INTERVIEWS WITH SUICIDOLOGISTS

John Connolly & David Lester

In the 1990s and early 2000s, John Connolly interviewed a number of those working in the field of suicidology about their professional and personal life. An effort has been made since then to obtain transcripts of the interviews, after which David Lester has edited them. They were then returned to those interviewed to be edited and approved by them.

The process has been long and laborious. The recordings have not always been clear enough for transcripts to be made, David has been slow in working with the transcripts, and those interviewed have not always edited their interviews in a timely fashion!

But we are making progress, and we are working on more.

The following are those interviews that have been finished to date (August, 2011).

Alan Apter
Alan Berman
Unni Bill-Brahe
Diego De Leo
Robert Goldney
Kees van Heeringen
Ronald Maris

We hope you find them of interest.

John Connolly
David Lester

INTERVIEW WITH ALAN APTER

Dr. John Connolly: Let us start with your background and your early years. Where were you born?

Professor Alan Apter: I was born in South Africa. I stayed there until I finished Medical School, and then I did my internship in a hospital in Tel Aviv.

Dr. Connolly: Tell me about your family and your early years in South Africa.

Prof. Apter: My father was a doctor, who later became a psychiatrist. My mother was a psychologist, so I had a family background in mental health. Growing up in South Africa at that time was problematic because of apartheid.

Dr. Connolly: What years are we talking about?

Prof. Apter: I was born in l946, and I graduated in medicine in 1968.

Dr. Connolly: So growing up was problematic in South Africa at the time?

Prof. Apter: There was a lot of trouble and, as a minority, it was uncomfortable.

Dr. Connolly: You didn't, as some children do, take it as normal?

Prof. Apter: Not really. I always felt uncomfortable.

Dr. Connolly: And that left a lasting impression?

Prof. Apter: I felt that I would like to live somewhere where I would feel more at home, with a feeling of belonging. There were times when it was not easy because, living in a racist country, there was also quite a great deal of anti-semitism. But generally life was very good, although I always felt that I would not stay there and, if I could, I would leave. So that is what I did.

Dr. Connolly: Do you have brothers and sisters?

Prof. Apter: Yes. My brother is also a psychiatrist. He is in Princeton, New Jersey, and my sister is a psychologist in Israel.

Dr. Connolly: So you followed in the family footsteps. You didn't feel like rebelling and going on to something quite different?

Prof. Apter: No.

Dr. Connolly: Why were you attracted to psychiatry.

Prof. Apter: I always felt it was the most interesting field of medicine, and I was always very interested in medicine.

Dr. Connolly: You have always struck me as a very spiritual and contemplative person. Perhaps you could elaborate on what part religion has played in your life.

Prof. Apter: Religion as such does not play a very strong part in my life. My wife is very religious, but I am not.

Dr. Connolly: Your religion would be more secular?

Prof. Apter: I have always been very involved in Zionism, which is a secular idea

Dr. Connolly: Were you a devout family?

Prof. Apter: Not really. We attended a synagogue, but I was involved with the Zionist Youth Group.

Dr. Connolly: Tell me about that.

Prof. Apter: It was a very active movement of people who were interested in supporting Israel, supporting the Jewish homeland and finding a place for Jews to live. I was very involved in that ideologically for many years from a very early age. Most of my extra-curricular activities were with the Zionist Youth Group

Dr. Connolly: That is very interesting because I have recently been reading a biography of Isiah Berlin who was Jewish and Russian and on the borders of Zionism all the time, but not really fully committed, and who was very approving of the Jewish state when it emerged. What led you to more active Zionism?

Prof. Apter: It could be very difficult for somebody who was Jewish to assimilate in South Africa because the ethnic groups were very strongly demarcated. As a result, many of my generation emigrated. They didn't stay.

Dr. Connolly: To all over the world?

Prof. Apter: All over the world.

Dr. Connolly: Tell me more about your early background. What kind of reading did you like? What made an impression on you?

Prof. Apter: I was very much influenced by the British tradition in reading, and I was very interested in Victorian novels -- Jane Austin, Charles Dickens. I liked P. G. Woodhouse very much, novels with a clinical psychological interest, and history. I have always been interested in history.

Dr. Connolly: Reading, of course, is very important in the formative years. Was there any book that stands out in your mind that you might say, “It changed my life”?

Prof. Apter: No. I couldn’t say that.

Dr. Connolly: Was music important in your developmental years?

Prof. Apter: Yes, I was interested in music. Now I am very interested opera. The opera in Tel Aviv is very good.

Dr. Connolly: Have you any musical talents at all?

Prof. Apter: No, unfortunately.

Dr. Connolly: Do you play any musical instruments?

Prof. Apter: No. I tried. Of course my children do.

Dr. Connolly: What are your other recreations?

Prof. Apter: I am very fond of sport, and I played a lot while in medical school, especially rugby. I was very involved in that, and it was great. I still play a lot sport. I played a lot of rugby until recently, far longer than I should have. I play a lot of tennis. I spend a lot of time at sport and reading.

Dr. Connolly: Were you good?

Prof. Apter: I was on a university team, and that was quite a distinction. I was also on some of the youth provincial teams.

Dr. Connolly: How many children do you have?

Prof. Apter: I have three.

Dr. Connolly: Are any of them following in your footsteps?

Prof. Apter: No. My son is at university, doing computer engineering. My other son has just finished his military service and he hasn’t really decided what he wants to do, although strangely enough he has just become very interested in Ireland. He spent two months in

Belfast with me at a conference. He has not really decided what he is going to do. I have a daughter who is doing her military service, and I don't know what she wants to do. It looks like the family tradition of mental health is not going to continue. My wife is a radiologist.

Dr. Connolly: Were your medical school years in South Africa enjoyable?

Prof. Apter: They were very enjoyable. Medical training in South Africa is very practical and very interesting. I enjoyed the hands-on approach that they have there, and there was an opportunity to do a lot of volunteer work in the townships. So I enjoyed my years in medical school very much, although it was a very hard, strict, disciplinarian approach to medicine in those days.

Dr. Connolly: Were there any teachers in medical school that impressed you?

Prof. Apter: I formed a very close relationship with a professor of psychiatry. He was very inspiring. I worked with him a lot. I did some research with him, even while I was a medical student. The first paper I published was co-authored with him on the topic of personality and peptic ulcer.

Dr. Connolly: Apartheid must have caused problems. The mentally ill who weren't the right color were probably stigmatised.

Prof. Apter: Correct. But psychiatry in general in South Africa never had a very high profile and, of all the specialities, I think it was the least acceptable.

Dr. Connolly: Was medical treatment the same for all races?

Prof. Apter: No. The South African white patients were fairly well treated, but not black patients.

Dr. Connolly: You qualified in South Africa, and then you went to Tel Aviv for your internship. Was your interest in Zionism shared by your family or was it unique to you?

Prof. Apter: No. It was a personal thing.

Dr. Connolly: Do you still have relatives in South Africa.

Prof. Apter: Yes I do, but my parents have come to Israel.

Dr. Connolly: Do you ever go back there?

Prof. Apter: No. I haven't been back there in fifteen years.

Dr. Connolly: Was coming to Tel Aviv a culture shock for you?

Prof. Apter: No, not really, because I had been very involved in the Zionist Youth Movement, and I went with a group of doctors from my youth group. My mistake was in staying with one of my brothers, but in general I enjoyed the internship very much. It took a little time getting used to the medical practices in Israel.

Dr. Connolly: Having finished your internship, you went into psychiatric training?

Prof. Apter: No. I was in the military for four years. Initially I was in a battalion artillery unit for about a year and then in an infantry unit for another two years. I was very unlucky because after three years, when I was supposed to be discharged, the Yom Kipper war broke out. I had to spend another year there. I spent four years in the military.

Dr. Connolly: Did military life appeal to you?

Prof. Apter: Not very much. Being a military doctor can be very stressful, and of course there are a lot of jobs that you have to do that were not very interesting. When I was there initially there was a period of what was called the War of Attrition. Then I was at the Suez Canal for a long time, and that was very difficult. Later on, the Yom Kipper War was quite stressful. I saw quite a lot of action.

Dr. Connolly: You had friends who were killed in the war?

Prof. Apter: Sure. From my unit.

Dr. Connolly: That is very disheartening.

Prof. Apter: I also saw a lot of psychiatric casualties.

Dr. Connolly: Did that keep your interest in psychiatry alive?

Prof. Apter: Yes. A lot of the work in the Army is mental health oriented. There is some public health work and occasionally trauma, but it was mainly mental health work.

Dr. Connolly: So you continued with your interest in psychiatry in the military.

Prof. Apter: I didn’t have much of a choice.

Dr. Connolly: What did you do after military service?

Prof Apter: I started my residency in Tel Aviv. I spent three years doing general psychiatry, and I enjoyed it very much. Then I went to the United States where I worked at the National Institute of Mental Health and the National Children’s Hospital in Washington, DC,

where I did my child psychiatry residency. I was there for two years and had some very good teachers.

Dr. Connolly: Tell me about that.

Prof. Apter: The person who had a great deal of influence was Joseph Noshpitz who was a very well-known child psychiatrist in Washington. He was a very thoughtful person and inspiring. The program at the Children's Hospital was very good. There was a lot of supervision.

Dr. Connolly: Did you have a personal analysis?

Prof. Apter: Not formally, although I was in psychodynamic therapy for quite a long time. Washington in those days was the center of the psychodynamic movement. It was very stimulating, but at the same time I was part-time at the National Institute of Mental Health. I was influenced by Dr. Eliot Gershon who was a geneticist. Those have been my two interests -- genetics and psychodynamics -- which are very different. I have tried to keep a foot in both camps, which in a way has been bad since I'm not a great expert on either.

Dr. Connolly: Maybe we need people who are going to bridge the gaps and achieve a synthesis.

Prof. Apter: I tried in some ways to make sense and integrate the more empirical forms of psychiatry and psychodynamics and to bring them together. Much of my research has been trying to encourage psychodynamic research.

Dr. Connolly: You have done a lot of research in almost all aspects of psychiatry, haven't you? Where did this drive to conduct research come from?

Prof. Apter: I am not sure. I think being at the National Institute of Mental Health helped. I was always very interested in having an academic career and very interested in the two fields that I have mentioned. I had a drive to understand and to get psychiatry to be more evidenced-based. I always felt that, although psychiatry was interesting, a lot of what we were doing was unproven and perhaps wrong. Most of my work has been with adolescents, and I was often worried that we were doing little except talk to the patients. One of the first studies I did was on suicide. I had the feeling that we were doing very well with our anorexic patients in our unit. I did a follow-up to see what had happened to these patients three or four years later, and I found that a substantial number had committed suicide even though they had gained weight. This showed that research is very important, and you cannot conclude that you are doing well if you don't critically evaluate what you are doing.

Dr. Connolly: That was in the early days, and of course research has become much more sophisticated.

Prof. Apter: A little later I was very fortunate to have two teachers who had a great deal of influence on my life. One was Professor van Praag from Holland who came to Israel for a time. I was very impressed by the work that he was doing in the field of suicide research. When he went to New York to work at Albert Einstein College of Medicine, I decided to go there for a fellowship in biological psychiatry, which I did in l988-1989. While I was there, I met Professor Donald Cohen of the Yale Child Study Center. Those two people had a tremendous effect on my work, and they really helped me to get my academic career on track. Living in a small country like Israel, it is very important to have collaborations with people overseas, and so Professor van Praag and Professor Cohen gave me a lot of support and encouragement. The third person was more of a friend than a colleague, with his first-class research on suicide, was David Brent from Pittsburgh. Through becoming religious, he became very interested in Israel, and since then he has been helping me to set up our research on the situation in Israel. Working with these three people, we were able to do a lot which we wouldn't have been able to accomplish ordinarily in a small country.

Dr. Connolly: Tell me about your fellowship. What was your thesis?

Prof. Apter: My main interest in the fellowship was the relationship between the different psychological dimensions related to the dysfunction of serotonin metabolism, and one of the major threads of dimensional theory is that the nosological categories are somewhat artificial. They don't correspond to biological findings, and there are certain psychological dimensions that cut across nosological boundaries and that are much more important biologically. For instance, anxiety is related to disturbed serotonin metabolism, depression is related to a disturbed serotonin metabolism, anger and violence are related to a disturbed serotonin metabolism and suicidal behavior, or at least a certain type of suicidal behavior, is related to serotonin metabolism.

Dr. Connolly: Serotonin is a transmitter for all seasons!

Prof. Apter: That's right. My main work was looking at the relationships between anxiety, violence, suicide, and depression. That is what I did at the Albert Einstein College of Medicine, where I also worked with another very important psychologist, Robert Plutchik, who had a very strong influence on my career. One of the things that became very apparent while I was at Albert Einstein was that, while there had been advances in biology, one of the main hindrances to the advancement of biology is that we hadn't been able to define the phenomenology, or what we actually are measuring. That's the reason why there are so many contradictory results.

Dr. Connolly: It is far clearer now than it was when I started. How many years did you spend there?

Prof. Apter: I was there for two years, and then I came back to Israel and, with the encouragement of Donald Cohen of Yale University, started working seriously on research based on my military reserve experiences in Israel, which involved clinical psychological autopsies on soldiers who had committed suicide. In Israel, the army is very central to the life of the country, and at eighteen every boy and every girl has to spend some time doing military service -- three years for boys and two years for girls. It is a period of stress and a period where availability of firearms is unlimited. The suicides are taken very seriously. Every suicide is regarded as a tragedy and is investigated thoroughly. What seemed to me to be tragic, and what I became very interested in, was that many of the suicides were very successful and talented young people, which was contrary to what was being reported in other parts of the world, where the association was with alcohol and drugs, unemployment and problematic family situations. I became very interested in those people who committed suicide who didn't come from that kind of background and whose deaths were sudden and unexpected. Together with Donald Cohen, I published a paper in 1993 called "Death without warning." The reason it was called "Death without Warning" was because these were people who should not have killed themselves. It turned out that these people were set standards that were impossible to meet and were not able to share their feelings. I became very interested in the relationship between shame and suicide because, in a military situation, shame is worse than death. In fact, it is the motto of the Northern Command where I spent much time that it is better to die than to do something shameful, which of course is a problematical dilemma.

Dr. Connolly: There is not a great deal of work published on shame and suicide, is there?

Prof. Apter: No, but I was interested in the subject, which might even have biological connotations. I became very interested in another phenomenon involving suicide attempts, where some people are prepared to ask for help, whereas the very superior soldier, if he is suffering from depression and stress, really doesn't have a way out. That has always been a particular interest of mine -- the kind of suicide where the biology is probably less important as opposed to the impulsive, drug and alcohol-related suicide where impulsivity and problems with serotonin metabolism are relevant.

Dr. Connolly: You have done a lot of work on that?

Prof. Apter: Currently I am looking at both successful suicides, where I think culture is important, and then at the people that I investigated together with David Brent, mostly impulsive, violence-related suicides. John Mann is also interested in this subject. There is a vague notion of instability and impulsivity in the central nervous system which may be related to decreased activity of serotonin metabolism and which allows these people to become very upset at what most people would think were minor stressors. People like that become very anxious and very frightened, and such people can become very impulsive. This leads them to abuse drugs and alcohol and, being impulsive, they tend also to make suicide attempts. Some of them kill themselves, especially when alcohol and

drugs are involved and when they have access to lethal methods of suicide. This kind of suicide seems to be related, as I said, to serotonin metabolism and seems to have quite a substantial genetic component. Originally some of this work stemmed from work on the Amish population who have a predisposition to bipolar affective disorder. In only one subgroup was suicide an issue, and many of these families showed violent behavior.

Another factor is that many suicide victims come from families that are very abusive and violent. This was always regarded as being a psychosocial factor, but David Brent, among others, noted a genetic component independent of some of the psychosocial risks and of the psychopathology that is related to impulsive violence. There is a lot of evidence relating this to serotonin metabolism. In Israel, we could not do lumbar puncture studies because of ethical considerations. Of course, now we do have the ability to look at the structure of the genes for serotonin and their polymorphisms. Although the genes are in general the same, there are some differences in the immunoassays. A race started to look for certain genes that are different in suicide victims, and the first polymorphism was related to TPH. Unfortunately, most of our results up to now have been negative, and we have to see whether the increase in technology and the ability to do whole gene scans will help. Perhaps then the results will be better, and we will be able to find something more specific.

At the moment I think the verdict is that we have not really found anything that I could swear to as a positive finding. Most of our findings have been negative. Another very interesting study that I am doing with David Brent is on a Bedouin family in a village in Northern Israel. It is a very interesting village with just three families. Each family has about 1,000 to 1,500 people. One of the tragedies of many Arab populations in Israel is that they believe very strongly in inbreeding, and they are only allowed to marry within the family. This causes a lot of genetic problems, like deafness and mental retardation. In this particular tribe, one family is very much afflicted by suicide and violence whereas the other two families are not. I was approached by one of the leaders of the village, the principal of the High School, Mohammed Al-Heib, to investigate this, and David agreed to help me. It is interesting, of course, that there are also cultural issues involved.

Dr. Connolly: What else are you involved in?

Prof. Apter: One of the studies that we have done, together with Dr. van Praag, on violence in suicide is a study on murders in Connecticut –- on the relationship between murder and suicide. Recently another interest of mine has been the relationship between certain psychiatric illnesses in adolescence and suicide and depression. My main clinical responsibility over the last twenty years has been running an inpatient adolescent unit. I have been struck by how depressed and suicidal these patients are. I felt that this was a different phenomenon -- that they were demoralised by their psychiatric illness. Another topic that I have been very interested in is the relationship between anorexia and suicide. I found that these kids suffered tremendously from this terrible illness. They had this tremendous desire to be thin and were not allowed to be remain thin by the society. Many of them took their lives. But also all the other psychiatric illnesses of adolescence such as

schizophrenia are related to suicide, and so another interest of mine has been the relationship between depression and suicide and psychiatric illness.

Dr. Connolly: We often hear that young people take their own lives at a high rate.

Prof. Apter: That is one of the studies that we are doing at the moment, looking at the relationship between insight into psychiatric illness and suicide. Young schizophrenic people with a good prognosis are most likely to kill themselves.

There are a lot of conceptual problems in investigating suicide in young people. Wherever you look, there are problems with definition. We don't really know where the line is between self-destructive behaviour and suicide. If you work with adolescents, one of the things that you become aware of is how hell-bent on destroying their lives. The more you help them, the more angry they are with you. One of the things that was very difficult for me was that I would work very hard and be very good to the patients but, instead of thanking me, they were very angry with me for keeping them alive or for stopping them from destroying their lives. The other thing that is very interesting is the interest that adolescents have in suicide. It is remarkable, if you listen to adolescents, to see how much suicide is on their minds.

We do surveys that ask questions about the extent to which they think about suicide. The definitions are very important. It seems that suicidal behaviour in different populations can be very different. I have had the opportunity of studying suicide in very different situations. Suicidal adolescents are very different from suicidal soldiers, and these are very different from the people I see in emergency rooms. (I have been doing a study with the WHO monitoring group on those who come to the emergency room after a suicide attempt.) You have this tremendously interesting question of why does one person attempt suicide while another kills himself. The relationship between those two behaviors is very difficult to understand. Of course, a very interesting phenomenon is why children do not commit suicide, yet they like living dangerously such as driving fast or hang-gliding. We had a problem in the army with Russian roulette, and a classification of this behavior is very difficult. It is very interesting in child psychiatry, when you are doing assessments of suicide, that you can't use the same method for a 6-year-old child and a 16-year-old adolescent. Another very interesting aspect of doing research with children is that you get one story from the child, one story from the father, one story from the mother, one from the teacher and one from a friend, and then you have to make a diagnosis. If you do a study with mothers, the teachers or the children themselves, you can get very different results, and that is very confusing.

Dr. Connolly: Are you involved with the International Academy of Suicide Research?

Prof. Apter: Not really. I am not a member of the Academy. I have recently applied, but my membership has not been confirmed. I have only just started to become interested in suicide. Most of my efforts have been in child and adolescent psychiatric organisations, but when I was invited to take part in the WHO study, I met people from different countries. That was my first suicide research, and very important for me in terms of entry

into Europe. Through them I became interested in organisations, such as the European Symposium on Suicide. I have also become involved in the American Suicide Prevention Foundation, beginning when I studied in New York. We established a branch of that organisation in Israel devoted almost entirely to survivor groups, and now we now have six groups in Israel. It has been very rewarding working with survivors, but the research interest is still paramount.

Dr. Connolly: You mentioned ethical issues earlier. There are a lot of ethical issues in this field. You mentioned one concerning lumbar punctures in Israel, and I was not aware of that. Looking at the larger ethical problems -- euthanasia and assisted suicide -- what are your views on that particular area.

Prof. Apter: Well, one thing perhaps I should have mentioned in my biography was that I changed my job two months ago. I left my work with adolescent psychiatric inpatients and have moved to a Childrens Hospital. While working with adolescents in a psychiatric hospital, I was sheltered from the assisted-suicide issue. Now working in a children's hospital it has become more real for me. In general, I would be very much against it, but it is only now in the last two months, since I have been exposed to several patients with terrible suffering, that these issues have come up. I think in a couple of years time I would be able to give you a better answer. Of course there are a lot of ethical issues in research, especially in genetic research. One method of doing genetic research is using the parents as a comparison group, and sometimes you can find things, such as that the father is not really the father. Using people's genes for DNA research, storing them for example, raises ethical problems. One of the techniques that we are using is immortalising cells, so that we can keep somebody's DNA alive forever! That raises grave ethical issues.

INTERVIEW WITH ALAN BERMAN

Dr. John Connolly: I would like to start by exploring your early life. You were born in the United States?

Dr. Alan Berman: I was born in Cambridge, Massachusetts, the home of Harvard University and the Massachusetts Institute of Technology, two of our finer Universities. I wasn't born at a university. I was born in a hospital, as most of us should be. At the time, my family lived in a city named Malden, which was named after a town on the East Coast of England, Maldon. It was one of the earliest settlements in Massachusetts, settled by the pilgrims in 1640. I am the youngest of three children, all males. I believe I was an accidental baby, although it has never been confirmed by anyone in my family. My middle brother was seven years older than me and, at the time I was born (in l943), my father was in the U.S. Coastguard during World War Two. He didn't go overseas, but I have the sense that I was an unintended child. That has not particularly affected me, as far as I know, but there I was with brothers who were eleven and seven years older than me, so that in growing up I barely knew my oldest brother. My first memories are at the age of five or six, and he was seventeen and ready to go off to college. Before too long, my middle brother also went off to college, and so I was raised more or less as an only child.

Dr. Connolly: What has been your relationship with your siblings since then?

Dr. Berman: My middle brother was the 'black sheep' of the family. My oldest brother became a physician and, having done the "right thing" according to my parents by going to medical school, he was the adored child. My middle brother, who was not academically successful, was the best athlete of the three of us, but that wasn't valued by my parents. I was closest to him in age and in growing up and had some interactions with him at the age of eleven or twelve when I started developing my athletic skills. I was closer to him at that point. He then went off to college, and he got involved with sports betting during college. He was involved in gambling for the rest of his life. He died in a motor vehicle accident in 1994 at the age of fifty eight, younger than I now am. There were a lot of questions about how this death occurred. He had stopped gambling (he had been involved in Gamblers Anonymous), but he was clearly the child who had the most significant overt problems of the three of us. By that time, I was closer to my older brother, because I was a professional and he was a professional, and we shared much more than I ever truly shared with my middle brother, except for sports.

Dr. Connolly: What about your parents?

Dr. Berman: My parents were an interesting story. My grandparents on my father's side were immigrants from Russia and on my mother's side from Poland. My parents were both born in the United States, first-generation Americans. My father was very bright. He went to the Massachusetts Institute of Technology, which is an engineering school, one of two or three top engineering schools in the country. He then went to Harvard Law School and

that was about as good as it gets. But at the end of his first year in Law School he dropped out and went to work in his father's store. My grandfather sold women's-wear -- gloves, hosiery and handbags. This was 1932 or so, the Depression Era. I understood that this was expected -- the family had to make money, and he was needed in the store. He was the oldest son, the only male of the three kids. His father said, "Come and work for me," and he spent the next fifty years of his life unhappily working as a businessman in a small store. My mother was also very bright but became a housewife at a young age. I believe she was married at eighteen and never went back to school. She became a homemaker and created a social life for the family. But she stopped using her brain. My father was always the one who pushed and accentuated intellectual activities while she did not. I was much closer to him growing up as a result of that. So, in effect, because my mother was not as important to me, I grew up in an all-male household. She wasn't the ideal mother. She was better at presenting her children socially than she was in praising, acknowledging and reinforcing her kids. She didn't create a very close bond with us.

Dr. Connolly: What about your early school years?

Dr. Berman: They were uneventful. I was a good student. I did the right thing. I was a student athlete from early on. I played baseball a lot. My house was located about fifty meters from a playground which had a baseball field, tennis courts and an activity area (a Jungle Jim apparatus). So, as I was sort of an only child, I spent most of my weekends going to the field, meeting up with neighborhood kids and playing baseball, much as European kids play football. I would go and bring my baseball glove, and we would play baseball all weekend. That is my fondest memory and the memory of greatest clarity growing up. In the same way, going out to play a round of golf is important to me today.

Dr. Connolly: Tell me about the intellectual climate in your family - reading, music and so on?

Dr. Berman: That is an interesting question. They didn't stress reading, and I don't have recollections of doing a lot of reading as a child. I'm sure I did, but it is not as if I spent hours engrossed in books. My father stressed intellectual life in terms of academics. It was very important that you did well in school. It was very important that his children become professionals, which is why my middle brother was the black sheep -- because he didn't become a professional. My middle brother was the most gifted athletically. He was also the most gifted musically -- he had a great singing voice, and he played the piano and won competitions, but that wasn't valued. What was valued was that you performed well in school, you went to college, you graduated and you went to graduate school, be it medical school, law school or whatever. That's what was valued. He would also stress intellectual thinking. I focus much more on hypothesizing. I think it is fascinating to think about certain things and to get people to discuss the various possibilities in trying to answer a question. That is more interesting to me than whatever the final answer might be. And that is the sort of style he created. He also clearly emphasized hard work in his own behavior. Your role and responsibility is to produce for your family, to work hard and to be the best you can - that was his model.

Dr. Connolly: What about religion?

Dr. Berman: It was a non-religious family. We were Jewish, but we didn't go to services. Once a year my mother might go, but my father had no interest. I grew up in a working-class suburb of Boston. I didn't know any Jewish children until high school. I grew up in an entirely Irish neighborhood. It was six blocks from an Italian neighborhood, and the Irish and the Italians didn't talk to each other. They were pretty much always at war, except on the baseball field. Everybody was equal on the baseball field. But we were the only Jewish family in the Irish neighborhood for ten years, so my best friends were Irish. It was wonderful.

Dr. Connolly: You had no experience of anti-Semitism?

Dr. Berman: No. Not an ounce. I did in high school when I realised that the Protestants and the Catholics were at war. I went to a party, probably during my junior or senior year in high school, where a mother came up to me and said something like "We have a Jewish family coming to visit for the weekend. What do Jewish people like to do?" What do Jewish people like to do? They like to breathe and eat. It was the first time anybody had communicated to me that they thought differently about cultures. It had never occurred to me before. In high school, I was on the basketball team, I was on the tennis team, and I played golf. On the ballfield everybody was equal, and I never had a sense of anybody being above or below anyone or of being looked at or thought of differently.

Dr. Connolly: What religious sensibility do you have now?

Dr. Berman: I don't have a religious sensibility, and I don't have a sense of religion being important to me. I understand its importance to other people. Spirituality is important to me. I think it is important to have a sense of belief in something, but I don't believe in a God. To me it is magical thinking, and I am too much of a realist. At the same time, every so often I will pray, and that that is hypocritical. So there must be some part of me that believes in something. I just don't know what it is. But it was never stressed in my family; it was just not an issue. I went to Catholic mass more growing up than I ever went to a temple, just because I was with my friends. My best friend was an altar boy, and I would watch him do his stuff. He went to a Catholic high school, and he was beaten by the Brothers. And so I never had a particularly positive feeling about any religion. It was just what they did. He is a-religious now. My culture was really not one where religion made a difference to me or to anybody that I was involved with.

Dr. Connolly: But you have a very strong moral sense, a sense of spiritual values?

Dr. Berman: I think so, but I don't know where I got them.

Dr. Connolly: What are your values?

Dr. Berman: I think it is important to give back. I think it is important that, if you have something that is working for you in your life and you have been successful in one or another way, it is important to find some way to equalize the playing field by giving freely of yourself. I have a strong sense of helping my fellow man, whatever that means. I don't know if I have a strong moral system in terms of right or wrong. I know the difference, and I don't believe in doing wrong versus doing right, but I'm not a do-gooder in the sense that one should always do the right thing. Sometimes you have to make a tough choice, and it may not be the right thing, but it is ethical.

Dr. Connolly: You went to high school, graduated and went on to university.

Dr. Berman: My father came home during my junior year of high school. He was in a family business. It was a small business. At one point he had three or four small stores. Eventually, it was one store, and it was in a lower-class community close to Boston. As suburban development increased, there was a community of shoppers that began to go out of the city to the shopping malls. The inner city stores weren't making much money, so our family never had a lot of money. He said I had to go to school in the Boston area and commute because he was going to pay my tuition. That was a Jewish moral stance for a parent - we owe our children education. He firmly believed that, but he didn't have a lot of money. The way he could save money was by not having to pay for my living expenses if I had to live on campus. To make a long story short, he came home one night, and he said, "I've learned there is school in Baltimore [which was 400 miles away]. If you get in, you can go to medical school directly from your undergraduate experience in seven years instead of eight." So instead of four and four, it was called the 2/5 program – you would go to undergraduate school for two years, and at the end of your second year in college, you would go directly to medical school, finishing off your undergraduate work, but compressing eight years into seven years. That saved him a years worth of tuition, and he strongly advised that I apply. He wanted me to go to medical school. I didn't know what I wanted to do, but I said, "Fine." From my perspective, it was the only way for me to live away from home. My oldest brother went to school two miles from my house. My middle brother went to school in Boston, four miles from my house. So this was my chance to establish my own identity.

I was admitted into this undergraduate program which was at the Johns Hopkins University, a wonderful all-male school [at the time], small and very intense. Johns Hopkins is a very scientifically-oriented school, and I took two chemistry courses in my first year in college and physics in my second year. I knew somewhere during my second year that what I loved was hypothesis raising. I loved questions. I loved observing. I loved collecting data. I loved the idea of research. I had no strong interest in biological science. I was doing fine academically, but I knew that to go to medical school I had to be interested in organic chemistry. These were just not the things that truly excited me.

Because I had no money, my father sent me $15 a week for living expenses, and that allowed me to eat but not much else. I couldn't even go to a movie. So I got part-time jobs. In my second year as an undergraduate I got a job on campus working for a

professor of social relations, a sociology professor, who had a federal grant to study high schools around the country to look at what influenced academic behavior beyond good teachers. The grant focussed on the influence of a peer group, the influence of social factors other than family and the academic milieu of the high school. I then spent the next 2½ years travelling around the United States while I was an undergraduate doing the things that one does when conducting research at that level. I was administering questionnaires; I was computer-scoring questionnaires; I was chauffeuring people that I travelled with to about fifteen different cities. We went to fifteen different high schools, and we collected data on thousands of subjects. Fascinating stuff.

Therefore, I got very interested in social science research, but I had no interest in sociology. I was much more interested in my psychology courses. So now I was not interested in going to medical school. I was interested in psychology, and I was turned on to doing research. That made for a pretty good mix, and it seemed that I should go into mental health and become a researcher. The complexity of this became clear as I was about to graduate. I hadn't thought about what to do after I graduated, other than the fact that this was the Vietnam-era in the United States which meant that I was going to war. The only way to avoid going to Vietnam was to stay in school. If you had a medical disability, you could stay out, but I didn't. So I had to figure out how I was going to stay in school. With about three weeks to go before deadlines were reached, I applied to graduate school in psychology, and I got in. Therein lies the beginning of a career. It was not so much a reasoned decision as simply avoiding going to war.

Dr. Connolly: What was your family's general attitude towards the Vietnam war?

Dr. Berman: We were Liberal Democrats, which meant that we were antagonistic towards the idea of that war, pretty much pacifists in general and not pro-war. This was an era where, if you were liberal, you protested. I was involved in demonstrations in college that the war was amoral. I didn't do a lot of drugs in those days, although I did smoke pot.

Dr. Connolly: You inhaled?

Dr. Berman: I inhaled. I didn't love it, but then it was like having a drink. I wasn't a hippie, but I was on that side of the ledger where, if there was a social cause, you demonstrated. When I was in college I was chairman of a group that was responsible for bringing musical acts to the campus. I had the opportunity to bring jazz performers and classical performers, but most of the people I brought in were folk singers because that was an era when, if you were liberal and a war protester, you liked folk singers.

Dr. Connolly: Where did you study psychology?

Dr. Berman: Catholic University. I went back to a Catholic school which was in Washington, DC. I did that because they gave me money. I had a Veterans Administration grant, which basically paid my tuition. I went immediately to work in the mental hygiene clinic

of an inpatient unit of a VA hospital. I spent four years of graduate school working in hospital settings.

Dr. Connolly: That didn't attract you back to medicine?

Dr. Berman: There were moments when I thought about it, but I liked what I was doing. I think I was mindless. I was young, and I didn't take time off between college and graduate school. You kept going, and I was interested in most of the things I was learning. I was doing well at it. I knew during graduate school that it wouldn't take a lot to be a star in whatever I was doing. Looking at the competition, I could tell that there were clearly two or three people that were far better than I was. I always thought of myself as an A-/B+ student. I could hold my own against most people, and I was streetwise. At the age of twelve, I would ride the subway system in Boston and go from here to way-over-there on my own when most kids would never be allowed to do that. I would just get on the train and go and explore. I knew that I trusted myself well enough that I could function in almost any environment, and I could manage. I knew that when I was in graduate school, and it didn't take more than a few years of being in the working world to see that I could establish an identity and do some fun work. I could soon be one of a very small group of people who were in the field, and I have always gravitated to that.

Dr. Connolly: Which teachers impressed you during your under-graduate years?

Dr. Berman: The sociology professor was most profound, and he was a bright, young research-oriented professor who stimulated me to a lot of independent reading in social science research. He was a very profound influence, and I still write him once a year. I send him my annual report from the association (AAS) just to keep him up to date on what I am doing. He is about seventy-five now.

There was a professor, Mary Ainsworth, who had done seminal research in developmental psychology. She had been to Africa and had studied mother/child attachments and interactions. I took three courses from her as an undergraduate. She was a very profound thinker about the influence of parenting on children and development.

I worked in an experimental psychologist's laboratory for a year running rats. I don't think the professor was as profound as the experience was - again hands-on research. That was a great thing about Johns Hopkins University. Johns Hopkins was the kind of institution where, if you wanted to, you could find a way to get hands-on research experience, even if you just cleaned cages. My most profound year in college was my senior year. At Johns Hopkins, I didn't have to declare a major. In the United States you have to declare that you are going to be an English major or a language major or a psychology major, etc. That means that you concentrate your courses in that particular field. At Johns Hopkins my major was liberal arts, which meant I had to have a minor. I had to have enough psychology credits to graduate with my degree in psychology but, as a liberal arts major, I could take courses across a broad field. In my senior year I had satisfied all my requirements, and I took an art history course, an English literature course, an archeology course and some fourth course - a broad range of things which

were fascinating and interesting and made a world of difference to me. I think this is why I didn't go to medical school. I hated the idea of it being so narrowly into science. I loved the idea that I had a very broad-based education. I think that way as a suicidologist. I like the idea that I haven't picked a very narrow framework and stayed within it. I know enough of the field overall without necessarily being in-depth about any one aspect. I enjoy having a broad knowledge, and I got that from my undergraduate experience.

Dr. Connolly: What about your graduate years?

Dr. Berman: They were pretty uneventful. You took courses, and you did your research. I had to do a masters thesis. I had to do a doctoral dissertation. That research involved doing what I already knew to do. I had a fairly good grounding in how to do research. It was designed to get me out, so that I could go to work. I don't have any profound memories of graduate school.

Dr. Connolly: Tell me about your doctorate.

Dr. Berman: I did a study involving schizophrenic patients at St. Elizabeth's Hospital in Washington, DC, which was a major federal hospital. [It is now closed.] If somebody threatened the President, he or she was sent to St. Elizabeth's. I had this large group of psychotic patients and, in 1969/1970, videotape feedback was getting in vogue at the time. My study involved giving schizophrenics feedback on their body image so that they could see themselves on a monitor. Because they had such a distorted image of themselves and the world, the theory was that, if you created a more reality-based vision, their thinking would improve. It was body-image focussed. Show me your arm, this is your arm, this is your hand, and then feeding this back to them on videotape. My control subjects were hospital employees, so I had schizophrenics and hospital employees given the same experimental manipulation. What was fascinating was that I didn't have any impact on schizophrenics, but my hospital employees on baseline were sicker than my schizophrenics, in terms of any measure of psychotic thinking. Why would anybody want that job. They weren't professionals, they were orderlies, psychology technicians, etc. So I found improvement in my control group, which I thought was wonderful. I published that study years ago.

I didn't focus on suicide other than the fact that, in my training in the hospital, I did a lot of emergency-room work, and I saw some suicidal people. What became clear to me then is that I knew that I was ill-trained, and I knew then that none of my colleagues were any better trained and that nobody was really doing anything significant.

I can tell you how I became a suicidologist. My first job after graduating was teaching at American University in Washington, DC. The position was a split appointment. I was teaching two or three courses a semester, but I was always in the clinical facility on campus. In my second year of teaching, which was 1971, two students approached me and a colleague who had started the same year, and they wanted to know if they could establish a telephone crisis service on campus, a hotline. This was fairly new at the time, thirteen years after the Los Angeles Suicide Prevention Center had

opened. I had done some reading about that. I had known it existed, but I didn't know anything about hotlines. At the time, there was only one other hotline in the United States on a college campus. This was a wonderful idea. They asked us if we would provide academic support for the service and we said, "Yes, if we can make it into a course so that we can get teaching credit and that it would be one of our courses."

Students who wanted to work on this hotline would have to take the academic course, and their service on the hotline would be part of the requirements. My colleague and I said, "Ok, we are going to teach a course on crisis intervention. I've had some hospital experiences, you've had hospital experience, we know what crisis intervention is, we've probably read some of the theory, we have got to come up with fifteen lectures. What should we cover?" We started listing the topics, and suicide was clearly one of them. We made a long list of crises, and I said, "What we have here is sex and aggression." He said "I'll take sex," and that left me teaching the classes on suicide and assault.

The first year we taught this course, one of the students was the son of a man who worked at the National Institute of Mental Health. In their suicidology branch, where Ed Shneidman had been two years earlier, this student's father, Berkeley Hathorne, was second in command to Harvey Resnick (Ed's replacement). The son told his father about the course and about the hotline experience. His father was involved with AAS which was then three years old and that April was meeting in Washington, DC, for its annual conference. His father asked me to make a presentation to talk about this course which was one of the few academic courses having to do with crisis intervention. I said, "Sure." Next thing I know, I am on a panel at this conference for this organisation I knew nothing about. On the panel were Norm Farberow, Jerry Motto and Bob Litman, and they were very interesting people. Here I was, two years out of graduate school, meeting people whom I realised were significant thinkers in the field. I got involved in the organisation and, therefore, with people who were doing research in suicide. Now I had people I could talk to. By l973, I was actively involved both in AAS and in collaborations with people I had read about, or whose writings I had read. Being streetwise, I said, "Well, this is interesting. Here are the players and, if I link up with them, we can do this and that and eventually I have a career!" I became a suicidologist within three years of graduate school.

I published my first piece of research on suicide in l973 or 1974. I got involved with AAS by getting on sub-committees. On the Accreditation Committee we were interested in looking at policies and procedures in hospitals to see if we could standardize them. Would anybody truly know the various levels of suicide watch so that, when the phrase 'constant observation' was used, it had a common meaning to everybody? Does a fifteen minute check make a difference when it takes only five minutes for somebody to kill themselves?

Those are the kind of questions I was involved with, but I am always asking questions. By the mid seventies, I was actively involved in doing the thing I didn't think I would be doing, which is narrowing myself and doing work only on suicide. It's been downhill from there!

Dr. Connolly: At that stage you were still working at the University?

Dr. Berman: I resigned my clinical appointment in l977 and started a small private practice. Actually three or four of us who were working together in that center resigned in that year because of administrative craziness. Universities are places where people dive to the floor for pennies because there is not a lot of money, and I couldn't stand committee work. I couldn't stand the bureaucracy of the University, so we resigned in l977 and built our private practices, while at the same time we could keep our academic appointments. I taught at the University until 1991, getting tenure and promotion to full professor.

I got involved more with AAS. I was President in l984-1985, so it took me thirteen years to go from not even knowing the Association to being President. That's crazy. In l991 I resigned my tenured position at the university. I had an opportunity to go to the Washington School of Psychiatry, which was founded by Harry Stack Sullivan back in the 1930's, one of the most respected post-graduate mental health training centers in the United States. The school offered courses and academic programs for mental health professionals. The person who was director of the school asked me if I would be interested in setting up a center for the study of suicide. That was a wonderful opportunity compared to being at the university, teaching the same courses every year. (I was getting bored.) Here was a refreshing opportunity, and I left the university and spent four years at the Washington School. I still had my private practice. I was doing probably thirty-five hours of clinical work in addition to the research, and I was probably working twenty hours each week at the Washington School of Psychiatry.

I left in 1995 for two reasons. I started looking for a new job because the Washington School was struggling financially, and it wasn't clear whether they were going to continue funding my work with them. At the same time I was elected editor of Suicide and Life-Threatening Behavior. It was at that point that the Executive Director of AAS resigned and, at a board meeting, AAS talked about moving the central office to Washington. I said this might be more interesting than my editing a journal. Editing a journal was one more academic thing to do, but I don't need that. I don't have to have anything more on my cv, but being Executive Director would allow me some new opportunities to move in a direction I had never moved, in administration, policy, advocating, and building collaborative alliances. I had never had to do any of that, and so to me it had the novelty of a new field within suicidology. I said to the board, "If you are interested in moving the Association to Washington and if you are interested in my doing this and if you would allow me to do it less than full-time, because I still have a full practice, I'll be Executive director. I'll cut back on the practice bit by bit, but I can't give you more than twenty-five hours a week to begin with. If you are interested, I'll give you those twenty-five hours, and I'll do full-time work because that is the nature of the way I work." They voted to do that. I resigned the Editorship, and Mort Silverman was elected as Editor. And that is what I have been doing since l995. The AAS central office is on the fourth floor, and my clinical office is on the sixth floor of the same building. I live my life either on the elevator or the stairwell, depending on whether I'm with patients or I'm in the office. And 90% of it has been great fun.

Dr. Connolly: In all of that time, of course, you got married and reared a family.

Dr. Berman: Yes, I did. I got married while I was doing my dissertation, before graduating, in 1969.

Dr. Connolly: How did you meet your wife?

Dr. Berman: I was about to head off to do my internship. It was going to be in New York City, and I was living in a townhouse in Washington with three guys who went to law school. They were a year ahead of me and graduating. She had just graduated from college and was looking for a place to live with some of her friends. She came to look at our house. I was immediately attracted to her. I got her telephone number through some ruse. I think I said, "We might sell our furniture and, if we do, I want to be able to contact you. How can I do that?" She fell for that (!), and we started dating. That was in the early summer of l967. We dated all that summer and, at the end of August, I moved to New York City. She came up one time. It was strange having this long distance relationship, and it was not going to work. So we stopped dating. I spent from September 1967 to July of 1968 in Manhattan. She was in Washington. I then made my first trip to England. After a year of internship, I had to come back to DC to finish my research, but I had $400 saved and I flew over to London. I had a friend who lived in London, and I spent two weeks touring the English countryside, camping out with an Australian woman with whom he fixed me up. I had a great time, a great introduction to Europe. Back in DC, probably in January, she called me. I had left my art history book with her before I moved away. She called and said, "I still have your book," and so I said, "Well, great. Let's get together, and you can give me the book back." We were engaged two months later. So we dated for three months, didn't see each other for over a year, dated again for two months, got engaged by March, and married in October, 1969. We have been married for thirty-three years.

Dr. Connolly: Any children?

Dr. Berman: Two children – my first son was born in l971, the second in 1974. The older child is a lawyer. He was a public defender, defending indigents, murderers and rapists (because they have a right to a good defence), and he was very good at that. Since the summer of 2001, he has worked as a legal counsel to a United States senator from New York. He has a liberal value system. He works in DC and has his own house, so we see him every ten days or so. My younger child now lives in San Francisco working for a dot.com Internet marketing company. He is Director of Business Development for this small company, where the CEO of the company is twenty-six, which is scary.

My oldest son's story is interesting. I influenced him just as my father did me academically. He was a non-student in high school. He was clearly very bright, but he wouldn't hand in homework. He would read, but he could care less about pleasing the teacher. He would get A's in some courses where he really thought the teacher was stimulating, but if he was not turned on by the teacher he wouldn't do any work. His grades ranged from A's to F's and it drove us nuts! He went to a small college in

Connecticut, a reasonable school but nothing great. Somehow he decided, when he got to college, that he was going to turn on, and he got stimulated and interested and performed in all sorts of ways so that he then went to Yale Law School which is, if not the best, one of the two best law schools in the States.

Dr. Connolly: That's where your father went?

Dr. Berman: On a par (he went to Harvard) with what my father did, that's right.

Dr. Connolly: You are very much on the International stage. You are on the board of IASP. How long have you been involved?

Dr. Berman: I have been a member of IASP for fifteen years, but I got involved only about six or eight years ago, maybe at the Montreal Conference. I don't know if I got involved as much as I started to go to the meetings, meeting people. I don't know how I got on the Board, I mean somebody said "Will you run?" and I said, "Ok." Then I started writing regularly for IASP's journal Crisis.

It has been an interesting experience because I am fascinated by what we can learn internationally. There are some countries with a high suicide rate and some with a low suicide rate. Nobody can explain why. It may be that the quality of the data is bad. Costa Rica has a low rate, and Hungary has a high rate but, when you listen to the researchers from Hungary, you find out that they don't know what is going on in Hungary. I don't know anybody from Costa Rica, but I don't believe that the data from there are good, so maybe their rate is ten times what they say it is. That would be interesting to study.

Dr. Connolly: What do you think of the controversies in the organizations at the moment?

Dr. Berman: Which one? Name one?

Dr. Connolly: Were you very much involved in Diekstra affair?

Dr. Berman: I am on an IASR committee to investigate that. I think that the Academy behaved badly. They kicked Diekstra out on the basis on what happened, but the Academy doesn't have any rules about membership. They have rules about getting in, but they have no rules about getting someone out. He has appealed, and I think it is an appropriate thing for him to do. We have a small committee that may ultimately look at whether he should be kicked out or not and that is obviously dependent on what we find out about what happened. At the moment, I don't even know what happened.

Dr. Connoly: You have collaborated and researched with a lot of people. What do you think is your most important piece of research?

Dr. Berman: How do you pick out the most important? Some of the best work I have done was with some of my students, where I would throw them an idea and then I would monitor and mentor their doing it. I did some very good stuff in the early 1980's with Ronny Cohen-Sandler on child suicide. We were able to do some good case-control research with kids who were hospitalized for suicidal behavior, mostly on psychological variables, but also on family and social system variables.

What else is there? I think I did some good psychological autopsy research around media influences, published in the American Journal of Psychiatry. There were television programs on suicide, and we asked whether they influenced copycat or contagion behavior. The research that had been published to date suffered from an ecological fallacy because nobody knew whether, if there was an increase in suicides after broadcasts, these suicides had watched the broadcasts? The only answer to that was by investigating it in greater depth, and so it was the only study at the time to actually look at that through psychological autopsy approach. I should also note the work done with David Jobes, another of my former students, now a colleague. I got David involved in questions of nomenclature, and he did some good empirical work on our efforts to define suicidal behavior.

What's happened in the last fifteen years is that I have become identified with promoting single-case research and intensive case-studies, and for that the psychological autopsy procedure is really powerful and important. I went out and did some work in the Los Angeles Suicide Prevention Center. I talked to Bob Litman and his staff. They had files of case histories that nobody had ever done any research work with, and so I offered to get at the data to start piecing together some protocols as to how you might look at what is in that data. That led to a book of case studies that I published, and since then people have asked me to write case studies for application of theoretical principles or empirical risk factors. As a result, I have become identified as focussed on case studies.

The one thing I am leaving out of this story on the case study approach is forensic work which over the last fifteen years has become my third job. It is a combination of thinking ethically about how one practices, thinking clinically about what good practice is and looking at what responsibilities we have as clinicians to deal with the single case and, even though we don't know a a lot about what we are doing, at least we do the best we can or at least do it well enough in treating that patient. That has been very powerful for me in terms of developing teaching material, thinking about the suicidal character and thinking about really how difficult the work we do is. We know what not to do, and the forensic work focuses on that dividing line between what we shouldn't do or what is bad versus at least what does not harm. But it makes me question whether we have any inkling about what works. If you medicate patients, can you really demonstrate that that is going to prevent them from killing themselves? You can't. There are no data. Marsha Linehan and Keith Hawton have done meta-analyses of randomized control studies of treatment, and the best we have got out of that is that some of the Dialectical Behavior Therapy and the cognitive behavioral interventions work for a short period of time. That's the best we have. We are all in the business of treating suicidal patients, and we don't know how to treat these patients well. I think some of them are untreatable, and it is painfully evident when I do my forensic work to find how difficult it is to treat patients

Dr. Connolly: How do you stand on the issues of assisted suicide and euthanasia?

Dr. Berman: I am fairly simplistic about this. I have a personal belief and a professional belief, and they don't agree. On a personal level, I understand that, if someone is truly facing a terminal life condition and they choose to take control over their death and therefore over their life by making that decision, when it is clear that they are going to die anyway and it is simply a matter of time and maybe a matter of pain, then I have no trouble with them killing themselves. Professionally however, I strongly believe we have an ethical responsibility not to aid and abet. Professionally I argue that it is a bad thing to involve me in your decision. If you can do it and you are physically capable of producing your own death and you are not a child or adolescent, I don't have any trouble with that. But I do have trouble if you invite me into it. I'm not going to participate. I don't know if that is hypocritical or if it's creating some artificial dividing line.

Dr. Connolly: A lot of research has been done in the past on suicide. Where are we going?

Dr. Berman: Where are we going? I fear we are going too far biologically. But clearly that is where most scientific data are coming from. I think it explains only a small proportion of the variance. That's where we are now, that's where the major focus in research is, and that's fine. I just fear for the loss of the psychological approach in the process of over-emphasizing the biology of suicide. Everyone wants to find a magic bullet – a biological marker for suicide. Witness the stir created when we thought the dexamethasone suppression test would be the be-all-and-end-all as that marker. It just isn't that simple. I am hopeful that at least in the United States there will be dollars available for evaluation research and, if so, we will try to demonstrate what does and doesn't work in preventing suicide. I was talking recently about a pamphlet an Irish group is creating - a standard educational approach to provide information and get it out to people. Nobody has ever bothered studying whether providing information and getting it out to people effectively changes behavior. Nobody has ever studied whether, if I give you a pamphlet or I mail you a pamphlet, do you read it? Do you remember what you read ten minutes later, a week later? Do you know where the pamphlet is? Could you find it, or did you throw it out? Six months later, has it had any impact in changing whatever the intended outcomes are? Now that is the kind of research which is very simple. Nobody has ever done it.

We are constantly putting stuff on paper and saying "This is appropriate prevention work; let's educate people." We don't know if it's worth it. I published a paper fifteen years ago on the quality of research in child and adolescent suicide up to 1980. I looked at issues such as did they operationally define whatever it was they were studying, was it a case control study, etc? Only a quarter of the studies were decent on any single criterion for good research. Looking from 1980 through 1995, probably one-half of the studies are what we might consider to be good research. My bet is that from 1995 to the year 2000 it's now sixty or seventy percent. The quality of our research is so much better now. So one place where we are heading is in training people to do good case-control research, training people that you can't mix suicide ideators and suicide

attempters if you are truly trying to understand one versus the other, because these are not the same behaviors. Training people to do good research will be a major advance, and I hope we are heading in that direction.

INTERVIEW WITH UNNI BILLE-BRAHE

Dr. John Connolly: You are Norwegian I gather, now living in Denmark, your adopted country. Tell me about your early years.

Dr. Unni Bille-Brahe: I was born in 1930 - a very good year because it gave me the opportunity to live in several different "ages," so to speak. Life in the 1930's was so different from life during the war, and again so totally different from the years after the war, not to speak of life during the last few decades when the world has kept changing with increasing speed. So I consider myself fortunate to have experienced all of this. Besides, I was born on a Sunday!

Dr. Connolly: Sunday's child. You went to school in Norway, I presume.

Dr. Bille-Brahe: Yes, I went to school in Norway. My father was in the army, and we were living on the station which was in a rather isolated area. I started at a small school in the neighborhood (three grades altogether, 12 to 14 children in one room). The school was five kilometres away, but we went to school only three days a week. During winter I went on ski, so I learned skiing early in life. Then the war came and, after my father was released from the prisoner-of-war camp, we moved to Oslo where I finished primary school and then high school. It was, of course, a change coming from the small country school to this huge modern school. Then there was the war. My father was in the Resistance and, at one point, the whole family had to go underground. But, as we know, children usually adapt, and so did I.

Dr. Connolly: It was a big adventure?

Dr. Bille-Brahe: Well, in a way I guess it was. But at that time children were children. We were not part of the grown-up world as most children are today. We had not constantly been exposed to "news" from, for instance, television. Of course, we knew we were at war, and we did what we could to tease the enemy, but I don't think that we, in the beginning at least, fully realized what was at stake. My parents and their friends were very sober about it. They did what they had to do, and that was that. One story I still remember very clearly. My father used to play bridge, and every Tuesday night he went to join some friends for a game. I was curious because he always carried a little package wrapped up with a string, and my father, like most men at the time, usually did not like to carry packages. So I asked what was in those packages and was told it was prizes for the winner of the game and, therefore, a secret. Only years later did I find out that the package contained a gun, and the "bridge party" was a group of men training in the basement of the house of my parents' best friends.

After I finished school, I started to work – at the Norwegian Statistical Bureau – and to study at Oslo University. After having taken the obligatory exam in philosophy, I started to study law, but then, during a winter holiday, I met – or rather bumped into – a Dane on ski, and that was the end of my university career. My husband to be was a

farmer, and my father, who had been breaking a long family tradition by not being a farmer himself, was very proud that his only child should be farmer's wife, even if it meant that I was moving to another country. So again, my life changed, this time from being a city student to a farmer's wife. Before our marriage, my husband, who was charmingly eccentric, warned me that he was manic-depressive, but at that time the diagnosis meant little to me.

The next few years were very happy. My husband was a very advanced farmer, and he ran the estate in a rather special way. For instance, he was the first in Denmark to import and use combine harvesters, and he used to work in the fields together with the men. So did I by the way – you may not believe it, but I was a rather good tractor driver!

Then, for the second time in his life, my husband was paralysed by a type of poliomyelitis. Contrary to the doctors' prognosis, however, he not only survived, but within a year he had forced himself back to an almost normal physical life. But then our second child died, and that was too much for him. He went into a deep depression that ended with his suicide.

Eventually I married again, to a Danish diplomat stationed first in India and later in Canada. It was an interesting period, but our marriage was not happy, and we eventually divorced. The children and I moved to Funen, and I started to study again, this time social science, as there was no faculty of law at the University of Odense.

Dr. Connoly: What about children?

Dr. Bille-Brahe: I have two daughters, one from my first marriage and one from the second. They are as different as can be, but the three of us have a very close relationship. Fortunately, they live close by, so I also have close relationships with my five grandchildren.

Dr. Connolly: Have any of them followed in your footsteps into research.

Dr. Bille-Brahe: No – at least not yet! My oldest daughter is a highly esteemed chef, running her own castle-pension. My youngest daughter is a journalist working at one of the two public Danish television stations.

Dr. Connolly: How long did you work in social sciences at Odense University?

Dr. Bille-Brahe: The study of social science at the University of Odense takes five years. During the last year I also attended the first part of the study of law at the University of Aarhus, but I did not take any exams. Originally, I had hoped to find a job in public administration, preferably dealing with juvenile delinquency (my dissertation had dealt with crime and deviant behavior) but, when I eventually passed my exam, unemployment was increasing, especially among academics, and my chances were few. Then I had a call from my instructor. His wife, who was a psychiatrist working at Odense University Hospital, had told him that an EU research project on suicide was being planned and, knowing that I was interested in deviant behavior and research, he thought I should try

and get in contact with the head of the department, Professor Niels Juel-Nielsen, who at the time was one of the few suicidologists in Scandinavia. That project never got off the ground, but others did, and they have kept me busy ever since. I should perhaps add that I have been involved in some other fields of research too, namely in two rather comprehensive studies, one on The Future of the Danish society and the other on Danish elderly.

Dr. Connolly: What was the EU project?

Dr. Bille-Brahe: The planned project was never started. It was turned down because it did not belong within the framework of the Rome Treaty. The next project was a comprehensive Nordic study on the so-called Scandinavian suicide paradox. How could it be that countries with high standards of living and welfare had some of the highest suicide rates in Europe and, furthermore, how could it be that the frequency of suicide could vary so much between countries that otherwise were very similar? You may remember that for years the rate of suicide in Norway was one third of the rates in Sweden and Denmark.

Dr. Connolly: Why should that happen when the countries were fairly similar culturally.

Dr. Bille-Brahe: The people are of the same ethnic origin, their languages are very close, and history and politics are more or less the same. When I moved from Norway to Denmark, I thought I was just moving across the street, so to speak, but I got wiser. There are many differences. Some of them, I guess, have something to do with their different geography and with the space and density of the population. You see the differences most clearly when you go out into the countryside. In spite of the fact that many Norwegians are living in rather isolated places, they are much more socially integrated than, for instance, the Danes, and their lives are to a greater extent based on the principle of mutual inter-dependency. A good example is the tradition of “doning” (the word may be of old Norse origin). When a farmer is going to build a new barn, he will invite all the neighbors, and together they raise the barn. When the work is finished, he and his wife will provide food and drink, and they will have a tremendous party. Another example, is that most of the care of the handicapped and others in need is privately organized, although it is paid for by the government. It was, by the way, this Nordic study that started my work on suicidal behavior and the question of social integration and social support.

Dr. Connolly: You soon became internationally known for your work in suicidology.

Dr. Bille-Brahe: Well, gradually. But as I started late – I was close to fifty when I graduated from the university- I had to hurry. However, I consider myself, this late in life, extremely privileged that I got the chance to work on something which is really worth while doing – and furthermore in an area where, for each answer you get, you have ten new questions.

Dr. Connolly: What are you most pleased with in your body of work to date?

Dr. Bille-Brahe: If you mean one single project, it is definitely having been involved in the planning of the “Reaching Young Europe” program. To my mind, that is one of the very best prevention programs ever. But generally, I have been most interested in working in suicidology from a cross-sectional point of view and applying these ideas to clinicians and to administration.

Dr. Connolly: That is a very big problem - applying research findings to clinical and Government action.

Dr. Bille-Brahe: Yes, it has been a problem because you have to make the “experts” realize that the various scientific approaches are not contrasting (or competing) – on the contrary, they complement one another. You will never understand suicide or develop effective prevention programs if you look at suicidal behavior from only one angle.

Dr. Connolly: I often think that in psychiatry we tend to use a much more old fashioned model than used in general medicine or even surgery. They seem to take much more into consideration social factors and cultural factors.

Dr. Bille-Brahe: And suicide prevention should learn from that. Suicide is, however, not a disease – it is an act carried out in the context of society.

Dr. Connolly: Are you suspicious of the psychological autopsy studies that tend to diagnose depression.

Dr. Bille-Brahe: Yes. I think there has been a kind of inflation of the term depression. Of course, people don’t commit suicide if they are happy – they kill themselves when they are desperately sad and unhappy or not able to see any other way out of their problems. But that does not necessarily mean that the person in question can be diagnosed as suffering from a depressive disorder.

Dr. Connolly: The difference between depression and sadness.

Dr. Bille-Brahe: Yes

Dr. Connolly: I have no doubt in my mind that depression is a major factor in suicide. I have, however, seen a lot of people who have attempted suicide, including young adolescent boys who tried to hang themselves and fortuitously were caught in the act and saved. They would have died had somebody not been on the spot, but a psychiatrist examining them the next day found no psychiatric problems, not a thing.

Dr. Bille-Brahe: I met one of those the first time I visited one of the wards at the hospital in Odense. It was a 20-year-old boy who had been brought to the emergency unit the night before after a very serious suicide attempt. He was now sitting in his chair, happily

reading Donald Duck, while waiting to go home. In our need to find the "reason why," psychiatric problems – and especially depression – come in handy. But when a woman, who has lost her beloved husband to whom she has been happily married for more than forty years, kills herself because she simply does not want to go on living without him, is that depression in the psychiatric sense of the word?

Dr. Connolly: Some people do need explanations, and depression is a very convenient one. Nonetheless depression is a problem. Lithium and anti-depressants do have an effect on suicide rates, but depression is not the whole explanation.

Dr. Bille-Brahe: I agree, of course, that people suffering from depression are at an increased risk for suicide, but that is not my point. I have been studying many hundreds of death certificates, and in many cases the "reason why" was simply put down to depression. Three different cases will show you my point. One of the suicides was an elderly man who throughout most of his life had been in and out of psychiatric hospitals suffering from depression. Another was a man in his forties. He had for some years been drinking steadily, his wife had left him, he had lost his job, and now he was facing a desperate economic situation. The third was the women I mentioned before. In these very different cases, the conclusions were that the person had committed suicide because he or she was suffering from depression.

Dr. Connolly: Yes, but at the same time, we see all sorts of people with tremendous resilience who survive crushing blows without getting into what we will call clinical depression or tremendous sadness. Now, to change the topic, you are very much involved in the European Multi-Centre Study on Suicide and Parasuicide. Tell me a little bit about that.

Dr. Bille-Brahe: Yes, I have been involved in the study from the very beginning. In the mid 1980s, WHO published their program "Health for All by the Year 2000." One of the targets (target 12) was to decrease the rates of suicide and attempted suicide. In 1986, the WHO European Office in Copenhagen arranged a working meeting where the definitions of and the increase in suicidal behavior were discussed. At that meeting, the WHO/Euro Multicentre Study on Parasuicide was established. (Later, the name was changed to the Multicentre Study on Suicidal Behavior.) The purpose of the study was to collect comparable data on attempted suicide and to find predictors of future suicidal behavior. Under the guidance of a small steering group, appointed by WHO, initially 16, but by now 24, European centers have taken part in the study. During the period 1992-2000, the study was coordinated by my center in Odense.

I think we all have good reasons to be proud of that work. Furthermore, I believe it is rather unique that so many people from different parts of Europe have enjoyed working together for so many years, and this undoubtedly has contributed to the high quality of the study.

Dr. Connolly: That project will continue?

Dr. Bille-Brahe: I sincerely hope so, but new aims are going to be added. We would like to have more countries involved. The knowledge and understanding gathered about the complexity of suicidal behavior should be instrumental in setting up effective prevention programs as well as training and teaching courses. And, of course, our collaborative research has to be continued. There are still many open questions in the field of suicidology – and monitoring is a must if we are to be able to evaluate any progress in the field of prevention.

Dr. Connolly: Now you have fallen foul of ageism. You retired this year.

Dr. Bille-Brahe: Yes. As a civil servant in Denmark, you have to retire when you reach the age of seventy.

Dr. Connolly: But you are going to remain very much involved?

Dr. Bille-Brahe: Not on a regular basis. I am, however, still a member of the Danish board for the prevention of attempted suicide and suicide. My center was very involved in working out a national strategy for prevention. It is now being implemented, and it seems to work.

Dr. Connolly: That is a very big achievement because governments tend not to listen or to take in only part of the message, and they often let it drop very quickly.

Dr. Bille-Brahe: Well, it took a couple of years of solid preparation. At first, we were a small group of five people who were asked to work out the terms of reference for a planning group and a proposal as to who were to be members of that group. After one year of work, this planning group presented the government with their suggestions for a national strategy, and this was eventually accepted. So, Denmark is by now one of the few countries that can boast of having a national strategy for suicide prevention. The strategy is based on three principles. All suicidal persons should be properly assessed and offered relevant treatment and guidance; all persons who in their daily work meet with suicidal people should be adequately trained; and good training ishould be based on proper research.

Dr. Connolly: Over the years you have become very much involved with IASP.

Dr. Bille-Brahe: I was a member of the Board for two terms during the period when the membership wanted a revision of the constitution. It was very interesting, and I think that the Board came up with some sensible recommendations.

Dr. Connolly: Your previous legal training would have helped you a lot on that.

Dr. Bille-Brahe: Perhaps. The main thing in any constitution is, however, that it is kept as simple as possible, and that all rules and paragraphs are stated in an unambiguous way and in a clear, straightforward language. I hope that the “down” period is past by now, and that

IASP is growing again. There is definitely a need for this organization, and the Board and the task forces are doing a good job, except that the information distribution to the membership is somewhat insufficient.

Dr. Connolly: The Website might help.

Dr. Bille-Brahe: Yes, but that should not be the only type of communication.

Dr. Connolly: IASP hasn't been helped in recent years by the Diekstra controversy.

Dr. Bille-Brahe: Don't you think that this is an old story by now? I have worked with Rene for years, and I always found it a pleasure to work with him. He has a brilliant mind and a special talent for cutting through in muddling discussions. I never understood why he got himself involved in this mess or why he did not untangle it by simply saying, "I made a mistake. I am sorry."

Dr. Connolly: A lot of people were very upset.

Dr. Bille-Brahe: Yes. It was a big scandal, as it was not something "one" is supposed to do in academic circles. But the world is moving on.

Dr. Connolly: Another thing that caused a little bit of controversy and dissension was the setting up of the Academy.

Dr. Bille-Brahe: Yes, I know, but I never understood why. (I am a full member myself.) Senior researchers had a need for getting together and discussing their problems, and this need was not met by IASP whose task is to link researchers, clinicians and volunteers. When researchers attend one of the IASP (or other big) conferences, we have at maximum ten minutes for a presentation, discussion included. One can always continue the discussion in the foyer over a cup of coffee, but that did not meet the need for a place to meet where we could discuss various topics such as some special scientific method or the like. I think this need was both understandable and justified. The Academy was to be a place where juniors could benefit from the experience of the seniors, thereby improving the quality of suicidological research. I would like to add that one of the best papers I ever heard was presented at one of the Academy meetings.

By the way, another reason for creating an Academy was that governments and organizations such as WHO and WFMH kept asking for a smaller body that could provide them with expert information.

Dr. Connolly: Researchers need their own forum just as volunteers need their own forum. But there must be a coming together at some point. I'd like to know what sort of literature and music impressed you and how your tastes developed.

Dr. Bille-Brahe: As to music, I definitely prefer classical composers, the Vienna classics, for example, or Italians such as Rossini. But I am also fond of jazz.

Dr. Connolly: Do you go frequently to concerts?

Dr. Bille-Brahe: Not as much as I have wanted to, and now I mostly listen to music at home. I have, however, had the good fortune to listen to among others Bernstein conducting the New York Philharmonic Orchestra in Carnegie Hall, Dame Melba singing in Covent Garden, and Ella Fitzgerald and Louis Armstrong performing together at the O'Keefe Center.

When it comes to art, I am rather old-fashioned. Modern art is not for me! I like painters like the Breugels, especially the father, and Turner and the French Impressionists. And also Maigret, but that is as far as it goes.

Dr. Connolly: What about literature and philosophy?

Dr. Bille-Brahe: Both of my parents read a lot, and as soon as I learned to read I became an all-consuming reader. As a matter of fact, I was so eager that, at times, my parents had to restrict the time I spent reading. Then for many years, I read mostly professional literature and, for relaxation, a good crime novel. I am rather anglophile in my taste for literature. I keep returning to authors like Jane Austin, Aldous Huxley, E. M. Foster and Tolkien. Another favorite is Dorothy Sayers. But I also enjoy some of the new Norwegian and Danish authors, such as Fosnes Hansen and Leif Davidsen, but I would never pick up any of the so-called "confessional" novels by modern female authors.

Dr. Connolly: Are you a religious person?

Dr. Bille-Brahe: No – not in the traditional sense.

Dr. Connolly: What about your spiritual values?

Dr. Bille-Brahe: I don't think our minds are able to really understand terms such as infinity and eternity, but that does not mean that they don't exist. I believe they do, and that we, as human beings, are part thereof. So is everything else in the universe, and that is where I feel "at home."

Dr. Connolly: A kind of secular spiritualism?

Dr. Bille-Brahe: Yes, you could say that. I don't mean to be blasphemous, but I do find that the idea of one personal god is too narrow and too limited

Dr. Connolly: It sounds as if your two years in India had an impact on you.

Dr. Bille-Brahe: It might be. Encountering other religions, such as Buddhism, has definitely had some influence on me.

Dr. Connolly: But your family background was Christian?

Dr. Bille-Brahe: Being Norwegian, of course. My father was not very religious though, but my mother and her family were – especially my mother and my grandmother (who died at the age of 104!). It did give them a special kind of inner tranquillity.

Dr. Connolly: Have you achieved that?

Dr. Bille-Brahe: I am working at it. But with the way our world is developing, it is important to concentrate on that long-term perspective and not to end up in gloomy pessimism.

Dr. Connolly: At that meeting we had in Ireland, in Derry last year, it was the first time you spoke publicly about your grieving process. Was that a difficult thing to do?

Dr. Bille-Brahe: Yes and no. It was difficult in the sense that I had to involve my children and other living people, but it has never been a secret. I felt that, if anybody else could benefit from what I had to say, then that was a reason to do it. The Prevention Centre in Odense, which has been arranging courses for bereaved people, found that it was great relief for participants to be able to talk about suicide and to realise that others too have had the same feelings of frustration and anger, anguish and guilt. Few, if any, can get rid of these feelings completely, but with help they may learn to live with them.

Dr. Connolly: What was wonderful about that meeting was that we could have a researcher, a world-renowned person like yourself, talking about surviving. It brought a lot of people together.

Dr. Bille-Brahe: It was a great experience for me too. Suicide is still taboo, and I did not want to embarrass anybody. So it was a rather difficult presentation for me to make. But the reaction to it told me something about the need for more openness about the subject. People were simply crowding in,wanting to talk.

Dr. Connolly: So you have always been a person of courage?

Dr. Bille-Brahe: I don’t know if it has anything to do with courage. You do what you have to do, and that’s it, isn’t it? The other day, somebody asked me what I did when I had to make choices. I had no answer to that. In the concrete situation, you do what you think best, and that is that. Later, you might be able to see that it was not the best – but my point is that, at that time, you were convinced that it was. So you learn along the road – and hopefully you will be able to quote old Frankie-boy: “…regrets, I had a few, but then again too few to mention” from his song “I did it my way” (which happens to be one of my favorite songs).

INTERVIEW WITH DIEGO DE LEO

Dr. John Connolly: I would like to start off by getting you to talk about your early years -- your childhood, your parents and so forth.

Dr. Diego De Leo: I had the good fortune to be raised in a wealthy family with a very good atmosphere. My two wonderful parents are still alive, and I hold my father in particularly high esteem. He was - and still is at the age of 74 - an entrepreneur and very successful in his career. He regretted that I didn't continue in his work, but we are probably too similar, too much alike. He left me free to decide what I would like to do and, honestly, I couldn't decide. I have always been attracted to psychiatry, as many of us have, but I was very disappointed with the medical courses. When it was the time to decide what to do, I was so sceptical that I applied also to a business school as well as to the school of neurology. My thesis was in neuropsychology, which decreased substantially the probability of being accepted into the School of Psychiatry. But I was accepted, and so it was destiny to continue in this direction.

Dr. Connolly: What attracted you to psychiatry in the first place? It seems you were interested in that even before you studied medicine. Is this correct?

Dr. De Leo: Probably. The confusion that I was in myself, the talent for complex things and the need to see beyond the surface of things attracted me. I think that much of my interest was based on the many, many contradictory aspects of my personality, together with the ambivalence I had over whether to become an entrepreneur or a psychiatrist.

Dr. Connolly: Maybe they have something in common?

Dr. De Leo: In a way perhaps, and I probably inherited some propensity for organizing things from my father and from the very disciplined education that I received. Of course, our present society offers opportunities only if you compete, if you are able to organise things and if you can create some kind of structure, but this is very difficult without the help of the others.

Dr. Connolly: Then you went to California and worked with Professor Paul Watzlawick.

Dr. De Leo: I didn't work with him in the real sense, but I learnt a lot. At that time he was already popular world-wide, and I was curious to learn something about it. I was impressed by him as well as by the atmosphere of an American university – organization, facilities, space availability, easy access to professors, the fact that people call you immediately by first name. I was mesmerized by that short stay. But my institution was committed to a psychoanalytic approach. So I was under strong pressure to undergo psychoanalytic training, which I did for more than six years. I think that I learnt a lot in terms of personal knowledge and, useful or not, it is a way to interpret and understand

reality. I shifted to other domains and to other theories over the years, but my initial career was psychoanalytically oriented.

Dr. Connolly: Do you have any regrets about that?

Dr. De Leo: Of course, I have, with the wisdom of the day after. I would have preferred to have been more biologically oriented from the very beginning. Indeed, in my institute, I was the most biologically oriented, which caused me to suffer quite a lot at the beginning because the atmosphere was not very supportive.

Dr. Connolly: Six years of psychoanalytic training is a very big commitment?

Dr. De Leo: 0h, yes. Four sessions a week is certainly not a light endeavor.

Dr. Connolly: What was the turning point then when you switched from this to more biological psychiatry?

Dr. De Leo: I was very much intrigued by death at first, and I studied a number of books on death and dying in different cultures. But I wasn't able to produce much scholarly research on the topic, so for the first three years I wrote very little. It is, in some ways, implicit in the psychoanalytic tradition that you have to have a rather profound understanding before writing anything. I wrote something on neurasthenia but, while waiting to delve deeper into psychoanalytic issues, I began to take more interest in biology. I started with laboratory psychiatry, things like the TRH test and the dexamethasone suppression test in depression. My interest in suicide came very soon thereafter due to the loss of my first student, who was a very brilliant guy, a very nice person. For reasons of confidentiality, I cannot say more than that, but he was the kind of guy that you would rate as a very successful person, very funny, very sociable, etc. I didn't understand anything about this guy, and one day I read in the local newspaper that he had committed suicide by shooting himself in the head in the hills nearby. I was shocked. Afterwards, I learned that he was taking antidepressants, but I didn't realise anything at the time. It was such a trauma for me to realize that I was so arrogant in thinking that I could understand many things about human beings. I reacted to that, deciding to move towards studying suicide. I had many difficulties in the beginning as it was not a very popular topic and there were concerns that dealing with suicide might have created difficulties for the institution by attracting very peculiar clients and things of this kind. Eventually I obtained support from the head of the department and from other psychiatrists in Italy. Some of them were quite deeply interested in suicide, others less involved, but we started. Some years later we started to produce a journal which promotes reflection on the topic of suicide, with contributions especially from Italian scholars and students. We organised a number of congresses, some international, some national, others regional and local.

Dr. Connolly: Let’s go back a little bit and talk about your doctorate. Tell me a bit about that.

Dr. De Leo: In order to study and learn more about suicide, I started to think who were the persons to seek out and which were the best centres in the world to study suicidal behaviour. By chance I knew an Italian professor who was working in Holland and who mentioned to me in early 1984 that Professor Rene Diekstra was there (in Holland) and an international expert in the area. At his suggestion, I sent my c.v. to Diekstra and was accepted for the PhD course. In 1988 I presented a thesis entitled "Sunset Depression." It was my first official commitment after becoming a psychiatrist for the elderly. When I started my professional life, I had a number of options, and I chose the elderly because I thought that there was a scarcity of assistance available for them. This was a great problem at that time in Italy, especially in towns, where the rates of depression were particularly high in the elderly. I took the position of consultant at the Geriatric Hospital in 1981, and my proposal for my Ph.D. was to do something about this problem. Diekstra was enthusiastic about this idea and the basic scientific background of the thesis was to study the attitude of elderly people towards suicide in comparison to other age groups. I think that it was a good study because we learnt a lot from the experience, and we published a book based on the study with inputs from some people in the World Health Organisation. Various reviewers, such as Leonid Prilipko, Norman Sartorius and Herman van Praag, made suggestions, and the book came out entitled "Depression and Suicide in Late Life." It sold quite well and shed some light on the issue of elderly suicide. I continued to cooperate with the Institute in Leiden, offering a course each year for several years on the psychopathology of aging people. This also gave me the opportunity to continue my relationship with Diekstra. We did some nice work together. For example, we produced an instrument, which is becoming quite popular, that measures the quality of life in old age. The construction of these instruments takes an enormous amount of time. It came out as a technical report from WHO/EURO in 1994, and we have been involved in making several translations of the instrument and writing papers on it for the past two years.

Dr. Connolly: Subsequent controversies must have been a great upset to you?

Dr. De Leo: You mean what happened to Diekstra? Oh, yes. Very much so. It was very painful. It was also a personal tragedy, because I am very close to Rene emotionally. Also I think, the responsibility of the International Academy for Suicide Research compounded the problem. Some people were very firm in asking for Diekstra's exclusion, and they wanted me to step down from my position as President because I was not taking immediate steps to exclude him from the Academy. My reasoning was that we didn't have the ability to appoint an independent committee to verify the facts of the affair. So I tried to convince people in the Academy that we had to wait for the official process, or at least for the completion of the procedures, before taking any initiative in regard to that. But many people, I must say, were perhaps over-reacting and wanted to suspend Diekstra on the basis of rumors and suspicion. I didn't share this view, and I wanted to wait for a clearer picture. Meanwhile, the decision of the University of Leiden became public, but Rene asked for extra time to provide a different picture. The Academy agreed to allow

him that further time for his defence. But eventually that deadline expired, and the members took the decision unanimously to suspend Diekstra from the Academy unless he was able to provide evidence relevant to his innocence. Anyway, from a human point of view, it was a horrible experience, and it was really sad because I think this guy is a very bright and talented person. Everybody has limits, problems and deficits. Everybody makes mistakes. We are all simply human beings.

Dr. Connolly: You have collaborated with a lot of other people in research and publications. Who have been the most outstanding collaborators, and who did you like working with the most?

Dr. De Leo: I feel very privileged because one of the most charming aspects of being part of the international community is the great honor of working with extremely brilliant people. So you always have something to learn, and often you can spend time with very interesting people. Of course, I have many preferences, but I would feel embarrassed to say "No, for me, this is not a bright person" or whatever. I think that there is quite a difference between the normal setting in which you work and the international community. It is very creative and very stimulating. I was impressed by Rene Diekstra, David Jenkins (who is not in suicide research, but was one of the greatest researchers into the coronary-prone Type-A behavior pattern) and Norman Farberow. I feel very indebted to Norman Sartorius because I think he is one of the most talented persons I have ever met, and I learnt from him a manner for dealing with life and with scientific affairs. I learnt a lot also from people like Jouko Lonnqvist and Nils Retterstol. I must say also that participating in the long-term WHO study of parasuicide in Europe, with people like Armin Schmidtke and Unni Bille-Brahe was very important because they are bright persons, and I think that we learnt a lot from one another.

Dr. Connolly: It seems to me that, whatever you have undertaken, you were very quick in making an impact in that particular field, whether it was geriatrics, thanatology or suicidology. You became a professor at a very young age in 1991.

Dr. De Leo: I was not a full Professor, I was a Suppliant Professor, which is not a permanent chair. It is a chair that is renewed on a yearly basis. Italy is a very peculiar country, with a paralysed academic system. You may be reviewed only rarely, the number of chairs available is quite scant, and the selection criteria very questionable. The University of Padua is a very big university, with 70,000 students, and many students in the faculty of medicine. So, they have created positions which mean that you are charged with the responsibilities and commitments of a professorship, but you are not a tenured professor. In 1991 I was placed in charge of the teaching of psychiatry, but to obtain a tenured professorship I had to wait until my Australian appointment.

Dr. Connolly: That must have been a very big move for you?

Dr. De Leo: Yes.

Dr. Connolly: Has there been culture shock?

Dr. De Leo: Not yet. I have not really had time to notice the differences in culture, but I must say it looks like a wonderful country.

Dr. Connolly: Your work has been very well recognised, and you were President of the International Academy of Suicide Research. You were a big part in setting up the Academy in the first place?

Dr. De Leo: Yes, because I strongly believed in the idea. I had already almost ten years experience with the International Association for Suicide Prevention (IASP), and I realized that different fields and different domains were concerned with the same problems, but many of them tried to split science from clinical practice. The International Academy was established to bring experts on suicide together.

Dr. Connolly: Some people would think that this is an elitist view and may be divisive. How would you respond to that?

Dr. De Leo: I really don't see the creation of the Academy in that way, but rather as a more powerful engine to push things forward. I do not share the view that it presents competition because, at the beginning, the Academy was born as a part of IASP, just a sub-group of people who wanted to attract scientists. As is common knowledge, many scientists do not attend the meetings of AAS or IASP. So, the International Academy was a way to attract those people and to say to them, "Listen, you can join these congresses, and I can guarantee you that this part of the congress is where you can share your views with your colleagues in science." This was the initial idea, which derived from many similar examples in the medical field. However, science is made up of human beings, of course, and human factors play a major role in everything. Thus, we experienced a number of disasters, and it became evident that it was necessary to have a better location. The majority of the members of the International Academy voted for a separation from IASP. But times are changing, and some people are in favor again of staying together. I have no opposition to that, if we save the principles on which the Academy was created. I think that, to attract young people, you have to be more dynamic and not just simply someone who puts together a conference. You have to offer some other activity, a possibility to grow personally and scientifically. In any case, you should strengthen the impact of the research, even in the international organizations

Dr. Connolly: You got the Stengel award in 1991?

Dr. De Leo: Yes. I think it was based mainly on the work with the elderly, on the success of that book and on my scientific activity after that time. I think that people know me especially for my work with the elderly.

Dr. Connolly: What you consider your single most important contribution to suicidology?

Dr. De Leo: I haven't done anything very so far, important, so it is hard to say. I'm still looking to do something really helpful for the community, especially for those people whose lives are thrown away in the turmoil of an altered state of mind, and for those who remain out there coping with guilt, shame and stigma and who are exposed to an increased risk of suicide. Maybe I have made a contribution in drawing attention to the problems of the elderly, and maybe my experience with the telematic system (Tele-Help/TeleCheck) is valuable, or at least a basic idea with potential. I am happy to report that, after eleven years of supervising the system, it still seems to be effective in reducing suicide. Even though it works, especially with women, we should be considering in more depth a different prevention approach for men because, with women, it is probably effective to talk, but with men it is perhaps more effective to act or maybe to talk in a "different" manner. Our culture is still deeply influenced by the gender issue, and we probably have to pay more attention in the future to this issue and to designing different prevention strategies.

Dr. Connolly: You were at that session this morning which discussed the views of Szasz -- very controversial. There are a lot of controversial issues now, such as euthanasia and physician-assisted suicide. Tell me how you view those?

Dr. De Leo: I don't feel that I have reached a clear conclusion with regard to this. I am committed to the prevention of suicide in people who are suffering unduly, especially if they have impaired reasoning. I am quite open to euthanasia and assisted suicide because my clinical experience with old people and terminal illnesses has played a major role in my personal development. I feel, therefore, quite open with regard to this possibility, even if my main task is to prevent suicide. This can be seen as contradictory, but I think that we need to clarify more what is the nature of suffering in the terminal condition and what is the perception of life when you are very old, when life becomes very difficult, before stating some theoretical assumption that you "shouldn't do something" or "shouldn't allow something else." So I have no problems in admitting that my position is still contradictory and in conflict. But I don't have preconceptions. I am not a strictly religious person, so I am not bound by religious or rigid moral values.

Dr. Connolly: You mean of course religious in the formal sense, but what about your spiritual values. What are your spiritual influences?

Dr. De Leo: Let me add something about euthanasia. As I said, I feel quite open on this point, and my uncertainty is mainly due to the fact that it is not really clear if someone has to be considered severely depressed to think of suicide. If I had a firm opinion with regard to the issue, probably I would also be more definite in my conclusions. That is why I am promoting a study which is almost ready to be published which, to the best of my knowledge, may provide more insights on this issue. It is a study performed in a hospice, one of those places where people go to die. Besides a battery of the usual tests to measure

the degree of psychological suffering, depression, etc., there are also open-ended interviews with people and focus groups made up of relatives and the people working in that hospice. Furthermore, we are using a list of potential descriptors for a possibly different characterization of depression in near-death conditions. Up to now we have collected some thirty cases, and the results are quite upsetting, in the sense that only a minority of these people are depressed in the usual clinical sense. So, if this evidence is confirmed by a larger sample, either we establish new criteria for depression in these conditions, or we have to conclude that they are hardly depressed. Many people still hope, and the degree of their physical pain makes a difference. This study could open a new perspective, especially considering that the available scientific literature (with methodologically sound design, control groups, recording of the closeness to death, etc) is really very limited. In conclusion, I'm still waiting to see what it really means to be a terminal patient before I decide in one way or another.

With regard to the issue of spiritual values and influences, I was born in a very Catholic region of Italy, and my formal education has been strongly influenced by those values. However, my father was not a practising Catholic nor a believer, and my mother believed ion God but practised only infrequently. As a result, we were usually regarded as a family “lost” to the religious community. I do believe that there is meaning in life and a purpose in the universe. I believe in the concept of “soul” and a superior being or entity. I am fascinated by the history of religions and by their immense influence on human development. However, my ideas are subject to frequent changes, and I can easily fluctuate from absolute agnosticism to (a desire of) faith in miracles.

Dr. Connolly: Apart from the research that you have mentioned what other influences in literature, the arts, and philosophy have you experienced?

Dr. De Leo: It is hard to say what influenced me more. I am a very curious person, a true novelty seeker. I’m an intense reader. Everything might potentially influence me. I can recognize that I went through different stages in my growth. At the beginning, when I was very young, I was very much into French writers, poetry and philosophy. I adored Jacques Prevert, and I plunged with deliberate masochism into the dark pages of Sartre and Camus. Then I suffered for a longer time from a kind of Austrian-German syndrome during which Schnitzler and Musil, Mann, Roth, Hesse and Heidegger were my favorites. Of course, Freud was omnipresent. The Anglo-Americans, apart from Hemingway, arrived very last, with Wilde, Joyce, Scott Fitzgerald and Steinbeck.

Dr. Connolly: What about music?

Dr. De Leo: I am a fan of music. I play some instruments very poorly - guitar and piano. I love singing, even if I am bad at it, but it doesn't matter. I love music, any kind of music. I do like classical music and opera, but I still follow rock music. Otis Redding and Pink Floyd are among my favorites.

Dr. Connolly: It would be very interesting to do a survey of musical interests of suicidologists. Do they prefer the more depressing composers like Mahler?

Dr. De Leo: I have a very strong feeling for Schubert. I like Vivaldi, Mozart and Handel. But I also like, of course, Beethoven. His Third Symphony is the one that I would like to listen to on my last day of life.

Dr. Connolly: What about modern composers?

Dr. De Leo: The most modern that I like is Rachmaninov. Maybe modern classical music is too difficult for me to understand? I stopped at the beginning of this century. I like Respighi and Prokofiev, but not many others.

Dr. Connolly: One event that is changing your career is your move to Australia? What's going to be different in your research there?

Dr. De Leo: There are several reasons for my move to Australia. First of a1l, I wanted to have the chance in my life to focus only on research and not to have the huge clinical commitments of before. Three years ago I had a very severe road accident which strongly changed my life. I went into a canal in my car, and it was horrible because I didn't know how deep it was. The water was climbing inside the car, and I was panicking. Eventually, I successfully broke the rear window so that I could exit, but it was horrible. The car was destroyed. I was incredibly lucky. The crash happened because there was a rubbish container in the middle of the road, pushed there by the wind. I was proceeding quite fast on the road and, to avoid this obstacle, I went into the canal. If you could see the car, you would hardly believe that someone could survive because it was crushed. I was rolling and rolling and then entered the canal. I had experiences similar to a post-traumatic stress disorder – such as flashbacks - and I couldn't sleep for two months. I had to take pills or wine in order to sleep. I recovered, but I became a little different, maybe “better.” I am not as ambitious in the same way that I was before. I think that many people who suffer a similar experience which they survive just by chance probably believe that they have to do something in exchange. So, you have the feeling that you have to do something to deserve what happened to you. I entered into a kind of spirituality if you like. Australia is a country with a huge rate of suicide in young people. It is a real battlefield in my eyes since I am coming from a country with a low rate of suicide. To be a suicidologist in a country in which suicide is a minor issue is a kind of contradiction in terms. So I moved to Australia to give myself the possibility of achieving something. I feel very much committed to this project. I am also lucky to have the chance to spend some part of my life in a totally different country and to learn from the experience. As I said earlier, I am a very curious person, and I am very interested in not continuing along the same old lines, although, if you have a family, it is a very difficult choice.

Dr. Connolly: We haven't touched on family at all. You have two children?

Dr. De Leo: Yes, two boys, aged eleven and twelve.

Dr. Connolly: Looking at suicidology, what do you see for the future?

Dr. De Leo: I am very optimistic because we are now capable at last of performing very complex research, integrating biological factors with psychosocial factors. In the past, 99 percent of suicide research was psychosocial research. Now we need to look in much more detail at the biological factors. This is not new, but what is new is the possibility of integrating this knowledge and studying one topic from many perspectives. Also, the level of accuracy reached by transcultural investigations may provide very valuable insights. This is a very promising time in regard to that. Our improvement in methodology will allow us to have a better insight into suicide intervention. We now know the importance of the size of our samples and the need for randomized control trials. The integration of these perspective appears to me to be very important and very promising.

April 1, 1999

INTERVIEW WITH ROBERT GOLDNEY

Dr. Connolly: You are Australian born?

Professor Goldney: Yes. I was born in l943. Australia was a very different country back then. As I was growing up, it was changing from a predominantly Anglo-Saxon country to a multi-cultural one. I remember in those early post-war years that Australia was essentially a poor country, and there were big problems because of the war. The school numbers were enormous. All through my primary education, there were about 60 students in each classroom, and there were a large number of German, Yugoslavian and Italian students as well as those from the U.K. It was like being brought up in a big melting-pot. Then after primary school I won a scholarship to college, which is like a private secondary school. That was a totally different experience.

Dr. Connolly: What part of Australia are we talking about?

Prof. Goldney: Adelaide. Adelaide then would have had about a half million people, essentially an agricultural community. But there were quite a lot of changes after the war. General Motors came in and incorporated with Holden, which was an Australian car company. It became General Motors/Holdens and they had a big factory in Adelaide. For the first two to three decades after the war, the economy developed a manufacturing base -- a lot of white-goods industries, refrigerators, washing machines, that sort of thing. There is still a large rural community with wheat, sheep and cattle and, of course, wine. The population is now about 1.2 million.

Dr. Connolly: Do you have siblings?

Prof. Goldney: Yes. My father was killed during the war. I was the only child in the marriage, but then my mother re-married. I have a half-brother and half-sister. My sister is a doctor, a general practitioner, and my brother is a school teacher. They have been important to me, and I'm glad not to have been too over-indulged as an only child.

Dr. Connolly: Do you have any memories of your father?

Prof. Goldney: No, apart from attending the openings of war memorials as a young child where I guess he would have been eulogized.

Dr. Connolly: What about the origins of your family?

Prof. Goldney: They were from the West of England. In Bristol there is a Goldney House, which is like a University College residential accommodation, and I assume that relates to my forebears. It is an unusual name, maybe a Jewish name. I know there was quite a large Jewish population in Bristol, but my family has been in South Australia for five generations now. We don't have any direct contact with any relatives in the U.K.

Dr. Connolly: You mentioned that your primary schooling was a sort of “melting-pot” situation, with different cultures and races. How important was that in the way you turned out?

Prof. Goldney: I think it was very important because you had to communicate with everybody. It was easy to go up to anyone and talk with them. I have a number of friends from European countries, and it seems quite usual, whereas secondary college was very much a white Anglo-Saxon Protestant school. It was very conservative and a very different atmosphere - very good in its own way. I think I had the best of both worlds by having a melting-pot mix until I was about 12 and then having that other education.

Dr. Connolly: What about your religious background? How important was religion to you?

Prof. Goldney: Not important at all. I went through the usual - confirmation in the Church of England - and it was important at college in the sense that it was a good socializing experience. I quite enjoyed singing hymns in the morning. I went to chapel every morning for six years of secondary school. If you do that every morning for six years, it must have some effect on you.

Dr. Connolly: You are a very kind, caring person, with some spiritual values. What determined those for you?

Prof. Goldney: I think it must be my parents. Both my mother and stepfather were kind and caring. My stepfather was a kind and tolerant man, and my mother always had a wide circle of friends. She is now in her early 80s, but she is very busy. Whenever you ring up to go and see her, she checks in her diary to make sure that she is not playing bridge or mah jong or gardening, or doing something with the church. She is still quite religious. My values come from the family.

College also had an effect since it was a religious school and promoted ideals of service for other people. The motto is “Pro deo et patria” which means “For God and country” so there was the sense that, rather than focusing on the individual, the focus should be on what one could do. Also the war had an effect on most Australians. There were what we call Cadets in Australia, which were like a junior army in secondary school, a bit like the Boy Scouts, except more fun, with firearms. You went into the Cadets as a matter of course because there were several generations of people who had gone to the First World War and then the Second World War. You didn’t question it. You went in, and there was that sense of doing something for the community.

Dr. Connolly: What about your early reading. You read very widely now obviously, lots of interests. When did that start?

Prof. Goldney: It just grew. Very early on there was the Arthur Mees Encyclopedia, and then there was a wonderful library at school. What sticks in my mind about that time are

books on the Antarctic explorers. I read about Shackleton, his diaries, and everything I could find. That caught my imagination. But I always liked reading.

Dr. Connolly: Apart from the Antarctic, is there any one book that you would say changed your life?

Prof. Goldney: No.

Dr. Connolly: Why did you choose medicine?

Prof. Goldney: I have asked myself that! Maybe because of my friends. I remember, when I was about twelve, an aunt took me to an open-day at the University because she wanted her son to study medicine. I tagged along. He didn't end up studying medicine, but I can't really say that that influenced me. I think it was more that my friends were doing it. I didn't really know what I wanted to do, so I ended up doing medicine.

Dr. Connolly: You had no regrets?

Prof. Goldney: No, no regrets. I think that medicine is a terrific first degree, and I think psychiatry is a tremendous postgraduate degree because both subjects open up many opportunities. The opportunities are endless. If we have students in 4th, 5th or 6th year of medicine, you can always say, "Look, just get the degree and then see what you want to do." It requires discipline, and it opens up many opportunities.

Dr. Connolly: What teachers and subjects impressed you most in your medical school days?

Prof. Goldney: That is interesting! A few things stick in my mind. In first year of medicine, one of the students committed suicide. It had quite an effect on us. It was unexpected, so that sobered people up. I think my most enduring memories are not so much the medicine itself, but the friendships I had made and the friends that are still there over thirty years later. It is a marvelous bonding experience. It is a real "rite de passage." Perhaps this is not the answer you want. If you want some sort of role model, there was one physician who was a very tall, imperious man whom I will never forget. I did my first lumbar puncture under his supervision. It was late on a Saturday night. A person came in with a sub-arachnoid hemorrhage. I was a few days into my clinical term, and this man was a bit like a God. He ran me through how to do a lumbar puncture on this patient. That is one of the few things that really sticks in my mind. But the main things are the friendships!

Dr. Connolly: Why did you take up a career in Psychiatry? It wouldn't have been the first choice of a lot of people in those days.

Prof. Goldney: It was my last choice. I graduated from Adelaide in 1967, and Adelaide had only two main hospitals then. There were about 120 graduates, too many, and there weren't opportunities for broad clinical experience. For example, in surgery you might get to hold

a retractor if you were lucky. So, many of us went to either New Zealand or other states. There were a couple of states in Australia that didn't have medical schools then. One was Tasmania, and I went there as an intern and had a marvelous experience. We did our own squint operations, Achilles tendon and bunion operations and looked after a small coronary intensive care unit. The world was our oyster. You had to do just about anything.

There was a psychiatrist there who, if I can put it politely, wasn't a good role model and he wasn't held in very high esteem. I certainly didn't miss psychiatry there. When I returned to Adelaide I was offered a position on a physician-training scheme. I wanted to become a physician, and I went to a particular hospital on the understanding that I didn't have to do any psychiatry. I was given a female medical ward, and the general medicine was quite easy. However, the patients wouldn't get out of bed and recover until you sat down and talked with them. It seemed quite obvious to me that there was a lot to the emotional aspect of illness. I also had the experience in my internship where some patients divulged extraordinary things to me in the course of their admissions. For example, one person told me that he had actually killed someone many years ago. He was a miner from Tasmania, and parts of Tasmania were very, very remote. He was being admitted for an orthopedic procedure, and he asked me to pull the curtain around the bed because he had something to tell me. He said that he had killed his partner about thirty years before and thrown his body down a mine. He wanted to talk to someone about it. He was an old man, and I didn't tell anyone about this. Perhaps I should have. I'm not quite sure what one should do under the circumstances. It was pointless to tell the police. There were some experiences like that that stuck in my mind. I realised that I seemed to have some capacity for listening to people and that I was interested in what made them tick.

I asked the superintendent of the hospital, with my tail between my legs, could I please do some psychiatry to see what it was like? I found that I enjoyed it. It was the era when there were exciting discoveries being made about schizophrenia -- you may remember the 'Pink Spot' which became known as the 'Red Herring' -- one of the early biochemical investigations into schizophrenia. It seemed quite exciting at that stage. That's when I decided to go into psychiatry -- in the last half of 1969 – and I've never regretted it.

Dr. Connolly: And now you are a Professor?

Prof. Goldney: Yes. When you are young it seems daunting to be a professor, particularly a Professor of Psychiatry, as it can seem rather threatening to some people. When you get there, like so many other things that you achieve, you think, "OK, so what!" It's not as important as you think it should have been. It is just another job with different responsibilities.

Dr. Connolly: Going back to the postgraduate training years, I remember in medical school thinking how all our Consultants then were all so old. Now we are at that stage. I wonder what they think of us?

Prof. Goldney: Yes, you are quite right. However, some of those old men are still around. They are not that much older than us! In fact, the Professor of Psychiatry when I was an undergraduate, a delightful man, is still alive, about 80 years old, and he hasn't changed much.

Dr. Connolly: Which of your teachers in psychiatry impressed you most?

Prof. Goldney: A number of them, some through fairly fleeting contact. People impress you in different ways. There was one particular person who had quite an impact on me because he was around when I was struggling with my doctorate. He was a visiting psychiatrist to the department, Norman Kreitman from Edinburgh. I was doing a thesis on attempted suicide in young women and, in just a few hours one day, he brought it all together and provided the impetus to go on. I'd had a bit of a block before then, and he patted me on the shoulder and said, "Look, it is o.k. Go ahead and do it." Another person who has had an influence is Norman Farberow, from Los Angeles, who has been very important in offering support over a period now of 20 years. He was one of the people I had wanted to meet at my first meeting of the International Association for Suicide Prevention in Ottawa in 1979.

Locally, there have been a couple of people who have been important. One was a Senior Lecturer in Psychiatry, who was very rigid and obsessive and demanding. He was particularly demanding of himself, so much so that he hardly ever wrote any papers because he was looking for the perfect paper. I respected him for his attention to detail and intellectual rigor.

Another person who had an influence was the Superintendent of the first psychiatric hospital I worked at. On the very first day he said, "The important thing about psychiatry is the tolerance of ambiguity." I have never forgotten that. It is a phrase I often use with patients, that we have to tolerate ambiguity. There are no answers to many of life's questions.

There was also another person who was the head of our department for a number of years, Issy Pilowsky. He was a demanding taskmaster, but there wasn't slapping on the back and encouragement in that sort of way. It was encouragement in a rather distant way -- that you had to make your own 'cabbage patch.' In fact, those were his very words. You would make your own cabbage patch, try to become an expert in that area. But he didn't try and get you to come in on his cabbage patch. Some young people want to have a lot of guidance for what they do, whereas he fostered an independence of thinking that I found very useful, and it suited me.

Dr. Connolly: Did you do all your psychiatric training in Australia?

Prof. Goldney: Yes. That is one of the things that I now regret. I probably should have worked abroad immediately after doing the Australian and New Zealand Membership, as it was then called, now Fellowship, in l973. At that stage I was married with two young children, and the examinations were quite demanding. I thought that the family deserved

a bit of a break, so we went for a four-month holiday to the U.K. and Europe. I sat for the British exam, and I have got the British Fellowship, but I haven't worked in the U.K. I have had several periods of study leave, but not an extended stay in one place. I tend to use study leave for writing and completing research.

Dr. Connolly: You mentioned your M.D. thesis was on suicide attempts. How did you choose that topic?

Prof. Goldney: I was very much a generalist. I still regard myself as a generalist because I certainly have other interests besides suicide. But I gained a university appointment and, if you had that, you were expected to do a doctorate. At one stage I registered to do a thesis on depression and calcium metabolism. I had this all set up with an endocrinologist and we had done part of the work. However, I realized that I was not really interested in this, and it seemed as if I was being simply a research assistant for the endocrinologist, rather than doing something that I felt I had more control over.

At that stage I was running a busy outpatient clinic, and you could always catch up time because of those persons who didn't attend, and those persons who didn't show up were nearly always those who had attempted suicide. It intrigued me, and so one of my early papers was on "Out-patient follow-up of attempted suicide: Fact or fantasy" published in 1975. It seemed that often follow-up was pretty much fantasy, and so I started to look at the area of suicidal behavior. It seemed that a lot of research had been on unselected samples of both genders and all ages, and so I narrowed it down to young women, 18-30 years of age, who had taken drug overdoses. I examined the issues of lethality and suicidal intent. Beck had recently published his Suicidal Intent Scale, and I used that with measures of depression, hopelessness and locus of control. We studied three levels of lethality: high, intermediate and low lethality and compared the psychological test scores.

Dr. Connolly: You started writing papers very early on in your career which is unusual!

Prof. Goldney: It is unusual, I suppose. It didn't seem unusual to me because I clarify my own thoughts by research and writing and by attempting to gain closure on a subject. I certainly do my best by writing things down. For example, the first paper I wrote was on "Abusing Parents: The legal and therapeutic aspects." Here was I, a young psychiatrist in training, and it was very arrogant to be writing on a subject like that. But I had had a woman who had attacked her child, and I had found it difficult to treat the woman as a patient. She had been psychotically depressed and, at that stage, I had young children myself. By researching and writing about it, I gained mastery over the subject, as much mastery as one could. I presented it at a clinical meeting, and someone said, "Why don't you publish it?" So I did. After that there was a marvelous example of a family which was psychotic, an example of folie a famille. I read the literature and sent off the case report. Then I wrote a paper on 'Normality in the Psychiatrist' which was a way of sorting my thoughts out about it. If you sort out your own thoughts, perhaps someone else

may be interested in it. You can send it off and see if anyone will publish it. I found that occasionally people did publish my papers.

Dr. Connolly: What publications are you most proud of?

Prof. Goldney: I think the one that really gave me the most pleasure was the synopsis of the M.D. thesis in the British Journal of Psychiatry in the late 1970s. For Australians to get their first paper into the British Journal of Psychiatry was considered an achievement. There was also a paper on a cohort analysis of suicide rates in Australia that was published in the Archives of General Psychiatry which was the first to demonstrate that there was an increase in suicide in the youth of Australia, just as there had been in the North American studies. It looked as if we were to experience an increase, and unfortunately that is what happened. I think that every paper you write gives a lot of pleasure. It is like having a child in some ways. There is the thrill of the hunt to see whether or not the ideas you come up with might be approved by the reviewers of the journals. I still get pleasure from papers being accepted for publication.

We have a couple of papers at the moment that may also be of value, one in the Journal of Affective Disorders and the other in Suicide and Life-Threatening Behavior. These are on mental health literacy, which I think is a potentially useful concept. It is all very well having treatments but, if the general community doesn't accept those treatments, you might as well not have them. Mental health literacy is the knowledge and opinions that members of the community have about a condition, and it influences whether or not they will seek help. We have looked at a large random and representative sample of the population, over 3,000 people, focusing on major depression and other depressions. It is a truly representative community sample. We have included questions about mental health literacy, and it is very sobering to find that the knowledge about available treatments in people who have major depression and suicidal ideation, and who have had a lot of contact with the helping professions, is no better than those who are not depressed. There are enormous impediments to treatment, and this is an area which is important. We are going to have to focus more attention on public education.

Dr. Connolly: More recently you have become very interested in the history of suicidology.

Prof. Goldney: Yes. It strikes me that, particularly with the computer retrieval of information, most of the information on suicide obtained is only from the last twenty years. Much of it is more recent than that. But when you read some of the old literature, some of the 19th Century literature, there is so much that is pertinent for today. For example, there are some marvelous summaries of the state of the art of suicidology before the Twentieth Century. In 1892, there was the wonderful dictionary of Daniel Hack Tuke which presents an account of suicide, a large proportion of which is still spot on.

The other thing that intrigues me about that is that so often people think that the study of suicide commenced with Durkheim. People don't question it. People need to question everything, including the precedence of who has written what. If people 150 years ago have written something which still is true, they should be given credit for it. It

is very interesting to review what early researchers wrote, and I have spent very pleasant hours in the Wellcome History of Medicine Library in London. I think more people should do it.

Dr. Connolly: Do you teach a lot?

Prof. Goldney: Yes. I'm in an unusual situation for Australia. I work at a 70–bed private psychiatric hospital associated with the University of Adelaide. We have final-year medical students attached to our clinic, and there are also lectures to give in the first couple of years for the medical school as well. Our students tag along with us and take some responsibility clerking cases. There is also broader community work as well, talking with General Practitioners and writing in the General Practitioner and General Medical journals - articles on the management of depression or suicidal behavior. There are also contributions for what are essentially commercial magazines which are given to every doctor in Australia. Some academics might feel it is a bit below them to write in those magazines, but they are the magazines that the average General Practitioner may read. I think we have to write in them.

Dr. Connolly: You are very much part of the international scene in psychiatry. You have been involved with IASP for a long time.

Prof. Goldney: Yes, the first meeting I attended was in Ottawa in l979, and I have been to all but two since then. I had just finished my thesis, and I suddenly come across a whole group of people that spoke the same language. It was quite exciting because, when you do a doctorate, you tend to become a bit introspective and isolated. You finish it, and you end up knowing a reasonable amount about a fairly small area. But then to come across a whole group of people who have read the same literature that you have read and who sometimes share the same views is exciting. Perhaps it is more exciting when they don't share the same views. I remember coming home from that meeting after having met so many of the people whose works that I had read, and I was very excited and determined that I would continue on in the area after that. That's when I first met Norman Farberow, although I had communicated with him beforehand. That was the start of a personal friendship.

Dr. Connolly: What about other people on the international scene that have impressed you and had an impact on you?

Prof. Goldney: There are several. The late Professor Ringel was a marvelous character. To a colonial Australian, he represented the pinnacle of European Psychiatry and the dogmatism of a revered Professor of Psychiatry -- you weren't meant to question anything. I remember a meeting in Vienna where I asked a few questions about the financial state of IASP, and there was a hush in the room. He was so affronted that anyone would ask questions about it, and he responded quite angrily. Afterwards people came up to me and said that I shouldn't have done that, but at the same time they said,

"We're glad you did." Occasions like that stick in your mind. Another memorable incident was at my initial meeting in Ottawa. I remember Brian Barraclough presenting a very careful examination of the possible influence of the Samaritans. Brian's work demonstrated that there was no significant effect. I remember him saying, "To put it quite bluntly, there is no effect," at which point Jerry Motto got up and said, "Well, I'd rather not be blunt. I'd rather be sharp," and he went on to speak in support of such volunteers in these organisations. That was one of those moments that for a young person lives in your memory.

Dr. Connolly: You have played an active part in IASP ever since, becoming president and holding the Congress in Australia.

Prof. Goldney: Yes.

Dr. Connolly: It must have been a lot of hard work. Have you recovered? It takes a long time!

Prof. Goldney: It does. But there were so many people helping. The meeting in Adelaide was 1997, and by that stage I had made a number of friends in the international organisation, and there was also great local support. IASP is the most important organisation for suicide prevention worldwide, and I think it should be fostered. People came to Australia to promote IASP, and it was very important also for the Australian community to have international experts coming to Australia. We have had quite a problem with suicide, and it was a salutary lesson to governments in Australia. In fact it did make a difference. For example, our South Australian Government set up a task force after the conference which was a direct outcome of having had the conference there. And the federal Australian government also took advantage of the presence of experts in Australia and sought advice from them.

I became president of IASP almost by default because traditionally it's been very much a European or American position. To have somebody from Australia was somewhat unexpected, and I had no idea that I would be elected. It was totally unexpected. I say by default as I'm confident that Europeans preferred not to have a North American and the North Americans preferred not to have a European. Therefore the Australian got the votes!

Dr. Connolly: I don't believe a word of that! Then there is the International Academy of Suicide Research. You are now the President of that organization.

Prof. Goldney: The Academy arose understandably when IASP was floundering a little. People wanted to have a forum for research, but I think it was a pity that it wasn't kept within IASP as simply a research arm of IASP. I feel quite strongly about that because rather than the Academy being seen as an exclusive organisation, I think that suicide research should be an activity that is relevant to everyone in the field. We need to have the cooperation of all people for suicide research. For example, we know that the volunteer sector has trained tens of thousands of people worldwide in the principles of listening and

suicide prevention. There are data which indicate that they do have some effect. We need to have those people on our side. We need to have junior researchers on our side. I think that all the activities in the Academy could be subsumed under the one umbrella. We are not a big enough community to have widely differing organisations. Nevertheless, I can well understand why the Academy was established, but I think it is important that Academy members should support IASP and should be intimately connected with it, and that it should work closely with IASP and also with national organizations such as the American Association of Suicidology. It should not be seen as exclusive, but simply a group of people dedicated to suicide research and cooperating with other organizations.

Dr. Connolly: What do you think are now the most important issues in suicidology at the present time and for the next few years?

Prof. Goldney: The most important issue is appreciating that there are many people who can contribute. That is important because sometimes people get on their own hobbyhorse to the exclusion of others. Second, there are very good statistical techniques now for examining various issues about which people have previously tended to say, “We don’t know. We don’t have enough evidence.” There are enough case control studies, and longitudinal studies to demonstrate that there are certain predictors of suicide; and there is increasing evidence about resilience factors, although only at the aggregate level and not for any individual. However, we have to temper this knowledge with the dilemma that suicide is a low base-rate phenomenon, and we have to be innovative and creative in our research designs. I don’t see any point in replicating low-power studies which are going to give results similar to results that have been published for over a hundred years. I think a number of studies are like that. Those studies can be a learning experience for young researchers, but I don’t think large sums of money should be put in to studies which really aren’t going to demonstrate anything new.

Another issue is that we need to rank the importance of various contributing factors to suicidal behavior, and there are statistical methods for doing that. For a long time, psychiatric illness wasn’t seen as important, or its importance was minimised. Now, for example, we can address questions as to how important individual factors are by using the population attributable risk statistic, and we can advise Governments where money should be put.

I appreciate that not all may agree, as it means that some areas of inquiry probably don’t warrant as much attention as we are giving to them. For example, the media influence in suicide. It is important, but it is not near the top of the list. I made this point in my IASP presidential address that, if we are critical about the media, the media could turn around and say, “Ok, you say that the media is responsible for suicide. How much?” Our estimates are perhaps 1% or 2% overall, and then the media could say, “Ok, what about depression?. How much is suicide related to depression? Have you treated depression well?” We don’t have our own house in order. We know that inadequate detection and management of depressive conditions will affect suicide mortality far more than media influence. We need to have our priorities correct. Now, that might seem to be one person pushing his hobbyhorse, but I believe that it is a hobbyhorse that is backed up

by data. Ultimately we have to do things that have a sound scientific basis, albeit with compassion and caring as well. We have to be very careful that we don't go too far without a good evidence base.

Dr. Connolly: I would like to address ethical issues, euthanasia, assisted suicide and so on. In one of your Australian states, it is legal. Is that still the case or was that law repealed?

Prof. Goldney: That is repealed now. In fact the Commonwealth overruled the state, the Northern Territory. However, we have to appreciate that the reality is that it is still happening. Now in saying that, I'm not condoning it, but I am simply making an observation that it does happen, and even people who I have heard speak most vehemently against euthanasia acknowledge that they, their parents or friends would want to have death with dignity or whatever you want to call it, without having unnecessary life support at the end. There is a fine line between the various definitions of euthanasia. It depends on exactly what you mean. In addition, Australian community attitudes have certainly softened towards euthanasia. There have been a number of studies which have demonstrated that.

Now, whether or not one can ever legislate is a very different issue. Part of the reason for legislation is an anti-professional attitude which has arisen in the community, that doctors can't be trusted. I accept that one can't turn back the clock, that people do have those attitudes. But when the crunch comes, I think that people want to have compassionate doctors who aren't going to let them suffer. How that translates into legislation I don't know. I don't think anyone has got it right. But it is a fact of life that euthanasia, depending on how it is defined, does happen.

Dr. Connolly: You mentioned interests other than suicidology.

Prof. Goldney: I do some medico-legal work. I find that quite fascinating, although a lot of my colleagues don't like it because you have to go to Court and justify your opinions. I find that quite stimulating and challenging because the legal profession is a profession that I have the most profound respect for, particularly judges who have to sort out information as it is being conveyed to them. It is a challenge to present psychiatric concepts to the court in such a way that the court can understand them.

If I may be permitted to speak about interests other than work, I have great pleasure from the achievements of my family, my wife and three children, and there are also now four grandchildren, probably five by the time this is published. The grandchildren in particular remind me that I may have spent too much time working.

INTERVIEW WITH KEES VAN HEERINGEN

Dr. John Connolly: First of all I would like to explore your early background. You were born, of course, in Holland?

Dr. van Heeringen: I was born in Holland in 1955. I spent my childhood in Holland and attended secondary school there also. Then I decided that I wanted to study medicine, and I applied to the University in Amsterdam, which was very near to which we lived. There is a system in Holland which accepts only about 1,700 people at university to study medicine; there is no room for the others. You get a number, and it is a sort of lottery. Only the numbers between 1 and 1,700 can start studying medicine. We learned from friends of our family that it was possible to study medicine in Belgium where there is no limitation on the number of students. So I applied for a place at the University of Gent, and I studied medicine there.

Dr. Connolly: Were you an only child?

Dr. van Heeringen: No, I have two sisters, one older and one younger.

Dr. Connolly: Was there much sibling rivalry?

Dr. van Heeringen: It was not always easy to live in a house with two sisters.

Dr. Connolly: What sort of an influence did your parents and relatives have on your subsequent development?

Dr. van Heeringen: I think there are two major issues. The first thing is that my mother was a nurse, and she worked in a hospital, first in England and then in the Netherlands. She stopped working when the children came, but I inherited the wish to take care of people, which I also notice in my two sisters. One is an art therapist, and the other is a nurse for young, mentally-handicapped kids. So the three of us went in that direction. The other influence is more general in that my parents have been very supportive in accepting what I wanted to do and creating the possibilities for me to do what I wanted to do. I was 18 years old when I had the opportunity to go to Gent, which is about 250 kilometers from home. They were very supportive and there was no question about whether would it be possible or not. They just said, “Go and do it.”

Dr. Connolly: What did your father do?

Dr. van Heeringen: My father died five years ago - just before the Gent Symposium, which I organised. He had been ill for about two years, and we knew that he wouldn’t be able to make it to the conference, which he would have enjoyed very much -- the opening ceremony and things like that. Unfortunately we had to say goodbye to him a couple of weeks before the conference started. He was an accountant. He studied economics at the

University of Amsterdam. He was born in 1921, and he first studied to become an accountant. He always wanted to get a university degree in economics, and so, when he was about 40, he went back to university and started studying again. He had a room in Amsterdam where he stayed during the week. He worked during the day, and then in the evenings and nights he studied economics. He was very dedicated to that.

Dr. Connolly: In your formative years what interested you in literature and music?

Dr. van Heeringen: There is not very much that I remember with regard to reading. I have always enjoyed music very much, but not reading.

Dr. Connolly: Tell me about your music then.

Dr. van Heeringen: I play guitar -- not as much now as I used to simply because I don't have the time to do it. I have played in different bands, rock music in secondary school and then during my years as a student at the university in a band. I was also part of an orchestra which performed on different occasions during the academic year. I have always enjoyed playing modern rock-like music, and I still do.

Dr. Connolly: Do you like modern composers?

Dr. van Heeringen: My preferences are rather broad. I like opera very much - Puccini and others. I like good old jazz music. Then in terms of modern music, I like some English music, but I am not very much into American music at all.

Dr. Connolly: What about religion?

Dr. van Heeringen: I was brought up in a rather religious home. My parents were both very religious - Protestant, which is the most common religion in the area in which we lived. I wish there had been more discussion between my parents and us about religion. One of my sisters still goes to church and lives in the same way my parents did, while myself and my younger sister never go to church. That has been a difficult issue, especially for my father who would have liked very much that for us to follow in that direction.

Dr. Connolly: Yet you have a great number of spiritual values and humanistic values. What shaped those other than formal religion? Were there any influences, philosophical or otherwise?

Dr. van Heeringen: No, I wouldn't say so.

Dr. Connolly: You went to medical school. Did you enjoy those years very much?

Dr. van Heeringen: Yes, I did.

Dr. Connolly: What led you to psychiatry?

Dr. van Heeringen: Well, that is a strange story. What I actually wanted was to become a pediatrician. In the penultimate year of studying medicine, you have to plan the internships that you want to do during the last year. This is to prepare yourself for becoming a GP, a pediatrician, internal medicine, or whatever else you want to do. I composed my internships based on the idea of becoming a pediatrician. I didn't chose psychiatry as an internship, but I did include neurology. My supervisor at the neurology ward where I worked for a couple of months was a psychiatrist and, after two weeks, he called me into his office and said, "You have to do psychiatry. You are a psychiatrist." This was a totally new idea for me. I checked with the administration of the university whether it would be possible to change my program of internships. The least I could do was take an internship in psychiatry just to get the flavor of it, and so I did that. I worked for a couple of months in a psychiatric ward in the general university hospital, and indeed I noticed that I liked it very much, not that I always liked the people, but I liked the approach, the problems, the way you can deal with these problems and the different approaches that you have for tackling these problems. So I changed my plans.

Dr. Connolly: You were obviously a good listener, even then

Dr. van Heeringen: I worked for a couple of months in the psychiatric ward, and it fitted. I felt fine, and apparently it was the other way round as well, because the head of the department of psychiatry asked me to stay. He offered me a position so that I could take the training in psychiatry. When I finished my training, he asked me to stay in the hospital, then they asked me to become a member of the staff, and then to be a professor of psychiatry.

Dr. Connolly: You became a professor of psychiatry at a young age.

Dr. van Heeringen: Quite young, yes, due to, I don't know what. Working hard?

Dr. Connolly: And brilliance?

Dr. van Heeringen: I don't know if you could call it brilliance. I wouldn't use that word. It is something that sort of evolves when you like your job - an excellent combination of doing clinical work, seeing patients and doing research. That combination is excellent.

Dr. Connolly: What proportion of your work is clinical work?

Dr. van Heeringen: Too much! Officially we have an 80-20 division? 80% clinical work and 20% research, but we also have to do teaching, management regarding the hospital, meetings and many other things.

Dr. Connolly: Do you enjoy teaching?

Dr. van Heeringen: Yes, very much.

Dr. Connolly: What first awakened your interest in research?

Dr. van Heeringen: My first involvement in suicide research was a pure coincidence again. My boss at that time gave me the opportunity to do a follow-up study of suicide attempters. There was no history of research in our department. Nobody did research. He was asked to join in a multi-centre study, and he came to me and asked me whether I would be interested in doing that study in our hospital. I accepted it in 1986.

Dr. Connolly: What did that research entail?

Dr. van Heeringen: It was a one year follow-up study of attempted suicide patients - a naturalistic description of what happened to these people and also a randomised control trial to study the impact of a specific intervention. All of the patients who were seen at the A&E Department for a suicide attempt were sent home after the medical, internal and psychiatric evaluation. The experimental group were referred for outpatient mental health care after their suicide attempts and, in case they didn't show up for the appointment, we sent a community nurse to their houses to talk to them to try to understand the reasons why they didn't take up the treatment. Then the nurse tried to match their needs with the opportunities for mental health care. The idea was to improve compliance with aftercare in attempted suicide patients. That was the main aspect of the study, and I had to coordinate the follow-up, collect the data, carry out the analysis and write papers about it.

Dr. Connolly: What was your thesis?

Dr. van Heeringen: In this study we collected baseline information on all suicide attempts who were admitted to the Emergency Department. This was built up into a database on characteristics of suicide attempters and their attempts. We decided to continue this monitoring after the actual intervention study stopped, so we collected, and are still collecting, information on suicide attempts. Therefore, I got involved in what you can call an epidemiological study of attempted suicides. My thesis was about epidemiological aspects of attempted suicide - age, gender, marital status and employment status. That is one reason for my being involved in suicide research. There is another reason as well

Dr. Connolly: What?

Dr. van Heeringen: At the beginning of my training as a psychiatrist I did liaison work seeing people with psychiatric or emotional problems in the General Hospital, and one of the patients that I met was on the physical rehabilitation ward. She was a young girl, 15 years old, who had jumped in front of a train in a suicide attempt and lost her legs. She was trying to learn to walk with prostheses. I had many talks with her because I was intrigued by the problem. It was summer, and we have this summer city festival in Gent. I was

sitting on a terrace and looking at young, nice-looking girls with nice legs walking around and wondering how is it possible that a young good-looking girl can jump in front of a train and get mutilated in that way, particularly because she told me about the reasons why she did it. She left school one hour earlier than she should have just to meet her boyfriend, and she was seen by an uncle standing on the street with this boyfriend, talking to him. The fact that this uncle saw her made her take her bicycle, struggle through the meadows to the railway line, and jump in front of a train. It was such a trivial reason for her to do it. I got involved with this girl in a therapeutic way, and I had many discussions with her, talking about the reasons why people do this.

Dr. Connolly: Was she mentally ill?

Dr. van Heeringen: Apparently not. So that was another reason for me to become intrigued by the problem. That is one of the reasons why we started collecting data on suicide attempters - to try to understand who they are and why they do it. My interest was in finding out whether anybody can attempt suicide, but now I don't think that everybody can do it.

Dr. Connolly: You are part of the WHO/EURO multi-centre parasuicide study. Tell me a bit about that.

Dr. van Heeringen: I can tell you why it has been important for me to join the group. It has put our work on the European map of suicide research. It was a major vehicle to achieve that. It was an opportunity to meet many nice colleagues and make some good friends with whom we communicate quite often about research and methodological problems.

It also allowed me to organise the European Symposium in Gent two years ago which was due to the fact that I got in touch with many other people and made friends who got to know me, the kind of work I do, etc. This is partially related to having joined the multi-centre study.

Dr. Connolly: The organisation of the conference is a big undertaking. We never realise what it entails until we actually do it. We take it very much for granted. I've had the experience. Yet I want to go for the IASP Conference in 2005. It is crazy. Perhaps I should see a psychiatrist?

Dr. van Heeringen: There are many many difficult problems that you have to solve in organising a conference like that. On the other hand it is very satisfying. You tend to forget the negative things and the problematic things and remember the good ones.

Dr. Connolly: Going back a little bit in your career then, which psychiatrists and colleagues were the most use to you in your development and your progress through the system.

Dr. van Heeringen: Well the first one I have to mention is Keith Hawton. I probably met him for the first time at the European Symposium in Bologna (Italy). At that time I was preparing

for my oral examination and making up my mind about writing my thesis. I already knew that it was going to be on the epidemiology of suicidal behavior. He knew a lot about the methodological issues regarding epidemiological studies and so I made an appointment and went to Oxford to discuss possibilities of doing a PhD with the data that we had collected. After that we met again on other occasions. He is now a very good friend of mine. I see him as a teacher for me, and the relationship evolved into a very good friendship.

Dr. Connolly: What did you learn from him?

Dr. van Heeringen: Methodological issues. As I told you, there was no history of research in our department and, in fact, in psychiatry in Belgium. There was nobody with any knowledge of how to set up studies, what things you have to look for, how you can avoid methodological problems and things like that. He gave me a very basic knowledge of how to design the studies.

Dr. Connolly: Tell me a bit about your current research and your current interests.

Dr. van Heeringen: I established in 1996 what we call the Unit for Suicide Research, which is located in the Clinical Department of Psychiatry which is good because the research and clinical work stimulate each other. The research can be good for the clinical work, and we need patients for our research. The work that we do can be divided into three main issues. The first is epidemiology which includes monitoring studies like the WHO Study which I do for the Flemish Government. We also monitor attempted suicide in several other hospitals in Flanders. We have also studied specific risk groups, for instance, homosexual youngsters.

The second part of the work is the development of prevention programs. The first program was for secondary school students in which we developed a program, not for the students, but for the teachers. We organised meetings with small groups of teachers and had them sitting around a table with local mental health care professionals from community mental health centres so as to establish personal contacts between teachers and mental health care professionals - training teachers how to recognise suicidal pupils and things like that. There have been several other prevention programs. Now we are involved in a broad regional suicide prevention programme in Flanders, and we are also involved in the development of specific prevention activities through schools, GPs, and the police.

The third area is what we call the psychobiology of suicidal behaviour, looking at the psychological and biological risk factors and the relationship between the two. This is what I find particularly interesting, and what is very nice about this kind of research is that you meet researchers with different backgrounds, such as nuclear medicine people, radio-pharmacists, psychiatrists, and psychologists, and you take a multi-disciplinary approach to the study of risk factors. We tend to talk different languages as psychologists or as biological psychiatrists, but we are actually talking about more or less the same things.

Dr. Connolly: Where do you think the future of suicidology research lies?

Dr. van Heeringen: In what we are doing. It sounds very self-confident, doesn't it? It is all happening in the brain. There is a growing insight into what is happening in your brain between hearing or experiencing something and reacting to it. We all know about risk factors like interpersonal problems, or unemployment, etc., but on the other hand we know that not all people who have interpersonal problems or who are unemployed become suicidal. There are individual differences in information processing, and we are now beginning to see where these individual differences are located, which biological and psychological mechanisms are involved. I am sure that this will provide opportunities for new approaches.

Dr. Connolly: Which brings us quite naturally then on to the problem of transferring research findings into clinical practice, which is something that comes up at all of these meetings. What would you say about that?

Dr. van Heeringen: The general idea of course is that clinicians or mental health professionals should have evidence-based guidelines on what to do, but one of the problems in managing suicidal patients is that there are so few evidence-based guidelines. This is one of the challenges for us in the coming years -- to develop such evidence-based guidelines. There is a great need for collaborative large studies of suicidal patients and the effects of psychotherapeutic or psychopharmacological approaches. We have to be very confident as researchers or as opinion-leaders that we have good evidence for what we are telling people.

Dr. Connolly: Regarding the setting up of suicide prevention programs in schools and working with government departments, how successful have you been? One of the problems with school-related programs is that they don't get accepted with great enthusiasm, and then they gradually get whittled away and lost. There is no continuity there. How do you achieve that?

Dr. van Heeringen: We don't. I told you about theprogram we developed for schools to bring together teachers and mental health professionals. We did get a grant for developing the program and conducting a pilot study which took us about three years, from developing to testing, but after that the grant stopped. We have kept talking to the minister of health about the necessity of developing a prevention program. We have epidemiological data showing the increase in attempted suicide, especially among young people. About three years ago, she finally decided to develop plans for a regional suicide prevention program, and she made money available, including a little bit for our research center, but especially for the community mental health services. Every centre should have a half-time suicide prevention person responsible for the region. This half-time person is responsible for contacting police, schools and emergency departments in general hospitals, and anybody else who could be involved in the prevention of suicide. That was a way that we could

integrate the prevention program that we had developed for schools. About a year ago, the Flemish Minister of Health Policy determined that the prevention of depression and suicide should be one of the five health targets. We are currently involved in developing a broad prevention program which incudes work in the schools.

Dr. Connolly: You have been involved with IASP for a long time. How important is the Academy, IASR?

Dr. van Heeringen: I think it is important. It is very important to have an academy as a platform for discussion, exchanging experiences, exploring methodological problems and trying to find solutions, a platform where you can consult colleagues and also a platform for the presentation of preliminary data from studies. I think it can be very helpful to have an academy like that.

Dr. Connolly: I agree with that entirely as long as it doesn't become remote and as long as it doesn't stop the kind of communications that can take place at the general meetings of IASP. To move on, you have published quite a lot?

Dr. van Heeringen: Yes, quite a lot, but not as much as I want to.

Dr. Connolly: You are still young, not like some of us. What are you most proud of having produced?

Dr. van Heeringen: The International Handbook of Suicide and Attempted Suicide for a couple of reasons. It was a pleasure producing it, working with my former teacher and now friend. It was a good experience, and the response has been quite good.

Dr. Connolly: You have also done a lot of work with Ad Kerkhof.

Dr. van Heeringen: I have indeed worked with Ad in a very productive way. We have just produced a Dutch book on treatment strategies, a very practical book for mental health professionals in Belgium and Holland.

Dr. Connolly: I saw the book. We ought to set up a little group to look into translating books like that because so much is published in languages other than English which unfortunately never gets into broad circulation.

Dr. van Heeringen: That is a good idea. A third book was published in 2001 called Understanding Suicidal Behaviour which is about the suicidal process approach and the consequences of this approach for the treatment and prevention of suicide. There are some intriguing biological and psychological data supporting the process approach.

Dr. Connolly: We might finish by getting back to more personal things, your marriage and that kind of thing.

Dr. van Heeringen: That might be interesting for the reader. One of the reasons I stayed in Belgium and did not go back to Holland was because I met my wife while studying medicine. Of course, it is very nice to live in Gent. Then the children came - they are now 12 and 14 - lovely kids. Of course, I am sure that everybody will tell you that when you have to do clinical work, teaching and research, and you have your family, there is always a conflict between priorities.

It is not always an easy life for your family to understand why you are so involved with something that has to do with work. The first time that happened was when I was writing my PhD thesis. My wife doesn't have a university background, and so she was not familiar with the huge amount of work involved in producing a PhD thesis. I had to spend all my holidays, weekends, evenings and nights sitting at a computer. Sometimes she was ready to throw the computer out of the window.

That was at the beginning of my research career, but now she has seen the results that have come out of it. The next major thing was the Handbook which took us about two years to prepare. Again that took all my weekends, nights and evenings, and it was very time consuming, but by that time she understood. She was more confident that it was not an escape from the family, but was well necessary to produce a good book.

I have been working very hard for the last ten years, and now I feel the rewarding aspect. Two years ago I received the first Dutch suicide prevention prize, which was nice. When the books come out and are well received, it feels like a return of the investment, and that keeps us going.

Dr. Connolly: What about relaxation and hobbies. You mentioned music. What else do you like to do in your spare time, if there is such a thing.

Dr. van Heeringen: Sometimes there is. I used to be a bit of a sportsman. I played squash quite seriously, and then I switched to tennis. I go to the movies and go out with friends, and I enjoy good food.

Dr. Connolly: And wine

Dr. van Heeringen: And good wines. Absolutely. And travelling, which is also a nice part of the research. If you only do clinical work, there is no opportunity for you to go to Australia, New Zealand, or to America.

Dr. Connolly: Is there anything else you would like to add?

Dr. van Heeringen: In the end the most important thing is the suicidal person. You can talk about the benefits of doing research and travelling and things like that, but in the end it is the patient that we are all thinking about. That is what I like very much -- the combination of clinical work, seeing patients, and doing research. Many of the research questions are phrased by patients, and it is by listening to them that you can focus your attention on what we have to study.

Dr. Connolly: I think that is a lovely point to end on. How do you feel about being interviewed like this?

Dr. van Heeringen: I like it.

Dr. Connolly: It is something we don't get a lot of experience of in our jobs, but I also like interviewing people.

Dr. van Heeringen: I get a lot of requests from newspapers and magazines for interviews, and sometimes I am a bit reluctant to talk about suicide because we are all aware of the potential media effects of such articles. Sometimes you get questions from journalists which are difficult to answer if you take into account the potential negative effects of talking about suicide.

Dr. Connolly: That's true, and I am in that position quite a lot in Ireland at the moment. I suppose you are damned if you do and you are damned if you don't. If you don't talk to the journalists they are going to talk about suicide anyway but, if one co-operates with them, one can at least have an input and try to minimize the bad impact.

Dr. van Heeringen: A crucial aspect with regard to interviews with the media is that it gives you an opportunity to point out that help is available. In that sense the media can be very helpful in increasing the access to appropriate treatment.

INTERVIEW WITH RONALD MARIS

Dr. Connolly: Tell me about your early school days.

Dr. Maris: I grew up in the Midwest. I'm not sure I can make much of my early school days. They were uneventful with the exception that I had scarlet fever as a young child. My father created a lot of problems since he was an alcoholic.

Dr. Connolly: What books did you like to read?

Dr. Maris: I read a lot, mainly adventure stories.

Dr. Connolly: Was your family religious?

Dr. Maris: Yes and no. My grandfather and my uncle on my father's side were very religious. We talked about life and death a lot.

Dr. Connolly: What about school?

Dr. Maris: I was a good student. I was very involved in art. I did a lot of drawing during my senior year in high school. I went to the University of Illinois which was in my home town. I never really thought about going far away. I majored in chemical engineering, and I earned good grades. But I had doubts about majoring in chemical engineering. I wanted a more liberal education, and I switched to English and philosophy. The major change that I made at university was that I decided to give up my athletics scholarship in track and try to go to Harvard Divinity School. I did go to Cambridge (Massachusetts) in 1958.

I enjoyed it there, and I loved Cambridge. Although I did not see myself having a career in religion, I was in fact a Methodist Minister for five years. I was ordained as a Methodist Minister and had two churches, and that was an important part of my life.

Then I came back to Champaign, Illinois, and got a Masters degree in Philosophy, focusing on British linguistic philosophy. Again, I decided to switch interests, after I got my masters, to social and behavioral sciences. Almost by accident, I read Durkheim's book on suicide as a Master's student, and I decided to do theoretical and epidemiological work on suicide in Chicago. I got a grant from the National Science Foundation to do that for my Ph.D. dissertation.

That was my first work on suicide. I don't really know why I picked suicide. I had been interested in Durkheim, and he was a social philosopher who happened to write about suicide, Jack Gibbs once said that if Durkheim had written about stuttering, there would be a huge literature on the sociology on stuttering. So it was somewhat accidental. I taught for a year at Arizona State University (in 1966), but I was very unhappy in the southwest. A couple of months after going out there, I got a job in at Dartmouth College in Hanover, Hampshire, to teach sociology.

I went up there for two years and decided that I wanted to do more clinical and psychiatric work in suicidology. At that point I had only an epidemiological and statistical understanding of suicide; so that was a crucial juncture in my development.

In 1968, I left Dartmouth College and went to Johns Hopkins Medical School where I stayed for five years. I started with a post-doctorate fellowship in suicide prevention and suicidology, and then I stayed on for four more years as an Associate Professor of Psychiatry. I ran the MD/PHD program in behavioral science. I created a program where students got both degrees in six years. I ran that program for four years, and I received an NIMH grant to study suicide. I went back to Chicago and did another survey study of suicide there. I received a lot of supervised clinical training in the Johns Hopkins Psychiatry Department, and I took a clinical internship in Los Angeles at the Suicide Prevention Center where I worked with Ed Shneidman, Robert Litman and Norman Farberow. I stayed at Johns Hopkins Medical School until 1973, but I have continued to take post-doctorate fellowships in psychiatry. In 1971, I had a World Health Fellowship in West Berlin; in 1980, I had a fellowship to go to Austria to study with Professor Ringel who was still alive. Recently, in 1993, I took a year off and went to Pittsburg to study psychobiological suicidology with Dr. John Mann.

In 1973, I got tired of living on soft money and research grants, and I got a chance to be a tenured Full Professor at the University South Carolina, and I have stayed there ever since. I became Chairman of their Sociology Department in 1973, and I was chair of the department for eleven years. I created the Center for Study of Suicide in 1985, a state agency in South Carolina where we trained masters, Ph.D.'s and a variety of other students in suicide prevention.

During part of that time I was President of the American Association of Suicidology (in 1981) and Editor of their journal (Suicide and Life-Threatening Behavior) for 16 years (1981-1995). I did a lot of writing – for example, an original monograph called Pathways to Suicide (Johns Hopkins University Press) based on my Chicago research. I edited a book on the assessment and prediction on suicide (Guilford Press, 1992). I still do some of work on philosophy, like the issue of rational suicide. I travel quite a lot, I have been fairly active in international suicide prevention associations, and I'm a member of the Scientific Advisory Committee of the American Foundation for Suicide Prevention.

Dr. Connolly: Are you still involved in foreign travel now?

Dr. Maris: It has declined. I had become tired of travelling. For a while I worked with Professor Ringel and other people in Europe, including Michael Kelleher in Ireland. I attended Michael's conference in Ireland, one in Greece, and one in Israel with Israel Orbach.

I am a member of the International Academy for Suicide Research, but my understanding is that their organisation has faltered. I have been a co-author of books, both with Dr. Rene Diekstra and for the International Association for Suicide Prevention.

Dr. Connolly: Can we just go back a little bit now. In your student years, who made you interested in suicide?

Dr. Maris: Indirectly Durkheim. I started off reading Durkheim, and he was a major influence in terms of thinking very critically about philosophical issues, such as whether suicide is ever appropriate or not? Durkheim talks about that. At Johns Hopkins, I did a lot of psychoanalytic training. Several of my teachers were psychodynamically-oriented, such as Avery Weisman, Seymour Perlin, Ben Riggs, and Jerry Motto. These were the people that I worked with during my fellowship years. I also spent some time with a fairly eccentric character in Germany, Klaus Thomas, a hypnotist.

Dr. Connolly: Did you practise hypnosis?

Dr. Maris: No, but I visited Dr. Thomas one summer night, and he was putting people to sleep for therapeutic purposes. Erwin Ringel was another major influence in my life. I spent about a year working for Katschnig and Ringel. John Mann has also been very influential in my life regarding the biology and the neurochemistry of suicide. I also had Seymour Perlin for a fellowship, and I worked with Brian Tanney in Alberta for a year.

Dr. Connolly: What about in Divinity School?

Dr. Maris: In Divinity School I studied primarily with Paul Tillich, the German theologian. I was there when the really famous professors were there -- George Ernest Wright, a Professor in the Old Testament, and Kristen Stendahl, a Professor in the New Testament, as well as professors in Greek and Hebrew studies. Paul Tillich was a major influence in my life. While I was there, I also took philosophy courses at Harvard.

Dr. Connolly: What about Popper?

Dr. Maris: Not much, I knew about him, of course, as well as Ayers, Russell, Wittgenstein and Nagel.

Dr. Connolly: Popper and Wittgenstein didn't get on very well did they?

Dr. Maris: Wittgenstein was a rich, eccentric man, but I don't really know their interpersonal history.

Dr. Connolly: Actually, Wittgenstein spent sometime in Ireland!

Dr. Maris: Did he? Interesting! I remember him working with Russell. Norman Malcolm, who was a philosopher at Cornell, who went over to Ireland to write a book about Wittgenstein. Wittgenstein had a safe in his apartment and a lawn chair, and the students would come in and there was no place for them to sit, so they would sit on the floor. He had a phobia of his manuscripts burning up. He wrote only two books in his life, the Tractatus Logico Philosophicus, which had seven propositions and, when he finished it,

he figured it solved all philosophical problems, so he quit philosophy. He built a house for his sister and then he wrote his second book, Philosophical Investigations.

Dr. Connolly: Did you have do military service?

Dr. Maris: I never went into military service. My father was in the military, as were my brother, my brother-in-law and my uncle. My early kidney disease disqualified me. I took the physical but failed. Not that I would necessarily had to serve because at the time I was involved in my graduate studies and, if you were a student, you could be deferred on that basis.

Dr. Connolly: Were you disappointed about that?

Dr. Maris: I was a little disappointed because military service was the norm at the time. It was the thing to do, and I was an athlete. But I failed the urinalysis test. I was somewhat disappointed, and I felt that I wasn't like my father or my brother (who is now a Business School Dean in Ohio). On the other hand, I was close to being a conscientious objector at the time because I had religious views that I had difficulty reconciling with war.

Dr. Connolly: Has that grown or lessened as you have got older?

Dr. Maris: I think it has grown. I don't hunt or fish anymore because I can't kill animals. I'm not a vegetarian, although two of my daughters are. But I just can't justify killing for sport. So in that sense it has grown. On the other hand, I'm not naïve about the fact that there are complex issues involved. I wrote an essay as a college student about a soldier who had the opportunity of killing his enemy, and I let the soldier be killed because he could not pull the trigger.

Dr. Connolly: How old were you then?

Dr. Maris: I was probably about 18 or 19.

Dr. Connolly: Speaking of such dilemmas, what about assisted suicide and euthanasia? Oregon has just legalised assisted suicide.

Dr. Maris: I am very sympathetic to some assisted suicides. On the other hand, I think that most suicides are inappropriate. I don't have a major aversion to helping people die. We shouldn't abandon people when they are dying. If my internist and I talked about my illness and, if I felt that there was no reasonable way to live my life, then I would hope that I might be permitted to die with his help, much as someone might have an abortion. We shouldn't be abandoned in our time of real need. If I asked my physician for a lethal overdose, I would hope that he would be willing to help me die, after certain conditions were met. We are all going to die anyway. No one is getting out alive.

Dr. Connolly: Many people are worried about the slippery slope argument and the possible pressures put on people to commit suicide.

Dr. Maris: That's a real concern. I have read most of the arguments. I have read Herbert Hendin's book and his argument that physicians, on their own authority, make life and death decision about the needs and interests of their patient, often without consulting them. I remember Kevorkian would not remove the carbon monoxide mask from his client, Hugh Gale, even though Gale wanted to stop the procedure. On the other hand, there is a danger that a woman may need an abortion but ends up torturing herself because she can't go to a clinic and get it done safely.

I would hope that, just because I felt the need to die, that I would not have to do it alone in some dingy hotel room, with nobody there, using a method which might just mutilate me. Some people really need to die, and many people need help in doing so. I have been fairly close to Derek Humphry over the years, and I have talked to Derek about the fact that most of the objections to assisted suicide have to do with religious issues. As I have become older, I have become less religious in the conventional sense. Most people don't believe in killing because they think it's God's role to make that decision. I don't believe that. I'm not sure anymore that there is even a God in any doctrinal sense.

Yet, I am very spiritual, very concerned, very sensitive, and very worried about things that are ethical. But I would never not help somebody because it was "against God's will." That just does not make any sense to me.

Dr. Connolly: There is very interesting statement from a Bishop in Scotland who published a marvellous tract on morality, exploring it all.

Dr. Maris: Probably you could discuss intriguing moral issues with him. One of the things that initially attracted me to the Christian religion was its morality and ethics. But you can have those without the theology. Even in philosophy the arguments about the existence of God were just web-spinning logic.

For example, when I was President of AAS (in 1981) I wrote a paper on rational suicide which caused me a lot of trouble. Basically I said that, under certain conditions, I thought that suicide could be appropriate. Most of the people in the organisation would not endorse that view of suicide. Suicide is a fascinating subject and a very important matter. We ought to exhaust all our nonsuicidal alternatives and, even if there is no God and no after-life, you should still want to have the fullest life you can. In fact, that there may be no after-life might even make life more precious.

Dr. Connolly: Yes indeed! A friend of mine used to have a reoccurring nightmare, and he would wake up terrified. He realized that, when he died, if there was a God, he would know but, if there wasn't a God he would never know.

Dr. Maris: I think that's true. It's more terrifying that there may be <u>no</u> God or Hell. The fact that most people are terrified by that possibility is an indication that the belief in God is a comfort. There is concern that your consciousness might be annihilated, and we spend 60

to 80 years developing our soul and our spirit and our mind and then they are just gone. What a waste!

Dr. Connolly: Maybe the alternative is even worse -- survival of the mind for ever.

Dr. Maris: Certainly. Living forever would not be marvellous.

Dr. Connolly: But I expect that the controversy about rational and assisted suicide is going to rage on for some time.

Dr. Maris: It will. We will probably see it waxing and waning. We have already seen Oregon pass an assisted suicide law, and then the federal government rescind it in effect by controlling narcotics licences. California and the state of Washington have come very close. Several other states have put propositions on the ballot which have narrowly failed to pass. I predict that there will be more of those attempts to pass legislation and set up suicide assistance centers as opposed to prevention centers where those worried about dying or wanting to die can go. On the other hand, every time you get a Humphry or a Kevorkian making the news, a reaction is generated which sets the liberal cause back. So you end up often going backwards.

Dr. Connolly: Assisted suicide certainly raises great emotions.

Dr. Maris: It certainly does. On the other hand. I can empathize with people who are opposed to abortion. It's an extremely difficult issue, particularly when you have a fetus that has no thoughts, no rights and no power. It's similar to the position of young children. Children have very few rights and little power. So somebody needs to be an advocate for unborn children. On the other hand there are situations where life becomes a little too precious in some respects. Death is something that can be pornographic. I was watching a Discovery Channel nature movie, and you see that there is death all the time in nature. Animals eat each other, and big fish eat little fish. It's an everyday, ordinary activity. Yet, with humans, we get bent out of shape about the unique importance of a particular human life. Of course, if it was my life or your life, then that's a different story. The death of others is all around us, but premature death can be unfortunate.

I think most suicides are premature in a sense that, eight to ten weeks later, the suicides themselves would have changed their minds, if they could have, and, if they would have treatment, they might have not even wanted to die.