INTERVIEWS WITH SUICIDOLOGISTS, VOLUME 3

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 two sets of interviews, edited by myself and the interviewees, have been placed on the website www.drdavidlester.net.

Volume 1
Alan Apter
Alan Berman
Unni Bill-Brahe
Diego de Leo
Robert Goldney
Kees van Heeringen
Ronald Maris

Volume 2
Keith Hawton
Antoon Leenaars
John Maltsberger
John Mann
Isaac Sakinofsky

I am pleased to present Volume 3, now on the same website. The interviews are with:

Israel Orbach
Antapur Venkoba Rao
M. David Rudd
Armin Schmidtke
Morton Silverman

INTERVIEW WITH ISRAEL ORBACH[1]

Dr. Connolly: Thank you very much for agreeing to this interview. First of all, I would like to explore a little bit about your early background - where you were born, family life and so on

Dr. Orbach: I was born in Russia. My family were Jews living in Poland and fled Poland at the beginning of the 2nd World War. When I was two years old, we came back to Poland and then to Germany, to a refugee camp. From there we went to Israel in 1948, and so I grew up in Israel. I went through the same course of development as any other Israeli - high school, the army and the six-day war. I came to the United States after I received my BA in psychology in Israel.

Dr. Connolly: What are your early memories?

Dr. Orbach: I was raised by my Grandfather and my Uncle and Aunt. My earliest memories are from the refugee camp in Germany. As a child, it was a great time for me. I wasn't aware of course at three-years-old of the history of the family. I learnt about it much later. We were a rich family that lost, not only part of the family, but all the property we owned. I have memories from Israel. I grew up in Israel in a small village, with immigrant Jews from Yemen. I remember that I was very scared by these little dark-skinned kids. I had never seen anything like it before. But, all in all, it was great childhood.

Dr. Connolly: What were the influences on you there?

Dr. Orbach: It was my Grandfather who was a very loving, warm, wise person. We had a wonderful relationship. I was number one for him among all the grandchildren. He has guided my life until today. A very powerful person but so warm and so loving. He was the person who influenced my life more than anybody else, more than teachers, more than friends, the army. Nobody else stands out.

Dr. Connolly: Did you have a religious upbringing?

Dr. Orbach: Yes. He was orthodox. The entire family was orthodox. The family that remained from the holocaust lived together in one court, and it was great. We had a kibbutz-style life. We shared a lot of things and even some of the properties. We had a small farm which belonged to the entire family, and everybody took his share in the duties. There was an atmosphere of cohesion, warmth and protection and, as a childhood, it was great.

Dr. Connolly: What about music?

Dr. Orbach: There was no music. Nowadays, I have very simple tastes in music. I don't listen to classical music. I don't understand it, unfortunately. I read a lot. I like literature.

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[1] Dr. Orbach's death in 2010 prevented him from editing this interview.

Dr. Connolly: What do you recommend?

Dr. Orbach: I read a lot of Israeli literature, and I just completed a book on the relationship between a man and Israel which portrays Jewish emigrant from Iraq confronting the different protocols in Israel and the independence war which was one aspect of what we went through in Israel through the liberation and the conflict. The book brought up the social conflicts for emigrants who come to Israel.

Dr. Connolly: How old were you when you became aware of the holocaust?

Dr. Orbach: I always knew something about it inside. It was intuitive. In spite of the happy childhood and the good family experience, there was always something there that was sad. My parents and aunts and uncles would speak about the life in Poland. They were very affluent, and they lost everything. They lost family members including my grandmother and some of the children who stayed behind. There was always a tone of bereavement in the family, and I think I got more conscious of things and more aware around the age of ten.

As a child, we were aware of the situation which was always in danger. When we came to Israel, it was in the middle of the independence war in 1948. I remember the war in 1956, and in 1967 I took part in the war as a paratrooper. The sense of having to defend ourselves, of being surrounded by enemies, was always there. In my experience, this was stronger than the awareness of the holocaust, which came much later.

Dr. Connolly: Tell me about your early years at school?

Dr. Orbach: I went to sixth grade in a village, a low-grade school. All the students were children of immigrants who were hassling every day for bread and really didn't have time to devote themselves to the education of their children. After sixth grade, I went to another school in a nearby city which was a different world. They were different kids, and they looked more like Israelis then myself. They spoke with a different accent than mine, and I was very apprehensive and afraid at the beginning. I merged very quickly into the school, and I became a very good student. This was for two years. Then I went to yet another city, to Tel Aviv, to a very prestigious high school, very competitive. It wasn't easy to get into this school. It was tough, but I met many kids from different backgrounds. They were sharp and intelligent. The teachers were very demanding but, on the other hand, it was a very enriching school. The student that sat next to me was Hanoch Levin who later became the best Israeli play-writer ever. This was a great experience, knowing him and listening to his wonderful compositions. It gave all of us perspective on our own narcissism. Our teacher right away recognised his great talent and encouraged him. He came from a very poor family and would not have been able to complete school if it had not been for this teacher. All in all, the influence of this school was great. I learned how to think, to integrate and to analyse

But, in terms of education and interests, I was a self-made person. All of us carry our own dreams.

Dr. Connolly: Is it there you developed your love of literature?

Dr. Orbach: Well, I haven't mentioned this, but I wrote poetry since the age of 10.

Dr. Connolly: You still do?

Dr. Orbach: No. I quit when I met this friend Levin because I saw that, if I would be a poet, I would be a very mediocre one, so I stopped then. At the age of 16 I stopped writing.

Dr. Connolly: You didn't believe in what Bernard Shaw said, that if a thing is worth doing, it's worth doing badly!

Dr. Orbach: Right. I didn't believe it.

Dr. Connolly: After high school, then what?

Dr. Orbach: After high school, the army is mandatory for all Israeli kids. I got drafted into into the paratroopers. They were two and a half very tough years.

Dr. Connolly: Was that a time of war?

Dr. Orbach: It was before the war. There was no war in 1962 or 1963. I was an enlisted soldier and didn't make it to an officer rank.

Dr. Connolly: What did the military experience do for you?

Dr. Orbach: It's basically mental strengthening and provides a sense of identity. It helps you make transition from adolescent to adulthood. It puts tremendous responsibilities on you. It teaches you how to be with other people, and how to relate to other people; the necessity of being together at times of stress; to adjust to the most difficult situations; and knowing that, no matter how bad it is, it goes away after a while when you get adjusted. The experience was that every day you learn more about life in terms of your ability to cope and to survive and to be able to sustain yourself in stress and being proud of being able to do it. Of course, it brings you close to other people, to your friends, to your mates in the army, to your peers. You have the sense that what you are doing in the army is not only for your yourself, but also for your friends in the army. You learn to be together and to work together.

Dr. Connolly: To be a team. After the army, what then?

Dr. Orbach: Before the army, I met my future wife Esther. We met in Ruth's Movement. I fell in love with her right away. We went out for three years while I was in the army and then, right after the army, in 1965, we got married. I was 21 years old, and she was 20 years old.

Dr. Connolly: Could you afford it at the time?

Dr. Orbach: Yes we could. She came from a rich family. Then I started to go to the university for my BA. I knew then that I wanted to study psychiatry.

Dr. Connolly: Why?

Dr. Orbach: It's difficult to say what made me do that. For a long time, I considered a career in teaching or in literature until I met a writing journalist before I got married. I knew that I would not be able to make a living from writing and, all of a sudden, it hit me that I was interested in psychology. It was the best profession for me, loving people, listening to people, liking to help and liking to be helped.

Dr. Connolly: Which university did you go to?

Dr. Orbach: I went to Bar-Ilan University which is near Tel Aviv. It was a young university, founded in 1955, and it was a great learning experience. Every day I would go to the university and come home and think about the next day. I knew that this was what I wanted to do and that this was the right choice for me. Then came the six-day war. I participated in the war. I was in Gaza, and I hit a mine with the vehicle that I was in and lost consciousness. So my participation in the war was quite short. Then I graduated.

Dr. Connolly: What was the system of psychology in that university?

Dr. Orbach: It was the only university that we had at that time with clinical psychology, and there were some teachers who came over from the United States with a strong clinical, dynamic, psychoanalytical method.

Dr. Connolly: Not behavioral?

Dr. Orbach: No behavioral psychology, although we covered behavioral psychology in some courses in experimental psychology. We had a very good basis for research, but it was the only university to expose students also to dynamic approaches. It was soft psychoanalysis, and not the pure psychoanalytic approach. At that time, there was no PhD in psychology. I had an offer to come to Boston and to do some work with Jewish youth in Boston for Israel. I decided to combine this with my studies. We moved to New York. and I was accepted to several places. I choose Yeshiva University, and this is where I got my PhD.

Dr. Connolly: Tell me about your thesis?

Dr. Orbach: I spent a long time thinking and trying to do a thesis on freedom of choice and decision making and the way a person constructs his life. Then my supervisor left the university. So, I did a dissertation on an idea that came up in one of the seminars that I took on aggression. I studied aggressive behavior and a fear of retaliation. How does the fear of retaliation affect your aggressive behavior? What I wanted to do was very quickly finish my dissertation and go back home. Part of the education was also an internship which I did at Albert

Einstein School of Medicine, a tough place. I was exposed to very good people and a variety of approaches and gained quite a lot of experience. Then we stayed one more year in the United States to pay all our debts before we got back to Israel. I worked as a chief psychologist in St Mary's Hospital in New Jersey for one year, and I loved it. I felt there my studies had provided me with some tools, insights and courage that I could use.

Dr. Connolly: Which of your teachers made most of an impression on you, either there or in Israel?

Dr. Orbach: In Israel, it was more the atmosphere of learning than any one particular teacher. At Yeshiva University, I was influenced by a number of people, one of them being Morris Eagle who was a psychoanalytic therapist. But it wasn't so much the people as what they offered. The dominant approach at the time was the interpersonal approach. I learnt from one professor not to give up your personal intuitions and your unique way of looking at things in favor of a specific method or a specific approach. Be yourself in the way you approach people, in the way you see things and in the way you explain things. I was most influenced by him, not by using his point of view or approach but in being able to be myself.

But there is one story I must tell you which is related in a way to being awarded the Dublin Award. When I was in school going for my PhD, one of our classmates committed suicide. A beautiful girl, Susie. Of course, we felt bereaved, and we felt guilty. We wanted to do something about this, so we decided to establish a hotline. None existed at that time. I am talking about 1971 in New York. The head of our program got in touch with Shneidman and Faberow. For us, they were only names in the field, and they had got together and established a hotline. We, the students, took turns on our hotline and, when my turn came, I was sitting and chatting with the supervisor. The telephone rang, and I got paralysed. I couldn't lift the telephone and talk to the person on the other end of the line. The supervisor was Joseph Richman, and he looked at me and looked at the phone. I looked at him and looked at the phone, and finally he picked up the phone. The next time it rang he put his hand on my shoulder, and I picked up the phone, and this is how I started my career as a suicidologist - being paralysed by the telephone for the hotline and being really helped and supported by Joe Richman.

In the area of suicidology, I was strongly influenced by Richman's family perspective and, of course, Shneidman's emphasis on the phenomenological, subjective perspective. Also, Charlotte Ross and the way she translated theoretical ideas into practice in an artistic way.

After I worked as a psychologist in New Jersey and came back to Israel, I felt guilty for not being there for so long, five years. I had missed the Yom Kippur war. I wanted to do something, and so I volunteered to work in a school for disturbed children. This is where my career in suicidology started because, on the first day, my first meeting in the school was with a 7-year-old who she told me that she was going to kill herself. I was shocked and didn't know what to do. I went to the principal and told him that this 7-year-old girl wanted to kill herself. He said really, but what about this one and this one and this one, and so on. It was a school for disturbed children, and so he knew much more about suicide in children than I did. This is how I got into suicide.

I was bewildered by the fact that such young children talked about wanting to kill themselves in the way that adults talk.

Dr. Connolly: What is the youngest suicide you know of?

Dr. Orbach: The youngest suicide that I know of (but I did not come in direct contact with) was a 9-year-old girl who hung herself from the handle of the refrigerator which says a lot about the determination and the energy she put into killing herself. And a ten-year-old boy who burnt himself. He left notes that he was going to kill himself A lot of what I know about suicide and the way I work today in therapy was influenced by those experiences with the kids. When I first started to study about suicide, we didn't know what death means to them and how it is related to suicidal thoughts. I was also intrigued by the fact that I would sit in the room with a child and talk about life and her wishes to kill herself and then, half an hour later, I would see her playing with other kids, seeming to be very happy. You couldn't tell that this was a suicidal child. I was intrigued by how the state of mind could change so quickly and what does it mean that she is so happy playing in the yard but, when she is with me, she is talking of trying to kill herself.

This is where some of my first ideas about suicide started to develop, as well as what I learned from books, conferences and other people. The first thing I learned is that, when one is suicidal, one is not always suicidal. The state of mind consists of a matrix of different things, and one can have moments of happiness and be busy at work and carry on a relationship with family, and then, at times, a suicidal process takes place and this state of mind takes over. This led me to develop one of my first theoretical conceptions about suicide which I called *mental attitude tendencies*. Attitudes towards life and death are different facets with aspects such as attraction to life, repulsion by life, attraction to death and repulsion by death. All these facets and processes take place in all of us, but they have a different profile in the suicidal person. I started to study this in suicidal children. For these four tendencies, I made up stories which I believed measured each of these dimensions. The children had to complete these stories, and the way they completed them provided an insight into the degree they felt attracted to life or repulsed by life, attracted to death or repulsed by death. This was guided by the idea that the suicidal person is a whole person, and different states of minds or reflections of the soul take him to this situation.

I realised that one major difference between suicide in young children and adolescents on the one hand and adults is that the youngsters' suicidal behavior is strongly related to family processes. This is where I learned a lot from Richman. You cannot always see the destructive dynamics that go on in the family when you study the child alone. You have to study the suicidal child in the context of the family. Suicidal behavior in the youngster is an index of the suffering of the entire family. People have written about the dispensable child, the scapegoat child. One of my theoretical conception was that suicidal children and adolescents are pressured to resolve unsolvable problems, usually family problems. The pressure is to resolve something that cannot be resolved, and they are blamed for not being able to resolve it. This brings them to a state of despair, hopelessness and helplessness.

I'll give you just one example. I had started to get a reputation that I work with suicidal children, and so I made it my responsibility to talk about the issue - that very young children can kill themselves. I came out very strongly against psychologists and psychiatrists who denied the existence of suicidality in young children because children don't have a concept of death. I never understood this idea - why not having a realistic concept of death does not enable them to commit suicide. It could be just the opposite. If they believe that there's a life after life, then it's easier to commit suicide because you believe that you will go on living. This is what I call attraction to life and to death which is a facilitator of suicide. A young child of 9 came to me for treatment and talked about suicide and wanting to die. I tried to find out why he wanted to die, what was wrong, what was bad, and what was he suffering from. He couldn't tell me. He kept making suicide attempts. Then I learned that his sister had made several suicide attempts and threatened suicide a year and a half earlier. The parents went to a psychologist, and he suggested that they buy a dog for attachment and love. She stopped talking about suicide but, a few months later, her younger brother started talking about suicide. After working with him for a few months and getting nowhere, I decided to meet with the family. I discovered that there was a divorce issue in the family in which the father wanted to divorce the mother. The mother was terrified by the idea, but she didn't do anything about it. She started to encourage, I believe unconsciously, the children to talk about suicide and about death. When they talked about death and suicide and wanting to kill themselves, she said, "I cannot talk with you about this. Please go to bed." She used the kids as messengers to the father. "Listen, if there is going to be a divorce, there is going to be a suicide in the family". The children participated in this without knowing. This I call an unsolvable problem. We developed a scale that measures the experience of unsolvable problems that an adolescent faces, and we did some research on this.

Dr. Connolly: Are you still on this journey?

Dr. Orbach: I took a turn in my career, a radical turn. I started focusing most of my research on non-mainstream research. I don't focus on the risk factors and correlates or the epidemiology of suicide behavior. I try, the best that I can, to get to the heart of the matter, so to speak, into the inner dynamics and the inner world of the suicidal person. One of the questions that bothered me and directed my research is that we all have these risk factors. What are the additional processes that we don't look at that make the difference. This is what guides my interest, my curiosity and my research. This is how I came to talk about attraction to death as a facilitator of suicidal behavior. My focus is not on the risk factors, but on what makes suicide possible in terms of the inner state of mind and the inner world.

Most of my research ideas come from the clinic, from the therapy room, and from my experience with working with people and what I observed there. This is how I got to study the issue of the body in suicide because, time and again, I saw that the way that the patients are speaking about their body must be meaningful in terms of the suicidal state of mind or the suicidal process. I came across stories about not feeling pain and being able to sustain physical pain. I started to think about what role does this have in suicide. It's

not a cause of the suicide. But being numb, being able to sustain physical pain, believing in life after life and viewing death in a positive way may make the difference between suicide and no suicide. If you don't like your body, if you don't have any pleasures from your body, if you feel detached from your body, and if you can tolerate physical pain, then it's easier, at a certain moment, to carry out an aggressive action against yourself.

Dr. Connolly: Does this aspect of suicidology get enough attention?

Dr. Orbach: No, but I was given an award for this research.

Dr. Connollu: Congratulations.

Dr. Orbach: Thank you. I get a lot of mail from young psychologists, young therapists and young researchers who show a lot of interest in this, and there are a lot of studies going on with it now. The four dimensions scale has been translated into Japanese, French and Italian. The body issue gets a lot of interest from young people who are not yet used to thinking about the major risk factors and correlates of the risk factors and correlates of depression and are ready to do research in a different way. I am particularly proud about this award because part of this award is about my non-mainstream research.

We have just completed a series of studies which constructed a scale of mental pain. Shneidman defines mental pain mostly as an outcome of frustration of the most important needs. Different people define it in different ways. We went to people and asked them to tell us stories about what mental pain is. We analysed the narratives until we got a scale of 45 items yielding nine factors of different aspects of mental pain. We have now started to use the scale. This allows us to measure to mental pain and to confirm Shneidman's concluding remark about suicide - that suicide is an outcome first and foremost of intolerable mental pain in the psyche.

Dr. Connolly: How do you relate your community research with the biological aspects of mental pain?

Dr. Orbach: Mind and body go together. Suicide starts with biology, and then biological processes and psychological processes go together. You can approach it from either side, and I approach it from the soul side, the mind side. But the first thing I do, when people come to me for depression or for suicide, is to send them to a psychiatrist for medication. I try to persuade them to take medication. I think my work is easier if can we alleviate some of the pain. You cannot work in a dynamic way with a person in pain. I think that we should work together. What comes first? We know that biology comes first but, later on in life, what influences us? I think it biology is less relevant.

Dr. Connolly: You've done some teaching all over the world, haven't you?

Dr. Orbach: Yes. First of all, I teach at my university, and I love teaching. But suicide is not my only area. I have a great interest in unconscious processes, and I have a book on unconscious processes which they sell here for $225. This is why I don't sell many of the books! It's not worth $225; $25 is enough.

I am a personologist. I have taught theories of personality for many years, and I teach clinical methods and supervise young students. I can say that I have quite a wide perspective in looking at suicide from a more general theoretical standpoint. This shows in some of our work. A series of studies we undertook and still do about suicide from the perspective of self-psychology and about suicide from a perspective of relational-psychology. This helps me a lot. I love teaching, and I love talking!!

Dr. Connolly: What do you learn from your students?

Dr. Orbach: I learn from my students. As a matter of fact, this is also related to suicide and to my work in suicide and also meeting with parents and educating teachers about suicide prevention. I tell parents that the prevention of suicide is to hug your child every day, as long as he lets you, and to teach him something new about life every day. To enhance the problem-solving ability and the love of the self, the body and life itself is antithetical to the suicidal process. I cannot tell you at this moment any specific thing that I learn from my students, but I love listening to them. I love listening to their fresh perspectives and their paradoxical ideas; sometimes to things that I have been thinking about for years and here come the first-year students of psychology with the answer. I think life itself is an ongoing experience of learning, and you can learn something everyday from everybody.

Dr. Connolly: Tell me which of the suicidologists in the world you most admire?

Dr. Orbach: Ed Shneidman is my bible. I am not a little Ed Shneidman, and I am not a second Ed Shneidman. We don't think alike, and we don't agree on everything. He doesn't like that! We had an ambivalent relationship for many years, but now we are good friends. I was captured by his insight, by his ability to see through and summarise complexities in one sentence. I think he has a great interest in people. I wouldn't say that he always gets along with people, but he is so perceptive and so sharp, and I particularly like his approach because of his phenemological and subjective perspective - trying to see things from the perspective of the other. He emphasises the narrative approach. I didn't learn that from Shneidman. I learnt that from one of my teachers in school, but this is one of the reasons why I like Shneidman's approach. His insight is incomparable. I have never heard anybody show such deep understanding of human beings.

Dr. Connolly: Anybody else in the suicidology field?

Dr. Orbach: Richman in his work with families and seeing suicidal behavior from the family perspective. I learnt a lot, a lot from him.

Dr. Connolly: Who are the up and coming stars?

Dr. Orbach: I think maybe David Jobes who combines an objective formal research into the narrative approach, trying to get to the heart of the matter, to the soul. I like the work of Thomas Joiner, but I don't like him at all! I like when somebody is able to capture the complexity the inner complexity, not just

studying a variable and its relationship to other variables. One other person I was influenced by later on is Terry Maltsberger and his dynamic approach, his psychoanalytic approach. He is relating to the suicidal person with whom he is sitting. I am less enthusiastic about the pure behavioral cognitive approaches.

I have just completed a book in Hebrew that I am going to publish in English on my three or four years work with suicidal individuals in the course of therapy. I lay out my approach in therapy which is so much in contrast to the behavioral cognitive approach. My approach is the empathic understanding of the suicidal wish. Trying to be with the person in his suicidality is a way of reducing, first of all, his isolation and his being misunderstood, while respecting his pain and even his death wishes; not agreeing but respecting. Basing the therapy on a very strong alliance; being with the other and being affected by him; and working together out of the suicidal state of mind. I think my book will demonstrates this.

The way a person constructs his worldview and himself is related to language. Suicidal people use a suicidal language which has some effect probably on their suicidality and their general state of mind. I work with children, but I have noticed how many similarities there are between very young children and the older suicidal person. I believe there is some basic characteristic of suffering and wanting to live and wanting to die. Trying to understand the different cultures and different languages teaches you about differences and similarities in regard to understanding suicide.

Dr. Connolly: What about the future of suicidology?

Dr. Orbach: I am pessimistic, very pessimistic. I think we will have more programs, and we will be more efficient and there will be better drugs, but it will not eliminate suicide because suicide is part of the human condition. I think that as the world gets more populated, there will be more suicide. I must say pessimistically that suicide is one of nature's way to deal with over-population.

Dr. Connolly: Which brings up the issue of euthanasia and assisted suicide. What are your views on that?

Dr. Orbach: I can talk about different feelings that I have about this issue at different times. Sometimes I feel the person should hold on to life because things may change, except in very extreme situations. But sometimes I feel that the pain is so great and the future is so bleak, so why not? I don't have a definite stand on this. It depends on where I am at a particular time and on a particular day. There's something in me that wants to say "No" to it. But sometimes you see such suffering that you ask yourself what would you do? What would I have done?

Dr. Connolly: Are you a very religious person?

Dr. Orbach: I am not a very religious person. I am not religious in the sense of ritualistic ritual. On one hand, I can say, speaking rationally, that I can't believe in God. On the other hand, there is something in us as human beings that needs and wants God. The very fact that sometimes I find myself very

angry at God means that I believe in God. I think religion is a basic need, and I would like to believe in this spiritual person, but it's very difficult.

People can get to a point of wanting to end their lives. So many authors who wrote about the holocaust have committed suicide, and I wondered about this. Was it a delayed reaction to the Holocaust. At a time of weakness, does the memory come out and is there a sense of failure, of not being able to make a difference? Wars go on, atrocities go on, traumas go on. People suffer all over the world. These authors make it a mission in life to bring about a change, and maybe they feel that they have failed. I don't know anything in their personal life that would cause this

Dr. Connolly: You're a grandfather?

Dr. Orbach: Yes. I love being a grandfather. That's a great experience. I have, I think, a wonderful relationship with my grandchildren. They love me. I love them. We can't wait to see each other! It's such a pleasure to be with them, to learn with them, to try to teach them. It's so much simpler to love grandchildren than children. You know the joke that, if we'd known this, we would have started with the grandchildren! Both me and my wife Esther have a different relationship with each one of them, something unique. We have them over in turns each week. One of them stays with us for the weekend. This where I come back to my old loves of writing and storytelling because one of things I like to do is to sit with them and make up stories together.

Dr. Connolly: Do you write the stories?

Dr. Orbach: No. My last book is, in a way, a story. It's a popular book. It's maybe a professional, popular book. There is a little bit of me as a writer in this last book. It's called *The Killer's Cry*. It's a story of a suicide and my experience of working with this woman. How I experienced it and how I understood what was going on.

I like so much what I do, and I am so busy with what I do. I like the research. For me, research is also storytelling. You start with a question, and you end up with two questions. I love it. I love doing the research and the therapy, and I combine the two.

But the grandchildren brought up in me the poetic aspect of writing and of storytelling, of being a child again.

INTERVIEW WITH ANTAPUR VENKOBA RAO[2]

Dr. Connolly: First of all, where you were born? Tell me about your family and the influence they had on your development in childhood.

Professor Rao: Let me start somewhere in the middle and work from there. I started at the Madras Medical College in the year 1915 where I earned my MBBS. I married my classmate soon after our graduation. She won the blue ribbon at the Medical College as the best outgoing student. We had a difficult time to start with, which is why she had to find a job. She worked as a demonstrator in the Department of Physiology, and that enabled me to pursue my clinical studies in general medicine. She has been a great support to me, mentally, economically and domestically, and we have collaborated on scholarly publications.

We had three children, and we lost one of them in an accident this year. One of them is a doctor. She is a Professor of Pathology in the Medical School in Chennai, and our son-in-law is a pediatric surgeon. Our son passed the Indian Administrator Service exam, but he is a bit of a rebel and disinclined to be in the service. He studied literature and is presently Professor of English Literature in the Central Institute of English and Foreign Languages. He has his PhD, and he spent quite a long time in the United States. His wife is also a teacher of English literature in Somas College, and they have a daughter. My son is a very good writer and has published many books in English.

After I passed my postgraduate examination in general medicine, the Director of Medical Education promised me a post in general medicine in Chennai, but I turned it down. He said there is a vacancy in the Mental Hospital. You can work there for two months and I will find you a job in general medicine afterwards. I am still waiting!

I spent three years in Madras Mental Hospital and, after three or four years, the Director of Medical Education suggested that I switch to psychiatry. I finished five years of training in psychiatry and earned a DPM (Psychiatry) from NIMHANS, Bangalore. I transferred to Madras in 1962 to organize from scratch the Department of Psychiatry in the Medical School. It became the Institute of Psychiatry. At the same time, I did research, and I worked on a PhD at Madras University. I was the first clinician to get a PhD in research. Clinicians never have time for a PhD, and it is mostly non-clinicians do it.

My chief research interests in Madras when I started organizing the department were depression, suicide, the history of psychiatry, and biological psychiatry. My wife and I collaborated on research on stress and other topics. We also organized a number of international conferences in Madras, including a World Federation of Mental Health Conference. For one study, we followed up a sample of depressed patients for ten years, and the paper was published in the *British Journal of Psychiatry*. My department became a post-graduate center for training in psychiatry, and a number of my students are working all

[2] Dr. Rao was not able to edit this interview before his death in 2005. The transcript from the original recording that I was given was poor, and so I had to cut much of the material.

over the world - in the USA, the UK, Ireland and Australia. It gives me satisfaction to see my students all over the world and doing very well.

Dr. Connolly: Why did you decide to specialise in suicide?

Professor Rao: When I was in Madras, a colleague of mine, a professor of forensic medicine, asked me one evening about the son of a friend of his who was very depressed. He was a college student. I didn't see the boy, but I told him that, from what he told me, he seems to be a very depressed boy. He should treat the boy's acute depression as a psychiatric emergency and seek treatment. I said why don't you bring him and I will treat him? I realised the importance of psychiatric emergencies, and I collaborated with this professor of forensic medicine for about two years on autopsies of suicides, not psychological autopsies but regular autopsies. We published the first paper on suicide in Madras, I gave him first authorship. I was the second author although I should have been first author. We studied suicides by poisoning, drowning, hanging, etc.

From then on, I studied attempted suicides and completed suicides. I was very lucky to have had clinicians in the hospital who cooperated with me, and they gave me free access to attempted suicides. At the same, I was training the students and clinicians in our weekly clinical society meetings in the hospital. I was able to introduce a number of general physicians, surgeons and other specialists to psychiatric care.

I came across a report that depression was rare in non-European countries. But we have all sorts of depression, so I began to study depression in the 1970's. When I presented my observations on 30 cases of depression at conferences, there were barely twenty people in the audience to listen to the paper. I started collecting cases and followed them up for nearly ten years - what happens to them, the course and the outcome of depression - and that was published. I also studied topics such as general paresis and the history of psychiatry. A couple of years ago, a publisher in India wanted me to write a book on psychiatry for undergraduates, and that has done well and recently been translated into Hindi.

Psychiatrists do not see most attempted suicide. Cases of poisoning go to the alcoholism wards for detoxication. Others are placed in the medical wards. I published a paper on 100 consecutive cases of women with burns. I collaborated with the plastic surgeon to whose unit the burns cases are taken. They suffer so much from burns that it is very difficult to talk to them.

I edited the Indian Journal of Psychiatry for nearly eight years. I was the founder and president of the Indian Association of Psychiatry, and organized many conferences including one for the World Psychiatric Association in Delhi.

Dr. Connolly: I just want to go back a small bit now to your medical school days and ask you which of your teachers made an impression on you.

Professor Rao: We had wonderful teachers in those days who taught us very sound clinical methods, teachers in pathology, anatomy, and physiology.

Dr. Connolly: But not in psychiatry?

Professor Rao: there was no department of psychiatry in the medical school when we were studying medicine. The professor of mental diseases who was in the mental hospital used to come and teach a couple of classes. That was all. We did not have any exposure to psychiatry.

I consider psychiatry to be the most fascinating speciality. One of the things which has interested me in the last 20 to 25 years is examining the Indian classics and scriptures to show how they are relevant to the understanding of mental health and treatment methods, especially psychotherapy.

It gives great joy when you help a patient. They never forget it. If you've been in practice for more than forty years, you see three generations I have treated the grandfather, the son and the grandson. Recently, somebody said, "Sir, you treated my father, and you treated my wife," and here was the son getting treatment. I think in no other speciality can you get this type of a satisfaction. Patients become attached so much more to you.

Dr. Connolly: What made you go into medicine in the first instance?

Professor Rao: There are no doctors in my family. My family wanted to send at least one boy to the medical college. My grandfather had other ideas for me, but my father said that I would do medicine.

Dr. Connolly: You have done a great many studies on religion and psychiatry. Were you always a very religious person or was that something that developed over the years?

Professor Rao: I have been interested in religion for the last twenty-five years because I feel that, with that background, you can pursue the patient's problems much better.

Dr. Connolly: Was your father a very big influence on you growing up?

Professor Rao: Yes, He was of great help to me, a very great help. He was very insistent that I get through all the examinations and become a doctor, even though every family has difficulties supporting a big family. In my early childhood, I used to spend most of my vacation time with my paternal grandfather. He has a very impressive personality. He owned a big farm and had many comforts, which in those days was a luxury. He influenced me more than my father did. They were religious people, going to the temples and praying.

Dr. Connolly: What about brothers and sisters?

Professor Rao: I have one brother who studied psychiatry. He passed away last year. He was a very heavy smoker, and he had emphysema and heart failure. I have two sisters. Both are married with children. One of my other brothers is a veterinary surgeon, now retired, and one other is an engineer involved in the construction of houses. We have good family relationships, with no in-law conflicts.

Dr. Connolly: What about the big issues in psychiatry today, like euthanasia and assisted suicide?

Professor Rao: I have written a paper or two on the topic. The laws on this in India are still being debated. At the moment, it is being practiced unofficially, without being legal.

Dr. Connolly: In your lifetime, you have seen enormous changes in India, politically and economically. Can you talk about those a little bit? When you were born, the British were ruling India, or thought they were.

Professor Rao: There have been a lot of changes. When I entered psychiatry. people used to go abroad for training in psychiatry, such as to the UK. Now we have our own teachers who have been trained by us, and our former students are now chaired professors. Psychiatry has grown enormously. Fifty years ago, our association had only thirteen members! Today, we are about 3,000 strong in the Indian Psychiatry Society. That's a small number for a big country like ours. We don't have enough have manpower with psychiatric training to meet the demands of the public. Community psychiatric has come a long way, but there still is stigma attached to seeking treatment.

Dr. Connolly: What is the future for psychiatry?

Professor Rao: The future for psychiatry is very bright. More brilliant and intelligent people have chosen psychiatry, but unfortunately the work load is so heavy that there is little time for the research. Basic research is suffering because very few people are interested. Everybody wants to be a clinician. We don't have good teachers to teach neurophysiology and anatomy which are very important with the changing concepts in psychiatry, especially studies of the brain. Some people complain about psychiatry becoming neurology. There is nothing new about this. One of the definitions of psychiatry was that it was neurology without the science!

INTERVIEW WITH M. DAVID RUDD

Dr. Connolly: Where were you born?

Dr. Rudd: I was born in Beaufort, South Carolina. Both my parents were from North Carolina. My Dad was a Marine at the base in South Carolina. I was born there, but I was raised in Texas, in the Dallas/Fort Worth area, from about age 5.

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

Dr. Rudd: Three. I am the youngest. I have an older sister and an older brother.

Dr. Connolly: You father was a Marine. Was he away from home a lot?

Dr. Rudd: No. He fought in the Korean War, and he retired when I was 3, after 21 years of service. We moved to Arlington, Texas, where I lived until I went away to college. He worked as an executive for an aircraft-manufacturing firm that he eventually owned. When I was in junior high school, he took over this company. They manufactured what are called stabilizing bars for aircraft - computer generated bars that go on the wings to balance the plane. He had contacts in the military because of his military service.

Dr. Connolly: What about your early days?

Dr. Rudd: At elementary school, I was pretty active in athletics, and from third grade on I was a football player and a baseball player, but I also loved to read.

Dr. Connolly: What were you reading?

Dr. Rudd: Pretty much everything I could get my hands on. As a six-year old, I read more than anyone had ever read. At my little elementary school, you got points for reading. It was a fascinating program, but I loved to read. I have instilled that love in my children. They too have always loved to read.

Dr. Connolly: Do you have much time for reading now, aside from suicidology?

Dr. Rudd: No, not outside of my field. I don't do as much reading but, whenever I do, I like to read history and presidential biographies, which are a fascinating way of learning history. But, as you know, it is difficult to read outside of your field when you're stretched a little thin.

Dr. Connolly: Tell me a little about your mother.

Dr. Rudd: My father died this past year from cancer. My mother still lives in Arlington, and she is currently an administrator at the University of Texas. During my childhood, my Mom was a stay-at-home mother, a housewife. She started working when I was in junior high school. She went back to work and eventually went to college part-time. It took her 10 or 12 years to get her

degree, which she finished in 1984, and then she became an administrator. She's in good health and doing pretty well, but it's been a tough year after my father's death. They were together for fifty years.

Dr. Connolly: Were you close to your father?

Dr. Rudd: I was a pretty independent kid, and I was probably a little closer to my mother than I was to my father. My Dad spent 21 years in the Marines, and you know there was a Marine persona. Then he was a businessman, and so there was less intimacy in his relationships.

Dr. Connolly: What about religion?

Dr. Rudd: I'm a fairly religious person. We were raised Presbyterian, and we were consistent in terms of our involvement with the church. There wasn't much intensity in our involvement outside of some of the ordinary rituals and religious practices.

Dr. Connolly: What are your religious practices now?

Dr. Rudd: I am a member of the Methodist church, and I am very involved in the weekly programs. Our children are involved in Sunday school, and we're educators for the Bible school program. I'm involved in some of the men's program, and I volunteer with an organization called Mission Waco in which we provide pro bono services for homeless. That is an outgrowth of my faith.

Dr. Connolly: What does your faith mean to you?

Dr. Rudd: It's a foundation for my life, providing a fundamental set of core values.

Dr. Connolly: What part does it play in your work?

Dr. Rudd: I was trained as a scientist. I went to the University of Texas in which psychology is a scientist/practitioner program. I see myself as a scientist, but I'm also driven to do some of this work as a function of my values. I see it as a service in many ways to my fellow man.

Dr. Connolly: And what are your core values?

Dr. Rudd: They are for the most part pretty traditional core values, consistent with a Christian perspective in terms of general notions of love, commitment and grace.

Dr. Connolly: What of your family?

Dr. Rudd: Both sides of my family were from North Carolina, outside of Raleigh-Durham. There is a long history on both sides of the family of being tobacco farmers, so I tell people we did our part in the tobacco settlement law suits that generated enormous sums of money in the United States. My grandfather on my mother's side was the first to go to college and get a degree. My father

went to college part-time in the service but, once he took over the company, he didn't have time to go back to school and finish his degree.

Dr. Connolly: Have you traced the family tree?

Dr. Rudd: My brother has done some genealogical work, but we've never traced it back beyond the immediate grandparents on both sides.

Dr. Connolly: How about high school?

Dr. Rudd: I went to Sam Houston High School, and I was the only member of my family to go there because it was the poorest high school in town. We lived on a street that was the dividing line between the richer high school and the poorer high school. In Texas, sports are a big deal, and I was a football player. My brother and sister went to Arlington High School, which was wealthier and known to have a better academic reputation. I had planned to go there, but I attended the spring training for football there, not knowing that I wasn't supposed to do that until I actually entered the school. I was disqualified. I ended up going to the Sam Houston High School, which had predominantly minority students, so that I could continue to be involved in athletics. That had a profound influence on me in because I was exposed to so many minority students.

The school had a lot of African American and Hispanic students, and it helped me grow and develop as a person in many ways. I came to see diversity as being a critical issue in understanding people in the work that I now do professionally. It had a large impact on me, and it was something that broadened my understanding and perspective about people.

I was extremely active at school. I had a lot of friends, and I was very active athletically and academically. I was the president of my class. I excelled academically and graduated in the top ten in my class, which laid the foundation for college.

Dr. Connolly: Did any of your teachers there inspire you?

Dr. Rudd: The one teacher I remember is my first-grade teacher who inspired me to read so that I developed a joy for reading that persists. In junior high school, I had a math teacher there, Mr. Tyner, and he was a wonderful man. He helped me learn how to think. I maintained a peripheral connection with him throughout the years, and he attended my wedding. He died the following year from an aneurysm at a relatively young age.

Dr. Connolly: What books do you remember from that period?

Dr. Rudd: I read a lot of philosophy (such as Spinoza) and European fiction (such as Dostoyesky and Cervantes).

Dr. Connolly: That must have been unusual in your school?

Dr. Rudd: It was, but there was a core group that was academically able.

Dr. Connolly: Did you get any flack for your academic interests?

Dr. Rudd: Not really. I think a part of it was that I was athletic and that buffered the ridicule.

Dr. Connolly: You came to philosophy at an early age.

Dr. Rudd: I did, and I chose to go to a fairly good private university where I could pursue my academic interests.

Dr. Connolly: What subjects did you pick at college?

Dr. Rudd: I went to Princeton University in New Jersey which was a fair distance from my home. That was a big move for me. The university where I now teach is just a couple of hours from where I grew up, and I thought seriously about attending there and was planning to, until I met an alumnus of Princeton University. They had a college open house at my high school, and they had representatives from a couple of Ivy League schools there. I met an alumnus of Princeton University and developed a relationship with him. Part of what developed the relationship was that I played athletics as well. I got very interested in Princeton and applied there and also to a couple of other Ivy League universities. It was a tough transition. It was a very intense school, and I wasn't used to working that hard to do well. I didn't really have to work very hard where I had been in order to do well, and it was a little bit of a struggle for the first year.

Dr. Connolly: Did you have some influential teachers there?

Dr. Rudd: There were two. I met John Darley who is a well-known social psychologist in my first year at Princeton and then John Jemmott who was a health psychologist there. Jemmott is now at the University of Pennsylvania now, and Darley is still at Princeton. I was in some small seminars with eight to ten people, and I developed a good working relationship with them and started doing research as a sophomore. I had to do both a junior project and a senior project, and I developed a love for psychology.

Dr. Connolly: What was the research on?

Dr. Rudd: I did a literature overview of attributional theory for my junior thesis, and an experiment for my senior thesis that is comparable to a master's thesis. We did a study on pain perception, and we looked at pain tolerance. We had people submerge their hand in ice water as a measure of pain tolerance, and we looked at the measure of pain tolerance relative to anxiety, depression and general attributional style. Therefore, from the very beginning of my exposure to psychology, I was involved in this notion of pain perception and pain tolerance. It's very consistent with the work I do today.

The one person I haven't mentioned yet is my wife whom I met when I was 13 years old in junior high school. Initially, she rebuffed me, but I persisted, and we started dating when I was 14. We continued all the way through high school, but we went to different universities. She went to the

University of Texas in Austin, and I went to Princeton University. That was a difficult decision for us to make, but it clearly was the right decision. We had talked about getting married throughout our college years, and we decided that we were going to get married when I had finished. The University of Texas in Austin has one of the better psychology departments, and so I applied only to the University of Texas. I was admitted, and we got married the summer before I started there.

Dr. Connolly: What did she do at college?

Dr. Rudd: Her undergraduate degree was in deaf education and communication, and she was a deaf education teacher for seven years. When I started graduate school that first year, she taught full-time and also finished her master's degree in deaf education. I haven't mentioned the way that I paid for school. I was as an athlete, and I had opportunities for scholarships to pay for my undergraduate education. I decided not to pursue athletics as one of my primary interests, and Princeton, as an Ivy League school did not offer athletic scholarships. They offer need-based scholarships. My family did well enough that I as not qualified for these. I accepted a military scholarship from the Army, and so my undergraduate schooling was paid for by the Army which meant that, when I finished, I would have to go into the service. I delayed that by going to graduate school.

Dr. Connolly: What years are we talking about?

Dr. Rudd: I graduated from high school in 1979, from Princeton University in 1983, and finished at the University of Texas in 1987.

Dr. Connolly: What were your graduate years like?

Dr. Rudd: The psychology department at the University of Texas is an empirically driven program and so, from the very beginning, I did research. There were a couple of people that I worked with there. One was Ira Iscoe, a wonderful man and a guiding influence in my life. He was very much a thinker, and he was clinically involved as well. I worked hard there, full-time, twelve months a year for 4 years. We didn't take the summers off, and so I was able to progress rapidly through the program. One of my best friends was getting a doctorate in computer science, and we are still close. It was a competitive program, and you had to work hard to move through the program. As part of that, I did a practicum placement at the Houston Child Guidance Center, and I started working with the new suicide program there. I was doing an outcome study of family intervention for suicidal adolescents and their families, and that's where I first became involved with suicide as an issue

Dr. Connolly: Why did you pick that topic rather than any other?

Dr. Rudd: I didn't know that the adolescents were suicidal. I was interested in a program they had on extended family therapy. I watched a couple of the sessions, and it was fascinating. There were four or five therapists, and they would bring in, not just the parents, but the grandparents, aunts and uncles and

anyone that was thought of as a family member. They had extended family intervention. They sometimes used psychodrama and other techniques as a part of this. You could never this do today because of cost issues. I picked that as a program to work with, and it soon became very clear that the vast majority of the cases were young people who were suicidal. I became really interested in that, and we did an empirical study and published several articles. My dissertation developed from that project, and that set the stage for the work that I would do after that.

Dr. Connolly: So you got your doctorate?

Dr. Rudd: I got my doctorate. I hadn't done any military service yet, so it was understood that, when I finished my degree, I had to go into the Army to pay back my scholarship. I did my internship in the Army at a hospital out in Calfiornia.

Dr. Connolly: Was it a culture shock going from university to an institution like the military?

Dr. Rudd: It was. Even as an undergraduate, I did not understand how the military worked. My father had been in the military, so I had some sense of what it means to be in the military, but not in a realistic way. It was a difficult transition, but as an officer you are accorded a certain amount of flexibility which you're not allowed otherwise. For the first couple of years, I functioned purely as a psychologist. I worked in a hospital surrounded by medical personnel, and so I was buffered. But after I did my internship, I went to Fort Hood in Texas where I was a division psychologist. I worked with a combat unit for the last couple of my years in the service, and that was very much a real military experience. Prior to transition, I had basic training which was a unique experience.

Dr. Connolly: Was it a mistake to join the military in terms of your development and research?

Dr. Rudd: No. I look back on that as a valuable experience. In the military, you're given an enormous amount of responsibility very quickly. I had a tremendous amount of responsibly and opportunity to do a lot of different things. I worked with people in that hospital setting whose psychopathology was fairly severe. It was a unique experience. I ended up applying for and getting an NIH grant for five years in which I was able to do a randomized-controlled trial that I couldn't have done anywhere else because the military has a structure that provided an opportunity to do a randomized trial on service members. In the military, you don't have to worry about issues such as where the patients are and insurance coverage. We had a fair amount of control over the patients.

Dr. Connolly: Was it published?

Dr. Rudd: We did a comparison of inpatients versus outpatients in a hospital setting. The outcome was comparable for both groups in terms of treatment success. We did a long-term follow-up with high-risk individuals, and we found that

the effects persisted. But the more significant finding was that we were one of the first researchers to demonstrate that outpatient care for high-risk patients was just as effective as inpatient care.

Dr. Connolly: How long were you in the military?

Dr. Rudd: I was in the military for five years. It was originally supposed to have been for four years, but I was there for part of the first Gulf War. I was due to get out the month before the war started, but they have a mandatory retention policy for times of war

Dr. Connolly: Did you get to go to the Gulf?

Dr. Rudd: I didn't go to the Gulf. We were on and off the tarmac! We were supposed to go. They deploy units in pieces, and they deployed medical units. We were ready to deploy when the ground war started, but the ground war lasted only 100 hours. They already had medical assets in place from other units. My time during the war was spent evaluating large numbers of people for months on end who did not want to deploy for psychiatric reasons.

Dr. Connolly: Why did you leave the military?

Dr. Rudd: I had never intended on staying. I had always wanted to be an academic. I had done it as a means of supporting myself through college. I found it to be a good experience, and I had a history with my father. I felt it was an admirable thing to do. But the opportunities for psychologists were limited. I would have been doing for another twenty years what I was doing in those first four years.

Dr. Connolly: You were married. Was it disruptive to family life?

Dr. Rudd: My wife was pursuing her career. We had discussed what we wanted as a marriage, and it wasn't disruptive. We didn't have any children - we had made a conscious decision to wait for more stability before having any. Afterward, we ended up staying in that area. I was an adjunct faculty member for Texas A&M College of Medicine. I used to train the medical students on the military base, and I met the new chairman of psychiatry at the college about two years before I got out, Jay Burke. He had been a division director at the National Institute for Health, and he was recruited to build the department. I was applying for academic positions, and he and I had developed a good relationship. He offered me a job, and my wife and I decided to stay. I moved to the Scott and White Medical Center at Texas A&M College of Medicine which was an integrated health science center. I worked in a medical department of psychiatry for almost eight years after that. During that time, my wife Loretta went back and got a masters degree in administration. She wanted to move into administration rather than be an educator. We decided to have kids. My son Nicholas was born in 1994 and my daughter in 1997. During that time my wife completed her masters in administration. She did a fabulous job, but having children after twelve years of marriage was a challenging transition.

Dr. Connolly: What kind of Dad are you?

Dr. Rudd: I like to think I'm good Dad. I love being a Dad. There is nothing more important in the world than to be a Dad. It was the best decision I ever made. I look back on that, and I'm thankful that we were able to have kids. We waited twelve years without a lot of thought that it might not have worked out the way we wanted to, but we are blessed to have two beautiful children who are healthy and happy kids.

Dr. Connolly: They are re-educating you.

Dr. Rudd: They are. They change your life in dramatic ways - what you do in terms of commitment of time and your working schedule. We used to do pretty much what we wanted to do. If we wanted to go somewhere, we could. If we wanted to work and if I wanted to write, we could. Now we have to be careful how we schedule our time. How much time I spend away from home is a critical issue for me and my wife. You become involved in things you would never have been involved with in terms of school and activities related to school. I coach some of my son's teams, and my daughter takes dance lessons. They both do music and other activities, and so it really keeps you jumping.

Dr. Connolly: What are your tastes in music?

Dr. Rudd: As a youngster I was a classic rock fan. Over the years I have transitioned to jazz and classical music, but I still enjoy the same rock music. It brings back good memories - of high school days and the energy that comes with that.

Dr. Connolly: Do you play an instrument?

Dr. Rudd: I don't. I played guitar when I was going to grade school, and I stopped because the fellow that was teaching me told my mother that I didn't have any musical abilities! So I stopped. I really regret that now. We have gotten both children involved in music fairly early. It's so critical. My son is a wonderful piano player. He didn't enjoy it for the first few months, but he loves it now and spends a lot of time doing it. I wish I had done that more intensively as a youngster because, although I enjoy music, I can't actively participate.

Dr. Connolly: You are still working in the psychiatric department in a medical school?

Dr. Rudd: I left Texas A&M after about eight years.

Dr. Connolly: What research did you produce while you were there?

Dr. Rudd: I did a lot of research in terms of outcomes, looking at differentiating attempters, repeated attempters and ideators, and a number of predictive studies. I wrote a primary treatment book and an edited book with Tom Joiner on suicide science. That's where I met Tom. He was an intern at the VA where I did some rotations and teaching. He went to Princeton four years behind me

and went to the University of Texas four years behind me, and so we have those connections. We started collaborating on different projects in his internship year, and we have maintained that friendship and collaboration. I've worked with Tom Ellis, and I did a post-doctorate fellowship at the Beck Institute in 1995 and 1996. I became very interested in cognitive therapy, and we revised our treatment model to incorporate cognitive therapy and theory for suicidal individuals.

Dr. Connolly: Tell me about your research with the Air Force.

Dr. Rudd: While doing some training, I met Dave Jobes at AAS, back in the 1980s and developed a friendship with him over the years. The Air Force contacted me because they were interested in doing some training. They formed a working group a couple of years ago to develop a program to manage suicidal behavior and train clinicians to do that. Dave was the lead on that while I was more peripheral. I became a little more active two years ago. I really enjoyed it, and we have a couple of projects planned, including a retrospective review of their case files on suicide cases, trying to better understand the critical points for intervention for suicide, looking for opportunities missed. As a part of that we are looking at the issue of what is a reasonable target suicide rate. We are not going to be able to prevent every suicide but, for the others, can we identify them and see what opportunities exist for intervention?

The major reason why I left that position at Texas A&M was that I was doing too much clinical care. I wanted to have more time for academic activities. To do that, I had to take away time from my kids and my family, so I decided to look for a full-time academic position. I had been a clinician first and an academic second, and I wanted it to be the other way around. When my wife went back to do her doctorate, I found a position as a professor at Baylor University. I have been there for five years now, and my wife finished her doctorate last year. She also got NIMH funding, and she's having great success with her research program.

INTERVIEW WITH ARMIN SCHMIDTKE

Dr. Connolly: First, tell me about your formative years, your family and your early education.

Dr. Schnidtke: I was born in East Prussia in the last years of WW II. In the last months of war, my mother fled with me to a region of Germany near to the border with France, and later to a separate independent state called Saarland where I grew up in a relatively small city. My early education was in a humanistic high school, what we call Gymnasium. After my military service, I started my studies at the University of Saarbrücken, at that time a very multi-cultural university with a strong French influence. We had a lot of French professors, and my first professor in psychology was a Swiss professor, Professor Ernst Boesch, who was interested in developmental psychology and cognitive psychology, a former student of Professor Piaget, and co-working with UNESCO. As a result, we became familiar with international research and international connections. For example, I wrote my first master's thesis half in German and half in French and, for this master's thesis, I had to test French and German students in summer camps in their respective languages to see whether changes of national stereotypes are possible through personal contacts. After I finished my studies, I accepted a position as an Assistant Professor at the University of Mannheim, a university specialising in life-span development and economics.

Dr. Connolly: Tell me about your family.

Dr. Schmidtke: One of my early and also later interests comes from my mother's family because my grandfather was once a director of a daily newspaper, one of the bigger newspapers in the country and, later, an editor and owner of a newspaper and printing company. Still today one can buy in antiquarian bookshops famous photos made by him So I became familiar in my early years with all the things associated with newspapers and their production, the writing, making photos, the printing, the selling, and dealing with the distribution. I grew up between Linotypes, Heidelberger printing machines, and I very much enjoyed it. I never lost this interest, and it led to my interest in the influence of mass media and especially on the influence of the press on changing human behaviour. We used to talk about it nearly every day. It was our life at home.

The joy in teaching came also from my mother's side of the family, because I grew up in a family with very emancipated females, all teachers. For example, my grandmother was one of the first teachers for vocational training in Germany, and at that time it was very difficult for women to become such a teacher. She dared to go to court during emperor's time to make this possible. As you may know, in Germany in the last years of the past century, it was, for example, not allowed for women to study some disciplines such as medicine. So my main interests came from two sides, teaching and the media.

From my father's side came the interest in economics. He was a producer of paper products and, for example, already very early he was thinking to replace plastic bags with paper bags.

Dr. Connolly: Tell me about your thesis.

Dr. Schmidtke: My main interest at that time was in pure methodology because I was trained in mathematics, statistics and experimental methodology. My master's thesis dealt with testing the limits and learning potential of feeble-minded children with culture-free test procedures. I had to use different methods to assess the subjects' intelligence potential. Therefore, I standardized and edited the first German version of Ravens Culture-Free Matrices Test (CPM). In some statistics books, one can still find statistical tables developed by me, for example, for curtosis and excess of distributions.

After I finished my studies at the University of Saarbrücken, I went to the University of Mannheim where I was offered a position as assistant professor and lecturer. The University of Mannheim at that time was very methodology orientated, and so I taught methodology, statistics and experimental methodology. The head of the department, Prof. Groffmann, was also interested in life-span development, and this interest shaped my work later in suicidology because I was asked to test if one can use statistical methods (time-series analyses) for the prediction of the development of suicide rates. This was my first connection with suicidology, and I became interested in the behaviour itself and tried to apply behaviour analytic psychological methods to suicidal behavior. I worked at the University of Mannheim from 1972 to 1982 and, after the early sudden death of my boss, I then moved to the Central Institute of Mental Health in Mannheim, belonging to the University of Heidelberg, a WHO collaboration center, as Deputy Head of the Department of Clinical Psychology. There I got into contact with Professor Heinz Häfner, who used to be an WHO adviser, and with health officers at the WHO office in Copenhagen, especially Dr. John Henderson who used to be the WHO adviser for Psychiatry at WHO/EURO in Copenhagen and with the WHO Headquarter in Geneva (Dr. Faria). Our main interest was on imitation of suicidal behavior, and we started to do more suicide research in this field.

We did research on, the so-called Werther effect. We performed studies on the sociological background of suicide attempters and on learning theories of suicidal behavior. In 1984, we planned, together with Professor Häfner, to launch a major suicide project on how we could improve the situation for suicide attempters in Europe. I worked with Dr. John Henderson in Copenhagen, Professor Nils from Denmark, and Peter Kennedy from York, UK. We started this project in Mannheim and, in the first two years, we planned it from Mannheim. This project, the WHO Multicentre Study on Suicide Attempts, stimulated a lot of research and resulted in more than 10 books and several hundreds of papers from various cooperating researchers (and also stimulated many careers). We had a lot of contact with old and young researchers, the contacts and friendships lasting until today (with Professor Kerkhoff, Professor Faria, Professor Soubrier, Professor Fekete, and Professor Wasserman).

In 1986, I got an offer to become the Head of the Department for Clinical Psychology and Psychotherapy at the University of Wurzburg, and we transferred parts of our project in 1989 to Wurzburg. When people visited me in Wurzburg, they were always astonished that I am also responsible for

clinical wards, the ward for behavior therapy and the ward for psychotherapy, and for the training of the doctors and psychologists in psychotherapy.

Dr. Connolly: I am amazed by this because I did not realise, until Ad Kerkhof told me, that you had a very full clinical and administrative role in the department. I began to wonder how you can be so prolific in your research and in your publications. How is it done?

Dr. Schmidtke: How is it done? Sometimes people laugh and say that I am the inventor of the 25-hour day. At work, I have a good team, longstanding and very motivated. We are well organised, and everybody enjoys the combination of research and the clinical work. It is my opinion that suicide researchers should not lose contact with patients. You can't understand suicide in your ivory tower only from figures and graphs and from files. You have to deal with patients or else you will lose the ability to understand the patients and to build hypotheses for your work, or you work in a way that we call armchair psychology. I always enjoy having contact with patients and to be responsible for them while doing research. Sometimes people are astonished, asking how I can treat patients if I am so interested in methodology. I believe that a good clinical psychotherapist must also be a good researcher. Treatment of a single person is clinical research. You have to build a hypothesis, you have to test your hypotheses, and you have to think about intervention and treatment and how to control your efficacy. Every single patient is like an experiment. This has been my experience especially in suicidology. This kind of thinking also prevents you from becoming dogmatic. As a result of this combination, we always had a lot of foreign postgraduates from other European countries, including Hungary, Turkey, Norway, Armenia, Poland, Italy, and Austria.

Despite the workload, which is sometimes heavy, I wouldn't give up the research for the clinical work. We have a good reputation for our work, and I think that the department has a good reputation because of this combination of tasks. I enjoy it, but sometimes I am asked how can you cope with suicidal persons? I think that, if you have the right strategies, it is easy. You mustn't lose your patience or you sense of humor. You have to find good coping strategies.

Dr. Connolly: All of us who work with suicidal patients have had a patient who has taken his or her own life, which is very traumatic and can be quite devastating for the therapist. What sort of mechanisms do you have inside yourself for coping with this?

Dr. Schmidtke: It was sometimes not easy to lose a patient, especially young patients. One of my principles was that every therapist needs supervision and has to be controlled. I speak on a continuous basis with my assistants, and we have them under continuous supervision. On a daily basis, I have a colleague supervisor, and we talk about our cases. We speak about the cases to see if we have made mistakes and at which point of time we should have worked in another way We also had, in addition, an external supervisor for our department. Professor Fred Kanfer, from Illinois, who comes in at least once a year to talk about problems. We were also the first German unit to invite Professor Marsha Linehan to visit, with funding from the Germa Research Foundation (DFG), in

order to learn about the treatment of suicidal persons. Her strategy at that time was not yet named DBT, was very new, and a little bit strange perhaps for the old German schools of treatment. I also learned from my mentor, Professor Häfner, who said, during a lecture, that to be humanistic means to accept that a patient has the right that sometimes he should be heard against his will. That is really humanistic thinking, and I always act in this way. I teach my students to think always in the interests of the patient, and not to think in terms of revenge or because you are exhausted with such cases. If you go home at evening and you wonder if you have done the wrong thing, then you did the wrong thing. It is better to act in the interests of the patient even if the patient doesn't like you at this point. You don't always have to be liked by the patient. We lose some patients despite all our efforts. We should accept that we are not master of all lives We should accept our inability. We talk about these problems with patients, and we tell them at the beginning of therapy that we can't control everything. We do also not want to control everything.

Dr. Connolly: Your research covers a wide range of topics in suicidology. What are you most proud of?

Dr. Schmidtke: I think we can be proud of our research on the imitation of suicide behavior. The basic idea goes back to the early 1970's when we started to think about behavior therapy and learning theory-based therapy. But I must say I am also very proud that we very early detected that the papers of Jerome Motto, David Lester, David Phillips and Marsha Linehan could have a big influence in suicidology, and we are to obliged to the German Research Foundation which funded us 1987 to be able to invite Professor Linehan to visit long before other people wrote about her work. We were able to see the relevance of this kind of therapy for the treatment of suicidal patients. Later we also got funding from DFG to invite Professor Phillips and Dr. David Clark. One result of our research was that our group received the first Hans-Rost Price from the German Association for Suicide Prevention (DGS) in 1988 (later on also a second), and we are, up to now, the only Germans to have received the Stengel Award from IASP.

Dr. Connolly: You mentioned one of your mentors earlier on. Who are your other mentors, the people who most influenced you?

Dr. Schmidtke: One of my first mentors was my first professor, Professor Ernest Boesch, a pupil of the development psychologist, Jean Piaget, who trained me to think in a scientific clinical way. His calm and sophisticated manner in dealing with clinical problems also impressed me. I liked him very much. He trained me not to think or act in a dogmatic way, but to formulate a hypothesis, then test this hypothesis, and depending on the results formulate a new, improved hypothesis. Later there was Professor Heinz Häfner in Mannheim, a German psychiatrist. I was very impressed with his clear thinking and his strategy for dealing with problems. He taught me how to cope with scientific methodological problems, and I learned a lot from him. I also learned a lot from Professor David Philips whom I like very much. One of my first books I read was *Why People Kill Themselves* from David Lester which was very impressive. (At this time, we nearly had not German scientific books

on suicidology). I am very proud that I have been able to publish with him. I obtained this book first when it came out in 1972, and it was one of the first books about suicidology I read in my life. I never thought that later I would be able to be able to publish with David. I think these were my main teachers.

Another person who later influenced me was Terry Maltsberger. I admired his clear thinking and strict methodology. Beside the scientific influences, another person whom I admired was John Henderson at WHO. I met him first in 1983, and I was impressed by the way he dealt with people from various international backgrounds and organized meetings and research. I always wanted to emulate him.

Dr. Connolly: When did you first become involved with IASP?

Dr. Schmidtke: Very early. In Germany, since the 1970s, we had a yearly meeting, but no German association existed. These German meetings were organised by the late Professor Pohlmeier, and the international meetings by Professor Ringel, an Austrian professor, and also Gernot Sonneck. I had the opportunity when the director of the psychiatric clinic in Kassel invited us to a lecture, and I met Professor Ringel. This was my first contact with someone from IASP. In 1973, I had the opportunity to get funds from my university to visit, along with some of my students, Dr. Sonneck's center in Vienna. The first congress I officially visited was the IASP Congress in Vienna organized by Professor Ringel and Professor Sonneck, and Ijoined the IASP as one of the early members. I later became co-editor of Crisis, when Professor Pohlmeier was the chief editor.

Dr. Connolly: You soon got very actively involved with IASP?

Dr. Schidtke: Not really. I have been on the scientific committees of some IASP Congresses, but I never took on an official position in IASP because I was involved in German and USA associations. For example, I was chairman of the German Association of Suicide Researchers, and this position was a part of the German Association for Suicide Prevention. I was a member of several AAS working groups and the first international representative in the AAS directory. In Montreal, I was asked to run for the position of Vice-President of IASP but, at the time, I was already Secretary of the International Academy for Suicide Research (IASR), and I had been asked to run for the Presidency of the Academy (and was then elected). I did not want to confuse positions. Thus, I was more engaged in other organisations than in IASP itself.

Dr. Connolly: You are now President of the Academy.

Dr. Schmidtke: Yes.

Dr. Connolly: Congratulations.

Dr. Schmidtke: Thank you

Dr. Connolly: The Academy, in its structure and its running, has caused a certain amount of comment and controversy. It is often seen as an elite group. What are your views on that?

Dr. Schmidtke: Yes. I have heard these objections. The Academy was founded mostly by IASP members as an association for suicide researchers and their needs. Some researchers thought that they needed a special organization for researchers because some of the problems that researchers face and have to discuss are not connected with the problems of more general politically-oriented associations, such as the Samaritans or lay people engaged in suicide prevention, who are not interested primarily in doing research. Ideally, it should be an association of people in the field who are good researchers, perhaps the leading people in their countries, who want to promote suicide research and prevention, and want to distribute their knowledge about suicide research and prevention. The Academy also created a more scientifically-orientated journal. This does not mean that the organization is exclusive. I think the various suicidology organizations have different aims and goals. I see them as complementary and not as enemies.

Dr. Connolly: During your term as Secretary of the Academy, the Diekstra controversy rocked the boat a little bit. Was that a difficult time?

Dr. Schmidtke: Yes, it was a difficult time for the Academy and all persons who were involved. When I took over the Presidency, I inherited the problem with the so-called scientific misconduct of one member. The case is open at the moment, the member is suspended, and a committee will give advice on how to deal with the case. Since nobody thought, at the creation of the Academy, that such a case would ever arise, there are no formal rules in the Academy's constitution for dealing with such a situation. In addition, a few people concluded that there is something wrong with the Association when such a case is possible, which is not the case.

Dr. Connolly: You yourself published with Diekstra, as did many members of the Academy

Dr. Schmidtke: Yes. René also influenced me, and I regard him as a friend. I admired his bright ideas, his enthusiasm and his ability to deal with problems. We had several contacts when he worked at WHO Headquarter in Geneva. I published books together with him, and I also used his ideas, especially about imitation, and one of my assistants tried to write her dissertations with René. I was very surprised when I first heard from the accusations, but I wanted to keep the matter very calm. It is not my way to act in a histrionic way to a crisis and to promote arguments. I always say to myself wait and see also the other side of the coin. You have to try to understand why people do this, what normally not belongs to their character and you should not sentence them without hearing them. Everybody has a right to be heard and one should also bear in mind the reasons why people are so eager and over-persistent.

Dr. Connolly: What about the future in your research? Where do you go from here?

Dr. Schmidtke: One of my teachers used to say that, if you read more, you don't have to think so much. This is true. Sometimes I have the impression that some researchers in our field try to invent the wheel again and again, always saying the same thing. You see their work and say that this was already published twenty years ago without having any effect. Some feel that it is a pity that money is spent on such research.

Research in this field can also be very narrow and rigidly. During one period, only social factors are studied, during another period only biological factors. During one period, only pre-natal factors and in another period only early stages in development are studied. I saw these effects in comparing suicide research in the former German Democratic Republic. Suicide research dealing with socioeconomic factors was nearly non-existent, despite their high suicide rates (never published). We need a more comprehensive holistic view for the field. I think we need to get away from what is called type A research (domain research), which means to look in the field and collect only data. We have to develop theories, then hypotheses and then test them – type B (doctrine research). Without type B research, we can't develop valid methods of treatment. There are not many studies showing the effect of treatment or prevention efforts, and the results of the research is not very overwhelming. One question we have to resolve is why is our theoretical knowledge is not put into practice and why is it not effective. Is this too complicated? Don't people like to deal with research results or logical thinking about it?

We also have to bear it in mind that there are not only some external factors which are important, but also biological, psychological and sociological factors. Life is too complicated to be seen only as unidirectional or dependent only one variable.

Dr. Connolly: What do you do to relax?

Dr. Schmidtke: People ask me when do I relax. For example, I am collecting old maps, and I am often asked why are you collecting old maps? To collect old maps is really interesting because you can see, on old maps, the quality of the development of the brain and thinking, as in the development of a child. The very old maps are very egocentric based. No north, no south. People were standing in the middle of the map and deciding where to go. If there was a church with two towers, they painted two towers and you had to go in that direction. Later the maps developed in a more symbolic way. Every map has the north on the upper side and south on the lower side, and you can see the development of the brain and of the thinking. I very much enjoy this.

I used to engage in sport. I participated twice in the so-called Nijmegen march, and I was champion of the army reserve in skiing in Saarland.

Dr. Connolly: Do you still ski?

Dr. Schmidtke: Yes, but very carefully. I'm older, and so the risk of injury is greater. I used to take longer runs.

I also read lot. I still write for non-scientific journals, and I sometimes take and publish non-scientific photographs, as I used to when I worked for journals during my studies. That is still relaxing. I always used to learn beforehand about the region or city where I go and look around, and I enjoy

that. It is fun when you go somewhere, and you can discuss with the local people about their history.

Dr. Connolly: Other than scientific books, what have been the most important books that have interested and impressed you. I often feel that psychiatrists would be better off spending far more time reading novels and literature than reading textbooks of psychiatry.

Dr. Schmidtke: Yes, that is true. I was impressed by French literature because I had to read a lot of it in school, but I really can't say that one special book influenced me. If I choose one German writer, it would be Heinrich Heine who had to go into exile to France. Sometimes he was a little bit cynical, but I liked his view of life behind the curtains, describing reality. He was not liked at the time, and he is not liked very much today, but I think he was one of the writers who really impressed me. I like him especially for his poems. I was also very much impressed to read Uncle Tom's Cabin. Such books can influence you, and that book made me think about fight for the human rights.

Dr. Connolly: What about music?

Dr. Schmidtke: I have a daughter who is now in her 20's. She likes pop music and has always taught her father how to appreciate this. I was always up-to-date with this music, and I really like it. I also like operas, operas with suicides. It is always very interesting to see the suicidal development on stage. I like Mozart, and I have a collection of all of Mozart concertos.

Dr. Connolly: Has religion played any part in your life?

Dr. Schmidtke: Religion is very important for me. I grew up in a very religious household. My mother had what we call in Germany a special license to teach religion, which meant that she could teach religion in schools. My grandfather had many connections to priests and monks, and so we often had such guests in our house. I think religion plays a big role in our life. I am not a church worker, but I am religious in a certain sense.

Dr. Connolly: Would you say religious or would you say spiritual in a secular sense?

Dr. Schmidtke: No. In a certain sense, I am religious. It is a very funny thing, when I had my training in psychotherapy, what we call the week of self-assessment, self-encounter, one of the trainers in the self-encounters said, if you are narcissistic, if you think you have to fight against certain systems and you are offended, go for a walk during the night and look at the sky. See all the stars and think about your inferiority. That is a good thing to keep you modest, and sometimes I do it.

Dr. Connolly: You mentioned your daughter. What other family members do you have?

Dr. Schmidtke: My son studied also psychology and media, but he is working for a publishing company. We call him a work and economy psychologist. My

daughter is more creative, and she used to take photographs. So we are still all connected to the press. There is a saying in Germany that, if you have color in your veins, you will never lose it. This is sometimes true.

Dr. Connolly: Printers ink.

Dr. Schmidtke: Printers ink, yes. It is strange. I was never forced to do anything, andI never forced my children to do anything. It came from them. I never wanted my son to study psychology. It was his own decision, and he likes it, but he doesn't do any clinical work as I am doing.

INTERVIEW WITH MORTON SILVERMAN

Dr. Connolly: Tell me about your early years.

Dr. Silverman: I was born in 1947. My parents moved within a year of my birth from New York to New Jersey. My father was a Board certified clinical psychologist and held a number of academic and teaching positions. My mother was an educational psychologist with expertise in school psychology. I remained in New Jersey until I went to college.

Dr. Connolly: How large is your family?

Dr. Silverman: I have an older sister who has cerebral palsy and a younger brother.

Dr. Connolly: What is the impact of your birth order?

Dr. Silverman: Having an older sibling who was intellectually challenged placed me in a different position. In some ways, I became the older child in terms of expectations such as performance and responsibility. Yet, in other ways, I was number two in the family. my sister being the eldest child. I also have a younger brother. I guess one could make a case for me having the middle-child syndrome.

Dr. Connolly: What formative events happened during your childhood?

Dr. Silverman: My younger brother had quite a number of illnesses, and I remember that there was great concern about his health and welfare. He was in and out of hospitals with one problem after another - allergies and illnesses. Other than that, my life was very stable. We moved when I was approximately a year old, and then we moved when I was six to the home where I grew up.

My father was an academic and a clinical psychologist with a private practice. He published a number of books on family therapy and psychotherapy, as well as being an accomplished poet.

My mother went back to school when we were growing up and has her Masters in school psychology and completed her coursework for her doctorate - what we call in the United States, “all but the dissertation.” The message I got growing up was to be very sensitive and to be responsive to those less fortunate then myself, especially to individuals who had mental disorders or other types of mental disabilities.

My parents were very active in associations that dealt with developmentally- and intellectually-challenged children because my sister was developmentally-challenged. My parents were very active, both clinically and in professional organizations, with an emphasis on special education and caring for people who had special needs. My mother earned her state licensing certificate as a school psychologist, and she was focused on students who needed special accommodation. A lot of my upbringing, a lot of the dinner table talk, and a lot of activity at home, emphasised exercising sensitivity and the recognition that many others were not as fortunate and had needs to be identified and addressed.

Dr. Connolly: Was it a religious household?

Dr. Silverman: Yes. My father came from an Orthodox Jewish home, and my mother came from an Orthodox/Conservative Jewish home. I was brought up in a conservative Jewish tradition. We observed the Sabbath on a weekly basis and also most religious holidays. I attended Hebrew school a few afternoons each week, and I was bar mitzvah, as was my younger brother. We had a very strong Jewish identity.

Dr. Connolly: What about now?

Dr. Silverman: The same. My wife grew up in a Reform Jewish family, and we have always been members of a Jewish synagogue. We brought up our children to have a very strong Jewish identity, and they too have all had religious training – bar mitzvah and religious high school confirmation classes. It's always been a very important part of our family lives.

Dr. Connolly: What influence does your religion have in your daily work?

Dr. Silverman: It provides some balance, some sense that there is more to life than the day-to-day frustrations and headaches. There is a saying in the Talmud, which is a sacred Jewish book of writings, that translates something like, "If you save one life, it is like you have saved the world." I came upon that phrase four or five years ago and, when I saw it, it immediately resonated with me and helped me. I like what I do and why I do it, and this perspective helps to validate and support what I do - the time and effort and the sacrifices that I make for my work because, as with any other profession, we have to make choices and sacrifices. We have to weigh alternatives - to do this or to do that - where you are putting your time and energy - balancing between one's chosen vocation, family life, friends, recreation and personal activities.

Dr. Connolly: Getting back to your childhood, what did you read back then?

Dr. Silverman: I loved reading murder mysteries and comic books. I particularly like murder mysteries because of the challenge of figuring out who did it and how and when, and trying to solve the mystery before the last page reveals all.

Dr. Connolly: That was your first step in research!

Dr. Silverman: I guess so. I also enjoyed reading adventure books, stories of heroes, of people who had ambition, or who had a view of something and went out and did it. Just in the last year, after a long illness, I have started reading adventure books again - true stories of people who had to fight the odds, who have had to pick a path that is not the usual path and who challenged themselves and did things that other people have not done - sailors fighting against hurricanes, how to survive on Mount Everest after sudden avalanches, and other challenges such as that.

Dr. Connolly: Were you athletic in your youth?

Dr. Silverman: Not really. If this ever gets into print, my kids will probably laugh and say, "Daddy, 'Not at all' is what you really should have said," and that's probably true. I never broke a sweat and never was interested in doing so. I enjoyed playing basketball more than anything else and a little baseball, but I have no athletic coordination and no ability in that arena. I just didn't have what it takes to be athletic. Basically, I remain unathletic.

Dr. Connolly: What university did you go to?

Dr. Silverman: I went to Franklin and Marshall College which is in Lancaster, Pennsylvania, with the intention of being pre-med. Back in high school, I had decided that I wanted to be a doctor. At the time, Franklin and Marshall College was one of the premier, small liberal arts colleges with a strong pre-med curriculum.

What I found was that Lancaster in those days was an isolated community, very different from anything I had experienced before. I had grown up in the city, and I always enjoyed the benefits of public transportation, theater, museums and shopping and being part of something big. When I started at Franklin and Marshall, I found myself out in farm country at a small, all-male school. I knew this in advance, but it did not sink in until I got there. I was very unhappy.

I was fortunate enough to get good enough grades and to have a strong enough high school record that I was in a position to transfer. I left Franklin and Marshall at the end of my first year and transferred to the University of Pennsylvania which was in Philadelphia, a big city and an urban campus - a larger school with more options. During my orientation week as a sophomore, I met my wife-to-be. She was starting as a freshman and, since I was a transfer student, I was expected to participate in orientation for new students. We didn't spend a lot of time together during the ensuing three years, but we knew about each other and were aware of each other's activities through our mutual friends.

At the end of my fourth year at college, we reconnected and, as they say, the rest is history. We have been married thirty years. In hindsight, the education I got was fine, but the fact that the school provided the opportunity for us to meet was the best thing that happened to me.

I graduated from college as a psychology major with some pre-medical courses. This was 1969, and the Vietnam War was raging. The competition to get into medical school was fierce because it was the only deferment from active military service for young men. A number of my friends and classmates, who would have otherwise gone on for Ph.D.'s in biology, chemistry, physics, or one of the other sciences, were all applying to medical school.

I was placed on a number of waiting lists, but I did not get accepted at first. I used my science background to secure a position as a junior high school science teacher back in northern New Jersey, in the junior high school that I had attended as an adolescent. I returned there as a science teacher and reconnected with some of the teachers who had taught me eight or ten years earlier. I taught in the public school system for a year and then reapplied to medical school. During that year, I courted my wife-to-be, and we were

married in July 1970. I was accepted to medical school and went to medical school in Chicago in the Fall of 1970, and received my MD degree in 1974.

Dr. Connolly: You didn't serve in the forces?

Dr. Silverman: No. Being a science teacher in an inner city was considered to be a sought-after profession in high-demand, especially in underserved and disadvantaged neighborhoods. I was fortunate to receive a military deferment so that I could teach science in a junior high school in Newark, New Jersey. I then went to medical school and fell in love with surgery. I had always known in the back of my mind that I liked psychology, but I fell in love with surgery, in particular, neurosurgery. I finished my required clinical rotations and saved up all my vacation time so that I had six months' vacation. We went to London, and I pursued a medical student rotation at the Maudsley Hospital Neurosurgery Unit and a rotation in cardiology at St. Bartholomew's Hospital. My wife was working on her advanced degree, and she would spend her time at the reading room of the British Museum while I went to work. I was convinced that I was going to be a neurosurgeon. I found it exciting, stimulating and at the forefront of medicine - uncharted territory. However, at the Maudsley, I was working with Murray Faulkner, whose area of expertise was temporal lobe epilepsy. There were many people suffering from temporal lobe epilepsy who were medication resistant, and they would be referred to Professor Faulkner whose expertise was in removing temporal lobes to cure the epilepsy.

There was a Psychiatry Registrar assigned to Professor Faulkner's team because part of the evaluation and work up prior to a decision to undergo surgery included a psychiatric assessment to be sure that the individual was an appropriate candidate - that they understood the procedure and understood the possible side-effects. I found myself spending more time with the psychiatric registrar who was doing the interviewing than I was with the surgeons, although the surgery was interesting and fascinated me. I wanted to learn more about these patients' histories - how they struggled with the illness and had come to this point where other treatments had failed.

I came back to the United States for my fourth year of medical school and, although I was still interested in surgery, I decided to focus on psychiatry as my fourth-year clinical elective. In 1974, medical school clinical rotations did not require psychiatric training. It was an elective rotation. I guess there was a part of me that was resisting pursuing psychiatry because of my mother's and my father's vocations. There was a part of me which resisted following in the footsteps that I was "genetically environmentally destined" to pursue.

In any event, I did a rotating medical internship at Cook County Hospital that was one of the largest public hospitals in the country - a very famous hospital in the United States- and then I entered a psychiatry residency at the University of Chicago. We had decided to stay in Chicago since my wife was a graduate student at the University of Chicago, pursuing her Ph.D.

Dr. Connolly: On what topic?

Dr. Silverman: It was on the relationship between the artist and the audience during the French revolution, exploring whether the reactions of the audience and art critics, the patrons, and the people who were attending the concerts and salons alter the artists' work, their views of themselves, their productivity, and the types of artistic endeavors that they pursued. After I finished my Psychiatry Residency and was a junior faculty member in the Department of Psychiatry at the University of Chicago, we moved to Paris for one year. My wife received a fellowship to finish her dissertation, and her primary sources were in Paris. At that point, we had a two-year-old daughter, and we spent a year in Paris – a "time-out" for me overseas.

One of the most significant events during my residency involved my mentorship with the Chairman of the Department of Psychiatry at the University of Chicago, Daniel X. Freedman. Danny was the Editor-in-Chief of the *Archives of General Psychiatry*, which was the premier research-oriented psychiatric journal in the United States. During my residency the residents met on a monthly basis for a journal club at his home, where one resident each month would select an article to read. The resident was asked to present the article, discuss it, and reference all the relevant literature. I presented an article which I still remember exactly - on post-partum depression. Pretty soon afterwards, Danny called me into his office and told me that he was looking for an editorial assistant to help him with the journal, and so I began working with Danny as a Special Assistant to the Editor-in-Chief of the *Archives of General Psychiatry*. This was one of the few defining professional experiences in my life. I worked with him, mainly on weekends, for a few years as his Special Assistant and had access to all the authors that published in the *Archives* and all the submitted manuscripts. I saw all the reviews that came in, and I watched him make decisions about what needed to be done to the manuscripts, make decisions about what needed to be published and why and when and how. I would sit in his office while he was on the phone with people from around the United States and around the world talking about the science of psychiatry. I became hooked on pursuing editing and publishing.

After I finished my residency, I stayed at the University of Chicago as an Assistant Professor of Psychiatry and also as a staff psychiatrist at the Student Counseling Service. I had worked there during my residency training as well, and I found a clinical area that I enjoyed - which was working with young adults. I had that clinical assignment, my academic career and also work on the journal. As we were planning our year in Paris, Danny put me in touch with the World Health Organization, and I was able to serve as a Temporary Adviser for the re-review of International Pilot Study on Schizophrenia, I was given charts to review and abstracts, in order to confirm diagnoses as they prepared to publish the results. That was a great experience to work with Norman Sartorius, Assen Jablensky, and Richard Day. It was a great year.

I wasn't there full time. I used to go and come from Geneva on a part-time basis. The exposure to the World Health Organisation and their activities in the areas of mental health and substance abuse opened my eyes to a larger public health world perspective that I hadn't seen before. When I returned to the United States the following year, I began working at the National Institute of Mental Health in Washington, D.C.

I was hoping at that point to focus on public health. I was there for seven years and, while I was there, prevention became a hot topic and an area of research that was just beginning to be supported. Within a few years of my being at the National Institution of Mental Health, they created the Center for Prevention Research, which was a brand-new program in mental health. I became the first director of the Center.

I was the Director of the Centre for Prevention Research for a number of years and started some prevention research programs looking at preventing depression and fetal alcohol syndromes. Subsequently I became the first Associate Administrator for Prevention in the Alcohol, Drug Abuse and Mental Health Administration, a public health branch of the U.S. Public Health Service that no longer exists. At the time I oversaw the prevention activities for the National Institute on Drug Abuse, National Institute on Alcohol and Alcohol Abuse, and the National Institute of Mental Health. It must have been around 1984/1985 when I started interacting with Mark Rosenberg at the National Centers for Disease Control and Prevention (CDC) who was very active in developing prevention programs for behavioral problems

Soon after I began that position, the Secretary for Health and Human Services started the Secretary's Task Force on Youth Suicide, and I became the representative for my agency to participate in these activities. This is when I met, for the first time, Bryan Tanney, Richard Ramsay, Lanny Berman, and Ron Maris.

I found that the field of suicidology was the perfect intersection of my interests in Public Health, prevention, and addressing a problem that we could do something about. The challenge was finding or looking for the disorders, settings, or disfunctions that were amenable to interventions and prevention.

I could probably summarise the next 16 years by saying I stayed with it, because of my ongoing interests in saving lives, the challenges, and the hope for making a difference. I still believed it was the right thing to do, and the right place for me, so that's how I got to be in this field.

Dr. Connolly: You've done a lot of research?

Dr. Silvernman: I don't know that I have done a lot of research. My major contributions are as a synthesizer, disseminator, and thinker in the field. I don't do hands-on research. I have tried to translate prevention approaches from other fields, such as preventing motor vehicle accidents, and apply them to the problem of suicide - looking at models for prevention to see which models are applicable to suicide. I try to read broadly and think broadly and then make that knowledge transfer to this field.

Dr. Connolly: You've been editor of Suicide and Life-Threatening Behavior for how long?

Dr. Silverman: Five years. The other significant thing in my career is that I had the honor to serve as a consultant to the Federal Steering Group that developed the National Strategy for Suicide Prevention. Developing national strategies have been a passion of mine since 1993 when Richard Ramsey and Bryan Tanney asked me to participate in the UN/WHO Regional Expert Workshop in

Canada. That was the first time that a group of international experts got together to develop guidelines for developing and implementing national suicide prevention strategies. I had the opportunity then to help formulate the general principles. That's something I am very proud of.

Dr. Connolly: Tell me a bit about your present position?

Dr. Silverman: I'm a husband and father of three kids - that's my avocation! But that's not really a job - that's the fun part. My real job is Director of the Student Counselling and Resource Service at The University of Chicago. I have been doing that for fourteen years. The Counselling Service has a staff of twenty clinicians who work with me, providing a full range of psychiatric services to a university community of about 10,000 students. It is a very demanding, but also a very gratifying, job to do. I'm also an Associate Professor of Psychiatry at the University of Chicago. I teach in all four years of medical school. I mainly teach about the assessment, treatment, and management of suicidal behaviors, and I supervise and train psychiatric residents.

Dr. Connolly: What is the future of suicidology?

Dr. Silverman: We need to devise better interventions, techniques and tools, and become able to better identify those at risk. Also better ways of helping, better understanding of what the biological and non-biological contributions to self-injury might be.

Dr. Connolly: One other issue we should look at is the issue of assisted suicide and euthanasia.

Dr. Silverman: How do I address that? Recently I was asked to comment on a special issue of a journal where the focus was on "hastened death." I am concerned about the evolution of the terminology in this area. What I am concerned about is the tendency to smooth over, by the use of terms, an activity or a decision that I have difficulty with.

I don't think that we can label something with a euphemistic term, like "hastened death," to make it more palatable. I have very ambivalent feelings about this area. I personally, and professionally as a physician, could not participate in a physician-assisted suicide - that process whereby I would assist someone in terminating their life rather than letting natural events take their course. I find that very difficult to deal with as someone who has been trained to preserve life, to do whatever I was capable of to ameliorate people's pain and distress. I don't think I am the best person to comment on this subject because I don't see myself as a participant.

I can intellectually understand that there are cases where it maybe (emphasize *maybe*) be a humanitarian thing to do to shorten someone's pain and suffering. I personally haven't been involved in these situations, and I don't think I would feel comfortable being in these situations. It's not something that I would want to be part of.

Dr. Connolly: Is there anything else I should have asked you?

Dr. Silverman: The only other area in which I have made a major professional investment is the issue of standards of care. I have spent a lot of time trying to clarify the standards of care in the assessment, diagnosis, treatment and management of suicidal patients. I teach about this, and I think about this, and I am trying to raise the level of the standard of care so that problems are addressed and dealt with appropriately and consistently.

Dr. Connolly: Do you do much legal work?

Dr. Silverman: I do some around the issue of standards of care in treatment and assessment

Dr. Connolly: What about music in your life?

Dr. Silverman: That's a great question. I was a clarinet, saxophone, and bassoon player. I played all these instruments in high school and through college. I was also a bass drum player for a marching band at the University of Pennsylvania. Unfortunately, although I still listen to music, my playing days were over by the time I began medical school.

Dr. Connolly: What music do you listen to?

Dr. Silverman: I listen to some blues and classical music, but I mainly listen to jazz, particularly piano jazz, more than anything else.

Dr. Connolly: You mentioned your children. What are they up to?

Dr. Silverman: My daughter, 24, is a graduate of Harvard University, and she is a legislative assistant in Washington, focusing on the environment. I've a 19-year-old son who's a freshman in college, and I have a 14-year-old son who's still at home.

Dr. Connolly: Will any of them follow in your footsteps?

Dr. Silverman: I don't think so. My daughter is following in my footsteps to the extent that she believes in doing something for others and not just for her own self-interests. She is working for the common good. My son is very interested in international relations and international conflict and how to resolve conflict. I don't know yet about the passions of my 14-year-old son.