

Henry Meurig Nicholas Rees (1927-1999):
Welshman, Psychiatrist, Thinker, Mentor, Friend—
A Tribute and a Reminiscence

Ian M. Evans^{1,2}, PhD FRSNZ

In the powerful movie *Equus* (1977), based on Peter Shaffer's play of the same name, the psychiatrist treating the disturbed teenager is played by Richard Burton. In the movie he is highly introspective and drives a brown Rover. Every time I see the film I'm reminded of Henry Rees, who also was Welsh, drove an identical Rover, and thought deeply about his child patients. Henry loved the puzzle many of the children presented. He once told me that he had originally trained in internal medicine and had been working on treatments for Welsh miners with lung disease. Then a new drug was discovered that essentially cured their illness, rendering his work obsolete. So he thought to himself: *What is a medical field where there won't be any ground-breaking discoveries for a long time?* And so he re-trained in child psychiatry!

Henry Rees's psychiatry training was, I believe, at the Maudsley Hospital (Institute of Psychiatry, King's College) in London, sometime in the early sixties. There were various brilliant child psychiatrists there at the time, such as Michael Rutter (now Sir Michael) and Lorna Wing, of Asperger syndrome fame. When I met Henry he was the consultant psychiatrist at the Belmont Hospital Children's Unit, in Sutton, Surrey (South West Metropolitan Region of the

¹ Professor Emeritus, School of Psychology, Massey University, Wellington, New Zealand, and Clinical Affiliate, Clinical Studies Program, Department of Psychology, University of Hawai'i, Honolulu, HI 96822, USA. For correspondence regarding this essay, contact me by email: i.m.evans@massey.ac.nz or evans4@hawaii.edu.

² I am grateful to Professor Emeritus Clifford O'Donnell, University of Hawai'i, who assisted greatly with my internet search and was able to track down some vital biographical information on Henry Rees

NHS). In the UK, consultants typically did “sessions” at various clinical settings, which meant that Henry was only in the Unit one or two days a week. I was there as many days as possible, coming by train from Victoria Station. Sutton was the first stop on the fast train from London to Brighton. Henry arrived by car—the Rover—from his home in Horsham, Sussex, twenty miles to the south. He typically wore a slightly scruffy beige mac, a sportscoat jacket, and wooly-looking ties, smoked a pipe, and had a rosy complexion to his round face and thin nose.

The Children’s Unit had been the brainchild of the hospital Superintendent, Dr. Louis Minski, who had made a name for himself championing the cause of psychiatric patients who were deaf. Recognizing that the challenge of diagnosing and treating deaf patients was further complicated when they were children, he set up a six-bed child unit in 1953. I met Dr. Minski often, as he regularly came down to our meetings to discuss individual cases, along with his Registrar at the time, Dr. Shepperd. He was a down-to-earth, blunt but kindly, old-fashioned doctor, in the image one might expect of a gruff, country physician on a TV drama. He knew from the start that a hospital ward was no place for children. So he moved out of his official Superintendent’s residence on the hospital grounds and turned the house into a short-term residential unit for young children from all over Britain. A couple of years later he persuaded the Nuffield Provincial Hospitals Trust to establish a second facility, and they bought and equipped a large detached, Edwardian family house in the Sutton suburbs, afterwards called the Annexe (Minski & Mary J. Evans, 1961).

Thus, by 1966 the Belmont Hospital Children’s Unit consisted of two family-style homes with about six children in each, staffed by nurses and nursing assistants called housemothers, none wearing uniforms of any kind. The two senior nurses, both young very capable women who shared a flat nearby, were Patricia Evans (no relation) and Rosemary Williamson. In the first

house, meals were delivered from the main hospital; in the Annexe there was a full-time cook, who could have come straight from a BBC period drama. There was an austere, well-regarded Educational Psychologist, Dr. Agatha Bowley, who provided the psychometric testing, and a full-time teacher of the deaf, Miss Joan Taylor, who ran the classroom in each unit. There was also a social worker who worked with the parents and families, thereby completing what the great American child psychiatrist Leon Eisenberg once called “the holy trinity”: the medical psychiatrist, the psychologist, and the social worker.

In early autumn 1966, my first year as a doctoral student in psychology at the Maudsley, I was introduced to this rich and complex setting by an experienced Australian clinical psychologist, James Humphery. Some years earlier, Jim had come to London to work on his PhD under Professor Hans J. Eysenck. I had become close friends with another post-graduate student, Rosemary O. Nelson, who was on a one-year visiting Fulbright scholarship from the USA. We were both very keen to gain practical experience in the rapidly advancing field of behavior therapy, and Jim took us out to the Belmont to show us what he had been doing using simple reinforcement procedures with some of the children as part of his doctoral thesis on the outcomes of behavioral treatments. However a problem arose in the presentation of his statistics and he failed to pass the oral exam and returned abruptly to Australia. This left Rosemary and me the inheritors of his program and we gradually adjusted it and made it our own.

Henry was fascinated by the potential benefits of behavior modification. The clinical application of Skinnerian operant conditioning principles represented a new approach in Britain, and both Rosemary and I were well versed in the theory. But it was his broader interest in data and research, and his total commitment to understanding and improving the lives of the young children in the units that allowed me to learn an enormous amount from Henry about every

aspect of the mental health of our complex and multiply diagnosed children. Due to an earlier rubella epidemic we had deaf children, as well as children with intellectual disabilities, children with autism, children with developmental aphasia and elective mutism, children with what at the time was referred to as minimal brain damage, and children with emotional disturbance. Most children showed symptoms of more than one such condition. Adding to that complex mix was the fact that a few children came to us from highly deprived family environments: one child's parents had both been institutionalized with schizophrenia; another child had been tied to a cot all day by his elderly grandmother to "keep him safe" while his parents were away working. Children with severe social withdrawal, and marasmus (failure to thrive), as a result of such extreme physical and emotional deprivation, were the ones who responded most rapidly to the warm, nurturing, family atmosphere of the two houses. Henry often pointed out how different that pattern was from the social "avoidance" of the children with autism, which seemed relatively unresponsive to the positive emotional atmosphere of the two houses..

In the early months Rosemary and I were at the units, Dr. Minski ran the monthly formal case conference discussions. He sat at the head of the table and asked the educational psychologist to present her tests scores. Then he asked the social worker for a summary of the family, and then he wrote up his conclusions and decisions about the child. "Wrote up" is a misnomer. He confidently dictated his clinical report there and then, speaking into a small Dictaphone, while the rest of us sat silently around the table—holy trinity indeed. While I didn't necessarily disagree with Dr. Minski's summaries of each case, there was no attempt at a conceptual or psychological analysis. When Henry took over these events, however, his style was completely different. He asked detailed questions, formulated hypotheses, wanted evidence for our assertions, and ended up not so much with a categorical label as a functional description

of the child's needs. For eager younger scholars such as Rosemary and myself interested in behavioral assessment rather than textbook diagnoses (Evans & Nelson, 1974), his approach was the ideal form of good clinical description and analysis. If some degree of certainty around a diagnosis could not be established, it was put on hold until we had more opportunity to observe and to try out little experimental tests to see what the child might do under different circumstances. Henry was in no hurry to plonk down a diagnostic label and he was in no hurry to medicate any of the children unless the nurses reported one of them was physically ill.

On one occasion the staff were concerned that Simon was not eating at mealtimes and efforts to cajole, demand, and threaten him were not working. I suggested a simple operant shaping procedure, starting with a very low demand ("Finish these three peas"), followed by a simple reward ("Good boy! Now you get a scoop of ice-cream"). The criterion behavior was steadily increased, and the reward placed on a partial (intermittent) schedule—always praise but not always a treat afterwards. After some weeks of this program, at one of the group case meetings, Rosemary Williamson, announced with some enthusiasm that "Ian's plan worked wonders and Simon is now eating normally." Henry sat up in pretend high dudgeon and said "Nonsense! *I* solved it. I've been giving him a pill that increases appetite!" A classic example of confounded variables in assessing treatment outcomes, and we all laughed and learned together.

Henry fancied himself as an excellent general practitioner. I had a perfectly good GP in Pimlico, central London, where, after a year in London House, I lived in a bed-sit in Warwick Square. To get to see him, however, required a full morning of sitting in the sparse NHS waiting room of his surgery. I preferred to cough and sneeze my way through my train journey and then get wet in the typical rain, walking from Sutton station to the hospital. On arriving as a drowned

rat, I would complain to Henry: “I think I’m getting a bit of a sore throat. Maybe I’m coming down with strep or something.”

“Ooh, let’s see boyo. Stick out your tongue and open wide,” Henry would respond.

He’d then dig around in his doctor’s bag for a tongue depressor and a little flashlight he produced from his coat pocket.

“Ah yes, boyo, I see some *swell*-ing,” he’d say. He’d rustle around in his bag and find a free-sample bottle of pills and carefully read the label:

“Here you go, swallow these. It says take one, but take two, boyo, take two; get it into the blood stream!”

Henry gave Rosemary and me a tremendous degree of free license to design our intervention programs, mostly around the development of spoken language given that a communication deficit was the one common feature of all the children. While there were occasional outbursts of negative tantrums and aggressive behavior, the overall level of challenging behaviors was very low, despite most of the children having one at least comorbid diagnosis of autism. Rosemary and I basically followed Jim Humphery’s program at first, but then added to it by combining our reward and shaping procedures with some ideas from speech therapy (Nelson & Evans, 1968). We were aware of Ivar Lovaas’s work at UCLA because two of his graduate students, Irene Kassorla and Bernie Perloff, had arrived that same year at the Maudsley, with Irene starting a doctorate under Eysenck. But applied behavior analysis was not well known in Britain at the time and we were the only program in the UK applying operant

principles with children—the BBC (Midlands) even came to the Unit and made a documentary on what we were doing³.

Henry implicitly supported a positive, reward-based approach to behavior modification and so punishment procedures or any other negative interventions simply never arose as a possible intervention strategy. His humanity and caring for the children always took precedence in any treatment decision. He added a strong interest in neurological issues, about which Rosemary and I knew very little. He had simple clinical tricks for establishing cortical dominance, such as handing a child a toy telescope and observing which eye he or she put it up to. And he was an acute observer of what are sometimes called “soft neurological signs,” which helped *us* to be more observant of the children’s idiosyncrasies. He was fascinated by repetitive motor mannerisms (stereotypies) as well as echolalia, and was the first clinician I had encountered who suggested the core difficulty for autistic children was, in his words, “They have a perceptual problem, a sensory problem; they don’t experience the world the same way we do.” He had a delightful way of confronting the issue of whether autism could be considered a true syndrome in nature: “It’s like the Irishman who is asked about leprechauns. ‘Oh,’ the Irishman would reply, ‘there’s no such thing—they’re about so high’”—holding out his hand to gesture the height of about three feet off the ground!

³ It is worth mentioning here that the BBC team had originally come intending the documentary to expose the evils of behavior modification. They were armed with some graphically barbaric historical footage of children being conditioned in Russia as the opening sequence. But after they saw the programs we were actually doing with the children they totally re-wrote their script to extol the marvels of behavioral methods. I believe the documentary was only ever aired in the Midland region and sadly they’ve been unable to trace it in their archives. There were two amusing incidents. One was that two of the children kept putting their hands all over the big camera lens. The other was when they decided they needed to come back a second time and shoot some more footage. But in the meantime Rosemary Williamson had cut her hair short, and they had to have a long wig made to ensure she looked the same as on the previous occasion. The infamous Simon, 6 years of age, promptly put the wig on his head and paraded around in it.

I think that apart from being a trained physician, Henry's interest in the children's neurological problems derived somewhat from his own dysphasia. He would sometime stop in the middle of a conversation, indeed in the middle of a sentence, and pause for quite a long time. Often one could guess what he was about to say, but if you filled it in for him, he found it very disruptive. He explained to me once that in his conscious mind he knew what the next words should be, but he could not express them. He described that while he was in this state of suspended speech, he felt a strong, palpable sensation in his stomach or diaphragm. He did not know why, and he never said anything more to explain his condition, other than openly acknowledging it.

Henry and the staff of the units gave Rosemary and myself an amazing amount of freedom—I shudder when thinking about it. Jim Humphery had set up a little lab in one of the hospital buildings and we walked the kids up there for structured teaching sessions. Later I actually managed to persuade—who exactly?—to let me have one of the bedrooms in the Annexe which I converted into a one-way observation therapy room and where I built an operant-style console for presenting stimuli on a screen from a projector in an adjacent room (Evans, 1970). Without any formal release, the Children's Unit allowed Rosemary and me to take one of the kids, the afore-mentioned Simon, for a day's outing. We picked him up on Saturday morning and took him into central London to see the changing of the Queen's Life Guard at 11.00 am at Horse Guards Parade. There was quite a throng and I lifted Simon up and put him on my shoulders so he could see what was going on. There was a moment of silence while the guards were being inspected and Simon used the opportunity to shout something out, very loudly. As I told the story later, I claimed that the guards all snapped to attention, but that is entirely apocryphal. I doubt they even twitched slightly, but lots of people turned and looked at

Simon, unaware that we had spent countless hours teaching him words and were thrilled that he shouted anything at all. We hurried away and bought him an ice-cream. But what in heaven's name were they thinking letting two first-year graduate students, neither of us British, just take one of the children for an outing without any formal consent process whatsoever? We managed well, I have to say, but not being parents ourselves the one challenge we didn't anticipate was having to urgently find him a toilet in the heart of London.

While relishing this high level of trust and confidence in me, the feature of my interactions with Henry that I valued the most was the many hours we spent just talking about the children. Autism research was in its infancy at the time, no pun intended. Henry was well-informed on the epidemiological research being carried out by Michael Rutter and his team at the Maudsley, which reported an incidence of early infantile autism (Kanner syndrome) of approximately 1 in 2,000 children. (Compare that figure to contemporary estimates of the prevalence of ASD!) Henry also knew, and once invited to the Unit, Dr. Mildred Creak, the granddame of child psychiatry in Britain. Her "working party" had recently specified nine points, being the criteria for diagnosing autism—although they unwisely called it "childhood schizophrenia" (Creak, 1964). Apart from years of confusion, this eventually resulted in Rutter pointing out how the syndrome bore no resemblance to schizophrenia. Young children with autism often developed neurological problems, such as seizures, in adolescence; they do not end up looking at all like patients with schizophrenia.

Henry was interested in language, particularly echolalia, and the children's self-stimulation and fascination with spinning or flickering objects. And so we spent many hours observing the children, trying out little mini-experiments, and observing everything such as gait, balance, self-stimulation, lining up rather than imaginative play with toys, finger dexterity,

cerebral dominance, aversion to touch, and gaze avoidance. He inspired me to do a small N-of-1 study of Sharon, who after being seemingly mute for a number of months after arrival was very echolalic once she started using words (described in Evans, 1971). Henry often interspersed our stimulating medical discussion with his theoretical ideas and general wisdom about life.

Sometimes these discussions went on so long into the evening that I would miss the last train back to my digs in London. “No matter,” Henry assured me, “you can just come home with me. We’ll have some dinner, and I’ll find you a toothbrush.” So back to his house we’d drive, in the Rover, a terrifying journey as Henry was still engaged in analyzing some issue about one of the children and paying absolutely no attention to the road. When we got to his house it was all dark. Clearly his wife Nansi⁴, a GP in the local area, had gone to bed and there would be a terse note about his dinner being in the warming oven. Of course there was a phone in the units, but it never seemed to occur to Henry to let her know he was running late. Finding me in the house the next morning didn’t please Nansi, but she took it in her stride. She just made me a piece of toast with Marmite, and Henry took me to Horsham Station for a train to Victoria—via Balham and Clapham Junction. I can still hear the guard, in his strong Indian accent, singing out these stops on the line.

At some point in time of the three or more years I spent connected to the Children’s Unit (eventually being formally appointed and paid as a Staff Psychologist from 1968-9), Henry took up a new consultancy. He moved to Birmingham, a large city in the Midlands about a hundred some miles north-west of London, and was employed as a consultant in child psychiatry at the

⁴ Henry married Nansi G. Gwynne (born April 1927) in July 1951 in Cardiff, Wales. Some time after I left Britain for Hawaii I had heard that they were divorced.

Birmingham Children's Hospital⁵. I was not privy to his reasons for the move; however I think he felt there were some interesting possibilities allowing a more traditional mental health and family focus to his work. He spent some time telling me how he worried the new residential estates were socially and emotionally disastrous. These estates were rapidly replacing the traditional English working-class attached houses all in a long row down a street. Row houses in deprived areas were being bulldozed in cities like Birmingham in the name of progress, to make way for high-rise towers of modern flats, on large estates that also had some sterile playgrounds and pubs and other 'amenities'. Henry believed these arrangements were a major cause of family dysfunction, mental illness, and crime. He argued the traditional row house might have only had a tiny back yard, outdoor privy, and washing line, but ensured excellent opportunities to hang over the fence and talk to your neighbors and for the children to go right out onto the street to play. Mothers were totally isolated in high-rise buildings. They were too fearful to let their children leave the flat unaccompanied—the lifts (elevators) were seen as dangerous and the entire area infested with drug use. No-one, he claimed, went to the modern pubs on the estates as they didn't have the casual run-down atmosphere of the residents' former local. I think he saw this whole situation as a challenge for a psychiatrist with a social conscience and an understanding of community mental health.

For me personally, and I think for Rosemary Nelson as well, the freedom and intellectual stimulation of an intensive practice setting with good, caring people, was a marvelous learning experience. After a year, Rosemary returned to the US to begin a clinical doctorate at SUNY-Stony Brook, and she later became a highly regarded professor at the University of North

⁵ My thanks to Maria M. Callias, PhD, who confirmed this appointment and that while she was doing her clinical psychology training at the University of Birmingham, Henry gave lectures on child psychiatry.

Carolina, Greensboro, and one of the most influential cognitive-behavior therapy (CBT) scholars of our generation⁶. After I completed my PhD under Professor Hans Eysenck and Dr. Irene Martin, I took up an Assistant Professorship at the University of Hawai‘i in Honolulu and immediately pursued clinical work with children with autism. That is another story, but it was made possible because of having Henry Rees as a teacher and role-model.

Sadly, I lost track of Pat Evans and Rosemary Williamson when I moved to the US. But there is no doubt that their skill with children with disabilities, their professional competence, astute clinical judgment, and their warmth and humanity and sense of fun is what made the Children’s Unit a special place. The positive emotional climate of the two houses was a direct result of their commitment to their work.

Of course, in retrospect, there were many deficiencies in the services offered at the Children’s Unit, which had begun primarily as a short-term diagnostic service. Subsequent educational opportunities for the children were limited—indeed an official category of intellectual disability at the time in Britain was *Ineducable*. The power of positive behavior modification allowed such a categorization to be seen as meaningless once applied behaviour analysis surged across America and eventually into Britain. However, the language programs we implemented paid scant attention to natural language acquisition contingencies and generalization, although we did ask everyone on the staff at the units to rehearse and practice communicating with the words we were teaching. What was perhaps most unusual, given contemporary practices, is that the parents and families of these children (living all over the British Isles) had little or no contact with the program and certainly never gave consent to any of

⁶ Rosemary O. Nelson-Gray, PhD, Professor of Clinical Psychology, University of North Carolina at Greensboro.

the procedures we implemented—including taking their child to London for the changing of the guard. The Unit was proud of how much like a family the setting was, but actual families were nowhere to be seen, nor given support to continue interventions we had established. I don't know what Henry thought about such matters. He had, somehow, met all or most of the parents, perhaps when the children were first being officially admitted to the Unit, and he had interesting thumb-nail sketches of some of them. One child's mother, he told us, had “run away with a pastry cook”; another had schizophrenia, a third had had rubella during pregnancy, one father was an alcoholic. Yet the clinical implications of this anecdotal information were rarely explored, although he always commented on the importance of finding out if child had been “wanted”.

As a person, as a doctor, and a scientifically-minded psychiatrist who valued psychology and had little time for psychoanalysis, however, Henry was a magnificent teacher. I became immensely fond of him, perhaps not appreciating that fact until he was there no more, and we had a rather arrogant new consultant psychiatrist who curtly ordered the junior nurse to make him a cup of tea on his arrival. The contrast with Henry was extreme. And while Henry was not a tortured soul like Dr. Martin Dysert, the psychiatrist in *Equus*, he shared not just Richard Burton's Welsh accent and a Rover 2000 P6 car, but also his intelligence, thoughtfulness, curiosity, and clinical skill with young people. Henry Rees was an outstandingly warm, genuine, and talented person, totally devoted to the children in his care, and I feel very privileged to have had him as a supervisor and mentor⁷.

⁷ In 1976 Henry married Patricia Margaret Kenderdine in Bromsgrove (Birmingham). He died on the 2nd of February, 1999. His death certificate reports that Patricia Margaret Rees, widow of the deceased, was present at his death from a heart attack. Henry was 72.

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A few photographs I took during my time at the Belmont Hospital Children's Unit



Pat Evans, in the Annexe backyard



Ian Evans Andrew McC Rosemary Nelson,
keeping data



Rosemary Williamson

The most junior assistant housemother



The cook



Sharon has her fingers pushed into her ears