**INTERVIEWEE: BARBARA FISH**

**INTERVIEWERS: Marcia Meldrum, Beth Bromley**

**DATE: September 11, 2008**

**SESSION 1**

## I. Childhood and Education

MM: Okay. We're ready. Good morning, Dr. Fish. This is September the 11th, 2008, and we're starting our oral history interview with Dr. Barbara Fish here in her lovely home facing the sanitary landfill in -- is this Brentwood or Encino?

BF: No, it's just L.A.

MM: It's Los Angeles.

BF: Same one as UCLA.

MM: Same one as UCLA, okay. Los Angeles, California. I'm Marcia Meldrum, one of the interviewers. So to begin with, Dr. Fish, I wonder if you could tell me a little bit about where you grew up, who your parents were, how many kids there were in your family?

BF: Well, I was an only child. My father thought even one was too much. (she laughs) I was a mistake; no, I wasn't a mistake. [Certainly, at least my father wanted a boy, who was to be called Robert, nicknamed Bobbie. They couldn't figure out what to call a girl, but finally settled on Barbara, who could also be called Bobbie.] He was a mechanical engineer who was brought up in the ghetto of the East Bronx.

[pause]

MM: So we're welcoming Dr. Beth Bromley, who has joined the conversation. You were just saying that you were an only child and your father was a mechanical engineer.

BF: Right. The only one in his family [who went on to higher education] – well, his younger sister became a teacher, but the other [brothers] were not very well educated, did one kind of thing [or another]. He couldn't even spell correctly in school and flunked [arithmetic], but somehow calculus was easy, so he became an [mechanical] engineer. Don't ask me; (chuckles) I don't understand that kind of mental development. But he was brainy in his own way.

My mother was a very anxious and nervous type lady. And they somehow got together to play tennis. That was all they had in common, except me, which wasn't very much to hold a marriage together. And he really was not the congenial marriage type.

So they were fighting from about when I was five [and I desperately wanted to go to sleep so I wouldn't hear it, but of course I couldn't]; and finally he left when I was nine.

But he and I had a certain kind of relationship, all about science, because he was interested in that, too, and that was what fascinated me. He was very good about that. I remember when there was a total eclipse in 1925,[1] when I was five. And we [had] a walk-up apartment in the Bronx, on the top floor, which was supposed to be best for good [fresh] air, but was the cheapest; that was the true explanation. But he would explain [and demonstrate] with a kitchen bulb and a grapefruit and an orange, and explain the eclipse to me, which was going on. We would walk -- and [examine] ants and bees, and he'd get a book and we'd read about these things. So I was very encouraged [to be interested] in nature study and science, and somehow that always fascinated me. And Madame Curie[2] was my heroine [from my reading about her life when I was about 10 years old]. I would have loved to have become that great a scientist, but was not. A lower grade, definitely. But my interest was always in science.

MM: So after your father and mother separated, did you continue to see him a lot?

BF: Oh, yeah. I saw him every week, and he continued to encourage me in whatever intellectual goings on there were. My mother was kind of a hovering nervous type that wanted me to be dependent on her forever, instead of remarrying, which she should have done. I eventually had to break away; it was just too smothering.

But I was always interested in science and reading and so forth.

MM: And you went to the Ethical Culture School[3] in New York?

BF: Yeah. The local public school was full when I was five, and I had the only tantrum of my life. I was a very good child. I somehow knew that things were very rocky at home. You know, you had to watch out for what the currents were. But my friend across the street was a year and a half older, and she was at school and she could read. And I wanted to read. So I had the one and only tantrum in my life. She [BF's mother] got all flustered and didn't know quite what to do and called her best friend – there were three families there. The kids, all four of us, were going to private school eventually.

So she called her friend, Edith, who was a wonderful, motherly person who really mothered all four of the kids, since we all had rather nervous mothers, except for her, Edith. So she said, "Well, Daniel went to this school and if you pass the exam, they might give you a scholarship." So she [my mother] took me down where she was told to go. In the gym, you walked way up, to me it was way up there. Miss Gillingham, who

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[1] The total eclipse occurred January 24, 1925 at 14:54:03 Terrestrial Time.

[2] Marie Sklodowska Curie (1867-1934) shared the Nobel Prize for Physics in 1903 and was the sole winner in Chemistry in 1911, for her work on radioactivity. She was the first woman to earn a Nobel Prize in any field. For more information, see http://www.aip.org/history/curie/.

[3] The Ethical Culture School was originally founded in 1878 as a private free school for children of the working poor. It became the Ethical Culture School in 1895 and expanded to enroll paying students, and moved to 33 Central Park West in 1905. The high school division (grades 7-12) was moved to Fieldston Road in the Bronx in 1928, and became known as the Fieldston School. See www.ecfs.org .

was a psychologist, she tested me. I remember the only one was when you have to find the ball in the field.

MM: Yes, I remember that test.

BF: Yeah. Well, the one thing I remember was that when I went around in the circle like a spiral, going to the center, at five, she sort of looked [surprised], and I thought, I got the right answer! (all laugh) But I later looked it up because I was curious when I got into the field. That was apparently a thirteen-year-old response. Well, on the whole test I wasn't that smart, but I got in. It was a marvelous school. I had a scholarship free, went free all the way through high school.

MM: Excellent.

BF: It was downtown and then the Fieldston High School[4] in the Bronx.

MM: And did they promote your interest in science? Was there an opportunity to –

BF: Oh, yes. Well, not in the lower grades, particularly. But we had just wonderful teachers, so you got interested. Whether it was the Crusades and in 5th grade, we made a tapestry, whatever. But then in the seventh grade we went up to Fieldston. Oh, I remember the seventh grade teacher taught us how to outline, which I clung to all through the rest of my training because it was marvelous.

MM: Right, to write papers with.

BF: Yeah, well, to take down notes for classes. And then to study for the exam, I would boil it down to a page, so I could memorize all the key issues. Many of them, as in quantitative chemistry, I would forget immediately afterwards. That was in college. But the outlining helped me go all the way through. I could boil a course down to a page of outline and could cram for the exams. And then organic chemistry I would forget by the next day. (all laugh)

MM: So what was your favorite subject?

BF: Science. And we had a wonderful -- Mr. Kelly, or Dr. Kelly, was the biology one, and we all adored him. He was wonderful. And then we had -- well, the chemistry professor [Mr. Klock], and his assistant, Mardie Munzer. You know, they were just wonderful teachers, and if you were interested in the subject, they radiated everything back to you.

MM: This was in the 1920s, and certainly at some schools at that time, a girl who wanted to be a scientist would not have been much encouraged.

[4] See note 3.

BF: Yeah, but this was different. Whoever you were, you were encouraged. They didn't tell you your marks, but I discovered later that I, and Bobby Jacobson, who also had to take the elevated train from way up in the East Bronx down to the Ethical on 63rd Street, we were the two bright ones in the class.

MM: Top of the class.

BF: I discovered this later.

MM: They didn't tell you your marks.

BF: No, we never were told our marks. And our parents were very careful not to let us know. They didn't want to spoil me and make me know that I was smart, so I didn't think I was that smart.

MM: What kind of things did you do for fun?

BF: Well, we had all kinds of things, all kinds of clubs and whatnot. Dance I loved. I was always on the scrub team for hockey or something like that. I wasn't that gorgeous at athletics. I could do it, but it wasn't the thing that I was most interested in. But I was very interested in art and painting, and we had a wonderful art teacher. In fact, when he came down for something or other to the chem lab, he said, "Barbara, what are you doing *here*?" But I loved both the science and the art and dance.

MM: In science, did you like the laboratory work, the experimental work?

BF: Yeah, everything.

MM: Was there a particular class or experiment that you remember?

BF: Well, we used to have experiments in chemistry, and we used to do dissection, but not in [chemistry, in] biology, especially if you went on. I seem to have gone on taking the more advanced classes. I remember dissecting a rat and actually putting the skeleton back together again. Made a model. I was good with my hands at all things like that.

MM: I think you must have been. I'm sure I made a hash of my first dissection. You couldn't have put it back together if you tried.

So, your family was Jewish. Were they strongly Jewish?

BF: No. My father would take us back to his family for the holidays, and I would have to ask, "Is this a happy one or a sad one?" Yom Kippur,[5] of course, was the sad one, I discovered much later. So I would know I was not to put on a smiley face with my grandmother. But he was the eccentric in his family, and he just decided that science was it, all this other religious stuff was rubbish. So he made science fascinating for me, and

[5] Yom Kippur, or the Day of Atonement, is the most important religious holiday in Judaism. It occurs on the 10th day of the 7th month of the Hebrew calendar, usually in late September.

nature study, and everything. That encouraged me. And reading Madame Curie, the great scientist, was another important figure in my life, actually.

And the high school, it was a wonderful school. It was just marvelous. You could do everything. The festivals. I was the shortest little blonde long-haired girl, so I was always the angel, or whatever, in the Christmas festival, Gerda in *The Snow Queen*.[6] I could remember all those lines, I could never do that later.

My mother didn't want me to go away to college. I could have gotten a scholarship anywhere. So I had to go to Barnard,[7] which was very dull, in those days. The only courses we could take at Columbia were music, so all my arts were music. I took what I had to.

MM: Did you play an instrument?

BF: Oh, I'd been given piano lessons, which was, you know.

MM: I just wondered because you said you were taking music.

BF: And then I had to take the violin, which was terrible. But, you know, I never hit it right. But I was in the school orchestra in high school, just because the conductor was benevolent, and there was one girl flautist who was really very good, and I was the second violin and I squeaked along somehow, covering up. But I didn't go for that in college. I took mostly modern dance, whatever I could, because I loved that. In those days, it was much too bone bending, which is a lot of what my neck problems and all my skeletal problems are, from that. You know, we'd over-bend and over-stretch.

MM: Really stretching the body.

BF: Yeah, but really over-stretching your spine. But I loved it.

MM: And your major at Barnard was?

BF: Science.

MM: It was just science, it wasn't biology or chemistry?

BF: Well, I mostly liked the biology. So I ended up, I think, like ninety-eight points of science and fourteen, or whatever was required, in each of the other two section –

MM: But you said the teaching there was dull?

BF: No, some of the professors were interesting. The ones in science were really interesting, except the zoology guy. I used to somehow work with him. Oh, I was doing

[6] *The Snow Queen* is a classic fairy tale by Hans Christian Andersen (1805-1875).
[7] Barnard College was founded as a women's liberal arts college in 1889 and became affiliated with Columbia University in 1900, although maintaining a separate campus, faculty, and endowment.

his lab work, counting snails' eggs. It was heredity, some kind of genetic experiment. Because I needed to make money in college. I was on NYA,[8] and it paid for half of it.

MM: It paid for half of it, and you had to work to make the other half.

BF: The thing was, we didn't have that much money at home.

MM: Well, it was the Depression.

BF: But they got confused because apparently I was the only one whose parents were split that they had encountered. In those days, people just stayed together, whether they hated each other or not! [she laughs] So they had to count both salaries. My mother worked as a teacher's clerk in the principal's office, like a secretary. And my dad, he had joined up with a man who had a factory. During the war, they got -- well, he usually would make these experiments and then he would often get government contracts, because he could imagine how it should be and simplify it so it would cost less, and then he could lower the bid -- so that was how -- but until the war, he didn't make much money, and we just sort of scraped along.

MM: Yeah, it was the Depression. I mean, most people weren't making much money.

BF: Yeah. No, I offered to give up my nickel a week allowance, because in the stock market, you could invest like ten percent[9] and lose a lot, which he [BF's father] did. Well, you know, everybody did.

MM: Yeah, everybody did, but that's too bad.

BF: So I offered to give up my nickel a week allowance, but they said they could manage that.

MM: Now, that was a nickel a week when you were about ten, right?

BF: Yes.

MM: Later on, you must have gotten a larger allowance?

BF: Really only after -- in medical school. Because then that was during the war, *the* war [World War II]. So he could get government contracts, and he was very good at designing whatever they needed.

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[8] The National Youth Administration was part of the New Deal, established by executive order in 1935. Students received tuition grants in exchange for campus or community work. The NYA was abolished in 1943.

[9] Investors who buy on margin pay a % of the value of the stock purchased; if the margin in 10%, $1 buys $10 worth of shares. This is essentially a loan from the broker. If the shares go up in value, the investor profits; but, if the shares go down, the investor loses not only the original $1, but owes the broker for the remaining $9. This risky practice was popular in the 1920s and led to many bankruptcies after the 1929 crash.

MM: Okay. But while you were at Barnard, you were still having to work.

BF: Yeah. Well, they couldn't somehow figure out, so that was why I had the half scholarship, two hundred dollars.

MM: Oh, I see, because they couldn't figure out that your parents -- how to account for that.

BF: They knew that my parents were split, but they didn't make any allowance for that fact, that there were two separate households. Somehow it just baffled them. It was when Dean Gildersleeve[10] was there. Oh, she was very distressed because here I had all these ninety-eight points in science. "You know, Barbara, this is a liberal arts college." I said, "Yes, but it's permitted." "Yes, if you –" But anyway.

MM: She didn't want you to go into science.

BF: Well, not to be so lopsided.

MM: Yeah, okay. Take more English.

BF: No, but after the wonderful English we had – we had an English seminar at Fieldston. We read one of the classics every week and wrote it up. Elbert Lenrow,[11] he was a marvelous teacher. He continued to be interested in us at reunions, and in every one of us. He had individual sessions with pairs of us.

MM: And you would work on one classic, or part of a classic, or --

BF: Yeah, it was like a seminar. You [were] selected if you produced something or other, I can't remember what. It was a small [group in the senior year] -- so we read all the classics. You read one classic [book] a week and wrote a book review on it. My mother would take me along with her to play golf on Sunday at Mosholu Parkway.[12] It was a public course and I had to sit for hours [waiting to tee off]. So that was when I read my [assignment] and wrote it up. We had to do it on the weekends, because the school -- we had all kinds of activities all the way till five o'clock, the clubs and all of it. It was a marvelous school.

MM: It's such a New York experience, going back and forth on the elevated train and spending your days in a brownstone. That's wonderful.

BF: Oh, yeah. My mother standing over me eating cold cereal. No, it was a boiled egg. Have you ever eaten cold boiled eggs?

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[10] Virginia Crocheron Gildersleeve (1877-1965) was Dean of Barnard from 1911 to 1947 and a leader in advancing educational and professional opportunities for women in the early 20th century. See http://www.columbia.edu/~rr91/3567/sample_biographies/virginia_gildersleeve%20-%20bio.htm,

[11] Elbert Lenrow (1903-) was the author of a classic textbook, *The Reader's Guide to Prose Fiction.*

[12] Mosholu Parkway Golf Course is located in Van Cortlandt Park in the Bronx.

MM: Yes. My mother thought they were good for you.

BF: Yes. My mother thought they were good for me, so she [stood] over me. My father would say, "Leave her to me for one week. She'll eat." I thought, oh God, what's he going to do? But then I had to sit there over the cold eggs, and then I would go down [on] the elevated train and vomit them up. Every morning.

MM: No, ow! I hope you then got something to eat at school or --

BF: Yeah, we had lunch at school. Well, I went to the camp in the summer, also on scholarship, with my two best friends in our bunk. They were the two black girls in the class, sisters, and they're still [my] best friends. They both went into medicine, too. Their father was a doctor.

MM: They were sisters?

BF: Yeah. Well, Jane got left back because she had a reading disability.

MM: And where was the camp?

BF: Oh, the camp was marvelous.

MM: Where was it?

BF: Oh, up in Cooperstown, New York,[13] on Lake Otsego. We swam and canoed, everything.

MM: A great summer.

BF: Watched the -- in August, the lights, the Northern Lights.

MM: The Aurora Borealis.[14]

BF: Yeah, the Aurora Borealis. We'd just lie out on the beach and watch it, or go out in [a] canoe in the water. It was like exciting to watch that. It was so weird, with all this explosion of light, with the beams going and the waves rising. You felt there should be some sound, like thunder or lightning or something. But it was wonderful. And the camp was marvelous.

MM: It sounds like a great experience. Was it mostly outdoor activity?

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[13] Cooperstown, a small but historic New York village, is located at the southern end of Lake Otsego, the source of the Susquehanna River. It is associated with the author James Fenimore Cooper (1789-1851) and the home of the National Baseball Hall of Fame.

[14] The Aurora Borealis, or the "Northern Lights," occur in the ionosphere, the inner edge of the Earth's magnetosphere. They are generated when a temporary magnetic connection is established between the field lines of the solar wind flowing past the earth and those of the magnetosphere, an effect most common near the poles.

BF: Oh, yes.

MM: Sometimes today they have like science camps and things like this, but this was --

BF: No, no, no. We did everything. I had to play baseball. I was always in the outfield, I wasn't very good. (she laughs) And tennis, I liked tennis, and swimming. Shopwork, made jewelry. Did a lot of silverwork.

MM: Was it for the whole summer or just for a few weeks?

BF: No, it was for July and August. Free. For me anyway, and Jane and Bobbie, too.

MM: With a scholarship. That's amazing and wonderful.

BF: It was a wonderful way to grow up. I got away from home. I mean, they heard from my mother that I wouldn't eat, so I was put at the diet table with the fat kids and a couple of skinny kids.

MM: And they would feed you up.

BF: Well, they discovered that I ate like a pig when I was away from my mother. So they said, "She doesn't need to be at the diet table." After a week, I was able to join the rest of the campers. But we just had a wonderful time. Actually, the three of us went all the way up through bunk nine, at sixteen. Bobbie, Jane, and myself and another black girl [Nancy]. Each year, we moved on up somehow. I guess seven to nine is – it was [age] sixteen in the oldest bunks. Then my friend Ruth and I became very junior counselors and stayed on. And then I became a real counselor and then finally a full counselor.

MM: Was that when you were still at Fieldston, or were you --

BF: No, it was --

MM: You were at Barnard then.

BF: Yeah, it was actually -- I stopped at, I guess, 21 -- when I went to medical school.

MM: So all through college, you were --

BF: So I went all through college. It was such a wonderful camp.

MM: Sounds like it. Sounds like a great camp.

BF: It was marvelous. We did everything. They grew me up. My teachers at Ethical and then the group at ECSC [the Ethical Culture School Camp].

MM: Okay. So you're at Barnard now and you're still working in science. You're taking all these science classes.

BF: I'm taking all the science classes, including physics and chemistry, all the way up through organic. But that didn't really -- my best friend was marvelous at physics. It was fascinating to her, but her father was a great mathematician and she had that kind of brain, and I didn't at all. Actually, we were the first class that they gave the big exams to, like the college entrance exams. They tried [those exams] out on us.

MM: Like the SATs.

BF: Yeah. But there was one -- and I said to Edith afterwards, "What was that Civil war question?" I just couldn't make that out at all. And she said, "That was quantitative analysis." Quantitative analysis! She recognized it. Her head was really mathematical and chemical and all that. Somehow that never dawned on me. But she never had to study and would come through with a B+, and I would cram and I would get the A+. But I really didn't deserve it. I would forget it.

MM: But you liked biology.

BF: Yeah, I loved biology. And I had to count snails' eggs for Dr. Crampton.[15] Somehow I had some seminar work I would do for him. I can't remember why, but I used to have these meetings with him. And in his office -- oh, I was writing -- for my freshman [year], you had to write a big -- in that horrible English class, we went back to grammar. But it finally ended up, you wrote a big book review, so I wrote it on evolution and Darwin and that fascinated me. So when I was working for Crampton, I saw the book of one of the scientists there, that they didn't have in the library, and he had it. I wanted to borrow it, and he said, "That's for professors!" And it seemed to me, if you're a student and you're fascinated by it and you wanted [to read] it -- so I eventually got him to loan it to me.

MM: Do you remember who it was, which scientist?

BF: It began with a D. I do not remember.[16]

MM: That's okay.

BF: Go on, go on, go on. But anyway, that was – what was that name? And then I really wanted to go to medical school, but I didn't think we could afford it, so I was

[15] Henry E. Crampton (1875-1956), American paleontologist and evolutionary biologist, was professor of zoology at Columbia and Barnard from 1904 to 1943.
[16] Possibly Theodosius Dobzhanksy's *Genetics and the Origin of Species* (Columbia University Press 1937).

planning to teach biology or something. But then the war came, so I was able to go to medical school and went to NYU.[17]

MM: So you still needed to stay in New York.

BF: Yeah.

MM: And that was because of your mother or --

BF: Yes. (she chuckles)

MM: But NYU's a good school.

BF: Yeah. I went to a good medical school.

MM: So your family was able to afford the tuition at that point? Because of the war.

BF: I got a scholarship [a prize from Barnard], but the scholarship was a couple hundred dollars [$400, I think]. Then my dad was able to give me some money.

MM: Okay. Now, you were interested in science, and you thought you might be teaching it.

BF: Well, then I went to medical school and I just got fascinated by doctoring.

MM: But you must have had an early interest in doctoring before you went to medical school. There's a difference between being interested in science and deciding you wanted to work with patients, really.

BF: Yeah. Well, I took a medical internship, and you did all the scut work in those days, including fluoroscopy[18] and all the blood work, you did it, and you took admissions until midnight, twenty-four hours [shifts] on alternate days. We worked hard.

MM: They made good use of your labor.

BF: If you had five admissions to work up at midnight, you worked until you finished them.

MM: The next day, yeah.

BF: That was at Bellevue.[19]

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[17] New York University, chartered in 1831, is the largest private nonprofit university in the US. The Medical School was founded in 1841 and merged with Bellevue Hospital Medical School in 1898. The medical campus is on the East River waterfront between 30th and 34th Streets.

[18] Fluoroscopy uses an X-ray machine and fluorescent screen to obtain a real-time, animated image of a patient's internal anatomy.

MM: Wow! And that was a busy, busy hospital.

BF: You took in a sea of admissions.

MM: But you found that interesting, enjoyable?

BF: Yeah. You just got immersed in doing the fluoroscopy, and a patient fainted. I had to do the fluoroscopy, so I tried to hold him up! You learned -- you saw everything. You took dozens of admissions and worked them all up. You learned a lot.

MM: Now, you went to medical school, and this was during the war.

BF: Right, so we had to do the four years in three,[20] so the men could go in the army; but we just didn't have any vacation, but we didn't march out in the street and we didn't get paid the way they [the men] did. And they wouldn't let us join.

MM: The army.

BF: As soon as we graduated, they wanted to take us in. I said, "You should have taken us through medical school." Now we could get internships, because we had more of a choice of where we could go in the hospitals, because the men –

MM: – were gone.

BF: Yeah. They were fighting in Korea.

MM: So there were a lot of opportunities open to women just at that moment.

BF: Yeah. So I went to Cornell[21] for one year. I took medicine; and then I really loved kids, so I decided to take pediatrics. I had two years of pediatrics. And then in pediatrics, I found what I loved most was the talking to mothers and the babies developing, and all that. So I wanted to go back, and I knew Lauretta Bender,[22] who was head of the child psychiatry at Bellevue.

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[19] Bellevue Hospital, founded in 1736, is the oldest public hospital in the United States. Medical instruction began at the current site in 1811 and the Medical College (see note 17) was founded in 1861.

[20] In order to meet the armed forces' medical needs, American medical schools compressed their four-year, nine-month curricula into three years of continuous instruction. See Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. Oxford University Press, 2005.

[21] Cornell University Medical College, now Weill Medical College, was founded in 1898 and affiliated with the New York Hospital, now New York-Presbyterian, in 1927. It was one of the first medical schools to admit women students; but took even fewer women than NYU-Bellevue, which had a 10% admissions quota.

[22] Lauretta Bender (1897-1987) was a leader in child development and [child] psychiatry at Bellevue from 1930 until 1956. She introduced the Bender-Gestalt test to evaluate visual-motor maturity in 1938. Bender's interest in child development began when she herself experienced difficulties in reading and writing as a young child. For an example of her work, see Bender L. Childhood schizophrenia. *Psychiatric Quarterly* 1953; 27:663-681.

MM: Had you met her before?

BF: Well, we took some rotation [in medical school], and I was kind of fascinated by her teaching us about the schizophrenic children. So I wanted to go and, after my pediatrics [2 years: internship at Cornell, then chief resident at NYU pediatrics], I wanted to have a year or two with her. And they said, "Barbara, you have to start at the beginning." So I had to take one year of a rotation in psychiatry, in the general psychiatry.

MM: With the adults.

BF: On ward seven with the really -- they were practically all catatonic schizophrenics up there. And then the adolescent ward, and they were a very mixed bunch of kids. And, one of the other adult wards in between. And then I was allowed to take a couple of years with her. She had a senior and a junior [resident]. We got more pay.

MM: So you were her resident essentially.

BF: A resident, but then you got this extra pay if you got to be the junior. So I had one year working under Al Freedman,[23] then the next year I was the senior. So we split the three hundred and fifty admissions we got, every year to the children's service.

MM: Wow! So these were parents bringing their children in? Or schools –

BF: Or they came from various agencies around the city.

MM: Now, correct me if I'm wrong. Bellevue was the city hospital. That's where –

BF: So we took everybody that nobody else wanted, from the Bronx and Manhattan [and Staten Island]. We were a much better outfit than Kings County,[24] which took Brooklyn and Queens. But we covered all the children in the city. And you learned a lot. It was like cramming. I mean, we had five admissions [a week] and we split them, Al and I, and he was supposedly supervising me. But then we'd present our five cases every week to Lauretta, and she would see much more than we would and it would be a teaching session. She would demonstrate everything. So it was really a fascinating cram session.

MM: She really sounds like a very interesting person.

[23] Alfred M. Freedman (1917- ) became Professor and Chair of Psychiatry at New York Medical College in 1960 and served as President of the American Psychiatric Association in 1973-74.
[24] Kings County Hospital in Brooklyn was founded in 1832 and, like Bellevue, is part of the New York Health and Hospitals Corporation.

BF: She was a fascinating person. She had been married to Paul Schilder.[25] He was also a genius, and she was a genius. Yeah, I knew their children growing up. I used to go out weekends to her place. They had a home [in Long Beach]. Well, he died; he got run over when their third child was [born] in the hospital. He was a scientist, crossing the street to see his little girl.

MM: Not looking.

BF: They had three kids, but it was with the third one that he was killed by an auto accident. And he was a big professor [the Chair of Psychiatry at NYU-Bellevue].

MM: Also in psychiatry?

BF: Yeah. He'd been in Germany.[26] You know, these great people that came over included Paul Hoch,[27] who became [mental health] commissioner of New York state. These were the people I knew. I met them through Lauretta – and then I got fascinated by schizophrenia. I mean, that was my first patient. She was sent from the state hospital because they were doing lobotomies[28] at Bellevue. With the five professors sitting around [her], she talked garbage. She was frightened, and was as crazy as a loon. But when I spoke to her –

MM: How old was she? Do you remember?

BF: Fifties, thirties, forties, somewhere in there. Not more than fifty. She'd been in the state hospital for a long time. They were doing it [lobotomy] on chronic schizophrenics. So she was crazy as a loon in front of these five men, but with me, I was interested in what she was feeling and thinking, so she acted more human. There were these glimpses of this sad person. That was very moving to know how crazy she could be when they were all confronting her -- and how when someone was sympathetic and listened, you could get the human part of it.

MM: You were picking up on her then -- this was an adult patient; this was before you were working with Lauretta Bender.

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[25] Paul F. Schilder (1886-1940) was born in Austria. He was director of clinical psychiatry at Bellevue when he was killed in a traffic accident. He is considered a founder of group psychotherapy.

[26] Although the US never increased its immigration quotas to open doors for Jewish and anti-Nazi émigrés fleeing Germany and Austria in the 1930s, the path was easier for academics such as Schilder and Albert Einstein.

[27] Paul H. Hoch (1902-1965) was New York State Commissioner of Mental Health from 1955 until his death. He was born and educated in Austria.

[28] A prefrontal lobotomy is a surgical procedure which severs the connections to and from the prefrontal cortex. The procedure usually makes the patient more docile, reduces affect, and may impair bodily functions. It was introduced and popularized in the US in 1936 by psychiatrist Walter Freeman (1895-1972) and neurosurgeon James W. Watts (1904-1994). Freeman introduced a transorbital lobotomy in 1946, which he said could be performed by any psychiatrist. Lobotomy had been generally discredited by 1970, but procedures were still performed into the 1980s.

BF: Yeah, this was on the adult service, on seven. The really whacked out [psychotic patients]. And they were getting hot tubs, cold tubs. I mean, that's all they had.

MM: To control their behavior, yeah.

BF: And shock treatment.[29] They didn't have Thorazine.[30] That came in just a couple of years later.

MM: Right, late forties.

BF: So, you know, it [schizophrenia] just became a fascinating disease. How crazy, but she really could reach out as a human being and you could feel the difference from the way she had been with all the professors.

MM: So there was a way to access the person.

BF: Yeah. It just seemed a fascinating disease, how someone could act so crazy and talk absolute gibberish, but there was this human being locked up inside, and you could just reach something so human and sad. It was really tragic. And the thought of her getting scooped out of her brain, just killed me.

MM: Did she have a lobotomy, do you know?

BF: Yes.

MM: That's sad.

BF: That's what they were doing. So they [the patients] became emptied out. They weren't any trouble.

[29] Electroconvulsive shock treatment (ECT) uses electrical shock to induce seizures; after the patient regains consciousness, it usually results in improved mood and cognition for a limited period (up to 6 months). It is most often used today in major depression, in which it is considered very effective, and rarely as an initial treatment for schizophrenia.

[30] Thorazine, or chlorpromazine hydrochloride, was the first antipsychotic drug, synthesized by Paul Charpentier of France in 1950. It was approved in the US in 1954. Although it has a number of troubling side effects, including sedation, constipation and dyskinesia (involuntary, repetitive movements), schizophrenic patients who can tolerate long-term medication show marked improvement. Thorazine and its descendant drugs have led to the outpatient era, in which patients are discharged from mental health facilities, placed on long-term medication, and encouraged to resume normal lives, with mixed results.

## II. Child Psychiatry and Starting the Longitudinal Infant Study

BF: But on the children's service, the psychotic children got electric shock; that's what they had. We didn't have Thorazine [yet]. We had Dilantin,[31] which didn't do much of anything. We had Benadryl,[32] which was a little soothing. And that was it. You know, each new drug they would try. They had play therapy. We had all kinds of activities. And we had some wonderful aides we kept on the service, who did marvelous recreational therapy of all kinds. Then we had a public school upstairs that they went to. It was a very good setup, basically.

MM: I have a whole bunch of questions here, so let me just go back to – at one point you said that Lauretta Bender, in your writing, you said she was very holistic.

BF: She was marvelous.

MM: Could you just talk about the way she sort of approached the children? Or anything that particularly impressed you about her?

BF: Yeah, she could sort of get inside them. It didn't seem mothering, and yet it was. She could do that and ask very blunt questions and get right into the heart of what was troubling them. I found, when the kids that I was working with, when they went for this electric shock, they would say, would I come with them? So I would be there and I would hold their hand. I found that afterwards, they would go to sleep. But somewhere in the course of that nap, when they would wake up, it was like all the hallucinations were coming out.

I found that if I sat with them and held their hand and could sort of soothe them when they went through that turmoil, and they would go back to sleep, they seemed to be calmer later. So I would see them through. But I realized that it was just as though the electric shock was getting all of this garbage out, and they sort of had to experience it and then put it away. And it would help them. They wouldn't be as frightened of the ECT if they knew I was going to hold their hand afterwards. Somehow that frightening period stuck with them.

So it did help them. Actually, we had a parents group to work with the parents of schizophrenic kids, and it later became the big association. I forget the name [NAMI, the National Alliance on Mental Illness].

MM: I don't know either.

BF: It's the big parents group for schizophrenia.[33]

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[31] Dilantin, or phenytoin sodium, is a common anti-seizure drug, often given to epileptics; it was first synthesized in 1908 and approved by the FDA for use in the US in 1953.

[32] Benadryl, or dipenhydramine hydrochloride, is an antihistamine and sedative often used with children. It was developed in 1943 and in 1946 was the first prescription antihistamine approved by the FDA.

[33] The largest group today is the National Alliance on Mental Illness (NAMI) for all people with mental illness and their families, founded in 1979. See www.nami.org. There are several internet-based groups specifically for the parents of schizophrenic children, including the North American Society for Childhood Onset Schizophrenia (NASCOS), founded in 2004. See www.nascos.org.

MM: Okay. We'll look it up.

BF: Yeah. But it started as the group therapy that she had on the service. During the Depression, they had all the teachers and all kinds of people working with the kids. So she used whatever was available.

MM: So what was kind of the goal of treatment? Was it to find a way to get the children to normal functioning so they could –

BF: Yeah, as normal as you could and then find special schools if they needed some help with this, for the more disturbed kids. And some of them had to go to state hospitals. But then they were working with the parents.

MM: And was the perception that this would be a lifelong disease, at the time?

BF: [Yes, this was what Lauretta Bender and several of our other professors taught us.] Well, she was following the kids, so she had started in 1930, and I came there in the early fifties, '50 to '52. While I was there, she had gotten five of the mothers, [whose kids] had grown up, who kept baby books, [of] everything that happens to your baby.[34] And she analyzed their development, when they sat and stood and so forth. And there was an indication that they would look bright, and then regress in infancy, in the first year. And I thought, well, that's fascinating. I had done well baby work as a pediatrician, and I'll be able to just pick up these kids and study them. I'll study the offspring of schizophrenic mothers. She wanted me to do it then and I couldn't possibly. You know, if you're working up a hundred and fifty kids, you couldn't do it. So I said I'll start when I finish [my residency], and that's what I did. That's how my research started. Schizophrenia first just fascinated me.

MM: I can see that it would. Okay. Now, this is something that we had some difficulty with when we were reading many of your descriptions of the patients. It seemed that some of the patients were what we would call now autistic, so we're kind of wondering how childhood schizophrenia was understood at that time. What was the definition? Or what did these children -- and it also seems that you looked at the children, and you saw a wide variety, and later you made a typology.

BF: And there was a spectrum. There was a whole spectrum of them. When I was then running the service later, we were studying this in depth. This is quite a jump.

MM: Yeah, it's quite a jump. So go back to when you were working with Dr. Bender. What characterized a schizophrenic child? Weren't some of these kids actually what we would call autistic?

[34] For more on baby books, see http://www2.library.ucla.edu/pdf/Library_Development_News_Spring_2007.pdf.

MM: And when you say schizophrenic, we're talking about kids whose thoughts are disordered?

BF: Whose thinking is disordered, whose patterns of growth are disordered. She saw it as -- she had studied neurology a great deal and worked – Schilder, you know, was a neuropsychiatrist, and wrote [about] the body image.[35] So it was all tied up with neurology in her mind, and, you know, the brain. I mean, there's everything from neurology to language and psychiatry. It runs the gamut, and you see this with the children. So that when you're drawing from the craziest children – out of New York's then population of five million, you take half the city. Even the smaller number of [those who experienced] onset in childhood we saw a lot, a fairly large number. That's the ones that you would call the more autistic to those with language and hallucinating, and so on.

MM: And were there some who were -- again, this is something I sort of picked up in the articles, kids what we would call again hyperactive, who were just very, very active and somewhat destructive and hard to control, but possibly --

BF: Yeah, and conduct disorders, too; we had everything.

MM: And they all sort of came -- you had to deal with all --

BF: We had three hundred and fifty a year. Oh, you know, the small number that then needed to go to the state hospitals. But others that we would try and place, depending on what their needs were.

MM: So at least part of what you were doing was kind of trying to differentially diagnose them and figure out what they --

BF: Yeah, then those that needed a hospital and ECT. But even some of the psychotic children, after shock treatment, the little ones were able to go back home. But then she had this parents group, so that the parents would understand the erratic behavior of the more mature schizophrenic kids, those that weren't autistic.

MM: So it was in the baby books that you got this idea.

BF: Yeah. Well, she studied those baby books and said, "Barbara, look. Their development is crazy from the beginning." So I said, "Well, I'll just go out and study them." I'd been in pediatrics, I'd been in the Well Baby Clinic, and I knew there were some pretty crazy mothers coming through there, as well as all different kinds of kids. So I said, "As soon as I get out, I'm going to start the study."

[35] Paul Schilder's book, *Das Körperschema* [The "Body Scheme"] was published in Berlin in 1923. The expanded English edition appeared in 1935 as *The Image and the Appearance of the Human Body; Studies in Constructive Energies of the Psyche.* (London: Paul, Trench, Trubner, 1935.) For more on Schilder, see note 25.

MM: Okay. Let me get the timeline sort of straight here. You finished your training with Dr. Bender.

BF: In '52.

MM: And weren't you at William White[36] for --

BF: Yeah, I was doing that at the same time. I was getting analyzed and had a child patient that Janet Rioch[37] was supervising me with. I went down to Washington to get supervision from Frieda Fromm-Reichmann.[38] It was quite an experience at the White Institute.

MM: Was that a place you had to apply to, to get into?

BF: Oh, yeah. The New York Psychoanalytic[39] was very orthodox. You had to believe in oral, anal, and whatnot. That made no sense to me. I'd seen kids in pediatrics.

MM: You had seen the kids in pediatrics, and this oral/anal stuff made no sense to you.

BF: Yeah. Well, I knew, for instance, the Puerto Rican mothers were very over-enveloping and very permissive. But they would start the [toilet] training at seven, eight months, and their kids didn't become compulsive obsessive-compulsives. They were growing up in a permissive home. So this oral/anal crap, it made no sense as far as real child development [went].

MM: But you had to do this training?

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[36] The William Alanson White Institute is a psychiatric training institution, founded in 1946 by Erich Fromm, Clara Thompson, Harry Stack Sullivan, Janet Rioch, Frieda Fromm-Reichmann, and other independent-minded practitioners, and named after American psychiatrist William Alanson White (1870-1937). The founding group had left the New York Psychoanalytic Institute after the dismissal of Karen Horney. The White Institute emphasizes the analyst's authentic use of himself/herself in treatment, an analytic process that extends beyond the Freudian to address problems of living, and political advocacy of social change to support human individualism. See www.wawhite.org/history/brief_history_WAWI.htm.

[37] Janet Rioch Bard (1905-1974) was the first Chief of Child Psychiatry at St. Luke's-Roosevelt Hospital in New York (until 1957) and the first President of the American Academy of Psychoanalysis. She is known for her work on the transference phenomenon.

[38] Frieda Fromm-Reichmann (1889-1957) was trained in German and came to the United States during the Second World War. She was married to the famous psychoanalyst and philosopher Erich Fromm; they separated before the war, but were associated professionally in the United States. The psychiatrist in the famous autobiographical novel *I Never Promised You a Rose Garden* (by Joanne Greenberg, 1964) is based on Fromm-Reichmann. For more information, see Hornstein GA. *To Redeem One Person is to Redeem the World: The Life of Frieda Fromm-Reichmann.* NY: Other Press, 2000.

[39] The New York Psychoanalytic Institute, the first such training center in the US, was established by the New York Psychoanalytic Society, the oldest psychoanalytic organization in the country. The Society was founded in 1911 by Dr. Abraham A. Brill and several colleagues to promote and practice the then-revolutionary psychoanalytic methods of Sigmund Freud in the US. They trained young analysts informally and then established the Institute as a formal center in 1931. The Institute continues to be Freudian in orientation and has been a leader in the field. See: http://www.psychoanalysis.org/about.html.

BF: But the point was, that's why I didn't go to the New York Psychoanalytic, that's where you learned the orthodox theory, you know, bow down to Freud.[40]

MM: Oh, okay. I got it. I'm sorry.

BF: I went to the William Alanson White, where it was Sullivanian,[41] it was all his stuff with language, and that was a little too garbagey for me. But I had very good supervisors there. The best one was Clara Thompson,[42] who was a real down-to-earth Maine lady who was just great. She had a sexual relationship with a guy who couldn't divorce, and it didn't bother her at all. She had – you know, this was fun. Anyway -- so I was going to an analyst who was -- actually, I was one of her supervised cases in training. She was wonderful, Judith DeForest. She was just a lovely person, a real *mensch.*[43]

MM: That was a good experience, huh?

BF: Yes.

MM: Did this help you to understand anything about yourself?

BF: Oh, yeah. I mean, well, it took me five years to work through my mother. But it was only a three time a week [session], because I could only afford the ten dollars. No, I think I could only afford the ten dollars twice a week [from my "allowance" from my father at first]. But we made it. And then I was supervising with the kids, with Janet Rioch. I had to go through my own stuff, and supervise with Clara. She was marvelous. She was so down-to-earth, a real Maine lady. And then Frieda Fromm-Reichmann, who was God.

MM: You mean people looked up to her.

BF: Yeah, but she also considered herself quite a god, I think. (all laugh) She was difficult. You had to bow down. But I did. I traveled to Washington once a month to see her.

MM: And that was also part of your analysis.

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[40] Sigmund Freud (1856-1939) was one of the most important thinkers of the 20th century. He revolutionized both medical and popular ideas about the development and working of the human mind and personality. For a thorough discussion of his thought and work, see http://www.iep.utm.edu/f/freud.htm.

[41] Harry Stack Sullivan (1892-1949) was an American psychiatrist who laid the foundations for the field of interpersonal psychoanalysis. He differed from Freud in his privileging of verifiable observation v. abstract theory in analysis of the human mind and in his emphasis on interpersonal relationships in the genesis of mental illness. He was a leading founder of the White Institute. Many of his books, including *Conceptions of Modern Psychiatry* and *The Psychiatric Interview*, are still in print through the Norton Library.

[42] Clara M. Thompson (1893-1958) worked at the White Institute from its founding until her death. She is noted for her work on the development of psychoanalysis as a field and for her insights on gender as a cultural creation. See Thompson CM. The different schools of psychoanalysis. *American Journal of Nursing* 1957; 57:1304-1307.

[43] *Mensch* is a Yiddish term for a person having admirable qualities.

BF: My analytic training. That was after I finished with Judy. Somewhere along the line, I was admitted to the White Institute. My second analyst I got there, Ed Tauber,[44] he was very good, but totally different. He took me on, he said, because [although] I was a goody-goody proper patient, but he saw me park my car [makes whooshing sound]. (both laugh) He said, "There's something in that girl. She's not just sweet and compliant." When he saw me park my car. So he brought that out. And at that time, I [had already] started going with Max.[45]

MM: Okay. I think this may be a good place to pause for a few minutes.

BF: Okay.

[pause]

EB: I will probably pick up on somewhere you were just going, and then bring us back to something we talked about a few minutes ago. Because as you mentioned Frieda Fromm-Reichmann, of course she was one of many thinkers who really believed that mothers could cause schizophrenia [BF: not from my knowledge of Frieda]. Not just mothers, but parenting, poor communication in the family, could lead children to develop schizophrenia. Or at least, as we look back retrospectively, that's a sort of notorious story about Frieda Fromm-Reichmann and psychoanalysis at that time. I'm thinking of you in this environment with those kinds of ideas. I'm not sure how prevalent they were, or whether that was really something you were taught in your analytic training, but how were those ideas dealt with in your life at Bellevue with Lauretta Bender?

BF: Well, I knew already. When did I start to study? In '52? I can't remember when I started at the analytic school [William White; she started there in 1951]. I'll have to look up my CV, or maybe it just has the graduation there. But I went there for about five years, so I started to take classes then. And that's probably when I started working with Tauber as my supervisor. He had worked with another one of the Europeans, who worked with the White Institute people, I can't remember which one [Erich Fromm].[46] But he'd been schooled in the whole early stuff, as well as the White Institute, which had much more of an interpersonal relationship. You lay down on the couch if you really wanted to go into things that were difficult and deep, or you could sit in the chair, like this, and talk. So it was a very flexible kind of approach.

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[44] Edward S. Tauber (1908-1988) did pioneering work on dreams in animals. He was trained by Fromm and Thompson and was associated with the White Institute from 1945 until his death.

[45] Max Saltzman (1917-2001) was Dr. Fish's husband, an important color chemist who received the Macbeth Award from the Inter-Society Color Council in 1986 for his pioneering research in dye identification of ancient textiles. He is discussed at more length below. See also http://www.colorantshistory.org/SaltzmanBiography.html.

[46] Erich Fromm (1900-1980) was an influential philosopher, psychoanalyst, and critic of Freud. He was trained as a psychoanalyst in Heidelberg, came to the US to 1934 and worked there and in Mexico until he retired to Switzerland in 1974. Fromm emphasized a humanist psychology centering on the embrace of free will, relatedness to others, and creativity. His most famous work, *Escape from Freedom*, was published in 1941; these and many others of his books are still in print. See http://www.logosjournal.com/issue_6.3/funk.htm.

I don't remember any of the work I did with Frieda. She was a very overwhelming person and you didn't argue with her. So I probably just went along with her and got her advice on patients and learned whatever I could pick up from her that was useful. But I learnt much more from Clara. She was a real *mensch*. Just a very earthy person. And if you supervised with her, she recognized what kind of people these analysands were from what you could tell her.

EB: More commonsensical than some of the theory-driven --

BF: Very common sense. A real Maine lady.

EB: Did you feel a kind of aversion to the sort of highfalutin theory?

BF: It didn't make sense. Here I'd been doing pediatrics and worked with mothers and families and then with crazy kids; I knew there was a difference, there was something biological going on. There was no question about it. And by '52, that's what I was going to study in terms of their neurological development. How did it start? What did it look like? Lauretta had seen a couple of these crazy kids, and their development was cockeyed. So if I looked at them, eventually I would find someone who – and I wanted to study that. Because that, to me, was going to be a clue as to schizophrenia, and how it began.

EB: Did that seem to you at the time really an issue of severity? I mean, you were dealing with very severely ill children.

BF: Yes.

EB: And that struck you as clearly biological.

BF: Right.

EB: There's something off about the brain, their developmental trajectory. You put those kids in a different class in your mind then?

BF: No, to me, it was like a gradient. It could be severe, you could have the childhood schizophrenic, the one who could speak but spoke all scrambled, down to the autistic ones, that some of them were just like brain damaged, the most severe. We didn't know what was wrong with the brain. It was certainly something much more massive than what seemed to be schizophrenia, where something got twisted, but you could have a very intelligent person. At least the ones – especially those with later onsets.

EB: Did some of the psychoanalytic ideas that made sense to you about your own life or about development in general, did those ideas seem applicable to what you were seeing with the schizophrenic --

BF: No. It had to do with more neurotic people like me, the adults who had had screwed-up parenting in one way or another. So that, while with Judy, I worked on my mother, my all-enveloping, pulling me back mother, to my father who, in a brain way was stimulating, but really himself was too detached to be very connected, and became paranoid really, when he was senile. So he may have been schizoid in some way.

EB: You saw these kids as different kinds of problems.

BF: Yeah. There was definitely something wrong in the brain in schizophrenia, there was just no question about it. The ones you saw later, things were twisted; but they weren't as damaged as they were in the early onset kids. I mean, they had such difficulty in development that few of them -- the ones with more language were able to go to special schools. We would try and find various placements. Later on, there got to be more of those available. But you knew there was something biologically wrong, and that it was probably there with the adults too, but attenuated, you know, if it only showed up later.

A later onset meant you could have a more normal development and you had some brilliant people, talented. Those were the ones whose parents formed the parents' group, mostly. We had the ones that started with the early childhood group, and they began the organization. But many of those later, they were troubled. They had these brilliant kids who then, before college, or maybe the first year, somewhere in there, would slip out and just slide away from all this brilliant development. And it was heartrending to see someone who's brilliant and then falls apart, your child.

EB: Right. And as you were looking at these children with – you know, there's a lot of interest now in identifying schizophrenia as early as possible, in adolescence and even younger. Now it's thought the number of kids with true childhood-onset schizophrenia is very small, but then there would be a larger number of patients where we could really find the very early signs of schizophrenia, earlier than frank psychosis. Did you all have a sense that these were the kids – did you think that this is the same disease we see in adults, it's just starting earlier?

BF: Yeah.

EB: You had a sense of you were predicting a life course for this illness for the kids that you see early on.

BF: Oh, yes. It was just, if it was more – if it started earlier, it affected more development and stopped the progression earlier. So you'd have more intelligent people who had developed and gone through high school and been brilliant, while there were others that broke down still later, but a lot of them in early adolescence, 15 on. They had just developed further and they had more on the ball, but then it depended how severe the psychosis was. It was just a spectrum as far as we looked at it.

EB: Right. Same illness, it just depended upon how severe it was, when it would start. I was fascinated when you were expressing some frustration about the therapies that you

had, the therapeutic lobotomies – the touching story about the woman who was to receive –

BF: They were doing a lot of it then.

EB: Yeah. And you felt that frustration at the time. It's very easy to look back and say how terrible.

BF: No, I felt it at the time. You could feel the humanity in this person, and the anguish. She'd been so frightened by these five men. She didn't know what was going on. To get her to sign a permission to have part of her brain scooped out. It was pretty awful. Because at least electric shock, you could see that it affected the brain, but then they could come up out of it. You know, when I saw the kids go through their shock treatment. You weren't taking a piece of the brain out, you were sort of rattling things up a little bit and if it came together and they didn't have scary nightmares and hallucinations, that was an improvement.

EB: Right. But there was a reason she got to the point of needing – that those five doctors decided she needed a lobotomy.

BF: Well, they had nothing else to offer, so they were trying lobotomy on these very chronic schizophrenics in the state hospitals.

EB: So they too had a sense that we just have so little to do here in this grave circumstance with someone who isn't improving, no matter what.

BF: We're not doing anything for them by just keeping them in an institution, so at least they won't be as destructive, so they'll be docile rather than aggressive. It's just better than being in a camisole.[47] I mean, on the seventh floor, they were in camisoles and solitary, and then the cold baths to try and freeze them. There really wasn't much available. So ECT was mild, compared to lobotomy. But you knew it was the same disease. It's just as if you have a brain disease earlier, it affects all development. If it starts later, and you've accumulated knowledge and you've developed a personality, it damages the personality, but it doesn't bring you all the way back, unless – I guess, in some of them, it did.

But it was a spectrum. We saw it as the same thing. Because in my five or six [infant cases from the state hospital], the sixth was one who came from -- it wasn't a schizophrenic mama. She was damaged, she was paranoid, but seemed more brain damaged than schizophrenic. But only one of those became psychotic, the boy who at fifteen began to hallucinate and really flipped out.

MM: This is the well baby sample?

[47] A camisole is another term for a straightjacket, a garment with long sleeves that can be used to restrain a patient's movements.

BF: No, not from my well baby, from the state hospital offspring. He actually had not only a schizophrenic mother who was chronic and [had] been there, but she had had a relationship with another supposedly schizophrenic, but I couldn't get the full -- you know, the state hospital charts are not always that informative. I couldn't be positive he was really crazy because he got out soon after. The mother never got out. So I think he had two parents who were disturbed, but the man wasn't as disturbed as the mother, who was a chronic state hospital patient. He went on – Luckily, his adoptive parents, who lived in Fairfield, Connecticut, and were wealthy -- well, it was unfortunate in ways because they expected too much of him. We had to go through a whole lot of --

EB: Educating? What to expect?

BF: Parenting and changing, and they went to groups. They needed a lot of help. But he was still totally rejected by the father, and the mother had problems with it. And he just became a chronic Yale patient.[48] He lived in one of the housing -- they had places where they could room and come to the clinic, and he went to this clinic, and he went to that clinic if he had problems, because he drank. So they worked – he saw several doctors, and they kind of kept him from being hospitalized a lot of the time. He had a couple of breakdowns.

EB: So the notion that this was -- I know you have questions about the well baby sample, but you're talking a lot now about --

BF: One of the well babies was not so well, but the grandmother was taking care of him. And then I looked it up, and the mother had been hospitalized. She was hospitalized with every pregnancy, at the end. That was when she went back, each time she got pregnant.

EB: We were getting the sense that perhaps the well babies at the Well Baby Clinic at Bellevue were not so well.

BF: Yeah, they came from the poorest Lower East Side slum.[49] So you could have this baby taken care of by the grandmother.

EB: I think we'll get into that a lot more. I just had one more question because I'm so curious about it, and I'm fascinated by your description of it. In terms of these ideas of schizophrenia as reflective of internal dynamic conflict, from a psychoanalytic perspective – I know there were children up through the forties that the approach to their misbehavior or inattention was really psychoanalytic, that the kids and the parents should

[48] The Yale Psychiatric Institute, originally a separate facility run by the Yale University Department of Psychiatry, specialized in the long-term treatment of adolescents and young adults from the early 1960s. The Institute became part of the Yale-New Haven Hospital system in 2000.

[49] Historically, the Lower East Side refers to the area of Manhattan along the East River from Canal Street to 14th Street, roughly bounded by Broadway on the west. It was a center of immigrant working class for generations of new Americans, from Germany, Russia, Italy, Poland, and other countries, including many Jewish families. Hispanic immigrants became more predominant in the second half of the 20th century.

be – that was not the approach you all were taking, but I'm just curious if there was a conversation about that controversy at the time.

BF: Well, yeah. Oh, there was a lot of that, because you had people like Margaret Mahler[50] and Annemarie Weil,[51] who understood schizophrenia from the German background that they had come from, but also were using psychoanalysis as a treatment. But I worked with kids that they had worked with. And Annemarie Weil knew what she was dealing with, and Mahler did too, because they came from the European background. It was the American psychoanalysts who went way over, you know, everything was mothers. It was Americans. They'd go all one way or all the other way. They'd go from one extreme to the other. They couldn't make any idea of a spectrum of a biological disease that is worse the earlier it starts in the brain and is much less worse when it starts later. I mean, certainly not autistic. You know, there is a spectrum. And they try and cut things short. Well, it's cheaper if we just look for two years before the flipout. But they start much earlier.

EB: Did those ideas, did that fuel your work at all?

BF: Oh, sure.

EB: You knew you knew that there was – you'd see the crazy approaches and –

BF: Oh, it was definitely a biological –

EB: And you felt a certain urgency, a kind of real intellectual drive to demonstrate that and to argue –

BF: Oh, yeah. Well, even the N7 patients, these catatonics – that's not neurotic, no matter how crazy your parents are, or strange they are, you don't turn out like that. You can turn out antisocial and not get along in the world in almost as bad a way, but it's different.

EB: So you were involved in this very –

BF: Biological, you know, starting with these early kids.

EB: It was a fascinating conversation at the time, though, about the nature of schizophrenia, I imagine.

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[50] Margaret Schönberger Mahler (1897-1985) was a Hungarian physician who moved to the US in 1938 and began working as a psychoanalyst with young disturbed children. In 1950, she co-founded the Masters Children's Center in Manhattan, where she developed the separation-individuation theory of child development. Her book, *The Psychological Birth of the Human Infant*, originally published in 1975, is still in print.

[51] Annemarie Phiebig Weil (1910-1994) was trained as a physician in Switzerland and came to the US in 1940. She graduated from the New York Psychoanalytic Institute in 1949 and was on the faculty there, as well as Columbia, until her death. For an example of her work, see Weil AP. Thoughts about early pathology. *Journal of the American Psychoanalytic Association* 1985; 33: 335-352.

BF: Yeah, and I got it differently from Frieda than from Clara.

EB: And from Lauretta and from what you were seeing, what struck you as --

BF: Yeah, but Clara wouldn't have an argument with Lauretta. I mean, her common sense psychiatry embraced reality.

EB: Yeah. Eclectic, kind of biopsychosocial, all three of --

BF: A down-to-earth Maine lady. She was earthy, she was wonderful to work with. That was a supervisor!

EB: But also a little of a sophisticate also? She's having this affair and living in Manhattan.

BF: Oh, yeah. She could live the way she wanted.

EB: I don't want to put words in your mouth, but just free of constraints maybe.

BF: Well, her own civilized constraints, but it wasn't going to cramp her style.

EB: OK.

[pause]

MM: Okay. Here we go again. Wow! I have two or three different things I could ask you at this point, but let me just go to the – I think we should start talking then about the well baby study a little bit, if you're ready to talk about that. So the first study you did, looking for these early evidences of schizophrenia, was in a group of sixteen kids who came into the Well Baby Clinic at Bellevue.

BF: Yeah, but eventually there were just twelve of them that continued. A couple of them had moved and I saw them at ten, but couldn't follow them after that.

MM: But quite a number of them you managed to follow – you managed to follow quite a number of them.

BF: Yeah, I did.

MM: For fifty years, really. And that's quite interesting.

BF: After they married.

MM: And grew up. Okay. So the kids were coming in for well baby care.

BF: Right.

MM: How did you select the babies that you wanted to – how did you select them for the study?

BF: Well, I had every Wednesday; they came in every day. The nurses all knew me because I'd worked in the clinic as a pediatrician. So I would alternate between an early-comer to the clinic and one of these disorganized people that get there late, or come on the wrong day, so they have to squeeze them in. There were a couple. So I had a very motley mix. And the more normal ones were the ones from the new immigrants. Some of them were Puerto Rican. More of them were Puerto Rican. Some came from part of Italy and one of the islands, I remember. You know, it was a Lower East Side mix. And the most normal ones were, of course, the Puerto Rican kids. Well, some of the others, too.

MM: So the small group of kids, you picked them – so it was a random selection.

BF: It was a random Wednesday selection of early-comers and late-comers.

MM: Late-comers, I like that.

EB: I love that sampling strategy. (she laughs)

MM: And then did you talk to their parents and say –

BF: Oh, yeah. I would tell them that I was interested in – everybody's different. Babies are all different, and I'm interested in how they grow up. And, of course, all mothers, especially the new mothers, are so happy that someone's really interested and listening to them. Their feelings about the baby, their feelings about the husband, attitudes toward having babies, you know, the whole schmear. Having been in pediatrics for all that time, I was used to both normal babies and these weird babies. And it fascinated me.

MM: You examined them numerous times during their first two years. Those were regular baby visits, or were they coming in especially for the study?

BF: Well, the well baby visits, I could follow them to get them in the first months, the regular Gesell times[52] when I tried to get them. They more often came in at six weeks then twelve weeks, but I tried to get them close to monthly. When I had the state hospital babies, then I was able to schedule them because I went to their homes if I needed to catch them on those visits.

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[52] Arnold L. Gesell (1880-1961) was a pioneer in the field of child development; in the 1920s, he published the Gesell Developmental Schedules, for physician to use in assessing a child's progress in motor, language, adaptive, and personal-social skills. Infants were observed at birth, 4, 6, and 8 weeks, and then at 4-week intervals until the age of 56 weeks; then at 18 months, 2, 3, 4, 5, and 6 years. See Ball RS. The Gesell Developmental Schedules: Arnold Gesell (1880-1961). *Journal of Abnormal Child Psychology* 1977; 5: 233-239; and his entry in the *Biographical Memoirs* of the National Academy of Sciences, at: http://books.nap.edu/html/biomems/agesell.pdf.

MM: Okay. Thinking back to that first sample of babies –

BF: The ones from the clinic.

MM: The ones from the clinic.

BF: Yeah. And there was only one [that developed schizophrenia]. Peter is his fictitious name.

MM: And reading through your work, we get to know Peter quite well.

BF: Well, I looked back later, and I realized that I was just plain lucky.

MM: Exactly. That was my next question.

BF: Not only to find him; but the ones I picked up later, maybe there was just one exam where they were suddenly regressed, but if I hadn't picked them up regularly, I would have missed it. But with him, with the neglect on top of this tendency for abnormal development, it exaggerated all his [delay in development] -- I might never have been able to pick up that much. Science was lucky!

MM: But he had a very neglectful home.

BF: Well, the grandmother, she was dealing with these three kids, a new baby and a runabout one-and-a-half-year-old and a sobbing three-year-old, who'd gotten bounced from Mama to Grandma and a couple of different –

MM: And Mama was hospitalized or something, right?

BF: Hmm?

MM: Mama was in the hospital or something.

BF: Yes. His mother was in the hospital at that time. So then they had the grandmother. She made no bones about the fact she was pretty dumb. We never quite knew whether she was a little schizy or whether she was just senile, but she certainly didn't have all her marbles. But it was like the Jukes and the Kallikaks.[53] There had been so much illness in that family for generations that there were not much brains left. Peter, when he got over his infancy and was helped a little bit at the boarding school, he wasn't so dumb.

[53] The Jukes and the Kallikaks were two pseudonymous families described by late 19th-early 20th century eugenicists, such as Richard L. Dugdale (1841-1883) and Henry H. Goddard (1866-1957), as exemplars of the argument that criminality (the Jukes) and mental retardation (the Kallikaks) were hereditary traits.

MM: Okay. Now, this is something that you and Beth were talking about, but I'm going to phrase it in a somewhat different way. So we're talking about the children, and they have a neural – there is a disorder which they're essentially born with.

BF: In the brain. It probably starts at two-and-a-half months [in pregnancy].

MM: Right, but it must be essentially genetic.

BF: Yeah.

MM: Either inherited or possibly some sort of genetic mutation.

BF: Yeah.

MM: So they have this basic defect. And this disorder – what you noticed was that it wasn't only just regression in development, but that there had to be a kind of pattern of accelerated and then regression and then scattered development in different areas?

BF: Yeah. I analyzed, I reorganized Gesell, so that the higher cognitive – separating things out somewhat from him. So that the social, the language, you know, cognitive was the highest, and then this neuromuscular stuff, and the brain development. And you could get this in the head circumference also.

MM: By just measuring the head.

BF: Yeah. So that it was the neurological stuff that I analyzed, but then was fascinated by the difficulty in the language. Like the really psychotic boy, he started – he seemed bright as an infant and then regressed at about – somewhere [at 8 weeks of age]. I didn't see him after two years, and he was fine. Then, apparently, by the time he was ready to go school at six, he'd already regressed somewhere between two and six.

And then the little girl that I was able to follow because her grandmother was concerned about her -- her grandmother was paranoid, but still concerned about this baby. So that I saw her more frequently through four, when the grandma got too busy. So I saw her actually regress between two and four. She just lost language.

MM: Really lose functions they have had before.

BF: Yeah.

MM: Okay. Some of the early evidence, though, you noticed was in the – like in Peter, was the difficulty in posture, in sitting, as a very young baby.

BF: Yeah. Well, they all had some early developmental regression, sometimes only on one exam.

MM: Well, that's what I mean. Not every time.

BF: No, it wasn't.

MM: Other times it would look perfectly normal.

BF: Yeah, or smart. He was very smart. He was cute in a funny way.

MM: They sounded cute.

BF: Well, babies are cute. I like them.

MM: It seems, though, if a kid is suffering from this kind of difficulty, and they don't understand what's happening, and no one is able to connect with them – like the lady you described before when she was faced with the five psychiatrists – as people are not able to connect with them, this is going to make the kid less secure, more anxious, and more fearful. So isn't there a point at which –

BF: But psychological comes into it, too. You have mothering mothers and baffled mothers and mothers that aren't really prepared. That was part of the trouble with the psychotic boy, ["Andy"; real name omitted].[54]

MM: I don't think it was [name omitted] – Was it Conrad? Or Frank?

BF: No, not Frank.

MM: No, Frank turned out okay.

BF: He was just [the child of] a neurotic mother that we had to help all though his life.

MM: I remember which boy you're talking about.

BF: I get mixed up with their real names and their pseudonyms.

MM: Well, we don't want to mention their real names.

BF: But the one who became psychotic ["Andy"], he was very bright in one part of infancy, and then went down, really down. Just can't remember which of the early months, but it was like two or three months [it was at 8 weeks]. And then popped up and looked smart at a year, when he was adopted. I guess they got him at about ten months.

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[54] Several of the children in Dr. Fish's studies were referred to by different pseudonyms in different published papers. The boy she refers to here was given the name "Andy" in the most recent paper co-authored with Kenneth Kendler (see note 59). See Fish B and Kendler KS, Abnormal infant neurodevelopment predicts schizophrenia spectrum disorders. *Journal of Child and Adolescent Psychopharmacology* 2005l 15: 348-361 (available online at: http://www.liebertonline.com/doi/abs/10.1089/cap.2005.15.348. "Peter," "Frank," and "Linda" (see below) are described there under those pseudonyms. The original paper reporting her research is Fish B. The detection of schizophrenia in infancy. *Journal of Nervous and Mental Disorders* 1957;125:1-24.

So that they were happy. But they were in Fairfield, Connecticut; so when he became dumb, the father gave up. He wasn't going to be able to take – this boy wasn't going to be able to take over the business. And that was it. He could have thrown him away right then, so that wasn't much help. So the mother was neurotic and trying and then told by the father, and it was tough on that family.

They finally got some group therapy at one of the hospitals where he went. I was in at that family meeting, and it went wild; you know, like the whole group would get into this family. That was pretty crazy, but apparently it helped some people. And, you know, working on their problems with their kids. So the father even came around and was more supportive of his wife. But they escaped. He had a good excuse; his business was better in another place, and so they could leave the psychotic boy in the hospital. But it was Yale, so he was well-taken care of. They had a very good outpatient group, with the housing for these poor schmucks.

MM: So the original group, including Peter, you were following them pretty intensely, as much as you could, during the first two years. And then you picked them up again at ten years. Is that about right?

BF: Right. Some of them I was able to see earlier.

MM: In between time.

BF: I had also moved to Bellevue and had the whole children's psychiatric service to take care of. That was partly what took up my time.

MM: And in the meantime, you had started the new sample.

BF: No, I started that before.

MM: Right, before [she collected the state hospital sample in 1959, and returned to Bellevue in 1960]. That was the kids born to mothers who were schizophrenic.

BF: Right.

MM: And you had in mind all along to compare these kids.

BF: Yeah. There was some overlap even, because I was still doing some of the follow up of the – in between, I had five years at Cornell before the Bellevue job. They had a very good pediatric clinic, so I moved some of my kids up there, you know, the normals, as well as anyone I could follow. But I was still picking up babies in the state hospital.

MM: Now, picking up the babies –

BF: Because they wouldn't give me any money.

MM: I was going to ask you about funding, but let me just ask you about the babies again. The babies for the second study, the state hospital study, were they – the mothers were already sort of state patients, and did you then have to get consent from guardians or someone to follow the babies for the long period of time?

BF: There was a state hospital kind of – it didn't describe the full study or anything. You got a consent form. It only became complicated when they had human protection committees.

MM: That was a little later.

BF: And then it got far more complicated [in the mid-1970s], but you could change that on a computer. (she chuckles) Back in the state hospital days, we didn't have the computers. You had to go through the charts.

MM: So now you have two samples of children, and you've made a batch of observations on them. Was there anything that particularly surprised you as you were following these kids? I mean, you had the Gesell norms to work against. Was there anything that sort of stood out?

BF: Well, I was looking for anything abnormal, regression as well as acceleration. And irregular development of one part, going along in one way. So I was analyzing all this in detail. But that's what I was looking for.

MM: Anything abnormal.

BF: Yeah, in the neurological development and then psychological development. But the psychological development wasn't part of my pandysmaturation.[55] It was basically the growth and cranial development, the brain development.

MM: Was it surprising to you that they were showing motor difficulties sometimes at such an early age?

BF: No, because Peter had it exaggerated, because he was left in a crib alone.

MM: Oh, poor thing.

BF: Yeah, he was such a beautiful child, you know, just angelic.

MM: It's sad. Peter was kind of a model for the other kids? He told you what to look for?

[55] Pandysmaturation (PDM) is Dr. Fish's term for the irregular, inconsistent development patterns across all systems that she saw in the infants who later developed schizophrenia spectrum disorders. See Fish B. Infant predictors of the longitudinal course of schizophrenia development. *Schizophrenia Bulletin* 1987; 13:395-410. Available online at: http://schizophreniabulletin.oxfordjournals.org/cgi/reprint/13/3/395.

BF: Yeah, because it was exaggerated. But it's basically what I was looking for, because that was what Lauretta had picked up from these baby charts, that there were regressions and progressions. I was looking for wide scatters, as well as –

MM: That's a good way of describing it.

BF: But I mean, some kids are better at this than that. Some are better motorically and others are better with thinking. Everybody's different. So you pick some of the personality stuff up, too.

MM: And at the same time, I know in many cases you were working with the mothers or the guardians –

BF: Well, but you see, the ones from the state hospital group were often – cause these [mothers] were chronic schizophrenics, many of them – so that they were placed in good homes, and some of those mothers were just marvelous, normal, black women. But they'd say, "Dr. Fish, this little girl, she's very smart, but she's not like a regular child. I have to calm her and hold her." And she would tell me how to approach this two-year-old, who [she makes crying sounds].

MM: So you were really in regular contact with them.

BF: Oh, yes. And they would call me if they had problems. I was looking through for one of the papers, and there wasn't one child out of the twenty-four where I didn't get a call. For one of the normal ones, it was, "I think she's going to marry this guy! married so young!" And I have to do a job on the mother. But everybody was different. You know, you get close to the mothers, too.

## III. Pharmacological and Psychiatric Research at Bellevue

MM: During this time, you had been working in Cornell, I know, but when you started working at Bellevue again, were these mothers and children getting the same level of care as you were providing then to your other patients? Were they getting kind of special care because they were in the study?

BF: Oh, yeah. I mean, they could call me any time.

MM: So if a child who had come into the Bellevue program a couple years later and shown the same signs probably wouldn't have gotten that same level of attention?

BF: By the time I came back there, I raised money so that there weren't just the two of us. We had a big fellowship and residency program. So if you've got nine fellows in each of two years, they're really working with the children. And if you have the social workers there who work with the outside agencies and they develop – we basically ran a clinic on the ward. If they wanted an emergency [consult], they could come on the ward

and they would be examined by my two senior people, or one of them. You know, get the parents' history and the child's development, everything that they knew I wanted. And I was there to consult with them. If they could find a clinic, if it was really that kind of a case, then they would refer them to the clinic, with the idea that if this gets worse again, you can always bring the kid back. So we were really running a clinic from upstairs, as well as the outpatient department that was officially downstairs.

MM: This was a kind of a new model, do you think, of mental health care for children? I mean, was anyone else doing this that you know of?

BF: Well, I know they weren't doing as well by the families of Kings County, in Brooklyn and Queens. They just didn't have the people with the same kind of background. No, we ran a very special group. The point was, we then could keep the census down; instead of eighty, climbing the walls, we could have thirty-five.

MM: And keep the inpatient census down.

BF: We had more residents and fellows in child psychiatry. We had the two years worth of nine in each group, so that they had plenty of doctors and they could really work with the kids, and we had the parent group, and the group therapy, and we had everything that was available.

MM: And where did the funding come from?

BF: There was some from, I think, one of the private foundations, maybe the Grant Foundation.[56]

MM: Harriett Ames?[57]

BF: Oh, Harriett Ames, that was my wonderful – yeah. Her part of it was she wanted them to have real food, not just hospital food. So I had to take a third of my grant from her and have parties for the kids every Wednesday; we always had ice cream and goodies. And they had special playthings that the recreation people would work out, outdoors in our yard, big yard in the back. We had great celebrations and things carrying on, and she would come. The kids thought it was great, too. She even had – there was an architect who was helping make it look less like a hospital, cozier and different places. Yeah, it turned out that giving them ice cream and frankfurters and hamburgers – it turned out to be pretty good.

MM: That's helpful.

[56] The William T. Grant Foundation supports research to improve the lives of children, adolescents, and young adults, ages 8-25. It was founded in 1936 by William Grant (1876-1972), owner of a successful chain of dime stores. See www.wtgrantfoundation.org.
[57] The Harriett Ames Charitable Trust of New York City.


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BF: And then the rest of the money I could use for research. So she started me off. She wanted to do good, and she did good by the kids and by me.

MM: Okay. We're going to keep coming back to the kids, because this is such an interesting and central theme in your work. A number of the children in the state hospital sample were diagnosed with schizophrenia later in life, but according to the last report I looked at, there were still a number who, although they had various kinds of depressions or difficulties –

BF: Yeah, who were not schizophrenic. But this is when I got up-to-date modern diagnoses, DSM III – or whatever it was – when Ken Kendler –

MM: DSM-IV?[58]

EB: Three.

BF: Three. And he was marvelous.

MM: That was Ken Kendler.[59]

BF: Yeah, Ken Kendler. He has his own huge studies that he does. But as an interviewer, he's fabulous. So he picked up the same stuff that I had.

MM: And then these kids, some of them are in their forties and fifties.

BF: Yeah. Well, I didn't see them. Well, a couple of them would come back. Yes, my first one, Peter.

MM: And then overall, though, the degree of defect noted in infancy was paralleled by their later degree of disorder as an adult. Do you think that's a true statement?

BF: Yeah, pretty much. The thing is, in Peter, much of that regression was exaggerated and prolonged in him because of the neglect at home. That was, quote, "lucky for me" because that exaggeration made it easy for me to pick up, so I knew what I was looking for. I sort of knew from Bender's handful [of case histories].

MM: Right, but it was good to have that confirmed.

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[58] The *Diagnostic and Statistical Manual of Mental Disorders* is published by the American Psychiatric Association and provides descriptions and diagnostic criteria for accepted mental disorders. The original, known as *DSM-I*, came out in 1952 and listed 106 disorders; large parts of it were based on the diagnostic classifications developed by William C. Menninger (1899-1966) for the Armed Forces during World War II. It was revised as *DSM-II* in 1968. *DSM-III*, developed by a task force under the leadership of Robert Spitzer and published in 1980, made extensive use of recent research findings and was considered, with 265 diagnostic categories, to have transformed psychiatric diagnosis. The *DSM-IV* appeared in 1994.

[59] Kenneth S. Kendler, MD, is the Banks Distinguished Professor of Psychiatry and Professor of Human Genetics at the Medical College of Virginia.

BF: Yes. So some of them, there was just one month when they went down, and then seemed to be okay.

MM: And there was the child Linda?[60] I mean, she seemed like such a bright little child.

BF: In Bender's schizophrenia, a lot of things were called schizophrenic which were not, which were other things. DSM-III was not out, and it's stricter. So she [Linda] had psychotic periods, but then she'd just become – after she railed at me and screamed at me and stomped out of the interview room and stomped back in again and stormed around, and then, "Will you take me out?" She was just a needy kid, with a lot of trouble. She had been in – oh, God, such neglect and home and family.

MM: Yeah, very sad background in early childhood.

BF: Terrible.

MM: So not schizophrenic after all?

BF: No, she wasn't.

MM: Because in one of the papers, when she was about ten you were saying that she was frankly schizophrenic.

BF: Yeah, right.

MM: And it was the refinement of diagnosis.

BF: And it was the refinement of diagnosis that – you know, she was a behavior problem and a stormy kid. But she had had irregular development, but she'd also been neglected, and she was a very needy kid, but difficult.

[pause]

EB: Was it unusual to be doing longitudinal studies? When you started, perhaps you didn't know how long you would actually follow these kids, but what models did you look to, to think about doing a longitudinal study like that?

BF: Well, I wanted to follow them into adulthood to see how they really turned out, but I lost some of them in between, especially some of the normal ones. Some others would stay maybe through the eighth month or the tenth month of development, but wouldn't stick with me. But then I could catch up to them later. So the ones I was interested in, I was able to follow and get them to come back. If families find you're really interested, they become very cooperative, involved.

[60] See note 54.

EB: They become very invested and involved, yeah. So that was not an unusual approach. There were other researchers that you knew of who were starting –

BF: Well, in the – some of the normals that I kept up with. The mothers got used to asking me questions. The mothers always want to learn more about their concerns and marital problems; everything would come into it. Even with the normal families, they have -- I mean, little [name omitted],[61] when she started to take care of horses, her mother was so worried that she was going to become a jockey. She really did need to get to the racetrack and take care of her jockeys and her horses. But she was a delightful child.

EB: Yeah. It sounds like -- would you say that a lot of your research approach came from things you learned in the clinic, from being a clinician?

BF: Oh, sure.

EB: It sounds like that's what you're describing.

BF: Yeah. I mean, here I'd had everything from neurology to psychiatry to normal well baby clinics, and always interested in the mothers and babies. They always have questions. I always enjoyed that kind of interaction. And then the adoptive parents were mostly wonderful, earthy people. Unfortunately, not with the psychotic boy.[62] He had wealthy parents who expected too much –

EB: Too much of him, yeah.

BF: He should have been in a poorer home, with more earthy people, but Yale took care of him.

EB: I trained in New York as well, at Columbia, and there was often that sense that troubled kids, troubled adolescents, they really wouldn't come to your attention until much later, because their families were just more tolerant, particularly Dominican families could tolerate more. The psychosis didn't bother them as much. They kind of didn't have high expectations about what the kids would do.

BF: They could accept more.

EB: Yeah. And you saw that as well, I think.

BF: Oh, sure, with the Puerto Rican families. They were the immigrants that we took care of in the fifties.

EB: And then I just had one more thought about the sample from the mothers in the state hospitals. If you can recall, did you think that all of those babies would likely have

[61] This child is given the name "Annie" in the Fish-Kendler paper. See note 54.
[62] "Andy." See note 54.

abnormalities, or that – were you looking for just a sicker sample, or were you thinking that probably all those babies were going to have some developmental abnormalities you'd be able to identify?

BF: Well, I thought in the schizophrenics I would find them, but the definition of schizophrenia was much broader in the US in those days, so that when Ken re-diagnosed the mothers, it really narrowed the group. And the girl who had so much problems,[63] who was not taken by her mother until she was four, and then rejected by the mother within a couple of years, she had an awful time. Well, this was the one I mothered all the way through. I mean, you know, that's what happened. But she became a good mother.

EB: You must have seen that, that it helped the kids developmentally to have someone – to have *you* interested in them.

BF: Yeah. The one I call Peter, when he thought he needed a psychiatrist, but then he didn't go to see Paul Lehn, who ran the clinic then at Bellevue. He said, "I'm used to you. You can do it. I can talk to you." He decided he just didn't want to see anybody else. So he probably never would have gone to anyone. Just like his mother never went to anyone, except, when she broke down. Except he had me there. And then he had this adoptive father, who took over. And I had to keep him from wanting him [Peter] to become a lawyer or someone in the business. He finally accepted him for who he was. Having a homosexual papa wasn't such a bad thing for him. So he wants me to do a little something for him, it's all right with me.

EB: While we're thinking about kinship and families, I guess – a lot of women with schizophrenia, or severely ill women who are in state hospitals, before you were a professional, many of them were sterilized, had their ovaries removed, had their uterus removed.[64] This was before – I imagine that wasn't happening at the time you were training.

BF: No. That wasn't happening. That was probably earlier, in the 1900s.

EB: Yeah, decades earlier. But was that ever an issue, discussed, something that was thought of as the barbaric past, things that we've realized are not necessary?

BF: No. I thought they could have done more. It depended on the psychiatrist on the ward. Because I thought some of the women would have wanted birth control or something, but to get that to happen took a patient who was more verbal and working with the doctors. Some of the doctors there in the state hospital were really very good, and you could really work with them, you know, about their patients.

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[63] "Linda." 54.

[64] Compulsory sterilization for eugenic purposes, specifically directed at women who were mentally retarded or mentally ill, or at convicted felons, was legal in at least 27 states between 1907, when Indiana passed the first such law, until well after World War II, up until 1981 in some states. Deaf, blind, handicapped, and epileptic individuals were also targeted. The practice has now been widely rejected under international law.

EB: Or sometimes they really didn't recognize that women who were that sick might still be having sex, might be –

BF: Oh, well, they knew they –

EB: (laughs) They knew, but they didn't think about it.

BF: It was going on on the ward. (she laughs)

EB: It's the same way today. It's easy to forget maybe for some of the clinicians. They would forget that this would be an issue for the women.

MM: Okay. Thanks. I wanted to talk just a little bit then about drug studies. You've spoken of electroshock therapy, which was used very commonly with children, because there weren't very good drugs.

BF: Yeah, until we had the phenothiazines.[65]

MM: Right. The phenothiazines then were introduced, and you began to use them in private practice.

BF: Well, I was using them at the hospital, too.

MM: And the hospital as well. I know one of the first papers you published was on your observations in children in private practice.[66]

BF: Yeah, because I had accumulated a lot of patients before I quit.

MM: So do you want to talk a little bit about how it struck you that the drug therapy had advantages or disadvantages over electroshock therapy?

BF: Oh, there was just no comparison. I mean, to be able to give a pill that would help as compared to what seemed to be so traumatic. Totally different.

MM: Was it difficult finding the right drugs for the children, though?

BF: Well, the first drug study I did was just thorazine versus Benadryl versus placebo. I did that with Ted [on the 7-11 year old boys].

MM: Yes, Dr. Ted Shapiro, okay.[67]

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[65] Phenothiazine is a tricyclic organic compound, first synthesized in the dye industry, that forms the basis for many psychoactive drugs, of which Thorazine (see note 30) was the first to be introduced.
[66] Dr. Fish maintained a part-time private practice in child psychiatry in New York City between 1952 and 1965.

BF: During his fellowship with me. And then he became professor at Cornell. He enjoyed doing that kind of comparative work. In fact, he did more neurological studies on those kids. He had some separate papers he wrote about them. But after the first big trial, then I worked mostly with the schizophrenics in the nursery, the two- to five-year-olds. Those were the ones that we did trials of all different – the new stuff that came along that looked to be good for psychosis. So there was a whole bunch of those.

MM: In about 1960, you were able to set up a pharmacology research unit at Bellevue, with a grant from the NIMH.[68]

BF: Yeah. I can't remember which year that was, whether it was –

MM: I think it was '60. [It was 1961.]

BF: It was either '60, '61, [or] '62. The Grant Foundation or one of the foundations gave me money before, or starter money.

MM: And that was to make a systematic study of the phenothiazines in children [the Thorazine, Benadryl, and placebo study].

BF: Of the medications that were available and try them out on children.

MM: Because previous to this, they had not been studied very systematically in children.

BF: Well, they were just coming in.

MM: But they'd been around for most of the fifties, I think, hadn't they?

EB: Fifty-four.

BF: In Europe.

EB: These are the first studies of –

BF: The very first studies were done in France.

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[67] Dr. Theodore Shapiro is now professor emeritus of pediatrics and psychiatry at Cornell Medical College and is also on the faculty at Columbia University and at the New York Psychoanalytic Institute. He and Dr. Fish were close collaborators from the 1960s into the early 1970s. Among their papers together are: Fish B, Shapiro T. A descriptive typology of children's psychiatric disorders: II. A behavioral classification in child psychiatry. *Psychiatric Research Reports of the American Psychiatric Association* 1964;18:75-86; and Fish B, Shapiro T, Halpern F, Wile R. The prediction of schizophrenia in infancy: III. A ten-year follow-up report of neurological and psychological development. *American Journal of Psychiatry* 1965;121:768-775.

[68] The National Institute of Mental Health was founded in 1949 as part of the National Institutes of Health and has had major influence on mental health research and treatment in the US through its extramural funding programs. See www.nimh.nlm.gov.

EB: Your studies were the first in children?

BF: Yeah.

EB: With Thorazine?

BF: Yeah. There may have been some private practitioners who were doing stuff, but not official studies. So in the ACNP,[69] I was the only one doing children.

MM: Okay. And the model that you used, first the children were on placebo, so that you could observe their normal behavior. [These were the studies with the psychotic and milder children 1.5 to 6 years old in the nursery at Bellevue.]

BF: Right.

MM: And then often you would put them on drug A, and then there would be a washout with placebo, and then drug B. So the children would serve as their own control. That's a crossover model. Why did you use that model in particular?

BF: Well, we got so we could know the children very well. If you know the child, you can tell how the behavior has changed, whether they're stimulated or depressed or cranky, or whatever it is, using them as their own control. So you could tell the differences between the medications. But the groups that we split up, even within the schizotypal sample, those that were really just retarded and those that had some language comprehension but no speech, and those that had the speech. I think there were five groups that we divided up. It was really only the group five with the most language function that really got better. Group four had such minimal speech and remained much more retarded. And likewise those that didn't have speech. But we could stratify them by their type of language and comprehension and motor behavior and social behavior.

MM: But some of the drugs worked better than others.

BF: Oh, yeah. Some of them stimulated the kids, even though they sedated adults. There were a lot of differences. I forget – there was one drug that we thought was great, but they had to take it off the market because, when they did bigger studies with adults, it had some other side –

MM: Toxic effects.

BF: Yes. That were not good.

MM: That wasn't Stelazine, now?[70]

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[69] The ACNP is the American College of Neuropsychopharmacology, an honorific research society founded in 1961. Barbara Fish was one of the first 4 women to be elected to membership. See www.acnp.org.

BF: No, no. I'd have to look up the literature, my own literature. I can't remember all those details. (she laughs)

MM: I think Stelazine, which is trifluperidol [trifluoperazine], you thought that worked really well.

BF: Yeah. That was really good. And what was interesting is, my severe nursery kids were like the chronic state hospital patients. And we could compare notes as to which drugs did what.

MM: You compared notes with the adult psychiatrist.

BF: Yeah. We had a group of twelve or thirteen, something like that, that started off. I had the only child group, because Eisenberg[71] just did the hyperactive stuff, and then he went to Harvard, and forgot all that.

MM: So then there was just you with the children.

BF: Yeah, at Bellevue. So this pilot group that they first started with was for the psychopharm group. We found that there were parallels. Some of the worst state hospital schizophrenics would respond to some of the medication like my little ones did. But sometimes they would have different effects on the kids, more stimulating and less sedative. There was one kid who was one of a pair of supposedly identical twins, but he had language in his -- but was very crazy, like [type] 3.[72] And the brother, the twin, was just dumb [mute], just born organic. He [the Type III twin] was psychotic, but he acted the opposite of what he was supposed to, for most drugs. He was funny, he was very cute.

MM: His reactions were not what you would have predicted.

BF: No, and it was different from the others.

MM: So it's really very clear the children reacted individually, and that was another good reason for using –

BF: Yeah, but we had to stratify them, according to social and language development. It was those that had basically no function at all, except motor function, that [failed to respond].

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[70] Stelazine, or trifluoperazine hydrochloride, is another of the phenothiazines, introduced in 1957. It is not widely used among adults because of the relatively high rate of tardive dyskinesia (possibly irreversible, uncontrolled movements).

[71] Leon Eisenberg (1922- ) joined the Harvard faculty in 1967. He is well-known for his work on autism and evidence-based psychiatry and cofounded Harvard's Department of Social Medicine in 1982.

[72] In Fish and Shapiro's typology, Type III children showed heightened anxiety and neurotic reactions. See the references cited in note 67.

MM: In order to assess toxicity, you would increase a dose until the child showed toxic effects.

BF: Right.

MM: And then cut it back.

BF: Right.

MM: And this was also different for the children? Some of them were –

BF: No, I did that in practice.

MM: No, I mean some of the children were able to tolerate higher dosages than others?

BF: Yeah, the nursery kids apparently could tolerate – it was a different range than they find in the adults.

MM: But, I mean, a kid's body weight's pretty small.

BF: Yeah, but even if you figure per pound, the dose would be higher.

MM: And did you have any concerns about – you put the child on a placebo, you put them on a drug, you put them on a placebo, you put them on a drug, you put them on a placebo again. Any concern that that kind of multiple drug changes might affect them in some way? Or was it just that anything was better than nothing, or – therapeutically, what –

BF: We didn't keep them in the hospital if they got well enough to move on, but we would keep them if they still needed hospital care, and then we would try these various different medications.

MM: But if a child was doing well on a drug, but the next step was to put him on a placebo, you would do that because you needed to do the study.

BF: Well, if he was well enough to be discharged, we wouldn't keep him in the hospital just to try the medication.

MM: Okay. So if he improved markedly, he would be discharged.

BF: Yeah. No, the idea was to get them out if they could move up. So then some of them would just be followed in the clinic as a research follow-up. But only the top level ever got that good, the ones with *some* language.

MM: And you said that the ones with little language –

BF: Even if they had just some comprehension, but not language, not enough language, just two words.

MM: They didn't improve very much. Were you better able to work with them in any way?

BF: Yeah. I mean, it depended on what their symptoms were, but if you could relieve the symptoms so that they could get along in a special group, you could find placement for many of them. No, we'd boot them out if they did well.

MM: If they did really well.

BF: Yeah, but the one, that little one, he was there for a long time. But the parents would come in and they would see him.

MM: So one of the ways in which you assessed the behavior, there was a non-blinded staff that knew what drugs the children were getting.

BF: Yeah, Ted didn't know. Magda and I –

MM: Ted was the blinded psychiatrist.

BF: Yeah.

MM: And he assessed them for specified periods of time, without knowing what drug they were on.

BF: Yeah, or knowing when they were on and off. He would just score them, I think it was weekly or something like that.

MM: And then you would look at the observations of both the blinded observer and the non-blinded observers. And they didn't necessarily always agree.

BF: Yes, but we would take the blind rater.

MM: Even though he had only seen them for a short period of time?

BF: Well, you sort of – you look at all the data. We would have – if she picked up toxic effects. You look at the whole thing. But if he couldn't pick up that there was an improvement – if she was non-blinded, I wasn't going to take her [assessment].

MM: When you say "her," you mean –

BF: Magda.

MM: Magda Campbell.[73] Did I get that name right?

BF: Yes.

MM: So, the blinded psychiatrist – that was Ted, Ted Shapiro, his view would be determinant on whether or not the kids had improved.

BF: Yes.

MM: But not necessarily on toxicity.

BF: Well, we put all the data together, to describe the good and the bad effects.

MM: Okay. So tell me a little bit about Ted Shapiro?

BF: Oh, he was wonderful. He was a great one to work with.

MM: He came to you as your student, as your resident?

BF: Yeah. He was just going to get a little, a year in Child, but I seduced him. He just got fascinated with what you could see.

MM: In the children.

BF: Yes. So he ended up doing psychoanalysis with children, and still working with me and being the blind observer, until he took over and then started the child unit at Cornell. But I remember, oh, I think his little girl had some waking up at night problem. I saw her, and it didn't look like anything really worrisome. And I think I sent them to Renee [Wile], my social worker, who was a very earthy, fabulous social worker, and she really couldn't tell me. "Oh, I don't know." So I just told them to relax, but she would do much more subtle stuff with them. They just were hovering too much over her, their first kid. And somehow they just relaxed. Whatever she did –

MM: It worked.

BF: Ted did not remember what she did, he just stopped worrying about whether she was going to sleep or not. So he found that more helpful than his analyst.

MM: How interesting.

BF: She was going to take the child in for five years of work. She didn't need it.

MM: Didn't need that.

[73] Magda Campbell remained on the Psychiatry faculty of New York University for her entire career. She is the co-author of a well-known textbook on child and adolescent psychopharmacology.

BF: No.

MM: Okay. Now, Magda Campbell, she was also –

BF: Well, she was just too damn rigid. She could follow my routine. She was from Yugoslavia, and it was just a different way of thinking. Ted stayed for about three years after I left, and he was wonderful. He was a fabulous human being.

MM: He clearly thinks a lot of you, too.

BF: Well, we grew up together. (all laugh)

MM: You learned together.

BF: We helped each other grow up. No, Ted became a really professor professor, and he was a great teacher. I think he still is, for whatever he does at Cornell. He's emeritus something. He just fused whatever the New York Psychoanalytic got him to do with the ego and the id and whatever, and somehow could fit the Bible into what he learned from me. He made his own mix.

MM: You sort of did that, too.

BF: Oh, yeah. Whatever works.

MM: Now, one of the things you did with the drug studies is, you developed a typology, which you just described. You had to stratify the children.

BF: Yeah.

MM: Can you remember which came first? Were you doing drug studies and you realized you needed a better way of grouping the children?

BF: Yeah.

MM: Because the ways that people had been grouping them weren't working?

BF: Yeah, I think our system was still better than the current system. (she laughs) That's why I gave up when they started with DSM-III.

MM: You gave up on them.

BF: Yeah, it was too rigid.

MM: You had four groups in your typology.

BF: Yeah. Well, someone explained to me later that we had reproduced what this psychologist was doing,[74] without realizing it. We cooked up our own.
MM: Right. Which psychologist?

BF: I don't remember.

MM: Okay. We'll find out.

BF: The four groups grew from our typology, but then we had to subdivide the nursery kids because the ones in the nursery, we had all ranges of language function, so that broke it down.

MM: So that broke that group down further.

BF: Made it smaller. So it was like having the subgroups within the type I psychotic kids, and that depended on the language and the comprehension and the motor behavior.

MM: And language is very, very key.

BF: Yes, it is, it's how much brains you got. But with children, you get a bigger range of motor function and other things too, that you have to deal with, because that's part of their development.

MM: Yeah. It's all part of their development. Can you sort of describe how you see these things fitting together? On the one hand the motor development, on the other hand the language development, on the other hand their thought disorder. I mean, are these all sort of related together?

BF: Well, language and thought are from the same territory.

MM: Some of the kids showed motor development deficiencies in hand-to-eye integration, hand-to-hand integration. Would you think those would be later reflected in difficulties in using contexturalized language, developing language skills, or are those -- would you see those as necessarily related?

BF: It depends upon what ages you're talking about. We're jumping around here. Because while motor development and cranial measurements are very important in very early development in the brain, when you're following babies, they branch out into much more sophisticated cognitive functions. So it takes – you have to examine them at different levels when you're looking at different ages.

MM: Right.

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[74] For more information on typologies of child psychiatric disorders in this period, see Rutter M. Classification and categorization in child psychiatry. *J Child Psychol Psychiat* 1965; 9: 71-83. Available online at: http://www3.interscience.wiley.com/journal/119730820.

BF: You have to look at a range of function.

MM: But might they have motor skills that were at a normal level at age two and later showed retarded language development at age five?

BF: Well, you'd see something about language by two. You wouldn't bet on it, but you're going to predict language development. You're looking at the infant and how they're grasping what you're, interested in what you're saying.

MM: I guess what I'm trying to say is, are all the manifestations based on the same sort of neural disorder? Do you see what I mean? Am I asking this question right?

BF: You mean looking for the neurologic problems of schizophrenia?

MM: Right, if you would see –

BF: Yeah, but after a certain age, I don't know that the more primitive functions are very helpful by one year.

MM: Okay. They don't tell you very much.

BF: Yeah. And you're looking much more at the adaptive and the social and the language, and that's what's still continuing then into the cognitive.

MM: Okay. So that's what becomes important.

BF: Oh, yeah.

MM: Did you have some more questions?

EB: I had a little bit of follow up on the study design questions you were talking about. Who were you working with or collaborating with to develop that study design? Were there other groups doing similar things?

BF: Well, Ted and I were working on it, and we worked on the typology together and worked that out. And we still enjoyed our typology later. It worked.

EB: Still made sense. Yeah, it sounds like it. But there were other drug researchers working with adults, I'm sure, in other –

BF: Yeah, but we were the only early clinical drug evaluation unit for children, for a long time.

EB: Did you look to the early clinical drug evaluation units? There were other groups in New York and Long Island that were –

BF: Well, the ECDEU groups.[75] Well, we started with just about either twelve of us or fourteen, somewhere. And we used to even see each other rather frequently, the same gang, you know, used to meet regularly.

EB: And you'd talk about –

BF: Yeah, I'd talk about the children.

EB: The typology.

BF: We'd all talk and we'd visit each other's units.

EB: Do you remember people in particular whose studies you admired and tried to emulate, or people who gave you good guidance about how to do your studies?

BF: Well, we were the only ones working with kids then, so that the effects we were finding were often different than what they could see in the adults, because they were working with higher developmental functions. So we would try and see what parallels there were or how the kids were different.

EB: So more about questions of how the drugs were working, that's really what you talked mostly about with your colleagues?

BF: Oh, yeah. That's what they wanted us to talk about.

EB: Was there a lot of worry about designing the study in the right way, or getting the methods –

BF: Oh, yeah, there was a lot of talk about the methodology. Eventually [around 1976], they got bigger cross-sections of people to get more people involved in this kind of work, and also to react to what we were doing. But I left that work when I left Bellevue. I'd learned what I wanted. I liked to see how they affected different kinds of kids and different functions. But after that, it gets to be just one drug after another. Especially now, they just multiply them. They have to really compare the old ones to the new ones to see if the new ones are really better and compare the toxic effects versus the positive effects. What troubles me is they get so now it becomes just medicinal, and really working with human beings is much less – it's not compensated, the time.

EB: Right. So it's just the drugs.

BF: Yeah. When I go see my shrink, she's got ten to twenty minutes with me.

EB: That's the only expertise, yeah.

[75] The Early Clinical Drug Evaluation Unit research groups were sponsored by NIMH. Their work resulted in the ECDEU Assessment Manual for Psychopharmacology, edited by William Guy, and published by the NIMH's Psychopharmacology Research Branch in 1976.

BF: So I'm on two of the things that are supposed to help your brain. I can't tell if it's helping me. (all laugh)

EB: Well, you're doing great today.

BF: Who knows whether I'd be regressing faster? But my short-term memory is zero.

EB: I wouldn't notice, but –

BF: Well, you'd only – Like, I found – I went into the shower last night. I don't take a shower every day, too much trouble. So I found myself in the shower with my glasses, instead of having taken them off.

EB: Well, it's good to be able to see in the shower.

BF: Well, I could see without them in the shower! So I had to put them carefully not where I would step, but way in the corner, without dripping too much. (she laughs) And by the time I finished my shower, I had totally forgotten what I had done with my glasses. And we spent looking all over the house for those glasses, and I thought, I don't think I would have walked from the kitchen to in there without my glasses. And there they were on the corner of the shower. And I remembered.

EB: Of course.

BF: That I'd been in the shower and I'd forgotten them for that long. So you're getting a better history in the past with a few blank spots. (she laughs) My short-term memory is zilch.

EB: It's difficult when you notice things like that. Your mind has been so much a part of your work and your engagement with people.

BF: Well, and also, you lose your age mates. I mean, everyone I know is a generation or more younger.

EB: They say that's good, to begin to get younger friends and to remember the whole range –

BF: Well, you need friends. My best friend had been a student of mine when she was a fellow. She was great, my best one. Now she keeps an eye on me.

Dorothy, who lives with me now, was Max's nurse; and then she's a very smart lady, and she moved up, took courses all the way through college while she was still a practical nurse. So now she does much more high-level inspection of nursing homes for their qualifications and stuff like that. It takes her more than an eight-hour day, cause she has to travel. But the point is she has connections, so that when I've been sick, she's been able to get somebody for me, to stay with me.

EB: That's great. Very important.

BF: That works out very well. So I can get in-house care when I need it.

EB: Yeah, the special treatment you deserve.

BF: But I turn down this housing stuff. They've got some for faculty now. They're building stuff on Wilshire. But that's an apartment. Would you go to an apartment if you could live here?

EB: No. Not with all those trees.

MM: No.

BF: I like to say if I lose my marbles, they can wheel me out there and I can smell the roses, or something.

EB: That's a good spot right there.

BF: It's so peaceful.

MM: It’s a perfect view. I think you should stay here.

BF: It makes me feel serene just to look out there. I don't know if you can see the roses from where you're sitting. You can really see them from every room in the house.

MM: We'll get up. I think we're going to pause now so we can see the roses.

**End Session 1**

**INTERVIEWEE: BARBARA FISH**

**INTERVIEWERS: Marcia Meldrum, Elizabeth Bromley**

**DATE: September 25, 2008**

**SESSION 2**

## IV. Organizational Work and Research in New York

MM: Well, good morning. Today is Thursday, September 25th, 2008, and we're starting the second session of our interview with Dr. Barbara Fish, and the interviewers are Dr. Elizabeth Bromley and Marcia Meldrum. We're very glad to be back here again.

BF: Welcome.

MM: We have some continuing follow-up questions. I wanted to talk a little bit more about the longitudinal study because, I must admit, it's a fascinating, fascinating sort of follow-up of these children for thirty-five years. At different stages, you re-interviewed the children and made a provisional diagnosis, and then at the very – or not possibly at the end of the study, but most recently, Dr. Kenneth Kendler, he interviewed them or he assessed the files?

BF: No. He read the transcripts, the verbatim transcripts.

MM: And did a blind assessment.

BF: As well as other parts of the files. He could look at any part of the file he wanted to look at, but mostly it was the verbatim transcripts he worked with.

MM: So it seems as if, you know, you're thinking about what was going on. Some of the children changed substantially as you watched them get older. Would that be a true statement?

BF: Yeah, and also diagnoses changed along the way, too.

MM: Yes, I noticed that.

BF: I mean, the term schizophrenia was very loosely used in the U.S. in the early days, and it included a whole lot of borderline kids, some of whom now would be called not just schizoaffective, but borderline cases. And some of them are really more in the affective spectrum of those two. But we didn't – when I was at Bellevue, we weren't picking that up. Everything was schizophrenia.

MM: You were sort of looking at them all as possible schizophrenia.

BF: Well, they were a cross section of the most disturbed kids in Manhattan and the Bronx. I mean, it was half of New York City's total lower [class] population, so that's a big population, and we got the most disturbed ones. The other hospitals wouldn't touch them. They had nothing to pay. They had no insurance.

MM: And you had been thinking – you were looking, based on your work with Lauretta Bender – now correct me if I'm wrong – that there was a neural defect that would be apparent at infancy.

BF: Yeah. She saw it as a whole neurological, all up and down the whole nervous system spectrum, a little broadly. And she actually got the baby books from five of the mothers of the ones who were very early onset childhood schizophrenia and looked at them according to Gesell, not just his standards for from birth on, but this one *Embryology of Behavior* that he wrote on the preemies,[76] they were the preemies in one of the world -- it was an exhibition of worldwide something or other, and he had these preemies who were there to be seen as museum [exhibits] for the New York audience. But they studied them and did their developmental history. And since they were preemies, it was like minus four weeks, minus eight, and even minus three months. He called it *The Embryology of Behavior*, so he concocted his standards back to the minus four or minus eight weeks, minus three months.

So Lauretta said, "There it is!" They're going backwards and forwards and advancing and regressing, just the way she thought they would. So I thought, “Well, I'll just go out and measure them,” because I'd been doing that in a well baby clinic at Cornell, and I'd worked in pediatrics at Bellevue after Cornell, and I knew there were all kinds of babies that came in there. Because it was the real Lower East Side of New York, which was new immigrants that were probably the healthiest of the poor babies, mentally, and then those in New York City that had sort of regressed to the lower group.

MM: Socioeconomic group.

BF: Yes. So the number one baby, that I called Peter, he turned up – I started in July when I finished my residency, and I was teaching in pediatrics by then, but I came in Wednesday and saw either the first baby or the last baby, because the latecomers would tend to be the more discombobulated families, who would not always have appointments and arrive, “we need help!” kind of thing. So I would alternate between the prompt ones and the late ones, and just ask the nurse to give me whatever babies. There would usually be about five that hadn't been seen before. So I would get to one of them and just take a very detailed history both of the family and the baby. The mothers loved it, because finally there was a doctor who was talking to them for an hour, instead of for five minutes. So they were grateful that they could ask all the questions and watch me examine the baby and have them sit up and go through the whole Gesell routine. They were very happy to have that kind of interview. I mean, it was all voluntary; I just appeared. And then we also did the well baby routine, too. So it was a cross section of New York Lower East Side at the time, at Bellevue.

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[76] Gesell’s *The Embryology of Behavior: The Beginnings of the Human Mind* was first published in 1945. It is currently out of print.

MM: You comment at one point that your sample was small because it was difficult to get funding, and it was difficult to get funding, because most of the experts in the field were considering that schizophrenia was actually more developmentally and environmentally based, that they were disagreeing with your basic premise.

BF: Yeah. I actually – I had some connections. Ernie Gruenberg was a sociologist.[77] I can't remember how I got to know Ernie, but because I was *the* child psychiatrist at Bellevue.

MM: The only one?

BF: Well, I was head of Child Psychiatry at Bellevue, and Bellevue was the best of the city hospitals. Kings County was –

MM: Not so good, yeah.

BF: So they had Brooklyn and Queens; and we had the Bronx, Manhattan, and Staten Island, too, as it is in the song.[78] So it was half of New York. I got off the track. What was I starting to tell you?

MM: We were talking about Ernest Gruenberg.

BF: Oh, yeah. Ernie was a friend of mine from some connection, I don't remember. So when I got turned down on my request to – I guess it was in the fifties. I had started in '52, and I think when those babies were about three, and they were finished in the well baby clinic, I started to write up a very rotten report; I didn't know anything about that stuff. But anyway, I got some help on writing it more completely. And had been turned down [for funding]. So Ernie managed to get Sapir.[79] "I understand I'm not supposed to put this all in writing," he said. "That's not nice." Because he was head of the NIMH at the time, or at least the main bureaucrat in Washington, who was in charge of those grants. So, I guess through Ernie, I saw Sapir and whoever was in charge of that committee, who had turned me down. So apparently, I impressed them, but they ended up that they would fund me for looking at the well babies, my controls, but they didn't want me to do the state hospital babies.

MM: Why not?

BF: I guess they didn't believe in schizophrenia.

MM: In hereditary, maybe.

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[77] Ernest M. Gruenberg (1915-1991) was professor of psychiatry at Columbia until 1975 when he became the chair of the Department of Mental Hygiene at Johns Hopkins, a position he held until his retirement in 1981. He is considered a pioneer in the field of community mental hygiene.
[78] The song, "I'll Take Manhattan," was written by Richard Rodgers and Lorenz Hart in 1925.
[79] Philip Sapir was head of extramural grants at NIMH and later president of the W. T. Grant Foundation.


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BF: Yeah. So I said, "Well, thanks very much, but no thanks." I was just a squirt at the time. I said, "I'm going to do the study, and if you won't pay for it, then I'll just do it on my own." And they were a little aghast. You're supposed to bow down and kowtow to the heads of NIMH, but I didn't. I just walked out. I said, "I'm going to do the study on my own."

MM: Good for you.

BF: But then I had connections because of Lauretta. I mean, she was very famous. Well, even the analysts in New York, especially the European ones, respected her, not the extremists, but mostly the European psychiatrists recognized that schizophrenia was a basic disease, even when the Americans were on a kick that didn't agree with the world. So she put me in touch with Paul Hoch,[80] who was in charge of the whole New York State system. Then he put me in touch with Brill, not Norm Brill, but [Henry] Brill who was in charge of a couple of the state hospitals.[81] He was like number two man in the state system. But then I knew all these people at ACNP, when that started in '63. We were buddies by that time.

MM: They knew you because of your pharmacology studies mostly?

BF: Yeah. Well, they had – there was Brill. I think I was sitting next to him in that first dinner picture, between him and Heinz Lehmann,[82] I think. So I knew all those key people, and they were doing the adult studies and I had the only child study; they were the group that I was following. So once I got to Brill, there were no human subject regulations in those days, so he would just tell the head of – I guess it was Manhattan State and the Creedmoor, the Brooklyn State Hospital.[83]

So I got babies drawn from those boroughs, and they would call me if they had a schizophrenic mother who was delivering a child. So the nurses knew me in the newborn nursery, and they loved that. Instead of working with these crazy women or men, they were assigned to a nursery of anywhere from three to five or six babies, and it was lovely to work with little newborns. So I had friends with the nurses there. And they would call me when a new baby was born, and I would head off – my husband would drive me out at midnight or wherever, you know, to see the infants when they were in the first twelve

[80] See note 27.

[81] Henry Brill (1907-1990) was an authority on drug addiction and a leader in facilitating outpatient treatment of the mentally ill in New York, through the use of psychoactive drugs. Brill interned at Pilgrim State Psychiatric Center in West Brentwood, Long Island, and served as its director 1958-74. He was the first deputy commissioner of mental hygiene in New York. Norman Q. Brill (1911-2001) is best known for his pioneering work in military psychiatry during World War II. He became the first Chair of Psychiatry at UCLA in 1953 and the founding director of its Neuropsychiatric Hospital.

[82] Heinz E. Lehmann (1911- 1999) emigrated to Canada from Germany in 1937. He is known as the first psychiatrist to use neuroleptic drugs in North America, at the Douglas Hospital in Montreal. He was Chair of Psychiatry at McGill University 1971-75.

[83] Manhattan State Hospital was opened on Ward's Island in 1899, and was the largest psychiatric hospital in the world at the time. It was later renamed the Manhattan Psychiatric Center. Creedmoor State Hospital in Queens Village (later Creedmoor Psychiatric Center) was opened in 1912 with 32 patients as a farm colony of Brooklyn State Hospital; in the 1950s, it became notorious for overcrowding. Patient deinstitutionalization later reduced the census and part of the site is now a park.

hours. And then I'd see them at three days and then follow up at four weeks and do the Gesell schedule after that, as long as they were around.

And then I could follow them often through – most of them, because these women were psychotic and were in the hospital, they didn't take the babies, they just were in a state hospital. So the babies were put up for either adoption or, certainly, in the agency care, and they would choose really good mothers for most of them. The Catholic agencies, I think, were not as eager to cooperate. I think they didn't have such a good setup, and they didn't want psychiatrists snooping around. But I got access to most of them. I just worked with the agency and with the foster mothers, and they would often pick really good mothers for these kids, and I'd work with them.

MM: Did it seem to you, thinking back, that the quality of mothering made a difference? It seemed with some of the kids who eventually were diagnosed as schizophrenic, nothing seemed to really change their course. They got worse and worse, no matter what.

BF: The really good mothers could put up with a lot and would tell me that this one is very fragile, and she's just very touchy, so give her a little room. I remember I had to stay at a distance at first and then gradually work my way up to sitting next to the kid and talking with her. But the mother would – she knew this one was different from her sisters, because they each had different fathers. There were three of them.

MM: She would know.

BF: She took all three, and then when there were some more, they went to someone else. She said three was enough for her, but she was a wonderful foster mother. So that they often were much better than they would have been if they'd gone to – like one of them went to the grandmother, and she got along well in the world, but she really was kind of paranoid. That wasn't such a great home. She turned against the kid as soon as she began to have problems and threw her out. We had all kinds of emergencies.

That one, actually, I had to take in to Bellevue and put her on the adolescent ward, and then worked with her. We tried a lot of stuff with her, but she couldn't make it. She would drop out. She'd see me, but she was very secretive and gradually she slipped away. She said she didn't – she turned eighteen. She'd gone to the Bellevue school, and they got her kind of – we had her as an outpatient, and they worked very hard with her. But, when she was eighteen, she said, "I don't need anybody," and she slid down into the depths after that. That was terrible.

But I just followed them, and the ones that had problems were the ones I saw the most often, like every six months, when I would come to New York from here. Those were the ones I would line up first, and then I would follow up whoever else I needed to follow up.

MM: I was going to get to California in a bit, but let's just clarify that. So you moved out here in the early seventies, I think.

BF: Yeah, '72.

MM: But you continued to go back to New York to follow the children.

BF: Yeah, I went back every six months, I think. I can't remember. It wasn't quite six months apart. It was the better months in New York. (all laugh) I think it was more like April and October.

MM: Good planning.

BF: I used to spread it out like that.

MM: Okay. Did you want to ask some questions?

EB: I do have a few. I wondered if you could say a bit more about NIMH at that time, when you were applying for research funding. Did NIMH have a particular mission or a particular identity within the profession or the academic world, and did that mission differ from what most people were doing? Was there some sort of difference between what NIMH wanted and what most researchers were doing? Were they trying to guide the field in a particular direction, would you say?

BF: Well, I guess Sapir[84] had to do whatever the edict was from above at that point, because I know later I met him again at – I guess he was with one of the foundations, I can't remember. The Grant Foundation;[85] he was head of the Grant Foundation. He moved from NIMH to there. And they were – at this later date, they were supporting many of the high-risk studies of babies at risk. And then I was asked to join the group, when the Grant Foundation had these meetings of the high-risk investigators, they finally caught up with me.

EB: They came around to your side.

BF: Yeah. And then he was very friendly. They had a mission, and I had started before anybody else. I had started in '52, and this was – then in '65, NIMH started a study when Rosenthal was a big high-risk fellow, and he – I remember talking with him, and he was very encouraging and was interested in what I was doing. He had done the studies of the quintuplets. Quintuplets or quadruplets? I guess it was the quadruplets that were all offspring of a schizophrenic mother.[86] And it was a very famous study. So he was very encouraging to me and was fascinated with what I was doing. We exchanged data, and he gave me some of the baby data from the quads, which was interesting, and I analyzed it. You know, we were exchanging material like that.

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[84] See note 79.
[85] See note 56.
[86] David Rosenthal (1916 -) of NIMH led a famous study of four quadruplet girls, all schizophrenics, known by the pseudonyms, Nora, Iris, Myra, and Hester Genain. They were born in 1930 to a mentally unstable father, whose family had a history of mental illness, and an over-protective mother, and were studied intensively at NIMH in the 1950s. Although genetically similar, they showed distinct differences in impairment and adjustment. See Rosenthal D., ed. *The Genain quadruplets: A case study and theoretical analysis of heredity and environment in schizophrenia.* New York: Basic Books, 1964.

That was back before I was invited to join the other high-risk people. But I had people who were recognizing my work, like Dan Freedman,[87] and he organized a big meeting -- oh, God, I can't remember all the organizations, but they would have one big meeting like a roundtable and key people would present papers. Dan ran one on schizophrenia, and I presented the work on infants, as well as the autistic kids that I'd studied at Bellevue.[88]

EB: And this was in the fifties? You mean you had people recognizing your work, even if NIMH had maybe been skeptical.

BF: Yeah. In fact, Dan was trying to recruit me, because we were at ACNP together.

EB: That was in the early sixties?

BF: Yeah. By that time, I was doing the ten-year-old follow ups of the Bellevue kids, the first ones I had studied. Dan was involved in all that, and then he found that I was getting fed up with Bellevue and the way I was being treated. Although it got better as soon as Sam Wortis died.[89] Because he was really basically a neurologist, and he didn't like Lauretta. He was jealous of Lauretta Bender and David Wechsler[90] because they were the stars in the department, of course, and he was a neurologist. He got in because of his wife's family. So he wasn't very encouraging. And all the men were getting paid much more than I was. Because I was working full time.

EB: Probably more than that.

BF: Sometimes until eleven at night, and Max would come and pick me up. "You can't be working like this. This is wrong." I said, "Well, there's a lot to do." (she laughs) But I'm getting sidetracked.

EB: We were talking about the reception of your work in the fifties as opposed to the sixties and the seventies, where you were much more in line with the mainstream.

BF: Well, in the seventies – you see, after the sixties, NIH was involved then. And Dave Rosenthal was in charge of that study. He was the head of the psychology department and he had been working in the area of schizophrenia for a long time, and was a very good person. And it was only then, after they did their study, which started –

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[87] Daniel X. Freedman (1921-1993) was a pioneer in biological psychiatry. He worked at Yale, Chicago, and UCLA, where he was Judson Braun Professor of Psychiatry and Pharmacology from 1983 until his death. He also served for many years as editor-in-chief of the *Archives of General Psychiatry*.

[88] See Fish B. Biologic antecedents of psychosis in children, in Freedman DX (ed): *The Biology of the Major Psychoses: A Comparative Analysis, Assoc Res Nerv Ment Dis*, Volume 54. New York, Raven Press, 1975, pp 49-80.

[89] Samuel B. Wortis was head of Psychiatry at Bellevue from 1942 until his death in 1969.

[90] David Wechsler (1896-1981) was the chief psychologist at Bellevue from 1932 until 1967. He is best known for developing the Wechsler Adult Intelligence Scale and the Wechsler Intelligence Scale for Children, which are both widely used.

they started with latency-aged children.[91] They didn't start in infancy. But basically they could pick up children that would become schizophrenic, and they had this big study from 1965, children with and without schizophrenic parents. So when their work came out and did well, then NIH officially put out grants [requests for proposals] in the seventies.

But, actually, I had been working with Niki Kimling[92] at the Psychiatric Institute even before that, because she was helping me pull the charts of the state hospital mothers. And I knew her work. Somehow you are exchanging work with people that you connect with.

EB: Maybe on that topic, maybe you can tell us more about the origin of the ACNP. What brought you all together? What were you trying to do with the organization early on, would you say?

BF: Well, it was the beginning of the work on psychopharmacology. We were all – I was at Bellevue. I think I got a Grant Foundation [grant], five thousand dollars to start it off, and then NIH put out -- there were about twelve of us who were doing early clinical drug evaluations. They've got a much larger group, I understand, now, doing that. But there were about twelve of us starting, and I was the only one with a child unit, and the only woman. I had a very good time. So I was kind of a star in this circle, and it was fun.

In the ACNP, there were a hundred men and five women. Lauretta Bender, Else Kris,[93] who was also a state hospital person that Lauretta knew very well. I collaborated with her on some stuff, because she knew what I was doing with the babies. Then there was – oh, I know her so well. A woman who was the wife of -- they were both doing neurophysiology [Keith and Eva Killam].[94] Her name will come to me. Geriatric memory.

MM: We can put it in later.

BF: Yeah, we'll stick it in.

EB: It'll occur to you.

BF: But she was doing neurophysiological work, like her husband was. And then there was me doing the child stuff. And then there was an official for ACNP, who was sort of there because she was keeping an eye for ACNP. Executive secretary or something, I don't know what. I don't remember her title or her name. So we were the five women, and a hundred men. So that could be a lot of fun. It was a good comradeship. I just knew a lot of them who were working in the field.

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[91] Latency age is the period of latency in sexual development, from about age 6 until puberty.
[92] L. (Niki) Erlenmeyer-Kimling is Professor of Child Psychiatry at Columbia and Chief of Medical Genetics at the New York State Psychiatric Institute.
[93] Else B. Kris was director of psychiatric research with the New York State Department of Mental Hygiene in the 1950s and early 1960s.
[94] Keith F. Killam, Jr., and Eva K. Killam (1922-2006) were Professors of Pharmacology at UC Davis; Keith Killam was the Founding Chair of the Department. Among other problems, their research dealt with the physiological correlates of EEGs.

EB: Would you say in the beginning you were meeting to work on trial design or to attract new trainees or –

BF: Oh, I did that at Bellevue. Yeah, I was doing all that at the same time.

EB: Or to lobby in some way, to perform a professional organization that could –

BF: I was running – if you look at my CV, in New York –

EB: Yeah, but I was wondering about the mission particularly of the ACNP, kind of the impetus for getting together. What did you feel you could do together?

BF: We had not just the annual meetings, but those of us that were doing this early clinical work, the dozen of us, were getting together. And then there was a larger group, I know. Cause we would meet with Heinz Lehmann from Canada and some of the big figures in the field as well. So that if you look at that first dinner picture of the ACNP, I think I'm sitting between the big state hospital guy, [Henry] Brill, and Heinz Lehmann.[95] They were my buddies and they were brilliant guys. It was all very exciting. So I was part of the gang.

EB: Right.

BF: And when we heard – I guess it was in '63 or '64, the head of NIMH gave a speech there[96] and said we were all going to solve schizophrenia in twenty years. And we looked at each other, those of us at the ACNP, and we knew he was just full of shit. Here's this government guy, it was dreadful. And actually that was when they started to close the state hospitals. They were curing schizophrenia, and they threw them out in the street, and it was just a disaster.

EB: Right. He was saying that you're going to cure schizophrenia.

BF: Could you remind me of his name?

EB: No, I don't remember [Robert H. Felix].

BF: It's infuriating. We just all looked at each other at that ACNP meeting and thought, “That son of a bitch!”

MM: You knew that wasn't true.

BF: No, they couldn't possibly do this. He had this big government position, and he was just going to be clever and throw some money around and try and make himself more of a big shot than he was, and it was obscene. I mean, it was just a disaster. So

[95] See notes 81 and 82.
[96] Robert H. Felix (1904-1980), originally Director of the Institute of Mental Hygiene at NIH, was instrumental in the creation of NIMH in 1949 and served as its Director until 1964.

they threw the people out of the state hospitals without any preparation. I remember because one of my classmates then, Al Miller, who was a very decent person, but he'd been parked in the New York State system.[97] I said, "Alan, you simply cannot do this. This is a terrible thing. And there's no facilities that are ready for these people." He acted as though he was helpless and he had to do whatever they told him to do, or something like that. He was a fine person when I knew him, but I just thought he's got no balls at all.

EB: And you all had become somehow a way to rationalize this decision to close and reduce populations in state hospitals.

BF: Well, we were against it. All of us who knew what was really going on, at the ACNP, certainly, knew that schizophrenia wasn't going to disappear, and they weren't going to cure it all up in twenty years.

EB: And yet his position, the NIMH director, he was perhaps saying, look, we've made such progress in drug research, even in the last nine, ten years, and the science is –

BF: This was in '63; it was one of those first years of ACNP.

EB: Twenty years from now, maybe we can find the right drugs that would help people manage the illness well. That didn't strike any of you as rational.

BF: That the drugs were really going to cure schizophrenia. I mean, it was just expecting more than what was going to really happen.

EB: What were the state hospitals like? We have a stereotype of them now that these were warehouses and there was no care delivered, or that maybe there were drugs handed out kind of willy-nilly without much plan.

BF: Well, they were trying. They would try the new drugs that came along. Lauretta, actually, was then in charge of the Queens unit, and she had Gloria Ferratra there, and they had children and adolescents and were working as hard as they could with them. But, of course, it's always an overloaded population. They had to take all comers, at least the ones that are really sick. And that was the Queens unit.

MM: Okay. Let me just sort of try and clear up just a little bit.

BF: I wander about. I'm sorry.

EB: No, not at all. Actually, you know what, you were reading my mind. I was just about to ask you about the institutionalization and how that affected your work. I'm fascinated that you have this story about the particular position you were put in.

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[97] Alan D. Miller succeeded Paul Hoch as New York State Commissioner of Mental Hygiene in the late 1960s and early 1970s.

BF: Well, all of us. We just all looked at each other aghast, when he said this. Because we just knew that we weren't curing schizophrenia, and here they were going to throw them all out in the street, which they did. And I was a big wheel in New York, because we just set up – oh, it was all these women psychiatrists who were analysts, but who were trying to do important community work. So I got all involved with this whole New York City thing.[98] We had – I guess I was the head of stuff. But she was a big wheel. Oh, God, I'll have to look that all up. There was Margaret Mahler and some great European psychiatrists, but the big New York City people, one of them, she was all involved with some of the community organizations; and I just popped right up and before I knew it, I was running a whole big community setup for New York City. We had – I don't know, if you look at the CV, you can see all those organizations.

EB: It's clear your work was very socially engaged.

BF: We were trying to do something for the patients, and there was a lot going on in New York City. We really had a group working together, getting a lot done in the community. It used to be, at Bellevue, people would call up, and the porter could be the only one in the office and he would pick up the phone, and you know how helpful he could be.

So one of the first things I did is, we had this whole New York City thing, was to have the phone numbers of the key people, both in Brooklyn and Manhattan. We had Manhattan, Bronx, and Staten Island, too. We had the head person from the school, the head person from the state hospital children's unit, from the big social organizations. There was one for each thing, and we would meet as an executive committee of half a dozen people. The state hospital people would claim these kids didn't have any schooling, and then we said, "But they're shipping them from New York. They shouldn't be shipping them out there."

Yeah, we finally – each person had their problems, and we really tried to resolve these things, that the schools wouldn't just ship them out, we would have to go through the whole process and screen these kids and do something. And if you had a problem, you called – we had these key people from the state hospital and the schools. You could call the head person and try and straighten it out. It was a very useful operation finally, to cut through all the red tape and just have people be in touch with each other and not just ship the kids around.

Then when I had these good people that I had trained, we practically set up – it was a setup when the schools would ship a kid in – it was just too much, they couldn't do anything [with the child]. My two head people, one of them – they would screen them, and they would test them, and they would do a good evaluation. And if really the kids they needed medication, we would then set up something and say, well, try this, and get the agency then to work with the child and not just ship him off to a state hospital, but try and get things done with the home and stop all this shipping kids around. So it really was working.

[98] From 1962 to 1973, Dr. Fish served on the Citizens Committee for the Children of New York, on the Subcommittee for Mental Health Services, and on the Advisory Committee on Mental Health Services for Children to the New York City Community Mental Health Board.

MM: Yeah, I like that.

BF: Yeah, you had the phone numbers and knew whom to call. The head of the Child Guidance Clinic, or you'd call the state hospital person, or you'd call the person at Bellevue. And it wasn't chaos.

And then the judges got into it, and we had – because they were also faced – Florence Kelly was head, and – oh, that wonderful – who's the other one? She was very famous and a very, very wonderful person [Justine Wise Polier; see note 118 below]. Her name just slipped before I got to Kelly. But she was the children's – Kelly was the head of the New York City child's thing. I'll have to look it up. But I worked with her [Polier] much more closely, and she got me involved with the courts. And this was also part of this whole networking thing, so that, again, the kids just weren't shipped. You could get an evaluation and a screening. Here we had this whole New York City setup, and it really worked.

MM: It sounds like it. And do you know what happened to that?

BF: Well, when I came to California then, I had Mike Kalogarakas, who was head of the adolescent unit, who was a very smart guy. So I had him take over that role with the judges. She was a Jewish judge. Famous Jewish family. God, what was her name?

MM: We'll find her. Don't worry about it.

BF: Anyway, there was this whole networking system. So if you look at my CV, all of those people are in it.

MM: We'll find them. You're sort of answering my question, I think, which is, What was your idea of the ideal treatment for the children? Drug treatment was not enough, clearly. I'd like you to sort of tell me how you see the children being followed. You have the children, they're being diagnosed as schizophrenic or schizoid personality disorder.

BF: Or some of them were –

MM: ADHD.[99]

BF: Yeah.

MM: So what's the goal of medication?

BF: Well, the goal of medication was to try and control some of the symptoms.

[99] Attention Deficit Hyperactivity Disorder is a neurobehavioral disorder occurring in childhood; the child is prone to impulsive behavior and finds it difficult to maintain consistent attention to any activity. Hyperactivity may or may not be observed (if not, ADD is the more appropriate term). Although recognized in DSM-IV and by many pediatricians, the definition and etiology of ADHD remains disputed. Some authorities and critics consider ADHD children to be the extreme examples of common behavior patterns.

MM: So that --

BF: But you still had to do something about the whole social setup for that child, whether it was the family or the agency or an institution. You had to do things with the environment as well and change as much of that as you could and do what you could with the schools.

MM: Do you think that for a lot of the kids it was possible for them to attend normal schools if they had medication and regular follow up?

BF: Yeah, for some of them. But we also had the really disturbed ones, including one of my high-risk kids. She was at Bellevue on the adolescent service, and I got one of my people to work with her in therapy. She got pregnant and we had to work with her, so she understood what it was going to be and she wasn't up to being a mother at fourteen. So she agreed to abort the baby, and she was greatly relieved afterwards, and really became almost high, it was such a relief. Because the foster mother had thrown her out, and there was her grandmother – as soon as she became pregnant, phooey. "You slut!" Of course, she was just a passive poor little whacked-out girl and the twenty-year-old boy upstairs just got her pregnant. It wasn't her fault.

So she – we rehabilitated her, and we had -- at Bellevue we set up this -- one of the ex-nurses, she was probably the best charge nurse around, and she was then made nurse of this unit, which was connected to the inpatient service that worked with the kids and was helping to get them accommodated so that they could go back to a family, or a foster home, or just grow up there and find a job. And this girl eventually, when she refused to stay with any of the units, they got her placed in the big kitchen for one of the hospitals. But anyway, she went downhill, in spite of all they could do. She just couldn't make it on her own, as she thought she could.

MM: Okay. I have a couple questions that sort of dropped into my mind. At one point you were using EEGs, which were rather new at that time.[100]

BF: Yeah, we had a good EEG guy at Bellevue.

MM: And I was wondering how you saw the EEGs as useful to you, whether they were diagnostic, or helped to understand the effects of the drugs, or -- what good were EEGs?

BF: Well, I can't even remember what we found. We wrote a paper. We did a before and after study, or a before and on drug study. And I'd have to read the paper again to remember what we did. (she laughs) Something came out of it. But the EEG was in a

[100] EEG, or electroencephalography, is the recording and measurement of electrical activity of the brain. Although experiments were reported as early as 1875, the German physiologist Hans Berger (1873-1941), who began his work in 1920, is generally credited for developing EEG as a research and clinical tool. See Millett D. Hans Berger: From psychic energy to the EEG. *Perspectives in Biology and* Medicine 2001; 44: 522-542; available online at: http://muse.jhu.edu/journals/perspectives_in_biology_and_medicine/v044/44.4millett.html. The American EEG Society was established in 1947.

pretty primitive state at that time. But he was a very good guy who was doing the work at Bellevue, but for the life of me I can't remember.

MM: Okay. The model that you used in the drug studies for the children, where the children acted as their own controls, so a child would get drug A and then a placebo and then drug B, which I think is -- it's a very -- I like this model.

BF: Yeah, it's a good model.

MM: But it's not a standard randomized control trial where you have group A on drug A and group B on placebo. I was just wondering about, if other members of the ACNP were using similar models to test psychoactive drugs, or if this was something that you just felt was the best for the children?

BF: Well, the first study we did was a more standard study. It was like we had a cross section of the kids that were more hyperactive on the ward, and that goes across from neurotic to behavior disorder to psychotic, [the whole] spectrum. Those were the ones who were seven to eleven. We had mostly boys in that age group. I don't remember if we had some of the girls in there, too. There might be a half a dozen girls and thirty boys on the ward, not eighty the way Lauretta had. We were able to keep it so that we could work with the children more closely.

So we did a Thorazine – which was the only anti-psychotic we had at the time – a Thorazine-Benadryl-placebo study, was our first. Ted and I worked out a typology ourselves,[101] just dividing the kids.

MM: Dividing the kids into four groups.

BF: Dividing the kids up, because a kid could be psychotic or a behavior disorder, but that wasn't very much help, and the DSM 1 and 2 were not very useful. So we ended up with our typology and tried to classify them as groups. So we had – the Is were the really psychotic, more autistic kind of kids, but at the older range. So it was a different group; if they were still autistic at six or seven, they weren't going to change very much. Then the IIIs were the more neurotic, and the IVs were the acting out kids.

Then there were these kids that were neither fish nor fowl, and they were the IIs. They were just immature. They had behavior disorders, but you didn't know which way they were going to go. It turned out that they also were in between as far as neurological findings. And the Is of course had the most neurologic disorder, brain disorder. Probably the IVs should have been IIIs, because they were worse than the IIIs, which were neurotic kids. But we just – they got numbers before we had studied them. That really worked out very well. We had a couple of those on placebo who improved, but more of them were IIIs than any other, the more neurotic ones, anxious and scared. So that was the big – we set up our typology in that group.

But then in the nursery, it was like they were all Type 1, but there we had to split them up because they were so different. They weren't maybe autistic, but some of them had – we split them according to whether they had speech or no speech. Then if they had

[101] See the articles cited in note 67 and discussion in Part 1.

no speech, did they have comprehension or not. I think – if they didn't have comprehension, I think, were they hyperactive or not. I don't remember the final split of the non-verbal kids.

But really it was only the top kids that really could get better. I mean, we even had some sets of twins where one was a 1, you know, mute and the other one was more neurotic, but a little crazy. Neurotic but crazy. And that worked out pretty well. So it really turned out that we could help some of the 2s – the Bs. We did them A hypoactive, B hyperactive, C some comprehension. You could help their hyperactivity or hypoactivity, but you couldn't do much more. The only ones that really could improve to some degree were the ones that had some speech. So we knew once we typed them that way, you could really test them on the different medications and see what it did. Did it help these kids in their motor hyper- or hypoactivity, whatever it was, and did it help the ones with language to really improve, so that we could judge a lot of the different drug effects that way.

MM: And no one criticized you for this model, or said what you should do is take the Type 1's and divide them in two groups?

BF: Well, we measured the kids against themselves. We scored them on placebo, and Ted scored them and he was blind, but he was very good at it by that time, at scoring. Because it was our system. It was much better, I think, than the DSM-III. (all laugh)

EB: It was 1 probably at the time?

BF: Yeah, it was probably DSM-1 at the time. And it didn't have anything for kids. If you tested the kid against themselves, you knew how this kid behaved, and you could see how they did with placebo, and then you'd see how they did with drug A and drug B, as long as they stayed around. If they got better, then they moved out. Or if they could go to some kind of an institution, or whatever, or family.

MM: In one paper you said that children before puberty do not tend to become addicted to medication. Do you still think that's true?

BF: Yes.

MM: That children are protected from addiction? Is that a common finding? Just asking.

BF: Yeah, we didn't find that.

MM: Okay. I'm sort of ready to go on to California. Do you have some more questions?

EB: That's fine. I do have questions, but they'll fit in later.

## V. Move to California and Working at UCLA

MM: Okay. So tell us a little bit about how you decided to make the move to Los Angeles. I mean, you've commented a little bit about how hard they were working you at Bellevue.

BF: Oh, yeah. Well, I was enjoying –

MM: It sounds like it.

BF: I mean, having organized New York City!

EB: Good setup.

MM: Where were you living at that time? Were you living in Manhattan?

BF: Oh, yeah. When I was at Cornell, we were living fairly near there. Then we moved to 10th Street, which was nice, in the Village.[102] 70 East 10th Street. And that was great. From there we moved to California, when Jolly recruited me.

MM: Jolly.

BF: Jolly West. Louis Jolyon West.[103]

MM: So how did he recruit you?

BF: Uh – how did he recruit me? I think it was at a – like that meeting that Dan Freedman organized, and I think it was somewhere in there. But Dan was recruiting me at the same time, for Chicago, and Jolly was trying to recruit me for UCLA.[104] Dan and I really clicked more than I clicked with Jolly. Jolly was, you know, in everything, master of the whole world. A little bull.

MM: Yeah, a little bull.

BF: Whereas Dan I really would have preferred.

MM: Right, you had an affinity.

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[102] Living "near Cornell" would be a residence on the Upper East Side of Manhattan. "The Village" is Greenwich Village, the historic residential area on the West Side, south of 14th street between Broadway and the Hudson River.

[103] Louis Jolyon West (1925-1999), well-known for his work on hallucinogenic substances and post-traumatic stress disorder, was Chair of Psychiatry and Director of the Neuropsychiatric Institute at UCLA (now the Semel Institute) from 1969 until his retirement.

[104] The University of California, Los Angeles, was founded in 1919 and moved to its present location in Westwood, then a rural area west of the city, in 1929. The School of Medicine was established in temporary quarters in 1947 and the Neuropsychiatric Institute opened in 1960. UCLA is consistently ranked today among the top universities and medical centers in the United States.

BF: But he was at Chicago, and did he have the money? Apparently, he was working with Sapir, I think, to get the money for me. That's how Sapir came back into my life.[105] I didn't know he was there. I found that out afterwards, after we collided at the later stage, when he was at the Grant Foundation. He said what Dan had gotten him to do. But that was getting him to put money into the chemistry department for my husband.

MM: Oh, yes, he had to recruit both of you.

BF: Dan had to do something about Max, and Max was so brilliant that he was sure he could find something. So he was working something out, but then the political situation, whatever, the money disappeared. And then when California got closer, it was another stir, but it fell through. And then they got – finally they got Joe Marcus instead,[106] and I went to California.[107] After I went to California, Dan got Joe from Israel.

MM: So why did you decide to come then? I mean, they offered you a job, and they offered your husband a job, but you could have stayed in New York.

BF: Yeah, but that meant working till midnight. There was just not enough support at NYU, in those days. Now they've got a wonderful setup for the gal who is in charge.[108] She's doing some interesting stuff.

MM: Was that because they didn't value child psychiatry?

BF: They didn't have the money. We had to raise money. I don't know why they didn't have it, but they got much more money after. They got some big donors. But the one they got after me was just a – he basically took apart the whole psychiatry department, and everything was just going to be behavior disorders, some sort of garbage. He was not interested in – Harold something, I forget his name. Anyway, I thought he was just – I was just, "okay, NYU!" Then they got this woman and she's really good. I keep meaning to write her and tell her. But she's in ACNP now. So she's doing a very good job. But she's head of child – she's head of psychiatry, and the guy who is doing some work with the kids is more interested in something else. He's doing good studies, but not schizophrenia. She's interested in – actually, she's interested in the ones where the fathers are involved, and there's less heredity, and how they become schizophrenic.

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[105] See note 79.

[106] Joseph Marcus is Professor Emeritus of Child Psychiatry and Behavioral Neuroscience at the University of Chicago. He co-developed the Jerusalem Infant Development Study which followed 15 infants at high risk for schizophrenia through adolescence. See Hans L, Auerbach JG, Auerbach AG, Marcus J. Development from birth to adolescence of children at risk for schizophrenia. *Journal of Child and Adolescent Psychopharmacology* 2005; 15: 384-394, available online at: http://www.liebertonline.com/doi/pdfplus/10.1089/cap.2005.15.384.

[107] Barbara Fish was appointed Professor of Psychiatry at the UCLA Neuropsychiatric Institute (now the Semel Institute for Neuroscience) in 1972. She was named Della Martin Professor in 1989.

[108] Jennifer Havens is Vice Chair of Child and Adolescent Psychiatry at NYU and Chief of Service at Bellevue. The NYU Child Study Center was founded at Bellevue in 1997 under the directorship of Harold S. Koplewicz.

MM: That is interesting.

BF: Yeah. So she's got her turf. I keep meaning to write her, and the letter – there's always some stuff on top of it that I have to do first. I'm very slow these days.

MM: Okay. But you came out to California. And aside from the fact that you didn't have –

BF: But I feel much better about Bellevue now.

MM: That's good.

BF: Finally, she took over from this character and he was kicked upstairs, where he can be an administrator, or raise money, or do something. And she's really studying things that should be studied. So I felt better about that. That's why I wanted to write her. So you started to say –

MM: So you came out to California. Aside from the fact that you didn't have the problem with having to work so many hours –

BF: And I could work with my longitudinal study subjects.

MM: Exactly. But how was it different otherwise? Did you find your colleagues less interesting, more interesting, the working environment more interesting?

BF: I found the head of Child [Psychiatry at UCLA] was a jerk. I mean, I knew he was, because we had turned him down for his grant. He was interested in learning, and he was working with a psychologist who gave him the electrical prods, behavior modification in children, with a little electric shock. We turned him down, Dan and I. I mean, it was – Dan had him demonstrate on himself, what it felt like, and that answered the question. (all laugh) He wasn't going to have kids subjected to that! Then Pete Tanguay came along,[109] and I thought he was going to be better than he turned out. He had a good idea, but when his good idea ran out, he didn't have any other ideas. He went back to the South with his wife and became a big professor there.

But the guy in charge, Jim Simmons[110] – he's dead now, so I can speak freely. He was an army guy. He was the one that was doing this shock stuff. He was a general, and he still would go on whatever they do to revive their generalships, Army credentials. That's basically the kind of brain he had, so he was, in my book – but he was in charge of Child. And George Tarjan was over him,[111] and he was in charge of all the mental

[109] Peter E. Tanguay is currently Ackerly Professor of Child and Adolescent Psychiatry, at the University of Louisville Medical School in Kentucky. From 1992-1994, he was acting chief of the Division of Child and Adolescent Psychiatry at the UCLA Neuropsychiatric Institute (now the Semel Institute).

[110] James Q. Simmons (1925-2005) took a fellowship in child psychiatry at UCLA, was appointed to the faculty of the Neuropsychiatric Institute in 1962 and remained there throughout his career.

[111] George Tarjan (1912-1991) became Director of Child Psychiatry at the UCLA NPI in 1965, and founded UCLA's Mental Retardation Research Center (MRRC) which developed research programs in many areas of child psychiatry and psychology. He is recognized as one of the great leaders in the field.

retardation and brain research group – he had a lot of good researchers. And I'd known George from before. But I was too compliant. He was my boss; I knew him from before; and he wanted me to be under Jim, and when I [came], I thought, well, I'm supposed to be part of the hierarchy. Jolly was a little horrified, but George cleverly came with me to tell Jolly, so it was locked up. If I had just gone to Jolly myself, he would have saved me.

But I was a good soldier and this was the setup; I had to take it. But it wasn't a comfortable situation. He had a program where I was supposed to teach people in all different backgrounds of training, and somehow they were all supposed to understand child psychiatry, and it was hopeless. I don't know, they had – I didn't find them a very good group to work with. They were disappointed in me, and I was disappointed in them. It was somehow too banal to kind of spread out over people with every kind of background, and to teach them all at one time – I'm supposed to teach them about schizophrenia and you know, it was not a good fit. So I wasn't fitting into what they wanted me to do, and that was what was paying for the program.

MM: Your position, yeah.

BF: Yeah, the position. But eventually I managed to get out of that. I took a cut in pay; some money went with it. But I wanted to just get rid of it. Yeah, when the men are in charge, the women don't make out very well. So once I put myself under Jim and George, that was it, and I was stuck. George and I were very friendly, but he held all the cards. And Jim wasn't very smart, but he was the general and he ran the outfit. Of course, he knew we had turned him down. That didn't help our relationship. And he had me under his thumb.

Then Denny came, and Denny was very bright, but he had his thing, the hyperactive kids.[112] He worked with me until he got his own turf, and then that was the end of that friendship. He would tear down what I was doing with the students. And when I went on sabbatical, he stopped that course completely. I was teaching them about interviewing and using those old – the videotapes. I had some new ones, interviews. He thought that was bullshit. He didn't like it.

MM: And he discontinued it.

BF: Well, when I came off sabbatical, the course was gone. So I just worked with – we got trainees, and I worked with the ones I wanted to work with. So I had Gaye[113] and I had Rochelle,[114] and there were usually some good ones.

MM: It sounds like you found it a little less satisfying.

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[112] Dennis P. Cantwell (1939-1997) was Joseph Campbell Professor of Psychiatry and Biobehavioral Sciences at the UCLA Neuropsychiatric Institute from 1980 until his death.

[113] Gabrielle A. Carlson is currently Professor of Psychiatry and Behavioral Science at SUNY Stony Brook School of Medicine. Her research interests include bipolar disorders in children and psychopharmacology. In 2007, she won the Ittleson Research Award from the American Psychiatric Association.

[114] Rochelle Caplan is currently Professor of Psychiatry and Biobehavioral Sciences at the UCLA Semel Institute for Neuroscience. Her current research deals with the neurophysiology of higher-level language skills in children and their dysfunction in epilepsy, schizophrenia, and other disorders.

BF: It was not my turf. It was Jim Simmons' and the army's. So I just had to cut out – basically, it was clear to Gaye and to me what they thought of women. We did our best, and she escaped. But I kept my turf. I would take a cut in salary. Basically, I ended up with just my FTE. And Denny was getting about three hundred thousand, plus his FTE. It was slightly uneven, shall we say?

MM: Yeah, just a little.

BF: That's what happens when the men get in charge. But I was doing my own studies, and I would – usually I had some good trainee that I would work with, like Gaye and Rochelle. And then I cut back when they made me do certain things. I just took a cut in pay and said, "Fuck you." I didn't need that money. We had no kids anymore. The kids were all grown. They were on their own by the time I came out here, so that I didn't have to stay in New York to keep an eye on Ruth [her stepdaughter] or, you know, Mark [her stepson] was in the Midwest.

MM: You could do more what you wanted.

BF: Yeah. So Max did what he wanted and had a whole new career there, and I continued with my research. It was funny because when they were interviewing me about the research, you know, it was so small, my sample. And Don Guthrie,[115] who was the statistician who knew what I was doing, he was there, too, when we were being –

MM: Grilled.

BF: Reviewed by the committee [for grant funding]. I think he helped ease me into – he was describing the statistics and the way we were working. And then he eased me into starting to talk about the kids, and that was when they woke up. I knew the kids so well, the subjects, their whole life histories from the beginning. So that was when they began to brighten up, and they realized that this was a different study. There were some larger studies, but I really knew these kids. So that's how we got a grant for three years that I somehow spread out for twice as long.

MM: So you continued following the kids.

BF: Yeah, and going back to see them.

MM: How then did the concept – I don't know how to pronounce this – pandysmaturation. Can you tell me a little bit about how you developed that? Because it came along fairly late in the study, didn't it?

BF: No. The term came along, but I was trying to describe what I was looking at, which was basically really looking at some basic central nervous system functions and how this affected development. Early on [in the child's development], it was really the

[115] Donald Guthrie is Professor Emeritus of Psychiatry and Biobehavioral Sciences and Biostatistics at the UCLA Semel Institute for Neuroscience.

cranial development and how fast the skull was going and even changing and dipping. And then the postural motor development, because they were the early functions that were pretty – reflected the nervous system. Then toward the middle of the first year, then the visual motor and attention, and the eye-hand work. That became more important. But it varied.

So the pandysmaturation was basically the initial cranial and neurological development. But somehow, like by the end of the first year, or even maybe the ten months, that became less critical, and these other higher cognitive functions, and then language was more critical. But I was looking at that early part, and that was the pandysmaturation. And when we analyzed it, some of it just occurred for one month.

MM: So if you blinked, you could miss it.

BF: Yeah. I mean, you had to see them regularly, so I did, according to the Gesell schedule. I mean, the one who was the worst – I can't remember what I called him, which was the name.

MM: Peter?

BF: No.

MM: Peter or Frank?

BF: No, Peter and Frank were in the first group, and Peter was the offspring of a schizophrenic, and Frank just had this neurotic lovely sweet mother who needed her hand held all the way through his college, actually. They were very symbiotic, but I couldn't break it up. She eventually went on her own way, which was better. No, it was – I have to remember the pseudonym.

MM: Okay. There was Andy.

BF: Yeah, Andy.

MM: He had adoptive parents.

BF: And they were, unfortunately, wealthy. I mean, if he'd gone to a nice middle-class family, they would have accepted him much better. But the papa figured out pretty early, by the time he was six, when he was already going downhill. He looked very smart early on, and then had this one dip, I think at two months. But smart at a year, and they adopted him at ten months. So that was – they chose him at that time, and he looked real smart. But he wasn't going to keep up that way. It was sad.

MM: It was very sad, yeah.

BF: Those parents just – I tried to get them to accept him and say he was – I could tell them on the testing what he was good at and what he wasn't. I tried to get them to accept him.

MM: They just wouldn't.

BF: The papa wouldn't. We went through – They finally got him to some hospital. He went from hospital to hospital. It was sort of a crazy group therapy thing, but that somehow seemed to do some good. The father became a little more cooperative. But eventually they moved to Canada and left him here. At least, it was a good university setup, and basically he was maintained like home. They rented these like homes – he could rent a room within housing that they had.

MM: Group homes, yeah.

BF: Then he had a social worker that he met once a week. And then he had another kind of neurological problem, so he met that person. Then he was drinking too much, so he had – he had about three different therapists, and that kept him going, week by week. He had another breakdown when his father died, which was interesting, because the father hated him. But he had all the guilt that he hadn't lived up to his father. So they left, and he was under very good care. It was a good university setup.

MM: So how did you start working with Ken Kendler?[116]

BF: Well, I met Ken when we were trying to recruit him, unsuccessfully, at UCLA. Jolly was giving the big bullshit. He was great at that. But I took him to dinner, and we had a good long talk. He was interested in what I was doing and I was interested in what he was doing. So I kind of threw out the thing of I was going to need a blind observer. So we made some tentative connection at that point. Of course, it was years after that that I was finally ready to have him look at my kids.

But he remembered and he agreed and did the blind diagnoses, which were amazing. He would spend like an hour and a half, and he would get through all this verbatim data and tons of stuff that he had. He apparently knew what to select, what he wanted, and he made super diagnoses on all my kids. Because it was quite unbelievable. There were just too many at risk. I mean, statistically, it didn't make any sense. But that's who they were.

MM: Right. I mean, if you'd picked a random sample of the population, you wouldn't have had such a high rate of disorders.

BF: Well, I picked a random sample. Peter came from Bellevue, and all the rest came from the state hospital group. And ones that were diagnosed in the old days as schizophrenic were not all schizophrenic. Like the – I guess he was the number four.[117] I can't remember all the pseudonyms I gave them.

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[116] See note 59.

[117] These comments refer to "Daniel" in the Kendler and Fish article. See note 54.

MM: A girl, a guy?

BF: He was really – oh, they ended up calling him just hyperactive, but he had all kinds of problems. He functioned as a garage mechanic, or a gardener, or – he could never hold anything, he could never hold down a job. He married a girl just like him. They were well matched and they set up – The parents, he had wonderful adoptive parents, and they put up with all his shit. He was impossible. But they still helped him, and they gave him all this furniture that the kids needed, all kinds of stuff.

MM: I'm going to put this on pause now, because I have a feeling it's about time.

[pause]

MM: Say that again, just in case.

BF: Justine Polier was the judge in New York, the New York children's court, who was a wonderful, wonderful human being.[118]

EB: So how was care for children different in L.A. when you got here? What was the clinical –

BF: Well, see, Bellevue, we took all comers, and UCLA was very selective. So it was a different mix. Everything was different, the whole atmosphere. I mean, at Bellevue, the elevator man knew me, the porters knew me; they had seen me grow up. I was a student and eventually came back as a professor. They still go, "oh, you're here again." They know me. And we'd have a dinner dance at the end of the year. And like my black recreation worker, Jerry, who was just marvelous with the kids. He was there and I would dance with him. He was a great dancer.

When I came to UCLA, you walk into the elevator, and the doctors talk to the doctors, and the Hispanics talk to the Hispanics, and the blacks talk to the blacks, and the class structure was – it was just so different. When I said – we had some marvelous black aides who were wonderful with the kids. You have a mixture of kids from all different ethnic and sociological groups, and you had these high-caliber nurses, super trained. But no one – I said we had these wonderful aides, and Jim [Simmons] looked at me. They were black. "Well, you just don't mix with them. They'll screw the nurses up. You know blacks, they all like to have sex with white women. Don't you know that? You can't have that on the ward."

EB: That must have been shocking.

BF: It was a lovely introduction to UCLA. Just the class structure in the elevator hit me. It was not like Bellevue, where we all were part of a family, working for the kids. So it ended with my having some of the key women that I enjoyed working with.

[118] See page 64. Justine Wise Polier (1903-1987) served as Judge of the New York City Family Court for 38 years (1935-73). She was the daughter of Rabbi Stephen Wise and a crusader against antisemitism.


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EB: You found a group that --

BF: Yeah. Well, when I walked in, I was the only woman. There were fifteen men, and I walk into the room, and I said, "You don't have any women here?" I had trouble keeping the men at Bellevue because they could make more money in private practice, so I would keep them part-time, to have a mixture of men and women working with the kids. And here it was all, you had to be super whatever. I was horrified by the whole class structure and that whole thing. So I did my thing on the ward, and I enjoyed working on the ward. When Gaye [Carlson] was there, we had a great time.

EB: Do you think that that just had to do – that was just a result of the personalities there at UCLA, or was the profession –

BF: Men are different. They're used to being in charge, they want to be in charge, even if they have no sense.

EB: So it wasn't that the profession was different on the West Coast than on the East Coast necessarily, it was that you had some unpleasant people, really, who were making decisions that didn't work so well in that environment.

BF: It was definitely not a warm atmosphere for women. So I was the first woman in any decent position in the department. There were some women psychologists. There were a couple I had recruited from pediatrics. Marian Sigman.[119] I had worked with them over in Arthur Parmelee's group.[120] I worked across different lines.

EB: Yeah, to find –

BF: And Arthur was wonderful. I knew him from the child development group. I worked with his pediatricians and with him. So I found the niches where I would be comfortable, and if I was pushed to do some of this other crap, I just took a cut in pay. So I ended up with my FTE.

EB: I'm thinking back to what you had talked about before, being a young girl interested in science and lucky enough to be at a school where that was encouraged. Was this the first time in your life that you had to actively confront such sexism? Obviously, you'd seen it before, but was this the most glaring?

BF: Yeah, it was the most glaring thing, because at Bellevue, NYU, when we were going through med school, there I was one of the boys. We want you in our group, because they were smart. They were too smart (she laughs). We had the Jewish group, the Italian group, and the Irish Catholics. The Irish Catholics mostly became surgeons,

[119] Marian Sigman is Professor of Psychiatry and Biobehavioral Sciences and Psychology at the UCLA Semel Institute for Neuroscience. Her research areas of interest include the biological and social factors involved in autism, mental retardation, and anxiety disorders.
[120] Arthur Hawley Parmelee, Jr. (1943-2006) was Professor of Pediatrics at UCLA and a member of the Brain Research Institute.

and the Jewish group mostly became psychiatrists, and the Italian group were mixed. There were some very good, warm people in that group. So they were Catholic, but they were not so proper. But there was something about the male/female bit that was just different here. I mean, the stratification in the elevator, it hit me as soon as – it was my first day at work, and it was just totally different. I don't know what it's like in your department. I hope it's better.

EB: Yeah. Did you notice improvements over the time you were at UCLA?

BF: No, not in psychiatry.

EB: You managed to get good work done, nonetheless, do you think?

BF: Yeah, but I did it by cutting out the stuff I didn't want to do.

EB: Salary as well, cutting it.

BF: Yeah, I took a cut in pay, but it was worth it. Max didn't want me to do anything that –

## VI. Closing Comments

EB: I have some questions about a different topic, actually. I wanted to pick up on something you said earlier, that after DSM-III, and when Ken Kendler started to look at the files of your subjects, a number of them were diagnosed with mood disorders. Mood became an important part of their diagnostic picture, maybe in addition to psychosis, but he categorized more mood, perhaps, than you had initially seen.

BF: Yeah, because we didn't – this was the original American mish-mash.

EB: How did you think about mood in the kids you were seeing in the fifties and the sixties? Did you see kids as depressed?

BF: Yeah, we would see them and we would think of them as like neurotic. We were not looking at manic-depressive depressives. This was not – we didn't know that it could occur so early. So I think there were changes. As there were changes in the diagnostic criteria, it became clearer that there were kids. And Gaye was very interested in that because she had worked with Fred – whatever his name was [Goodwin] -- at NIH on depression and manic depressives.[121] So she taught me, basically. She was a student of mine, but she knew more about that. And yet, I picked up the fellow who was depressive before any of his fellows did, including Gaye. And he killed himself.

EB: Oh, you had a research fellow.

[121] Frederick K. Goodwin was a researcher at NIMH from 1965 to 1994, serving as scientific director 1981-88 and as institute director 1992-94. He is now research professor of psychiatry at George Washington University.

BF: He was one of the students. He was a Child fellow, and when I interviewed him, there was something a little flaky. He was smart, but in describing his somewhat checkered career, I got funny vibes, and I was worried about him. I didn't think he was a good bet, but he was bright, so Fish was overruled at the group meeting. And they took him. He was bright in the group, but he got in more and more trouble and ended up injecting himself with curare.[122] I mean, what a way to take yourself out. Oh, God! I mean, to go out in convulsions, terrible. Gave me the willies.

And the resident and fellow group, the Child fellows, were just absolutely devastated. Basically, a couple of classes turned into grief relief, because they all felt so guilty they hadn't picked it up. How could someone have been so troubled? They knew I had picked him up. In fact, I think we had talked about it. And I was just troubled. Something was a little flaky. That's not a diagnosis. (all laugh) I'm afraid that's a hangover from –

EB: It is kind of – what I was thinking of, though, do you think it's helpful to think about mood more in kids? I mean, as that became more common.

BF: Oh, it's important, it's very important. You have to think about it in your fellows, too.

EB: Yeah. I mean, one thing that's lost, you were talking about the typology you developed really helped you see what worked for individual kids. You knew them, you could watch to see what helped those individual children. What we do now instead is think about categories of children, and we try to decide if a drug or an intervention might help these categories of kids, those with manic depression, or those who are depressed, or those who have a certain kind of autism. We lose the picture of the individual child.

BF: Yeah, I know. I think also the restriction of time that's given to make a diagnosis, to do anything for people. They're restricted. My shrink is restricted to seeing me for twenty minutes. So I'm on some meds, and I'm doing okay on them. I don't know if the -- I always get the Effexor and the Exelon mixed up because they start with E.[123] The Effexor certainly worked, took care of depression in three days. It was incredible. Whether the Exelon and the Namenda do anything for me, I don't know.[124] I'll take them.

EB: So we start to talk about drugs and whether a drug works, as opposed to really getting to know the child well.

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[122] Curare refers to one of several drugs first identified in the Amazon region in 1800 by Alexander von Humboldt, where they were in use as arrow poisons. Curare is a highly effective muscle relaxant and has been used as a surgical anesthetic and treatment for tetanus; however, in toxic dosage, it causes asphyxiation and death.

[123] Effexor, or venlafaxine, is an SNRI (serotonin-norepinephrine reuptake inhibitor) antidepressant. It was introduced in 1993. Exelon, or rivastigmine, is a cholinergic (acting on acetylcholine) agent for the treatment of mild to moderate Alzheimer's, approved in 2006.

[124] Namenda, or memantine, is another agent for treatment of moderate Alzheimer's, first synthesized by Eli Lilly in 1968. It acts by inhibiting the NMDA glutamate receptors.

BF: Yeah. I think it's very hard for them if they are only given twenty minutes. You can't do a thing in twenty minutes. You can titrate a drug. You can say, is your father still giving you trouble, or your mother? I mean, what can you do in twenty minutes?

EB: One thing you're bringing up is that opportunity – there isn't any longer a child's ward at UCLA, and it is very uncommon to have children in the hospital for any length of time. That was something that was so crucial –

BF: There's no child ward at all? That's disgusting.

EB: That was such a crucial part of how you learned to think about children. You could see them over time.

BF: The trainees don't even get to see them?

EB: They do, but they have to go elsewhere.

BF: To children's homes.

EB: Or to – there isn't any longer one at NPI. They may still have one still at Harbor UCLA [Hospital], so they get a small exposure, but most of it is outpatient training, for a child psychiatrist.

BF: Oh, they get some outpatients at least.

EB: Right, yeah. So it's hard to imagine your work evolving if you only saw outpatients.

BF: Yeah. I guess you can to some extent – I don't know. I think it's a shame not to have a children's ward. I think it's a real loss for training. They decided – it was more of a cost decision, I am sure. Didn't bring in enough money.

EB: Yeah, and it's not just a local trend. Across the country, there are fewer and fewer inpatient beds for children.

BF: Well, there are generally fewer and fewer inpatient beds, period. So I suppose the kids they cut out first. Boy, I'm glad I'm retired. (laughs) I think that's a shame for training, and for people. That's why it's all behavioral medicine, I guess. What do they do with psychotic people? What do they do with psychotic patients? I guess they're working with them in adult psychiatry, aren't they?

EB: Typically, the hospital stays are very short, and an effort is made to have people with schizophrenia come into the clinic. There are some teams that will go out to them where they live, but that's uncommon. There just aren't many services.

BF: For the poor schizophrenic.

EB: Right.

BF: So you treat behavior disorders and manic depressives, but they need a little help, too. But they get short shrift as well. What a stinking system. It's the money.

EB: Yeah. Well, the NIMH director said maybe we've cured things now. We have the right drugs and –

BF: Oh, yeah. Oh, I'm so glad I'm retired. That's a terrible way to work. Wouldn't you find it frustrating?

EB: Yeah. Oh, I do, yeah.

BF: That's why you got into other stuff.

EB: In some ways, yeah. I do work on a team where we have social workers and nurses who can go out to see people with severe mental illnesses, so at least there are some settings where you can provide more than just medications.

BF: And you work with them as a consultant, then, is that it?

EB: Right.

BF: Do you see the patients?

EB: Yeah.

BF: You actually see the patients.

EB: Yeah.

BF: They bring them in and you go out?

EB: Both. Either way, yeah.

BF: Well, that's more satisfying, I guess. But the ones in training don't get to do that at all then.

EB: Sometimes they do, but it's not very common.

BF: What are they training to do?

EB: Typically, they get a lot of training in medication management. Some training in doing therapy, but obviously therapy takes a long time to learn. I think the sense is you get a certain amount of training in some things, but then you have to go on in your career and gain other skills, depending upon the setting you're working in.

BF: Depending on what you want to do.

EB: Yeah.

BF: But also depending on what's available to do.

EB: Right, what kinds of settings you can work in at all. Some people would say that's because pharmaceutical companies have so increased their influence and their involvement in the profession.

BF: Including guys like the guy at Harvard, in Child,[125] who's reaping in money, and now I know why he's only diagnosing depression. I mean, three hundred thousand here and five hundred thousand there. That's stealing. That's really nauseating. I find it revolting. I always thought he was a jerk, but now it was proven. But it's changing medicine. And the drugs aren't that great, as you know. They're limited. Even some of the old ones, they're finding, are as good as the new ones. I read. I think medicine has to change. I don't think this is a good system. Wouldn't you like to see it change?

EB: Definitely, yeah. It's clear from what you've been talking about that we've lost a lot, a lot of skills, a lot of resources.

BF: The human element is completely down the drain. I mean, we're dealing with people. It's terrible.

EB: How do you think that happened? As you think back, even over the last couple of decades in your career, how did that happen?

BF: Well, I guess some people are just hungry for money. I mean, to me it's – you know, what do they go into medicine for? Or I guess I'm an archaic being, having enjoyed working in a hospital. It's not where you make money. But if you want to really take care of sick people, you have to see them where they are, I guess, but you're going out to these places, so you see them.

EB: Yeah.

BF: But there's something in the reward system that it's not working. It's sick. I think medicine is having a lot of – I mean, the whole business is business, and it didn't used to be. I think something has to really change in the country. I don't know if Obama's up to it. (she laughs) I don't think they're going to let him do much of anything, if he even gets in. The economic circumstances are going to be such that I don't know.

EB: Not to put you on the spot, but I wonder if you think there is more that the profession or professional organizations can or should do. That puts you on the spot, but do you think there's – did we miss the ball in some ways?

[125] See note 71.

BF: Well, we saw the first one when the head of NIMH came to ACNP, for that meeting. I think that was the beginning of the downward slope, when they threw all the people out of the hospitals. Some people need a hospital. And the whole system – I don't know whether other countries are doing the same. I think I saw some statistics, but exactly where I can't tell you, where really the healthcare systems like in Sweden were still somewhat better than what we've got. Socialized medicine, or whatever. They raise hell when we use that term, but we're supposed to be taking care of people and not just making money.

MM: A lot of people fall through the cracks, really, and don't get adequate care.

BF: Yeah. It's a lousy system. I mean, you're trying to work it through in what you're doing.

EB: I think you're right. I think even one of the things that's important about today and this process is to understand from you where the profession was, what was valuable about the environment that you trained in, what was valuable about different work settings, the kinds of things that helped you think of new ideas, design innovative studies. What was it that helped you do that? Those are such important things to keep sight of, to not lose.

BF: You're under many more constraints that I was, really.

EB: I think so, as you describe it, yeah.

BF: And a lot of it's dried up that should be living. I mean, this guy who's head of psychiatry now, I thought it was his coming in, but apparently this is going on all over. It's the money system.

MM: It's not just one person. Finances are sort of one of my areas, and it's a matter of – they try to make each component, like the hospital, look cost-effective. And when you start applying concepts like cost-effectiveness to medicine, where are you? It doesn't work very well.

BF: Well, it certainly doesn't work well when you're taking care of poor schizophrenics who aren't going to do a big economic job when they get out.

MM: Not with people who need long-term care.

BF: Right.

MM: And it's [the same] in other areas. It's not just mental illness.

BF: I face it and I'm just lucky, because I've saved up enough money that I can stay here. And if I lose all my marbles, they can wheel me out, and Dorothy will get someone to take care of me and wheel me out there. They were talking to me about one of these

adult facilities, and they have them for – they're setting up these big buildings for UCLA faculty. Well, I left an apartment house. I don't want to be in an apartment house! (she laughs) At least I have some say in what's going to happen. But too many people won't have any say in what's happening. They're losing their homes. I mean, what can they –

EB: You've talked a lot about this, but as you think back about the most important people in your career, the most influential figures in your career, who are those people?

BF: Well, Lauretta first. My husband. (pause) I don't know, I have to get off that. I'm stuck.

EB: How about people today, maybe even people in the ACNP, who you think we should definitely interview, someone that comes to mind that –

BF: Oh, I'd have to go look at the book to see who's still alive. A lot of my buddies are gone.

EB: That's okay if you can't think of anyone.

BF: Dan's dead [Freedman]; [Heinz] Lehmann's gone, I think. They were the outstanding people, I would say. I mean, [Henry] Brill and [Paul] Hoch and none of them are around. The Killams, I guess, are around.[126] But they were a different – they worked at a more basic level in research, not the clinical. So I don't know. I know my friend Gaye is still doing things. Rochelle is still doing things. Gaye is probably more in the public area of child psychiatry. Niki Kimling, I think, is still around, I hope she is. I should be in touch with her. I think actually Gaye is doing some work with her. I'm not sure. I should get back to her. Because our group kind of broke up. They decided we weren't really accomplishing, we should just work with whomever we're working with. So I'm working with Tom [McNeil], and then he's working with Assen Jablensky[127] in the Western Australia group. They're running this – having a session, a Barbara Fish session.[128]

EB: That's quite an honor.

BF: Before I die. (laughs) A going away present! But going down there is too much for me. Your gang is going to have to –

MM: We'll come and we'll do a videotape. That will be great for us.

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[126] See note 94.

[127] Thomas F. McNeil is Professor and Chair of Psychiatry at the University of Lund in Malmö, Sweden. Assen Jablensky is Professor of Psychiatry and Clinical Neurosciences at the University of Western Australia in Perth. They continued Dr. Fish's longitudinal studies of infants born to mothers with mental illness.

[128] McNeil and Jablensky chaired a Barbara Fish Symposium at the International Conference on Schizophrenia Research (ICOSR) in San Diego in March-April, 2009.

BF: Yeah, they're doing good work. Tom is still working on his data, the high-risk group.

EB: They're doing longitudinal studies? Is that why they named it for you?

BF: Yeah. He began with infants. Actually, he was originally working with the guy at USC.

EB: Sure.

BF: I don't know who he's got at USC any more.

EB: Well, that's a good list.

MM: I wondered if you wanted to say a little bit about your husband, because he was very supportive of your career.

BF: Oh, he was wonderful.

MM: We've alluded to him a couple times. And you met him when you were a resident, is that right?

BF: I guess I was still – Yeah, I was in child psychiatry.

MM: In New York.

BF: Yes. His friends – his two, I guess, best friends at the time, lived upstairs in a co-op building or something, with a couple on the main floor who knew that – I had gone with Herm when I was in medical school and knew that it hadn't worked out. And, actually, I convinced him it was all right to marry my dear friend Natalie. He wasn't sure he could really love anybody, and I said, "You love her as much as you're going to love anybody, and she's wonderful, and go marry her." And he said, "Thank you." And he did. They had four children and then went to a party and got drunk and had the twins, and I think those were the two smartest ones. I think one of them's at [University of] Washington, and I came across the other one's name as a social psychologist or something, but he was doing some fascinating research also. So, a good drunk; it was a good pregnancy, a very happy pregnancy, with those twins. (all laugh)

MM: Sometimes they work out.

BF: Anyway, so the dinner was with these two – a classmate of Herm's, who I didn't think much of because he had gone for the money at Mount Sinai, and he was different. They were downstairs. I guess the ones upstairs asked them, "Do you know a nice professional woman who's looking for a professional man?" And they said, "We have just the one."

But anyway, so they had the dinner. Ducky and her husband had a dinner. There was an outdoor patio in the apartment building, with about a dozen or fourteen people. I come late, of course, because I was working at the hospital. So there was this big table, and I just sat down here, don't really know anybody. They may have just named some people, but I'm not sure.

All of a sudden, I hear this booming voice down at the bottom of the table saying, "What? Steak again?" Steak, an intern at a hospital, how often do we get good steak? So I thought, who is this character? Well, this character took me home, and he kept taking me out. He was interesting, smart, a really smart guy. I guess after a couple of weeks or two, my analyst Judy [DeForest], my first analyst, the one who took five years to work on me and my mother. The next one took three years to work on me and my father. (she laughs) But Judy said to me, "Hmm. Seems like the first one that's been nice to you." And I thought, "Hmm, yeah. Yeah, I think that's true. (she laughs) So I began to look at him again!

Not too long after that, when he brought me home in his car – we each had just started to drive. I had a little Chevy convertible, and he had a Chevy with a roof. So he brought me home from wherever, visiting my friends, his friends, or something. Apparently, when I got out of the car, I patted it and said, "Goodnight." And he immediately picked that up, being a smart fellow, smarter than I was. So he realized that it was okay to sleep overnight that night, which it was, which I had signaled unconsciously and Freudian and all the rest of it. So we stuck together.

And he was so smart. I could argue with him and I could fight with him, and he wouldn't fall down. And it was wonderful. The other men all ran like hell if you started to get up on your hind legs and say, you know, what the hell is going on here? It was terrific. So we came together.

He had married too young. He was at Sinai as a chemist. And all the guys married nurses, you know, the doctors, this one and that one, who were the young, lovely women. So he married a nurse – and his friend, who was a social worker but a wiser guy, and not so young as my young Max, who got out of City College at sixteen. That's too fast. So he was too young, wet behind the ears. The nurse who he married had a psychotic breakdown after the second child, after Ruth was born. And it turned out she'd been in and out of the hospital after that.

But in those days, you couldn't get a divorce while someone was in the hospital in New York. You had to prove adultery. How do you prove adultery when someone's a hospital patient? So his very dear friend, a lawyer, had him change jobs and work out of Las Vegas. So he had to take a couple of years out.

MM: He got a divorce?

BF: Finally got a divorce. I went out there and spent some time with him in Vegas. Then I got appendicitis while he was out there. And my mother comes to the house to take some things for me, and she finds the – no, he had club feet, and she came across these shoes. He had it so early that he had the shoes. So she was horrified, when she was taking my clothes to the hospital. So she told her sister, my aunt. Tsk, tsk, tsk. But anyway, eventually we married.

The [Max's] kids had been – Ruth had been put in a foster home with a lovely Jewish grandmother, "Ruth, that's all right!" Okay. She wouldn't tell her, "Ruth, you have to go to the dentist," because that would start her screaming. She was lovely. But he [Mark] was three and a half and he rejected one foster home. Why they didn't put the two kids together is appalling. But anyway, they didn't.

So Max – they were going to send him up to Pleasantville, which is like a big group home in the Jewish childcare outfit.[129] He took a look at the place and decided he didn't want Mark going there. So being Max, he looked and he looked and he found this lovely small private school up in Clinton, New York, where the two were – this couple were wonderful, Bank Street trained, wonderful teachers.[130] And about eight or a dozen kids. Lived up in Clinton, New York, in this big rambling house. It was like a big family. They'd pile into two station wagons and go down to the local – but it was a lovely private school. So that's where Mark was.

Ruth, when the thing went to trial –

MM: The custody?

BF: Yes. Because they couldn't have a resolution trial until Olga [the first wife] was out of the hospital. So she made a great speech in front of the judge, as only a schizophrenic could, and this idiot judge was going to send the kids back to their mother. A mother is a mother is a mother, right? Who's better than a mother? Max was signaling to the lawyer, so he made an objection, would the judge please take the two kids into chambers and talk to them privately. Ah! So the judge did. And both the kids wanted to come to us. So what did he decide? "A mother is a mother is a mother." So Ruth had to go to the mother, and Mark was left at school, which was fine. So, of course, Ruth had a horrible time, and objected to the mother. And she was eight at the time. So we took her [Ruth] every weekend, and she had money to call Max if there were problems.

Finally, it took just three months of tantrums from this eight-year-old to flip the mother out completely, so she couldn't handle Ruth. Finally, Ruth called and said, "Mommy's talking to the television," and Max said, "You know what to do," so she said, "Yeah." And by God, this psychotic woman, hallucinating, helped Ruth go down and get a taxi. That always gave me the chills. Isn't that tragic? But she had enough of the mother left in her –

MM: To put her in a taxi. Scary.

BF: Hallucinating as she was, she put Ruth into a cab, and then we called her sister to pick her up, and she never got out of the hospital after that. Eventually, they move them

[129] The Pleasantville Cottage School was established in 1912 by the Hebrew Sheltering Guardian Society (founded 1879) to care for destitute and orphaned children. One of the first child psychiatric clinics in a children's home was established there in 1925. HSGS merged with other Jewish societies in 1940 to form the Jewish Child Care Association. In the postwar years, the Pleasantville School evolved into a home for emotionally disturbed children, ages 7-15.

[130] The small private school in Clinton, New York, does not appear currently to be in operation. The Bank Street College of Education in New York, which incorporates a children's school within a master's level graduate program for teachers, was founded in 1916 by Lucy Sprague Mitchell as the Bureau of Educational Experiments.

into kind of a nursing [home]. So Ruth had quite a time for those three months. But then we set up and moved to a large enough apartment and took both of them out of Clinton, New York, and out of where they were.

MM: How old was Mark then? Your son or your stepson?

BF: He's my son.

MM: He's your son. That's nice. Ruth was eight and he was –

BF: Yeah, by then he was eleven. And he went to Columbia Grammar, and got on the swimming team; he's fine in the water.

MM: And your husband was always supportive of your career.

BF: Oh, fabulous, fabulous. When I told him – oh, I know. It was when I was analyzing the data for the first time, and I told Lauretta, "Peter turned out that way." And she said, "Of course." Deflated young research worker. She knew all the time; I didn't find anything out that was new. And Max says, "Listen, for her it was a theory. You've actually done the experiment. That is different scientifically than having a theory! Write it up!" (she laughs) So it went on like that. He was the right guy for me.

He was working for Allied Chemical.[131] But he was such a talented guy, he could do anything and everything. And he worked out a whole system for color identification. It happened to be for automobiles, but he got working with museums. People would call for help. And if anyone wanted help like that, they'd say, "Max!" So he did things with the Natural History Museum[132] and the one downtown just near where we used to live at Stewart House, on 10th Street.

MM: MOMA? No. I don't know.

BF: Cooper Union.[133] It was right across the square from us. He had all sorts of things he was doing while he was working. And then he was working for the [company] president downtown. Allied Chemical took over this little chemical firm. They made very high quality automotive paint that worked. Then when we moved out here, when Jolyon West recruited me out here, Max said, "If it's good for you, we'll go." And he would take early retirement. He said he'll find something to do. He said he didn't want anybody looking for a job for him. The last time – that was no good at Chicago.

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[131] Allied Chemical and Dye Company was formed by the merger of several smaller companies in 1920 and is today part of the multinational conglomerate Honeywell.

[132] The American Museum of Natural History on Central Park West in New York, was founded in 1869 and is recognized as having one of the largest and finest scientific collections in the world.

[133] Cooper Union for the Advancement of Science and Art is actually a select private college founded in 1859, with programs in art, architecture, and engineering.

So he knew who the Nobel Prize winner was in chemistry,[134] and he walked into his office. He made an appointment to see him. I forget the guy's name. And told him what he would like to do, and they got him a lab and we rounded up some money and got research assistants for him. He did what he really wanted to do and had been doing for museums back in New York, [which] was to go into ancient Peruvian dyes and look into the history of all those things and where they found the ways to make these different dyes and pigments. So he had his career. He changed, and he – in fact, he spent six months down there.

MM: In Peru?

BF: Yeah, with the museum people, going through and helping them sort these wonderful tapestries there. So he had a ball.

MM: That's a wonderful story.

BF: When things got tough for me in the Department, he would encourage me to just say, "The hell with this!"

MM: I guess that's what husbands are for.

BF: To back up their wives.

MM: Yeah. Okay.

BF: So a career wife needs a Max.

MM: Okay. I think on that note we're going to conclude the interview. Maybe we'll come back and have some follow-up questions at a later time. Thanks very much. It's been a really good interview. It's a pleasure talking to you.

BF: It's fun to work with you. Like my analysis all over again. (all laugh) Like all kinds of things.

[end]

[134] Willard F. Libby (1908-1980), who won the Nobel in 1960 for his development of carbon-14 dating. He came to UCLA in 1959 and was appointed Director of the Institute of Geophysics and Planetary Physics, where Max Saltzman would have his laboratory, in 1972.