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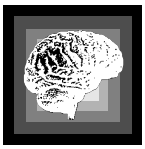

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Classic Text No. 133

‘Maxwell Jones and the Therapeutic Community’, by David Millard (1996)

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Abstract
This text was David Millard’s departing gift to a field to which he had contributed for 30 years, as practitioner and later as Lecturer in Applied Social Studies and editor of the *International Journal of Therapeutic Communities*. Charting the chronology of Maxwell Jones’s career as a world-renowned psychiatrist and therapeutic community pioneer, Millard contrasts Jones’s contribution at Mill Hill with Tom Main’s at Northfield. Jones’s most distinctive contribution was allowing patients to become auxiliary therapists and freeing nurses from the nursing hierarchy. Focusing on a subset of therapeutic communities in adult psychiatry, Millard’s paper is not an academic history of therapeutic communities as such. The roles of happenstance and positive deviance are demonstrated in the way change occurs in therapeutic communities. The ‘charisma question’ is briefly explored.

Keywords
Maxwell Jones, Mill Hill, Northfield, therapeutic community, Tom Main

Introduction: ‘I concur as a clinician’

Biography of David Walter Millard

David Walter Millard was born in Stroud, Gloucestershire, in 1931; his mother was a nurse and his father was a chemistry teacher. He qualified as a doctor at Birmingham University in 1955. Following house jobs at Burnley General Hospital, he took a Short Service Regular Commission in the Royal Army Medical Corps, serving in Germany 1957–60.

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Millard's interests moved from General Practice to Psychiatry, and he returned to Birmingham to a Registrar post at Rubery Hill Hospital, where he was introduced to therapeutic community practice by John Yerburgh. Taking his Diploma in Psychological Medicine (DPM), Millard joined Sir William Trethowan's newly established Psychiatric Professorial Unit at Queen Elizabeth Hospital in 1962 as his first Registrar, and established a therapeutic community in Ward North 5A. In 1965–66 he became the first holder of a newly created Senior Registrar Post in Child Psychiatry before returning to Rubery Hill in 1966 as Consultant Psychiatrist, where he was involved in establishing two further therapeutic communities.

Millard acquired a range of teaching experiences, including Visiting Lecturer in Social Studies at the Selly Oak Colleges and giving courses in psychology to social work and theology students at the university. A fellow consultant, RA Lambourne, had obtained a lectureship in the Theology Department at Birmingham University, where he established a post-graduate Diploma in Pastoral Studies. This represented an attractive career move for Millard, who had developed a growing interest in the overlap between medicine and social science and wanted to 'find a cross-disciplinary role for myself in life' (Millard and Fees, 2001). In 1970 he applied for a lectureship in Applied Social Studies in the University of Oxford.

Once in Oxford, Millard became involved with the newly formed Association of Therapeutic Communities, joining its Steering Group in 1977, convening its Research Group (1977–83) and becoming Editor of the *International Journal of Therapeutic Communities* (1983–91). He also took on clinical and teaching positions within the university and the local NHS, including individual psychotherapy in Professor Michael Gelder's newly established department of psychiatry at the Warneford Hospital, and extending his work to London as Consultant Psychotherapist to mental health day-centres in Kensington and Chelsea. He was a member of the Council of the Institute of Religion and Medicine (1970–90). Almost certainly uniquely for a psychiatrist, Millard was instrumental in the creation and development of a new Oxford College: he was a founding governor of Green College, later Green Templeton College (Dixon, 2021).

On retiring from his university post in 1991, he took a number of locum consultant psychiatrist appointments with the Oxfordshire Health Authority, before moving to a substantive post as a psychogeriatrician for the Oxfordshire Mental Healthcare Trust (1994–2000). He maintained his interest in this field as a Trustee of Vale House in Botley (an Alzheimer's home) (2000–6), the facility in which he eventually spent the last days of his final illness. An accomplished musician, he obtained an MA in musicology in 2005 (Millard 2006; Millard and Agulnik 2021).

David Millard, FRCPsych, MD, MA (Mus), died on 13 January 2021, while this special issue of *History of Psychiatry* was in preparation.

The clinician moves to academia

Millard's move to Oxford in 1970 limited his direct clinical involvement in therapeutic communities. It allowed him to develop his teaching and his intellectual interest in multidisciplinary work and in the overlaps between medicine and the social sciences. It also allowed him to make significant academic and practical contributions to the therapeutic community movement. The launch of the Association of Therapeutic Communities (ATC) at a conference at Littlemore Hospital in 1972, and the developing apparatus of a newly self-conscious field, attracted and gave scope to his personal and professional interests (Kennard 2010). Settling into Oxford and the university, Millard gradually brought his academic focus to bear, beginning to write about therapeutic community more frequently from 1976. In 1983 he was invited by RD Hinshelwood to become joint editor of the *International Journal of Therapeutic Communities* (later, simply *Therapeutic Communities*), a position he held until David Kennard succeeded him in 1991.

In his inaugural editorial, Kennard (1991) wrote that Millard had 'devoted considerable talent and energy to establishing it as a respected academic journal'. Millard wrote many lengthy editorials on topics ranging from the history of mental health legislation, reforms of the NHS and the nursing profession, to reflections on the philosophy of science and scientific explanation. Much of this writing was subsequently brought together post-retirement in his 1994 MD thesis, which also included one newly written and two previously unpublished documents.

Millard's final act as the editor in 1991 was to oversee publication of a special double issue devoted to the life and work of Maxwell Jones, who had died in Nova Scotia the year before (Millard, 1991). Compiled by guest editor Stuart Whiteley, its objective for Millard was to convince a sceptical professional world that here was a therapeutic method which was clearly defined, empirically grounded and with 'an intellectually convincing set of theories', effective in clinical practice and successful independently of charismatic individuals. 'Jones was a figure larger than many,' Millard wrote in the Classic Text, 'but a succession of others have found that they also have sufficient gifts to employ this technical apparatus effectively and to the great benefit of their patients' (Millard, 1996: 602).

The relative contributions of Maxwell Jones at Mill Hill and Tom Main at Northfield

In the late 1960s Maxwell Jones's name was 'probably better known throughout the world than that of any other British psychiatrist', according to Morris Carstairs (1968: 9). Millard's text affirms Jones's place in the history of psychiatry, taking the reader chronologically through Jones's career: charting his transition from biological psychiatrist/researcher to pioneer of a therapeutic method whose working material was social interaction, through to an international reputation as a champion of the therapeutic community.

Millard wrote of Maxwell Jones working at Mill Hill, and Tom Main working quite independently at Northfield Military Psychiatric Hospital. The most striking thing was how, from different starting points, they arrived at a similar conclusion: that there are therapeutic benefits to be gained from professional staff withdrawing some of their authority and handing over some of their responsibilities to patients. How much authority and which responsibilities are matters for judgement and debate. The assertion was that acquiring this agency and exercising these responsibilities, and discovering and working through the consequences, constitute the whole or at least a major part of treatment.

This conclusion was arrived at by different routes, as the institutions Northfield and Mill Hill were different in many respects. Northfield was a military hospital, Mill Hill was civilian, although largely given over to treating military personnel. More importantly, Northfield was staffed by psychoanalytically oriented colleagues selected for their independence from mainstream psychiatry, while Mill Hill, sited in an evacuated North London public school, had been commandeered by the Maudsley, the UK's pre-eminent psychiatric teaching hospital. Group psychotherapy and group-based programmes were at the heart of the work at Northfield with full support from the Directorate of Army Psychiatry (Bridger, 1990), while for Jones this was new and uncharted territory. For all these reasons the odds would have favoured Northfield as the birthplace of the therapeutic community, despite an early miscarriage.

In 1942 the psychoanalyst Wilfrid Bion started his tenure on the 'somewhat chaotic' Training Wing at Northfield by diagnosing an organisational problem: 'what was required was the sort of discipline achieved in a theatre of war by an experienced officer in command of a rather scallywag battalion'. He formulated a working hypothesis that the discipline required in this situation depended on the presence of: (i) 'the enemy who provided a common danger and a common aim',

and (ii) an officer who 'being experienced, knows something of his own failings, respects the integrity of his men, and is not afraid of either their good-will or their hostility' (Bion, 1961: 12–13). The gist of the experiment was to get the men to regard neurosis as the common enemy, to be defeated by their own common efforts. Millard describes in some detail what happened next, and the outcome is well known: Bion was transferred before the experiment had time to bear fruit, although not before the patients 'began to bear at least a recognizable resemblance to soldiers' (Bion, 1946/1996: 90). A longer-term outcome was that Harold Bridger and Tom Main, arriving at Northfield some two years after Bion had left and learning of his fate, were mindful of the importance of working with the wider hospital system (Bridger, 1985; Main, 1983).

Main is perhaps best known for the rousing 1946 paper in which he influentially used the term 'a therapeutic community' (the origins of which are contested; see Fees, 2005) to describe developments at Northfield:

> The Northfield Experiment is an attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the *immediate* aim of full participation of all its members in its daily life and the *eventual* aim of the resocialization of the individual for life in ordinary society. (Main, 1946, our emphasis; see Editorial note for explanation)

In marked contrast, Jones brought no professional background or prior involvement in group or organisational dynamics to his work at Mill Hill. Recruited for his experience in research on psychosomatic disorders, Jones was put in charge, together with cardiologist Paul Wood, of the 'effort syndrome' (or, more colloquially, 'soldier's heart') unit. Like Bion, Jones too embarked on an experiment, but from a pragmatic rather than theoretical starting point. Once it became clear that effort syndrome was generally a psychosomatic complaint, 'it seemed reasonable to explain to the patients the psychological mechanisms involved in the production of the symptoms' (Jones, 1952: 3), and an educational programme was set up. What was more revolutionary was Jones's attitude towards the nursing staff, whom he came to treat as professional equals, involving them in reading and discussing the medical notes. In an account of the making of a documentary film of the work at Mill Hill, Edgar Jones comments:

> Doctors allowed nurses to approach them directly rather than through the ward sister; they also encouraged the nurses to communicate freely with patients and take an active role. In part, this relaxation of protocol was a function of wartime circumstances. [Maxwell] Jones recalled that 'educated mature women from the professions' often chose nursing as their war work and 'such people expected and deserved an active role in the treatment programme'. (Jones, 2014: 313)

This placed Maxwell Jones on a collision course with the nursing hierarchy. As he later wrote:

> These early changes in the community structure threw a considerable strain on the Ward Sister who felt that her authority was being undermined; in fact the whole development almost broke down as a result of the anxiety aroused in the senior nursing group. Luckily the Medical Superintendent and Matron supported the reform and without this sanction the development would have had to be postponed. (Jones, 1952: 2)

This does not appear to have been a problem at Northfield, where the role of the nurse was integrated into the developments taking place and nurses 'explored over a long period the nature of their role in such a therapeutic community' (Bridger, 1985: 105).

Millard makes a point of seeking to specify those innovations introduced by Jones that have made a lasting contribution to therapeutic community practice. However, it is difficult to maintain a clear distinction between specific innovations at Northfield and Mill Hill. Millard's claim that

Jones introduced, 'apparently for the first time in psychiatry, the use of the large group' is questioned by Harrison (2000: 228), who notes that the approach was 'didactic rather than psychotherapeutic'. (Jones made this observation himself, when watching the Mill Hill film at his home in Nova Scotia with Craig Fees in 1990.) The idea developed by Jones that 'treatment was considered a continuous process operating throughout the waking day and over every aspect of the life of the patient' was also shared with Bion, who noted as a guiding principle that 'Study of the problem of intra-group tensions never ceased – the day consisted of 24 hours' (Bion, 1946/1996). The development at Mill Hill of small groups, including informal nurse–patient working groups, was similar to developments in the Hospital Club at Northfield (Bridger, 1946/1996), although Millard notes that an emphasis on patients being responsible for creating and selecting their own group activities was a feature at Northfield but not at Mill Hill.

Perhaps the most distinctive feature at Mill Hill was what Millard identifies as a '*flattening of the hierarchical relationship* between doctors, nurses and other staff, and the patients' (Millard, 1996: 585, our emphasis). Main had famously railed against, even lampooned, 'the anarchical rights of the doctor in the traditional hospital' with his 'captive children, obedient in nursery-like activities' (Main, 1946: 67). His target was the doctor–patient relationship, but at Mill Hill the key challenge was the nurse–doctor relationship. We suggest that the two most distinctive and long-lasting innovations under Jones at Mill Hill were, firstly, allowing a didactic educational programme to develop into an educational-cum-therapeutic role for patients *in relation to each other* as they acquired knowledge and understanding of their symptoms; and secondly, the freeing up of the role and personality of the nurse from the tight reigns of the traditional nursing hierarchy.

It was only after Jones's time at Mill Hill, when he was at Belmont and later at Dingleton, that his reputation burgeoned into the charismatic figurehead of the therapeutic community movement. At the end of the war, the work at Northfield was more widely known, thanks to the visit by a team of American psychiatrists headed by Karl Menninger in 1945 and the resulting publication of papers by Main, Bridger, Bion, Foulkes and others in the *Bulletin of the Menninger Clinic* in 1946.

Unknown to Millard in the early 1990s when he was writing, Main and Jones converged briefly again, when the post-war Cassel Hospital was seeking a new Medical Director and both men applied. Main was appointed, and remained the Director until he retired in 1976. The more mercurial Jones went on to establish what became the Henderson Hospital on the other side of London, and subsequently, leaving the Henderson in 1959, had a complex cross-Atlantic career (Fees, 1998; Vandevelde, 1999).

The Classic Text and beyond: from history to happenstance

Writing 'Maxwell Jones and the Therapeutic Community' was a departure for Millard (1996). He had a significant body of writing concerning therapeutic community theory and practice behind him when he was encouraged by his friend and colleague Hugh Freeman to contribute a chapter about the history of the therapeutic community to the second volume of *150 Years of British Psychiatry* (Freeman and Berrios, 1996). Given his personal and professional knowledge of many of the protagonists, and his depth of reading and theoretical engagement, it would be difficult to know who could have been better placed to take on the task at the time; and it met with his reflective turn towards his personal and professional history, as manifested and gathered into his MD thesis.

Volume 1 of *150 Years of British Psychiatry* was given out free to delegates at the Royal College of Psychiatrists' Annual Meeting in 1991 (Berrios and Freeman, 1991). As its title '*Aftermath*' implies, Volume 2, published in 1996, picked up some key institutions, ideas, and people missed from Volume 1. 'Maxwell Jones and the Therapeutic Community' was its final chapter. The President of the Royal College of Psychiatrists, John Cox, said Maxwell Jones would have approved

of this, as it gave him the last word (Cox, 1998: 249). It was also the first extended treatment of the history of the twentieth-century therapeutic community as a discrete, consistent, coherent and meaningful narrative to appear in such an academically and professionally prestigious setting. It fairly quickly became an influential and much-cited baseline for medical historians, psychiatrists and therapeutic community practitioners alike (e.g. Adams 2009; Cox, 1998; Fussinger, 2010; Gallagher, 2020; Harrison, 2000; Jones, 2004).

Although the chapter is called 'Maxwell Jones and *the Therapeutic Community*' (our emphasis), it is worth noting that Millard confined himself to addressing Jones's impact within a specific stream of adult psychiatric therapeutic community. Millard was aware of the wide range of therapeutic communities, and touches briefly on these, including those for children and young people, and for adults in prisons and in addictions. But they were not part of the story he chose to tell, and he justified this by saying: 'the version associated with Maxwell Jones, sometimes referred to as the democratic model, has had the widest influence and *is perhaps that towards which all have tended to converge*' (Millard, 1996: 597, our emphasis).

Nor was it an academic history. Millard only used readily available published sources and personal knowledge. His narrative is in the 'Great Man' tradition of historiography, focused on the acts and agency of influential individuals. He approaches therapeutic community as a therapeutic technology which has been arrived at through a series of discrete, identifiable innovations: 'I concur as a clinician', he wrote, 'in viewing the therapeutic community as a technique – similar in status to, perhaps, a new family of surgical interventions, or a new class of psychomotor drugs . . .' (p. 602).

It is notable that the Classic Text does not address the actual 'how' of how innovation happens. In taking the reader along the narrative path of therapeutic community's history, Millard steps from stone to stone of 'what happened' but avoids addressing the river of flowing process underneath. But, by paying attention to his narrative of the 'discovery' of the therapeutic community we can already discern the role of chance, which comes to interest him more explicitly later. 'Therapeutic community' gradually emerges in history as an organised enabling of happenstance: discovering, enabling, and facilitating the generation of solutions from within the community itself which are original, positive, productive and useful, and which deviate from the standard repertoire of responses to the problems around which the unit, ward, or hospital had originally been organised.

For example, establishing the baseline from which the Maxwell Jones therapeutic community diverged, Millard writes: 'At first (in 1940), the wards of the Effort Syndrome Unit were indistinguishable from those of a general hospital, as was the regime and the roles of the nursing staff. However, *matters were to change*' (p. 583, our emphasis). He quotes Harrison and Clarke's interpretation of the process of change and divergence which happened at Northfield (Harrison and Clarke, 1992: 704):

> The soldiers were given opportunities to realise that the solutions were largely in their own hands. (Bion) achieved this by *apparently relinquishing his responsibility* for solving all the problems presented to him and *forcing the group to fall back on their own resources.* (Millard, 1996: 587, our emphasis)

Millard then gives Jones's own even more radical formulation of the process, from his interview with Brian Barraclough (1984). In this conversation Jones describes how even problems which the unit at Mill Hill had not set out to solve – e.g. 'unpopularity' – were nevertheless unpicked by relationships and flattened hierarchies, and by 'open ears'; and by the unplanned evolution of solutions which could not have been commanded or taught or even hypothesised from the top down, in the standard model of a psychiatric hospital, but were arrived at by what would later be called 'positive deviance' (Pascale, Sternin and Sternin, 2010):

> 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 . . . (Millard, 1996: 584–5, quoting Barraclough, 1984: 167)

Highlighting the immanence of happenstance and positive deviance in the invention and development of therapeutic community in Millard's narrative links the Classic Text to the other papers in this special issue, both thematically and historically.

How much is the man, how much the method?

Turning back to the main protagonist of the Classic Text, Millard (1996: 602) rounds off by returning to the knotty question arising from Jones's success: 'how much is the man and how much the method?' In the commemorative double issue of the *International Journal of Therapeutic Communities* devoted to Jones, the anthropologist Robert Rapoport wrote an article entitled 'Maxwell Jones and the charisma question'. He examines the concept of charismatic leadership and charisma in therapy and notes that Jones was 'able to play a heroic reformer role outside the unit while eschewing leadership within as a matter of principle' (Rapoport, 1991: 104). Of his personal qualities, Rapoport echoes Millard, writing that Jones had 'a blend of Irish charm, Scottish superego and a British sense of protest towards a dehumanizing bureaucracy'. His conclusion was that Jones:

> did not have the genius of some of the other therapeutic community innovators, but he did have the sense to spot an idea with potential, the creativity to develop it in its social application, and the doggedness continuously to ward off enemies at the gate. He did this with *brio*. (p. 108)

Millard might have gone a step further, and looking between the stepping stones of 'what' at the flowing process of 'how', might well have said the question was posed wrongly. As the papers in this special issue show, the creation of novel and effective solutions to intractable problems is not a straightforward either/or.

Editorial note on the Classic Text

The Classic Text as originally published contained a number of errors which we have identified with the help of the copy-editor and, with one exception, have corrected. The errors fall into the categories of those which affect the meaning of the text, and those which do not.

Examples of the latter include sources cited in the text, but not included in the list of references, such as Jones and Rapoport (1955), which contained another error: originally ascribed to 1956, there was a dating error in the citation itself. We have corrected mistakes such as these, and added a few missing sources to the reference list. We have also silently corrected other mistakes: substituting Maricopa for Manicopa (a county in Arizona); changing Willmer to Wilmer in psychoanalyst Harry Wilmer's name (Wilmer later became an eminent analytical psychologist, but at the time referred to was still working in the Freudian tradition); changing Woolfville to Wolfville (Nova Scotia); changing Arcadia University and Woolfville University to Acadia University (which is in Wolfville); and changing 'a' to 'the' in *One Flew Over a Cuckoo's Nest*, and Dennis to Dean in the name of Dean Brooks, Medical Director of the hospital in which the film was made.

In one instance, we have made a silent change in the text which does affect meaning. When Millard calls one of Maxwell Jones's books 'arguably the single most influential book in promoting the therapeutic community world-wide', his citation gives the date for Jones (1962), but the title for Jones (1968a). They are different books, although both drew on lectures Jones had written as a Visiting Professor at Stanford University in 1961, which is the additional information Millard gives. Without outside empirical evidence, and without anything more from Millard, a case could be made for either publication: the first was published by the prestigious specialist American publisher Charles C Thomas, and will have been given significant academic and professional weight because of that; the second was published in paperback by the more generalist and accessible British publisher Penguin Books. Through Kennard's personal and professional experience and knowledge, as a participant in the period and events described, we have chosen to go with the later text: Jones (1968a).

The one instance in which we have identified an error, but chosen not to correct it, is in Millard's quotation of Tom Main's well-known, and indeed classic, definition of a therapeutic community (Main, 1946). Millard uses it correctly elsewhere (Millard, 1994: 14), and we have given the correct quote in our Introduction. Here, Millard substitutes the spatial term 'central' for Main's temporal term 'eventual', substituting 'essential' for 'immediate': keeping the process in the fixed present, and removing the temporal pivot from 'immediate' to 'eventual' through which Main conveys the dynamic and time-based nature of the therapeutic intention as a sequence from process to outcome. We have not corrected it because, though small, the change itself is critical; and as Millard's text has been so widely and influentially read, and the incorrect quote or its interpretation may well have made its way into other texts and others' thinking, we feel it is historically important to retain a record of the source.

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Classic Text No. 133

‘Maxwell Jones and the Therapeutic Community’, by David Millard (1996)

Maxwell Jones was born in Queenstown, South Africa in 1907 and died in Nova Scotia on 19th August 1990. Although his influence was by no means confined to Britain, it emerged powerfully and principally from his work in two British institutions – a unit at Belmont Hospital, Surrey (later to be known as the Henderson Hospital) where he practised from 1947 to 1959, and Dingleton Hospital on the Scottish borders (from 1962 to 1969). But there exists a story both prior to and following those experiences. He was the leading apostle of the therapeutic community at a period in the history of British psychiatry when personal charisma counted more than rigorous scientific research as the engine of psychiatric advance.

History is never tidy, but it seems possible to organise this chapter into four phases. First, I shall comment briefly on Maxwell Jones’ career before the 1939–46 war and before the therapeutic community. Second, I shall consider developments during the war and the immediate post-war period when the principles of the therapeutic community were first explored. The third will describe Jones’ period at the Belmont when these principles were brought to maturity, and briefly survey the subsequent fortunes of the therapeutic community movement. The fourth phase covers a broadening of Jones’ personal contribution, including his work at Dingleton and beyond. Within each, I shall set the man into context – in the belief that it is good history, good psychiatry, and indisputably crucial to therapeutic community practice always to attend equally to the individual and the social environment in which he or she is operating.

The earlier years

Maxwell Jones, almost universally referred to as Max, several times briefly described his own background in print. His ‘gifted and liberal’ (Jones, 1952) family originated in Northern Ireland and were engaged in education or religion, but his parents emigrated to South Africa towards the end of the nineteenth century and the family lived near Mafeking until Jones was five, when his father died. William Wilson Jones, a schoolteacher, was apparently popular, gregarious, and drank too much (Murto, 1991). After his father’s death, Jones’ mother brought Max and his two older siblings to be educated in Scotland, where he attended Stewarts College and later Edinburgh University. Of his schooldays, he chose to mention matters of which echoes emerge later: ‘terrified of what seemed to be unnecessarily harsh discipline and a feeling of confusion and outrage at the use of corporal punishment’. On the other hand, he became captain of school rugby and ‘learned at first hand and for the first time the importance of group morale and purpose, of personal relationships and of leadership’.

‘I suppose I had something of my father’s roving spirit’, he told Barraclough (1984), in the course of explaining his wish as an 18-year-old to become a Kenyan coffee-planter. Frustrated by failing to raise the £2,000 then required to enter the government training scheme, he settled for his ‘second love, which was psychiatry – the idea of knowing people’. He reports a schoolboy interest in reading some of the great novelists of human character – the Brontes, Dickens, Dostoyevsky – and of being-influenced by reading William James’ *The Varieties of Religious Experience* (Murto, 1991) – but no-one seems to have identified any other factors contributing to what in 1925, and in the absence of a family background in medicine, must have been an unconventional and uncommonly specific

career choice. However, Jones was always quite clear: 'I slogged through medicine in order to become a psychiatrist. It wasn't a love of medicine at all, just an interest in people' (Barraclough, 1984). He was not a distinguished medical student, but a long-term colleague (Tuxford, 1991) notes a particular interest in physiology which reappears in his work as a young researcher.

After qualifying in 1931, five years were spent at Edinburgh acquiring a training in psychiatry and in research under professor D. K. (later Sir David) Henderson. The influence then predominating at the Royal Edinburgh Hospital was Meyerian psycho-biology, although both Henderson's work on *Psychopathic States* and the influential *Textbook of Psychiatry* (with R. D. Gillespie) also give a good deal of emphasis to the social dimension. But Jones set off on a series of investigations into the biological correlates of neurosis. He worked on carbohydrate metabolism and enzyme chemistry, and his early papers deal with acetyl choline and choline esterase in relation to anxiety and depression as well as with a variety of endocrinological studies in psychiatric disorders. This work was split between Edinburgh and the United States. Jones had become a lecturer in Henderson's department, but in 1936 obtained a Commonwealth Fund Fellowship to spend a year at the University of Pennsylvania and a second year at Columbia Medical Centre, New York. Henderson had of course been greatly influenced by his experience at Baltimore with Adolf Meyer, and Jones' relationship with transatlantic developments in social psychiatry was to become similarly close. Four of his seven books (1952 to 1988) were published in the United States. However, during this period his research was entirely laboratory-based, and it was his intention to continue animal work on his return to Britain.

It was on the basis of this career in biological research that Aubrey Lewis recruited Maxwell Jones in 1938 to the staff of the Maudsley. This move was of some historical significance, for it placed Jones within the psychiatric establishment – and thus in a position where later he was to be both protected and influential – and it provided almost directly the setting for his earliest work in the very different field of social psychiatry. Initially, he became interested in physical treatments and published a couple of papers on insulin therapy in schizophrenia. But by this time, the life of the nation was dominated by the threat of war. A Royal Medico-Psychological Association memorandum of about this time had predicted (pessimistically, as it turned out) that the outbreak of war would be accompanied by high levels of psychiatric morbidity, and psychiatric institutions were being prepared in various ways for the onset of hostilities.

Under the threat of air raids, the Maudsley Hospital was evacuated from its inner city location to form Emergency Medical Services (EMS) hospitals on two suburban sites. Part went to Belmont Hospital, Surrey, and part, including Walter Maclay (as director), Aubrey Lewis, Eric Guttman, several of the more psychotherapeutically-orientated staff, and Jones himself, to Mill Hill where they occupied the premises of the public school, itself evacuated even further afield.

With his interest in psychosomatic disorder and psychosomatic research, Jones was placed there in charge of a unit to deal with Da Costa's (or Effort) Syndrome. He remained in that setting for about five years, during the earlier part of which he was able to combine clinical responsibilities with continuing research. Working with the distinguished cardiologist Paul Wood, Jones established biochemical indicators associated with the syndrome of left-sided chest pain, breathlessness, giddiness, etc. Despite the prevailing vicissitudes, three or four papers were published on this work between 1940 and 1942, and Jones was able to write it up for his Edinburgh MD (obtaining thereby the first Gold Medal ever awarded for a psychiatric topic).

Prodromata of the Therapeutic Community

The clinical basis for this work was a unit of 100 beds, through which passed a succession of military personnel. At first (in 1940), the wards of the Effort Syndrome Unit were indistinguishable

from those of a general hospital, as was the regime and the roles of the nursing staff. However, these matters were to change.

The earliest report of this work (Jones, 1942), having described the psychiatric background of patients with cardiac neurosis, refers to attempts during the first two years to treat it with individual psychotherapy 'under rather difficult conditions' including the pressure of a large number of cases on a small staff. Thus 'it was decided to try a form of group therapy . . . The treatment was tried on a group of 50 patients, the remaining 50 being given individual psychotherapy'.

There were three meetings a week, at 9.00 am on alternate days; the patients and the doctor were seated comfortably, the whole atmosphere being completely informal. The junior nurses working on the wards sat at one end of the room. An educational format was used and 'the talk lasted on an average 20 to 30 minutes with a quarter of an hour at the end for open discussion'. Jones' teaching model presented three levels of CNS activity – cortical (roughly the equivalent of consciousness), thalamic ('un-differentiated emotion') and brain stem (control of visceral nervous activity) – through which the patients came to learn something of psycho-somatic mechanisms. There was some attempt in practice to avoid the use of the phrase 'effort syndrome' (Crocket, personal communication). The other large emphasis was on the development of group responsibility, which in this military situation was thought of as closely linked with morale, as involving (like a rugby team) some sacrifice of individual wishes in the interests of the immediate group, the war effort, and indeed the nation as a whole.

The attempt at a controlled trial implicit in the foregoing description came to nothing, but Jones reported 'impressionistically, the results so far have been far better than with any other previous method', with the virtual disappearance from ward conversations of a preoccupation with heart disease, and a rise in the number of men returning to Army duty to a higher level than at any time since the unit had started, two and a half years before.

By 1944: 'Since . . . 1942 we have greatly widened the scope of our methods' (Jones, 1944). Patients were being seen in groups of about 90, only one third of whom by this time had Effort Syndrome, the remainder having anxiety states or depression and being 'the more chronic constitutionally endowed material, the "better" neuroses going to the military neurosis centres'. Ward groups met thrice weekly from 9.00 to 11.00 am and continued to follow an educationally based syllabus of 12 topics. An increasing reliance was placed on discussion among patients, and staff were able to 'set the goals and let the men work out a solution for themselves with the minimum of help.' Verbatim accounts of two such sessions are preserved in *Social Psychiatry: A Study of Therapeutic Communities* (Jones, 1952, pp. 4–12).

The common rooms had been redecorated by working groups of patients and nurses, and adorned with educational pictures featuring the adventures of 'Nervy Ned'. Furthermore, a form of what he called group projection methods had been introduced – a species of drama therapy in which patients in each of the eight wards in turn were required to devise and present to the whole unit a play setting out some personal problem, and the audience was asked to consider possible solutions. The nurses, often pressed into service in this activity, also presented their own plays in two series, one demonstrating the family dynamics underlying common neurotic problems and the second a re-enacted psychiatric clinic – again with the expectation of audience response.

By this time, there had also been changes in the social organisation of staff and patients. The nurses were having two 'lectures' each week – one being didactic and the other a general policy meeting – the whole involving what Jones called a 'constant revision and scrutiny of group methods by nurses and doctors.' There was also a one-hour general meeting of the entire ward community. A more detailed account of this regime is available in Murto (1991).

Reflecting in 1983, Jones reported:

> As they (the patients) all had the same clinical condition, common sense dictated that we should begin to treat them as a group. So we had daily meetings with 100 men and all staff on duty . . . 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 learned what we had learned about the lack of homeostasis in relation to their exercise physiology. (Barraclough, 1984)

It is worth specifying the ways in which this practice has, and – in the light of our understanding 50 years on – has not, the features of a therapeutic community. First, Jones introduced, apparently for the first time in psychiatry, the use of the large group – though the point is inadequately acknowledged in other historical accounts (*cf*. Kreeger, 1975 p.17). There had been earlier examples elsewhere, for instance in the field of progressive education where in certain residential regimes something similar occurred as part of an ideology of self-government (Bridgeland, 1971; Farquharson, 1991; see also Murto (1991) for a comparison of Makarenko and Jones). But there is no evidence that Jones was aware of these in the 1940s or was influenced by them. The large group has subsequently developed in various manifestations. Most prominently, it has persisted in the form of the community meeting as a virtually universal feature of therapeutic community regimes, where it constitutes an essential technique for introducing a social dimension into therapy, and it has been the subject of a good deal of conceptual analysis and some empirical research. Outside the therapeutic community, the large group has a place in training in the fields of psychotherapy and human relations (e.g. in the Tavistock/Leicester Conference, Rice, 1965) and as a free-standing form of therapy (as developed especially by de Maré (1975) and others within the field of group analysis).

Secondly, Jones developed the idea that, within the boundary of the unit, treatment was considered a continuous process operating throughout the waking day and over every aspect of the life of the patient. Although this also was later to become a well recognised principle in therapeutic community practice, it clearly had a relatively restricted meaning in the Effort Syndrome Unit, where much of the emphasis was on the staff-led educational task of getting the patients to understand the mechanisms underlying their psychosomatic complaints. In particular, it was not associated in that setting with a strong emphasis on patients selecting their own activities.

Thirdly, the Unit developed some use of small groups with this same educational end in view. These included informal nurse-patient working groups, but more particularly a variety of sociodrama. It is unclear to what extent the latter were consciously based on the work of J. L. Moreno, which was well-developed by that time in the USA (Davies, 1988). Jones may well have known of it, though he never cited it in the early reports. However, Moreno subsequently visited the Belmont Unit several times (Whiteley, 1980).

Fourthly, Jones recognised that changes in the power structure of the unit were inevitable. More open communication resulted in some flattening of the hierarchical relationship between doctors, nurses and other staff, and the patients. In particular, the therapeutic potential of the relationship between longer-stay patients and newer recruits emerged as crucial. Some emphasis has been placed on these points because of the problem presented to historians of the therapeutic community movement by the relationship between Maxwell Jones' contribution and that derived from work at the Northfield Military Hospital. To that issue we shall return shortly; meantime, this account must be taken one further step.

At the end of the war, the Maudsley was asked to take responsibility for a 300 bed unit at the Southern General Hospital, Dartford, a military establishment designed to assist in the

rehabilitation of the most disabled among the large numbers of prisoners of war returning from Europe. Jones was psychiatrist in charge of this unit. Its work combined two features – a replication of the Effort Syndrome Unit inpatient regime and a substantial, and successful attempt to recruit the local community to this task of rehabilitation. As regards the former, the six cottages, each housing 50 men, had a daily community meeting; many of the Maudsley/Mill Hill staff had transferred there and were able to sustain 'a supportive environment where the trust level was high (and) 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' (Barraclough, 1984). There was a patients' committee and staff groups. Travelling around the local area, as he records, on a push-bike, Jones obtained the help of some 70 local employers who supported the men in part-time work. Difficulties and psychological problems at the workplace became also the subject of discussions within the communities. Some 1400 men passed through the Dartford Prisoner of War Unit in the space of some 11 months.

Clinical practice at Dartford did not greatly advance the proto-therapeutic community in any technical sense. But it demonstrated the successful application of some of its principles to a somewhat less homogenous group of patients, introduced the emphasis on purposeful work which was to become a significant feature of the Maxwell Jones model of the therapeutic community, emphasised the crucial importance to the life of the institution of the social environment in which it is set and (foreshadowing the later work at Dingleton) raised the possibility of close collaboration with this wider network. It also marked the end of Jones' specialist career in the psychiatry of psychosomatic disorder.

The work of the two early Experimental Communities is described in the chapter of that name which opens *Social Psychiatry: A Study of Therapeutic Communities* (1952), Jones' first book-length account. At discharge, 12% of the first 100 Dartford cases remained clinically unimproved, and only 8% were not placed in employment (though the benefits of a full-employment economy were acknowledged). A follow-up postal survey by the Ministry of Labour, three and a half months later, revealed that 610 of the 687 patients admitted during a six-month period were in work or training. This excellent outcome, together with that found among the much less disturbed population passing through the Army Resettlement Units, persuaded the Ministry of Health to establish the experimental Industrial Neurosis Unit at Belmont. Its purpose to investigate the rehabilitation of unemployed civilians – casualties of society rather than of war. Jones went there in April 1947. The unit was eventually to become internationally famous and to develop into the Henderson Hospital.

The Northfield Contribution

We come now to an entr'acte in this chronological account. Of major significance in the history of the therapeutic community were events, essentially unrelated to Maxwell Jones, which took place at Northfield Military Hospital (Hollymoor Hospital), Birmingham. These have been widely written up (Main, 1989; Bridger, 1990) – most recently and attractively by Harrison & Clarke (1992). They are of inescapable significance, however, and must be briefly restated here.

In April 1942, Northfield became a military hospital and rehabilitation unit for soldiers with neurosis, most of whom had been treated earlier in the war in the Emergency Medical Services centres. It came under the command of Army Psychiatric Services which, throughout the war, were heavily and constructively influenced by ideas and personalities associated with the Tavistock Clinic. J. R. Rees, pre-war Director of the Tavistock, had been appointed head of Army Psychiatric Services in 1939 in the rank of Brigadier, and Dicks (1970) has argued that it was the relative independence of the Tavistock tradition – neither in mainstream psychiatry nor narrowly committed to

psychoanalysis – which resulted in its selection to respond to what was predicted to be unique scale of psychiatric demands resulting from the war (see Manning, 1989). Among the personalities significantly involved with what later became known as the two Northfield Experiments were the psychoanalysts Wilfred Bion, John Rickman, Harold Bridger and S. H. Foulkes, and the psychiatrist T. F. ('Tom') Main.

The first 'Northfield experiment' occupied about six weeks in 1943, but there had been a precursor in work briefly undertaken by Rickman at Wharncliffe Emergency Hospital, Sheffield (Bion, 1961). By 1943, Rickman was in charge of a Hospital Wing at Northfield and Bion was posted to command the Rehabilitation Wing, which had developed serious problems of 'slackness, indiscipline and aggressive untidiness' (Bridger, 1990). Bion and Rickman determined to meet these problems by building on their previous experience at Wharncliffe. The essential step, as Harrison and Clarke make clear, was an organisational diagnosis: 'the difficulties were symptomatic of the neurosis of the whole unit and the organisation of the hospital was a 'retreat' from neurosis'. This military language is reflected in the earliest account of the experiment (Bion & Rickman, 1943) – what was needed was 'the sort of discipline achieved in a theatre of war by an experienced officer in command of a rather scallywag battalion', namely, an accurate identification of the enemy (neurosis) and a determination to attack it together. Harrison & Clarke summarise what occurred:

> The soldiers were given opportunities to realise that the solutions were largely in their own hands. (Bion) achieved this by apparently relinquishing his responsibility for solving all the problems presented to him and forcing the group to fall back on their own resources. In practice, he paraded all the men and presented them with five regulations and an announcement that there would be a 30-minute daily parade 'for making announcements and conducting other business'. His covert intention was that the meeting would provide a framework for men to gain insight into their activities and the progress of the unit as a whole: 'the first step towards the elaboration of therapeutic seminars' (Bion & Rickman, 1943).
>
> The next few weeks saw a marked change in the performance of the men and the unit. The Commanding Officer remarked on the improvements in cleanliness. The parades developed into constructive and active meetings.

The five regulations included orders that men were to belong to one or more activity groups and that they could create a new group if nothing suitable already existed. A range of activities developed, but each involved only a few men. Bion 'reported this back to the daily meeting, suggesting that the whole enterprise was a facade' – like the 'eyewash' (as the men characterised it) of much of what went on elsewhere in the Army. He provided no further elaboration, 'leaving the audience looking as if they felt they were being 'got at'', and thus encouraging them to reflect on their own behaviour and recognise that many of their perceptions of the Army were actually projections of their own internal conflicts (Harrison & Clarke, 1992).

Despite this apparent success, the experiment was brought to an abrupt conclusion when Bion and Rickman were posted away from Northfield. Harrison & Clarke briefly review the reasons which have been advanced for this: the intolerance of the military establishment of the disarray surrounding the early weeks of a self-managing unit ('the chaos in the Hospital cinema hall, with newspapers and condom strewn floors, etc.' – de Maré, 1985); the implicit conflict between the military need to prepare men for return to service and the assumption of most of them that health entailed a return to civilian life; Bion's strict handling of a particular incident of financial dishonestly involving officers. But the important lesson, taken over into the second Northfield Experiment, concerned failing to involve the wider environment (in this case, the whole hospital community and its administration), which came to be seen as a necessity if an unconventional therapeutic regime was to become established and survive.

The leading protagonists of the second Northfield experiment were Foulkes, Bridger, and Main. Foulkes, a Frankfurt-trained psychoanalyst, had been at Northfield from 1943 and initially was practising small-group therapy (as he had in private practice from 1940). Bridger, originally a mathematics teacher from Coventry and by then a major in the Royal Artillery, after several years of experience (like Bion and Rickman) in the War Office Selection Boards, was posted to command the Rehabilitation Wing at Northfield in 1944. Main succeeded Emmanuel Miller in command of the Hospital Wing in 1945. The second Northfield experiment occupied about 18 months and its work was described in a single issue of the *Bulletin of the Menninger Clinic* in 1946 (Main, 1946; Bridger, 1946; Foulkes, 1946), where Main first used publicly the term 'therapeutic community'.

A Therapeutic Community

> The Northfield Experiment is an attempt to use a hospital not as an organisation run by doctors in the interests of their own greater efficiency, but as a community with the essential aim of full participation of all its members in its daily life and the central aim of the resocialization of the neurotic individual for a life in organised society.

What were the practical manifestations of this experiment? First, an organisational change brought the hospital and rehabilitation wings into closer relationship. Foulkes was able to extend the use of small group therapy from the former to the latter, and a wide range of educational activities, arts and crafts, recreational activities, but also industrial trades, became available. For his part, Bridger was able to identify himself as 'social therapist' to the hospital as a whole, using the device of a social club in which men were expected to take responsibility for the organisation of their own activities. Bridger (1990) shows clearly the central place given to stimulating mutual help and responsibility among the patients, and to the wide range of activity groups both within the hospital and in the wider locality – maintenance work in local Child Guidance Clinics, groups in industry, etc. Patients were seen daily by their psychiatrist and there were both weekly ward meetings and a hospital-wide meeting of ward representatives with senior staff. Bridger comments:

> Despite a constantly changing patient population, committee meeting minutes make it possible to trace trends of a society developing in almost direct proportion to a growing sense of achievement and responsibility. At the beginning there was a collection of individuals, most of whom were self-appointed ward representatives, airing personal grievances and grumbles. Now the meeting of the ward committees is a constitutional body conscious of its value and responsible to the hospital community as a whole. (pp. 81–2)

How, then, are we to understand the interplay between the work at Northfield and that of Maxwell Jones? Manning, who discusses this matter at length, suggests it is an example of the familiar phenomenon of simultaneous scientific discovery. Clearly there are both similarities and contrasts. In both the Effort Syndrome Unit at Mill Hill (but not hospital-wide) and at Northfield, there came about a setting aside of conventional psychiatric approaches involving a power hierarchy (authoritarian doctor/passively recipient patient) in favour of a more egalitarian, self-directed approach to treatment. In this respect, Northfield was more radical, and the policy perhaps more consciously contrived, than at Mill Hill. Both used a combination of large and small groups, but here Jones seems to have the priority in terms of time. On the other hand, as Manning (who himself later made distinguished contributions as research sociologist at the Henderson Hospital) accurately points out, Jones' work lacked any substantial theoretical basis and was therefore inadequately conceptualised, particularly in terms of social analysis. By contrast, at Northfield

there was a clear theoretical background in psychoanalysis, modified by the Tavistock-style appreciation that neurosis is closely linked with poor social relationships which it is the task of the hospital organisation to re-examine and adjust.

There is not much evidence that Jones was aware of the Northfield work as it was going on. But Bridger visited Mill Hill before taking up his appointment at Northfield and later (1990) wrote, concerning 'hospitals . . . which influenced the strategy and practice I eventually formulated':

> The first, Mill Hill, a neurosis centre in the EMS seemed to me a large hive housing a conglomerate of every type of treatment – physical, psychotherapeutic and psycho-socio-therapeutic, where the patients seemed incidental. In Maxwell Jones's ward everyone was taking part and shared in the various therapeutic tasks – but it was a relatively closed system and centred on Maxwell Jones himself. I was later to compare his approach to that of Joshua Bierer, who also used a dependency closed-system relationship in his ward at Northfield as the setting for his therapeutic work. After the war, of course, Maxwell Jones had much scope to develop hospital wide activities of which he has written fully (1968a). (Bridger, 1990: 76–77)

But Jones seems to have been sensitive to this lack of relevant background. Both in Edinburgh and at the Maudsley, the psychiatric tradition had been generally antipathetic to psychoanalysis; nevertheless, by 1947 he had entered a training analysis with Melanie Klein (pursued for three years and not completed) and had supervision within the Institute of Psychoanalysis with Paula Heimann 'because of the need I felt to improve my skills in group psychotherapy and psychodynamics generally.' Commenting much later, Rapoport (1991) wrote:

> At the close of the war the psychoanalysts who were qualified returned to their private practices. Maxwell Jones was protected from this by not having qualified as a psychoanalyst. He was, furthermore, positively orientated to parts of orthodox psychiatry – however critical he was of other parts. (He always referred to Henderson in his work, and he was loyal to his mentor and protector Aubrey Lewis.)

And Hinshelwood (1991), himself a psychoanalyst and now Director of the Cassel Hospital, adds in respect of Jones' ideas of personal learning through a social environment and a social movement:

> Psychoanalysis has proved much more stuck in its individualistic orientation, and it would have been more hampering for Maxwell Jones whose horizons were set on major social change. To that extent he was a child of his times, and psychoanalysis was not useful for him.

Still, psychodynamics, chiefly in the psychoanalytic and group analytic traditions, has continued to make a potent contribution to therapeutic community theory and practice.

The other factors identified in Manning's discussion of the later influence of Mill Hill and Northfield are power and charisma – the former social and the latter personal attributes. Both Jones and Main were senior psychiatrists; Main was five years the younger, but had ended the war with the kudos of military service and in the rank of Lieutenant Colonel (Jones remained a civilian). In peacetime practice, both were powerful enough to dictate in some detail the regime which should operate in units for which they had clinical responsibility, and Bridger attributes Jones' later influence to his medical consultant status. His place in the psychiatric establishment – the Maudsley connection, the World Health Organisation, government committees – was also significant.

Within the therapeutic community movement, Main emerged as by far the most powerful of the Northfield group, becoming Medical Director of the Cassel Hospital in 1946, immediately training as a psychoanalyst, and retaining the Directorship until his retirement 30 years later. At the Cassel, he developed a distinctive version of the therapeutic community which retained within

the treatment regime a more prominent place for individual and family psychotherapy or psychoanalysis. He wrote and travelled somewhat less widely than Jones, but there exists a network of organisations in the United States – Chestnut Lodge, the Austen Riggs Centre, the New York Hospital – adopting a very similar philosophy (Hinshelwood, 1991). The influence of Main and the Cassel Hospital has been the subject of a commemorative issue of *Therapeutic Communities* compiled and edited by Denford (1993), which includes a comprehensive bibliography, and Main's Collected Papers have also been published (1989).

We now return to consider the further work of Maxwell Jones and to some discussion of the charisma question.

The 'Therapeutic Community Proper'

Without being inappropriately swayed by notions of a mid-life crisis (Erikson, 1950), it is worth remarking that Jones became Director of the Industrial Neurosis Unit at Belmont in his fortieth year. Renamed successively the Industrial Rehabilitation Unit and the Social Rehabilitation Unit, it became in 1959 the Henderson Hospital. Thus, the sophisticated concepts and practice of the therapeutic community elaborated there were the work of a man in his maturity and at the height of his considerable abilities. His subjective account (1968a) of this transition from organic to social psychiatry starts by noting the fragmented and frustrating state of psychiatry in the 1930s:

> Anyone with an enquiring mind was driven to seek an orientation which seemed to offer promise for the future and some sort of satisfaction for the patient . . . out of necessity I was driven to explore the biochemical and endocrinological fields in relation to psychiatry . . . and learned enough to realise that, with my limitations and the limitations of the field, I would not find the answer to psychiatric treatment in this direction . . . The war years were my salvation.

The conviction of the fundamental effectiveness of therapeutic community approaches, and the urge to demonstrate it, remained his guiding principles throughout the Belmont/Henderson years and beyond. Nevertheless, a characteristically astringent comment by Aubrey Lewis (1952) should also be noted:

> For the socially directed work which began during that period he was less well prepared . . . Dr Maxwell Jones has carried over much of his earlier scientific training and experience to the conduct of that experiment . . . and to its use for research. But faith and zeal are effective in carrying through a pioneer social venture when habits of objective verification and severe stage-by-stage appraisal would impose delays or be out of keeping with the aims of the project. Dr Maxwell Jones wanted to take the tide at the flood, in the post-war period . . . He has demonstrated the effect of such a therapeutic community as he developed at Belmont upon the mental health and occupational fitness of men whose character and medical history argued badly in these regards. What he has not demonstrated so clearly, though it can be inferred from what he has accomplished, and is known to those in touch with his work, is the unremitting energy, sustained purpose and enthusiasm which he has put into this difficult enterprise. To these qualities and his judgement and experience it chiefly owes the success.

But of his commitment to this venture there is actually no doubt: it is reported that during this period he rejected invitations to consider both the clinical directorship of the Maudsley (in succession to Eric Guttman) and the Chair of Psychiatry at Birmingham (Merry 1991).

Julius Merry was recruited by Louis Minski (then Physician Superintendent at Belmont) and assigned to be one of the junior doctors on the Industrial Neurosis Unit from September 1947: he remained for five years. Merry has provided a pen portrait (1991) of Jones in middle age:

Thus I met Max, as everyone called him, a well groomed, clean shaven man with a strong chin, and tightly combed scalp hair. His accent was a mixture of Scottish and American, and he often sported a bow tie. He drove a small two-door Ford Popular which I learned he had borrowed and later bought from a girl friend. Max's firm had several supernumerary registrars who were doctors who had served in the Army and were going to pursue a career in psychiatry . . . [Merry names Ben Pomryn, Julius Rowley, and Tom Freeman, but there were also others.]

Max had very high clinical standards and he was a hard worker. He was in his office at 8.00 am and had started work while I was contemplating my breakfast. Work for the rest of us started at 9.00 am with a meeting of the entire community. But that was not early enough for Max, so he began to have an earlier meeting with a selected group of patients at 8.30 am. Max would work through the day with individual patients and small groups. He was a meticulous note taker. His notes were clearly written and he always took a Maudsley-type history. He was a clear thinker and expressed himself well. It was always a pleasure to listen to his contributions at the weekly case conference held with the entire staff of the main hospital [including another charismatic figure, William Sargant whose unit exploring the use of physical treatments was elsewhere in Belmont. As a contributor to these case conferences Max was head and shoulders above the rest of the senior medical staff for his analysis of the case and for his reasons for reaching a diagnosis and proposing a plan of management.

[Merry describes Jones travelling each afternoon to St. John's Wood for his analysis with Mrs Klein] . . . he could fall asleep with ease during the train journey or he would engage a fellow traveller, usually female, in conversation. He was a charming man, and there were many young women who before they knew what had happened had become volunteer workers at the unit. Max was, through his charm, a great recruiter of women volunteers and permanent staff to work at the unit.

A constant theme of Max was the unnecessary role of the doctor as a therapist. He could see the day when the therapeutic community would not need the leadership of a doctor-therapist. Thus from time to time he would argue that for the registrars, including the older supernumerary registrars, it was not necessary for them to spend time studying for the DPM. Of course this was felt as nonsense by registrars who were married and depended on the DPM for promotion. Moreover they were angered by the knowledge that Max had worked hard to get his MD when he was already a consultant and in that sense the MD was just a gong. This anger was also fed by the fact that Max was a bachelor and had no immediate family responsibilities and surely also by jealousy of his intellect, his personality and his achievements . . . [Jones lived initially in the Belmont doctor's mess, although later in this period he married his first wife Kerstin.] . . . Thus, although the concept of the therapeutic community was accepted by the four junior doctors on the unit there was a rift between the older married registrars and Max.

(This) . . . continued to the point that Max wondered whether there was any point in sustaining the Unit. A meeting of the Unit medical staff was called at one time to discuss this. The other junior doctors were all for calling it a day and it fell to myself as by far the youngest doctor to rally them to support what I saw as a most important contribution to psychiatry. The Unit survived. I was young, unmarried, and starry eyed about Max but in retrospect I, like Max, had appreciated neither the depth of rivalry nor the day-to-day problems of the older married registrars with children. The medical staff failed to work through this problem.

Apart from the intra-Unit tensions, there was a constant threat to the unit from the main hospital. The Unit was a wing of the hospital contiguous with the main building. There was always a stream of professional visitors . . . they came from the UK and from abroad from Europe, the Americas and as far afield as Japan. But there were no visits from the Senior Medical Staff of the main hospital. From these Senior Staff there was condescension, scorn, even open hostility until at one point the Management demanded that the Unit be closed. The then Regional Board instigated an enquiry headed by the late Professor Desmond Curran. The enquiry was thorough and lengthy and eventually found no good reason for closing the Unit.

Practice at Belmont has been described several times (Jones, 1952; Whiteley, 1972, 1980; Manning, 1989; Murto, 1991). The Unit initially accommodated 100 patients in four wards, although the occupancy had dropped to about 40 in the 1970s, thus freeing space for a wide range of activities. Later, following a fire, it was re-housed from the original Victorian work-house building into what had previously been the nurses' home. Manning's account emphasises the development of the unit from being experimental to achieving a place within psychiatry as an established, specialised facility. Research was always an important feature at Belmont: the early years were reported in a number of publications including Jones (1952), and the next phase in a stream of publications collected in Rapoport's *Community as Doctor* (1960). After Jones departed, this tradition continued in the work of Whiteley (1980), Manning and others.

Initially the Unit catered for persons identified by Disabled Resettlement Officers of the Ministry of Labour, or by psychiatrists (or both), all over the country as the 'hard core' of the chronically unemployed. Psychiatrically, they had for the most part chronic neurosis or character disorder, but they were also described as including 'some of the most anti-social elements in society – people who have also served prison sentences, drug addicts, prostitutes and so on.', who 'frequently exert a strong negative influence on the environment from which they come' and who were 'much more ill' than the patients at Dartford (Jones, 1952). Over later years, the clientele gradually became more identified as psychopathic personalities (hampering, indeed, the therapeutic community movement through the spread among psychiatrists of the opinion that if this approach was 'good for psychopaths' it could not be good for any other types of patient).

By the time of his 1952 account, most of the characteristic elements of the Maxwell Jones type of therapeutic community were in place. From 8.00 am to 9.00 daily, patients undertook work activities to keep the ward environment tidy; on weekdays, there was some form of community meeting from 9.00 to 10.00 for all patients and all staff free to attend; there were patients' work groups from 10.00 to 12.00 (and staff meetings) and from 2.00 pm to 4.00, with a wide range of activities; free time from 4.00 to 7.00 during which patients on pass could leave the hospital; and from 7.00 to 9.00 an organised social programme, prepared by a patients committee and 'readily censured at the group discussion should it fail to cater for all needs'. In addition, there was a full range of hospital-wide social activities. In the early Belmont years, the full range of physical therapies and individual psychotherapy were also used, although reliance progressively became placed on the effectiveness of the social processes and group psychotherapy to achieve the desired outcomes. An example of these processes (dealing over about ten days with the occurrence of a number of thefts in the community) may be found in Jones (1952, pp. 165 – 187).

Behind this time-table lies the theory that in such a rich social environment every patient would find opportunities to replicate the problems they had experienced in the outside world, the whole being open to scrutiny, analysis, challenge, and reparation within the community interaction. It was in this sense that Jones claimed (as well as the principles that 'everything is treatment' and 'all treatment is rehabilitation') that 'all patients (once admitted) should get the same treatment'.

The staffing of the unit has been analysed by Rapoport *et al*. (1960) in terms of 'core staff' – the most highly trained (doctors, the charge nurse, the psychiatric social worker, and the psychologist), adjunctive permanent staff (staff nurses who, initially, were medically but not psychiatrically qualified, workshop instructors, and disablement resettlement officers) and the 'transient staff'. The latter comprised social therapists, of whom Rapoport wrote:

> (They) are untrained in any of the core or adjunctive professional skills, but are employed in the position of assistant nurse. (They are) brought in for six months to a year to implement the Unit's particular approach to treatment rehabilitation. In many cases they have had some university education, usually in social work, but they seldom have any nursing training. They do not, however, form part of any definite career line, and go into various occupations after their experience in the unit.

Briggs (1986), reported in Murto (1991), adds from a recorded conversation with Jones:

> We soon found it almost impossible to find young people in Britain who wanted to work in this setting, for low pay and with no opportunities for advancement – it was a dead end job . . . About this time, we had a social work tutor from Norway come to visit the unit . . . she was impressed and asked if she could send some of her students to get experience.

Murto explains that the practice of recruiting social therapists from Scandinavia started in this way, and adds that the advantages were their democratic character, that patients could in turn teach them something of the language and culture, and that they improved the morale of patients and staff, 'for they were full of life and ideas'.

The work at Belmont attracted a large number of visitors – psychiatrists, social scientists, criminologists, etc. – both academics and practitioners from Britain and overseas, so much so that special 'visiting day' arrangements had to be set up. In many countries, the processes of liberalising the old mental hospitals were then getting under way, and ideas emanating from Belmont were highly influential – though not, of course, to be exactly imitated. Thus, Clark (1965) later defined a helpful distinction between the 'therapeutic community proper' (Belmont in pure culture) and the 'therapeutic community approach' (a partial application of these ideas in the wider mental health field). Jones personally became an increasing force, not only in Britain in connection with such bodies as the Ministry of Labour's National Advisory Council on the Employment of the Disabled (for which he received the CBE in 1954), the board of the Tavistock Institute of Human Relations, and in his representations to the Royal Commission on Mental Illness and Mental Deficiency (where the provisions for psychopathic disorder in the Mental Health Act, 1959 owe much to this input), but also internationally. He travelled world-wide, partly as consultant on Rehabilitation to the World Health Organisation (Jones & Stoller, 1952) and increasingly as a lecturer and consultant.

Uncertainties about what was going on nevertheless remained. The question: How much is the man and how much the method? arose in various quarters (e.g. World Health Organisation, 1953). Accordingly, Jones set about establishing a programme of proper sociological research. On one of his visits to the USA, he recruited an anthropologist, Robert Rapoport to come to Belmont – initially (in 1954) to study the phenomena of psychopathy and its treatment. Subsequently, the focus shifted somewhat towards a precise characterisation of the Unit's regime. In 1955 generous funding by the Nuffield Foundation enabled a large research team to be appointed. The subsequent studies of Rapoport and his co-workers described in much more detail and with less bias than Jones' own publications, and with a sound basis in theory, exactly how Belmont operated. *Community as Doctor* (Rapoport, 1960) described the regime, which did not differ from that set out above (except that the community meeting was occurring earlier, so that 'the 8.30' entered therapeutic community mythology as something of a technical term) and proceeded to evaluate it – clarifying, for example, the place of social control in the scheme of things. This study also defined the four cultural principles – democratisation, permissiveness, communalism, and reality confrontation – which although by no means uncontroversial, have broadly guided therapeutic community theorists ever since.

Jones himself, having set the Rapoport investigations in motion, evidently became uncomfortable with them – early on, there was one co-authored paper (Jones & Rapoport, 1955), but none later – and he effectively distanced himself from them. He left Belmont at about the same time as it became an independent hospital, then renamed the Henderson, and within a few months of the publication of *Community as Doctor*. Jones was disappointed in the book, partly because it disconfirmed his belief that the therapeutic community regime was applicable to every type of patient – Rapoport demonstrated that less robust personalities might do badly in a confrontative regime

– and it was not well received by the Belmont staff generally. Nevertheless, he later acknowledged it as 'a rewarding, but painful learning situation for us all' (Jones, 1968a: 18).

Manning later collaborated with Rapoport in reviewing the impact of this study (Manning & Rapoport, 1976), and replicated some of the initial work. His more general account of both the significance and the limitations of *Community as Doctor* should be consulted (Manning, 1989, pp.103 ff.). The importance of that book resides in having firmly established the features of the Maxwell Jones model of the therapeutic community, and for its prominence within a research tradition which Jones brought to Belmont from his Maudsley background and which has persisted in the therapeutic community movement.

The Therapeutic Community Movement

A second brief entr'acte here will suffice to note the further evolution of the therapeutic community in Britain after Jones' departure from the Henderson. So far as the Henderson Hospital itself is concerned, the story up to 1980 has been well recorded by Whiteley (1980) and later developments by others (e.g. Norton, 1992). Whiteley reviewed the continuing stream of research studies which emerged during the 1960s and '70s (and which has continued), the major contributions to professional training (especially, perhaps, of social workers and probation officers), the contributions to policy development in the fields of criminology and the management of psychopaths, and the ambivalence of conventional psychiatry which, on the one hand, has regarded it as a valued specialist resource in the treatment of patients with severe personality disorder and, on the other, has launched repeated attacks designed to get the hospital closed.

In Britain, parallel to Jones' work at Belmont, the liberalising of the mental hospitals was proceeding fast. Examples include the work of David Clark at Fulbourn from 1953, later described in *Administrative Therapy* (Clark, 1964) and in several papers, and that of Denis Martin, appointed consultant at Claybury in 1955 and who contributed *Adventure in Psychiatry* (Martin, 1962). Corresponding developments in the United States produced such work as *The Mental Hospital* (Stanton & Schwartz, 1954), *Human Problems in a State Mental Hospital* (Belknap, 1956), *Asylums* (Goffman, 1961), and *Ego & Milieu* (Cumming & Cumming, 1962). This forms part of the rich transatlantic influence noted earlier.

Developments in the therapeutic community movement in Britain from the 1960s have been analysed by Manning (1989). His account defines two further stages. During the 1960s, enthusiasm for the therapeutic community began to wane partly because, within the life of the hospitals, it was not found to offer the comprehensive revolution in the social organisation of custodial institutions which many idealists sought, and also because hospital-based care was being circumvented by moves towards care in the extra-mural community. Although therapeutic community concepts began to be applied in community care settings, the movement as a whole entered a phase of what Manning calls 'legitimacy deficit'. In medicine generally, a new idea may make some initial headway on the basis of the enthusiasm of its advocates, but it will not ultimately survive unless it satisfies the criteria of scientific research. Psychiatry was not at that stage convinced by the protagonists of the therapeutic community. Nevertheless, the therapeutic community movement did not die out, either in Britain or elsewhere. Somewhat to the surprise of its critics, it persisted as a form of practice during the 1970s and 80s and developed a growing literature of sound, if unexciting, research. This process was aided by the formation in 1972 of the Association of Therapeutic Communities and by the establishment in 1980 of its Journal and of a number of training activities. Kennard (1986) described this as the shift from a 'movement' (of social reform) to a 'method' (of therapy).

Greater clarity has been achieved about the several models of the therapeutic community, and the several historical pathways through which they have developed – progressive education and the Planned Environment Therapy Trust (Farquharson, 199l), the Northfield experiments and the work

associated with the Cassel Hospital (Barnes, 1968; Main 1989), residential treatments for alcohol and drug abusers including large elements of self-help (the Concept House model, De Leon & Zeigenfuss, 1986), and others. But the version associated with Maxwell Jones, sometimes referred to as the 'democratic model' has had the widest influence and is perhaps that towards which all have tended to converge. While individual therapeutic communities tend to develop and decline according to changing local circumstances, the movement remains firmly rooted in Britain and North America, in some European countries, notably Holland and Italy, in Scandinavia, Israel, and Australia.

Wider perspectives

To rejoin the chronological narrative: by 1959, the essential features of Maxwell Jones' model of the therapeutic community were firmly in place. The last 30 years of his life were characterised by two themes: experiments in the application of these principles in a wide variety of institutions, mainly in North America but also at Dingleton ('clinically the most creative period of my life' Barraclough, 1984), and the extension of those ideas, which he increasingly referred to as 'social learning', to the wider social and political scene. The latter was evidently accompanied in his later years by an internal, spiritual exploration.

Among the many visitors during the early years at Belmont was an American psychoanalyst, Harry Wilmer; he also visited Main at the Cassel and T.P. Rees at Warlingham Park and, as he later remarked 'saw what I believed was the future hope of psychiatric hospitals' (Wilmer, 1991). Later, when teaching at Stanford University, California he was instrumental in Jones obtaining a one-year Post as Visiting Professor. During this period, the lectures were written (though actually delivered in Washington DC) which later became *Social Psychiatry in Practice: The Idea of a Therapeutic Community* (1968a) – arguably the single most influential book in promoting the therapeutic community world-wide. Wilmer is himself an exemplar of the proliferation of such units, being personally responsible over the years for a 38-bed ward at the US Navy Hospital, Oakland (where he acknowledges a debt to both Jones and Main), a VA Hospital ward for schizophrenic veterans, a unit for Vietnam combat veterans, a therapeutic community at San Quentin prison, and a unit at the Langley Porter Institute for casualties of the Haight/Ashbury drug culture. Jones visited and consulted at each of these units in turn (Wilmer, 1991).

His next three years were spent as Director of Education and Research at Oregon State Hospital, Salem and Clinical Professor at the University of Oregon Medical School. With the assistance of an enlightened Medical Director, Dr Dean Brooks, Jones was here to have his first personal experience of moving a large, traditional mental hospital (where *One Flew Over the Cuckoo's Nest* was later filmed) to one showing most of the characteristics of a democratic system. He also continued to lecture all over the United States and to write.

He was ultimately dismissed from this post. According to Jones:

> What happened has become all too familiar 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 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 I was no longer welcome and it was hinted that I was a communist! (Barraclough, 1984)

However, Clark (1991), in the context of discussing the abrasive and destructive side of Jones' charismatic personality, adds: 'his constant baiting of the all powerful Governor's wife was said to be the main reason for his dismissal.'

Thus, on the instigation of Professor G. M. Carstairs, Jones became in December 1962 Physician Superintendent of Dingleton Hospital, Melrose. Dingleton, a 400-bed hospital, was already widely respected for having become under the leadership of George Bell one of the first – perhaps *the* first – British mental hospital to have a comprehensive open-door policy, although in other respects it continued to run in the traditional autocratic way. A long-serving member of the nursing staff recalls that the Physician Superintendent was:

> a nice man, but really isolated from the staff and patients and he treated the hospital as a one-man show. The Matron was very authoritarian and autocratic and quite fixed in her ideas of what was right and what was wrong. People were promoted not so much on the basis of merit but on retirement dates and death vacancies through seniority. (Elliott, 1991)

Jones made a quick start. Within two days, a twice-weekly senior staff meeting had been established and within four weeks a Work Therapy Committee. The Hospital Administrator described the effects:

> The words therapeutic community meant little. Why the emphasis on egalitarianism? Staff eating with patients! No more hierarchy, off with uniforms and call me Max! By the end of January 1963 the honeymoon was over and new structures throughout the hospital were the order of the day. Quite a few staff felt their jobs were threatened. All the daily scrutiny was becoming a little tiresome. The number of visitors even became overwhelming. There was a flattening of the hierarchical pyramid but although it meant sharing decisions and authority with junior colleagues and patients it did not absolve those officers from their responsibility. Gradually at first, but eventually most people came to accept the principle of the therapeutic community which attempts to make the greatest use of each person's potential and encourage everyone to play a more adult role in their own treatment or training. By the end of 1963 we had arrived at a position whereby the hierarchy had been truly flattened to make a democratic organisation which provided open communications to all levels and one in which authority could be openly questioned in a constructive way by everyone in the community. (Millar, 1991)

Jones kept a diary throughout the period and described these events in *The Process of Change* (1982). His own later summary – that he was 'able to satisfy himself that a traditional mental hospital could become an open system given time and sanction from above' (Barraclough, 1984) – scarcely conveys the trauma and anxiety, but also the excitement, created by such institutional change. Similar reforms were of course taking place simultaneously in many British mental hospitals (there was talk of the 'New Moral Treatment' of the insane) and in some they were explicitly associated with therapeutic community practices. Dingleton represents Maxwell Jones' personal participation in this wider movement. His own clinical work was mainly with long-stay patients, leaving the admissions wards to his two consultant colleagues, although he held himself available to help any staff or patient in an emergency – providing they first defined it as an emergency. A record of one such incident has been preserved (Briggs, 1991). Murto (1991) gives a more extended account of the Dingleton period.

But the other important aspect of Jones' work at Dingleton was outreach into the wider community. This was partly to do with 'community mental health' (narrowly defined), and partly with the extension of his concepts of social learning into other contexts. A consultation system involving the 60 or so general practitioners in the Borders, local clinics, a crisis intervention service, community nursing, day centres, and group homes were all established. Beyond this was a wide-ranging educational programme involving Womens' Rural Institutes, church groups, Toch H, and indeed any organisation interested in listening to a small team presenting the work of Dingleton. And beyond this again, Jones with others including personalities such as Sir David Steele and the

local nobility established the Border Forum which for a time held discussions – a kind of public community meeting – of such issues as the closure of railways, education policy, or the rural way of life.

Jones took early retirement from the National Health Service in 1969 and, although remaining an inveterate traveller, thereafter made his home in North America. He went first to a Professorship at the University of Colorado and an association with Fort Logan Medical Centre, but he and his third wife, Chris, settled in Phoenix, Arizona. His final continuous contact with a therapeutic community occurred here in collaboration with Dr Leonardo Garcia-Bunuel at the psychiatric unit of Durango Detention Centre, a minimum-security jail in Maricopa County (Jails in the US penal system are remand facilities; convicted prisoners serve their sentences in penitentiaries). Jones worked part-time at this unit until he moved to his retirement home in Wolfville, Nova Scotia in l982. Garcia-Bunuel (1991) describes the now familiar process of introducing a daily community meeting, a staff after-group, a patients' committee, etc., among a population which was at first substantially of personality disordered patients, but increasingly came to include detainees suffering major psychosis.

Alongside a continuing involvement in the clinical practice of therapeutic communities, the final years of Jones' life were marked by an increasing interest in spirituality. His contacts with Heronbrook House, a Roman Catholic therapeutic community for clergy and members of religious orders, at Knowle, West Midlands brought these strands together. Here, he was staff consultant, member of the Board of Governors, and facilitator of staff and residents' discussions; he continued to visit periodically as long as he was physically able to travel and sustained a vigorous correspondence with the Director until a few days before his death (O'Sullivan, 1991). He used the word 'psychospiritual' in connection with this community.

On the wider front, he undertook a consultant role to certain teaching activities of the Department of Educational Psychology at a local institution – Acadia University, Wolfville, Nova Scotia (Little, 1991). Personally, he was concerned to explore as fully as possible the experiences of ageing, bodily frailty (he had a coronary artery by-pass in 1984), and approaching death. His final book, *Growing Old: The Ultimate Freedom* (1988) deals briefly with these matters and describes a discussion group on this theme he conducted at Acadia University. His religious views tended towards the holism characteristic of the New Age movement (he had referred approvingly to Ferguson's *The Aquarian Conspiracy*, 1981) and he described a number of personal experiences of a mystical nature during the final years (Garcia-Bunuel, 1991).

The Man and the Icon

'The name of Maxwell Jones is probably better known throughout the world than that of any other British psychiatrist': thus Professor G. M. Carstairs in 1968. The basis of that claim (surprising to us in the present day) was, of course, precisely Jones' identification with the concept of the therapeutic community: 'one of the most valuable contributions of social psychiatry' (Carstairs, 1968). By the examples of his work at Belmont and Dingleton as well as in North America, by his 'eloquent expositions' both in individual interaction and in formal lecturing all over the world and in encouraging emulators, by sustaining an extensive international correspondence, but especially (and most favoured by Jones himself) by practical demonstration wherever he found himself in a group setting, he promoted his philosophy of social learning. There are several recorded examples (e.g. Toch, 1991) of his ability to turn an academic lecture into an exciting, instructive, and enraging occasion of mutual learning for sponsors and audience alike.

Such a degree of influence generally derives from rather unusual personal characteristics. The question of charisma in relation to Maxwell Jones has been discussed by Manning (1989)

and Rapoport (1991), and also by his friend and near-contemporary David Clark (1991) who comments:

> Meeting Max was always an exciting and stimulating experience. He bubbled with enthusiasm, even in his eighties. He was always excited about some new discovery or person or book. He welcomed visitors and new causes with delight, convinced they would have much to offer . . . Of course there was the other side, he would rage against those who did not see his version of the truth. His joy in elevating the humble was matched by a savage delight in humiliating the pompous, the rigid, the traditional. Sometimes he harried senior office holders, especially older women, quite mercilessly. Often one left his unit infuriated as well as challenged, – but always stimulated.
>
> In talking of his impact on British psychiatry it is important to mention the effect that his puckish charm had on powerful men, especially those senior to him . . . Certainly attempts to destroy his work were thwarted time and again by powerful protectors who would intervene, even if apologetically, to protect Max and his work – Professor Sir David Henderson at Edinburgh, the Hon Dr Walter Maclay at the Board of Control, Professor Sir Aubrey Lewis at the Maudsley and Professor Morris Carstairs in Scotland. Max's puckish charm was often deployed with immense effect on the Great and the Good . . .
>
> Max used to speak of himself as a 'change agent'; that he certainly was. He deployed charm, intelligence and erudition in every situation, challenging, questioning, teasing those he met. He changed the lives of many colleagues and patients, he changed several institutions permanently, he made a major contribution to the permanent change in British mental hospitals.

That Jones was not unaware of these matters is evident from the self-critical references which occur repeatedly in his writing. They raise, of course, the issues of leadership and of Jones' concept of an 'open system'. It becomes very clear in, for example, *The Process of Change*, that Jones never thought of psychiatric institutions as being leaderless. Rather, he always argued for notions of multiple leadership, where this function flows around a number of people over time and independently of their ascribed roles or status within the organisation, for the degree of openness and regularity of communication which makes such an arrangement feasible, and for the continuing possibility of democratic challenge to such leadership by any member of the community willing to mount it responsibly (*per contra*, in a closed system, leadership is autocratic, and communication uni-directional and not open to challenge). It is a powerful model.

From a psychodynamic perspective, Jones was himself always reticent in what he wrote. One brief attempt to relate what is known of his family background to certain aspects of the therapeutic community may be quoted:

> What is immediately apparent is the early loss of the father, the presence of the strong but perhaps emotionally ínaccessible mother who coped resourcefully with a family emergency and the emergence of a rather cosmopolitan cast of characters and environments.
>
> With the therapeutic community concept emerging in wartime practice, Max found a string of opportunities to which he resonated. The archaic father was banished in favour of the peer group; the mother figure was split into a bad external one (Matron) and a good internal one (Sister) assisted by a corps of attractive but untrained youthful nymphets; a total world was created within the manageable hospital premises in which everyone bent their efforts together to understand all that was going on. The giving of affection was part of the sought ethos, and the sharing of decisions served to diffuse responsibility and therefore guilt. When disorganisation mounted and destructive tendencies threatened to gain ascendancy in the community, heroic measures could be taken by the leader to re-create the idealised group – a process which was subsequently identified as sociotherapeutic in that insights were gained by all through participation in the 'oscillations'.

> From the point of view of followers – both patients and staff – charismatic qualities were called for by the social temper of the times. (Rapoport, 1991)

Concluding his sociological review of the recovery of the therapeutic community movement from its state of legitimacy deficit – indeed its evolution to routinisation – Manning wrote:

> The therapeutic community is both a scientific innovation in psychiatric medicine and a social movement to change residential psychiatric practice, therapeutic education and the treatment of addictions. In both of these aspects it has worked with some, but not complete, success.

I concur as a clinician in viewing the therapeutic community as a technique – similar in status to, perhaps, a new family of surgical interventions, or a new class of psychotropic drugs – which enables the social dimension to be brought seriously into therapy. Many (perhaps most) psychiatrists are in practice pluralists, accepting something akin to Popper's Three-World model: the world of physical events (in this case, chiefly biological), the world of mental events, and the world of social events (Popper & Eccles, 1977). However, we are generally poor at understanding and mobilising the world of social events and too often, as the psychiatric literature repeatedly attests, take refuge in the unsatisfactory concept of the 'psychosocial' – by which is presumably meant something like an internalisation of the social world. But therapeutic community techniques provide precisely that events in the social world (World 3) may, along with the psychological (World 2) and the biological (World 1), be addressed separately in their own right.

Moreover, the question 'how much is the man and how much the method?' has an unfortunate overtone. Certainly, Maxwell Jones was a charismatic figure, in some respects much larger than life. But psychiatry is very accustomed to the idea that many techniques, whether psychoanalysis, cognitive therapy, or even the familiar processes of the psychiatric history and the clinical interview, are better applied by some practitioners than others. Any implication, therefore, that the personal skill with which a technique is applied is in some way irrelevant to the outcome is fallacious. Jones was a figure larger than many, but a succession of others have found that they also have sufficient gifts to employ this technical apparatus effectively and to the great benefit of their patients. It is for delivering that technology into the hands of psychiatry and its sister disciplines that the life of Maxwell Jones deserves to be honoured and recorded.

Acknowledgements

This account draws heavily upon a generally laudatory but not unwholly critical commemorative issue of the *International Journal of Therapeutic Communities* compiled and edited by Stuart Whiteley (1991), which includes *inter alia* a complete bibliography of Jones' publications. Also indispensable is N.P. Manning's *The Therapeutic Community Movement: Charisma and Routinization* (1989). Especially for the earlier years, I have used Jones' largely autobiographical introduction to his *Social Psychiatry in Practice: The Idea of a Therapeutic Community* (1968a) and a recorded *Conversation* with Dr Brian Barraclough conducted for publication in the *Bulletin of the Royal College of Psychiatrists* (1984). An important and more recent resource is Kari Murto's *Towards the Well-functioning Community: The Developments of Anton Makarenko and Maxwell Jones' Communities* (1991), which includes material from interviews with Jones as late as 1988.

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