I remember almost being lynched by the Sisters outside Superintendent Walter Maclay’s office—they were not going to put up with this new-fangled stuff. I thought they were going to physically attack me. This was at the height of change when the forces were terribly threatening: this was the beginning of the therapeutic community.

Maxwell Jones
A SEMINAR WITH MAXWELL JONES

On The Early Development of Therapeutic Communities

Dennie Briggs

Here Maxwell Jones speaks candidly about his early experiences at Mill Hill, Dartford, and Henderson; how community meetings evolved, the development of the rôle of social therapists, psychodrama, and resistances—internal and those from the outside.

Max was joined by colleagues Joy Tuxford and Pat (Tait) Howard at Dingleton Hospital, Melrose Scotland, January 28 and 29, 1969, for two seminars with the Social and Work Therapists.

Max often referred to Pat Howard as the first social therapist. She joined him at Mill Hill, accompanied him to the Dartford POW project, and to Henderson. Joy Tuxford came to Henderson soon after Max established the Social Rehabilitation Unit there and subsequently became a colleague in research and in staff and development capacities on several projects in Britain and the U.S.

Dennie: Several years ago when I met Max and got interested in therapeutic communities. . .

Max: . . . 100 years ago!

Dennie: Sometimes it does seem like that! There was an issue of the Bulletin of the Menninger Clinic which has become a classic historically, put out after the Second World War, to document some of the developments in social psychiatry mainly in Great Britain. The whole issue of that journal was very interesting because it showed how an exciting idea originated and from it there were lots of off-shoots.1 especially remember the article by Tom Main and the Northfield Experiment. I’m not clear how, if at all, this was related to Mill Hill. Were you involved with Tom Main or was Mill Hill totally separate? I thought it might be a nice opportunity this morning since Joy and Pat are with us, if the three of you would recount your experiences. I know Pat was with you at Mill Hill. I don’t know about Joy, but I do know she was at Henderson when I first visited in 1956. It seems to me that there must have been some ingredient there that we’re lacking today whereby such a germ of an idea took place that could radiate into so many new things. How did you get started?

Max: Well, actually your references are unfortunate, because they were pirates, Tom Main being the leader of the group, who in a way played a somewhat doubtful rôle. But that was the Northfield experiment, which wasn’t at all Mill Hill. Mill
Hill was running consecutively during the War with the army project. Mill Hill was an emergency medical service, a precursor to the National Health Service and the two didn’t know much about each other, although later on in the War, I visited Northfield when Tom Main was there; but they were developing therapeutic community concepts which were not followed throughout the War, much like the American scene.

American and British psychiatry were much alike by the end of the War; then the Americans whistled home and of course money was their main lure: they all went back into private practice and so on. Hospital psychiatry didn’t get the impetus from the war years there, whereas in Britain practitioners came back, joined the NHS, or the prelude to the NHS, and the momentum was carried through; hospitals emerged with a much more democratic structure, and Mill Hill was where I would say that the therapeutic community concepts started.

Pat was in on this; we got nurses, you know, lovely people in the widest sense of the term; physically and mentally, or mentally and physically, and it really was a tremendous time. You must admit the calibre of the nurses was fantastically good; there was conscription so women either had to go into some ghastly uniform which didn’t fit, or they went to do hospital work, munitions or factory work, and a lot of them, including the youngest, came into the hospital service [Pat laughs] and we had a fantastic time because we had high quality people and new ideas. And I also remember being almost lynched by the sisters outside the superintendent’s office because they were not going to put up with this new-fangled stuff—I thought they were going to physically attack me. This was at the height of change when the forces of change were terribly threatening: this was the beginning of the therapeutic community.

Pat: Yes.

Max: But I don’t want to take the discussion away from Pat. I think you should say what it was like in that beginning stage.

Pat: I arrived, entirely innocent of everything to do with medicine or nursing, and met Max, absolutely by accident. I’d been an arts student; I didn’t want to go into the Army or the Navy because I thought it was unsuitable and I didn’t know what really to do about the War—I was looking for something, I suppose. I quite literally bumped into Max one day, and he said: “Come along and let me tell you about my work, because I think you might be interested.”

And I was of course. So, I went into his hospital which was something unlike you probably know of, in that it was full of starched uniforms, and matrons, and a hierarchy; I was kept giving baths, antiseptics, and so on, for a long time; this kind of thing was basic in being turned into a nurse. I went in as a junior probationer. I began to have nursing instruction; how to bandage fingers and all the usual things. I did in fact, take the intermediate exam before I left and nearly the last one. This all went on concurrently.

The hospital was divided up into various houses and there were children in one, from all around London. I think those who came were disturbed. There was
another house with local oldish people. There were soldiers, but no airmen, isn’t that right? And no officers; there were the upper ranks essentially. I think that was probably all. And the nurses spent time on each kind of ward, so that I was with the children at times, which was thoroughly free. They had a goat that would occasionally get out and get into the other wards. But one was doing fairly ordinary, not very inspired, practical things most of the time.

But then I went to work with Max on the Effort Syndrome Unit. The soldier patients were all terribly nice, kind, worried, anxious people, who had these lectures on heart disease, and who had been in the Army, I think all of them. Max was beginning to teach them. This was a new conception as far as I know, about their bodies and how they worked, and why they should get their pain, that it could be muscular, and that they were not dying—which meant physically starting groups because they had to be put into the same room together to be talked to about this, and we had diagrams of the body, you know [laughs] and on a blackboard and so on.

About this time, Max—and you must correct me if I’m wrong about this—but as I remember it, you realized that there were a number of us who were quite free, and young and interested, and we no doubt said quite surprising things considering how fearfully fussy nursing was. And we were also very frustrated because we didn’t know anything about the patients, you see, we wore starched caps, and we mustn’t show our hair, and, we weren’t allowed to know anything about the patients. We were to take orders from the sister or the doctors, although the doctor was not really expected to speak to the nurses. And Max wanted us to see the case notes. I think he actually showed us case notes and then there was a row about it. He thought we might perhaps be allowed to know what was the matter with the people we were looking after, and this was not allowed.

There was a period of great tension with the sisters marching in a team like battleships in uniforms, very large and puffed up and starch crackling. I think off scene, there were a number of rows which Max can tell you about, but the end of this was that we were indeed allowed to read what was the matter with the people we were looking after.

And Max followed this up by asking us to take on patients. Each one of us had a patient to take special interest in and to treat as a human beings and come to try to understand him. Max produced a very sensible sort of form on which we were to write our impressions about the people with practical, factual information which was quite a good way of making a dossier, you know, of what they looked like, how they behaved, what they were feeling, how they’d been this week. Generally the way we did this was to do an essay about our feelings and what was likely to be good for them. And coming out of the blue, Max, after he
had asked me to write up my impressions of one patient, asked me to write an
essay about myself and what I thought this all meant to me. There was about half
a dozen of us and we wrote up how we felt about morale and it got us to think-
ing about it.

As for psychodrama—correct me if I’m wrong—I’m not sure, but this idea
was being discussed with patients—I think that was an idea we picked up from
America. . .

Max: No, no, no—not at this point. It was a long time after.

Pat: Sorry. The psychodramas. . .

Social Therapist: What was Max’s position at this stage?

Pat: I should have explained, perhaps—I don’t know exactly what your title was,
Max. He was in charge of one wing of a larger hospital and most of the equip-
ment was terribly natural and he was young and wanted to make a difference.

Dennie: Max, had you worked in anything like this before—the physical side?

Max: It was a very important Unit to study effort syndrome. It was a big problem in
the first World War and had not been solved. We were given one hundred beds
and had one of the best cardiologists from London and myself.

Dennie: Had you gone there directly from the Maudsley?

Max: No, no. I was a Senior Registrar. Before that I’d had a two-year fellowship in
America.

Pat: Psychodrama started and this was a particularly creative feature. It was staged
and carefully produced and based quite simply on one of the patients’ own cases.
It was sticky, but interesting; after the psychodrama, the patients called on all of
us for questions and then Max or someone would make points about human
behavior. Up to that time people didn’t really talk about people—themselves.
Later on we installed a theoretical family, with the hysterical mother, psycho-
pathic daughter and so on.

Max: What you left out was the extraordinary feel-
ing of destiny; that fact of a hundred patients
and staff—very good staff—we all knew
what we were doing could be a very impor-
tant factor in British psychiatry. This had
been a big problem in the first World War and
had not been cracked. In the second World
War it was still left. It was a fantastic oppor-
tunity, it came just at the right time and by
the end of the war, we had resolved the problem in medicine and psychiatry by
very careful physiological studies which were later confirmed by the Harvard
Fatigue Laboratory, which was the big research center for the American Army. I
was awarded a gold medal for this: that was the last time I was respectable!
[laughter] It was very, very heavily substantiated.

Joy: You saved the country a lot of money too, because they didn’t have to any longer pay these thousands of people pensions, which is what they had done following the first World War.

Max: And we got a fantastically large number back to the Army—I think we got back 78 percent or something like that—not to active service, but to clerical duties and so on.

Dennie: Patients as well as staff had a sense that the research was important too?

Max: Oh, yes indeed! There was a large meeting room which was much larger than our conference room [at Dingleton] which held 100 men; they all had the same cardiac condition—left chest pain, breathlessness, palpitations, giddiness, and fainting. So they all had the same condition and that was when I began to realize that the large group made a hell of a lot of sense. By the end of the war we had a picture, “Nervy Ned,” which depicted their symptoms in pictorial form. It was also a humorous character. I don’t know if you were there at the time, Pat, but we were screening people’s chest movements when the bombs were dropping and we could see the actual movements and put in a mark to measure the constriction. And we were able to show that these people who had left chest pains, had this rapid shallow breathing—didn’t have deep breath.

We had one person who had a cardiac whose heart was in the right hand side, and he of course, got the pain in the left hand side thinking that his heart was there. [laughter] We had some fascinating experiences but the point was that we were able to work out the whole sequence of events that their symptoms were broken down into what we actually found. We did root blocks of pain that would go away for two or three days and when the anesthetic would wear off, the pain would come back. We could inject into the muscles. And the men came to realize the nature of their conditions by Nervy Ned, by discussions from physiological lectures—which they took over ultimately and gave themselves. They’d talk about the whole mechanism of how the heart works and so on. By the end of the war the cardiologist said he was not needed anymore and we were left with the whole dimension of how do we change their attitudes.

Dennie: And did the patients then not come expecting to be “cured?”

Max: No, they still came expecting to be treated for heart disease; they’d been seen by various heart specialists in the army who said they were malingerers. But the soldiers would say, “What do you mean, I’ve got this pain and I’m fainting.” The doctors would say, “No, there’s nothing wrong with you, my man. You’re heart’s as sound as a bell!” Damned cardiologists! The soldiers were outraged; they had something wrong with them—they were fainting, their hearts were pounding. But the older patients would say, “Don’t worry, buddy. We’ve all got bad hearts. You’ll hear all about it. That’s a mechanistic thing—that heart trembling doesn’t do any harm. That’s not heart disease, you coon. You’ll get an injection and it’ll put it away.” The patients taught physiology, symptomatology and it changed
their attitude toward their symptoms. It was like taking out their organs and looking at them and putting them back again and saying, “Now I understand.”

Pat: It was also a tremendous amount of relief and rather exciting among conscientious, gentle people.

Max: But then we got one real coronary. With the cardiologist there we were all set up to do very careful physical investigation. We wanted the patients to exercise, to run around and, so on. We told this patient, “Now don’t you run upstairs!” And of course he was different, he didn’t have this neurotic attitude. He ran upstairs, had a coronary and collapsed and nearly died. And after that we really couldn’t put a foot wrong because if we said someone was going to have a coronary, they did! [laughter] We built up a kind of legend that we really were damned good doctors and if you had these symptoms, they didn’t matter—we’d got them to fully overcome that fear. It was natural that they thought they had heart disease.

Joy: The other thing that must have been very upsetting to the rest of the hospital, was that you told the patients about their illness and told them about the other’s illness.

Max: We sat down and listened to them and then gave them excellent physiology—how everything worked physiologically and so they were very much a part of everything.

Dennie: You were participating with the patients.

Max: Sure. Sure

Joy: Max, could you say something about how you got the rest of the staff in the hospital to agreeing to all these revolutions?

Max: Because we had a great man, Walter Maclay—unfortunately he’s died—as the leader. He believed in us—and I think it’s enough to say that—he believed that we knew what were doing. And Stokes of course was the deputy—he became professor in Toronto—and these two really felt we knew what we were doing. And it was their sanction when I said I was nearly lynched by these furious sisters, Dr Maclay came out of his office laughing and said, “Poor Max. Don’t destroy him!” [laughter] That somehow cleared the air and this public sanction from above saved us. Positive high level sanctions are all important if you’re going to have a revolution.

Dennie: It seems that it was also important that you had young people like Pat who were non-medical.

Max: They did it! You see, they were the people who made it possible because they weren’t acculturated to the medical profession; they wanted to learn. So we developed a new concept of the role of the social therapist.

And when things went on, the top American brass—you know Karl Menninger and all those people—came over to see what was going on, which all added to the importance of the discovery.
Dennie: What kind of qualities would you both—and Joy too—see in these people who were non-medical participants? There must be something that would allow the person to enter into this kind of adventure, or...

Pat: I’m not sure what you mean.

Max: They were creative.

Dennie: Exactly.

Max: This was 1944 and 1945. What made some of the girls outstanding and some of them drift into the hierarchy?

Pat: I don’t know, except that it was fascinating and one learned about one’s self all the time.

Dennie: You said you were an artist before you went there, Pat?

Pat: Yes.

Max: But weren’t you allowed to discover your own role? You painted and you wrote beautifully—I’ve still got your first report (see appendix). If you had a skill, you were encouraged to develop it. The same with drama.

Joy: The pantomimes, to my recollection and from what I’ve heard, was a creative and imaginative undertaking but it didn’t necessarily have anything to do with the talk; it was to get spontaneous interaction started.

Max: It was around Christmas when they turned the entire upstairs into a full Medieval village, no, it was a beer garden, with ivy all over the place, on tables, on the walls; I think we actually got beer. Another was a baronial hall. They hired costumes and old things like battle axes: it was unbelievable the energy that went into the production—a whole set for Christmas dinner! All from the patients and staff. They had turned it into a village, complete with pots and pans.

Pat: I remember one room when they’d made the berth of a ship which took forever to do with all the items and things and whatnots.

Social Therapist: This history—it’s incredible that this experiment in democracy, which it must have been in a way—occurred at a time when democracy was more or less suspended in this country.

Pat: I suppose it was. I don’t think we thought about it so grandly in those days—it was needed by me, but Max probably thought in bigger terms.

Dennie: What did you see it as, Pat, can you recall?

Pat: I saw it simply as my life, at the time waffling into something that interested me.
The war was a background, we were a bit tense, and you did rather feel that you should make hay, you know?

Joy: What has happened to effort syndrome, Max? Do young people nowadays experience the symptoms?

Max: Middle aged housewives get it, not young males. Young men go to the pubs or such. It’s rare that this symptom hits the male population, but it’s very common in medical outpatient departments in post-menopausal women—palpitations and fainting.

Pat: You also started what the patients called the “truth garden.” We had terrific sessions of people reenacting their lives. Or perhaps it came later. I don’t know how that fits in.

Dennie: Your orientation was very much on the present—the day-to-day happenings—rather than going into the past.

Pat: Yes. The past’s over. That’s you now. It’s a much more your sort of way.

Joy: What was the staff like—five doctors or six sisters [nurses], or . . .

Max: I think I just had one intern.

Joy: Two doctors and one sister for a hundred patients.

Pat: And I think probably a total of a dozen.

Joy: If you compared that with this hospital [Dingleton] with 400, we have a much richer staff. You were pretty skinned in strength. Do you think part of the morale was that you were such a small . . .

Max: That’s fair. We were a psychosomatic unit for cardiac neuroses; they were not neurotic, they weren’t psychotic, and they weren’t psychopathic. They were real people and they could put a tremendous amount of energy. The same at Henderson, they were psychopaths, but they weren’t psychotic. These two units had this enormous latent energy among the patients, which we don’t have here at Dingleton.

Dennie: Or at least we haven’t figured ways to bring it about!

Max: Well, yes, that’s true, but in between we’ve had the Christmas ball for years which in many ways is the combination of Mill Hill and the 100,000 prisoners of war who we had were the most neurotic of those who came back—they were fantastic people and we went right into the community. There was no gas, so I pushed my car about ten miles around the area and I got 67 inquiries—no one helped me—I got 67 yeses and I didn’t get one no, from ship building yards to various factories. The government gave us gray line buses and every day the patients would pile into the busses and went around to the entire community, dropping them off to six or seven different places. Some wanted to work with a chicken farmer—to recreate life—and then to find that a chicken farm wasn’t quite what he wanted. He had to keep books, learn how to finance, compute
income tax and so on. And so they changed their minds about chicken farming. The psychologist went down to the sites, the production lines, and looked at people—a brave new world in psychology where you actually looked at people in action and you moved them around like chessmen until they found what really suited them. It was a fantastic period of creativity.

Social Therapist: What got you to using the employers in the community?

Max: The fact that we felt that work therapy and all this stuff was so goddam dull and stupid. They’d been locked up for five years and didn’t any longer know how to buy a pack of cigarettes, little things like, “How much is that?” They’d forgotten. They felt self-conscious.

Social Therapist: Max, if you wanted to create a situation or experience with these qualities again to tap the energies and creativity, could you name some of the ingredients you would have to have to create that setting?

Max: Well, I’ve touched on some. Wartime’s a great time. This was towards the end of the war about Hiroshima time—and these people came back, they were heroes for the time being. The people in the factories felt guilty. They hadn’t been conscripted. They’d worked in the factories and here were these guys coming back after a hellish time locked up and everyone wanted to help them. And they themselves were feeling a bit guilty for having been captured—it was a funny business, you should never get captured, in fact, that was a stigma in the first World War, but this time they were much more imaginative and we tried to help them become rehabilitated. I remember our top admission rate was 40 in one day. Now, if you’re admitting 40 people in one day, with a small staff, you don’t talk about 40 hour weeks; people just piled in and we got a tremendous thrill out of challenge.

Joy: But I think the fact that it was during the war, everyone worked eighty hours a week and there was firewatching, and they were doing other things, and there was a tremendous sense of enthusiasm and helpfulness.

Max: And these people—these men—had been cooped up so that discipline was an intolerable problem and so it was to hand it to them; they disciplined themselves or we’d never have gotten away with it. Drinking, you know was a temptation, it was very strong but by setting up this democratic system, it saved us.

Joy: Who set it up? Was it . . .

Max: There were housing units of 50 and we had six. Each Unit of 50 had its own democratic organization, community meetings. They’d look at what was happening.

Social Therapist: Max, how do you fit in a democracy within a sort of service, an army, a military service-oriented. . .

Pat: It was awkward, really. That’s why people outside the Unit got so upset by it.

Max: We were given sanctions and we did have a thankless job. The government had
17 resettlement civilian units scattered all over Britain for the Prisoners-of-War. We got the most severe of the whole hundred thousand and because we had a thankless job they really did give us a free hand.

Joy: There was a kind of sanction to try to treat them as human beings; again it stems from it being a war. You find it a surprise that all these revolutionary things occurred then?

Social Therapist: Yes I do, because I’ve been trying to set up a democratic organization with recent ex-servicemen.

Max: They took on responsibility. They had their own structure which they brought with them; they learned sociology the hard way. There was a careful study by Adam Curle and Eric Trist which is a classic really where they singled out 50 ex-prisoners of war who went to the Oxford area and interviewed them. They found from the wives that these men were very much more sensitive about the roles they played: would the wife have to do all the washing up; could we both decorate the room together—new ideas about role-relationships. It was social learning from a Prisoner-of-War camp—an asset which didn’t get much credence. A lot went on but the good ones learned a lot about living; it has some relevance to the present-day student riots.

Joy: How far did this experience—from the prisoners and so on—how far did you use that in the work you did in prisons?

Max: I think Joy, you should talk, as well as Pat about Henderson because that’s where all these ideas really crystallized in some kind of form.

Joy: Well to me, of course, Henderson was terribly exciting and probably the most fun job I’ve ever had or am likely to have. It was exciting and rewarding and frustrating and I remember it as a hugger-mugger place where people were talking and hashing out problems all the time and I think like Pat and Max, things that happened at Henderson had their beginnings at Dartford and Mill Hill.

Max: We’re talking about 1947.

Joy: And when I went there, in 1948, the task in the Unit then, was to try to rehabilitate the chronic unemployed. This was a time when there wasn’t enough people to fill jobs in the country and they wanted to enhance the labour force. They sent to the Unit, the chronic unemployable. So it was a place for the down and outs—and they really were very down and out. In some ways—it, not having worked in a hospital before—reminded me of in part what I’d expected of a hospital. You could recognize the doctors, they still had things like stethoscopes and occasionally they wore white coats and they carried these things to take blood with. Staff were in uniforms and not known by their first names, but by their titles—nurses were addressed as nurse. Soon after I went there, the nursing situation became quite difficult—I initially went there to do research. There weren’t enough nurses so Max began to recruit people who weren’t nurses to work in hospital and this was—as I see it—a revolution, really. The effect of this certainly spilled over
into the field of social work. Max, perhaps you could say how you recruited these people because I think it’s important: their motivation and why they came, and what they came for. I think they contributed a lot.

Max: It was our good fortune really rather than planning. We had a request from a social work instructor from Norway who asked: “Would you take a student who hasn’t got a nursing training?” That’s how we got started. There was strong motivation and they didn’t have middle class consciousness—they didn’t care if you’d been to Eaton. They were amazingly good because of their capacity to treat everyone alike and they had a good education. They didn’t know anything about nursing—didn’t give a damn about it—and we didn’t need nurses because these were psychopaths and we always had at least one nurse. We discovered they were going to have to find a role for themselves from the onset that would be much more appropriate than this preconceived idea of the nursing rôle. So they found a role which we eventually called the “social therapist.”

Joy: And they wore this hideous type nurses uniform at the beginning which they discarded.

Max: For a very pretty one, like an airline hostess!

Joy: That Pat wore when she came back in the early 1950s. The other thing that was so important about social therapists—because they came from Norway—they had some difficulty with the language and they didn’t know their way around London. Because of this, they were forced to ask patients for help, so there was a very good egalitarian relationship from the very beginning with these social therapists and the patients—they were the staff who were with them most of the time. They helped each other with their problems. I cashed in on this because I had to do the social work when another social worker finally left and there was no social worker. Patients came and asked if I would do things for them and I wasn’t a social worker. I can remember saying, “I’ll willingly do it if you tell me what to do.” I learned the beginning of social work from the patients themselves—I had no alternative. Initially they were the down-and-outs and they knew exactly how to get money and other things and so I learned an awfully lot from them.

I remember the early days at Henderson very much as a mutual learning process—it was a shared thing and for me that was the most exciting things that I’d learnt from Henderson. The other thing was that in addition to all the medical things, electro-convulsive therapy, abreactions, and so on, there were the groups that had an important effect for me in the early days (1948-1951). All the staff were expected, along with the patients, to take part in all the activities. And one of the attributes I often think, in relation to Henderson, is the fact that if you were prepared to take charge you had plenty of chances for change. This is one of the aspects of the therapeutic community that I see as valuable; there was always someone wanting to use you in this community and so we all took part in
these daily routines whether on our own or sharing. And it didn’t matter if you were as green as grass—and I was terribly green when I went there—there was an awfully lot of help if you were prepared to get yourself into the game and use realities. If you fell flat on your back, it was okay. I think the same is true of here too. The thing that happened is that I was detailed-off, but the kind of democratic detailing-off, to take the patient’s group meeting one day a week. I had the audacity of speaking to them about bringing up children, and I think I was 22 and looked it! So there were questions of how could I learn about bringing up children? [laughter] And it was a riot, we fought each other, we challenged each other. So I asked them to help and this was another stepping stone for me and a sign post for learning.

Max: I remember the instructor for painting—to show how utterly generous he was—when the patients did too much work too quickly, they had time to chat and they had a very pretty, but silly, girl there and one of the lads said, “Gee, Becky, you’ve got fine boobs there. Let’s see them!” And she proceeded to show them [laughter] and the instructor just stood there! [laughter]

Joy: Everything was shared! [laughter] I can’t remember laughing so much.

Pat: [to the group] Are you getting what you want?

Dennie: I certainly am. I don’t know about the others. [agreement]

Joy: I have to go at half past.

Pat: I’m afraid I do too.

Dennie: Would anyone like to continue this seminar?

Joy: Pat will be here until Wednesday, so it might be possible to meet again.

Dennie [to the group] Would you like to think about it? [voices of agreement to have the seminar continue] Well then, how about on Tuesday?

Pat: I’ll try to think of some of these things in a much bigger way.

Social Therapist: I like this way of learning where there isn’t any designated leader; it gives us all a responsibility.

Joy: It’s a mutual process

The Social and Work Therapists asked Max, Pat, and Joy if they could continue the discussion and so the seminar resumed on January 28, 1969. Joy Tuxford followed up with her account of the Industrial Neurosis Unit at Belmont and the development of psychodrama in the early 1950s.
Joy: In the early phases, the staff acted out the patient’s difficulties on the stage in front of the patients and then the patients were asked to change anything and discuss it—this was first done at Mill Hill—but after the staff presentations, the patient would be asked to come up and play the part. I thought this was a very significant piece of projective technique because a young patient would take the place of doctor/leader, who’d been ranting and raging and hitting his wife. We were frightfully naïve and green and we never asked ourselves what effect we’d have with the patients if they saw us in these roles [laughter]. It was wonderful!

Social Therapist: How many patients did you have?

Joy: There were over 100 (70 men and 30 women) in the early days and every week we’d have to decide who we could discharge so that we could admit the new patients who’d be arriving. We had to take in these patients every week. As it changed, the pressures came off. I can remember for the first two years agonizing weekly discussions about who should leave on a Friday to make room for the four new people coming in on Monday. And the anger that people felt and would blame it all on Max: why didn’t he do something about this? He couldn’t do anything. How do you deal with being the bad guy?

Pat: It was about this time that the staff began having their private meetings one time a week.

Joy: It wasn’t for the first couple of years, it must have been about 1953...

Pat: I think the therapists started it as they were having some practical, ordinary difficulties and they were always falling in love madly with patients—no wonder! But I think it must have been Pom who really began questioning what we were doing and what we were getting out of this.

Joy: There were also staff meetings but they were administrative meetings.

Pat: We started groups once a week. Max, I think you should talk about this.

Max: The thing I would say, just to start the ball rolling, is to look at the [US] West Coast ideas which go from group dynamics through the whole spectrum, the behavioral sciences to the kind of wild ideas that some of us have a feel for—[Virginia] Satir, [Fritz] Pearls, and others; I’m not making a value judgement, because some of us clearly identify with these—to the new groups at Esalen, which is just a journalist’s extravagance with what they do with the interaction—Dennie’s probably been to these groups!

Dennie: They aren’t extravagant at all!
Max: Okay. Well, they are essentially attempts to bring about communication between people and some awareness of the many selves that we have; the self that we represent as a therapist is a highly artificial self and we use various frames of reference as part of our training; we’re trained to play a rôle. I usually dramatize it by saying if I’m interviewing Jeannette because she’s got some difficulty in going outside, if she had a phobia, say claustrophobia, and I was interviewing her, I would be interested in her rigid home background. I would gear my questions at picking out what I wanted to hear. Perhaps she’s saying “Well, you know, the trouble’s my foot,” and I’d say well, let me finish what I’m talking about—I’m just dramatizing this—but she’s really got a gammy foot. This would be an extreme example of the absurdity of the doctor’s frame of reference: he tries to find what he wants to hear. Or if in a treatment session, there’s a “good session” if you hear what you want to hear, or a “good group” because the patients talked about their fear of sex or some familiar topic which we think ought to come out. Whereas I think that Hal’s [American psychiatrist then at Dingleton] kind of distilled out a lot of the various approaches which have this one thing in common: Who are you? What are you? How do you relate to people? Either through your professional frame of reference, or how far can you vest yourself of this formal self, this engineered, artificial self, and relate to people as people? This is, to me, what I think is the general theme. Now the quality Hal displays here, we were—with out any knowledge of Moreno, way back in 1940, without the knowledge of anything going on in hospitals—experimenting with, Pat and Joy, and really asking ourselves what are we doing and why are we doing it? One of the interesting things Pat mentioned—was it in 1941?

Pat: 1940 or 1941.

Max: We were beginning plays which were based on the themes that patients showed in this unit for cardiac neurosis and each ward took it in turn to present a play which might be presented directly with characters and props of some kind, right? Some forms might go all the way from one room to another so you might need a microphone. It was an interesting technique because it was like listening to a radio and was impersonal. From that we began to look at the whole question of how could we recreate the real situation so that people became a part of emotionally charged situations and empathize with what was going on. So that from individual case histories which were usually masked at first, we moved on to things like the “Misfit Family”—this was about 1946; did the Misfit Family begin at Mill Hill?

Pat: It was beginning there.

Max: Well somewhere between 1943 and 1946, the patients themselves were involved in social problems and we had, for instance, one family of the dominant mother and three daughters; one was a schizoid, one was delinquent, and the other was hysterical. I think we mentioned this last time. Week after week these four characters performed, with the doctor playing the “normal” father. [laughter]
Max: No, I hadn’t been “helped!” [laughs]

Dennie: Because I was wondering how you arrived at this point of view rather than more traditional group therapy? You did spend some years at the Maudsley with Aubrey Lewis.

Max: Because I’d rebelled against the Maudsley system which was the best teaching hospital in Britain.

Dennie: Why did you rebel against it?

Max: Because of its archaic structure and its relative distance from the patient. I was fed up with Aubrey Lewis and all the academic world, teaching and research—and the patients low down in priorities. You saw this.

Pat: And you were still seeing patients individually off and on all the possible time, weren’t you?

Max: This is where the Misfit Family was really a way of getting patients involved in social problems which were very familiar and it’s a kind of crystallized out in our concept of social learning, not that you don’t learn by listening—you learn by interacting—if you just listen you’re not being taught and you memorize. We make this sharp distinction between learning and teaching. Teaching is what poor kids get at school and learning is what we’re trying to develop here [Dingleton]. You need both, but this again is very much in mental health right now.

Dennie: Max, could I ask you once more, because I think this is important to try to find out how you arrived at your viewpoint because it’s still not happening in most training organizations. How did you move from what you’d been taught up to this time into a social learning concept?

Max: The structure: it came very early on. We met with these 100 soldiers collectively and we soon learned that as well as talking about their symptoms, (I talked about that last time) which we were working on, we also began to talk about social problems. They would say: “Look, can we talk about this with Sister on Ward Three. She really is a bitch...”

Dennie: You didn’t do this at the Maudsley?

Max: Hardly!

Joy: It was only very recently at the Maudsley that nurses were allowed to look at case notes.

Pat: I have an idea, Max, that perhaps it began because there were a couple of drunks and people were worried about this and the question of drunkenness came up in the group meetings. From this quite directly, the idea of acting out something about drunkenness grew, and then drunkenness was discussed with the whole population and it started something.

Max: That’s true. But it still comes back to what’s been my basic philosophy, once you have a structure which encourages communication then feelings are allowed to
come out and when feelings are allowed to come out, then you get two-way communication and the opportunity for change—learning and change.

Joy: That’s a nice theoretical way of looking at it, but I always thought that on the emotional level one of the things that always was highly important, was the fact that you were wanting to share, not just with your staff but with the patients too and you made this quite clear last time when you talked about Nervy Ned and the way you shared your medical knowledge with the patients. And although theoretical and philosophical concepts are very important, it wouldn’t have jelled if there hadn’t been this real emotional motivation of sharing.

Max: At Henderson, the role of patient cancels what Dennie was so impressed by—the sharing. The patients in fact took on their own roles.

Dennie: But in “good” analysis or “good” social case work don’t you eventually get two-way communication?

Joy: Not necessarily. One of the things that struck me so much was that if you begin to share, then you will have to accept the fact that people will criticize you. If you share your medical skills, they begin to ask you why you are not a better doctor? If you share your social work skills and describe, for instance, through sociodrama or something of that sort, what went on when you visited a family, the whole 100 patients will say, “Well, why didn’t you do this?” And on occasion will tell you how to interview a family and “Why in hell were you this way?”

So, it was a much more fundamental than just sharing one-way, it was also accepting criticism.

Max: I wish I had asked Melanie Klein why she had been such a failure as a woman!

Joy: You wish you had?

Max: In respect to Dennie’s remark about two-way communication, because you don’t ask your analyst usually why she has such bloody awful furniture? Or something like that. You keep to yourself; not about her—although it can happen—but the frame of reference is essentially, “I’m not the patient; you’re the patient,” or “You’re the subject.”

Joy: Once you start this process, which I think is an emotional sharing of problems and making yourself very vulnerable to criticism, the whole organization and structure and function of the individuals in it, becomes something that everyone can question and comment on.

And so, I can remember in the early days at Henderson, a great deal of pressure, primarily by the nursing sister (whose bark was much worse than her bite) to maintain the status quo because it became very disturbing when the patients began to address the nurses by their first names, and when the nurses wanted to smoke with the patients, and sit on the patient’s beds. What was really happening—the Unit was commenting on the way professional people behaved. And then for me, this was the beginning of a very exciting phase when we became very self conscious about the whole structure of the Unit.
Dennie: How did this happen Joy? At many places I’ve seen similar things happen, but they didn’t continue to experiment like you did.

Joy: My memory is so faulty, one glosses over some things and highlights others. I can only say what I thought it was. “Once you are in for a penny, you’re in for a pound.” Once you start this there’s no turning back. I think it was fortunate and good management on Max’s part that the staff who came to the Unit, particularly the social therapists (which we talked about last week) were able to very easily become part of this process and so it was a lot of excitement and enthusiasm and people wanted to go on and see if you could do the same kind of things in a different sort of way.

Max: But wasn’t it the cult of the patient, really, Joy? We began to believe in the role of the patient as the central part of the social structure.

Joy: Well, I think that this was something that you brought to Henderson. When I got there, at the beginning of 1948, the patient was a participating, on-going member of a group-oriented structure. There were meetings every day—they were structured, but they really allowed a tremendous amount of interactions.

On Monday, there was the Grumbles Meeting, which eventually turned into the “8:30” meeting, which happened then everyday. But this was a meeting where the patients were allowed to comment on the activities of the hospital and it usually was about draughts, food, and what have you, but also occasionally it got into role-functioning of staff members increasingly.

On Tuesdays, there was a film and a discussion about work. This linked up with working on the inside and outside so that the two things—the community and the hospital—came together.

On Wednesdays, there was a discussion very much like Nervy Ned, things, which Max talked about last week, with discussions about headaches, somatic symptoms, and various sorts of treatment. It wasn’t always the same every day, as we were always trying new things.

Dennie: Nervy Ned was a projective technique—to get detachment from yourself, for better understanding?

Joy: Just to try to learn how you functioned. A patient might say, “Why have I been constipated for a year?” Or “Why do I get headaches?” Or “Why does my wife get backaches?” They would be told just the physiology and functioning, and various doctors would talk about this.

Max: It really was the precursor of the wealthiest country on earth using video tape! It was a visual projection.

Joy: If my memory serves me right, this would then very often turn into something very similar to what Pat described about alcoholism. There would be a long series of discussion about things like headaches or restlessness or backache or being unable to get out of bed in the mornings—things of this sort, and it might go on for a long period.

Then there was a period when the patients wanted to ask for information
about birth control, factual information about marital relationships, about child-
bearing, child-rearing, so it became a mutually learning process about things
these people knew nothing of—the fantasies they had about their bodies were
very similar to those the general public have, and how they functioned and so
on. Venereal disease was also touched on and this was where what you brought
to the Unit began to flower because from it being an impersonal discussion about
someone with headaches or some one with stomachache, someone in the group
would say, “Well, I’ve had this kind of symptom.” And the patients assumed the
doctor’s role, or the medical kind, and showed a great deal of their cleverness by
trying to relate the symptoms to the social situation of the patient.

Max: But this is what occurred as a result of training.

Joy: Concomitant with this, the staff began to ask for help. They thought the patients
were getting more information than the staff were getting. So, the daily tutorials
for the therapists were not only to deal with interpersonal problems but also to
do with factual things. So it was as if there were a nurses training school actually
going on within the ward culture—seven days a week. Different people partici-
pated and the 13 girls and others who might be involved, would learn at their
own rate and would learn about the things that they wanted to learn because they
were experiencing difficulties in this area.

Dennie: Joy, could you briefly describe a tutorial?

Joy: Dennie, you took part in the tutorials—I think you should.

Dennie: They were the most exciting learning situations I’ve ever seen.
They went on from four to six each afternoon. When I was there, Max took them
on Saturday and Sunday. I remember one quite
vividly that Eileen Skellern, the nurse, gave
that was the first one that really got to me. The
13 young women got together and soon one of
them began to cry. She’d gotten involved with
one of the male psychopaths and he’d been
working up to her; gradually she’d gotten her-
self into a situation where he had propositioned
her sexually. She was really shook up. She had
led this on and now he was going to meet her
that evening; things had been arranged and agreed upon between the two of
them. One of the other social therapists fed this into the tutorial and this is when
she broke down in tears.

The tutorial immediately turned into a therapy session; the others spent a
great deal of time getting the history of the affair and worked with her feelings
intensively. She was new, had only been there a month or two. Eileen then took
the remaining hour and put the situation into a seminar where she listed the types
of psychopaths (she listed David Henderson’s main types on her little black-
board) and some of their characteristics, and discussed theoretical issues such as
transference and counter-transference—after supporting the social therapist. The tutorial was absolutely fascinating.

And then the tutorial ended by proposing some alternatives for the young woman to handle the situation she was faced with. In those days, the social therapists worked until nine evenings each day—they attended the evening social lasting from seven to nine. Now, she was going to meet the patient, but had two or three alternatives than to meet with him alone. The tutorial had moved all the way from anxiety and despair, to intellectual understanding, to practical means to deal with the situation. There was excitement and enthusiasm to see what would develop that night as she now returned to the Unit with both feelings of support and some new approaches. Everyone was looking forward to the tutorial the next day to see what had transpired, so we could all learn from the situation.

I was most impressed with the genuine warmth and love that the 14 women showed to one another. I thought I ought to have felt like an outsider, being the only male in the group, but I didn’t. I contrasted this experience of seeing women display so much love toward one another to those I had experienced so much competition, and down-right “bitchiness” when some women get together.

Joy: The important thing that you mentioned, Dennie, was that it was a continuous process, day after day. It was always extremely valuable that Max brought all these things together on the weekends because it meant there was a coming together and a feedback; so from a clinical and administrative point of view, Max could feel that all the things were gathered up. And this was very reassuring for those of us who were involved in the community, because often there was no time to feed back everything.

The other thing you have to have to work in this kind of system is mutual respect and trust not only for people’s imagination in their work, but also for their intellectual creativity as well. This again is Max’s contribution very much: allowing people to be creative even though he didn’t always agree with them. This made for a marvelous sense of freedom in the Unit; you were free to communicate everything and you knew it would all be gathered up once or twice a week and come together; you could experiment and do things that maybe people wouldn’t even understand or approve wholeheartedly, but if you went on feeding back, if you could meet people’s comments, questions, and criticisms—at Henderson, you could go ahead and do it. But you couldn’t do it in the broom cupboard and you couldn’t do it outside the system; you had to be prepared to bring it in. And I think this was the essence for me of the excitement and enthusiasm, the freedom—also the discipline—and the creation of a real sense of responsibility both emotionally and intellectually.

Max: Why don’t you tell about the early family groups of 25 years ago we were having in the outpatient clinic? There were those interesting characters in the Mystery Family once a week for the staff; the other shift was having an outpatient clinic. You know, I’ve just come back to this after 25 years. God knows why we’ve lost some of these things from the training angle, but it’s a magnificent training device, and I’m thinking of small groups; now, simply take your
staff and you take a recent case that you’ve had as an outpatient, you rehearse it briefly—just give the dominant theme—the dominant mother, the passive-rebellious child, and so on. And you then, as a doctor or social worker, knowing the case, you actually develop it. We were doing this 25 years ago and it was enormously successful in getting the patients involved in social problems and then of course projecting their own social problems into the discussions.

This “warming up” technique: I saw a patient on Saturday, for instance—an eccentric Orkadian—you’d be beautiful for this Dennie, you could be the eccentric old Orkadian very nicely now! I’d tell you he was a maths teacher who was late for every class. He had an appointment with me at 10 on Saturday and arrived at 11. I said, “You’re a little late.” “Oh, that’s alright,” he said. And then I said, “I thought you were going to bring your wife?” “Oh, that’s alright,” he said. He’d left her in Melrose. Whether he’s an early schizophrenic or not, I don’t know. He comes from Orkney where they never know whether they’re people or pixies and have a very odd culture. And this case you’d claim very quickly simply by picking up his role and then his wife who lives with this odd fellow and is very fond of him.

But we have to make up our minds as to where does eccentricity begin and end, and where does schizophrenia begin and end. And I would simply brief you, Dennie, and your wife Joy—if she was your wife! She would play her role with me as the doctor and we would reproduce this situation—we would have the topic of an eccentric man who was on the borderline of schizophrenia. The patients would recognize this fairly quickly in the social context, so they’d become so involved you could hardly keep them out of it. It usually broke down from a play, or a Misfit Family, or an outpatient clinic, and the patients were enveloped: audience-participation occurred almost spontaneously.

This is how it evolved, didn’t it?

Joy: Suddenly someone would say, “You don’t behave like that if you are an eccentric,” and then the doctor would say, “Well, why don’t you come up and play this role?” And someone would get up and play the wife. There was so much involvement that it was very spontaneous.

The other thing that happened with this technique was that the patients got to know the staff very well. And could realize that there wasn’t such a gap between the so-called “sick” and the so-called “healthy.”

Max: I was always cast in the role of the horrified, controlling superego and I resented it very much!

Joy: But I think it did mean that there were points where there was a lot of sharing.

Pat: I think one should make it clear too, that quite often it was a real patient with a problem who, on the spot, was acting-out his own thing. And again, getting people to show what they would do if they were in the same situation. It wasn’t always a remote thing.

Max: Some of the plays were brilliant. the Community Theatre, which was the best repertory in London at that time, got really interested in it; they used to come
along. In fact, one of our “unknowns” became a writer. He, Charles Baker, wrote a script for them. He did some beautiful productions.

Dennie: The patient would write the psychodrama and rehearse it? And you had psychodramas on Fridays?

Joy: When I first went to Henderson, it was not the patient who did it—the patients would choose someone and the whole week was spent in preparation. This was a time when we all doubled up in everyone’s roles because we had to. We had one telephone for all the 35 staff to use in the office. There was one secretary who also produced psychodramas, so you had to do a lot of your own clerical work and people did it with great willingness. So she was off in another room producing. I can remember very vividly a production—and they were superb productions—with all kinds of symbolic ways of expressing things.

Max: The voice of conscience would come over the microphone and say, “You’re a bloody liar!”

Joy: Yes. They were tremendously exciting, curtains drawn and lights at the right moment. The secretary was a very creative, very humble, very sharing person.

Max: She couldn’t do shorthand though or typing, but was a very good secretary! [laughter]

Joy: In this one psychodrama—in the middle of a very dramatic second act—someone from the audience said “it wasn’t like that at all, you’ve got it all wrong.” And the patient whose story it was, got up on the stage and played himself, and this was a man who had been a transvestite. Something very difficult to talk about with not only 100 patients, but visitors as well there. This, I felt was a tremendous break-through because after that, by and large, the patients had no difficulties in portraying their own problems.

Dennie: You developed all this without knowledge of Moreno?

Max: Particularly without the knowledge of Moreno. We discovered him later on and I think many of our techniques would have been much better had we known. (From 1941 onwards, at Mill Hill and Dartford, and from 1947-1957 at Henderson).

Joy: They began to wane away in 1954.

Pat: Why did they stop?

Max: Because the community meetings became so alive—they became the psychodrama—they were humming! You’d walk in and be greeted with, “Who the bloody hell are you?” And you’re in, you can’t sneak out! “You look a bit odd, you like my being tall?” You’re a person from the minute you walk in. You really are entering a psychodrama where communication actually is free—fantastic!

Dennie: Max, was this a combination of your own progress in changing the structure, so you’d have more freedom and communication plus having psychopaths at Henderson, who would be more blunt?
Max: Because the here-and-now became more important that the recreation of the past—and now it was a group.

Joy: I remember, and this is only my impression, of it coming out of the Grumbles Meetings—that the Grumbles Meetings concentrated so long on food, draughts, and bad beds and uncomfortable toilets, and all the rest of the things—weeks on end the lavatories would be discussed and it was always the same. The other thing that went on was that each ward had it’s own meeting, so there was a feedback from the wards into the Grumbles Meetings and the realization that maybe we should spend more time looking at the here-and-now and so the Grumbles Meetings ceased to be just a gripe session and became a way of looking at the total structure.

In some ways, I think that the follow-up had a little bit to do with this because one of the things that the patients who were followed-up said, without exception, when they were asked what it was that helped them to get better, everyone thought they’d say it was the ECT’s [electro-convulsive therapy], or the pills, or the discussions with the doctors or something, and they all said it was just being in the place. And so, self-consciously, I began to be more conscious of the effect the place would have on people.

Max: We didn’t use the jargon, “living-Learning” but it was a living-learning situation—social learning essentially.

Pat: There was another factor too, in that the Unit was the “wicked” part of the much more classical larger mental hospital which may have seen itself with a sort of pride. Its rather rough handling of the Unit therefore resulted in uniting amongst ourselves because we were against the rest of the hospital—or they were against us.

Dennie: You were always in trouble with the matron!

Pat: And this was frightfully good, I’m sure...

Dennie: I remember the first meeting when I visited Henderson, the very first issue raised was that someone had pulled up all the matron’s flowers.

Max: That was nothing—that actually was a day off! [laughter]

Joy: Another time a patient climbed on the roof and they got drunk.

Max: There were far worse things that I can recall when the local pub came in—I lived out, the house I had bought for the social therapists to live in, in Epsom Downs—they lived there for nothing; they had a free telephone and so on, all on my own money. I know it sounds like a brothel but it certainly wasn’t! It was a very healthy arrangement and when I’d come in in the morning—I used to dread coming in because I didn’t know what I’d see: these damn psychopaths. The worst morning of all—there were these two ghastly ornamental flower pots in the front of the main entrance, the side of the superintendent’s window (who hated us)—and there they were lying broken and at the front stairs, their hideousness fractured, and oh God! Every day there were windows broken...
almost without exception—it was sort of a routine, the window breaking session.

Joy: And Max was always on the carpet literally.

Max: Oh, literally. I suppose I spent one-third of my time trying to fight the establishment, trying to protect the Unit. I could tell you endless stories, but I remember the Board of Management wanted to see me in the high dungeon and Pom, who was my number two, said, “But he’s in a group!” They said, “We insist on seeing him immediately!” Pom repeated, “No, you can’t. He’s in a group!” Just like a surgeon would do about an operation: you can go to hell, we’re doing treatment. And he got away with it! Not that I was let off.

But one day when the air raid sirens went off like every day of the week—I’m sorry, the fire alarms—I was in a board meeting where they were absolutely clobbering the Unit and I just kept my fingers crossed: “Oh God! Don’t ring that damned fire alarm today!”

Joy: The firemen even came. [laughter]

Max: And off it went—everybody got up, it was almost as if you’d pressed a button: “We’re going to see the Unit.” And I thought, “Oh God!” And so I trailed along about half a mile after this angry Board of Management and I saw this horrid little red-head and I knew something awful was going to happen; you couldn’t be nearer to the end than that. I saw her head bobbling down and then whiz, a lemonade bottle crashed! [laughter] It was much like LSE! How we survived, I don’t know because they set up two boards of inquiry; Minsky, the superintendent who hated our guts, and who had the power, set up, first of all the Board of Management, and then set up a Committee of Inquiry which lasted two to three days. My brother, who was a Q.C., said that I should have had legal advice with me because I was really liable time and again to their furious board members who’d say, “What are your views on prostitution or prostitutes?”

Joy: We were all indited on the second one, where we all had to say what kind of people we were and where they asked us about our personal lives. But I don’t think it was only the hospital that was against us, but again the practice of psychiatry and again, the practice of social work—I don’t know how it was for you as a doctor—but, when I began my professional training and came back, [to Henderson] I was told that this was a very stupid move, that this was very unprofessional and that I couldn’t expect to get any further employment if I returned to the Unit, where professional conduct was very suspect: people were called by their first names and you let people do social work who were not training and patients went on home visits and did assessment and all kinds of things together with a member of staff.

I’m sure, Max, you must have had the same kind of things.

Max: I’d forgotten that—patients went on home visits?

Joy: On occasions I would go with a patient to a family—this was before we’d admitted family members—where a patient would say, “I think I understand Jock’s
wife and I like Jock. I think if I came along . . .” And so it became practice to share with the patients the involvement we had with the families and they would say, “I think so and so could be helpful in this situation.”

Max: Well of course the patients became therapists in the admission/assessment sessions, didn’t they? They would ask the questions about the Unit, “Why do you want to come?” Very good questions. And after showing them around the Unit, the staff and patients as a committee, would share assessment and often realize: “There’s nothing for you here, Jock. And don’t come if you just want to get out of the winter cold!”

Social Therapist: This closeness that resulted from the outside aggression—the people outside the hospital—did that extend to the patients too?

Max: Very much so. After the pub [the Californian] was smashed up or something like this happened, I’d say [to the community] something like, “I’m terribly anxious and I need your help. We’re going out of business if we do this sort of thing. Do you really want to go out of business? And it never failed to work.

Joy: We also had on-going relationships with people in the community who were important—the probationary service particularly. The police were another group. Both these groups were very anti the Unit until in the end after we’d worked with them for a number of years. I can remember one boy, after he was convicted of burglarizing something like 98 houses while he’d been a patient, we went down to the station with him—some of the staff, some of the patients. The police eventually came to visit the Unit to interview him and other people and were so concerned at seeing the personal side of the crime that they brought him all kinds of things, clothing and socks, and recognized that this boy never had a chance. And in the end, we got two probation officers seconded to the Unit—one half-time and one third-time, a man and a woman—so there was a much closer liaison with that part of the community, which was very important. The same thing was true of the Ministry of Social Security—we got them to come in, but it was a very slow process.

One of the things I like here [at Dingleton] is that everyone wants things to change in six months and we are talking here of a process which started at least in 1940 and was still going on in 1959. So change takes an awfully long time and also one has to hand on the process of change to other people.

Max: But change could also occur quickly, Joy. Because if you take the second “Committee” which was set up to finally destroy us by this “lovable superintendent,” the Hospital Board of Management failed to destroy us just because it was touch-and-go. I was accused of being a homosexual because we’d employed a homosexual teacher for “music and movement,” and so on. I had to face a lot of lies which were thoroughly sifted out and it was shown that the superintendent, by his own hand, had employed this homosexual and not me. A lot of things like that were a witch-hunt.

Joy: They really worked up the dirt about everybody.
Max: The fascinating thing was the second “Inquiry” by the Regional Hospital Board—can you imagine having an “Inquiry” set up by the Regional Board to destroy us? It was a terrifying experience. Professionally, I was going to an absolute death, but they couldn’t find anyone to serve as chairman, first of all because people were decent enough to say, “No, I don’t want to get involved in this—this is a witch-hunt.” They finally got Noel Harris, who was head of both the Department of Psychiatry at Middlesex Hospital and the University there. But this time was better as I didn’t have to go it alone. Others were called in, such as Joy and so on and by the end of the two days of hearings, Noel Harris said, “Look here, I think this is a fascinating place. Can we be shown around?” And then he said, “Would you talk to my undergraduates, because I want them to learn about psychopaths.”

Now that was learning of a very, very dramatic kind—more dramatic than psychodrama really. That was learning very quickly about distortions and misunderstanding.

Social Therapist: You’re saying that change can occur quickly?

Max: Yea. He wasn’t blinded by prejudice; he’d unwillingly taken on this job for the Regional Board as chairman, he knew they were out to destroy us, but he found this wasn’t at all what he expected.

Dennie: Use of crisis!

Max: A very good use of crisis—tremendous—and confrontation!

Joy: And then if we’re talking about saving the Unit, the last savior was John Conrad, who came to the U.K., from California, after Max was in America and he decided not to come back... Then the establishment saw their chance to close down Henderson or make it respectable and thereby destroying it by making it traditional; it really looked as if it were the end. We went to see Kenneth Robinson, then shadow cabinet Minister of Health [Minister of Health in 1968] and he said there was very little he could do, but would try. Then John Conrad arrived in the U.K. Who was he Dennie?

Dennie: He was then Chief of Research for the California Department of Corrections.

Joy: He’d seen Max quite recently and admired his work. The influence of this was now being felt in California. He wrote, what I thought was a grand article for the Observer which really did have a liberal editor and management board, printed it on the leader page. It was very forthright, saying that if the British government closed this experimental Unit, the whole world would ask why? And after that, we were alright.

Max: But remember Joy, that had preceded by a year before by the Royal Commission on Mental Illness taking up the idea of the psychopath. And it never would have been written into the English Bill if it hadn’t been for Henderson. They wrote in the psychopathic clause which said that it was a separate entity and that these people were ill and not bad. This was a great step forward in Britain and we
were very proud of the part we played in it. It came 20 years before I thought it
could ever happen and this in a way put the cap on what we’d done at
Henderson—we’d really done this.

But this is a sad story—social workers please note—that although we had
achieved this—the medical profession weren’t willing to follow the lead and the
Royal Commission and the Bill recommended many units for the treatment of
psychopaths—I don’t think at the most one has followed through: a tragic reflec-
tion on the medical profession. It was clear they should see people as ill, sick,
and not sinful, to use Barbara Wooten’s phraseology.

The government can recommend something but it needs the medical profes-
sion to implement it and they never did it. Doctors are a miserable lot really—
this is one reason why I really became anti-medical. They are such a selfish lot.
They always take the nice “treatable” cases—this is why the universities person-
ally I don’t like, it’s the same thing. They see the cases they’re interested in but
the run-of-the-mill alcoholic or chronic rheumatoids, and so on, they’re not inter-
ested in them—they want the cream! You can’t blame them, but it was a bitter
disappointment to us that no one followed up on Henderson, although it’s still
alive.

Joy: And the ideas of the therapeutic community have come into other places.

Max: Yes, but Joy, when you can get people to work with meths drinkers, when you
can get some to work in family service units, and so on, why the hell can’t you
get some of these doctors to work with sociopaths?

Joy: They work outside the establishment. No decent social worker, no professional
social worker would touch them and they still won’t. The important thing for me
about the experiment at Henderson was that this was a revolution within the
establishment—in sharp contrast to Ronnie Lang who had a revolution outside
the establishment And, it was a revolution.

Photographs courtesy of Chris and Maxwell Jones.

NOTES AND REFERENCES

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