Psychiatric Bulletin (1992), **16**, 593–604

Interview

In conversation with Ismond Rosen

Hugh Freeman interviewed Dr Rosen recently

Dr Ismond Rosen
MB, BCh (U. Witwatersrand) 1946
DPM 1951
MD 1954
FRCPsych (Foundation) 1972

Dr Rosen is a psychiatrist, psychoanalyst and sculptor and was born in Johannesburg, South Africa. He was a student at the Ecole des Beaux Arts and the Academie Julien, both in Paris. He was a senior registrar at the Maudsley and Bethlem Royal Hospitals from 1952–58; psychiatrist at the Portman Clinic, 1958–59, research psychoanalyst at the Hampstead Clinic 1967, visiting professor of psychiatry at Meharry Medical School, Nashville in 1967 and consultant psychiatrist, Paddington Centre of Psychotherapy from 1958. He has been an exhibiting artist from 1947 and had one man exhibitions at the Whibley Gallery, London in 1972 and the Camden Arts Centre, London 1974 and group exhibitions at the Royal Academy, London in 1953. He has acted as consultant to TV programmes and was contributing editor to *Sexual Deviation*, 2nd edition, 1979. He is a Fellow of the Royal Society of Medicine, Royal College of Psychiatrists, Portrait Sculpture Society and a member of the International Psychoanalytical Association and the British Psychoanalytic Society.

Were there any important influences from your early life in the development of your career?

I had significant relationships and influences with both my parents; they were caring and courageous people, who valued emotional closeness. But the circumstances surrounding my birth were very dramatic. I was born prematurely and unexpectedly. My father ran out into the street for help, saw a nurse in uniform, picked her up bodily and carried her to my mother's bedside, where an aunt had already cut the cord. My mother was hospitalised for three months and required an operation for a retained placenta and septicaemia. It could be said that both my mother and I were fighting for survival at that time. Only recently have I realised that she must have focused on her new-born babe as the spur to her own survival. This early maternal deprivation, together with the compensatory intense closeness and over-protection, contributed a sensitivity in me to the quality of togetherness in relationships, which may also have gained expression in judging aesthetic proportions in art. I have observed patients with a history of severe early deprivation who seemed to have compensated for such deficiency with enhanced intellectual capacities, as if they were trying to restore an emotional gap with some area of perfection under their own control.

I grew up in a large hotel, run by my parents in the centre of Johannesburg. My mother was a gifted listener, and complete strangers would pour out their problems and life histories to her. My father had been part of the mass immigration in the 1880s from Russia into the United States. On arrival in New York, at the age of 6, he sold newspapers; had his own business, with assistants at 14, and gave up a flourishing photographic studio at the age of 19, when he emigrated to South Africa. He photographed Cecil Rhodes and the officers of the Argyle & Sutherland Highlanders in the field during the Boer War, then led a very romantic life, farming, losing everything, and beginning again. My parents expected success from their offspring.

Their warmth and family dedication were applied equally to the atmosphere of the hotel. This was my developmental background – a service institution

where I came into everyday contact with members of the public, to whom I was expected to show a sense of responsibility and tact, though they included artists and players from touring companies and drunks who were potentially violent. All very good practice for dealing later with difficult psychiatric patients. A typical chore, when my parents were away on holiday, was to cash-up in the bar around midnight and write up the books, wake at 4 o'clock in the morning to go to the fruit market, return for breakfast, and then be on time at the medical school for 8 o'clock! There was no particular remuneration for this; it was just one of the routines.

Could you say a little more about life in the hotel?

Another advantage was the experience gained working in every kind of hotel environment – in the office, kitchen, dining room, and bar. My first clinical experience as a psychotherapist occurred when I was a second-year medical student, aged 17. I was quite friendly with a young barman, whose wife had given birth to a stillborn child. A few days later, he asked whether I would see his wife, who was mute and refusing food. I found her in bed, with her parents sitting in silent despair. With no previous experience to guide me, I intuited that I had to be alone with her, and summoned up the courage to ask her parents and her husband to leave. After what seemed an eternity of silence, the very young girl and I became acquainted, as words came to me and she gradually became able to reply. We talked about her feelings regarding the stillbirth, and she came right out of the depression. The barman was much gratified, and as we walked back to the hotel, I recall telling him that this was the sort of work I would like to do in life. My previous experience was of helping boys with their problems at boarding school, where as a prefect I called them in for 'pep-talks', which in retrospect were short-term psychotherapeutic interviews.

How was your time as a medical student?

I became a medical student a few months after my sixteenth birthday, in 1941. There was some sense of guilt at not having joined the army, but I was underage and had to help with the hotel. As students, we worked and played hard; there were some who subsequently became distinguished academics internationally, but who never shone as students. Our intake at Wits medical school was the last one without formal selection procedures, yet our year's record of professional achievements was head and shoulders above that of subsequent ones.

Why was that, do you think?

It could have been a higher quality of motivation, but of course, that's very difficult to measure. As students, though, we were fortunate to have fine teachers, among whom were magnificent models for identification. One who taught us much about personal behaviour was Raymond Dart, the Dean and Professor of Anatomy, who was also a famous physical anthropologist. He thought in historical and developmental perspectives, using his studies of ape-men and aggression as the earliest human behaviour. An example of his thinking occurred early in the second year. Two hundred students dissecting in the anatomy hall were chattering away, clattering their wooden stools on the concrete floor with deafening effect, when Dart quietly entered, took up a position in the centre and hurled a stool to the floor, creating an instant, if frightening silence. With all attention now riveted on him, he raised the same stool above his head and set it swiftly on the ground without a sound. This was anatomy in action! Dissection took place in hallowed tones thereafter. He used to invite his great rival, Robert Broome, the palaeontologist to lecture to us – "He will probably only talk about the beauty of the Karoo", Dart would say, "but he is a real personality".

I became involved in the rivalry between these two great men after qualifying, when I modelled the soft tissue reconstruction for Australopithecus ('southern man-ape') Prometheus. Dart, its discoverer, called it this because fossilised ash had been found in the breccia. He showed how animal bony remains at the site had been used as weapons and instruments for stripping flesh, which he believed was the first evidence of human aggression and violence, though later researchers regard the bony markings as due to other scavengers. Photographs of my soft-tissue re-constructions appear in Dart's book *Adventures with the Missing Link*.

Could we talk about how you first got involved with psychiatry?

During our fourth student year, we had formal teaching in it at Weskoppies, the country's main mental hospital, in Pretoria. A few students would spend some days there, wandering about on their own, familiarising themselves with the patients. The chronic patients were kept in back wards connected by an interminable corridor, built according to a Victorian design, while the acute patients inhabited buildings like large country houses, each with its grounds encircled by tennis court fences. Entering one such day room, we found a solitary patient standing on his head on a settee. We waited for about ten minutes, until he eventually came down, and I wondered what to say to him. He appeared to me to be Jewish, which prompted me to ask "Are you the Messiah?", to which he immediately replied, "Who else?". I was chuffed at the encounter, feeling I had made some special contact. I found the patients

fascinating to meet and understand. Of course, we were all rather scared before we went. Afterwards, the most frightening aspect was the isolated beauty of the place, where contact with the outside world and life's endeavours had ceased to exist. At that time, there was an enormous amount of public hostility and stigma attached to the mental hospitals, which I felt required altering, but I was heading for a career as a plastic surgeon, based on my interest in portrait sculpture. Since the end of my first year in medicine, I had regularly done minor surgery at Casualty, stitching up the wounds which resulted from the endemic violence. In my fifth year, though, I went on to do the first three years of the dental degree. It was only after I qualified that I decided against taking up plastic surgery because I had a partial red-green colour blindness, and opted for psychiatry instead. Personal limitations play as important a part in determining career choice as talent or preferences.

Can I ask you how your artistic work began?

I saw one of the young Africans who worked in our house making small clay figures of oxen, when I must have been about six. I found it quite easy to make things, and produced my first sculpture, which happened to be a skull, when I was about eight; I used to carry it round in my pocket as a sort of talisman. In high school, we had Walter Battiss, the foremost artist in South Africa, as a master, but it had been decided by the family that I would do Latin rather than art. So from then on, there was always a conflict – medicine or art – I wouldn't give up one for the other, and the conflict went on until I realised that the two weren't in conflict at all. I had to do both.

If you produced your first sculpture at the age of eight, that seems quite remarkable. How did you know what to do?

I don't know. I sort of just did it. My father had never had a formal schooling, but he believed that if you needed to do something, you just went ahead and did it. This was very important for me later with things like therapeutic experience, because when I actually started to work with psychiatric patients, one could get very little guidance from any of the consultants. They were mostly organic psychiatrists and had very little experience of talking to patients psychotherapeutically, so when I started in a psychiatric hospital, I discussed things with my immediate colleagues. We all helped each other, and that was a wonderful experience of learning without a competitive spirit, but rather with one of mutual enlightenment.

Contemporary registrars with me who attained high academic status were Professors Dick Cheetham, Fred Frankel, Lynn Gillis and Lionel Hersov. We unknowingly emulated the experiences Freud went through – in that we taught ourselves to hypnotise. At that time, there were still quite a few hysterics around, and we found that with hypnosis, you could get a severe hysteric who was completely unable to walk, to start walking.

It took further experience, though, to learn that severe hysteria is a much more serious condition than appears in the presenting symptoms, and several of these people from whom we had removed their hysterical defences subsequently became much more ill. For instance, one had a heart attack. In that way, we learned that there were unfathomable depths and layered defences in human personality. It then became clear that what might initially have been something of a gift or a sensitivity to unconscious mechanisms was insufficient; one needed formal training.

How did you actually start psychiatric work? Did you become a medical officer in a mental hospital?

I did my house jobs – medicine and surgery and some casualty work – and then was appointed medical director of the John Gray Community Health Centre. This was in the poorest white section of Johannesburg, funded by the money collected during the university rag. The director was Helen Joseph who gained fame afterwards as an anti-apartheid campaigner. So it had a certain prestige and research capacity and one of the specialists attached was Dr Wolf Sachs, who was the only practising psychoanalyst in Johannesburg at that time. I was one of the few male staff, with a lot of females, most of whom were psychologists or social workers. That year was one of an initial coming to terms with dynamic problems, both in the family and in the community.

What was the next stage of your psychiatric odyssey?

I was appointed as one of the first registrars at Tara Hospital, a fine house in beautiful grounds which was administered by the provincial authorities. This was quite new for psychiatry, as all the other psychiatric services were in large mental hospitals under central government aegis. Tara was a neuropsychiatric service, so that we registrars were trained in neurology, and in treatments for neuroses, personality disorders, and early cases of schizophrenia, such as ECT, insulin, and psychotherapy. Maxwell Jones came out from England, which fired our enthusiasm, so that we started groups of every description – small therapeutic ones, those where patients were responsible for administering their activities, and a large weekly group where one of the registrars met all 100 patients. One of the ideas I formulated then was 'group handling for nurses', the sisters being trained to conduct these with the nurses: one would act the role of the patient and another that of the nurse, in some difficult or aggressive situation. We imagined the

https://doi.org/10.1192/pb.16.10.593 Published online by Cambridge University Press

same thing must be going on everywhere else, and that everybody knew about it, so no-one thought of writing it up. It was all done again much later in England by people like Bertram Mandelbrote, who was a registrar at the Maudsley when I arrived, but there was no knowledge there that we had already done it.

Did you have experience of working in a large mental hospital?

Yes. One of the aspects of our South African DPM training, which was for three years, was spending six months at Weskoppies Hospital. I was given 800 patients from the chronic wards to look after, yet we weren't overworked. One visited the wards every day and did the notes and examination of patients, according to statutory needs. Within a short time, I found I was running the malarial ward, the dispensary, the insulin ward, and giving ECT and then I went on to take charge of more active units, including the forensic ward. The hospital was an active treatment centre, the consultants were friendly, and we all worked happily together. One of the pleasures at that time, being in my early twenties, was residing in my own house in the hospital grounds. Black patients tended the garden, where they secretly grew their own marijuana. I did a lot of sculpture portraits, both of the patients and staff.

At Tara, I had to deal with a patient who was one of the main broadcasters over the radio in the morning. At a time when there was no television, he would wake the whole country up with his sunny personality. Unfortunately, his voice was reduced to a croak because of an hysterical aphonia. He had suffered this twice before and had been given a last opportunity for treatment, with the understanding that if he didn't improve rapidly, he was going to lose his job. Through hypnosis, I tried to reveal the basis of his problems as quickly as possible, which fortunately was achieved. Waking up every morning, I would switch on the radio to see how the treatment was progressing. What I discovered with this patient, like Freud previously, were the limitations of hypnosis. In this case, the cure was based on the working through of the sexualised use of his voice, in an oedipal conflict.

In 1948, we were doing sodium amytal interviews at Tara with people suffering battle stress from the Second World War. I applied this experience to one of the chronic catatonic schizophrenics who hadn't spoken for nine years and who would stand immobile in the exercise yard, where he would be moved by other patients so as not to be burned by the sun. Yet within a few interviews, this man emerged as an apparently normal human being, who talked and assumed a completely different physical demeanour from when he was catatonic. He remained normal for a few days, and then slipped back. I didn't have the knowledge to keep him out of catatonia, and there was a very painful episode after my seniors decided that he be given ECT. We took him up for treatment and he literally fought like a wild tiger; the ECT regressed him right back into catatonia.

You seem to have had a very wide experience in psychiatry.

I feel that I was privileged in being able to be part of some of the major developments over the last five decades. We had many cases then of GPI, which were treated with malarial therapy, though it was being superceded by penicillin, which was only just beginning to be available. Insulin coma was a particularly awful treatment to have to give. It was highly dangerous and the nursing staff and I used to celebrate every morning with a particular feast – avocado sandwiches – when all the patients had come out of coma. There were times when you literally had to fight because a patient in deep coma had bitten off the metallic end of the airway with clenched teeth. The danger of death then was from suffocation, so one had to force open the locked jaw, extract the airway, put a new one in, and of course bring the patient out of the coma. When I was at the Maudsley later, on the insulin service again, Brian Ackner was in charge. He did the double-blind study on insulin coma which gave the *coup de grâce* to the whole thing. So, I was part of that as well.

There were experiences too in public duties. After I had gone back to Tara, I was asked by our superintendent to attend the inauguration of a mental health society in Pretoria. I was to get a lift with the Johannesburg Medical Officer of Health. Though I wasn't qualified yet as a psychiatrist, he insisted on me going, saying that I wouldn't have much to do except be present in case some little old ladies wanted to ask a few questions. Travelling with the MOH, we were laughing most of the way, until I asked him if he had the programme. This proclaimed the inauguration of the Pretoria Mental Health Society at the City Hall, under the aegis of the Mayor. The wife of the Minister of Interior and various speakers were named. 'Main Speaker' had a space opposite. I asked "Who is the main speaker?", at which the MOH said, "You are!". The laughter became a little hysterical on my part and a few minutes later, we drew up at the imposing City Hall, with the Mayor in his robes waiting to greet us. I was shown into a large assembly room, filled with men in dark blue suits who were looking very severe. I spoke about the work I had done in individual and group therapy, including work with the delinquents, and about the need for services for young people attempting suicide. What I then realised was that this was a politically determined meeting, at which the

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University of Pretoria was aiming to take over the mental health services, and that no-one from the Government service or from Tara Hospital had been invited, apart from myself. One of the things about growing up in a country like South Africa was that as a young man, one had opportunities like this. We quickly became very responsible and experienced clinicians with the confidence to deal with people.

How was it that you decided to come to England?

In South Africa at that time, most people wanted to have a European experience. I wanted to further my artistic work, make the decision whether I should go into art or stay in medicine, and also get more experience in psychiatry. So as soon as I completed my DPM requirements, I left home. I arrived in England in October 1951, rang up the Maudsley, and arranged to see the Dean. I found David Davies very kind and he arranged for me to see Professor Lewis. Of course, we had all heard of Aubrey as a most formidable figure, but he was also quite charming to me at first, though rather formal. In those days, I was a rather 'nice young man', fairly shy but wanting to get places, and the interview wasn't at all easy. He asked me what I had done and then what I'd read. In South Africa, we followed the Scottish model and our textbook was Henderson & Gillespie. I told him I had read that and a few other books, which I thought was really quite an accomplishment, but of course he said, "What else have you read?". I mentioned a book on personality, and when he asked me who the author was, I couldn't for the life of me remember! That made me feel an absolute idiot, though previously I'd been rather proud of having read it. He asked me what I intended doing, and I told him I wanted to go off for about a year, study art, and give myself a chance at that, but would be very happy if I could get a job at the Maudsley in a year's time. He said he wouldn't be interested in giving me one in a year's time, but would think of giving me one in six months. I agreed to that, spent a few weeks in London, and on the day I was to leave for the Continent, got a letter from him confirming the offer.

How was your French experience?

I arrived in Paris with some artist friends and went to the art school I had chosen, the Academie Julien, but that evening, I got the most awful news – that my mother had died suddenly. The shock was compounded by the fact that my friends had gone off. Then the school closed, as it was December, and I was all alone in Paris, unable to speak French. This was supposed to be the opportunity to discover if I had any creativity, but mourning was hardly the occasion for that. However, when the school reopened, I did some stone carving at the Ecole des Beaux Arts, as well as life drawing, and then travelled south – being at the first post-war Mardi Gras in Nice – and right through Italy, reading Freud in Florence in the morning winter sunshine, and on to Rome. There, I had a dream which seemed to resolve my conscience, because it said quite clearly – choose medicine. At that point, in late March, I decided to return to London and resume my psychiatric studies at the beginning of April.

So you followed Freud, who also I think had dream experiences relating to Rome?

Yes, these things seem to be significant in one's career. Starting at the Maudsley, though, was a very curious experience, because the atmosphere was so unlike what I'd been used to at Tara, with its warmth and feeling of working together. There was a most cold and distant relationship between everybody. I can remember sitting at a table with two senior registrars, neither of whom talked to me at all. A friendly American sat down, waved his hand at them, and said "Hi-ya fellows". They both looked up at him, said nothing, looked down again, and went on conversing between themselves. The idea at the time seemed to be that nothing that you could say when you arrived was worth listening to. You were really an infant, needing to be regressed, and after this treatment for a couple of months, you would start to learn what they wanted to teach you. I was on the Professorial Unit, which had two institutions through which Aubrey Lewis operated clinically; one was the Admission & Discharge conference and the other was the Monday morning conference. I am very grateful to him for one thing – he was one of the great teachers, if you could only learn from him – and what he taught me was how to think. I didn't know how before that, but I responded to this systematic questioning – the Socratic form, plus the Cartesian view that there is nothing I can be sure of except my doubt.

Later, as a senior registrar, one of one's important tasks was to prepare junior colleagues for the Monday conference. We developed the skill to think of every question that one could possibly ask about that particular patient, and this was where the thinking process came in.

However, I was due to assist Denis Hill with the DPM clinical examinations one day, when I got a call in the morning that my father was severely ill and that I should fly back to South Africa, which I did immediately. When I arrived, he was said to be dying of cancer of the lung. I didn't think my medical experience was all that wonderful, but there was one thing I could do, and that was to be like Aubrey Lewis and systematically go through and question everything that had happened to him. What we eventually found was that he only had a calcified mass, which was an end-on view of one of his vessels

in the lung. This had been misdiagnosed by the radiologist, and they had then given him deep therapy and burned his chest. In fact, what they took for cachexia was really a depression that he had developed with the prognosis, but in two or three weeks while I was there, he was completely cured. He would have died, I'm sure, otherwise. So that in clinical work, asking questions, and taking the history in detail, and going through it again, seems to be the most important thing you can do.

What were your other experiences of Aubrey Lewis?

In 1952, at the end of the year, the registrars put on their first pantomime. It was 'Dick Whittington' and was about a professor from Adelaide who sold his soul to the Devil for the Chair of Psychiatry in London! This was dynamite. I had been chosen to play the professor, which I did as compassionately as possible, but there was Aubrey sitting in the front row. He looked on with a smile, but deeply pained underneath, as I could see. This was given as two performances, on the Friday and Saturday nights. On the Monday, as I was Lewis's assistant in the out-patient department, I had to present two cases to him, and the whole staff waited to hear what he was going to say to me. As you can imagine, I was terrified. Aubrey came in, we saw the two cases, one after the other, and did the letters. He never said a single word about the pantomime, which I thought was quite extraordinary. I don't know whether he didn't know what to say or felt it was the best thing just to say nothing.

However, when I came to leave for a job at the Portman Clinic, and started in private practice, I 'phoned the Maudsley on the first day, to see if there were any messages for me. I was told there were two people trying to get hold of me. The first was the Professor, who asked if I was going to apply for the Chair in Psychiatry in Johannesburg. I asked him why he was asking me this, and he replied that someone else had asked him to be the referee for them, and he felt that if I was going to apply, he would rather be the referee for me. I was enormously pleased, but said that as I had to find time for both my analysis and my art, I had given up the idea of an academic career. The other person looking for me was David Stafford-Clark, who was referring a new patient – so both calls were very welcome.

What was the feeling toward psycho-analysis at the Maudsley then?

When I joined, it was highly ambivalent. I remember Aubrey asking me if I'd thought whether I was going to do analytic training. This was really a difficult question to answer, because I had already applied and been accepted! He said "Of course, you realise that you aren't going to do your work as well as possible, and it will interfere with you getting a Chair", and various things like that. But on the other hand, I had his support when I was doing psychotherapy with an extremely difficult patient – and of course, the Maudsley got some impossible patients to deal with. He asked me when I was going to present this case, and said he would particularly like to come and listen – as he did. Another time, he asked me if I wanted to be a senior lecturer in psychotherapy, but I said it wasn't something I was interested in doing then. The Maudsley experience was one where eventually one made many friends, at a depth of intensity that doesn't occur in other training experiences, and of course, so much original work was being done. I also worked with Erwin Stengel, a most eminent psychiatrist with an enormous clinical facility and a way of helping research and the writing of theses which Aubrey never had. He encouraged us, and in many cases, our theses were based on his own interests. He had a wonderful sense of humour, but with a very political twist to it. He used to give a clinical demonstration once a week; one particularly difficult man occupied over half an hour, making manifest each of his vignettes of clinical deviation. At the end of this, Stengel said, "Of course, you do come to the Maudsley for other purposes as well, don't you? Perhaps you could tell us about them." The patient said, "Well, I come up here to the psychology department, I'm one of Professor Eysenck's normals". Of course, there was enormous conflict between Eysenck and the analysts particularly. He seemed hell-bent on trying to destroy psychoanalysis, perhaps because he was trying to clear the way for behaviour therapy.

Did you have experience of psychotherapy with schizophrenics at the Maudsley?

Yes. I found that I could tolerate a good deal of anxiety from the patients, which perhaps many clinicians couldn't. Following the work of John Rosen, I spent up to five hours a day continuously with some severely regressed patients. I took one man into a side-ward, where there was a piano, and as we were talking, he lifted up the lid and tried the keys, but they were silent – it was a practice piano. He had been a most brilliant scholar, who knew several languages and everything about music, but practically nothing about the real world. He was in such emotional pain that we gave him one or two ECTs and later, he completely recovered; perhaps as a result of the psychotherapy he had, he could make the jump back to normality. At that point, he said to me, "The one point in the treatment when I realised that you really understood me was when you took me into that side-room with the practice piano, which was silent. You realised I was silent in quite the same way." These chance matters can have a considerable bearing with such patients.

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Have you any particular recollections of the introduction of the neuroleptics into psychiatry?

I was indeed present when neuroleptics were introduced at the Maudsley and also when Linford Rees was doing the first double-blind studies. With the introduction of chlorpromazine, we certainly could see how helpful it was for psychoses, and when double-blind trials were being done on the same set of out-patients with successive different neuroleptics, improvements occurred serially from each one, which seemed a bit remarkable. But some would relapse back and we didn't know at that time how long people would have to stay on such drugs, and that some would have to stay on them almost indefinitely. The Maudsley was always wary of sedatives or anxiolytics as 'wonder drugs'; routine serum bromides were still required when I joined the staff. Continuous baths were also preferred to drug sedation for mania, until more specific remedies became available. My later experience was of being involved with psychotherapy patients who required anti-depressant treatment. There was a school of thought that people should not be given any drugs at all, because it would interfere with the therapeutic process, but I was never of that opinion. I believed that the needs of the patient were always the first criterion , and if there was suffering, something had to be done to relieve it. In this way, some patients could make progress that they would not have been able to make in psychodynamic therapy if pharmacological treatment hadn't been available. Curiously enough, a group of analytically trained psychiatrists at the Camden Clinic, of which I was one, published the first out-patient controlled trial of Tofranil.

Shall we talk now about how your involvement in psychoanalysis began?

As I mentioned earlier, in South Africa I had met Wolf Sachs, who gave me some supervision. Just before leaving, I gave a lecture on group therapy in a prestigious Philosophy of Science series, which I then thought was my major interest. The Reader in Philosophy, Dr Yourgrau, very kindly gave me a letter of introduction to Anna Freud, so that I made an appointment to see her after I arrived. I remember feeling that I should be with her as little time as possible, because she was so important. When I returned to England in April 1952, I saw her again and applied formally for training at the Institute of Psychoanalysis. I was duly accepted after being seen by Winnicot and Mrs Hoffer, both of whom were masters at interviewing. After an interval in my formal training, I qualified in 1958.

The one thing that I recall was the enormous amount of work one had to put in. During the last year of training, one was required not only to be in personal analysis five times a week, but to analyse two people daily, as well as attend seminars most evenings. So the schedule ran something like this: I saw my first patient at the Institute at 8 o'clock. At 9.15 I had my personal analysis for 50 minutes in Chelsea, and then went to the Maudsley as rapidly as possible to start the day's work until 5 p.m. which, being senior registrar on a Professional Unit, was a taxing occupation. At 5 p.m. I would see my second analytical patient at the Maudsley, then have dinner rapidly, attend life drawing classes until 8 p.m. at the Regent Street Polytechnic, and then pop round the corner to the Institute of Psychoanalysis, where the seminar would run up to 9.45 p.m. This was quite an exhausting schedule over a year, and there wasn't much time for socialising or even for reading, which one was supposed to be doing. But somehow one managed.

Sounds like the life for a bachelor.

Yes. It was, but what happened in my case was that I intended to marry after finishing the full training and, fortunately, that worked out very well.

Shall we talk about the culture of psychoanalytical training?

What was most acute at this time was the rivalry between the various groups at the Institute, particularly between the Kleinians and the Freudians, with the 'middle group' or independents led by thinkers of their own. The original standard-bearers of these scientific theories were then present and very active. If you were presenting a patient to Melanie Klein, for instance, she would run riot over you. Then, if you took up what she was saying, as I did on one occasion, and presented another case in that manner to Anna Freud in the following week, you got into hot water all over again. It seemed to me that people coming from the Continent had a loyalty not only to individuals but also to a philosphical system of ideas, which was somewhat at odds with British pragmatism and with the eclectic approach with which I was familiar in South Africa. There were logical reasons for both points of view, once you accepted their premises, but at times one could be put in an invidious position through these conflicts.

Can we talk next about when you left the Maudsely?

If one had trained there, this was the springboard to the major step in one's career. I was looking for a psychodynamic institution in which to work, and so was very pleased to take a job at the Portman Clinic, which specialised in problems of sexual deviation and delinquency. There were notable consultants such as Harry Rubenstein, Edward Glover, William Paterson-Brown, and later Adam Limentani. I had already had experience in the delinquency field,

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working with Peter Scott, who had wanted me to stay in that specialty, but I felt it was too narrow. When I did my MD thesis on 30 cases of schizophrenics with obsessions, I found that if you wanted to do research, it was important to have as many suitable patients as possible. So I tried to restrict my Portman patients as much as possible to one particular type. Many patients had been sent by the courts because of exhibitionism, so I decided to use both individual and group psychotherapy for them. This turned out to be a very good idea because 1960 was World Mental Health Year and I organsed a national congress on sexual deviation at the Royal Society of Medicine. It was a great success and I was able to present the results of my studies there. This was followed-up with a book, with other British contributors, which was published by Oxford University Press in 1964 under the title, *The Pathology & Treatment of Sexual Deviation*, and it became quite a standard work in the field.

I did a review of it at the time.

Yes, I remember that. Fifteen years later, though, with leading world authorities, we produced what OUP described as the Second Edition, but which was really a brand new book called *Sexual Deviation*. My idea was that all the various approaches towards deviant sexuality would be brought together. But the analysts said there wasn't enough psychoanalysis in it, and the psychiatrists said it was full of psychoanalytic lingo, so that they couldn't recommend it. I think it was you who said "What are you worried about, when everybody's reading it and buying it?". I was very pleased when it was quite clear that it was being used as the basic text by very serious places of study all over the world. Now that another 15 years has almost finished, the question is whether to produce the next edition, because work doesn't proceed very rapidly in this field.

How did you find the process of editing books?

I had been spending a lot of time producing a major art exhibition, and hadn't given enough time to the book, for its second edition. When I did get busy with it, it seemed to take an inordinate length of time; many contributors wouldn't send in their material, though as usual, those of the highest standard were the speediest. One day, I received a telephone call from Phillis Greenacre, the doyenne of American analysts, who asked me what was happening with the book. She had already sent her chapter in, and now someone else had written to her, asking for a contribution on that topic – which was fetishism – for another volume. I had a fright with this, because I knew that if she withdrew her chapter, there would be no book and everyone else's work would literally go down the drain. So I promised her we would do things as soon as possible, and the book finally appeared. On a later visit to New York, where she entertained us to dinner, I reminded her of this. She said, "You know, I did it on purpose, just to buck you up." So distinguished analysts are not always people who just listen and never act.

In recent years, childhood sex abuse has become a very important topic. How did it figure in your work at the Portman Clinic?

From psychoanalytic work with adults who were abused in childhood, one knows that all such children should have access to psychotherapy. Psychotherapy with such adults is very time-consuming and particularly testing of the counter-transference. But the Portman Clinic emphasised that the abusers also require just as much treatment. Indeed, the whole family does, but where are the trained people who will have the skills to deal with these problems? The fact that many offenders who are sent to prison don't receive any treatment whatsoever is disturbing, because there is evidence that in selected cases, one can achieve life-saving results. Magistrates and others involved haven't sufficient knowledge that offenders who go into prison may re-offend, and that this is part of the acting-out before such behaviour can be dealt with in a therapeutic relationship. A great deal of education is still required in the field of sexual deviation. We do know that sexual behaviour is the final result of a complicated pathway in development, which has biological as well as psychological and social determinants, so that we shouldn't fool ourselves with any simplistic approaches. We also have to face the fact that the scene has been affected by the politicising of homosexual attitudes. One of the points I have tried to make in TV broadcasts such as Channel 4's *Comment* and the *After Dark* programme is that young people with homosexual behaviour should not be made to feel that they have a fixed homosexual identity, but should have the opportunity of psychotherapy to be given a 'second chance' to mature in relationships and sexual preference. Of course, we have to be tolerant of all people, but still recognise as psychiatrists and as scientists that we have a right and a duty to understand the psychopathology of people with every type of sexual behaviour, including the normal, and to help where we can.

Did your first consultantship involve both the Portman Clinic and other places?

I received an appointment to the Camden Clinic shortly after I joined the Portman, preferring to keep my interests as broad as possible. The Clinic was a small house on Camden Road which originated under the name of The British Hospital for Functional Nervous Disorders. It was the first psychiatric

https://doi.org/10.1192/pb.16.10.593 Published online by Cambridge University Press

out-patient clinic in England, and was set up by private subscription. We were happy doing general psychiatry as well as psychotherapy, but some years later, were amalgamated with the West End Hospital for Nervous Disorders and the Paddington Hospital as the Paddington Clinic & Day Hospital, in Harrow Road. We had a very prestigious start, but were subsequently run down in number of consultants, and in 1974, the option came up whether or not we would join St Mary's. As the only consultant left, I became chairman and had to deal with a most hostile group of professionals. We decided, however, that we would try to make a go of remaining an independent clinic, and were able to appoint some experienced consultants. However, the staff in the Day Hospital had what they regarded as their own particular brand of treatment, which finally culminated in a legal tribunal examining the work of the consultant concerned. I spent five days in the witness box, having my whole administration put under the microscope.

Does that cause célèbre *have any general lessons for the question of consultants' responsibilities?*

Yes. I think that a consultant, although responsible for his own work and acting according to his own judgement, should nevertheless still be responsive towards the attitudes of his colleagues. There is a very fine boundary between clinical freedom and abuses requiring collective responsibility for patient care. Where a specialist psychotherapeutic function had been adopted, some psychologists, social workers, and nurses at the Paddington Centre were loathe to accept a medical consultant's responsibility for their work. They felt they had sufficient training to be fully responsible for their psychotherapeutic way. This applied particularly to social workers, but the administration refused to grasp this nettle, because they did not want to make a judgement between the medical and social work staffs. This remains an unresolved issue.

From your experience of the Paddington Centre, what do you feel about the relationship between psychiatrist and administrators?

Having avoided absorption by St Mary's Hospital in 1972, the Paddington Centre came under heavy fire by the district administration as an easy target by which to save money. After three experiences of almost being closed down, we became more adept in showing ourselves to visiting assessors, so that fear at having to reveal our clinical work gave rise to a more confident outlook. The administrators then became personally involved in understanding psychotherapy and turned into staunch supporters. I think we were among the first NHS clinics to practise modern techniques of survival. When under threat by the administration, it was important, firstly, to target and reveal the anonymous individuals in the administration who were responsible for decision-making. The second aim was to arouse professional and public opinion, whose weight was brought to bear on the administration. Because of our excellent relationships with local bodies and services, they gave active support and enlisted other institutions such as the House of Commons. In a situation where the administration wasn't really interested in whether one service or another should continue but where they had to save money, they were often swayed by the weight of such opinion. The effect of the losses and the pressure to survive wasn't wholly negative though. We had to show statistics on the number of patients that we were treating, and having a high ratio of consultants to junior staff, we discovered that we could give supervisory training in psychotherapy to honorary therapists, who would then treat the patients and so help many more than the staff could alone. Sir Keith Joseph, as Minister of Health, complied with my request that the Paddington Centre for Psychotherapy be recognised as a psycho-analytic clinic within the NHS.

You have had a lot of involvement over the years in the fields of public education and the media.

Yes. This began rather early in my career. In South Africa, we were encouraged to look at the wide implications of psychiatry, particularly through the activities of the National Association for Mental Health, as well as having more direct contact with the public. Before I left, I had organised the first series of radio broadcasts on psychiatry, which did something to reduce its stigma at that time. While at the Maudsley, I became a founder member of the Public Information Committee of the NAMH, and appeared as the psychiatrist in one of the earliest television series, *Fantasies of the Night*, on understanding dream interpretation. Later, I was privileged to take part in some of the prestigious productions such as *Life-line* with people like David Stafford-Clark, and created TV programmes for BBC 2 *Horizon* on sex education, violence, and particularly with the production of a documentary of one of Freud's cases called the Rat Man. This had an interesting origin, commencing with a letter from Anna Freud stating that she has been approached by the BBC about a documentary on the Rat Man and would I please deal with them, which I took to mean I should refuse on her behalf. Some unconscious ambivalence was expressed in a simultaneous letter to the BBC, referring them to me as being very experienced and able to give them every assistance. Bruce Norman, the BBC producer, came to see me and within a fortnight, we had a shooting script prepared from the very complicated material. One

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had not only to make the analytic process intelligible, but also invent Freud's dialogue with the patient. The BBC then realised they didn't have Miss Freud's official permission. I declined to act as intermediary, so that when the BBC approached Miss Freud directly, she replied with, "Didn't Dr Rosen tell you that I never give permission for such things and that the answer is no?" The BBC were aghast because they had already sunk £10,000 into preparing the sets. Eventually, she gave permission for the production, with the condition that a disclaimer appeared at the end of the film, stating that it had nothing to do with her or her family! Her attitude was based on Freud's notion that the complexities of psychoanalysis would be over-simplfied, and therefore corrupted, by the mass media. The film, in which Edward Fox (of *Day of the Jackal*) played the patient, went on to win many awards. It is an excellent teaching aid for the understanding of this case, in which Freud unravelled the psychopathology of obsessional neurosis from a psychoanalytic point of view. Later in the year, I presented the film in New York to a meeting of the American Psychoanalytic Association, where it was very well received.

Why do you think almost all analysts in this country live in North London?

I must preface my reply with the experience I had when I first arrived in England. Out of choice, I wanted to live in Chelsea – probably because of the romantic associations of the district – but then rented a room in North London because I was told all the analysts lived there. When I eventually went into analysis, I had to travel daily to Chelsea, where my analyst lived! I don't think we really know why they all live in North London. It's a very beautiful area and was where Freud settled initially. But perhaps the main reason is that it's fairly close to the Institute, so that analysts would naturally tend to live nearby.

Of course, all this time, there had been another side to your life, which was your artistic activities.

Yes. I decided I would always continue them as best I could. As a student, I had already done two medical busts – one of Lister and one of John Hunter (which is now in the Royal Society of Medicine). When I came to London and was appointed to the Maudsley, having come directly from Rome where I had been studying Michaelangelo's Moses. I thought it most appropriate to do a head of Henry Maudsley. Professor Lewis supported this, and I think he may have paid the £50 which it cost to cast it in bronze out of his own pocket. This is a very large head with its flowing beard; it's one and a half times life-size. I had the opportunity to do the work at the Royal College of Art, because one of their prize-winning young painters had developed a schizophrenic illness, was admitted to the Maudsley, was put under my care, and made a very good recovery. As a result, I became friendly with one of the professors of painting, and hence the *entrée* to the College.

One Saturday afternoon, when the College was closed during the summer holidays, I was busy casting the Maudsley head. I was pouring plaster into the negative mould to form the positive cast. The mould was delicately balanced on a chair, and as I was turning it and swirling the plaster around inside, it somehow managed to slip off and crash onto the floor – which I thought was the end of the Maudsley head. I was going to the theatre that evening and was in rather a hurry, so the only thing I could think of was to take some string, tie the two remaining halves of the negative mould together, place the shattered pieces together as best I could, and pour in the rest of the plaster, leaving it to set and hoping for the best. In fact, it turned out perfectly, except for a small bit missing at the cranium, which I was easily able to remodel. The following year, the head was honoured with the most prominent place in the Sculpture Hall of the Royal Academy Summer Exhibition.

How do you combine an artistic career with a clinical career?

I think one gets urges, ideas that one wishes to make into reality – whether it be a sculpture, a drawing, a painting, or a scientific paper. It's the strength of wish which really forces one into action. You never find the time for creative activity, you have to make it. Of course, you have to work harder. When I was a houseman, we used to work from 8 in the morning until 6 in the evening, as well as completely through the night on two evenings a week, including working through the next day. I would come home from the hospital, have my supper and work on my sculpture from 8 o'clock until midnight. I always had a lot of energy and feelings of dedication and pleasure in what I was doing. My most difficult time was in 1973–74, when I was concurrently chairman of the Paddington Centre, running a busy private practice, and spending every spare moment preparing over 100 new works – stainless steel sculptures, paintings, lithographs and etchings – for a major exhibition at the Camden Arts Centre. During the year, I did the catalogue with its essay on creativity and a lecture at the Tate Gallery on the Psychology of Richard Dadd. Of course, I was very tired at the end of it and took quite some time to recover. Even if I had only ten minutes to spare, I could go up and do some work on a sculpture or drawing, and each activity would somehow freshen me for the other.

When you are working under that sort of schedule, all sorts of remarkable coincidences occur. This is an area I am researching at the moment, but which we

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don't take a lot of cognisance of as psychiatrists. I think that in research, whenever one has coincidental experiences they should be recorded, much as one would record experimental observations, and at the same time, one should try to record one's inner feelings about them. I believe that if you recorded these, you would find that the experience of coincidences would go on day after day, sometimes for weeks, particularly if one had a 'creative phase'.

Professor Lewis was apparently said to feel that the head of Maudsley was like his super-ego outside his office, and was very pleased when it got moved to the Institute of Psychiatry! I also did the bust of Henry Reay for his retirement from the Maudsley; he and I had shared rooms in Harley Street for years. There's also the head of Dame Betty Paterson in the Paterson wing of St Mary's, named after her as Chairman of the North West Thames Regional Health Authority – a most gracious lady, an expert administrator, and very reminiscent of the Queen Mother. She arrived for the first sitting at my studio with her chauffeur bearing her television set. She didn't think she could just 'sit' and in any case, she wanted to watch the snooker! In fact, though, we dispensed with the television set and initiated a most wonderful series of discussions. There are many modes in which art, psychotherapy, psychoanalysis, and psychiatry function in common. A good portrait isn't merely a likeness produced by looking at the person; something mysterious happens when your hands create an image in a different medium. A whole communicative process occurs, ranging from the perception of the person to the final aesthetic proportion and expression. The meaningful portrait is the resultant image of the relationship that is set up between sitter and artist.

What about people who are dead, like Henry Maudsley?

He was really prettied up for his portrait. I had pictures of him, and the wonderful inspiration of Michaelangelo's Moses helped to give some embodiment to the spirit and idea of the man, as well as to the idea of the Maudsley Hospital. It was a challenge to make mature interpretations of both Maudsley and Stengel, some 40 years later, which Lundbeck Pharmaceuticals presented to the College for its 150th anniversary.

I have been fortunate in the quality of sitters I have been commissioned to portray; for example, the bust for the retirement of Professor Dorothy Stuart Russell from the chair of morbid anatomy at the London Hospital Medical College. I felt I was in the presence of a remarkable personality and that it was important to capture her evident femininity, which she had preserved in what was originally an all-male preserve, as the first woman consultant to be appointed to the hospital. She took me to the window of her office, from which we could see a sign – 'Mission to the Jews'. She explained that having had to work so hard to overcome the traditional prejudices against females in medicine, she felt a sense of identification with the Jews.

Do you feel there is an artistic side to psychotherapy?

I certainly do. Good psychotherapy is essentially a logical and aesthetic pursuit of understanding and togetherness, much like an artist in realising an inner vision. It's part of an 'aesthetic' approach when one takes a good history, revealing an image of the balance of forces within that individual. I liken this process to the uncovering in a good anatomical dissection, where, like a good sculpture, the planes are in correct perspective. One can be either very sensitive or not to how the facts relate, particularly to those areas which are silent and require further elucidation. At the end of a diagnostic interview, one can have an 'artistic' appreciation of the make-up of the personality and of the problems and relationships of this person. When it comes to therapy, the balancing becomes more complex, because correct timing of therapeutic interferences has to be taken into account. These may be in the nature of imparting understanding, reassurance, or explanations linking unconscious material with transference relationships. Of course, therapeutic interpretations are most potent where one demonstrates to the patient patterns of behaviour which have occurred in childhood, in the present reality and in the transference relationship, and their relevance is clearly communicated and understood, leading to intellectual and then to emotional insight. That to me is an artistic process, and its imparts the same pleasure to therapist, patient, or artist.

What about the relationship of dynamic aspects of the mind to the organic structure of the brain?

I have a very good case illustration on this point. When I was appointed to the Camden Clinic, I inherited a lot of patients who had been attending for a long time. One particular man, who was into his middle 70s, was a depressive and suffering from what appeared to be arteriosclerotic difficulties, in that he was very forgetful, but just able to find his way home. We became friendly and he started to tell me about factors in his early life. He related how, as a boy, he had come from school and when he met his father, he mimicked another boy at the school who had a stammer. His father objected to him imitating the stammer, though, and told him to stop it; the boy took fright and couldn't stop stammering, at which his father struck him to the ground and he had stammered ever since. In fact, he stammered while telling me the story. A few sessions of working through the affective aspects of this traumatic experience resulted in his stammer disappearing. He remarked how sad it

https://doi.org/10.1192/pb.16.10.593 Published online by Cambridge University Press

was that he hadn't had this sort of help early on. He used to play the piano in a bar, had a good singing voice, and would have loved to sing there, but he couldn't because of his stammer. In this elderly patient with organic brain damage, the repressed affects were still dynamically available in the unconscious, and his life-long symptoms could be relieved by simple, compassionate psychotherapy of the kind every trained psychiatrist should be happy to do.

How do you see yourself working in the future?

I am engaged in projects which integrate my various activities and experiences. The most significant of these will be an exhibition to be held at St Paul's Cathedral in London, of 'The Holocaust Chapel and Sculptures', where three full-size bronze figures depict Christ as a Jew in the Holocaust, as a symbol of Nazi atrocity, and as representing the need for universal religious tolerance.

https://doi.org/10.1192/pb.16.10.593 Published online by Cambridge University Press