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Interview with Professor Sir Michael Rutter

By A/Prof Daniel Fung, Editorial Board Member

Professor Sir Michael Rutter is Professor of Developmental Psychopathology at the Institute of Psychiatry, Kings College, London. He has been a Consultant Psychiatrist at the Maudsley Hospital since 1966, and was Professor of Child Psychiatry at the Institute of Psychiatry from 1973 to 1998. He set up the Medical Research Council Child Psychiatry Research Unit in 1984 and the Social, Genetic and Developmental Psychiatry Centre 10 years later, being Honorary Director of both until October 1998. His notable research has included the genetics of autism; the study of both school and family influences on children's behaviour; the links between mental disorders in childhood and adult life; epidemiological approaches to test causal hypotheses; and gene-environment interplay. He was Deputy Chairman of the Wellcome Trust from 1999 to 2004, and has been a Trustee of the Nuffield Foundation from 1992-2008. He was elected a Fellow of the Royal Society in 1987 and an Honorary Member of the British Academy in 2002. He was a Founding Fellow of the Academia Europaea and the Academy of Medical Sciences, of which he is currently Clinical Vice-President. He has received numerous international honours and has published 40 books and 400 scientific papers and chapters. Considered the Father of Modern Child Psychiatry, SMA News had the pleasure of meeting up with Prof Rutter during the Asian Society of Child and Adolescent Psychiatry and Allied Professions Congress. Prof Rutter was the Distinguished Speaker at the conference.

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Dr Daniel Fung: Could you tell our readers how you got into Psychiatry, and your work in this area?

Prof Michael Rutter: I did not go into medicine intending to do Psychiatry. I was going to be a family doctor like my father and my grandfather. I had an interest particularly in public health aspects because both of them went on from general practice to work in public health.

I became interested in Psychiatry as part of my undergraduate training. Like many people in those days, I was advised to get training in Internal Medicine, Neurology and Neurosurgery before I went on to Psychiatry, and that was what I did. And as it happened, I also trained in Paediatrics, which was not anything to do with wanting to do Child Psychiatry.

Then I went to the Maudsley Hospital in London for my training and Aubrey Lewis, who was the head there at that time, decided that I would do Child Psychiatry. I was initially a bit resistant to that but I said I would give it a go. And he was right. He saw that academic Child Psychiatry could play to my strengths. He knew that I had done some relevant research, looking at connections between parental illness and problems in the children. But he made out two conditions; one was that I should never receive training in Child Psychiatry. He said that the training was of poor quality and moreover, it would inhibit my curiosity. So I have never been trained in Child Psychiatry. I certainly would not give the same recommendation today but in those days, that was probably correct. The second condition was that I should be trained in child development, and so I spent a year in the United States doing that. As part of my general training in Psychiatry before that, there was sufficient systematic teaching in Psychology for there to be recognition that it should count as Psychology as well as Psychiatry. Then I went into research, and I have been engaged in both ever since. But I have also continued to do clinical work.

The thing that I guess is most distinctive about what I have done is tackling new questions

that people said could not, or should not be investigated. My study of successful schooling and my reassessment of maternal deprivation in the 1970s would both be examples. Another would be using twin studies to study autism with results showing a strong genetic influence. Also, the follow-up study we undertook in the 1960s was the first one to show that organic problems were likely to be important because a substantial minority of individuals without known neurological abnormalities developed epilepsy during late adolescence. The Isle of Wright epidemiological studies did much to show the relationships between organic brain dysfunction and psychopathology too.

I first became interested in genetic issues when I was in the States, when I undertook a small pilot study of temperament in twins. The work was looking at the interplay between genes and environment. I guess these have taken much of my time in recent years – using both quantitative and molecular genetics, as well as measures of environmental risks. One of the things I

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pioneered was the use of natural experiments to test whether the environment was truly having environmental-mediated effects.

DF: You have been described as intellectually gifted. Do you think that doctors have high IQ in general and that this is in fact a good thing?

MR: Well, statistics show that on the whole, doctors indeed do have a higher IQ than the population average. Yes, of course, I think it is a good thing. But I would regard at least as important the qualities of curiosity, and questioning the given wisdom of the day. Very early in my career, I had to give a vote of thanks to Leo Kanner whose memorial lecture I attended, I told him that the thing I most admired about him was his irreverence and the willingness to question authority. He was delighted, fortunately. I was not quite sure if he would see that as a positive quality, but he did.

Leo Kanner wrote a very interesting essay on differential diagnosis, which has as its subtitle: "The children haven't read those books." He was speaking of course with tongue-in-cheek, but making the point that the neat answers in textbooks about depression, schizophrenia, depression or autism, do not fit with the very next patient you see in the clinic. It is much messier than the textbooks suggest. And you have got to be on the lookout for what does not fit. Of course, his discovery of autism would be a prime example. So out of the mass of children who developed problems he picked out a group that was distinctly different. And with very few exceptions, his observations have proved correct.

I have tried to do the same, in the sense of not being concerned to prove my ideas right. I wrote a paper and commented on this, in which I said that I was fortunate in having been wrong several times in my career. None of my friends liked the paper. But the point I was making was that what is exciting about research is discovering what you did not know. Showing that you are right is all very reassuring but if I have never proved myself wrong, it would mean that my research could have been a total waste of time because I knew

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it all to begin with. Now obviously, one does not want one's factual findings proved wrong, and there really are no factual findings of mine of any significance that have been proved wrong, but what I was wrong about was the interpretation of something. So the challenge is to discover that and put it right.

DF: Just a point on that. There are many doctors who are experts in their various fields, how does one interact with them, being the master clinician that you are?

MR: One of the good things about medicine is that there is no disgrace in turning to a colleague who knows more about it than you do. Doctors do that all the time. That is different from some other professions. You cannot be an expert in everything. Learning from one's colleagues is an important part in what one needs to be doing, and you do it all through your life.

During the time I went through medical school, I spent a year living with my grandparents because geographically it was more convenient. My grandfather then was in his 80s. He was off on his last refresher course, while I was struggling with anatomy, physiology and biochemistry. So there was he, still trying to learn new things and he of course qualified in medicine in the previous century. Virtually all his practice depended on what he had learned since qualification. That was a time when science was slow. Now, it is much faster, so that what you know by the time you qualify, most of it will later prove to be irrelevant and some of it will have been shown to be wrong by the time you retire. Training in Psychiatry and medicine as a whole needs to foster an ability and interest in new learning which is going to go on throughout life.

DF: What do you think about very structured training programmes like the Americans have, versus a model with more apprenticeship?

MR: I think you would want to mix it. You need to have taught courses but you also need not have too much in the way of structure. It is a balance. I have an ambivalent view of structured instruments. We need them and they do make a big difference but they carry the danger that you can only ask the questions that you think are going to be asked, and I think that is damaging. You have to be on the alert for things that do not fit, and structured questionnaires and interviews are not good at that.

DF: Can you share a little about your family and how this has influenced your work. You said you come from a family of doctors. What about the ladies in your family?

MR: The lady in the family whom I am most influenced by is my wife. One of the books I most enjoyed is the one I did with her, on developing minds. She is both my strongest critic and strongest supporter, and both are very important. She has had somewhat different experiences but she has also been a pioneer. She was in danger of being put in prison at one time because as a nurse specialist, the local hospital, King's College Hospital, had allowed her to do various procedures, including writing prescriptions. And the powers-that-be said that was not to be allowed. The compromise came for a period when she ran her clinic with a doctor sitting in the corridor who countersigned her prescriptions without seeing the patient, which was total nonsense. So she has been a pioneer in that, and in counselling and assisted conception. Her creativity in the work she did, and sensitivity to the human issues in all of this, has been very important to me.

DF: Psychiatrists are sometimes demonised by the mass media, and stigmatised by the public. Do you see any solutions to this?

MR: They are demonised sometimes, but I think that sometimes they deserve to be. The attempt by psychiatrists to give instant diagnoses of people in the media whom they have never seen – they might be right, they might be wrong, but that is just silly. In the research arena, those who put forward certainty on the basis of one study, again, they deserve criticism. And having total answers to things, whether it is psychoanalysis,

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family therapy or psychotropic drugs, again, it is not good.

So yes, there are unfair attacks in the media. But I think the job is up to us to show what good Psychiatry and good Psychology are all about. And some of our colleagues actually are an embarrassment.

DF: I suppose this is more so in Singapore, but Psychiatry was not really seen as mainstream medicine for a long time. It is only beginning to become recognised as important in the holistic management of patients.

MR: That changed earlier in Britain. In the days that I did Psychiatry, I got the British equivalent of the Boards of Medicine. When I was doing my training in Psychiatry, I taught the trainees in general medicine because I had learnt much more than they had. Aubrey Lewis wanted people who were experts in something among the trainees. There were others who came in with degrees in basic science or pharmacology. Aubrey Lewis emphasised breadth and that is important. Certainly, he saw Psychiatry as part of medicine. Not that there are no distinctive differences between Psychiatry and other branches of medicine. Nevertheless, Psychiatry is part of bio-medicine and you neglect that at your peril.

One of the things about modern science is that the degree of technical expertise required has gone up enormously because you can do things unheard of in our training. But it is also striking that many of the major steps forward have come from people who moved in from outside. Looking at molecular biology, who were the pioneers? Many of them were physicists. They saw the opportunities in biology because that is where the action lay. So you need to have breadth as well as depth. Is that challenging? Yes, it is. Is that frightening? Yes, it is. But it makes life interesting.

DF: Would you recommend young doctors to specialise in Psychiatry and what are the things required?

> “What is exciting about research is discovering what you did not know. Showing that you are right is all very reassuring but if I have never proved myself wrong, it would mean that my research could have been a total waste of time because I knew it all to begin with.”

MR: Yes, I would, because I think that understanding the workings of the brain and mind are one of the most exciting challenges ahead of us. Let me put it in a slightly flippant way – so little is known that if you do a half-decent job, you are bound to discover something of interest. That is flippant, so do not take it too seriously. But the opportunities are so great. For me, it is equally important to be dealing with people as human beings. That has always been one of the things I have enjoyed in my research and it has been crucial to me in continuing with clinical work. I like the clinical challenges. Psychiatry is a humanities as well as a science, and I hope it remains both.

DF: What are your comments on the internet and information technology (IT), and how it has

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affected children in their adolescence? Do you feel that internet addictions are a real disorder or a symptom of pre-existing and underlying issues like poor parenting in the family?

MR: Well, it can be an addiction and a compulsion certainly. I think the internet has the potential to be a huge power for good. As an example, I think it is positive that patients come to you having said that they have looked up something on the internet or read about it. Of course, they do not always know that a lot of stuff on the internet is rubbish, but a lot is also very good. So it is a power for the good but if it is misused it can become a preoccupation.

But I am not the right person to ask. My grandchildren regard me as a 'special needs adult' in relation to IT. They are adept at zooming through things in a way that I am not. Because IT is powerful – for the good and the bad – what we need to do is try to take advantage of what it can give us while at the same time being concerned with the negative. And this applies to all new advances. The issue is not whether new scientific findings could be misused. If they are any good; not only can they be, and they will be. Our job is to try to ensure that is least likely to happen. But to stop doing research because you might find out something damaging would be silly.

DF: We only have 114 psychiatrists and about 10 practising child psychiatrists in Singapore. What would you advise? Should we grow the number of child psychiatrists?

MR: Well, you can grow the number. What should the number be? I do not know. One of the issues is always about how far you need to do things yourself, and how far you work through other people. But all over the world, you are going to have to do both. There is no way in which it can make sense for psychiatrists to do everything. In trying to recruit more high quality people here, one needs also to think of working with colleagues – paediatricians, neurologists and psychologists – and to do so in non-competitive sort of ways.

DF: We have very few clinical psychologists in Singapore.

MR: In the UK similarly, we have very few psychologists, by American standards. But we have good working relationships with those we do have – not always of course, and there is some rivalry but a degree of that can be quite productive.

In the States, many of the psychologists are outside of medical schools and departments of Psychiatry. There is a kind of antipathy which is ignorant and silly. So I think it is very important to avoid that. It would be important to have respect for the differences with other colleagues. So psychologists are not psychiatrists – they overlap hugely but they have different sorts of skills as well.

DF: What are your views on empowering allied health professionals through cross-training?

MR: I am in favour of inter-disciplinary training. There are some things where you need to have separate groups, but there is so much that is overlapping. I think learning alongside paediatricians, neurologists, psychologists and nurses is good. I do not have a pet solution but put in this way, the World Health Organisation's expectations on mental disorders are focused particularly on depression, which has probably been the second most important cause of ill health in the United States. It is clear that we are dealing with common, yet seriously impairing disorders. So the idea that this is just dealing with the foibles of the middle-class people who are not being fruitfully happy is not what psychiatry is about. It bothers me that there is such a preoccupation with happiness. Of course one wants to be happy but there is a great muddle between happiness as sort of a hedonic notion which is a mixed quality, and satisfaction that you are doing things that you enjoy doing well.

DF: Thank you for granting us this interview. ■