Interview with Paula Clayton, M.D.

Interviewed on October 29, 2010

Interviewed for the Minnesota Psychiatric Society

Interviewed by David Cline, M.D.

Paula Clayton, M.D.: -PC
David Cline, M.D.: -DC

DC: Good morning! Today is Friday, October 29, 2010. We are at the 57th Annual Meeting of the American Academy of Child and Adolescent Psychiatry at the Hilton [Hotel] New York, New York City. I am Dr. David Cline, and I’m from Minneapolis, where I am clinical professor in the department of psychiatry, in child psychiatry, and have a private practice. Dr. Deane Manolis and myself are conducting an oral history project for the Minnesota Psychiatric Society, interviewing senior psychiatrists from our community to hear about their experience in Minnesota psychiatry and how their lives were during that period of time since 1940s, ‘50s, and on. We also are doing an oral history project for the Academy of Child and Adolescent Psychiatry, which is part of this endeavor as well.

This morning with me is Dr. Paula Clayton. Paula, thank you for coming to this interview.

PC: My pleasure. Thank you for inviting me.

DC: We’d like to hear about your life in psychiatry, both at Minnesota and then, here in New York, your work in suicide prevention. But let’s start with your early experiences – where you were born, where you grew up and how you became interested in medicine and then psychiatry, and your career thereafter.

PC: Thank you. I’m Dr. Paula Clayton and I was born in St. Louis, Missouri, on December 1, 1934. I was the third girl in my family, with two older sisters. My mother and dad both went to college. My mother went to two-year teaching school and was a teacher. Her brother, who was younger, was killed in France in the First World War, and her father, who was also in the service, died the same year in the flu epidemic, so she and her mother survived. The mother, my grandmother, lived with us the whole time I was growing up. My dad was also in the First World War and went to France but came home and, through the church, met my mother and married. He, too, went to college. He was an accountant, really on probably something like the GI Bill (I’m sure they didn’t have it). We were brought up with the idea we’d go to college. There was no question about it. I remember deciding that when my sister went away – she was seven years older – every time she would come home the family was so excited about her getting home that I thought – I’m going away to college – to be appreciated! [chuckles]
My mother, for reasons I never really clarified, always thought I should be a doctor. I mean, 
from as long as I can remember, she wanted me to be a doctor. Both my sisters became teachers, 
and the one then finally worked for a newspaper. With me, she wanted me to be a doctor. She, 
for instance, took me to visit – she had a friend whose son was a doctor, and he arranged for me 
to visit in high school other women physicians in St. Louis. My father was not very happy with 
that but he didn’t say much.

I went to Michigan with the idea that I would go to both college and medical school there. When 
I got there I realized I probably wouldn’t get in. There were many, many competent people in 
Michigan, and they took mostly state graduates, which they should have, so I then came back to 
St. Louis after four years of college and went to Washington U in St. Louis, and I graduated in 
1960. I was one of two girls in my class, and I always felt that they probably took me because 
they needed a second girl in the class, because I’m sure … the class seemed much smarter than I 
was, [chuckles] I don’t know. But I did well and I became AOA in medical school, so I finally 
got into the groove of things. I failed my first anatomy test. I just couldn’t figure out why those 
muscles weren’t running the way my cadaver muscles were running. The bodies were all over, 
and they marked those little muscles and you’d have to tell what the name was and all that.

DC: And attachments and …

PC: I was so anxious. They tutored me, and by the end of the year I was adept at it. I liked 
medicine in medical school, and at Washington U the Department of Psychiatry was very much a 
medical model psychiatry department. I also, then, wanted to have children young, so I got 
pregnant in medical school, and I had a child in my fourth year, and that determined, then, my 
choosing psychiatry over [internal] medicine, because medicine was such a high-powered 
residency. You had to be on call every other night, and I just felt I couldn’t do that. The closest 
thing to medicine then, was psychiatry in my mind. I went to the residency program there. So, in 
my training, you went to an internship first and then three years of psychiatry. In my third year 
they asked me – Dr. [George] Winokur asked me – if I wanted to be the chief resident, and I said 
– Well, why should I do that? – because, I was going to practice. And he said – “It’ll make a man 
out of you!” [laughter] And of course he couldn’t have said that now, but then it was funny. And 
laughed, as he always did. I talked to my husband and he said, “well, I like him, why don’t you 
stay?” So I stayed the extra year, and that, then, automatically meant you could join the faculty 
if you were the chief resident.

I began my research in my residency – I did my first study of bereavement in the residency, 
because you had to, you had to do research, and then I just continued. I collaborated with George 
[Winokur], and we wrote a book on manic-depressive illness in the ’60s. My first manuscript 
that was published was a follow-up of patients who were in the hospital who we diagnosed 
mantic and we wanted to see what happened, and so we sort of defined mania. That paper was 
probably in ’66, or something like that. My husband was always amazed, he would say – “Why 
would somebody come back from southern Missouri just to talk to you?” But they did. People 
were cooperative. They were glad you were curious about them and what has happened. After 
that we wrote a paper defining schizoaffective illness and then a whole set of papers on 
bereavement. So, my research has been on manic-depressive illness, depression, and 
bereavement, and that kind of followed me through promotions and all this other stuff.
I was pregnant with my third child by the time I finished my residency, and I worked part-time after that for probably five years, and then I went back to full-time work. My part-time work was every day, and I will now – always, after that – when I talk to women, which I usually have to do if I go to some school, I have to talk to women faculty – I say, if you work part-time, don’t work every day. Work two days a week or three days a week, because I never got away at one [day]. I’d work from eight to one or nine to two, and it always took longer. So it was unwise being paid for half-time work and working longer.

When I went to medical school, you went to medical school six days a week. We went all day, every day, and Saturday mornings, too. The department functioned that way, too. The whole school functioned that way. We would have our most important grand rounds, like on surgery, on Saturday morning, so you just got in the habit of working that way, and it stood me in good stead for research. I had a very nice husband who liked the kids and was more than willing to pick up and take the kids to school and the things I didn’t do. I think probably people at Washington U were sort of groomed to be chairmen. It was sort of expected that that’s the way you got … and I think probably in my years there were probably seven of us that became department chairmen.

So my main mentor, Dr. Winokur, left in the 70s to go to [become chair at] Iowa, and then I was sort of second of command to the then chairman, Sam Guze. Sam really thought I should become a chairman. I’m sure that happens because people put your name out there, and I’m sure they did that kind of thing. He would always encourage me to go and interview. He said you can always go to a place once, but if you go back a second time that really shows an interest. So I went to several places to look at chairmanships, but didn’t feel comfortable. The first one was Buffalo, and you go to Buffalo and they’d had 100 inches of snow, [chuckles] and you think, oh, my goodness, could I recruit to this place, and you go back and you think no. You can’t build what you want to build.

So I went to several other places, but didn’t go back, and then I was invited to come to Minnesota. It was a very solid department. As you know, it had a good department, it had research, it had a research budget; the state had provided a research budget and they had some very solid research projects going on. It gave good clinical care, and the medical school was good, as well as the financial base. It was solid compared to some of the others. So, I went back and was recruited and came in 1980, so I was at Washington U from ’65 to ’80, and then chairman of the department of psychiatry [at Minnesota] from ’80 to ’99. The [medical school] dean in that arrangement, when we were trying to arrange my coming, promised me a neuroscience lab, because we had a lab at Washington U, but I wanted to build a more comprehensive lab, so he gave me the space for a laboratory and gave me four positions to fill those, and the first one was Boyd Hartman, and he hired an anatomist and physiologist and chemist or something. So that was one thing.

DC: The dean at that time was … Neal Gault?

PC: Neal Gault, right. I guess I should say I was the first woman chairman of psychiatry in the country, and the first woman chairman in the medical school at Minnesota. People say, well, what was that like? And I said – We sort of think I changed their language [laughter], because
we have these luncheons once a week of all the chairmen, especially the clinical chairmen, and I’m sure they told stories that they stopped telling when I … it was a notable medical school, so the chairmen were quite distinguished.

DC: You became chairman – chief of the medical staff, as well, at Minnesota.

PC: Right, I did – I was voted chief of chiefs.

DC: And that was a first for women, probably in the country.

PC: Yes, I’m sure that’s true. I didn’t think of that, but that’s true. The other thing that happened while I was there – I’d worked on grants at Washington U, mainly a big collaborative study of depression, like 1,000 patients and 1,000 relatives, and that, then promoted my career. I wanted to write grants at Minnesota, but I only got one, but when I came to Minnesota I think I really changed the culture. The way I changed it – in the medical school there was not a rotation, it was an elective, for the third year, and so not everyone was being exposed to psychiatry, and that was not good. So the dean also – they were doing a curriculum revision at the time I was being recruited, and he assured me that it would include a six-week rotation through psychiatry, so that was important. We also had, at that time, for residents, no affiliation with the VA Hospital. I don’t know how it got lost, I’m sure it was there before, I don’t remember.

DC: It was. [there before]

PC: I agreed to send our residents through the VA, because I wanted an affiliation with the VA, it wasn’t that far, and it had a good faculty, and they had a PET scanner, and it seemed to me that that was going to further research in psychiatry, and we needed to be familiar with the VA to get that done, so that was the second thing. And then the third thing I instigated was weekly grand rounds, because before that they had not. They had some meetings, but not weekly grand rounds.

The chairman before me was not an academic in the sense of the rest of us, the one before him, I mean. In that I was part of the academic culture of the United States and the world, so I could bring people in that he probably wouldn’t have been familiar with. So the idea was to bring people in to speak to the faculty, and for them to meet my faculty. I thought it was very important for these people, wherever they were from, to know what was going on at the University of Minnesota, to then highlight our researchers and clinicians. Then the second thing was to have an audience for the faculty to speak about their own research, and not only psychiatry, but medicine or surgery, whatever that might – because we did a lot of good consultation liaison service, and so we needed to know what was going on in bariatric surgery or whatever, so it was a way for them to come and for us to learn. And thirdly, we presented patients, and we would have a grand discussion about a single patient. I don’t even know if you could do that anymore.

DC: Currently, it’s more topic related.

PC: Those were my favorites. Because you would show a depressed patient who’s had all sorts of treatment and is still not well. So then, the whole faculty would discuss – not in front of the
patient – but would discuss the possibilities of the next step. Our residents usually had to present, so they learned how to organize a history and give a presentation, and then I usually interviewed the patient, and then we had this discussion. I thought it was a great learning experience for all of us, and it was something that was done at Washington U, so it wasn’t something I dreamed up, but I really felt that that was an important addition to the department. As far as my accomplishments there, I don’t know [laughter] …

DC: Tell us what you thought [chuckles].

PC: I think it was varied. It was a harder department to manage than Washington U because it was much more diverse. I was always taught that the way you learn is through redundancy. You hear the same thing more than once, and so at Washington U everybody sort of thought the same way, there wasn’t a lot of dispute, and so you learned very quickly a solid basis of psychiatry, but only that. At Minnesota it was much more eclectic. The department had a huge array of people with different trainings and different interests and so that made great clinical conferences, but sometimes it made decisions about progress more difficult.

The other thing I did which you were part of is start – again because it was at Washington U – a clinical faculty meeting, and you would help us decide on who should be appointed and promoted. Before that there was no – I’m sure there were clinical appointments, but there was no mechanism by which you could apply to become a member and be promoted, and the clinical faculty actually made up the rules. Dorothy Bernstein, because her husband [Irving Bernstein] had done it in Ob-Gyn, was the one that laid down the rules for appointment and promotion, and we had monthly or quarterly meetings, at that faculty, too. I think it brought the clinical faculty and the full-time academics closer together, too.

DC: There was a close-knit community then, and at these quarterly gatherings. I remember them.

PC: Then we’d have a dinner once a year for the entire faculty. The faculty was all over St. Paul and Minneapolis, so it was good to bring them in.

I saw patients, and I loved seeing patients in Minnesota. I miss that most now. I don’t have a license to practice in the state in New York, and that I miss most, because patients are so … I mean you learn so much from patients and they make you think about many different things. I think it enriches your life, so I miss that part.

DC: In that regard, psychotherapy, and your interest in that and where your emphasis related to that in Minnesota and in your own outlook.

PC: The best story is illustrated by the student who was first in my class at Washington U, and we started our rotations together, because I was a C and he was a B, and he got depressed. I actually was a little angry at him because the faculty kept asking him all the questions, and I thought they’re not asking me my share. But, it turns out they were trying to support him – he was depressed – and he dropped out, and he got all the new antidepressants that were on the market, including Tofranil [imipramine], and an MAOI inhibitor, all those things, and then he got ECT, and he was back in school and graduated with our class. But he had a serious
depression, I mean he was retarded beyond belief. So we learned to use Tofranil in the clinic in 1958. We used it on patients.

DC: It came in ’57, that’s one that was first out.

PC: Yes, and we used lithium early, too, because Dr. Winokur read about it in a thing, and he went down to the pharmacy and had them make lithium tablets, and I treated the first patient with lithium. He was an inpatient and he had been a private patient. He was a minister who was very manic, he started writing bad checks and all this other stuff, and his doctor, a very competent woman, gave him … there was always psychotherapy, and … I think she gave him two courses of ECT, and he didn’t get better, so she turned him over to the ward service, the non-fee paying group, and they made lithium tablets for him, and he got well. I was then in the outpatient clinic, and I was assigned to follow him when he was discharged from the hospital, so I did treat the first patient – and that would have been in ’62.

I was taught psychopharmacology early, but it was always … it worked, but they didn’t really believe it. My chairman still treated most depressives with psychotherapy and Sodium Amytal. We were taught a spectrum. The kind of bottom line at Washington U was you were agnostic. You doubted all therapies until they were proven to be efficacious. So, I’ve always done a combination of my own psychotherapy, which is probably most like CBT [Cognitive Behavioral Therapy]. There wasn’t CBT then, but it really is kind of – without the homework. [chuckles] I never gave patients … I gave them drugs and some kind of psychotherapy. I knew my patients’ lives and what went on in them, early on, while I was seeing them. It was very important to me, so I think I got to know my patients pretty well. So that’s important, I think. I don’t know how you teach that, though, that’s the problem. It’s individual, and unless you have somebody sitting with you – which I did, I mean we ran a depression clinic, and one of the current faculty members sat with me once a week for a year, doing a mood disorder clinic, and he’s now an expert, I think. Barry Rittberg, I think.

DC: Oh, yes, Barry’s …

PC: It’s hard to decide. Anyway, I stayed at Minnesota. It was difficult the first years because there was contention. I was expecting more of them than they had done in the past, been asked to do. But then, as I settled in it became fun. But I did something else. I raised money. That was the other thing I was taught, that you should try to enrich the department with chairs. When I came there was only one endowed chair at the University of Minnesota, and that was the one at the VA, the Paul … was it a …

DC: A neuroscience chair?

PC: No, no, he was a pediatrician. I don’t know his name. [Paul Quie] Anyway. I was fortunate enough to be there at the time when the Mayo Clinic decided it wanted to be private again. It was a state … it started, remember, as a state medical school They only had a graduate program, and then sometime in the ’60s or something they must have started a medical school, and then they decided they wanted to go back to being private, and the state decided that if they did that they’d have to pay them back the money they had given them to support the medical students. So, we
got a kind of windfall of money, and the president or the dean, I don’t know who, decided that in the departments in medicine, that if you raised an equal amount of money you could get that amount.

DC: Matching funds.

PC: Yes, matching funds. They gave us a million dollars and I raised another million, and we had our first endowed chair. And then, along the way, we raised money from a single person, paid over time, and we have a second endowed chair. And then the Bernsteins [Dorothy and Irving] decided that they wanted to endow chairs, and so they endowed two professorships, one in child psychiatry and one in adult psychiatry. And then there was another man who was always interested in training, and he left money to the department to pay a stipend of a resident for a year to do research.

DC: Harold Lawn?

PC: Yes, Harold Lawn. Harold would do little things along the way, but in the end when he died, his estate was left to the department, and it was ear-marked for a resident stipend. So I think that has enriched the department, too. The problem with me was that … I think you burn out [chuckles] and I think that by the time I’d raised the money for the second chair, I really felt — and these two chairs, the Bernsteins, because I hadn’t filled those either — that I couldn’t recruit for them. I’d been there nineteen years — eighteen years — by that time, and that was such a rich pool of money in addition to whatever a new chair would give, that the department would be better off with a new chair who could fill those positions and his own. I decided it was time to step down. I was in my 60s, then, mid-60s, so it seemed reasonable anyway. So then I retired to New Mexico.

DC: Santa Fe?

PC: Santa Fe, New Mexico. It was wonderful. I went there because of the opera and the good food and the beautiful skies, but mainly it was a highly artsy place, and close to my daughter, who lived in California, and her family. As my friend in Minnesota says — Sally Howard — says — You failed retirement, Paula, you just failed retirement. So, after two years of traveling, I then went back to work at the University of New Mexico. I first volunteered and then they hired me, and I worked half-time there.

And it was from that job that I was recruited to New York. When they asked me they did it by e-mail. They sent me an e-mail at the University of New Mexico, saying would you be interested in this job, and I thought — Oh, goodness, this suicide … you know that’s the outcome we all work to avoid, and especially when you do work on manic depressives and depressives, you really … you write papers on it. So I thought, that’s interesting, and I’ve always wanted to live in New York City for awhile, so I’ll apply, and I did. I asked the person I was living with and he said — “Sure, why not?” And I thought, oh, they’ll never take me, I’m too old. [laughter] I mean, it really was a gamble, on their part. So they then came and interviewed me in Santa Fe, to see if I was a reasonable candidate. I took them to an outdoor elegant little Santa Fe restaurant, and he thought that was very classy [chuckles]. I didn’t know that was important, but that’s what
happened. Then they asked me to come to New York, and I came a couple of times, and they offered me the job. I started in January of 2006, so I’m in my fifth year. [as Medical Director, American Foundation for Suicide Prevention]

Here, we are the only foundation that supports research in suicide, so we raise money, now mainly through contributions, through community walks – We had 250, and like 70,000 walkers this year, and through an overnight walk, when they start at sunset and walk through the night – Out of Darkness – and they’re usually people who have lost someone to suicide, and they have teams, and so our money comes from those kinds of events, and we then spend 40 percent of that money on either research or on education, and I’m in charge of that. I have a small department of four or five people, and we take in grants till December 1st. We get about 100 grants and we review them the way NIMH does, with two first reviewers, etc. I oversee all that. Because, as I’m sure you know, suicide is falling in adolescents and young adults and in elderly, but now the suicide rate is going up in middle-aged people, 46 to 64. But, a number of our grants are given to children, adolescents …

DC: Oh yes, tell us about that.

PC: You know David Brent, I’m sure you know him; he’s a child psychiatrist at Pittsburgh, has always been interested in bipolar illness and depression. He’s done a number of studies on suicide, and he, then, has a tier of people that we fund. His mentees and things like that. There’s another big suicide group at Columbia, and they are interested in borderline [personality] people who make both [suicide] gestures and attempts, and safety planning, and so we fund grants for them – but really all over the country. We fund some VA studies. We have a hard time getting into the Army, but [chuckles] they have their own system. We really fund both adult and child. Not as many geriatric studies, and some interventions, but the money we give is small enough that they can only sort of do feasibility studies. Can we get a set of patients in, like we did a study of policemen, and looking at their implicit thinking on death and suicide, and the numbers are small enough that you couldn’t publish a paper probably on it, but you could use that as a basis to get a larger grant, with appropriate controls, at NIH. So that’s sort of the way we work that [providing seed money].

DC: Now, as you look at your life and think – would you do anything different? What would you do over or how happy are you, how have things been?

PC: I think the happiest part of my academic life – and having kids and raising a family, that was a great addition to a life – was when I was doing research. It was most fun to think of studies and to carry them out and to then write the results and speak about it. The hardest part was being a chairperson, because you never knew what would happen that day. You’d come to work and some wonderful thing would happen, or some terrible thing would happen. You have all levels of employees, and so that was the hardest part. I thought for awhile that if I had to do it over I probably wouldn’t be a chairperson, but I think now as I’m older I think it was the right thing to do. Plus, it was just hard going from St. Louis, which is a very different city, to Minneapolis-St. Paul, and I think it took me five years to really feel at home in Minneapolis-St. Paul. I mean, it was a private school that I went to and worked for, and this was a public school, and there are just a lot of different things.
The thing I would do different is I would retire in a different way. I would actually probably stay – I loved my house in Minneapolis, too, and I probably would stay there and work part-time for a few years before I decided to move permanently someplace else. Maybe I would have stayed in Minneapolis forever, I mean I might not have moved, but I’m not sure why I felt I had to get out. One of the chairmen in Minnesota was a dermatologist, quite a distinguished man, and we had a good relationship because he had a lot of patients that had delusional parasites – what is that called? He would send them to me. He retired, and he actually went to San Diego and got on the faculty there and taught there. So he left the city completely, and the Bernsteins, of course, did that, too. They spent a lot of time in San Diego. So I think that I used that as my model, and I probably didn’t have other models of retirement at the time, and I think, in retrospect, looking at how other people have done in their retirement, I think it’s easier if you stay where you are and just give up the leadership, which is easy to do [chuckles], and then just teach and see patients. And maybe go back to doing research. That, I would have done differently. What about you?

DC: Oh, well, I’m still working pretty regularly, and there’s plenty for me to do when I do retire, but I really enjoy my practice and I like being busy and doing a lot of things, so as long as strength holds up and energy holds up, I’ll probably continue to do this.

PC: I think personally that taking this job in New York City is the best anti-Alzheimer’s thing I’ve done. [chuckles] It was a challenge to move to New York City and learn the subway system, I mean there were so many new things to learn. I advise people to take on those big challenges as they get older.

DC: Stay with it, stay in it. Remain a player.

PC: Right.

DC: Well, I hope you remain a player for many years to come.

PC: I don’t think I shall [laughter]. It’s been a great experience. People say – How did you feel about your mother deciding … I said, I really feel that that was an advantage. I really didn’t ever think about doing anything else, and that’s what made life so simple. [laughter]

DC: Yes, you did what your mother wanted you to do.

Thank you, very much.

[End of interview]