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In conversation with Heinz Wolff: Part II

This is the second part of Sidney Bloch's interview with Dr Heinz Wolff. Part I appeared in the June issue of the *Psychiatric Bulletin*.

SB You have made several allusions to the training aspects of psychotherapy and it is obvious that it is in this area that you have carved out a particular niche and indeed established a reputation for yourself. One noteworthy part of this story is your conviction in starting people early and I wonder if you could talk about your UCH student psychotherapy scheme.

HW I would first like to respond to your question about teaching students early; by that I mean before they have had too much formal and factual training which can restrict students' ability to develop their own ideas and think for themselves and to use their critical faculties. This applies not only to the teaching of psychotherapy, but at least as much to the teaching of medicine and of psychiatry in general. Of course one has to strike a delicate balance here. Basic factual and scientific knowledge is essential, but all too often I have seen students being taught in a rigid manner at the cost of being discouraged to think for themselves, so that they lose their enthusiasm and sense of discovery. My own experience has been particularly fortunate in these respects. At Cambridge subjects like mathematics, biochemistry and physiology, even anatomy, were taught by outstanding teachers who encouraged us to discuss and think rather than remember facts. At UCH teachers like Sir Thomas Lewis, whom I mentioned earlier, took a similar line, and as a student he gave me space in his laboratory to take part in research.

I also believe strongly in learning from taking clinical responsibility as early as possible in one's career. My experience in the RAMC, just after qualifying, taught me more about medicine than the more formal training I received at UCH before and after the war. And, as I said earlier, my knowledge of psychiatry is largely based on having had to teach myself, and from clinical experience over the years, except for the brief and inadequate period of training at a mental hospital in India during the war. I had to formulate my own ideas and approach each patient as a new problem to understand and investigate. This does not mean, of course, that I do not value and use established psychiatric concepts. Many of these I have learnt over the years from colleagues at the Maudsley and at UCH, especially from Sir Denis Hill whose clinical approach has always impressed me greatly, and who in many ways served as a model for me. Similarly, as a teacher I have always tried to make students formulate their own ideas and stimulate their interest; this applies equally to medicine, psychiatry and to psychotherapy.

This then brings me to your other question about the student psychotherapy teaching scheme at UCH. Tredgold and I both recognised that some students had greater natural gifts in understanding their patients' emotional problems than others, but during their clinical years there was little opportunity to help them develop these gifts further. In fact, under the influence of the scientific training, some of them lost their interest in the psychological and social aspects and in their patients' personal problems. It is now thirty years since Tredgold and I first offered volunteer students at UCH in their first clinical year the opportunity of treating a patient in dynamic psychotherapy for an hour once a week, for one to one and a half years. An absolutely essential part of this scheme is the weekly supervision of the students in small groups by experienced analytical psychotherapists or analysts. Not only have the majority of patients benefited from the therapy they received from the student-therapists, but most of the students have later expressed the view that they have learnt a great deal about psychodynamic understanding and how to relate to patients. I want to make it clear that our aim has never been to train students to become psychotherapists but to help them become better doctors, able to relate to their patients and handle some of their emotional problems. Many of them have later become general practitioners, a few have become psychiatrists and psychotherapists or analysts. They all agree how essential the supervision groups have been in helping them to work with their patients.

A valuable extension of this scheme has been a joint research project with the Psychosomatic Clinic in Heidelberg where talks we gave about our scheme led them to start a similar project for some of their students. I

managed to get the European Community to fund this joint project. The students and supervisors from UCH and Heidelberg enjoyed travelling between London and Heidelberg, working together and getting to know each other. We have published our findings in a book on *First Steps in Psychotherapy*. I am sorry that no Department of Psychiatry in Britain has taken up the scheme on a regular basis in spite of considerable interest expressed by some departments. I suspect that anxiety about letting students undertake such responsible work so early in their training, and antagonism to the psychodynamic approach, may have played a part there.

SB You sat at one time on the JCHPT psychotherapy sub-committee which nowadays has the responsibility for setting down guidelines for training. It seems a very different approach to the one that you have just been talking about; more formal even, some critics say, bureaucratised. How does that fit in with what you have been advocating?

HW Well, my interest in the teaching of psychotherapy to postgraduate trainees in psychiatry led to my getting involved in politics within the College, first as member and at some time chairman of the psychotherapy section, and later, as you say, as a member and chairman of the Psychotherapy Sub-committee of the Joint Committee for Higher Psychiatric Training (JCHPT). I have always regarded these political and administrative tasks as an essential part of my work as psychiatrist and psychotherapist; although often hard work and time-consuming, I enjoyed and valued the opportunity of promoting the subjects I felt strongly about. This applied particularly to persuading the College to accept that training in psychotherapy should become an integral part of the training of general psychiatrists. This was by no means the case in the '60s when I first got involved in committee work in the College. I recall how hard we had to fight to have the first Guidelines for the Training in Psychotherapy accepted by the Council and other committees in 1971. For me it was less important exactly what the guidelines said but rather that the College should acknowledge the importance of training of psychiatric trainees in dynamic psychotherapy. Later on my work on the JCHPT, especially the accreditation visits, gave me plenty of opportunity to see how far this was or was not being achieved and to promote this further. I realise that we still have a long way to go.

SB When one looks around there are many psychiatric trainees who do not get to learn how to conduct psychotherapy. Some would argue that the establishment within the NHS of consultant psychotherapists has perhaps served to obstruct this development. In other words, that by setting up a specialist psychotherapy service this spares the psychiatrist from learning psychotherapy skills. Might this be an issue?

HW No, I don't think so. I know many psychiatrists who combine their expertise in general psychiatry with understanding of their individual patients' psychological problems and use a psychotherapeutic approach to help them. At the same time, I believe we must accept that doctors, psychiatrists included, are bound to differ in their particular interests and skills. There are those who are more interested in the biological basis of psychiatric illness while others are more interested in the psychological and psychodynamic aspects, and some are able to combine the two to a greater or lesser extent. Speaking for myself, I have always retained an interest in the biological aspects but, as you know, my main interest and expertise are directed towards psychological understanding and psychotherapy. What concerns me is that the different groups should have more respect for each other than is often the case. Some biologically oriented psychiatrists fail to recognise the value of the psychodynamic approach and some psychoanalysts, even those with a medical background, overlook the importance of biological factors and the functions of the brain and the body. I find this surprising, because Freud himself always stressed that our ego is a body ego.

Making allowances for these differences I would like to feel that I have helped some psychiatrists to acknowledge that their patients, whatever biological, for example, genetic or biochemical factors may be relevant to their condition, also have a mind and that their mental processes and personal experience profoundly affect their illness and need attention in their own right. I believe it is possible and essential to integrate the two and to teach at least some basic psychotherapeutic skills to the majority of psychiatric trainees.

You asked me whether I thought that the establishment of a specialist grade of consultant psychotherapist in the NHS might have interfered with this development. I don't think so. On the contrary, many patients require highly skilled psychotherapy from experienced analytical psychotherapists; those who provide such psychotherapy and teach or supervise others need to have had specialised training and experience in their subject in

order to teach psychiatrists and other professionals at a high academic level. Only the existence of a specialist consultant grade of psychotherapists can ensure that these aims are achieved. I should like to add that in my view the most important part of the training of a specialist psychotherapist consists of his having had his own personal analysis or analytical psychotherapy.

SB A controversial topic. Do you think personal analysis or some form of therapy is required of just the specialist psychotherapist or of all psychiatrists, given the argument you advanced that all psychiatrists should be understanding of the inner world of their patients?

HW I have a straight answer to that one. Definitely no. I think no one can or should be *made* to have personal psychotherapy or analysis. That can only come out of a personal wish of one's own. So, to make this a necessary condition of training for all general psychiatrists would be quite impossible. It wouldn't work. The position is different for specialist psychotherapists. To give an example, if someone decides to train as a group analyst he needs to have the experience of being a patient in a group himself. And, similarly if someone decides to become a psychoanalyst or analytical psychotherapist he needs to have the personal experience of having an analysis. But to expect every psychiatrist or general practitioner who uses psychotherapy with his patients to have his own therapy as a condition of training would be inappropriate and counter-productive. It depends on the individual person's motivation and on the level of psychotherapy at which he wants to practise.

SB I take the point. Does this mean that the idea that has been incorporated into the Australian and New Zealand College of Psychiatrists' requirement that all examination candidates wishing to join that college have to conduct an individual psychotherapy case of at least fifty sessions is not sound?

HW Not at all. I think that is a very sound idea and I have always been envious of the fact that the Royal College of Australia and New Zealand, unlike our own College, takes that view. But to expect every psychiatric trainee to have some experience of conducting individual psychotherapy under supervision is quite different from expecting every psychiatrist in training to have personal therapy.

What it does mean is that the trainees should see at least one patient regularly once a week for a year or longer in psychotherapy under the supervision of a trained and experienced psychotherapist. It is the supervision process that is fundamental here. My experience in the student psychotherapy scheme at UCH, and as supervisor of psychiatric trainees at the Maudsley and at UCH, has taught me that. The weekly supervision by a trained psychotherapist helps the trainees to recognise the role of unconscious mental processes, and to understand what happens in the relationship between them and their patients, or in technical language, to recognise and use the processes of transference and counter-transference. It is the supervisor's task to put the personal experience of the patient and of the student and of their interaction into the very centre of the supervisory process. This is how the trainees learn to conduct psychotherapy. The majority of them are, of course, not in therapy unless one or other of them has chosen to do so for personal reasons or because he has decided to become a psychoanalyst.

SB I would imagine that many of these ideas about training that we have discussed emanate from your many years of leadership in the Maudsley Psychotherapy Unit, but intriguingly through this time your were also still at UCH, your old medical school, and perhaps there conducting a different sort of psychiatric practice.

HW Yes, that is quite right I used to say that I had to make a daily transition crossing Waterloo Bridge. At UCH I was both a general psychiatrist and a psychotherapist, and I looked after psychiatric in-patients and out-patients. Ultimately I became Head of the Department of Psychological Medicine and started the Academic Department of Psychiatry. At UCH we did not have this problem of a split between biological psychiatry on the one hand and dynamic psychiatry and psychotherapy on the other. My predecessor, Roger Tredgold, and I and most of our colleagues took it more or less for granted that these aspects of psychiatric practice should be integrated, both in clinical practice and in teaching.

When I crossed Waterloo Bridge to go to the Maudsley where the Psychotherapy Unit largely functions as a separate unit, as you know, the split between psychotherapy and general psychiatry was much greater than at UCH. This meant that at the Maudsley I was and functioned almost entirely as a specialist psychotherapist. In a sense I felt more relaxed at UCH where I could function in both roles but, if I may put it like this, my missionary zeal was greater at the Maudsley. There I felt the need to bring about more integration between the two approaches, especially when teaching

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psychiatric registrars who came to the Unit, and at case conferences and staff groups on the wards.

SB Why didn't they create a Chair at UCH and why didn't you become the first incumbent?

HW I will try to answer this. There were several reasons for it. First of all, as in many other medical schools, it took a long time before psychiatry was given full recognition as a major subject to be taught in the undergraduate curriculum. As I said earlier, when I was a student at UCH in the late 1930s we only had a few lectures on psychiatry and about a week of demonstrations of patients with major psychiatric illnesses at a mental hospital. After the war this changed and by the late 1960s the psychiatric clerkship had grown to three months full-time, largely as the result of Roger Tredgold's efforts. I think the introduction of liaison teaching on medical wards and the importance we attached to the close relationship between psychological medicine and the practice of medicine as a whole led our non-psychiatric colleagues to value and support our efforts. But this was still a long way from the establishment of an Academic Department and a Chair in Psychiatry. I fought that battle in the Medical School for many years and got a good deal of support but there was a great deal of competition for University funds and whenever it came to the crunch preference was given to academic posts being established in other disciplines. Ultimately I was asked to start an academic department and was appointed its Honorary Director. In essence, this meant that my salary did not have to be paid by the Medical School but by the NHS as before. I did, however, succeed in getting funds to appoint a senior lecturer and a lecturer. In a sense this arrangement suited me because if I had been appointed to a Chair at UCH I would have had to leave the Maudsley Psychotherapy Unit, which I was very reluctant to do. As you know, recently a joint Chair in Psychiatry has been established in the new Joint Academic Department of the University College and Middlesex Hospital Medical School. This Chair has evolved out of the Chair in the Middlesex Hospital Medical School, originally held by Professor Sir Denis Hill before he went to the Institute of Psychiatry.

SB I must say it seemed a puzzle to me that UCH didn't launch its own Chair earlier, like many of the other London schools did in the '60s or early '70s.

HW I might be a bit provocative in my reply to that. Some of the reasons I have just described, but in a way UCH may actually have benefited from not having a professor appointed earlier. UCH has for many years had a high reputation for its under- and post-graduate training in psychiatry and the number of our students who ultimately became psychiatrists was higher than in most other medical schools. Our emphasis on the close relationship between medicine and psychiatry and on integrating a psychodynamic with a biological approach when working with each individual patient has, I believe, contributed a good deal to this. We often feared that this tradition might be disturbed if a professor were appointed who held very different views and might impose these on the department. We therefore valued our relative freedom but we undoubtedly paid a price for this, especially where research and the expansion of the academic department were concerned.

SB One of the trademarks of that school of psychiatry must be the textbook that you and Roger Tredgold wrote and which I gather is coming out in a new form very soon. Is there anything particularly distinctive about that textbook?

HW Yes, there is. The new *UCH Textbook of Psychiatry*, about to be published, has developed out of the much smaller, earlier *UCH Handbook of Psychiatry* published by us in 1975. It has, however, been written in the same tradition as the earlier book, emphasis being placed on the individual patient's experience in the context of his personality development and the life cycle, and how this interacts with social and biological factors involved in the causation of psychiatric illness. In the new book this integrated approach also finds expression in detailed accounts of the various forms of dynamic psychotherapy and the need to combine these with physical treatments and social rehabilitation when appropriate. The new textbook is much more comprehensive than the previous one and has been written for psychiatric trainees as well as for medical students. I think what distinguishes it from other textbooks is the integration of the descriptive, biological, social and psychodynamic approaches, and the detailed consideration of psychosomatic medicine and liaison psychiatry. I hope that for these reasons it will be at least as popular and widely read as the earlier book.

SB It is seven years since you are officially retired. I use the word official because I know that you are still as busy as ever. What occupies your time these days?

HW That is so. For me to retire has meant changing my work rather than giving it up. I knew before I retired that as far as possible I would want to continue doing what I had done before. However, it is a relief no longer having to administer two departments, one at UCH and one at the Maudsley. This gives me much more time to continue my psychotherapeutic work with patients. I enjoy that a great deal. What I enjoy most is knowing that if I work in the right way with a patient for long enough he will mature and grow. It is that process of growth through therapy that I value most and I now have much more time for that than I had before.

But, in more personal terms, something very similar plays an important role in my life nowadays. I have seven grandchildren between the ages of one and thirteen. I thoroughly enjoy seeing most of them on Sundays for lunch; playing with them and seeing them grow and develop is a great source of pleasure for me. The other thing I value is that I am still teaching students and watching them develop. I continue once a week to supervise a student psychotherapy group at UCH and similarly, once a week at the Maudsley I run a supervision group for psychiatric registrars. I think the common denominator which makes my retirement so enjoyable is that in my family and by continuing to teach and to treat patients, I can help and watch many young people develop.

SB I have always known that you had an interest in nurturing young people and we spoke about this earlier, and indeed I felt much like a sort of son to you even throughout my period at the Maudsley. It also wasn't a surprise when we organised the first AUTP conference on teaching dynamic psychotherapy in Oxford, in 1982, that we invited you to give the keynote address and I remember on that occasion that we all saw you as *pater familias* and indeed still do. This discussion also reminds me of another paper of yours which I would group with the one on Loss as a contemporary classic; it is the one on the 'Therapeutic and Developmental Functions of Psychotherapy'. I must say it is another paper which I often recommend to my students.* And I do wonder if there is something within that paper, and related to what you are now talking about, which suggests that the nurture of young minds is really what gives you the greatest pleasure.

*WOLFF, H. H. (1971) The therapeutic and developmental functions of psychotherapy. *British Journal of Medical Psychology*, **44**, 117–130.

HW Yes, you are right; for me to help people to develop their own potential and to facilitate that development, is crucial. That reminds me of something that I haven't mentioned earlier. The psychoanalyst who has had most influence on my work as a psychotherapist was Donald Winnicott. He started as a paediatrician and then became a psychoanalyst and always emphasised the importance of providing a facilitating environment in which children can mature. If, after growing up they still have problems of a serious nature, it becomes the task of the psychotherapist or analyst similarly to create a facilitating environment in which such further development can take place, even much later in life. This is the developmental function of psychotherapy which I have emphasised in the paper you refer to. So in that sense this is very much a unifying theme in my life.

SB You have devoted almost half a century of your life to teaching and developing psychoanalytic psychotherapy in this country, but I know you have also travelled to other places and I wonder whether you feel that the British psychoanalytic tradition has something to offer to the world.

HW I think I can best answer this by saying a word about my visits to the United States. I was very fortunate in the early 1970s to be asked by Professor Peter Whybrow, then Chairman of the Department of Psychiatry at Dartmouth Medical School, New Hampshire, whether I could spend some time there teaching dynamic psychotherapy. Many years earlier Peter Whybrow had been a medical student of mine at UCH before he became a psychiatrist and went to the USA. I was therefore delighted to spend several weeks teaching in his department, and did so for several years running. I also visited and gave lectures or seminars on psychotherapy in many other psychiatric departments in the United States.

It was a pleasant surprise for me to find that we did, in fact, have many contributions to make to psychodynamic psychotherapy in the States. For example, the concepts of the British school of object-relations theory were of great interest to psychiatrists, psychoanalysts, and psychotherapists in the USA when I first started to teach there, especially the findings of Fairbairn, Melanie Klein, Balint, and particularly those of Winnicott, whom I mentioned just now. I would like to add that I thoroughly enjoyed teaching in the USA and made many friends among colleagues and students over there. I also learnt a

great deal from them which in turn helped me in my work back home. I found too that there was considerable interest in recent developments of psychodynamic concepts in several countries on the Continent, especially in Germany, but more so in departments of psychosomatic medicine and among psychotherapists than among psychiatrists. I hope that the need to integrate the psychodynamic with the biological aspects will continue to gain recognition among psychiatrists, in this country and abroad, so that patients can benefit from this wider approach.

We have learnt with deep regret that Dr Wolff died on 2 June 1989. An obituary will appear in a future issue of the 'Psychiatric Bulletin'.

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Why admit to a bed? Disposal of 1,000 referrals to a Regional Adolescent Service

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Twenty-five years ago, the Ministry of Health recommended that 20 to 25 beds per million population were needed for treating psychiatrically disturbed adolescents, a figure similar to that recommended by the Royal College in 1956/57. The College also recommended in 1976 the provision of one adolescent psychiatric team per half a million population. None of these norms has been met, nor are they likely to be this century. The decline in the teenage population may slightly reduce the need temporarily until the anticipated increase from the late '90s. Meanwhile, government financial restraints call for innovative and creative alternative solutions for the treatment of disturbed adolescents wherever possible without admitting to a residential unit. Indeed the pressure is so great that a number of adolescent units have already been closed, or their beds drastically reduced.

In his 1968 Isle of Wight study, Rutter estimated that around 21% of adolescents are suffering from socially handicapping disorders, of whom only one in ten were receiving professional help. Other surveys support his findings. The largest consumer group appears to be those exhibiting emotional and/or conduct disorders (around 90% of the disturbed population) and there is no current and reassuring evidence that such disorders are on the wane – on the contrary.

Mersey and the North West Regions are served by three adolescent units – one at the western end of Mersey Region with ten beds, and one in North Manchester with 20 beds serving the North West; my own unit, with 19 beds strategically sited at the eastern end of Mersey and south of Manchester, serves both regions. Referrals to us, amounting to around 250 a year, are about equal annually from each region.

Since we opened in 1970, the greatest demand on our service has been for treatment of the largest consumer group – emotional and/or conduct disorders – and indeed the diagnostic profile of referrals to us matches that shown in studies of adolescent disorder in the community; our in-patient population too appears to be a representative sample, although consisting of the more seriously disturbed. As psychotic adolescents appear to be harmed by placing them in the emotional turmoil of a unit treating serious conduct disorders, it was agreed when the unit in North Manchester was opened, that they would treat one portion of the psychiatric spectrum of disorder – including psychotic adolescents – leaving us to manage the more seriously acting out adolescents with emotional and conduct disorders. Between us we are able to offer two contrasting models which equip the service to meet differing needs as appropriately as possible. This integration enables the two teams to provide a reasonably comprehensive service.

The team based at the Young People's Unit in Macclesfield is largely community-based; only one-fifth of the referrals are admitted. Nevertheless the cost of admission remains high. Since the service is extremely thinly spread, it is essential only to treat those patients for whom treatment can reasonably be expected to be effective. A careful assessment process has been evolved. A majority of referrals are first assessed in the community in their own homes. Assessment is primarily concerned with three questions:

(a) Is the disorder treatable by the resources and skills of our team?
(b) If so, what changes do the family want?
(c) How much motivation to use help is likely to develop in the young person (and family