Dr. Cahn: Today I am interviewing Dr. Heinz Lehmann.

To start with, can you tell us how you became interested in psychiatry?

Dr. Lehmann: Well, I was an adolescent, about 14 years old, and I had suddenly developed difficulties in learning, achieving in school, to the point where I could not do any homework at all, and things looked pretty grim. Now, in retrospect, I think I would make the diagnosis that I probably had a depression. Nowadays we know a lot about adolescent depression. In those days, there was no such thing - adolescents and children had no depression. So there was no diagnosis and no treatment and no way out. Apparently, I wasn't able to do my high school work, and my parents were told to let me learn a trade instead; but they engaged a tutor for me. He was a student, a university student, who at that time was very interested in Freud's writings, and he was very psychologically-minded. He came, he did my homework with me - often for me. He came every day for about a year and I got out of my depression. At the time that happened, I was very much interested in psychological writings - in fact, between the ages of 14 and 15 I read everything Freud had written at that time. I still remember quite a few passages - where they were, on which page, and so on. So that gave me a mind-set for psychological thinking and influenced me as far as Freud was concerned for the rest of my life and my career.

But I also was always very interested in physics and chemistry and all natural sciences, so when I came to make a decision of what I was going to do later on - my father was a physician - I chose to go into medicine. But I immediately made up my mind that I would become a psychiatrist, which, from a 15 year old at that time,

sounded awful to my surgeon father and everybody else. They all said: well, if you go into medicine, you cannot know what you are going to do in the end; besides, psychiatry? there's no future in it! True, in psychiatry there was no treatment then; nobody could make a proper diagnosis, the whole thing was the least promising specialty in medicine. But I insisted that I would go into psychiatry later on and so I did. I also always remained very much interested in physical sciences. It followed that I was, from the beginning, interested in the biological aspect of psychiatry, and, of course, also in the psychological and psychoanalytical, psychodynamic aspects, because of the early imprinting. This combined approach has pretty well been my whole ~~pro~~perspective in psychiatry all along; the biological and the psychodynamic aspects having about equal weight.

Dr. C.: So this started out in the country where you were born. Would you like to tell us a bit about your moves?

Dr. L.: I was born in Germany, and I finished my university studies there, in Berlin. I also studied in Vienna, in Marburg and Freiburg, as one did then in Europe - one went to as many universities as one's father's pocket book could afford. Then Hitler arrived and I had to leave Germany. I came to Canada, to this hospital where we are now, Douglas Hospital. I walked in here on the fourth or fifth day after my arrival in Montreal, asking whether I could get a job. I did get a job, just before the war, so several of the other doctors and many other staff people had to leave. I had a caseload of about 600 patients and had to look after them alone, with one nurse, and a lot of untrained attendants, as they were called then, and it didn't leave me much time. I started at 8:30 in the morning and I finished at 1 or 2 at night. That was my postgraduate training in psychiatry. I never

had the time, or the taste, to go for formal postgraduate studies in psychiatry. I learned it here, without much apprenticeship and formal teaching, but by "total immersion" one might say.

Dr. C.: Things began to change after the war, when what important events happened?

Dr. L.: After the war there was a kind of revolution in psychiatry in North America. The snakepit-like conditions of mental hospitals underwent a change, the mental hospital environment was much improved.

Within about eight to ten years, the psychotropic drugs were discovered: to start with, antipsychotic drugs in France, the phenothiazines. I was one of the first to read those French reports. Because my wife is French Canadian we speak French at home, and so I could read the French medical literature; I became very intrigued by one or two of the first papers by Delay and Deniker from France, on a new drug that apparently produced peculiar affects. I was so much intrigued that I decided I would try these drugs out here. The next day I cornered the first psychiatric resident I met and asked him whether he would work with me on this new drug, which seemed to be almost incredibly effective in conditions for which nothing else would work. He joined me in the research - it was Dr. Hanrahan - and within three months we had treated more than 70 patients with the new drug, incidentally, without any grant money. I did not even have to ask my superintendent whether I could do the study - I just did it. There was no informed consent concept at that time. Of course we didn't have any extra staff, it all had to be folded into the daily work, not even secretarial help. Within three or four months we had the first paper ready - that was the first paper in the English language on antipsychotic or neuroleptic drugs.

Dr. C.: That was chlorpromazine, or largactil, as it was named by the company.

Dr. L.: Yes, that was chlorpromazine. From then on it followed that I became rather absorbed in psychopharmacology. I was actually urged by the NIMH to apply for a grant. It sounds strange today, but in those days in the study groups of the NIMH, where I was also invited to work, we sometimes did not know what to do with our money; I remember one time when we had a million dollars in Washington we had to spend before the end of the fiscal year, and we did not know what to do with it. So, in the next ten or twenty years I was doing a great deal of clinical trials work, and there is probably hardly any drug, either antidepressant or antipsychotic or anxiolytic, that I did not work with in clinical trials at that time.

Dr. C.: Can we just talk for a moment about imipramine which was the first major antidepressant drug?

Dr. L.: Well, there again, I think ours was one of the first papers in English - ours, that is yours and mine - we both were co-authors. I had read about Kuhn's work who was the one who discovered the antidepressant effects of imipramine. I had read about his work in a Swiss journal.

Dr. C.: In German?

Dr. L.: In German, yes. The other one on chlorpromazine was in French. Of course so many, if not most, of the real breakthroughs in psychiatry came from Europe until quite recently, and so also the anti-depressants and a little later the benzodiazepines, the anxiolytics were added to all the clinical trials we were doing, most of it here in this Hospital in Montreal.

Dr.C.: Who were some of the people who influenced you the most?

Dr. L.: As I said before, Freud is one of them. Afterwards, as a student in my first year of university I was supposed to study only medicine, but I was also studying philosophy. I became interested, and definitely came under the influence of the existential philosophers, especially Heidegger - I was in his seminars in Freiburg on St. Augustine, Kant, Hegel and Husserl, and in seminars of other philosophers; so the existential aspects and the epistemological problems of psychiatry and of making a diagnosis, as well as making experimental studies - all this has always been very important to me. The existential aspect of philosophy also influenced my psychiatric approach to patients, so that I have really three perspectives for each patient: an existential one, a psychodynamic one, and a biological one.

Dr. C.: Were there any Canadian psychiatrists who made a difference to you?

Dr. L.: Well I was and I am still reading very widely in psychiatry. I spend on an average two hours every day just reading psychiatric literature. In that way, every psychiatrist who publishes had or has some influence on me.

Dr. C.: No one stands out in particular?

Dr. L.: No.

Dr. C.: What about American psychiatrists?

Dr. L.: No. It is strange - I have no hero, except Jaspers and Kraepelin, the cornerstones of modern European psychiatry, one might say. And then, of course, Freud. But I have never taken postgraduate training either, as I mentioned before, so there is no particular person

whom I would consider a mentor, although I have of course met many of the outstanding psychiatrists in North America and in Europe, but none of them has had any particular influence on my psychiatry.

Dr. C.: What do you think have been the most important developments in psychiatry in the last ten years?

Dr. L.: I know what most people would say and what I am expected to and do tell my students, with qualifications: the most important recent developments are obviously the neuroscientific discoveries and the technological advances, the imagery, the sort of thing like the PET and the MRI, the quantified EEG, that can make us actually see an image when people think, where they are thinking in the brain, or whatever physical processes take place in the brain while they are thinking, what it looks like on graphs and false colour images. But while that is a great progress, it is to me also a danger to psychiatry, because, as I see it, the psychological understanding and the psychiatric treatment of a patient is not really helped very much by these technological breakthroughs. I still have to see how the PET and MRI - as they have existed now for fifteen years or so - have helped in the treatment or even in the understanding of patients. Neuroscientifically, we can explain molecular processes much better today because molecular biology and discoveries in neurochemistry are helping us to develop more specific and often more helpful drugs. And the molecular biological breakthroughs in genetics - they are remarkable - but again, as a psychiatrist, somebody who is treating, not just trying to explain, mental illness, there is not anything that can be done with our genetic discoveries at this point, and perhaps not for the next ten or twenty years - at least, not anything

that we have ~~now~~ not been doing for many years, like genetic counselling.

Dr. C.: Coming back to your own contributions, I know you are a modest person, but would you like to tell us about what you think were your most important contributions to psychiatry?

Dr. L.: Well, the demonstration that psychotropic drugs, such as chlorpromazine, for instance, are actually effective, so effective that there remains no doubt about it, even for the sturdiest psychoanalyst. Eventually they all had to admit that there is a physical substrate to, say, schizophrenia and bipolar or manic-depressive disorder, because certain physical substances, drugs, definitely are helpful in treating these disorders. Before that, until the early 1950s, it was archaic and very unsophisticated - almost simplistic - to think that anything physical could be done in the treatment of schizophrenia. It had been tried for so many years, decades, and nothing had ever helped, so one would have to understand schizophrenia on psychodynamic terms, and the only rational intervention was psychoanalytical or psychodynamic treatment. Well, the fact that I was able to demonstrate, with others, that physical substances can profoundly change the course of schizophrenia and other psychoses made it quite clear that there was a biological substrate as well as psychodynamic factors involved in their causation - for that matter probably both in equal measure.

Dr. C.: In other words, there is no major mental disorder which does not have some kind of physical or chemical basis?

Dr. L.: Oh, I wouldn't say that.

Dr. C.: No?

Dr. L.: No. For that matter, every thought has a physical basis, of course. If we would not breathe oxygen we could not think. But

where does the reductionism stop? It can go down to the single cell that is activated, or fires at certain rhythms, the gating of ions in the neuron, and so on, in the brain, but that does not give us any idea - and probably, in my conviction, never will, tell us anything about the particular thought in which the firing of that cell is involved. All we can say is that as long as we are alive we must be biologically functioning, based on physical substrates. But what has that to do with human psychology?

Dr. C.: In the future of psychiatry as you see it now what would be the most important developments?

Dr. L.: I am often asked what I think is the next big breakthrough, and sometimes, not always, I say that I am expecting no new drug or no new physical discovery or treatment to be a really new breakthrough, but I am hoping for the media to produce some sort of a psychological revolution in the public area, just as the sexual revolution came about through the media, although it had been something that had been unthinkable ten years before. So I hope that eventually there will be a psychological revolution, meaning that people will really begin to think and act seriously regarding psychological problems, such as, how to raise children, how not to beat them up - or how to structure one's value system away from money and power, which are the fundamental values for every red-blooded American and Canadian today. Change our value system to constructive social interactions and to creativity, and consider money merely as a necessary thing and power a thrilling, but dangerous pleasure, but nothing to particularly strive for or spend time with. That will be a long time off, but once we get there I suppose it will have a great influence on peace in the world.

If only everyone knew how not to treat children, how to be better parents, we would probably, in my opinion, reduce all mental disorders by 25 to 30%. Other more immediate progress will, I hope, take place when we begin to realize that there is no polarity between either the biological aspect of psychiatry or the psychodynamic, and that the two are welded together. Now, I know there is the biopsychosocial model: everybody talks about and everybody says this is their model, but very few people really respect it; people give lip service to it by saying "oh yes, of course, I know there is a biological substrate - we are physicians, we have to know a lot about physiology and we have to use drugs" - but they are really passionately involved only in psychodynamics; or the other pole where psychopharmacologists will say: "oh, of course, I know there are psychological aspects to be considered, placebo effects, and dynamics and so on" - but they are really completely involved only in the biological and psychopharmacological neuroscience aspects. If the two would really come together and get equal weight, in teaching as well as in practice, then I think we will really make progress in psychiatry. Right now we are on a dangerous course, as I see it, because it takes endless hours for psychiatric residents to study neuropharmacology and neuroscience which they will never quite master because they have not got a PhD. But dabbling in it takes a lot of time, much too much time, away from being with patients, understanding patients, dealing with patients, talking with them, listening to them. Also, it is too easy to take cook book recipes, simulating psychopharmacology; and we are, of course, seduced by the fact that when we have a PET scan we have something that other physicians and other

specialties have, namely, some objective graphs, some objective evidence. In psychiatry we have always been hungry for that sort of thing and often feel under-privileged because we do not even have any sphygmomanometers or thermometers, to objectively evaluate our patients. Instead of feeling under-privileged we should feel privileged that psychiatry is the one specialty in medicine where we can and must transcend the biological machines and molecular assemblies.

Dr. C.: Is there anything else you would like to say?

Dr. L.: No, I just wish that my hopes will be fulfilled.

Dr. C.: That concludes the interview with Dr. Heinz Lehmann, whom I consider a "psychiatrist for all seasons". Thank you very much.