In Conversation with Maxwell Jones

Brian Barraclough interviewed Professor Maxwell Jones at his home on 23 September 1983.

BMB Do you come from a medical background?

MJ No, more of a religious background from the North of Ireland. One of my forebears was a Moderator in the Church. My father's family was involved in the educational field. My aunt was headmistress of Harrogate College, a prestigious girls' school. So my parents' professional backgrounds were education and religion.

BMB You were born in Ulster?

MJ I was born in Queenstown, South Africa. My father went there at the end of the last century when lots of young men were attracted to an adventurous way of life. We lived in Mafeking until I was five, when my father died.

BMB What year were you born?

MJ 1907.

BMB So you came back to England in 1912, just before the war.

MJ Yes, it was a courageous thing for my mother to do because she had three children and, my father being a young man, we didn't have much money. Her father had emigrated to Indianapolis when he became a millionaire. She knew no one in Edinburgh, but knew that a good, inexpensive education could be obtained there. This didn't please the rest of her relatives, but nevertheless, she did it.

BMB Where did you go to school?

MJ Stewarts College, a typical Scottish day school—hard working, hard playing. I am a great respector of the Edinburgh schools. Plenty of competition among the numerous excellent schools.

BMB Then what happened?

MJ I wanted to be a coffee planter in Kenya. I suppose I had some of my father's roving spirit. I needed £2,000 which the government required if you were to go to Kenya to develop a parcel of land. Unfortunately, no one seemed eager to lend it to me. So, I settled for my second love, which was psychiatry—the idea of knowing people. I had read many of the classics and thought the character studies were fascinating, and so I decided to study psychiatry. I slogged through medicine in order to become a psychiatrist. It wasn't a love of medicine at all, just an interest in people.

BMB How old were you when you made that decision?

MJ I guess just school-leaving age, because I tried very hard to get the money to go to Kenya. I remember having to do some Latin at the last moment in order to get into university.

BMB That was Edinburgh University—where you graduated in medicine?

MJ That's right. I suppose I was an average student. I wasn't thrilled with medicine. I was always inclined to look at the lot of the underdog. It may not be so bad now, but in those days, it seemed to me that patients were dehumanized; to see a young woman patient in a lecture theatre exposed physically to 200 students without being forewarned didn't thrill me—I thought it was insensitive, the lack of privacy, everything about it was so callous. And I never made friends with any of the lecturers. I resented their aloofness and lack of warmth, although I suppose this was inevitable given the size of the classes—200 each year. Still I count myself lucky to have been able to go to university and enjoy the athletics and so on. But my goal was quite clearly psychiatry, not medicine or surgery. That was unusual in those days because it wasn't highly regarded as a profession.

BMB Was there any psychiatry in the undergraduate curriculum in the '20s in Edinburgh?

MJ A little, because Edinburgh had the first Professor of Psychiatry in Britain, Rosy Robertson, and he was followed by Sir David Henderson, who really made a name and was the great high priest of psychiatry at that time. So I was able to make a good start in my training with Sir David Henderson.

BMB Had he been with Meyer in Baltimore?

MJ Yes, that was *the* place to go at that time, and Henderson became his best known pupil. Meyer was a psychobiologist really, which is quite remarkable. He was ahead of his time.

BMB What kind of teaching did you have as an undergraduate in psychiatry?

MJ Pretty traditional. Sir David Henderson gave lectures and we had the inevitable exposure to the 'loonies' and I was very unhappy at the rather cold 'objectivity' of it all. I liked good writing, and I liked rather romantic interludes, but it was all stark fact. I wasn't very happy until I began to see what I could do working with more exciting neurotic, psychopathic and psychological disturbances. I worked for nothing for six months in order to get into the clinical field I wanted, and Sir David was apparently impressed by my motivation. Then, to my amazement, in 1936, I was awarded a Commonwealth Fund Fellowship to the United States for two years. I was by now doing quite a lot of research in carbohydrate metabolism and enzyme chemistry which no doubt helped me to get this Fellowship. In those days it was considered to be prestigious as they took only thirty people each year from the universities of the entire Empire. I worked for a year at the University of Pennsylvania where I continued to do non-clinical research and we had some exciting times—looking at cholinesterase and its effects

on the transmission of nerve impulses, etc. I went for my second year, 1938, to Columbia University Medical Center in New York. By that time, I was determined to do animal work which I had already begun before I left Edinburgh. I had a very good year studying hormones using experimental animals and then Aubrey Lewis invited me to come to the Maudsley. This was 1938.

I stayed with Sir Aubrey for five years at the Maudsley (evacuated to Mill Hill School). My psychosomatic interests and research resulted in my being asked to head a unit on cardiac neurosis or Effort Syndrome, a condition called neuro-circulatory asthenia in the USA. I worked with a colleague called Paul Wood, an outstanding London cardiologist from Australia, who stayed with us for 18 months. We did, I think, a pretty thorough bit of clinical research and demonstrated that this syndrome of left chest pain, breathlessness, giddiness, etc., had some real chemical indicators. We had a unit of 100 beds filled with army personnel for over five years. The Harvard Fatigue Lab later confirmed our findings and agreed that the poor response to exercise pointed to a poorly integrated autonomic nervous system. I wrote up all this work and got a gold medal MD from Edinburgh which was, I think, the first they had ever given in psychiatry.

BMB Did you do that work in America before you joined the Maudsley?

MJ No, this was all in wartime. The challenge resulted from the large number of Forces personnel with this condition.

BMB It was a military problem?

MJ Absolutely. In fact, it was hardly noticeable in peace time, although sometimes affecting overstressed housewives, but in wartime, with increased physical output in army training, it showed up.

BMB Are you a religious man?

MJ I am becoming one. My mother was a good Scottish Presbyterian, but it is very interesting what happens as you grow older. I must interject one other thing that is relevant about the Effort Syndrome soldiers—100 men in all. As they all had the same clinical condition, commonsense dictated that we should begin to treat them as one group. So we had daily meetings with 100 men and all the staff on duty. We had nurses, etc., because in wartime, everyone was recruited. Some of these recruits were artists and they contributed audio-visual aids which we hung on the walls showing the patients' symptomatology in a very dramatic way, including diagrams of the autonomic nervous system. It was tremendously exciting, as patients and staff were working together in furthering treatment with the patients themselves being a valuable resource for teaching. Moreover, it helped to undermine our unpopularity as we were inevitably trying to get them back into army service. So they listened with open ears to their peers. We were there as resource people and didn't say too much because there was always a nucleus of patients who understood their clinical state as they had learned that we had learned about the lack of homeostasis in relation to their exercise physiology.

This experience over a period of five years, opened my eyes to the power of the patient peer group in treatment and I began to wonder why much more is not done in a metabolic hospital ward with a diabetic group or whatever. You get an immense amount of material from the patients, much of it distorted or erroneous which you can then modify and direct in healthy directions, but I don't think I have ever heard of anyone doing this. Anyway, that's how we started learning from patients.

BMB Where were these 100 beds?

MJ At Mill Hill. The public school was evacuated when we were moved from the Maudsley to Mill Hill. And the other half of the Maudsley, mainly organically oriented staff, went to the south of London to Sutton, Surrey, to the Emergency Medical Service (EMS) hospital there.

BMB And who was with you at Mill Hill?

MJ The more analytic crowd. Sir Aubrey, himself, Walter McClay and Stokes, who later became the Professor of Psychiatry at Toronto, and those of the Maudsley staff who were psychodynamically oriented.

BMB Were you recruited to the Army?

MJ No, none of us was. The Army was in part associated with the Tavistock Clinic and the Navy was with Desmond Curran and the St George's crowd. The Maudsley was the EMS. It was weird. When the war ended, the Maudsley were asked to take over a unit situated in a hospital near Dartford, Kent, for the rehabilitation of the most disturbed 100,000 prisoners of war returning from Europe and the Far East. I was asked to head this unit of 300 beds. It was a fairly natural transition from the physiology of the Effort Syndrome group to the sociology of the POW group. The army were doing much the same thing in their 17 civilian resettlement units—but what we had were supposedly the most mentally disturbed of the POWs.

BMB European prisoners of war?

MJ Yes. At Dartford, things were very well organized. The Government put all the Green Line buses we wanted at our disposal. These were needed for our plan to rehabilitate the men in real life situations. I went round the Dartford area on a push-bike and got 70 employers to agree to take our men and help them to find their feet after being isolated in prison camps for up to five years during wartime. We had them in everything from shipbuilding yards, to market gardens, to shops, and the Green Line buses went round and dropped them off at their chosen places of work. They worked for short periods, four hours or so, and were treated very understandingly by the regular employees, and then came back. We discussed their difficulties at work, their nega-

tive self-images, lack of confidence in social situations, fear of impotence after years of separation from the opposite sex, paranoid feelings about their wives and others.

The men were housed in six cottages each with 50 beds. Each unit had a daily community meeting along the lines we had developed at Mill Hill. We were still an annexe of the Maudsley and had retained most of our original staff. In a supportive environment where the trust level was high, the men discussed their fears about returning to society and to their wives and children born in their absence, their adequacy as husbands, and so on. We had a year at Dartford, 1,400 admissions in that year, I remember. We worked unbelievable hours, but the morale was high. A follow-up study of our rehabilitation results done by the Ministry of Labour showed that something like 86 per cent were at work six months later.

BMB But, what were they cases of?

MJ They were cases of maladjustment resulting from imprisonment and then release to their old world, but now feeling like strangers. Emotional reactions, depression, paranoia and fear of impotence and inadequacy generally—so it was another syndrome like the previous syndrome. And now we had a POW syndrome with a cluster of symptoms evidenced in a similar form in most of the cases, plus a few psychotic and other reactions.

BMB Were they men who had had a trial back in civilian life in England or had they come straight on release?

MJ This was before release from the Army. They were screened and if they were found not to be well enough to return home as civilians, the government said we must help them to rehabilitate first.

BMB Whose idea was it to have this rehabilitation emphasis at the Maudsley?

MJ I think the Army must have said that the Maudsley should take some part in this process. We didn't have to collaborate with the Army. We did our own thing, but learned retrospectively that our methods and those employed at the Army units were very similar. We were now asked by the Ministries of Labour and Health if we would tackle another social problem—the down and outs in London. Initially they were characterized as the 'hard core' unemployed. They were not just workshy but also lacking in motivation to do anything approaching an organized existence. And that was the start in 1947 of what I've spent the rest of my life on evolving—a therapeutic community. When we first saw these people, we soon realized that they were quite outside our previous clinical experience and our training to date wasn't much use. So we more or less taught ourselves as we went along. The war was over and an atmosphere of change was in the air. We all wanted an end to wars and a better world for everyone, including the disadvantaged. The idea of accepting another challenge was appealing to us, especially as it was in a sort of 'no man's land' between medicine, social work, social psychology and economics.

We had a well balanced team of mental health professionals, including three psychiatrists and were housed in a decrepit old building which was once a workhouse. The main hospital had been Sutton EMS Hospital during the war. It was now known as a neurosis centre and the personnel there clearly disapproved of our proximity as well as our clinical outlook.

BMB What period are we speaking of?

MJ I'm talking about the 12 years I spent at Belmont, later called Henderson Hospital, from 1947 to 1959. We continued to evolve the community and group methods we had started during the war and relied increasingly on inputs from the 100 clients or 'patients' of both sexes for help. Most of them came from the poverty areas of London and had never known a stable or supportive home or social environment. Psychiatry tends to label these people as sociopaths or psychopaths. I'd prefer to see them as anomalies of growth, probably environmentally determined. Unlike the mentally retarded with low IQs, these people were emotionally retarded. Our aim was to create an environment conducive to social maturation. It had a 'family' atmosphere—no locked doors, no drugs, first names only (staff and patients) and an essentially democratic social structure.

BMB How did you set about that?

MJ Well, we opened up communication of thoughts and feelings at our daily community meetings of all 100 patients and about a dozen staff. These were followed by small group meetings of around 10 patients with a staff leader. What evolved has come to be called a therapeutic community. We aroused considerable interest in psychiatric circles both in this country, the USA and some countries in Europe—Scandinavia in particular. In fact, treatment facilities calling themselves 'therapeutic communities' are now commonplace, but often bear little resemblance to the original model. Henderson Hospital has continued to evolve as a treatment centre for character disorders to this day, under the leadership of Dr Stuart Whiteley, and is spearheading a specific training programme in this field.

BMB What happened next?

MJ After 12 years at the Henderson, I needed a change and was glad to accept a teaching post in California, at Stanford University. There was much interest in therapeutic communities in the USA and we had been given the Isaac Ray Award by the American Psychiatric Association in 1959 for our work in this field.

BMB Did you stay in America?

MJ Yes and no. I stayed there for four years before returning to the UK. After the year at Stanford University, I was offered a teaching post at Oregon State Hospital. I was eager to demonstrate that a therapeutic community

was relevant to any psychiatric facility and not just in relation to character disorders. I went to Salem, the capital town, and stayed for three years in which time a large traditional mental hospital was transformed to one which showed most of the characteristics of a democratic system. It would have been an impossible transition but for the support of a very liberal Medical Director, Dr Dean Brooks.

BMB Why did you leave Oregon?

MJ What happened has become all too familiar an experience to me or anyone else attempting to be a change agent. Although the democratic system we were developing helped staff and patient morale as well as treatment results, the new freedoms signalled dangerous signs of change to the conservative, hierarchical forces in psychiatry, in politics, public opinion, big business and bureaucracy generally. Disapproval emanated from the Governor's office, which unfortunately was situated near the hospital. Rumour, misinformation and prejudice followed. I was made to feel that I was no longer welcome and it was hinted that I was a Communist!

A suggestion from Professor Morris Carstairs in Edinburgh that Dingleton Hospital in Melrose, Scotland, would soon become vacant proved to be an irresistible temptation. Nowhere could a social ecological approach to treatment and prevention be more likely to succeed than in this the first 'open' mental hospital in the English-speaking world, thanks to the pioneering work of Dr George Bell.

BMB And you went to Dingleton?

MJ Yes. I was there from 1962 to 1969 and was able to satisfy myself that a traditional, autocratic mental hospital could become an open system, given time and sanctions from above. Clinically, this was the most creative period of my life and I have tried to describe the process of change over a period of seven years in a book of that name.

BMB Is *The Process of Change* published in this country?

MJ Yes, by Routledge and Kegan Paul in 1982. I left Dingleton because I was nearing retirement age and seeing no chance for further work in the UK, I returned to the US having been offered a teaching post at Fort Logan Mental Health Center in Denver, Colorado and later a clinical Professorship at the University of Colorado.

BMB What do you feel about present day psychiatry?

MJ We seem to have regressed from the pioneering days of the post-war era and especially the 1950s and 1960s when much of the excitement and change in social psychiatry stemmed from the mental hospitals, rather than the universities. Men like T. P. Rees at Warlingham, Rudolph Freudenberg at Netherne, Denis Martin at Claybury, Duncan McMillan at Mapperly, David Clark at Fulbourn, Cecil Beaton of Portsmouth, B. M. Mandelbrote and B. Pomryn at Littlemore virtually created the field of social psychiatry. It seems to me that both in the UK and the US a rather dreary conformity predominates now and the abuse of power persists largely unchallenged. I know this will sound too extreme a view to many psychiatrists. But in an age when enormous changes are occurring in Western Society, whether technological or cultural, we in mental health are contributing far too little to the humanization of our hospitals and social systems generally.

BMB Could you explain that statement further?

MJ Take the authority structure in most mental health facilities. The doctor usually remains dominant and makes the final decisions. His skills are essentially organic and clinical with little exposure to, or training in, social systems, communication theory, learning theory and the behavioural sciences generally. As a result, staff morale is often poor with resulting high turnover and absentee rates. It saddens me to see more interest in systems for change in at least some businesses where enterprising firms are re-examining their entire operation—their roles, role relationships, authority structure, values, attitudes and beliefs. Everyone in their employ is being given a new importance and an opportunity to communicate and contribute to change and progress. If all this can happen in the name of profit, surely we have a similar responsibility to attempt to change hospital and medical systems generally in the cause of humanism.

BMB What exactly does that mean?

MJ I find that nowadays mental hospitals are unhappy places with frustrated staff and relatively neglected patients. Compared with the 1950s and 1960s, these institutions seem not to be going forward or evolving. There are exceptions of course, including therapeutic communities like Dingleton, Henderson, The Cassel Hospital, Fulbourn, etc. But cross fertilization with traditional facilities, including the universities, is rare. On the positive side, Henderson Hospital and others have evolved a Therapeutic Community Association which is developing training programmes in open systems theory and practice. These are organized by Graeme Farquharson, a social worker, and others. The *International Journal of Therapeutic Communities*, edited by Bob Hinshelwood, helps to integrate people interested in this approach on an international scale and Dr Stuart Whiteley organizes an annual conference at Windsor which attracts many people from Europe and some from the US.

BMB Have you anything further you'd like to say before you finish?

MJ Yes, I'd like to summarize how my work with open systems and therapeutic communities has shaped my own personal philosophy. I feel that the striving for freedom and peaceful conflict resolution which characterized much of our immediate post-war thinking

became epitomized in the therapeutic community movement. We played an important part in the evolution of social psychiatry which helped us to see the importance of social ecology and the lessons we must learn from nature. These liberal qualities then became confluent with the social evolution in the Western countries beginning in the 1960s and is still gaining momentum. As Capra, a distinguished physicist, points out, we seem to have reached a 'turning point' where the familiar reductivist scientific approach to learning and growth is being implemented by an integration of Eastern and Western cultures and a new conceptual framework for economics, technology, physics and medicine.

In a more specifically Western context, there are numerous cultural movements including environmentalists, feminists, consumer advocates, peace movements and many others. Part of this changing climate of public opinion is the growing disenchantment with the abuse of authority by the professions such as law and medicine and by government generally. In this context, politicians seem to be more concerned with the retention of power than with societies' individual needs. If we consider a hospital to be a microcosm of society, then a therapeutic community is associated with all the foregoing problems of social structure, decentralization, information sharing and shared decision-making at all levels of the social organization from patients to governing bodies.

In the therapeutic community movement we have come to have a deep distrust of reductivism in the form of scientific research unless it is linked with a humanistic orientation and subject to constant discussion and recycling with a view of achieving consensus with all the participants. We are not afraid of social values which highlight morality and the need to keep a constant check on the abuse of power. We evolved a democratic system which inevitably clashed with the more authoritarian and technocratic systems in other psychiatric facilities and in our surrounding environment, dominated by professional tradition, rationalism, and secularism.

At the same time, we became conscious of the effects resulting from our change from an individualistic society to one with a group identity. We began to experience new strength and a feeling of security which was badly needed to combat the constant attempts to liquidate us which came from our own profession. This empathy amongst staff and patients was the start of a growing synergism and we began to comment on our feeling of fulfilment which at first as individuals we were at a loss to explain. We even dared to recognize a growing spirituality which helped us to explore new dimensions of consciousness such as intuition and the motivating driving force. Our group consciousness and open system organization seemed to have something more than the aggregate wisdom of a number of people with their individual inputs and good will. In effect, it was synergistic and creative.

It is in this context that the therapeutic community has relevance. Its survival as a model for change, its positive healthy effect on the people involved, its answer to the abuse of power by delegation of responsibility and authority to the level in the system where it belongs, its conceptual framework of multiple leadership, social learning, growth and creativity reflects one approach to the cultural dilemma of our time. The general principles worked out in a microcosm of society, a hospital, can be applied to all levels of our cosmic society if adapted to the culture and social environment as required. It has taken me forty years to arrive at this point as one individual with, I hope, many peers who epitomize this spirit of change which seems to grow daily everywhere. Can the gradual metamorphosis to holism be speeded up in time to prevent an atomic holocaust or famine on a world scale?

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