0160-2527(95)00011-9

Reflections on the Oak Ridge Experiment with Mentally Disordered Offenders, 1965–1968

Richard Weisman*

Until the early 1960s in Ontario, the only publicity accorded to persons found not guilty by reason of insanity was the occasional newspaper item that would report on the courtroom account of their deeds or the panic that would reverberate throughout the province should they escape confinement. At these moments, all the fears associated with madness would surface in headlines that spoke of 'maniacs', of sudden and unpredictable violence, of axes and knives and bare hands and innocent, vulnerable victims. Then, just as abruptly, the story line would end and the mad man or woman would disappear from the public domain as if they had no significance apart from the scandal of their madness. Where they went and what became of them were questions, it would seem, that no one thought to ask and no one really tried to answer.

That is, until the originators of a bold, new experiment in the treatment of those still misleadingly described in 1965 as the 'criminally insane' began to promote a strikingly different view of this population. The Oak Ridge Branch of Penetanguishene Mental Health Centre—the only maximum security mental hospital in Ontario and reserved exclusively for men—started to encourage visits from high school and university students, from judges and lawyers, and from internationally renowned visitors who were themselves experts and innovators in forensic psychiatry. Even more surprisingly, newspaper reporters and a radio journalist were invited to spend up to a week on the experimental ward living in the same spartan cells and participating in the same routines as the patients. Over the next ten years, between 1966 and 1976, film crews from the BBC, from CTV, and from the National Film Board of Canada would shoot vivid and evocative footage of the activities of the experimental program,

*Associate Professor of Sociology, Glendon College, York University.

Correspondence should be addressed to the author at Dept. of Sociology, Glendon College, York University, 2275 Bayview Avenue, Toronto, Ontario, M4N3M6, Canada.

E-mail address: rweisman@venus.yorku.ca

and a thinly disguised, fictional account of the history of the experiment ("Out of sight, out of mind") would appear on the CBC television series, *For the Record*, in 1982.

What emerged from this welter of publicity was a new image of violence and madness and a reassuring response to the question of how the 'criminally insane' were being treated. Journalists and film-makers came away with reports of a program that was vibrant and energized, and in which the patients themselves seemed to be enthusiastically involved in their own therapy. Just a few years after Frederick Wiseman had made his now famous *Titticut Follies* at Bridgewater Hospital for the Criminally Insane, Norm Perry's *F Ward* — filmed at Oak Ridge in 1971 and shown on national television in Canada — offered a happy contrast to the unrelieved misery of Bridgewater. Instead of the disfigured, floridly disturbed, and abused inmates that populated the Massachusetts facility, here were young, handsome, and intelligent men discussing their violent actions with insight and understanding, and apparently interacting with their peers in a manner that was both honest and compassionate. Elsewhere, in a series of feature articles, reporters described a program that was unafraid to risk intensity and to encourage open expression of the volatile feelings that raged both within the patients and towards each other (Hollobon, 1967, March 18; Bruner, 1977, March 26; Valpy, 1968, December 7). That somehow men who had committed the most heinous acts of multiple murder, rape, and arson, and that, more improbably, those branded as psychopaths, could be brought to the point of confronting their defenses on a daily basis and choosing caring over cruelty and hope over despair was the psychiatric equivalent to walking on water. An editorial in the *Globe and Mail* well articulated the dream and the paradox — "on a shoestring, with a slim staff and in what most people view as the most terrible institution of all, (the 38 men of G Ward were) working out their own salvation" (1967, March 18.) In place of the scandal of madness was a story of redemptive suffering in which a wholesome and healing community had sprung from the most prison-like of hospital environments.

Now, with the hindsight of a generation, it becomes possible to take a closer look at the program that generated so much public attention not only to better understand its origins and its guiding assumptions, but also to take cognizance of the profound changes in sensibility that have occurred in the way we interpret these events.

In the following pages, I have drawn extensively from hospital records, government archives, and from interviews with ex-patients and former members of the staff and professional team to reconstruct the history of Oak Ridge prior to and during the development of the program. "Jack," "Albert," and "Kevin" — who are quoted later in this paper — are pseudonyms for ex-patients interviewed as a part of this study. "Mark" — mentioned later in the paper — is also a pseudonym. I have used Michael Mason's real name, since he is already identified in his published writings as a patient in the program during the first few years of its operation.[1]

---

¹Both 'Mark' and Mr. Mason died some years ago.

From Carceral Institution to Therapeutic Community

When the history of institutions such as Oak Ridge and its kindred asylums in England and the United States is finally written, it will have to be acknowledged that they differed significantly both from the mental hospitals with which they were administratively grouped and the prisons to which they were often disparagingly compared. Unlike the patients who were held involuntarily in ordinary mental hospitals, the confinement and release of those men who made up the majority of Oak Ridge's original residents—those who had been found not guilty by reason of insanity or declared unfit to stand trial—was the prerogative not of medical authority as embodied by the physician or psychiatrist, but of the state acting through the Lieutenant Governor. Moreover, this authority to hold individuals "at the Pleasure of the Lieutenant Governor" for an indeterminate length of time did not entail any obligation to treat or correct the person, nor did it specify any conditions that had to be met for discharge. Unlike the prisoner, the patient on a Lieutenant Governor's Warrant was not confined for a specified period in order to be punished or rehabilitated nor, like the ordinary mental patient, was he confined in order to be treated; strictly speaking, he was simply "kept."[2] What was distinctive about institutions like Oak Ridge is that this purely carceral power to detain existed along with the more conventional psychiatric power to admit, treat, and release persons according to criteria of mental health and mental illness. In part, the history of Oak Ridge is the history of how these two powers were joined—whether in opposition, or in mutual support, or with the one clearly dominant over the other.

The forming of the Social Therapy Unit—as the experiment came to be called—constituted the crowning moment in a period of rapid transition at Oak Ridge during which the relations between these two powers were decisively altered. Between 1933, when its doors first opened to 100 inmates from Guelph Reformatory, and 1960, when the last psychiatrist to serve as superintendent took over its operations, Oak Ridge had functioned essentially as a carceral institution in accord with its legal description as a place of "strict custody." This is not to suggest that medical authority was irrelevant even in the earliest days of Oak Ridge's existence. Especially in 1933, in the age before civil service unions and review boards, the powers granted to the superintendent as chief medical officer and chief executive officer of the mental hospital to "direct and control the treatment of patients" and "hire and discharge . . . nurses, attendants, and employees" (Hospitals for the Insane Act, R.S.O., 1914, s.5(2)) were almost unrestricted in scope.

But even then it was well understood that it was the crime for which patients on Lieutenant Governor's Warrants had been acquitted, rather than their state of mental health, that would determine when and if they would be released. As Dr. O'Gorman Lynch, Oak Ridge's first superintendent, wrote in 1937, "there

[2]Crankshaw's Criminal Code of Canada, 6th edition, 1935, s.969 provides that the Lieutenant Governor "may make an order for the safe custody of the person found to be insane in such place and in such manner as to him seems fit." S.968 provides that persons unfit to stand trial are "to be kept in strict custody." Use of the phrase "kept in strict custody" remained in the Criminal Code until the recent decision in R. v. Swain (1991), 63 C.C.C. (3rd) 193.

are many patients (Warrant Patients) who would most certainly be discharged were it not for the serious crimes they had committed . . . after prolonged observations of many of these patients who have regained their mental health, I am satisfied that they are better fitted to meet the everyday problems of life than many discharged from civil institutions . . . " (Lynch, 1937). Whether out of deference to a hostile and unsympathetic public, as Lynch speculated, or the result of some grim political arithmetic, men who had been acquitted of murder on grounds of insanity could expect to remain at Oak Ridge until their death. Likewise, those acquitted of lesser crimes could expect to spend far longer than their counterparts in prison who had been convicted for similar offenses. In one instance, a man who had been acquitted of "placing an obstruction on a railroad track" that resulted in no injuries spent 19 years at Oak Ridge, despite reports in his hospital record that after a few years of confinement he showed no symptoms of mental illness.

Yet Oak Ridge's carceral emphasis arose not just because it was the favored site for male Warrant patients. By design or by circumstance, Oak Ridge became the place of ultimate confinement for all of Ontario, and, on occasion, for other provinces as well. Its original inscription as the "Criminal Insane Building" was misleading, and not just because the term "criminally insane" was an oxymoron that connoted criminal culpability and acquittal from criminal responsibility at the same time. From its inception, Oak Ridge drew its population from two groups other than those referred by the courts. One group consisted of men transferred from prison or reformatory who had experienced psychosis while incarcerated. Lynch reports that the riots at Kingston prison in 1932-33 resulted in the largest number of applications to Oak Ridge of any period during his administration (Lynch, 1937), just as forty years later the Kingston riots of 1971 would cause another sudden bulge in the patient rolls. Such patients were expected to complete their sentences, whether upon return to prison or at Oak Ridge, and they could be detained even after the expiration of their sentence if judged mentally ill. The second group included men confined in other mental hospitals throughout the province and who, according to Lynch had injured or killed staff or other patients, or were so "abnormal while undergoing treatment . . . that for their safety and the welfare of other patients," they were transferred to Oak Ridge. "Abnormal" behavior could consist of assaults on staff or other patients, attempts to escape confinement, or what was perceived as an uncontrollable desire to act on homicidal or suicidal feelings. It was from this source that Oak Ridge would later draw its largest group of patients—by 1960, referrals from other mental institutions constituted 45% of its total population (McKnight et. al., 1962). As the endpoint of two systems of involuntary detention, Oak Ridge developed a rationale as a place that could control behavior that other institutions could not or would not. The mental patient who acted out in less fortified surroundings would learn that here there were the resources and the will to use the force that other institutions lacked. The inmate who imagined that Oak Ridge was easy time would discover that escape from this facility—"the Alcatraz of Canada" (Boyd, 1963)—was even less possible than at prison or reformatory. Oak Ridge's position as the final recourse of the state to control "dangerous" conduct lent prestige and importance to the very carceral powers that made it for some "the most terrible institution of all."

By the early 1960s, Oak Ridge, with its large and growing population of long-term patients and its carceral orientation, had developed a distinct method of operation. Unlike other mental institutions in Ontario, which were staffed by a mix of attendants and nurses (often with more of the latter than the former), the lives of the patients at Oak Ridge were controlled almost exclusively by male attendants whose duties and whose occupation of reference placed them closer to correctional guards than to health care workers. Indeed, early job descriptions characterized the skill of the Oak Ridge attendant as requiring not just the prison guard's anticipation of riot, escape, and assault, but the front-line psychiatric worker's preoccupation with suicide, self-mutilation, and other self-destructive acts. Although much of what transpired during the day would not have distinguished the facility from any custodial mental hospital of the period—those patients who could work helped with maintenance or repairs or food preparation and so forth, and a privileged few worked on an outside crew that engaged in such activities as construction or gardening—some practices reveal the awkward compromises made between security and care. Built into the collective memory of the attendants were graphic episodes where a fork had been plunged into the eye of an unsuspecting victim, or the jagged edge of a broken spoon placed against the neck of a visitor, or a moment's inattention had left time and space to carry out a suicide. These combined with the job-threatening public inquiries that followed a successful escape generated a myriad of rules and rituals to prevent what were perceived as the many disruptive possibilities inherent in this group. Whereas two patients conversing together in the same cell might strike the outsider as simple sociability, for the security-minded attendant, it could be a prelude to illicit sex or a conspiratorial plot; hence, the two-in-a-room rule forbidding such encounters. Likewise, the position of chairs in the large meeting room at the end of the corridors could not be altered just to suit different social arrangements—if the chairs were not kept in their original position against the wall, they could more easily be deployed as weapons. If, for reasons of personal hygiene, patients had to shave, it was also true that shaving required access to sharp implements and so, given staff shortages, patients were shaved just twice a week by an attendant, hence contributing to the Oak Ridge resident's permanently stubbled visage.

Complementing these and other rules and practices was a more informal system of rewards and punishments. Patients who were perceived as trustworthy and who had established a relationship with a particular attendant might be the recipient of small kindnesses, such as an extra snack, or more time in the shower, or some records or books—kindnesses that had great value in such deprived circumstances. For those who were defiant or, worst of all, those caught attempting to escape, Oak Ridge had developed a justifiable reputation for toughness. Roger Caron describes his encounter with attendants in 1962 after they found him sawing through the bars of his cell—"I was in the institution only a few weeks when the sleeper was used on me (a method by which patients were choked into unconsciousness with a towel.) As additional punishment, I was carried bodily up to the Violent Ward and tossed naked and freezing into what they called a therapeutic cell, better known as a padded cell (Caron, 1978)." Finally, for patients who exhibited signs of madness, there was confinement to specially equipped rooms, medication, and, on occasion,

electro-convulsive therapy (ECT) or psycho-surgical interventions such as leucotomy. Just a few years before the Social Therapy Unit was begun, Oak Ridge had developed a culture premised on maintaining what one memo called "a secure and safe environment." This secure environment required that patients defer unconditionally to the authority of the attendant and that disturbances, whether intentional or the outward signs of madness, be forcefully suppressed. Any changes in routine in the name of treatment or therapy would be evaluated and judged in terms of how they affected this stable order.

That an institution so tightly controlled would undergo a fundamental shift throughout the next decade can be credited to changes that were both external and internal to Oak Ridge. The most obvious pressure point was the sheer number of patients Oak Ridge already held and the demand from other institutions that it accommodate more. In 1958, Oak Ridge had added a new wing to the old building, doubling its occupancy from 152 to 304 beds and, even with the increase in capacity, it was difficult to find space for the flood of referrals from mental hospitals and reformatories. This change in the volume of demand was accompanied by an equally dramatic change in the kinds of patients coming to Oak Ridge. Whether or not because of the recommendations of the McRuer commission in 1957,[3] the courts of Ontario began to allow broader interpretations of the insanity defense, and so persons who might formerly have gone to prison were now redirected to facilities such as Oak Ridge. One estimate mentions that between 1960 and 1968, the proportion of men at Oak Ridge diagnosed as having a personality disorder increased from 6% to 40% of the total population.[4] The presence of a growing cohort of young men who were cognitively intact argued for a different approach to confinement.

But the more important changes were less easily quantified. The new superintendent, Dr. Barry Boyd, combined an activist approach to therapy with an appreciation for social systems and their effects on treatment that was reflective of broader changes taking place in public policy towards the mental patient. A diverse literature in corrections, social psychiatry, and the social sciences, as well as public policy directives, began to acknowledge that social institutions, including mental hospitals and prison, could contribute to pathology as well as reduce it. If pathological or "antisocial" behavior was reinforced in certain environments—notably prisons—and if the three hours spent with trained therapists did not begin to compensate for the remaining "165 hours (per week) in the antisocial prison community" (Boyd, 1963), then the problem was how to create an equally powerful system that counteracted these effects. In a short article that sketched in 1963 the changes about to occur, Boyd wrote that "it should be possible to control the social environment of the inmate so that the experience in reformatory or prison results in his being released better able to adjust to normal society (Boyd, 1963)." Moreover, since at Oak Ridge there would never be enough professional staff to provide therapy for all the patients, treatment would have to be based on "interpersonal contact between

---

[3] Also known as the Report of the Royal Commission of the Law of Insanity as a Defence in Criminal Cases, 1957.

[4] As stated in lecture entitled "Development of Oak Ridge" given by Dr. Barry Boyd at Clarke Institute of Psychiatry, April 14, 1978.

inmate and guard and amongst inmates to accomplish our purpose." Especially with respect to those who had antisocial personalities, Boyd suggested, the "most hopeful treatment . . . lies in their exposure over time to a social environment which will change their self-picture, their values, and their attitudes towards responsibility." Together with the carceral power to confine and detain would be the power of psychiatry to alter the social environment to bring about positive change.

That a therapeutic community could have been imagined as the solution to Oak Ridge's problems might well have struck a contemporary observer as the least likely possibility. As originally conceived by the British psychiatrist, Maxwell Jones, immediately following World War II, therapeutic communities embraced values that were deliberately antithetical to the autocratic and custodial asylum.[5] Instead of a rigid hierarchy in which professional helpers would dictate the terms of treatment to their incompetent charges, Jones proposed that patients be delegated more powers so that they could assume more control and responsibility for their own care. Rather than relying on front-line workers to enforce the rules and professionals to supply the motivation, therapeutic communities mobilized the resources of the group to put pressure on its members and to establish its own norms. Most unsettling for those accustomed to quiet and docile wards, Jones advocated a relaxation of controls and restrictions to encourage patients to divulge their feelings to the group without fear of retaliation. Whether one takes these values as ideals or as ideologies that masked actual practices, the emphases on communalism, democracy, and expressiveness were clearly at odds with Oak Ridge's carceral culture.

Yet for all its ideological awkwardness, the model of the therapeutic community had features that made it more than just a utopian fantasy. From a purely pragmatic standpoint, its populist virtues fit the economic constraints of the institution—patients treating patients meant treatment without incurring additional costs. Moreover, Jones had concluded from his experiences with a population diagnostically similar to that of Oak Ridge that therapeutic communities were particularly appropriate for patients with "psychopathic personality disorders" (Jones, 1954; 1962). The "social sickness" of the psychopath called for a social therapy that would treat values as well as symptoms, and democratization removed the distraction of an authority figure on whom such patients could focus their anger—the more patients participated in creating the rules they wanted to have enforced, the more likely, it was reasoned, they would invest these rules with binding authority. Against those who might object to this new model of institutional change, the therapeutic community could be defended because it was cheap and because it was intended for the very persons who represented a growing proportion of Oak Ridge's population.

But this general receptivity to the idea of the therapeutic community cannot by itself account for the specific changes that the concept underwent in its adaptation to Oak Ridge. Indeed, the concept of therapeutic community has always had multiple meanings incorporating the most diverse of social experiments—any category that can accommodate R. D. Laing's loosely structured Kingsley Hall and Chuck Dederich's minutely ordered world of Synanon bor-

---

[5]For fullest articulation of these values, see Rapoport, *Community as Doctor*, 1960.

ders on linguistic anarchy. Even at Oak Ridge, there were two models that for a time coexisted, although one was far less elaborated because of its shorter duration. The first was a brief experiment started by a psychiatrist who had spent time at the therapeutic community at the Henderson Hospital in London, and it faithfully reflected its origins. Just as at the Henderson, there was a modest flattening of hierarchy with the staff asked to make themselves more available and the patients taking more initiative in decisions affecting their everyday life. The patient was expected to feed back information on problematic encounters to the group, and the group of peers, in turn, would help him see connections between his everyday behavior and the problems that led to his involuntary detention.

It was the other therapeutic community begun by Dr. Elliott Barker that would form the basis for the Social Therapy Unit. Barker, a psychiatrist who had just completed his residency, had an already well-developed interest in the relationship between community and personality before he arrived at Oak Ridge in 1965. The year prior to accepting a position at the facility had been spent traveling around the world visiting some of the most well-known pioneers in the setting up of communally oriented programs for psychiatric patients. Besides the obvious pilgrimage to Jones' already 15-year-old experiment at the Henderson and George Sturup's well-known facility in Herstedvester, Denmark, for treating "criminal psychopaths," Barker had made some detours to less conventional sites. A visit with the iconoclastic R. D. Laing and David Cooper, together with journeys to a kibbutz in Israel to meet with Martin Buber and to Maoist China to observe methods for reforming character in a Chinese prison camp, completed the eclectic tour. Elements from all these experiences would take root in the forthcoming experiment.

The Social Therapy Unit did not develop a coherent set of therapeutic principles until it had been in operation for several years. But the values and practices that evolved during this period would make it unique among therapeutic communities of the time and, in a sense, a preview of developments to come in other such experiments with captive populations. New ideas about coercion and freedom coexisted uncomfortably with the standard discourse on democratization. The use of cathartic drugs and extreme social situations to expand the potential for self-expression and self-discovery stretched the limits of what Jones and others had more innocuously called permissiveness. The involvement of patients in every phase of the program, including decisions about treatment, discipline, medication, and release, carried the flattening of hierarchy far beyond what Jones, Sturup, and other reformers had envisaged. Barker began with a single ward (G Ward) of 38 patients in 1965 that expanded to include half the population of Oak Ridge, or approximately 150 men, by 1968. By the time the Social Therapy Unit had unfolded, it had become an original experiment in social engineering—grafted onto the general framework of the therapeutic community was a new social form.

The Ordeal of Therapy

The original cohort of G Ward patients comprised volunteers and draftees—some hopeful of change, others happy to leave their former circumstances at

Oak Ridge, and still others who were transferred to the unit contrary to their declared preference. For Jack, earnest and personable, then in his early twenties and a warrant patient who had been "acquitted" of murder, the experiment could not have come at a better time. He had been languishing in a ward "doing nothing except going to a group meeting once every two weeks." He recalls that when Barker told him that "I think you have something to contribute and I want you to join me—you'll also benefit and you won't be here for the rest of your life," he felt he was finally going to be part of something that was "serious." Albert, bespectacled and scholarly, a warrant patient who had been found not guilty by reason of insanity of several murders, remembers hearing through the grapevine about this "crazy psychiatrist who was going to get patients to treat patients." He did not want to leave what by Oak Ridge standards was a relatively comfortable situation on another ward, but he found himself moved to G Ward nonetheless, and exposed to the films and texts in psychology that would initiate the first group of patients into the world of the Social Therapy Unit. Mike Mason, thoughtful and eloquent, who would co-author the major theoretical papers on the experiment and play a decisive role in its development, himself a warrant patient who had been tried on a charge of murder, reminisced years later in an unpublished work about his first meeting with a young psychiatrist who had piqued his curiosity and aroused his hopes that he could be cured. A sampling of G Ward patient rolls from four separate dates between 1965 and 1967 reveals that approximately one third of the 38 patients in the experiment were on Lieutenant Governor's Warrants, and a majority of these had been found not guilty by reason of insanity of a capital crime. It was not until 1963 that the first such patient would be released after 43 years in captivity, to be followed during the next two years by six more "capital cases" who would have their warrants vacated. The Social Therapy Unit thus drew a significant portion of its first generation from men who only quite recently had reason to believe they would never get a second chance to be free.

The remaining patients of G Ward were drawn about equally from men transferred from psychiatric hospitals and from correctional facilities, with a majority of the latter coming from reformatories. Compared to the rest of Oak Ridge's population, both they and the Warrant patients were generally younger (most were in their late teens and early twenties), more verbal, more cognitively intact, and more able to participate in a therapy that relied extensively on the individual's capacity to communicate in groups. Again, using the above sampling as representative of the distributions during this early period, about half of the 35 patients had been charged with murder, rape, arson, or indecent assault, one quarter were transfers from reformatory having been convicted of such minor crimes as theft, discharge of a firearm, or break and enter, and another quarter had been referred from other mental hospitals for escaping, attempting suicide, assaulting staff, or "strange behavior." The population was divided just about evenly between those diagnosed as schizophrenic and those diagnosed as having "psychopathic personality disorders." All had been specially recruited—whether by persuasion or conscription—into a program that promised more and demanded more than anything else they had experienced at Oak Ridge.

The Social Therapy Unit began rather unremarkably at the end of 1965 with a simple increase in the number of ward meetings, but soon expanded in ways for which previous therapeutic communities offered no precedent. By March, 1966, a patient committee system had been formed, but in this case its powers were neither illusory nor negligible—a medication committee could recommend which drugs patients could take or, in some cases, should take, another committee could determine which penalties or loss of privileges should result from which infractions of the rules, and still another committee could choose which patients would go into which groups—all subject, of course, to veto by the unit director but, as a matter of policy, all likely to be enforced. Through April and May, the ward meetings, small groups, and committee meetings were supplemented with new social arrangements—patients were locked in their cells with partners and required to interact in dyadic encounters and produce a written report that would in turn be evaluated and verified by a third party; also, mirror groups consisting of nine patients each were assembled in which members would take turns expressing and evaluating their feelings towards each other. All such structured activities were made compulsory, so that patients could be forcibly escorted to a meeting and prevented from leaving it. By November, even patients believed to be suicidal or violent towards others were obliged to attend meetings—in a bold reversal of contemporary trends, these men were placed in cuffs and paired with another patient who would serve not just to guard against risk to them and others, but to guarantee their continued presence. As of February, 1967, patients were involved in compulsorily structured interactions requiring at least 80 hours per week, and plans were underway to fill the weekends with equally intense programming.

Accompanying these drastic changes in routine were new approaches to medication and a willingness to explore the limits of interpersonal communication by creating unusual and extreme social situations. Instead of drugs that reduced anxiety or suppressed symptomatology, the Social Therapy Unit began to rely on medicines that were variously cathartic, hypnotic, disorienting, or hallucinogenic. From March to July, 1966, virtually all G Ward patients were injected with sodium amytal for its carthartic effects, while during the same session receiving injections of methedrine to help combat feelings of drowsiness. While still affected by the drug, each patient was interviewed, each interview was recorded, and each recording played back to the patient. Later in the same year, scopolamine, with its disorienting and hallucinatory qualities, also began to be administered in combination with methedrine to persons insufficiently responsive to the other medications. LSD—already well-known for its hallucinatory and cathartic potential—became part of the pharmaceutical repertoire of G Ward in February of 1967. Those who had been brought to the point of despair or rage during their involvement with the program were accommodated in "safe rooms," there to be outfitted with untearable gowns and to sleep on concrete slabs, their every movement recorded by two fellow patients, who would take turns observing them through the night. For others whose symptoms prevented them from participating in group activities, a special room was reserved in which they could work through their madness while closely watched by their peers in case they might harm themselves or others.

Then, in early October, 1967, 30 of the 38 G Ward patients embarked on a

marathon encounter in which all would remain together for two months, and 16 of the 38 for four months, in the same room all day, eating, sleeping, and eliminating in close proximity, with all obvious distractions such as books, TV, games, and records removed, with bright lights on during the night and only brief respites for showering or emergencies. But the apotheosis of this early period of experimental creativity was undoubtedly the construction of a special chamber—called the total encounter capsule—that was a windowless, safe, and self-contained room equipped with tubes for feeding and an open toilet, together with a one-way mirror overhead for constant monitoring, in which patients could be together unclothed and undistracted by external stimuli, free to express themselves with no inhibitions and secure in the realization that should they overstep the generous limits that had been allowed, they would be restrained (Barker, Billings, & McLaughlin, 1969).

Reconstructing the Violent Self

What gave coherence to this rich vein of therapeutic innovation was a radical vision of personal transformation and how to bring it about. The objective of the program, as formulated in "The Insane Criminal as Therapist," was "a major reconstruction of personality," and it is clear that patients were expected to achieve some permanent and profound change in how they experienced themselves and how they related to others before release or transfer would be contemplated, and before they would be viewed as free from their original pathology. But this reconstruction was not to be the result of a gradual process of disclosure and feedback in which participants could set limits on their involvement with each other. The therapeutic orientation of G Ward was premised on the assumption that its members suffered from a severe disturbance manifested by many in violent actions towards others or themselves, but by virtually all in what Barker and Mason called a "failure of communication" (Barker & Mason, 1968a). The crucial corollary to this assumption was that if these patients were to have any chance for recovery, their illness, which most of the time lay dormant or buried under a facade of normality, would have to be brought to the surface and re-experienced in order for it to be treated. Merely to articulate one's problem, or have a textbook knowledge of one's pathology, or have correct intellectual insights about one's illness that had not been won through experience could never result in the changes required. Progress on G Ward consisted not in controlling one's pathology, but in letting it show. The formerly calm and congenial man who was now expressing his anger would ideally be supported in his transition from surface normality to a demonstration of his underlying pathology, rather than attacked for the added strain he placed on his fellow patients. The radical vision of the Social Therapy Unit was that the "major reconstruction of personality" required a break with normality and a re-experiencing of one's pathology, and that the resources of the community would be mobilized both to accelerate these changes and to make sure that they resulted in greater health.

But the patient could gain access to his illness only by abandoning the defenses that blocked its expression. For some, this would mean risking exposure of the omnipresent beliefs and fears that they knew others would regard

as mad fantasies. For others, it meant revealing some deliberately omitted and highly embarrassing detail about their crime, or even confessing to violent deeds that had not yet been uncovered. For still others, it meant acknowledging fantasies of forbidden sexual longing for other patients, or re-experiencing painful memories of self-loathing or helplessness, or suffering guilt over events that had long since been denied or forgotten. The ordeal of therapy involved the relinguishing of control over these secrets and unwanted memories and disturbing feelings, and a capacity to endure the chaotic and disorienting sensations that this abandonment might occasion. The promise of therapy, as articulated by Mason, consisted of the "increased knowledge, increased control, and increased ability to suffer pain and experience joy"[*] that would result from this unburdening. In the world of the Social Therapy Unit, even the most committed and ardent believer in the value of such catharsis would need help to overcome the resistance that would inevitably surface while undergoing this ordeal. For others, however, especially those who did not agree with how the group defined their problem, it would take more than simple encouragement or innovative therapy for them to surrender their defenses and risk loss of control — it would require additional pressure, and pressure that was backed ultimately by force.

There were, of course, policy arguments to be made in favor of an activist approach to treatment — since the state required demonstrable change in the Warrant patient as a condition for release and if, as Barker and Mason suggested, "for many of our patients, the first sign of relapse would be rape, murder, or arson" (Barker & Mason, 1968b), then, it could be claimed, the risks of inaction were greater than the risks of intervention, both from the standpoint of the patient who wanted his freedom and the community that wanted protection. Indeed, Albert recalls that he and other patients would justify the pressure they imposed on each other by saying, "anything I can do to make your stay shorter is for your benefit." But the more substantial and compelling rationale for increasing psychological pressure had to do with the ordeal of personal transformation itself. One of the mottos of G Ward — "a healthy ward was an upset ward" — made explicit the assumption that raising the level of tension on the ward was necessary to bring out the pathology that, under normal and less turbulent circumstances, would remain "untreated."

One device for increasing tension was the small group encounter. For those already overwhelmed with guilt or shame, or unable to hold back their raw feelings or hide their madness, the group might offer support as well as concern over whether the person was a risk to himself or others. For others, however, who rejected the group's interpretation of their problem, the response was apt to be aggressive and confrontational. Albert recalls small groups in which the purpose was to drive the person to react, whether by shouting at him or pushing him physically or by some more provocative gesture; Kevin, a veteran of a maximum security prison and later at Oak Ridge for a capital crime, remembers a group that lasted over three days — "there was a guy there who was always nice — he never raised his voice . . . he was extremely passive —

---

[*]From paper entitled "Buber Behind Bars" as presented to Ontario Psychiatric Association, Guelph, October 21, 1966, p. 12 (Darby, Barker, & Mason, 1966).

after we got out of the group, we figured that's the way the guy was—we did everything we could—we called him names, we ran his family to the ground, we took his watch, we took his radio, we took his shoes—the guy never got pissed off—(he'd say) if you want to keep them, keep them." The forced dyadic encounter was another such device to build psychological pressure. While dyads were sometimes assembled on the basis of mutual attraction, at other times, they were intentionally arranged to bring about contact between persons who were known to dislike each other. Unlike the voluntary relationship from which one could "unhealthily choose to withdraw," the compulsory, prolonged encounter with the other would force the patient to become aware of his "failure at communication" and seek ways to overcome it.

But perhaps the most ambitious of all these strategies to bring out the patient's disturbance was the deliberate intrusiveness of the program itself. The principle formulated in "Buber Behind Bars," that the therapeutic community should be a total experience was gradually carried to its ultimate if logical conclusions. A weekly schedule from May, 1966 shows a comprehensively structured day in which patients were required to participate in committee meetings, group meetings, dyads, and other therapeutic programs from 7:30 a.m. to 10:30 p.m. seven days per week, save for two hours a day to be used for meals, showers, and a coffee break. At 10:30 p.m., according to the schedule, therapy would continue with the patient at rest or in sleep constituting a "monad," during which time the process would continue in solitude, only to have the cycle begin early again the next morning. On G Ward, there would be no relief from the glare of therapy—no opportunity to withdraw from the unsettling and tension-provoking power of the group—as Barker and Mason wrote, "Ideally, the patient should be allowed no experience that does not in some way contribute to his getting well. . . . " (Barker & Mason, 1968a). The pressures that were built up through confrontation, forced encounters, and a drastic reduction in privacy would hasten the patient's movement through his illness and towards recovery.

Throughout this process, whether in support or confrontation, the patient would know that there were few alternatives to participation. Apart from the ubiquitous peer pressure and the force that could be used to insure the patient's physical presence in the program, those who did not cooperate or who were not sufficiently forthcoming could be referred to the appropriate patient committee for further treatment or for sanctions. Jack remembers being referred by another patient for "hiding his mental illness," and that this resulted in his placement on a committee where he would have to be more outgoing and demonstrative—the patient who referred him later referred himself for the same reason. For those designated as disruptive or negligent, the outcome could be loss of various ward privileges, such as not having access to one's room during the day, or humiliations such as having to wear a 'baby doll'—a short, sleeveless gown made of unbreakable material—for a specified period, or having to write an essay on the subject that gave rise to the offence. Between 1965 and 1968, it was still possible for patients to have their requests for transfer out of G Ward accepted, but their most likely destination would be the Oak Ridge unit that allowed the fewest amenities and the least freedom of movement. It did not take long for patients who had been transferred in this

manner to ask for another chance in G Ward. Eventually, however, the patient would recognize that his acceptance or defiance of the program was linked directly to his opportunity for release from confinement. The indeterminate sentence — or "the goad to freedom," as Barker and Mason called it — was the final lever in a sequence of controls designed to propel the patient willingly or unwillingly through the ordeals that would result, it was hoped, not just in liberty, but in personal transformation.

Maximum Therapy and Maximum Security

Yet was it not risky and imprudent to raise tensions and bring out pathology in a ward where most had already committed acts of extreme violence towards others or themselves? How do you permit and indeed sometimes force the "disintegration" of the patient's psychological defenses without risking a repetition of the acts of violence believed to have accompanied his breakdown before he arrived at Oak Ridge? While the Social Therapy Unit struggled with the conundrum familiar to all therapeutic communities — how to expand the boundaries of self-expression while placing limits on self-expression — its solutions were in keeping with its radical vision and its unique institutional environment. If G Ward was not the only program in the mid-1960s that depended on catharsis as its primary therapeutic tool, there were few other settings that had the resources and the will to carry a cathartic therapy quite so far. To realize the full benefit of this therapy, the patient would have to go beyond his defenses, even if this meant a direct confrontation with his mad fantasies, or his homicidal or suicidal tendencies, or his cruelty, or his sexuality. But this license to explore without inhibition the full range of one's feelings was possible only because these feelings could never be translated into action. The G Ward slogan — "maximum therapy and maximum security" — gave voice to the belief that the greater the external controls, the less need for the inner controls that would restrict therapeutic movement. From this vantage point, the very oppressiveness of Oak Ridge constituted its greatest therapeutic strength. The thick, clanging doors at the end of each corridor provided the secure physical boundaries without which emotional openness would be fraught with danger, either to one's self or the other. The cage-like cells multiplied the opportunities for close surveillance and rapid access in case of emergency; the finely latticed windows and spare furnishings fastened to the floor meant that fewer objects could be used as weapons of violence or self-destruction.

But the front line defence against danger was the vigilance and ubiquity of the patients themselves. The members of G Ward were expected to monitor each other's moods and feelings, and to take proper action when they perceived a fellow patient to be at risk — someone evaluated as suicidal might be placed in a room even more fortified against damage than the usual Oak Ridge cell, and observed closely by other G Ward patients, who would take turns on 4-hour shifts for a full 24 hours a day. The emphasis was on prevention and anticipation of risk, rather than reaction to emergency — severe sanctions were imposed on patients believed to be negligent in their duties or derelict in reporting the incipient signs of suicidal behavior and, for a while, observers were obliged to wear photographs showing the grisly results of a successful suicide

as a constant reminder of their responsibilities. For those viewed as potentially assaultive, the response might be a demobilizing tranquillizer such as Nozinan coupled with the same close observation accorded those who were suicidal. The hoped-for effect of these various measures was that the demands of security would interfere as little as possible with the expression of pathology, however extreme, or the patient's continued exposure to the program. It was because of these provisions for constant surveillance and the possibility of a highly controlled physical environment that those who had been brought to the point of despair were free to live through their pain in the unstructured but protected "psychotic sunroom"—there to be watched by their fellow patients who, through familiarity, would know how to interpret their moods and when to intrude on their fantasies. It was consistent with these therapeutic values that, when a patient suggested during a ward meeting that persons who were suicidal or homicidal be placed on cuffs and attached to another patient, his recommendation was accepted after some debate as a way of meeting the demands of security without compromising the therapeutic process. Hereafter, even those viewed as dangerous to themselves or others would not be isolated from the catalytic effects of the group—cuffs made of seat-belt material would be fastened to their arms or wrists in various ways and attached to someone they trusted, who would then make sure that they continued to be part of the program. Once again, therapy was possible only because of the strength and versatility of external controls.

Even so intensely focused a therapy, however, was not beyond improvement in terms of its own ideals. For some patients who were committed to the goals of self-transformation, perhaps frustrated by their own lack of movement or the apparent immobility of others, the program did not go far enough or fast enough. Possibly, there was also concern that the setting up of review boards in 1967 to which involuntary patients could apply for earlier release removed one of the levers—the indeterminate confinement—by which these men had previously been motivated to face the ordeals of therapy. Whatever the underlying cause, by 1967, there were efforts to augment the already considerable psychological pressures on G Ward and to overcome some of the problems that the program had encountered in its first year. A few patients held such prominent positions in the community that they were unlikely to be confronted; others were so articulate and verbally "potent" that they intimidated or outmanoeuvred their peers. The attempt to create tension was itself counteracted by the need for order and efficiency in the running of committees and ward meetings. Moreover, it was apparent from the interviews conducted while patients were undergoing the effects of amytal that cathartic medications did not always eliminate defensive behavior. At the same time, even a maximum security facility could not offer enough controls to contain the effects of a rigorous therapy—it strained the resources of G Ward just to provide for the all-day monitoring of the four or five patients who might at any given moment be assaultive or suicidal. If the pace of therapy were to intensify and the number of planned crises to increase, the community would be overwhelmed.

When each of the members of G Ward was asked in mid-1967 to design the ideal setting for therapy, it is not surprising that many imagined buildings that had "plexiglass windows," or "no windows," or "completely padded walls and

floors," or that the building so designed would be constantly monitored by closed-circuit TV, or that patients would wear untearable clothing at all times, save for receiving visitors. In some proposals, it was suggested that the unit should be as free from distraction as possible to prevent any opportunity for escaping from the other or yourself. Others argued that forcing someone to be surrounded by patients who would challenge their complacency could lead to a breakdown or greater effort to get well and that, if the building was safe, the former outcome was not necessarily to be feared. To bring about these improvements in the therapeutic community, then, it would be necessary to push further the limits of self-expression and physical containment.

Certainly, one method for intensifying the therapy was the introduction of more powerful drugs, most notably scopolamine and LSD. Scopolamine, administered in combination with methedrine, was given to patients believed not to have been affected by the other forms of treatment. As described in contemporary accounts, the physical symptoms would consist of dizziness, dry mouth, and occasional feelings of nausea, loss of motor control, and eye fatigue. More importantly, the intended psychological effects were to bring about disorientation and even delirium as a way of breaking through the patient's defenses. In "Defence-Disruptive Therapy," scopolamine-methedrine is characterized as having "greatest value in loosening the rigidly implanted patterns of behavior behind which many patients hide the turmoil of their disorders (Barker, Mason, & Wilson, 1969)." Hervey Cleckley's The Mask of Sanity (1964) — probably the dominant work on psychopathy during this period — had offered a lasting image of the 'psychopath' as someone whose surface normality was belied by profound inner confusion, and there can be little doubt that the avowed purpose of this powerful drug in the Social Therapy Unit — to disorient the patient "with calm exterior and abundant social graces" so that he might "have the intense chaos of his disturbance made more obviously clear to himself and others" (Barker, Mason, & Wilson, 1969) was moved by a similar vision. Scopolamine was directed primarily at patients diagnosed as having a "psychopathic personality disorder," and the expectation was that the "consummately skilled performer" or the aggressively "potent disruptor" of G Ward, when finally confronted with his own deep-seated disturbance and his dependence on others, would become more committed to personal change and less intimidating to his peers.

LSD — which began to be used in 1967 — represented another escalation in the pharmacological assault on the patient's defenses. By this time, LSD was already well-known and widely available to the youth of the period, and at least one of the experiments conducted in the early years of the Social Therapy Unit on the effects of the drug reflects the interpenetration of popular and medical culture. Here patients were given LSD under varying conditions, one of which simulated clinical austerity with nurse and doctor in attendance and the patient lying on a hospital bed, and another of which, identified as "the responsible street model," "consisted of a mattress and cushion in place of the bed and a room furnished with incense and bright flowers all to be experienced with contemporary music in the background" (Barker & Buck, 1977). The approach eventually chosen for the LSD session was consistent with G Ward's distinctive therapeutic culture, in which persons taking the drug would select a

38.

fellow patient whom they trusted to stay with them in a setting free of distraction and secured against danger. Under the effects of LSD, the experiences that were too painful or inaccessible to be aroused even in the emotionally intense environment of G Ward would hopefully resurface into consciousness, so that they could be explored and analyzed. Typically, the person taking LSD might be asked about parts of his crime that were believed to have been repressed, or feelings about other people towards whom he felt attraction or hostility, or the feelings that accompanied an act of forbidden sexuality, or any other aspect of his life that it was felt he had blocked from his experience. As with scopolamine, the contribution that LSD made to the abreactive process was felt to outweigh the various risks of prolonged hallucination, feelings of despair, and so forth, as long as precautions against violent or self-destructive actions were adequate. Finally, another strategy for intensifying therapy on G Ward was to discontinue medication altogether in the hope that the sudden suspension of tranquilizing and sedative drugs would bring out the conflicts and tensions underlying the patients' relationships with each other.

But the experiment that carried the assumptions of G Ward towards their logical, if radical, conclusions was not initiated until the end of 1967. The utopian community that had been imagined only a few months ago could in fact be realized with just a few unorthodox but practicable changes in physical and social environment. The therapeutic intensity that was built up during the long hours of confrontation, support, and analysis and then dissipated by letting everyone retire to the privacy of their rooms could be maintained and even heightened by creating conditions under which all members could be physically present to each other 24 hours a day. This increase in intensity—however necessary to accelerate the recovery process—could never have been tolerated in a conventional setting in which patients might have access to sheets, towels, spoons, belts, glasses, and windows—"a veritable armoury for any person who might be upset enough to think of hurting himself or others." Only if such a setting were made truly safe—if all activities were confined to an enclosed physical space thoroughly purged of all conceivably dangerous objects—could patients be allowed to take the hazardous journey to health that might lead them through deep upset, despair, and even "a wish for self-destruction," but which, for many, was believed vital to their treatment.[7]

The new "compressed encounter therapy"—as this bold experiment was first called—would mark the most complete reconciliation so far of the principles of maximum security and maximum therapy. A single, specially prepared 40 × 12 foot room would accommodate up to 30 of the G ward patients at one time. Here, there would be none of the distractions that weakened the impact of therapy in what by comparison had been a "normal" situation. To meet the stringent demands of safety was also to eliminate the objects and routines that prevented full communication. In the absence of television, books, magazines, and tobacco, the occupants of this special room would be deprived of the usual, socially acceptable ways of escaping interpersonal contact. All furnishings would be removed save for the mattresses and untearable blankets brought to the room at 10:30 p.m. and removed at 7:00 a.m. No medication would be

---

[7] All quotes in paragraph are taken from a memo describing the experiment to relatives of patients.

given to numb the senses or lower anxiety; only "defence-disruptive" drugs such as scopolamine, methedrine, amytal, and dexedrine would be available. Nor would the former denizens of G Ward be able to fall back on the labyrinthine committee structure that had organized their lives in the months before. There would be no clocks or calendars by which to keep to schedules, and no diversionary contacts with the outside world such as letters and visits—not even conversation with the attendants, who stood just outside the room prepared to intervene in case of crisis. The retreat into sleep itself would be rendered difficult by the continuing glare of the bright lights on the ceiling. In place of structure and routine would be the inescapable presence of the other with whom one shared eating, sleeping, and eliminating for an indefinite period that would end not when the inhabitants wanted, but when it was felt that the treatment had taken effect.

The experiment took place over approximately eight months and involved four successive groups—the first group began with 30 of the 38 patients on G Ward, of whom 14 were allowed to leave after two months; the 16 patients remaining spent 100 days with each other before their eventual release in the winter of 1967. The next two groups also consisted of 16 patients and lasted 40 days each; the final group had only 8 patients and continued for 50 days (Barker & Mason, 1968c). A memo explaining the experiment to the relatives of these patients conveys the clear expectation that the processes already set in motion in the rest of the program would be further accelerated. Under such extraordinary and discomforting conditions, even the most adept and well-defended member of G Ward would be forced to reach some liminal point of self-discovery where he would have to face what lay beneath the glib phrase and the smooth performance. The inexorable presence of others—the extreme absence of privacy—would insure that the feelings so aroused were not dissipated. One could anticipate continued tension and feelings of despair, perhaps even feelings of suicide, but in any case therapeutic movement towards a more rapid recovery and release.

But the results of the first group did not entirely fulfill these hopes. Certainly, there were desperate efforts to leave the situation—Barker and Mason mention the "tide of demands, pleas, threats, cajolements, and manipulations" (Barker & Mason, 1968c) that began and continued after the first few days in the room. Albert, who was part of this first group, recalls that one of the patients even contrived a plan in which he would provoke so much hatred towards himself with his cutting remarks that attendants would have to terminate the experiment in order to rescue him from being murdered. What emerged from the group, however, was less hostility than silence and indifference. When one patient went for an X-ray after punching out a window, no one even asked why he had done it or what was bothering him.[1] A few weeks before the group was disbanded, members had stopped talking to each other altogether, and no amount of medication, it would seem, was sufficient to revive the earlier intensity. Despite the pressures generated by this environment, each of the groups eventually reached a limit to mutual involvement that even so drastic a curtailment of privacy could not overcome.

---

[1]The best accounts of Kingsley Hall are by Mary Barnes and Joseph Berke, *Mary Barnes: Two accounts of a journey through madness* (1973) and by Clancey Sigal, *Zone of the Interior* (1978).

From the vantage point of Barker and Mason, the "hundred day hate-in" could be described as both a success and a failure. The patients who reported that the experiment led them to new realizations about themselves — for some a recognition of "horrifying parts of themselves that were previously hidden" — lent support to the claim that only extreme situations such as these could bring out underlying problems of communication. Yet the experiment was also a failure because it had still not removed the opportunity for withdrawal nor sufficiently reduced the risk of danger. Towards the end of the first group, patients began to find ways to use even the slender resources of the compressed encounter unit for amusement and distraction. A thread could be unwound from a sock and placed through a button that in turn could be used to catch flies. Jack remembers building these "mojos" to deal with the boredom and the silence of the final weeks. Besides, there were still windows to look out from and clothes to play with and "meal times and bed times for extraneous interaction" (Barker & Mason, 1968c). At the same time, several of the patients had exhibited what were taken as clear indications that they were on the brink of violent or selfdestructive action, and it was felt that even the catastrophic precautions that had been taken — including the removal of dangerous objects, constant surveillance and the availability of tear gas as a last resort — might be too slow or difficult to implement because of the room's architecture.

The Total Encounter Capsule

The failings of "compressed encounter therapy" resulted in the innovation that would most fully embody the ideals of the Social Therapy Unit. Within four months of the last of these groups, a special room had been constructed that overcame the deficiencies of its predecessor. In the "toal encounter capsule" — more often called the "capsule" or the "box," participants could be allowed a degree of openness and intensity greater still than what had been possible so far. The 'capsule' consisted of an 8 × 10 foot room that was windowless and sound-proofed, thus insulating those inside from the distractions outside. It was continuously lighted so that the inhabitants were free to create their own rhythms of sleep and activity according to the demands of therapy, rather than those of convention. The room was completely self-contained with a wash basin set into the wall and an open toilet located at the rear; food was ingested through plastic straws connected to a liquid dispenser attached to the front door. On top of the capsule was a one-way mirror through which the occupants would be under constant surveillance — audio monitors and closed circuit TV would offer added opportunity for observation and feedback. The absence of furnishings together with a floor consisting of thick-piled rug fitted over a soft foam base would reduce the potential for violence or self-destruction, but just in case these stringent precautions proved inadequate, once again an attendant would be positioned nearby armed with tear gas.

Typically, groups of 5 or 6 patients, but sometimes as few as two, would enter the capsule for a period determined according to various formulae — sometimes, the stay was indefinite and could be terminated only by the decision of others; other times, the occupants had pledged that they would stay for two weeks and would be held to that agreement no matter how eagerly they sought

to break it; less often, those who entered the capsule would be let out only if the group voted unanimously to end the encounter. The groups could consist only of 2 trusted friends or those who found each other's presence most troubling. Patients could compose their own group for admission to the "capsule," but their plan would have to be approved by the appropriate patient committee, and then by the unit director. Participants were usually expected to shed all their clothes upon entry—not only was there a significant contemporary literature that associated nakedness with emotional openness and "authenticity," and clothes with concealment and artifice, but nudity made for a safer and more focused environment without the hazards and distractions that had plagued the compressed encounter therapy.

The capsule would be the ultimate therapeutic tool for breaking down defenses and bringing about personal transformation. Here members would engage each other with an honesty and lack of inhibition that would contrast with what had become the ordinary and routine intensity of G Ward. Sometimes, to speed up this process, each person in the group would be asked to state his feelings and level of trust for the other members, as well as to respond to other matters in a series of prescribed questions called "mirrors." Or, later, the group would listen to a series of tapes that drew from the burgeoning encounter group movement, and work through the various exercises designed to focus each member's attention on the present and on each other. Always, there was the availability of "defense-disruptive" drugs and methedrine to raise the level of tension and reduce the likelihood of withdrawal through sleep or fatigue. In the capsule, one could express hatred, anger, or even engage in shoving or pushing without the session being interrupted. Or one could test the boundaries of then forbidden sexuality by discussing homosexual feelings while in a state of arousal or by embracing another in affection and even passion, as long as it was not consummated and as long as the observers understood that the physical contact was part of a therapeutic movement. Or the group that was desperate to leave the capsule could plot to destroy property or to shatter the mirrors and windows on the inside of the structure, all without prompting the observers outside to force an evacuation. Or one could simply go mad for hours or days, giving vent to the underlying pathology that could no longer be hidden. Here at last, one could tolerate and even encourage the volatile emotions that under less guarded circumstances would be unsafe to express.

If the program of the Social Therapy Unit were ever to fulfill its ambitious goal of "personality reconstruction," here, according to at least some of the patients, was where the transforming power of the intense encounter was most likely to occur. Kevin recalls that it was not until his time in the capsule under scopolamine that he ever revealed to his fellow patients the hard, angry, and dangerous man beneath his surface affability. Jack believes it was only after his session in the capsule that he began to understand the true causes of his mental illness, and that he could begin to live "from the heart instead of from the mind." For others, the revelation might take other forms, such as the open expression for the first time of the fantasy that motivated much of their action, or a sudden disclosure of an unrecorded crime, or some other secret or secret identity finally to be shared with the other patients on the ward.

But perhaps no one made fuller use of the capsule than "Mark," the patient

who, more than any other, came to exemplify the ideals of the program, both in terms of the level of commitment it would take to go beyond one's defenses and the changes that were possible for those who emerged from this ordeal. Mark had entered the program as someone described in his medical records as fitting the profile of the "classic psychopath." The crime that led to his confinement at Oak Ridge involved the shooting and killing of two persons, both of whom were strangers, for reasons that were never understandable to the police, lawyers, or psychiatrists involved with his trial. What staff and patients found most striking, however, was his attitude of indifference towards his victims: Reports taken during small group meetings mention Mark talking about his crime in a "cheerfully delighted bragging manner," or stating that killing people was just like killing bugs, or boasting about the power you held over someone once you made a decision to kill them. Mark became significant to the Social Therapy Unit because few were perceived as so "well-integrated" and 'solidly entrenched' in their defenses, and fewer still pledged themselves with greater tenacity to the ordeal of self-transformation. He was in 9 of the first 13 groups to go into the capsule, sometimes there at the request of others as the person to whom they were most willing to reveal themselves and, other times, it was his "pathology" that was the object of attention. Yet the culmination of his therapy did not come until several years later when, despairing that he would ever change even after his numerous experiences with "defense-disruptive drugs" and sessions involving prolonged encounter, he asked that he again be placed in the "capsule," this time to be deprived of sleep—"I should like to go in the box . . . and be kept awake as long as possible with whatever drugs you think would do this. I think sleep is one of my biggest defences, and I'm aware from past experiences that a couple days sleeplessness really upsets me and changes my thinking drastically." It was here that Mark would show his fellow patients and staff the inner chaos believed to lie below the social mask—a lengthy letter would give details about the world he had inhabited and was now prepared to share. In the culture of the Social Therapy Unit, the capsule was to be the site of extraordinary events—of breakthroughs and recovery.

For those eager to change, the intensity of G Ward barely kept pace with their aspirations. For Jack, Albert, and Kevin, the promise of the Social Therapy Unit was that they would become "new men"—no longer the person who could in cold fury murder the woman who reminded them of their mother or who could "knock someone off" without any feeling, or remain at the mercy of feelings they could neither control nor understand. For patients such as Jack and others, the process was so important that they would astonish the review boards before whom they appeared by preferring treatment under confinement to liberty—claiming that they needed to complete their therapy before they could ask for release. Still others would write tributes to the program, avowing that whatever deprivations they had endured, the results amply justified the means. For some, however, who did not want to change in the ways prescribed by the program, compulsory placement in the Social Therapy Unit was a continuing battle of wills against an overmatched foe—sometimes to be pacified by pretending to comply, other times to be resisted by evasion or outright defiance, but ultimately an ordeal for which the best possible outcome was survival. Just as there were testimonials by grateful expatients, there were also

pleas for transfer and complaints about the use of force, with some patients
protesting as new demands for participation were being introduced against
what they perceived as excessive and unwarranted intrusions into their lives.

On Force and Freedom

It is just one of the paradoxes of the Social Therapy Unit that the ordeal it
required of its charges can be described as easily in the authoritarian language
of the 1950s as in the emancipatory rhetoric of the decade that followed. If
patients were expected to undergo a "major reconstruction of personality,"
would this transformation resemble a Laingian journey towards self-discovery
or the forced march of involuntary resocialization? On the one hand, in "Buber
Behind Bars," Barker and Mason wrote in defence of coercion that "if our
patients did not choose to deviate from society's norms, but rather were driven
to such deviations by internal unresolved conflicts, then we should help them
by every means at our disposal, including force, humiliation, and deprivation,
if necessary" (Barker & Mason, 1968a). Elsewhere in the same article, the
authors wrote that "if anything is being brainwashed into or forced upon Oak
Ridge patients, it is, we think, the concept of an open system of evaluating,
comparing, and questioning, rather than a closed system of revealed truths,"
also implying that aggressive methods could be justified if directed towards
benevolent purposes. In a series of forthright publications, Barker and Mason
described a therapeutic process that was neither permissive nor primarily sup-
portive, contrary to the prevailing ideology of therapeutic communities, and in
which coercive controls would play a central role in reconstructing the patient's
personality.

On the other hand, accompanying this harsh, activist language that spoke of
"force" and "brainwashing" and "personality disintegration and reintegration"
was a softer discourse that drew its inspiration from the hortatory literature of
the human potential movement. From this vantage point, the process of ther-
apy was less one of forcing change than of creating opportunities for greater
psychological freedom. The Social Therapy Unit borrowed heavily from the
writings of Laing and Buber, and the "reconstruction" of the personality be-
came as much a quest for transcendence as a process of compulsory resocializa-
tion. To change meant to reach some irreducible, undefended core in one's
being from which one could relate to others in ways that were free of fantasy
and manipulation. From Laing came the belief that the transition from surface
normality to overt psychosis might constitute a movement towards sanity in-
stead of the reverse (Barker & Mason, 1968b). From Buber came the faith that
full engagement with the other—genuine dialogue—could be the occasion for
decisive personal transformation. Where coercive therapy involved forcing
compliance and repressing dissent, the humanistic literature of Laing, Buber,
and others stressed openness, self-expression, and transcendence through ca-
tharsis.

To be sure, it is an understatement to suggest that the ideas of Buber and
Laing were deployed selectively. That communion could ever be achieved
through compulsory interaction was explicitly antithetical to Buber's views on
genuine dialogue (Buber, 1961). And Laing's own experiment with therapeutic

communities—the anarchistic Kingsley Hall—was anchored in a philosophy that rejected the use of force or intimidation in any form whatsoever as an adjunct to therapy.[8] But this is not to imply that the inclusion of these writings was merely strategic or insincere.

The Social Therapy Unit began with the optimistic view that emancipatory goals could be accomplished through coercive means. Freedom connoted not the absence of constraint, but an inner state that lay at the end of a therapeutic process. Indeed, rarely has a therapeutic program articulated a philosophy so dramatically and audaciously at odds with liberal ideals of choice and freedom. In the political equation that emerged on G Ward, the achievement of inner freedom was virtually unattainable without abandoning one's freedom to be left alone, to remain private, or to be protected against external interference. Thus was the paradox of humanism and coercive therapy resolved: Force was a necessary condition for freedom.

The Social Therapy Unit in Historical Context

For all the changes in programming and leadership that occurred between 1968 and 1978, the Social Therapy Unit continued to adhere more or less to the original radical vision that had been concretized in the first few years of its operation. Even after Barker had chosen to be replaced by another psychiatrist in 1972 and the Social Therapy Unit had expanded from one to four wards comprising 150 men, the intense communalism of G ward remained as an ideal to be emulated. The program was not without its crises and challenges during this time, but it survived an Ombudsman's investigation in 1976 and a Federal Inquiry into the Canadian penitentiary system in 1977. Ironically, it was only 11 months after the chair of this Inquiry described the program as "the most fruitful in the universe" and Oak Ridge as "the single most impressive institution that I have seen in travelling across the country" (Minutes of Proceedings, 1977) that the Social Therapy Unit imploded in a confrontation from which it never recovered. A dispute between the unit director and the attendants in which the former was accused of undermining security and the latter of sabotaging the program resulted in a lockout of the professional team and that team's subsequent transfer to other treatment sites at Penetanguishene.[9] In the aftermath, the core innovation of the experiment—the total encounter capsule—was dismantled, and five successive unit directors were hired and replaced within a period of two years. Despite Barker's part-time reinvolvement in the program in the early 1980s, the remnants of the Social Therapy Unit were jettisoned in 1985 following the recommendations of a report published in 1984 by a special committee that had been struck by the Ontario Ministry of Health[10]—well before evidence of the success or failure of the program to meets its objectives had become available.

---

[8] The best accounts of Kingsley Hall are by Mary Barnes and Joseph Berke, *Mary Barnes: Two accounts of a journey through madness* (1973) and by Clancey Sigal, *Zone of the Interior* (1978).

[9] An account of this episode is contained in AO, RG10-67, B.4, Accession 18385, March 28, 1978 W C. Jappy, Director, Psychiatric Services Branch to Mr. D. N. Teasdale, General Manager, Direct Services Division.

[10] The report was published in 1985 under the title *Oak Ridge: A Review and an Alternative.*

The history of the Social Therapy Unit reflects both the often unacknowledged permeability between psychiatry and its cultural milieu and the sobering residue that remains when the guiding assumptions of one generation can no longer be sustained by its supercessors. A therapeutic regime that exalted the patients' experience and devalued professional expertise as a source of knowledge about madness was compatible not only with the ethos of the therapeutic community movement arising in England, but also with the even more aggressively populist self-help movements emerging in the United States, and represented most notably by Alcoholics Anonymous. Eventually, later variants of this populist strain, such as Synanon and Daytop, would devise their own unorthodox methods for affecting radical personal transformation through intense communal involvement—methods that invite close comparison with those developed in the Social Therapy Unit. Similarly, the emphasis on self-disclosure and self-expression as a means of overcoming inner psychological constraints was consistent with a burgeoning contemporary literature that favored abreactive approaches to therapeutic change. Visitors who witnessed the extraordinary measures taken by patients on G Ward to "crack" through each other's defenses would have had no difficulty finding common points of reference outside the recesses of Oak Ridge, whether in the encounter group movement or in other social experiments of the period. The belief that personal growth and recovery required a break with "normal" sanity, whether spontaneous or triggered by extreme social situations, represented an elaboration of ideas developed by Laing and Cooper—indeed, the idea of a "psychotic sunroom" was borrowed directly from one of Cooper's own improvisations on a psychiatric ward. If these guiding assumptions of the Social Therapy Unit seemed plausible to contemporaries in the initial stages of the experiment, their validity was no longer so obvious even a decade later, as a new generation began to ponder the costs of situationally induced psychological crises and the dangers of allowing groups, whether under the auspices of therapy or religion, so much power over the individual.

In the early days of G Ward, a standing joke for those who could understand it was that some 200 years after Philippe Pinel had liberated the mad inmates of Bicetre from external restraints, Barker's innovation was to reintroduce what appeared to be almost identical physical controls at Oak Ridge. The humor of the remark could be appreciated only if the audience recognized that the purpose of cuffs in the Social Therapy Unit was the obverse of what chains and fetters had been used for in 18th-century France. At Oak Ridge, one restricted movement not to repress or to punish but to facilitate self-expression and to prevent withdrawal from the community. Only a generation after the introduction of this technology, however, the line separating the daring and revolutionary innovation from its earlier appearance in the service of repression had become blurry indeed. The committee that reviewed Oak Ridge in 1984 claimed that it could not see "how the procedure (cuffing) could be regarded as therapeutic" and viewed it as a "matter of grave concern that (cuffing) occur in a psychiatric hospital when these practices could not be used in a prison (Oak Ridge, 1985)." As the symbols that justified this and other G Ward innovations have lost their cultural authority, what remains most visible is what contemporaries either ignored or chose not to view as problematic. If

one no longer accepts or comprehends the original vision that linked external constraint to psychological freedom, the psychiatric power that allowed patients to be conscripted into continuous, unrelenting scrutiny and control over each other's bodies and minds appears even more limitless and unbounded than the carceral power it replaced.

The Social Therapy Unit is still remembered by some as a successful venture in utopian experimentation; for others, it embodies the ultimate of modern tyrannies—the state-authorized subjection of the individual without any countervailing restraint. If one version vastly understates the costs and difficulties of coerced change for those who experienced it, the other fails to acknowledge the attraction of a totalizing therapy for those who yearned for personal transformation and who wanted to distance themselves from their violent deeds. When Donald McCulloch, then director of the Queen Street outpatient clinic and a member of the faculty of psychiatry at the University of Toronto, wrote in 1966 that "nothing short of a major brain-washing program in an institutional setting could bring about the altered value system complete with the altered inner controls" to change persons who repeatedly defy accepted codes of conduct regulating violence and sexuality (McCulloch, 1966), he was expressing a pessimism widely shared among psychiatrists at the time that the kinds of patients who made up a growing proportion of the Oak Ridge population were untreatable by conventional methods. But while he assumed that ethical constraints would preclude the drastic solutions required, the originators of the Social Therapy Unit decided not only that treatment was possible, but that the stakes were sufficiently high to justify an intensive and radical therapy despite the professional and institutional risks that might be involved. A generation later, the problem of the "violent psychopath" has been redirected from psychiatry to criminal justice (Kjeldsen v. The Queen), optimism about the possibility of "restructuring" personality has given way to a loss of confidence about the effectiveness of therapeutic intervention, and the scope of psychiatric authority has been bounded by legal strictures that allow patients the right to refuse treatment (Mental Health Act Amendment Act, 1987, s.35(2)). What remain are questions about the use of therapeutic discourse as a resource and justification for a program of coercive resocialization, the interplay between patients, attendants, and psychiatrists in the building of a distinct therapeutic culture, and the limits of human malleability under extreme social conditions.

References

AO, RG10-67, B.4, Accession 18385, March 28, 1978, W.C. Jappy, Director, Psychiatric Services Branch to Mr. D. N. Teasdale, General Manager, Direct Services Division.

Barker, E., & Buck, M. F. (1977). LSD in a coercive milieu therapy program. Can. Psych. Assoc. J., 22, 311-314.

Barker, E., & Mason, M. (1968a). Buber behind bars. Can. Psych. Assoc. J., 13, 61-72.

Barker, E., & Mason, M. (1968b). The insane criminal as therapist. Can. J. of Corrections, 10, 3-12.

Barker, E., & Mason, M. (1968c, October). The hundred-day hate-in: A stubborn attempt at staffless milieu therapy. Paper presented to Ontario Psychiatric Association, 1-14.

Barker, E., Billings, D., & McLaughlin, A. J. (1969, March). The total encounter capsule. Paper presented to National Scientific Planning Council of the Canadian Mental Health Association, 1-19 not including appendices.

Barker, E., Mason, M. & Wilson, J. (1969). Defence-disrupting therapy. *Can. Psych. Ass. J., 14,* 355–359.

Barnes, M., & Berke, J., (1973). *Mary Barnes: Two accounts of a journey through madness.* Middlesex: Penguin.

Boyd, B. (1963). Correctional service training. *Can. J. of Corrections, 5,* 343–346.

Boyd, B. (1978, April). Development of Oak Ridge. Paper given at Clarke Institute of Psychiatry.

Bruner, A. (1977, March 26). "The Penetang Experiment." *Globe and Mail.*

Bruner, A. (1976a, June 10). Frank young men of F Ward have histories of horror. *Globe and Mail.*

Bruner, A. (1976b, June 11). Freaking out. *Globe and Mail.*

Bruner, A. (1976c, June 12). Caged men who long for freedom. *Globe and Mail.*

Buber, M. (1961). *Between man and man.* London: Fontana Library.

Caron, R. (1978). *Go-boy Memoirs of a life behind bars.* Toronto: McGraw-Hill, Ryerson.

Cleckley, H. (1964). *The mask of sanity,* 4th edition. St. Louis: C. V. Mosby.

Darby, G. H., Barker, E. T., & Mason, M. H. (1966, October). Buber behind bars. Paper presented to Ontario Psychiatric Association, Geulph, Ontario.

Editorial (1967, March 18). *Globe and Mail.*

F Ward (1971). Written and produced by Norm Perry, CTV News.

Hollobon, J. (1967, March 18). My Therapist, the Psychopath. *Globe and Mail.*

Hospital for the Insane Act, R.S.O., 1914.

Jones, M. (1962). *Social psychiatry.* Springfield: Thomas.

Jones, M. (1954). The treatment of psychopathic personalities. *Proc. Roy. Soc. Med., 47,* 636–638.

Kjeldsen v. the Queen (1981), 64 C.C.C. (2nd) 161 (S.C.C.).

Lynch, D. O. (1937). Some observations on the criminally insane with special reference to those charged with murder. *Ontario Journal of Neuro-Psychiatry, 12,* 39–52.

McCulloch, D. J. (1966). Some observations on psychopathy. *Can. Psych. Assoc. J., 11,* 132–138.

McKnight, C. K., Mohr, J. W., & Swadron, B. B. (1962). The mentally ill offender in the Oak Ridge Hospital unit. *Criminal Law Quarterly, 5,* 248–258.

Mental Health Act Amendment Act, S.O. 1987, c. 37.

Minutes of Proceedings and Evidence of the Sub-committee on the Penitentiary System in Canada (1977, March 8). Ottawa: Queen's Printer (Supply and Services Canada).

Oak Ridge: A review and an alternative (1985). Report of Committee to Review Oak Ridge and its Programmes. Toronto: Ministry of Health.

Out of sight, out of mind (1982). Toronto: CBC-TV, *For the Record.*

Rapoport, R. (1960). *Community as doctor.* Springfield: Thomas.

Report of the Royal Commission of the Law of Insanity as a Defence in Criminal Cases, 1957.

Sigal, C. (1978). *Zone of the interior.* New York: Popular Library.

Valpy, M. (1968, December 7). *Naked in the box. Globe and Mail.*