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Interview

In conversation with John Howells

(Part 1)

Hugh Freeman interviewed Dr John Howells recently.

Dr John Howells

I would like to ask you first about your early life and particularly about anything which may have influenced you in your later career from that time?

Well, to ask a dynamic psychiatrist that question to begin with seems very appropriate. Perhaps I ought to mention, though, that I am a Celt, and we Celts are a little 'melancholic'. I should also add I am a North Walian, and there are significant differences between us and those from the south; we are much more tranquil and our big city is not a Welsh one; it is Liverpool. I was brought up in Anglesey, and lived for many years at Holyhead. You may know that Anglesey is dominated by Holyhead Mountain; as long as man needed a vantage point, that was it, looking out immediately over the Irish Sea. As a child, I would fish off the 'Rocky Coast' below it, and climb its cliffs for birds' eggs. If you look away from Holyhead Mountain, you confront the mountains of Snowdonia. I find myself more comfortable with that kind of country, and sometimes find a need to return to the mountains of Wales.

What about your parents?

In my formative years, the biggest influence on me must have been my mother. She was the intellectual one in our family. Her father, my grandfather, was originally a farmer, but as soon as his boys could handle the farm, he became a lawyer, a politician, and a chemist – he actually made an ointment from local products. He was a man of many interests, and I think this influenced my mother. She was a person who felt strongly about causes, particularly about the underprivileged, and her special interest was the plight of black people in the United States. Now this may seem a strange interest for a woman in North Wales, but I can recall her sending my father off to the bookshop to buy me a book on the life of Abraham Lincoln. To her, Lincoln was the nearest thing to a saint. When my father came back with *Uncle Tom's Cabin*, her scorn that he could confuse the two things was enormous. You may see a link between her and my interest in psychiatry, because in a sense, psychiatric patients are a minority and an underprivileged group.

And your father?

In a way, my father may also have contributed to my interest in psychiatry, because he was a gregarious, sociable, eminently likeable man. My children called him *taid*; you only had to mention that word and a ready smile would come to their lips.

What does 'taid' *mean?*

It means 'grandfather' in Welsh. Almost as soon as I could walk, he would take me fishing and shooting. He had a cousin who was a patient in a mental hospital at Talgarth, near Brecon, and occasionally my father would visit him, and I would go with him. He would park the car just down the road from the hospital and instruct me that I was not to talk to anyone who approached the car, was to keep the door locked and the window shut. He would then disappear through the big gates and after a while would return. He would make no comment on his visit; it seemed to be a taboo subject, but I naturally wondered what was going on behind those gates. And this may well have fired some interest or curiosity about psychiatric patients.

What was the atmosphere of your childhood?

The atmosphere, I suppose, turned around the chapel; as a child, I looked forward to the long

sermons, which were often oratorical efforts rather than religious contributions. Occasionally, to enliven things, they would bring in a local singer, and this would have been my first introduction to music, which may have precipitated my interest in opera later on. There were not many big choirs up in North Wales, though they were a feature of life in the south. But there were a lot of eisteddfods, and I suppose these would have influenced me, because I am very much interested in poetry and particularly that of Dylan Thomas. This has led to an analysis of his writings, which I have lectured about in America a number of times.

What about your school?

It gave me a very good grounding in scientific subjects – especially in chemistry, almost despite my disinterest. My history teacher was an eccentric Irishwoman, with whom I had a special relationship. I can recall her impersonating the Younger Pitt in the House of Commons when they derided the way he pronounced "sugar". She stood erect and declaimed over our heads "I said sugah, Mr Speaker. Sugah". Welsh interests were prominent there, but not excessive! I was very taken with cricket, and was captain of the school team in an indifferent year, but any real accomplishment I had was in the direction of the academic. I couldn't sing and couldn't compose poetry, as many other Welsh children could, though of course, I could speak Welsh. It's of interest that two Scottish medical superintendents of Welsh mental hospitals learnt fluent Welsh – Ian Skottowe and P. K. McCowan.

Then a sad thing happened. In my adolescence, I lost my mother. It was a major loss and I sometimes think I have never really sufficiently grieved her death.

How old were you then?

I must have been 15, and the blow was such that I sometimes think my melancholy isn't so much due to the Celtic temperament, but is a throw-back to that moment of stress. Indeed, I can recall once suffering a severe disappointment and immediately after it, the death of my mother came to my mind, and I burst into tears, which was an additional moment of grieving.

What brought you into medicine?

Oddly enough, it wasn't my mother who ordained my going into medicine, but my stepmother. She was a singer who married my father about 18 months later. Like all adolescents, I wondered what I should do in life, and in fact, my first interest was in trees. At that time, there was a great deal of government activity to train people in forestry, presumably because of the depletion of forests during the First World War. However, after discussion between myself and my father and stepmother, my thoughts were turned greatly towards a helping profession. Becoming a veterinary surgeon came to mind as a possibility, to which my stepmother said, "Well, why not go the whole hog? Why not go into medicine?" I caught on this avidly, because I realised that it was the longest university course, and a lengthy period at university was, above everything, what I desired.

Why did you feel that?

Because at that time, I was curious about so many things and it seemed to me that university was the gateway to knowledge. But in particular, the gateway to London. Happily, our general practitioner, who was consulted at this point, had trained at Charing Cross Hospital. The obvious place to go would have been Liverpool, which is where North Walians generally study medicine, but to me the place was London.

Why were you drawn to London?

Because it seemed to open so many doors to so many things, and when I did go to London, I had metaphorically to eat it all up. There was so much to fascinate one.

I was also vaguely interested in politics. The reason is that one of the saints of North Wales was Lloyd George; he was very active at that time and I saw him on two occasions. Once he was in Holyhead, when he came to support his daughter in an election campaign; he was a very impressive figure, very charismatic, and an orator to his finger tips. The second time was at the start of the war; he made a speech in the House of Commons in which he advocated an effort to make peace with Hitler. This was not well received, and someone dared him to go back to his constituency and make the same speech.

Did he?

Yes. He took up the challenge, and my father and I went to the meeting, which was held in Caernarvon, in the old building for the National Eisteddfod. They were so pessimistic about his attracting an audience that they only put seats in the first ten rows, but in fact, the place was packed. Lloyd George came on stage, and he first of all invited the audience to sing a few hymns and in so doing, he created the *hwyl* – the atmosphere. Then he painted a word picture of the dove of peace flying over the flooded water between the Siegfried and the Maginot lines and of course immediately, he had the audience in the palm of his hands. He did repeat what he said in the House of Commons, and he did get away with it.

Did you pursue your interest in politics?

There was a moment during my medical training when I did actually wonder whether I should beg an interview with Lloyd George, and see if he could somehow or other introduce me to politics. But there was a conflicting thought – during my early spell in

London, I studied many things, including logic. I began to discern that politics was really something which came after the event, that the great trends were in fact precipitated by the creators, the innovators, and it was afterwards that politicians came along and applied them by regulation and law. So I felt it was really more important to belong to the innovators than to the politicians, and that curbed my interest in politics.

Where were you studying then?

I was at King's College. In those days, Charing Cross pre-medical students joined the students from King's College Hospital and also from Westminster and St George's at King's College. One of the privileges of being a student at King's College is that as it was founded as a religious college, you could take a free course in theology for the AKC – a theological qualification. This was of great interest to me, because having been brought up in a non-conformist milieu, I was interested in theology. One of the things I had done when I got to London was to study all the different types of religions; I went to meetings of Christian Science, The Ethical Movement, The Humanists, the Quakers, various types of non-conformists, and to the Catholic Cathedral. During my holidays, I did a bit of lay preaching. However, I was also reading logic and the result of my theological training, far from bringing me closer to religion, was to take me further away. I found myself happy with Christian ethics, but very unhappy with the nature of God and of the deity. So I ultimately came to be a humanistic agnostic – that may be the best way I could describe it.

What other matters fascinated you?

Another privilege of a student at King's is to take a course in another faculty, again free; in my case, I wanted to take it in philosophy, but when I went to enrol for it, they told me the course was full. However, there was a vacancy on a psychology course, which was in psychopathology, by J. A. Hadfield, who had written a bestseller on *Psychology and Morals*. There was another, allied course, on Developmental Psychology, actually taken by his wife, and I booked up for both. He was a fascinating lecturer, introducing many case histories from the First World War. I think we tend to forget that there was a British school of psychopathology, really emanating from the First World War; people like Crichton Miller, J. A. Hadfield and J. R. Rees; they were founders of the Tavistock Clinic. That movement with a careful basis of research, could have been the basis of a sound British psychopathology. But psychoanalysis was introduced and choked the local product, so that British psychopathology disappeared, and we have yet to resurrect it. It was Hadfield who introduced me to psychiatry. Later on in my medical training, my nickname was 'Psycho'; it was very unusual for a medical student at that time to be interested in psychiatry or abnormal psychology.

I had the opportunity of seeing Hadfield in action with patients a couple of times in 1958, through the RMPA's Psychotherapy Training Scheme. He used hypnotic techniques, but his appearance and personality were enormously impressive. What other interests did you have then?

Art galleries, theatres, music – my interest then was in orchestral music, but later it became operatic and after that choral. I also had two other particular interests – one was the Law Courts. King's is, of course, very close to the Law Courts, and after lectures in the afternoon I liked to go along, and through the good offices of the porter, could find in which court there was a summing-up. I loved to sit there and hear the judges marshalling the evidence, and coming to a conclusion. The other was politics, as I mentioned before. I lived at that time in Pimlico and I would often walk to and from King's – in those days, one did a lot of walking. On the way I passed the House of Commons, and I would pop up there to the Gallery and listen to the debates.

Where did you live then?

In a Toc H Mark – a mark is something like a club. The Toc H movement was founded in the first World War as an inter-denominational movement. The idea was that people from diverse backgrounds living together, would get to understand one another. I had the privilege of meeting Tubby Clayton, who founded the movement. He was the sort of chap who, though there might be 50 people in a room, gave you his undivided attention while he spoke to you; you felt he was just interested in you. It was a remarkable quality. This was a rich experience for me, because these people were very diverse indeed. On the one hand, we had a compositor from Fleet Street who was a communist, and at the other extreme we had the son of a well-known family, who really did nothing everyday except the *Times* crossword. I used to rather look down on this guy, but once you really got to know him, you realised that he had something worthwhile to tell you. To live there, one had to perform some social service, which was led by someone called the 'pilot', but it was done without any publicity.

What happened when you finished the preclinical course?

Almost as soon as I got to Charing Cross for the clinical course, the War started, and the hospital was evacuated to Ashridge Park, in Hertfordshire, with the medical school in a large house nearby. Part of the hospital was still functioning in London. We had less lecturing than pre-war medical students, but I think we had a great deal more practical experience.

We were expected to help with the bombing casualties in London, and with the wounded when they came into Ashridge.

How did you divide your time between London and Hertfordshire?

Every so often, we had a spell in London; during the bombing, for instance, one was virtually a stretcher bearer. The Casualty Department was in the basement, sandbagged all round, but we lived as students on the first floor. Any patients who came in would be evacuated in the next day to Ashridge Park. The bombing during that period was really intensive, and many casualties were brought in. I remember the night when a bomb went down the stairway of the tube station at Trafalgar Square, which was very close to us. It finally exploded down at platform level, so that many casualties were brought in. I also remember when they brought the casualties in from the *Cafe de Paris* bombing. Our first task was to go down the row of stretchers, take out the dead, and then try to identify those cases which needed immediate operations. There was a gasp from a fellow student, and he said "Snakehips". Sure enough, there on the stretcher, dead, was Snakehips Johnson, who was the dance band leader of the *Cafe de Paris* and a very prominent musician at that time. Possibly our most disagreeable task was at the end of the evening, when the dead had to be taken to the mortuary on the first floor. We had no lift that would take a stretcher, so each body would be tied to a stretcher, which would go vertically into the lift. One student would go up with the body, holding the stretcher vertical, while the other ran up the stairs to meet the lift; that, in the dark, with the body tending to fall on you, was a very disagreeable task.

Who were the most important figures at the hospital?

One who had a considerable influence on me at that time was Norman Lake, the senior surgeon. I met him in a curious way. At that time, one had to make one's own amusements, and the 'Brains Trust' was very popular. So the hospital had its own, and it consisted of a consultant, in that case Norman Lake, representatives of the junior medical staff and nursing staff, and a medical student, who happened to be me. When people asked questions, I tended to take a psychological slant, which at first bewildered Lake. He was a very remarkable man, though, the senior examiner for the Mastership of Surgery in the University of London, as well as having a degree in engineering and another one in music. He kept a little notebook with him always, and recorded any unusual event or information in it; that evening, it would be read up in his reference works, and in that way, he accumulated a vast amount of knowledge about all sorts of subjects. I imitated him in this habit and ultimately, over 25 years, collected enough material on psychiatry and abnormal psychology to make a two-volume Reference Companion to its history. He was curious about this student (myself), and became more and more interested in psychology and abnormal psychology himself. Ultimately, he made the monumental statement that no surgical out-patients was complete without a psychiatrist in attendance.

Did you do house jobs at your teaching hospital?

I did two house posts before going into the army. The first was to the firm of Sir Gordon Holmes, who was the senior physician, and E. C. Warner, who was the editor of *Savill's Textbook of Medicine*. Warner was a very fine clinician, but of course, the dominating influence was Holmes. He was a formidable man to work for – tall, iron-grey hair, tremendous fluency of thought and rapidity of speech, and impatient with people who couldn't keep up with his pace. He kept a patellar hammer by his side and when impatience was too much, he would use this on you; his edict was "Maybe I have to bang it into you".

On what part of you?

He always went for the head. It could be hurtful, but one did learn neurology from him. I recall a patient who had been admitted from out-patients, where he had been seen by Warner, and the diagnosis was anxiety state. When I did my examination, I could find no abnormal physical signs. When Holmes came round, he said "Boy. Have you examined the patient?" to which I replied "Yes Sir". "Pray, what is your diagnosis?", Holmes asked. I said "anxiety state". Later people told me that this was like a red rag to a bull. Holmes said nothing, but examined the patient, and then turned to me and said "And what do you observe?" I had followed his examination and could see no abnormal physical signs of any kind. I said "No abnormal signs, Sir". To which he said, "You're not very observant today, Howells. I will concentrate your attention on the abdomen". And so he did the reflexes of the abdomen. He then said to me "Now Howells, what do you observe?" I was a little bewildered and said "Four reflexes, Sir". "Howells you're very inattentive today; I will repeat my examination for you" came the reply. So he did them again, and said, "Now, what do you observe". By then, I was completely bewildered and said "Four reflexes, Sir". "Howells I will make it easy for you. Have you not noticed that the right lower abdominal reflex tires before the left?" He did them again, and with the eye of faith, you could argue that possibly this was so. He said "Now Howells, I'm not impressed with your performance today. You will examine this patient every day for the next week and will then tell me what you observe".

And what happened?

Sure enough, during the next week, all sorts of physical signs appeared. When he came the following

week, he said "Have you done what I told you?" I said "Yes, Sir". He said "What is your diagnosis now?" "A frontal lobe tumour, Sir". "Quite right. You've wasted a week Howells. Now get hold of a surgeon". This was exacting stuff, but very good neurology, so I was really very fortunate in having that sort of apprenticeship.

What was your next job?

House surgeon to Norman Lake. This was as pleasant as the other experience was, in a way, personally unpleasant. He was a very gentle, modest person. One inevitably made mistakes, but he would point them out with a little smile and then would add something encouraging like "Of course, you will soon put that right". Not only was he a general surgeon but also a neuro-surgeon, which was quite unusual in those days. He did his brain surgery on a Sunday morning, with the advantage that things were quiet in the hospital then. There would be a mix of cases – bullets and shrapnel in the brain, and the occasional brain tumour. This made the weekend very busy for me because I would have to prepare the cases for operation on Saturday and look after them on Sunday afternoon and evening. What I liked so much was the intimacy of the occasion. In the theatre, there was just Lake and me and the nursing staff. For shrapnel and bullets, one had to try to estimate the position from X-rays, done from various angles. Then, we had to try to discern the best approach to the problem, so that I learned a great deal of brain anatomy. I developed an interest in neurology then, and later on did a neurological job at Queen's Square.

Did you meet the psychiatrists at Charing Cross?

I attended the psychiatric out-patients at Charing Cross whenever I could. There were two psychiatrists there – A. A. W. Petrie, a well-known superintendent and an ex-President of the RMPA, and Clifford Allen, whose special field was sexual pathology. Allen was an interesting man and was very helpful to medical students; we were allowed to take case-histories from the patients, most of whom were war casualties.

What did you do next?

I went into the Services. I had toyed with the idea of going into psychiatry, and consulted Petrie. He said "How old are you?". I was 24. He said "I think you are too young to specialise. Furthermore, if you want to go into psychiatry later on, you ought to look around first, and if you decide to do it, your military experience will be invaluable to you." I think this was probably right. So after training at the RAMC Depot at Crookham and a short period in a field ambulance, I found myself with an infantry battalion. I still go to their annual reunions. It was through this battalion that I came to practice in Ipswich. Before D-Day, many troops were moved over there, to give the impression that the attack was coming from East Anglia to the Low Countries; then overnight, they were switched in a magnificent logistical effort to the south coast. So for three weeks we were in this area, the sun shone every day, and I remembered it as a fine place to be.

What was life like in an infantry battalion?

Sir Richard Doll has given a good picture in a series of articles in the *BMJ* recently. With the regiment, one learned about life, how to look after oneself, and a little psychiatry of a sort. For instance, just a few minutes after the Battalion was told they were going on active service, a man was brought in with a self-inflicted injury to his foot – a nice clean hole. There was also a certain amount of marital and other similar problems. A regular attender was the Battalion butcher, who had a very tiresome wife; after every leave, he would come back upset and would have to come and talk to me about it. As a matter of fact, at every reunion since the war, he has still consulted me about his wife.

Any curious episodes?

Human nature exerted itself. I once had a message from the commander of D Company, who said that a strange thing was happening to his men; they all seemed very phlegmatic and exhausted. So I went along and found these men were guarding a pontoon bridge across the Rhine; I examined a number of these 'exhausted' men, and could find no physical cause, but there was no doubt that they were exhausted. So I said to my batman-driver, "I want you to circulate among the men and tell me what's going on". He went to the cookhouse and after about an hour, came back; I could tell that he had obtained some information. The top and bottom of it was that no-one except military personnel was allowed to cross this bridge, but many Germans wanted to do so. So at night, they were allowed to cross if the women slept with the guards, and this was happening so frequently that the men were exhausted. So I drew the company commander's attention to the need to be more in touch with his men.

Ultimately came the time when I left the Regiment because the European war had ended, and I found myself in a Field Ambulance, but was very unhappy there, feeling like a caged bird! Then, they put me in charge of a Reception Station, which was a hospital of about 20 beds, with a couple of medical officers, a dentist, and a number of medical orderlies. I quite enjoyed that; we were at an attractive part of the Rhine.

This was when you attended a course at Göttingen?

Yes. I was selected by the Army to go on this course, which was a partnership between German and British professors, and one saw their different

techniques. For instance, the Germans placed much greater reliance on laboratory findings, whereas Professor Tunbridge asked us to make an estimation of the degree of anaemia in a patient by physical examination, looking at the lips and eyes, etc. When we looked at the laboratory findings, they were identical with our clinical estimates. An impressive feature of life at that university hospital was the post mortem meeting at 12 noon every day, which everyone attended, and learned about the mistakes they had made. Something comparable in psychiatry might be possible; when a patient is discharged prematurely or commits suicide, the psychopathology could be thoroughly explored – a kind of post mortem.

What happened when your demob came?

I was so happy to go that I arranged for an ambulance to come behind my truck, with instructions that should I have an accident, my body was to be put on the train anyway! After the actual demobilisation, there was a short period when one gathered breath and wondered what one should do. At that time, the National Health Service was coming in and it wasn't clear what the role of the general practitioner was going to be. So my thoughts turned to psychiatry.

How did you start in psychiatry?

The Maudsley had set up a training scheme at St Ebba's, Epsom, which was run by Linford Rees; one became a supernumerary registrar in the NHS, with a view to taking the DPM. Then he suggested that I should think of training at the Maudsley. So I had an interview there with William Gillespie, who was a child psychiatrist. I still remember that he started off the interview, as you have today, wanting to talk about one's early experiences, and looking back, this was absolutely right. He was a very quiet, modest man, but I think a first-class clinician; later, he was one of my supervisors in the children's department. Presumably through his good offices, I was selected for the Maudsley, where some of my contemporaries were D. L. Davies, Trevor Gibbens, Desmond Pond, Michael Shepherd, David Stafford-Clark, and Anthony Storr.

What did you feel about your time there?

I am delighted to have had a Maudsley training, which I regard as one of the best in the world. But nothing is perfect, and certainly there were problems there in my time. One of the things you noticed was the tremendous tension about the place, and this even resulted in trainees occasionally committing suicide. There was a curious formality, that led to distancing between people. If you passed a senior colleague in the corridor, you never acknowledged him and he never acknowledged you. But one trainee, passing Eric Guttmann one day, was moved to say "Good morning" to him. Guttmann passed by, as he always did, without acknowledging him. The trainee ran after Guttmann, stood in front of him and said "Good morning, Good morning" to which, with surprise, Guttmann replied "Good morning", politely. Clearly, he didn't regard it as his role to communicate with people, and this seemed to apply to the staff generally.

I remember this atmosphere very well myself. What was the cause of the tension?

I think one has to mention the personality of Aubrey Lewis, because he dominated the place. On the clinical side, it was very similar to the continental system – Herr Professor and no-one else counting for very much. He was brilliant intellectually, but at the same time, I thought he was basically an anxious person – his anxiety didn't allow him to drive a car for instance. And of course, he was abysmally shy; at a party, you could see his torment. It seemed to me that his defence against anxiety was his intellect; he struck first, before anyone could possibly hit at him, and I think this created tension around him. I well remember the Monday morning conferences. I was on his firm and we used to meet in the Villa, around a table covered with a green cloth. Lewis would come in, pick up a ruler, start tapping the table, turn to the presenter and ask him to start. It was a harrowing experience. When my turn duly came, he said "Well, who is presenting this morning?" I said, "I am Sir". Then he said to me, "This whole exercise is getting rather tedious, isn't it? I think this morning, for some relief, you should give us your presentation reversed". I was immediately in a panic state and thought he literally meant that I should start at the end of a sentence? Then I collected myself and realised that the part of the history that normally came last should now come first; somehow or other, I got through it.

Presumably others suffered too?

There was one of us who decided that he was going to put Aubrey Lewis on the spot by presenting the 'history of all histories' without a flaw. So he took a two-week holiday to work through it, and arrived cockahoop for his Monday morning stint. Well, he got about six sentences along, when Aubrey stopped him and said "Dr so-and-so, am I to understand that you *really* mean that?" The fellow managed to answer, but a dent had been made in his self-confidence. He then got another few sentences along, and Aubrey stopped him again in the same way. Ultimately, he was like jelly, and could barely finish his history. A few weeks thereafter, he left. I think that sort of thing is not good teaching. There were very few people interested in human relationships on the Maudsley staff at that time.

Was there a positive side to him?

Yes. Aubrey did a great deal; he put the Maudsley on its feet after the War, and created new departments,

though when you consider his creative output, one is bound to say it was rather small. The person who impressed me very much, though, was Eric Guttmann, whose short textbook with Curran was a very sound introduction to psychiatry. He was a clinician to his fingertips. When I joined his firm, there were three cases of anorexia nervosa on the ward. One proved to be Addison's disease, another pulmonary tuberculosis, and only one was a true anorexic. But Guttmann was completely at ease with the situation; he could examine these patients and make the differential diagnoses.

Was Aubrey Lewis a good clinician?

In the observation ward, I had immediate clinical contact with him. One usually had to make a diagnosis within three or four days, so that the patients could be classified and moved out to wherever they needed to go. But at the end of my presentation of cases there, Lewis' stock reply was to find some investigation which I hadn't carried out, and therefore he couldn't express an opinion until this had been done. Well of course, by the time he came the following week, the patient had moved on anyway. Guttmann, though, seemed to be able to make patients emphasise whatever symptomatology they had, so that one could come to a ready diagnosis.

Did you have much personal contact with Aubrey Lewis?

I noticed that in his reminiscences, Felix Post mentioned how he used to travel by tram with Lewis from Vauxhall in the morning. Well, I sometimes did the same. I travelled in from Epsom to Vauxhall Station, and I used to pray Aubrey wouldn't be on the tram. But quite often he would be and then, when we left the tram, we had to walk up Denmark Hill together. In preparation for this, I thought of a subject almost every morning, which I hoped I could put to Aubrey and maybe get a response. It never worked, though. One began to feel an utter fool. But at the same time, once we lapsed into silence, we seemed to have some sort of companionship as we walked up the hill. I had noticed that he was always very kind to someone who was religious, of whatever denomination.

Did you ever consider returning to The Maudsley?

Some years after I had left, Aubrey and I met at a conference in Cambridge. He indicated that he would like me to return, and in fact gave me some advice on how I should proceed. Kenneth Cameron, head of the children's department, who was also a close friend of mine, suddenly died. I was just embarking on a round-the-world lecture tour when the post was advertised, and I decided to apply. I thought I would be in Hong Kong at the time they would be sending out the papers, and asked for them to be addressed to me there. Well, these arrived in Hong Kong alright, but they went by surface mail and were returned to me some months later! So I never applied for the post. Perhaps a happy escape for both parties – who knows?

You benefit from Maudsley training; it gives you self-confidence and in Aubrey Lewis' day, it also taught you history-taking, which I found invaluable later on. If one was bewildered by a patient, one would do a Maudsley-style history and then quite often the diagnosis emerged.

After you left the Maudsley, what did you do next?

I think I know the exact morning that I decided to leave. I had gone temporarily to Queen Square for neurological experience, and then went back to the children's department. One morning, someone asked "Why is this child disturbed?" The answer seemed to be come constitutional, genetic factor. But I felt that very little attention was being paid to the patient's emotional environment. Part of the problem was that the division of labour was for the social worker to see the parent and the psychiatrist to see the child, so that the psychiatrist was largely ignorant of stresses emanating from the parents. I became very upset by this situation, and felt that a great deal more attention should be given to the management of the parent/child situation as part of the family. So I decided that I would try to study family psychopathology systematically on my own.

Where did you decide to go?

I was just 30 at the time, so the only possibility would be a consultant post outside London. Two of these were going – one in Swansea and the other in Ipswich. I remembered the nice weather in Suffolk when I was in the Army, so I applied for that post, which was an unusual one in that it was at a general hospital. I think my Maudsley training was mainly responsible for my getting the appointment at such an early age.

How did your writing career start?

The Regional Board had given me some financial help towards research – a full-time secretarial post – and after the end of ten years in 1960, as agreed, I sent a report on my work. They said it was rather interesting and ought to be published. So this was my first book, *Family Psychiatry*, ultimately published in 1963. In the meantime, I was given a WHO fellowship and had gone to the States to survey all the family centres there. It became clear to me that in fact, there were three quite distinct trends in the family field. One was family therapy, founded by Nathan Ackerman in New York, another was the study of family and schizophrenia, of which Lidz was a representative, and then there was family psychiatry from the United Kingdom.

What are the differences?

There is still a great deal of confusion about these quite different approaches. I got to know Nathan Ackerman very well. He was an analyst by training who discovered by accident that he could help the individual patient better through conjoint family therapy than he could by individual psychoanalysis. But this is not family psychiatry – it's individual psychiatry – using the group to restore health in an individual. In family psychiatry, you regard the sick individual as an index of a sick group, a sick family, and all your efforts in diagnosis and treatment are geared to restoring health in the family group; then, of course, health is restored to the individual patient also. Through being part of a healthy family, the index patient then remains healthy: the primary focus of effort is always the family and not the individual.

The field of family work in relation to schizophrenia is also an individual approach; again, the idea is to restore the individual schizophrenic to health. But the thing that struck me in visiting these US centres, was that none of them were treating schizophrenia. They seemed to me to be treating severe neurosis or personality disorder. Later, with a colleague, I surveyed the literature on all this work and wrote a book *Family and Schizophrenia*, in which we came to the conclusion that it had certainly not been proved that family psychopathology is responsible for schizophrenia. But that did not mean that the family is not important to schizophrenia. Just as a spastic child in a disturbed family will have more restlessness and more abnormal movements than he will in a tranquil family, and an epileptic child will have more attacks, so the schizophrenic is certainly assisted by being a member of an emotionally tranquil family. In fact, if you look for reasons for admissions of schizophrenics to hospital, it is often because the family can't manage, and it can't do so because it's disturbed. I don't think the disturbance causes the schizophrenia, but it causes the admission.

My Chairman's Address to the Child Psychiatry Section of the RMPA in 1961 was on "The nuclear family as the functional unit in psychiatry". Again, I was trying to make clear that family psychiatry is not only for child psychiatrists, but is for all psychiatrists. The index, presenting, patient who is indicative of family disturbance can be of any age-group. The family is sick, and it follows that one has to examine and treat the psychopathology of the family, so that the true 'patient' is the family unit. It also means that one has to have a diagnostic system for the family. In this field, I think that far too much attention is given to treatment and too little to diagnosis: many films on 'family therapy' are in fact about family diagnosis. A few years ago, another colleague and I wrote a book on *Family Diagnosis*, to emphasise its importance.

How did your post-graduate teaching programme start?

After I had been in Ipswich for a number of years, a Ministry Memorandum came out, suggesting that post-graduate teaching should develop in district hospitals; the idea was to attract good clinicians to these hospitals, by giving them a teaching role and to bring the trainee to where most of the material was to be found. Shortly after, another Memorandum suggested that where the climate was right, research units should also be created in district hospitals. The Regional Board seized on this and founded our Institute of Family Psychiatry. This was defined as having four roles. First of all, to construct a clinical service in family psychiatry; secondly, to undertake research in the subject; thirdly, to arrive at useful preventive measures; and fourthly, to teach. The Board made me director of the unit, and increased our permanent administrative research staff to five.

How did you organise your research?

Our research was of two main types. Firstly, clinical. An example is our exploration of the whole field of play therapy, which at that time was a centre of interest, but since, for some mysterious reason, has ceased to be so. As a result of that, we created a department of child therapy, run by occupational therapists who had a two-year, full-time training programme with us, and that is still going on. Then we explored new techniques of treatment by analysing tapes, and this produced 'family group therapy'. We developed new procedures for family assessment and family diagnosis. Again, clinical research resulted in the evolution of 'vector therapy', involving a systemic repatterning of emotional forces.

Secondly, there were formal studies. An example would be our study on separation, exploring the hypothesis that the experience of separation was responsible for much mental ill-health in children. We found, that it was not separation itself that was responsible, but rather the deprivation consequent on separation; the results were published in *The Lancet*. Then we evolved the new technique of the Family Relations indicator, which has been published in a number of languages, including Russian. Again, we did a large study of hard-core problem families, and its findings were published in the *American Journal of Psychiatry*. In another formal piece of research, we undertook a 1,000-family survey in the Ipswich area to explore the pattern of relating in the family. Analysis of the data from this survey has revealed some significant findings for social life and clinical practice, but so far they are unpublished.

What of your teaching programme?

First of all, we had our senior registrars to teach, then registrars doing their Membership, and we ran a two-year course in child therapy. We had four annual

courses: for general practitioners, for psychiatrists, for social workers, and for nurses; each was of a week and usually residential. The GP course ran for more than 30 years. Each winter, there was also a ten-week course for local professional groups.

Can you comment on the differences between family psychiatry and family therapy?

Over the course of time, misunderstandings arose about family psychiatry. The common one was not to understand the basic philosophy, which became confused with family therapy, particularly when that came into the UK in the 1970s. In family psychiatry, the principle is that an individual who becomes sick is an element in a sick family. If, for instance, mother is depressed then if you look at the family, you may well find that the father has migraine and personality disturbances, the son has got asthma, and maybe his sister is failing at school. This is a total situation, and if you are able to bring harmony to it, then mother's depression clears up, father's migraine clears up, and the children return to normality. You restore health to the whole group. In conjoint family therapy, the principle is to use the family to get the identified sick person well. But if you concentrate simply on improving the health of one member, then others can get worse or someone else can become ill. Once conjoint family therapy was developed, it became a sort of cult – it was said that one could only help the family in a family group. In fact, there are a number of techniques which are useful for helping families: sometimes an individual approach is appropriate, sometimes a dyadic one, sometimes a family group approach, or an intergenerational one. Bringing the previous generation into the family treatment situation was our most potent discovery in family treatment. Just occasionally, multiple family therapy might be appropriate. One uses whatever tools are right for a given clinical situation. I described these developments in a series of books – originally *Family Psychiatry* and later *Theory and Practice in Family Psychiatry*, which went into a number of foreign editions, including Japanese. These were followed by *Principles of Family Psychiatry*, which again went into several foreign editions, then *Advances in Family Psychiatry* and finally the Society of Clinical Psychiatrists report on *Family Psychiatry for Child Psychiatrists*.

How did your 'Modern Perspectives' Series start?

In our teaching programme, concentrating on the child as the identified patient, it seemed appropriate that our registrars should learn about current developments in child psychiatry in this country. So I got together a book called *Modern Perspectives in Child Psychiatry*, which passed into American hands and the publisher thought that this idea would have worldwide interest. So we then produced *Modern Perspectives in World Psychiatry*, which was followed by others, ultimately making 13 volumes. The most exciting one, I thought, was *Psychiatry in Surgery*, which appeared to be a very neglected area. More recently, I continued with *Modern Perspectives in Clinical Psychiatry*, then in *Modern Perspectives in Psychosocial Pathology*, *Modern Perspectives in the Psychiatry of Neurosis*, and *Modern Perspectives in the Psychiatry of the Affective Disorders*.

How did your preventive programme develop?

In our programme at Ipswich, the disappointment was in relation to our efforts at preventive psychiatry or health promotion. Originally, I had a notion of trying to do a 'Peckham Experiment' – having an establishment where families could attend and be given a model psychiatric service, as well as other family benefits. The local Council went so far as actually to pinpoint a building and start negotiating for its purchase. But unhappily, that fell through and then local authorities lost the right to undertake medical ventures, so that was that. Another opportunity came when a new Director of Education arrived and seemed very interested in these ideas; we pinpointed a small town where we could set up a model psychiatric service, but again nothing came of it. I think the preventive side has been the weakness of the whole National Health Service. But one aspect we did concentrate on was that of child abuse. I had long felt that the gospel of 'no separation' and of a child's own home being better than any other home was basically wrong; there are times when a child is sorely deprived in his own home, and I think that can constitute an argument for separation. In surgery, you don't lightly remove someone's leg, but on rare occasions it is life-saving. I felt very strongly about the Maria Colwell case, and wrote a book called *Remember Maria* as a sort of protest and to try to clarify the situation.

Part 2 of this interview will appear in the October issue of the *Psychiatric Bulletin*.

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