INTERVIEWS WITH SUICIDOLOGISTS, VOLUME 2

JOHN CONNOLLY AND DAVID LESTER

At the turn of the century (the year 2000+), John Connolly interviewed several suicidologists, mostly when he met them at international conferences. The first set of interviews, edited by myself and the interviewees, has been placed on the website www.drdavidlester.net.

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

I am pleased to present the second set, now on the same website.

The interviews are with

Keith Hawton
Antoon Leenaars
John Maltsberger
John Mann
Isaac Sakinofsky

INTERVIEW WITH KEITH HAWTON

Dr Connolly: Where you were born?

Dr Hawton: I was born in Barnet, North London.

Dr Connolly: What was your family background?

Dr Hawton: Fairly ordinary. My father was a legal secretary in the Transport and General Workers Union, and my mother was a housewife who occasionally worked in schools and kitchens. I went to a local grammar school, a very good school. It was a new type of school and, as a result, it really helped me develop considerably. I was very lucky to be with a group of academic pupils, and we spurred each other on. About six or eight of us in the class obtained better exam results than we would have otherwise obtained, and that allowed me to get to Cambridge, for which I am forever thankful.

Dr. Connolly: Did you have any siblings?

Dr. Hawton: I have one brother, nearly ten years older than me, who used to work as a quantity surveyor. He eventually became an entrepreneur in various fields.

Dr. Connolly: You found school very interesting and soon became academically inclined?

Dr. Hawton: I was hard working. I was interested particularly in biology, and I intended to become a zoologist. I was put off that when I got to university and discovered that most of the zoologists seemed to be a rather unusual bunch of individuals. I didn’t quite fit in with their style.

Dr. Connolly: What were you reading during your school years?

Dr. Hawton: I used to read many classic writers from that period - Steinbeck, Kafka, Dostoyevsky and Salinger.

Dr. Connolly: Were you always an avid reader?

Dr. Hawton: I was then, but less so now, probably because I’m so busy working.

Dr. Connolly: What about music?

Dr. Hawton: Rock`n’Roll right from its beginning - Bill Haley. I have continued to enjoy that sort of music - not just the old stuff, but some of the new developments. I like rhythm and blues. I am also a passionate fan of Leonard Cohen.

Dr. Connolly: What about your religious background?

Dr. Hawton: I went through a phase in my early teens of becoming avidly religious and underwent what would have been seen as a conversion. That didn’t last very long, probably about a couple of years, but it was an interesting time.

Dr. Connolly: Are you a churchgoer?

Dr. Hawton: No, not now, except on special occasions - Christmas and the carols, weddings and funerals mostly.

Dr. Connolly: You had intended to read zoology. When did you make up your mind about your career?

Dr. Hawton: Not until I got to the university. I was reading natural sciences. Later on, I decided to pursue psychiatry mainly because I was studying experimental psychology there. I read psychology for Part I of my degree, and I loved the experimental method. We had some brilliant teachers, major figures in the field like Richard Gregory, Larry Weiskrantz and Liam Hudson, people renowned at the time and who were very inspiring. I then specialized in experimental psychology in my last year, and I enjoyed the psychiatry lectures in particular. The psychiatrists who gave them made the lectures spicy for us, which added to the interest. I can't remember the exact point when I decided that I wanted to do psychiatry. At that stage, I didn't realize I had to study medicine to become a psychiatrist. I went to my tutor, A. T. Welford, who was a well-known psychologist, and said that I wanted to become a psychiatrist. He told me that I would have to do medicine, but that it wouldn't be a problem. I would have to spend the next year at Cambridge doing anatomy, and so I had very enjoyable fourth year at the university.

Dr. Connolly: You mentioned some people who inspired or influenced you. Tell me about them.

Dr. Hawton: There were a lot of people there who were at the peak of their creativity. Richard Gregory was a somewhat hypomanic character who, even in our tutorials, was testing out hypotheses, particularly looking at perceptual phenomena. Alice Heim worked on intelligence testing, and she developed a test that distinguished among the top five percent of the population. She supervised me and my roommate, who was also studying psychology, in an undergraduate project that went very well. People had to learn pairs of words with different degrees of association between them, and that resulted in my first publication - in the *Quarterly Journal of Experimental Psychology*. That was exciting. There were also a number of neuropsychologists there who went on to become major figures in the field. I found the way people were using tight experimental designs to test hypotheses inspiring. We were encouraged to develop research methodology ourselves at that stage, and it was a huge contrast with what went on in other subjects I was studying. I was in a group with some very bright people, the most well-known of whom is Colin Blakemore. The whole experience was very positive and encouraging and made me keen to pursue research. That started my interest in research.

I went to Oxford to do my clinical training, and I stayed on for my psychiatry training. I was in the Department of Psychiatry, and there were some people around who were quite inspirational. The rigor of the scientific work there was extremely high and, in addition, the clinical training I received was pretty good. I found psychiatry a bit less stimulating than psychology had been, but I was fortunate to be able to carry with me some skills and an attitude of mind that I got from studying psychology which I was then able to apply in psychiatry. That has influenced my work ever since.

Dr. Connolly: Were any of your teachers influential?

Dr. Hawton: The most influential one was John Bancroft; there was also Michael Gelder who was head of the department and had a very traditional approach to things, which meant that there was a great emphasis placed on the very careful assessment of patients and well-investigated formulations of patients. He inspired partly by inducing fear in many of us but, nonetheless, we had enormous respect for his approach. I was also influenced by brushing shoulders with and working alongside psychologists in that setting, people like John Teasedale, Derek Johnston, and Andrew Matthews, who were all becoming major figures in psychology.

Dr. Connolly: You did all your basic training in Oxford. Where did you go next?

Dr. Hawton: I stayed on! It's one of those places where a lot of people stay on. I don't know whether that is a good or bad thing, but it is a very nice place to be.

Dr. Connolly: When did you become a consultant there?

Dr. Hawton: 1984. Before that, I was the equivalent of a senior registrar for maybe ten or eleven years, doing research. I had a research post, then a lecturer's post and then a tutor's post, all of them below consultant level. I enjoyed that time enormously. Michael Gelder in his wisdom restricted the clinical commitments of the junior academic staff to a reasonable level so that we were able to really focus on developing research. It wasn't that we shied away from clinical work, but we had a good balance between clinical and research responsibilities. I developed the basis of my research program even before I became a consultant.

Dr. Connolly: Tell me about your research.

Dr. Hawton: In 1976 I started our Oxford monitoring system for attempted suicide in which we collect information on everyone who presents to our local general hospital following intentional self-poisoning or self-injury. That has become an incredibly rich database. There has been a theme of work running through it, which has been largely epidemiological. Some other areas of my research have come partly from my interests in the psychology of suicidal behavior. I think that's an area I could have developed further and still might do. Our recent research in media influences on suicide developed because of an opportunity to carry out a project that has become one of the landmark studies in the area. Much of my work of late has concerned treatment and prevention of suicidal behavior. I have covered a broad area - perhaps a bit too broad. Suicidal behavior is multifactorial so that to focus on only one line of work is unnaturally constricted and not in keeping with the full picture of suicidal behavior.

Dr. Connolly: What do you think is your most important work?

Dr. Hawton: The work on treatment of suicide attempters is my most important contribution. I have been involved in four randomized control trials of the treatment of suicide attempters. In more recent work we have tried to amalgamate all of the studies that had been done worldwide in order to make sense out of them and to see what they show overall. In some ways, this has been disappointing because the quality of the treatment studies is poor, including our early studies. We were naïve in the way we approached the studies in the early days, particularly in terms of how many

participants were needed. That's something I'm keen on now - trying to help other people avoid the same pitfalls.

The problem concerns the power of the studies. If you are trying to reduce repetition of attempted suicide, you have a variable which is black and white. To reduce the repetition rate from 20% to 15%, a clinically significant difference, you need several hundred participants in a study. I think our work may have contributed somewhat to people designing better studies, but none of them have been totally acceptable. We were left not knowing whether a particular treatment is effective or not. We did one of the studies (home-based treatment versus outpatient treatment of suicide attempters) because patients were often not turning up for outpatient appointments. We found a difference in repetition between the two groups but, because it wasn't statistically significant, we came to the conclusion that home-based treatment wasn't worth doing. That influenced the development of our local services and maybe services elsewhere. In fact, if we had had sufficient numbers and if we had found the same difference, it would have had a very different impact on services, and I would have probably developed home-based treatment services much more.

Dr. Connolly: What else?

Dr. Hawton: Some of the epidemiological work we have done using the Oxford Monitoring System for Attempted Suicide has been influential. The database is comprehensive in terms of identifying, as near as one can, everyone who has self-harmed and comes through our general hospital, which is a large one. We have been able to identify trends in attempted suicide, which have been reflected elsewhere in the country. We became seen as *the* center for reporting on what is happening regarding attempted suicide. The most important recent example would be where we have interviewed patients who took paracetamol overdoses, and that made a contribution to the legislation that was introduced in September 1998 in the UK to limit the size of packs of paracetamol and aspirin to a maximum 32 tablets in chemists [pharmacies] and 16 tablets in non-pharmacy outlets. We have now been able to evaluate the impact of that legislation, and we have shown that it seems to have had a significant effect in reducing deaths from paracetamol or aspirin overdose, the numbers of liver transplants, and the numbers of people taking large overdoses. That is perhaps one of the most rewarding pieces of work we have done.

Dr. Connolly: You talked a bit earlier about the teachers that influenced you. Who else?

Dr. Hawton: Well, I mentioned John Bancroft, who interestingly is known primarily for his work in sexology and who later became Director of the Kinsey Institute in the USA. I also did quite a lot of work in the sexology field for many years. John started a program of work on attempted suicide in Oxford, and he became aware of the problem of so many people presenting with overdoses, particularly to the local hospital, which reflected the huge increase happening generally throughout the UK and elsewhere. It was he that got me into that area. He offered me a job working on my first treatment study, and so he was a major influence in terms of getting me into that area and on my approach to research design. I found him fascinating and very influential.

Dr. Connolly: I remember hearing you talk once about the influence of Stengel.

Dr. Hawton: I didn't know Stengel. I read his Pelican book as an undergraduate, and that certainly interested me. Alvarez's book "The Savage God" was also influential. It's a wonderful account of the history of suicide and used Sylvia Plath as an example. Alvarez tried to reconstruct the event of suicide, the full context of the behavior, and to understand the motives involved. He believed that Sylvia Plath's suicidal action that lead to her death wasn't intended to result in her death. It did so through chance factors. That book was quite influential for me.

Dr. Connolly: What people in the field have influenced you?

Dr. Hawton: I admired Norman Kreitman. He was a wonderful epidemiological researcher. His attention to detail, his carefulness, his self-criticism, his ways of looking for other explanations of his findings other than the obvious ones to make sure that he wasn't coming up with false evidence, all were influential for me. I am pleased to have done some collaborative work with him and Stephen Platt.

We have conducted a fair amount of work on suicidal behavior in young people, particularly adolescents. I have admired the work of David Shaffer, David Brent and Madelyn Gould in the United States in that area. They have made significant contributions to that line of work. I have also admired the Finnish program of research. The Finns decided to look at suicide in Finland in a comprehensive way by studying every suicide in one year in Finland, in depth, using the psychological autopsy approach. The wealth of information that their study provided is an example to us all. If you are going to do a study like that, do it well and then you will need only to do it once. Their work is the best example in the field. It has generated an enormous amount of knowledge and has contributed to a research-based approach to suicide prevention in Finland which hasn't really been followed by any other country to my knowledge. I think lots of countries have elaborate guidelines on suicide prevention, but they don't have that sort of information base that the Finns have had. The Finns have been able to take an approach which is based on really sound knowledge about what seems to contribute to suicide.

In psychology, I like the line of work that Mark Williams has developed, particularly in relation to problem solving and the psychological processes that are involved in problem solving. That has been an influential area of work, and one in which we have done some work. I admire some of the biological researchers in the field such as John Mann and Herman van Praag, although it's not an area of work in which I've been so involved. I would love to be more involved in collaborative work where one looks at the psychology, the psychiatry and the neuropharmacology of suicidal behavior. I think that is a very exciting area and it's going to be a growth area, not just in relation to suicide, but in psychiatry in general, particularly in relation to chronic stress and what can go wrong with brain transmitters and the associated psychological processes.

Dr. Connolly: There is a lot going on in the field of preventing suicide?

Dr. Hawton: There is. Suicide is a multifactorial problem, and one needs to influence each of the factors that contribute to suicide, whether it be the available means for suicide (such as firearms, specific drugs, pesticides etc.), the better detection and treatment of depression, the choice of antidepressants, and the way the media portrays suicidal behavior. Each of these factors contributes to the totality of problem and, in terms of

prevention. One has to think about each of these but in a way that is testable in terms of evaluating their impact.

Dr. Connolly: What do you think of the research into lithium?

Dr. Hawton: The research on lithium and suicide prevention is increasingly convincing. We have just done a systematic review of all the trials that have been done of lithium versus placebo, and in none of them individually is there convincing evidence of an impact on suicide. However, when one combines findings from these trials it does appear to be effective .I'm thinking in particularly of seeing whether lithium has had particular benefits on suicidal thinking above and beyond the benefit that is related to its impact on depression or mood disorder.

Dr. Connolly: What about the up and coming bright stars in the field?

Dr. Hawton: There are a number of people who are doing good work, but it is difficult to say who are going to be influential. I think Tom Foster's psychological autopsy study in Northern Ireland was an admirable piece of work and confirmed a lot of what was previously known from Brian Barraclough's work in the late 1960's and early 1970's. The work by Kees van Herringen on the suicide process and the role of the prefrontal cortex in suicidal behavior should lead to some pharmacological developments down the line. Lewis Appleby's work on suicide in people with recognized mental illness has been very influential in our country. David Gunnell's epidemiological work on suicidal behavior is also a significant contribution.

Annette Beautrais in Christchurch in New Zealand has done some excellent work on suicidal behavior in young people. Her work has not only increased our understanding of suicidal young men, but has also contributed to efforts in New Zealand to prevent suicide. She has challenged the extent to which unemployment contributes to suicidal behavior in a case-control study which suggested that the impact of unemployment may be relatively weak and that any impact you see statistically may be explained by other factors, such as mental health problems which may contribute to both unemployment and to suicide. In the Far East, Andrew Cheng's work on suicide in Taiwan has been a significant development. In China, Michael Phillips has developed a very ambitious prevention program using local community resources to identify suicidal people and to provide support and help for them. It will be fascinating to see if that sort of work can be shown to have a significant impact.

Dr. Connolly: All in all, you are a person who has had an immense influence and made great contributions to the field of suicidology. Would you agree with that?

Dr. Hawton: It's very flattering of you to say so. In terms of treatment research, I feel reasonably confident that I have had an impact on the people with whom I have been involved in the design of new treatment studies in this area. I am happy to accept that that may be so. It's always difficult to know how much influence you do have on people, however flattering they are to you. Have we really had an impact, and is it beneficial? Maybe we have!

Dr. Connolly: You are very much on the international stage at the moment. You have been involved with IASP and the European Symposia for some years, but I think you came to this fairly late.

Dr. Hawton: When I started in the field in the 1970's, we had a lot going on in the UK. There were several researchers in the area. Brian Barraclough was still very active, Gethin Morgan in Bristol, Norman Kreitman in Edinburgh, our small group in Oxford, and so on. There was enough going on locally to feel that one could get what one wanted from other people's research in the UK. That was very blinkered because, of course, things were going on elsewhere. I now regret to some extent that I didn't get more involved in the international scene earlier.

Dr. Connolly: Where do you see the future for IASP?

Dr. Hawton: I think its main role has to be in trying to facilitate initiatives in individual countries. It can't introduce those initiatives itself, but it can facilitate people in various countries who are serious about trying to do something about suicide prevention. It must offer the benefit of experience from researchers and from people who have tried to introduce suicide prevention policies in other countries, to make sure that people don't make the mistakes that others have made, such as being over ambitious, trying to tackle suicide on every possible front without thinking about the implications of that, and especially trying to understand the local context.

Sri Lanka is a very good example. If you applied a typically Western approach to that problem of suicide there, it wouldn't have a chance of succeeding because the main thing there is the availability of means, namely pesticides, and the fact that you can't get people to travel to outpatient clinics. A splendid program was developed there by Sumithrayo, a befriending organization, with team members going into villages and identifying people who made suicide attempts and arranging care for those people in a village context. They had to tackle the attitudes towards mental health problems and suicidal behavior, and that is an example where they have addressed the problem with a full understanding of the local context. Errors are made when people try to apply a Western mental health approach rather than using the family and the local village community as the therapeutic agents. I think IASP has got rather too caught up on internal political problems which is diverting it from that sort of initiative, although I think now things seem to be progressing better.

Dr. Connolly: But international organizations are always involved with internal political issues.

Dr. Hawton: That's a great pity. I tend to shy away from getting caught up with the politics. Some would say that's not taking on responsibilities, but the politics can be so time consuming and draining of energy. The danger is that you miss out on the main point, which is about doing something positive for people. Unfortunately, in this field, as in many others, you have some large egos that need to be kept placated. I don't think that does us any good at all.

Dr. Connolly: You received the Stengel Research Award from the International Association for Suicide Prevention.

Dr. Hawton: Yes. It was a great pleasure to actually have tangible recognition in that sort of way. I'm not a great person for honors, but nevertheless that was an important landmark for me and added to my self-confidence about the work I was doing with others. This concrete example of what other people think about your work is really exciting and very rewarding.

Dr. Connolly: What about the International Academy of Suicide Research?

Dr. Hawton: The Academy started off with the aim of providing an organization for researchers in order to facilitate research. That is a laudable aim. Unfortunately, it became caught up in issues which deflected the organization from that initial aim. I support the notion of providing an opportunity for researchers to get together, to present their work and to exchange ideas. I ran a similar smaller project like that in the UK – a meeting once a year of researchers to discuss research methodology. It's very exciting and invigorating and a tremendous way to generate ideas. The idea of doing it at international level is good. It can be seen as elitist, but I don't see it that way as long as the organization brings in up-and-coming researchers and provides a forum where they can hear more experienced people talking about research, where they can be given advice about research, and so on. I see that as very valuable. Some people value the journal that comes from the organization, the *Archives of Suicide Research*. Initially I questioned whether we needed another journal in the field? Now I think it is justified, and it should be a forum for doing exactly what I have been talking about, allowing people to examine the methodology of suicide research and to provide high quality examples of suicide research. Unfortunately, such a journal is always going to be competing against the needs of researchers to get their publications into the more important journals, particularly now that many countries, including ours, are judging research output through the citation impact of the journals in which we publish. But I support the overall aims of the Academy, and I hope they can be achieved.

Dr. Connolly: There have been a number of issues impacting the academy, particularly that involving Renee Diekstra.

Dr. Hawton: Yes. I find the events surrounding Renee's resignation from his post at the University of Leiden to be very sad. I edited a book with Renee back in the early 1980's.The recent events are extremely unfortunate. I know it has had a big impact on suicide researchers in the Netherlands and, of course, it has cast a black cloud over the academy.

Dr. Connolly: Let's get back to the first the academy you belonged to?

Dr. Hawton: The International Academy for Sex Research. There are a several researchers in the suicide field who also have researched on sexology. As I said earlier, I was inspired by John Bancroft and got involved in treatment and research concerning sexual dysfunctions. The International Academy of Sex Research is an example where there is interchange between researchers, through meetings and informal contact and with its journal, the *Archives of Sexual Behavior*, works extremely well. So the parallel with the International Academy of Suicide Research is remarkable. My time for work in sexology is very limited, and I conduct hardly any research in that area now. I am also less involved with the Academy of Sex Research.

Dr. Connolly: You are a teacher too.

Dr. Hawton: Yes. I like to think that I am quite a good teacher. I like students. I greatly enjoy having contact with medical students, and I feel I can still relate to students in a way that doesn't daunt them and make them shy away from me. I have had reasonably positive feedback in that regard, and I enjoy seeing junior doctors take up my ideas and appearing to be inspired by some of them. I get a great kick out of seeing their development and feeling what I and my team have contributed to that development. I don't do as much teaching these days as I would like to, but I enjoy it, and the students seem to enjoy it. Hopefully, I'm reasonably effective, but I'm sure I can improve a lot.

Dr. Connolly: You work on cognitive therapy?

Dr. Hawton: Yes. I was heavy influenced by Aaron Beck - Tim Beck as he is known to most people - from the United States. Of course he is the person who really developed cognitive therapy initially. I'm very fortunate in being in a department where there are a lot of people doing cognitive therapy. I think our department in some ways is becoming the world center for cognitive therapy. I personally don't have enough time to practice cognitive therapy although I do in my clinical work with patients with sexual problems. I certainly do encourage my junior staff to get as much experience as they can in this approach.

There have also been developments in psychotic drugs, the antidepressants and lithium. On the other hand, in terms of psychological treatments, cognitive-behavioral therapy has had an enormous impact, and it has good evidence base. One problem is that we don't have enough practitioners who are well trained in cognitive therapy to ensure that the treatment is available to all who need it.

Dr. Connolly: You also researched into yuppie flu.

Dr. Hawton: Yes. I saw what was happening in terms of the demand from sufferers with chronic fatigue syndrome. I was very involved in work in the general hospital, mainly research, and I happened to have working with me a bright young junior doctor, Mike Sharpe, who was looking round for a project in the general hospital. I was referred a couple of cases with chronic fatigue syndrome which got him interested in the area, and together we did quite a lot of work trying to reduce their handicaps and helping them get back to work. That was an exciting line of work, but it came to an end when Mike moved to Edinburgh. I would like to think that, even in that short time, we contributed to the knowledge about the problem which, for many doctors, was just a source of frustration. Of course we had trouble of battling against the patient organizations, which was actually a bit of a nightmare. It made me realize that, while collaborating with patient organizations can be very rewarding and is increasingly part of the health agenda, when you have organizations that have a militant and self-interested approach to things, they can actually be very obstructive. In our case, it went to the extent of having a senior member of these organizations contact a journal where we were trying to publish a major paper suggesting that the results were bogus. The person was identified and duly cautioned by their institution, but it was quite a shock. It seems that chronic fatigue syndrome afflicts some people who have anti-medical views which can obstruct research and can obstruct people benefiting from the research,

Dr. Connolly: We have neglected to talk about your family.

Dr. Hawton: I'm married to a clinical psychologist whom I met in 1970. We married in 1978, and we have two teenage girls who are doing very well. We have had a happy family life, although sometimes it's been difficult with both of us working in the same field. One time we were working on the same ward, which was enjoyable at the time. We were both very positive about the way clinical work was developing. We would argue, however, about sharing the housework!

Dr. Connolly: You enjoy sports.

Dr. Hawton: I love all sports, but especially cricket, rugby and fishing. I suppose fishing is probably my major passion, but cricket is not far behind. I enjoy playing golf. Sport is time consuming, but the great thing about it is that it is usually totally absorbing, particularly fishing, and takes one away from one's work, providing distraction in a positive sense. I find that this re-energizes me such that, when I come back to work, I feel much more positive about it.

Dr. Connolly: Where did your interest in fishing come from?

Dr. Hawton: I don't remember precisely. I remember starting around the age of eight. My mother took me and a friend fishing in a river, something she always remembered and talked about right up until her death. I don't think she did introduce me. I think I persuaded her to take me fishing! In those days we fished for perch, chub and roach, and then in the early 1970's I discovered fly-fishing for trout. That really took over. I discovered it first in Loch Sheelin in Ireland when I went on a fishing trip with a friend. When we got there, he got out his fly-rod, and I watched him fly-fish. I also went out with a gillie, Jim Keogh, a marvelous character, and watched him throw out a cast for a fish about 25 meters away and catch a 3 lb. trout – a magical act!

Dr. Connolly: What other interests do you have?

Dr. Hawton: I have a great interest in wine, and I was lucky enough to put a cellar in our house a few years ago and build up a significant wine collection. I greatly enjoy being able to drink fine wine, and I enjoy talking and reading about it. I'm not an expert in wine, but it's rewarding to meet somebody who knows something about a particular wine area and to be able to talk about it and the wineries. My approach to wine is very blinkered. I know a bit about wines from France, Australia and New Zealand, but some wine-growing areas are a complete mystery to me, for example, Germany and Italy. I take great pride in my collection of wine, and I enjoy sharing it with other people although, unfortunately, there are not enough opportunities to do so.

Dr. Connolly: What about art?

Dr. Hawton: I have a sort of secret belief that I have artistic skills. I remember doing art at school and coming top of the class in it, and then having to give it up because I went into a more academic stream where art wasn't considered very academic. My mother didn't do much art but, when she did, she showed remarkably good skill even at a late age. I enjoy art. I particularly enjoy modern art rather than classical art. I like the impressionists, and Paul Klee is one of my favorites, particularly his picture, 'They are

biting,' which shows a figure with a fishing rod and a fish taking the bait which I remember seeing at the Tate Gallery many years ago. I loved that particular picture. I do have paints and crayons, and I have taken them on holiday and do the odd sketch like many people - one of those things one thinks one will do in retirement.

Dr. Connolly: Are you looking forward to retirement?

Dr. Hawton: I think so. I would like to retire gradually, which unfortunately isn't all that easy in terms of the National Health Service. I would like to have a phase of several years when maybe I work part-time on research. I would like to keep my research team going and find a successor to take over my line of work in Oxford. I haven't done so yet. I saw what happened to Norman Kreitman's unit when he retired - it was closed down and the work ceased very suddenly there. That's a great pity because a group of researchers builds up a momentum and, providing you get the right sort of person in, they could take that over and move on to better things. It would be a huge sadness for me having set up Oxford as one of the centers in this field if I don't find someone else to follow me.

One other thing I would like to mention is the pleasure I have got from becoming involved in the European program of research work, particularly the WHO/Euro Study of Suicide Behavior. It's been a pleasure to establish such a large number of friendships through being involved with that - people like Diego de Leo, Unni Billie-Brahe, Armin Schmidke, Kees Van Herringen Ella Arensman and several others. I think of us as being a sort of family of researchers in the field. One of the problems with international collaborations that it's often difficult to carry things through, but the friendships and loyalties that have come from that collaboration have been very rewarding and enjoyable.

One of the great rewards from doing this program of work has been the large number of people with whom I have collaborated and worked, in my team in particular. The loyalty of those people and the dedication from most of them to the program of work, and not just to the individual projects in which they are involved in, has been enormously rewarding. Without their input we would not have the reputation we have achieved. To use a corny expression, sometimes the whole is greater than the sum of its parts.

INTERVIEW WITH ANTOON LEENAARS

Dr. John Connolly: Tell me a bit about where you were born and your early life.

Dr. Antoon Leenaars: I was born in a small village, Ulvenhout, in the Netherlands. It's in the southern part, very close to the Belgian border. We could walk to the Belgian border. It was a forested area. It's a rural farming community, and my neighbors had cows. One of the neighbors was my uncle, my mother's oldest brother. My uncle and aunt and their children were and still are my closest relatives. My uncle even gave me a pet cow; we would go to pasture and I could ride the cow home. We didn't have any cattle, but we had a horse. I still remember going to the blacksmith. It was a very pleasant community. Church was very much part of life. I remember having to go often twice on Sundays. We would go in the morning and then the afternoon. We were in the Catholic region of the Netherlands. In my mother's family, there is a history of priests and nuns and, already in the 1500's, a Bishop.

Dr. Connolly: Which persuasion was that?

Dr. Leenaars: Roman Catholic. Probably the most influential person was my grandmother (*Oma*), then my mother. My *Oma* early on identified some of my characteristics which were not all positive! I was a little bit of a prankster at times and somewhat problematic. She was really quite a guiding mentor and early on encouraged me to become a priest. I remember getting gifts like a play altar, etc. However, this was not to be, although I think people in psychiatry and psychology are very much like ministers and priests. We are healers.

The education was very old-world. We never saw girls at our school, which was taught by nuns. I remember one of my first memories in kindergarten was sitting in the back of the room doing multiplication tables. I took a fancy, as a kindergarten kid, to multiplication tables. My grandmother died in 1956 which was probably the first saddest memory that I have. Keep in mind; it had nothing to do with the candies, which she used to bring home every Sunday after Church, which I liked so much! We never got any candy so these candies were very important to me. Sometime, when I was 10 years old, we immigrated to Canada. It is probably the second saddest event in my life. I lost my home, family, friends, my dog, my cow; LOSS! I remember the boat across the Atlantic, the entry to Canada, and my early experiences of the snow – all of the changes and the differences.

Dr. Connolly: Why did your family emigrate at that time?

Dr. Leenaars: This was the 1950's and 1960's, shortly after the WWII hell, and there were major economic problems in much of Europe. There was massive emigration, and my uncle, my mother's other brother, had already emigrated, and he told us that the streets in Canada were paved with gold. So my father thought this was a marvelous opportunity, and so we travelled to Canada.

Dr. Connolly: What was his business?

Dr. Leenaars: He had a greenhouse business which, as you know, in Holland is quite an enterprise. In our region of the Netherlands, my father was the only one with a

greenhouse business. His main crop was tomatoes – we even had grapes. It was a happy childhood there.

My early memories of Canada are different. The family was very depressed in Canada. The environment was not supportive to immigrants. I don't think my mother coped very well with the change. School was not very supportive. They left us, immigrants, just sitting in the back of the classroom. I learned English from comic books; Superman and Batman were my English teachers. We were bullied in the schoolyard. Things were different! I had to adjust. I became the typical Canadian adolescent. School was not very important to me. Having fun with my friends was, and girls became very important as a teenager. One high school friend was Susanne Wenckstern, was a German immigrant. I met her when we were 14-15.We were friends, and we even went out on double dates. Although other friends came and went, Sue was there. We both went to university, even graduate school in psychology. We were in the same canoe in our lives' journey, and we continue to be so. We married after graduate school, and we have three kids. She is also a suicidologist, and we even have published books together…one could want no better partner.

But, there was trauma too. In grade 11, the first event of suicide occurred in my life. There was a friend, Tom, whose last name began with L too, and in those days we had to sit alphabetically. Tom spoke to me often, and I remember clearly, as if it was yesterday, one time on a street near his home standing there and he talked about his sadness and depression. Things were not going well. That was the last time I saw him. I had a summer job and, when I got back to the school in September, I learned that Tom had drowned himself. [He was a life-guard.] A sad part was nothing was done by the school staff. I remember being left in my sadness. Nobody spoke about it, nobody did anything but we, his friends, talked and still do. Of course, later on, partly because of Tom, I started doing work in suicide prevention, including postvention, in schools.

Dr. Connolly: How old were you at that time?

Dr. Leenaars: About 16-17 years old. What struck me was that it wasn't spoken about. It was taboo! Nobody at school said anything about it. I felt very strange, not knowing what to do with those feelings. And guilt, because he had spoken to me. Later on in high school I developed an interest in psychology.

I was, as a young teen, still very much involved in the Church. I was the head altar boy, the president of the youth club and all of those kinds of things. But there was another part of me that was a bit of the juvenile, nothing criminal, just teen mischief. One of my favorite stories about high school concerned a teacher in grade 13 who knew nothing about chemistry. It was the first year that they had a new chemistry book, and she would do these equations but make mistakes. I would put up my hand and correct her and she would order, "Go to the office." I would get hauled to the office and asked, "Why are you here?" [My calculations were always right.] This happened repeatedly, and the students in the class loved it. They would laugh! Later on in high school, I started reading everything. I even read the *Iliad* and the *Odyssey*, but I was also going out and drinking with my friends. I had two major girlfriend relationships. One lasted for about two and a half years.

In my last year of high school, I took a special history course on using personal documents to understand people's lives, and I realized then, how different the textbooks were from what people were really experiencing - like slaves in the old South of the U.S. This teacher, Mr. Dan McMaster [who later was one of the guests of

honor at my PhD party] did a marvelous job at introducing us to what people really said. He was a true teacher - rare, I think.

Dr. Connolly: What books in particular made the biggest impression on you during high school?

Dr. Leenaars: Carl Jung made an impression on me. I read everything he wrote. I found him rich and abstract in thoughts. I read everything about Freud, but I had some real reservations about Freud. Everything was reductionism, such as the sexual drive. I thought it was too limiting based on how I experienced myself. I was more in agreement with what Jung wrote, than Freud. I assumed others were too. Fyodor Dostoevsky's *The Notes from the Underground*, was very important. I read everything Nietzsche wrote. I read Herman Hesse's *Demian, Siddhartha,* and *Magister Ludi.* Those books became like my bible. I was also reading philosophy then; I was very interested in Buddhism. [I later got an undergraduate degree in philosophy, as well as in psychology.] I also read the classics, like the *Iliad* and the *Odyssey.* I read a lot about mythology, especially Greek mythology. I realized that there were greater interests than what the schools were teaching. I was more interested in my own education. Later in high school, I sometimes got top marks, but often my grades were mediocre. If the teachers were not intriguing or interesting, I just turned them off. I was bored; I yearned for more.

Dr. Connolly: Did your parents despair?

Dr. Leenaars: They despaired over me all the time! They were not bad parents, but I don't think they really understood me very well. That's why I mentioned my *Oma* earlier because I think she understood me better than my parents did. I think that it is deeper; I identified mainly with the van Hooijdonk family, my mother's side.

So getting back to those books: They were really rich. I would sit after class in my father's backyard, reading. [It was a wonderful garden and I have a wonderful garden now myself - I love to escape into the trees and the flowers and the vegetables. I owe all that to my father.] We settled actually in St. Catharines, which is in the Niagara Falls region of Canada. After high school, I planned to go to university out of town, Waterloo. But my father had a heart attack [he was only 55], and I had to change my plans because they needed help. My older sister had already left home, and I had a younger brother and sister and so I went to Brock University in St. Catharines. It turned out to be a most fortunate chance event. It's the best education that I ever had. In fact, I have now sent my oldest daughter there, who is studying psychology.

So I went for my undergraduate studies to Brock University. I have many fond memories. First year, I had to take an algebra class, and I failed the first test. So did most of the class, except that this was not acceptable to me. I wanted to change what I could. By the end of the course, I got the highest mark and by the end of second year I was the teaching assistant for the statistics course. Professors Jack Adams-Webber and John Benjafield were very influential for me. Jack, John and David Lester all went to the same graduate school, and so they were all friends. John Benjafield was probably the most influential psychology professor whom I met. He taught the history of psychology, and a class on thinking and cognition. He made you think. The history course was wonderful; absolutely wonderful. I became his teaching assistant. My education there was wonderful, and there were unique opportunities for me. They

made me a research assistant and a teaching assistant, which was unheard of for a second or third year undergraduate student. I still am friends with John now.

Dr. Connolly: Tell me about how you got into suicidology.

Dr. Leenaars: When an undergraduate, I found, at the university book store, a copy of Ed Shneidman and Norm Farberow's book, *Clues to Suicide*. It had a collection of suicide notes in the appendix; I read and read them. I started having answers to why Tom killed himself. From that day, I never left the field of suicidology. Although I had already communicated with Ed and Norm in the 1970's during my graduate studies, I met Ed Shneidman in 1983 at an AAS conference in Dallas, Texas. I presented a study on suicide notes. Later on, I was home, and there was a problem with the pool. I was deep in water in the pool trying to fix it, and my wife, Susanne, says, "Ed is on the phone". I asked, "Ed who?" "Ed Shneidman", she said. We talked for three hours and he encouraged me to do some research on his theory. He thought that this would be important and we started doing studies on Ed's theories, looking at suicide notes. I also started collecting different notes, young and old and different sex, methods, countries, and those kinds of things; we wanted to get beyond just studying the genuine and simulated notes with Ed's sample from the 1950's.

Then I started going to conferences and other meetings. I met David Lester in 1984 at a conference in London on thanatology, and David and I have become wonderful friends and colleagues. I remember being with David at that conference, and we were talking and talking and talking. We had a wonderful time. He raised all sorts of questions about this and that. He has a different way of thinking and looking at things than Shneidman. I appreciated the differences.

Dr. Connolly: William Balance was your academic advisor at graduate school, wasn't he?

Dr. Leenaars: Yes. One of the things about Bill that was really helpful was that he allowed me to do what I wanted to do. He did not force me to do his research. I thought of a different way of studying suicide notes; others have called it, "novel." It is a theoretical-conceptual analysis. Bill said, "This is a wonderful idea. Go with it." That was unique because most of the professors wanted you to do their research. Nobody spoke about suicide at the university, but I did my dissertation on suicide notes. [*Dank U* to Ed Shneidman and Norm Farberow.] There was, in fact, hardly any discussion of suicide in graduate schools or in the medical schools in Canada. [Is it different now?] There was a document that came out entitled, *Suicide in Canada,* and the psychologists and psychiatrists who were interviewed said that they knew everything there was to know about suicide. "Is that true?", I wondered. In those days, it was believed that suicide was depression and depression was suicide. All was simple. Was it?

Dr. Connolly: Can you tell us more about your alliance with the pioneer, Dr. Edwin Shneidman?

Dr. Leenaars: My relationship with Shneidman developed, and we visited him, many times a year, at his home with wonderful picnics in his backyard, under a marvelous very large Birch tree. [Ed and his wife, Jeanne, called me, "son", a mixed blessing. I found a 'father' in Ed for whom I was yearning.] Ed would barbecue, and I would meet a whole host of people who were "Who's who" in the fields of psychiatry and

psychology. These were wonderful experiences because we would sit and talk about the patients I was seeing who were suicidal. These later on became important cases in my forthcoming book on psychotherapy, *Psychotherapy with Suicidal People,* for which Ed was the consultant. There are case consultations with him on almost every one of the patients whom I discussed. It is a precious trove of clinical insight. We would spend hours talking, and he would also ask, "What about you?", addressing the counter-transferences. He was the best case consultant ever. I should mention one other master clinician, Dr. Terry Maltsberger, who influenced me greatly. He is a Harvard professor, and we edited book together, *Treatment of Suicidal People.*

Ed and I also talked about research, although he was more keen on qualitative studies. He did not have a mathematical mind, and he thought quantitative research was not important. [We differed in this way; I believe both are valuable approaches to knowledge.] I started writing my book, *Suicide Notes,* in the mid 1980's, and he wrote the foreword to that book. He always encouraged me. *Suicide Notes* became quite a hit. That book sold more copies than any other book I've ever done. The newspapers got hold of it and television too.

Dr. Connolly: Tell me about your endeavors in teen suicide prevention.

Dr. Leenaars: I should go back to my career a little bit. Before I finished my doctorate, I got a job at the Windsor Board of Education. I worked in that position for about three or four years, but it was also where I started developing a deeper interest in suicide and especially postvention. I graduated in 1979, and in 1980 I got a phone call from one of the Superintendents. One of the kids in grade 6 or 7 had killed himself and the superintendent said, "You know about suicide. Please go to the school and do something". Now, I had had conversations with Ed about postvention, and so we did one. I think that it was one of the earliest suicide postventions in schools. Truthfully, many of things that I did back then are still what I advocate today. Susanne got a job with the same school board a year later, and we started doing work together on suicide prevention in schools. Later we produced an edited volume called, *Suicide Prevention in Schools.* It was, I think, one of the first books on suicide prevention in schools. However, an opportunity opened for me to get a position at the University of Windsor and so I left the school board. They were saddened; they even had me hire my replacement. To this day, I continue a relationship. I also see many teachers in my private office.

I didn't stay at the university very long. The atmosphere was not positive. Most of the older professors had retired. It was a younger faculty, and there was not a strong interest in suicide. I had an eclectic, open-minded approach. Many there had a narrow approach. One of the psychologists was in clinical psychology; yet, he had never seen a patient and was running rats. [Behaviorism.] I always wondered what that had to do with clinical psychology, but he was obviously wiser than I am! I had already started my private practice at that point, so I left in a few years and my main activity became and is now seeing patients. [I wanted to help the Toms of this world.]

Dr. Connolly: Why did you leave the university?

Dr. Leenaars: Because of my private practice. A beginning professor is very limited. For example, we were allowed $200 for Xeroxing per year, and now I spend that sometimes in a week. In private practice, I could make three or four times as much

money as I could in academia. I liked working with patients, letting them tell me their stories and assisting and helping them. I am person centered, not mental illness centered. The opportunities in private practice are unique. My patients are still teaching me. I remember so many of them. For example, Justin was a four-year-old boy who had attempted to kill himself by hanging. When I first met Justin, he still had the rope marks on his neck. I recently wrote up his case in my psychotherapy book. Of course, I wasn't just seeing suicidal people because I believe one has to be more than just a suicidologist in a clinical practice. One has to see a wide array of patients. One has to know people generally, and the suicidal person specifically. [The nomothetic and the idiographic.] Besides, seeing only suicidal patients would burn you out. One can only see a few highly lethal suicidal patients in one's practice at a time.

Dr. Connolly: It would not have been easier to research suicide at a university then?

Dr. Leenaars: No. On the contrary, after I left the university, I started doing more research. I had more time to do research. I started writing more books. At the university, we were confined to classes and sitting on useless committees. When I left the university, my curriculum vitae exploded. My studies with David Lester increased as well as my studies on suicide notes. At this point, I started developing a collection of suicide notes which included Ed's 700 notes, but now my collection is over 2,000 suicide notes from around the world. I take an ecological view. The private practice allowed me to have time to set aside for research and writing. I always set Fridays aside for my writing but you have to understand that people cancel, and there isn't another patient waiting for you until the next hour. I had all these hours, on occasion, to write and proof read, so I ended up having more time and started writing and editing more books. I even became the first and founding Editor-in Chief of the international journal, *Archives of Suicide Research.* In 1989, I received the Shneidman Award for my research, which was a wonderful gift. I appreciated that recognition. [Just in 2001, I was honored with the International Association of Suicide Prevention's prestigious biannual Erwin Stengel Award, for outstanding research in suicide prevention.]

Dr. Connolly: Tell us about the Canadian Association for Suicide Prevention.

Dr. Leenaars: Probably my major administrative and programmatic effort was the Canadian Association for Suicide Prevention. There was already an attempt at the Canadian Association for Suicide Prevention (CASP), but it disintegrated. There were many reasons, and CASP ceased to exist after a few years. There was talk among us to resurrect it, and a distress center, Suicide Action in Montreal, did a marvelous job in getting people from across Canada to meet to try to resurrect this association. As I left for the meeting, I remember saying to Susanne, "I think that they'll elect me as the Vice-President," and when I came home she said, "Well, did you get elected Vice-President?" I said, "No," and she said, "I'm so sorry for you." I said, "I'm President." It, I think, was the Shneidman Award because that gave me visibility and was useful to the new association. I put a lot of energy and time into trying to re-make the association. The new Board voted to dissociate CASP from the old beginning - too much internal system-destructive strife. We had the first meeting at a university in Toronto, and I realized quickly that it was a mistake because people did not stay together after the meeting. We needed to talk. We needed to work as a whole. Thus, I decided that our next meeting would be at Lake Louise in the Canadian Rockies, because it is a majestic setting and more isolated. People stayed at the location. We

talked, ate, and played together. It worked, and Lake Louise is now the spiritual home of suicide prevention in Canada. There is an old hotel there. It was one of the first winters that Chateau Lake Louise was open, and it cost us almost nothing to stay there – maybe $80 a night, whereas now it is $500 a night. It also snowed, and so people were stuck there. It produced a wonderful alliance. Building up the Canadian association took a lot of work and time. It was due to many of us.

I should back up and tell you that, by this time I had two children, Lindsey and Heather. Lindsey is now studying psychology, and Heather left this year for Veterinarian school. We set up the association in my home, and the kids would put the stamps on the envelopes and whatever. Susanne became CASP's first secretary. There was a person always in the background, consulting with me - Ed Shneidman, the founder of AAS, who shared his experiences with the American Association of Suicidology (AAS). By the early 1990's, I had served as president for about five years. The Canadian association was doing quite well and is now very active. I became the First Past President of CASP.

My third daughter, Kristen, was born in 1990. My wife and children have always been very supportive when I had to write, despite the occasional, "No dada, me."

I also became very involved in the American Association of Suicidology after being awarded the Shneidman Award. Someone once asked me, "Why don't you become president?" I thought, "But I'm not American"; yet, I became the first non-American president of the AAS, which was a wonderful opportunity. I am still the only non-American president of AAS, an honor.

Dr. Connolly: Tell me about your private practice.

Dr. Leenaars: I've seen a wide array of people in my clinical practice. The youngest suicidal person who made an attempt was 4 and the oldest was 92. In my suite, there is my office, a waiting room, and then there's a playroom for my younger patients. I have lots of wonderful toys there - my hockey game and my doll house. Kristen, my daughter, thinks this is funny. A couple of Christmases ago she bought me new doll furniture as my Christmas gift and laughed to all her friends, that she was buying her Dad doll furniture. I actually sit on the floor and play with the kids and the dolls. It's wonderful to see what we can do with play therapy [I also do CBT with kids]. There are no electronic toys or anything. It is all interpersonal interaction. As with all ages, the therapeutic alliance is key with kids.

I am also licensed in forensic psychology; I do Death Scene Investigations. I investigate deaths - natural, accident, suicide, or homicide (NASH). Ed, Norm, and another of our friends, Dr. Robert Litman were my teachers. They taught me the psychological autopsy (PA). I am planning to do a large scale PA study.

Let me back up. By this time, I also started doing other research because I realized that, although suicide notes were really important, research on them alone would limit me. As a result, I began, for example, doing research on gun control with David Lester. We also did comparisons between Canada and the United States because the Canadian government had put out a document called *Suicide in Canada*, but it should have been called *Suicide in Canada based on American Data*. I conducted research to show that our rates and patterns were different. At the same time, I met with George Domino and we showed that the attitudes in Canada and the U.S. were different. We looked at a whole array of issues, trying to take ownership of suicide in Canada, because the bureaucrats seemed to be interested in simply taking

the American point of view. Canada had to own the problem. We had to set our own priorities. We had a meeting in 1990 with Perrin Beatty, the Minister of Health, which, by the way, is the last time anyone in suicide has ever met with a Minister of Health. Suicide in Canada is still a taboo topic. I'm blacklisted by the Government and the bureaucrats, but so were subsequent CASP presidents and the association itself.

Dr. Connolly: Blacklisted in what sense?

Dr. Leenaars: The Canadian government didn't want to address the problem of suicide. We don't have a national policy, and it's not a priority. I think that there's a taboo in Canada much different from your experience in Ireland. Suicide used to be glossed over in Ireland, but it's glossed over much more still in Canada. We're back where you folks were in the 1980's in terms of addressing the problem of suicide. In February of this year, we had the first meeting of researchers and practitioners, to set research priorities. This was recommended over twelve years ago, in 1990, to the Minister, Perrin Beatty. Now, the President of the association is still struggling to get a national policy on suicide. The government is still refusing to meet and discuss it. Perhaps ten years from now something will be done. So far there's no money made available for the priorities that we proposed. As for *Suicide in Canada*, the document that the Government produced, there were wonderful recommendations made, but not one of the recommendations has ever been implemented. They are great at producing documents in Canada but not at doing anything. Similar problems occurred in Canada with drug reforms in the 1970's and mental illness. Of course, it may not simply be a taboo about suicide, but also mental illness in general. It may also be bureaucratic ineptness or prejudice and bigotry. What I do know is that there is stigma in Ottawa!

Dr. Connolly: You have been keenly interested in suicide among indigenous people.

Dr. Leenaars: From the beginning of CASP, I took an interest in The First Peoples of Canada. [I should mention in my childhood in Ulvenhout, the only plus to going to Canada was that I was going to meet "Indians". The other kids' were jealous. I did!] They have very high rates of suicide, although there are communities with low rates. And there is a real prejudice against our native peoples. Together, we became blacklisted more in Ottawa.

Let me talk a little bit more about my interest in Aboriginal people. A unique opportunity presented itself for me in 1990 to go to the Arctic. I remember flying out first to Yellowknife, near Great Slave Lake and then Rankin Inlet, which is on the Hudson Bay. I then went to Iqaluit on Baffin Island, the capital of Nunavut. And I flew for a day trip up above the Arctic Circle to Pangnirtung, the hamlet of "Pang." You fly in through this fjord. Many people there still have a traditional hunting and fishing lifestyle. I travelled to more of the Arctic. [It was like I was in a dog sled crossing the barren North.] However, I want to give you an idea about Pang. I was there in early September, and suddenly there was a snow storm. The plane could not land. There were no hotels in those days in Pang, so where was I going to stay. Fortunately, I had earlier met and was taken in by the minister of the Anglican church, and I offered to make dinner. So I went to the Great Northern Store which is the Hudson Bay Company. I bought 1.5 lbs. of hamburger, 2 cans of tomato sauce, and noodles that I needed for a spaghetti dinner. I also bought bread and peanut butter. It cost like $ 44.95! [A carver said, "Groceries are more expensive than Inuit carvings."] I started making supper and this Inuk girl, around 10 or 11, came in and said, "That

smells good." of course, I understood and said, "Well you know, there's plenty". I continued, like a naive *qablunaats* (*kadluna, "whiteman"*). "Would you like some? But you first have to ask your parents". She looked at me and said, "I'm an Inuk". I had an "Ah!" experience; I knew my mistake right away. Among these peoples, they respect their children to make good decisions so, if the child makes a decision, they will respect it. It is a cultural tradition. It is the ethic of non-interference. Well, of course, word spread, and she was not the only one at the table. By the beginning of the dinner, I had twelve kids sitting around the table, and I was feeding them. It is truly a collective community. During the conversation at dinner, the girl asked, "Where are you from?" I described my home in Windsor, Ontario and the peach trees in my backyard. We, I related, were just picking the peaches before I left, and she said to me, "I've never seen a tree before."

Since Mr. McMaster's history class on personal documents/stories, I strongly believed in the narrative; people telling their stories. In the Arctic, I started gathering stories from the Inuit of what their lives were like. I not only spoke to people from the larger communities, but also smaller ones like Arviat and Churchill. I asked the Inuit about their lives and suicide. The pain there is phenomenal - unbearable pain. I met with some of the kids in the schools and listened to their stories, including stories of sexual abuse. I recall one woman telling me how she had been in a residential school where they were not allowed to speak their native language, and they were not allowed to see their parents. It wasn't just the Catholics, but also the Anglicans and Presbyterians. Many of them were sexually abused, and the woman said, "Dr. Leenaars, it happened to everyone," but later she asked, "Why do you think I am so depressed all the time?" There was no awareness that there might be an association to her depressed mind. There are barriers - huge "icebergs."

I also had an opportunity to go to Australia and met with the Aboriginal people there, gathering their stories. They had high rates of suicide too. We wrote a paper entitled, "Genocide and Suicide amongst Aboriginal People: the North Meets the South" about the genocide, the atrocities and the pain. The high rates of suicide are due to colonization and acculturation. I collaborated with four people on that paper, and we told the indigenous suicide stories: Jack Anawak and Lucien Taparti, Inuit from the Arctic, and Colleen Brown and Trish Hill-Keddie, Aborigines from Australia. We, I strongly believe, need to listen to the person and people in our offices and the world. What do they say?

Dr. Connolly: Can you offer a concluding remark about your efforts in suicide prevention?

Dr. Leenaars: Around the world, I continue to work with indigenous people and other high risk peoples and nations [such as Lithuania]. I am very interested in high-risk groups. Therefore, I looked at aboriginal peoples. My questions are: Why do people kill themselves? And: Why do some people kill themselves more often than other people? I think that my studies have shed some light. I think that by studying the high-risk person, people, groups and nations, we come to know the unbearable pain and suicide better. They tell us, why. And that "why" has direct implications and applications to culturally competent, person-centered *prevention* - the how. It seems that, since those early days with Tom, suicide has looked for me. I hope that I have helped someone.

INTERVIEW WITH JOHN (TERRY) MALTSBERGER[1]

Dr. Connolly: Tell me about your early years - where you grew up and so on.

Dr. Maltsberger: I was born in South West Texas. My father was a cattle rancher and so was his father and his father before him. My mother was a teacher by training although she didn't do very much teaching. There were two of us - myself and my brother who is three years younger. It was plain to me by the time I was in high school that I had to get out of there because there is no life that I could possibly live in South West Texas on a ranch, so I worked very hard in school and left Texas. I studied for two years as an undergraduate at what is now called Rice University in Houston and then transferred to Princeton University. I have lived in the east ever since. After Princeton university, I went to Harvard Medical School to train in psychiatry.

Dr. Connolly: When did the family come to America?

Dr. Maltsberger: Well the Maltsbergers came with William Penn. They were probably Bavarians, although I am not sure, and they came to Pennsylvania. There were three brothers, and they had a tobacco shop. Then my great-grandfather, whose name was George Washington Maltsberger, led the Mormons to Utah. He was not a Mormon, but he was a scout. He was willing to show them the way west. Then he took his savings and moved down near San Antonio where he bought a little ranch and raised a family.

Dr. Connolly: What has become of the ranch now?

Dr. Maltsberger: My brother still has it.

Dr. Connolly: You visit quite frequently?

Dr. Maltsberger: Sometimes. My brother and I do not get along very well.

Dr. Connolly: Has that always been the case?

Dr. Maltsberger: Pretty much. Sibling rivalry

Dr. Connolly: You grew up in Texas?

Dr. Maltsberger: I went to public schools, tiny little public schools, where I had the blessings of 19th Century school teachers. It was an old town, and they didn't have too many modern ideas. I started school in 1940. It was small, it was old-fashioned, and it was strict. The children were expected to behave and to work hard.

Dr. Connolly: It sounds like the Irish Christian Brothers!

Dr. Maltsberger: Maybe

[1] Unlike the other interviews in this series, this interview was not edited by Dr. Maltsberger before he died.

Dr. Connolly: What about your religious background?

Dr. Maltsberger: Well my father had no religion. He was never seen inside a church. My mother was very religious, and she sent us to the Methodist Sunday School, and I went to Church with her. When I was an adolescent, I began to move away from religion, but nevertheless I had by then been thoroughly infected. My paternal grandmother who was a very important person in my life. She was sort of a self-employed social worker. There were no social services in this kind of town, and two-thirds of the population were Hispanic. This was before the days of social security, and many of them lived in a bad way.

There were no Government provisions for the elderly. Many of the elderly, who had worked all their lives as cowboys on the ranches, as domestics or in the little shops, had nothing when they were old. Some of them were in a very bad way, and my grandmother helped these people. She was fluent in Spanish. She would put them in her car and take them to the county officials in order to confront the officials. She would and ask what the officials were going to do for them. She was in cohoots with the priest and a couple of nuns, and she used to take me and my brother to high mass at Christmas and Easter although she was not a Roman Catholic.

Dr. Connolly: I think there were some nuns in San Antonio from my own home town Ireland at one time.

Dr. Maltsberger: Very likely. In later years when my mother was about 60 and she became very religious, she converted to the Catholic Church. I was received into the Catholic Church two years ago.

Dr. Connolly: Why?

Dr. Maltsberger: I have always had a strong religious sense, and I was always very interested in religion. I have a degree in the philosophy of religion. However, I was a thorough-going agnostic until I was a medical student when I was confronted one day with the horrors of the neuro-surgical ward in the Children's Hospital. It was quite a shock to me to see that medicine and surgery at wonderful Harvard University could do so little for these children with awful brain tumors. The long and the short of it is that I decided that the choice was to be either a thorough-going atheist or to believe in the absurdity of the Christian religion.

Dr. Connolly: There is a famous story about Evelyn Waugh, the English writer. Somebody asked him why he chose to convert to Catholicism rather than to the Anglican faith and he said it is better to be with something that is absurd and consistent than something that is absurd and inconsistent.

Dr. Maltsberger: That's correct.

Dr. Connolly: So this is a very important part of you?

Dr. Maltsberger: I go to Mass every Sunday.

Dr. Connolly: But that's since medical school. Before that you were an agnostic?

Dr. Maltsberger: Actually I was a High Church Anglican, or Episcopalian, until about three years ago. You may or may not be aware that the Episcopal Church in the United States has been torn by heresies and irregularities. They are making women into bishops which was unheard of. They are tinkering now with the creed. I had enough of it.

Dr. Connolly: We think that the Catholic Church has been destroyed in some areas by the sexual abuse scandals.

Dr. Maltsberger: We have had a lot of that in Boston, but at least you know that the bishops aren't saying that it's okay.

Dr. Connolly: So your young days, with the village background and the spiritual values, played a very important part in your life.

Dr. Maltsberger: Yes I would say that. I had a religious upbringing, and my grandmother set me an extraordinary example by her life which was devoted to taking care of helpless people. That was a big factor in my going to medical school. The other factor in going to medical school was that the family doctor was my friend. I was an asthmatic child and the general practitioner in my little town, would come and sit beside the bed for fifteen or twenty minutes and the asthma would go away. Later, when I was in medical school, I saw one of most beloved teachers sit with a patient for fifteen or twenty minutes and say the right things.

Dr. Connolly: What other influences had you in those early days? Literature, music?

Dr. Maltsberger: There was not very much to do except hunt and ride horses. I liked riding horses, and I did help on the ranch with the work. I was often on horseback in the early hours of the morning, but I didn't like it, and I could not wait to get into a cool room and read a book. We lived in the country in the summer, so there was nothing else to do but read. I got through a lot of books, especially history books. By the time I was out of high school, I had read all of Dickens. I had a pretty good acquaintance with 19th Century English and American literature. My mother was a great reader. There were many books around the house.

Dr. Connolly: You read some books at too early an age, I would imagine?

Dr. Maltsberger: Probably.

Dr. Connolly: I have often felt that about my own reading.

Dr. Maltsberger: But it is fun to go back

Dr. Connolly: Yes it is - to see what you missed.

Dr. Maltsberger: That's right. As a result of that, I nearly became a literature teacher. I am never without a book.

Dr. Connolly: What about Henry James?

Dr. Maltsberger: That was one author I read when I was too young.

Dr. Connolly: What were the books you came across in your early life and later life that changed your life.

Dr. Maltsberger: I have never thought about it. I can't single out a single book, but it was through reading books that I knew that there was a complex, rich, interesting cultural life lived someplace outside of South West Texas. My friends think I am an Anglophile which I think is true, but it is because some of my earliest friends were 19th century characters.

Dr. Connolly: You went to Princeton University. Why Princeton?

Dr. Maltsberger: I was in my second year at Rice University but, while it was a great improvement over South West Texas, at that time it was a technical school. It was an engineering school, and people who were interested in and wanted to study liberal arts were very much a minority. My father had not allowed me to have any other choice. He thought that I was very good at science, and he thought that I should have a scientific training and maybe become an engineer if I wasn't going to be a cattleman. I was there under his thumb in some way, but I was restless. At the beginning of my second year, a visiting professor came from Princeton University- Willard Thorp. Professor and Mrs. Thorpe were from a type of people that I had never known and teachers that I had never known. He came to teach a few courses, but he also reached out to the graduate and undergraduate students. He organised all kinds of things for us. We had worked up a program in which different scenes from Shakespearian plays were played out at different places on the campus. The architecture of that place was a sort of renaissance architecture in some respects, with balconies in places. I remember that, among other things, we had the balcony scene from Romeo and Juliet played by undergraduates, and the whole place turned out for this. It was a year of tremendous excitement. There were other theatricals. They would invite the students to their home for parties, and it was enormously stimulating. I loved both of them and, when the time came for them to go back to Princeton University, I went with them and stayed.

Dr. Connolly: What did your father feel about that?

Dr. Maltsberger: Well at one juncture, I said to my father that I would like to go to medical school, and I wondered what he would think about it. "Not much", he said. But I am fairly certain that behind the scenes my mother put her foot down.

Dr. Connolly: What about your medical school years?

Dr. Maltsberger: They were glorious. I loved medical school. I arrived at medical school late one summer - it must have been late 1955 or 1956 - and one of the last polio epidemics was raging in Boston. There were a great many sick children, and the medical students were volunteering in the hospitals to help nurse the people. It was a very dramatic introduction to very sick people, and a very immediate lesson that one could be useful. It did wonders for my self-esteem to get a medical training. I made friends that I still have, and there was a wonderful warm feeling of congeniality. There

were only about 100 people in my class. We all lived together and had our meals together and, unlike some medical schools, it was not competitive. It was collaborative, and we helped one another. It was a wonderful time of my life. We worked very hard and drank too much on the weekends. When I arrived at medical school, I thought that maybe it would be psychiatry for me.

Dr. Connolly: Why was that?

Dr. Maltsberger: You may remember that Somerset Maugham said that he went to medical school because it was a way to see into the hearts of people, that if you wanted to understand what people are like, you should be a doctor. I don't think that he ever practiced medicine.

I felt that, if I had a medical degree, I would see the great panorama of life, the life that I would not see from a library stall if I became a literature teacher. Medicine led off into so many directions so that it couldn't be a mistake, and it wouldn't be a trap. I went to medical school, and I was very interested in psychiatry from the beginning, although the rest of it was enormously interesting to me too. In succession, I was going to be a neurologist (very briefly - I quickly gave that up) and then a pediatrician. By the time I was near graduation, I was very tempted to go into surgery, and I was offered an excellent position at Massachusetts General Hospital to train in surgery. I was very tempted and, when I turned it down, they were very disappointed. The Chief Resident said that, if you want to study psychiatry, I suppose you will, but don't you think it is terribly vulgar?

I wanted to train at only one place, and that was the Massachusetts Mental Health Center which, in those days, was a golden time at that institution. Students tried very hard to go there because there were two or three outstanding teachers, the most obvious of whom was a man named Elvin Semrad. He was a country boy from Nebraska. His view of life was in many ways very simple although, of course, as a psychiatrist he was as sophisticated as he could be. He loved the patients, and he loved his students.

I had a number of personal experiences with him that were formative. In that first year, we were put directly into the wards, to admit, work-up and take care of patients. The rule was that, once you admitted a patient, that patient stuck to you like glue. You could not get rid of a patient until the patient was discharged and, after discharge, you were expected to follow the patient in the clinic for as long as necessary. It was like being pitched into hell because many of these patients were suicidal while others were terribly psychotic. This was 1960 and while we had Thorazine and ECT, we didn't have much else, but ECT was discouraged, although we did use it from time to time.

The general atmosphere was very anxiety-inducing. As an example of what happened that year, I had a thin, silent, little woman for a patient, a little girl really, who had a schizo-affective disorder. She was a terrible cutter. She had been in the ward for some time, and she continued to cut herself. I could not think what to do about it. Then one day, during rounds, we were all sitting in a room - the chief resident, the chief nurses, students, about twenty people - and somebody said maybe there is something not right in her psychotherapy. Every eye turned upon me, and I thought that I would go through the floor because I didn't know what I was doing. I had taken the case to various supervisors and had tried to do what they said.

One day, I was sitting in my little room with her. They had changed all the old seclusion rooms into offices, and there was an old battered rug on the floor that had an oval pattern. It was one of those days, like most of them, when she wasn't speaking to me. I fell silent myself for a moment and looked at that rug, and it seemed to me as though those ovals were arteries and that blood was spouting up out of these ovals into a fountain. Then it came to me that I wanted to cut her carotid arteries. I was very shaken up, and I thought I was going crazy.

I decided there was nothing else to do except to take it to Dr. Semrad. He had a policy of always keeping his door open unless he was with a patient, so that you could see what he was doing or if he was busy. He was working on papers at his desk, and he told me to come in and, in my best intellectual Harvard Medical School manner, I began to present this case. I was trying in the way that I had been taught to keep the affect out of it and, as I got on to describe how she would cut herself, I began to lose control of myself and began to cry. I felt so humiliated and so ashamed and, when I recovered myself a little bit, he said, "I can see how much this patient matters to you. You care for her. I am not sure, but I think if you will show the patient what you have just shown me, she will stop cutting."

I immediately went and found the patient. We sat down and I opened my heart and told her that I felt helpless, that I didn't know what to do, that it hurt me terribly when she hurt herself, and that I wished that she wouldn't. I begged her to stop, and she did. That was the end of the cutting. I followed her for several years after that. She was discharged from the hospital, and the termination of the treatment came one day when she said to me that she wanted me to stop disturbing her at night. What do you mean? She said, you know perfectly well, you have to stop coming into my bedroom at night and bothering me. I said, "I don't really do it, but you think that I do it." She had to leave me because the treatment got more than she could endure. I never met her again. After about four years, she was working and had a reasonable life.

Dr. Commonnolly: How did you get interested in suicidology?

Dr. Maltsberger: That also came from another very painful, shocking moment that same year. She wasn't my patient, but the patient of a colleague, a friend. She was a very angry, suicidal, paranoid woman who somehow smuggled a bottle of chloroform into the hospital and hid herself in a remote washroom, tied a sweater over her face and chloroformed herself. Since I was the House Officer for that weekend, I had to handle it. It was profoundly shocking to me to see that a person could do this. One reads about suicides, one is afraid of suicide but, when one is thrust immediately into it, when you have experienced someone's suicide, it is unspeakably awful. It shocked all of us, all of the residents There were about 28 first-year residents working in these wards, and we were all depressed and upset. That is about the time that I began my psychoanalysis, and my friend Dan Buie, and I decided, after talking about this, that the only constructive thing to do was to learn as much about suicide as we could. So we took out the records for all the known suicides in the hospital.

Dan and I began to study these cases. and that was the first time that I ever read any works by Shneidman. Out of that experience, came the paper on counter-transference hate in treating suicidal patients. the first paper that I published on this subject. He and I wrote a number of papers together during the following years, and then his interests diverged. He gave much of his energy to being a training analyst in Boston, and I have continued with the study of suicide. These studies have a life of their own. They take a lot of your time and investment and then you begin to meet

other people and, before you know it, you are going to meetings and making new friends.

Dr. Connolly: You have published a great deal?

Dr. Maltsberger: Not as much as some people, but most of what I have published has been about suicide and virtually all of it comes out of my own clinical experience.

Dr. Connolly: What would you say is your most important paper?

Dr. Maltsberger: The one that is probably the best known and that people mention to me most often is the paper on counter-transference hate in the treatment of suicidal patients which was my first paper. The next paper that I like is a paper that was not printed in a journal - it is too long for most journals - it was printed in Ed Shneidman's festschrift (*Suicidology: Essays in Honor of Edwin Shneidman*, 1993). It is a paper about confusion of the self with other people in suicidal states. The basis of it is Freud's idea that, when you kill yourself, you are killing somebody else that you have introjected. The essay is elaborated with clinical data, and the argument is that it is not so much the whole self that becomes identified with somebody else but that it is the body-self, and an attack on the body represents and is best understood as an attack on an object, on another person. I like that paper.

Dr. Connolly: What are you doing at the moment?

Dr. Maltsberger: For years, I have kept up a private practice, so that I have never gone very far from patients. I consult at the Massachusetts General Hospital and at McLean Hospital, both Harvard-affiliated hospitals in Boston, and sometimes at other hospitals. I have a seminar, a post-graduate seminar on understanding of suicide that meets about once a month. We have about six active participants. We meet of an evening, and we either discuss a book or review cases. We are trying to do some writing. I do a small amount of forensic work, some of it as an expert for families who are suing doctors whom they think were careless with the person who has died by suicide. I am sorry to say that, at least in the United States, there are a great many people who don't take good care of suicidal patients. Sometimes I have appeared for doctors who I think are being unfairly sued because they did all that anyone could.

Dr. Connolly: What are you currently writing?

Dr. Maltsberger: I am between projects, and I don't know what I am going to do. There is no book written by one person on the care and treatment of the suicidal patient. Most of the writing is a chapter here, a chapter there, and I have thought about writing such a book.

Dr. Connolly: I think it a very important subject.

Dr. Maltsberger: It would be the Elvin Semrade/Boston approach. Developing a very personal and close relationship with the patient is the first task.

Dr. Connolly: You mentioned him as being one of the principal influences in your choice of career and your thinking. Who else has influenced you?

Dr. Maltsberger: There was another teacher whose name was Ives Hendrik. He was an eccentric person, an old curmudgeon, an irascible man, who had the most remarkable capacity to get close to a patient and to tune in empathically with the experience of all kinds of people - psychotic people, neurotic people. He taught me how to interview patients, and he was a magician in what he could elicit.

Another one was Lydia Dawes who supervised my cases in my psychoanalytic training. She was a little, thin, arthritic lady, even shorter than I am. She was hardly any bigger than a child, and it is no wonder that she was a very eminent child analyst. I went to her, and I told her about one of my cases. She listened to me, talked to me and agreed to take me as a student. At the end of the first interview, she came very close to me with this little narrow, arthritic finger - it looked like a little sparrows foot - and she rapped me on the sternum and said, “You are still afraid of me I know, and it is very reasonable that you should be because you have been trained over there, at that Massachusetts Mental Health Center, and there are a lot of bad people over there. You and I are going to be just fine.” Tap, tap. We became fast friends.

Dr. Connolly: There are issues like assisted suicide and euthanasia which are causing controversy. Would you like to say something about your views in that particular issue?

Dr. Maltsberger: I was confused about it for a while and helped prepare a paper for the AAS. on the pros and the cons about euthanasia, but I have come now to have the view that there is no dying patient who cannot be kept comfortable. That was hard for me to believe, but it was pointed out to me by a gerontologist that you can always give somebody a general anaesthesia and, once you make up your mind that people are not going to get well, I think it is perfectly proper for a doctors to devote their energies to keeping somebody comfortable, even if they die. I have no difficulty with that. I think that you don’t have to take extraordinary measures and that you can give people enough morphine and enough sedatives so that they can die comfortably. That may sometimes mean giving somebody so much that you put them into a coma so that they can’t eat and drink. That’s okay, but I could never deliberately give somebody an overdose of barbiturate or some medication expressly to kill them. I think it is abominable to give patients a prescription for a deadly medicine and to allow them to go off and take it by themselves.

Dr. Connolly: You presented a paper at the present meeting about very difficult suicide cases.

Dr. Maltsberger: We had at that hospital that I have been talking about a woman who was schizophrenic, frequently refractory, and she had made a number of dangerous suicide attempts in the past. At that time, she was at an in-between place. She was not actively suicidal, but we felt that, if we let her go home, she was likely to become suicidal again. We talked about her case, and we decided that we had offered her all that we could and that it would not be a kindness to her to make her a prisoner. We told her that we were going to let her go home, but that we hoped that, if she became suicidal again, she would come back to us. She could be admitted on demand. She was given a very caring doctor who was available to her, and we let her go. She killed herself within two weeks. You know it goes very deeply into the question of what right do we

have to interfere with other people’s self-determination. That has happened to me only that once and, up to now, I have not lost any of my patients to suicide.

INTERVIEW WITH JOHN MANN

Dr. John Connolly: Where you were born?

Dr. John Mann: I was born and grew up in Melbourne, Australia.

Dr. Connolly: Where did your parents come from?

Dr. Mann: They were emigrants from Poland who came out to Australia after the World War II.

Dr. Connolly: Do you have any Polish connections now? Have you kept in contact with anyone there?

Dr. Mann: We don't have any relatives left in Poland. Some left the country, but most were killed in the Holocaust. Family members who went to Palestine or France before WW II survived, in addition to my parents.

Dr. Connolly: Has the Holocaust had an impact on you?

Dr. Mann: It certainly has. We had a large family which was reduced significantly in size and, although I didn't experience it myself, it was very difficult for my parents to re-start life afresh in a new country.

Dr. Connolly: What did your parents tell you about it?

Dr. Mann: Not much. They were in a concentration camp for the last year and a half of the war and, like a lot of people who had that experience, they didn't talk about it. I think this is true for a lot of Holocaust survivors. It wasn't until they got much older, after I was grown up and married, that they came to terms with the idea of talking about it. It might have been different in other families, but we didn't discuss it much.

Dr. Connolly: Were you a religious family?

Dr. Mann: Yes. My grandmother and my aunt also survived and came to Australia, and my grandmother always remained observant. My aunt is somewhat traditional, and my parents a little less so. I grew up in a somewhat Orthodox Jewish environment.

Dr. Connolly: Where do you stand with religion now?

Dr. Mann: I'm still observant. We have an Orthodox Jewish household.

Dr. Connolly: Going back now to the early days in Australia, what was your schooling like?

Dr. Mann: I went to an Australian government day school, and we had religious studies in the evenings and on Sundays. Then I went to Melbourne Boys High School and then to Melbourne University. There is no college system in Australia. You go straight to medical school. I trained at the Royal Melbourne Hospital clinically, and I did my residency training there. I did internal medicine first and then psychiatry.

Dr. Connolly: What kind of reading did you do in your adolescence that shaped your thinking?

Dr. Mann: I read a lot of books. I read all of the Waverley novels when I was about 12 or 13. I found one, and I was so fascinated by it that I read the whole series. I read fairly widely. I was quite interested in English literature. I think medicine was really a way of just making a living.

Dr. Connolly: What about music?

Dr. Mann: Everybody seems to have a musician in their family as far as I can tell, but there were no musicians in my family. I never learned to play a musical instrument, and I was kicked out of the school choir because the chap standing next to me sang flat! I never pursued anything in the realm of music.

Dr. Connolly: What drew you into medicine? There are far easier ways of making a living.

Dr. Mann: That's true, but we were so young in those days. You had to decide what your career was going to be when you were in 10th grade, and in 10th grade you really don't have much idea what you wanted to be doing. When I was a kid, about 6 or 7, I was fascinated by the Flying Doctor Service in Australia. A lot of kids grew up wanting to be firemen, but not me. I decided I wanted to be a Flying Doctor. It seemed exciting - flying a plane and doing medicine. It stuck in my head, and I didn't think about a career except when I had to make a choice of going into the humanities (which gave you a choice of law, economics or business) versus the sciences (which were medicine, dentistry or engineering). I went for the sciences, and I followed the pack as it were. The best students generally went into medicine, except for a couple of geniuses in my year who became mathematicians. The rest of us didn't think we were smart enough to take a chance on mathematics so, like me, mostly went into medicine. I had never studied biology at school. In my last year at high school, I did two math courses, English, physics and chemistry, and so I had no idea what biology was like. I found out pretty fast though.

Dr. Connolly: What did your parents think of your choice of career?

Dr. Mann: They were pretty happy. It seemed like a sound way of making a living. My father in particular was happy because he had been a lawyer in Poland. He specialized in international law. He was a very gifted man. He was the best graduate they had had for a decade at Warsaw University, and he quickly advanced. He was invited to join a firm that practiced in international law, and he traveled all over the world at a relatively young age. He worked for foreign governments in Poland and then, when the war came and he had to re-locate to a new country, his law degree was worth nothing because it was from a different country with different laws. He had to start law over again in Australia as a student, and he remembered that. He always said to me, doctors have a portable profession. It's the same profession everywhere in the world. So he was happy with my choice.

Dr. Connolly: How many of you were there in the family?

Dr. Mann: I was an only child because, by the time my parents got through the war, they were a bit older, and it was hard for them to have kids. They were rather poor at the time.

Dr. Connolly: What impressed you at medical school?

Dr. Mann: The Australian system at that time involved a 6-year medical school program. You did two years of all the basic specialties. The first year was an introduction to biology, organic chemistry and medical physics; the second and third years you did anatomy, physiology and biochemistry. So we had a very good grounding in the basic sciences. That really helped me because we learned the subjects by looking at pivotal papers. We got an idea of the scientific process that led to the answers. I had a marvelous lecturer in physiology, a chap who is famous in Australia but unknown elsewhere called Roy (Pansy) Wright. Pansy Wright was a legend in Australia. He was a brilliant physiologist, had a lot of publications, and became very involved in upgrading research in Australian Universities, trying to reduce the brain drain. The bulk of Australia's best talent left and went overseas. He gave lectures that I found really exciting and that got me interested in research. I still carry round in my head many of the basic principles that he taught, and I still find them useful in thinking through research design and experimental methodology. The professor who taught much of the biochemistry course, also by analyzing key papers and how the researchers carried out their experiments, was also a big influence. I found the clinical subject matter disappointing. It seemed a bit disconnected from the basic science subjects like physiology and biochemistry. What's exciting about today is that gap has now vanished. We have much more of a translational relationship possible in medical research.

Dr. Connolly: Were there any other stars in Melbourne or Australia?

Dr. Mann: There were very talented clinicians. My first clinical instructor was a woman called Priscilla Kincaid Smith who was the discoverer of analgesic nephropathy and one of the early people to pioneer the use of anti-inflammatory agents and steroids in the treatment of renal disease and the use of the renal biopsy to establish what the exact diagnosis was, rather than just relying on general renal function tests. She is one of the greats of clinical nephrology. She was President of the World Nephrology Association. I found her combination of clinical skills and medical research interests very stimulating. When I graduated, I was very interested in research but, of course, you have to go into the trenches for a while because of your clinical training.

Dr. Connolly: Which trenches were you in?

Dr. Mann: I started with internal medicine, and I loved it. It never crossed my mind to do psychiatry. My original intention was to do cardiology, and then I became more interested in the brain and neurology. Then I did a psychiatry rotation as part of my training, and I found that so interesting. I thought, in regards to the brain, "That's where we should be looking. That's the raison d'être of the body - to keep the brain happy." The brain is by far the most sophisticated and challenging part of us, and it seemed neglected, like an orphan.

Dr. Connolly: What year are we talking about now?

Dr. Mann: I finished medical school, and I started my residency in 1972. I did three years of internal medicine, of which one year was devoted to psychiatry. After that, I decided I was going into a different track. I did the boards in internal medicine and passed those, and then I did psychiatry.

Dr. Connolly: That was all in Australia?

Dr. Mann: Yes, all in Australia at the Royal Melbourne. When I was doing psychiatry there, was a tradition in those days that people did what was called an MD, a Doctorate of Medicine, which is like an MD/PhD. In the Anglo Saxon world, you graduate from medical school with a Bachelor of Medicine and Surgery or an MBBS. I decided to do a doctorate. Actually my boss in psychiatry encouraged me to do it. I did a doctorate in neurochemistry because he felt that was a good idea. I was a bit intimidated by the idea because I had never been a star at the bench. I grew up in the tradition of trying to do the experiments in organic chemistry and physiology, but essentially using last year's laboratory book from somebody to make sure the quality was ok. We all did it. It reminds me of an old joke. "My mother has been serving us leftovers for so many years now that nobody can find the original meal." I think the laboratory books were like that. We had been copying laboratory books for so many years in our medical school that nobody could find the original laboratory book where the experiment was actually conducted. There was a chap in Melbourne at another hospital who had trained with Leslie Iverson at Cambridge University in neurochemistry and monoamine oxidase, and he was kind enough to show me the ropes.

Dr. Connolly: What was your thesis on?

Dr. Mann: It was on monoamine oxidase in psychiatric disorders, in platelets, which was all the rage at the time. I made a significant little change in strategy- I went and also obtained brain tissue. I was convinced that we couldn't keep doing research in platelets - we had to get at the brain and have a look. I got some brain tissue and measured monoamine oxidase, types A and B, in the brain, and I was convinced that that was the way to go.

Dr. Connolly: What was your first publication?

Dr. Mann: My first publication was almost unrelated to psychiatry. It reported a hyperosmolarity state induced by lithium treatment that I published in conjunction with the registrar in endocrinology who was my registrar when I studied endocrinology during my medical training. He went on to become Dean of the Medical School. He was the brightest medical graduate we had since World War II. He and I published the article in the *British Medical Journal*. That was the first.

Dr. Connolly: And you never looked back. How many publications have you got to your credit now?

Dr. Mann: I'm not sure. Perhaps three hundred and counting.

Dr. Connolly: What colleagues then, apart from this registrar, made an impression on you?

Dr. Mann: I owe a significant debt to Brian Davies. Brian Davies was a Welshman who trained at the Maudsley and became the first professor of psychiatry in Australia. He was a quiet and understated person, and it was often difficult to know what he was thinking, but he was a superb diagnostician without explaining how he arrived at his diagnosis. He was also a phenomenologist and methodologist, and he was into double-blind studies - there are very few people in Australia who were doing them at that time. I think that's why he encouraged me to go to the laboratory. He believed in reducing problems to simple elements that you could test and, while sometimes these models seem naive and over simplistic, at least they provided you with a model that you could disprove. You could find inconsistencies in them. It wasn't so complicated that you could never fail to explain an experimental result. Here you could fail to explain the experimental result because it forced a certain precision. That has been very valuable in trying to do psychiatric research for, otherwise, you never make any progress because you never really disprove your model - you just keep tinkering and fiddling around with it so that it still explains the result. You feel that you are moving in the right direction, but you might be really going round in circles. I owe him a lot. Then there was a very fine clinician who worked on the inpatient unit and who taught me a lot about clinical psychiatry and diagnosis and psychodynamic formulation and how to understand the patient.

Dr. Connolly: What was your first brush with the reality of suicide?

Dr. Mann: Like everybody, I had a patient who died by suicide when I was a resident. It was a big shock. I remember it was a young mother with post-partum depression, and we thought we had succeeded with our treatment. We were wrong because we sent her out on a day pass, and she went out of the hospital to the tallest building on the university campus and jumped off the top. That was pretty upsetting because she had a little baby. It was quite a shock.

Dr. Connolly: Did you get much support from your colleagues then?

Dr. Mann: Yes. People were very understanding. I had had to deal with disappointment and death in my medical training before. What I found far more moving was when I was a medical resident on a very busy in-patient and out-patient unit. We had a system where the in-patients were taken care of by the same attending physicians that took care of the out-patients and, as a resident, you looked after your patients and then you did two half-days a week with the out-patients. I had a chap who had a bleeding ulcer, and he bled to death. I was called from the out-patient department to run to the unit, and he was obviously bleeding. He looked really pale, and his blood pressure was hardly measurable. I put in two IVs running with saline. I called for blood, and they sent down a couple of packets because we had already blood typed him. I was kneeling on the bed, straddling him, and squeezing the two bags of blood with my hands to try and get the blood into him faster through these big-bore IVs, and he said to me "Doc, I'm dying." I said, "No you're not; hang in there." He died in front of me. That was terrible. I went to the autopsy. He had this massive ulcer with a big vessel right in the middle of it. Those two deaths, even 30 years later left an impression.

But I had no particular interest in suicide. I was interested in depression and mood disorders and lithium and mood stabilizers. Lithium was discovered by John Cade in my department. The first lithium clinic was established in our department, and I inherited the lithium clinic that had been started by John Cade. I got into suicide only

because of this postmortem brain research. After finishing my degree, I went to New York thanks to a job offer from Sam Gershon, who was an Australian running a research unit at New York University. I met him at an international scientific meeting to celebrate John Cade's retirement. They invited some of the great names – Mogen Schou, Frank Aide, Sam Gershon and some other people. I was the third author on a paper from our department. I went up to Sam Gershon during one of the breaks, and I said to him, "I'm interested in spending a year or two in the States, just to see what it's like overseas, before settling down." I had an appointment at The Royal Melbourne and Melbourne University, and he said, "Sure; no problem; come and work for me." He knew that Australians were relatively non-neurotic and hard-working, and the low salaries paid to fellows wouldn't bother us. I said, "It sounds great; terrific." I had never heard of New York University, but I was willing to go there. I had the idea that I was going to do lithium research, but I found out, from one of his young protégés, Baron Shopsin, that Sam had got a divorce and part of the divorce agreement was that Baron Shopsin took over the lithium clinic. So Sam said, "Why don't you talk to the other fellows, find out what they are doing and work out your own research project." I found that amazingly unstructured. In Australia, any job that you took in the medical academic world had been occupied by somebody else for the previous 120 years, and so the job description was really clear-cut. To be told that you're starting a job, and you can do anything you like, just tell me when you've worked it out, was quite disorganizing. I talked to the other fellows, figured out a few research projects and went on from there. We were only there for a year or two.

Dr. Connolly: You are married?

Dr. Mann: My wife is a fifth-generation Australian. She is also Jewish. Her mother's family came out on the first fleet of free settlers, and so they are famous. They played a role in the early days of Western Australia and Melbourne and Victoria.

Dr. Connolly: In those early days, would there have been a large Jewish population in Australia?

Dr. Mann: There has never been a large Jewish population in Australia, but there were Jewish convicts on the first fleet. In Tasmania, which was called Van Demons Land in those days. The convicts built a synagogue. There weren't many Jews, but they played a big role because Australia's first Governor General, when it became independent at the start of the 20th century, was Sir Issac Issacs who was Jewish. I never felt that there was any anti-Semitism in Australia, but there was obviously some prejudice.

Dr. Connolly: Did you encounter any of that in your school days?

Dr. Mann: No, not particularly. I went to the Royal Melbourne Hospital annual dinner for the attending medical staff at the Melbourne Club, a club which did not permit Jewish members! When the Governor General was Jewish, he was automatically invited to become a member, but he saved them the trouble by saying that he didn't want to be a member. Golf is big in Australia, and the annual doctors' golf outing was in a club that had no Jewish members. (It may sound funny to Americans that Australian doctors have a golf tournament.) Coming to New York was an eye opener, a heterogeneous city of tolerance that was a long way ahead of Australia and Melbourne. Australia was very homogenous in the days when I was there. It was pretty much all Caucasian and,

when my kids arrived in the States, my three-year-old daughter had never seen anybody who wasn't white. One day, she pointed and said, "How come that man over there is brown?" We came from a very homogenous country with a society where things were done in a particular way. There wasn't a lot of innovation, and there wasn't a lot of tolerance for change in those days. (Australia is very different today.) The United States was the exact opposite. It was an absolute cauldron of bubbling activity, vitality and constant innovation, with a variety of people from different countries. The variety of emigrants and the tolerance for emigrants was much different in the United States because they had had a steady stream of emigrants throughout their history, whereas Australia had a bunch of people who came out in the early days, after which emigration slowed down. It was very controlled. There was a surge after World War II, but they were called "New Australians." There were New Australians and Old Australians. There was a clear sense of where you fell into society. My wife still has that prejudice in her although she doesn't realize it. When I mention my Australian identity, she'll immediately tell you that I was born a couple of weeks after my mother landed in the country. I'm a New Australian whereas she is a fifth generation Australian.

America was a real eye opener. Of course, in Australia we had all sorts of prejudices about Americans. We thought Americans were rash, superficial, materialistic, uneducated, not very cultured, and did a lot of things that were silly. When I first arrived in New York, I thought, all the streets are numbered because they couldn't figure out names. It's been a long process of been humbled because soon I realized that you can tell the block of the dwelling from the street address, so it's really brilliant. It's a lot more user-friendly than our system with all the names because you have no idea where the street is from its name alone. With their system, it's a grid, and everything makes perfect sense.

Researchers don't read old papers and give proper acknowledgement to the people who came before you. That's not universal, and there are lots of people who are very careful about those things. Americans will spend the money necessary to get the right answer to a question, and much of the rest of the world doesn't seem willing to invest the resources to solve a problem. It's true for social problems as well as scientific problems. Americans are willing to put resources that other countries would not in order to get the right answer, the right solution or the right product. They are not afraid of innovation, and they reward hard work. In Australia, the academic scene has changed a lot. When I was there, there was a leisurely pace. I remember coming back to visit my old in-patient unit, and I couldn't find anybody. I asked one of the nurses, "Where are all the doctors?" and the head nurse reminded me of morning tea! I had forgotten. We used to take breaks for morning tea and afternoon tea. I had completely forgotten about that and, if you worked too hard there, people were suspicious. There was something a little odd about you.

Dr. Connolly: You came to America for two years?

Dr. Mann: I came for two years, and I realized shortly after I arrived that I was about a year behind on where the scientific frontier was. People were talking about methods and findings that I had never heard of. Of course, I realized that they are hearing about this because they talk to each other all the time. They go to conferences where the research is discussed, and they know what is going on. After I caught up I realized that being in the States (and maybe it's the same in Europe) you were at the epicenter of what's going on. If a person did a big study, it was important, and you heard about it on the

grapevine. You didn't design experiments, as I was doing way back in Australia, without having much idea about what was going on except for what was published in the literature. By the time something is published, a lot of other work has already happened. You might not want to design the experiment that way if you knew about it. There was an enormous advantage to being in touch with what was happening in the field.

I was still planning to go back, and then I had a few fortunate breaks. I started getting into postmortem brain research because the medical examiner's office was across the street. It's in the NYU Medical Campus. By walking across the street, I could start collecting brain tissue. I happened to share an office with Mike Stanley, and that's how we got into this research. He got the idea that, if you want to study depression, get the brains of people who commit suicide. I started collecting the brains of people who committed suicide, I started reading the literature, and I realized that only about 60% of these folks are depressed. What is wrong with the others? There's a serotonin abnormality but, in reviewing the literature, you could see the abnormality was there regardless of whether the suicides were depressed. People in the UK and Sweden had clinical information on the patients who died by suicide and, when I divided them into depressed and non-depressed, I saw that the serotonin deficiency related to suicide regardless of the diagnosis. I realized that we may be trying to study depression, but we're actually studying the pathophysiology that's related to suicide. Around the same time, I became aware of the work of Marie Asberg and Lil Traskman-Bendz at the Karolinska Institute with CSF 5-HIAA. It was a different approach and a different method but the same thing, Serotonin was related to suicide independent of psychiatric diagnosis.

Dr. Connolly: Where do you go from here?

Dr. Mann: We have learned an enormous amount by looking at the brain directly. The suicide research on the brain has revitalized postmortem studies and given them an enduring place in psychiatric research in terms of understand the details both at a neuro-circuitry level as well as at a cellular level - the molecular components that go wrong in psychiatric disorders. Post-mortem studies are going to be an indispensable part of that process now. That was very exciting, not to mention the huge amount that was learned about the precise things that have gone wrong in depression and in suicide, right down to the gene expression level. That's been very exciting. The post mortem work is valuable for many reasons, but it also gives us a scientific basis for designing brain-imaging studies. Designing brain-imaging studies without the post mortem work is guesswork but, if you have the post-mortem data ahead of time, then you can see which receptors and which enzymes are altered, and you can then make your imaging studies much more specific. Of course, the great question is: do you see the same thing in the living patients at risk for serious suicide attempts or suicide that you see post-mortem in people who have died by suicide. Are there serotonin and other receptor abnormalities present in our patients and can this form part of a biological diagnostic or screening for risk system, just like Priscilla Kincaid Smith with renal biopsies? We need to get to the biopsy level. There is no biopsy in the brain for psychiatry, but there are brain scans, so we need to get to that level. Hopefully, that will also inform us about medication selection and prognosis, in addition to helping us diagnostically. I believe that treating people empirically with drugs that take 6 or 8 weeks to work, without knowing what kind of biochemical abnormality they have, is unsatisfactory. We need to get to the point where you do an assessment, maybe brain scans, genetic

profiling or a combination, and you can say, you are an SSRI responder, you are a norepinephrine drug responder, you need an Alpha II adrenergic receptor antagonist, or you need CBT or DBT because medications aren't going to work.

Dr. Connolly: How far away is this?

Dr. Mann: I think the next generation is going to be practicing differently from the way that we do.

Dr. Connolly: Changing the subject, you're President of the International Academy of Suicide Research.

Dr. Mann: I'm the President-elect.

Dr. Connolly: How do you feel about that organization?

Dr. Mann: I think that it is a very important organization that needs to be totally revamped. It's important because there is no other international organization for suicide researchers, and we need to enhance our dialogue. We need to take a more international view of what we're trying to accomplish. We have to stop inventing the wheel in each of the countries in which we're working, and so we need to improve that organization. It's an organization with relatively few members, and there are more talented investigators outside it than inside. Everybody agrees that there are a lot of people who need to be involved with it.

Dr. Connolly: Have you been involved with IASP?

Dr. Mann: I have been to a few of their meetings. I think that it does a very fine job. It has been doing to some extent what the Academy should. I belong to the organization. I'm a very big supporter of it, and I think it plays a crucial role because it also brings in all of the hotline people, crisis intervention people and suicide-survivor support-group people, and it casts a broader net. It is a forum where you can have a dialogue between the basic researchers, the clinicians, the family support groups, individuals and so on. I think that's very important.

Dr. Connolly: Tell me about your involvement with the American Suicide Prevention Foundation..

Dr. Mann: I'm very involved with that. It is probably the major source of funding for suicide research. The Foundation is dedicated to that task, and that's important. A third of its money goes to overseas investigators. It has a very fine scientific advisory board that has a lot of people from overseas and from the USA. It's growing significantly. We give about a million dollars away for research projects, and about the same amount is spent on educational types of activities. The amount of funding hopefully will be going up progressively. It's grown a lot in the several years that I have been associated with the Foundation. I'm very enthusiastic about that because it publicizes the importance of supporting suicide research to the general public and to people who would like to donate money to support it.

Dr. Connolly: We have a branch of the Foundation in Ireland now. Kevin Malone is working hard at that.

Dr. Mann: I'm very proud of Kevin. He spent quite a bit of time with us in the United States and has gone back to Ireland. There may have been a number of Jewish convicts on those ships that were sent to Australia, but there were a heck of a lot of Irish. The British treated the Irish badly. I didn't fully grasp this when I was in Australia because, just as my parents didn't talk much about their experiences in World War II, the Irish didn't talk much about the bad experiences that brought them out to Australia either. I went to school in Australia, and I had the classic education. I went to one of the better schools in the country, and they told us practically nothing about what happened to the Irish in Australia. The most famous guy is Ned Kelly who was not representative of the Irish in Australia. It wasn't until I read the book "The Fatal Shore" that I learned about the past. I went and talked to Kevin Malone, and I said, "This is really shocking." I read a lot more about Irish history. Australia had a difficult relationship with England, which is a polite way of putting it.

Dr. Connolly: It's to become a Republic soon, isn't it?

Dr. Mann: Australians are very independent minded. If the government tells you, "This is a good idea," they'll vote against it just because the government said it was a good idea. They had a referendum for Australia to be a Republic. Ninety percent of Australians think Australia should be a Republic and that having the Queen as the head of state is an idiotic idea but, because the government supported that, they voted it down.

Dr. Connolly: That's the Irish element!

Dr. Mann: Absolutely! If a government is consistently giving you a very bad time, you develop a culture of attempting to defeat the government and its machinations. That has become part of the Australian character along with other interesting characteristics - a self deprecating sense of humor and a strong antipathy towards privilege. Australia is highly egalitarian.

Dr. Connolly: What about the issues like assisted suicide and euthanasia?

Dr. Mann: Assisted suicide or euthanasia of people with terminal illnesses is something I am fundamentally opposed to. I believe that the goal for those individuals should be to relieve their suffering, not to kill them. A lot of people who develop a fatal illness will, in the initial phases of that illness, feel that they want to die. It may be a progressive illness, and there is a sense of pessimism and grief that they experience. If you follow these individuals for a longer time, after a while, they begin to evolve in their reaction to their illness. They begin to think, "I've got a certain amount of time left, and there are certain things I'd like to do constructively." They begin to learn to use the terminal phase of their life in a more constructive fashion. This is not surprising when one looks at the stages of grief. First there's disbelief, then there's the sense of anger and loss, and then there's reconstruction. People with fatal illnesses can get to that stage. If they're not in a clinical depression, the evolution of the grief reaction to the illness can result in an evolution of their thinking, wishes and desires.

The second thing is that we know that, for people with conditions that involve a lot of pain, pain management is sadly lacking in a lot of settings. If we stopped

worrying about the person becoming addicted to opium when they've only got a year or two or less to live, then we'd do a much better job of relieving their suffering. If you can relieve their pain, they're not going to feel the same way about wanting to escape from life. I see that as an area where medicine can play a constructive role in people's lives. That's the attitude we should have. I think the business of society legalizing assisted suicide tends to obscure these points. I remember Everett Koop, who was the Surgeon General, say, "Doctors, we're in the business of saving lives. Whether or not to end people's lives is a decision for society, not a decision for the medical profession". There's a lot of truth in that.

Dr. Connolly: Remember the old saying, "Thou shalt not kill."

Dr. Mann: Every patient deserves the maximum we can help them achieve in quality of life. There has to be a sensible assessment of what they want, what their families want and what the prognosis is. Then we try and design a treatment to give them the very best result for them in their circumstances. That's not always major surgery.

Dr. Connolly: That's right. It's amazing what the hospice movement has done.

Dr. Mann: Yes. My father is still alive, but my mother died in our home. She didn't want to be in a hospital, and so we nursed her at home. When it was too much for us, we got some help at home. That should be the goal for everybody. Everybody should try to die at home. It's much better than being in hospital if you have the right support system. The last place you want to die in is a hospital.

Dr. Connolly: What about recreation? What do you do to relax?

Dr. Mann: I'm a runner. Running is big in Australia, but I took up running because my brother-in-law, who is a GP in Australia, is a runner. He conned me into it by taking me as an assistant to the Boston Marathon when he ran it. I now run regularly, and that's relaxing. Australia is big on sport, and I love sport. I'm a big fan of lots of sports, and I like to play them.

Dr. Connolly: You're pretty fit?

Dr. Mann: I think so, more than average. I took up golf because my two sons are playing golf. I play with them on a Sunday morning at 6.30 am - just 12 holes. It's fun, and it doesn't take too much time away from the rest of the family. We have a good time together. I like a lot of sports. My dad was a big sportsman. That might sound funny for a Jewish man from Poland, but he was nationally ranked in table tennis, he won the national toboggan championship, and he was in the top volleyball team in the country.

Dr. Connolly: Is your father still alive?

Dr. Mann: Yes. He'll turn 95 in two weeks.

Dr. Connolly: And sound in limb and mind?

Dr. Mann: As a matter of fact, the only medications he takes are vitamins. That's not bad.

Dr. Connolly: What about theatre and music and reading?

Dr. Mann: I still read a lot. My daughter is doing a PhD in Medieval English so the reading tradition is being carried on. We go to the opera and the ballet which in New York is great. And I'm a painter.

Dr. Connolly: Are you really?

Dr. Mann: Yes. Oil paintings. I like to do portraits mainly. I had an orthodox upbringing, and you're not supposed to be an artist. I started by drawing famous Rabbis, and I went and studied with the art teacher of my wife's aunt, a Frenchman. I learned portrait painting and then landscapes. I've got a few paintings at home. I don't have as much time to do that as I used to. I really haven't painted anything for a while. Time is precious. Harry Truman, the United States former President, had a wonderful saying – life was all about deferring things that are urgent in order to concentrate on things that are important. I think it's an important principle for us in medical research. I try to tell my students to think of an important question. You can publish lots of papers and you can do lots of research, answering little questions, but try and think of an important question and it'll be worth it.

INTERVIEW WITH ISAAC SAKINOFSKY

Dr. John Connolly: I would like to start off with your early life -- where you were born, your family etc.

Dr Isaac Sakinofsky: I was born in Cape Town, South Africa. My parents were from Latvia and Lithuania, Baltic states of Eastern Europe, and they came independently to South Africa, my father to escape pogroms and my mother because she was an orphan who happened to have relatives in South Africa. First, she emigrated as a young teenager to Israel to stay with relatives. Then as a young woman she moved to South Africa to connect with other relatives. She and my father met and married in their 20s, and I was the first born of four children, three boys and a girl.

Dr. Connolly: How long did you live in South Africa?

Dr. Sakinofsky: Until my mid-thirties, when I emigrated to Canada, including a four-year sojourn outside South Africa doing postgrad training in London. My childhood was not very remarkable other than that I grew up in a working class neighbourhood, Woodstock, where my father ran a small store and where many boys my own age were ruffians. We lived there in South Africa during the Apartheid era, a time when the racial groups were segregated, as you know. Racism often extended to other forms of xenophobia. Because we were Jewish, we children had to face the obligatory anti-Semitism from some of our peers and sometimes from a few of our teachers. I was called names such as "Jew boy", and subjected to other intended insults and that sort of thing when I was in the local elementary school. I had a few fights with people about it.

In high school (S.A.C.S.) my parents sacrificed to pay the private school fees, but I did not encounter overt anti-Semitism from my peers. A fair sized minority of the students were also Jewish, only they came from the more affluent homes in the upscale suburb where the school was situated. Some of my cousins had attended this school before me, done well academically and distinguished themselves in rugby and cricket. Some of them had gone off to World War II, and their war exploits had brought honor to the school. I too played the obligatory summer and winter sport at SACS but, unlike my cousins, I was pretty undistinguished as a rugby footballer or cricket player. However, I did immerse myself in the school magazine and was an editor and contributor for years. I loved English literature, and one time an English teacher even predicted that I would be a writer one day. Unfortunately, he was wrong as far as writing fiction is concerned.

As a day scholar, I went home to Woodstock at the end of the school day, where I tried to blend in to the community with everybody else, while the family, myself included, at the same time continued to observe the major Jewish holydays and traditions. My hard-working parents, although they tried to be observant, were not Orthodox. My mother kept a kosher home, but both parents worked in their store on the Sabbath, for instance. Their main goal in life seems to have been to ensure that we children would grow up having had the good education for which they never stood a chance. But I wasn't sure myself at that point what I wanted to do when I grew up. For some years I wanted to be a writer and regularly contributed short pieces for the school magazine, but I can remember times when I also wanted to be an architect - probably the usual toying with different career images of themselves to which adolescents are prone. I suppose the critical determining influence on my ultimate

choice of career was that I had a boyhood hero, an uncle of mine, who was awarded the MBE in World War II for pulling a pilot out of a burning plane and helping to operate on him while the plane was at risk of blowing up. He was quite a hero, and he undoubtedly influenced me indirectly to become a doctor, somebody who saved lives in a spectacular way. But I also had another much-loved uncle (my mother's only brother), who had a bad heart and, as a medical student, I frequently found myself called upon by the panicking family during his cardiac crises of pulmonary edema. Helpless myself, I "held the fort," trying to preserve calm and pervade reassurance – in which I had little confidence – while we all waited for the real doctor to come and give him intravenous aminophylline. Poor man, my uncle - I saw him die during one of these acute attacks, unable to get his breath because of pulmonary edema.

During clinical years in medical school I discovered that I liked taking social and personal histories and the opportunity to get insight into people's lives, and I was intrigued by the interplay between an individual's life stressors and the medical disorders that they were suffering from. At that time, there was a resurgence of research interest in psychosomatic disorders. I found the psychodynamic theories of psychophysiological disorders extremely compelling, but of course they have lost much ground over the years.

Dr. Connolly: Was your family religious?

Dr. Sakinofsky: My parents were believers and tried to keep the Jewish traditions, but they also had to make a living, and sometimes the two came into conflict. If he were truly Orthodox, my father would have closed his business on the Sabbath, but we didn't. We kept it open except for the Jewish New Year and for the Jewish Day of Atonement (Yom Kippur). I wasn't sent to a *cheder* school, but my parents hired a Hebrew tutor for me once a week, Mr. Rosen, a nice man, who taught me Hebrew and Jewish history. Like most Jewish people who had immigrated from Eastern Europe, my parents tried to preserve some of the traditions in the family and to pass them on to us. In addition to the High Holidays, they observed other Jewish holidays such as Passover, and we used to have wonderful Sedorim, which are the two nights of recounting the story of the Exodus from Egypt while eating a dinner that includes symbolic foods, such as hard-boiled eggs (new birth) and salt water (tears and suffering). Jesus attended a Seder, as depicted in Leonardo da Vinci's famous picture, *The Last Supper*. Because my mother kept a kosher home, it meant she had to buy three sets of dishes, one for meat dishes and the other for dairy and a third for the Passover. I also remember, when I was about ten, taking some chickens down to be kosher slaughtered for my father, and I saw the chickens (whose throats had been cut) clucking around for some time after. This made such a traumatic impression on me that for many years I did not eat poultry until long after I was married. To this day, chicken is not a preferred meat of mine, to be avoided if possible.

Dr. Connolly: Have the spiritual aspects affected your life?

Dr. Sakinofsky: Spirituality? Well my belief in God was seriously challenged by World War II and the Holocaust. It affected our family directly in that my father's entire extended family was wiped out in Latvia. Our best information was that they were rounded up with all the other Jews and taken into the forests on lorries, where they were machine-gunned to death after being made to dig their own graves. I never believed that the Determining Force behind our world was similar to a human being in form, but rather

an abstract presence that we cannot imagine. But it seemed reasonable that there had to be some creative force that set in motion the process we call evolution, and which eventually designed humans, animals and everything else. All this was, of course, before I encountered the ideas of Stephen Hawking, but even his explanations to my mind, do not account for all the facts, not that I am an expert on his ideas. Of course, in my work as a psychiatrist, I take great care not to allow my own theories to be imposed on my patients.

Dr. Connolly: What is your experience of the Holocaust?

Dr. Sakinofsky: As I mentioned, my experience of the Holocaust is quite personal because my mother had lost her siblings, and my father lost his parents and several brothers and sisters and their entire families. He had no information about them after the Nazi Occupation and, after the war, the Red Cross found no trace of them. I remember him sobbing when that news was received. For some years after that, my parents nourished the hope that at least Tamara would have survived, the infant child of his favorite brother, perhaps fostered or adopted by neighbors, but we never found any evidence to sustain this wisp of hope. I have. of course. visited Yad Vashem in Jerusalem and the Holocaust Museum in Washington, DC and seen the visual evidence of the mass murders that took place.

In a North American city there is a professor who, in spite of everything, denies that the Holocaust occurred, and a historian who wrote a book about Holocaust-deniers such as he, has been sued for libel by him. This is quite mad. The professor in question suffers from a form of delusional thinking, I am afraid, the delusion of denying the Holocaust in the face of the abundant historical evidence and testimony that exists. I think the Holocaust has left a deep imprint on me, and has tested my beliefs in a protective Deity who protects the innocent and punishes the guilty. I believe that, as a child, my innocence was stolen from me, along with the family experiences I might have had, and I developed a need to see that justice is done. Personally, I am somewhere between a believer, an agnostic and an atheist depending on which frame of mind you catch me in.

Dr. Connolly: You had a very serious illness this past year.

Dr. Sakinofsky: Yes. It wasn’t very pleasant. I had angina and had myself investigated. My cardiologist showed the coronary angiogram to a surgeon who recommended an operation, so I had the bypass operation, and I was quite phlegmatic about it. Whatever the outcome, I was resigned to it. I remember waking up in the ICU and looking at the ceiling and registering the fact that I was alive. I was quite surprised that I had survived. I felt I had bought myself more time, and I owe that to the doctors, especially to the woman surgeon who agreed to operate on me when another surgeon would not.

Dr. Connolly: As an adolescent, did you read widely?

Dr. Sakinofsky: Yes, I read quite a lot, everything I could lay my hands on - the classics, good fiction.

Dr. Connolly: What books stand out?

Dr. Sakinofsky: Well I read all the novels of Charles Dickens and other classic English writers. I read books by Dostoyevsky and Tolstoy. Among contemporary writers I enjoyed all the works of C.P. Snow for their psychological insights.

Dr. Connolly: Have you read *Finnegan's Wake*?

Dr. Sakinofsky: Oh, yes. But it was difficult.

Dr. Connolly: You graduated from Medical School in South Africa?

Dr. Sakinofsky: I went to school and university in Cape Town, South Africa. After I qualified in medicine, I decided I wanted to be a psychiatrist, and trained in psychiatry also at the University of Cape Town. At this level I was much influenced by a respected teacher, Henry Walton, and his wife, Sula Wolff, who had both trained at the Maudsley and who later emigrated to Scotland to join Maurice Carstairs in Edinburgh (coincidentally, on the *Pendennis Castle*, the same ship and the same time that my wife and I and our infant daughter were traveling in to join the Maudsley as a registrar). After being exposed to these two Maudsley alumni I determined to augment the training I had in the relatively small psychiatric center in Cape Town at the time, and decided to go to a world-class center where I could be sure that I would get a first class training in Psychiatry, which was the Institute of Psychiatry of the University of London, known as the Maudsley.

So, after I graduated from medical school and did my internship, I went into psychiatry. Psychiatry in Cape Town was just developing at the time, and the head of the department was actually a neurologist, trained in London at Queen Square, very elegant, precise and impeccable both in his social manner and his professional conduct. In those days, neurologists customarily also treated psychiatric patients, and the department was thus called a Department of Neurology and Psychiatry. Some of the faculty to whom I owe a debt of gratitude for what they taught me as a registrar included Frances Ames, Jim McGregor and Harold Cooper. Then Henry and Sula Walton joined us. He was an ex-South African, and she was originally of Viennese origin, possibly a child refugee from Europe, and they had met at the Maudsley. Henry later became a professor at Edinburgh University jointly with Bob Kendell, and Sula Wolff became a world-renowned child psychiatrist. The chief in Cape Town, Sam Berman, taught me some very useful basic neurology – that I have never regretted – and I had to learn to type (for which I am also eternally grateful) to prepare the new patients' case notes in advance for his ward rounds. He absolutely insisted on it and would not accept anything handwritten. Frances Ames taught me empathic psychotherapy and later, Henry Walton taught me a whole other set of psychiatric skills. Soon after Henry arrived the department was split into departments of neurology and psychiatry, but I continued to learn from both as senior registrar. Later, after I completed a doctoral thesis on the social and cultural determinants of psychiatric illness (of which a major portion was analyzing the comparative inter-racial rates of attempted suicide), I left Cape Town for the Maudsley where I was privileged to study with renowned individuals such as Sir Aubrey Lewis, Michael Shepherd, and S. H. Foulkes, ultimately serving as senior registrar (chief resident) on the professorial unit of Lewis and Shepherd.

Dr. Connolly: What year were you at the Maudsley?

Dr. Sakinofsky: I was there between 1962 to 1965,

Dr. Connolly: What were the influences on you in the Maudsley. Who was there at the time?

Dr. Sakinofsky: Professor Michael Shepherd was one of the people who interviewed me for admission to the Maudsley, and his unit was my first placement. Shepherd was the Reader in Psychiatry, considered to be a very critical thinker, a widely published epidemiologist and psychopharmacologist, much respected, but rather aloof and intimidating. Anyway, as a registrar, I remember the first six months as a time of major adjustment, and I got a real workout in the competitive climate. You can imagine the anxiety everyone felt. It was so very competitive at every level, and everybody tried to outshine everybody else, but once you were past the first six months and less likely to be let go, you heaved a huge sigh of relief. I remember one poor fellow who was not allowed to go on after six months and who killed himself. It was scary, to say the least, but the learning curve among the junior staff was almost vertical. On the other side of the coin, there were checks and balances. We had our Junior Common room where the registrars spent a fair amount of time, and where some collegial bonding took place, which helped to counter the anxiety. It was also a place where useful information was shared and where one was exposed to a high level of discussion of intellectual issues, not only about psychiatry but also about contemporary affairs. It was a veritable cauldron of social and professional learning and, sometimes, I wondered whether I was learning more from my peers than from my teachers. I also look back with great pleasure on the group visits to the opera and theatre that were organized from time to time by one of us, Oscar Hill, a polished and urbane man to whom we all should have been more grateful. On the PU (professorial unit) we registrars met Friday mornings for a case conference. The anxiety of the presenting registrar would be over the top, just trying to meet Sir Aubrey's exacting expectations. Having probed the presenter's depth of knowledge Lewis would go around the room addressing a probing question to each of us in turn, like Socrates, debating our (to us) pathetic answers from the vantage point of his Olympian intellect and total mastery of the literature. I had never before in my life encountered anybody approaching Lewis's intellectual stature, nor have I since - definitely a man to be looked up to and emulated, if one could.

From Lewis and Shepherd, I moved off the PU to study group psychotherapy with S. H. Foulkes, one of the numerous German-Jewish refugees whose flight from Europe enriched British psychiatry. Foulkes was one of the pioneers of group psychotherapy that came out of trying to manage large numbers of soldier-patients with "battle fatigue" in World War II. I observed him conducting groups, and he supervised my groups for about a year. I attended some of the meetings of the group psychotherapy society that he had started and over which he presided, and I remember we were served Pym's Number One drinks and dainty sandwiches. But I had already gained some experience of group psychotherapy from Henry Walton in South Africa who had himself trained under Foulkes at the Maudsley. Henry was pretty impressive to watch in action. Then, as I neared the end of my term, I had a phone call from Michael Shepherd that he could arrange for me to work in suicide research in Chichester with Peter Sainsbury, but I was on the point of returning to South Africa and, to my great regret, I had to decline. I had met Sainsbury a few times and regarded him extremely highly, but duty called.

Dr. Connolly: Why what made you do that?

Dr. Sakinofsky: First of all, when I went to the Maudsley, I had a fellowship from the South African College of Physicians and Surgeons that was conditional on returning to South Africa to teach for at least three years. Secondly, I had family business to attend to. My father had died about a year before I went to London, and I had to make sure, as the eldest child, that my mother and siblings would be all right. So I rejoined The Department of Psychiatry in Cape Town as a senior lecturer. I taught there for exactly three years to fulfil my obligation, and then circumstances permitted me to move to Canada.

It was 1967 and, at the time, I was actually in charge of the Department, the acting head, while the Professor, Lynn Gillis, was on his sabbatical year in America. One evening I got a phone call from the registrar on duty at the hospital, Dr. Tockar, who told me that I had better come to the hospital because the Prime Minister, Dr. Verwoerd, had been brought in by ambulance after an attack and was dying and, in another ambulance, his alleged assailant had also been brought in and needed a psychiatric evaluation. So I went across, and I knew this was going to be fun and games because this was South Africa at the height of the Apartheid Era, and Dr. Verwoerd was known as its intellectual architect. When I arrived, security officers and police were milling around the accident and emergency department of the Groote Schuur Hospital (the same one where Christiaan Barnard did the world's first heart transplant). The room where the alleged assassin was being held was crowded with police, military police and non-uniformed security, possibly about 50 of those guys in there. There was no hope of getting a decent interview with the man, so I had to say, no way, you know you don't do psychiatric interviews with an audience of 50 people and, therefore, the room needs to be cleared. So there was a bit of a standoff with the security people but, with the support of the hospital administration, eventually the room was cleared, leaving Tockar and myself alone with the patient. We were able to complete and record the interview, but I needed time to mull it all over before releasing our findings, and so a press conference was arranged for the next day. However, the police did arrest the patient (Demetrios Tsafendas) immediately after our interview and took him away to prison and pre-trial while their own psychiatrist started his evaluations. It was clear that he was ultimately going to trial for the murder of Dr. Verwoerd. A handful of psychiatric colleagues from UCT and myself were enrolled as expert witnesses for the defense and gave evidence at the subsequent high level trial that he was psychotic and unable to plead, and ultimately this viewpoint was upheld by the court. Naturally, there were government psychiatrists who believed he was competent, but their thesis did not prevail. Tsafendas was found unfit to plead by reason of insanity. Subsequently, several books have been written about it, and my evidence has been transcribed in some of those books. The assassination took place not long after the Kennedy assassination so, in preparing for the trial, I wanted to get as much material about the Kennedy assassination as I could, and I approached the U.S. consul's office, and they were very helpful. I discovered, incidentally, no doubt because of my involvement in the case, that the F.B.I. had opened a file on me, so you could say that I earned a certain notoriety but, in spite of that, I then had an offer of a job from the Albert Einstein University, New York, and about the same time one from McMaster University in Canada. Based on the specious logic that Canada lay somewhere culturally between Britain and the United States, I decided on moving to Canada. A good friend of mine had also vouched for me at McMaster and, knowing that he and his wife were living in Toronto, only an hour away, also made the choice easier.

Dr. Connolly: How did you get into suicidology?

Dr. Sakinofsky: When I made up my mind to become a psychiatrist I determined that I would focus on the severely distressed at not "the worried well." Even when I was still a registrar in Cape Town, I was asked to see and treat such people. A few of my erstwhile professors asked me to treat their wives who had attempted suicide or were thinking of it. I did have a medical student who took her life, with devastating effect on me, and I developed an even greater determination to improve my skills with suicidal people. I think she had gender confusion in a country where homosexuality was kept in the closet at that time. She used to run well, was an athlete and worked well at her medical studies. She then took a break from her psychotherapy to prepare for her exams and died in her room in the medical student residence with a blanket around her and an empty bottle of tablets. I went through the aftermath of that, my first patient suicide. As Kreitman once remarked, you can count the suicides but not those whose lives you may have saved. I think there have been some of those too, judging by letters I have received from patients or their relatives over the years. At the end of the day, when you look at what you have done in this world to justify being here, we need memories like that, because that's all that matters.

Dr. Connolly: You save one life, you save them all?

Dr. Sakinofsky: Yes.

Dr. Connolly: You have published a lot on what suicidology's future is?

Dr. Sakinofsky: Some, but not as much as I would have liked. I always had jobs that were pretty burdensome clinically and loaded with administration. I think it would have been better in Canada if we had a different healthcare funding system - more salary-based and less fee-driven.

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

Dr. Sakinofsky: It's hard to say which ones. We just finished a study which is going to be in the next issue of SLTB that I'm quite proud of. It is a study of suicide in the Canadian Armed Forces among peacekeepers. You have to understand that peace keeping is very important to Canada ever since Lester Pearson was the Prime Minister. Pearson was very active in the United Nations and believed that the United Nations should keep the peace in the world and that Canada should play its part. Canada was always regarded as a fair and unbiased country, a good country to find peace keepers for the trouble spots. Then there was a rash of newspaper stories that Canadian peacekeepers in Bosnia had committed suicide, and it was the horrors of peacekeeping that were responsible, and so I was asked to come back to independent research and put together a team, which I did - scientists with first class experience in epidemiology, biostatistics and psychological autopsies. Our findings were presented in a report to the defense authorities and over public television (CPAC).

Dr. Connolly: Where is suicidology going from here?

Dr. Sakinofsky: The $64,000 question. I think increasingly we are making neurobiological advances in suicidology. But the complete picture has got to be biopsychosocial, and is still elusive. Even in the presence of severe mental illness, no matter how hopeless they may feel, most people would see that they do have alternatives to suicide and would preferably choose one of those alternatives. The minority do choose suicide because of their thinking processes. So it is understanding the cognitive process, and why the cognition goes towards suicide in one person and away from suicide in another, that is the enigma that I personally would have liked to have spent a long time researching. I've got patients with not much adversity in their lives really but who are or have been very suicidal.

Dr. Connolly: This would link up with the biggest issue this year, that of physician assisted suicide or physician assisted dying?

Dr. Sakinofsky: Physician assisted suicide? Well that's different. The suicides that I try and prevent are suicides in people who have had unbearable conditions and who have been suicidal in the past, but fundamentally they are ambivalent. They seek us out to help them make it possible for them to go on living in a healthier or better state. I don't get involved with people who attempt suicide to kill themselves, genuinely failed suicides, unless they are suffering from potentially treatable illnesses that would make them change their minds if they recovered from them. I do not hold the utilitarian view that people's lives belong to the state. They belong to the person. I've seen enough suffering to take a humane and compassionate physician role. I think there are situations where they can be assisted and should be assisted.

Dr. Connolly: But could you assist anybody in that way?

Dr. Sakinofsky: Myself? No, I don't think I could but, on the other hand, I don't know how I might react if it was a dear one suffering terribly, and no one else would help. You cannot say what one would do under those circumstances until you are actually in that position. Even famous suicidologists, like Nico Speyer, a famous Dutch suicidologist, took their own lives when confronted by inordinate predicaments.

Dr. Connolly: He's a Dutchman.

Dr. Sakinofsky: One time he was a big name in suicidology. Ringel, Austria's leading suicidologist and secretary of IASP is another name that comes to mind.

Dr. Connolly: Yes, I had felt very let down by the sub-group who were kind of heroes in my time.

Dr. Sakinofsky: No, I don't judge, you see.

Dr. Connolly: Are you involved with AAS?

Dr. Sakinofsky: I've been involved with AAS; I've been going to their meetings, but I have not sought office.

Dr. Connolly: What about your interests in art and music?

Dr. Sakinofsky: I enjoy music - classical music and some jazz too, but I don’t enjoy jazz as much. I didn’t have a musical background at home. My parents were too involved in the harsh realities of making a living in a strange country. It was only in high school and when I was a medical student that I started going to classical concerts with friends. Not being able to play an instrument has always been one of the lasting regrets of my life.

Dr. Connolly: London was wonderful for musical concerts, wasn’t it?

Dr. Sakinofsky: London was, yes, I liked concerts there.

Dr. Connolly: Do you now have much contact or any contact with South Africa?

Dr. Sakinofsky: No. My mother emigrated to Canada together with my sister and her family in 1997, and she died in Canada. I had a brother in South Africa and have made the occasional visit. My wife has been back more often; she has many of her family there.

Dr. Connolly: Have you been back there since the change of government?

Dr. Sakinofsky: Yes. It is a very beautiful country.

Dr. Connolly: What do your children do?

Dr. Sakinofsky: My daughter has a human resources company that she started herself, and she hires people for quite large organizations. I’m very proud of her. She has an MBA from the University of Toronto and is a fine young woman in, the way she relates to people. and she is an excellent mother and wife and daughter. My son is a lawyer but burdened by problems of physical health.