MAXWELL JONES AND HIS WORK IN THE THERAPEUTIC COMMUNITY

(*ORIGINAL TITLE IN DUTCH: DE STUDIE VAN MAXWELL JONES EN ZIJN WERK IN DE THERAPEUTISCHE GEMEENSCHAP*)

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I. RESEARCH METHOD

1. Research Method

In the writing of this thesis, I want to search for the core of all the ideas of Maxwell Jones, mainly viewed from his professional and family background. In the first place, where – and whenever possible – I have used his own books and articles which were published in the long period between 1935 and 1991. Jones has always discussed and critically evaluated his own career and professional work in a scientific and analytical way.

A detailed description of the professional life of Maxwell Jones, with attention for the development of his main concepts, form the starting point of my analysis and is at the same time the main aim of the work below. I have endeavoured only to bring those aspects under attention, which have been either written by Jones himself in extensive detail or by other authors in a congruent and consistent way.

Swanborn (1994, p.218) talks in this connection about fundamental research, whereby "the posing of problems of clear theoretical or methodological nature give direction to the research." Such research can be based on direct (gathered by the researcher) as well as indirect data sources. Consultation of the works written by Jones himself should be placed under the latter category and is described by Swanborn with the term "literature study" (see 2)

2. Research material and its reliability

The books and articles published by Jones himself, in which the development of the therapeutic community is described (scientifically) form (see 1) an important part of the used research material. Also publications of other authors who have described or commented upon the work of Jones were studied.

At the same time and additionally I used data which were described by Swanborn (1994) as "direct" or "directly gathered". I was in correspondence for quite some time with a number of professionals (with some of whom I still maintain an excellent (professional) contact) who throughout their career had the chance to work with Maxwell Jones, or were well acquainted with him as a friend or relative, or both.

1. Dennie Briggs, an American psychologist, especially well known for his work on therapeutic community principles in prisons (see Whiteley, Briggs and Turner, 1972) had the opportunity to observe Jones at work in Henderson and Dingleton. Besides this professional contact, he enjoyed a very close friendship with him.

   He is also the author of two large volumes: "Memoirs of Maxwell Jones (1993) and "Dialogues with Maxwell Jones" (1991) in which he gives an often personal) view on who Maxwell Jones was and how his professional career developed. (Letters/e-mails of 31. Oct 1998, 22, Dec. 1998, 27. Feb. 1999, 13 March 1999, 30 March, 1999, 9 Apr. 1999, 17 Apr. 1999)

2. David Anderson (e-mails 18 Feb. 1999, 2. Mar. 1999, 8 Apr. 1999) head of Social Services in the Dingleton Hospital at the time of Jones and now working at Dundee University, was described by Jones himself as:

> *'David Anderson was a good example of such a person who frightened no one and had a warm but authoritative personality.' (Jones, 1982, p. 142)*

3. Craig Fees, archivist of the Planned Environment Therapy Trust (PETT) Study Centre, with whom I, besides a number of correspondence (e-mails 26 and 27 Jan. 1999, 5 Feb. 1999, 10 Feb. 1999, 19 Feb. 1999, 24 Feb. 1999 en 22 Mar. 1999.) also had several conversations during a visit to the Archive and Study Centre. Craig Fees interviewed Maxwell Jones just before his death in 1990. Fees (1998 p. 65) himself writes the following about the archives: (see page 2)

> *' An archive and study centre is a place into which experiences in its many forms flows, is stored, is protected against decay, and when called for is made available again, with safeguards for confidentiality. Behind it is the belief that a society or a profession with a deep and critically tuned memory is more likely to live well through difficult, dangerous, or simply new and unexpected experiences than ones that live by the seat of contemporary memory alone, however rich in organisation, structure and tradition.'*

   Also Kennard (1998) in his most recent book talks about the importance of the Planned Environment Therapy trust and describes it as a place for research and discussions about the therapeutic community.

4. Kari Murto (e-mails 17.Jan 1990 and 28 Mar. 1999), a psychologist from Finland, and author of the book "Towards the well functioning community" (1991) in which he compares Jones's communities with those of Makarenko in Russia. He had the opportunity to interview Maxwell Jones in his house in Nova Scotia from 3 – 8 Aug. 1988.

5. A number of one-off contacts
   Stuart Whiteley (letter, 23. Jan 1999)
   John Cross (Chairman of PETT, letter 18 Feb. 1999)
   Harry Wilmer (22 Jan 99)
   CeIS Modena (e-mail, 29 Sept. 1999)
   CeIs – Rome (e-mail, 20 Oct. 1998)
   Prof. Serge Verhaest (KUL – visit 22 Oct 1998)
   Christine Jones (Maxwell's widow, letter 31 Jan 1999)

I have also tried to contact – via David Anderson – Kerstin Jones (Maxwell's first wife) and his three daughters, but have not succeeded so far.

The therapeutic communities of Mill Hill, Dartford and especially Henderson have constantly been the subject of various studies (Sandler, 1952 – as described by

Jones 1952 – and Rapoport 1960) who throw an objective viewpoint on these communities (Murto, 1991)

Nowhere have I established any contradiction in the descriptions of the therapeutic communities in both studies and the way Jones portrays them. Neither show the experiences of the Dingleton therapeutic community – as written in 6.5, any inconsistencies with data from the Dingleton report of David Anderson (e-mail, 28 Feb. 1999) nor from Murto's book (1991).

According to Briggs and Millar, Murto's description of the Dingleton situation was strikingly accurate. There is just one discrepancy: according to Murto the name of the brother of Jones was Sinclair, whereas in the interview with Briggs (1991) Jones talks of Gerald.

3. Research questions

The life and work of Maxwell Jones has not been written about in Dutch scientific literature, while in the international scientific forum many questions remain unanswered about Jones, whose influence on the concept of the therapeutic communities can hardly be overstated. I have therefore chosen to draw my analysis from the family and professional background of Maxwell Jones and so, besides a detailed description of his life and work I have paid attention to various specific research questions. The development of Jones' most important scientific concepts such as "social learning", "two-way communication" and others were closely linked to the description of the development of the therapeutic communities which Jones set up, namely, Mill Hill, Dartford, Henderson, and especially Dingleton.

The research questions include the following:

1. Thorough and detailed description of Jones' (professional) life.
2. The relationship of Maxwell Jones to psychoanalysis.
3. How was Jones influenced by the Northfield experiments ?
4. How do the "democratic" therapeutic communities compare with the "new" hierarchic therapeutic communities ?
5. How is everything integrated? Decisions towards concepts of present-day therapeutic communities.

4. Limitations of the research.

The biggest (inevitable) limitation of this research is that it is impossible to discover how Maxwell Jones would have evaluated the present thinking of the therapeutic community in general and especially studies like this one, if he had still lived. He died in 1990 after a long heart illness. Despite my constant effort to mainly use his own words, by citing from his many works, I personally regret very much not to have met and interviewed him. That is why I think it so important to promote the case of study of the life and work of Maxwell Jones as soon as possible (in a wider context than is possible here) while there are still people alive who have known and followed Jones from the beginning of his professional career (apart from the above mentioned professionals I also think of Harold Bridger, Don

Ottenberg[1] and others). Last but not least another important restriction can be blamed on the fact that there is an almost complete absence of Dutch literature and little availability in other languages about and from Maxwell Jones in our Belgian universities.

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[1] Donald J. Ottenberg died on August 20, 2004 (cf. Broekaert, E., Vandevelde, S. & Yates, R. (2005). Dr. D.J. Ottenberg, friend and humanitarian. A personal account of a therapeutic community pioneer. Therapeutic Communities. The International Journal for Therapeutic and Supportive Organizations, 26(2), 215-224).

II IN SEARCH OF FAMILY BACKGROUND OF MAXWELL SHAW JONES

Maxwell Shaw Jones was born on 4th January 1907 in Queenstown, Cape Province, South Africa, as the youngest of three children. When Maxwell was 5 years old his father William died, probably through excess of alcohol (Briggs, 1993)

> ' I think he did a little university teaching, too. I'm not sure about the details – see, my mother didn't really want to talk about her married life too much because it's been tragic in the end, see, with the alcohol. She never said that but I don't know much about my father… ' (Interview met Jones, 1988 in Murto, 1991, p. 82)

His mother chose not to return to her country of origin, America, but instead went to live in Edinburgh, Scotland, with her three children. Maxwell, who was very attached to his family, later describes his mother as follows:

> 'Though quiet and unobtrusive, she was a firm idealist, and she impressed on us a belief in social responsibility, particularly through human service' (Jones, 1991, p. 48)

> 'My mother was an outstanding scholar at school and was a warm sociable person who was liked by everyone rich or poor, black or white. ... Mother was very permissive and never told us NOT to do things, so the 3 children grew up to be independent and responsible' (Letter of 14th Sept. 1987 in Murto, 1991)

That the three children were growing up with a sense of social responsibility shows clearly from the fields of study they undertook. Margery, who was 4 years older than Maxwell, studies to become a teacher. Gerald (Jones, 1991 – see remark I.2) born in 1905, studies law and later becomes a judge. Maxwell looks up to his older brother and sister but has a special admiration for the rebellion of his brother Gerald. About that period of time he says himself:

> ' But if Gerald was a rebel, then I was a conformist. The moral values of both my mother and my brother deeply impressed me. I felt inferior to them, and needed an identity of my own.' (Jones, 1991, p. 48)

In 1988, during an interview with Kari Murto, a Finnish psychologist, Jones says about his brother and sister:

> '... in a sense I suppose ... my sibs, my brother and my sister were really quite high at chambers in worldly sense. They ... I mean the arts, music, and travel travelling global, they're not belonging to any country, and I suppose in that sense one always had an international perspective.' (Murto, 1991, p. 83)

During his life Maxwell Jones was married three times. He met his first wife Kerstin in the Henderson Hospital where she worked as one of his social therapists. They have three daughters (College of Psychiatrists' Bulletin, in Casselman 1991). After their divorce he married Jeannette, whom he met while he was Head of the medical team in the Dingleton Hospital in Scotland. This marriage did not last either and next Maxwell married Christine, a teacher whom he met after his "active" retirement (Letter from Dennie Briggs, 22.12.98).

It is likely that Maxwell Jones has always felt uneasy about his own biography, which explains why he (in the various interviews he had with people) does not tell much about his private life. Christine Jones, his third wife, writes: (see page 6)

> *'There is no biography of Max ... Max was more interested in having his work speak for itself and being remembered for his professional contribution rather than his personal life.' (Letter of Christine Jones, 31st Jan. 1999)*

III THE PROFESSIONAL CAREER OF MAXWELL JONES.

1. Education

Maxwell Jones went to the Daniel Stewarts School in Edinburgh and finished there in 1925 when he was 17 (Jones 1991) Afterwards he declared himself to have two diametrically opposing loves: literature and sport, mainly rugby:

> ' I was enthusiastic about team games and believed that the morale of the team was as important as its skill. I remember in my last year, I was captain of the rugby team ...' (Jones in Briggs, 1993, p. 5)

> '... at the same time, I enjoyed reading and I became particularly interested in those authors such as the Bröntes, Dickens and Dostoyesky, who portrayed human character with great sensitivity and skill.' (Jones, 1968, p. 15)

After his studies Maxwell wants to go to Kenya to become a coffee planter (Jones 1968 and 1991). However, he does not find anybody prepared to lend him the necessary means to fulfil his dream, so he decides to become a psychiatrist, because he is increasingly interested in human behaviour. For this he enters the University of Edinburgh, where he receives a gold medal in 1930 for his work on the effects of carbohydrates on neurotransmitters.

> ' The entire eight years spent in medical school and working in hospitals were, frankly, a nightmare. I hated dealing with physical misery in the midst of professional indifference.' (Jones in Briggs, 1993, p. 6)

Afterwards Maxwell Jones specialised in psychiatric relief work and was appointed assistant to Sir David Henderson, professor of psychiatry at Edinburgh University. At that time Jones felt quite unhappy (his own words) about the way he was pressed into the conventional way of psychiatry, as it were (Jones 1968) Professor Henderson insisted strongly Jones researched the endocrinological and biochemical aspects in relation to psychiatry and during the 1930s there appear a number of articles of that nature (see e.g. Jones, 1935)

In 1936 Maxwell Jones receives a scholarship, which enables him to go to the U.S. to study at the University of Pennsylvania and Colombia University, where he works together with a specialist in enzymatic chemistry and a biologist. From this co-operation Jones draws his main conclusion, namely that the most ideal way of dealing with psychiatric difficulties is probably not to be found in the biology orientated direction. (Jones 1968). In 1938 he starts work in the Maudsley Hospital in London, under the leadership of Dr. Aubrey Lewis, who has a psychoanalytical background.

With the outbreak of the Second World War the Maudsley Hospital is closed down. In its stead, there are two temporary Emergency Hospitals established, staffed by personnel of the Maudsley Hospital. The intention is to treat soldiers suffering from

neuroses so they can resume their functions in the army. The first is North of London, in the buildings of the Mill Hill public school, a former boarding school (Shorter, 1998), the second south of the capital, in Sutton, where soldiers with the most acute forms of neuroses are received and treated by a number of methods who act upon the biology of the body (like "modified insulin, ether abreaction, continuous narcosis, narcoanalysis") (Jones, 1952).

2. A first therapeutic community avant-la-lettre:

Mill Hill (1940-1945)

In his later work (see Jones, 1952 and 1982) Jones describes Mill Hill Hospital as an early experimental therapeutic community, where people tried to change the dominance of the medical model and the passive role of the patient (Jones, 1973). Although the name "therapeutic community" was first used by Tom Main (1946) it is Maxwell Jones who is on the whole seen as the person who has given shape to the development of the (democratic) therapeutic community (Murto, 1991; Jongerius, 1989/ Clark, 1977).

Maxwell Jones is being employed in the "Effort Syndrome Unit" of the Mill Hill Hospital, this on the express wish of Aubrey Lewis. At first the hospital is run according to a very strict and rigid tradition.

> ' The Sister's (charge nurse's) word was law and very little free communication existed between nurse and doctor, and nurse and patient.' (Jones, 1952)

Through the circumstances of the war all women were compelled by the government to serve in various ways to help the war effort. Many of these (often well-educated and artistic) women chose to go into nursing and so came also to work in the Mill Hill Hospital, where patients were treated who complained of "left chest pain, palpitations, breathlessness, postural giddiness, fainting and fatigue", typical characteristics of "shell shock" or "effort syndrome" (Jones, 1952 and 1982)

During an extensive research project, involving all of the 100 patients of the Mill Hill, Jones comes to discover that all these symptoms are expressions of a psychosomatic reaction to stress and have no obvious biological reason, a conclusion which will be confirmed later by a research done by the Harvard Fatigue Lab (Jones, 1991 & 1948).

After Jones had come to this conclusion he thought it only normal to inform the patients of this news. It did not seem to make sense to him to have separate conversations with each of the soldiers individually and he had the idea to discuss his findings with the whole group of a hundred soldiers. So he started a big change concerning the social structure of the hospital.

At the same time Jones shared his knowledge and findings with the nurses, so they all began to feel part of the project. More and more they began to contribute new ideas themselves. Maxwell Jones had always admired artists and performers – perhaps partially because of the respect he felt for his brother and sister, whom he

admired greatly for their artistic work – (see Chapter II) – and he urged the nurses to "invest in the project with their talents and enthusiasm". (Jones, 1991) Thus Jones explains the creation of psychodrama groups within Mill Hill; an evolution which was thought of at about the same time by Moreno, who also gave it its name.

> *' Actually we developed psychodrama quite independently from one another and at about the same time. Only he (=Moreno) came up with a name for it. I only heard of Moreno and his work some years later.'* (Jones, 1991)

The discussion groups did not just limit themselves to the mere symptoms, but soon extended to all aspects of the social structure of the department. Increasingly the social problems were presented for discussion by the nurses and it wasn't long before the first patient joined in this "psychodrama". Besides, it also meant that the patients took a more active role in the proceedings. The patients who had been in Mill Hill for a longer time than their newer "colleagues" began to explain their illness to them and gradually encouraged them to partake in the discussion groups (Murto, 1991)

2.1 Conclusions regarding the work at Mill Hill Hospital

Jones himself looks back on the results of the Mill Hill Hospital (Jones, 1952)

1. The treatment of the patient is seen as a continual process. Not just the interview with the doctor is seen as therapy but gradually attention is given to the reactions of the patient on what happens all around him.
2. In order to perform these necessary, thorough observations, the social structure of the hospital will change – according to Jones. The former hierarchy is exchanged for a free communication between doctors, sisters, nurses and patients.
3. Increasing attention is given to the integration of the patient in society after their service in the army, to try and avoid stress in their civilian life as much as possible.

2.2 Community meetings and psychodrama.

2.2.1 Short history:

Broekaert (1998) writes that Bierer sees himself as pioneer concerning the "therapeutic social club", which will lead to the concept of the therapeutic community later on. Bierer is especially inspired by the "individual psychology" of Adler, who wants to make a study of the psychology of "the individible person" and introduces the concept of "globality" with this. (Bierer, 1983) Moreover the idea of the "social club" can be strongly defended from Adler's basic concept:

> *' Adler's basic concept is the 'Gemeinshaftsgefühl'- the social identification – that implies that human beings are born as friends and as equals, and not as ennemies to each other.' (Bierer, 1983)*

After this pioneer – at the outbreak of World War II – we can distinguish two directions within the creation of the therapeutic community (Broekaert, 1998). On the one side of course the direction of Maxwell Jones, on the other the so-called "Northfield Experiments", which took place at the Hollymoor Hospital, Northfield, with as important proponents, J. Rickman, W.R. Bion (Northfield I) and S. Foulkes, T. Main and H. Bridger (Northfield II) from 1942-1948. It is highly probable that the two trends were influenced by each other, although this was not always put into words.

> *' After the war, of course, Maxwell Jones had much more scope to develop hospital-wide activities of which he has written fully. It is only sad that in private he has frequently acknowlegded his debt for the ideas and dynamics he drew from Northfield I and Northfield II, but has not, to my knowledge, done so publicly in his many books. (Bridger in Harrison and Clarcke, 1992)*

By installing an empty room – the social club – a kind of therapeutic space is created, by the need of people to have agreements (see e.g. Broekaert, 1998).

2.2.2 Community meetings in the Mill Hill

Maxwell Jones starts off with group meetings also (cfr. supra) at first with clear educational aims, namely to teach the soldiers about the way their bodies work and the symptoms they experience because of the "shell shock". Soon however the talk during these meetings is also about other matters which concern them: questions about how people will regard them and how their families will react towards them when they return home. By discussing such intimate things the department obtained of its own accord a more personal character. (Jones, 1991). Increasingly the problems are dealt with by the whole group.

> *'... at the same time indicate how their problems are handled and influenced by the group.' (Jones, 1948)*

Within these meetings the psychodrama played an increasingly important role. Remarkable is the input of the nurses in this aspect. Besides their indispensable enthusiasm they came up with many new ideas (see II.2)

> *' As I said, the nursing assistants were involved from the beginning and had unexpected talents from their own backgrounds ...' (Jones, 1991)*

Maxwell Jones concludes that drama and spontaneity are fundamental aspects of a therapeutic community.

' I might add that they are essential to learning and discovery…' (Jones, 1991)

2.3 Problems inside the Mill Hill

Naturally the changes of the social structure in the hospital did not always go smoothly. Especially the trained "sisters" (as opposed to the "nurses") rebelled against Jones. Not only because he encouraged the nurses to associate with the soldiers freely and spontaneously, but also because he allowed them to look freely at the patients' medical records, a practice which until then had been strictly out of bounds in all hospitals. According to Jones this reluctance to his new approach was never overcome. Jones relates:

' Anyway, when I arrived at work one morning, a delegation of the nursing hierarchy were wating outside my office. The rage which had been suppressed, became so violent when unleashed, I was afraid they might attack me.' (Jones, 1991)

3. The "ex-prisoner-of-war unit" in the Southern Hospital, Dartford: a second start of a therapeutic community (1945-1946)

After the war Maxwell Jones received the opportunity to establish a department for returning, war-weary prisoners of war, in the Southern Hospital at Dartford, a small town about 15 kilometres distance from London. He took with him a large part of his staff from the Mill Hill (namely 6 psychiatrists, 50 nurses, 1 psychiatric social worker, 1 occupational therapist and 1 psychologist). The department had a capacity of 300 beds and during the eleven months it was functioning 1,200 patients were treated (Jones, 1952). The soldiers who were admitted needed some time before returning to everyday life in society.

' For some, there was a loss of identity or alienation, as they had experienced a kind of existential crisis during their internment, and now were estranged from their families and friends. Life had an entirely different meaning for them ...' (Briggs in Jones, 1991, pp. 19)

Jones housed the patients in six sections, of 50 soldiers each, who quickly formed their own small (therapeutic) communities. (Jones, 1952). Right from the start he also introduced a daily community meeting, during which at first the behaviour of the patients was discussed, but soon it developed the excellent function of talking about their uncertainties and problems which they experienced when returning home. After Jones had seen the power of psychodrama at the Mill Hill, this also became soon part of the programme in the Southern Hospital. Indeed, Jones himself saw this as the most important opening within the start of any therapeutic programme with prisoners of war. For many of these soldiers who had spent years in their prison camps, drama had often been their only permitted amusement, so for them there was very little nervousness for this method. (Jones, 1991).

Besides these two methods which Jones had got to know during his work at the Mill Hill Hospital, he also organised a number of other activities. Every week, during 2 morning meetings the mechanisms of psychosomatic illnesses were explained and discussed. The following day a video film about the subject was shown and again followed by a discussion (Murto, 1991). The last day of the week was reserved for a kind of "community meeting" during which all sorts of problems were brought to the fore and solutions were tried to be found. (Jones, 1946)

Jones is also convinced that they must try to get the soldiers back into society as soon as possible.

> *' In the post-war era, Max accepted the challenge of applying his new method of treatment to the 'social rehabilitation' of people ...' (Briggs, 1993 p. 8)*

For this, he goes himself in search of companies, shops, farms etc., nearby the hospital who are willing to employ one or more patients and so ease their return to society. This early form of occupational therapy was made possible by practical help of the government, who made three buses available to ferry the patients to and from work. Meanwhile, within the hospital itself (Jones, 1952) he establishes a higher cultural life. Increasingly the soldiers write their own plays and act them out. Also a magazine, "The Grapevine" is created which amongst other things ensures an improvement of the quality of the food at the hospital. This happened after a satirical cover of the magazine – on which the low standard of the food was insinuated – had reached the Ministry. It goes without saying that this event had a very positive influence on the self image of the patients.

1. Conclusions from the work in Dartford.

1. The conclusions Jones formed from his experiences within Mill Hill Hospital are strengthened by the ones of the Dartford community.
2. Jones himself speaks of a "transitional community" which has as the main aim the social rehabilitation of the ex-prisoner of war soldiers (Jones, 1968)
3. Much importance is being attached to the manner of the gradual rehabilitation into society of the patients by assistance in the work place.
4. Jones instigates a follow-up study which shows the effectiveness of the treatment.
5. Maxwell Jones becomes convinced of the importance of the '"therapeutic community'" concept.

A. The follow-up study

Jones (1952) carried out a follow-up study of 100 patients who had gone to live in London after their stay in the (therapeutic) community at Dartford.

The figures were as follows:

completely recovered:	22
Improved	66
Not improved	12

They, who called themselves completely recovered felt the same as they did before the war.

Characteristically, they who had not improved stated that they had felt better during their treatment, but afterwards relapsed into their previous neurosis. So we could in fact conclude that the majority – during and/or after treatment – felt better.

Also the figures concerning employment in a working environment prove the effectiveness of the (therapeutic) community at Dartford. Of the total group, 60 people say they are content with their work, while 16 declare to be confident there will be improvement in the near future (Jones, 1952)

There results which were reached in Dartford, according to Jones, surpass by far those at Mill Hill and later at the Henderson Hospital. He attributes this to the fact that only the strongest prisoners of war returned; the weaker ones died of deprivation in the often inhuman circumstances.

B. The importance of Therapeutic Communities

Gradually Maxwell Jones realises what a promising prospect the therapeutic communities have for the treatment of people with psychiatric problems

> ' By the middle of the 1940's I was firmly convinced that we were on the threshold of an important new treatment model in mental health, but I didn't know at that time what direction it would take - or where it would take me.' (Jones, 1991)

3.2 The importance of Mill Hill and Dartford for Maxwell Jones and the therapeutic community.

Both experimental therapeutic communities, as Jones called them himself, had a big influence on Jones's ideas and his evolvement from orthodox doctor (Briggs, in Jones, 1991) to one who paid special attention to the social organisation and structure of the psychiatric hospital.

He attributes this change to the exceptional circumstances in which he had to work, namely during and for a short time after the second World War. In a humorous remark, but without doubt a truthful one, Jones writes (1968) that the war saved him (from the traditional psychiatry). When Jones is asked to judge his early work he writes

> ' It seems doubtful that this rapid transformation could have occured in peacetime; hospital traditions are strong. The general tendencies to change were due to the crises of war-time, the temporary nature of the hospital, and nursing staff from other professions. We had evolved a process of growth, without any conscious inkling, spontaneously.' (Jones in Briggs, 1993, p. 8)

Jones also insists (unwarranted, in our opinion) he knew himself to be strongly supported by Aubrey Lewis and Walter McClay (the Director of the Maudsley Hospital and the Mill Hill Hospital) and so he therefore deserves little credit. In our opinion the realisation of such aw fundamental change needed a lot of courage, initiative, zest for work and knowledge.

> *' It was a tense, yet exciting time, and one did rather feel one ought to make hay of the situation - there might be not much time left to do it. We were, as they'd now say, task- rather than job-oriented an no one ever thought of a 40 hour week.' (Jones, 1991, p. 23)*

In the experimental therapeutic communities we can find important origins for future basic ideas within the concept of the therapeutic community. "Social learning" according to Jones, stems from the ability of free communication and discussions with each other.

The effects of "catharsis" and "re-education" (see e.g. 1948) – yet unknown terms in those days – are for the first time observed and studied, especially during the psychodrama sessions.

The effects of group meetings is acknowledged even though little was known about them. ^

> *' Group methods of treatment are still too undevelopped to have evolved any specific treatment thechniques.' (Jones, 1948, p. 104)*

The thinking behind the therapeutic communities, thanks to Jones's early efforts, gets to be known by the Ministry of Health, Work and Pensions, which in turn allows a department to be set up to help people with problems, or "social misfits" as Jones calls them (1968).

Maxwell Jones is put in charge and so begins the development of perhaps the best known therapeutic community in the world: the industrial neurosis unit, Belmont Hospital, or the later Henderson Hospital.

4. <u>The Industrial Neurosis Unit, Belmont Hospital: later the Henderson Hospital (1947-1959)</u>

In 1947 the Ministry of Health, together with the Ministry of Work and Pensions establishes the Belmont Industrial Neurosis Unit (IRU) – with Maxwell Jones in charge – for the treatment of "chronic unemployed victims of the industrial society" (Jones, 1991).

Ironically, the IRU is housed in the buildings of the former Sutton Emergency Hospital, where during the war years soldiers with "effort syndrome" were treated and where still a very strict and authoritative regime prevailed, which draws the following comment from Jones:

> ' ... now the two diametrically opposed treatment units were to co-exist, though not compatibly, on the same ground for the better part of the next three decades.' (Jones, 1991, p. 30)

Officially the IRUs were started up to build a bridge between the treatment and the employment of "adults with character disorders" (Baker, e.g. 1953). According to the report of the Ministry of Labour and National Service (in Jones, 1956, p. 985) we have to regard the function of the IRUs as follows:

> ' In the process of rehabilitation, a distinction may be drawn between the part in which the medical aspects are of major importance and that later part in which resettlement and employment become the predominant interest. ... industrial rehabilitation is directed to the preparation of a disabled person for the performance of a normal's day work under ordinary industrial conditions, and not to the remedying of specific disabilities.'

The Belmont IRU had places for 100 adults who, because of emotional problems, were unable to function adequately in society (Jones, 1952). Essentially it catered for people between 18 and 60 years old, but most were young adults who were often described as psychopaths (Baker, 1953, Jones, 1952) because of their rebellious and aggressive behaviour. Besides them there was a group of people who could be described as neurotic. Rapoport (1956) describes the population as follows: approximately 60% suffered from personality disorders (psychopaths, etc.) 20% belonged to the psychoneurotic group, about 10% were psychotic people and the remaining suffered other disorders, sometimes from a physical cause. Sandler (in Jones, 1952) draws also the distinction between "aggressive" (about 5%) and "inadequate" (about 23%) psychopaths. (See also Murto, 1991). Jones (1991, page 30) describes it as follows:

> ' But this new group had been shuffled from pillar to post and to survive had developed ingrained traits that alienated them from society. Many of the women had been involved in petty crime most of their lives ; some had resorted to prostitution ... The men, on the other hand, without acceptable work habits, had developed real skills of manipulation and were engaged in criminal activities, often with violence ; most were experienced con-men '

He distinguishes in this the fundamental difference with the patients of the Mill Hill and Dartford. The latter had already gone through the process of (more or less) successful socialisation, but encountered psychological difficulties as a reaction to the dramatic circumstances of war. In other words the basis of social skills were already present on which the organisation of the therapeutic communities could find support. The patients who ended up in the Belmont IRU did not always have these basic skills, because often they had been "outcasts" (Jones, 1991) all their lives.

4.1 Short history of the Belmont IRU

Whiteley (1980) talks of three different phases in the long existence of the Belmont IRU, which in 1959 was renamed the Henderson Hospital by Maxwell Jones, after his mentor Professor David Henderson, connected to the University of Edinburgh and author of the influential work "Psychopathic States" (1939) (Briggs, 1993; Whiteley, 1980).

The first decade in the existence of the Henderson Hospital is characterised by the conception and growth of many ideas and opinions about the therapeutic community concept. Increasingly the work done at the Henderson received recognition and admiration, even though many people remained suspicious ... not least those working in the other wing of the hospital, some of whom scornfully called Jones's department "Max and his gangsters" (Briggs, 1993).

The next decade (1957-67) is mostly characterised by the search for more theoretical speculation, based on wide scientific research. Especially R. Rapoport is seen as the prime force behind a number of research papers, who were later put together in a volume called "Community as Doctor" (1960).

From 1967 till the present day we can state that the Henderson Hospital has specialised in the treatment of people with character disorders and at the same time formed a sociotherapeutic model within the framework of the therapeutic community.

4.2 Organisation of the Department.

4.2.1 The staff

Maxwell Jones had quite an extensive number of staff at his disposal during the twelve years he led the Belmont IRU. Beside a (large) number of doctors and nurses, they employed also a social worker, a psychologist, workshop instructors, someone from the Probation Service, domestic staff and two "Disablement Resettlement Officers" (DROs) (Jones, 1991)

Jones himself regarded the nurses "the most important members of staff concerning a large number of aspects" (Jones, 1952). Because of the low wages and the long working hours it became more and more difficult to attract young English women to do the work, so Jones was compelled to employ girls from abroad, especially from the Scandinavian countries. With hindsight this turned out to be an important advantage as the patients seemed to accept these "strangers" better than the "native" nurses. (Jones, 1991)

Generally Jones distinguishes three roles in the task of the nurse, namely an authoritarian, a social and a therapeutic one. Instead of the term "nurse" Jones prefers to call them "social therapists" (e.g. Jones, 1991), whose function it is to be representatives of the "culture of the Unit".

'... in general the nurse's treatment activity is limited to her transmission of the Unit culture to the patients...' (Jones, 1952, p. 39)
' The social therapists are in a sense the carriers of the unit culture ' (Baker e.a., 1953, p. 228)

Jones wants to change the conception people have of the doctor as being a kind of magician who can treat any complaint with a pill or a potion. As has earlier been mentioned, he broke the deep-seated hospital rules by letting the nurses look into the patients' files and by discussing with the patients their illnesses and what could be done about it. In other words, he gave responsibility to everyone who was involved in the therapeutic community, not least the patients themselves.

The role of the doctor can be described according to five motions:

Social, supportive, as an example, encouraging and interpreting.

Moreover, Jones sees the (informal) relationship between doctor and patient as an "important principle of social interaction", because this way, when unexpected events occur, intervention can happen straight away instead of having to use reports or oral representations of earlier happenings.

' ... retrospective accounts of the patient ... , these are all subject to distortion and in some circumstances may be grossly inaccurate.' (Jones, 1959, p. 201)

The "Disablement Resettlement Officer" (DRO) – who works under the authority of the Ministry of Labour – performs an important function in the therapeutic community of Belmont. The most important one is to guide the patients towards a work environment. By – like the doctors – maintaining an informal contact with the patients it makes it a lot easier to approach them and in return for the patients to approach the DROs (Cann in Jones, 1952). The DRO is also responsible for supporting patients who participate in training courses, organised by the state.

Lastly we want to pay attention to the role of the patient within the Belmont therapeutic community. Jones himself states that this role is the hardest to describe. He points to the possibility to look at it as an anticipating role, with the aim to help the patient to learn what his function is within the therapeutic community and to accept it as such. This role is aimed mainly to help form a tight group, so the total culture of the unit becomes a therapeutic culture (Jones, 1952).

Of course "peers" play a very important role, although they also pose a real danger, in the sense that during the normal activities in the unit there are unavoidable clashes and problems. (Jones, 1959) These problems are brought in the open during the daily "community meeting" (see 4.2.2.1), where mostly the patients themselves solve these problems due to their thorough knowledge

of each other and the intuitive appreciation they have of each other's difficulties. As far back as 1948 Jones talks in this context of "catharsis".

' The group discusses the scene ... and by explanation and emotional support, aims at strengthening the patient's ego ...' (Jones, 1948, p. 104)

The social structure is naturally subject to constant changes which allows for the best possible and the most liberal communication between doctors, nurses and patients (Baker, e.g. 1953)

4.2.2 <u>The practical organisation of a therapeutic community: therapeutic meetings, workshops and leisure time.</u>

The main feature of a therapeutic community is perhaps that the whole time the patients take part in it is regarded as treatment, not just the interaction with the doctor is seen as the most important.

Emphasis is put on the fact that the patient is an integral part of society as well as the community where he lives only temporarily (Jones, 1952)

The therapeutic activities, the workshops, the way their leisure time is spent within the Belmont therapeutic community, are deemed to be important in the treatment.

4.2.2.1 <u>Therapeutic meetings</u>

<u>Individual meetings with the staff</u>

Although the group meetings are used as much as possible to discuss various problems, the psychiatrist tries at least once a week to talk with his patients individually. The duration of these interviews can vary from a few minutes to about an hour (e.g. Baker, 1953).

At the time when the patient is first admitted at IRU Belmont he will attend several interviews, namely: (1) with the psychologist of the unit, (2) the social worker, who will assist if there are any difficulties at home, and (3) the DRO, who will keep an eye on the (professional) career of the patient and advise him on job opportunities (Jones, 1956). Coinciding with this the patient is also welcomed by a volunteering fellow patient and shown around the therapeutic community (Jones, 1952)

<u>The 8.30 a.m. meeting</u>

This meeting, organised daily from July 1952, "is of great importance to what the therapeutic community" in Belmont has to offer. It originally came in existence because of the disciplinary problems the doctors encountered with some of the patients. Until then each doctor had his own approach – within the rules of the IRU – to deal with these people, so there wasn't a real consensus about "punishment" of "defaulters".

> *' In order to try to improve an unsatisfactory situation, a daily meeting of 'defaulters' was instituted.' (Baker e.a., 1953, pp. 223)*

The first few days the doctor had a "Fault-Book" in front of him, but before long he took a seat within the circle in between the patients. After all, it was not the intention to punish the patients, although they themselves did fear this would happen. At first the attendance was strictly limited to those patients who had in some way committed an "offence". Increasingly however other patients chose to come and watch the proceedings ... while simultaneously the doctors determined that the patients were obliged to talk about their offence which in turn seemed to propel them to look for a motive.

> *' He (= een patiënt) went on, however, to speak of the relief which the meeting afforded him, and that he approved of the method whereby the patient himself was made responsible for his behaviour.' (Baker e.a., 1953, pp. 225)*

Later on Jones calls it the "community meeting", which begins at 8.30 and ends at 9.45 a.m. It is attended by all (100) patients and all the staff (30) (Jones, 1957)

The Unit – discussion meeting

At 9 a.m. every weekday a group meeting is set up where all 100 patients and part of the staff are present and during which a subject of a sociological nature is being addressed. Also, during two of these meetings a short lecture is given, either by the doctor, a staff member or a guest speaker. Almost always the subject is related to the life of the patients, for example matrimony, rearing of children etc. During these meetings projection techniques, like psychodrama, are often used (see 4.2.2.5) (e.g. Baker, 1953; Jones, 1952).

Ward meetings

For half an hour each week the patients get together with the sister and the two social workers attached to the unit. Emphasis during these meetings is put on aspects to do directly with the ward itself, although here also free communication is the norm. Patients are encouraged to find solutions themselves.

Staff meetings

Members of staff get together for half an hour every day at 9.45 a.m. during which the earlier unit discussion meeting is analysed and they examine what the influence of it will be on the total group.

Then there are three lunchtime meetings a week, lasting an hour each. During these meetings any inter-personal problems between members of staff are looked at and discussed, to ensure optimal co-operation. It goes without saying that here too is an opportunity for free discussion of any topic that is raised.

Furthermore there are daily meetings (Jones calls them "tutorials" (e.g. Baker, 1953) organised for the "social therapists", during which views and information are exchanged between doctors and nurses.

Then there are meetings (weekly) between the social therapists and a doctor, always the same one, to talk about possible tensions and the unwitting motives which guide them in their work at the Belmont therapeutic community.

4.2.2.2 Workshops

It was Maxwell Jones's viewpoint that the strength of work therapy was to be found within the Belmont therapeutic community and not in the outside world (e.g. Jones, 1960; Jones 1956). The patients were not offered any training, but an opportunity to work together on a project which would benefit the community itself. The most important aspect of the workshops was that they were tightly linked to the therapeutic group meetings.

> ' ... we see the work itself as of only secondary importance. Our major interest is in the behaviour of patients within the work environment.' (Jones, 1960, p.68)

Every day, after the community meeting, it is expected of the patients that they attend one of the five workshops, from 10.00 to 12.00 and from 13.00 to 16.00. These workshops are: furniture restoring – painting and decorating – sewing – polishing and building.

When they are first admitted to the Belmont IRU they can choose which activity they want to partake in, provided there are places free, while there are possibilities later to change "jobs" if they so wish. For the importance of these workshops see 4.2.2.5

4.2.2.3 Leisure time

As much attention is paid to the patients social role as to the one during the workshops (e.g. Baker, 1953). The way leisure time is spent is left – for a great extent – to the more active patients, although Jones tries all the time also to involve the isolated patients in the activities. To have attention for the needs of those patients in danger of becoming estranged of the group events is one of the main tasks of the "social therapists".

4.2.2.4 A number of other activities

Lectures
Apart from the twice weekly talks by the doctor or another member of staff (see 4.2.2.1), lectures are given about the way the human body works and the physiological symptoms of certain illnesses (Murto, '91). Maxwell Jones had started these activities in Mill Hill and Dartford and because of the good results continued them at the Belmont IRU.

Family Groups

Jones himself attributes the origin of these meetings to the work of the social worker and the nurses who – by visiting the patients' families at home – were convinced about the importance of involving the whole family in the treatment process. Moreover, it had the extra benefit for those patients without families to observe the problems as well as the joyful moments of family life (Jones, '91).

> *'At first they took some patients along until it was decided to have family groups as a part of the rehabilitation.' (Murto, 1991, p.125)*

Dancing lessons and weekly organised "socials"

The nurses gave weekly dancing lessons to a few patients together with a number of women who were invited by the patients.

Also once a week a "social" could be organised, but for this event, the patients themselves were put in charge. (Murto, 1991)

Seminars with professional visitors

Jones (1956c) describes a weekly meeting, organised during two hours on a Friday morning, where a large number of staff members and a representation of the patients attended. This way the staff members (and the patients) could learn not only from their colleagues, the professionals could also test how the patients regarded the "unit culture" because there was always room for discussions.

From what has been written above we must remember that in my opinion all these activities have as their main goal to draw the individual closer to the group and at the same time to introduce a group feeling of responsibility.

4.2.2.5 About the importance of psychodrama and work therapy

Psychodrama

Jones began to use this technique from 1944 in the Mill Hill (see II.2.2.2) and because of the outstanding results they continue in the Belmont Hospital as a therapeutic method (Murto, 1991; Jones, 1952) During these drama sessions of about ½ hour duration, the patient presents his problem to the whole community. To start with the patient/author remained anonymous, but later on this was not the case at all. Moreover, intimate facets of their personal life were increasingly brought into the open.

Several times Jones mentions the high quality of the "plays":

> *' These are carefully produced plays which often reach a high standard.' (Jones, 1948, p. 108)*
> *' ... but frequently a surprisingly high standard is achieved' (Jones, 1952, p. 63)*

The value of the psychodrama has to be looked at from three angles:
1.   the patient himself
2.   the group who (together with the patient) performs the play
3.   the audience

As basis concept Jones uses the notion of "identification" to explain the working of this technique (Jones, 1952).

The patient has to be able to identify himself with all the characters in the play, in order to explain their personalities and their relationships with each other, to the cast and of course also the audience. That this did not always go without a hitch is clear: it forces the patient to return to often violent events (physical or psychological). A clear benefit of such a confrontational method is what Jones calls "catharsis" ("to re-enact a strong emotional experience by placing the patient in a situation which resembles the original and asking him to relive the experience if possible") (Jones, 1948, p.104) A large proportion of the patients reported a considerable lessening of stress after they had re-enacted their story.

At the same time the patients in the audience identify with the people in the play and so, in the follow-up discussion these perceptions and attitudes can be confronted. Jones writes:

> *' The group has definitely changed during the years we have been using a dramatic technique; the attitude now is one of much greater responsibility than formerly towards the person whose problem is being dramatized, and the group participation in the discussion afterwards is correspondingly greater.' (Jones, 1952, p. 66)*

These psychodrama techniques can also be used for other purposes, for example in the framework of education. Difficult social circumstances can be truthfully simulated and interpreted. (Jones, 1949)

Work therapy

Jones attaches great importance to "work therapy", not so much because of the actual work (see 4.2.2.2) but more because it can be seen as a form of group therapy, on condition that the patients' interaction – during the work situation – is studied and discussed. This is the exact reason why the external workplaces were exchanged for the workshops inside the community. The acute problem of potential payment for the achieved work is also solved this way.

> *'... the patients themself came to see the workshops as part of treatment and will no more expect payment for the work as they would for attending one of the doctor's groups.' (Murto, 1991, p. 123)*

4.3 <u>Characteristics of the Belmont SRU</u>

The SRU (social rehabilitation unit) functions according to a number of ideals which we can best describe on the basis of four global themes (Rapoport, 1960):

    4.3.1   <u>Permissiveness</u>

The patient is given the opportunity to freely express all his emotions without running the risk of punishment or any other form of retribution or censure. This principle is given shape by the (almost complete) lack of formal rules within the therapeutic community.

> ' ... *formal, explicit, rules and regulations are kept to a minimum. In the Unit, it is said that there are only two basic rules : ' To attend the community meeting each morning at 8:30, and to be in pajamas ready for bed each evening at 9:00.' (Rapoport, 1959, p. 59)*

Instead of taking punitive measures when one or more patients transgress (like running riot in the unit while drunk, or aggressive behaviour towards others or themselves), it is thought better to tolerate the situation and instead put it up for discussion at the next 8.30 meeting, where the cause of this "acting out" can be sought. This way of handling difficult behaviour can be just as hard to accept and deal with as traditional punishment. (Rapoport, 1956). Jones (1957, p.217) talks in this context of

> ' ... *to create a permissive and understanding environment, where the patient is afforded the opportunity of gaining some awareness of his personality as other people see it, and of getting help in modifying his behavior and way of relating to others ...'*

Exactly by reacting permissively to the patients misdemeanours Jones brings about an important change in the continual process of transgression and punishment; the same process the patients so often experienced in the outside world. When he is so continually confronted with the impact of his behaviour on his fellow patients even an "anti-social isolate" will find it hard to continue with his behaviour (Jones, 1957). Nevertheless, there is always the chance that these patients will identify themselves with newly arrived patients who have not yet got used to the culture of the unit, in which case the climate of the therapeutic community becomes unsuitable for a good and responsible way of treatment.

Concerning this Rapoport (1956) talks of "oscillations" – a tendency to cycles of destruction and repair (Jones 1957) – within the therapeutic community.

It goes without saying that permissiveness must not be confused with a "laissez-faire, laissez-passer" attitude. Like the term "democracy" (see e.g. Rapoport 1957) permissiveness does not mean people were lax or negligent and approved of everything the patients did.

' In some situations the limits of permissiveness are set by other therapeutic directives, in some by a social role or a role obligation, in some by personal needs or capacities, and in some by the desire to preserve a tolerable state of harmony in the total network of social relations' (Rapoport, 1959, p.61)

4.3.2. <u>Democracy</u>

In the Belmont SRU (social rehabilitation unit) people try as much as possible to create an "egalitarian democracy" (Rapoport, 1956), with as few as possible hierarchical structures. The aim is to offer everyone the same opportunity of participation. Rapoport (1960) calls it: "A hospital where nothing differentiates the doctors from the patients". Outer characteristics, like uniforms and titles are indeed being omitted – much against the spirit of those days.

By allowing open communication and interaction between the patients, the doctors hope to see the previous behaviour of the patients transferred to the (interpersonal) life within the therapeutic community, where an analysis of the hidden problems can be done by the doctors and fellow patients.

' In the Unit, there is not only a flattening of the hierarchy but also a blurring of the role structure. ... patients can select more freely the kinds of people to whom they tend to relate, and to relate to them in ways dedicated by inner compulsions rather than the role prescriptions.' (Rapoport, 1957, p. 130)

The democracy in the SRU can of course only be guaranteed if the staff members exercise and adjusted authority. Rapoport (1957) points out six ways of handling authority, - inside the SRU -:

1. have as few as possible formal symbols around (like e.g. uniforms)
2. introduce as few rules as possible
3. give the whole group responsibility
4. refer to previous solutions to problems
5. a certain number of difficulties have to be referred to a higher authority
6. select staff with personalities who are fully behind the therapeutic community principles.

Kennard (1998) points to the important difference in perception of Jones and his staff with regard to democracy; a difference which was induced by different views of the concept of therapeutic communities. Where Jones sees the therapeutic community mainly as a therapeutic method where the omnipotence of the therapist/doctor is bypassed, others see it as a strong ideological weapon against society's inequality. Dependent on which phase the therapeutic community finds itself in at that moment, in regard of the

"oscillations" (namely in the democratic phase – or as Jones calls it, the phase of repair), the practical consequences will be the same.

> ' ... difference between seeing the therapeutic community as a method of treatment to be used at the discretion of the therapist, and seeing it as an ideology concerned with the abolition of inequality between different classes ...' (Kennard, 1998, p. 64)

4.3.3 Communalism

It is thought that by "face to face" communication and free interaction a feeling of solidarity, sharing and belonging is established, to which the therapeutic community owes a lot of its therapeutic climate (Rapoport, 1957) The organising of the various social events in the SRU gives true value to the therapeutic community. Every patient belongs to many therapeutic groups, as they are compelled to take part in 1) the social life on the ward, 2) the therapeutic group where the (same) doctor participates, 3) the workshops (see 4.2.2.5)

On top of that, during the community meeting, a strong sense of solidarity develops.

4.3.4 Reality Testing

Again and again the patients have to be confronted with the image that others have of him/her, and the effects thereof. This offers a concrete counter balance for the patients who often persistently deny having any problems or minimize them.

> ' The Unit 'mirror' aims at having rehabilitative value by replicating within the Unit as closely as possible the social situations of ordinary life outside.' (Rapoport, 1956, p. 359)

In this context Jones (1957) talks of the therapeutic community being a microcosm of society which explains the strong connection between reality testing and permissiveness (Kennard, 1998). In principle, patients can do what they like, but at any time they can be held responsible. All behaviour which is contrary to the ideals of the therapeutic community is subject to confrontation and interpretation. Kennard, (1998, p. 74) wrote:

> ' This combination of permissiveness with confrontation and interpretation is central to all therapies based directly or indirectly on psychoanalysis.' (zie IV.1.)

Besides these four ideals of Jones of the SRU, Rapoport (1960) points to a number of characteristics which are also present in other therapeutic communities. The importance of the "oscillations" in the climate of a therapeutic community must be recognised. It is indeed possible (and

desirable) at certain times to hand over a lot of responsibility to the patients and at other times members of staff will have to take over. Rapoport (1956) differentiates four phases:
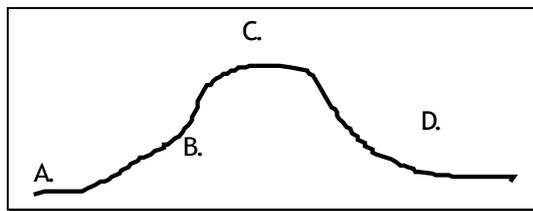
    A. the biggest organisation possible
    B. "constructive" patients replaced by "new" patients
    C. stress peak → has to lower to guarantee safety
    D. reorganisation

Rapoport also points to the difference between treatment and rehabilitation with reference to a discussion between members of staff. One group put the emphasis on the treatment of the patients in the therapeutic community, whereas the others thought the preparation of the patients for the world outside was more important (see e.g. Kennard, 1998)

4.4   Conclusions from the Work in the Belmont SRU

4.4.1   General findings

Jones (1952, p.25) formulated a number of aims at the start of the (then – in 1947 – still called) Belmond Industrial Rehabilitation Unit

1. to study a sample of this group and as far as possible understand its clinical characteristics.
2. to give appropriate psychiatric treatment
3. to decide on the most suitable job
4. to arrange resettlement, preferably while the patient is still in hospital
5. to test the effect of these procedures by carrying out an adequate follow-up study

    1. Jones himself indicates the big change in the target-group (Jones, 1968). At first the Belmont IRU directed itself mainly to "unemployed drifters" with the purpose of social (and especially professional) rehabilitation. Later the target group consisted increasingly of people with all sorts of character disorders (see 4). This change coincides with the change of name for the Unit: the IRU becomes SRU, social rehabilitation unit.

    2. Increasingly Jones becomes aware – during his work in the SRU – that the therapeutic community has valuable possibilities for the treatment of people with psychiatric problems. Later Jones wrote

that indeed especially during the 12 years he spent at the Belmont SRU he elaborated the concept of the therapeutic community. Yet, not until 1968 did he publish his most well known work, "Beyond the therapeutic community", in which he answers a number of therapeutic questions and goes deeper into the basis concepts of the therapeutic community.

3. Jones becomes convinced of the advantages of work places within the therapeutic community instead of outside it. Murto (1991, p.103) writes concerning this

' Working outside the hospital was given up. Work was seen as a part of the therapeutic and rehabilitative process. Work inside the hospital was considered more appropriate since the many aspects of work could thus be studied together'.

4. An interesting initiative was taken – mainly at the request of the social worker – when meetings were set up with the family of the patients in a way that prepared the patient for his return to his natural environment and at the same time the family's own emotions, difficulties and problems could be discussed.

5. The start of a follow-up study is extensively described by Tuxford and Sandler (in Jones, 1952). The main conclusion was that the adaptability of the individual patient gave a better prognosis for recovery than the severity of the illness.

' Thus a very ill person who improves considerably in hospital has a tendency to a better prognosis, than a mildly ill patientt who shows relatively slight improvement.' (Jones, 1952, p. 156)

Furthermore we must not forget to mention the influence of the research team around Rapoport at the SRU from 1953 until 1957, which led to the publication in 1960 of perhaps the standard work about therapeutic communities, "Community as Doctor". Jones himself writes:

' ... and we were glad to be able to finance, through a generous grant from the Nuffield Foundation, a variety of research programmes designed to explore several aspects of the concept. ... This proved to be a rewarding, but painful, learning situation for us all.' (Jones, 1968, p. 18)

We can also point out a number of achievements and conclusions from the work in the Belmont SRU. From the above it seems clear that certain proven methods which were used in the Mill Hill and Dartford, like psychodrama and "community meetings" also bore fruit in the Belmont. However, that these methods did not always succeed was probably because some of the patients

were so difficult to treat, (Murto, 1991) due to their inadequate experience of the socialising process (see 4) in contrast to the ex-POW for example.

The importance of the staff meetings needs to be mentioned again also. Not only are the relationships amongst staff members looked at and analysed; it is also a good opportunity to acquaint new members of staff with the specific way of working. (Kennard, 1998). In Dartford and Mill Hill there was no question of these daily meetings during which the last "community meeting" is discussed. Jones (1991 p.62) talks of the "post-mortem", or the "post-group" discussion".

> ' It does revert back to medicine. ... I think nowadays we'd call it a 'process review'

A report was made of these meetings, which the next day was used as starting point for the community meetings. Murto (1991, p.103) views this method as the basis of what Jones later calls social learning.

> ' This later became a fundamental part of Jones' creation of social learning based on the analysis of common experience.'

The Belmont SRU or later the Henderson Hospital is perhaps still the most well known "democratic" therapeutic community and attracted world wide attention.

4.4.2   The influence of the Belmont experience on Jones

Jones has always had difficulties with the general view of the hospital of which his therapeutic community was part. He writes:

> ' My memories of those 12 year of pointless strife with the main hospital are painful, but it thaught me the need to consider and plan for the resistances in the surrounding community.' (Jones, 1991, p. 40)

There were not only conflicts with the hospital though; the Belmont SRU was also heavily attacked from another (unexpected) quarter. There were worries from the Church of England about a rumour that in the SRU no, or very little attention was paid to the protection of a number of moral rules and an investigation committee was sent to look into these matters. During this period Jones was subjected to intense investigation, not least because of his personal circumstances.

> ' Being in my fifties and as yet unmarried didn't look too good. My inquisitors asked personal questions like what were my attitudes toward prostitutes... Why were they treated in the Unit ?' (Jones, 1991, p. 42)

These problems seem to have only strengthened the stubbornness and enthusiasm of everyone who cared about the fate of the therapeutic community

in Belmont – not least Maxwell Jones himself -. Jones writes about this period of the Belmont SRU:

' This was the beginning of what came to be known as the therapeutic community movement.' (Jones, 1982, p.4)

5. During and after Henderson

5.1 The World Health Organisation (1950-1952)

From 1950 till 1952 Jones worked also as temporary "consultant" for the WHO.

With the aim of researching and clarifying the development of the rehabilitation concept, he visited many establishments in, amongst others, Norway, Sweden, Denmark, UK, USA, Canada, and also Belgium (Jones and Stoller, 1952).

He studies a number of neurosis centres, rehabilitation programmes, day centres, therapeutic clubs and projects concerning sheltered living accommodation.

Strongly influenced by his previous experiences Jones pleads for integrated rehabilitation thinking where as much atte3ntion is given to the social as the medical aspect.

' In conclusion we feel that rehabilitation services should be closely linked with all the relevant medical and social services. On this organization much of the success of any rehabilitation programme will depend.' (Jones en Stoller, 1952, p. 84)

Jones gathers the findings – together with Alan Stoller – of this two year study in a volume, published by the WHO, called: "Rehabilitation in Psychiatry (1952)".

5.2 A trip to America …. (1959-1962)

In 1959, after his pioneering work in the Henderson Hospital, Jones decides to accept the offer of the Stanford University in California to teach "social psychiatry", as guest professor for one year.

'I was pleased to go because I felt the need to leave the specialised field of character disorders and get back into general psychiatry.' (Jones, 1968, pp. 18-19)

Nevertheless, he still spends a lot of time on developing the concepts and ideas concerning his work in the therapeutic communities of Mill Hill, Dartford and Henderson. He meets many American professionals and also visits "Synanon",

the first therapeutic community for drug users, which was set up by Chuck Dederich (Briggs, 1993; Kennard, 1998).

> *'Max was especially interested in the use of 'games' and their general approach with addicts. Most of all, he wanted to exchange views with the founder, which now was becoming well-known. ... Max, who now had become very critical of the program, surprised me : instead of inquiry, he was telling the founder about his own approach and not very subtly suggesting how he would change Synanon. This encounter of course was disastrous – the two exchanged few further words and the meeting was over.' (Briggs, 1993, p. 32)*

From 1960-1962 Jones works as "Director of Education and Research" at the Oregon State Hospital in Salem, and also as professor at the Oregon Medical School. He extends the hospital as a therapeutic community with special attention to the possibilities of "community mental health services expanding into the surrounding community". (Jones, 1982, p.4)

Jones also has interest in starting therapeutic community ideas in prisons. This results in the publication of a book in 1962, in which the concept of the therapeutic community is further elaborated and widened to the society in general and a number of specific settings in particular (like prisons). (Jones, 1962).

However, despite the importance of this first democratic therapeutic community in the USA, Jones came up against a lot of resistance from the very conservative state Oregon, so Jones decides to move elsewhere. He returns to Scotland, where he becomes senior doctor in the Dingleton Hospital at Melrose.

> *'Indeed I was even kicked out of the State of Oregon by Governor Hatfield. I was developing an open-system hospital there in Salem and it went jolly well but then the bureaucrats started worrying about patients wandering around uncompanied. Of course, they never faced me . Instead the put pressure on the superintendent who said to me with enormous embarrassment, 'Max, I think you could find a better opportunity for your skills' or some such bull.' (Interview met Jones, April 1987 in Murto, 1991, p. 132)*

6. Dingleton Hospital Melrose, Scotland (1962-1969)

6.1 Introduction

In 1962 Maxwell Jones returns to the country where he grew up, forced by the resistance he experienced in his work in the USA. For the first time in his career he will have no direct superiors in his job as head of the Dingleton Hospital. Jones is elated by his return to Scotland and writes:

' Professor Morris Carstairs, then head of the department of psychiatry at Edinburgh, encouraged me to return from Oregon to my native land and this I was glad to do. ... I was familiar with Dingleton from the past and liked what Dr. George Bell, my predecessor, had accomplished in creating the first totally open mental hospital in het English-speaking world. (Jones, 1982, p. 5)

Yet, just as all the other hospitals in that era, the Dingleton is run in a strong hierarchical way. The doctor and the matron are in charge and so can count on considerable standing and authority. Jones blames this fact on the slow and difficult process of change although Dingleton seems to him a dream chance to evaluate his therapeutic community concepts.

' The most difficult part of the process of change (Jones, 1986 b) was my initial impact with an established traditional psychiatric hospital' (Jones, 1982, p. 5)

Whiteley (1991, p.79) writes:

' This return to the border country was an opportunity to develop therapeutic community principles in a district mental hospital and expand them into the catchment area, involving GPs, families and social services in the process of creating an 'open system'.

6.2   Short history

Dingleton Hospital was established just over 100 years ago in the small town of Melrose, south of Edinburgh (Jones, 1982). It carries a long tradition of fighting for revolutionary and controversial ideas in psychiatric treatment.

Already in 1949 an "open-door policy" is introduced under the influence of George Bell, who was then the head of the hospital. His main concept is described by Millar, a member of the Dingleton Hospital Board of Management, as follows:

' Take the community with you and a great deal can be accomplished...' (Interview met J. Millar, in Mack, 1969)

In a time when hospital regimes hardly differed from life in prisons (see also Jones, 1952) Bell improved the "quality of life" considerably for psychiatric patients (Carstairs in Macalister, 1972, p.8)

The appointment of Maxwell Jones in 1962 meant the development of a therapeutic community and also renewed attention for the concept of "community care", in the sense that Jones started a project whereby help was offered within the home situation of the patient. Jones made such a mark on the hospital during six years that Taylor and Davison (1994, p. 210) remark:

' The hospital structure has matured but remained similar since then, and it is his still pervasive influence which is undoubtely why Dingleton is so different from other psychiatric hospitals.'

6.3 Dingleton Hospital and the importance of the process of change

6.3.1 An outline of the changing process.

Dingleton Hospital with a capacity of 400 beds, had a relative small number of staff of about 90, trained in therapy: 5 doctors, 84 nurses and 1 social worker, as well as a number of logistic staff members. (Murto, 1991 and Jones, 1982).

6.3.1.1 The establishment of the senior staff committee

In the beginning a strong hierarchic structure prevailed, (see 6.1), which Maxwell Jones broke up (1962) by installing two-way communication and a joint decision making method on every level in the organisation of the hospital. Jones (1982 p.11) describes his main aim as follows:

' My goal (desired future state of affairs) was, as already stated, to bring about a social environment for creative fulfillment by fostering learning as a social process.'

To this end the social organisation of the hospital had to be radically changed and Jones seemed to be the best person to do this with his former experience in five therapeutic communities (Mill Hill, Dartford, Henderson, Oregon Sate Hospital and an advising role in the Fort Logan Mental Health Centre in Denver, Colorado (see 7.1) (Jones, 1982)

In the beginning everybody seemed very happy with the arrival of Jones, who talks of his "honeymoon" period and during which he had excellent contact with all the members of the "senior staff". Of course this easy time did not last (Jones had expected nothing else), but it enabled him to establish quickly and accurately the main problems in the (social) organisation of the hospital.

Soon Jones noticed the deep division between doctors and the nursing staff, induced and strengthened by the lack of communication and the strict rules concerning authority and leadership.

6.3.1.2 The establishment of the senior staff committee, nursing meetings and other gatherings: Jones's realisation after one year.

Two days after his arrival, to deal with this problem straight away, Jones sets up the Senior Staff Committee (SSC); a committee consisting of the secretary, four heads of nursing, the five doctors, the

social worker and his secretary and other members of management, twelve in total (Murto, 1991 and Jones, 1982)

Every decision concerning the hospital was taken via this committee. So, not only was Jones freed from taking unilateral decisions (which would be completely at variance with the "democratic" therapeutic community principle), but it also gave the kick-start to using the concept of decision-making by consensus (Jones, 1982)

Of course these rapidly introduced changes put Jones in a vulnerable position, because sooner or later there would be resistance against these changes and only Jones would be held responsible. Jones knows the possibility of confrontation is inevitable with the introduction of a new (open) social structure in every system:

' An open system implies that anyone, including the director, can be questioned regarding his statements and actions. Clearly, it is much easier and less risky to confront a peer, or someone lower in the pecking order, than a senior. I feel that this freedom to question anyone is mandatory if an open system is to survive and to grow.' (Jones, 1976, p. 42)

Officially the "sacred threesome" (Murto, 1991), consisting of head doctor, head of nurses and the secretary, were responsible for the smooth running of the hospital. In reality only administrative matters were talked about during these meetings and if there were to be discussions about certain people they were invited to be present. Afterwards, the subjects of discussion were brought up as possible suggestions to the SSC, so the ultimate effective decisions rested with them.

' In this way all important decisions were made by the Senior Staff and the teams complemented one another rather than competed.' (Jones, 1982, p.82)

' So, from the very beginning the concept of decision-making by consensus was implicit in our SSC. (Jones, 1982, p. 28)

However, Jones noticed that the nurses were still not involved with the decision making process, in spite of the presence of the "Matron" as their representative, in the SSC. For this reason meetings were organised – at certain set times – which were open to every member of the nursing staff, so interaction and consequently also social learning were made possible (see 6.3.2) This development made sure the nurses became more vocal, which was for Jones a welcome evolution:

' Meetings were becoming less inhibited, and junior staff no longer remained silent while 'listening' to their seniors. Fear of reprisal was disappearing as any threats of this kind could be fed back to the following

meeting. In other words the abuse of authority was 'contained' (zie 6.3.2.3./S.V.)' (Jones, 1982, p. 31)

The perception of everyone's role in the hospital was therefore thoroughly changed, especially for those who carried the biggest responsibility (Jones, 1982). For example, the Matron could be confronted at any time by nurses of a lower status, so she was unable to take unilateral decisions without protests – in sharp contrast to the way it was before.

Of course it could not be expected of one committee (the SSC) to find answers to all the problems (often practical) which confronted Dingleton (especially during the first year of Jones's leadership). That is why Jones established a weekly meeting, concerning on one hand the work therapy, and the more medical aspects on the other, besides the already mentioned meeting for the nurses.

On top of that, after four weeks, he started aw discussion group. During these monthly gatherings every member of staff was enabled to express their feelings, which was not always possible during the other, more structured, committees. It goes without saying that the "community meetings" were also established, whose importance and relevance Jones had already experienced in his previous therapeutic communities. Briggs (cited in Murto, 1991 p.139) writes:

' On Fridays at 1500, those patients and staff who were interested attended a hospital-wide community meeting. ... As many as one fourth of the hospital community ... patients attented and sometimes 50 staff ; as few as 30 patients and 12 staff. Max almost always attended...'

6.3.1.3 <u>The second year: daily learning situations ("living learning") and leadership</u>

The main aim, according to Jones (1982) 2as now to enhance the consolidation between the open communication and the decision-making power of the SSC. Especially the Matron seemed still to have problems with consulting the nurses before representing them at the Senior Staff Committee. On the whole she appeared to have by far the most resistance to the changes in the social structure of the hospital.

Looking back on his work in Dingleton, Jones's view of this resistance is not a negative one, but a probably necessary brake on his own urge for change.

' Matron had a braking effect on my tendency of overenthusiasm and exuberance. I could sometimes convince myself and other people that a new idea would work before it had been fully digested.' (Jones, 1982, p. 35)

37

Jones appears to indicate that the preparatory team-building phase is now finished. Two-way communication, leadership (SSC), trust and the setting up of a number of meetings have been established (Jones, 1976) and now Jones directs his attention to the ultimate changing process, with "social learning" as its main purpose.

The leadership crisis in the Dingleton Hospital is solved at the end of the second year by the appointment of two new doctors, namely Paul Polak and Shail Kummar, who could act as facilitators, when conflicts started in the SSC (Murto, 1991).

6.3.1.4 A confrontation with the Regional Health Board: strengthening the enthusiasm:

Until now Jones had not come across any problems with the Hospital Board of Management of the Dingleton Hospital on which a number of dignitaries from the little town of Melrose had seats, nor with the South Eastern Regional Health Board in Edinburgh, responsible for all hospitals in the south east of Scotland.

However, the Hospital Board seemed to find themselves increasingly passed by, in the sense that they were forced to have an observing instead of an active role. On top of that it appeared that one member of the Board especially had problems with the way the Dingleton tried to handle acute staff shortages. Young people of 16-18 years old had been accepted at the Dingleton to work as temporary volunteers to help the nurses where necessary. Jones writes:

' The scheme was limited to eight young woman and, was deliberately planned so they were not involved in 'nursing' duties. Their role was to help interest and activate the geriatric patients, and, when requested, to help the nurses with bedmaking, etc., but always under their supervision.'
(Jones, 1982, p. 58)

Jones managed to re-establish good contacts by confronting the Board of Management and openly discuss matters and so, once again, (see 6.3.1.2) he is able to reaffirm the importance of opposition in a therapeutic community. (Jones, 1982).

Word had reached the Regional Health Board however that young (female) volunteers were working in the Dingleton. Jones had not waited for permission for this experiment – although the Board of Management had supported it – and had started the project. Rumours that moral values in the hospital were violated under Jones's democratic and very permissive attitude were believed to be true by the Regional Board. It was said that already a number of nurses had been

made pregnant after sexual contact with patients. Jones was summoned to appear before the Regional Board. He declares:

' During the discussion, I pointed out that I felt fairly certain that behind all the rumours was a personal attack on myself, but more particularly on my ideas. I had encountered similar resistance, first at Henderson Hospital (zie 4.4.2./S.V.) and later in Oregon Hospital in the U.S.A. (zie 5.2./S.V.), because the democratic egalitarian social structure of a therapeutic community threatened the authority of an established hierarchical hospital system. (Jones, 1982, p. 63)

After a visit by a member of the Regional Board to Dingleton the permission to continue with the project is withdrawn, even though the rumours appear later to be without foundation. Jones criticises the fact that they won't approach the girls themselves in spite of his strong urging to do so.

Eventually – after six months – Jones is allowed to continue with the project, all be it under strict conditions: for example, the girls are not allowed to work on the men's wards. (Murto, 1991)

Later Jones declares not to have asked permission for the project on purpose, knowing it would not have been allowed. It is more difficult to disallow something which has already been implemented than something which is still only on paper, according to Jones (1982).

When Jones looks back on the conflict with the Regional Board, he writes that one has sometimes to endanger one's position to get what one wants; knowledge he gathered from experience in the Henderson Hospital:

At Henderson Hospital in London I had learned that growth might well entail the risk of putting one's job in jeopardy. But there I lacked sanctions from above, where the Henderson Board of Management were my accusers.' (Jones, 1982, p. 72)

Meanwhile the "living learning" situations as a technique is applied undiminished and the above described incidence gives a perfect illustration that confrontation – as a method – also continues to be used by Jones.

6.3.1.5 <u>A growing decentralisation and the success of "multiple leadership"</u>

Jones is happy to see that "multiple-leadership", as introduced in 1964, is finding favour with the staff of Dingleton. He describes the principle as follows: (1968b, pp 33-34).

' To be effective, a therapeutic community needs several leaders, all of whom are well trained in group work and have the training personality,

and skills to be accepted when the formal leader is either absent or himself involved in an emotional interaction or conflict wiht another group member.'

Maxwell Jones feels that every misunderstanding or conflict can be used as a learning situation; an experience which is made possible by the spontaneous development of leadership and the taking on of a facilitator-role by a number of staff members of the Dingleton therapeutic community.

At the same time Jones noticed a heightened attention for what is now usually called "community psychiatry", the treatment of patients in the outside community and no longer only in institutions (Jones, 1968c). Yet nowhere does Jones talk in a negative way about institutionalisation. As long as the hospital creates a better environment for the patient than society, Jones can't see any disadvantage. (Jones, 1982 and Jones, 1979)

In this context it is interesting to mention that t he first "club" for ex-patients was established a year earlier, in a small town near Melrose, as well as a hostel for 8 male patients, who had employment in the outside community, which was situation in the grounds of the Dingleton therapeutic community. Also in 1966 a start was made with house visits, during which the patient's G.P. was usually also present. This innovation encountered heavy resistance, not in the least by the G.Ps themselves, who before the arrival of Maxell Jones used Dingleton more or less as a dumping ground for patients they did not want to treat themselves (Jones, 1982).

' Now we screened patients in their homes, which meant more work all around, but involved the families from the start and allowed us to assess the strenghts and weaknesses in the family for future reference.' (Jones, 1982, p. 87)

At the same time a team was formed consisting of a psychiatrist, a social worker and a nurse charged with preparation work in the outside community. Three other teams were divided according to the regions and could therefore fully concentrate on the work inside the therapeutic community (this "dividing" was the most important aspect of the increasing decentralisation of Dingleton – see 6.3.1.5).

6.3.1.6 <u>The establishment of three regional sections (1967)</u>

The trend towards decentralisation led to the setting up of three regional sections; a change with consequences for staff as well as (later) the patients. Jones had observed the advantages of decentralisation in practice during a visit to the Clarinda State Hospital

in the USA, where different geographical sectors were responsible for their own regions. (Murto, 1991).

First he divided the staff of the Dingleton into three different teams (see 6.3.1.4). After that the patients were assigned to these sections according to the geographical region they came from. However, the total splitting up of the hospital into three semi-autonomous sections was never realised. To have three different reception wards put too much pressure on the members of staff. Jones (1982, p.90) writes:

' So we ended up with a mixture of geographical and functional hospital units.'

The following compromise was reached: each team was responsible for the treatment of about 75% of the patients of their own region. The care of the reception ward, the geriatric ward and the ward with people with learning difficulties was shared amongst the three sections. (Jones, 1982).

' The final form of the three county teams emerged at the end of 1967, and almost inevitably the major thrust switched from the hospital to the development of effective community services with each county team developing its own model. (Jones, 1982, p. 105)

Increasingly stories about the excellent results of the treatment in the Dingleton Hospital are spreading all over the country and abroad, ("nothing succeeds like success" (Jones, 1982, p.104), which makes it easier to attract new staff. While in 1962 only seven student nurses were employed, the figure is now fifty or more. In this context Jones (1982) talks of the disappearing difference between training and treatment, in the sense that all staff members are expected to take part in the, mostly informal, group training. The thinking behind this is that people living under strain from personal problems are unable to treat patients effectively.

Growing interest for the activities in the Dingleton therapeutic community was also shown by the academic world. The University of Edinburgh, where Jones himself had received his medical education (See 1), especially the psychiatric faculty led by Professor Morris Carstairs, showed great interest in Jones's work in Melrose. In 1969 the University of Glasgow – in close association with the School for Social Studies in Glasgow – showed their interest as well in the work of the Dingleton Hospital. John Mack makes a series of five video recordings, during which he conducts an interview with Maxwell Jones, one with Jimmy Millar (the secretary, who, according to Jones (1982) functioned as interpreter of the local culture in Dingleton – see 6.2), he films a "community" and a "sensitivity meeting" (T group) and a meeting of pupils and teachers (see later) (Mack, 1969).

6.3.1.7 <u>Consequences of the Administrative Reorganisation of the Scottish Health Service (the green report)</u>

In 1968 the "Green Report" was published, the formal announcement of the administrative reorganisation of the medical and social assistance in Scotland. The main points of this reorganisation showed a lot in common with the treatment as practised in the Dingleton therapeutic community and Jon4es dreaded the advance of an anonymous bureaucracy whereby the (relative) freedom of Dingleton would be affected. Jones, (1982, p.117) writes:

' *As we learned later (after my departure), our worst fears regarding the bureaucratization of area health boards and local authority social services were realized ! ... The freedom and intimacy of our own Board of Mangement for Dingleton was to disappear to be replaced by a faceless bureaucracy run by people who are often too far removed from the patient world to have any hope of knowing or understanding the very people whom they purport to serve.*'

At the same time Jones felt his leadership slowly being eroded as multiple leadership and joint decision making – two important concepts in the democratic therapeutic community – were being fully incorporated by the staff. Personally Jones was very relieved by this development because he knew only too well the problems when he had been in the role of the only authoritative figure, especially during discussions and problems when his formal leadership was threatened (which he found an emotional experience). A striking illustration in this context is described by Jones himself, (1982, p.108):

' *My dual role of physician superintendent and leader of the Berwickshire team became increasingly arduous, and finally, when I returned from a trip to the U.S.A. in May, I was informed that I was no longer the team leader. Fair enough ! My poor attendance at the Berwickshire team meetings deserved replacement by a very competent nurse.*'

Probably partly because he saw the above mentioned principles blossom in Dingleton and also because of his discontent about his own role within the hospital, Jones considered to leave Dingleton and return to the USA where he had been before (see 5.2 and 6.1).

Besides, he noticed he increasingly started to take unilateral decisions, which he attributes to his impatience and boredom of the confrontation with the – in essence – same situations over and again. Jones (1982) mentions two more reasons for his increasing restlessness.

Firstly he realised that of the original plans to expand industry in South Scotland, not much was left, since the closure of many railway lines.

Secondly there was very little unity and co-operation between the different villages and towns who together form the "Border" of Scotland, which Jones very much regrets (1982, p/.116).

'We dropped the Border Forum largely due to a lack of community response, which was symptomatic of the feeling that some of us had that no strong Borders identity existed, or at least we had failed to mobilize one.'

6.3.1.8 <u>The last year with special attention to the departure of Maxwell Jones:</u>

During his annual visit as "consultant facilitator" (in April 1969) to the Fort Logan Mental Health Centre at Denver, Colorado, Jones is offered a position there from September onwards and because of the reasons mentioned in 6.3.1.6 he decides to accept. Another reason was the threat of his forced retirement at 65, which would automatically occur if he stayed in the National Health Service in Scotland. In spite of the fact that Jones was only sure of his leaving in April, the idea of Dan Jones taking on a new leadership role had been talked about (Jones, 1982) at the beginning of the year during a sensitivity group.

Although he had been appointed as assistant head of the department, Dan Jones seemed not very keen on taking on this new role. David Anderson (in Mack, 1969) head of social services at Dingleton, speaks in relation to this about the power which emanates from the creation of a new role in a therapeutic community:

' ... if you create a new role, then everybody's role is threatened and that in itself is a producer of change, provided that you can handle the anger (and anxiety/S.V.) that you receive.'

It also became clear that two other experienced staff members were going to leave Dingleton during 1969 and together with Jones's departure there was a real leadership crisis in the hospital;, which resulted in the creation of a new model of leadership (Jones, 19182).

It was decided to set up a management committee consisting of three doctors, the head of the nurses and the social services, and Jimmy Millar, the secretary, as representative of the Board of Management.

This meant that David Anderson, who probably had all the capabilities to lead Dingleton but was not able to do so because he was not a medical doctor, which was a necessity, as well as Dan Jones (head of the medical service) could have joint leadership. Jones himself regards this model as a democratic solution which gave equal status and power to doctors, nurses, social workers and administrative personnel. Jones (Jones, 1982 and Murto, 1991) regrets that this form of joint leadership was used only in the therapeutic community itself and that the

Regional Board still only expected to deal with one person as representative of the hospital, namely the head of the medical service, Dan Jones. Murto (1991, p.146) writes pointedly:

' *This body (Regionale Raad/S.V.) situated over a hundred kilometers away had not been affected by Jones multiple leadership.*'

Despite the difficulties Jones encountered by leaving the Dingleton therapeutic community, he still managed to establish an interesting project during 1969, which would integrate the therapeutic community concepts with education. Important aspects regarding "cross-age teaching" were uncovered during this study (see 6.4.1)

6.3.1.9 <u>Social learning – the key-notion in the changing process in Dingleton</u>

Jones (1982, 1976 and 1968 b) describes social learning as "two way communication which arises from an inner need for stress and which leads to the (open or closed) expression of feelings, whereby cognitive processes and changes are involved."

' *The fact that social learning is a process involving many factors which, according to circumstance, will have many different combinations and permutations and is incapable of definition.*' *(Jones, 1982, p. 133)*

He tries to explain the notion more accurately by using a dozen or so dimensions. Nevertheless, Jones warns repeatedly against the analytical approach of this concept, supporting the well-known principle of the "Gestalt-psychology" which maintains that the whole is more than just the total of different parts. (see e.g. Bernstein, 1994).

Social learning (and therefore the treatment of psychiatric patients) cannot exist by itself, according to Jones, but has only meaning in the light of the (social) environment. Previous to his experience in the Dingleton Hospital Jones writes: (1962 b. p.646)

' *The psychiatric hospital ... even with the new tendency for new patients to stay only a few weeks, sees the social environment as a major factor in treatment.*'

6.3.2.1 <u>Social learning and the role of a "facilitator"</u>

In this context Jones (1988 and 1982) refers to the Socratic method of teaching which is so well described by Roszak (1978). Here Socrates is regarded as the "midwife" of the learning process in the sense that he helps to bring out only the knowledge he supposes us to possess already, without imparting his own knowledge in any form. Jones (1988 p.56) sees here a lot of resemblance with the concept of "facilitator" (see 6.3.1.2)

' to be a facilitator is to assume a degree of responsibility for the social growth of the group, while at the same time denying the authority usually invested in a professional helper.'

The role of the facilitator carries with it enormous possibilities according to Jones (1982), for example changing crisis situations into moments of learning. So can a certain problem, which is being discussed at a "community meeting", be perceived quite differently by all who are present, dependent on the different interests people have in the subject. It goes without saying that the facilitator, acting as a mirror for the therapeutic community and without introducing new elements into the discussion, can be of great service. That the "mirror image" which is thus shown to the person concerned, is not always favourable leads to the conclusion that "social learning" is often a painful process. (Jones, 1982).

In this context Jones talks of "Painful Communication" (Taylor and Davison, 1994) in the sense that "to expose oneself to new ideas can lead to the reviewing and even overturning of long held personal convictions."

Right up to the present day the notion of "painful/difficult communication" seems to occupy an important place in the Dingleton Hospital (see Taylor and Davison, 1994).

Murto, (1991 and 1991b) describes social learning as a process whereby people solve their difficulties and problems together and afterwards look for the characteristics and possibilities of their own actions: (See figure 2)
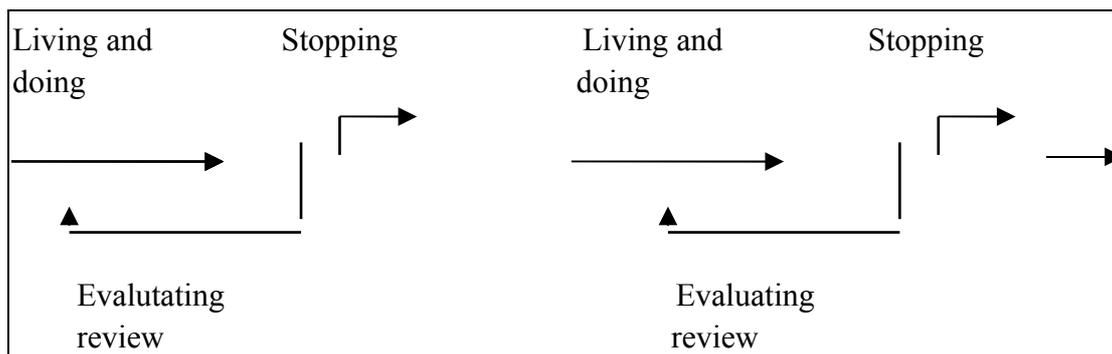

Figure 2 : Social learning (Murto, 1991, p. 173)

In reality this process takes place during the "community meeting" where people look back on earlier situations. Jones gave special attention to the timing of intervention. If this happened too early it could hinder the free expression of emotions or even stop it completely, whereas intervening too late could aggravate the crisis. (Murto, 1991 and Jones and Polak, 1968).

6.3.2.2 <u>Leadership</u>

A therapeutic community assumes joint leadership, whereby everyone gets a share of responsibility and decision-making (Jones, 1968c)

This form of leadership is possible by establishing on the one hand two-way communication at all levels and on the other hand an adapted joint decision making method (see 6.3.1). Jones (1982) was certainly aware to have sinned against this principle when he began at the Dingleton therapeutic community, because he took a number of unilateral decisions (for example the setting up of the SSC, Senior Staff Committee). He justifies this as it having been necessary as a first step to make the decision-making a democratic method and the only way not to lose valuable time to create a group identity.

One of the most important abilities of a leader within a therapeutic community consists of knowing when to facilitate learning experiences and grow chances (in other words "social learning", Jones, 1962b) according to Jones (1982, p.40) as well as a number of other skills and characteristics:

' The attributes a leader wishes to demonstrate in the evolving system would include group as opposed to unilateral decisionmaking, risk-taking, focusing on learning, giving positive feedback and criticism, flexibility and openness, resiliency, welcoming the unexpected, and showing confidence and trust in people - all essential in sanctioning change.'

So, instead of using the term leader (always keeping in mind the notion of joint leadership) in a therapeutic community it would be better to use the term "catalyst" or "charismatic leader" (Jones, 1968). In this connection Jones himself writes: (1991, p. 76)

' ... the leader changes his function to meet the needs of the community. There are times when he must be more active and may sometimes have to make unilateral decisions temporarily. But when a community is functioning properly, then the leader, in a sense, disappears - is less observable. ... This ability to change with the needs of the community (a sensitivity a leader must have or acquire) is tremendously important.'

Multiple leadership is regarded by Jones (1982) as a separate dimension concerning social learning, although we will deal with it here due to its relevancy.

Ideally different leaders, each with their own specific skills, should be able to deal with any situation. Jones (1982) (See 6.3.1.4) is happy to note that during his last three years at Dingleton there were six different leaders who each, when necessary, could take on the role of

facilitator. Yet, after he announced his resignation, there appears to have been a leadership crisis (see 6.3.1.7)

' ... if you're making so much fuss about one leader dropping out, what is wrong with the multiple leadership ?' (Jones in Mack, 1969)

Murto (1991) clearly draws the permeable structure of the therapeutic community, whereby (multiple) leadership, as seen by Jones, could be implemented without accusation of it being a "would-be democracy" (see 6.3.2.4. and figure 3).

LEADER
(Available for anyone at anytime)

The Commanders'Council (Makarenko/S.V.) / SSC
(Meetings open for everyone interested)
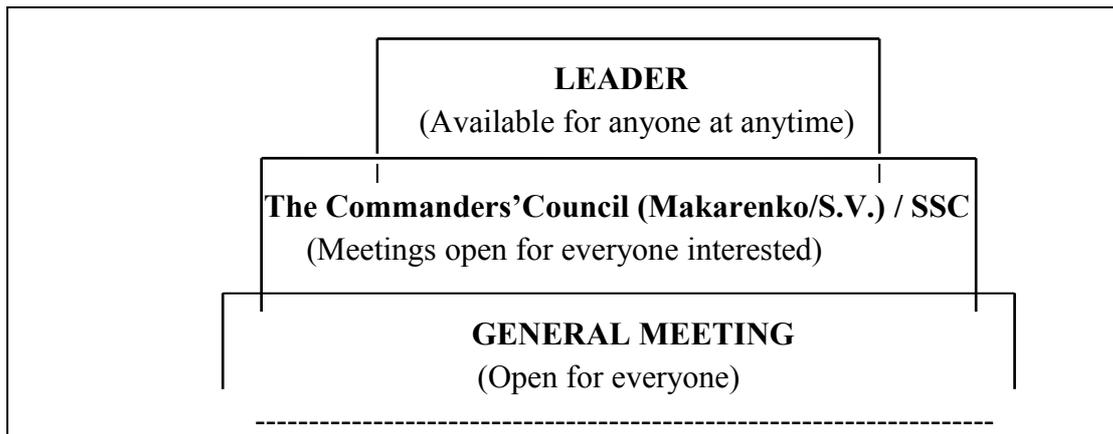
GENERAL MEETING
(Open for everyone)

Figure 3 : Upward permeable structure of a Jones-type therapeutic community and the communities by Makarenko (Murto, 1991, p. 178)

He describes the way in which Jones practises his leadership as "leading an interaction process, where it is crucial to develop the community and to make decisions through group and community processes in common forums organised for that purpose". (Murto, 1991, p.78). (See page 46, figure 3)

6.3.2.3 Containment

Jones (1982, p./43) has always been aware of having a kind of desire for power, about which he writes:

' In other words, although I firmly believed in a democratic structure and shared decision-making, my natural tendency was for an active and at times aggressive role which contradicted my open system beliefs and demanded that I be 'contained.'

Every charismatic leader has the need for a number of alternative leaders who can reflect how he is perceived by others. When Jones watched the video film again which was made of the Mill Hill Hospital in 1943 (Report from Britain, 1943), he was amazed how authoritative he still came across (Fees, 1999), by for example always (literally) sitting or standing higher than the patients. This would probably not

have happened had there been someone of similar strength to point this out to him.

6.3.2.4 Joint decision making

From his experience in the therapeutic community Jones regards a decision taken by the whole community more valuable than any unilateral decision (see 6.3.1). Of course it is a fact that the extent of responsibility given to a patient at a certain moment is dependant on a number of factors. Jones (1968c) mentions a few: the clinical state of the patient, the education, socio-economic status, expectations of the staff, etc.

Murto (1991b) speaks in this connection of a process-directed development strategy as used in the democratic therapeutic community, with the central features:

1. The progress in the development of a therapeutic community is mainly propelled from below upwards, whereby, according to Murto, in the first place attention has to be given to the needs of the personnel who work with the patients in direct interaction.
2. The therapeutic community develops itself as an entirety; at all times one looks for the best possible way to keep and advance the integrity of the community.

Both characteristics point definitely to the importance of a decision making procedure whereby everyone is involved (not least the nurses who are in closest contact with the patients).

There is a danger, closely related to the principle of joint decision making, that the leader of the therapeutic community can manipulate the group by indeed listening to what others have to say, but then disregarding it. Jones (1968b p.41) writes:

' The director (de leider van de T.G./S.V.) may try to railroad a decision while achieving some semblance of sharing. He may appear to listen to his colleagues and then retain the final decision-making power. How he interprets the preceding group interaction may be highly subjective and his decision may not be open to question. This is a very commom form of 'democracy' and a director who operates this way, may when challenged, angrily protest that, after all, the really creative ideas are his !'

6.3.2.5 Consensus

Jones (1982) defines consensus as "the chance of every member of the community – independent of status – to give his/her opinion and at the same time have respect for the feelings and opinions of others in the group." Therefore consensus is a group-event whereby y the individual is influenced in a reactive way by the whole group (Jones 1968b).

It can be regarded as a more sophisticated and advanced form of a joint decision-making method (see 6.3.2.4). It is assumed that the group as a whole has discussed a decision and that every individual (more or less) agrees with it. The strength of this method, e.g. the creation of a group identity, is of more value than the disadvantages which are inherently attached to it. It is after all a time consuming technique and can have painful consequences for an individual when he/she is asked to relinquish their viewpoint for the good of the community.

6.3.2.6 The continuation of the community

Despite the problems Jones experienced with his departure from the Dingleton therapeutic community, he remains convinced that once a therapeutic culture has been established, new leaders can be absorbed and the therapeutic community does not collapse with the leaving of one or more leaders (Jones, 1982). There is no better proof of this statement than the fact that the therapeutic community in London (Henderson) and Melrose (Dingleton) are still in existence now, as open systems. Henderson Hospital is still known as the most eminent democratic therapeutic community and to this day is being used as a training centre for students and professionals. Dingleton is still in use for the treatment of psychiatric patients, for the most part following Maxwell Jones's ideals (Taylor and Davison, 1994). Hinshelwood (in Jones, 1982) mentions the setting up of the "Association of Therapeutic Communities" created by three pioneers (Whiteley, Hinshelwood and Manning), who were or still are working in open systems and emphasises the continuation of the therapeutic community, not only as a theoretical but also as a present-day treatment strategy.

6.3.2.7 Social Learning as a process

Jones has always regarded the process of social learning a lot more important than the results thereof. He put the emphasis on the social and developing characteristic of learning instead of the cognitive aspects (Ottenberg, 1984, p. 42):

' Goals must give way to process, in that we must be able to turn laterally, rather than be always goal-centered.'

Jones (as cited in Ottenberg, 1984) gives a few guidelines for a successful process of social learning:

1. One has to have regard for the time aspect
2. there should be no interruptions
3. the key notion is interaction
4. just like listening, it is a skill which has to be developed.

6.3.2.8 Intuition as a guide:

The fact that Jones has observed the development of the therapeutic community during his career compels him to regard intuitive thinking as an important supplement to the traditional rational reduction thoughts. (Jones, 1982) Breda O'Sullivan (1985) lets Jones speak for himself:

' The therapeutic community as it is known today is the offspring of religion in a field dominated by science and medicine. ... I have found it to be an evolutionary process which eventually embraces spiritual values.' (unpublished, 1984)

Especially at the end of his life Jones seems to have chosen for more spiritual and intuitive thinking. In his last work, "Growing Old: the ultimate freedom", (1988) he gives his vision on ageing as the phase in which spirituality and contemplation form the main values.

6.3.2.9 Risks as stimulance for change

Jones (1982) sees the taking of risks as an important part of change in general and of Social Learning in particular. Elsewhere (see 6.3.1.3) the fact has been pointed out that Jones was convinced of the necessity sometimes to put his job in jeopardy, to be able to accomplish a change. Of course a safe environment (see 6.3.2.10) where there is trust will stimulate risk taking and is therefore more open to changes.

' Everyone must be concerned about the evolution of a caring and trusting social environment, one where it is reasonably safe to take risks and examine consequences. That, I think, is the basic element of a social system conducive to change.' (Jones, 1991, p. 93)

The strength of an open system, according to Jones, is exactly to not only allow risk taking but also to recognise the stimulating role of it.

In the Dingleton Hospital the role of "risk taker" was quite soon taken up by a nurse, Reg Elliot, who before Jones's time, had already clashed several times with the hospital authorities, came to be seen as the rebel in Dingleton. Jones (1982, p.1982, p.147) writes:

' ... so much that his career as a nurse was in jeopardy. When I left Dingleton seven years later he was number three in the nursing hierarchy and his contribution to our growth had been enormous.'

6.3.2.10 The importance of the social environment

Jones (1982 and 1991) himself regards the social environment as the most important factor in the process of social learning. During an interview with Dennie Briggs, at the end of his life, he describes social learning as a growing process which asks for a special interaction between people in an adapted environment of trust. Instead of calling himself psychiatrist, he prefers the term "social psychiatrist" (Jones, 1998b) or "social ecologist". (See e.g. Jones, 1991) which explains his attention for the importance of the environment.

He also uses the term therapeutic community less and less but prefers to talk of "open system", diametrically opposed to the "closed systems". In 1988 (p.48) he writes:

' Such systems, often called closed systems are hierarchical and are the antithesis of holism. What the world seems to lack are open or democratic systems where everyone belongs and has a say in the social organization and decision-making process of the total organization.'

Dingleton Hospital was to a large extent an "open system": there were no locked wards, visitors were welcome at any time and did not have to enter through locked gates first.

Also Dingleton had a very nice cafeteria which was used by staff and patients alike (a situation which reminds on strongly of the social club of Bierer, see 2.1.1.1) (Jones 1982). Of course there are a large number of other factors responsible for the social environment. Jones (1982 p.147) writes:

'The social environment of a hospital... is subject to change in accordance with innumerable variables, whether planned or unplanned.'

6.4   Conclusions of the work in Dingleton

6.4.1   General conclusion

Jones has always regarded Dingleton as an important opportunity to try out and evaluate the concepts of the therapeutic community (see 6.1) in a different setting and with a different patient population.

The Henderson Hospital, Mill Hill and Dartford were innovative projects … in the sense that although they had ties with the traditional general hospital, the therapeutic communities started from scratch, so Jones could develop them the way he chose. On the other hand, Dingleton already was an established psychiatric hospital with a long tradition, so Jones was constrained to build upon the existing basis and implement his therapeutic community model that way. By installing a two-way communication and a joint decision-making method he managed to break through the traditional (hierarchic) structure of the hospital and create a democratic therapeutic community. Again he had shown that the therapeutic community could also be successful in a different

setting. Critics had reproached him to have worked out a treatment model which was too narrow in its application and only suitable for helping psychopaths. (Jones, 1982)

Dingleton Hospital can also be recognised as the place where multiple leadership was pioneered and proven to be a very successful principle in practice. The excellent working of the SSC (Senior Staff Committee) and especially the attitude of Jones have added considerably to the smooth manner of Jones's departure (in spite of the problems mentioned in 6.3.1.7) Jones (1982 p. 125) writes:

> *' On the whole, I felt that the SSC had done the best job possible under the circumstances, and said that I doubted if my leaving could have happened in such a sophisticated manner in any other institution in the country'*

Murto (1991) sees the development of a functional structure – in which apart from the SSC meetings all other gatherings had their place – as the guarantee for the continued existence of multiple leadership, whatever other organisational reforms took place in the hospital.

We should also mention the tendency to decentralise, which started in 1966 in Dingleton, as well as the development towards a more "community" directed treatment. Jones has always stimulated contact with the community in which Dingleton was situated, for example by involving the school with his "open system".

In 1969 he set up a project, together with the staff of the school of Roxburgh, convinced that there were (or could be) a great number of similarities between the "learning" at school and the "social learning" in a therapeutic community – "Cross-teaching" was widely discussed. Jones (1982 p.126) himself declares:

> *' When they (pupils/S.V.) feel sufficiently confident and clear about what is to be intended, they each interact with two or three pupils, usually two years their junior.'*

From the early days he had seen the importance of the transfer possibilities of the ideas of the therapeutic community (Jones 1962) and he points to the enormous opportunities of social learning at schools, about which he keeps having thoughts till the end of his life.

Jones managed to give staff as well as patients plenty of input in Dingleton. Patients could be elected leaders of the workshops, the same as in the Henderson Hospital, and could also act as support figures for the weaker patients (cross-age teaching). Jones talks of POT (Patient Occupational Therapists) and PANs (Patient Assistant Nurses) (Murto, 1991). Murto writes about two more important realisations: (1991, pp 133-134)

> *' The importance and role of the risk taker, the facilitator and the containment function were outlined from the viewpoint of exercising power and changing the organization.'*
> *en*
> *' At Dingleton Jones integrated the psychodynamic and sociopsychological theoretic frame of reference of the therapeutic community with the system theoretic concepts.'*

6.4.2   How Jones was influenced by Dingleton

Dingleton Hospital was the place where Jones could take on the role of Medical Director for the first time, (Fees, 1998) in contrast to his time in the Henderson Hospital, where there was always someone hierarchically above him. This gave him enough power to steer Dingleton in the direction which he thought most valuable (certainly in the first year).

It has become clear that Jones had been looking for a position of Medical Director in a psychiatric hospital for a long time, when recently a list has become known of applications for the job of MD of the Cassel Hospital, which contained the names of Tom Main, J.D.W. Pearce, David Jones as well as Maxwell Jones (Fees, 1998). That Tom Main got the job was probably due to his experience with the Northfield Experiments II (see 2.1.1.1), but Fees asks himself the question (and I agree) what would have happened to Maxwell Jones if he had become MD so much earlier and how these complications would have influenced the (not very rosy anyway) relationship between Jones and Main (See IV, 1.2)

Jones (1982, p.132) left Dingleton in 1969 with – in his own words – mixed feelings, but seems happy with the results and goals he achieved.

> *' I left Dingleton in September 1969 with very mixed feelings. It had been an extremely happy and productive seven years in my work and my family life. ... The succes of an open system in a mental health hospital and its surrounds had far exceeded my expectations, and we attracted visitors from all over the world.'*

Jones (1982) also expounds widely about the strong friendships and the great respect he has for a number of staff members (e.g. Jimmy Millar, the secretary and David Anderson the social worker) and says that it is with great regret he has to leave such "unique" and able people behind.

On the whole he is happy to have been able to prove during his Dingleton years that his therapeutic communities could be applied in a much larger universal way than many (and Jones himself!) had thought, or dared to hope beforehand (see 6.4.1).

7. About Jones' career and life after Dingleton (1969-90)

7.1 Fort Logan Mental Health Centre, Denver, Colorado (1969-1975)

In 1969 Jones returns to the USA, partly because he felt ready to leave his job as "physical superintendent" at Dingleton and also because he wanted to delay his retirement (which was compulsory at the age of 65 in Scotland). He sets to work as "Senior Staff Consultant" in the Fort Logan Mental Health Centre and also accepts a chair at the University of Colorado at the same time. (Jones, 1991; Murto, 1991). His main study is the development of the therapeutic community concepts in schools and prisons (Whitely, 1991). He also writes the book, "Maturation of the therapeutic community", (1976) in which he comments upon the relationship between "system thinking" and the therapeutic community (an "open system") and in which he describes the main concepts of the therapeutic community.

In 19175, after the departure of his good friend Alan Kraft, who had co-operated with the transformation of the Colorado State Hospital to a therapeutic community (or "open system") (Jones, 1982) Jones decides also to leave Colorado and he departs to the Virgin Isles (Jones, 1991, Murto, 1991).

7.2 A short stay on the Virgin Isles (1975-1976)

Jones answers to a proposal of the "Mental Health Division" of the Virgin Isles to work as "consultant". He hopes to be able to change the culture there concerning the social environment towards his own therapeutic community ideas. Later Jones regards his short stay there as a failure across the board and returns to the States (Jones, 1991).

7.3 Phoenix, Arizona (1976-1986 and Nova Scotia (1986-1990

He goes to live in Phoenix, Arizona, where he assists with the development of a therapeutic climate in prisons. However, he does not stay there and moves house for the last time (in 1986) to the small university town of Wolfville, Nova Scotia in Canada, after a visit during a study trip. Here he devotes the rest of his life to writing and consulting of a number of organisations, amongst whom the Italian CeIS (Centro Italiano di Solidarieta).

He writes his last book, "Growing old: the ultimate freedom" (1988) in which he describes the gathering of ageing people – which he organised himself – and at the same time he gives his vision on spirituality, a subject which has concerned him deeply since his eighties.

He corresponds with colleagues all over the world and invites several to come and talk about the development within the therapeutic community ide3als (Whiteley, 1991)

On August 19th 1990 Maxwell Jones dies from heart disease.

IV. A few subjects further explained

1. Maxwell Jones' thoughts on psychoanalysis.

1.1 The view of Jones of psychoanalysis

Jones has always felt ambivalent about the psychoanalysis (Hinshelwood, 1991) (Letter of David Anderson, 28.2.1999). Educated at Edinburgh University (See II.1), according to quite a strong biologically orientated paradigm, Jones comes rather late into contact with the psychoanalytical orientated Aubrey Lewis, under whose supervision he works at the Maudsley Hospital for two years (Letter from Dennie Briggs, 13.3.1999). It is also a fact that Jones during the forties – while doing his medical studies – was under supervision of Paula Heimann while working with psychoanalytical patients (Hinshelwood, 1991).

In the beginning Jones felt strengthened by psychoanalytical insights (like the role of transfer and re-transfer in the doctor-patient relationship), and he writes:

> *' It is for this and other reasons that it might be argued that ideally every nurse on the Unit (Belmont I.R.U./S.V.) should have been psychoanalysed.' (Jones, 1952, p. 39)*

Afterwards, when he himself has been in analysis with Melanie Klein (which he experienced as worthless) he changes his mind about that. (e-mail from Murto, 28.3.1999).

Jones (1991, p.55) in an interview with Dennie Briggs, explains this himself:

> *'I was in analysis with Melanie Klein during the time I was at Henderson. I used to have to drive through London to her house, and you remember what a core that was. I often had extremely bad luck driving across London ... I would be worried about being late, since if I was, it would be interpreted as resistance. And so often, I would be angry as I rang her bell, even before lying down on the couch.'*

And also:

> *' I had a very unsatisfactory analytic training with Melanie Klein who thought I was a lousy analysant.' (Jones, geciteerd in Broekaert et al., 1998)*

In spite of his resistance to his analysis with Klein, he admits – in an interview with Kari Murto (letter, 28.3.1999) at the same time to have learned a lot from it. According to Jones, in analysis too little account is taken of the influence of the social environment, a key concept in his ideas. On top of that he did not

like the position of power which psychoanalysts gave themselves during an analysis, and he was convinced of the beneficial influence of a group, by restricting the power of the individual. Jones (1982) speaks in this context of "containment" (See III 6.3.2.3). David Anderson (letter, 28.2.1999) also refers to the importance of curbing the power of one single individual by means of the group process, although he admits that Maxwell Jones himself was loath to give up his central role. "One had to challenge him, confront him, make him listen. This is a stimulating experience for people who have the strength to do it, but a frightening one if you are unsure."

> *' This accords very well with the ideas of Group Analysis as the analysis OF the group, rather than analysis IN the group or analysis BY the group.'*
> *(Brief van David Anderson, 28 feb. 1999)*

Psychoanalysis seems to have been increasingly applied in the treatment of individuals and as we have to place Jones' main interests in "social learning", we can only assume that he did not have much use for psychoanalysis. In this respect, according to Hinshelwood (1991) we have to see Jones as a child of his time, in which the process of (social) change was, by far, the most popular tendency.

Finally, Jones (1982 p.137) shows clearly the difference between psychoanalysis and "his" social learning:

> *' Social learning doesn't imply insight (although this may happen) as in psychoanalitic theory and practice, when the client's unconscious material is made available to his consicous mind. In fact the learning process may not be conceptualized at the time, or be available for instant recall. Rather it may be an 'awareness'...'*

1.2 The relationship between Jones and his more psychoanalytically orientated colleagues:

Briggs (letter, March 13th 1999) mentions the existing cross-pollination – in the fifties – between Maxwell Jones and Tom Main, the Director of the more psychoanalytically orientated Cassel Hospital. A number of the Cassel Hospital nurses, most of whom had had a psychoanalytical training, came to work in the Henderson Hospital as "consultants". However, rivalry between the two pioneers of therapeutic community ideas remained and was probably the cause that there was no more co-operation and integration of each others' ideas (Briggs). Hinshelwood (1991) writes that Jones once described himself and Tom Main as "two lions, locked in two adjacent cages".

> ' This rivalry may have kept them each from employing the other's development in his own work. It has given rise also, to a tendency for psychotherapy and social therapy to remain somewhat unintegrated within therapeutic communities. (Hinshelwood, 1991, p. 111)

Fees (1998b, pp 247-248) points also to a strange fact during the digitalisation of the author/subject catalogue (concerning unpublished papers and articles) of the library of the Cassel Hospital: in it there appear to be only two referrals to Jones, and they were indirect:

' While he (Maxwell Jones/S.V.) is the lead author on 'Some common trends in Britain and American hospital psychiatry' (1963), for example, it was card-catalogued under the name of co-author Joy Tuxford. The other publication… was naturally catalogued under lead author Harry Wilmer, with Maxwell Jones sandwiched between co-authors Dennie Briggs and Robert Rapoport.'

2. Maxwell Jones and the Northfield Experiment

Tom Main was strongly influenced by his psychoanalytical inclined colleagues Bion and Foulkes in the Northfield Military Hospital in Birmingham and you could argue he developed his therapeutic community from a well thought out basis of psychoanalysis (Hinshelwood, 1991)

' Group methods of treatment, especially group analytic psychotherapy, which had developed at Northfield in Birmingham, spread from the Maudsley Hospital and the Tavistoc Clinic in London and became a popular method of treatment in outpatient clinics.' (O'Sullivan, 1985)

Jones, on the other hand, - rather more through circumstances (World War II) and a lot more intuitively – discovers the therapeutic community approach ahs many possibilities and so pragmatically develops his therapeutic community as a "charismatic renewer" (Rapoport, 1970; Manning, 1991) or as a "change agent" (Clark, 1991).

The relationship between Maxwell Jones and Tom Main (see 1.2) has never been without rivalry, although nobody knows exactly how this has influenced both their ideas. A little of the veil is lifted by Bridger (in Harrison and Clark, 1992, see III, 2.1.1.1) when he accuses Jones of never admitting (on paper anyway) in how far he was influenced by the Northfield experiments.

Whiteley (in Whiteley, Briggs and Turner, 1972) states that the Northfield and the Henderson model differ very little. He outlines this as follows:
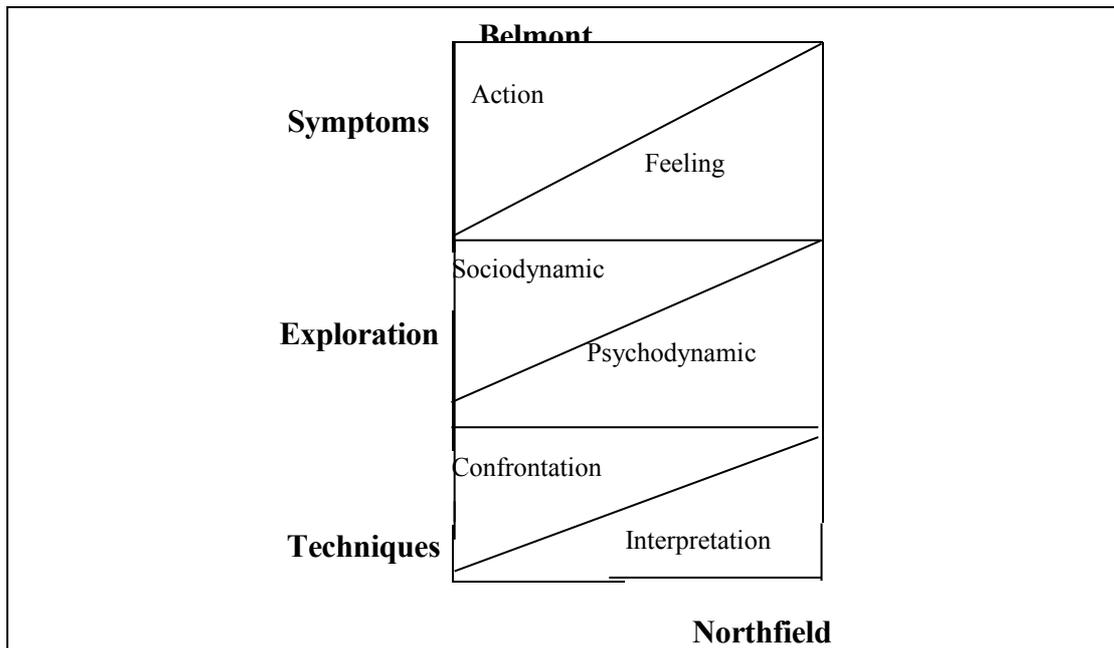
Figure 4 : Differences between Belmont (Henderson) en Northfield

In spite of the fact that the Belmont Hospital was more directed towards sociodynamics and action while the Northfield model had a more psychodynamic character, both approaches were closely related in the sense that all the characteristics were interchangeable and so could also overlap. The proposition that the approach of Jones and the Northfield experiments are very similar is a true one, which however does not exclude that both approaches were created independently from each other.

3. The "democratic" versus the "new hierarchic" therapeutic community and the
 attitude of Jones

At about the same time Maxwell Jones was developing his therapeutic community there was also a treatment method created in America (for drug addicts) which people also called therapeutic communities. In 1958 Chuck Dederick founded Synanon, the first concept-therapeutic community, characterised by a strong hierarchic structure (Kennard, 1998). Jones, (1991 p. 27) writes:

 '... many of the drug abuse programs that I've called the 'new therapeutic communities' to distinguish them from what we practiced.'

 Broekaert et al. (1998, p.19) describes democracy, placed opposite autocracy, as "a form of management in which the whole population takes part in the leadership". Hierarchy (placed opposite arbitrariness or behaviour without system or structure) characterises itself then especially by an arrangement, the taking up of a position.

Briggs (letter of March 30th, 1999) refers to the interest Jones showed for Prigogines' concept of self organisation within living systems, Bohm's vision of how dialogue can push someone over the line towards change and can so be transformed, so to speak (see e.g. Peat 1997) and for his ideas about "implicit" and "explicit" order.

The "explicit" order (perceived reality by the senses) is part of the total reality (including the not perceivable) or the "implicit" order.

> ' The freedom of the individual as arising out of the collective, and the collective as enfolded within the individual' (Bohm, geciteerd in personal communication, 1999)

Jones was extremely interested in the question in how far this principle could be applied to "social groups, in which each member generates intensity sufficient to transcend the normal limitations of individual consciousness".

> 'If so, it might be possible for consciousnes to function in a truly collective way, whith each speaker responding to a common pool of information... (het 'collectieve onderbewustzijn' van Jung/Briggs) Not only would the group respond to a collective pool of information, but its effects would extend beyond the boudaries of the group itself...(the community/Briggs) a level of frustration arises that is so great that it breaks down the entire system. It is at this point that a radical change in meaning can occur.' (Peat, cited in personal communication, 1999)

This could be the basic explanation of the changes within a democratic therapeutic community, which in essence differs greatly from the operating conditioning we find in many of the "new" therapeutic communities (see e.g. Broekaert et al. 1998) as the source of change. (Briggs, letter March 30th 1999)

Maxwell Jones has always shrunk from codifying the therapeutic community concepts (which has always been the case with the "new" therapeutic communities) (Jones, 1991).

He himself has always developed his concepts more intuitively and pragmatically (Hinshelwood, 1991) so a few terms (like for example, "change") came across as a bit vague, in the sense that Jones always implied something "extra" (the implicit order?) This might be the explanation for Jones' interest in more spiritual themes and authors like Jung and Bohm, in later life.

> ' The TCs have not been codified. Inadequate, imprecise, or controversial terms and concepts must be abandoned. The logic, connecting structure with value, goal with method, and community with society, must be formulated. Lack of codification, more than any other factor of government misalliance

or historical development, most reinforced the experience of identity crisis for TC people (De Leon en Geschner, 1976)

Aside from the lack of understanding of what open systems are all about, it strikes me (Maxwell Jones/S.V.) as terribly authocratic and frightening.' (Jones, 1991, p. 50)

Maxwell Jones, always apprehensive about his own charismatic leadership and his possible downfall (see III 6.3.2.3) and IV 1.1) has diligently worked for the introduction of multiple leadership, after he left Dingleton. He saw "containment" as one of the most important tasks of the alternative leaders (Jones, 1982 and 1968b) so as to guarantee the democracy in the community.

4. <u>How the concepts of Jones are still of present interest</u>

Maxwell Jones is generally seen as <u>the</u> founder of the democratic therapeutic community (see II.2). The by him elaborated concepts concerning the therapeutic communities in general and the social learning in particular do still have a clear relevancy for the therapeutic community concepts of today. Kennard (1998) describes a number of common characteristics of four treatment methods, who are all called therapeutic communities. For example:

1. The therapeutic community approach (transformation of the "total institution" (Goffman, 1963) towards a more active and human approach)
2. the democratic therapeutic community (often called the Jones therapeutic community)
3. The concept therapeutic community/"new" therapeutic community (originally an American idea, mainly aimed towards the treatment of drug addicts, although there are also therapeutic communities for criminals).
4. The communities who sprang up under the influence of the anti-psychiatry (see e.g. Cooper and Laing).

According to Kennard they share the following characteristics:

1. An informal friendly atmosphere
2. The importance of community meetings
3. Attention for the therapeutic role of the patients/residents themselves
4. The responsibility of everyone to work together for the good of the community
5. Sharing of authority
6. Having respect for certain values – psychological equality, to regard therapy as a learning situation – feeling of solidarity, etc.

It is obvious that Maxwell Jones therapeutic communities have played a pioneering role in the creation and development of the above characteristics, not only because he was one of the first who started the therapeutic community, but also because he wrote extensively about every characteristic and scientifically explained them in his many publications.

A great many of these concepts and ideas appear to have great value right up to this day. Cox (1998) speaks of for example respect for people, acknowledging the fact that staff as well as patients have to fulfil a therapeutic role, the importance of clearly defined leadership (whether there is one leader or multiple leadership) and the role of "containment" (Jones, 1982).

It is not the case that Jones has never had his critics … Lansen (1989, p. 38) writes: "… and a typical fault of the charismatic leader: what you yourself can achieve in special circumstances by your own personality and then to assume too easily it can be put into practice in other situations and countries and by other people."

In my opinion this criticism is not wholly correct: Henderson as well as Dingleton still exist as "open systems" even after forty and thirty years respectively. Still, Jones does admit (1991) to have had too little consideration with other cultural situations (with reference to his consultation work on the Virgin Isles (see III 7.2) in which he thought he had failed badly).

Manning (1989) also criticises Maxwell Jones regarding Jones' description of the work in the Belmont therapeutic community. He thinks Jones directed his analysis to a one-sided role concept, he did not use role and status consequently and did not explain accurately his own power as leader in his descriptions.

However, Manning and also Lansen based their criticisms only on old literature and I think Jones only described his therapeutic community concepts scientifically in "Beyond the therapeutic community" (1968), "Maturation of the therapeutic community" (1976) and "The process of change" (1982).

Therefore Jones' earlier work cannot be regarded as a relevant representation of his complete range. (Lansen does admit that "Beyond the therapeutic community" is of grater value than Jones' first work – "Social Psychiatry" (1952) – which is mainly descriptive and comes across as increasingly inconsistent).

To me it seems apt, on the basis of what has been extensively described above, to regard Maxwell Jones as an outstanding important pioneer for the social psychiatry in general and the therapeutic community in particular.

In a letter from Christine Jones (1999) she writes it is more important that people appreciate him because of his professional achievements than because of who he was.

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