

Interview with Dr. Klaus Minde, MD

(interviewed by Normand Carrey MD)

Dr. Klaus Minde is Full Professor, Departments of Pediatrics and Psychiatry, McGill University. He is also a distinguished Fellow of the American Psychiatric Association and Life Member, American Academy of Child and Adolescent Psychiatry. He has served in the past as an executive of the World Association for Infant Psychiatry, Co-Chairman, Task Force on Practice Parameters for the Diagnostic Assessment of Infants and Toddlers (AACAP), and Chairman, Infancy Committee (AACAP). His publications include numerous articles and chapters in English and German, including the book *Infant Psychiatry: An Introductory Textbook* (1986).

Q. Can you tell me a little about where you were born and your family?

A. I was born in Leipzig, Germany in 1933. My dad was the technical director of Germany's public radio. He lost his job six weeks after Hitler came into power because he would not join his party. He managed to remain employed because the postal service that was part of the same ministry found him a job within their organization. He in fact was involved in creating the first true television transmissions in Europe, if not the world, at the 1936 Olympics in Berlin. Following the war, he was given added responsibilities as one of the very few survivors who had never joined Hitler's party. However, six months after the Russians had taken control of East Germany, he was downgraded again as he refused to join the communist party. My mother came from a very musical family and was working in the classical music department of the local radio station where she met my father. My one younger brother is an opera conductor in the US.

My family put me in a boarding school, associated with a choir, in the same town we lived in at age nine, because both school and choir had been founded in 1212 and, based on their very powerful tradition, were able to maintain a relatively humanistic educational program. Furthermore, the cultural importance and recognition of the choir (J.S. Bach had been the conductor between 1723 and 1750 and

had written most of his choral works for the choir) provided somewhat of a haven of civility in the boarding school both during the Nazi and subsequent East German times. The choir also, in addition to three concerts per week in our church, regularly performed in then West Germany and foreign countries after the war, allowing us children to experience different political systems and cultures. On the other hand, we were obviously still seen as the enemy by the state authorities. For example, after finishing high school I was not allowed to go to University because of my 'failing commitment to the new social order.' This necessitated me to leave town for West Germany at 17 and not see my family for many years.

The philosophy my family had, based on the guiding principle of justice against any type of fascism, for civil rights negotiated rather than decreed behaviours, is still very much with me. It even translates into child psychiatry which I see is a science but with an important function of advocacy to fight for the betterment for the next generation.

Q. You then went to med school but soon developed an interest for pediatrics?

A. I left East Germany to attend medical school in Munich in 1951. I knew that this was a one way street, as I could not return to see my family in East Germany. I had to support myself through med school by doing various odd jobs although for the last two years I received a scholarship through a professor who had an interest in music. The scholarship required that in addition to getting good marks, I had to attend concerts and other cultural events and write an annual report on these extracurricular experiences. This was a total life saver as it literally paid me to stay involved in more than just medicine.

I became interested in pediatrics—because as a boy in my home town I had been very impressed and influenced by our pediatrician. Pediatricians in those days would come to the home every four to six months for their well baby

check-ups—and our pediatrician always addressed me as his helper when he asked me to open my mouth. This gave me a sense of being his partner and I remember that at the age of five years I decided that I wanted to become a pediatrician like him and do his work with other children. A little later I also realized that he himself had lost three sons during the war.

Soon after graduating from medical school a professor of pediatrics suggested that it may help my pediatric training if I would spend some time in America and urged me to apply for a Fulbright scholarship. I was lucky enough to pass the selection and spent two years in New York City. The first year I worked as a resident in pediatrics at Bellevue Hospital. Bellevue was a downtown hospital which cared primarily for poor people. This meant that we came in contact with poor children from various immigrant groups who suffered from all kinds of different diseases. We saw many children whose parents could not read and write. We tried to deal with deficiency diseases but the children often would come back six weeks later with the same condition because the families did not have the means to deal with them. Other children, e.g., those suffering from TB, would be admitted for up to six months and develop all kinds of behavioral problems on the ward because their mothers would visit, if they came at all, only every two or three months. It was terrible.

After one year in this environment I felt I needed to learn something about normal development. I was accepted into an MA program in developmental and clinical psychology at Columbia University. During this period of time I also was a research assistant at the Sloane Kettering Cancer Institute in a lab dealing with cancer in children. The psychology program gave me a sense of science, some competence in statistics and the epidemiology of disease that I had not experienced in medicine where the truth was what the professor said. Developmental psychology also seemed to have more of an overarching strategy, based on normal development, and had clear definitions for deviancies and their possible etiologies. That year also gave me a sense of integrating scientific principles with clinical practice and being open to involving more than one group of professionals. Thus I have never done a research study without involving colleagues from psychology or other specialties in it as they have tools that go beyond those used in pediatrics or psychiatry.

Q. When did you become interested in child psychiatry then?

A. I had heard about child psychiatry during my Fulbright years; there were some people doing work with children but it was not an organized field—the AACAP had only around

120 members. While still in the States I met with Leon Eisenberg and Lauretta Bender the heads of child psychiatry at NYU and John Hopkins who talked to me about child psychiatry and they told me this was the way to go. They talked to me also about Canada and the possibilities there. However, I had to return to Munich to finish my training in pediatrics and see Nina again, my future wife. I also met with people in Germany who were potentially interested in child psychiatry but they all advised me to go back to North America where things were more developed. I therefore applied to do my residency at McGill and had the chance to join Taylor Statten who was head of child psychiatry at the Montreal Children's Hospital. Tay was a wonderful person and role model who always saw the full part of the glass and recognized and furthered the individual needs and wishes of those training with him. We did not make much money in those days so he would invite us to his farm and some of us helped him and got paid tapping maple trees and selling the syrup. As part of the child training, we also had one year where we observed a baby and his mom, supervised by Irwin Disher a psychoanalyst who had trained with Anna Freud and Winnicott. The latter also came as a guest for the tenth anniversary of child psychiatry at McGill.

Q. I understand that you undertook psychoanalytic training as well?

A. Yes—I chose as a supervisor Dr. Wittkower, a German Jew, who left the University of Berlin in 1936 to go to London and came to McGill after the war. He was an important member of the group developing the field of psychosomatic medicine—thus had a much more scientific approach than other psychoanalysts of the day. He also founded the field of transcultural psychiatry as well as its first journal. He modeled the option for being a psychoanalyst as well as an evidence based researcher.

Q. This was during the time that you were hired on as child psychiatry staff at McGill?

A. Yes. Dr. Statten offered me a staff position right after my residency and said to me—Klaus you are now on staff—you can do what you want for the first year—there are no clinical obligations. I felt somewhat lost after three months of this freedom and I wanted more structure. He suggested I see Gaby Weiss, who was also one of my supervisors, and John Werry, investigators of one of the early studies of hyperactivity in children, together with a multidisciplinary team. They eventually followed these youngsters up to 22

years. I had my MA in psychology—and John felt I might be ok in research so I joined him and Gaby.

Q. You were analytically trained. Did it conflict with your scientific approach?

A. No, because Wittkower, as I said before, had expertise in both areas. He would even read and discuss my papers and their potential scientific value while he had me in analysis. At least to us, it did not feel that psychoanalysis and traditional scientific study could not live with each other. However, after spending two years in Africa following my analytic training, their training committee suddenly felt that I had not been sufficiently trained and required me to do a fourth analytic training case.

Q. How did your interest in attachment and infant psychiatry come about?

A. Our first son was a premature baby and he was born when I was a resident in psychiatry after we had immigrated to Canada. We were not allowed to visit him and could just look at him through the window of the nursery. Nina was crying during virtually every visit as he looked so forlorn and small in his incubator. As we lived just opposite the hospital, they let him come home to us when he just weighed four pounds. He was feeding every second hour—and each feed lasted one hour, thus one of us fed him for 12 hours per day. That part was not easy—and became part of my emotional heritage but I know it was even worse for his mother (my wife Nina).

Three years later Marshall Klaus and John Kennell, pediatricians from the US, began to talk about bonding and how premature babies suffered a higher rate of abuse because they were insufficiently bonded because of their long stay in the nursery. I thought this was important and became attracted to this whole issue of how mothers cope. And that got me into this whole field of attachment and infant psychiatry. I was also hearing about the work of Mary Ainsworth, a Canadian psychologist who worked with infants and mothers in Uganda.

Q. Why did you become interested in Uganda?

A. In the early 1970s I had my psychology degree, had finished my psychiatric residency and training as a psychoanalyst and thought it was time for me to do something for my wife's career. She had done her PhD in Slavic languages in Germany. She had written her thesis about a Serbian poet who happened to get the Nobel Prize in literature one month after she handed in her thesis. As there was comparatively little known about him, her thesis was printed as a book and became well known. We therefore wanted to go to Russia for two years but they did not want to give us visas. At

that time the person in charge of transcultural psychiatry at McGill said that the WHO wanted a child psychiatrist in Uganda, so I applied and got the position. There were no child psychiatrists at all in East Africa but there was a very good medical school in Kampala, founded in 1928, so that is where I ended up.

Q. How did you find that experience?

A. It was during the time of the presidency of Idi Amin—it was a difficult time; he had become president after the flight of the previous president Obote, and the world as well as the then chairman of psychiatry at Makerere, were seeing him to be a much better president than his predecessor. However, this changed quite rapidly and during our second year there, he engineered the departure of all the Asians. This in turn led to suicides of some medical students, who came from Tanzania, Kenya and Uganda, challenging all the activities we had instituted clinically in the country. But it was also a wonderful experience for all of my family, as the Ugandans in spite of Idi Amin were and are a very loving people. The head of psychiatry left as his wife from the Seychelle Islands was threatened and I became the acting chair of psychiatry while all other white people were running away. Because Nina was afraid for our children, she managed to get hired as a music teacher at our children's school and even had two of Amin's children in her class.

Amin would pull off weird stunts as he was also the chancellor of the University. For example, he demanded that every professor be present at a certain place at the university so that he could address them. At the time of the expected address, and while everyone was waiting for him, three big empty limousines would show up. Amin would arrive three minutes later, riding a bicycle that he mounted just before entering the university. Shenanigans like that depicted in the movie "the King of Scotland."

Q. Then you returned to Toronto. Why Toronto and Sick Kids?

A. I was hired there as the director of research in the department of child psychiatry even before we left for Uganda—but the then chairman, Quentin Rae-Grant, allowed me to start two years later. It is there that we started our premature study—with a sample size of 170 premature children weighing less than 1500 grams and other studies. We had a wonderful team of exceptional psychologists, nurses, and neonatologists.

I was cross appointed to Pediatrics—hence was able to become part of the neonatal intensive care unit during the years of the study and do rounds with them three times a week. Later on they made me the co-director of the transplant team, so every child with a transplant had a psychiatric

consultation. It was intense but I learned a lot—especially about how physicians working in these high stress areas cope. Moreover, after five years I could say I've had enough, I am going to work with colleagues in the diabetic clinic, but the oncologists were stuck with dealing with that very challenging population until they retired.

Q. After this you had a sabbatical in London. Tell me about that a little.

A. It was a wonderful time as I was able to meet with John Bowlby, the originator of attachment theory, on a regular basis all during my time there. He told me a lot about his own beginnings and his role within the psychoanalytic community in London and I was even able to persuade him to come to Toronto and then Kingston when I was the chairman there to provide us with some of his profoundly sound thinking about attachment and child development in general. He was also very committed to nuclear disarmament and when I was asked to write a chapter about this later, he was willing to read it and gave me some additional ideas.

I also spent one day per week at Anna Freud's therapeutic nursery, interacting with the children and the staff. My main office was at the department of child psychiatry at Great Ormond Street with Philip Graham where I participated in research studies but also saw some patients in the preschool program. The most amazing thing about these months was the fact that I could regularly visit the working place of Anna Freud, Bowlby, and Mike Rutter at the Institute of Psychiatry while this was impossible for local psychiatrists as they had to be faithful to their respective institutions and clinical philosophies.

During the other six months of that sabbatical year I was at Yale University and spent a good deal of time writing the first textbook on infant psychiatry. This arrangement had been made by Al Solnit, the then chair of the department of child psychiatry. While he was a highly valued psychoanalyst, he also met with a group of community pediatricians every two weeks for more than 20 years, discussing their questions about their patients and learning from them. He also supported and hired neuro-psychiatrists and Sally Provence, a pediatrician who has been one of the most distinguished infant specialists. I was able to see lots of patients with her, help out in the attached nursery school and lived within a truly superior academic environment.

Q. You then became chairman of the department of psychiatry at Queen's?

A. I was obviously flattered to be asked to lead an adult department of psychiatry at Queens. I also looked forward to work with the then chairman of Pediatrics, who was a

nun and quite open to team up with somebody like me. My obviously grandiose idea was to see whether one could add an overall developmental construct to a department of adult psychiatry, highlighting the fact that development is a life long theme and should be addressed in our work with both children and adults. I had to realize after two years that this would not work, at least at Queens where a traditional way of dealing with adult patients had been practiced for a long time. Thus an attempt to integrate developmental parameters into the psychiatric diagnosis and care through the ages was hard to establish.

Q. You then returned to Montreal and McGill?

A. Yes. The faculty of psychiatry wanted to start a division of child psychiatry and asked me to lead this group. Child psychiatry had been a sub-department of pediatrics since its beginning.

Q. You then went back to Africa ten years later, but not Uganda. What attracted you to Johannesburg?

A. My wife and I had a love for Africa and I was interested in helping people dealing with kids living in slums so I went there after speaking to David Schaffer the head of child psychiatry at Columbia University, who is originally from South Africa. He recommended either Cape Town or Johannesburg to us. So I attended an annual meeting of the South African child psychiatrists to look at both places. Cape Town appeared too traditional to me, so I decided to join the group in Johannesburg where I worked at a number of clinics both in Soweto and Alexandra, another township in Johannesburg. In Alexandra we saw a good number of AIDS orphans and their grandmothers who suffered from multiple losses (mothers for the children and daughters for the grandmothers) and faced significant economic difficulties. With the help of our wonderful head nurse and Nina we started a support group for grandmothers. This proved to be a phenomenal success as these grannies are regular competent individuals who are confronted with immense challenges. This means that they make excellent use of support and in fact became the nucleus of a whole movement that now recognizes the essential role these grannies play in the management of the AIDS epidemic. I also managed to do a study that established the validity of assessing the attachment patterns in African preschoolers, using a paradigm developed in the West. The Stephen Lewis Foundation is

now providing funds to continue this work in many African communities.

Q. A long standing interest of yours is the treatment of anxiety in children?

A. Anxiety is very common, and there is a treatment—CBT and then, if necessary, medication. The real reason for my interest was to see if children aged three to seven could benefit from CBT, as this had traditionally been denied. However, our data and those of others now seem to indicate that this treatment works if it is appropriately modified.

Q. You also do volunteer work with street kids in Montreal, an organization called, “Dans La Rue.”

A. Yes, they are drug addicted or otherwise compromised teens—who live on the street but attend a center that offers them physical and emotional support as well as a chance to continue their education. It was founded by father John, a truly inspirational individual. I try to support the

professionals who deal with the young people and devise ways of motivating them to look after themselves more.

Q. You have witnessed but have also shaped the field of infant psychiatry. Any closing comment?

A. In the field of infant psychiatry, probably more than in other areas of child psychiatry, you have to earn your place on the team. This means earning the respect of other physicians, various types of caretakers—and the young children themselves. The now well documented plasticity of the brain also allows you to potentially facilitate an environment that furthers the reconstruction of compromising brain functions of the infant. Furthermore you can help parents to create more appropriate parental caretaking practices that actually prevent later difficulties in the children. This to me is an achievement we all aim for in medicine and, just maybe, infant mental health professionals are closer to making it a reality than our colleagues in other specialties. It also means that one remaining challenge is to persuade our adult colleagues to more often think about patients within the context of their past and present relationships.

Many thanks for your time Dr. Minde.



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