INTERVIEWS WITH SUICIDOLOGISTS, VOLUME 4

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

Volume 1	**Volume 2**	**Volume 3**
Alan Apter	Keith Hawton	Israel Orbach
Alan Berman	Antoon Leenaars	Antapur Venkoba Rao
Unni Bill-Brahe	John Maltsberger	M. David Rudd
Diego de Leo	John Mann	Armin Schmidtke
Robert Goldney	Isaac Sakinofsky	Morton Silverman
Kees van Heeringen		
Ronald Maris		

I am pleased to present Volume 4, now on the same website. The interviews are with:

Volume 4

Jan Beskow
Yeates Conwell
Herbert Hendin
Ad Kerkhof
Steven Stack
Mark Williams

INTERVIEW WITH JAN BESKOW[1]

Dr. Connolly: Tell me a little bit about yourself, your early days, your development, and family background?

Dr. Beskow: My father was a musician. He was a head of a hospital for tuberculosis and he got tuberculosis himself when I was born. My mother was also very sick when I was born. For first three months of my life, I was treated at in a hospital, and this was a severe disruption of the attachment process in my life. It has given me the feeling of being a bit of an outsider which may be a good position for a suicidologist. I also had a kidney disorder in puberty, and so I was away from school for two periods in 18 months, and that was a good thing in many ways. I learned to type more rapidly than everyone else among my classmates and friends, and I learned that, if you are free from school, you can get higher school grades than if you go to school. I worked hard during my period of sickness. But, of course, it was another disruption. I had no typical adolescent time with my peers. During this time, I was alone. I think this has strengthened my position as an outsider, but I have never been depressed. I have never had any psychiatric disorder, and I have never been suicidal.

Dr. Connolly: How many of you were there?

Dr. Beskow: There were five children, and my mother and father were very good parents.

Dr. Connolly: Where did you come in?

Dr. Beskow: I was number two. That was also a bit difficult because they had ambitions for my brother. He was viewed as having a talent for music while I was unpractical and unmusical. In fact, it took until I was fifty before I could get over this obstacle and could be free to enjoy music. That is interesting because it shows how important are the words which parents use.

Dr. Connolly: Tell me more about the influence your parents had on you then? What about your father?

Dr. Beskow: My father was a scientist from the 18th century. He was a great humanist. He was interested in poetry and art, and he was very kind to everyone. But as a father he was a bit distant, and so our relation wasn't very open. He always was writing articles and books, especially when he was retired. He was very important for me as a model. When he was 86, he got stomach cancer. He was very quiet. We talked about it, and he said it is a natural thing. I was told to go to work at the hospital so I would not be breaking down. On Friday morning he put down his pencil and said, "Now I am too tired to work," and on Saturday evening he was dead. All the family was there.

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

[1] Dr. Beskow died before he was able to edit this interview.

Beskow: He was 85 or 86, and it must have been 1988. I was born in 1931, and so I was 57. This has been very important, to have a model meeting death with tranquillity, open-mindedness and no fear. That will help me to meet death one day too. Of course, you don't know how you'll react when you are there, but nevertheless it would be good to let go. My mother, on the other hand, was a very practical woman. She was trained to be a teacher in cooking, and she was a good cook. My father's side of the family had a humanistic tradition with priests and poets, but my mother's side had a tradition of enterprise. My grandfather had a factory with about 250 workers making paper, and we went there every summer. In fact, during my first year, I lived with my grandparents, so I had two mothers, my mother and my grandmother. I often feel more affiliated with my grandmother than with my mother, and I think this has to do with the disturbances in my early years. During the last decade of my life, through my present wife, I have been engaged in business, and I feel I have come back to one side of my talents which have been not used for 60 years. They can be used now, and that's wonderful. I like it very much.

Dr. Connolly: What books and reading influenced you in your childhood?

Dr. Beskow: I read very broadly. The first book I bought was the History of Mongolia! I had a problem in that I read very slowly. At university, I usually read literature just once while my peers would read it twice. I read articles line by line and, when I was studying internal medicine, I read only two thirds of the curriculum. I needed luck in order to pass the examination. Usually I had no problems in my studies. Now, I have learnt to read more rapidly and abstract the essential things more rapidly, but it took time to master this. It was the same with my father. He was perhaps a bit too interested in details. I have an appreciation for details and how you put them together, how you can increase your knowledge by developing theories that encompass all these details. I have been very interested in qualitative research.

Dr. Connolly: In your school years, what sort of teachers did you have? Did any of them make an impression on you?

Dr. Beskow: The first woman teacher I remember was very cruel. She was a strict, disciplinarian, and we all disliked her very much. She was a good teacher in many ways, but I disliked her very much. She was not a positive model. Later I had positive models, especially in the research field. I started working in social medicine with Professor Ragnar Berfenstam, well-known all over the world for his studies on children's accidents, and later Professor Jan-Otto Ottoson who is I the most well-known psychiatrist from our country. In them, I had very good models.

I was born in the countryside, and I like nature. Another memory from my early childhood, during my sick period, I struggled very much with the concept of death because, when you are lying there alone in a room for month after month, apart from your friends, you ended up having a very strong religious conviction. One day, about ten years later, I was burdened with anxiety and feelings of guilt, and I talked to a priest about these problems. He said, "You have not a proper feeling of guilt. You must go away and come back to me when your guilt feeling is more genuine than you have today." I went

out of the church, and I never back again. But, nevertheless, I have always been interested in existential problems, and this has of course been of useful for my work as a suicidologist.

Dr. Connolly: Which church did you belong to?

Dr. Beskow: The Swedish church, and I am still a member of the Swedish church. Sometimes I go there, and so I am not definitely against it. But that was really a break in my life, and I think it was good because my religiosity was a burden to me.

Dr. Connolly: Where was your medical school?

Dr. Beskow: It was in Uppsala.

Dr. Connolly: Why did you choose medicine?

Dr, Beskow: I never reacted against my parents in any way. I was very practical. My mother and father were, of course, interested in what I should do. I was angry at these illnesses coming back again and again, so I decided that I could be a physician. The choice was also a consequence of my religious interests and feelings. I refused to go into the military, and that was more sensational in those days than it would be today.

Dr. Connolly: What about the war years? Did the war must have had some influence on you?

Dr. Beskow: Yes. That had a big influence. We were not at war in Sweden. I remember once the Russian had bombed Stockholm and in the Upper North. My parents and I studied a map and saw that now they start there and soon they will come here. They prepared us for the possibility, which was very good. I tried to understand war and that was one reason for refusing military service.

Dr. Connolly: What philosophers influenced you in your existentialism?

Dr. Beskow: The first were the religious thinkers like Luther. I read a biography of him. But later the existentialists like Kierkegaard. and later Heidegger. The existentialists impressed me very much, which was typical of my generation

After coming to Uppsala where I did my medical studies, I lived with a friend of mine who also studied medicine. There were three rooms in our apartment, and one of the rooms was rented by a Hungarian refugee, a boy who had great difficulties finding his place in the Swedish society. He developed suicidal ideation, and eventually he died by suicide. He took a boat to the Island of Gotland and, on the way there, he threw himself in the water. We knew that it may happen. Before he went on the boat, he had a small feast for us at a restaurant and gave us gifts. Earlier, we tried to talk with him and to seek help for him, but it was impossible to find any way out of this situation. Of course, this also has influenced me. I had a primary responsibility in this affair. There was no conflict between us, but I had little idea of what to do about his suicidality. Of course, with us living there, you always raise questions of what should you do and what should you have

done. You can find things you could have done better and so on. That had an impact on me.

Dr. Connolly: Was that the first brush you had with suicide?

Beskow: Yes, it was. My studies took a rather long time. I studied for about ten years. I had a one-year break for the military service. I took a break for half a year when I worked in industry in order to meet ordinary people because, at that time, I had an interest in social medicine. At Uppsala, we have a special association for people coming from certain parts of the country and, for one year, I was the head of that association. That has followed me when I was a physician, and I have worked in different associations.

Dr. Connolly: How about your post graduate studies. What direction did they take?

Dr. Beskow: Before my studies were finished, about two years before, I made contact with Professor Berfenstam who did research in social medicine. I followed him to Umeå University in the North of Sweden where he got a professorship. (He had been an associate professor in Uppsala.) We developed the first department for social medicine. He stayed there one year, and I stayed there for seventeen years.

For two and a half years I was professor in social medicine without any qualifications really for it but, of course, I learned very much, and I was able to do some research. I had a very broad medical training. I worked in internal medicine for two years, and I have worked as a general practitioner. Then I worked also in psychiatry. It was my interest in society that led me to social medicine. My interest in people and my humanistic interests led me to psychiatry.

I have written about other topics. I have a paper in pathology, and I have a paper on pharmacological testing, but mostly I work in suicidology.

Dr. Connolly: What was your first piece of research?

Dr. Beskow: My first piece of research was to explore how people stored their medications in their homes so that the children could get them. District nurses made visits to the homes and investigated where people stored their drugs, and they assessed how it easy it was for the children to get at them, whether they were locked up or not. My next piece of research was about attitudes to vaccination (for polio). There are always people who don't like to vaccinate their children, and we wanted to know the reasons for that. That was an investigation with interviews.

Dr. Connolly: Coming back to psychiatry, tell me the topics you focused on in your suicide research?

Dr. Beskow: The plan was to do a retrospective psychological autopsy study. We wanted to focus on male suicides because suicide is most common among males. I had 150 men from Stockholm and the surrounding district and 110 men from the North of Sweden to compare suicides in regions with high and low suicide rates. It was a very ambitious study. I visited all these 250, either in person or by telephone. For about two or three

years I was going over the country. I had a flat in Stockholm, but I was traveling all over this big country. You learned very much sitting in the homes, speaking with the relatives and hearing how they discussed the man who died by suicide. I also had a social worker who collected information from the medical records and if they had any data from crime and welfare records. It took time. I started in 1969, and I was ready to write it up in 1979. That was an interesting time. It was hard work, and I added two researchers (two dissertations) to help me. One, Dr. Ulf Åsgård studied 104 female suicides from Stockholm and he is now an associate professor here in Stockholm. Another investigated 58 youngsters under the age of 29, and another who investigated 85 elderly people in Gothenburg. In total we investigated suicide in young and old men and women and got a total picture of suicides in Sweden.

Dr. Connolly: What about your current research?

Dr. Beskow: I have worked in different fields of suicidology. I have one theoretical paper that had to do with discussing suicide as a process or suicide as an emotional problem. I have been interested in viewing suicide as psychological accident. I introduced the idea of suicide as a process and that was the focus of my dissertation, an idea which has become popular in Sweden. You can also view as an accident in that it is not purposeful. The definition of suicide is that it is intentional. Think of a man who is not so good at driving, going out in his car which has bad brakes on a snowy day when there is ice on the road. He has made a lot of decisions, and when a lot of people make such decisions, it will result in a number of accidents. You can view the suicidal person as having made a lot of decisions and finding himself in a situation which he cannot manage. Looking at it in this way, you see that the differences between accident and suicide are not as big as you thought.

There is another similarity which was very striking. In accidents, you have a lot of people who were driving too fast. Some people have small collisions without much damage. You have a smaller number of people who are hurt, and a few of these are invalids for life. Very few are dying, very few if you count the total number of people who are driving carelessly. It is the same with suicide.

You have quite a lot of people who are depressed. You have many people who have suicidal thoughts, and who can't manage their life. Compared with these numbers, there are not many who are attempting and even fewer who are dying by suicide. In accidents, it is physical abilities which cannot be managed. There is another car suddenly coming up, there is child running out into the road, and you do not have enough time to avoid him. That's the same for the suicidal person. You have threats, you have situations which you have difficulty managing, and sometimes the psychological abilities make it impossible for you to manage. The theoretical picture is roughly the same for accidents and suicide. Therefore, I think it's quite correct to call suicide or a suicide attempt *psychological accidents*. Suicide in people who are healthy and sitting quietly is rare. Suicide is always accompanied by psychiatric distress or some type of psychiatric disorder. If you study cancer, some people choose suicide when they get their diagnosis of cancer or when they have much pain. They have become depressed. People who are not depressed do not choose suicide.

One important study is from Finland was carried out when the HIV and AIDS epidemic started. Professor Juoko Lönnqvist and his co-workers carried out a psychological autopsy study and they found 28 individuals who chose suicide even though they did not have AIDS. They were depressed over the idea that they might have AIDS. At that time, none of the individuals who had AIDS chose suicide. This underlines that it is not what you have, but rather how you can understand it and how manage it, and that is a psychological problem.

Dr. Connolly: That brings us to the idea of assisted suicide and euthanasia. what are your views on that area?

Dr. Beskow: My primary idea in this area is not very original. Some physicians think that the will to live is usually very strong, and it is possible for people to have enough hope in order to live in very difficult situations. If one person wants euthanasia or suicide, there are 100 people in the same situation who don't choose this way out of the situation. The Samaritans and hospices have shown that it is possible to help people to live until they die if you have a good relationship with them and if you discuss their existential problems. Therefore, my position is rather conservative. The problem is, of course, the question of autonomy, that you have to respect every person's right to make his or her own choice. But we are still not very good at establishing good relationships with suffering people. We need to create better possibilities for people to live until they die while respecting their right to choose death. The way we handle the person differs from case to case. We must also remember that we have created a society with many possibilities for people to live a better life, but for some people their life is bad. We must be prepared, as my father said, to let nature have its way. We should not try to handle our own anxiety by doing everything medically possible to keep each person alive in pain for just one or two weeks more. I think it's a question of developing a more mature understanding of suicidal problems and better ways of communicating with suicidal people.

Dr. Connolly: What about the future of suicidology? Where is it going?

Dr. Beskow: I think that one of the most important developments is the research by Mark Williams and his collaborators. Of course, he is not alone, and he has taken ideas from different fields but in a very good way. He has outlined a way to understand the suicidal situation in a way that is more substantial than and more in line with the facts. It is revolutionary in suicidology. He is building on ethology and evolutionary theory and on sound natural science experiments. He focuses on how people get into the suicidal situation.

The first step is negative perceptions. Some people have an affinity to perceive events as threatening and negative. To have anxiety has survival value. If you can't feel frightened, then you will die very soon because cars would hit you and other bad things could happen and hurt you.

If you study people who are frightened of spiders, they see them more quickly in a picture of nature than other people do because they have a genetic disposition for observing threats. That's very good. But, if the fear is too strong, it can be dangerous for

them, and these people who have these negative perceptions have a tendency to identify themselves as losers. It has to do also, of course, with their background.

The second step is the feeling of entrapment. I work in cognitive psychotherapy, and we work on schemas, that is, patterns which you have learned previously. You can have a lot of such patterns, and these help you when in danger. This has to do also with your memories and how you use your memories. One problem here is over-generalization, a tendency to generalize more than is good for you. For example, when you see a spider, there is a tendency to over-generalize so that you see them everywhere. If you ask a patient to recall a situation that made him happy, a normal patient can say, "I remember when my grandchild came and gave me flowers. I was so happy." A man who over-generalizes says, "I am happy when people give gifts to me." He cannot have concrete pictures. In the same way, bad situations are over-generalized, and so he doesn't have the courage to look for solutions, and he feels entrapped. To find a solution, you must be concrete. The solution of a problem is never general. It is always concrete in a specific situation. We must help him build skills for those situations which entrap him.

The third step is to find positive things which could help him out of this entrapment. Some researchers have shown that there are people who often get depressed but, when you talk to them, they are not depressed. They do not have a strong tendency to depression. Other people ruminate about their depressive thoughts and have a lesser capacity to find positive things in their lives.

The important task here is tackling why people so rapidly and suddenly can become suicidal because they feel entrapped and they can find no way out. This has been known to suicidologists for decades. Shneidman, Littman, Aalberg and Stengel have described situations in which you feel entrapped. For example, the lost person who can't see any positive things can be trained, when he is not suicidal, to remember every day what was positive that day and, later, what was positive during the last week and what was positive in this last month. He can train his capacity to see and remember good and positive events. That is the next step.

I am very interested in public health. I have worked administratively with suicide prevention programs in Sweden. But it has been very difficult to know what you can teach people. We know warning signals, but the problem with warning signals is that they are very general. A lot of people have them. But I hope that it's possible to find ways for public education to use this.

Dr. Connolly: Turning to public health, can suicide be prevented?

Dr. Beskow: Yes, of course, it can be prevented. It is necessary to see suicide in a historical and cultural historical context. Suicide can also be seen as part of the modern world, currently industrialization. In Sweden, for instance, when the taboo against suicide was strong, the suicide rate was low. In countries where religion is strong, the suicide rate is low. After industrialisation and modernisation, suicide rates rose. Suicide has very much to do with anxiety and depression. We must work hard in order to get people to have enough courage to talk about it, to overcome the taboo. Young people are more willing to talk about suicide, and they know that one must confront death in order to live. To know what it is to live you must have some opinion about what it is to die. It is important to discuss death and to try to understand it for, if you don't, then you lose the spirit of life. Young

people know that. Elderly people are too frightened to speak about it. We have seen in the last decade in Sweden that the topic of death is more open now.

It's a question if you are brave or if you are not brave, if you are doing the right thing or the wrong thing. The core of the moral discussion is that suicide is a psychiatric disorder and an existential issue. It has these two parts, and you must have knowledge about psychiatric disorders and existential issues to communicate with and understand young people. You can build up positive spirals or negative spiral. Stress situations enable bad mental states to endure, but you can recover from them. We have much knowledge about pharmacology, cognitive psychology and emotional psychology. This knowledge must be transformed into a language that ordinary people can understand. I am a head of a Network for Suicide Prevention, and we are striving to develop a new language so that ordinary people can understand. If we succeed in this, we will have lower suicide rates.

Dr. Connolly: Getting back to your personal life, you are married and have children?

Dr. Beskow: I married relatively early. I met my first wife when I was 18, and we married four years later. We had four boys, and we had a very good marriage. But I wasn't satisfied, and so I left her. That is not very moral, but I have a good relationship with my first wife. I married again and, in that marriage, I had one son who is now 27. W meet every week. He lives in Gothenburg. I got divorced again, and now I am married for the third time, to a psychologist at the Centre for Cognitive Psychotherapy in Gothenburg. My marriages have been long. My relationships have been about 20 to 25 years each, and I never left my marriage when my children were small. In the first marriage the youngest was boy was 14. I have had rather good marriages from many points of view, and we are not enemies in any way. But, of course, I think that this not very good. I don't really know why I am the way I am. I think that perhaps those very early disturbance in relationships may have influenced me in some way or another. But we had some very good time, and I have six grandchildren, all boys. My children are living with or married to people who have their own children, and I count them all (11 in total) as my grandchildren, and I have some responsibility for them all.

Dr. Connolly: Have your children followed in your footsteps?

Dr. Beskow: No. None of them. My first wife was a physician and we have four boys. If you have two physicians in family, I think it's not so stimulating to choose the same work, and it's hard for the children. The eldest boy is an engineer working with computers and now working at big railway company. My second son is a lawyer and has his own company. The third is working in human relations and is head of personnel for IBM in Sweden, but he is now seeking higher positions elsewhere in Europe. My fourth son is working with music. He is a director of opera. My youngest son learned about computers by himself, and he has got a job and worked five years as a web master. Now he has gone back to university. Perhaps he has been influenced by me because he's reading philosophy and psychology and also sexology.

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

Dr. Beskow: I can think of one thing that I think is important, and that is to understand the historical situation of the development of the population. For 100,000 years, there were less than 100,000 people on the earth. Then, about 2,500 years ago, the population rose. We came to understand how to combat death, but we did not how to control the birth of children, and so we got this huge population.

The first step in communication was, of course, the creating of language millions of years ago. The second step was about 2500 years ago when we learned to write and, for the first time, man could put his own thoughts down on paper. We developed an efficient alphabet, and we could start a dialogue with ourselves and with everyone around us. Then in the 15th century Gothenburg developed printing, and then, in the middle of the 20th century, we had the computer.

The capacity to communicate has changed very much and, if you look on this from the perspective of information, then you see that in the last 2,500 years we have had a cultural revolution. We have names or thoughts spiralling in the same way as genes and mutations, but much more rapidly all over the world. In addition to this cultural revolution, you have a personal revolution. We each are unique in three ways. You are unique with your genes. No one of these six billion of people have the same genes as you have, and none of them have been born in just the same situation as you have. The interaction between your genes and your situation is quite unique, so that you are a unique person, and that is very important in what you are thinking because it is from the individual that the solution of the new problems will come. This means that we stand in a unique situation where we can destroy all the development over the previous millions of years.

If you are frightened of looking at your own death, you will never be able to look at the possibility of the death of the earth, of *homo sapiens,* and you need to do this in order to increase your level of awareness. We may not change rapidly enough to solve the cultural and technological problems of our time. I see most of the psychiatric distress has to do with anxiety and depression. Every man has the capacity to adapt to very different situation and increase his level of understanding. But you must be able to confront death.

Suicidology has a very important mission today. Suicidology has stressed only the behavioral component. Suicide is something that you do. It's much better to speak about suicidality which has both emotion and knowledge. Suicide seeks to solve the problem of death through flight. We have to find out what is healthy suicidality. Unhealthy suicidality is the accident. When people try to understand death, when they are forced to do so because they are entrapped and forced to look at death, there is a very high risk for a psychological accident. We have to create positive suicidality, healthy suicidality.

INTERVIEW WITH YEATES CONWELL[2]

Dr. Connolly: Where were you born?

Dr. Conwell: Wilmington, Delaware.

Dr. Connolly: Tell me a little bit about your early life and your mother and father.

Dr. Conwell: I'm the youngest of two children. I have on older sister, three years older than me. We lived in Wilmington from 1953 through 1962. Then we moved to Australia for three years. My Dad was a chemist and worked for the DuPont Company. My mother was a homemaker.

Dr. Connolly: Do you remember those early years vividly?

Dr. Conwell: Yes, very well. I grew up in the country. Even though we lived in Wilmington, our house was in the country, in rural Pennsylvania. I felt somewhat isolated from my friends. I was happy romping around in the fields and streams. I didn't get to do much fishing then. There were just small ponds. Sports? Baseball and the kinds of things you think of in a Norman Rockwell painting. Typical American stuff.

Dr. Connolly: Were you spoiled by your parents and sister?

Dr. Conwell: Definitely not by my sister. We had a healthy rivalry. It was a fine, pleasant childhood.

Dr. Connolly: How did the household operate?

Dr. Conwell: In a very standard manner. Dad came home at 5-6, and we'd all sit around together while he had a cocktail. I can remember doing homework, watching television. A very vanilla lifestyle. A pleasant and safe feeling.

Dr. Connolly: What about books and music?

Dr. Conwell: I don't have much recollection. Maybe the Hardy boys?

Dr. Connolly: What about religion?

Dr. Conwell: We are Episcopalism, Protestant. We were fairly active at that point: Sunday school with my sister; got confirmed; regular attendees.

Dr. Connolly: Did it mean much to you at that stage?

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[2] All the previous interviews were based on transcripts sent to me by John. This interview was sent as audio recording and transcribed by me.

Dr. Conwell: Something that the parents made you do. It gets into the rhythm of life and sets up a tradition. Creates the fabric.

Dr. Connolly: Are you still active in the church?

Dr. Conwell: Yes, fairly active. We have a small church where we live, and I've served on the vestry and governance of the church. I was much more involved when our kids were growing up, for the same reasons that I was involved as a child. Part of family life.

Dr. Connolly: What is the influence of religion on your work

Dr. Conwell: Not much. I don't approach my life in terms of religion. It's more of a place where one is reminded about spiritual elements of life. It is reflected in my long-standing interest in issues of continuity, mortality and meaning in life.

Dr. Connolly: How were your early school day?

Dr. Conwell: Very good. I attended a fine private school in Wilmington (Tatnall) where my sister also went. I was very happy there. I had lots of close friends. I remember sunny days.

Dr. Connolly: Did your teachers inspire you?

Dr. Conwell: Not at that stage in life.

Dr. Connolly" What about Australia?

Dr. Conwell: My father was transferred there by the DuPont Company in 1962 when I was 9. My sister was 12. We picked up and moved there for 3 years. My father was developing a Far East office based in Sydney. I felt that it was going to be an exotic experience. Kangaroos and the bush. I thought we'd live in grass hut with kangaroos in the yard. Instead, we lived in Sydney – Rose Bay.

Dr. Connolly: Did you resent having to go there and lose your friends?

Dr. Conwell: Not at all. I knew it was time limited, and it was a great adventure. It was a remarkable privilege for us to be able to do that. I would recommend parents to give their children that kind of exposure. Not that Australia is that different. On the way there we stopped in Hawaii where my father had been stationed during the war. We visited friends of his in Maui where there was no tourist industry at that point - no hotels to stay in. We went to Tahiti and Fiji on the way and, on the way home. India and Thailand, Hong Kong and elsewhere. We flew crossing the equator twice and getting a certificate! An eye-opening experience for a 12 year-old.

Dr. Connolly Have you been back there?

Dr. Conwell: A couple of times. I went to a school there called Cranbrook which was an English public school in spirit. Grey flannel uniforms, shorts, knee socks, tie and hat. I walked to school and had a new set of friends.

Dr. Connolly: Did you see the outback?

Dr. Conwell: We traveled quite a lot: the outback, the Great Barrier Reef, and South Australia. I never got to Tasmania or to Western Australia, and I still haven't. After I came back, I was in 7th grade at a different, but similar, school. My parents gave me a choice, and I choose a school that my sister didn't go to. I stayed there for 3 years and then went to a boarding school in New Hampshire (St. Paul's School) where my father had been and where my grandfather had taught for many years as a mathematician.

Dr. Connolly: So maybe you've inherited a mathematical outlook. Did you have any inspiring teachers at St. Paul's?

Dr. Conwell: I had several. Those high school years were very influential. One influence was an English teacher, a remarkable grammarian. A very effective teacher about the rhythm, beauty and structure of language. I value that still. Another taught religion and helped me formulate abstract thinking and, indirectly, interested me in psychiatry.

Dr. Connolly: Any reading in those days?

Dr. Conwell: Not a particular genre. I prefer non-fiction now, but that was not the case then. I remember reading Ian Fleming's 007 stories often.

Dr. Connolly: Music?

Dr. Conwell: I never took music lessons or was a musician. My parents didn't push that. But I bought my share of 45 rpms and albums. Earliest Motown, Rock-and-Roll.

Dr. Connolly: Have your tastes changed over the years?

Dr. Conwell: I still like the golden oldies, but also classical music and jazz.

Dr. Connolly: When did you decide to study medicine?

Dr. Conwell: Not until two years into college. I went to Princeton University looking for a liberal arts education, but medicine didn't crystallize until my sophomore year when I took a year off from school to do some pre-med requirements in summer school that I hadn't yet done if I was going to medical school. I wanted to spread my wings a little and travel and to get some experience with medicine in order to make a firm decision. After my sophomore year, I took organic chemistry at summer school. In the Fall I worked in a rehabilitation hospital for 4 months as an orderly which was very influential in terms of my later interests. Then I went to Germany to a language institute for 4 weeks, and I worked in a factory in Frankfurt for 3 months. I then travelled for the rest of the time.

I still value those experiences very highly, working as an orderly with two groups of people: young people who had been hospitalized with brain or spinal injuries (motocycle accidents and diving into swimming pools, tragic accidents). Helping them with their activities of daily living (e.g., eating, bathing, ambulation, etc.) and bathing them. Sobering and difficult tasks initially, but you get through that quickly and appreciate the hard work that's involved for the nursing staff and the orderlies that make such a difference in the lives of the patients. I got to appreciate the resilience of people in those circumstances. These guys are devasted, but they manage to re-define themselves. The other group was older people who have had strokes or fallen and broken hips. I appreciated their recuperative spirit. That was the genesis of my interest in geriatric psychiatry and issues related to death and dying.

Dr. Connolly: What were your first experiences with death and dying? Was in with that group?

Dr. Conwell: There hasn't been any major, untimely loss for me personally. Both my parents and sister are still alive. My grandparents have died, but in old age. That work was my first experience up close to people who were close to death and dying.

Dr. Connolly: Tell me about university.

Dr. Conwell: Princeton University is a remarkable place. Coming out of my background or excellent schooling, then landing in this excellent place, I felt very prepared, which I was, but what I found rich about Princeton was the depth and breadth of the people from all walks of life, people who distinguished themselves intellectually in so many different ways. That was very stimulating and tremendously stimulating, developing life-long relationships and expanding one's horizons even while being in a small focused place like that.

I was a biology major and also studied science and human affairs, which enabled me to not study bench biology, but rather to study the philosophy of science and the applications of science to the human condition. At Princeton, one has to do a thesis as a graduation requirement as well as a junior paper which becomes the preliminary background for the senior thesis. As a result of my work in the rehabilitation hospital, I got interested in the hospice movement which, in the United States at that time (the 1970s), was quite new. The hospice in New Haven was the first for residential care, and there was a specialty hospital in New York City for cancer called Calvary Hospital. I studied those models for terminal care and looked at the ethical perspectives involved.

Dr. Connolly: Today, those are hot topics. How do you feel about assisted suicide and euthanasia?

Dr. Conwell: My interest in suicide didn't stem come that. It came through my interest in geriatric psychiatry and late-life mood disorders, and then suicide as another perspective on understanding that set of illnesses in older people. I realized that the situations that suicidal older adults find themselves in are very much like the situations of the people I was caring for after strokes, fractured hips and hospitalizations - facing institutional care and nursing home care. Those two lines of experience came together to form my initial

interest in suicide. The great majority of older people who are suicidal and who take their own lives do so because of the diagnosable and treatable psychiatric conditions, depression in particular. Over time, however, my understanding of suicide in the elderly has become more nuanced.

Dr. Connolly: Where did you go to medical school?

Dr. Conwell: I went to the University of Cincinnati.

Dr. Connolly: What were the reasons for that choice?

Dr. Conwell: My advisors suggested it. I sent in my applications, got accepted and went there. It was a large class, close to 200 students. It was a very standard medical school curriculum: two years sitting in lectures, attending labs, and the final two years clinical experience.

Dr. Connolly: Were there any memorable teachers?

Dr. Conwell: That whole 4 years is a blur. Very intense. Not very creative intellectually. I look at the curriculum offered now at the medical school where I am, at the University of Rochester, and I wish that I had had that. It's so much more creative, patient-oriented and problem-oriented now, much more stimulating. I don't remember medical school as stimulating except for the contact with patients.

Dr. Connolly: And then?

Dr. Conwell: I knew pretty much from day one that I wanted to go into psychiatry, although I didn't share that with my professors. It was, unfortunately, a stigmatized specialty. I did well and was accepted in my rotations as someone who might become a surgeon or an internist. But I knew early on that I wanted to do psychiatry.

Dr. Connolly: What tipped you toward psychiatry. Was it a "road to Damascus thing"?

Dr. Conwell: No. I had good friends with that interest. There were 8 of us who ended up going into psychiatry, a solid group of people with that interest. The rotations were also good ones.

There was a fellow named Jerry Kay who was a director of medical students and training at the university. Subsequently, Jerry went on to be the chair of the department of psychiatry department. He was an excellent educator and certainly was influential in instilling in me the joy of the diagnostic system and patient-centered interviews. I enjoyed the inpatient rotations with very sick people who were treated very well. I also did a rotation at the National Institute of Mental Health, during my senior year. I was already committed and applying for residency programs at the time. I very much enjoyed that clinical and intellectual experiences at NIMH in intra-mural units. That's really the first place where I saw research being conducted and in a really rigorous way.

Even though it was short experience, it is why I went on to do my residency at Yale University because there were 3 faculty members at NIMH who had just finished their training at Yale. One in particular, who went on to become the chair of psychiatry at Michigan, was very influential in helping me to recognize the benefits of going to Yale, as were the others. All three were very enthusiastic their work - their work with patients, their research, and the experiences that they had had as residents. This was before they had a matching system for residences. Then you could work out these deals individually. Tom helped me get familiar with the options at Yale, and I signed up there to continue my training after medical school.

Dr. Connolly: Was Yale an eye-opener?

Dr. Conwell: It was an excellent program, large as these things go. It was at the top of its game at the time. We had 22 residents per year, a dynamic, diverse, talented group of people many of whom (maybe 10 or more) continued in academic psychiatry. Talking about mentors, there, I was most influenced by Craig Nelson who was a general psychiatrist and a geriatric psychiatrist. He was Director of the Yale-New Haven unit where I worked as a resident for 6 months and where I went back as a chief resident. Craig is now at UCSF. Larry Price was another very influential person.

Dr. Connolly: When you begin to get involved in research?

Dr. Conwell: At Yale one did a full year of medicine as an intern, so there was no psychiatry that year. In my second year at Yale-New Haven. I worked with Larry and Craig, watching what they did, which was very influential - seeing clinical research conducted in such a seamless way with good patient care being provided in an evidence-based fashion. Asking questions informed by observation of patients, searching the literature, being able to test hypotheses in the course of routine clinical care. As a second-year resident, I was able to work with them on some research that they were kind enough to include me in as co-author, relating to lithium augmentation for treatment-resistant depressed patients. Then it was a very busy time for the next couple of years. I started to look at late-life depressive disorders so stayed at Yale on a geriatric psychiatry fellowship for an extra year after completing my residency. I worked with Craig on his unit looking at issues like the age of onset of depressive disorders. Older people who develop a first episode of depression in the second half of life have a phenomenological and perhaps a pathogenetically different disorder than those who have a recurrent depression in later life. Most of my work at that point was descriptive phenomenology, looking at symptom patterns, which led ultimately to the decision to study suicide as a set of behaviors that stood out as having a distinct profile in later life, and was epidemiologically distinct, yet closely related to depressive disorders.

Dr. Connolly: What did you do after Yale?

Dr. Conwell: I moved in 1985 to the University of Rochester. I had looked there already at their geriatric psychiatry fellowship, but I stayed at Yale. I was eventually persuaded to go to Rochester though and it wasn't a hard sell because they had such a strong geriatric

medicine and psychiatry program. There was another fellow at Yale, Ron Miller, whom I knew quite well, a fellow who had received his geriatric medicine training at Rochester at the Monroe Community Hospital. MCH was established by Frank Williams and was a premier geriatric medicine teaching facility at the time. Frank went on to become the second director of the National Institute on Medicine after Gene Cohen had established it. Therefore, there was the attraction of an established geriatric psychiatry program very closely connected with a wel- developed geriatric medicine program. There was a lot of attention to experience with and sensitivity to the special needs of old people.

Dr. Connolly: How about your current research?

Dr. Conwell: After the initial transition, I moved from studies of late-life depression and suicide in particular, to suicide across the life course. It's a very large program that we have now. My primary mentor there has been Eric Caine for the most part. Eric and I worked very closely for a time. He's currently Chair of the Department of Psychiatry and we are co-directors of the University of Rochester Center for the Study and Prevention of Suicide. My focus had been the definition of risk factors, the pre-intervention factors for suicide in older adults. Using primarily case control studies, we looked at the correlates and risk factor for suicide and attempted suicide in older people in a multi-axial way - the relation to psychiatric illness itself, the symptoms, the symptom clusters, but also personality traits - through work with Paul Duberstein who came to work with us as a Fellow - as well as physical illness, functional impairment and social circumstances. We were trying to appreciate the multi-dimensional nature of suicide. That has been on-going since 1987 when I got my first NIMH grant to look at this and continues right up until the present time.

More recently, over the last 5 years, my own work is evolving to the application of pre-intervention research to the design of prevention intervention strategies. It has always been tantalizing to get risk factors defined but for what end? The end is to design prevention programs in order to lower suicide rates. It's time to do that. It's tough stuff, as you well know. These things take a long time to play out.

Dr. Connolly: Ten years on, where will suicidology be? David Lester has already said that suicidology is dead.

Dr. Conwell: What does David mean, though. We must ask him. I'm curious about it because I think that might be true from this perspective, that is ultimately we need to be preventionists. With prevention science teaching us that interventions that address much more distal risk factors are going to be require complex interventions that take a public health and population-based approach rather than addressing the issues of high-risk populations. This is complex for me to think about, trained as I am as a clinician. As a psychiatrist, we are trained to work with high-risk populations. That's our focus, our scope. But I think that, ultimately, that is not where the big bang for the buck is terms of suicide prevention.

Dr. Connolly: I always feel that as psychiatrists and clinicians, we have the same relationship to suicide as A&E people have to road traffic accidents. We are dealing with the casualties of society. We are a sort of fire-fighting service.

Dr. Conwell: As a profession, we need to broaden our scope to see how we can inform the development of prevention science. I think that, sometimes, we have even gone so far as to have placed road-blocks to that as a profession. We really need to change that. So where will be in ten years? I think we are going to be out in the community. We are going to be contributing to the development of programs that help keep people well and prevent them from developing the states and situations that constitute risk, that is, several steps back from the precipice. Right now we are at the edge, pulling people back, but I would hope that, 10 or 20 years from now, we would be a couple of blocks from the edge, trying to create safety nets for people to prevent them getting any closer to the edge.

Dr. Connolly: Are you still involved in the hospice movement?

Dr. Conwell: No, I'm not. Rochester is the center of some of that with Tim Quill and others. Several of my colleagues have, over the last couple of years, moved into studying issues of late life mood disorders in the context of palliative care and terminal care.

Dr. Connolly: I ask that question because I was interested in what Herbert Hendin had to say about the need for assisted suicide and euthanasia and the lack of palliative care services, pain control, and hospice care. How would you rate that?

Dr. Conwell: As a geriatric psychiatrist I see the impact of ageism everywhere here in the US. I think older people as a class are very vulnerable to discrimination although it is couched in other terms. So while I don't have any trouble with the concept that there are plenty of situations in which it is reasonable and rational to want an early end to one's life, at the same time, that perspective is easily distorted by a set of biases against older people that could very easily lead on everybody's part, including the older person, to a belief it is almost an obligation to end one's life early, the right thing to do and the easiest solution, when what we as a society ought to be doing is grappling with the our inability to provide adequate care and resources to keep people well.

Dr. Connolly: What are the other key issues in suicidology today?

Dr. Conwell: I think one is the complexity of the topic. There is a tendency that we all have to oversimplify it. We do it in our research when we develop one dependent variable and then try to explain it in terms of another independent variable. Suicide is such a varied set of behaviors. One of the challenges that we face is to figure out how to overcome various barriers that prevent us thinking about it in its full complexity, barriers such as the lack of standard vocabulary for discussing it, the lack of sufficient funds and networks to do the large scale, multi-site collaborative research necessary to generate the sample sizes necessary to conduct the multivariate statistics necessary to understand the inter-relationships between the variables. We tend to oversimplify for all those reasons and more.

Dr. Connolly: How influential has your work been?

Dr. Conwell: That's an interesting question. In geriatric psychiatry, which is a little world, I have been very surprised by the response, and it is not necessarily fairly attributable to me. I have brought to light certain things about late life suicide owing to its association with the utilization of primary care services, and so that actually does not come from findings directly from our research. It's not a direct one-to-one correlation though. It's about having a voice suicide prevention in geriatric psychiatry at a time when few others were studying it, articulating it in a variety of ways and places where I was fortunate enough to able to convey an important message. And we have a talented team. So it has been influential, but not for reasons that I can take credit for.

Dr. Connolly: There's a life outside work. Tell me about it.

Dr. Conwell: There is, but not as much as I would like.

Dr. Connolly: Are you married?

Dr. Conwell: I am and have been for 24 years. Three kids, aged 19, 17 and 13. My wife is director of the Genesee Land Trust which a non-profit organization dedicated to the maintenance of open space, something like the Nature Conservancy, trying to convince land owners to protect their land through the use of tax relief mechanisms, etc. It's been great fun to see that develop over time

Dr. Connolly: It's a great area up near Rochester.

Dr. Conwell: It is. The amount of farmland that is being sold off is scary. So much of the quality of life up there is based on being in a rural environment like that. My wife has always been interested in conservation and nature. She has been an outdoor educator and teacher.

Dr. Connolly: How did you meet?

Dr. Conwell: At Princeton. We got married in the summer between my third and fourth years of medical school.

Dr. Connolly: Tell me about the kids.

Dr. Conwell: My oldest, William, is a freshman at the University of Rochester, just down the street. His interests are evolving, but he would say political science or the law. He's just joined the rugby team. He's a big boy, 6 foot 4, 250 pounds. A big man. My second is Claire, a junior in high school. Just before this meeting, we were touring colleges in Washington and Philadelphia to give her a basis for her plans for college. She has broad interests, and it is too early to choose. She is very engaged in lots of things with lots of *joie de vivre*. Our youngest is Gus, an eighth grader, and he's into sports: hockey, lacrosse, soccer.

Dr. Connolly: What are your family origins?

Dr. Conwell: The only genealogy I have knowledge of is on my father's side. They go back to England and Wales with some coming to southern Delaware in 17th century, and there is some traceable lineage from that time forward. There were several Yeates Conwells before me. They were a farming family in southern Delaware.

Dr. Connolly: What are your current interests and hobbies?

Dr. Conwell: I like the idea of fishing very much. I don't get much opportunity to do that. We live in a lovely setting in a little upstate town just outside Rochester on 13-14 acres on a little river which has a lot of pan fish but no trout. My most pleasant off hours are simply puttering around there, spiffing the place up in the summer, that cycle of life where you plant the flowers in the spring, put the gardens to bed in the fall, and hunker down for the winter.

INTERVIEW WITH HERBERT HENDIN[3]

Dr. Connolly: Maybe we might start off by asking what are you working on at the moment?

Dr. Hendin: The project I am most engaged on is called the suicide databank. The object of that project is to get information from therapists who are treating patients who kill themselves. It's like a psychological autopsy study except that the informants, rather than being relatives, are therapists who have been involved in treating patients at the time they killed themselves. We have been doing psychological autopsies for about eleven or twelve years, and we have published three or four papers on this topic, and two more are about to come out. I think that our study provides a dimension that is missing from psychological autopsies studies that depend upon relatives because, very often, the relatives do not know what was going on with the suicidal individual. In contrast, the therapists have often seen the patient the same day or a couple of days before their suicide, and they have been treating the patient for a period of time. We have the therapists fill out questionnaires with clinical, psychodynamic and demographic questions and, in addition, their own reactions to the suicide. We can, therefore, look into what impact the suicide had on the therapist. Although that was not our original purpose, it is something that the therapists really wanted and insisted upon, and so we modified the project in order to do that. One paper has been published in the *American Journal of Psychiatry* and another is about to come out in the next few months.[4]

We are learning something about the emotional states of these patients that can help us identify when somebody is in an imminent crisis with regard to suicide much better than we were able before. The ultimate test of this will be prospective. We could apply what we are learning and see whether or not we can differentiate between depressed patients who are suicidal and those who are not. We are using a control group - patients who are treated by the same therapists who are significantly depressed but who have never made a suicide attempt – to compare with the depressed patients who died by suicide. That is the project that I am most engaged in right now. It is a project that I could not have done if I had not become involved with the AFSP foundation because no one therapist has more than one or two experiences like this, and it is very hard to collect the information. The foundation is in touch with many people who are treating suicidal patients. It has been slow work because the therapists have to write a fifteen-page narrative. We pay for them to come to New York, and we spend several hours with them. We take only two at a time, and we spend a whole day with them. That is the day of the year that I find most enjoyable in my work. I have been doing it a long time, and I learn something new every year.

Our foundation funds research done by other people, but we do a few projects internally. I just came from Hungary where we have been engaged for the last four years in a suicide prevention project. The actual work is done by the Hungarian investigators, but we helped shape the project. Hungary has had, over the last hundred and twenty-five years, the world's highest suicide rate. It is not the highest now, but it is still very high (close to 30 per 100,000 per year). The project is in a rural province in Hungary that has a

[3] Dr. Hendin died before being able to edit this interview.

[4] *American Journal of Psychiatry*, 2000, 157(12), 2022-2027; *American Journal of Psychiatry*, 2004, 161(8), 1442-1446.

suicide rate twice the Hungarian rate (55). We are educating the community and the doctors about depression in order to improve their treatment of depression with a view toward seeing if we can prevent suicide attempts and suicide in this high rate region. We are using the rest of the province (which has two hundred thousand people) as a control to see what happens.

It's very much modelled after the Gotland Study. These studies are going to build on each other and correct problems in the Gotland study such as no control group. Our study has a control group. We are also doing a psychological autopsy study in connection with this project in which a member of every family with a suicide is interviewed. No one has ever done an autopsy study in a region with a high suicide rate, and that will be valuable. It is also important to see which suicides we were unable to prevent and why. We are relying heavily on their being seen by doctors who will pick up their depression, and we are educating the doctors to ask every patient about depression and suicide. However, the many of the people who kill themselves never go to doctors. They tend to be alcoholics who are not in the medical system. If you are going to detect them, you have to do it some other way. So that's a second project that I'm involved with.

We are also about to start a project in which we are going to look at the National Suicide Prevention Strategies of different countries, not so much with an idea of developing a model for suicide prevention, but with a view toward seeing the things each country does and whether there is any evidence that the strategies work - how much the built-in measures can tell you and whether there is any significance to what they are doing or not. We just had a preliminary meeting here with people from fourteen or fifteen countries, and we are going to hold a conference next year in Europe. We want to do this on an ongoing basis for maybe ten years so that we follow this over time. Things are different culture to culture. Michael Phillips, who was there from China, has different problems, and he could not do the same things that you can do in Ireland or the United States. That project is just beginning.

Dr. Connolly: Is Ireland represented in that group?

Dr. Hendin: Yes, with Kevin Malone. He was a pupil of John Mann, and John and I are the two people who are involved in organizing this. Kevin came in just for that meeting. He wasn't planning to come to the conference.

Dr. Connolly: Kevin is on the Board of Directors for the Irish Association of Suicidology. I am trying to get some action going in our country. It is badly needed, and it is very useful to have people like Kevin Malone come across to the USA and come back to Ireland having had that research experience with John Mann.

Dr. Hendin: I think it was nice because countries in Europe, particularly Eastern Europe doctors, can't make a living, and so they come for training to America and they never go back home. You know we're happy to have them here, but it's a terrible loss for their home countries. The doctors in Hungary go to work for pharmaceutical companies because they can make twice the money that they can make any other way, or else they go to England or America and they don't come back. I knew Kevin a little bit when he was in New York. We played tennis a little, and I knew his wife always wanted to go back to Ireland.

There was an increase in youth suicide in Ireland, and that was one of the reasons that seemed to sway him.

The only other research project that we're also doing is a screening project for depression and suicide on college campuses. I was involved in developing the project, but that project is being done at Emory University We supervise it, but we don't actually do the work.

I have spent a good part of the last seven, eight years doing work on the problems of assisted suicide and euthanasia.

Dr. Connolly: You were born in America, of course. Where were you born in the States?

Dr. Hendin: New York.

Dr. Connolly: Can you tell me something about your early life then in New York?

Dr. Hendin: I'm one of very few New Yorkers who have lived in all five boroughs in New York. Almost nobody does. When I was in the service, I was stationed on Staten Island. The people who live in Staten Island usually haven't lived in the other boroughs, and the people in the other boroughs don't usually ever live in Staten Island. I also went to school in every one of the different boroughs, except Staten Island. I went to college at Columbia University. I was one of those kids that moves fast through school, and I skipped several grades in school.

Dr. Connolly: Tell me about school?

Dr. Hendin: I entered college before I was sixteen, and I graduated from Columbia by the time I was eighteen. I finished school before I was twenty-two. All my life I was the youngest person in the group, and now I have to adjust to being the oldest person in the group.

I had an English teacher in high school, and she turned me on to study. I did very well, but I wasn't stimulated by it. I would have gone to college anyway because my parents expected me to, but I wouldn't have been excited about it if I hadn't had that teacher. Columbia University was a turning point in my life because I met people from all over who had thought about things and read things that I had never read and never experienced. I am still friends with people that I met when I went to Columbia in 1943.

Dr. Connolly: Do you have brothers and sisters?

Dr. Hendin: No. I am an only child, and I was determined that I would have at least two children because I thought I would have liked to have a brother or a sister. I have two sons.

Dr. Connolly: Tell me about your reading back then What significant books shaped you?

Dr. Hendin: The reading in college was unique. I don't think there's any college that gives you a well-rounded and liberal arts education like Columbia University. They have a two-year core curriculum. You start with ancient civilizations and go to modern times. They don't do what most colleges do, which is let you take a course in this and a course in that, etc.

It's a core curriculum that everybody has to do for two years, and they've maintained it even in the fifty years since I graduated. That curriculum stimulated me because, when I was in medical school, I used to re-read the books that we had to read in college that I thought had maybe gone over my head in college! I still have as a hobby reading about Greek civilization. I'm interested in Greek mythology, Greek history and Greek literature. History is one of my interests, and American history is a strong interest of mine.

As far as what was a defining experience for me in college, I took a course in abnormal psychology with a very distinguished social psychologist named Otto Klineberg. I wanted to take a course with him. I took his course in abnormal psychology because he wasn't teaching the course in social psychology. He was the first person who suggested to me that I should think of going into psychiatry. I had not been planning to go into psychiatry, but I was turned on by the course, and he saw that I had a feeling for the material in that course. That was the turning point. I was one of a few in my class that knew for sure that I was going to medical school and specialize in psychiatry.

Dr. Connolly: What about the influence from your parents?

Dr. Hendin: In terms of intellectual life, my father was the biggest influence. My mother treated me as if she had great confidence that I could do anything. She wasn't a worrying type of mother so that she had an effect on how I approached life. My father's family originally came from Sweden. They were evidently captured during the Russian-Swedish war in the late 1800's, and they were not allowed to come back to Sweden. They became Russian. My father came from Russia. but his grandfather told him that they had originally come from Sweden. Marie Åsberg and I were together (after giving her an award), and she asked whether my family come from Sweden. She told me the history of that war. I didn't grow up thinking that I had any connection to Scandinavia. The first big project I did was a study of suicide in the Scandinavian countries, and people always assumed that I did the study because I had some roots in Scandinavia.

Dr. Connolly: What about your religious background?

Dr. Hendin: My father left Russia before the revolution. He was a young communist in Russia, and his brother, who was 19, was arrested when the anarchists in Russia set off a bomb. Everybody was arrested who was a radical. His grandfather had inter-married into a Jewish family. If I identified him with any religion, it would have been as Jewish, but he was the way communists were in those days - very much an atheist. He had the Marxist idea that religion is the opiate of the people, and so I was not raised in a religious tradition of any kind. My father was very active politically. He went back to Russia in the 1920's as head of a communist delegation, but he was the only one that spoke Russian. He heard from all the Russians how terrible things were; that; if you had any kind of political dissent. you were sent off to the gulags. He became very anti-communist as a result of that. He became a communist under Tsarist Russia where almost anything looked better than the Tsar. It turned out that communism wasn't good. He remained what you would call a socialist. He ran for Congress on the socialist party ticket and came very close to winning in 1932. That was the year that Norman Thomas, who was

the head of the socialist party in America, won several million votes. But the socialist party had no chance in America. Franklin Roosevelt adopted all of their good ideas, and so they were not going to go anyplace.

It took my father a month or two of walking to get out of Russia. He came to the United States at the age of 16. He had one distant relative here. He had two jobs at night and in the afternoon, and he put himself through college and dental school. He had an accident, and one arm was crippled. He felt he couldn't practice dentistry, and so he turned to writing - political writing. My feeling was that the he always wanted to get out of being a dentist, and he used the arm as an excuse because it didn't seem to interfere with his playing golf! My father didn't have that much to do with me in my early childhood. He became interested in me when I could argue politically with him, and then we were very close. I remember pretending to be pro-communist just because I knew I could get a rise out of him, the way adolescent kids do. In that sense, I wish he had lived long enough to see the change in Russia, but he didn't live long enough. He was very strict. He was upset when my mother tried to learn Russian. She had come from Russia when she was 4 or 5, and he objected strongly to her learning it because he was so anti-Russia in those days.

Dr. Connolly: Who were the significant teachers you had?

Dr. Hendin: Columbia University had wonderful teachers. John Dewey was the leading philosopher and probably our most famous philosopher. He was a marvellous teacher. Mark van Doren was a great Shakespearean scholar. I had wonderful teachers in college, but I think I learnt as much from the other students. I was surrounded by very bright young people, and they were a big influence.

In medical school, I can't say there was any one teacher who influenced me. The most significant thing that happened to me was that I had an elective in my second year of medical school. and I wanted to do something with suicide. I had a patient during a psychiatry elective who seemed to have everything going for her. She was a very attractive woman, came from a very well-connected family, and was very suicidal. I was very struck by her as a patient, and I wanted to learn something about suicide. The head of the department was a political figure, running around the country campaigning to become president of the American Psychiatric Association, which he eventually did. He said that he didn't want to take on suicide because he was doing an experimental study of EEG's. He wanted me to be an assistant on that project, but I said no. If there was a person who influenced, it was the deputy chairman of that department who was very nice and really ran the department. He told me to come back and see him the next day. He told me that he liked the idea of what I wanted to do, and I should see a doctor in the department who ran one of the wards to get started on the project. It was on the tip of my tongue to say that he had heard what the chief had said - that I couldn't do that project - when I realized he had heard and he was telling me to do it anyway! I just kept quiet, and he assigned me to this doctor who was not a teacher of mine in a sense of taking classes, but who encouraged me. It was a project looking at every attempted suicide that came into the hospital over a long period of time. That's how I started and, naturally, I published a paper on that before I finished medical school. When I came back as a fellow, I did further work on that project. By the time I was 25, I had published two papers on

attempted suicide in those patients. That deputy chairman has remained a friend for a long time. He encouraged me and made it possible for me to do things that I could never have done. The doctor to whom he assigned me was the same. He did not try to use me as an assistant for his research but encouraged me to do my own research. That's how I got started doing research.

Dr. Connolly: Did you undergo psychoanalysis?

Dr. Hendin: Eventually, and that was probably the biggest intellectual influence professionally. My analyst was interested in cross-cultural research, especially in primitive cultures. I began a study under him that made my career, although our analysis suffered a little. When I finished the study, he wanted to write it up with me. I had spent years in the Scandinavian countries learning the languages, doing the work. I had all the data. I had done all the interviews. I was reasonably tactful in saying that I was sure it would be a better study if we did it together, but I wanted the experience of doing it myself.

I had gone to Denmark because somebody asked for my advice on a study of suicide in Denmark. I was going only for two weeks to advise him. They knew that I had an interest in cross cultural studies, and he thought I could see what was unique in the Danish culture with regard to suicide. I ended up thinking that it would be easier for me to get involved and do the study rather than try to advise them about how to do the study. I spent the next 3 or 4 years on the study. I wasn't there all the time. I would be there for months at a time. I started in Denmark and then I went to Sweden and then to Norway. I published papers on the project and eventually wrote a book called *Suicide in Scandinavia*. I won some psychiatric awards for that work and, when I came back, somebody at Harlem Hospital asked me why I didn't do a study of suicide among the black population, so my next project was a study about suicide among blacks in New York City.

Dr. Connolly: Were you in military service?

Dr. Hendin: I was in military service during the Korean War, after medical school and before my internship. That's the reason I got to Staten Island. I was hoping to go to Korea or at least to San Francisco to get out of New York. The government sent me a check for 15 cents to cross on the ferry to Staten Island, and 10 cents for the bus. It must have cost them at least $1 to make out that cheque for 15 cents, but that's what they did.

Later, I wrote a book called the *Wounds of War* with Ann Pollinger Hass who still works with me. Then I also got a grant to do a study of post-traumatic stress in civilian life. In the early 1980's, I set up a center for psychosocial studies, and that center was involved in the veterans' project. We studied all kinds of psychological issues that had a social impact (such as drug abuse or delinquency and psychological problems) in which society had a stake. If you have a phobia about elevators, you and your family suffer, but not society. But if you have a drinking problem, if you are suicidal, or if you get into crime, then society has a certain stake. Initially I linked up with another center, and then I formed an independent center which I linked with New York Medical College which was connected with the main VA Hospital.

When that project ended, I was working for New York Medical College, and I ran an outpatient unit for them while I was finishing writing up this material. In 1986, some people came to me who wanted to start a foundation to deal with suicide. There were several business people and some scientists involved, and among them was David Shaffer. They wanted to set up an educational foundation that would educate the public about the increase in suicide and the need to do something about it. I wasn't interested in that idea but, if they were interested in a foundation that funded research much like the American Cancer Society, then I was interested. They didn't seem interested and they left but, about a week later, they came back and said that they had talked it over. If I were willing to lead the foundation, they would change the focus and make it a research service. I told my wife that night that I had got myself into a job that I wasn't looking for. I always thought there was a need for this, but I never thought that I would be involved.

One businessman was willing to give me five thousand dollars for a few months to get the foundation started. I didn't own a computer, and so I hired a graduate student who taught me how to use a computer. We wrote letters and raised thirty thousand dollars in the three months that he had given me to get things started. I wrote to all the scientists I knew in America who were interested in suicide. I knew most of them. Within a year and a half, we were able to start funding grants. The foundation has grown so that now we have about 20 chapters around the country. We have one in Canada and one in Israel. I was the first president, and then I became the executive director. I was serving as executive director, medical director and research director. We got big enough that we hired a professional administrator, and I am now doing what I like much better. I am the medical director. I determine how we spend the money. Although I have contacts, it is easier for a doctor than a lay person to raise money from pharmaceutical companies. I am very much involved with fund raising for the foundation which I don't mind doing. I believe in the work. Our budget is a few million dollars a year, but we plan to restructure the foundation in a way that has worked for other big foundations. If this restructuring takes place, we will go from two million dollars a year to 20 or 30 million dollars a year. We will use our chapters around the country to raise the money so that you get hundreds of people involved. You use your central office to educate them how to do it, rather than having 6 or 7 people in New York trying to raise all the money for the foundation. I know we can transform this into a foundation like that for diabetes or cystic fibrosis. Cystic fibrosis raises 130 million dollars a year, and yet there are only 125,000 people in the country who have cystic fibrosis. We have 30 thousand people who kill themselves each year in America and, if you take all the depressed people at any one time, you are talking about 10 million people.

Dr. Connolly: What have we left out about your life?

Dr. Hendin: The only thing that I left out at the personal level is that tennis was a big part of my life recreationally. I lived in a district where there was not a great high school. I played tennis against an academically better high school, and I was the only one who won a match. The coach of that other school asked me why I was going to my high school, and I explained this to him. He told me to come to see him the next day, and suddenly I was able to go to the other high school. This made a big difference. The high school I had

been attending was training me in machine shop and mechanical drawing, and I wasn't terribly talented in machine shop.

I played tennis for my college, I played tournament tennis, and I still play tennis. If I could retire from work, I would play in tournaments for my age group. There are very few people my age that play tennis.

Dr. Connolly: What age is that?

Dr. Hendin: 76. I have a friend who played with me in college who is one of the top-ranked players in his age group 75 and over. I still play tennis singles twice a week and, if I play tennis twice a week, nothing bothers me.

As for music, there are two aspects to music for me. I played a lot of the guitar when I was younger. My younger son is a musician. He makes a living doing other things, but his heart is in music. I like to say that I taught him this, but it's not true. He was better in a week than I was in a lifetime, but I can't resist telling him that I was his inspiration. I like opera, especially Mozart's opera. We go to Hungary every year where they have one of the most beautiful opera houses in the world. Last year we got to see *The Marriage of Figaro* there, and that was just glorious. I was so afraid that I would be distracted by the beauty of the opera house that my wife and I took a tour of the opera house the day before so that I wouldn't be looking at everything around me.

I didn't mention was that, when my father became a writer, he made a living selling paintings. In my younger life, I bought paintings for him and, if I had a second career, it might have been in art history. I am more interested in painting than in music. I was in Paris in 35 years ago, before I was married. My wife said to me, "We've been married 35 years, and we've never been to Paris together." So we went, before we went to Budapest.

In 1956, I had bought some paintings from an art gallery on the left bank in Paris. We went back to that gallery but, unfortunately, the owner had died three months before. Her two daughters were running the gallery in the same place where it had been in 1956. It looked nicer because, back then, it had a mustier look - the way galleries used to look. They weren't so conscious of being clean and nice. They just showed the paintings. It was nice to visit the family there and tell them my story. I was sorry I missed their mother by a few months, but one of the things I enjoyed doing in Paris was going back to places I had been, just to see what they were like now. In New York, the odds of a store being there 50 years later are nil. It couldn't happen.

Dr. Connolly: Can we address the assisted suicide and euthanasia issue? How did you become involved in that?

Dr. Hendin: We were initially called the American Suicide Foundation back in 1986, and we took no position or interest in assisted suicide or euthanasia. Then, along came Derek Humphrey and Jack Kevorkian, and the public became interested in assisted suicide. People called us up and asked, "You're the American Suicide Foundation. Are you for it or against it?" I was asked to look into the problem of assisted suicide and euthanasia. If you had wanted to know about the issue, you had to go to the Netherlands which was the only place that was practising assisted suicide to any degree. When I went to the

Netherlands, I was concerned only with the fact that I had a grant to study suicide among older people. I was very struck that older people, when they became ill, often became depressed and suicidal. I was very much afraid that the Dutch would be putting to death older people who were ill and depressed, but who could be treated. That was my concern. It never occurred to me that they weren't giving good care to people generally who were terminally ill. In my country, care was poor for terminally ill people, and I assumed that it had to be better in the Netherlands. That was my concern. They sensed that I didn't have a fixed position on assisted suicide, and they were certain that I would be persuaded of the merits of their system. So they gave me access that they don't give to foreigners, and they put me in touch with doctors who were practising assisted suicide regularly. They would present their cases to me, and I would see what was going on.

While some of the cases were straight-forward medical cases, some of them were psychiatric cases. The majority of these cases wanted to relieve their suffering both psychologically and medically. Those people didn't want to die. From the standpoint of the doctors, I was a student, and they were certain that I would be persuaded of the merits of their system. It turned out to be the opposite. I came away scared to death of what they were doing. Euthanasia had become an easy option for them. You think that it's supposed happen under unusual circumstances where you couldn't do anything else for the patient, but it had become the easier and routine way of dealing with the end of life. I studied palliative care in the Netherlands in the best hospitals, and I saw cases that they didn't think you could do anything for. When you told them how an American doctor would handle that same problem, they were astounded. They admitted right away that, had they known that, they would have chosen a different option.

I spent hours with a woman who had lost her son to cancer and wanted to die. One doctor volunteered to be involved in her suicide. She told him that, if he wasn't going to help her now with suicide, she was going to it by herself. He asked for some consultants, but they didn't even want to see the case. The doctor was, in my opinion, succumbing to emotional blackmail. If a woman tells you that she is going to kill herself unless you help her, but you know that people recover from acute grieving even without treatment, you don't have to assist her suicide. Nobody is ever happy who has lost a child, but she would not necessarily have been suicidal.

That was the beginning of my involvement with this issue. I published material on all the interviews. The biggest condemnation of what the Dutch do is in their own studies. The government has conducted studies which are very difficult to read, and the Dutch don't bother reading them in detail. If you do read the studies, you see that there are thousands of people each year whom they put to death where the patient doesn't agree to it. The Dutch don't get excited by this. If they hear about it, they say that it's wrong, but the doctor meant well. He thought he was doing the right thing.

One example was a nun who was dying of cancer and would have died in a few weeks. The doctor knew that her religion would have made her against euthanasia, so he considered that he was being compassionate and justified in ending her life without telling her. He didn't understand that, for somebody from my country, the immediate reaction is that was her privilege to decide whether she wants to die that way. It is her right to decide whether to put up with some pain and to die on her terms. He didn't answer me because there was no answer.

I spent a lot of time with palliative care doctors studying the situation in one state in America, and my bigger concern is that doctors are not trained in how to treat end-of-life patients, and especially how to relive their suffering. We don't (and can't) cure a lot of diseases. We don't cure diabetes, we don't cure heart disease, but we enable patients to live with the diseases. The arguments for euthanasia are usually compassion and autonomy but, if you don't know how to help somebody, you can be compassionate but doing bad medicine. If you don't know how to relieve their suffering, so that the patient's only choice is to continue to suffer or to hasten death, that's no choice. People are going to choose to hasten death but, if you know how to relieve their suffering, they may not.

The people that are most against assisted suicide are people who treat end-of-life patients and who are specialists in palliative care. We haven't trained general physicians to do that. Palliative care is much harder than ending some life with an injection or giving patients a prescription. In addition, it's emotionally very draining. The finest people in medicine are the people who take care of people at the end of life and are willing to stay with them to the end. Just the knowledge that you're going to be with them to the end changes their whole attitude toward everything. For the most part, when doctors don't have a medicine that can cure the cancer, they tend to walk away from the patient. It's as though the patient is only of interest when they have a medicine that will help them. If the medicine isn't helping them, they tend to abandon the patients. Palliative care doctors have ways of making those patients feel comfortable until the end, and then the patients want to stay alive. You can change their whole attitude.

I haven't studied many end-of-life patients, but the few that I've seen that want to die are usually panicky at the idea of what is going to happen to them. They are afraid of what will happen over time. They have seen other people die painfully, and they don't know that they didn't have to die painfully. I remember one patient who wanted to die. He was only 32, had acute leukaemia, and he wanted to die right away. He ended up taking a course of treatment that didn't work and so he died 6 or 7 months later. But in those 6 or 7 months, he became closer to his parents and to his wife than he had been at any time since he was married. I saw him the day before he died, and he told me how grateful he was to have those six months

I don't come to my position from a religious standpoint. People who are for euthanasia tend to assume that everybody who is against comes to their opposition out of religious beliefs or out of an ideological conviction in the sanctity of life. The World Health Organization has said that no country should consider euthanasia until they are providing good end-of-life care for their citizens. Putting people to death as a social policy whom you could be helping seems to me to be a mistake. I am working to improve palliative care because I think that, if we don't legalise euthanasia for another ten years and if we keep improving end-of-life care, the issue will go away by itself. I am not so much interested in fighting the battle politically. I think it's more important to improve the care that we provide so that patients have options. Would you rather die quickly or have your suffering relieved and die in six months, relatively comfortable and having some kind of life that's meaningful? The answer isn't getting into a political fight about it because, if we don't provide that care, euthanasia will win. If we're not going to relieve suffering, then of course people are going to choose to get relief.

I probably wouldn't have gotten involved with this issue if it wasn't for the foundation. I had access to the Netherlands partly because of the foundation and partially

because, at the time, the Dutch were hoping that I would come to a different opinion. It's been very satisfying to me. We ended up writing a brief for the U.S. Supreme Court. We decided not to argue against the constitutional right to die. The constitution says that people have the right to life, liberty and the pursuit of happiness. All people are going to die, and so you can't have a right to die. If it's a right, you can take it away, but nobody can take away the right to die. I arranged a seminar on the issue. I had people on the other side, and I had a palliative care expert. I told them that we were going to disagree on legalization, but we could agree on the important issue and that is that we have to improve end-of-life care. Where we disagree is whether legalisation will help or hurt.

We don't think the other people are murderers, that they are looking to solve the social problem of a great number of elderly people by getting rid of them, or that they have any malicious motives. We think that they're mistaken. The tone of the meeting was very good. We hope that they don't think that we are religious fanatics with regard to it or have some belief that suffering is good for the soul. The members of the meeting had an argument on the substance of the issue, but it was polite.

Hawaii was about to legalize it, and somebody invited us there to speak to them. We spoke to the legislators there, and I think we had an effect in persuading not to legalise it. That's satisfying. I told the people in Hawaii that you may have won for this year but, if you don't improve the palliative care you provide to patients, you are going to lose eventually. However, some of the people on both sides are more into the politics than into the patients.

Dr. Connolly: About family matters, are you married?

Dr. Hendin: Yes. I was married when I was young and divorced when I was young. I was single from 27 till 40. I married again when I was 42, and we have now been married for about 35 years. I am very much in love with my wife, and my week in Paris was as romantic as it could have been 35 years ago. We have two children, two boys now aged 32 and 30. The 30-year old manages web sites, but he is basically a musician, trying to make it in the field of rock music. His chances are about one in a million, but he has to take that chance. At night, he plays in clubs and makes records, and maybe he will be lucky. My older boy is a brilliant student and went to Harvard and onto graduate work in a telecommunications and electronic engineering. He works in Silicon Valley on telecommunications, designing cell phones and anything that has to with wireless communication. Silicon Valley is like one big graduate school campus and, in the restaurants, my wife and I were the only people over 40. It is all young people excitedly talking to each other. My wife said to me that it looks like a graduate school class, with the same kind of intensity that you see in graduate schools. Since he will never move from that area, I accept all invitations to lecture in California so I can visit him.

Dr. Connolly: We have talked about euthanasia. What are the other big challenges in suicidology at present?

Dr. Hendin: You need treatment centers to test one treatment against another treatment versus combining the two treatments to see if they work better than either separately. We don't have a good system of evaluating the treatments that we have, and the number of people

who kill themselves is not large enough that you can draw any conclusions. You need a wider population base, and that's why you need this network. Our foundation can persuade the government to set up a network, but it will take 4 or 5 years. If enough people put enough pressure on Congress, eventually Congress will give you the money that you need only because they have a constituency and they want to remain popular or they want you to go away.

I think that psychiatry is hung up on the fact that the basic approach is exclusively biological, but there are others who are opposed to that and who see it as more psychosocial. I don't see that there is an intrinsic conflict between the two approaches. I find the discussions are limited by very bright people on either side who have become ideologically involved.

Prior to the last decade, we saw cases that were not treated medically and could never get better. But I have seen a smaller number of cases where you see that a treatment didn't work unless you didn't solve a psychosocial problem. If you solved that problem, the medication suddenly worked. I'll give you one example of what I mean. A patient was referred to me by another patient whom I had seen 30 years ago. She was 70 years old, and her 38-year-old son had developed multiple sclerosis a year or two ago and was going to a faith healer in Germany rather than accepting the new medical treatments which seemed to be slowing down the multiple sclerosis. She became depressed because she was unable to persuade her son to get medical treatment. She was going to a psycho-pharmacologist, but she didn't have confidence in him, and she hadn't responded to the medication that he has prescribed for her. I saw her four or five times. From what I could see, the psycho-pharmacologist had prescribed the correct medication and increased it somewhat because it hadn't worked up to that point. She told me that she saw him for forty minutes the first time, and subsequent visits lasted five minutes just to renew the prescription. That's how the people who do psychopharmacology practice. In the first interview, he had asked for the whole story but, as she finished, he said to her, "Do you have any children?" That meant he hadn't listened to her. He had decided she was depressed, he decided on the medication, but he really wasn't listening. She was furious with this doctor and, in some way, she was not going to let this medication help her no matter what it was. I suggested to her that she go back and see him and tell him what had pissed her off. She did that, and she recovered immediately. I let her stay on the medication for a month or two. He called me and was very grateful that I hadn't told her to stop going to him. That's what I mean about a psychosocial situation.

We don't know for sure whether certain medications prevent suicide in certain types of patients. There is still a big debate whether antidepressants prevent suicide. A treatment research center could help you decide this provided that you have a large enough population base. That to me is one of the most important challenges that remains. I believe that our work in the data bank is going to be helpful in helping counselors know when somebody is in real suicidal crisis. It's going to be much more accurate than simply relying on measuring hopelessness. I think we have much better measures.

INTERVIEW WITH AD KERKHOF

Dr. John Connolly: Where were you were born?

Dr. Ad Kerkhof: In 1952 in Holland.

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

Dr. Kerkhof: My father was a hairdresser, and my mother did the housework. Of course, I had to go to my father for my haircuts although I didn't want to. There was something strange about my father. If he was at home, he wasn't really there. It seemed as if he was avoiding contact. I have a sister who is a year older than me. She was strange too since from a very young age onwards she demanded respect from everybody. She wanted to be treated like a queen, so nobody liked to play with her. I was fairly good at school, went on to the secondary school, and went to university at age 17.

My parents didn't have a happy marriage. There were lots of hidden fights and no acceptance of each other. There was not much affection or even friendliness for each other. My mother did not like me to express any emotion. She could not handle emotions and denied having emotions herself. She was cold as ice, and she repeatedly said that I wasn't good enough. She also wanted to be treated like a queen. I really did not understand the things that were going on in my family, and I did not see things in my family that occurred in other families. But nobody ever listened to me, and no-one saw me. In my youth I was therefore sometimes quite unhappy and very lonely. Between the ages of 11 and 14, I had suicidal imagery nearly every evening, especially when feeling that I wasn't good enough. Lying in bed, I had clear imagery of me standing in front of a train, pulling the trigger of a gun to my head, etc. That was not frightening at all. These images were just there and seemed to comfort me. I must have been depressed at that time.

Dr. Connolly: You had lots of friends and you were very athletic.

Dr. Kerkhof: I did have a lot of friends at school and through my sports - volleyball, and athletics - I had a lot of friendly experiences. One time, a mother of a friend asked me, what do you think about this option? I was shocked because I realized that it that this was something my mother or father had never asked me. I realized, from the happy families of my friends, that my father and mother had no interest in my thinking or feeling. They weren't interested in each other, and they were not interested in the mental well-being of their children. My emotional development had to happen outside my family.

Very much later, and after many years of clinical work, I became aware that my mother had a narcissistic personality disorder, and my sister as well. They had zero empathy and no self-reflection. In my mother's family there were more females with this disorder, and so it seemed to be hereditary. I wonder whether my father had features of autism spectrum disorder. He never had any friendships or good relations with another person. He never had any relationships at all, not with my mother, nor with his children. In my father's family autism was abundant.

Dr. Connolly: What about reading? Was there any book in particular that stands out as being formative in your thinking or your attitude to life?

Dr. Kerkhof: Yes, I read very much – lots of books. I was especially interested in books with psychological content in which there was a development of a character or where there was a story with people who developed in their psychological processes,

Dr. Connolly: We are talking now about when you were about aged about 12, 13, 14 and 15?

Dr. Kerkhof: Yes,

Dr. Connolly: Why do you think that you focused on that particular area?

Dr. Kerkhof: I think maybe that there was something which I was missing in my life, I was catching it up by reading. It opened up that part of the world which I didn't see in my family - how people relate to each other and how people develop feelings.

Dr. Connolly: I read some books when I was too young to understand them. Did you have any experience like that?

Dr. Kerkhof: Of course, I read many books which I re-read at a later age and then realized that I hadn't got the full meaning of the books and their depth. But still they appealed to me,

Dr. Connolly: They appealed to you, and you got something out of them?

Dr. Kerkhof: Certainly.

Dr, Connolly: How did you develop your habit of reading?

Dr, Kerkhof: My mother had some books at home, and we were a member of the local library. We went there every week and took two, three or four books home. When I was young, I read all the books in the library for my age category and then went up to the next category.

Dr. Connolly: What about music in your early days?

Dr. Kerkhof: I didn't play an instrument. I did sing in a boys' choir for a brief time, but I couldn't sing well.

Dr. Connolly: What is your taste in music now?

Dr. Kerkhof: Classical music, I like it very much now and also when I was young. We had some records at home.

Dr. Connolly: What do you remember of your early school days?

Dr. Kerkhof: I was a good student, and I liked going to school. I liked the intellectual challenge. I had no problems in school although I was always the youngest in my class. There were no particular traumatic events.

Dr. Connolly: Has religion played a very important part in your life?

Dr. Kerkhof: No. Not really!

Dr. Connolly: But you were motivated to study religion!

Dr. Kerkhof: In some of my studies. I was always interested in cultural psychology.

Dr. Connolly: Your family was Catholic, but you began to disbelieve at a very early age. What were the reasons for that?

Dr. Kerkhof: At 11, 12 or 13 years of age, I tried to not go to the church. I preferred to go to a friend of mine and play table tennis. That seemed pretty normal to me. Church hadn't any appeal for me because the religious rituals had no meaning for my life. My parents said they were Catholics, but I could see that they were *pro forma* Catholics. Religion had no meaning for their lives.

Dr. Connolly: Are they still alive?

Dr. Kerkhof: Both my parents have died.

Dr. Connolly: You went on to university?

Dr. Kerkhof: Yes, in Nijmegen - Radboud University. I studied psychology and found it the most interesting topic. I didn't study much because my time was occupied with volleyball. I became very good at that and played on a national team of young players. I played volleyball every day. That was nice. Apart from that, once or twice a week I would play billiards and cards and go dancing. Sometimes I went to exams because I had to earn my college grant. I would study for two or three days for an exam. I always passed my exams with no problems.

Dr. Connolly: Did any of your teachers make an impression on you?

Dr. Kerkhof: I had this psychologist who was a priest, Han Fortman, a very famous man and a very nice man, a professor of cultural psychology. I read all of his books, especially about Buddhism and Hinduism. He also told us about the role of projection in religion. He was very inspiring. I also studied mathematics. My grades were good, and the professor provided me with an opportunity to give workshops in statistics to first-year students. When one of the teachers became ill and had to be replaced, I was asked to give his lectures. So, there I was at 20, lecturing in statistics before an audience of 300–350 first-year psychology students.

Dr. Connolly: After university, what was next?

Dr. Kerkhof: I went to the University of Leiden and, having written a thesis on the analysis of non-verbal interactive behavior, I became a kind of junior researcher with the Department of Mathematical Psychology. It was an interesting project but poorly paid. After six months, I moved to a much better position at the Department of Clinical Psychology, where I began to study suicide. Before that, I was never really interested in suicide. I did get over the suicidal imagery in my youth and, when the professor asked me to come to his department and study suicide and suicide attempters in the general hospital, I found it interesting and stayed in the field thereafter.

Dr. Connolly: How did your interest in India start?

Dr. Kerkhof: I always was interested in Buddhism and Hinduism from an intellectual point of view. When I was in Nijmegen, I lived in a house with other students, and one of them had gone to India. He showed me some slides which interested me and so, before finishing my studies, I went overland to Asia with a French friend of mine for six months. We went through Turkey, Iran, Afghanistan, Pakistan, India and Sri Lanka. It was a wonderful experience. I met many people and made some friendships that I have still today.

I have always had an interest in Buddhism and Hinduism, but I have never developed spirituality, I'm an empirical and rational person. I don't believe anything before I see it. I am an empirical scientist, and it is this way in my life as well. I need proof or data to base my thoughts upon, so I'm not a very spiritual kind of person, except that I do have a lot of Christian values in my life because I live in a culture which is a Christian culture. I have a deep sense of responsibility for others, for people with handicaps or mental handicaps, and for my fellow citizens. I do feel an obligation to be part of a community, to improve things, to be aware of the needs of fellow persons and to help them as much as I can, a Christian way of feeling responsible for others in your environment, without considering myself to be a Christian.

Dr. Connolly: How many times have you been to India?

Dr. Kerkhof: About ten times. India is a fascinating country because it's so different. In India, if you walk on the street or watch television, you have a new experience every five minutes. You have unexpected encounters with a totally different culture. It is a challenge to understand why people do things and a challenge to live in that culture. My six months there was a wonderful experience because, then I had to adapt, to live in completely different surroundings and still find ways to interact in a way that was agreeable to me and for others.

I try to understand how people behave, and I also try to learn the language. It was easy to learn to count, say goodbye and hello, thank you, and this price is too expensive. People love it when you try to understand their language

Dr. Connolly: How long have you been married?

Dr. Kerkhof: 21 years now.

Dr. Connolly: Children?

Dr. Kerkhof: Two girls aged 7 and 6.

Dr. Connolly: Are they spoilt?

Dr. Kerkhof: A little bit, yes!

Dr. Connolly: I bet they can manipulate their dad very well.

Dr. Kerkhof: Not really! Not that much! Their mother is much worse.

Dr. Connolly: Is your wife a psychologist?

Dr. Kerkhof: She specializes in educational psychology. I have a wonderful family, and I enjoy my family life.

Dr. Connolly: Do you manage to separate work and family life?

Dr. Kerkhof: Yes. When they were young, I wasn't able to work at home because the children took all my attention. Later on, I found myself working at home too much.

Dr. Connolly: I remember you telling me once that, some years ago, you did a bit of private practice as well as your academic work. Do you still do that?

Dr. Kerkhof: One day and one evening a week, totaling 12 psychotherapy sessions a week.

Dr. Connolly: How do you feel that contrasts with your academic work?

Dr. Kerkhof: I would not like to miss it because real people keep you informed about psychotherapy. Otherwise it's only books and statistics and students. I love my students and colleagues, but I also want to see some normal people

Dr. Connolly: Lets' talk about your academic career.

Dr. Kerkhof: When I was at university as an assistant, about 22 or 23 years of age, I did some basic computing, at that time very basic. I did some programming and helped a senior colleague analyze data for his dissertation. I did some research and taught courses in the Department of Mathematical Psychology so that, when I was finished, I was really a mathematical psychologist as well as a clinical psychologist. I first pursued mathematical psychology at Leiden University, and then I was asked to move to the Department of Clinical Psychology. I was 28 at the time.

Dr. Connolly: What led you to clinical psychology?

Dr. Kerkhof: It was part of the deal that, while doing research, I would also try to obtain my professional clinical qualification. I decided to work one and a half day a week in the outpatient mental health clinic in order to obtain my qualifications as a clinical psychologist.

Dr. Connolly: What philosophy do you have as a psychotherapist?

Dr. Kerkhof: Basically, cognitive behavioral therapy, a type of treatment that can be evaluated easily and that has been shown to be valid. Of course, it reflects my personality because I am rather rational. It was the most appealing system to me. However gradually I developed an interest in the motivational aspects of behavior in which you can discuss the basic values of the person, their strivings and their personal goals and projects, That is very appealing to me, and so I call myself a cognitive motivational psychotherapist.

Dr. Connolly: Are you successful?

Dr. Kerkhof: I try to follow-up my patients once every year, and then I see how many have improved, how many stayed the same, and how many deteriorated. Just from this intuitive task, I think about 80% of my patients benefited from the therapy, but a few definitely did not. I have had three cases of suicide in my patients.

Dr. Connolly: How old were you when you had the first suicide?

Dr. Kerkhof: 35

Dr. Connolly: How did that affect you?

Dr. Kerkhof: It was awful. I had the opportunity to discuss it with my colleagues from the clinic, and it made me much more aware of the danger. We (myself and the psychiatrist who was treating her with pharmacotherapy) came to the conclusion that we had done everything we could. We had evaluated her suicide risk, and we had given her the proper treatment. She had been admitted several times, and so the risk was always there. I really did not feel guilty afterwards but, still, it was awful.

Dr. Connolly: Getting back to your academic career, you then moved to Amsterdam?

Dr. Kerkhof: I spent seventeen years in Leiden and, from 1996 onwards, in Amsterdam. In Leiden I did a lot of work on suicide and suicide prevention. I did research on the management of attempted suicides in hospitals and some work on the elderly, as well as some work on the National Suicide Prevention Programs. I proposed a working-group task force in the Netherlands with all the different professions in order to develop a protocol for the management of suicide attempters. We had a conference, and we reached a consensus of how this should be done, and from 1985/1986 we have had a protocol which has been adopted throughout the Netherlands. I was involved the WHO Multi-Centre Study, among others, improving the quality of research in countries outside

Western Europe, and that has been realized. We have good research centers now in Estonia, Lithuania and Hungary, and elsewhere.

Dr. Connolly: What are your main conclusions?

Dr. Kerkhof: There are some conclusions about the epidemiology of attempted suicide. The numbers are much higher than we expected. We noticed the difference between the centers. We found that about 60% of suicide attempters are repeaters. We also have more information on repetition so that about 40% of attempters repeat within one year in some centers, which is a very high proportion. We have a repetition prediction project, and we have tried to validate possible instruments. Some are better than others, but in general the level of predictability of repeated attempts is quite low - only about 26% of the events can be explained by multiple regression analysis. Attempted suicide will remain very hard to predict. We did hope to get more details on profiles of suicides.

Dr. Connolly: You became a professor in Amsterdam?

Dr. Kerkhof: Then there was a vacancy in Amsterdam in 1996, so I decided to give it a try. There were many colleagues who applied for the job who were much better qualified than I was, and I thought that they wouldn't pick me. I felt really relaxed and had a good conversation with the interview committee. To my surprise, they really wanted me.

Dr. Connolly: Being a Professor is not what one imagines it to be really is it?

Dr. Kerkhof: No. It's rather disappointing. At work, I can be totally absorbed by the personal problems of staff members, management problems, education program changes, etc. I had to set up a new post-graduate program in healthcare psychology. That took me four years and two days a week. I think 80% of my time was dedicated to education and other management issues, and 20% to research.

Dr. Connolly: And, if you don't do research, you perish!

Dr. Kerkhof: Yes

Dr. Connolly: It's a double bind?

Dr. Kerkhof: Yes

Dr. Connolly: How do you rate yourself as a manager?

Dr. Kerkhof: I don't know. With most people in my department, things were going smoothly. I had some extra training in management, but it is very difficult because you have personal relationships with people and, at the same time, you must distance yourself. The balance between connectedness and distance within your team is quite delicate. I don't think that I was a particularly good manager. I even suffered from burn-out which paralyzed me for

a few years, obstructing the writing up of important research results - not being good enough.

Dr. Connolly: Being outspoken is a problem in being a manager as well at times,

Dr. Kerkhof: Yes. It is very difficult sometimes not to be able to say what you would like to say, what you think is necessary to be said. Sometimes you simply have to shut your mouth, because some people can't stand the truth. In the science field, we have too many narcissistic personalities, and I always end up having troubles with these personalities.

Dr. Connolly: You also have done a lot of work in evaluating suicide prevention plans, and you are an assessor for the Finnish national program. Tell me a bit about that.

Dr. Kerkhof: That provided an opportunity to evaluate how such a program performed in reality. We carried out a lot of interviews and studied all the data. It was very impressive, and the suicide rate has declined a little in Finland. It was an intellectual challenge to do justice to the program and to be fair. We were independent, we could say what we thought, and we could do what we wanted. But at the same time, if you evaluate a suicide prevention program, you should also look outside the program. For example, what about the number of psychiatric beds available in the psychiatric hospitals? Are these related to the suicide prevention program? Isn't it contradictory to save money on crisis beds and to spend money on a suicide prevention program? Our report stimulated further development of the program.

Dr. Connolly: To what extent can suicide be prevented?

Dr. Kerkhof: We had until very recently no National Suicide Prevention program in Holland. The Government decided that it was not necessary. They said that suicide is a mental health problem, and they left it to mental health clinicians to do a better job. But we have had a decrease in suicide by 25% since 1984.

Dr. Connolly: David Shaffer raised the point in one of the meetings earlier on in this congress that, in spite of what we do or don't do, suicide rates seem to be falling.

Dr. Kerkhof: Often several things are operating at same time – the economy, the happiness of the population, etc. We are the second happiest country in the world after Iceland. Furthermore, we have improved the quality of healthcare, with better prescribing, better diagnosis of depression, better treatment of patients in hospitals, and better education of doctors and psychologists. All this combines into a better quality of care. The percentage of suicides occurring in psychiatric hospitals and among people in out-patient treatment and private psychotherapy has been increasing while the overall number of suicides in the Netherlands has declined. That means, I think, that we have increased our ability to identify suicide risk early and to concentrate this risk in places where the best treatment is available.

Dr. Connolly: That's a very reasonable assumption because that's similar for coronary deaths. There are more in intensive care units, but fewer in the community.

Dr. Kerkhof: As long as the total number of suicides is dropping in your region, then the proportional increase in suicides in hospital is not bad, so you are doing a good job. Remember, those hospitals have the more difficult patients. You expect to have more cancer deaths in cancer hospitals, and so you expect to have more suicides in psychiatric hospitals. In the Netherlands, we have good referral by physicians, good mutual collaboration, good referrals and a good system, and all that helps to prevent suicide. But it can be better still. We are doing research looking for improvements and refinements

Dr. Connolly: I'm not fully familiar with the Dutch mental health legislation. Are there grounds for detaining a person?

Dr. Kerkhof: In general, not if there is only suicidal ideation. If you have a depressed and suicidal patient who has never attempted suicide before and is only thinking of suicide, in general that is not enough grounds to admit a person without his consent. And there is a limited number of beds. It's only after a person has been treated over and over again and is schizophrenic or very depressed, and/or has a history of attempts and suicidal gestures, and an immanent danger of suicide is assessed by the treating team, then the situation becomes different. But, in general, we are very reluctant to admit suicidal patients.

Dr. Connolly: What is your legislation on euthanasia and assisted suicide?

Dr. Kerkhof: In the Netherlands, euthanasia or assisted suicide is available under strict conditions. If clients want to have assisted suicide, you can discuss it and, in that process, you have the opportunity to detect the irrational elements and treat these.

At this moment, the laws say that, when performed with care under the regulations which are set out, then it is not illegal. If you don't abide by the rules, it remains a crime. If there for instance, is no second opinion, then it is murder and you can be brought before court.

A doctor has to report each case to a regional committee, which consists of an ethicist, a lawyer, and a medical specialist or doctor. If anything is not done properly, then they report to the prosecutor. At this moment, we have had about two thousand cases of suicide a year and about 60 cases of assisted suicide. Most of these people are in late stages of HIV, ALS and cancer, and so most of these events relate to the shortening of life by a few days or weeks. At the same time there are about five cases a year in which there is no physical disease or no terminal disease, and the decision is based on severe mental problems that are considered to be untreatable, and the suffering is unbearable.

Dr. Connolly: Some people are worried that this could be the beginning of a slippery slope.

Dr. Kerkhof: People who think so have to prove that there is a slippery slope. They ask me all the time to prove that there is no slippery slope but then my answer is that I don't believe that there are little green men on Mars. Do I have to prove that there are no little green

men on Mars? I think that those who believe that there are people on Mars should prove that there are!

Dr. Connolly: I suppose the image of Nazi Germany has an influence.

Dr. Kerkhof: That is totally different because, in Germany, people were killed by decisions of the government and not by decisions of the people themselves. It was murder. In Holland, euthanasia means voluntary death. There is no involuntary euthanasia.

Dr. Connolly: That would be murder.

Dr. Kerkhof: Yes. In Holland, euthanasia is voluntary, and there is no doubt that it is voluntary.

Dr. Connolly: What about people who aren't competent to make the decision?

Dr. Kerkhof: We do not have euthanasia without the person's consent. Of course not. Only in very young children with debilitating diseases and intolerable massive suffering, the consent of parents of course represents the wish of these children.

Dr. Connolly: What about living wills?

Dr. Kerkhof: The doctor doesn't have to respect these, and he is not obliged to assist euthanasia if he thinks that it is not reasonable, or if he thinks there is still treatment available. These wills are written ahead of time, and they can be of help. But they don't have judicial power.

The reporting of cases to the government in Holland is improving. The quality of the decision-making process is improving. Doctors freely discuss cases with one another. We have a consultation service set up for difficult cases, so I think we have increased skills in doctors for dealing with these cases. I don't see any evidence of a slippery slope. We haven't had more cases of euthanasia over time. The number of cases is stable, and the total number of suicides is decreasing.

Dr. Connolly: How about the future of psychiatry and psychology? People say that medical and genetic advances will bring us wonder drugs and suicide will be taken care of by primary care doctors and that psychology is dead.

Dr. Kerkhof: Who says that?

Dr. Connolly: Some psychologists have said that to me.

Dr. Kerkhof: The genetic part and the biological components are very important of course. We know that there are genetic and biological factors that lead to vulnerability. But dealing with vulnerable individuals and helping them cope with their vulnerabilities is something that psychologists are good at. We know how to help these people. There may be better antidepressants in the future, but that won't render the services of psychologists obsolete.

Dr. Connolly: You have been involved with IASP?

Dr. Kerkhof: For two years I have been on the board of national representatives. I have been to the congresses because it is a good opportunity to meet people and to hear about developments. Before the 1992 Hamburg conference, I had edited together with Diego de Leo a special issue of *Crisis* on the elderly suicide. I heard that there was a lot of uneasiness about the format and the quality of the journal. I knew that David Clark from Chicago had voiced some ideas for improvements for the journal. I supported these suggestions, and David Clark and I became the new co-editors-in-chief of the journal.

We had a hard time getting it set up in the way that we wanted. It took a lot of work in the first few years, but we gradually improved the journal. And IASP as an organization has improved considerably in empowering scientists, clinicians and volunteers alike serving the common ideal of suicide prevention.

Dr. Connolly: What will you be doing 20 years from now. Will you still be working?

Dr. Kerkhof: I think I will have a house in Sri Lanka, climbing trees and picking cocoanuts!

Dr. Connolly: You will be a bit old for that then, won't you?

Dr. Kerkhof: I don't think I will stay in this position for more than twenty years.

Dr. Connolly: What research would you like to do that you haven't touched on, if you had a free hand?

Dr. Kerkhof: If I had a free hand, I would go more into the decision-making processes. How do people make decisions regarding the end of life? At the moment, I am helping a doctor who is doing research on people who have cancer and who have been treated, but who will die within half a year. We have repeated measures on how they suffer and what their suffering is. What aspects of the problem make them feel that it is unbearable. Unbearability is a very important criterion for euthanasia or suicide. Unbearability is a subjective evaluation. How do people reach this judgment? I would like to do this with people who are considering euthanasia or assisted suicide, and I would also like to follow the life of people who are thinking of suicide and to study their decision-making processes.

Dr. Connolly: What about your own death?

Dr. Kerkhof: I hope it is still a long way yet for me!

Dr. Connolly: Do you have any fear of death?

Dr. Kerkhof: Not at all, It will come one day and, when it comes, it comes, I will not be afraid of the process of dying or of being dead. I'll take it as it comes, I hope.

INTERVIEW WITH MARK WILLIAMS

Dr. Connolly: Where were you born?

Dr. Williams: In North Wales, in a little town called Mancot, Hawarden, just over the border from England near Chester. My father was a minister in the local Presbyterian church there - his first church after training. I was born the third child in a family of five. My father moved around, first to Aberystwyth in West Wales and then when I was 8, to Stockton.-on-Tees in 1961, so most of my memories of childhood come from Stockton-on-Tees in the north of England, an industrial area. We were there in the 1960s, and it was an exciting time for the family. I left there in 1970 when I went to Oxford to read Psychology and Philosophy.

Dr. Connolly: Tell me about those early days.

Dr. Williams: The years in Stockton were characterized by a slow start. I felt from the outset that the move to England was for me a good one. I felt that this was real life. Life in Wales had been quite isolated. Aberystwyth is a beautiful place, but isolated. My family and myself all felt isolated, I think. Despite feeling that it was a good move in one sense, it was also a strange move from a gentle rural community to an industrial community that was more violent. There were bullies in school, especially for new kids, and I had a Welsh accent so was a target. After a while there, I was moved to a Church of England school. My parents, quite rightly, thought that I needed protection! It was a much gentler school where I felt I could be myself. That school was a rescue. I could see myself as having a future. It was a much more academic school too.

Dr. Connolly: Were there hardships in being the son of a minister?

Dr. Williams: There were advantages and disadvantages. You did get bullied. I was unfortunate in that my first teacher in Stockton was rather sarcastic about religion. I was only 8 at the time, and it was difficult to tolerate her remarks. When I went to the church school, it was not unexpected for people to have a religious background. Another advantage of being the son of a minister was you get an immediate circle of friends. You mix with a lot of people of all ages who are moving through the house all the time. It's a good preparation for later interactions in life. There's a regularity to the week and to life, although I've rejected a lot of the strictures about 'not doing things on Sundays', there's a sense of belonging to a community and a foundation to life which never leaves you, even if you want to leave it.

Dr. Connolly: What spiritual values did you acquire?

Dr. Williams: I was aware of the sense that all the people around me, parents and grandparents, were aware of a Presence and a Power in the universe which they called God, and at times in my life I have too. They prayed to God which gave meaning to their lives and to the tragedies in their lives. That possibility, the sense of there being a rumor of God through the ages and in this family, was very palpable, even as a child.

Dr. Connolly: What about now?

Dr. Williams: Through the ups and downs, I've ended up reconnecting with the religious side of life. As a teenager I thought I would follow my father into the ministry. But it didn't happen. Later on, when I was at Cambridge, I got the same calling, and I eventually trained and got ordained as a non-stipendiary minister in 1989. This meant I continued as a psychologist but assisted with church services and pastoral work.

Religion is about the daily and weekly practices and the commitment to an organization, to a body of scriptures and of knowledge, a way of doing and believing things. The spiritual side is an inner life. For me that was much enlivened by becoming a student of Buddhist practices through my experience in psychology.

Even with people who practice religion, you can make a distinction between going to church as a habit versus going to church as a personal nourishment. Studies of religiosity often don't make that distinction. There are, of course, spiritual experiences outside of church, and these days often there is *more* spiritual experience outside of church. The church has been rightly criticized for killing off spirituality and focusing on organization. If spirituality is like a river running through our lives, the church has sometimes tried to divert this river into its own channel and then to restrict access to that water to those who do and think certain things. The church needs to release the river back onto the land.

Dr. Connolly: What did you read as child and adolescent?

Dr. Williams: I wasn't a great reader of novels as a child. I was more interested in philosophical books. As with many people who get into philosophy, as I did later, it's the philosophy of religion that they get intrigued by, that you can think seriously about issues such as the existence of God. The idea that you can argue about this, especially for people brought with a religious faith, is a great revelation because you feel like you are going back to basics and not just having to take things on authority. It's a very liberating thing to read that sort of book. The Philosophy of Religion, John Hicks's book of that title, was one of my earliest life-changing books. Then I looked for any book I could find on philosophy. There's a book by A. D. Woozley called *The Theory of Knowledge* which explores how we know something is true or not and that was a very influential book in my adolescence. I was trying to think things through for myself having been brought up in the church where we had to take things on authority. It was very liberating to read things through for myself.

Dr. Connolly: How did going to the Anglican school work out?

Dr. Williams: My parents had always been very ecumenical, not worrying about which denomination. My mother started off as an Anglican. Her father was a missionary and became a bishop in the church in Africa. My father was brought up in the Presbyterian church but, then when it came to the early 1970s when the Presbyterian church was going to unite with the Congregational church, my father was a big supporter of the union

between different churches, and he would have to liked to see more progress towards uniting of the churches instead of splitting apart.

Dr. Connolly: Were there any influential teachers?

Dr. Williams: We had interesting drama teacher. He was actually the biology teacher. He was not much good as a biology teacher. He just read from the textbook and expected us to take notes. But as a drama teacher he was excellent. There was also a guy called Tom Moffit who was a religious instruction teacher, and he was one of the people who introduced me to philosophy. We went through Plato and definitions of what 'good' and 'virtue' meant, and that was a wonderful eye-opener.

My father had been a conscientious objector in the Second World War and been sent to work as a forester in South Wales. It was a difficult time in that his bosses were people who thought that he should be fighting in the war. He had studied Latin in school but, when he came out of the forestry, he went Cardiff University to read classics and found to his surprise that he could read Latin fluently. He died three weeks ago, so he is much in my mind at the moment. Even up to his death, he was reading the Latin bible daily. He gave me this sense of excitement about the layers of meaning in a text and even these days, as I take services in the churches around Oxford, it's very meaningful to me, the way in which metaphor, parable and language combine in the text. The text has multiple meanings and exploring these is fascinating.

In the last 10 years, I've become interested in Buddhist practices, and you can see parallels between the ancient Christian and Buddhist texts - the sense that they were discovering and trying to express the same sort of truths about acceptance, accepting yourself as you are now, not yesterday or as you hope to be tomorrow. They both explore the nature of love, gentleness and compassion towards yourself and each other. Those issues are profoundly expressed in Christianity and other religions too. Now, I am interested in how to use the best practices and theories, without a religious connotation, in psychotherapy and in our work with patients.

Dr. Connolly: What about music:

Dr. Williams: Music was always important to me., I used to sing in the choir at both school and the church, singing both secular and religious music. I play the organ and the piano, and I write a bit of music (I've never told anyone outside the family of this before!) The music in the church helps to make the service meaningful for people because it involves your whole body and goes way beyond poetry.

Dr. Connolly: You're a very private person and a public person. How do you separate the two?

Dr. Williams: Trying to be just myself as best I can in every moment in whatever any domain that I find myself in – family life, public life, my work, conferences and so on. I used to keep my public and private lives very separate. My religion and spirituality were part of my private life, psychology was part of my public life. Over the last 10 years with the exploration of mindfulness meditation as a personal practice and as a therapeutic practice, this separation can no longer be sustainable. I have had to come out of the closet. That's

given me some pause for thought because I'm not naturally an evangelist about my religion. I have always kept them separate, and now they are not so separate.

Dr. Connolly: Tell me about university.

Dr. Williams: In my university years, I was involved in the National United Reformed Church Youth Movement and was quite involved in running camps for children. For example, we used to take children from Liverpool to North Wales, with canoeing and other activities with them for a week. I did that for a few years, and that was organized by the church.

In my undergraduate university days, I read philosophy and psychology.

Dr. Connolly: Why psychology?

Dr. Williams: I really wanted to read philosophy, but I wanted to apply to Oxford University because my brother was there. At that time, I was thinking of being in the ministry which would have meant going to Cambridge to train for three years. I didn't want to go to Cambridge for six years. So I applied to Oxford. But at Oxford, you can't just do philosophy on its own. You have to do it with something else, and psychology seemed to me to be the most interesting option.

I didn't want to do theology because I thought I'd do that. In those days, the church did not take 21-year-olds to train for the ministry because they thought that was too young. They asked me to go out and do something else first, and then go into the ministry. I thought that training in clinical psychology was a good thing to do. That training involved three more years at Oxford, and then I got an offer to do a doctorate on depression with John Teasdale at the Department of Psychiatry at Oxford.

I wrote to the church to ask them about postponing for a second time, and they encouraged me to go for the PhD. They said, 'You can do theology at any time'. But after 9 years (undergraduate, clinical training and doctorate), I thought that my initial impulse to go into the church must have been a mistake. I was so much into psychology and enjoying it that I decided that *that* was my career path. I applied for and got a job as Lecturer in Applied Psychology at Newcastle University helping to teach the clinical psychology course there.

Dr. Connolly: Tell me about your doctorate.

Dr. Williams: It was on psychological models for the treatment of depression, and I looked at the learned helplessness model of depression. I started by trying to replicate an existing study that Seligman had done in which he had given people unsolvable problems in one phase of the experiment and demonstrated that that made them helpless for other tasks such as a shuttle box in which they had to move a lever to avoid a noise coming on in 5 seconds. I couldn't replicate his experiment. In fact, some participants reacted to the initial failure by doing *better* than the control group and some reacted by doing worse. My thesis became a study of why people react to failure in these different ways - some do better but some give up. We looked at how people attributed their failure, their expectancies and how important the task was. The thesis derived and tested a model to account for the difference. That was published in *Behavior Research and Therapy* in 1982.

Dr. Connolly: You haven't mentioned your mother yet.

Dr. Williams: My mother was a very loving person who you were always sure of. She brought up 5 children and was a minister's wife, so she was very busy. She had gone to university but had given up after a year because her own mother was ill, and she went back home to care for her, but by then, she had already met her future husband at university. They married a few years later. She was a feisty person, unlike my father who was a pacifist. Her two brothers had been killed in the war, and she was going to get Hitler back in the only way she knew how. She went into the land army. She was intelligent with immense resources of courage. She is still alive, but in 1987, just a few months before they were due to retire, she had a major stroke which left her without being able to speak, and she still can't sixteen years later. Yet, she kept going. She's carried on, riding for the disabled, fallen several times, broken her hip and had to go into a nursing home. But she found a way of embroidering with her left hand and has done amazing embroidery. Doing that and watching Sky Sports from wherever cricket or tennis is being played throughout the world, she gets by and has become a source of support for many people despite the fact that she's in a wheelchair all day and can't speak.

Dr. Connolly: What about your siblings

Dr. Williams: I've got an older sister and an older brother and then two younger sisters. My older sister is a radiographer in Bath, my older brother was a schoolteacher and then headmaster and is now chief executive of the Dorset Connections Service which looks after kids post-16 who are at risk of dropping out of education. My younger sisters are an eye nurse, and the youngest, a social worker, who has just been ordained and become a missionary.

Dr. Connolly: What was psychology like when you were an undergraduate?

Dr. Williams: It wasn't what I expected. You could choose 4 areas out of 10, and I chose behavioral disorders, social psychology, developmental psychology and perception. I found it really fascinating, although it was a bit of a shock. I hadn't done any biology since the 5th form, and my first essay for my tutor was on the role of the hypothalamus in the regulation of thirst in the rat! So my first few days at Oxford were spent in the Science Library trying to find out where the hypothalamus was, trying to understand its role and writing the essay. Latin, English and history for A levels wasn't a great preparation for learning about the hypothalamus!

There were people there who were very inspiring. John Hutt, for example, talked about ethology, how to observe the behavior of animals in their natural habitats, how to write an ethogram. We studied Piaget and other developmental psychologists as you would expect. To me, this combination of neuroscience and behavior was an excellent grounding for later understanding the psychological problems in patients. Observing without judging behavior rather than making inferences.

For example, we learned that the early diagnosis of autism involves observing behavior carefully. When the child puts the hand of their parent on the door handle to get

the parent to open the door for them, but not looking at the parent during this, people had thought that the child was 'using an adult as an object'. We were taught to not merely make inferences, but to observe carefully. What you actually observe is that the child is averting their gaze rather than looking. We know that gaze-aversion is one of the things that both animals and humans do when they are over-anxious. Seeing the gaze-aversion in autistic children led to new understandings of autism and the chronic over-arousal from which children with this diagnosis can suffer. What happened to the theory is perhaps not the issue for me. The issue was the method of discovery, which was about close observation rather than rushing to make unwarranted inferences.

Dr. Connolly: So who else was there?

Dr. Williams: Jeffrey Gray was a lecturer and a hero to many of us because of the way in which he managed to transcend the animal/human divide with his series of anxiety studies. He later went to Hans Eysenck's chair at the University of London's Institute of Psychiatry. Lawrence Weiskrantz was the Head of the Department, a neuroscientist who discovered blindsight among other things. He discovered that when people are cortically blind, there is another pathway to the visual cortex which allows them to reliably discriminate which side an object is that you show them. They cannot see, in the sense of experiencing seeing, but they show by their behavior that they are seeing at some level. He also did some early work with Elizabeth Warrington showing that people with amnesia actually could remember some things, but they weren't aware that they were remembering. He was fairly influential on many of us. Later on, Gordon Claridge came to Oxford bringing his psycho-physiological theories of schizophrenia.

Among my peers, there were people like John Duncan who is now at the Cognition and Brain Sciences Unit, Sue Blackmore who is now interested in parapsychology at the University of Bristol, and Jane Wardell who became Professor of Health Psychology at the University of London.

Dr. Connolly: What about the philosophers?

Dr. Williams: My tutor in philosophy was John Kenyan who was a Humean and interested in the theory of induction. Other philosophers who taught us were Geoffrey Warnock – a clear thinker. Peter Strawson's lectures on the introduction to philosophy were the most complicated lectures I have ever listened to in my life, and I did not understand a word of them. A. J. Ayer was also around at the time, and I remember going to one incomprehensible seminar with him. He was a great proponent of logical positivism. It was a time when Oxford was still pretty dominated by analytic philosophy in which philosophy was really the philosophy of language. A lot of that was pretty dry, and I found it relatively dry myself as well. It was only recently that I came across a book which made sense of this, a book by Brian Magee who was both a philosopher and a broadcaster, called *Confessions of a Philosopher* which is his autobiography. He talks about analytic philosophy in Oxford and how dry and disappointing it was to him. Reading his book, I thought that is precisely what I felt but hadn't articulated. It's a wonderful book.

Dr. Connolly: You were nine years altogether in Oxford, and then you went to Newcastle. That must have quite a transition.

Dr. Williams: It was a big change. We had one child and another one on the way when we moved there, and another born when we were there. My parents by then were living in Newcastle-upon-Tyne, and my wife's parents were living in Stockton-on-Tees, so we thought we were moving back home, as it were. It didn't particularly feel home to us, but I was very glad of the three and a half years I spent in that job because the head of the clinical psychology course, a man called Peter Britton, was a very good mentor. He was very sound in his judgement and very good at explaining things. And he introduced me gently to the business of being a lecturer and a supervisor for the clinical course. He gave me the opportunity both to do clinical work and to do research. Although I didn't stay there long, being with Peter Britton gave me a very good solid foundation for later on.

Also, it was a time when I started getting seriously interested in cognitive therapy which hadn't been part of my original training as a behavior therapist in Oxford when I was doing clinical training because it was only just emerging in the 1970's. I explored it along with several colleagues, like Jan Scott who was a junior lecturer in psychiatry at that time in Newcastle. We saw patients and then went to workshops and met Beck when he came over to Britain and gradually got into cognitive therapy. It was out of those early workshops that my first book, *The Psychological Treatment of Depression* came, because I found that there wasn't a book that really comprehensively reviewed all the available treatments for depression. There was Beck's 1979 book, but that didn't go into the behavioral side. In order to teach my students, I brought together these treatment techniques in that book, which came out in 1984. Newcastle was good in giving me the time to do that. An opportunity to do full-time research came up at Cambridge as a post-doc in the MRC Applied Psychology Unit, and I moved there in January 1983.

Dr. Connolly: Again, a different world from both Newcastle and Oxford.

Dr. Williams: A very different world. I went there for a three-year stint thinking that three years would be good so get research underway. It is very difficult for young lecturers to get research up and running. I was very grateful that, in Newcastle, some lecturers there had incomplete data and asked me to help them complete the data gathering and analyze the data and they gave me my place in the publication. Without that, I might have floundered. When I went Cambridge, it was explicitly to give myself quality time to get research underway. It was at Cambridge where Fraser Watts and I began to look at the using experimental cognitive psychology to investigate underlying psychological processes in emotional disorders.

Dr. Connolly: How long were you there?

Dr. Williams: Nine years.

Dr. Connolly: Then you moved on?

Dr. Williams: Then I moved on to North Wales.

Dr. Connolly: What about the publications in Cambridge?

Dr. Williams: Well, it was there that I started being again interested in suicidal behavior.

Dr. Connolly: What awakened that?

Dr. Williams: It was probably because we were interested in psychological change. I picked up a theme that had come out of my PhD: why do some people react to adversity in a catastrophic way while other people react without a catastrophe. Suicidal behavior is something which is very catastrophic, but often, a few weeks after a suicide attempt, some people seem back to normal. I wanted to understand the psychological processes underlying emotional crises and how the crisis resolves.

When I was doing memory testing, I wanted to know whether their memories were biased. If you gave people a cue word that was positive, maybe, I thought, it would take them a long time to retrieve happy memories. This was the memory bias that had been found in depression but had not ever been looked for in suicidal people. Perhaps part of the black despair of the suicidal crisis was contributed to by this inability to retrieve anything positive from the past so that your past seems like a string of failures and disappointments.

We discovered that some of our patients didn't seem to be able to do the task at all. They came up with over-general memories, memories that summarized a number of events instead of a specific event. At first, we thought that perhaps they didn't understand the instructions, but it reminded us of a phenomenon that we found in cognitive therapy. Very often in cognitive therapy, after you know the person quite well and they've disclosed a lot of things to you, they still have difficulty in coming up with specific events in their past. There is a lot of 'general memories' rather than specified particular memories.

In cognitive therapy workshops I would advise novice cognitive therapists always to be specific. If somebody says, 'I've got no friends', ask them gently which friends have left them and which friends are still around. Be specific, name them, ask whether X or Y is still there. If people say 'My life is falling apart', at some point, ask for specific information.

It seemed we were discovering this same phenomenon using the cue word test. It turned out to be a very important finding because although this seems a subtle memory problem, it impairs problem-solving. It seems to be much worse in those who have a history of trauma. If people have had a trauma, particularly sexual abuse in the past, then it seems to affect their memory years after the trauma and, even when they are not thinking about the trauma, the trauma has impaired other aspects of memory, making it over-general, which then impairs their current ability to solve completely unrelated problems. We first published those results with suicidal people in 1986, since when it has been replicated in depressed psychiatric patients, those with PTSD, Vietnam veterans, children who have been through the Bosnian war, and many other groups.

Dr. Connolly: And after Cambridge back to Wales?

Dr. Williams: Back to Wales, another big culture change. We lived in Anglesey, off the coast of North West Wales, and worked at Bangor University, on the mainland. This part of Wales has consistently been one of the parts of the United Kingdom with the highest unemployment for the last seventy years. It is in the bottom 25% of Europe in terms of social deprivation. Yet it is stunningly beautiful, as is the rest of North Wales. The mountains are beautiful, the fields are wonderful, and the sea is incredibly clean, but that beauty hides an immense amount of rural poverty. It is linguistically a very Welsh-speaking area, and both my children and my wife and I learnt Welsh. That was a challenge. We didn't *have* to speak Welsh, because the University welcomed English speakers, but we wanted to do so.

We found the community and the university very warm and welcoming, and we were privileged to be there. Of course, we changed church as well because it was the Welsh Anglican church rather than the English church into which I had been ordained, with bi-lingual services. But only once have I managed to preach in Welsh. It was when I was on sabbatical, and I had the time to prepare a Welsh sermon. I would have done it again if I had more time, but it was not to be.

Dr. Connolly: What were you doing then in your years there at the University in Wales?

Dr. Williams: I was director of the clinical psychology course for the first six years I was there. We set it up as a three-year doctoral course, and it was the first professional doctorate in clinical psychology in the UK to be approved by a university and get up and running. Bangor was very proud of being the first one to do this.

After six years in 1997, I left the course to set up a research institute and also became Pro-Vice-Chancellor for research, helping to navigate the university through the Research Assessment Exercise for 2001, helping departments prepare their submissions. The research institute was called the *Institute of Medical and Social Care Research* and brought together psychologists, social anthropologists, public health physicians, and health economists to look at both public health aspects of community and social level interventions as well as individual treatments for mental health issues as well.

Dr. Connolly: In all of this time, your children were growing up. How many children do you have?

Dr. Williams: Three.

Dr. Connolly: What kind of a father are you?

Dr. Williams: What would they say? I think quite a busy father, a father who takes an interest in what they are doing whether they're succeeding at it or not. A father who hugs his children. We have a boy and two girls, and they hug me back and are sensitive to what they are feeling. They, in turn, are sensitive to what I am feeling.

Dr. Connolly: What career paths have they mapped out for themselves?

Dr. Williams: My son decided to do philosophy and mathematics and went to Christchurch College in Oxford and then stayed on to do a BPhil which is the professional post-graduate philosophy degree they do there. He has decided to go to St Andrew's to do his PhD where there is a very good mathematics and philosophy department. My middle daughter has gone to Liverpool, John Moore's University, to do applied computing technology, and she graduates next year. My youngest daughter decided to read English and she went to Worcester College in Oxford, and she has got another year to do in that.

Dr. Connolly: What age were they when you took holy orders?

Dr. Williams: My son was 11, my daughter was 9 and my youngest daughter was 6.

Dr. Connolly: How did they react?

Dr. Williams: I think they were quite intrigued. But it was hard too. I had to be away quite a lot when I was training. I had to take weekends away, and that was hard as that was my family time. But once I was ordained, I stayed at home more. When I got ordained, they were there in the Cathedral cheering me. They were quite involved in the Church themselves - in Sunday school and in the Young People's Group. None of them are as involved now as they were then, but I don't feel particularly worried about that and have no interest in pressuring them to seek church life or a religious life. It will happen in its own time if it's meant to happen.

Dr. Connolly: You are in the Anglican Persuasion?

Dr. Williams: Yes, by accident. I sort of fell off my bike into the Anglican Church for family reasons when we moved to Cambridge. It was a bit of a bind on a Sunday morning to get the children into the car and go into Cambridge for the Reformed Church services because we lived 3 miles outside Cambridge. We thought it seemed much easier to go to the local parish church in the village which was just a walk up the road. That's how we started worshipping in the Anglican Church. It wasn't high principle - it was really a matter of convenience.

Dr. Connolly: Tell me about your journey back to Oxford.

Dr. Williams: I was 50 in 2002. When we had been in Wales a few years, I realized that coming to the age of 50, I had to make a decision whether North Wales was going to be the place that I spent the rest of my life. Probably not. I felt that I had one more move in me before I retired. As Pro-Vice-Chancellor and also head of the research institute, my life was pulling me in two different directions. I wanted to continue the research, but my life as a Pro-Vice-Chancellor was about helping the administration of a large institution, handling large budgets and being at regular meetings to help problem-solve at a management level. I enjoyed both these sides of my job, but I realized I was going to have to make a decision.

When I was finishing off my Pro-Vice-Chancellor role, people would mention that 'the next thing for you is a Vice Chancellorship somewhere'. People started

mentioning me to head-hunting agencies, and there were e-mails from head-hunters about jobs that were coming up to lead various universities. How to decide? I realized, on the way home from work several times, if I had two things to read in my briefcase that evening and one of them was a document from a funding council and the other one was an academic paper, that I would always read the funding council paper first in order to leave the academic paper as a treat for afterwards, to be done for enjoyment rather than for just something I had to read. I realized that what I really enjoyed doing is research. But if I went back into psychology department somewhere, there's all the teaching and admin commitments that take you away from research. But there was one scheme that I thought I would explore and, if I didn't get that. then I would become an administrator. That was a very generous scheme called Principal Research Fellowships from the Wellcome Trust. You have to write a 5-year Program Grant and if you're successful in that, and you pass their interview, they will give a University the funds to employ you for ten years to do pure research.

I had, during my time at Bangor, started down this path of relapse prevention for depression using mindfulness meditation. I had continued my research on autobiographical memory in depression, and I had stayed with research in suicidal behavior. Here was an opportunity maybe to write a proposal for the Welcome Trust to bring together my interest in memory, my interest in relapse prevention using mindfulness and my interest in suicidal behavior.

I wrote a grant, which brought these three things together and submitted it to the Wellcome Trust, sponsored by Oxford University because of the ground-breaking research of Keith Hawton and his group in the Centre of Suicide Research there. Keith was very welcoming of the proposal and has been a tower of strength throughout the whole procedure, as was the Head of Psychiatry, Guy Goodwin, and the Head of Psychology, Oliver Braddick. I decided to ask for joint sponsorship between experimental psychology where I had been in the 1970's and psychiatry where I had been for my PhD, and to apply to go back to Oxford to do this ten-year program of research. It took eighteen months to write the grant. I submitted it and, a year later, was successful. The Wellcome Trust funds my post, two post-doctoral researchers and a post-graduate research assistant, a cognitive therapist, Melanie Fennell, a PhD and a research coordinator.

Dr. Connolly: When did you started in Oxford?

Dr. Williams: January 2003. This is the beginning of a huge adventure. It's a huge adventure. It's a high-risk strategy because you never know whether your experiments will work. We're using techniques that haven't been used before in this group, using mood induction procedures, taking people who are recovered from depression or from suicidal behavior and who are back to normal. We know that they are vulnerable, and we are trying to predict who will relapse and who will show later suicidal behavior. We are going to use a mindfulness approach which helps people to distance themselves from their suicidal thoughts, allowing their thoughts to come and go rather than trying to suppress them or escape from them. We hope to see if the mindfulness that worked so well for relapse prevention in people with three or more episodes of depression can be transferred to this suicidal group.

Dr. Connolly: What are your views on assisted suicide and euthanasia?

Dr. Williams: I have great respect for those countries, such as the Netherlands, who make provision for people who genuinely feel at the end of their life and at the end of their tether. I think that making a general principle that something like that should *never* be done is not necessarily always going to be the most loving thing to do for people. I believe that the most loving thing to do in any situation has to be judged in that situation. 'Situation ethics' is important here. There are occasions when you've got to set your principles aside and do the right thing. I think sometimes we get caught up in principles and forget that the right thing has to be done. I think that's true in euthanasia, and it's true in assisted suicide. Having said that, I cannot imagine myself in the situation in which I would want to give up with a person and suggest that to kill themselves was the best option.

There is a view within Buddhism that says, 'While you're still breathing, there is more right with you than wrong with you.' Given that most people in those situations of being in despair or having a terminal illness do not want to kill themselves suggests to me that the wish to kill yourself comes from a sense of hopelessness rather than the objective reality of the physical pain or the mental anguish. It may be that the very act of trying to deal with their pain and their anguish, mental or physical, has actually trapped them even more. They're like an animal caught in a trap that, by struggling, has made the trap tighten even more. Often people get caught up in their inner voices. As Marsh Linehan pointed out, when people say, "It would be better if I'm dead," how do they know? You can't get evidence about what will happen after your death! So I will always try to work with people to see what value there is in whatever life remains to them rather than knowingly declare that their life is no longer worth anything.

Dr. Connolly: We have this problem with the terminally ill in great pain that the measures that we take to alleviate that pain and give them some comfort and dignity is going to shorten their life.

Dr. Williams: We know that some measures shorten life in many cases, and there is an important distinction between intending to alleviate suffering and intending to shorten life. I want to work with the person to see how much of their sense of wanting to go was coming from a sense of their own worthlessness and their own depression and their own helplessness rather than the inevitability that their life was at an end.

INTERVIEW WITH STEVEN STACK[5]

Dr. John Connolly: We might just start off by asking you about your early life. You were born in America, I presume?

Dr. Steven Stack: Yes, on December 20, 1947.

Dr. Connolly: Tell me a bit about your early days then.

Dr. Stack: I don't really remember much about anything at all until about age five. I remember painting a fence with my father at our first house back in Rhode Island. I remember making lots of mistakes. He gladly corrected them with his big brush.

I spent much of my childhood studying for exams and trying to do my best in school so I would be able to go to college. My mother would not allow me to have any friends inside our house. She was not open to having anyone but family visit us. I had little contact with non-kin outsiders. I am first generation college. Money was always in short supply and so there was always considerable tension in the household. I would escape to the town library to study. My prized possession was my coin collection, but it fell victim to the family's financial situation.

Dr. Connolly: What did your father do?

Dr. Stack: He was a skilled metal worker. In the booming economy of the 1950's he was offered a white-collar job for the first time as a safety engineer at Sikorsky Aircraft. The family moved from Warwick, Rhode Island, to Stratford, Connecticut. However, there were cutbacks circa 1963, and he was the last to go in his small department. He ultimately went "back to the bench," as he put it, and remained a skilled factory worker until he retired. He often worked two jobs to support our family, including four children.

Dr. Connolly: What about brothers or sisters?

Dr. Stack: I have two sisters and one brother. I'm the second oldest. My older sister entered the US Navy after high school. She aspired to become an RN and a Navy nurse. Sadly, she became disabled as a result of a tragic event and received an honorable discharge. She was a Vietnam era disabled veteran with a 100% disability. She passed away from a pulmonary disorder at 63. She was buried in Arlington National Cemetery with full military honors. My youngest sister is an attorney in Virginia. My brother is retired from the U.S. post office.

Dr. Connolly: Tell me about your childhood. What did you read?

Dr. Stack: I have always loved the outdoors, and I read a lot of books about 19th century mountain men, fur trappers, and native Americans. I liked their cultural traditions and their battles to survive in harsh conditions. My favorite book was *Traplines North*.

[5] The original interview, like all of the others, was in 2000 or thereabouts, but Steven modified this version in 2021.

Dr. Connolly: What about music?

Dr. Stack: I loved playing percussion instruments, mainly the drums. I started in sixth grade and played all through junior high school and high school. I was in the concert band, jazz band, and marching band. At college, I was in marching band for three years.

I have a small stream of work on music and suicide. The most notable piece was one linking country music to urban suicide rates. In a sample of 49 large cities, the greater the radio market share of country music, the higher the white suicide rate. (Blacks were not country music fans.) That got me and my coauthor, Jim Gundlach, our 15 minutes of fame-- phones rang off the hook for 2 weeks. There was coverage in Newsweek, USA Today, CNN, the British press, etc. Willie Nelson called us "academic coneheads" in a Time magazine article. Ouch! But it was good to get his attention. Ten years later, we received the Ig Nobel Prize in Medicine for this work. The Ig Nobel, not the real Nobel. This was presented at Harvard University. Each year it goes to the authors of a study that, at first, makes you laugh but, afterwards, makes you think. We had been nominated every year-- the competition was tough, but we finally nabbed the award! We thought we were onto something, with a future as media stars, and we did additional papers on the media and suicide. However, articles on heavy metal, opera, and blues music and suicide were all published but attracted little or no media attention.

Dr. Connolly: What was your religious background?

Dr. Stack: I was a Catholic.

Dr. Connolly: Was it a religious household?

Dr. Stack: Yes, pretty much. Both of my parents were Roman Catholic, and I went through First Communion and Confirmation. My younger brother and sister both went to Catholic elementary school.

Dr. Connolly: Are you still a religious person now?

Dr. Stack: Somewhat. I go to church between 0 to 3 times a year, mostly during weddings, funerals, and Christmas. Maybe I would go more if they switched back to Latin. The Mass in English is not as meaningful for me.

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

Dr. Stack: My high school days? I remember studying for a lot of exams, I still have nightmares about walking to a class and there was an exam that I forgot about. I proudly played board #3 on the chess team, I was in the Latin Club, and I was in track for three years.

Anyway, I did pretty well at my studies-- I won an award ($50.00) for scoring the highest in a school-wide algebra test. I also won a big trophy for a project I presented at a county science fair. I scored the highest in the senior class on the Level II SAT mathematics achievement test.

Dr. Connolly: How did your nightmare end?

Dr. Stack: In those dreams I say, “Wait a minute. I’m not a student anymore. What am I doing here?” and then I wake up.

Dr. Connolly: What was your choice of career?

Dr. Stack: My mother told me that I could be a priest or a mathematician. I ruled out being a priest, I so that left me as a mathematician. At the university, I majored in math for a couple of years. I had always done well at math until my fourth semester of calculus when I got a “C.” I had never got a “C” before in anything, so I thought that either I should drop out of college or change major. I switched to English, and I got my degree in literature, primarily because I had a couple of professors that I really liked. I loved American literature and still read the work of my favorites including Hemingway, Faulkner, O’Neill, and Tennessee Williams-- including their biographies. I tried to get a job as a high school English teacher, but I didn’t get anywhere-- there was glut of English teachers in 1969. I did get one interview and they offered me the job at the end of the interview. I said I would like an evening to think about it, and they looked strangely at me but said ok. I called them up the next day at 9 o’clock in the morning and I said, “I’ll take it” They said, “Sorry, you can’t have it anymore. If you really had wanted it, you would have accepted it yesterday.”

So, I stayed in school another year and received my first master’s degree (in education, with a minor in sociology). I became fascinated with sociology and the study of structured inequality. However, I could not continue for a second year of grad school to work on a second M.A. degree in sociology because I was broke. I hit the job market and with my M.A. in education, I was able to find a job. They needed someone who was certified to teach in in both mathematics and English, a rather odd combination. That was me! I taught high school for just one year so I could save money and get back to earning an advanced degree in sociology. I made contact with some counter-cultural students who liked me and asked me to be faculty advisor to the school’s “Hearty Eaters Club.” That was really fun. Then, with my savings to get me started, I went back to my element-- the university-- and got my masters and PhD in sociology over the next five years. Being a professor typically involves working 60 or more hours a week, but I liked the freedom in deciding which days and hours and at what location I would do the work. You don’t have those choices as a high school teacher.

Dr. Connolly: This was all around the time of the Vietnam War?

Dr. Stack: Yes. I was really terrified at the thought of going to war. I took my physical and, at the end of the physical, the sergeant said, “Your eyes are bad, but not bad enough.” I thought, “Oh, no. I’m going to Vietnam. I’m dead!” But it turned out that I would be drafted only if there was an emergency. I was classified I-Y. That was just a step above 4-F.

Dr. Connolly: Did many of your friends have to go?

Dr. Stack: I never really had very many personal friends in high school. It was a working-class high school, and a good number of kids went to Vietnam. I don't know if any of them got killed, but one of them lost his leg, and the star basketball kid was shot in the head. It was pretty sad. My two close friends, who majored in the sciences and went to Johns Hopkins, did not go. Neither was pro war to put it mildly.

Dr. Connolly: You mentioned a sociology professor who was a big influence in your life. Tell me about that.

Dr. Stack: The main influence was Rosalio Wences, and he became my role model. He was very interested in inequality, including the predictors of income inequality (the subject of my MA and PhD theses). However, he left the university to become president of a university in Mexico, which was where he was from. Dr. Ken Neubeck became my PhD advisor. He also was keenly interested in structured class inequality. In those days I had little interest in suicide studies or even in deviant behavior, a broader area of sociology that includes suicide.

Dr. Connolly: What about the graduate program?

Dr. Stack: I was married, and my ex-wife was often suicidal. In my years as a graduate student, I was teaching 2 or 3 classes, often in the evenings at a neighboring university as well as on the main campus of the University of Connecticut. I was a full-time graduate student at the same time, so those were the years of my life when I was rather overworked. We had a couple of kids. I didn't have much time to develop friendships with the other graduate students. It seemed that many of the other students were enjoying themselves. I remember that, one year, I had a seminar that started at one o'clock, and I was teaching from nine to twelve, sixty miles away at Central Connecticut State College. I had barely enough time to get in my car at the end of teaching three hours to make it back to my three-hour seminar as a student. I would eat a sandwich in the car and drive at the same time. That was the busy schedule I had during those five years in Connecticut.

Dr. Connolly: Was your wife's depression the first experience you had of depressive moods in others?

Dr. Stack: Yes.

Dr. Connolly: How many kids did you have?

Dr. Stack: We had three: 1972, 1975, and 1978.

Dr. Connolly: How old are your children now?

Dr. Stack: (in 2021) Jimmy was born in 1972, so he will be 49 this year; Timothy was born in January 1975, he is 46; and Johnny will be 43.

Dr. Connolly: What are they doing?

Dr. Stack: Jimmy went to a school of public health at the University of South Carolina to work on a MA degree, but he didn't finish. In 2001 he worked for a water company and tested water samples for the county. He now (2021) works in a lab and tests blood samples from pets and humans for various diseases. Timothy was (2001) a computer analyst, but he switched to a career in the military. He is now a Captain in the National Guard. He holds a MA degree in Public Administration. He is currently in charge of an armory. Johnny received an MBA degree in business administration. He works at Geico and is in charge of a group of analysts. They are all pretty good kids, now men, actually. John is married.

Dr. Connolly: You describe yourself as rather shy. Where does that come from?

Dr. Stack: My mother was very shy. Part of my shyness is probably genetic.

Dr. Connolly: What is the most important element in your life?

Dr. Stack: I would say it's almost a tie between the love of my life, my second wife Barbara (we have been married now [in 2021] for 20 years) and my work. But, of course, Barbara comes out first! I am pleased and proud now to have published in the top scholarly journals and my work has proved to be valuable to others-- according to Google Scholar it has been cited over 15,500 times. Much of my work has been on suicide, especially media impacts, and religion, but I have also done some good work on the death penalty.

Dr. Connolly: Tell me about that.

Dr. Stack: Looking at the most publicized executions (about 20 of them), I found that there were 30 fewer homicides in the month of those executions, which is especially significant if you are one of the people that didn't get killed. The paper was published in the "number one" sociology journal, *American Sociological Review*, back in 1987. I didn't get into the politics or ethics of whether capital punishment should be abolished or not.

Dr. Connolly: You have carried out some research on copycat suicide.

Dr. Stack: Yes. I have about twenty papers on that subject. An article (*Suicide & Life-Threatening Behavior*, 2005) reviewed 419 findings contained in 55 studies. I tried to explain why some studies find a copycat fact, and the single most important factor is whether or not the suicide story is about a celebrity. I determined that research based on stories concerning the suicides of celebrities were 5.47 times more apt than other studies to find an apparent copycat effect. However, over sixty percent of the findings found no increase after a widely publicized suicide.

Dr. Connolly: What do you think of the media guidelines that have been published around the world, as in Ireland and New Zealand?

Dr. Stack: I published a critique of the work on media guidelines and suicide last year (2020) in *Social Science & Medicine*. There are actually only a few studies that rigorously test

aspects of the guidelines to see if presumably dangerous stories (ones that violate a guidelines), are actually any more dangerous than stories that don't violate the guidelines. The most rigorous study was done by David Phillips way back in 1979. He found that controlling for the sheer amount of coverage given to the story, all aspects of story content regarding guidelines (e.g., detailed mention of the suicide method, lack of a source of help, etc.) made no difference in predicting an increase in suicide. The few more recent studies often find that specific guideline violations have no effect on suicide rates following a story. Sometimes the findings are counter-intuitive. In an Austrian study, media coverage that included mention of a source for help (e.g., crisis line number), were followed by an increase in suicide, abd not the expected decrease.

Dr. Connolly: A lot of the guidelines say no pictures.

Dr. Stack: The study by David Phillips found that the controlling for the sheer amount of coverage given to a suicide story, the presence of a picture made no difference in the rise in suicide rates. Curiously, the Phillips study is often not cited in the relevant literature.

Dr. Connolly: How big is the sample you need to study for a reasonable conclusion?

Dr. Stack: My research and that of Philips is based on the whole nation of three hundred million people or on a large state such as California which has tens of millions of people. Phillips and I report a 2% increase in the number of suicides after a publicized suicide story in the nation as a whole. Using small samples, the change in the number of suicides, if any, may be too small to be statistically significant.

Dr. Connolly: What's your world view now of sociology's contribution to suicidology?

Dr. Stack: Sociology has focused on forces outside of the individual (e.g., trends in unemployment, divorce, marriage, religiousness, immigration, fertility) as predictors of suicide rates. This is in contrast to psychiatry which has an individual, intrapsychic focus stressing internal constructs such as genes, brain chemistry and mental disorders.

Dr. Connolly: Who are the bright, emerging, shining stars in suicidology?

Dr. Stack: Within sociology, currently (2021) the rising stars include Seth Abrutyn of University of British Columbia and Anna Mueller of Indiana University. There are many sociologists who publish one or a few papers on suicide, while most of their work is on other topics. Fred Pampel, a demographer at University of Colorado, is a case in point. Bernice Pescosolido at Indiana University has some papers on suicide that are widely cited, but she is known mainly for her work on the sociology of mental health. Jack Gibbs had a few outstanding papers on suicide, and a book on status integration theory and suicide, but he is mainly a criminologist. Zhang Jie, a sociologist at State University College at Buffalo, has published over one hundred papers on suicide. They are related to his strain theory of suicide. David Lester has published hundreds of papers which test aspects of a sociological approach to suicide. He often links suicide rates to unemployment, birth, divorce and other rates. There are an increasing number of persons

who publish work on sociological factors and suicide rates, but who are not sociologists. For example, Keith Hawton is a star overall, but has some work on sociological topics. Thomas Joiner's work actually borrows from the Durkheim concept of social integration in his concern with the similar but also different concept of "belonginess." However, writers in the area of the interpersonal theory of suicide and belonginess often fail to cite Durkheim and much of the work on family and religious integration – which are related to "belongingness."

Dr. Connolly: Have you met Keith Hawton?

Dr. Stack: I met him in 2000 for the first time. We currently (through 2020) see each other at IASP, IASR, and ESSSB meetings.

Dr. Connolly: He is here at the moment (2001).

Dr. Stack: I met him again yesterday (2001). I congratulated him on his award, and he thanked me for sending him some of my papers for a review he is writing.

Dr. Connolly: How long have you been involved in AAS?

Dr. Stack: Since 1978. I was honored to receive both the Shneidman (1985) and the Dublin (2003) awards for my research contributions.

Dr. Connolly: What are you working on at present?

Dr. Stack: Currently (it's 2021) I have a paper just published in *Suicide & Life-Threatening Behavior* on the link between social distancing and suicide rates in 43 large cities. It used census data on suicides and flu deaths for 1918, the year of the peak in the Spanish flu epidemic. I was able to get recently published data on the details of various physical distancing measures in the cities from a team of researchers. They were not interested in suicide, but on deaths from the Spanish flu. I found that for every 10 unit increase in days of distancing (lockdowns, school and business closures), there was an increase of 2.9% in the suicide rates. I also have a conditional acceptance for a paper on a 20-year review of the sociological work on suicide. I read 4,000 abstracts and many full articles on suicide. It's a follow-up to my pair of reviews for sociological research on suicide for 1980-1996, both published in *Suicide & Life-Threatening Behavior* in 2000. Those two reviews proved useful to many researchers, receiving 729 and 470 citations each.

Dr. Connolly: You presented a paper a few years ago at an IASP Meeting.

Dr. Stack: Yes. Currently, I have regularly attended the IASP meetings. I have been giving papers – usually 2-3 per meeting. I was honored to be a plenary speaker for the Asia-Pacific IASP in New Zealand, as well as the meeting in Tokyo.

Dr. Connolly: What else are you working on?

Dr. Stack: I am preparing a paper to be read at the annual meetings of the Society for the Scientific Study of Religion in 2021. It deals with the mediators of the link between religiosity and death by suicide. I explore the mediators with data from the National Mortality Followback Survey. It has data on 20,000 deaths including close to 1,800 suicides. The mediators dealt with include psychiatric factors such as depression, hopelessness, and anxiety, and a range of social factors such as marital status, income, job demotion, unemployment, as well as other conditions such as physical disability and illness preceding death by suicide. The main idea here is the extent to which, if any, religiousness will still predict lower odds at death by suicide once all these covariates of religiousness are teased out.

I've also been looking at the question of why some people publish more than others.

Dr. Connolly: David Lester must be the leader of the pack?

Dr. Stack: Yes. He's the most published psychologist, as well as suicidologist, in the world. We are actually doing a paper on gender and research productivity (citations, articles) among the most prolific suicidologists (those with over 70 papers on the subject of suicide as indexed in the Web of Science). These 110 researchers typically have few and often no sole authored papers in their most cited works. Much of the work comes from a core of clusters of researchers such as those centered around John Mann of Columbia University and Keith Hawton at Oxford.

I have a license to use a data set from the National Science Foundation on 40,000 PhDs. I published the first paper to systematically look at how children of different age groups affect research productivity of scientists. It is now (2021) one of my top 20 most cited papers. It came out in *Research in Higher Education* back in 2004 (321 cites). It explores the effect of children and their ages, marital status, the status of the university, etc. on number of reported articles by each of the 40,000 PhDs. I have published about a dozen papers on predicting research productivity.

My top twenty most cited papers (of 345 publications) contain five that have nothing to do with suicide. One of my top 20 most cited works (according to cites in Google Scholar) is a paper on predicting visits to pornography web sites using data from the General Social Surveys (356 cites). My most cited paper assesses marital status as a predictor of happiness (with 867 citations). Sometimes I think I might get back into happiness studies which might make me happier in my old age? I never published anything else on pornography or happiness. Unlike most researchers, most of my papers (my most cited ones) are sole authored. A few of the most cited papers in suicide studies by others have 200 co-authors. This reminds me of the old joke, something like, how many professors does it take to install a light bulb?

Dr. Connolly: What about the future of suicidology generally?

Dr. Stack: I'm not sure. I am not very conversant with the research that is being published on suicide in psychology and biology journals. I stick mainly to sociological research. Now (in 2021), there seems to be a great deal of attention to some topics while others are neglected. For example, there are now hundreds of studies on suicide in the military.

However, the military is just one occupational group of 630 groups covered in the Bureau of Labor statistics. Most occupations have never been studied in suicidology. That seems very odd.

Other strange and curious patterns exist. There are now thousands of studies on "suicide prevention," but they focus on behaviors short of actual deaths by suicide. Many of the suicide prevention studies should probably be re-titled "suicide attempt prevention" or "suicide ideation prevention" or "depression prevention." It may be a well-kept secret that most people who actually die by suicide have no history of a suicide attempt.

Another major problem in recent research is the lack of investigations of major national trends. During 2000-2016 the suicide rate increased substantially by over 30% in the USA. However, in most of Europe the suicide rate has declined-- about 22% in most nations, on average, over the same period according to WHO data. It would seem important for suicidologists to endeavor to understand why the rates in Europe are going down, down, while in the USA our rates going up. Possibly the USA could learn something from an analysis of what accounts for the big drop in Europe and, perhaps, import that understanding to address suicide in the USA. However, there needs to be caution here. Understanding long term trends in suicide may have little or nothing to do with the typical efforts at suicide prevention such as 1-800 crisis call lines and text lines. Major shifts in what sociologists call integration and regulation can go on behind the scenes (sometimes "upstream factors," so to speak), affecting mass rates of suicide-- either upwards or downwards.

Dr. Connolly: You have done some research on religion and suicide.

Dr. Stack: My first major article on religiousness and suicide was in *Journal of Health & Social Behavior*. It is one of the top journals in sociology and public health. I was very happy when I get that article in print back in 1983. Today (2021) it's one of my top 20 most cited pieces (317 cites according to Google Scholar). I developed a theory focused on religious commitment to a few core beliefs (e.g., life after death can assuage all manner of suffering-- divorce, unemployment, depression). The theory was supported using data from a large number of nations and their suicide rates. It has surprised me, as a sociologist, how few papers had been published on religiousness and suicide in the last century. More recently, in 2011, Augustine Kposowa and I found that such commitment predicted suicide acceptability in a large sample of persons in the World Values Surveys. However, measures of other aspects of religiousness-- religious coping, church attendance, and attending social events with co-religionists also predicted lower levels of suicide acceptability. That article has been cited in 184 other papers. One might say that some researchers are "bringing God back in," so to speak.

Dr. Connolly: That's fascinating. About twenty-five years ago, church attendance on Sundays was roughly 95%, and now it's down to about 40%.

Dr. Stack: That's exactly what I documented in the United States in a paper in the *Journal for the Scientific Study of Religion* in 1983. I looked at the period of 1950 to 1979, and I found the same thing. Church attendance among Catholics was cut almost in half and suicide

rates were up, especially among young people. The fall in church attendance in the United States was disproportionately among Catholics. Protestant attendance remained pretty much the same.

Dr. Connolly: What are your views on physician-assisted suicide?

Dr. Stack: I'm basically neutral.

Dr. Connolly: Well, we have covered a lot of ground here, haven't we?

Dr. Stack: I like talking about my work.

Dr. Connolly: More than about yourself? David Lester and I are doing this book of interviews, getting more personalized accounts from people in the field.

Dr. Stack: David has been trying to get me to finish my autobiography. I have about 150 pages, and one of my goals is to finish it. I have one chapter finished and one in draft form. I haven't worked on it for about 20 years and that's something I would like to do when I get the time. The longer I wait the more material I'll have!

Dr. Connolly: It's amazing that some people write their biography at the age of 25.

Dr. Stack: Life's not over then!

Dr. Connolly: It's hardly started. What do you feel about eternity?

Dr. Stack: As long as I am there with Barbara, eternity will be good.