DC: Hello, I'm David Cline, and I'm a psychiatrist practicing in the Twin Cities of Minneapolis, Saint Paul, Minnesota, and today, June 24, 2009, we are continuing our project sponsored by the Minnesota Psychiatric Society, entitled the Oral History Project. There's a maxim in medicine that goes something like this: If you want to find out what's wrong with the patient, listen to what the patient says. Listen to what the patient says. In our documenting what psychiatry has been like over the last several decades, we've decided to ask senior psychiatrists as to what their experiences were, practicing psychiatry in the Minneapolis area, or in some cases throughout the United States and the world.

Today with me is Dr. Joseph Westermeyer, who has agreed to tell us of his experiences and I welcome you very much to be part of this project.

JW: You're welcome.

DC: Would you start by telling us where you were born and some of your early experiences growing up and where you grew up, and school and things like that.

JW: Sure. I was born and raised in Chicago. I was born in 1937 and probably my earliest childhood, from about age four to eight, was a bit scattered in terms of where we lived and the war was going on at that time. My father was in the Navy. I had initially two younger sibs, and so the war influenced us a good deal, in terms of where we lived and the background of all that was going on. [There was] a good deal of scarcity but a good deal of resilience and people getting on despite it. [There was] a lot of reliance on an extended family, so I'd say I probably was parented by a village, in the sense that my aunts and uncles and especially my paternal grandparents spent a lot of time saving me from myself and raising me. After the war we went back mostly to Chicago until I was about age fifteen, and then my family moved up here to Minnesota, and then since [that] time Minnesota's pretty much been my home place, although I lived in Asia for about four of those years and spent three years in Oklahoma, but always come back to Minnesota.

DC: And your early schooling was where, here in Minnesota?
JW: My earliest schooling was mostly scattered around the country, in Chicago, a good part of it in Cincinnati, during World War II, and finishing up school in Chicago and high school here in the Twin Cities, and then college here in the Twin Cities.

DC: I believe you went to a private high school.

JW: I did. I guess you might say I went to private schools all the way through that period, but I think of them as public in the sense that they were Catholic schools. Tuition was low, mostly there were nuns and priests running the system, and so I really didn’t get outside of that more narrow ethnic-religious background until I went to medical school at age nineteen.

DC: I believe I remember some major leadership roles you had at Cretin-Derham, also and the military aspect of the program.

JW: Yes, being elected to class offices and sports and so I got a taste of leadership during that period, although I think it probably began a bit earlier than that, beyond my having any say over it, as a result of my mother having three of us, then being a solo mother and then working while my father was gone, so I probably did a lot of early parenting of my sibs, taking orders from my mother and learning from her how to delegate.

DC: Chief executive officer.

JW: Yeah, yeah.

DC: So university was here in Minnesota?

JW: Medical school was here in Minnesota, although college was at Notre Dame and Saint Thomas and a few other colleges, because I didn’t really have a place to stay or live at that time. My parents had moved back to Chicago and I had four younger sibs, and so I was kind of responsible for my own educational funding, so that kind of went the way of wherever I could manage a scholarship or a job or what have you while I was getting through school.

DC: My, that’s impressive. How did you decide to go into medicine?

JW: I think it was something probably initially that I more bumped into than had planned for, and so in college I really wasn’t sure what I wanted to be, but the courses that I took happened to be courses where there were a lot of pre-dent and pre-medical students, and I liked them personally, and I’d say through them, through osmosis, practically, I kind of learned their goals and their life plans for themselves, talked to my father about it, who was an attorney, and he thought that would be a fine thing to do, and then talked to some other college mentors I had. Probably behind it all was family physicians throughout my childhood – my family always had a family physician who kind of brought us through whatever crises – broken bones or pregnancies or illnesses – and so the idea of being like them was good. I mean, all of them were really fine people and good role models, and although they put in long hours, they seemed to enjoy their work and have a lot of empathy for us, despite the challenges we imposed on them.
DC: Are there physicians in your family heritage?

JW: Not one. No, as a matter of fact, despite my last name, I’m mostly Irish, and most of my Irish relatives are fairly recent arrivals, and so I would say relatively few of my greater relatives, other than my father, had gone to college. By the same token, I think, growing up in my family, going to college was sort of what you breathed in with the air, and so I never had a thought that I wouldn’t go to college.

DC: Mostly Irish and part …

JW: Mostly Irish and then a tad German, but that German grandparent died when my father was young and I never knew him, so I guess there’s some heredity there, but not much in the way of social parenting anyway.

DC: I see. And your people came what years, roughly, to this country?

JW: My grandparents came in the early days of this [20th] century as young adults, and then met in this country, married in this country, and then had a large family and were surrounded by their relatives, who were immigrants, too. So without really knowing it, I was surrounded by immigrants and people who were trying to make sense of the new society, and I think that probably influenced my later work with refugees and immigrants and socio-cultural differences.

DC: So then medicine came to you kind of by osmosis, you said. Was there any other area that you thought you might pursue?

JW: Not seriously, and I think that probably was part of it. I had grown up watching my father in his Navy uniform, and I thought that would be something I might pursue, but he took his uniform off after the war, and the military really didn’t particularly appeal to me by the time I was a teenager, so I was kind of bereft of my earlier aspirations.

DC: So medical school was at Minnesota?

JW: Medical school was in Minnesota--[completed in 1961].

DC: And then after that, what was your …

JW: I loved medical school, I loved every part of it and every course. I didn’t run into hardly a thing that I didn’t really savor, so couldn’t decide and didn’t have to decide in those years on a specialty, so I did general practice through the general rotating internship, and then did general practice in Saint Paul for three years before going to Asia as a volunteer.

DC: Tell us about Asia.

JW: I think Asia was one of those milestone times in my life. I enjoyed general practice. It was a lot of fun and a lot of challenge, but I felt I had gone as far as I could, that there wasn’t much
more that I could do or that my skills or training or privileges would allow me to do, and so I was beginning to think of going back, as many of my classmates were doing at that time, going back into residency, but couldn't decide on anything. I'd married by that time and had a child, and so I thought if I was going to do something adventuresome or different, that would be the time to do it, and had often thought of joining the Peace Corps or the Indian Health Service or something like that, and so looked around and [in 1965] ended up joining the Agency for International Development for two years. They sent me to Laos, where I worked in the public health division of that program in Laos, which allowed me to apply a lot of skills that I had picked up at that time – a lot of infectious disease, a lot of acute care, a lot of trauma – and then I think got very interested in public health, although I hadn't been interested in it earlier, or I came to see the implications of that in a setting like Laos. So that kind of opened up another door, you might say.

DC: Upon your return, what was your pursuit of medicine?

JW: I made arrangements, interestingly enough, even though I was steeped in acute medicine and surgery for those two years, what I really began to think about and drift towards was psychiatry, which surprised me a bit because it hadn't been what I'd been doing for two years, but didn't surprise me in the sense that I'd always gotten a lot of enjoyment out of my psychology courses, psychiatry courses in medical school and pre-med, and I came to see later that an awful lot of veterans of World War II and the Korean War ended up leaving up general medicine after being involved in the war and going into psychiatry, so I don't think of that as a total accident, but came back and made arrangements while I was gone to enter the program here at the University of Minnesota – came back from Asia just as residency was starting here [in 1967].

DC: Any particular things that happened in Asia that were rather profound or rather striking to you?

JW: The things that probably were in my awareness at the time – the [Viet Nam] war, the trauma, the work – certainly captured my interest and my imagination and my devotion. I'm not sure they directly had any immediate effect, but I think the long-lasting effect is I really got interested in refugees, combat veterans, post-trauma. I think, even though I was exposed to a lot of war when I was there – I was older, I had a family – I can't say that it didn't have any personal effects on me, I think it certainly did, but it didn't harm me personally in the same way that it has lots of people. It did harm people that I knew well and affected them in a variety of ways. So I think that probably, in the long run, did have a big impact on how I spent my career.

DC: Were you exposed to combat action?

JW: Yes, on a number of occasions, places that I was in were attacked, and day-by-day I dealt with people who were wounded, children, women, old people, combatants, militia, people in the regular Laotian army, and so even though I was a civilian, it was probably a lot like being in a MASH [military hospital—Mobile Army Surgical Hospital] unit for those years. When MASH came out as a movie – probably an ancient historical interject – it seemed like old home week. At the time we were all young people in our 20s, mostly people from Laos, and we really kind of made light of what was going on and enjoyed the moment and played a lot of tricks on one
another, played a lot of volley ball every day and sort of made light, I would think, of what was going on around us.

DC: So, back to Minnesota and Minneapolis [in 1967] and psychiatry residency.

JW: Yup. And I think it was a great time to train, looking back at it. There were still, I would say, two divided camps in psychiatry at that time -- people who had grown up and committed themselves very strongly to psychoanalytic theory and psychotherapy, psychodynamically-oriented psychotherapy, psychoanalysis, and we were steeped in that. I can recall during the first year that I spent an hour each week with one of three different analysts, which was a phenomenal experience, and one that I’m not sure anybody has any more.

DC: Do you remember who those were?

JW: The people? Well, they varied somewhat over that year. I’d have to go back and search my memory for their names, but their faces and their personal characteristics are etched deep in my memory.

DC: Otto Raths ...

JW: Otto Raths was one, I spent about an hour a week for a year with Otto.

DC: Hambidge?

JW: No, not with Gove, although I had Gove for a year in a seminar with our other residents, so at least 50 hours with Gove, 50 hours with Raths. Another guy who used to smoke cigars and the cigars would dribble down his tie.

DC: Is that the guy who wouldn’t light them?

JW: He would seldom light them, but he would chew on them.

DC: Always chew on them, yes.

JW: And so that was wonderful. And then I’d say the other hour was usually with whoever was heading the service, so an hour was with Dr. [Werner] Simon, who was himself, I guess, a refugee of the Holocaust in Europe, and maybe somebody who was very congenial to things that I had been through in Asia. Otto Raths had been through World War II, and so I think he was another person who helped guide some of my experiences and some of my interests in Korean War and World War II, that’s what I picked up at that time.

Anyway, in addition to that group of people who were steeped and skilled and very knowledgeable about psychotherapy, and I would say very knowledgeable about psychopathology, because I think you can’t really dissect the two, if you’re going to be comfortable working in that area, you really have to know what you’re rolling around in the midst of, so to speak. But also, around that time there were some real experts at Minnesota who
were heading up this new era of psychopharmacology, who were really pioneers, one of them being Burt Schiele, who was probably one of half-a-dozen national leaders at that time.

DC: What years are you speaking of?

JW: This would have been '57 to '60. So from that group, too, I think I really learned a lot about psychiatric research, about sampling, about use of [research] instruments. Since everything they did with these new medications at that time was new, they were really trying to use whatever was available in terms of research methodology to put psychopharmacology on a firm scientific basis in moving it ahead.

DC: So Thorazine and Imipramine would have been two major players.

JW: Yes, and fairly new and recent at that time, and still being evaluated at that time. And lithium not long after. We did the early ... I was part of a team, as a resident, and then later as a junior staff member, part of a team who worked on these various drugs, as well as Haldol and some of the newer generation of Thorazine-like medications, and lithium as well, and then later on various anti-depressants that would be assessed. An exciting time!

DC: Yes.

JW: But I think probably in addition to those two things, sort of steeped as I was, you might say, in trauma, in public health from working in Asia, I really started on my own looking at what I would call socio- and cultural issues, and so I finished off an anthropology degree that I had started earlier, a masters in anthropology, and started doing work towards a master’s in public health, took a lot of epidemiology. So, kind of brought to my training, you might say, something new that wasn’t provided in my environment, and that was going outside of psychiatry, you might even say going outside of medicine to beef up my background in socio-cultural principles and fundamentals, but also epidemiology, which would be the study of disorder as it existed in social groups or in populations.

[Ed. Note: Dr. Westermeyer completed his psychiatric residency, was awarded a Master of Public Health degree, and PhDs in Anthropology and Psychiatry—all in 1970.]

DC: A much broader perspective.

JW: Yeah. Looking back at it, I just sort of went through it like Topsy, you might say [chuckles]. But looking back at it, I had those three legs to the stool – psychology, psychotherapy, psychodynamics, the thinking world; and then medications and diagnosis and doctoral traditional medical kinds of things; and then, going outside of traditional psychiatry, traditional medicine, to look at public health and society at large.

DC: Very comprehensive view—incorporation...

JW: But maybe dangerous, too, ‘cause out of that I really learned rapidly you have to be able to focus, and you can get lost down in the side alleys and things of interest in books, things that
might be peripheral, so how to focus in on what might bind these together or allow those to be stepping stones to something, rather than a slide into minutia or esoterica.

DC: Well, you pursued an academic career almost immediately.

JW: Almost from the beginning.

DC: Tell us about that. How did you decide to go that direction?

JW: Again, I think probably I was lucky enough to trip into something. If I look back at my life, it was more a matter of not driving down a road, perhaps, but going across a body of water and the winds and the tides kind of pushing me as they will. So, as I was in the midst of this training and kind of getting towards the end of it, I’m thinking about – what is there in my day-to-day work that might let me bring together these three themes, or these three areas? Somewhat by accident, I was at one of the county hospitals when a staff member went on a lengthy leave of absence and left behind an addiction service, and I was asked if I would like to run that for the time that he was gone.

{Break in interview}

So taking over this addiction unit for several months was really another one of those accidental boons that kind of fell in my path, and while it was exactly the kind of thing that most people were avoiding at that period in time, I really enjoyed it. I enjoyed working with the patients, I enjoyed the medical dimensions, coming from a family practice, general practice background, the medical problems were interesting to me, and I think helpful in trying to figure out where the person was and what might be done next. From a socio-cultural standpoint, it also was interesting to me, because I saw people from various ethnic groups in Saint Paul, where I had grown up, and the way in which their drug or alcohol problems might manifest themselves were often interwoven with familial or cultural dimensions and so I actually started my first studies there that I later published, and so I thought, hey, this is a good place for me. It lets me intersect psychopharmacology, caring for people with behavioral as well as mental and emotional problems, and looking at things from an epidemiologic and a socio-cultural standpoint. Also, it didn’t seem like an area where I would have a lot of competition. It was sort of an open, fallow area where there was just beginning to be some interest. The National Institute of Alcohol Abuse and Alcoholism had just started.

DC: When was that, what year?

JW: This would have been in the late 1950s. I think the National Institute of Drug Abuse had not yet appeared, but was soon to appear in the subsequent year or two, so the timing was good, again, one of those accidents. If this ended up being a neglected area in healthcare or in psychiatry, I’d have probably been trying to push a big stone uphill, but as it was, it happened to be a good – but accidental – decision.

DC: Your experience with that service was about what year, do you recall?
JW: That probably would have been about '58, I think, '58-'59. [these dates are in question] And also, I would say, too, in the midst of what was the beginnings of the young people's drug epidemic, kind of interwoven with a lot of the anti-Vietnam political movement, a lot of almost revolutionary ferment among young people, in the midst of which was the use of new and sometimes old drugs as kind of a statement of rebellion.

DC: The roaring '60s of drug use and counter-culture, to follow there. So you had an interest there, in addition. How did it all kind of play out in terms of your choosing academia to spend your life?

JW: By my last year of residency [1970] I had developed a plan that I actually put together with two or three faculty members to start a study at the university to admit a group of alcoholics and also to concurrently do an epidemiologic study and a socio-cultural study. I went to Don Hastings who was the chairman at that time and presented him with that idea because it was going to mean having access to inpatient beds, it was going to mean spending a modicum of time off campus and at the State Department of Health, chasing down epidemiologic data, and much to my surprise, he just thought it was a grand idea. [chuckles] I thought this is going to be tough to sell in the medical school, but he really just was a great booster and said it was fine. Kind of turned me over to Burt Schiele and John Bransford [?] as mentors, and I chased down some other mentors from the School of Public Health and from the Anthropology Department, and those four folks then guided me for about two years, I would say. So that was another great advantage and something that I think would be very difficult to do in today's world. The resident's time is so lock-step, and the financing of residency is so tight that it would be difficult to accomplish. So it was, again, a boon from that time.

DC: How good that was for you. So that would naturally lead to academia and further pursuits, if it went well, and it obviously did go well for you. You took to it and it was a good fit.

JW: It was a good fit. I had good mentors. I think I had very good guidance, excellent guidance, and so my beginning works, then, ended up being fairly readily published. Not always, and not typically in first-line journals in the early years, but always published and probably if my current experience had been my experience then, I might have gotten discouraged, [chuckles] because I know now it isn't so easy to get grants and it isn't so easy to get published, but I think what I was doing at that time was new, there wasn't much competition, but there was a lot of interest, and so it was pretty easy to be successful early-on, and success tends to breed more of the same, and so things went well for me.

DC: This all took place in the Department of Psychiatry as home base, at the University of Minnesota Medical School ...

JW: At the university – which again was another advantage. I think then the university, perhaps even more than now, really was a good place to get started. There was the Minnesota Medical Foundation. There still is the Minnesota Medical Foundation, but both Minnesota Medical Foundation as well as the graduate school had funds available to help young people get started, so in the early years, just about every year one of them, two of them would give me some seed
money to get a project going and then those projects could oftentimes lead to additional funding, and again that was a key element.

DC: Your teaching experience – tell us about that.

JW: It’s interesting that you might bring that up, because I think probably like the average young physician, I really knew how to teach at the bedside, or to teach in the consultation room. I was good at that, even as a resident, I think because I had so many fine mentors, but when it came to doing a course or even doing a lecture, I really was behind the curve. I didn’t really know how to proceed, and you ended up being a mentor to me. I inherited a course from you. The first course I inherited from you was an interviewing course, which then I played with over four or five years and did a lot of the things you did with it and elaborated on it, actually had conversations with you about those elaborations, and then after about four or five years, inherited another course which was the psychopathology course for medical students, and again – I don’t know if you remember your innovations around theatre and the use of humanities to teach psychiatry – and so ended up not starting out with a plan to be a pedagogue, or involved with medical education, but then ended up really having a fair stream of my life involved with that.

I ended up at various times heading up several courses, starting several courses, heading up the medical student [psychiatry] education for probably a decade, becoming the chairman of the curriculum committee during your curriculum change that went on for three or four years. Got involved with the National Board of Medical Examiners, [American Board of Psychiatry and Neurology] was on committees with them for a dozen years, and am now just finishing up my career as chairman of the Addictions Sub-certification Committee of the American Board, so probably 35 years of this or maybe 40. So I’m finally getting to the point where I’m going back to where I was, doing some bedside and clinical teaching and going back to my roots.

DC: You had some important positions in the direction of psychiatry, being chairman of departments and other important things like that. Tell us about those.

JW: Again, I’d say, along with developing as an educator, as a pedagogue, which I think was purely accidental, [chuckles] not something that I went to, but having a chairman who needed somebody to take over in your footsteps – purely accidental ends up being a strong theme in my life. Another area that I didn’t have any aspirations for as I started out was to head up a department or be a chairman or a leader. But I think that changed when I got to be about 50 years of age and what I call my avuncular urge came to the fore, and avuncular relates to “uncle”. It’s an anthropological term to some extent. It has to do with uncles who are also father-like in certain cultures. And so, I felt like I had really loved my career. I couldn’t recall any part of it, even the difficult times, which we all have. I really liked getting up in the morning and going to work, and I began to think of all of the people that I owed this to, that really I was kind of a medium between accident and coincidence and these phenomenal people who mentored me and in whose footsteps I’d been lucky enough to follow and thinking about what in the middle I had been and just sort of the unformed clay and got to be thinking how could I help other young physicians in the meantime, and so I got to think about should I be a chair? I really became impressed that as a faculty you can have a strong influence, but it really is chairs who hire and create time, space, resource for young people to develop. And so, I became a chair for three
years [University of Oklahoma Medical School], then was asked to return to Minnesota as a
service chief at the VA [Veteran Affairs Medical Center, Minneapolis], which kind of let me
come back to Minnesota, which I really wanted to do, but also let me be in a position of
mentoring without necessarily being involved in all of the politics and the finances that running a
department entails. So, I ended up doing that for sixteen years. So, I had almost two decades
of that kind of leadership and mentoring, which I've been ecstatic about leaving. [laughter]

DC: Tell us when you left the head of the Department of Psychiatry at the VA.

JW: I gave it up just a little over a year ago, and it's interesting in some of the questions you
asked me to think about in preparation for this, some of my greatest joy and, I would say,
greatest accomplishments have occurred during these few decades of leadership or
administration. Mostly, I would say, in the guise of young people that I've had some influence in
their career development, and really has given me a satisfaction about life, so that as I go into my
senescence [chuckles] I feel really good about it. I don't mind going into my senescence with
that training behind. By the same token, I think some of the most distressing and difficult times
happened around the same kind of roles. That the worst and the best, you might say, occurred in
these administrative roles. I feel like I gave it my best shot and I'm very happy to get out of it
and back into being a clinician, being kind of a bedside mentor and getting my research back on
the front burner.

DC: In looking at both sides of that, what do you count as your best things you've ever done, and
to advance the question, what went wrong—can you cite some project that went wrong?

JW: I really count my failures as being my great teachers, since my successes rarely have taught
me anything. [chuckles] I just keep doing the same thing over again. But my failures always
Teach me a great deal, 'cause I mull over them, I don't shed them easily. They stay with me for at
least months, and sometimes years, and continue to inform me.

But to go back to how being in administration really led to some good achievements, I think one
of the achievements that I feel very positive about was the ability to kind of exercise some of the
thoughts I had about psychiatric services, based on public health models, public health
approaches, based on what I really learned from my psychiatrist mentors about the course of
illness and the course of recovery. It really let me redesign at the VA a lot of the services there,
and I count myself lucky to have had the bosses that I had there and at the University of
Minnesota, who also gave me a lot of support so that I could begin new models even as a faculty
member at the university years ago in my 30s and 40s, new models for care in the addictions,
started a program in that. New models for the care of people cross-culturally, refugees,
victimized people. A lot of opportunity on a small scale to do that, so by the time I took a
chairmanship and then by the time I returned to the VA here, I really had kind of under my belt a
lot of experience and confidence about how to develop a service that would lead staff to feel
reward in their work. Helped psychiatrists work out at the periphery of their skills rather than
kind of ensconced, [chuckles] protecting the last bastions of their skills.

Just as an example, when I first went to the VA, we had 90 inpatient beds and 3,000 patients a
year. Length of stay was out several weeks, a few months, and when I left we were treating
almost five times that many patients with only twice as much staff, and we only had 30 inpatient beds. Today we have 15 inpatient beds. By the same token we developed all kinds of new programs which innovative staff were willing to take on – day programs, evening programs, specialized programs for particular groups of people that were difficult to reach. Staff feeling empowered to take on particular groups of patients that everybody was trying to avoid, and without the leadership role, I would have had a grave difficulty doing that, because I had to find beds on campus that weren’t hospital beds. To achieve this I had to convince my supervisors and bosses that this was going to be a good thing, based on their faith alone, without having proven models in any system. So that was a great time for me personally, and it wasn’t easy, because some staff just couldn’t abide that and were very upset by it and left, actually. But, it was personally greatly rewarding, and did allow us to build both research and education that was ensconced around this kind of a model.

DC: That’s quite remarkable. That phase at the VA was when it all came together and you could formulate programs that incorporated all these experiences you’d had previously.

JW: Right. But also very lucky, because I was working with a head nurse, a head social worker, and a head psychologist at a time when these people were ready for change and in the VA as well as in other institutions – in fact I would say even more than other institutions at that time – the disciplines tended to be ensconced in silos, almost like castles, so that it was very difficult to do anything across disciplines that wasn’t already steeped in tradition. And, of course, what we were trying to do was to break down these silos and to have people work across disciplines in ways that were new and that there wasn’t any tradition for, particularly in day programs and evening programs or specialized programs. How they were going to work things out, how they were going to divide responsibilities was not at all cast in concrete, it had to be developed from the ground up by these folks willing to trust one another. I had faith that they would, given the press of patients and work. Fortunately, I was right about that. I think what really led them to share responsibility was that they both had more patient work than they knew what to do with. As we created a good model of care, we were deluged by more and more patients, which actually ended up driving innovation in the same way that I saw war, back in Laos, as a young man, driving innovation too. We found that people would rise to the occasion, that nurses and others could and would do things that were kind of out at the limits of their capacity when we were so loaded with wounded and ill that people had to do what needed to be done. I had faith that that principle could occur in the midst of peaceful institutions, and indeed it did.

DC: Maybe you could comment about this change and how it was reflected in the Department of Psychiatry -- and Psychology, I might add – at the university, because that department also had times when there was isolation and issues of control and power. We had an evolution that came out that both made improvement but also was sometimes bloody.

JW: That’s right! It’s interesting to think about that era, because just as psychiatry was sort of in a rift, as I started my residency, between psychoanalysis and psychopharmacology, and then those two things had to be brought together in some way over time. A similar process occurred when I was a young faculty member, as were you, at a time when psychology and psychiatry similarly were not companionable. As psychologists became more and more involved with doing psychotherapy, there had to be, then, some sharing of responsibilities and roles, and I think under
Don Hastings that process seemed to be going afoot. But then it hit on some bad times, and so in a sense there was like a divorce [chuckles] where many psychologists in the Department of Psychiatry left the medical school and went over to the psychology department in the general campus, in [the school of] Science, Literature and Arts. So in a way that was a difficult time.

DC: I think, the ‘70s.

JW: Yes. The psychologists who left, I think, made their mark and made it in ways that were sort of advancing psychology and psychopathology in the School of Psychology, but those who stayed behind I think also managed to bridge this rift between psychiatrists and psychologists. I can recall being torn, during that time, because during my training I had models in both disciplines. I had mentors who were psychologists and mentors who were psychiatrists, and didn’t feel torn internally any more than I felt torn by having mentors who were psychopharmacologists and mentors who were psychoanalysts. I felt on a day-by-day basis I was really able to integrate those and I didn’t feel the rift personally, but I was bothered by having this rift go on around me. But it eventually all kind of settled down and went on. I think probably that taught me some very important lessons about identity and discipline and things that were able to guide me subsequently as I was trying to bridge differences across disciplines at the VA, and how people get on to seeing a common vision, even though they might have separate visions as well and separate identities and separate responsibilities, but to help them see a common identity and a common vision in a way that would get them to forget their differences temporarily – not permanently and not absolutely.

DC: It’s been an interesting evolution to observe. Do you have some other impressions of the field that you have made, having the experiences you’ve had?

JW: In a way, I think I’ve seen through my career sort of the over-emphasis in psychopharmacology and biological psychiatry that I experienced, say, 30-40 years ago, when psychoanalysts kind of held turf. All of the major departmental chairs [of psychiatry] in the country were analysts, and it was very difficult for people in psychopharm to get a foothold in departments, and it was not an easy time for them. You would have thought that they would have kept an eclectic vision [chuckles] as they came to their time in power, and that hasn’t happened, which I guess has given me pause to think through how all of our institutions – the American Psychiatric Association, certainly, the National Institutes of Health – that are concerned with mental health really need to find ways of guarding against takeovers, kind of intellectual takeovers, in a field where such takeovers are anathema. And so, yeah, I see a current time when our graduating residents are really not steeped in psychopathology. Patients don’t stay on the inpatient for a month or three months, and so they don’t see somebody recover from a psychotic depression, and the schizophrenia day-by-day. They learn how to administer high doses of medication very rapidly to get patients out of the hospital, but then that hospitalized patient goes to somebody else. I do think that’s a problem. I’ve seen the American Psychiatric meetings kind of devolve into the psycho-pharmaceutical industry purchasing and paying for a lot of the most popular training that goes on, and of course it’s kind of predigested factoids that well-paid people come in and give to the practicing psychiatrist. It’s good information and has its value, but then the seminars and the symposia where practitioners are exposed to, say, the data that undergirds this are not well attended; and so kind of a de-intellectualization in psychiatry and a floating
away from knowing psychopathology really well is, I think, a current swinging of the pendulum in an untoward direction. I have every hope and faith that the pendulum will swing back, because it certainly has in my lifetime and we’ll get back to a more eclectic middle ground.

I think I mentioned to you that I’ve been lucky in making all of what I consider to be bright decisions, serendipitously. One decision I didn’t make that would have led to, perhaps, greater success is I decided not to commit myself to psychopharm and biological psychiatry, which really has been in the ascendency, whereas social psychiatry, psychiatric epidemiology, social approaches, administrative approaches, community approaches to psychiatric care are really on the back burner now. But I have every faith that that’s temporary. Perhaps our current president will be an entrée to provide greater balance, but I would be concerned that that should take over, and I hope it doesn’t. So we really need to find ways, I think, for a more eclectic vision in our field.

DC: Would you care to say some thoughts about psychotherapy, per se, and the role of psychiatrists or psychologists or others giving it.

JW: I think the idea that, at least, is espoused by the American Board [of Psychiatry and Neurology], that residents should learn several kinds of psychotherapy; that they should do them under mentors and stay true to these methods is a very good idea, and that they should have expertise in depth and experience with at least three of these methods is a fine, fine idea. I don’t see it playing out that way, however. I don’t think our trainees are achieving that level of expertise, so I think there’s a gap between what the profession thinks is happening and what is happening at ground level. Now, that may not reflect psychiatry across the board in the entire country. I’m sure there are times and places where that goal is being met, but I think there’s a drifting away from that. I think psychiatrists need to stay steeped in diagnosis and treatment and one of the fine treatments is psychotherapy. So, I see that as another pendulum that’s swung askew and, I have every faith[ it] will come back mid-line. By the same token, I think it is a new era and psychiatrists can’t and shouldn’t do all of the psychotherapy. The need is so great out there that we need to recognize that a variety of disciplines can be trained to do psychotherapy, but I think we need to be involved ourselves in that process.

DC: Do you have other thoughts or other comments that you would like to make as you give an oral history of psychiatry in your lifetime?

[break in recording]

JW: As a final thought, thinking about my career, but also my personal life, I think one of the great advantages I’ve had over my lifetime is having good support in a variety of ways from my spouse, my kids, my neighbors, my friends, my colleagues; and I think that’s always given me a good base from which to launch off and to try new things and to not feel as though I’m adrift, but I’ve got a good foundation and I could take chances, and if they go bad I’m still going to have a home and friends and family and neighbors. So, I don’t want to underscore that. Again, I think I’ve been very fortunate. By the same token I realize from my work with patients that obviously that’s taken some involvement and commitment in my part, that that doesn’t happen in a vacuum, but it doesn’t seem to have taken a lot of effort. I’ve really been blessed in that area.
Perhaps the last thing I would say that I’ve really loved about psychiatry, even more than general medicine (and I always enjoyed general medicine in the years that I did it) is the ability to kind of mix your personal interests with your professional interests. I’ve always had an interest in aviation. I started flying when I was about eighteen or nineteen years old. Again, an accident, a bunch of my buddies bought an old Piper Cub, and they needed somebody else with fifty bucks to chip in and pressured me, so I learned how to fly and really ended up enjoying it, and so aviation has been a part of my life.

Early on I got involved with disabled physicians because, probably, as a result of being interested in addictions and a fair number of disabled physicians had addiction problems, which kind of got me involved with disabled pilots. This led to my being involved with the Federal Aviation Agency, and with the Federal Aviation Agency as it would re-do its regulations, which it does from time to time, its psychiatric disorders in aviation – cardiovascular problems are the number one disorder, but the number two disorder is psychiatric problems – and so that’s been a great side interest of mine, and I have seen at least a few hundred patients over the years who’ve been pilots. I’ve been active with several airlines as they’ve had pilots with problems, and oftentimes trying to work out remediation so that pilots can safely get back into the cockpit, as well as at other times deciding when it would be too risky for pilots to get back into the cockpit. Not a minor decision, but one that enabled me to both bring my experience as a physician and psychiatrist, my public health interests, because if a pilot makes mistakes, an airline pilot, there’s a lot of people back in the paying seats. But also, aviation and what it takes to come in an airplane and bring a trip to a successful conclusion. So that’s been a great boon to me, and something that I really enjoyed. If it weren’t for psychiatry, probably would be one of those areas that would have had to remain a personal interest and not a professional interest.

DC: So you have been in on writing the qualifications to give a special issuance of an aero-medical certificate in reference to alcoholism.

JW: Yes. Early on, going back 30 years ago, if a pilot had a substance abuse problem they couldn’t fly again. They’d lose their license and they’d be out of a job, and, of course, that has changed with time. But again, special issuances can be a challenge. In other words, when do you let a senior airline captain back into the cockpit and taking command of the airline [airplane]. It’s not, sometimes, a simple decision.

DC: Are there some other facets of your life that have come together, interwoven with psychiatry, per se?

JW: Probably my work with the World Health Organization over a few decades. I would say, as a result of my early experiences in meeting people in international health, that as I got into psychiatry and into the addictions I was invited to consult with the World Health Organization in certain early projects and that really let me both use those early international experiences, but also bring in public health concepts and epidemiology and programming as well as mental health and psychiatry. So again, that’s been a volunteer or a part-time endeavor that being in academia has allowed me to do, so I could be away several weeks a year to do it. But it also has meant having supervisors who would let me be involved in that particular way.
DC: You played a role in the Group for Advancement of Psychiatry, which seems to correlate all of these interests.

JW: It does to an extent, although again I see it, to a considerable extent, as a pay-back. When I was a resident I ended up being nominated for a fellowship with the GAP, and at that time, still to this day, the GAP would involve people in their latter years of residency in going to two meetings a year. The GAP does its work as small committees, eight-to-twelve people, and they have a project that will continue on over a few years’ period of time. And these were oftentimes really senior people in their field, and so the committee that I was on had some outstanding folks on it. Great mentors to me, and so just watching how they chewed on a problem and how they conducted discourse amongst themselves and how they could really disagree, sometimes sharply on a conceptual level, around particular issues during the day and then just be the best of friends and fellows over lunch or dinner was really a great exposure for me to see how academia in its best clothes can really function; so that you don’t cross-cut ideas with people, and that you deed people the right to disagree very fundamentally with you, while keeping ultimate goals, common goals in sight.

DC: Are there other things that come to mind that you care to comment on?

JW: I think that does it. I think that kind of wraps it up.

DC: What do you see for yourself coming now, at this period of your life?

JW: What do I see down the road? I don’t know, but I think probably my life’s experiences lead me to be guardedly optimistic. I don’t change things suddenly. I tend to stay in my same rut while I try new things, so I think I’m staying at the VA while I’m trying some new things with my research, trying some new things in terms of thinking through two fairly early concepts that I got from some of the psychologists in the department, and they actually were playing with the notion of internalizing disorders and externalizing disorders, and how those kind of bred true through the lifetime. So I have some evolving notions about that, so that’s led me to look at some other kinds of behavioral disorders—gambling problems, in particular, pathological gambling—and how those might overlap or not overlap with other kinds of behavioral disorders or how they might overlap or not so with anxiety or mood disorders. But I’m doing it kind of from a familiar place in the VA with people that I know and continuing with my national buddies. I try to see them as often as I can. So, changing some things. I’m trying to sail more and see my grandkids more and have longer weekends. So that’s a change, kind of a senescent change, I guess [chuckles] The avuncular change.

DC: Avuncular change, another one …

JW: Another kind of avuncular change, but with a different generation.

DC: I am very impressed to hear this personal account of your life and your contributions. This is remarkable.
JW: I had to sit down and think about it. If you hadn’t given me the outline I wouldn’t have done it.

DC: Well, good for both of us.

JW: Made me think of myself as somewhat of an opportunist, [chuckles] a lucky opportunist.

DC: Well, you were asked.

[End of interview]