brieger[72] worked with hospital staff on behalf of the Trust for Group Analysis, as the hospital was attempting to “convert a psychiatric hospital run on conventional lines into a therapeutic community.” As part of this mission, Brieger met with hospital staff members ten times between October 1974 and June 1975, with a group member acting as group leader in the event of her absence. Brieger conducted two different groups of 12 members each in the beginning, one for “leaders of group-leader groups” and a senior nursing officer, and a second group for “registrars, sisters and social workers” at the hospital. Attendance hovered between eight and ten, dwindling to six by the end of the experiment. Brieger’s aim was to “introduce both groups to the basic group analytic model and discuss, if it was desires, possible modifications required to meet the requirements of the therapeutic community.” She found that, perhaps unsurprisingly, the problems exhibited by the groups of hospital staffers, “Related to the therapeutic community as a whole,” and “centered chiefly around the difficulties of authority, loyalty, the intensive preoccupation that the helping professions have with the responsibility for the wellbeing of their patients.” While initially there was “confusion” about her role as a conductor, in time “The therapeutic needs…become increasingly obvious” and treatable, which left many group members “impressed” with the process and Brieger as a conductor. Moving forward as a therapeutic community, she assessed, would mean overcoming their lack of experience “in any model of group work.” Like the analyst members of the GAS, healthcare workers subject to GAS training were expected to eventually learn to subsume their authority into the group, allowing for a flattening of hierarchy between patients and staff in the long run.[73]

The Therapeutic Community and the Large Group

The GAS seminars and conferences of the 1950s were primarily about how to conduct an analytic group, particularly the role of the conductor. A prevailing concern was forging democratic citizens out of democratic groups, teaching small groups to lead themselves. While this remained a feature of the GAS and group analysis, documents from the 1960s showed new concerns about the social nature of individual neuroses, and how to help individuals liberate themselves from the “multipersonal nature of neurosis” located in the group matrix.[74] Group analytic techniques could be scaled to larger groups where group members did not intimately know each other as individuals, further depersonalizing the therapeutic process. Moreover, such scaling further reduced the significance of therapeutic expertise. By the 1970s, the GAS was looking to new formats—large group therapy and therapeutic communities—that increased the

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[71] Isabel S. Jacobs, “Group Work Therapy – A Tool for Social Workers?,” p. 154.
[72] Only listed as “J. Brieger” in documents, but Peter Kutter’s *Basic Aspects of Psychoanalytic Group Therapy* mentions a Johanna Brieger in his preface (London: Routledge, 2014).
[73] Dr. J. Brieger, “Report on Barrow Hospital – Bristol, 1974/75,” Wellcome Trust, SA/GAS/B/1/17.
[74] Correspondence from Foulkes about a seminar group in Lausanne, 1 October 1966, PP/SHF/D/8/23.

distance between the individual patient and the therapist, making him or her even more reliant on the group or community for growth.

At the same time as they were reaching out to social workers and educators, the GAS was exploring alternative formats to the small analytic group. The Society's 1972 symposium, held at the Institute of Psychiatry in London, was convened under the theme "Group Analysis – the Widening Network," and was written up by Isobel Jacobs. Continuing the expansive outreach work of the 1960s, Skynner discussed his work on group analysis with families ("natural groups"). Dr. Vivienne Cohen gave a paper on "Cultural Factors in the Development of Group Analysis," discussing the work of group analysis in hospitals and prisons. The symposium also dealt with therapeutic communities and large group therapy, understood as a group of 50 to 100 people. The symposium also conducted an open forum on large group dynamics, led by Lionel Kreeger and de Mare, who had together operated a short-lived therapeutic community at Halliwick Hospital.[75]

Discussions of expanding analytic practice to wider groups during this time demonstrated economic and efficiency concerns in psychotherapy. Jacobs wrote that while "many dynamic features could be seen more clearly in large than in small groups," the large group was also "economical of therapists' time, and after the coming reorganisation of hospitals in this country, might be the only form of psychotherapy practicable in them."[76] *World Medicine*'s write-up of the symposium echoed this. The writer, Ann Shearer, noted:

> These, after all, are challenging days for group analysts, what with the therapeutic communities and anti-psychiatric encounters burgeoning to the left of them, and the NHS reorganising to the right, to show that district general hospitals are going to be able to turn over psychiatric patients with little more trouble than the average appendix. Analysts could be left looking just a little Luddite in those small controlled groups if they don't speed up the healing process or find their way to tacking a larger bunch of patients at a time.

She sat in on de Mare and Kreeger's forum on large groups, noting that de Mare, then the president of the GAS, sought "deliverance from small groups" and pointed that that "a large group technique could give analysis a stake in the efficiency-bound psychiatric unit of the general district hospital."[77] While from its conception group analysis was understood as an economized version of individual analysis. The proposition to apply group analytic techniques to the large group was controversial.

De Mare defended it, according to Jacobs. He spoke first to fears that, since neurosis is the "response to a maladjusted society", the large group would necessarily reproduce the "rage, chaos, splitting, and so on…where the social matrix (communication network) is only rudimentary." He argued that, instead, in time, the group can "evolve a matrix" that would contain these issues. "The large group," it followed, "provides a setting in which invisible intrapsychic barriers are projected as tangible constellations and role-playing relationships, which members then have the opportunity to reconstitute; if the boundary between inner and outer reality is kept permeable, growth and therapy can occur."[78] De Mare gave a paper at the

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[75] "GA Symposia 1970-72," Wellcome Library SA/GAS/B/5/56
[76] "GA Symposia 1970-72."
[77] Ann Shearer, "The Trouble With Being an Analyst," *World Medicine*, 1972, SA/GAS/B/5/33 World medicine article on GAS written in 1972, archived.
[78] "GA Symposia 1970-72."

symposium: "Large Group Psychotherapy: A Suggested Technique" and Kreeger one titled "The Background and Application of Large Groups," which demonstrated the challenges faced by organized group analysis and possible future directions, namely the imposition of small-group techniques into larger groups, institutions, and therapeutic communities. According to de Mare, a large group was constituted of 50 to 100 patients, arranged in a circle or two-tiered circle. Or, the large group could refer to the therapeutic community at large. For de Mare, the large group gave a "magnified" opportunity for the individual patient to "reconstitute" the invisible intrapersonal barriers between themselves and the group and for role-playing relationships. Therapeutic growth in the large group demanded that the individual patient work to maintain the "permeability at the interface between the self-system of the individual and the social system of the social system of the large group." The impetus on the individual to navigate the group was stronger in the large group than in the small analytic group.[79]

Kreeger echoed the economic concerns: the reorganization of psychiatric hospitals made it so that patients overnight stays would be limited. Moreover, with the "emphasis on community care," hospital staff would have less time with patients and less opportunity for "working with patients at any depth." Large groups were the "only possible way" to deal with the "psychotherapeutic needs of the hospital population." Most of his paper was about his own experience at Halliwick Hospital therapeutic community. He located the large group experiments within both the postwar history of therapeutic communities and contemporary scholarly work on community care in psychotherapy. While he believed that the large or community group was best complemented with small-group and individual psychotherapy, in their absence "the pressures within the large group may be directed towards obtaining personal growth and resolution of neurotic problems in the large group setting." The social or group matrix was as present in a large group as a small one. This flexibility of approach reiterated the GAS's approach to group psychotherapy as placing greater emphasis on the individual's personal interaction with the group matrix than the functional and lasting relationship between two people. That therapeutic effects could be gained from the diluted setting of the large group demonstrated this bias.

Conclusion

The Group Analytic Society, like those who advocated community care and the LCSS social workers, equated loneliness and isolation with mental disturbance. The perceived breakdown of organic units such as the family necessitated a synthetic replacement in the form of group psychotherapy. The group emerged as a form of self-help that drew on the energy of others—usually strangers or semi-familiar acquaintances—to conduct therapy without the help of a strong leader. The therapist's job was to reconsider his or her own expertise, to use his or leadership to wean the group off the guidance of leadership all together. While in the post-war years Foulkes used the idea of the group to bolster social solidarity and democratic citizenship, the GAS over time was more concerned with the individual's psychological well-being, separating them from approaches to group work defined by the Tavistock Institute.

While the individual's ability to relate was critical to his or her psychological function, the emphasis was on relating as a process and interface between patient and external world, rather than on the relationship itself as a durable object. This was made clear from the sociological concepts with which Foulkes and his colleagues anchored their psychotherapeutic practice. They understood society as an ever-shifting composition of small, intimate groups, and the individual as a node on a large network. Rather than valorizing the idea of the group as a phenomenon of

[79] De Mare, "Large Group Psychotherapy," from 1972 Symposium on Group Analysis, SA/GAS/B/5/56

social solidarity, the GAS and its members favored the individual who could competently utilize the group and navigate social networks adeptly. This forging of individualism with a fragmented and agile version of democratic sociability ultimately undermined the expertise- and solidarity-driven imaginary of the postwar settlement.

CHAPTER 3: EMPTYING THE ASYLUMS: COMMUNITY CARE AND THE EMPOWERED PATIENT, 1959-1985

This chapter analyzes the way loneliness as a social problem was projected through national policy and mental healthcare reform. Community care, an approach to care of the mentally ill, elderly, disabled, and others with chronic conditions, was guiding policy in Britain by the 1980s. The political history of community care, however, extends back to the drives to de-institutionalize in the 1950s and 1960s. As I have discussed previously in Chapter One, social workers in those decades equated state planning with loneliness among the rehoused populations of London. Early calls for community care, both official and within civil society, did much the same. As the psychiatric discourse around mental illness moved from morality to medical and environmental explanations for mental disturbance throughout the twentieth century, community care reflected the belief that a person's social environment could exacerbate or treat mental disturbance. Drawing on these assumptions about the social origins of all varieties of mental illness, with a particular emphasis on loneliness, mental healthcare reformers aimed to treat the chronically mentally ill in their communities, rather than in hospitals. This chapter will discuss the development of de-institutionalization in both policy and practice, beginning in the early 1960s.

The previous chapter was about social workers in London in the first decades of the welfare state who were concerned with the mental ill health of their charges and identified loneliness as a culprit. In doing so, they devised experimental techniques to engineer community and fellowship amongst rehoused people and those vulnerable to suicide. They were influenced by community development and other techniques that psychologized the problems of urban society. Their work in the 1950s and 1960s produced a left-liberal critique of the welfare state, targeting planning and the impersonality of bureaucracy. This chapter follows such critiques as they operated at the level of policy regarding the role of statutory institutions in mental healthcare. Developments in psychology about the social roots of mental illness and medical innovations in psychiatric medicine conspired with political and economic conditions away from large institutions and toward helping the mentally ill and infirm live amongst the community.

The result was community care, a policy system and philosophical approach to care that hoisted responsibility for care of the mentally ill from large state-run mental institutions and nursing homes to voluntary organizations, families, and (at times) empowered local authorities. Community care became part of official policy in 1959 with the passage of the Mental Health Act. In theory, community care policy was congruent with the tenants of community development and a belief that the cause and cure for mental illness could be found in an individual's interpersonal relationships. In one sense community care was reactive—a response to humanitarian concerns about large mental institutions and nursing homes as well as a cost-effective move for the state. It was also the culmination of study and practice in the care of mental illness that made isolation anathema to mental health, and depicted large-scale institutional planning as a culprit of communal fracture in the welfare state. Critically, particularly in the wake of budget cuts in the 1980s, community care has been almost largely panned as a failure, particularly because the closure of large mental institutions was not followed by sufficient funding to local authorities or voluntary organizations to properly care for the mentally ill.[1]

[1] Discussions of community care's failures abound, but some examples include Julie Leibrich, "Against the Odds: Community Based Care for Psychiatric Disabilities in Britain and New Zealand," in Paul Close (ed.) *Citizenship,*

This chapter dwells within these criticisms, and attempts to pull apart the contradictory underlying philosophy of community care policy in historical perspective. Chapter One magnified the practices of care conducted by a group of London social workers in the 1950s and 1960s and the researchers who influenced their work, focusing on the problem of loneliness in rehoused populations. This chapter focuses instead on community care for the mentally ill. Community care practice drew on an underlying belief that mental illness was either caused or exacerbated by isolation and detachment from an organic social milieu, and reflected that understanding of psychological problems in society. Like piecemeal and ad hoc efforts of social workers in the 1950s, community care from the 1960s through the 1980s leaned on informal social formations such as the family, surrounding neighborhood, and residence. This was not only for direct care of the chronically mentally ill, but such environments, proponents believed, could be organized for therapeutic effect. These policies—in their rhetoric—enshrined the idea of community, even when falling short of their aims. In many ways, the dynamics of community care echo those described in the previous chapter: the transformation and diminishment of expertise in the context of care, an aim to "understand" instead of "control" people with mental illness, and a belief in the power of free expression and repression as cure and cause of disorder. I discuss these, as well as the practical challenges faced by community care policy.

This chapter utilizes primarily the archives of MIND (known as Mind after 1990). Previously known as the National Association for Mental Health, a mental health charity and advocacy organization founded in 1946, the name MIND was introduced in 1972. As an overseer of the implementation of community care and advocate for patients, MIND was both participant in and critic of community care policy. Their records give insight both to the policy of community care and specific attempts to implement it through hostel care, groups homes, and self-help organizations. In addition, MIND's archives also show a shift within community care: the growth of the user movement. In this chapter, I show that in small community-care institutions such as hostels, the therapeutic emphasis shifted from recreating a family atmosphere and community reintegration to independence and self-sufficiency for patients and residents. Simultaneously, in the 1970s and 1980s, patient-empowerment movements for the mentally ill emerged, culminating in organized patients-rights and user-involvement movements, supported by the voluntary sector. Disillusionment with community care—both its therapeutic basis and its failures—gave way to a new understanding of how non-institutional care could serve those with mental illness. Community care proponents set their aim on personal isolation, as well as how communities could reintegrate the mentally ill back into society. This was attempted through techniques that operated on interpersonal relationships and the primacy of small groups as the objects of therapeutic intervention. While community care depicted mental-health patients as displaced from necessary group-bound intimacy, the user movement portrayed them as hollowed and disempowered individuals. The movement was individualistic and encouraged recipients of mental health care to position themselves as unsatisfied consumers of statutory products, echoing earlier emphases on independence and empowerment, rather than communal harmony.

This chapter will then discuss the challenges faced by community care in practice, and how these failures gave way to a new understanding of isolation and community in late-twentieth-century Britain. I will first discuss the optimism around community care as a humane alternative to large institutional care, and the transfer of community development practices into

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Europe and Change (Basingstoke: Macmillan, 1992), pp. 214-231; for an analysis of elder community care, Robin Means et al, *Community Care: Policy and Practice, Fourth Edition* (London: Palgrave, 2009).

mental health policy. Then, I examine the challenges community care faced in practice throughout the 1970s and 1980s, and the criticisms levied against it by MIND and its members. Finally, I end exploring the emergence of the user movement as a new way of imagining the individual in society, from understanding the mentally ill and others under the care of the state as being isolated to disempowered.

De-Institutionalization and Community Care Policy

Community care did not become widespread official government policy until the 1989 White Paper, *Caring for People*, which stated that "people affected by problems of ageing, mental illness, mental handicap or disability need to live independently in their own homes or in 'homely' settings in the community," and that the government's commitment to care would be expressed not in new institutions, but in an increased reliance on informal networks of families and neighborhoods to care for those with mental illness.[2] However, earnest calls for de-institutionalization and the movement of people out of hospitals and into the community began as early as the 1950s. Part of this process, as we have seen in Chapter One, included the evolution of the social work profession to include psychological services and community development work, as well as the development of psychiatric social work as an independent profession in the postwar period.[3] For the aged, children in state care, and people with chronic mental illness, dedicated and piecemeal plans to reduce the number of people in centralized institutions began in the 1950s, with various implementations, such as the 1962 Hospital Plan discussed below, in the 1960s.

In 1961, then-Minister of Health Enoch Powell delivered his memorable "Watertower" speech to MIND's predecessor, the National Association of Mental Health (NAMH). Powell's speech demonizing the centralized mental institution was given in the context the Mental Health Act of 1959, a pivotal piece of legislation encouraging a shift toward community care. Speaking of Britain's eroding mental hospitals:

> There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside—the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault.[4]

Powell's speech was a call to move mental healthcare out of centralized large mental institutions. He continued:

> We have to strive to alter our whole mentality about hospitals, and about mental hospitals especially. Hospital building is not like pyramid building, the erection of memorials to endure to a remote posterity. We have to get

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[2] Quoted by John Welshman, "Rhetoric and Reality: Community Care in England and Wales, 1948-74," in Peter Bartlett and David Wright (eds.) *Outside the Walls of the Asylum: The History of Care in the Community, 1750-2000* (New Brunswick, NJ: The Athlone Press, 1999), p. 204.

[3] Noel Timms dates the origin of care for the mentally ill outside of institutions to 1877 and the establishment of The After-Care Association for the Female and Friendless Convalescent on Leaving Asylums for the Insane, later known as The Mental After-Care Association. As a profession, psychiatric social work originated in America in the aftermath of the First World War, with some training programs in Britain (such as one at the London School of Economics) in the 1930s. The profession became specialized enough after the Second World War to establish its own Association of Psychiatric Social Workers. For a more granular time line, see Noel Timms, *Psychiatric Social Work in Great Britain, 1939-1962* (New York: Taylor and Francis, 2003), pp. 1-23.

[4] Enoch Powell, "Water Tower Speech," March 1961, delivered at the National Association for Mental Health.

> the idea into our heads that a hospital is a shell, a framework, however complex, to contain certain processes, and when the processes change or are superseded, then the shell must probably be scrapped and the framework dismantled.

Powell described a geographic shift in care of the mentally ill, from large centralized institutions to local authorities. Care no longer needed to be understood as belonging to a particular place (the asylum, the hospital) but as a set of practices that could follow mental-health patients into their local communities via a mesh of local statutory and voluntary institutions. Of those in institutions, "few ought to be in great isolated institutions," he said, emphasizing the counter-productivity of keeping those with mental illness away from their places of origin, referred to as communities.

Powell's speech was followed by the 1962 Hospital Plan, in which the Ministry of Health aimed to reduce the number of hospital beds for the mentally ill and "subnormal" over a ten-year period.[5] This was followed in 1963 by the Ministry's "Health and Welfare: The Development of Community Care" which outlined further plans to develop programs for community care services at the level of local authorities. In 1975, the policy report "Better Services for the Mentally Ill" further advocated for this shift from hospital services to social services for people with chronic mental illness. Between 1950 and the introduction of the 1983 Mental Health Act (which introduced provisions for involuntary hospitalization or "sectioning"), in-patient residency in institutions in England and Wales was reduced by tens of thousands of patients. These transitions were enabled by a broad cultural shift regarding mental illness and the desire to cut costs of maintaining large institutions in the context of spiraling health budgets, which combined with the scandalous physical conditions of many British Victorian mental institutions made institutionalization fall out of favor. In the later 1960s and 1970s this reformist impulse would be further fueled by the anti-psychiatry movement, which favored non-medical intervention. These included exposes such as *Sans Everything: A Case to Answer* in 1967 and *Put Away* in 1969, which revealed the poor conditions in British mental hospitals.[6] Finally, the pharmacological revolution of the 1950s, sparked by the introduction of antipsychotics like chlorpromazine in 1950 and thorazine in 1955, made it medically possible for people with severe mental illnesses such as schizophrenia to live outside of the hospital.[7]

By and large, the focus of historians and policy analysts regarding community care has been its "history of neglect," from penal institutionalization to the material austerity of community care.[8] Largely, this damnation has been due to the failure to replace institutions with anything comparable on the local level, overly relying on families to care for those with chronic mental illness at home.[9] While local authorities were empowered to generate alternatives, in the 1960s and 1970s this rarely went beyond uneven growth of group homes, hostels, and residential options, which will be discussed at length in this chapter.[10] By the time community care became official policy in 1989, its failures were already apparent to those keeping an eye on the personal

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[5] Welshman, p. 211.
[6] Robin Means, et al., *Community Care*. 54.
[7] Trevor Turner, "The History of Deinstitutionalization and Reinstitutionalization," *Psychiatry*, Vol 3 Issue 9, (1 September 2004), pp. 1-4; table on page 1; Randall G. Krieg, "An Interdisciplinary Look at the Deinstitutionalization of the Mentally Ill," *The Social Science Journal*, Vol. 38 (2001), p. 367.
[8] As described by Means, p. 35.
[9] This problem is discussed at length, along with the role of untrained (or unspecialized) social workers in Julia Twigg and Karl Atkin, *Carers Perceived: Policy and Practice in Informal Care* (McGraw-Hill Education, 1994).
[10] Means, *Community Care*, p. 55.

social services in Britain, such as MIND and associated charities. This chapter, rather than focusing on policy, closely reads the underlying philosophies of community care in practice, looking precisely at this very patchwork of hyper-local institutions meant to stand in for hospital care.

MIND's Position on Community Care and Loneliness

Overall, MIND was a proponent of community care. This was in part because advances in psychiatric medicine appeared to have made life in institutions less necessary. A 1971 report by MIND on community care reitereated the importance of medical advancements in psychiatric care as enablers of community-based care. MIND argued that approximately half of the 60,000 patients in mental hospitals "do not need specialist medical and nursing care" and, "if alternative facilities within the community, which local authorities have power to provide" existed, could live in their own communities.[11] Many patients who could live outside of hospitals, MIND argued in another report, "complain that they have nobody to talk to. They feel lonely and isolated - that nobody cares." General practitioners were described as "busy people [who] cannot always spare the time to talk to former patients and their relatives." In addition, "There are few opportunities for ex-patients to get together and to exchange views and to give each other support." MIND called for more professional infrastructure to be developed locally to create more affective bonds between patients, caregivers, and the communities they lived in. For example, MIND argued, GPs could be involved in the setting up of lodging houses and hostels to "reassure people" who lived nearby and "prepare the ground so that ex-patients are accepted into the local community." (MIND repeatedly found that one of the biggest challenges faced by community care institutions like hostels was, as a 1983 report put it, "the uproar that results when it is suggested that a house in the community should be converted into a hostel for people with mental problems.")[12] Psychiatric nurses and social workers were integral in creating the "enduring, compassionate relationships" that for mentally ill people could not "be over-emphasized." Nurses and social workers in the community in particular could help produce continuity for ex-hospital residents, as when leaving the hospital "these highly important relationships are arbitrarily broken. At the very time when patients most need that continuing relationship with known and trusted nurses it is withdrawn." MIND went so far as to suggest that "psychiatric nurses should be encouraged to maintain contact with their patients for at least a few weeks after discharge from the hospital."[13] The persistent underlying philosophy of community care was that isolation could affect a relapse into mental illness, and medical professionals could help patients being released from the hospital by both cultivating and retaining enduring and authentic relationships with their patients. By pressure groups like MIND, this was understood to be a process as or more effective than any kind of medical training or expertise.

In 1983 MIND produced a manifesto "for a comprehensive mental health service," in the wake of budget cuts, eroding institutional support, and a lack of funds going to local authorities for community care. In addition, MIND was concerned about the chronic mentally ill. In another information pamphlet, MIND had noted that admission trends to mental institutions had shown that there had been a "significant" rise in short-stay emergency admissions. Total admits in England had gone from approximately 160,000 per year in the mid-1960s to 200,000 in the mid-

[11] MIND Report No. 4, 10 October 1971, "Community Care Provisions for the Mentally Ill," SAMIN/B/23
[12] MIND, "Care in the Community: Keeping it Local. Report of MIND's 1983 annual conference." SAMIN/B/23 2 of 3.
[13] MIND, "Effective Community Care and the Mentally Ill," nd, likely between 1971 and 1976, SAMIN/B/23 1 of 3.

1980s. However, while only half of those were first-time admissions in the 1960s, in the 1980s that number was only about 25%, suggesting that acute "emotional distress" was a chronic problem for many, who were not being adequately treated by available services, creating a problematic population of chronically mentally ill.[14] Despite these problems, MIND and other mental health providers remained attached to the underlying philosophy of community care. Discussing the chronically mentally ill in 1984, the MIND manifesto stated that,

> The statutory services should integrate with, rather than cut across, the patient's natural systems of support—their affectionate networks—and recognise that people's lives are not lived in bureaucratic 'pigeon holes' but that all of us, and particularly the more disabled, periodically require propping up.[15]

The emphasis of mental health care should be on intervening in the patient's family or social network, and "when no network exists, to seek to create one."[16] This would change the nature of staffing mental health care as "Primary care staff now spend a considerable proportion of their time dealing with problems related to psychological and emotional difficulties," though GP training in this area was lacking. Even so, MIND praised the development of community psychiatric services, boasting that "Few health districts are now without a community nursing service, the estimated numbers being perhaps in the region of 3,000 compared to around 1,700 in 1981."[17] MIND's manifesto shows optimism for community care going into the 1980s, resting on a belief that localized care networks were more therapeutically effective than centralized institutions.

Community Care in Practice, 1959-1985

This section regards reports delivered to MIND regarding small-scale experiments in community care for people with mental illness during the postwar period. For people with chronic mental illness, community care institutions were not uniform. Instead, community care described a variety of institutions that mimicked the community, such as hostels and group homes. Throughout the period of deinstitutionalization, MIND closely monitored a number of these organizations, producing detailed reports on a number of them. What emerged from them was, first, the belief that isolation and mental illness were linked, making community care appear to be the most therapeutically effective approach. Second, by and large, these efforts aimed to re-create family-like structures for the benefit of the patient. Rather than strengthening the patient's own real family, they broke the family down into a series of interactions and relationships that were depersonalized from the patient's own real family history. In addition, like many other approaches to group-based community work, they undermined the role of psychiatric and medical experts, encouraging self-help and peer-resourced therapy. Finally, by the 1970s, community care experiments began to emphasize independence rather than community, foretelling the user and patient's rights movements.

One of the first community-care projects monitored by MIND, then still the National Association for Mental Health, was actually within the confines of a hospital in 1959.

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[14] MIND Information Pamphlet, nd, "Emotional Distress: The Scale of the Problem," SAMIN/B/25.
[15] MIND, "Common Concern: MIND's Manifesto for a Comprehensive Mental Health Service," 1983, SAMIN/B/23.
[16] MIND, "Common Concern: MIND's Manifesto for a Comprehensive Mental Health Service," 1983, SAMIN/B/23.
[17] MIND, "Common Concern: MIND's Manifesto for a Comprehensive Mental Health Service," 1983, SAMIN/B/23, p. 33.

Community care was a patchwork policy, a set of ideals and practices as much as a coherent policy system. While the aim of community care was to ultimately replace large mental institutions, MIND's monitoring of community care revealed that its implementation could occur within hospitals. By analyzing the way community care practice was implemented inside institutions, rather than being described as an absence of institutions, we can further understand the assumptions about mental disturbance that underwrote community care.

In 1959, Claybury Hospital in Essex attempted to integrate community care practices in the context of a large institution. This was attempted on an experimental basis, conducted by D.V.Martin, a psychiatrist and the Deputy Physician Superintendent of Claybury, a large hospital with 2,300 beds. The aims of the experiment show not only the levels at which community care permeated British mental healthcare, but also elucidates some of the underlying principles of community care. Martin wrote that the dysfunction that plagues large institutions was rooted in their system of hierarchy and submission, as well as a "lack of communication" between nurses and patients, and nurses and doctors. Thus "a vicious circle [is] established," and "disturbed behavior is called upon to suppress and control it using the same measures that produce it." The experiment aimed to open communication and encourage "a free expression of real feeling rather than a conventional interchange according to tacitly accepted standards of etiquette." Martin's belief was that the hospital should not attempt to control the "socially unacceptable manifestations of mental disorder," the standards of which were "arbitrary."[18]

Claybury was also an experiment in diffusing expertise. One aim of the experiment, Martin wrote, was "sharing out psychotherapeutic skills with nursing and other staff to enable them to gain a deeper understanding of the meaning of interpersonal relationships and a greater capacity to use them therapeutically." The institution, if the experiment succeeded, would operate by way of concentric small groups, rather than by systems of hierarchy and authority. Therapeutic groups for patients would meet alongside community meetings for staff and mixed patient-staff groups for each ward. Marvin described the process of weaning both patients and staff from authority and psychiatric expertise: "The more mature a community unit becomes, the less interpretation is required from the doctor and the more patients treat each other...pointing meanings hidden from the doctor because he is relatively remote from their daily lives." The Claybury experiment was not without challenges: Martin reported that among chronic schizophrenics the expressive environment at first encouraged the "rapid spread of phantasies" and that staff had trouble mastering their "own emotional response." However, he stood by the assertion that "It is only as we find ways to set people free that they can do their best work." As was happening in the social work profession, the early years of community care showed a move toward free expression, interpersonal relationships, and a willful erosion of authoritarian expertise as the recipe for a healthy psyche.[19]

Outside of the hospital, community care aimed to intervene in the patient's social environment and the way he or she related to it. In Chapter One we have seen how social workers came to broaden their professional practice to include more complex care for the emotional and interpersonal well-being of their charges. A belief that urban residents were emotionally isolated was central to this development, and in turn loneliness and a failure to establish social connections was understood to be a root cause of mental disturbance. Mental healthcare—rather than being portrayed as a medical specialty or the work of far-off asylums—

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[18] DV Martin, "Problems in Developing a Community Approach to Mental Hospital Treatment," *The British Journal of Psychiatric Social Work*, Vol. V No. 2 (1959), pp. 3-8.
[19] DV Martin.

was folded into social and voluntary work. A 1964 report by the Middlesex Advisory Committee of Mental Health Field Works—titled "A Service Is Born: The Community Mental Health Services"—exemplified this changing perception of what mental healthcare was and could be. The report showed more expansive implementation of experimental techniques used by individual social workers, such as those described in the previous chapter. The report discussed the implementation of therapeutic group work in a community setting:

> Some social workers in the mental health field are responsible for the running of therapeutic social clubs. These clubs are open both to patients discharged from psychiatric hospitals as well as others who do not need hospitalisation and are attending outpatient clinics. Often people who attend such clubs lack social contacts outside the immediate family circle and cannot make use of the normal social facilities which society provides. Social workers try to create an atmosphere in the club in which people with different symptoms and personalities can feel safe. Some social workers call discussion groups with patients, and there is little doubt that many people with emotional and social problems respond quite well to this approach.[20]

Enriching the social life of people who had been institutionalized or who suffered from mental illness, did more than reframe mental illness as rooted in social problems or disruptions in attachment. It also made care for the mentally ill a task in-reach of lay social workers and other non-experts. Untrained members of the community, in theory, could be trusted to participate in care instead of medical practitioners, nurses, or trained social workers. In the case of therapeutic community groups, the group work model was employed to help people learn to establish links with their communities, starting with fellow patients.

Hostels and group homes were a common form of community care for the mentally ill which local authorities and voluntary groups such as MIND took an interest in. While they began to flourish in the late 1960s, MIND's archives show experimental hostel schemes as far back as the Second World War. In 1941, they set up an agricultural hostel for "mentally handicapped men" in cooperation with the Ministry of Agriculture in order to put institutionalized men to work on the war effort.[21] In the 1960s and 1970s, MIND circulated advice on the establishment and operation of hostels. Local Associations for Mental Health helped operate hostels. The first to do so was the Ealing Local Association for Mental Health, which opened a group home in December 1965. The Norfolk Association opened a group home in October 1966, and by 1974 had eight such homes and a hostel with thirty beds. By the mid-1970s half of the Local Associations for Mental Health in Britain ran hostels or group homes operating in their localities. Most of the residents, per a 1974 MIND report on group homes, were elderly.[22]

Hostels' emphasis on creating a "family-like" atmosphere was illustrative of community care's reliance on women—professionals, volunteers, and actual family members. One hostel which demonstrated this tendency was Reynolds House, a hostel for boys who had left school but did not have functional families to return to, and needed a "bridge" to living independently in the community. Reynold's House received a grant from MIND (then still known as the National

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[20] Middlesex Advisory Committee of Mental Health Field workers, "A Service is Born: The Community Mental Health Services," 1964. MIND Archives, Wellcome Library, SAMIN/B/104.

[21] National Institute for Mental Health, "Agricultural Hostels for Mentally Handicapped Men," nd (c. 1941), Wellcome Library, SAMIN/B/58.

[22] Pricilla Reeve for MIND, "Starting and Running a Group Home," 1974, Wellcome Library, SAMIN/B/51, p. 4.

Association for Mental Health) in 1959, and formally opened in December 1963 in Bromley. Writing a report of the house's first five years in 1969, warden and psychiatric social worker David Wills discussed the importance of the female matron and her deputies. Their work in the hostel was meant, in part, to attune the male residents to "normal" domestic life, where women had a domestic role. Beyond that, Wills wrote, the women were usually alone and it was easier to talk to them in private, so the women "tended therefore much more than the men [staff] to be the repository of the residents' confidences—wherein to be sure they simply played the traditional mother role."[23] Wills acknowledged that this was "exhausting" for the women concerned. Even so, the work of hostel staff unsurprisingly resided in the emotional lives of the boys. Most residents came from broken homes. Of 28 surveyed residents, for example, only seven had their own father and mother living together, but their parents were unable to care for them due to mental illness, domestic violence, or neglect. Many had grown up in state care with only one known or surviving parent.[24] Wills described the emotional unavailability of the boys' parents in detail, and how the hostel needed to recreate normal family life for them. The staff was there to "supplement the general ameliorative tendency of the environment" through "personal one-to-one relationships between staff and boys on the one hand, and through the operation of group dynamics on the other."[25] Reynold's House staff, particularly women, were supposed to shed their role as experts in any kind of social work or mental health, and instead act in the organic role of mother, sister, and friend. Wills argued that success in rehabilitation was "the degree to which they had provided an experience of warm affective relationships" where the boy could learn to "relate." Thus, creating "affective ties" was not dependent on repairing relation's with the resident's biological family, but by learning the process by which such ties could be made with new people.[26]

Reynolds House also exemplified community care's emphasis not on creating communities per se, but on independence and individualism. By retooling social practice as individuals, the boys would eventually see themselves as "free, independent and self-supporting citizens." They should be discouraged from seeing themselves as "the pensioners of society."[27] The staff put a great deal of importance on money and personal finances, as "necessary to enhance their feelings of independence.[28] Even the parental role taken by the staff, Wills warned, should be handled delicately. Any reference to "affective ties with staff" or to "their possible role as parent-figures" should not be made while interviewing potential residents, to encourage them to see themselves as independent. Wills also explicitly rejected the notion that this mock-parental role was one of "authority", and should not be used to make the boys respect authority, as that was a type of dependence.[29] Instead, like in an ordinary family, the filial relationship with staff was flexible, temporary, and "finally taken for granted in the way that, in a good family, parents are taken for granted." In the end, the staff became a peer as much as a parent.[30] Disciplinary issues, should they arise, needed to be discussed as a group. The mandatory house meetings were therapeutic and pedagogical. It taught the boys, first, that societies had to make rules, but, like

[23] David Wills, "Reynolds House: A report on the first five years," April 1969. Wellcome Library, SAMIN/B/58, p. 6.
[24] Wills, p. 29.
[25] Wills, p. 28.
[26] Wills, p. 35.
[27] Wills, p. 46.
[28] Wills, p. 51.
[29] Wills, p. 62.
[30] Wills, p. 62.

many community care projects, this process was not dependent on authority or expertise. Instead, in the house's communal governing structure, Wills wrote, "Something was learned of tolerance...committee procedure, and everyone, even the weakest and smallest, was able to 'stick up for himself'—and effectively too—against any would-be tyrant."[31] This rejection of a strong explicit authority figure was exemplary of community care's disavowal of the "rule of experts." Re-enactments of non-institutional social structures such as the family could replace both a dependence on expertise as well as delinquent behavior. However, unlike community development practice such as those utilized by the LCSS in the previous chapter—and which acted upon the community as a whole—the community for institutions like Reynolds House emphasized the individual's independence from authority and the state.

As decentralized mental health practices for people with chronic mental illness, hostels and group homes had staffing needs that pertained more to flexible interpersonal contingencies rather than psychiatric expertise. In one 1970 report from the Buckinghamshire Department of Health and Welfare—where the first statutory mental health hostel appeared relatively early in 1962 —Senior Social Worker JC Fletcher noted that staff skillsets were different in community care. Quoting another psychiatric social worker GH Mountney, he wrote that a common mistake community-care institutions made was "believing that experience as a nurse in a psychiatric hospital is adequate preparation for taking on the responsibility of a community based psychiatric hostel, intended to be run on purely social lines." On the contrary, those who staffed local authority psychiatric hostels should be both "a housekeeper and a social worker." Hostels, Fletcher continued, were challenging to run. They required "a great deal of thought, effort and enthusiasm, and a high level of skill particularly in the field of human relationships, that is in the dynamics of personalities and groups." He noted that such statements rankled those who practiced "medically-oriented psychiatry."[32] Above all, hostel care was "social care", not medical care. Fletcher described the aims of the hostel as such: to create a "substitute 'home' environment," and by re-integrating people into their local community by encouraging resident to spend as much time outside of the home as they would in an ordinary biological family home.[33]

A MIND report in October 1971 monitoring community care provisions for people with mental illness analyzed 123 local authorities, and found that 75 had hostels for the mentally ill. Fifty had group homes, 37 had day care centres, and 106 had social clubs. These numbers referred to a mixture of voluntary and statutory efforts. For example, MIND found that in total there were 328 social clubs for people with mental illness, and 159 of those were run by volunteers. [34] Residential schemes were a patchwork when it came to authority and funding. According the 1974 MIND report on group homes, hostels were normally rent-subsidized by Local Authorities, while group homes were self-supporting. Some rented from a local housing association, others from a private source. The advantage of such housing programs, per MIND, was not just therapeutic for the patients, but also could help normalize mental illness for the

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[31] Wills, p. 72.

[32] Bucks Department of Health and Welfare and JC Fletcher, Working Papers No. 2, January 1970, Wellcome Library, SAMIN/B/58 pp. 6-7.

[33] Fletcher, p. 21.

[34] MIND Report No. 4: Community Care Provisions for the Mentally Ill, October 1971, Wellcome Library SAMIN/B/104.

house's neighbors. The patients who could benefit most from group homes were those who had "lost contact with their families" and thus needed to repair their interpersonal skills.[35]

MIND's advice on starting and running a group home illustrated the belief in the therapeutic potential of the home as an idea that could be reproduced. Repairing patterns of attachment could be done by running group homes like a family. In her report for MIND on how to run a group home in 1974, Priscilla Reeve wrote that the size of the house was a critical decision. She wrote, "If there are more than five or six people in the house it may lose its family atmosphere and become a mini-institution." Moreover, houses, rather than blocks of flats, were preferred because "Flats are not usually suitable as there is seldom much communication between people living in blocks of flats and so it will be difficult for the group home residents to become part of the community." Finally, the location of the house should be in a less-than-affluent neighborhood as in expensive areas "neighbours may be more hostile than a cheaper area" and somewhere without a large "floating population" of bedsitters, where "there may be little community spirit." In short, as much as possible, the group home should mimic that of an ordinary family home. For Reeve and MIND, this extended to the gender makeup of the house. Unlike hospitals, which may segregate rooms or wards by gender, "Mixed group homes seem to work well and resemble more naturally a family unit." Women residents, she argued "prefer to cope with the cooking and shopping" while men "usually do jobs such as gardening." Finally, like "most families," tension and conflict were inevitable, and like a family, the contingencies of the personalities and the situation would determine how best to proceed with conflict resolution.[36]

In practice, community care for the chronically mentally ill operated on two registers. First, and most often, the mentally ill person was taught how to recalibrate their interaction with others. Second, proponents of community care considered how to encourage informal networks to care for the patients who lived amongst them, either at home or in dedicated group homes. In a 1976 paper composed for the Mental Health Foundation's—another mental-health charity—Study Day, John Wilder wrote about facilitating community involvement to meet the "needs of patients living at home." Wilder demonstrated how community care for mental health sought to extend care beyond those designated as patients, and to engineer a specific iteration of "community" within broader society. He began his paper by discussing the work of community mental health councils in working-class areas of north and east London. Pulling on strands extending back to 1950s social studies, Wilder discussed how the "community attitudes" in places like Hackney were "especially tolerant" to the chronically mentally ill, as residents, he posited, could "identify with the casualties that occur." He continued, "Their resentment to the social deviant does not develop unless there is adverse involvement at the extreme level." Working-class urban communities were more sympathetic and helpful, he argued, "once convinced of their ability to contribute to a need." He went on to discuss how such a role for the community—inherent in some areas—could be reproduced elsewhere. Community mental health councils and other community-care entities needed to be involved with the community defined as "all of us." This included working with "relatives, friends, patients, ex-patients each with their own sphere of influence ranging through industry, local government, in fact every walk of life." That is, rather than acting upon the individual, care institutions would "[use] the community in a

[35] Pricilla Reeve for MIND, "Starting and Running a Group Home," 1974, Wellcome Library, SAMIN/B/51, pp. 5-6.

[36] Pricilla Reeve for MIND, "Starting and Running a Group Home," 1974, Wellcome Library, SAMIN/B/51, p. 9, 23-30.

constructive way to help the individual." This meant thinking beyond group-based therapy among patients living in or out of mental hospitals, as had been pioneered in the 1950s, and preparing communities to accept ex-patients and the chronically mentally ill.

Work with the mentally ill on a community-care basis fostered "involvement that teaches the art of relationships, and it is relationships that provide the opportunity for sharing, for love, for loyalty, for integrity and for many other ingredients of mental health that you can enumerate for yourselves," while enhancing the "personal dignity of every individual must be ensured."[37] Community care, he wrote, could be described as "'organised compassion.'" It was a "tribute to the civilisation of modern societies and their flair for managing or governing groups," he wrote, that "disruptive elements do not result in the absolute decay of the community." Wilder was deeply skeptical of the incorporation of community-care techniques by the state so that "may ultimately become a State function," in particular because of what he saw as encroaching professionalism in mental health care. He wrote that in statutory care, there was a tendency for "the management to become hierarchical and the career prospects of the caring individuals to take priority over the needs of clients." In addition, "the 'qualified'" would become an interest group in themselves, "determined to retain their right to care, and may shun the innate altruistic capacity of the community unless it can be organised officially."[38] Documentation around community care in practice illustrated a conflicted relationship with both the state and official expertise, and hopes to engineer caring practice among peers and neighbors.

Community care as a set of practices relied on pre-existing social organizations and institutions to carry out assistance for people with mental illness. One example of this was the use of boarding houses and hostels which had not previously been used to house de-institutionalized patients. In 1983, an independent working group based on the National Institute for Social Work and financed by the Department of Health and Social Security investigated the lives of the "elderly, disabled, or mentally disordered" who resided in boarding houses as opposed to receiving traditional care. The report found that for some people, their social needs were met more suitably in a boarding house than a formal care facility. For some, they wrote, a boarding house allowed for "freedom of choice to develop relationships with other people and to engage in activities which give personal satisfaction." The formation of interpersonal relationships with peers was central to the therapeutic aims of community care. Now, however, the process of making friends was framed as a matter of individual choice and personal satisfaction. The report was critical of this "benefit" of boarding houses: "Because boarding house life can place people in close physical proximity to each other it will be important for them to be assured of time and space for privacy within the house..." One's ability to make friends was framed as a personal, rather than a communal, gain. Individuals in care, though, should also be empowered to *not* interact with other people, and the writers' emphasis on privacy underscores the individualization embedded within community care practice. Finally, the report discussed how social needs could be met outside of the house, by "shopping, joining clubs, [or] attending church." Community care decentralized the therapeutic practice away from authoritative experts. It also diffused its location. Extended to a logical end, community care could be a floating set of practices enacted far outside the purview of the state or formal voluntary groups, but could in theory take place in a non-dedicated boarding house. Further, people with mental illness could

[37] John Wilder, "Community Involvement in Meeting the Needs of Patients Living at Home," Mental Health Foundation: Study Day, 6 May 1976, SAMIN/B/25, pp. 1, 5.
[38] Wilder, p. 3.

make use of pre-existing semi-public spaces to practice their socialization: the shopping center, the club, and the church. [39]

Hostels, group homes, and other decentralized approaches to caring for the chronically mentally ill illustrated community care's conflicting relationships with state-managed care and expertise. In addition, the language used to describe the successes and failures of hostels and group homes described community care techniques as alternately acting upon the patient themselves and their surrounding community. While community care was often associated with a tolerant approach to mental illness that saw the cause rooted in the person's environment, it just as frequently acted upon the individual's faulty relationships with those around him or her. In that sense, mental health problems could still be seen as an individual failure, and dependent on a self-help regimen of relationship building. As we shall now see, this focus on individual failures and successes, measured by their ability to utilize informal care networks, was reflected in the user movement.

Self-Help Groups and the User Movement

In the late 1970s and early 1980s, those invested in community care practices emphasized the move from dependence to independence for mental-illness patients. This illustrated a shift from understanding mental illness as a state of social isolation or disrupted attachment to a state of disempowerment of the individual. This sentiment was reflected in the user and patients' rights movements of the 1980s. Self-help groups for people with various mental health issues and organizations around patients' rights continued to organize around the problem of isolation, synonymous with institutionalization and the authority of experts. In supporting the user and patients' rights movements, mental health advocacy organizations such as MIND extended a positive belief in peer-driven therapy, as well as a negative outlook toward institutional care. In the late 1970s and early 1980s, MIND helped self-help groups organize themselves, and wrote information booklets with step-by-step instructions for starting one, offering space in their own Self-Help Team offices.[40] The development and proliferation of self-help groups further illustrated two movements in mental health care and therapeutic practice. First, the language of isolation and loneliness was deployed, as it had been in the immediate postwar period, against the institutions of statutory care and planned welfare. Second, they encouraged independence from psychiatric expertise.

One example of self-help groups that illustrated such attitudes about isolation, therapeutic practice, and the shedding of expertise was the Organisation for Parents Under Stress, or OPUS, reported on at length by MIND in 1981. OPUS was a collective of self-help and support groups for parents with a history of harming their children or who were at risk of doing so. OPUS groups began forming in Britain in the mid-1970s, following the foundation of Parents Anonymous in North America in 1974. By 1980, there were at least 40 OPUS groups in Britain. The writer of the MIND report, Molly Meacher, echoed discussions from the 1950s about loneliness when she wrote about the "necessary mobility of the nuclear family in capitalist societies" which contributed to "the isolation of young families in urban area and in particular in high-rise developments." The isolation of young families was exacerbated by the "breakdown of the small community." Without extended family or close friends in close proximity, young

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[39] "At Home in a Boarding House: Caring for the Elderly, Disabled or Mentally Disordered Residents in Boarding Houses and Similar Settings, 1983 Report of an Independent Working Group," 1983, Wellcome Library SAMIN/B/58

[40] MIND, "The First Steps," nd. SAMIN/110

parents did not have a nearby sympathetic ear to vocalize distress. Meacher pointed to the ineptitude of experts to ameliorate the problem. "Professional helpers," she wrote, such as doctors, psychiatrists, nurses, and social workers, were of little help, and past adverse experience with authority figures only isolated such parents further. Isolation, by Meacher and MIND's reasoning, was correlated with dependence, which was exacerbated by ineffective mental health professionals and the welfare establishment.[41] Overcoming such isolation was described as a "move from the dependent to the independent role." OPUS provided services that such experts did not. These peer-staffed services included a befriending service, hotlines, and a babysitting service. The report also closely analyzed the national group's telephone rota for acutely distressed parents. Out of 100 callers, all with "predominantly psycho-social problems," only one was referred to any state social services department. MIND speculated that OPUS volunteers—many of whom had had personal involvement with social services—saw themselves as in competition with social service personnel. While the report ultimately recommended stronger partnerships between self-help groups and official social service providers, for the benefit of parents under stress, MIND acknowledged that their analysis indicated a serious divide.

Meacher also analyzed the records of the Parents Anonymous Croyden and Tandridge (PACT)'s befriending service for 1980, demonstrating the scope of parenting self-help groups as informal support networks. They found that approximately 1000 contacts were made per year, and those included lengthy visits and babysitting services as well as brief informational calls. Five volunteer members of OPUS's befriending services had professional training in social work or an adjacent field, and they acted as group leaders for geographical areas. The report concluded that OPUS groups like PACT were best equipped not to replace statutory services, but could "make an effective therapeutic relationship with parents whose resistance to authority figures and whose feelings of guilt would prevent them ever seeking help from statutory agencies." A critical supplement to any state agency, according to the report, were community-based networks of "therapeutic relationships", which were more effective in drawing troubled parents out of isolation than experts within the state service apparatus.[42] At the same time, self-help groups drew upon already-existing community resources while also creating new communities built upon specific interests rather than locality. Finally, this report showed that the forces of community were marshaled to encourage independence from such services and the state, rather than building durable communities per se.

The logical end to community care, as portrayed and understood by MIND, many of its members, and affiliated organizations, was an individualized approach to mental health care and therapeutic practice. Isolation as the most important secondary cause of mental illness was slowly replaced with the idea of disempowerment in a faceless, unresponsive system. The user movement, patients' rights, and consumer movements in mental health care grew and strengthened as a response to the deficits of and challenged faced by community care, as dwindling state support diminished and called into question the entire enterprise. As the deterioration of psychiatric hospitals accelerated in the 1980s, community care became more central to mental healthcare policy. At the same time, users organized around patients' rights. According to a 1992 MIND pamphlet on "Empowering Users of Mental Health Services", in 1985 the major international conferences held in Brighton by the World Federation for Mental Health and MIND "gave a platform to user groups" for the first time. Rapid growth of self-

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[41] Molly Meacher, "Self-Help Groups for Parents Under Stress: A Contribution to Preventions?", 1981, Wellcome Library SAMIN/110.
[42] Meacher.

advocacy groups followed.[43] MIND's network, in their own words, "enshrined the principle of involving users and carers ..in community care planning."[44]

The user movement was associated with the idea of patients' rights as consumers of mental health care and welfare. This was in part a response to large-scale restructuring made to statutory services in the 1970s and 1980s.[45] In 1980, MIND published a collection of essays penned by Peter Edwards, the head of Liverpool MIND's commission on patients' rights. He wrote that "overstretched" social services had the effect of keeping thousands of people in mental institutions who were "only there because there is just no sufficient accommodation for them in the community." Without supplementary care outside of large institutions, it was impossible for "some people with psychiatric difficulties to be supported in the community." Echoing the sentiments of community care, Edwards wrote that it was a right of psychiatric patients to receive support that would "enable them to live their lives fully in the community" and detained in the hospital no longer than necessary.[46] To date, more than twenty years after the Mental Health Act, he wrote, "community care for this small group of extremely deprived people is still a fantasy, particularly in the Blackburn area."[47] The failings of community care to provide for people with mental illness led to the search for new solutions.

The lack of services offered under community care led to the formation of patient's councils. On a national level, Survivors Speak Out was set up after the 1985 Brighton MIND conference, which was the first to invite radical and anti-psychiatry groups. They were followed by the National Advocacy Network and MINDLINK, a patient pressure group within MIND which in the late 1980s had 800 members and six regional groups.[48] The first local group, according to MIND, was in Nottingham in 1986, followed by the Milton Keynes Advocacy Project in 1987, Brighton Insight in 1988, and after that a "host of groups." These organizations were indebted in part to radical and anti-psychiatry pressure groups from the 1970s, like the British Network for Alternatives to Psychiatry and the Campaign Against Psychiatric Oppression.[49] While moderated in their views of psychiatry, consumer advocacy movements in mental health care aimed to protect patients from the power imbalances and potential exploitations of mental health care. In addition, rather than being against psychiatry, the user movement aimed to empower the individual patient, both as a consumer and for therapeutic benefit.

User involvement recast community-based care by encouraging closer communication between patients as individual consumers and service providers. A MIND pamphlet from the 1980s on how to make user involvement successful framed this as a problem of communication. It read: "Service providers have begun to reach out to involve the people who use their services.

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[43] Jim Read and Jan Wallcraft, "Guidelines for Empowering Users of Mental Health Services," 1992, SAMIN/110; MIND Information, "The History of Mental Health," SAMIN/B/125, p. 1.
[44] Jim Read and Jan Wallcraft, "Guidelines for Empowering Users of Mental Health Services," 1992, SAMIN/110.
[45] Keir Waddington, "Enemies Within: Postwar Bethlem and the Maudsley Hospital," and Peter Barham, "From the Asylum to the Community: The Mental Patient in Postwar Britain," in Marijke Gijswijt-Hofstra and Roy Porter (eds.), *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands* (Atlanta: Editions Rodopi BV, 1998) pp. 185-202 and 221-256; John Turner et al, "The History of the Mental Health Services in Modern England: Practitioner Memories and the Direction of Further Research," *Medical History*, vol. 59 no. 4 (2015), p. 608; Peter Nolan, *A History of Mental Health Nursing* (Cheltenham: Stanley Thomas, 1993), pp. 140-142.
[46] Peter Edwards, "Small Voices One: Essays About Mental Health in the North West of England", 1980, SAMIN/110, p. 3.
[47] Edwards, p. 9.
[48] MIND Information, "The History of Mental Health," SAMIN/B/125.
[49] MIND, 1991 policy paper, MIND's policy on user invovlement, 1991. SAMIN/B/125.

So why are there so many problems in communication?" Service providers should involve users, not because it was en vogue or because they had been told to do so, but to "[share] power with those who have been disempowered in the past." The pamphlet went on to describe to service providers of mental health care could do to "open up your power" and "empower users." This involved informing users about their rights and not hiding "behind a mask of professionalism," as "honesty is empowering." The pamphlet also asked providers to ask patients what they wanted and to "talk to us" to break through the isolation of "emotional distress." Talking in a friendly way also made patients feel that they were being treated "as equals."[50] The provider guidelines employed much of the same emotive language as community care documentation, such as a concern with isolation, skepticism of expertise, and asking professionals to prioritize their own emotional labor. However, the focus was on "empowering" the individual via his or her direct contact with the care provider, rather than amongst members of the patient's community.

In the late 1970s, going into the 1980s, the user movement emerged as an extension of community care. MIND took extensive interest in these movements and the understanding of mental health patients as "consumers" of state services. One 1981 MIND report, written by David Brandon, justified the term consumer, as opposed to patient, when describing people in the care of the state. Patient, Brandon wrote, was too narrow a term and referred "simply to distressed people who are using mental health services in a very passive sense." On the other hand, "*Consumers* is a slightly wider expression which takes into account the substantial interaction between services and user, and acknowledges that attention should be paid to users' views."[51] At a 1988 International Conference on User Involvement in Mental Health Service at the University of Sussex Brighton, Mike Lawson, the founder of Survivors Speak Out, also discussed the matter of language. In his presentation, "Individual Need — Collective Action," Lawson said that "As little as 10 years ago, the majority of people working in the National Health Service would not have heard the term *'User* Involvement'" and would have preferred to avoid a term so linked to consumerism. Like Brandon, he defended the terms "user" and "consumer" on the grounds that the best way to help mental health patients was to better coordinate *information* between patients and services, and to increase communication between individuals and providers.[52] This approach to patients' mental wellbeing suggested a more individuated relationship with state services, as a negotiation between two parties. This was in contrast to iterations of community care that saw pre-existing social structures like the family or the neighborhood as the focus of restoration for collective mental health. In contrast, the consumer-focused movement empowered individuals through the collective but independent action of other individuals under care.

At the same 1988 conference in Brighton, David Townsend, the Director of Social Services for Croydon, suggested a council that would look after consumers' rights in social services. His own department had adopted a rights charter for adult services. He recounted it how users had the right to:

> Personal independence, personal choice and personal responsibility for their own actions. Have their cultural, religious, sexual and emotional needs accepted and respected. Have their personal dignity respected by

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[50] MIND, "User Involvement: How to Make a Success of It", nd, SAMIN/B/125

[51] David Brandon, "Voices of Experience: Consumer Perspectives of Psychiatric Treatment," 1981, SAMIN/B/125

[52] Mike Lawson, "Individual Need - Collective Action, The Potential for User Involvement in the UK," paper given at the International Conference on User Involvement in Mental Health Services at the University of Sussex Brighton, 26-28 September 1988. Printed by MIND in their "Common Concern" periodical, SAMIN/B/125.

> others, and be treated as individuals, whatever their disabilities...Look after their own personal needs as far as they are mentally and physically able. Privacy for themselves, their belongings and their affairs, including the right to receive visitors in private. Freedom to enjoy their sexuality and to have it recognised by others. The same access to facilities and services in the community as any other citizen, including registering with the medical practitioner or dentist of their choice. Education and information relevant to their individual needs. Choose whether or not to mix with people in the community, either by going out or by inviting people in to homes, hostels, or sheltered flats. Decide whether or not they receive official or personal visitors. Be addressed by staff in the way which they choose. See records which are held by the department containing information about them.

Mental health care providers, he continued, could assist with self-advocacy by offering "our personal support as individual people" while promoting the "philosophy" of user-participation. Lawson's presentation illustrated the emphasis on individual integrity and dignity of the user movement.[53] The movement carried from community care the importance of communication, but that communication was limited to the relationship between patient and his or her provider. The user movement had a communal element in the form of collective advocacy. At the conference, Irene Whitehill, an advocacy worker for the Newcastle Advocacies Project, discussed the "coming together of people with similar experience, as seen in traditional self-help groups." The impact of such collective work, though, was to "enable people to speak up and express themselves."[54] This would lead to—as phrased in a MIND South East User Information Pack—a "shift in the balance of power" and the "establishment of real partnerships" between users and providers. In addition, this process of user involvement was understood to itself be therapeutic and "cathartic." Unlike consumers of ordinary products, users of mental health services, MIND noted, could not "vote with their feet," and a re-balancing of power dynamics between user and provider was the primary means of effective care.[55]

In the mid-1980s, a campaign document by Northern MIND by Keith Richardson elaborated on these individuated sets of rights, and explicitly linked such aspirations with Northern MIND's criticism of "the failure of statutory services to produce plans for the development of...community based care." The underlying principles of patients' rights, Richardson wrote, should be to "Value the user as a full citizen with rights and responsibilities, having the power to influence relevant services …. Promote the greatest self determination [sic] of the individual … [and provide] care based on the unique needs of the individual." Care should aim to "minimise dependence on professions." In this document, Richardson assimilated the aims of community care—such as providing care "through locally accessible, fully coordinated multi-disciplinary" services and to "actively...re-integrate people in institutions, if they so wish"—with the individualized principles of the user movement. Elsewhere, he advocated for staffing at the local level: Referral Workers, Activity Workers, Residential Support Workers, and Community Support Workers. These final workers would live "near to the people who need support to live

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[53] David Townsend, "The Service Provider's Perspective," at User Involvement Conference, 1988. SAMIN/B/125. I was unable to locate any additional

[54] Irene Whitehill, "Newcastle Advocacies Project," at User Involvement Conference, 1988. SAMIN/B/125

[55] Maureen Hutchison, Georgina Linton, and Jo Lucas, MIND South East, "User Involvement Information Pack," nd, SAMIN/B/125.

independently" and in effect would be "'good neighbours' to two or three users," having received training on supporting the chronically mentally ill. This, he argued, could prevent people from having to return to the hospital, or becoming further dependent on professional mental health services.[56]

Conclusion

Social workers in London in the first decades of the welfare state were concerned with the mental ill health of their charges and identified loneliness as a culprit. In doing so, they devised experimental techniques to engineer community and fellowship amongst rehoused people and those vulnerable to suicide. They were influenced by community development and other techniques that psychologized the problems of urban society. Their work in the 1950s and 1960s produced a left-liberal critique of the welfare state, targeting planning and the impersonality of bureaucracy. This chapter followed such critiques as they operated nationally regarding the role of statutory institutions in mental healthcare. Developments in psychology about the social roots of mental illness, medical innovations in psychiatric medicine, and political imperatives to reduce the costs of healthcare combined to reconceive the treatment of the mentally ill as happening within the community rather than in large institutions. Community care took a variety of forms and remained more experimental than systematic though it did become more widespread and officially supported.

Community care policy and practice for the mentally ill reflected a belief that an individual's social environment was both the cause and cure of illness. By reading through the archives of MIND, which monitored and participated in community care practice, three trends emerge. First, particularly in the early part of the archive, community care proponents emphasized the recreation of domestic relationships within group homes and hostels. In this way, the patient or ex-patient could re-enact troubled family dynamics, though the "family" was depersonalized and an abstracted tangle of relational practices organized for the therapeutic benefit of the patient. Second, community care was increasingly framed as a means of the mentally ill achieving "independence" from experts and as individuals within society. Finally, as the failures of community care policy to assist the mentally ill and their communities became apparent, the individualistic frame extended into the user movement and patients' rights in the 1980s. These movements were a response to the failures of welfare state reforms, but also incorporated the individuated turn in mental healthcare and therapeutic practice.

[56] Keith Richardson, " Hitting the Nail on the Head: A Northern MIND Campaign Document," SAMIN/B/23a.

CHAPTER 4: LEARNING TO SHARE: ALCOHOLICS ANONYMOUS UK

Our capacity to share intimate details of our lives with strangers is a mundane expectation of everyday life, but this tethering of expressive social relationships with self-worth and actualization is not linked to technological innovation. This chapter expands on the problem of loneliness in postwar Britain, and the various therapeutic mechanisms and social formations that emerged around the idea of facilitating authentic relationships between strangers and a relationship-oriented subject. The support group, exemplified by Alcoholics Anonymous, was one such formation. As both a therapeutic practice and a social formation, Alcoholics Anonymous UK mirrored the affect-bound solidarity of contemporary new social movements. While not a political organization, it shared with them a dual emphasis on internal solidarity and a shared external goal. In their case, this goal was the growth and maintenance of an international organization with the resources and manpower to reach out to suffering alcoholics. Historians of Britain have long wrung their hands about the transcendent individualism that underwrote political upheavals of the late twentieth century, but I argue they were also dependent on a reimagining of society as decentralized networks feeling and reciprocal bonds, individuals forged by small familiar groups, and the noted absence of professionalized experts.

This discussion of AA UK's contributor-driven literature (as opposed to official one-author publications, like the Big Book) in the 1970s is concerned with the conduct of meetings and the association between psychological loneliness and alcoholism. As an indicator of the "culture of sharing," it is important that AA (in all its geographical varieties) did not facilitate free-for-all discussion. Emotional vulnerability and openness were integral to its success and a key component of attaining and maintaining sobriety for individual members. But even within the broad commandment of "sharing," the utterances in and of AA were filtered through a litany of implied and not-so-subtle expectations for what would be beneficial to themselves and the group. For the most part, these rules hinged on the connection between the individual's personal experience and the group's function to reinforce individuals' narratives from chronic drunkenness to sobriety. *SHARE* and the preceding newsletter transmitted these ground rules via a series of tropes related to the "alcoholic personality" as it related to the alcoholic's inner life and his or her social tendencies. These tropes were presented both as lifelong ailments that individual alcoholics were said to grapple with on their quest to sobriety, but also a challenge to be overcome in the context of small-group meetings of Alcoholics Anonymous. How a person did or did not behave in the group indicated his or her relative freedom from the pitfalls of the alcoholic personality. My discussion of *SHARE* will examine some of these tropes and oft-repeated narratives, and centers upon the process of an individual finding his or her "true" or "real" self via prescribed group interactions.

For better or worse, vital to understanding AA is the organization's explicit attempts to depoliticize personal narratives of addiction, and this imperviousness to external events is reflected in *SHARE*'s repetitive content. Even organizational changes (growth in membership, increasing internationalization) were only journalistically reflected upon in *SHARE*. That said, the non-alcoholic interest in AA UK and the fellowship's expansion into hospitals, prisons, and broadcast television may help the historian along. Following my discussion of *SHARE*, therefore I will attempt to historicize Alcoholics Anonymous UK practices by reflecting on the work of non-AA UK actors and institutions that collaborated with the fellowship, and expanding on their thought related to group therapy and the culture of sharing as a means of self-actualization and empowerment.

A Brief History of Alcoholics Anonymous UK

Alcoholics Anonymous was founded in the United States in 1935 by Bill Wilson ad Robert ("Dr. Bob") Smith. However, the organization's roots were Anglo-American. Bill Wilson, was a former member of the Oxford Group, an English Christian fellowship. The Oxford Group was founded by an American minister but originated in Keswick in England. In the 1920s and 1930s, the members of the Oxford Group engaged in public confession and group confession of personal sin, amounting to a form of spiritual talk therapy. This "sharing" with group members was meant to transform one's spiritual life and social interactions. One historian has referred to the social conduct norms of the Oxford Group as "an innovative agent of self-expression" in British culture.[1] Wilson, an American alcoholic, began attending Oxford Group meetings in Akron, Ohio after being released from the hospital for alcoholism, where he claimed to have had the spiritual conversion he would later consider the bedrock of sobriety. Later, in *Alcoholics Anonymous Comes of Age*, Wilson would discuss in the therapeutic method Alcoholics Anonymous used, which emphasized intertwined processes of self-examination and sharing, was a direct effect of his time with the Oxford Group.[2]

Beyond the anonymised meeting structure, Alcoholics Anonymous members drew upon a set of 12 "traditions" and 12 "steps," which remain unchanged from Wilson's original conception of them. Influenced by the spiritual progression espoused by the Oxford Group, William James, and others, the AA programmed involved constant moral inventory, and an admittance to being powerless to alcohol, and subject to the will of God. This (agnostic) religiosity appeared throughout the steps and the traditions, for example Tradition Two, which stated that "For our group purpose there is but one ultimate authority—a loving God as He may express Himself in our group conscience." The other traditions largely concerned the relationship between the individual and the group. Tradition One declared, "Our common welfare should come first; personal recovery depends on AA unity." Groups were open and autonomous. In Britain, a national General Service Board and regional Intergroups conducted any affairs that pertained the organization as a whole. According to the traditions, AA "ought never endorse, finance, or lend the AA name to any related facility or outside enterprise," greatly limiting what the organization would do nationally. [3]

Alcoholics Anonymous UK was the first branch outside of the United States, and held its first small meeting in 1947 in the Dorchester Hotel in London, after five geographically disparate Britons had written to the fellowship in America seeking a meeting in England. An American woman who was visiting with her husband, under directives from the foundation, convened these five in a meeting.[4] Initially, AA UK struggled to make its presence known. The small cohort stagnated as only one newspaper agreed to print their advertisement.[5] Their luck changed when the husband of a potential member arranged a dinner party with someone who the newsletter described as "a well-known psychiatrist," most likely referring to Lincoln Williams. He

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[1] David W. Bebbington, *Evangelicalism in Modern Britain: A History From the 1730s to the 1980s* (New York: Routeledge, 2003), pp. 232-246 (quote p. 234). Also discussed in Nathan Hurvitz, ""The origins of the peer self-help psychotherapy group movement." *The Journal of Applied Behavioral Science* 12, no. 3 (1976), pp. 283-294

[2] Bill Wilson, *Alcoholics Anonymous Comes of Age: A Brief History of AA* (New York: Alcoholics Anonymous World Services, 1957), p. 39.

[3] Alcoholics Anonymous, *Alcoholics Anonymous*, <http://www.aa.org/pages/en_US/alcoholics-anonymous>, p. 562.

[4] News Letter, September 1950 "How It Started in England", p. 3

[5] September 1950, p. 3.

introduced them to his ex-patients.[6] By their second year, the American woman who had helped set them up returned to an open meeting of 150 in London.[7] The first Scottish group came a year after in 1848 in Perth. The first provincial English meeting was in Manchester (the newsletter began advertising meetings in both Manchester and Liverpool in May 1949)[8]. In 1954 there were about 45 groups in England, and that year saw the first AA meeting in Wales. In 1960 there were 100 groups, and 200 in 1965, when AA UK held its first annual convention in Bruton, Somerset. In 1972, the number of groups was at 480 in England, Scotland, and Northern Ireland. In addition, there were 74 groups in hospitals and 62 in prisons. 1972 alone invited 50 new groups.[9]

Large-scale studies conducted by professionals outside of AA UK provided additional insight into how the organization operated and how people generally interacted with it. In 1976, Stuart Henry and David Robinson of the Institute of Psychiatry's Addiction Research Unit—in cooperation with AA's General Service Office in London—ran a survey of Alcoholics Anonymous groups in England and Wales. They received 170 completed and returned surveys (85.4% of those sent out). The results showed that members went to an average of 2.1 meetings per week, with 70% of members (both long- and short-term) had attended two different meeting groups in the last month, and 30% to four or more groups. They also found no meaningful difference between the level of involvement between men and women members.

Further, Henry and Robinson were also interested in the bonds created between members outside formal meetings, and how informal friendships emerged from formal meetings. Three quarters of members, they found, made new friends in AA, including 61.1% of new members with less than one year in the organization. Only 17.1% had never had another fellowship member as a guest in their home; about half of new and long-term members regularly had other members around at their houses outside of AA. Their survey described AA as being held together by a mesh of informal interpersonal bonds as much as by the shared goal, official literature, or the set program of sobriety. They wrote:

> The network of informal friendships, which ensures that the A.A. programme continues beyond the meeting, fosters a feeling that help is always available—it also enables people to offer help unsolicited instead of waiting to be asked for help. It would be peculiar…for general practitioners to telephone 'out of the blue' to ask their patients how they are. But in A.A. that is exactly what happens.

Survey respondents described these check-ins as diametrically opposed to the formal healthcare system's means of dealing with addiction. AA removed the pressure of having to ask for help, and the "network of informal A.A. contacts makes it unremarkable both to have problems and to be concerned about them." In contrast, conventional medicine's treatment included barriers of formality, like appointments, bureaucracy, and open hours. "Help," they wrote, "is given with pleasure when requested in offered spontaneously when not.,,it makes both needing help and helping ordinary everyday things."[10] As a decentralized organization centered ostensibly around a set of shared goals, "traditions", the twelve steps, and body of literature, the success of AA depended on the mobilization of members' feelings and obligations toward each other.

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[6] October 1950, p. 4 "How It Started In England: None to Command – Only to Serve"
[7] Newsletter, December 1950, "How it Started In England: Milestones" p 1.
[8] Monthly Newsletter, Alcoholics Anonymous [UK], No. 5, p. 1, Alcoholics Anonymous UK Archives, York UK.
[9] "Growth," Share, Vol. 1 No. 1, October 1972, p. 3. Alcholics Anonymous UK Archives (uncatalogued).
[10] Stuart Henry and David Robinson, "Understanding Alcoholics Anonymous: Results from a Survey in England and Wales," *The Lancet*, February 18, 1978, pp. 372-75.

Loneliness and the Alcoholic Personality

Throughout AA UK's literature, including *SHARE,* loneliness and isolation were a key component of what was referred to as the "alcoholic personality." This was a constellation of personality traits that led people to drink, though the alcoholic personality existed outside of a person's drinking habits. It was characterized by a large but fragile ego and a sense of distance or aloofness that separated the alcoholic from other people in his or her life. This personality type was discussed both in AA UK literature and by outside researchers. The informal histories of AA UK refer to the interest taken in the group by a psychiatrist, who also introduced his own alcoholic patients to the first conveners. Likely, the psychiatrist they referred to was Dr. Lincoln Williams, whose interest in Alcoholics Anonymous was related to his work as a doctor for people with addictions to alcohol as well as a proponent of group therapy. Williams's interest in Alcoholics Anonymous was related to his work as a doctor for people with addictions to alcohol as well as a proponent of group therapy. He contacted them at their inception in 1949, and regularly spoke at meetings until his death in 1969. One obituary credited his "dedicated activism" in getting the medical profession—as much as it did—to "take alcoholism seriously" and view it in a "sympathetic rather than judgmental light." Williams was inspired to work with alcoholics after a visit to America, and turned his private nursing home for the mentally ill—The Hall at Harrow Weald—into a home for alcoholics.[11] He was also the Senior Hospital Medical Officer for the West End Hospital for Nervous Diseases.[12] According to AA UK's literature, Williams was integral in legitimizing their method to the British medical establishment and by integrating what they did with mainstream group therapy. The first mention of Williams in the AA UK newsletter was for a lecture he gave at a meeting of the Harrow branch of the British Medical Association in 1949. The lecture ended with a discussion of group therapy, and he stated that "to its god fortune medicine had discovered a new partner in AA." In addition, three AA UK members were asked to speak on their experiences. Williams's work helps us place AA UK within the context of British medical history and the psychiatric establishment. One of the contentions of this project is the widespread dissemination of group therapy, cybernetic, and group models in society at large, and Williams demonstrates further headway of this way of thinking into the British medical establishment.

Early on in his work with AA UK, Williams gave a paper at the International Congress of Psychiatry in Paris in 1950 about new paths being driven in the treatment of alcoholism. Here, he examined recent developments in both psychological and physiological treatments, with an emphasis on Frederick Lemere and Walter Voegtlin's aversion therapy in at Shadel Sanitarium in Seattle and Alcoholics Anonymous. While seemingly opposed treatments—one physiological and one psychological—Williams's account placed both on the same side against individuated psychotherapy, which he described as "frankly punitive." His preliminary reasoning for the failure of psychotherapy and the success of both aversion therapy and AA was twofold. Both successfully disrupted the patient's "personality," or the patterns that facilitated drinking, and made treatment communal, and incorporated a communal element into treatment. Williams had observed himself that Lemere and Voegtlin's method, "after three or four days of vomiting and nausea," resulted not only in "a breakdown of the alcoholic pattern" but "there may be a

[11] "Obituary: Edward Lincoln Williams," *The Lancet* (December 27, 1969), p. 1430; Lincoln Williams, "An Experiment in Group Therapy", *The British Journal of Alcoholism*, Vol 54, No. 2 (July 1958) p. 109.
[12] Lincoln Williams, "Some Observations on the Recent Advances in the Treatment of Alcoholism," *The British Journal of Addiction*, 1950, p. 62; first read at the International Congress of Psychiatry in Paris in 1950.

profound disruption of other aspects of the patient's personality and a total change in the outlook achieved." Patients described themselves as feeling entirely different (vague as that may be), and were only then more amenable to traditional psychotherapy. To support this, he drew on BH Gottesfeld and HL Yager's "Psychotherapy of the Problem Drinker" (based on their work at the Blue Hills Clinic in Connecticut), which stated that psychotherapy needed medical therapy to gain a "hold" on the patient, and that "the physical approach is insufficiently utilized in the psychotherapeutic relationship." Similarly, he argued, "The Alcoholics Anonymous' programme demands a personality change." While less visceral than aversion therapy, the program's emphasis on personal powerlessness to addiction and the life circumstances facilitating it provided the same "ego-deflation" as aversion therapy. Similarly, he argued, "The Alcoholics Anonymous programme demands a personality change." While less visceral than aversion therapy, the program's emphasis on personal powerlessness to addiction provided the same "ego-deflation" as aversion therapy. [13]

Similarly, Williams noted that Lemere and Voegtlin conceded that the environment and accessories to aversion therapy likely had a significant impact. They had written, as quoted by Williams:

> The sympathetic attitude of the staff, the effect of patients on each other, our discussions with the patients of their problems and the efforts of a practical nature to rehabilitate the patient in his job, with his family and in his recreations, are all important adjuvants to the conditioning therapy.

Thus, Williams presented the axes of successful treatment, evident in both successful physical and psychological treatments: a psychological shock to the personality and a communicative practice. He ended by asking psychiatrists to reconsider both the purely psychological and individualist focus of their practices when it came to treating alcoholism.[14]

Williams continued to work with AA UK until his death in 1969, publishing volumes such as *The Sober Truth* in 1951 and *Tomorrow Will Be Sober* in 1960, along with numerous articles aimed at an audience of medical professionals. Much of his work in these twenty years integrated the program of AA with conventional psychotherapy, particularly group therapy. Independent of AA UK, Williams experimented with his own therapy groups for alcoholics. Again, in doing this he emphasized the role of communication and familiarity in disrupting the alcoholic personality and maintaining sobriety, as well as the role of loneliness in exacerbating alcoholism. In one article he described a 1954 experiment he orchestrated with a group of hospitalized problem drinkers—some who had been through hospital treatment for alcoholism. The treatment was a monthly informal Group Dinner and reception run like a combination of a social club and "psychiatricly directed" group therapy; dinner followed by an informal round-table discussion led by Williams. Unlike Alcoholics Anonymous dogma eschewing professional psychotherapy, Williams wrote that in such a situation, "The role of the therapist is extremely important." However, positioning himself against the work of contemporaries in alcoholic psychotherapy he wrote:

> …the therapist must clearly be able to accept the patient as he is. 'The alcoholic cries out for acceptance.' The scold, the crank, the moralizer, the contemptuous will utterly fail in his approach to the

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[13] Lincoln Williams, "Some Observations on the Recent Advances in the Treatment of Alcoholism," *The British Journal of Addiction*, 1950, pp. 62-66; first read at the International Congress of Psychiatry in Paris in 1950.

[14] Lincoln Williams, "Some Observations on the Recent Advances in the Treatment of Alcoholism."

> alcoholic. The therapist must completely win the confidence of the patient. In my view the relationship between doctor and patient is of major importance, and the nature of therapy itself is perhaps of much less significance than we think, bearing in mind that after detoxication and disruption of the drinking pattern the patient is certainly more amenable and better equipped to respond to psychotherapy.[15]

Williams vouched for the validity of his profession, going on to say that he discerned a positive transference to him from his patients.[16] This "emotional link" between patient and doctor was more important in recovery than any psychotherapeutic techniques the doctor may apply to treatment.[17]

Williams also claimed elsewhere that the low self-esteem that characterized both dry and drunk alcoholics was linked to their ability to bond with others. In *Tomorrow Will Be Sober*, he wrote that "The fundamental need of every human being is to be recognized and accepted as a human being by other human beings." Esteem for one's self could be reached in "the freedom and reciprocity of interpersonal discourse." He continued: "Properly used, the term 'self-respect' means what have when we are able to enjoy this kind of communication with others."[18] While maintaining the role of psychiatric expertise, Williams still conceded to AA's beliefs that emotional linkages and interpersonality, rather than medical expertise, were the driver of maintained sobriety in a therapeutic setting.

Overcoming Loneliness in AA

The first issue of *SHARE* was printed in October 1972, replacing AA UK's newsletter with reader-contributed content. The old newsletter had started in January 1949. In these early years, it chronicled the emergence of new groups and detailed the course of open meetings. The earliest issues also ended with advice from the editors to the general membership about how to conduct meetings, be a sponsor, and how to retain new members. In October 1950, the editors asked for contributions from readers for upcoming newsletters as a way of offering service to the fellowship.[19] They began printing these membership contributions regularly in November, 1951, when Tom from Birkenhead provided "A Personal Experience of one who has Found Freedom."[20] From 1952 onward, the newsletter was made primarily of contributions from the membership, with an editorial at the beginning and ending with news from individual groups and a financial statement. As late as 1953, they used the newsletter to report on the happenings of individual members—for example the ongoing health troubles of a "Bill D."—a practice that faded as the organization grew and the literature became more impersonal.

For all its limits, *SHARE* and the newsletter that predated it may be as close as historians can get to recordings of closed Alcoholics Anonymous meetings. In 1953, the editors of the newsletter asked that personal contributions include the writer's initials, rather than "Anon", so that readers could write in with their responses. In another note, they lamented that not all

[15] Williams, "An Experiment in Group Therapy."
[16] This transference element separated his own practice from AA, he noted, and he suggested that his own patients would be unwilling or unable to experience such feelings toward a lay person or a group. Still, he argued that "the psychiatric group approach and the AA approach must remain apart and yet achieve similar results."
[17] Williams, "Experiment in Group Therapy."
[18] Williams, *Tomorrow Will Be Sober* (Harper, 1960), p. 149.
[19] News Letter October 1950
[20] Tom – Birkenhead, "A Personal Experience of one who has Found Freedom," News Letter November 1951, p. 4.

contributions could be used “because an item…is not reflective on the author.” They asked that contributors confine their reflections to statements that would be appropriate for a meeting, writing that “authors could in this way give AA the benefit of their thoughts on what is the main preoccupation of us all—sobriety.”[21] Later, *SHARE* would tout itself as a virtual meeting conducted by correspondence.[22] While AA UK’s literature frequently proclaimed the narrow focus of sobriety, the goal was not to be achieved through any means or just any kind of talk. Instead, their newsletters and *SHARE* reveal a standardized and relatively narrow parameter of discussion topics.

For the historian, AA’s literature is maddening in the continuity and sameness of its language, as well as in its apparent resilience against external historical and political events. To write a history of AA UK based entirely on its newsletter and correspondence meetings would result in a story of impossible continuity. Current events and time-specific cultural idioms—counter-culture and hippies in the beginning of the 1970s, some very scant references to unemployment at the end of the 1970s—occasionally trickle onto the pages. For the most part, though, anything encroaching on political discussion—even that directly related to alcohol or temperance—was verboten. This is clearly laid out in the organization’s Tradition Ten: “Alcoholics Anonymous has no opinion on outside issues; hence the AA name ought never be drawn into public controversy.” The first issue of *SHARE* even devoted an entire article to Tradition Ten.[23] One *SHARE* contributor credited AA UK’s success as a democratic organization to this very “total absence of class consciousness and ‘establishment’ ruling bodies.” He continued:

> Love and compassion were the only pressures applied. This, then, represented to me true democracy at last. After all, where else had I ever found people of all races, creeds and backgrounds, banding together for a common purpose as we do in AA?...If ever the though should enter my mind that social barriers *did* exist in AA, I would need to hurry back to Step Four and take a look inside myself. Because that would be a mental slip, something no AA can afford.[24]

Aptly titled “Democracy With Love,” this essay illustrated AA UK’s enforced insulation from social issues potently mixed with interpersonal empathy.

Unlike the old newsletter, *SHARE* was devoid of administrative or organizational news. Most issues had a theme, such as “Leadership” (September 1973), “Gratitude” (July 1974), or “Power (June 1979), and began with an editorial. Other issues—usually two each year—were compiled with contributions from members of regional intergroups, made of groups from a given region, including prison and hospital groups.[25] However, besides a brief “Facts and Figures”

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[21] Newsletter, March 1953, p. 16.

[22] It explicitly had this purpose for people in rural areas or Britons working abroad in a location with no AA meetings. For example, Joanna, in “The Island Loner,” received letters from other “loners” and was in continuous touch with nine other members (*SHARE*, Vol. II No. 24, September 1974, p. 3.). Beginning in 1973, *SHARE* began printing a recurring “World Hello” segment about an international correspondence group (Vol. I, No. 4, January 1973, p. 9.).

[23] A hypothetical meeting was described in which a member uses his time to circulate a petition for a Minister in charge of Social Services, demanding that provisions for alcoholics be included in a “bit of legislation.” *SHARE*, Vol. 1 No. 1, October 1972, p. 16.

[24] Mick M., Ashford, “Democracy With Love,” *SHARE*, Vol. III, No. 35 (August 1975), p. 10.

[25] For example, the Merseyside Intergroup and North Wales issue, Vol. 1, No. 5, (February 1973), included in their “Facts and Figures” two prison groups in the area: Appleton Thorn and Walton Prison, p. 5.

entry at the beginning, chronicling the history of that regional collection of meetings, there was little distinction in terms of content between these various intergroup-produced special editions of *SHARE*. Like AA UK's apparent impermeability to historical events, this sameness across geographical difference is curious.

Despite its relentless continuity, *SHARE* provides insight into, first, the process of decentralized myth-making that AA's success depended upon. Members, through their independent experience with meetings and sobriety, coalesced around similar themes and narratives of interpersonal dysfunction. In its role of reinforcing the imagined community of AA-branded sober alcoholics, *SHARE* secondly illustrated the way support groups like AA sought to organize the relationship between individual, small group, and society at large by prescribing how a member can interact with the group to optimize his or her own recovery, and how the group can best disrupt the individual member's personality. This entire process is facilitated by each member's capacity to share openly with strangers, create lasting relationships with them, and the development of a "group conscience."

For members of AA UK who contributed to *SHARE*, alcoholism was propped up by loneliness, a key component of "alcoholic personality." *SHARE* contains many references to loneliness and isolation as a pre-requisite for drinking, not only as an effect of it. In 1972, Sean of Malta wrote in saying that "In our drinking days we alcoholics were unable to establish normal human relationships with other human beings. We were lonely, shy, introverted people, although we often sought to mask this by an excessive display of braggadocio." The failure to overcome emotional problems without the help of other people only increased drinking, and "increased out loneliness." In AA, he continued, quoting Williams, "We found, for the first time in years, a body of people who seemed to understand us. We were 'recognised and accepted as human beings by other human beings.'" Maturity and self-esteem following communication with other alcoholics.[26]

If *SHARE* was any indication, loneliness was a critical part of their own experience with alcoholism. However, loneliness was understood by members of AA UK not as social problem, but a psychological one. Members who wrote into *SHARE* frequently opined on the nature of loneliness in both sobriety and drunkenness, and the role AA UK played in overcoming loneliness. Mick P., a member who had moved to Auckland, New Zealand, wrote in to say that when he was drinking, "I felt a deep emptiness as if I was in a well of loneliness." When he started going to meetings, he thought "What a relief to feel a kinship."[27] However, AA UK was not meant to be a cure to loneliness, but rather a deliberate process by which the alcoholic was transformed into a person who did not experience loneliness in his or her own life. The group was not a replacement for the relationships one needed to cultivate outside of it, nor was it on its own a cure for isolation. It only gave members the means by which to combat interpersonal dysfunction in their own lives. One 1973 contributor distinguished between the loneliness of alcoholism and the pleasantness of solitude in sobriety, dichotomizing being "isolated" and being "alone." Social isolation was a fixture of pre-sober life. The writer, "MS", stated that "many alcoholics think of *alone* as being isolated, cut off from the world." This was a "fearful, depressing state to be in." The alcoholic was not alone, though, which MS characterized as being "all one" with "his spirit intact." Alone, the recovering alcoholic was "at peace with himself, at peace with the world." Isolation was a fearful state in which the individual was "set apart, torn to pieces." Many alcoholics, MS argued, were driven to AA by their fear of "total isolation," rather

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[26] Sean of Malta, "Why?" *SHARE* Vol. 1 No. 2 (November 1972), p. 8.
[27] Mick P., "Three A's in AA," *SHARE*, Vol. 2 No. 13 (October 1973), p. 10.

than fear that they were "dying as a result of drink." The alcoholic was "acutely sensitive to his feelings of loneliness, which he thinks his joining the AA fellowship will dispel." Continuing:

> Many an alcoholic looks for and finds in the AA fellowship freedom from both the compulsion to drink and from the fear of isolation. His belonging to AA, being part of an AA group makes him feel secure. Loneliness may creep in on him before and after a meeting, but during the meeting, he is unaware he is alone. His initial sensitivity gives way to a desire to identify with the feelings, thoughts and experiences of others. If he can satisfy this desire, he is content with the notion that sobriety depends on accepting and conforming to the format of the group.

The therapeutic effect of AA came from the listening and sharing experience of the group. The group was an absolute necessity for reaching long-term sobriety. At the same time, this sense of belonging and companionship was portable, and strictly for the individual's benefit. MS argued that the final step of maturity for the recovered alcoholic was his ability to carry the sense of belonging and community felt with the group into times when he was alone. The group was necessary for breaking down the anti-social tendencies of the alcoholic personality—"Resenting, rejecting, resisting"—but only insofar as its benefits were portable. Underlying these traits, MS argued, "is the fear of being alone, miscontrued as meaning isolated." Fear of being alone represented a different type of dependency, one which group work could break, allowing the individual to be alone without being isolated. The group was a necessary step to individual empowerment and authenticity.[28]

Continuing on this theme, in 1976 *SHARE* devoted an entire issue to loneliness and "learning to be alone." One essay, written by a woman under the initials "PS," painted a picture of alcoholic loneliness:

> An unkempt woman in a dressing gown stands in the middle of a neglected dirty room, swaying, clutching a glass half-full of alcohol—and *alone*, in the very depths of loneliness...locked up with herself...still alone and each time a little *more* alone and the thoughts are even more intolerable. So she starts [drinking] again.

After joining AA UK, "Gradually the loneliness was removed and slowly I began to communicate with people, to be grateful for them and their warmth and to help to share with them. The sickself-concern of introspection started to diminish." Again, while joining AA and communication assuaged loneliness, the end result was an individual who experienced psychic wholeness. PS continued: "Nowadays, not only can I stand my own company, I actually enjoy it. I have valuable and dear friends both in the Fellowship and outside it but I have developed quite a taste for solitude—which is just as well when one lives alone!" PS described her sober self as an "integrated human being," harmoniously integrated into the social world while maintaining emotional independence from others.[29] This was repeated in a later issue in a testimony written by a widow who, as a teacher from a big tightly-knit family who was "always communicating" started drinking after her husband died. The woman, "EC," wrote that after attending meetings "I can bear today's solitude as I have now learnt the difference between loneliness and being alone. I have learned not only to endure solitude, but to conquer and even harness some of it."[30] A

[28] MS, "To Be Free Is to Be Alone," *SHARE*, Vol. 1 No. 4 (January 1973), p. 11.
[29] PS, "Woman in a Dressing Gown," *SHARE*, Vol. 4 No. 48 (September 1976), p. 14.
[30] EC, "Missing Voices: How a Widow Came to Terms With Solitude," *SHARE*, Vol. V No. 60 (September 1977), pp. 4-5.

theme in *SHARE* was a fear of being alone which exacerbated drinking.. One anonymous writer in 1978 reminisced: "Time was when I could not bear to be alone, in the ordinary sense of there being no one else in the room." Loneliness was also linked to arrogance, and a protective mentality that one was above or different from other people.[31] AA literature drew a strong distinction between problematic loneliness and the productive way to be alone. This suggested that tasks like sharing and communication were meant to transform the individual, rather than the group.

Critically, loneliness was defined as a personality trait independent of one's daily interaction with or possession of family or friends. In fact, the alcoholic herself may have been the only one to notice or feel such emotional withdrawal from others, rather than exhibiting any observable social behavior that would suggest loneliness. Meetings disrupted these patterns of thought and way of being in the world. One writer claimed that alcoholics "never learned how to communicate" and were "emotionally hard of hearing."[32] Thus, *SHARE* contributors frequently touched upon overcoming loneliness or isolation in meetings. This involved the difficult process of learning how to share one's own innermost feelings, and listening to others' in return. The October 1973 volume was devoted to "Listening and Silence." In it, Abbie, a member from London, described the process as intimidating at first. "In the beginning," she wrote, when we first come into AA, there is a lot of talking. We're told to do this, go there, talk to someone else, take this telephone number…talk, talk, talk." After six months, she found herself more comfortable in the group, and could listen to others without feeling her own shame." In others she recognized her own "inward screams of terror" and anxiety, "formerly drowned out with alcohol." AA exposed her to "talk of people's innermost feelings and events in their lives that in normal conversation would be intolerable."[33] *SHARE*'s editors once wrote that, "Communicating is a two-way exchange and the new member gains his first positive relief when he can let go and allow that stream of confidences, confessions, idiot fears come gushing out." In turn, members must receive such confessions with "patience and understanding, and, yes, more often than not, identification."[34] Many writers described AA's steep learning curve, and the often-painful process of learning how to be honest and straightforward about their autobiography.

Sobriety, however, would not come to members who spoke however they liked at meetings, and part of the AA program (and one of *SHARE*'s aims) was to teach members how to communicate correctly. Numerous contributors described their continuing tendency early in their time in AA to engage in what they described as typical alcoholic behaviors when it came to how they communicated with others. The first of these was straying from one's own experience or trying to overpower each other with their knowledge of alcoholism. One writer wrote in 1974:

> Speak within your own experience…It is sometimes tempting to embroider our talks with fanciful details which we think will make our stories entertaining, or demonstrate that we really are one hundred per-cent alcoholics…If we do not speak sincerely and openly to one another, we will never learn more about recovery. We come to meetings to hear the language of the heart, and it would be ideal to suppose that there can be rules for teaching this

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[31] "I Want to Be Alone (But Not Feel Lonely)," *SHARE*, Vol. 6 No. 71 (August 1978), pp. 10-11.
[32] Peggy A., Beckenham, "GabbleGabbleGabble," *SHARE,* Vol. 2, No. 13 (October 1973)
[33] Abbie, London, "Learn to Listen, Listen to Learn," *SHARE*, Vol. 2, No. 13, (October 1973), pp. 2-3.
[34] Editorial, "Communicating," *SHARE*, Vol. II, No. 24 (September 1974," p. 1.

> language…Perhaps we can speak it more clearly if we remember, when asked to share our experiences, to keep it simple, short and sincere.[35]

Alcoholics Anonymous was a nominally non-hierarchical organization, but effective group leadership and sponsorship also helped maintain this balance between emotional free-for-all and constraint.

Two-way communication was integral to a common theme in *SHARE*: giving in. Echoing Williams's notion of disrupting the alcoholic personality, contributors to *SHARE* frequently described a waning of stubbornness or a dramatic deflation of their ego. In one issue elaborating on the concept of anonymity, reprinting an article from *SHARE*'s American counterpart, written by a Dr. Harry H. Tiebout in 1965. Anonymity was not only the preservation of one's private identity, but "the preservation of a reduced ego." Part of the alcoholic personality, he argued was the "state of feeling 'special'" which resulted in disappointment, cynicism, and destructive self-loathing. In a group,

> We cling to our somethingness with all the strength at our command. But the fact is that the person who does not learn to be as nothing cannot feel that he is but a plain, ordinary, everyday kind of person who merges with the human race—and as such is humble, lost in the crowd and essentially anonymous…A feeling of 'I am nothing special' is a basic insurance of humility.[36]

Self-acceptance, therefore, and the ensuing long-term sobriety, only appeared when the alcoholic stopped understanding himself or herself as an individual, and succumbed to their position in the group. For some, like "P.S.," a woman who remembered only loneliness from her drinking years ("An unkempt woman in a dressing gown stands in the middle of a neglected and dirty room, swaying…in the very depths of loneliness"), AA made them *less* introspective. When she started attending meetings, the loneliness "was removed" as slowly she "began to communicate with people" and felt "the sickself-concern [sic] of introspection start to diminish."[37]

Sharing with an AA group was only in part for the confessional unburdening of shame or revelation. In addition, many *SHARE* contributors described a similar process of reformulating their individuality by becoming part of a group. One letter by a frequent contributor—"V.H. from Caxton"—vividly described their own experience, linking egoism with alcoholism and the disintegration of that ego with sobriety. "Communicating with people," they wrote, "was never an external problem for me…I could always talk and listen. But I had a severe *internal* problem in that I did not relate to people—I was different." Writers to *SHARE* frequently described their alcoholic and pre-alcoholic selves as set apart from, more intelligent, and more knowing than others. V.H.'s transformation came about when they learned to "no longer think other peoples' thoughts for them, but [to] feel other people's feelings *with* them."[38] One of the most important lessons of group communication was to degrade one's oppositional stance with others. This resistance to being a "joiner" was an oft-evoked trait of the alcoholic. One editorial noted that it could be "fun" to be a member of a group, especially since "membership of anything one had to

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[35] Anon, "Think Before You Speak," *SHARE*, Vol. II, No. 16 (January 1974), pp. 6-7.

[36] Harry H. Tiebout, "When the Big 'I' Becomes Nobody," *SHARE*, Vol. III, No. 33 (June 1975), pp. 4-5. Originally printed in *Grapevine*, September 1965.

[37] P.S., "Woman in a Dressing Gown," *SHARE*, Vol. IV No. 48 (September 1976), p. 14.

[38] V.H., Caxton, "Gut-Level Relating," *SHARE*, Vol. II, No. 24 (September 1974), pp. 8-9.

‘join’—scouts, tennis club, church—had once been such an anathema to us.” For the first time, members felt they were “a member of the human race.”[39]

Frequently, fellowship members recalled the self-importance they possessed in early sobriety. John, from the North Thames Intergroup, recounted his own ego and pride. Early in his attendance at meetings, he recalled, “I felt I was God’s gift to AA. How pleased an ‘organisation’ like this must be to have acquired the expertise, the organizing abilities, etc. of someone of my caliber…How pleased I am today to know that I have been cut down to size.”[40] Another anonymous writer remembered seeing themselves as “a hero, a martyr, a saint,” prior to AA.[41] Another, who described the process of learning how to communicate in his life through AA, said she had come to realize that she was “no longer supposed to be running the universe.”[42] *SHARE* demonstrated how talk around the subject of alcohol was only a superficial component of sobriety, and instead members found themselves altering their entire self-image in relation to others. Paradoxically, the process of discovering (or creating) one’s authentic or real self required communing with others, focusing less on one’s own psyche, and seeing oneself as part of a group.

The group achieved its end—self-transformation of individual members—by teaching the individual how to "share." One letter to the editors of *SHARE* in 1974 lauded this practice: "How nice to be able to share! To communicate with people who care and understand and willingly accept.... Sharing cannot be done alone."[43] In 1975, Jim from Kensington wrote in that he was "No longer alone" after attending meetings, and "I began to share in the life of my Group." Critically, "sharing" was largely limited to narrative of one's own life experience and autobiography as an alcoholic. Jim continued: "The only story I can tell with certainty is the one I lived, so the only experience I can share is what actually happened to me."[44] This modest approach to therapeutic practice—sharing only one's own story—carried on throughout share. In 1977, an anonymous writer wrote in discussing how they had trouble relating to others from a young age, but associated drunkenness with constant talking, and calling up long-lost friends and relatives to "extract as much sympathy as possible." While they were good at talking, "honesty" eluded them. In AA, they learned to talk and share in a particular way, both to the group and their individual sponsor. They wrote: "Another great help to me nowadays when talking to others, has been the realisation that I am no longer supposed to be running the universe," or having an opinion or insight into other people's stories. Instead, "Through talking to people I get to know and relate to them and myself."[45] For members of AA UK, the aim was not simply free-form communication, but a very specific type of sharing that was believed to have a therapeutic effect.

AA UK in Hospitals and Prisons

Another way to analyze the support-group model's penetration into British society is through AA's proliferation into institutional settings, namely prisons and hospitals. The first mention of a prison visit in the AA UK newsletter was in September, 1951, when the fellowship

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[39] Editorial, “Recovering Incurables,” *SHARE*, Vol. IV, No. 37 (October 1975), p. 1.

[40] John, Warley Hospital Group, “The Last of North Thames Intergroup’s Admirable Set of Contributions,” *SHARE* Vol. IV No. 45 (June 1976), p. 14.

[41] Anon, “Finding the Real Me,” *SHARE*, Vol. VI No. 62, p. 7.

[42] Caroline, Caxton, “One to One,” *SHARE*, Vol. V, No. 60 (September 1977), p. 10.

[43] Diana and Jack, "Letter to the Editors," *SHARE* Vol. 2 No. 25 (October 1974), p. 17.

[44] Jim (Kensington Friday), "Takes All Sorts," *SHARE,* Vol. 4 No. 39 (December 1975), p. 17.

[45] "One to One," *SHARE,* Vol. 5 No. 60 (September 1977), pp. 10-11.

promised to take steps to "arrange for 'Unofficial Visitors' to visit men and women who wish to learn something about the movement."[46] The first prison groups were established in 1957 at Wakefield Prison in England and in Barlinnie in Glasgow.[47] In 1964, prison AAs were established at Appleton Thorn near Warrington and Walton Prison. Walton Prison's group at the time ranged between 12 and 20 members, and the sponsor for all members was a Church of England chaplain.[48] As of 1972 there 62 groups meeting in prisons, and 67 in 1975.[49] A 1972 *SHARE* chronicled prison group sponsors holding regular meetings of their own, and even a "mini prison convention" attended by "various groups from Devon and as far away as Hampshire."[50] Starting in 1973, the East Midlands Intergroup supported meetings at prisons, including Leicester Prison, and prisons at Gartree, Ashwell, Nottingham and Ranby.[51] It is notable that in these settings, the leaderless and peer-driven ethos of AA UK was mildly compromised, with professional, possibly non-alcoholic conductors holding the position of sponsor. Even so, it demonstrated AA UK's integration into these institutions as an alternative means of therapy and reform meant to supplement statutory care. One letter, written to *SHARE* in 1973 by an inmate in the Liverpool Prison Group, said that he was "amazed at the transformation that has taken place in me" due to attending meetings. He recounted "visiting members" who came from outside the prison, and while at first he resisted, he later learned to talk and tell his own life story in the same way as they did.[52] A 1979 issue even mentioned that for men in solitary confinement, a prison group "may have its own magazine in which men in isolation express how they are coming to terms with the problems, not least the booze."[53] As a form of group therapy, AA UK in prison's was a pedagogical project, which aimed to teach people to share intimate details of their lives with others.

It is hard to know by AA UK's own records how many groups were organized in hospitals, prisons, or halfway houses, but they are mentioned frequently in *SHARE*. The first issue of *SHARE* in 1972, recounting the history of AA UK, noted that "By now there were many groups...attached to hospitals and in prisons."[54] A 1973 issue focusing on the Merseyside and North Wales Intergroups, noting the "facts and figures" of the AA UK landscape in those regions, mentioned groups convened by a Dr. Cook of Northing Hospital, a Dr. Kemp at Walton Hospital, and a Dr. Madden at the Addiction Unit in Morten Hospital. [55] In 1976, a member by the name of John wrote into *SHARE* based on his experience at the Warley Hospital Group in the North Thames Intergroup region. He arrived feeling like he was "God's gift to AA," noting how "pleased an 'organisation' like this must be to have acquired the expertise, the organising abilities, etc. of someone of my caliber," only to be pleasantly "cut down to size." John was grateful to know that "the 'organisation' is in fact a fellowship without any 'power structure'; all Indians and no Chiefs, all trying to stay sober."[56] In the hospital setting, John's experience of AA

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[46] "Prison Visits", News Letter September 1951 p. 4 [pdf 52]
[47] "Outside, Inside," *SHARE,* Vol. 3 No. 29 (February 1975), p. 2.
[48] "Facts and Figures," *SHARE* Vol. 1 No. 5 (February 1973), p. 5.
[49] ND, "Growth," *SHARE*, Vol. 1 No. 1 (October 1972), p. 3; "Outside, Inside," *SHARE,* Vol. 3 No. 29 (February 1975), p. 2.
[50] "Break-in to 'The Moor,'" *SHARE* Vol 1 No. 1 (October 1972), p. 9.
[51] Anonymous, "East Midlands Intergroup," *SHARE* Vol. 8 No. 90 (March 1980), p. 3.
[52] "Letter to the editors from Allan/Jock of Liverpool Prison Group," *SHARE*, Vol. 1 No. 12 (September 1973), p.19.
[53] "AAs Takeway Meetings," *SHARE* Vol. 7 No. 59 (April 1979), p. 18.
[54] "Growth," *SHARE* Vol. 1 No. 1 (October 1972), p. 2.
[55] "Facts and Figures," *SHARE* Vol. 1 No. 5 (February 1973), p. 5.
[56] John (Warley Hospital Group), "The Last of North Thames Intergroup's Admirable Set of Contributions," *SHARE* Vol. 4 No. 45 (June 1976), p. 14.

UK was typical of non-hospital group members. In 1977, *SHARE* devoted an entire issue to AA in British medical and psychiatric hospitals, which discussed how AA in that setting worked largely in concert with mainstream treatments for alcoholism.[57] In a 1980 volume, a writer representing the East Midlands Intergroup, discussed how, beginning in 1973, "Formal communication was established with institutions and members of the professional community," which included psychiatric hospitals in Leicester and Nottingham and St. Crispin's Hospital in Northampton.[58] Finally, in 1980, even the Channel Islands Intergroup boasted having formal contacts with hospitals, prisons, and the Samaritans.[59]

SHARE in the 1970s included writing by non-alcoholic medical professionals, illuminating the relationship between AA UK and institutional care for alcoholics. For example, in on 1973 issue, JPW Hughes, a physician and non-alcoholic member of AA UK's General Service Board, applauded AA UK for helping make alcoholism be seen as medical and social problem, rather than one dealt with "police, magistrates, [and] prison officers."[60] In 1976, Dr. John Hughes, the Principal Medical Advisor "to a large industrial company" and a member of the Medical Council on Alcoholism wrote about his research into treatments for alcoholism, in which he found that "the Fellowship was more successful than any medical treatment in 'treating' the alcoholic," beating out "drugs and drying-out and vitamin injections." He noted that many doctors seemed to be joining him in his beliefs, including *SHARE* contributors Dr. Max Glatt (the vice-chair of the Medical Council on Alcoholism) and Dr. James Valentine, discussed below. He concluded, discussing doctors who believed "fervently" in the effectiveness of AA: "Doctors call it Group Psychotherapy and you call it Fellowship."[61]

In another 1973 issue, a guest writer, Dr. James Valentine, a Consultant Psychiatrist and non-alcoholic member of AA UK's General Service Board since 1963, wrote an entire short article for *SHARE* about hospital units.[62] He discussed the long-standing tension between AA UK and established medical professionals. After the Second World War, he claimed, the psychiatric profession by and large felt "invaded by sincere but unskilled enthusiasts." However, he noted that cooperation between the two groups had improved, and claimed that when the Ministry of Health set up Alcoholic Units in National Health Service hospitals in 1962, it was in cooperation with AA UK. He wrote that Alcoholic Units "based their treatment on a combination of group psychotherapy techniques and AA practice. Most have come to rely on AA for helping rehabilitation and after-care." He also cited a "recent United Kingdom Survey" that showed "that two out of three members [of AA UK] needed medical help for their alcoholism, and one in two passed through Hospital Units."[63] AA UK, by Valentine's testimony, had a similar relationship to NHS hospitals as informal and voluntary organizations had under community care. Based on the assumption that isolation went hand-in-hand with the mental distress that led to alcoholism, institutional treatment centers by the 1970s seemed to rely heavily on informal group-based organizations such as AA UK to supplement their care.

The only other documents made available to this researcher other than *SHARE* was a limited number of Conference Reports from national meetings of the General Service Board Conference, covering limited events from 1967 to 2014. This included information about AA

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[57] *SHARE*, Vol. 5 No. 56 (May 1977).
[58] Anonymous, "East Midlands Intergroup," *SHARE* Vol. 8 No. 90 (March 1980), p. 3.
[59] "AA in Guernsey and Jersey," *SHARE* Vol. 9 No. 98 (November 1980), p. 3.
[60] JPW Hughes, "A Non-Alcoholic Doctor Looks at AA," *SHARE* Vol. 1 No. 12 (September 1973), p. 9.
[61] John Hughes, "You Call It Fellowship," *SHARE* Vol. 4 No. 47 (August 1976), p. 13.
[62] James Valentine, "My Debt to AA," *SHARE* Vol. 4 No. 47 (August 1976), p. 3.
[63] James Valentine, "Hospital Units," *SHARE* Vol. 1 No. 6 (March 1973), p. 11.

UK's attempts to integrate the program into the medical establishment in the 1980s, and the response they were given. By 1981, according to national conference reports, AA UK was working to establish reliable relationships with the Regional Advisors of the Medical Council on Alcoholism, and had made a number of contacts with local Health Authorities. They reported that there were 113 meetings in the 200 psychiatric hospitals throughout England and Wales. In 1982, they reported that the 25 AA hospital liaison officers provided "a near 100% service to the alcoholic in hospital" in Scotland. In 1982, they discussed efforts to include AA ideology as part of a nurse training syllabus, and discussed how to incorporate more medical professionals into AA UK. Like the community care organizations discussed in the previous chapter, the General Service Board (GSB) was cautious about eschewing medical expertise with AA's method. They reported, after discussing the integration of AA UK into the hospital system, that "All A.A. members are reminded that doctors and nurses are responsible for the patients' entire welfare, and A.A. members are not qualified to comment on drugs and treatment regimes. It would be better [for A.A.] to have no hospital contact than use A.A. members who do not understand this principle."[64] AA UK aimed to make the medical establishment more holistic, rather than replace them. In prisons, by 1981, the General Service Committee reported that there was "100% coverage of Scottish prisons and...increased coverage of England and Wales." In 1983, they noted that they had a "good relationship" with Probation Officers and the Social Works Department Offices within the Prison Service. By the 1989 Conference Report, AA was consulting with the Scottish Prison Service to conduct training for Prison Officers, which they hoped would "[strengthen] existing links" with Scottish prisons.[65]

AA UK managed to form groups in traditionally hierarchical institutions such as hospitals and prisons, demonstrating that by the 1980s their form of group therapy had somewhat mainstreamed. As a volunteer-driven organization that did not rely on medical or psychological experts to carry out its primary functions, its involvement in hospitals and prisons in the 1970s and 1980s illustrated a general acceptance of the group therapy method for treating individual mental health problems such as alcoholism. This was not dissimilar from the underlying philosophy of community care during the same time period, which relied on peer-led treatment efforts and therapeutic practices. In turn, these practices were based on a model of mental health and human psychology that found loneliness and isolation to be the root of mental distress and a social disease.

Conclusion: The Cybernetic Self?

In his 1971 article, "The Cybernetics of 'Self': A Theory of Alcoholism," British anthropologist Gregory Bateson discussed Alcoholics Anonymous's program as it related to "Occidental" (mis)conceptions of selfhood and his own theories of symmetrical versus complementary relationships. Bateson specifically examined the notion of "alcoholic 'pride'" repeated throughout the literature of AA as well as their theology—their particular conception of "a higher power." Alcoholic pride, he argued, externalized alcoholism, making a sobriety an impossible battle of will. Alcoholics Anonymous, in contrast, encouraged complementary relationships with others versus an imagined antagonistic relationship with an imagined other. For Bateson, AA was in line with the cybernetic imaginings of an incoherent self that was made

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[64] AA UK General Service Board, "1981 Conference Report," and "1982 Conference Report," Alcoholics Anonymous Archives, York, UK. Uncatalogued.

[65] [65] AA UK General Service Board, "1989 Conference Report," Alcoholics Anonymous Archives, York, UK. Uncatalogued.

of and part of a system of inanimate objects and other people, as opposed to the bound "Occidental self." AA helped the alcoholic make the change from an "incorrect to a more correct epistemology." Ultimately, the disintegration of a fragile ego, which the alcoholic attempted to protect and preserve with alcohol, gave way to a socialized version of the self that was integrated into the lives of others.

I find Bateson's article useful because it creates the possibility of understanding the support group and other methods of group therapy as entirely new social formations. The small group as a therapeutic device was made possible by the production of intimacy and vulnerability by its members. In this sense, it is easily analogous to the family or a mythical-but-nonexistent "organic" social formation, such as the pre-modern village or the perceived intimacy of a pre-war neighborhood. While Bateson does not necessarily debunk the existence of this nostalgia, he makes a case for the newness of small-group social formations in the 1960s and 1970s.While such an impulse did exist in British popular culture and social and political thought, groups like AA did not represent an attempt to put the lid on encroaching individualism in favor of nostalgic organicism. Instead, in compelling participants to situate themselves in relation to the group was a new type of individualism, broken down into its relational parts. Moreover, Bateson invites us to think about how power operates in decentralized therapeutic groups. In addition, Bateson provides a means of studying AA beyond the science and pseudoscience of alcoholism and addiction, but rather as part of a culture of sharing. In compelling participants to situate themselves in relation to the group, AA brokered a new type of individualism, conscientious of its role in a small leaderless group.

Bateson suggested that AA and the support-group model were indicative of a new way of understanding "the self" in the west. However, the testimonies by AA members presented in *SHARE* in the 1970s paint a slightly different picture, particularly if we analyze them through the lens of loneliness. On one hand, those who wrote into *SHARE* often followed a trajectory of creative self-destruction. As noted in the above discussion, many AA UK members characterized their life before sobriety as lonely, though in a very particular way. Many referred to themselves as different, as outsiders, or even as pariahs. Many expressed a need to be seen as different or exceptional from the people around them. Along with this voluntary self-exile from society, many described an involuntary process of isolation, and a rejection from society both before and after drinking. They described being unable to form close bonds with family members and friends, and feeling outside of society generally. They often described alcohol as a means by which they escaped when this unrealistic sense of self was untenable. In this way, they fell squarely in line with Bateson's reasoning, which argued that pride and ego exacerbated drunkenness, and AA transformed the recovering alcoholic's sense of self away from the "flawed" western model of a stable and coherent self.

Despite this, by looking at the way *SHARE* writers described their own relationship with loneliness and sobriety, their testimonies illustrate a cohesion of individuality and wholeness. A recurring narrative for these writers was a fear of being alone to being comfortable being alone, as if isolation had the anxiety surgically removed. Fragmentation was a theme of alcoholism, recalling "MS's" 1973 contribution, recounted above, that described herself as both "isolated, cut off from the world," and "torn to pieces."[66] The transition from drunkenness to sobriety was often described as a reversal of this fragmentation. This process included an imagined re-integration into society, of which the small group was a microcosm. While the sober alcoholic was "networked," as Bateson suggested, those who discussed their experiences in *SHARE*

[66] MS, "To Be Free Is to Be Alone."

focused largely on how AA UK made them more whole. Arguably, by their testimony, Alcoholics Anonymous utilized the group to strengthen the individual's sense of self, reinforcing western individualism.[67]

[67] Gregory Bateson, "The cybernetics of "self": A theory of alcoholism." *Psychiatry* 34, no. 1 (1971) pp. 1-18.

CONCLUSION

In these chapters, I have told stories about experts constructing a deficit of relationships in the people charged in their care. Frequently, this was framed as a discovery, not unlike the "re-discoveries" of inequality and poverty made in the 1950s and 1960s, in which investigations of the welfare state unearthed new inadequacies and inequalities in the standard of living.[1] Like those inquiries, which led to a proliferation of domestic NGOs like Help the Aged and Shelter, the discovery of loneliness generated new practices and institutions, or helped popularize old ones. Group therapy, support groups, group homes, halfway houses, group work, community development, and twelve-step programs are all examples of how psychotherapeutic experts both identified mental health problems with loneliness and devised techniques to treat that isolation as a primary symptom. They were guided often by nostalgia for a mythical organic community (regardless of whether such a community had ever existed), but created something new. As my dissertation moves chronologically, we also see that these interventions into loneliness become less about critiques of the welfare state and more about the expectations placed on ordinary citizens to self-organize around their own well-being.

Chapter One begins with social workers finding a place for their profession in the newly forged welfare state. They explicitly critiqued the state's failings to fully provide for people living in the council estates where they worked. They cited suicide studies which correlated suicide rates with relative affluence in London, and affluence with loneliness. Their own studies and surveys into loneliness resulted in conversations about how to change their own profession and experiment with group work. The social workers I studied understood themselves as an important interface between ordinary people and the state, and their critical work was meant to serve the ends of the welfare state.

Similarly, the group psychotherapeutic techniques developed by the Group Analytic Society—discussed in Chapter Two—were also led by experts who believed loneliness was antithetical to wellbeing. Foulkes specifically, while never explicitly critiquing the welfare state, considered loneliness, community, and interpersonal conflict to be problems of deep social importance, and emblematic of the times in which he lived. The Society itself had members who aimed to intervene in the institutions of statutory care, namely social work. Like social workers, the work of the GAS aimed to wean patients off of their own expertise, and facilitate peer groups whose mental health was indicated by the absence of that expertise. They then attempted to diffuse these techniques into the arms of the welfare state's healthcare complex, by holding training sessions for social workers.

The techniques of community care in the 1970s and 1980s, discussed in Chapter Three, illustrated a significant shift from expert-led organization against isolation to patient-led iterations. This was evident in the emergence of the user movement, in which psychiatric patients collectively organized to protect their interests against both institutional psychiatry and the flailing community care apparatus. For me, this shift was unexpected, and an accidental discovery in the archive. What it demonstrated, however, was a move away from experts' concern over isolation, and instead patients' understanding of themselves as disempowered individuals. It is significant, I believe, that this gap exists between the gaze of administrators and

[1] For example, Peter Abel-Smith and Peter Townsend, *The Poor and the Poorest* (G. Bell and Sons, Ltd., 1965), which defined poverty as relative rather than a binary condition. Documentaries like *Cathy Come Home* in 1966 and *Seven Up* in 1964 demonstrated the persistence of class difference in a period of supposed affluence for the British working classes.

those who experience the state's care. On one hand, the user movement seems to be the logical outgrowth of community care, as self-organization of peers. On the other hand, the user movement was explicitly framed as an organization of consumers, not bound by reciprocal affect or solidarity. A future iteration of this project would more closely examine patients' rights and the user movements more closely, to determine the extent to which these organizations understood themselves as against the atomization of institutional mental health care and psychiatry at large. Or, did they represent the absence of such a politics, being a collection of independent consumers?

By the 1980s, I have shown in Chapter Four, twelve-step groups like Alcoholics Anonymous and proliferated in the United Kingdom, and possibly demonstrated how the peer-group model put forth by psychiatric experts in the 1950s and 1960s as an ideal came to fruition in later decades. While the group proliferated into prisons and hospitals in large numbers, AA UK also maintained independence from the state, and aimed to remain apolitical. Loneliness and isolation played a large part in discussions of recovery from alcoholism, as did the peer-based element. Critically, like the groups engineered by social workers and psychotherapists, AA UK professed that without expert leadership, free expression and sharing could help the individual overcome alcoholism.

In large part, much of what I have said above is my speculation, which is why I have left it for my concluding remarks. While common threads and narratives are apparent throughout these case studies, I cannot prove that the techniques put forth in the 1950s were put into effect in the 1970s, and if these phenomena are related empirically. I would speculate, however, that after the Second World War a new regime of self-help emerged that emphasized community, and made individuals responsible for forging those communities. While this process may have emerged out of critiques of the welfare state, it was likely exacerbated by decline of key social services, the abandonment of full employment, and other indicators of welfare's decline. I believe further research could indicate how specific personality traits—likeability, collegiality, teamwork and so forth—became a larger element of workplace expectations, for example. Overall, future additions to this project would engage in popular culture, news stories, and self-help literature to a greater degree.

Throughout this dissertation, I have talked about community, a word as amorphous and historically contingent as loneliness. In each chapter's context, community has meant a different thing, though in all it refers to an artificial, chosen collective. I take this to be a self-consciously modern definition of community, as opposed to "organic" communities such as the family or one's home of origin. Additionally, an important quality of community in these instances was that it was imposed from the outside, as an expectation and prescription. Rather than trying to pin down a definition of community, therefore, I would be more interested in examining what this modernized notion of community looks like when constructed from below. One avenue for this would be the new social movements of the 1960s and 1970s, such as feminism and gay rights. Numerous historians have discussed the political culture of these movements, and analyzing the way loneliness and community operated within them could be fruitful.[2] My own archival

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[2] For example, see the following works about youth culture and political activism in the 1960s and 1970s: Stuart Hall and Tony Jefferson (eds.), *Resistance Through Rituals: Youth Subcultures in Post-War Britain* (London: Routledge, 2006 [1975]); Jodi Burkett, *Constructing Post-Imperial Britain: Britishness, 'Race', and the Radical Left in the 1960s* (Basingstoke: Palgrave Macmillan, 2013); Celia Hughes, *Young Lives on the Left: Sixties Activism and the Liberation of the Self* (Manchester: Manchester University Press, 2015); David Bouchier, *The Feminist Challenge: The Movement for Women's Liberation in Britain and the USA* (London, 1983); Lucy Robinson, *Gay*

experience has shown that for many British second-wave feminists, the loneliness of family life and its overcoming was a key element of consciousness-raising. I have no doubt that a democratized history of community remains to be written.

Men and the Left in Post-War Britain: How the Personal Got Political (Manchester: Manchester University Press, 2007).

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