DAVID CLARK

Your father AJ Clark put receptor theory on the map.

Yes well, as regards receptor theory I have nothing of significance to say. You may have gathered that from the book. My father was an austere and brilliant man. I knew he did things up in his study and wrote books. It wasn't until years later that I discovered how important the motor action of drugs on cells was. He died when I was 21. We talked a lot about many things and I knew his views on life but we never talked about his work.

Since he died you must have had a whole range of people give you views on his role in the field how he brought all these ideas together?

Not all that many no. Of course there were one or two people who had known him but I moved into quite another field. It wasn't really until I started that book that I had to ask myself what did he do. What do I know about what he did? That's why I got Frank Lesser to write that piece because I'd realised that I just didn't know enough. Frank Lesser was a strange little man. He approached me sometime in the late 70s to say that he wanted to do a thesis on the development of the thoughts of A J Clark. I told him what I could and he trotted off and he did all kinds of researches, in all kinds of archives and he finally produced a piece. I don't know if it was actually published. He was an interesting character himself - he had been a member of the International Brigade in his youth. At one stage in his life he'd lived in Romania for three or four years and so on. But he was a non-medical man a research pharmacologist. He died a few years ago. That's why I got him to write that piece in the book - as far as I could gather he understood it.

The other person I asked was my old friend Guss Borne. He's still alive and well and he like me was a student of A J Clark's but he became a research pharmacologist so I would have thought there might be some value in talking to him. I'll give you his phone number and his two addresses. Guss was my best friend as a medical student.

What about the department - there were people like Condon there who apparently swore by your father and made life difficult for anyone else who came after him who couldn't fill his shoes.

Yes. Condon was an archetypal cockney - smart, street wise he was one of these brilliant technicians who could make anything with his fingers and make it work. He invariably referred to the Prof.

I was born in 1920. We lived in Welwyn Garden City at that time and father disappeared to London that's all I knew. Then we moved to Edinburgh and gradually as I got older he used to take me down to "father's lab". There was a phase in my natural history studies when I decided to take up taxidermy and I wanted to stuff things so he arranged for me to go down to the lab on Saturday mornings to do my thing. As the professor's son, I was indulged by Condon. For instance at one stage I remember I wanted to learn how to do glass blowing and Condon taught me and so on. There were various people who worked with my father who came to the house so I got to know them in particular Charles Scott who became almost an uncle to me and A C White. I

happened to be looking the other day at one of my books that was given to me as a Christmas present by A C White.

My mother developed tuberculosis when I was about 12 and she was more or less an invalid from then on so there was very little social life. My father didn't mind this really. All he was interested in was his work. So I had a good lively adolescence but I didn't have that business of the parents' friends coming to the house and getting to know them and so on. Except Charles Scott and his wife. They came on holiday to us, they were into hill walking and mountaineering with father.

I went off to Cambridge then, came the war and I decided I should finish my medicine in Edinburgh. I came back and I went straight into my father's class and I attended this lectures all through one term and then that summer he died. So I know about him as a student saw him. I have a pretty fair idea of how he was seen by the other professors and I've got a view on what he was like as a departmental head.

The students had great affection for him. There were plenty of professors they didn't have much affection for. They felt he was a pleasant kindly man. He had a style of lecturing where he would start a sentence about three times as if he was looking for what to say. It irritated those who tried to take coherent notes but pleased the others. And he was reckoned to be a fair man in exams and that sort of thing. In Edinburgh in those days there were a couple of hundred students and you really didn't have any particular contact with the professors. He'd wander around when we were doing practicals and watch what we were doing for them and he always liked to be asked out to student parties and that sort of thing.

My impression was though that father did his own research and other people came and went. In no sense was there, as I've seen in other places since, a big department full of people and the professor co-ordinating and leading their work and that sort of thing. They were doing their research and well good luck to them. His social group without any doubt were what you might call the medical biologists, the physiologists in particular and the biochemists. The Eggletons - these were an interesting couple who were both biochemists and they became great friends of parents. When my parents went away to South Africa on a long trip they came and looked after us. They definitely became aunt and uncle. There was Ida?? Daley, who was the professor of physiology. There was a man called Stuart who had been a calculating prodigy - he had one of these mathematical minds. I know they used to like talking about mathematical problems. In those days the New Statesman used to run a puzzle every week which was an intellectual mathematical one. They'd discuss these.

There was a staff table in the Students Union and he used to lunch there daily. And of course he was a member of the Senate and he got on quite well with the principal a man called Appleton, who'd been a very senior engineer in the Indian Civil Service. For the rest in the sense, that little collection of obituary notices in the book does give the flavour of what people felt about

him. Frank Crew who was a debonair character who was professor of genetics, wrote that he liked him greatly. What Adrian said is interesting. Adrian was not only the greatest brain in that field but was meeting everyone. Another great friend of his from student days was Edward Mellanby, who was the secretary of the Medical Research Council. Father did two long spells on the MRC all during the 1930s when he was going off down to London for meetings. They'd been students together at Cambridge under Dixon in the wonderful new field of pharmacology, which was just emerging from 1905 onwards.

Dixon appears to have had a big impact drawing people into this area.
Curiously enough nobody has ever talked to me about Dixon. I mean the one person from his student years my father mentioned was Joseph Barcroft, partly because Barcroft was a young Don at Kings and he had been a Quaker and so I think my father identified with him. Barcroft was still teaching when I was a medical student. He delivered a sheep in the physiology lecture room by caesarean section, which really excited the students.

I never remember a person turning up at home who had been a friend of my fathers at school or university or in the army. Whether it was because of his very high intelligence, he was essentially a lonely self-contained man. Courteous and friendly but he didn't need other people very much.

When he came to lecture you on how drugs worked, what was the approach – did he focus on his own work only?
He lectured from his book. His great passion was the medical students. He wanted to wean them from elegant prescribing in Latin. I mean there were still quite a lot of our teachers scribbling it all elegantly and for them we had to know about minims and so on. He was pushing us to use metric amounts against quite a bit of opposition. I mean all our clinical teachers taught us in Imperial. There was this tradition that a doctor ought to be able to write a prescription that the patient could not read, the local chemist could read which made the patient feel better and contained nothing that would do any harm and unlikely to do much good either. He inveighed against this. You should either give something that was going to have a desired effect or not give anything at all. As I moved into practising medicine and so on I realised that though that was an excellent scientific notion, a large number of people in distress who have gone to see someone called a doctor want to be given something and if it's given with a little magic too it may do quite a lot of good. It will certainly ease their distress. But he would have nothing of that at all.

In that year there were two lectures that all the students loved and that people who weren't members of the year or the faculty would try and get in on. One was Sydney Smith's lecture on rape – which was absolutely packed with wide eyed Scots lads, as you can imagine and the other was father's lecture on alcohol. He had a lovely slide copied from some American thing about the various stages of drunkenness. Which since we were all actually experimenting with drunkenness we found absolutely fascinating. He had a dry humour - he'd chuckle with pleasure at the stupidity of people. One of his great stories was that one about homeopathy. The homeopathic prescription

would ensure one molecule in a volume the size of the orbit of Neptune. So they learned lots of little quirks like that.

There was always this feeling, in the home too, that he was kindly and slightly amused about how silly people were. He never showed strong emotions of any kind. I never saw him embracing anybody or kissing my mother. I think I once saw him get angry. It wasn't part of him. This was part of the Quaker tradition obviously. But I mean there are plenty of passionate Quakers.

He must have got a bit worked up when they produced the pamphlet about patent medicines.
He did. Quackery was something that he really disapproved of terribly strongly. What he said was quite reasonable and the Medical Defence Union said they'd back him and the BMA said they'd back him and they were all set to do it. And then they talked to the lawyers and the lawyers said Professor you haven't got a hope. What you've said about the man that's attacking you will destroy his livelihood and that is the most serious from of libel.

Surely the defence of fair comment would save him.
They gave the classic legal thing. If you say Mr Bloggs the butcher is an adulterer and a fornicator, he can't sue you for libel but if you say Mr Bloggs the butcher puts dog meat in his sausages he could sue you and even if you prove it's true he may well win because you are being malicious in trying to destroy his livelihood. He was all set to go ahead and lose his life savings if necessary but they said no it isn't any good we'll just have to back down. What he did was he made a statement to the court that in these remarks - he didn't withdraw the remarks - he wasn't referring to this particular nostrum. This was in fact a man who'd brought a number of successful libel actions. He was a person who'd learnt that you could use the libel laws to screw people and get money from them.

One thing that certainly has changed now is this. There was a law passed, I think just before the war, saying that you could not advertise your medicine cured disease. I think that's what stopped that particular thing. The adverts for quack medicine changed and now they are very cautious.

In your book, you hint at how the action of drugs was viewed before receptor theory.
Well he certainly talked to us about cells. Many of the medical students in Edinburgh in the 1930s found that his little summaries at the beginning of his chapter gave them a better idea of biochemistry and physiology than all the lectures they had from Daley and his colleagues in the years before. He always started off from "these are the cells and what do these cells do etc. - the functions of the CNS, the metabolism of the CNS and things like that.

But if the drugs weren't acting on receptors and he was one of the few people at the time who thought they were, what was the dominant view at the time?
You're asking me what I remember about something that I wasn't terribly interested in 60 years ago. He wrote his book in the early 30s so by the time

he was lecturing to us in the early 40s it had been in his mind for 10 years and so I'm sure it would have leaked through in some way but I have no memory of receptors being mentioned. I would think they almost certainly were. And again as you know a professors job in teaching ordinary dim minded medical students is to hammer into their stupid little heads a few things and not to bother them with advanced theories. And he took that very seriously. He always said that we are the gatekeepers and the question always is, is it safe to let this young man loose on an unsuspecting public.

One part of family life was that once twice a year father would be seen with great bundles of paper. He would retire up to his study and come down bad tempered the following morning appalled at the stupidity of the answers that were fed back to him. One exchange that I do remember is this. One morning at breakfast he said "Morons they are Morons" and my mother said no dear they are not Morons they are stupid people. I have taught Morons and I know what Morons are like.

How about Gaddum did you have any contact with Gaddum who came after your father.

I have very mixed feelings about Jack Gaddum and I'll tell you why. I had quite a bit of dealings with him because he took over my father's department. When my father died he was in the process of writing the third edition of The Mode of Action of Drugs. In fact one of my first duties after he died was to go up to his study because the piles of manuscript chapter by chapter were on chairs all round the room. I had to sort of collect them all up and I gave them to his devoted secretary, who typed them all out. This was his great work and here he was going to say new things about it. So this was a very precious legacy. We asked Gaddum what we should do about it and he said he'd very much like to work this over and to publish. So we gave it to him. I got on with qualifying as a doctor and then went off to the war. Some two or three years later, Gaddum returned the manuscript to us saying he was terribly sorry but he hadn't been able to find the time to do anything about it. Charles Scott was terribly angry. If only we'd had it in time, we could have published it as a special edition of the Pharmacological Journal.

But it was lost. The manuscript still exists. It is now lodged in the Royal Society. Intermittently over the next 30 years or so I used to show it to people and they'd say well you know it's fascinating to see the way his mind worked but most chapters start off delineating a problem and saying things must be done to look at this and then say Do Experiments. So there it is. I felt let down about that.

The other thing was that my father had built up a personal professional library including Heffter's Handbuch which in those days came out yearly and he had a complete run of them. They were worth hundreds of pounds even in those days. These were in his study and Gaddum asked could they remain there so that the department could use them. My mother said well yes they were no good to us – even though we were advised they were really quite valuable. Then about three years later, Gaddum rather hangdog came to my mother to say he was terribly sorry but they'd just discovered that one of the lab boys

had been filching the books and selling them off to the book sellers in Edinburgh and there was hardly anything left.

Gaddum came down to Cambridge of course after that. I used to see him occasionally socially. His wife was something psychiatric - I can't remember it was so long ago. But I seem to remember him as a little man physically. Daley was a big booming man with a sort of flamboyant colourful charismatic style, Gaddum wasn't. He was a little man. I don't remember much else about him. 5'6"/5'8" dark hair, thin face. I last saw him 40 years ago.

It's odd that he worked in the same area as your father – receptors.
Oh there were people who whispered that all he wanted was the manuscript to take the ideas for himself and that he had no intention to ever publish it. I don't know whether that was true or not. I can't remember who it was but somebody said that. But ill-tempered malicious gossip amongst scientists is nothing new to me. Most of the adults I met were other scientists and I heard lots of gossip about them and their politics and how their politics intermingled with their science. The figure who my father used to refer to as JB's mad cap son Jack – JBS Haldane - they were about the same age. He'd known JBS Haldane when he was a mortar officer in World War I. Both of my parents were left of centre position but found both communists and the pacifists irritating and unsatisfactory though many of their friends were amongst them.

Lets move onto your own work. You went into medicine. Why did you chose psychiatry?
Good question. I'm just currently working on a little manuscript about that. As you know, as a medical student in your clinical years you get a whiff of all that's medicine. And some of you say I'd like to do that. And others you think oh my God no way would they ever get me to do that. Dermatology and the venereology aroused that response in me and various sub-specialities of surgery.

Now our professor of psychiatry was D K Henderson. His lectures were outstanding. They seemed to be about people. They were humane. I was very impressed by them. I thought well who knows what I might be but I might become a psychiatrist. My focus was quite clear in those years. The War was going on, my job was to get qualified as soon as possible and get into the army and to do battlefield surgery. Well I did. I had the romantic notion that I was not going to survive the war, quite convinced of that. When I got a permanent girlfriend towards the end of the war she said what are you going to do after the war and I said I don't really know. Let's wait until the war is over. I later wrote an account of my war time adventures which were quite considerable.

Then suddenly it was all over and I was still alive. So I then had to think well what do I want to do. I was whisked off into the Sumatran Jungle for a while and then various other jobs to do in Java and in Palestine. I was beginning to worry a bit. I thought I'd never done a House Physician job. I thought I must come to terms with medicine and then at a party I met Bob Blier who was the overall corps psychiatrist, when I was just kicking my heels in an artillery camp

with nothing to do. My medicine was all over in 20 minutes in the morning and it was just flat feet and dobiage. He said would you like to come and work in the hospital? I said, what a real hospital with real patients. He said yes, we've got a little psychiatric unit and we're really rather short of staff. At the same party was my very old friend Bobby Marquise who was the ADMS at that stage and so Bob went to Bobby and look can I have David for a few months. And so I went to a psychiatric unit in a British General Hospital in the middle of Palestine. For three months I did psychiatry there and I found it absolutely fascinating. From that point I decided that psychiatry was for me.

An awful lot of the social psychiatry after the war came out of people doing battlefield psychiatry. Why?
Well various reasons. One thing was as a psychiatrist in the army, you could change a person's life radically by administrative action. If you recommended that he be put on to non-combatant duty, you'd get him away from the guns that were terrifying him and get him into a situation where he could be some use. If you wrote that this person is simple minded and should not be allowed to have a loaded gun, they'd put him in an unarmed pioneer core. The army was packed full of misfits. You know people were pulled in and just shoved somewhere. Many people of course did very well but a certain number didn't and they were sent to psychiatrists and one was able to do a great deal of good for them. So the first thing to realise was that many people were miserable because of the circumstances they'd landed in and that in the army at any rate you could change the circumstances.

Another thing of course was the whole certainly for me the awareness of the problems of morale. I mean the classic thing for example was that it used to be said in Burma that if the VD rate in the battalion rose too high, the general shifted the colonel because he knew that somehow or other the morale in that unit had gone rotten and they were all getting VD. There were all sorts of things like that. I saw the effect of inspired leadership and bad leadership. That certainly was something that very clearly informed me when I went to Fulbourn. Fulbourn was in a pathetic state as a result of lamentable leadership. I realised in later years that one of the things I brought to Fulbourn without meaning to was a modicum of efficiency of administration. This had made a major difference to morale of the place.

Then of course there were a number of people like the Tavistock group - Sutherland, Israel, Bion, Max Jones, Tom Main and others who in fact during the war were doing social psychiatric experiments, which were working exceedingly well. So there were a number of people after the War who had found that social psychiatric measures worked prodigiously well.

I would say that there were a number of routes that led to social psychiatry in the 50s and 60s but a very considerable part of it was that there were a number of youngish men who'd been in the forces and seen the power of social factors, both to do good and to do ill.

Who were the people who shaped social psychiatry after the war. Maxwell Jones gets held up as one of the icons.

Yes he was. If you'd met him you wouldn't ask that question. Max became a very close personal friend of mine. He was a man with tremendous charm and charisma. It wasn't all softness. He was one of those puckish characters. He was always asking you questions that you never expected that threw you off balance and then forced you to look at aspects of yourself you never thought of. And he'd do it with a twinkle and a grin. All of us loved Max and many of us went through phases of hating Max because he could be quite beastly too. He was a far more colourful character than anybody else in the field. And again in the 50s, Belmont was quite unlike anything else in psychiatry. Going down there, blew your mind away. Here was a place where doctors, nurses, psychologists, patients all dressed the same. All called one another by first names and were open with one another, which was quite inconceivable let's say in the wards of the Maudsley, where doctors wore white coats and nurses wore uniforms and this of course was even more so in the old asylums which were still run as quasi-military organisations, like prisons.

But George MacDonald Bell the superintendent at Dingleton Hospital in Melrose opened the doors there in 1948, five years before the tranquillisers. It was an incredible achievement. This was several years before Rees and Macmillan opened their doors. He was a lovely passionate man. He wrote one or two articles about his work. I went and visited him at Melrose I knew him. One of the fascinating things about Melrose was that Bell was there and then there was somebody else and then Max Jones went there and did all his things in the 1960s.

In your unpublished manuscript Learning My Trade you describe an episode where a hypomanic doctor is brutally restrained and dies in the process. This graphically makes all these aspects of history live in a way that's quite different to reading about asylum brutality in history books.

That was one of the most dramatic episodes but of course there were plenty of other incidents of brutality when I knew or suspected what was going on. Having been in the army was a considerable advantage. You see in the army you had to learn to lie. You lied to your superiors. Your inferiors lied to you. One of the things that frequently happened is they'd tell you a lie and you know they're lying and they know you know they're lying. So you have to work out how to produce a certain effect. It's like the famous remark of one of our magistrates "we find you not guilty but if you ever do it again you'll be sent to jail for five years".

I had to learn to operate with that sort of system in the army and one used it in the hospital. "There are too many people having black eyes from bumping into the corners of doors, Charge Nurse. If this happens much more I think we'll have to arrange for you to move to another ward".

There is one thing travelling around the world I learnt. If any society decides to put a lot of people it doesn't like in an Institution and then pays people to look after them and doesn't pay them enough, brutality will inevitably occur, its as simple as that. I've seen it in one land after another.

There was a condition that was reported at the turn of the century called Asylum Ear. It seems to have been a type of cauliflower ear from being boxed around the ears but few people are aware that that was the origins of it. They wonder what on earth this was.
Well there were a certain number of fascinating asylum syndromes. The epileptic personality was the one that always fascinated me. It was described in the old books as a lachrymose, religiose, lying, devious, parasitic way of behaving, which was part of epilepsy. But it wasn't epilepsy. It was a simple mind coping with an intolerably oppressive system.

What about the drug treatments – the barbiturates. Were epileptic personalities relieved by the advent of agents that were less problematic?
Yes I'm sure to some extent. But the thing was that in every asylum there were a certain number of people who found themselves a slot. I remember the man who was the scorer for the cricket team in Fulbourn. There was a hospital messenger. There were people of that sort and very often epileptics got these jobs and kept them. They were sly, simple-minded people, who'd been dumped in the place. They had no hope of anything better - their families wouldn't have them back and so they worked themselves into a tolerable situation. Most of them by that time were very rarely having fits – one fit a year or something like that.

At Fulbourn, we had what was known as the Engineers' gang. This was a group of men who dug the necessary holes that had to be dug around the place. They were all epileptics and they all knew how to deal with epileptic fits and they looked after one another when they had their fits. They were strong as oxen. There was one particular nurse in charge of them, who knew them and they knew him. They all had to sleep on the disturbed ward because they had to be under observation at night in case they had a fit. They had their own table in the disturbed ward, which got the best food. And any time any real lunatic attacked one of the staff the epileptics would rise up and protect us. They were partly a ward police.

You describe the role of the doctor in the army, being faced with guys asking for sick leave when not sick or not asking for it when they were about to have leave. This brings home powerfully the role of social factors in clinical presentations. Medical teaching may teach you to think about why this person is here now but experience in an army setting really brings it home - brings the issues to a point.
Obviously there are doctors in the armed forces doing exactly that now but perhaps there aren't as many people who have been in the army and they don't really know about this

The basic assumption taught to every medical student is that sick people come to you because they want to get better from their sickness. If you go straight into hospital and then go into practice you remain quite happily within that framework. In contrast, if you are a doctor in the army it only occasionally happens that somebody comes to you in the hope that you will relieve a disorder from which they are suffering but it's very rare. Mostly people come

to you because you're the gatekeeper to all sorts of things. This is a perfectly appropriate function. Its nothing to be ashamed of – but it is worth recognising that that is what you're doing. It took me some time to learn that, as I was rushing round trying to find a treatment for people.

The place where this is terribly relevant these days is in the so-called speciality of forensic psychiatry. The forensic psychiatrist is not a doctor there to serve a patient. He is a medical man who's a limb of the organisation. When I had to do a certain amount of prison work later on, doing interviews in jails, I learnt an entirely different approach to people. I suspect an awful lot of psychiatrists make fools of themselves because they aren't aware of the pressures both on them and on the prisoner in this bizarre encounter.

The other thing that was extraordinarily powerful and needs to be re-emphasised because the magic is now lost was setting AA up against Antabuse. You showed how the drug treatments were often extremely useful for some people but in the main what worked was the self help approach.
I was terribly fortunate in that AA happened to start on the ward where I'd been working at that time. It left me with immense respect for any form of self help by a patient. The development these days of the various patient self help groups particularly in your field of psychopharmacology is tremendously important.

What about DK Henderson?
When I went first the junior doctors told me you'd better look in the chief's book and see what he says about such and such. Anyway you were expected to know everything he said in the book. There was a case conference once a week and one would present a case there. He did no formal teaching. In fact we were so bereft, we organised our own private Journal Club and presented papers to one another mostly on DPM spots. I remember doing a paper on diagnosis in psychiatry - I'd just come to realise that diagnosis didn't mean very much.

How much had Henderson been influenced by Adolf Meyer?
He always quoted Adolf Meyer. As of course did Aubrey Lewis. There was also a wild Canadian, Clifford Scott a psychoanalyst, who'd been taught by Adolf Meyer. I remember we used to say to one another at the Maudsley; what on earth did Adolf Meyer teach that DK Henderson, Aubrey Lewis and Clifford Scott all speak of him with reverence as their teacher and claim that they are doing what he told them, even though they were all quite different.

How much did the Meyerian biopsychosocial model feed into social psychiatry? Had it any influence at all.
Have you ever tried to read anything that Meyer wrote? Unreadable. This was one of the puzzles. I can remember thinking this was the man that taught the Chief, there must be something there. Meyer was a Swiss of course, writing in this second language. There's an awful lot of neologisms. Its almost impossible to follow.

When I was at the Maudsley what I found was different between myself and other people was how one applied psychobiology to patients. Basically what you did was you took a very thorough history and looked at all of their lives and any area you could see that was wrong you attempted to put it right. Whereas if you were a strict biological psychiatrist you had to make your diagnosis and treat the diagnosis. And of course our patients did better than the ones that were diagnosed. An awful lot of people, if a kindly doctor attends to the things that are most out of joint in their lives, get a good deal better. That was the beneficent thing about Meyerian psychobiology. But at the Maudsley people sneered at psychobiology and simply said well this is a way of avoiding hard logical and diagnostic work.

Mentioning the Maudsley, leads me onto a question. When I think of social psychiatry, I think of yourself and Maxwell Jones and others and then I think of the group that ends up in the Maudsley that began with Lewis but then moves on to Michael Shepherd and John Wing. This group also called themselves social psychiatrists. But it became a different kind of social psychiatry to what you were doing.
Well I would say a much more relevant figure and much more explanatory was Morris Carstairs. Morris was at the same school as I was, a couple of years older than me. He was a very close friend in the immediate post-war years. His family came to stay with my family and so on. I kept in close touch with him until his final disintegration. I suppose of all my contemporaries Morris was the one whom I got most from. I would talk over my ideas with him where I might be going and so on.

Of course Aubrey always said I am a social psychiatrist. Gradually it emerged that what he meant was that he wanted to do research into the social factors that cause disease, whereas what we wanted to do was to help people by manipulating social factors.

But he would say that you can't help unless you know the data behind things.
Of course yes. We were fascinated by the data but the basic thrusts were an investigative thrust and a therapeutic thrust. And of course Aubrey was a complete therapeutic nihilist. He didn't believe that anything did any good to anybody. He spent all his time disproving. The people he really had no use for were the William Sargant's, the enthusiasts who rushed into everybody and anything. If you read Aubrey's forward to Max's first book you will see there all his ambivalence displayed. His admiration for Max's intellectual brilliance, his approval of the work he did at the Cardiac Neurosis Unit. His unease about the enthusiasm that was bubbling up at Belmont.

I had always thought enthusiasm was rather a good thing and this came as a shock to me. So that was the division and it was fascinating. Aubrey set up this little unit at the Maudsley and the first person he asked to run it was Morris. Morris of course was very bright, very able and he had done his anthropological work and published and so on. He was also a committed left winger – I was never quite sure whether Morris was a member of the party, certainly many of his friends were communists. He gathered several of them

around him – Tizard and O'Connor, who was a party member right up until the time of the Hungarian revolution and deeply committed. At the Manor Hospital, which was one of the Epsom Hospitals for high grade feeble minded, they found these dim-witted youths being painfully taught boot making which took them years to learn and in the end they just made rather bad boots. Now they were interested in the possible use of work as therapy. So they got light engineering contracts and they got these youths fitting things together and in no time at all the youths were earning more than the nurses that were looking after them. This really set the whole place in turmoil.

The whole question of communist, psychologists, mental defectives and the Fountain hospital was another great whirl. John Wing joined that group as a junior member and then in due course when Morris went up to Edinburgh John Wing took over. John of course was much more interested in the research side. But he was fascinated about what we were doing in the mental hospital and he did the famous Three-Hospital study. I remember him coming to look at Fulbourn to see if he could include it and he decided not to – I was never quite clear why.

There was a continual feed back and fro. We were all in touch with one and other and we all respected one another's positions. I could never have lived doing the sort of things that John Wing did and I admired him for doing for the three hospital study. John Wing could never have run a mental hospital and he knew that. He was tremendously respectful of what people like Freudenburg did. That comes out in his book.

When Morris Carstairs became the Prof at Edinburgh after Kennedy, he recruited, Henry Walton, the group psychotherapist. What appeared to happen was that there was an influx into the mental hospitals somewhere in the 50s is you begin to get people with personality disorders coming in and being involved in group programmes of one sort or the other.

Oh that's not quite how I'd put it. What I would say was that before the war the asylum was what it had always been - a dump for mad people and for people who were a bloody nuisance. Lots of epileptics, lots of antisocial mental defectives and people of that sort. You know there was miscellaneous rubbish in there and they were all tamed and then they were taught to work for the institution and they stayed permanently. And of course in the 1930s life in the bin though it was degraded and bullied and so on, it worked and if you were not actually psychotic you might be worse off if you were outside. They tell me in the asylums on the West Coast of Ireland you at least had a roof over your head with food in the Winter.

Then psychiatry demonstrated its effectiveness in the medical services in the War and after the war the returning doctors wanted to get the services of psychiatrists. And of course social attitudes had changed and people began to admit that they were anxious and depressed and they wanted psychiatric treatment. So there was a tremendous proliferation of psychiatric outpatient clinics everywhere in the 10 years from 45 to 55. A large of people were admitted to the admission wards in the hospitals who were depressed,

anxious and suffering from psychoneurosis, so that many hospitals set up what were called neurosis units. Special nice places with nice clean wards and clean staff.

Was this pre-chlorpromazine?
Oh yes long before. Chlorpromazine was quite different. That was the next stage. No this was the immediate post-war period. These people would be taken in and given ECT, or deep sleep, or medication benzedrine by day and Amytal by night. They would get adequate sleep and the nurses would be nice to them and they'd spend four to six weeks there and then they'd go home. Anywhere around the country you could find that going on.

Now one of the problems as far as the asylums are concerned was that these people were all voluntary patients and you couldn't muck them about the way that you could certified patients. So that something new – there were people coming in as patients who the staff might meet socially. Whereas in the old days that would never happen. Now the psychopaths - well it depends how you define psychopath but certainly they would drift through amongst this crowd. Some of them would be moved on to the backwards because they didn't look like going. And these were certainly some of the people that were very valuable in getting some of the therapeutic communities going. These were people who were grossly disordered in their behaviour but had their wits about them.

But there were lots of other people. One of my most able people in Hereward House was a man who'd been a student at Cambridge and had developed schizophrenia. There was no doubt it was schizophrenia. God spoke to him and told him to do things and finally God spoke told him to make a proper demonstration and he went into Westminster Abbey and took the cross off the high altar and smashed it. So they sent him to Broadmoor and he settled down in Broadmoor and then he came to us. A charming man, intelligent, he learnt not to talk about his ideas but every now and then a sort of light would come to his eyes and he'd say I do have a mission in the world but what are we going to do to make the world better in the meantime.

Henry Walton – well he was caught shoplifting. And one of the finest things to emerge from it was a headline in the local paper "I did not know what I was doing" said professor of psychiatry. However he was put on probation or something like that anyway he had therapy and he's gone on. Is he still alive?

Morris Carstairs gave up the chair didn't he? And then went to do work in India.
No it was more complicated than that. He was made Vice-Chancellor of York University and everybody said wow. A psychiatrist moves to become VC of a university. It had never happened before. And you know he'd given the Reith Lecture. Everybody saw him as a really major emerging cultural figure and then suddenly at the age of 60 he resigned from York and went off. He left his wife, took a new wife and went off to India to a research unit there. Three years later he came back and it wasn't clear what had happened. Then I can remember talking to him and he'd say I can't grasp things anymore. Then his

new wife left him and it gradually became clear that he was suffering from dementia. He had quite a bit of insight into it. In fact he enrolled in a research programme at the Maudsley. It gradually got worse and Vera his first wife took him back to Edinburgh, put him in a nursing home and he steadily demented and died in his early 70s. It was an appalling tragedy. Suddenly psychiatry lost somebody who should have been a major figure. It was rather like Bill Trethowan's stroke. If he hadn't had that stroke he would certainly have been president of the Royal College and all sorts of things.

Did the fact that people like Bill Trethowan and Morris Carstairs fell by the wayside let in someone like Martin Roth?
No. I'd be very happy to believe that. As you must have gathered from your time here, Martin Roth's coming to Cambridge was very damaging for the work that I did it - put it right back. But I always remained on courteous terms with him even though he and I see the world particularly differently. But no the work he did at Graylingwell and in the early years at Newcastle on the differentiation of the dementing disorders of old age was a major step forward. When I started in psychiatry the elderly admissions were all addled and there wasn't much difference between them. There was no diagnostic difference between what we call senile dementia they now call Alzheimer's and the vascular dementias. He'd done substantial work he built up a very good department in Newcastle and he also of course he was the author of the Major Textbook and that's what got him the president of the Royal College.

Well there were two things yes I'm sure you're interested in this. The three likely candidates who stood there was Monroe who'd been the registrar of the RMPA, William Sargant who believed it was his by right and there was John Howells who'd been leading the ginger group for years and then there was Martin Roth. I think anyone of these could have beaten Martin Roth perhaps not Monroe but certainly Sargant or Howells might well have done but the RMP vote was split between those three and all the psychiatrists who never had anything to do with the RMP basically voted for Roth and got him in.

Lets be fair he was a very good first president. The fact that he mildly grandiose was to our advantage. A more modest man wouldn't have dreamt of taking the place on in Belgrave Square. He trotted round and he got money from millionaires, Lord Goodman and people like that and you know set us off on a very high flown style. A little bit of grandiosity at that stage was probably a good thing for psychiatry.

He ended up being very vocally anti the anti-psychiatrists. How does antipsychiatry sit beside social psychiatric activism?
First of all you mustn't lump Laing and Szasz together. All sorts of people do. Both of them objected strongly to being lumped together and they are quite right. One was a democrat the other was a neo-fascist. It's just that they both criticised psychiatry or psychiatrists at the same time. In the 50s there were all sorts of ideas around. There are always lots of different ideas about what psychiatry is and should be and what its social function should be. There are always groups within psychiatry pushing their own particular agenda and what emerges is an amalgam. There were some people in the 50s who said that

what we really wanted to do was to hold on to the asylum - that that was the basis of all that we'd ever learnt.

Then there was William Sargant who was saying that we needed to forget all about psychotherapy and what was needed was the approach of the physician who made a diagnosis and applied physical treatment with vigour. If the first lobotomy doesn't work, do another and another and another. He came from a family of missionaries. He was a great big tall man, with a gaunt face and a passionate belief. I've seen him fill a lecture hall in Cambridge here with students and absolutely have them hanging on every word. He was a missionary and he had a sort of sense of divine mission about him. He had a conviction that he was right. And the feeling that God had told him. He reminded me of a Billy Graham or people like that.

Then there were the psychoanalysts who were very riding very high in those days. Psychoanalysis was the answer to everything. If all statesmen were psychoanalysed, we'd have peace there would be no more war. Psychoanalysis was going to solve all the problems of industrial conflict and so on.

There were a number of us, you could say the young radicals, who were questioning the whole way that psychiatrists behaved. We were getting round to questioning the medical model in psychiatry and psychiatric behaviour. Then suddenly there burst out the works of Ronnie Laing. Some of us read them but it was much more that all our nephews and nieces, all the bright young people in the 60s, read these. And they said here's this man who explains it all and mental illness is really just like adolescence only a bit worse. And it's all because of one's parents.

Szasz on the other hand was quite different. He's a bright, hard, logical Hungarian. A lot about Szasz can be related to the well-known characteristics of Hungarians - they have an ability to see the illogicality in other peoples positions and point it out with a merciless brilliance. He started off originally with pointing out the illogically of the insanity defence for middle aged ladies caught shoplifting. But then he went on to challenge the whole concept of disease in psychiatry and as you know made a practice of refusing to be involved with any sort of coercive or involuntary psychiatry. I think it was a very valuable thing that somebody did point this out. To me one of the sad things of the current day is the rise and rise of what is called Forensic Psychiatry, which is doctors acting as jailers and talking about how benign and kindly they are. Psychiatrists are always caught in that trap you can't avoid it if you're going to be a public psychiatrist. But do you really need to be so hypocritical about it.

I think one welcomed the initial criticisms because they were absolutely right. The idea of the double blind hypothesis was very attractive and then one gradually found out that it was only a hypothesis that there was obviously more to it than that. And again Szasz pointed out the illegitimacy and hypocrisy of coercive psychiatry are true but on the other hand if nobody will defend those both mad and bad you know it's sad for society.

How much did the anti-psychiatry movement compromise social psychiatric activists of your sort. Because there was a backlash with people like Martin Roth saying we have to retreat to the medical model.
Well some of what we did is no longer relevant because there are no longer thousands of people locked up in institutions. But the whole development of the advocacy movement and patient involvement, a lot of what's being done in the more imaginative of the day centres of residential units, that all has its routes in what we were practising 20 years ago. I think that the social model is still very powerful in the mental health field. I'm not in touch with young psychiatrists enough to know and I have a horrid feeling that a lot of them are deeply trapped in their medical models and never really got out of it.

Remember, after all, the medical model rises out of medical practice. And people become medical students because they want to become doctors. Some of them get over that but an awful lot of them find the position where they sit in a white coat and tell somebody else eat these pills I know best, very attractive. I'm just sad that those sort of people have become dominant in psychiatry.

This brings up the place for role models in training. This is an issue that's lost in psychiatry and nearly all of medicine – the idea that training was and should still be an apprenticeship. The classic role models, the great men, aren't there any more. Psychiatry is now all about following protocols.
It's nearly 20 years since I retired. I have assumed that behind all those protocols there were people learning from a professor or someone. When I was running the hospital, there were people around like William Sargent to whom people went and from whom they learnt and whom they revered for the rest of their days. Surely that's still there – there are still one or two people like that around.

There may be some but given the importance of the research component in psychiatry these days a lot of professors are very good research models rather than clinical models. If you look up the OED definition of model one option is a shrunken replica of the real thing. It is increasingly rare these days I think to have clinicians in an area look to professors in the department of psychiatry for input on difficult cases.
I had my difficulties with Martin Roth but there was no question but that he was a man of stature, a person who on certain questions could say very relevant things. I saw a list of professors recently and I realised I didn't know any of them. So you may well be right. Of course, when I was a young man there were hardly any professors of psychiatry - it was the great superintendents who were a model. But of course they've vanished now.

Peter Brook did some studies on the recruitment of doctors into psychiatry and discovered, slightly to his surprise, that there was a tremendous number of people from St Thomas's who became psychiatrists. He came to the conclusion that it was simply the flaming personality of Will Sargent.

I'm sure a lot of my generation came in because of Ronnie Laing's writings but there's no-one pulling people in that way now.
Well I had an interesting experience when the medical school was starting up. I knew a young man, a very bright, sensitive, lively young man and I asked him what he thought he was going to do and he said paediatrics. I said what about psychiatry. And as far as he was concerned Douglas the professor of paediatrics had excited him more whereas Martin Roth had left him dead cold. I may be wrong but the impression that Martin Roth gave was that the job of a psychiatrist was to put a label on people and from that came the proper drug to give and presumably that doesn't catch the imagination of students.

No I think the neurological approach to psychiatry is fairly sterile. You suggested that the Meyerian approach got the same information but asked well what can you do for this patient rather than what is wrong with them.
Not only that but how did this person come to be here. That strange thing, the personal history that psychobiology required you to take, did force you to ask all sorts of questions about this person. How he got where he is.

Can I ask you a question that may be unanswerable. It seems to me when you talked about the things that have come out of social psychiatry, patient advocacy, less hierarchy, you're talking about the kinds of changes that came about with the 1968 Revolution or upheaval or whatever you like to call it. There was a change from a very hierarchical kind of society to a much less hierarchical society. Even patients had rights after 1968. What triggered 1968. Why did that upheaval come about? How did Laing contribute?
Well this is simply a personal view. I would say first of all that my view of Laing is that he was a poet who happened to be a psychiatrist. And he expressed in poetry the bitter anger that many adolescents feel about their parents. Phillip Larkin said it better than anyone else – they fuck you up, they don't mean to but they do. The explosion that blew up all over the developing world in the late 60s was surely some sort of reaction to the post-war world, where the survivors of the War had rebuilt a solid secure world, just like the one that had gone before and they didn't want anyone to ruffle it, to upset it – they wanted the world and people to always remain the same. There were local components. In America there was the Vietnam war. I think there was a revolt of the young people against the complacency of their fathers who'd fought in World War II and then rebuilt painfully an older world that they didn't want disrupted.

The social psychiatric work in the asylums had started well before 60s and was really unrelated. The asylums were overdue for a clean up whatever happened. They were pretty bad in the 30s and then with the war they got very dilapidated. There was a need to change things and move things around. Then along came the tranquillisers and that made it easier. It was part of a general view in the 50s that we ought to dismantle the ancient Victorian institutions, the jails, the orphanages, the mental defective colonies, the asylums. I do see as many of the lamentable aspects of turn of the century psychiatry as rising from the social attitudes of the Thatcherite years. The

only people who count are those who make lots of money and that the poor and the mad can be just be pushed down and shut up and held down.

What impact did the drugs have? Clearly things were changing before chlorpromazine. There's always been the debates about how much difference it made?
Well at the time because chlorpromazine was being pushed by the William Sargant, I took the view that it really makes no difference and I used to point out the fact that George Macdonald Bell had opened all the doors of Dingleton in 1948 and that TB Rees and Duncan MacMillan had opened their doors in the early 50s before chlorpromazine came along. But as time went on I realised that it had made certain differences. I would say now that there's no doubt that having the major tranquillisers around made it much easier to do humane psychiatry.

But if you operate say a mental hospital in Russia or in South America or some of those places you can have a hospital absolutely swilling over with Largactil and still brutalities and corruption will characterise it. In fact it makes it rather easier – under the Japanese system neuroleptics make it easier to keep people in hospital.

Now you've had a huge impact on Japanese psychiatry, can you tell me about it?
Well I was asked by WHO to go as a consultant to Japan in 1968. The Clark Report that came out of that visit shows a huge increase in hospital bed usage between 1955 and 1968, the period of time during which chlorpromazine was introduced. But one of the reasons why people in Japan paid attention to the Clark Report was that in 1968 I said if things go on like this the numbers will rise inexorably. And for the next 20 years they just went up and up and up. In 1955 it was 4.5 beds per 10,000, in 66 it was 18, and by 10 years later it was up to 30 beds per 10,000. My 1968 prediction proved absolutely true and this really shook them. Now they have done various things and the rise has levelled off and the figures have even come down a bit.

What I came to realise was that it had nothing to do with the nature of schizophrenia and not much to do with the efficacy of chlorpromazine. It was due to a malignant combination of sociopsychological and economic factors in the structure of Japan over the last half-century. One of the things that I came to realise as I went around the world was that very often the things that you saw in the mental hospitals could only be understood in terms of the health economics of that country. To think that it had to do with medical problems was fooling yourself.

You see the development of mental hospitals in Japan was very bizarre and as far as I know completely unlike anything else in the world. First of all back before the War, there weren't many people in mental hospitals. There were a certain number of public mental hospitals, which were just large bins on the German style. Then came the War and the period after the War, when the Americans were starving the Japanese, and most lunatics died. By 1950 there were hardly any lunatics around. Nobody liquidated the patients, it was

just starvation. I was talking about this to Tsuneo Muramatsu, who was the superintendent of Musashi Hospital in the years immediately after the War, and he said well you know one third of our patients died of starvation because the rations the Americans were allowing the Japanese were not enough to live on and of course people out in society outside scrounged for their food from the asylum patients so they died. It was nothing more than that.

It wasn't like Germany in the War, it was rather more comparable to what happened in Poland. When I went to Poland in 74 it became clear that during the war Polish psychiatry disappeared. The doctors were mostly Jews so they were killed and the patients were lunatics so they were killed. At the end of the War, they more or less had a clean sheet. It was much the same in Japan. The Japanese then opted for a system of insurance through which everybody was insured by some scheme or other which paid for their treatment. And people began to spot that there was an opening for running a small private mental hospital. The result was that by the time I got there in 68, the total number of private hospitals by 1967 had risen to 725 psychiatric hospitals.

The average size was 180 beds. What they were mostly were a couple of buildings down at the bottom of the doctor's garden, containing one hundred or so patients. The doctor was running it as his own private show. His wife was acting as the hospital secretary. His daughter was the head of nursing. It was a very comfortable private sideline. You filled the patients up with chlorpromazine so they didn't complain. The insurance companies paid so you made a nice little profit on that. The relatives were deeply ashamed of these mad people so they were happy if they were kept quiet in some other town. And the patients just sat there getting fatter and older. None of the doctors in charge were psychiatrists. There weren't 700 psychiatrists in Japan. These were just doctors who'd taken this up as a side-line.

I met one man who was running a very good hospital. But he had inherited it from his father in law who had run it as a surgical hospital. He decided there was more money to be made from running it as a psychiatric hospital so he just switched over. It was really quite a bizarre situation where nobody had any incentive to get anybody out of hospital. The patients were drugged to they didn't care. They were reasonably content. The relatives didn't want to know. The doctor didn't want to lose his livelihood. Japan was booming and society as a whole was prepared to go on paying the price. I said so quite strongly at the time.

Twenty years later I was asked to go back to Japan in 1988 and I wrote some reflections upon it. "This is a question for Japanese society to decide – are they going to keep hundreds and thousands of their fellow citizens in crowded, squalid, apathy and idleness for 30 or 40 years of their lives or are they going to embark on the difficult and challenging process of rehabilitation. It's a question of public policy and of humanity. Psychiatrists can only advise society of the relative advantages or disadvantages of each course".

I didn't appreciate it at the time but Japanese psychiatry was a very odd collection of doctors who'd never intended to have anything to do with lunatics but who'd taken up lunatic keeping and were making a reasonable amount of money from it without really understanding what was going on. They just wanted the money to keep rolling in. Now in the 30 years since then, things have changed. Many more of the people running this kind of hospital have had some sort of psychiatric training. But at the time I was there, these were men in their 50s, in other words people who had qualified in medicine in the late 1930s. The best of them were very good. The worst of them I didn't see. Some were said to be quite appalling. I was told in some places that the Yakuza, the gangsters, had invested their money in building mental hospitals because there was such a very rapid return. In these hospitals, sometimes the doctor was the proprietor but on other occasions, there was a proprietor who had put up the money and the doctor was his servant.

I could go on at great length about Japanese psychiatry. In total I spent 5 months in Japan and I was perplexed and confused by what happened. I couldn't understand what had gone on. After I left Japan, when I was in the Philippines finishing off my Report, I wrote a little piece called Some Reflections from a WHO Consultant in Japan. It's about attempting to communicate with the Japanese. I kept it a secret for a couple of years. The final remark about the harmonious mutual incomprehension is one that I rather treasure.

Well now last of all what happened in Tokyo University. Curiously enough I saw the very beginning of it. Right at the end of my stay in 1968, I had to give a lecture in Tokyo University. So I went along that morning and saw outside the department these great big banners with ideograms on them, that are just basically announcements. My friend Junichi Suzuki said you see that one's for you. And I could actually see D H Clark in the middle of it. But there was another one with a lot of red on it and I said what's that. He said oh that's something the students are up to. I don't know what it's all about. It probably doesn't matter. But that was the beginning of the whole hullabaloo. It was just boiling up as I left.

I left Japan, bruised and angry. I came back and I had lots to do at Cambridge and I got on with doing that. There was a bit of toing and froing about my report, which appeared to hang on year after year. The only contact I had with Japan was through Hitoshi Aiba. Now he was a very strange character. It's only as years have gone by that it's become clear to me what a maverick he was. He was a professor of psychology in one of the leading universities in Japan who turned up and took me off to a party the very first night I was in Japan. He took me around to a whole lot of places. He took me to the interesting hospitals and to parties and things like that. He was a lovely little man and I became found of him. He continued to keep in touch with me for a variety of reasons. He actually came and spent half a year in Cambridge in the early 1970s. He was always telling me the latest gossip. So nearly all my information comes from him. It's very second hand.

What he told me was that first of all the revolting students were revolting all over the place and their favourite thing was occupying departments. They occupied the ward in Tokyo University Hospital. They occupied Toshi's own department in Waseda and he couldn't get into his office for three years. This was happening everywhere and nobody knew what to do about it. It was boiling up - after all we're talking of 1968 it was happening all over the world.

There did seem to be something psychiatric about the focus. In Paris they ransacked the offices of Jean Delay but I'm not aware that they did anything in the department of surgery.
Oh yes I'm sure psychiatry was a target. After all they were saying that old people drugged, oppressed and locked up young people. That's what Ronnie Laing was saying and there was an element of truth in it.

Now at Tokyo University the faculty asked Hitoshi Utena, the professor of psychiatry to mediate with the students. He was their main front man. And of course as time went on it became clear that his efforts at mediation had not been successful. So I think he lost face both with the students and with the senior faculty members.

Hitoshi Utena is a lovely man. He's still a good friend of mine. We exchange Christmas cards and that sort of thing. He wrote the foreword to the Japanese edition of my Descent into Conflict. He had only become professor in 1968. Akimoto, the old devil, was still around. He has remained the most powerful man in Japanese psychiatry for 20 or 30 years. You see one of the interesting things in Japan is that the older they get the more powerful they become. Taking up a professorship is only one stage in the process. You have to retire from a professorship at 60. For most people - and this is true in many other areas - it's what you do after you've been a professor that really matters. So when I went to Japan in 68, they took me to see the emeritus professor Akimoto and then they took me to see the emeritus emeritus professor who was Akimoto's predecessor, Uchimura, and he was still regarded as a very powerful and important man. Interestingly enough the only thing he wanted to tell me about was that he was the man who introduced baseball to Japan.

Anyway Akimoto was the power broker all through the 30 years that I've known the man. I get on quite well with him. Only a couple of years ago he rang up and asked me if I could come over to Japan the following month to take part in some meeting. So in 1968 Utena had taken this job on and he had a rough ride as the professor. It turned out he had written a book about his War time experience. As a young doctor he also landed up down in the Netherland's Indies. He had some appalling experiences there. He was also a person who had come from a socialistic background, who hated the army and so on. So he found my tale and my experiences in the army fascinating and that's what led him to write the foreword.

He's a nice man but he's not particularly strong, certainly not as strong as Akimoto. They focused on him and they criticised him for doing things with bits of brain in the 1950s. I suspect that's something they happened to pick

up and thought it was as good a stick as anything to beat him with. So the student revolt was the main thing that went on but there was one other thing and that was the revolt within the Japan Society of Psychiatry and Neurology. You see, until the late 1960s, because Tokyo University was the premier university, it was absolutely routine for the professor at Tokyo to become the president of the Japan Society of Neurology and Psychiatry. But somewhere about 1971/72, there was a revolt and the young psychiatrists insisted that they should be allowed to have candidates and should vote for the post. This was revolutionary and in fact Utena was put out. This change was overdue of course. When they originally founded the society, I guess in the 1920s, there were probably only about six people in Japan who could call themselves psychiatrists. Then suddenly there was this explosion of psychiatrists after the War.

The other thing I heard was this. When I wrote my report, it went to WHO. Now WHO re-writes your reports and they are all in the third person. Then it was translated into Japanese and it went to the Japanese Government, the Ministry of Health and so on. A couple of years later people began to say well when are we going to hear about the Clark Report. Then a version of the Clark Report was published and the word rapidly got out that this was a bowdlerised version of the Clark Report. Now according to Toshi at one of these meetings of the Japan Society, there was a great cry of Publish the Clark Report. So finally they did publish it with, I'm told, a foreword by Dr Kato, in which he said Dr Clark is a Scotsman and Scotsmen are noted for how strongly they speak - with the implication that therefore his comments need not be taken so seriously.

Seemingly the pamphlet was a revolutionary document. But apart from Toshi and some Christmas cards I heard nothing from Japan for about 10 years. It wasn't until 10 years after that I was invited to go back. Then I found myself being an item. Before that I had being saying well you know I've burnt my boats with the Japanese but it was a nice experience. Well after that they had me back in 78, 81, 83, 88 with honour and acclaim every time which was rather funny.

There was a much stronger case then over in Japan than here that psychiatrists actually were locking up people.
Absolutely but the only thing was that the amount of brutality in Japanese culture was much less than in the British system. This was one of the things that really impressed me. The relationship between the staff and the patient was much more relaxed and much less punitive. Much less "you've got to hold them down doctor". One or two scandals blew up. There was one particular scandal about a doctor who used to go round with his golf club whacking people. This was something that blew up in the late 70s early 80s. The Asashi Shimbun, which was the crusading liberal newspaper, wrote reports on the appalling conditions that went on and finally they had a Governmental investigation and the doctor was sent to jail and so on.

I'm sure there were other places that were not great and there was certainly corruption although whether there was brutality or not I don't know. At least no

that I saw or heard of. Compared with what people say about American State Hospitals, there was nothing like that. I know that this sounds strange to people have been brought up with stories about the Burmese War but the Japanese people are very kind and gentle to people whom they see as sick and they are much less punitive than the Prussian, non-conformist, Scots, Calvinist tradition can be in our culture. If you define yourself as ill, they love being kind to you.

This comes out in The Structure of Amae, Doi's book. Well Takeo Doi is a personal friend, a charming man, the first American trained Japanese psychoanalyst. He trained as a doctor and psychiatrist and then after the war he went to the States to Menninger, where he trained as a psychoanalyst and came back to Japan. I met him in 68 and I liked him immediately. In those days he had to work as a psychiatrist to support his work as a psychoanalyst, because not enough Japanese people wanted analysis. He became fascinated by certain differences in the way that Japanese people related to their analysts. He explored this in a book called The Anatomy of Dependence.

This unfortunately has been picked up and been used by various people who like to say that Japanese people are fundamentally different to other people. So in some ways it's got a bit of a bad name. His point was that there is a transaction in Japanese life, where one person is weak and feeble and sick and another person is kind and succouring towards them and this is the Amae relationship. It needs two people. It needs not only the person who wants to be kind and succouring but also the other person who wants to be dependent, who want's to put themselves in someone else's hands. He said this comes up very strongly in analysis. He said his American analytic patients would spend several years telling him that he was a shit, that he was a slit eyes who couldn't possibly understand them, that he should be ashamed to call himself a doctor etc. Then very reluctantly after two or three years, they would begin to say they really saw him as rather wonderful, kind, decent and a good person. With his Japanese patients on the other hand, they all started off by saying that they realised how fortunate they were to be in the hands of somebody who was so good, so able, so kind, so understanding, so perceptive and so on. It was only after two or three years that they might allow themselves to say that he irritated them. He said that this need to be in a warm soft dependent relationship was a major part of Japanese life.

I certainly came across certain aspects of this. The Japanese are very kind when you are sick. They would even say he doesn't Amae very well, which means he doesn't allow himself to be looked after. And I made exactly that mistake the first time. I'd been there about a month and one day I woke up with a bad cold. I rang up and said I'm afraid I'm not well but it's alright I'll deal with it and I'll be in tomorrow. The phone started ringing "could they get a physician to come and see me". Some flowers arrived. I kept on saying that's very kind of you and I'll be quite alright tomorrow. The following day rather white and shaken I pulled myself together and took my two trains and turned up for work. When anybody enquired, I said I was fine. It was only months later that I realised that I'd behaved exceedingly badly. That here they had a

chance to be kind to me, to look after me, to do nice things for me and I turned them all down. I'd been unwilling to sink into a situation of dependence.

In Japan the anxiolytic market place is very big - much bigger than the antidepressant market. There is no Prozac. It's very like the way things were here up to about 1980, when the benzodiazepines ran into trouble. For whatever reason, whether they prescribed better or there are ethnic issues, the Japanese don't seem to become physically dependent on te benzodiazepines in the way we did. Or if they do it's not a problem in the way it became for us. Now today when you meet Western psychiatrists and face them with this fact, particularly ones who may think they know a little bit about Japan – they've read some article somewhere - they say "ah this is because the Japanese cannot accept negative affects. They really are depressed they just don't know it". We are right in the West. Any thoughts?
Oh yes many thoughts indeed. I had been to the States before Japan. I had not only done lecture tours there but I also lived for a year in the States. Now it was clear there were cultural differences - I mean in California many people were having personal analysis. Nevertheless what one saw were that the things that people went to psychiatrists for were very much the same. The hospitals had schizophrenics in them and deeply depressed melancholics and a few people with cyclothymic manic-depressive psychosis. In the out-patient departments, they saw anxious and depressed people.

When I went to Japan, in the mental hospitals, there were lots of schizophrenics, a certain number of epileptics and mental defectives and a few people suffering from manic-depressive illness and that was about it. So I said where are the depressive patients, your involutional melancholias. Oh they said we don't see them. And it was certainly a fact at that time that the classic tormented, depressed, suicidal, miserable person, the involutional melancholic didn't seem to be around. I talked to people about that.

I remember one little exercise I did. I wrote a little case history of a middle aged married women whose children had left home. Her husband began to find her weeping. She'd become incompetent doing her housework. She wasn't sleeping very well. What was the right thing to do? And they said "well she ought to go and talk to her mother or her sisters. Maybe she should go to her local shrine. Maybe she should see her doctor for a tonic. Maybe her doctor should advise that she went away to a rest ward in a sanatorium". Nobody suggested that she should see a psychiatrist. When I questioned this, they said "but of course she's depressed, all middle aged women are depressed. She's possibly suicidal but then that's the natural state of affairs".

My formulation was that Japanese people did not see depression as an illness. They saw it as a natural state of affairs. When a woman's children left home and there was nothing for her to do and her husband was busy doing other things of course she became depressed. Everyone accepted that. She accepted that. This was something they could live with. It would pass and there were various things you could do about it. It became clear that general physicians and GPs spent a lot of time treating people for what you and I

would call mild neurotic depression. Highly successfully. In those days, the suggestion that somebody should go to see a psychiatrist, a mad doctor, would have been seen as immensely shameful.

Now I'm quite sure that many more of them go to psychiatrists nowadays - there are of course many more psychiatrists. Just what the answer to that question that I asked 30 years ago would be now I don't know.

They haven't got all the antidepressants we've got. My hunch is they still see very few people as being depressed.
You see one of the things is that in our society being depressed is seen as an intolerable burden. Whereas if you are depressed in Japan, its not seen that way. I remember a Japanese person talking to me about when something happened and he said "well it must have been in the Autumn because I remember I was depressed - I'm always depressed in the Autumn". Now no one would talk about being depressed like that here. Being depressed is something that happens to patients. And of course there's the tremendous proliferations of new religions and things like that there that do a great deal to help the unhappiness of middle-aged ladies and so on.

What about Morita therapy – this idea about getting the person to rest for a while and then getting them involved in a graded re-integration programme.
Well when I went to Japan people talked to me about Morita therapy. Good I said I'd like to see some of this therapy. I kept on saying this for three months. It became clear to me that hardly anybody in Japan was doing Morita therapy but they all knew about it because this was supposedly unique to Japan. Morita was a contemporary of Freud. He developed his system during World War I and so they are very proud of this unique system. I did finally make my way to the premier nursing home of Morita therapy run by a Professor Kora. When I was there I found an American sociologist studying it, David Reynolds, who in fact then went back to California and he now teaches and preaches Morita therapy in California.

In fact, in this very small hospital of about 60 – 80 patients, only about half of them were actually having Morita therapy. The others were having all sorts of other therapy. But it does exist and it's a specific treatment for Shinkei-shitzu. This might be called social phobia over here or you can call it irritable weakness or chronic anxious hypochondriasis. Morita described his own Shinkei Shitzu. He said these are people who feel sick, who feel weak and feeble and if they try and do anything they are overtaken by bodily sensations. There's also the feeling that other people looking at them can see how feeble they are. Morita therapy educates them out of this. The big thing they do is to write a diary. Then every night the doctor reads the diary and he writes his comments down the margin. Do not think thoughts like this. They are weak and feeble. Spend more time in the carpentry workshop. So that's Morita therapy. Now whether there's still any going on in Japan goodness knows. It's one of these things that's been written up and got into the literature.

There was a man called William Caudill, an American social anthropologist who also worked in Japan. He was very impressed by a system of what were called Tsitsikois who were untrained people who were more or less servants to mentally ill people and lived in the hospital with them and looked after them. On my way to Japan, everybody talked about this but when I went there I could find no-one doing this.

Japanese life is so complicated, so sophisticated that you will never get it right. You may get it slightly less wrong that's all. I feel sorry for things that I muffed but I'm quite clear that as a Gaijin in Japan you are bound to get it wrong it is just a question of what way you get it wrong and how badly wrong you get it. At meals, for example, toward the end they would bring a wooden bucket full of rice. As far as I was concerned after a lot of snacks my reaction was thank good some food at last and I would eat it all but this was all wrong. It was bad form to hint that you might not have had enough.

There was another even stranger thing. Frequently, people would take me out for a meal and then we'd go on to bars. Everybody would drink and the Japanese go red in the face and start falling about the place, and get noisy on drink. Something to do with their metabolism of alcohol. Whereas we "hold" our drink. So in due course I would thank my people for a very pleasant evening and get on the sub-way to go home. I'd done quite well I thought and it was only ages later that I heard I'd done the wrong thing - he won't relax, he won't be confidential, he won't become friendly. You buy him a drink and he just holds it and stays stiff the whole time.

David Riesman has a lovely book called Conversations in Japan. In this he says that somebody said to him if you're business with the Japanese he won't tell you what's going on but if he takes you out drinking and he has one or two drinks and starts talking, listen to him with great care because that's when he's telling you the things that he really wants you to know. Having had a few drinks he's no longer responsible for what he's saying. He'll deny everything if it comes up later. Well I missed that completely.