

CLINICAL PERSPECTIVES

Interview with Dr. Gabrielle “Gaby” Weiss

The following is an interview with Dr. Gabrielle “Gaby” Weiss. This is probably the easiest (and most inspiring) interview I have done to date. I provided a few questions and Dr. Weiss took care of the rest. Interviews such as these indicate the breadth of exceptional experience and the tradition of senior mentors we benefit from in Canadian child psychiatry—a happy situation we should be very proud about.

N Carrey (Editor in Chief)

A Personal History of the Choice of Child Psychiatry as a Career

I remember that when I was still a small child I was interested in understanding my parents and the other adults and children around me.

I was quite young when my parents wanted to send me out of Berlin where I was born – before even securing their own safety. I knew nothing about being Jewish (or the Nazis) since we were Christian.

One morning, while lying in bed with my parents at the age of six years, my father asked me “how would you like to go to an English school in the French part of Switzerland?” I thought he was joking or testing my courage. I loved pleasing him so I said “I’d love to”.

When I landed in a boarding school in Switzerland I felt lost and confused and very alone except for my doll, which was soon torn apart by mean kids.

Why had my parents sent me to this awful country where everyone spoke a language (English) that I did not understand? I knew, and never doubted, that they loved me. Trying to understand my parents and the strange people around me became a childhood quest and understanding human behaviour and motives has become a lifetime undertaking. The kids I was with were very mean and it was only many years later that I understood why. They were children of wealthy businessmen and diplomats who rarely saw their parents.

When I was seventeen years old (and now happy with my parents in England) I left home to study medicine at McGill. I had not succeeded in receiving acceptance into the medical schools in England because I was not “English born”.

During the course of medical school a seemingly minor event influenced my choice of specialty.

I remember walking through the woods with a fourteen year old boy who was the adopted son of a neighbour. His name was Joseph. He had begun stealing from stores and had broken into a house. Unexpectedly on this walk, Joseph poured out his heart to me about his life and his understanding of his parents’ disappointment in him. At the end of the walk, Joseph told me how much better he felt because of our talk. I had done nothing but listen to him.

I made up my mind that what I wanted to do as a career was to understand and help children and their families; a decision triggered by Joseph.

How I influenced my two daughters to choose Child Psychiatry

I never tried to influence them but was it abundantly clear that I loved my chosen field and that I was inspired by it.

Jacky, my younger daughter, said that she was influenced by the stories (often including three generations) which I told them every Saturday morning, as I drove them to St. Sauveur for their ski lessons.

Margaret, my older daughter, started her academic career by completing a PhD at Harvard in the History of Public Health but wanted something more clinical and active. She wrote the following to me a few days ago while on her family vacation in Florence – “I always knew I would specialize in ADHD when I was in medical school. As a child I remember asking my mother how she could study one problem (ADHD) without getting bored. She replied that within the area of Child ADHD one could find the whole of life. My mother is a pit bull for defending the underdog and I believe she ended up studying ADHD kids because no one other than her and John Werry were really looking to care for ‘bad boys’ ”.

What I learned from our follow up studies (Hyperactive Children Grown-Up, Weiss G., & Hechtman, L.)

a) How the research started

John Werry and I were residents together at the Montreal Children’s Hospital. We had spent two years of training in Adult Psychiatry at the Allan Memorial Institute and had become good friends. We decided that once we began our training in Child Psychiatry we would combine it with research in the field. Research in Child Psychiatry was still very new and was clearly needed. We had, at that time, no idea what kind of kids we wanted to study.

The Psychiatry Department at the Montreal Children’s Hospital had a strong psychoanalytic orientation. Play therapy was the main treatment and was con-

sidered essential training for a resident and I appreciated this as it helped me to understand children.

However, perhaps luckily for John Werry and myself, hyperactive boys were not good at playing quietly, allowing the therapist to “interpret” their play. Instead they would run out of the playroom on the fifth floor on to the elevator and press the button for the twelfth floor. The therapist would follow but by the time he reached the twelfth floor the boy would be back on the fifth.

As a result of failing to benefit from play therapy there were no other treatments available so almost one hundred hyperactive boys were left and no one knew how to help them.

John Werry and I took them on and entered them into a research study on the medication “Chlorpromazine”. This did not help them. Our studies on medication always randomised the boys into a placebo (control) group as well as a medication group. The Department was very suspicious about us doing our research on children and tended to frown upon it, but they did need some treatment for the “untreatable” boys who did not benefit from play therapy.

After our trial of Chlorpromazine, which we considered ineffective, we did a placebo double-blind trial of Dexedrine. We discovered (what Bradley had initially discovered in Rhode Island in 1937) that Dexedrine compared to placebo was very helpful in reducing hyperactivity and improving concentration.

Towards the end of the Dexedrine trial, John Werry decided to move back to New Zealand. I was left with one hundred hyperactive (mainly) boys who needed treatment of some kind.

I started to follow their progress and so initiated the 5 year follow-up study which indicated that those who were given stimulants seemed, to us, to be better but we could not demonstrate a better outcome 5 years later than the ones that were not treated. At this point, Dr. Klaus Minde joined the research. Dr. Lily Hechtman later joined us and together we initiated the 10 and 15 year follow up. We followed them until they were 20 to 25 years old. What we established was that 66% of them still had difficulties related to their ADHD. Their outcome was partly dependant on their intelligence and on the quality of their family of origin.

Doing the fifteen year follow-up study, Lily and I had enormous fun. But we also encountered difficulties. As young adults some of the hyperactive probands had grown out of their problems and did not want to be reminded of them and therefore did not want to come back to see us. Others were doing badly and felt we had never helped them. Lily and I had to become expert salesmen to get them back. We brought ourselves a bottle of wine and once we were less anxious, we took it in turns on the telephone to persuade them to come back. We offered to see them anywhere they wanted, even in a B.C. jail or a hotel; the majority agreed.

b) What we learned from the follow-up study

Following a group of children at regular intervals is a way of really getting to know them and their families. You become an “outside of their family” confidante and get a first hand view of the vicissitudes of their development, throughout childhood and into adolescence and adulthood.

You also get to know the development of acting out behaviours and emotional distress, what the triggers are and what kind of things can help.

We learned how ADHD affects children and how it affects their adolescence and young adulthood. We got to know the stress on their parents, which varied depending on the child’s age and unique problems.

We came to understand that our control group of normal children also had problems. In other words, “normal kids” also experienced stress and developed symptoms at times. But they did not have a disabling chronic behaviour problem so their lives were easier.

We became very close to the patients we followed, and I was in touch with one of them (who became a social worker) until recently.

We learned that although medication (stimulants) were very helpful in ameliorating ADHD symptoms, they did not necessarily influence the outcome which was multi-determined (although severe learning difficulties influenced later academic achievement, and aggression in childhood and early adolescence predicted antisocial behaviour later). Even the ADHD children who did well, often had a less than optimal quality of life.

We learned as we went along some of the difficulties of doing follow-up research. We thought later that we wished we had sent the children we tried to follow birthday cards each year. This would have helped us to trace them more easily and it would have kept us in better contact.

Finally we learned about the adult outcome of ADHD. At the time it was still thought to be a childhood disorder. We recognized it to be an adult disorder which needs description in DSM-V. Some Family Doctors are still unfamiliar about diagnosing the disorder in adults or referring them to be evaluated. Yet about 66% of children with ADHD continued to be disabled by the disorder in adult life.

In the course of doing a follow-up study, Klaus Minde, Lily Hechtman and I became not only colleagues but very good friends.

One case from the follow-up study that really inspired me: *Michael’s Story*

I chose Michael’s story out of many, because he was in many ways typical of the “hyperactive children” we followed but he also had, as they all did, unique qualities.

I first met Michael at MCH when he was 11 years old. He was the only child of middle class parents who had high expectations for him. But Michael, in grade 6, was behind in all subjects and while of average intelligence, also had learning disabilities. He was academically under-achieving and he wished he could make and keep a

friend. His self esteem was low and he was argumentative. Family treatment produced better understanding of Michael and medication helped a little.

When Michael was 15 years old the family moved to Hong Kong. At that time Michael was 2 years behind in class.

Once in Hong Kong Michael refused to go back to school which had been a negative experience for him. He could not find a job, so he volunteered to try to find homes for stray cats he found.

Now 17 years old with little schooling behind him and no work record, his parents gave him a one way ticket to Australia, and said he had to earn his way back if he wanted to return.

In Sydney, Michael found his first job mowing lawns. He saved his money and lived cheaply. Michael, 6 months later, bought a second lawn mower and hired a friend to help him. He also moved to a better place.

One year after arriving in Sydney, Michael had saved money and met a girl, Jane, who was in nursing training. They fell in love and lived together. She helped him with his business and did the organization at home and at work for him. They were happy together and Michael, for the first time in his life, felt respected.

It was at this time that Lily Hechtman and I sent a package to Michael to complete as part of the 10 year follow-up study.

To our great surprise, Michael and Jane turned up unexpectedly from Australia in our office. Michael said, "That form you sent (the California Personality Inventory) is SO dumb I had to come and tell you". The couple had now saved up some money, were planning a family and felt very successful. They had made a landscape business in Sydney.

Michael was a changed person. From a confused child who felt pretty hopeless about himself he now felt successful. He completed the 10 year follow-up, and returned to Australia. He also completed high school and was participating in furthering his education.

I later learned that Michael and Jane had done well in their business and had a child. Sadly, Jane got breast cancer, and initially at least did well. Even after her death Michael had become established and was a good father, Michael's story was one of initial failure and later success and his wife had made the difference.

The Move to British Columbia

When our two daughters accepted positions at BC Children's Hospital (BCCH) in Vancouver and with their children moved there, my late husband and I were in a quandary.

When we finally decided to follow them because we missed them and our grandchildren so much, it was Dr. Derryk Smith (the Director of the Department of Psychiatry at BCCH) who made the move painless. I am eternally grateful to him.

The practice of Child Psychiatry was not really different in the two provinces. In Montreal there was a greater emphasis on Psychoanalysis and dynamic therapy. In BC, skilled use of medications was more evident.

BCCH had an ADHD clinic which MCH had not yet initiated. I worked in that clinic and experienced excellent teamwork on behalf of the children.

I recognized more and more that children with ADHD need teamwork requiring tutoring, Orton Gillingham, social skills groups, parent groups, recreational therapy and so on, which, in a solo practice, is not available.

My impressions about the field of psychiatry over the years – concerns and hopes

Child Psychiatry is a wonderful field. Those of us who are in it are very privileged. Patients (both children and adults) trust that their life stories of courage, despair, love and hate will be respected rather than judged by us and will be put to use to help them achieve their optimal state of well-being.

Those basic assumptions are what we are about as therapists. Many new modalities of therapy have emerged and some have been researched and are empirically based – such as Behaviour therapy or Cognitive Behaviour therapy and these have been added to our armamentarium. But not all of the professionals using these and other new modalities are well trained and may lack basic training in understanding the individual and the family.

Furthermore, the newer therapies do not require the depth of understanding of individual intra-psychic processes or family dynamics. They are manualized with an aim to reduce symptomatology. This means counsellors using these modalities require shorter training than those using psychodynamic therapies. The good part is that the number of helping professionals has increased so that more children and adults can be treated. The bad part is that relatively inexperienced or selectively experienced counsellors may miss major disorders which require medication and may reduce the chance of the patient being and feeling "known" to the therapist, which in itself is therapeutic and is required for optimal treatment.

What about the use of medication? New drugs for depression, anxiety, psychosis and behavioural disorders are constantly coming on the market. Over the years this has been of benefit as "better" drugs emerged with enhanced therapeutic effects and less side effects. The value of medication cannot be overemphasized for many major disorders.

The danger is however obvious. Looking for "syndromes" or disorders which respond to medication may result in a misdiagnosis and overuse of medication. If you only have a hammer, everything becomes a nail. For example, a child who is restless because his parents are on the verge of separating and have argued for years may be treated for ADHD unless a good history is taken.

A psychiatrist who is very busy may use medication

instead of helping the patient deal with a situation. I remember one mother who saw a psychiatrist for her Bipolar Disorder telling me “every time I tell my psychiatrist about some problem I have with my family, instead of helping me with the problem he ups my medication”.

In the future I would hope:

1. That psychiatric training of residents in the various modalities of treatments now available and which are “evidence based” will not neglect psychodynamic approaches which require the patient to be well-known by the therapist. Instead I hope new treatments will incorporate psychodynamic understanding.
2. I also think we have to understand the limitations of the “absoluteness” of “evidence based” whenever a treatment such as CBT, for example, is found to have evidence of effectiveness, this is usually determined on a subgroup of patients who are less co-morbid than those who come to the clinic. The fact that we search for effectiveness of a treatment is an advance, but the limitations must be understood.

3. Team work in Child Psychiatry clinics and out-patient departments is essential. The use of multidisciplinary professionals in understanding and treating children and families is very positive and should always be included in the Resident training programs.
4. Increasingly, Program Managers are assuming the leadership and administration of Child Mental Health Units. It has therefore become increasingly important that both managers and clinicians work collaboratively to enhance the mental health of children, adolescents and their families.

I want to end by saying that in almost fifty years of practicing Child Psychiatry, I feel as inspired and interested in the field as when I started. Learning to understand better the complexity of children and their families never stops and this is what makes our field eternally exciting.

Gabrielle Weiss MD, FRCPC
Psychiatrist

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