INTERVIEWS WITH SUICIDOLOGISTS, VOLUME 5

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 (if they were living), have been placed on the website www.drdavidlester.net.

Volume 1	**Volume 2**	**Volume 3**	**Volume 4**
Alan Apter	Keith Hawton	Israel Orbach	Jan Beskow
Alan Berman	Antoon Leenaars	Antapur Rao	Yeates Conwell
Unni Bill-Brahe	John Maltsberger	M. David Rudd	Herbert Hendin
Diego de Leo	John Mann	Armin Schmidtke	Ad Kerkhof
Robert Goldney	Isaac Sakinofsky	Morton Silverman	Steven Stack
Kees van Heeringen			Mark Williams
Ronald Maris			

I am pleased to present the final volume, Volume 5, now on the same website. The interviews are with:

Volume 5

Margaret Battin
Silvia Sara Canetto
Thomas Ellis
David Jobes
Cheryl King
David Shaffer
Yoshitomo Takahashi

and two new interviews conducted by myself and an avatar
Michael Kral
David Lester (John interviewed me, but the recording is lost and so I re-created the interview)

INTERVIEW WITH MARGARET BATTIN[1]

Dr. Connolly: Tell me about your early years. Where were you born?

Dr. Battin: I was born in the United States and grew up in Washington, DC. I went to a private school in Washington for 13 years, the same school that Chelsea Clinton went to and later the Obama daughters. I had an extremely stable early life, with a family that was entirely supportive, free from friction. I can remember only one moment of friction in all those years. I have one sister, and though we fought a lot in the way that siblings close in age do, it was not fighting in any serious way. It was a highly educated, very affectionate, loving, supportive, excellent family. In my family, I know of no one who attempted suicide or died by suicide. Nor have I had any such experiences.

Dr. Connolly: Tell me about your parents.

Dr. Battin: They are both dead now. My parents were both PhDs; both got their degrees from Columbia University. My father was a statistician who worked for the Department of the Navy as an expert on quality control. We spent a year in India, in Calcutta (now Kolkata), when I was 17-18. He was sent by the UN Technical Assistance Program essentially to bring the techniques of statistical quality control to the subcontinent.

After he retired from the Navy, he was called up for jury duty but, because he had a PhD, that meant that one side or the other in a court case doesn't want you. In those days, the term of eligibility for jury duty was one month, and so he spent a month sitting on a bench in the courthouse. While he was sitting there, he constructed a way of reducing juror waiting time which used statistical techniques to ensure that every judge who needed a jury could have one, but you wouldn't have to make people spend a month waiting to be called. If you reduce the time for jury duty from one month to one day, then people would be much more willing to do it. He set up a research unit, the Center for Jury Studies, and was a pioneer of the one day/one trial system. Over the next dozen years, he developed this different way of jury utilization, and it is now universal in this country.

My mother was a PhD in mathematical economics. According to the folklore in the family, in those days, the PhD committee at Columbia consisted of a dozen people, and she was the only person to receive all 12 passes in the history of that department. She worked for the government during the war, although I do not know in what capacity. She never talked about her work. At the end of the war, the movement was for women who had worked to go back into the home. She spent some years as a housewife but taught piano and wrote books on teaching piano with some colleagues.

Dr. Connolly: Are you musical?

Dr. Battin: I was expected to take piano lessons when I was a child but, when I was about 13, it was evident that I did not have much talent, so I was allowed to take bar-room piano, and that was fun. I had a very unorthodox teacher. I played a lot in college after dinner for a dormitory full of love-sick young women. I was good at torch songs for which there was a ready market in that environment. I haven't played for a long time.

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[1] Original interview 2000; updated 2021.

Dr. Connolly: What about your religious background?

Dr. Battin: When my parents discovered that they were going to have a child, one was a Methodist and the other a Congregationalist, they decided that they would like their child to have "some religion but not too much." They explored several denominations and narrowed it down to two: the Unitarians and the Quakers. I've been brought up in a way that involves regular Quaker meetings, but in a non-doctrinaire way, so that it was ideal. No original sin, no guilt, no huge crushing blows of fate, no hell, but a strong commitment to peaceable ways of life. I'm not religious in the sense of being a theist.

Dr. Connolly: Was it a bookish household?

Dr. Battin: There were books everywhere; my parents were well-educated. When we moved, my little sister and I carted boxes of books around – especially on statistics. Their library was heavier on technical books rather than literary ones.

Dr. Connolly: What did you read?

Dr. Battin: The first adult book I read, at age 13 or 14, was on the paranormal, debunking all the claims made. It was interesting because it was so irreverent. Then I spent a summer reading all of Shakespeare. We lived in DC, and it was hot—this was before air conditioning. I read Shakespeare in the basement where it was cool. I had Shakespeare's Complete Works in one volume, and I read the whole thing through one summer. It was wonderful stuff. I spent another summer reading American political theory. I have no idea why I did that. I don't remember reading lots of novels, and I have never been a reader of trash fiction. There are some wonderful detective stories – Sherlock Holmes, etc.--but I don't like them if they involve some measure of gratuitous violence and killing.

Dr. Connolly: What about your teachers in those early days?

Dr. Battin: I had some wonderful teachers. I remember clearly my first-grade teacher as a benign influence. She created a safe, protective and stimulating environment. It was a select school. Classes were small, and the kids were smart. I did pretty well in school. I liked school, especially the stimulation. My fifth-grade teacher was partial to me. In sixth grade, we did a year-long project on South America (which I still have – in two volumes). That provided a sense of enthusiasm for working on a project for a long time. Now, I like to write books more than anything else. It also stimulated my interest in the rest of the world. I like to travel. It's important to see the less-developed world to realize how peculiar our circumstances are. Here in Miami [where this interview is taking place], I got in a cab and told him to take me to the most Cuban part of Miami.

Dr. Connolly: Any more teachers?

Dr. Battin: My art teacher in 7th grade wrote “too changeable” on my report card. I’d start one project and scrap it and start another. That comment stays with me. In my adult life, I always have a great many things going on, often more than I can manage. But the good side of it is that you have lots of things that are being juggled, and you don’t get stuck just working on one topic. It’s been very important for me in working on suicide issues to not only work on suicide issues. Although suicide has been my central interest - end-of-life and assisted suicide - I wrote books on aesthetics and organized religion, and I’m working on global population growth, large-scale reproductive issues, infectious disease and drugs and justice. It’s changeable, but I can’t confine my interest to one issue.

Dr. Connolly: What about high school?

Dr. Battin: I hated the history teacher; we mostly memorized dates. On the other hand, the English teacher was a small bent-over man who taught by modeling. He did the *New York Times* crossword puzzle every day and, without saying anything about it, all 50 students in his class would try to do the puzzle every day too. He also encouraged writing, and he helped me write easily and clearly. I took Latin and French. In college, I took German and Greek. Now I’m learning Spanish.

Dr. Connolly: Why Spanish in particular?

Dr. Battin: We live here in the Western hemisphere. Everything south of here is Spanish-speaking. It’s easy to learn if you know Latin and French. There are wonderful opportunities for using it. When I was interested in population issues, I wanted to spend time in countries where population issues are pressing, and that is where population issues are critical. Policies on birth control play a major role. I wanted to be able to talk to people in those places. I can do interviews in Spanish and talk to people in the streets.

Dr. Connolly: What are the hot spots in suicidology? Where are we going? What will suicidology be like in ten years?

Dr. Battin: In the last 20 years, I see some growing maturity in the field. When I first got involved with suicidology, it seemed to be only epidemiology or brain patterns. Brain patterns are important, but it seemed to be exclusively brain patterns and attempts to identify changes in the suicide rate. Now there is more on treatment and biology. In this organization [AAS], there is more interest in social issues and survivors. But I work on areas in this field, especially physician-assisted suicide, that are regarded as peripheral, marginalized and dangerous. It would be odd to speak of myself as a suicidologist in the sense of someone who studies suicide. Perhaps I could speak of myself as a theoretician of suicide and the ethical issues of suicide.

Dr. Connolly: What are the important ethical issues now?

Dr. Battin: The most important issue at the moment is whether suicide can ever be a reasonable, rational and morally acceptable choice and in what circumstances. The assumption in suicidology is that suicide is always a tragedy and always to be prevented. In a great

many cases, that is true. But there are many cases where that may not be true. Suicide can sometimes be an understandable choice, a reasonable choice, a rational choice and a moral choice, a choice that not only is a person entitled to make, but also entitled to have support with, including assistance. The question is what kinds of cases, and how do you separate these cases? The situations usually mentioned are terminal illness and physician-assisted suicide in terminal illness. Other situations are suicide in old age in the absence of terminal illness.

I started to think about this maybe 25 years ago. I have to keep re-thinking and re-thinking. It's still a live issue for me. Sometimes people take a position and stick doggedly by it their whole careers. I don't.

Dr. Connolly: What are your fears about physician-assisted suicide?

Dr. Battin: The fear that is commonly discussed is the slippery slope argument. If it were to become legalized and accepted, then wouldn't that harm vulnerable groups - the poor, the elderly, those with disabilities, those with mental handicaps, etc.? We've heard that argument many times. If I thought that was true, my opinion would be affected. I would have to change my position. I have been a supporter of legalization over the years. But this an empirical question that we can answer. This practice is legal in the Netherlands. It is legal in Oregon. Why don't go and see what happens? Over the last 4 or 5 years, I've been working on the data, consulting with people in both regions, to find out what the facts are. The assembled data are quite complex, especially for the Netherlands because there is so much data and over a long period of time – 16 years. In every one of those categories, the rate of assistance in dying in vulnerable groups is lower rather than higher than for those in non-vulnerable groups. So the slippery slope claims are wrong. That's been very engaging to work on.

That's how I like to think about things, to try and figure out what the question is and what assumptions are being made, and then challenge the assumptions. It turns out that assisted suicide is a privilege for people who are educated and richer and who don't have disabilities, mental illness or the other vulnerabilities.

Dr. Connolly: But those are the official statistics. We don't know the unofficial statistics. In Ireland, some doctors have admitted assisting people ending their lives, but this is not counted.

Dr. Battin: The data from Oregon concerns only legal cases, but the data from the Netherlands also covers illegal cases as well, reported and unreported cases, cases that meet the guidelines and cases that do not. Even with the illegal and unreported cases, you do not see that effect, of greater impact on people in vulnerable groups. There are legal requirements, such as being 18 years old, having two oral requests plus one written request separated by 14 or 15 days. But it isn't impossible for an older minor, an emancipated minor, to have a pretty good decisional capacity. There are very few of these cases, like a child with cancer, and they do allow a child who is dying to make the decision with the physician and the parents as to how the life might come to an end.

Dr. Connolly: What about people who are depressed or have a psychiatric illness? How long should you go on treating people with no improvement?

Dr. Battin: That's a more difficult problem because it's harder to see what the long-term outcome would be. If we thought we could retrieve someone from suicide and they would go on a long and happy life, then it is an easy decision. It is much more difficult when you retrieve someone or keep someone from suicide, but life continues to be wretchedly miserable and there is no way of alleviating it. Cases of chronic and extremely painful cases of illness would fit into that category, or untreatable and painful psychiatric illness. This is where the issues get hard for me. I'm torn in two ways. In one way, I see it as a person's basic and fundamental right to decide whether to continue with life. Part of me sees suicide as a fundamental right, but that doesn't mean we have to support the person and it doesn't mean that we should never interfere, because such decisions are often made in an errant way. But for someone's whose decision-making ability isn't impaired, we have to recognize the decision as a basic right. However, in practice, it is hard to sort out a clear decision that has to be respected from one that is confused, made under pressure, or made in a state of great turmoil, with lots of psychopathology involved. Almost all of the cases that we talk about in these meetings are like that. The hard thing is what to do about accepting or intervening in cases where the choice may not have been made in a very clear way, yet the person is facing a continuing life of real suffering. Those are hard cases for me.

This morning [at these meetings], a speaker talked of a case of a woman who had made a videotape of the suicide that she planned. The woman was in terrible pain. We need to know more about this pain. Was it chronic? Was it terminal? Was it a figment of her imagination that could easily be resolved with the right kind of therapy? We should never be in a position about judging whether someone else's life is good enough to keep going or not. That is a judgment that we should never make about other people. But we cannot assume that they should always keep going. We have to respect people's choices much more fully than we do.

Dr. Connolly: It is hard for physicians to decide between allowing suicide and assisting it or, as Hendin has said, putting someone to death.

Dr. Battin: That kind of language, "putting someone to death," is extraordinarily inflammatory and misleading. It's a phrase we only use in a penal context. To put someone to death is what a judge or an executioner does in exacting punishment. None of those features are present in physician's assistance in dying. It isn't the physician who decides whether or not the person is going to die. The underlying disease decides whether the person is going to die in cases of terminal illness, and what the person decides is whether it is to be later from the disease or now from assisted suicide. The only thing that the physician decides is whether to respond to the patient's request for help. That is very different from deciding to put someone to death. Some distortions of this issue are considerable, and there has been distortion of the Dutch data. The Dutch practice is not malevolent and, in fact, is open and forthright, and 90% of the population supports it. Physicians in general support the practice as well. About half of them have had occasion to do so at least once, and the proportion who say that they would never do it has dropped to 2%.

Dr. Connolly: What is interesting is why so many people do not choose suicide while some do.

Dr. Battin: In the Netherlands, 2.6% [about 4%, by 2021] of the total annual mortality choose assisted suicide. It is understood to be an option by virtually everybody. Every time I go to the Netherlands, which is pretty often, I talk to as many different kinds of people in different walks of life – people on the street, bus drivers, as well as the professionals. Everybody knows about this possibility. It is not a secret practice happening in some hospitals. It is a widely known, discussed and understood option. The thing that struck me most of all is what a Dutch physician once said to me, "we Dutch don't have to worry about dying as much as you Americans do." The Dutch don't have to worry as much about dying as we Americans do because they have this additional measure of choice. It doesn't mean they'll make the choice in that way, but they know that it is an option. It's a comfort whether it's used or not.

Dr. Connolly: I wonder, in countries where it is not legal, how much of it occurs.

Dr. Battin: There have been studies in Australia and six European countries, and, in all of them, assistance occurs. The rate without current, voluntary request is higher in all of those countries than in the Netherlands. So if you want safeguards, you would want assistance to be legal rather than in the background. There have studies in America too, and every study shows a measurable frequency of assisted suicide and active euthanasia. It happens underground. The old argument was that we shouldn't legalize it, we should just let sleeping dogs lie. That means we would just have a continuing underground.

Dr. Connolly: Are there other ethical issues of interest to you?

Dr. Battin: The ethical issues that arise in religious groups interest me. Issues about confidentiality, informed consent and confessional practices. These differ in the different religious groups. In the Roman Catholic church, for example, the priest must never break confidentiality of what he hears in the confessional, but concerns with confidentiality range all the way from the Catholic position of absolute confidentiality to groups in which confessed sin is a matter for the whole community—in these groups, it is the obligation of the religious officials to tell.

Even in the Catholic church, in early times, before the 6th century, confession was public, although the parishioner did not tell the clergy in private. In some evangelical groups in present-day America, the church member tells the pastor in private but then the pastor reveals it publicly.

Some religious groups teach avoidance of medical care or blood transfusions. I've studied Christian Scientists and Jehovah's Witnesses. I have also written on missionary practices like conversion and how aggressive missionaries should be. Perhaps missionaries shouldn't be aggressive at all, only mild. On the other hand, if you believe that something is at stake, like possible salvation, maybe they should be aggressive. Writing this book, *Ethics in the Sanctuary: Examining the Practices of Organized Religion* {Yale, 1990], was a lot of fun.

Dr. Connolly: What about abortion?

Dr. Battin: I'm working on book on global population and other large-scale reproductive issues. It has a chapter on abortion on a global scale. This book is built around a conjecture: what would it be like if there were available for women and for men forms of contraception that didn't require current involvement to work. You don't have to look in the bedside drawer or go to the pharmacist for them - in-dwelling, continuously active methods that work unless you remove them or neutralize them, like the IUD or the subdermal implant. These technologies are called LARC, for Long Acting Reversible Contraception. With them, conception requires an active choice. What would it be like if both the male and the female had LARC? What would that do to the abortion rate? It would presumably decrease it to near zero except for cases of fetal defect or risk to the mother's life that arise after pregnancy.

Dr. Connolly: Let's go back. What about college?

Dr. Battin: I graduated from high school and spent the best part of a year in India, when my father was there with the Indian Statistical Institute under the auspices of the UN Technical Assistance Program, as I said, and my mother and younger sister and I were there too. This was extraordinarily educational. We travelled extensively around India. I was 17-18 at the time. I delayed my entrance into college for a year and, when I did go to college, I had more world experience than most other students. I understood how engaging intellectual work could be. I went to Bryn Mawr, an elite women's college outside of Philadelphia. I majored in philosophy.

Dr. Connolly: Why philosophy?

Dr. Battin: An accident. You were required to take a philosophy course, and I took one in my first semester. It was so interesting and exciting with an excellent teacher, someone who made these issues compelling, that I got hooked. I thought about majoring in psychology, geology and other majors, but I majored in philosophy, and it was quite engaging.

I spent my junior year in Munich. Before I left for my junior year, my mother was diagnosed with liver cancer. We were living in Washington, DC, at the time. She had an extremely pioneering surgery and had a check-up just before I was supposed to leave, at which time it was reported to me that things were all right. Whether this was the truth or not, I don't know. But while I was gone, the letters that I got from home, after a long time, contained accounts of people coming to visit them, but no accounts of their going out to visit others. By the spring of my junior year, I finally got a letter saying that the cancer had returned, and she didn't have much longer to live. So, of course, I came home. Because I hadn't been exposed to the ongoing development of the cancer, I saw her situation in particularly vivid detail. She had good medical attention and all the care that she could get, and I remember this very vivid thought of, "Look how difficult this is. Why doesn't she have a choice in this matter?" This was the 1960s, before Elizabeth Kübler-Ross's famous book *On Death and Dying*, so no one ever said that you were dying of cancer. In those days, even when there was a steady downward progression, the patient was told, "Oh, you'll be better in the spring. Things are bound to get better. Hang

on. Keep going." My reaction was that this woman deserved a choice. She's smart, intelligent, brilliant, but is increasingly treated in a way that deprives her of any say in the matter and puts her on the progression to this standard-issue death. That's where my interest in suicide comes from. I have no idea what she would have done if she had had a choice. She might have gone all the way to the end. She might have said, "I'd like some help from my physician." But that she didn't have a choice was the thing that was the origin of my interest in suicide.

Dr. Connolly: Tell me about your academic career.

Dr. Battin: Many people in the field of suicidology have been affected by relatives, spouses or children who have died by suicide, or who has been troubled by suicidal ideation themselves. That is not true for me.

I got a degree in fiction writing as well as philosophy at the University of California, Irvine. Then I moved to the University of Utah. At first it was a one-year temporary job and then I won a substantial and impressive award, from the National Endowment for the Humanities for a year of independent study and research, 1977-1978. My position, a temporary one-year job, became a tenure-track position overnight, teaching me that academia is full of hypocrisy in the sense that acceptance by one important party makes you more attractive in the eyes of others. I've been very comfortable in the philosophy department at Utah, where I still am in 2021.

In that first year in Utah, 1975, I had a new boyfriend, a young English professor who had been at Harvard and who came to Utah in the same year as me. We fell in love. He asked me to go on a river trip during spring break, but of course I knew I needed to stay home for the break and write the grant proposal for the NEH Fellowship. Going on the river trip with my new love would leave me only 4 days to write the proposal. So, of course, I went on the river trip—but won the fellowship anyway.

I used that fellowship year to do a book on ethical issues in suicide, and at that time there was nothing on the issues. There was nothing to read except the historical figures: Plato, Aristotle, Thomas Aquinas, St. Augustine, Hume, Kant, Nietzsche and beyond. The resulting book, *Ethical Issues in Suicide* (Prentice-Hall, 1982), later trade-titled *The Death Debate* (1995), as well as my later comprehensive sourcebook of western and nonwestern texts, *The Ethics of Suicide: Historical Sources* (Oxford University Press, 2015), which has an associated online digital archive at http://ethicsofsuicide.lib.utah.edu including all 600+ pages of texts and more. All of this began with that early work.

There's one other thing I've done in suicidology that I'm proud of, since I think it makes a real difference to the field. This is a direct product of my training in philosophy, which emphasizes conceptual clarity and challenging assumptions that go unnoticed. Issues about "physician assisted suicide" had roiled the field of suicidology for a long time, with experts lining up on both sides of the question of whether it should be legalized and/or socially permitted. At one of the AAS meetings, I convened a little group of suicidologists who were generally favorable and invited them to articulate the differences between "suicide" and what we'd now call "physician aid in dying." This produced a draft, which was then circulated among opponents. Interestingly, there wasn't much disagreement between the proponents and the opponents except about the question

of overlap. That document was then accepted by the board of the AAS and is now an official statement of the organization. I was told by lots of people afterwards that this produced a sense of relief that the organization wouldn't need to squabble over these issues much anymore.

Dr. Connolly: There is a life outside of suicidology. Are you married?

Dr. Battin: Yes. I married after I graduated from college, and I have two children from that marriage. We had moved to California, and the marriage came apart. It had lasted 12 years and produced a boy and a girl. My daughter just had her second baby last week, and now [in 2021] I have several grandchildren and greatgrandchildren. They all live in different cities, so I don't see them that much. My son was a computer person in a hospital in southern California and is now co-owner of a medical software company. My daughter worked for a bank in Seattle and now works for the University of Washington. They seem to be thriving. I married again. I married Mr. Right after 10 years, the man I went on the river trip with instead of writing that grant proposal, and it's been an extraordinarily satisfying relationship.

I had done a lot of fiction writing, early on when life was not that happy. I haven't done much since then. I'm about to publish some of the fiction I wrote early on end-of-life issues and suicide.

Later, in 2008, what seemed to be tragedy struck. My husband, my second husband, Brooke Hopkins, a healthy, athletic English professor, was riding his bike downhill on a canyon road and collided around a blind corner with a bike racer doing sprints uphill. The other guy wasn't hurt, but my husband broke his neck - a nearly fully complete spinal cord injury at C3/C4. He was rescued by a fully trained flight nurse who just happened to be jogging by. The rest of the story is told in a *New York Times Magazine* piece by Robin Marantz Henig, "A Life or Death Situation" (July 21, 2013), and in a TEDMED talk I gave (https://www.tedmed.com/talks/show?id=309088) about a life of total paralysis from the neck down, about the deepening of a relationship, and about together declaring that "this is only a tragedy if we make it that way." It is also about his choice, five years after the accident, to have his ventilator removed and so die. Along the way I wrote a little essay, "The Irony of Supporting Physician-Assisted Suicide" (*Medicine, Health Care and Philosophy,* Nov. 2010), which looks at some of the deeper issues in what I'd always supported, physician aid in dying, but in a much more painfully informed way.

Dr. Connolly: Do you believe in the hereafter?

Dr. Battin: No.

Dr. Connolly: Do you believe in God?

Dr. Battin: I was religious for two weeks when I was 18. My sense of God then had to do with human community. I don't believe in God in any conventional sense, although I do believe in human capacities. There is an old Quaker teaching that, "There is that of God

in every man." In every person you meet, look for what is good in them. That is part of my belief system, my personal version of religion, if you can call it that.

INTERVIEW WITH SILVIA SARA CANETTO

Dr. Connolly: Tell me a bit about your early life. Where were you born?

Dr. Canetto: I was born in Ferrara, a town about 40 km north of Bologna, in the Emilia Romagna region of Italy. Ferrara is situated at the delta of the river Po, the longest river in Italy. It is a very humid area. In the winter it is frequently foggy. Ferrara, a UNESCO World Heritage Site, is most famous for its Castle, a massive building with four towers surrounded by a moat, right in the center of town. During the Renaissance the castle housed the court of the Dukes of Este.

Dr. Connolly: What did your parents do?

Dr. Canetto: My mother is a homemaker and my father a farmer. Neither completed high school. My mother finished what would be seventh grade in the United States. Like many girls of her generation, she was not viewed as deserving of, or needing more education. She was the oldest of three, two daughters and a son, who was the youngest of the siblings. Her parents wanted to save the little money they had for her brother's education. Her brother ended up not being interested in school and he did not pursue an education. My father came from a family with a better financial situation. He started high school. He did not like school and was not very good at school so he quit after his second high-school year.

I am the first in my family to get a high-school diploma. I completed the five-years Classics Lyceum (at the Liceo Classico Sant'Orsola) and received the top score in the final national exam (the "maturity" exam, l'*esame di maturitá*, as it is called in Italy). I am also the first in my family to go to university and to complete university studies. I have graduate degrees from the University of Padova, Italy, the Hebrew University of Jerusalem, Israel, and Northwestern University Medical School in Chicago, Illinois, USA.

Dr. Connolly: What the influence did your parents have on you in your early years?

Dr. Canetto: In many ways my teachers had a stronger influence on me than my parents. I started first grade when I was barely five (instead of age six, as required in Italy). The reason I started elementary school one year early is that a cousin who lived across the street started first grade one year early. We were born a month apart. Our families treated us like twins--including dressing us the same way. Her mother was an elementary school teacher. My cousin wanted to go to school with her mother, so my aunt arranged for my cousin and I to informally be in the first-grade class of a colleague in her school. My cousin and I were clandestine first-grade students. At the end of the year we took an exam to be admitted to second grade.

I developed a strong attachment to my elementary school teacher, maestra Artioli. As customary in Italy, she was our teacher for the five elementary-school years. She was very complimentary about my school performance, effusively lauding me for my school work. I loved school. I loved learning. I loved reading.

Dr. Connolly: Which books?

Dr. Canetto: Any. My mother told me that as a small child, when I was sick, if I had to undertake an unpleasant medical treatment, for example, an injection, I would always ask for a book, "*a librino*," as a reward. As an older child I would hide in the vineyard or in the chicken coop to read and to avoid doing boring household chores, like dusting.

For most of my childhood, I lived with my extended family in a large house with a big fenced vineyard in the back. The household included my mother, father, and younger sister, as well as three cousins, their mother, my father's parents, and an uncle. These relatives moved into my parents' house a few months after I was born, following the death of my uncle, the father of the three cousins. The house was large but the family (11 people) was larger than the house so I never had a bedroom of my own. Not even a shared bedroom. I slept in a corridor, behind a movable partition.

Dr. Connolly: Did you like the farm?

Dr. Canetto: It was not a farm. It was a big house; a house connected with work and storage buildings, buildings for mechanics work and storage spaces for tractors, agricultural machines and tools, coal, fertilizers, and the like.

Dr. Connolly: What kind of farming did your parents do?

Dr. Canetto: It depended on the year. When I was a child, they grew rice. I loved the rice fields under water. The area used to be a wetland. Water has to be constantly pumped out to cultivate it. Growing rice brought water back to the land. All sort of birds lived in the area. Pears, apples, and peaches were also crops when I was a child. My recollection of farming is that it involved constant uncertainty, and therefore constant anxiety, about the weather, about the value of the crops, and about labor expenses. I remember the adults looking at the sky to see whether bad weather, especially hail, was forthcoming and might destroy the crops. We children were not shielded from farming anxieties.

Dr. Connolly: How did your mother's disappointment about not getting an education affect her?

Dr. Canetto: She told me that, when she was young, she cried a lot about not being allowed to continue her studies. She wanted an education, but there was nothing that she could do to stay in school. She had a little bit of training as a seamstress because that was a trade that her family thought was appropriate for a woman. She expressed bitterness toward her younger brother because family resources had been set aside for his education but, when his turn came, he did not study.

Despite her regrets about not getting an education as a child, my mother was not enterprising enough to get a high school diploma later in life. As an adult, she enjoyed the arts. She would occasionally go to the theater or visit Ferrara's palaces and museums. Also, for many years she served on a poetry award committee in her natal village.

Dr. Connolly: Tell me about religion and spirituality in your family.

Dr. Canetto: I have had substantial exposure to Christianity and Judaism. I have also read the so-called sacred texts and interpretative treatises of other religions, specifically Islam, Hinduism, and Buddhism. I am curious about religion. I can see what religion offers. I can see why people are drawn to religion. It gives people anthropocentric answers to the human quest for meaning and purpose and, in some religions, the promise of eternal life. It also provides certainties about issues that we do not know anything about, like where we come from or what happens after we die. Personally, I am fine with not knowing where we come from. I am also fine with individual death. I do not find appeal nor consolation in Christianity's or Islam's ideas of an eternal life. Quite the opposite. In Christianity and in Islam, eternal life requires bargaining with an elusive, narcissistic God. To me the idea of a personal God who, with proper adulation, grants individual favors as well as eternal life with physical resurrection is inane.

Dr. Connolly: What did you do after elementary school?

Dr. Canetto: After elementary school, at the age of 10, I went to a boarding school with my cousin Alda, the same cousin I went to elementary school with. I lived in the boarding school until I was 17. In the early years of boarding school, we typically went home twice a month, and just for a day. In later years we were allowed to go home every weekend, also for a day. During the last year of high school my parents moved to Ferrara where the boarding school was located. So for that last year I lived with my parents and attended the boarding school as an extern. My parents were very rigid and very intrusive, and so I felt less free, psychologically for sure, when I lived with them than when I lived in the boarding school.

Dr. Connolly: Was it a good school?

Dr. Canetto: Yes, it was considered a very good school. It was an academically-demanding prep school. It offered a so-called classics curriculum. We studied Ancient Greek and Latin every day. We also studied Ancient-Greek and Ancient-Roman history and literature, European philosophy; French and Italian history and literature; as well as physics, biology, chemistry, and mathematics. No English language classes and no psychology classes were offered in a classics high school. Classes were small, under 20 students. We were tested all the time. The learning was rote; with no discussions in class. We did not have access to newspapers, radio, or TV; only to the textbooks selected for our classes.

Dr. Connolly: Did you take an interest in those things?

Dr. Canetto: Yes. I took an interest in ancient and modern Mediterranean/European philosophies and literature. I considered pursuing university studies in those disciplines, but my strongest interest at the time was medicine. I really wanted to study medicine. My hometown, Ferrara, has a very good School of Medicine. Bologna, a town 40 km from Ferrara, has a world-renowned and very old School of Medicine. But if I studied medicine at either the University of Ferrara or the University of Bologna, I would have had to live with my parents because my parents were opposed to my living independently. They

made it clear that they would not support my studies if I moved out to study medicine at the University of Bologna.

My priority at the time was to move out of my parents' home. A couple of high-school classmates told me that they were going to check the psychology program of the University of Padova, 80 km away from Ferrara. I joined them in their visit to the University of Padova. They settled on psychology as their university path and started searching for an apartment in Padova. Their parents were friends of my parents. It was clear to me that studying psychology in Padova would be a way to overcome my parents' opposition to my moving out. Padova was further away from Ferrara than Bologna; it was also not as well served as Bologna in terms of trains. I figured that my parents might not like me commuting daily to Padova, especially taking evening trains back in the winter when it is dark early. I also figured that my parents would have a harder time opposing my moving out if their friends approved of their daughters doing the same. So I decided to study psychology. My friends' parents persuaded my parents to allow me to live in Padova with their daughters, and we rented an apartment in Padova.

Prior to starting university studies, I had never taken a course in psychology. Psychology was not part of my high-school curriculum. I had no idea what to expect from my psychology classes. I did not know if I would find psychology interesting and if I would do well in psychology. In high school I had a lot of practice studying; and I was and have always been interested in learning; about anything. At time of starting university, I was eager for new experiences. I applied myself to psychology as I had applied myself to other subjects in high school. I studied all the time and I did very well in psychology.

I found most psychology courses interesting. Because my original desire was to study medicine, I chose the physiological-psychology track. It was a track with more biology, anatomy, and physiology courses.

Even though I was still thinking about medical school, I decided to complete the psychology degree, and then see what to do next. I am someone who likes to finish what I begin. As I said earlier, during my University of Padova years, I studied all the time. I also took summer courses to get ahead. So I completed the requirements for graduation (that is, courses, practica, internship, and research thesis) in record time. I became a Doctor of Psychology at age 21, and with the maximum of points (110 e lode, summa cum laude).

In my last year at the University of Padova I wondered how I would continue in a professional path and at the same time support myself and live independently. Nearly all psychology students who graduated in my same year had started their university studies earlier. Therefore they had more psychology work experience and more professional networks than I did. I had been a fast-moving and academically successful student, but I was not competitive for employment in psychology upon graduation. I was aware of my liabilities in the job market. I knew I had to find a different path, an unconventional solution to my situation and professional goals.

I thought about pursuing opportunities outside of Italy, but I had no idea how to find them. Also, I did not know anybody who had gone the international route. It was not a common choice at the time. One day while at the Bo' palace (which at the time was the University of Padova's administrative building) I saw, in a bulletin board, an announcement about a Ministry of Foreign Affairs' program for international

scholarships. These scholarships were for postdocs from any university discipline, and for artists. It was a very competitive program. Without guidance nor mentoring, I applied to four of these scholarships: one for the USSR, one for the United States, one for Canada, and one for Israel.

To my great surprise, I was awarded one of the two one-year scholarships to Israel. My parents were also surprised that I had been chosen for a funded post-doc in Israel. They did not think that I was prepared for it, psychologically and practically.

I was also aware that I was not prepared for a year of studies and research in Israel. To start with, I did not speak English. My high-school curriculum did not include English; only French and only during the first two of the five years of high school. I had passed the very basic, written English-comprehension exam required for graduation by the University of Padova. But I was in no way ready to function in English, and in academic environment.

But I was determined to take the opportunity that so unexpectedly had been offered to me. It was either jumping into the unknown, or professional stagnation and economic dependence on my parents. So I accepted the scholarship to Israel and decided that I would figure things along the way.

Dr. Connolly: Were your university teachers inspiring?

Dr. Canetto: A few were inspiring. The most popular psychology track at the University of Padova was clinical psychology. It was a psychodynamically-oriented track. I didn't find psychodynamic psychology appealing. It made no sense to me. It did not have an empirical foundation. Also, critical thinking was not welcome in psychodynamic psychology classes. Professors and students treated psychodynamic texts and ideas as dogma. Students idolized the psychodynamic-psychology professors, so the psychodynamic classes were intellectually stifling. In those classes you were treated as if you had been disrespectful of the instructor if you asked critical questions. So I decided that the clinical-psychology track was not for me, and chose to enroll in the experimental-psychology track, specifically, the physiological psychology track. That track fit my interest in medicine and in science.

Eventually I connected with a small group of behaviorist professors and students. The behaviorist approach was attractive to me because it was grounded in the scientific method and it was based on research. In behaviorism, ideas did not have authority based on the status of the person who proposed them. They had authority if systematic empirical evidence supported them; and they would be discarded if empirical support was not sustained. In the behaviorist group, critical questions were welcome. Logical argumentation and accountability to the scientific method were expected.

At the time few psychology students were interested in behaviorism, so the behaviorist classes were small, which meant that students had easy access to the professors. The behaviorist professors were the professors I most learned from. I became close to some of them and stayed in touch with some of them even after I left Italy. I just saw two of them this past summer: Professor Meazzini in Venice, and Professor Sanavio in Padova. Professor Sanavio was my thesis advisor.

Dr. Connolly: What research did you do for your dissertation?

Dr. Canetto: For my University of Padova's dissertation I did behavior-modification research. My dissertation was on toilet training with long-term-institutionalized, profoundly-impaired individuals. Professor Sanavio, my advisor, had become a consultant for Padova's State Psychiatric Hospital in a ward with profoundly-impaired individuals. Many of these individuals had been in the locked wards for years; some for decades. Whatever brought them to the psychiatric hospital was forgotten and, in many ways, irrelevant at the time of our intervention. Their functioning had become severerly impaired, across domains, as a result of of being locked in a psychiatric institution for so many years. Many were incontinent.

Professor Sanavio invited two of his advisees, Vilma Bittante and I, to join him as clinical research assistants at Padova's State Psychiatric Hospital. We were charged with assessing the situation and then proposing and implementing a behavioral intervention.

As noted earlier, a problem for many of the long-term-institutionalized individuals was that they were incontinent. Their incontinence contributed to their being neglected by staff and treated if they were not quite human. Vilma and I thought that an important contribution we could make to these individuals' quality of life was to address the incontinence via a toilet training program, to set the foundation for a different relationship with staff, and to increase the likelihood that staff would reengage with them and treat them more respectfully.

For my thesis, I developed, implemented, and reported on the findings of a toilet-training-program for encopresis. Vilma did the same for enuresis. Our interventions were based on Azrin's and Foxx's toilet training method, a method that was published in a 1971 *Journal of Applied Behavior Analysis* article.

The toilet-training intervention was not easy work. It was also not glamorous work. In the short term our interventions were successful. The interventions were meant to serve as a demonstration, as pilot studies to be followed up by similar interventions with other individuals. I do not know whether, in fact I doubt that. our interventions were offered to other individuals or continued with the individuals we had worked with, after we left.

Dr. Connolly: Italy has now closed all the mental hospitals. Are conditions better there now?

Dr. Canetto: Italy has a national health care system that covers mental health. There is variability in health-care availability and quality by region. Some regions invest in healthcare, including in mental healthcare, while others do not. My region, Emilia Romagna, has a history of strong support for social programs, including healthcare. In other regions that is not the case. Following the Mental Health Act of 1978, also called riforma Basaglia by the name of its main proponent, psychiatric hospitals were closed. They were replaced by a community-care system. I worked as a trainee in Italy's mental-health care-system until 1977.

Dr. Connolly: Then you moved to Israel?

Dr. Canetto: Yes. I moved to Israel in the summer of 1977 to start the Ministry of Foreign Affairs-funded, yearlong postdoc. The postdoc scholarship did not set specific

expectations about what needed to be accomplished by the end of the year. The focus of my postdoc research was biofeedback; my supervisor was Dr. Friedlander of the Hebrew University of Jerusalem.

The Hebrew University of Jerusalem had a large program of classes in English, so that year I took some psychology (and other topics) classes in English. That was very difficult. When I arrived in Israel I could understand English well-enough to pass the TOEFL exam, a requirement for the scholarship. But from passing the TOEFL to taking classes in English was a huge jump. Whenever possible, I opted for Pass/Fail. Still I had to drop several classes because I could not keep up. I could not understand what was said in class, and I could not read fast enough. During that first year I also took Hebrew-language classes (called the Ulpan, in Hebrew).

By the middle of that first year, despite the challenges, I decided to try to pursue studies as a regular student at the Hebrew University of Jerusalem. I applied for admission in the clinical-psychology graduate program. I was offered admission in the general psychology program. The boundaries between the clinical and general psychology programs were fluid so I ended up getting both general and clinical psychology training. To support my graduate studies in Israel, I had applied for renewal of the Italian Ministry for Foreign Affairs scholarship. The scholarship application was successful.

Admission in the Hebrew University's graduate psychology program marked the end of my status as a visiting postdoc who could rely on classes taught in English and who could take and drop classes at will. I had entered a program designed for Israeli students. Nearly all classes were in Hebrew, and most of the texts were in English. The graduate program had a structured curriculum with progressively more advanced, required courses. All of this was a big challenge. To survive, I traded help with the Israeli students. For example, I gave them my notes from the class-readings in English in exchange for an oral summary of what had been covered in class in Hebrew and which I could not follow.

Once I advanced beyond the basic coursework, I had to find opportunities for clinical training--opportunities I was woefully noncompetitive for, given my low-level Hebrew, especially my reading and writing skills. Eventually a substance-abuse treatment center accepted me as a trainee. Learning to do clinical work in Hebrew was rough; but during my last six months in Israel I was doing assessments and therapy in Hebrew. The hardest task was writing case notes in Hebrew.

For my thesis, I drew on my physiological-psychology training. I sought opportunities for lab research involving animals, so I didn't have to deal with language issues. I connected with a psychobiologist, Professor Judith Jay Ganchrow, in the Department of Oral Biology, School of Dental Medicine of Hadassah Hospital. She offered me, and I accepted to work on studies of the development of taste in rabbits and rats, with funding from the Israeli Center for Psychobiology. Animal lab work was perfect for my skills and needs at the time. Rabbits and rats do not speak a human language. Animal lab work did not require knowledge of English or Hebrew! My Hebrew University thesis was on anatomical and behavioral aspects of taste in rabbits, and my first publication in English was a *Developmental Psychobiology* article on behavioral displays to gustatory stimuli in new-born rat pups.

During my fourth year in Israel, I applied for clinical internship positions in Jerusalem. This meant competing with many Israeli students for few positions. I was not competitive for those positions given my rudimentary written-Hebrew skills, although my spoken Hebrew had improved. Not surprisingly, I did not obtain an internship.

My plan B was a third round of graduate studies in the United States. I was still interested in the United States. The United States was one of the places I had originally applied to go to, via the Italian Ministry of Foreign Affairs scholarship program.

I applied for admission to a U.S. doctoral programs in clinical psychology. One of these programs, the Older Adult and Clinical Psychology Program of Northwestern University Medical School, in Chicago, offered me an interview. Normally the interview was conducted in person. Because it was impossible for me to travel to the United States for an interview, the director of the program, Professor Gutmann, found a Hebrew University's colleague, Professor Shahanan, to interview me in Israel. The interview, which was conducted in Hebrew, went well. I was offered admission, which I accepted.

I had never been in the United States. I had no idea what to expect. I booked a flight from Jerusalem to Chicago with a long stop-over in Rome and asked my parents to meet me at Fiumicino airport, for a goodbye. This time I was going to cross the Atlantic Ocean, not just the Mediterranean sea. It felt like I was leaving for the moon. I gave my parents a will in case I never returned to Italy.

This was 1981. I was about to start a doctoral program in English in an Anglophone country. My written English was not bad. I was slow but good-enough at reading and writing. My oral English however was weak, especially my comprehension. During my first year in Chicago, I could barely understand what was going on--in class, in clinical settings, and in daily life.

It is at Northwestern that I started doing research on suicide. During my first semester, I was assigned to work as paid research assistant for a new study of suicidal behavior led by a psychiatrist, Dr. Feldman. It was a study of couples in which one partner had been hospitalized, because of suicidal ideation and/or behavior, in the inpatient units of Northwestern Memorial Hospital. Dr. Lupei, a psychologist, and I were in charge of data collection, which included recruitment, admnistering surveys and projective tests and conducting interviews.

Dr. Connolly: Had you studied suicide before?

Dr. Canetto: No. This was the first time. I was a research assistant for the study for five years. Data collection was slow because the study involved couples, and also because we interviewed the suicidal person and their partner at a time of crisis. In any case, when it came time to choose a dissertation topic, I proposed a study that drew on the suicide-project data I had been collecting as a research assistant. Most of the study's suicidal participants were heterosexual women so my dissertation focused on suicidal women and their male partners. For my dissertation I used both structured/quantitative (i.e., survey) and less-structured/qualitative (i.e., interview) data.

I was awarded a Ph.D. in Clinical Psychology, with a specialization in older adulthood in 1987 following a clinical internship at Chicago's Michael Reese Hospital. Given the clinical-practice focus of Northwestern University's Medical School program, my first job was clinical. The year before I finished my Ph.D. and the year after, I was

one of two family psychologists in the Treatment Center of Chicago's Martha Washington Hospital, the substance abuse unit of the hospital.

In 1983 I started attending the conferences of the American Association of Suicidology (AAS). My goal was to learn from and network with people in the field; and also share my research. I presented the early findings of the Northwestern University's study at the 1984 Anchorage, Alaska, AAS meeting. Professor Maris, who at the time was the editor of the journal *Suicide and Life Threatining Behavior* (*SLTB*), attended my talk and then asked me to submit to *SLTB* a manuscript based on the presentation. My first *SLTB* article came out in 1989.

In the meantime, work as a family psychologist at Martha Washington's Treatment Center had become less and less fulfilling. My relationships with clients were good, so that part of clinical work was rewarding; intense and often emotionally demanding but rewarding. But the Treatment Center's professional environment was intellectually stifling. I was expected to do things the way they had always been done, without asking questions. And the ways things had been done, the center's established practices, were based on Alcoholics Anonymous (AA), not on science. I proposed evaluating the center's practices so we could systematically assess and learn from our experiences. My evaluation proposal was not supported. I also proposed adopting empirically-supported practices, like harm-reduction approaches. The response was to stick to the AA protocol and to generate billable hours.

To get a perspective on my situation and options, I reached out to Professor Lebow, a Northwestern University Medical School's former family therapy supervisor. After hearing about my experiences, he asked if I had thought about going into academia. I had never considered it. I could not consider it, I told him, because I had no experience teaching. Northwestern clinical psychology students did not learn how to teach because there was no undergraduate program in the medical school campus. Also, I did not have a research program.

In any case, it was clear to me that it was time for a job change. I started applying for jobs. Professor Lebow's question had prompted me to consider, for the first time, academia. All but one of my applications were for clinical positions. The academic job was a one-year visiting assistant-professor position in the Department of Psychology of the University of Montana. This position caught my attention because it was advertised in July for work that began in August. Clearly they needed someone quickly. The fact that it was a last-minute opening, and for a year, was perfect for me. This could be my experiment with academia.

I was invited for an interview for the University of Montana position. I had my interview at the beginning of August, at the 1988 Atlanta conference of the American Psychological Association (APA). I was offered the position on the spot. I returned to Chicago eager to set in motion another major life change. I resigned from my position at Martha Washington's Treatment Center and closed my private practice in downtown Chicago. By mid-August I was driving West, through forest fires, to get to Missoula, Montana, for my first year as a university professor. The director of clinical training, Professor Means, and his wife hosted me in their house while I looked for a place of my own.

To succeed in academia, you need a research program. When I started at the University of Montana, I didn't have a research program. My most substantial research

experience had been five years as research assistant for the suicide study. To establish a research program and a research record, I developed a manuscript from my dissertation study on suicidal women and their male partners and submitted it for publication. The article based on my dissertation came out in *SLTB* in 1993.

Another step I took to establish a research program and record was to articulate, in writing, my theoretical framework and my research questions. Questions of gender and culture had become central for me, personally and professionally, as a result of my migrations and of the languages I had learned as a result of the migrations. Having lived in countries (Italy, Israel, and the United States) that were very culturally different from each other, I had experienced the variability in beliefs, attitudes, and norms about women and men of these different countries, and the impact of these beliefs, attitudes, and norms on women's and men's lives. Having lived in countries where different languages were spoken (among them, Italian, Hebrew, Arabic, French, Spanish, and English), I had also experienced the ways in which language reflects and reinforces gendered beliefs, attitudes, norms, and behaviors. I wrote my first theory paper about gender, culture, and suicide drawing on these culture and language experiences. In that paper, which was published in 1991, I used cultural and gender lenses to examine the U.S. suicide "attempt" and substance abuse literatures. I theorized that, in the United States, suicide "attempts" and substance abuse function as gendered idioms of distress, as gendered life-threatening behaviors. One of my arguments was that in the United States the commonalities between the two behaviors had been overlooked due to the femininization of suicide "attempts" and the masculinization of substance abuse. A consequence of the femininization of suicide "attempts" was, in my view, that the suicidal aspect of overdoses had been missed, especially when overdoses involve men.

Many of the ideas of that article have been the foundation of my later scholarly work. An idea from that article that I have carried forward and developed later is that, in the United States, suicide "attempting" has been feminized--the word "attempt" itself implying indecisiveness and failure, though in suicide "attempts" the person survives. A focus on language has been a constant in my scholarship. Another idea that I have developed in later work is that, in the United States, suicide "attempts" are considered a symptom of the person's (usually women, in the United States) psychological flaws while substance abuse, in the United States, is viewed as the manifestation of the person's (usually men, in the United States) diseased state, something the person is a victim of.

Dr. Connolly: What you think is most important in your research?

Dr. Canetto: For a number of years I have been studying patterns and meanings of suicidal behaviors in women and men across cultures. I have highlighted the cultural variability in women's and men's suicidality, nonfatal and fatal. I have also brought attention to the commonalities in women's and men's suicidality across cultures. A commonality, a pattern, in many countries, including in the United States, is that women are more likely to engage in suicidal behavior but are less likely to die of suicide than men. In a 1998 *SLTB* article, Sakinofsky and I called this pattern the gender paradox in suicide. In that article we noted that the gender paradox is not universal; specifically, that the gender paradox in suicide is not consistently found *across* countries and that it is not consistently found *within* countries, when patterns of suicidality are examined by other dimensions of

social classification, like age and ethnicity. The United States is a country where there are exceptions to the gender paradox of suicide when the suicide data are disaggregated by age and ethnicity. For example, among U.S. older adults, nonfatal suicidal behavior is similarly infrequent in women and in men. These exceptions indicate that the gender paradox of suicide is not about women as women, or about men as men. It is about gender cultures of suicide. Whether the gender paradox occurs or not depends on the meanings of suicide, nonfatal and fatal, for women and men, in different cultures.

In my research I have sought to explore gender and suicide questions through a diversity of methods. I have done studies of beliefs and attitudes about women's and men's suicidal behavior. I have also interviewed women and men who survived a suicidal act in order to understand the events that, from their perspective, led to the suicidal behavior. And I have done studies of documents (e.g., suicide notes or diaries) left by women and men who died by suicide to get a sense of what these women and men identified as their suicide motives.

My studies have been inspired by and have built on the work of both suicide scholars and of gender scholars. They have drawn on the theory, method, and findings of, for example, anthropologists like Andriolo and Rubenstein, historians like Kushner, psychologists like Eagly and Marecek, and sociologists like Kimmel and Ridgeway.

Many of my students have been collaborators in my suicide studies. For example, my former student, Dr. Cato and I examined the suicide beliefs and attitudes of U.S. lesbian, gay and bisexual (LGB) youth, drawing on evidence that, in the United States, suicidality is more common among LGB youth than among heterosexual youth. In our studies we found that suicide was viewed as more permissible by LGB youth, and under a diversity of conditions, not just following LGB-specific difficult experiences, like "coming out." Our studies' findings, together with those of other studies, suggest a script of suicidality as expected and almost normalized by and for U.S. LGB youth. I plan to do more research on LGB suicide scripts, and also more studies on the suicide scripts of older adults.

Dr. Connolly: Do you have other plans for research?

Dr. Canetto: I have plans to do more research on assisted suicide and euthanasia. I seek to understand how the psychology of suicide differs from the psychology of assisted suicide, and what may contribute to the difference. When someone assists you in bringing about your death, as in the case of assisted suicide and euthanasia, some of the agency shifts, from you, the person whose death is hastened, to the person who assists you in hastening your death.

In the United States, and in other countries where studies of unassisted and assisted suicide have been conducted, unassisted and assisted suicide have different patterns by sex. In Oregon, the first U.S. state to legalize assisted suicide, men are more likely to kill themselves than women, but women and men are equally likely to die of assisted suicide. In the Netherlands, where both assisted suicide and euthanasia are permitted, unassisted suicide is more common among men while euthanasia, the most-performed hastened-death practice, is more common in women. I am interested in understanding what accounts for women being less likely to die by suicide but being equally as likely, or more likely than men to die by assisted suicide or euthanasia.

My research and research by others indicate that, in the United States, killing oneself is considered a masculine act. The English language of suicide itself reinforces an association of suicide with masculinity. Think about expressions like 'successful" suicide, "completed" suicide, and "taking" one's life. These expressions frame suicide as a relatively powerful act. Is not it interesting that in English a suicidal act is called "successful" when fatal?

In assisted suicide, someone provides the means for death. In euthanasia, another person uses the means to hasten the petitioner's death. Assisted suicide in the United States and in the Netherlands, and euthanasia in the Netherlands, are deaths that have been bureaucratized and medicalized. They are deaths by application, deaths that require approval by physicians. In Oregon permission for assisted suicide requires oral and written petitions, forms, witnesses, and waiting periods. Therefore, based on dominant gender ideologies, assisted suicide and euthanasia are more conventionally-feminine deaths, as I wrote in a 1995 chapter on older adult women and suicide. Physician-assisted suicide and euthanasia do not have the defiant and transgressive connotation of suicide—they do not have suicide's conventionally masculine edge. They are deaths that involve less agency, that have less transgressive agency than suicide. They are deferential self-initiated deaths; subdued self-initiated deaths.

Given dominant gender beliefs, it is therefore not surprising, in my view, that women are more numerous among those dying by assisted suicide/euthanasia than among those dying by unassisted suicide. In a study we published in *Omega*, Hollenshead, my former student, and I analyzed documents (e.g., letters, diaries, interviews) from and/or about individuals, mostly older adult women, whose suicide had been assisted by Dr. Kevorkian, a Michigan male pathologist. We sought to understand the psychology of assisted suicide, and also the role of significant others in the assisted-suicide decision and implementation. We also examined the U.S. cultural narrative of assisted suicide, specifically what made assisted suicide culturally meaningful and appealing for the people, again mostly (72%) women, whose suicide was assisted by Kevorkian. Incidentally, most of those who died with the assistance of Kevorkian were described as "White"--which means that there is also an ethnic specificity to the assisted-suicide appeal. In any case, in our study we wished to elucidate the role that gender ideologies might play in women being the majority of those whose suicide was assisted by Kevorkian. What was the financial and care situation of women who died with Kevorkian's help, we wondered; and how might women's socialized low sense of entitlement have affected their assisted suicide decision, considering also that they were older, often affected by chronic and disabling conditions and in need of care? Also, did the mediation and approval by an authority, in the case of Kevorkian, a male authority, contribute to women's over-representation among the suicide assisted by Kevorkian? As we expected, we found substantial evidence in support of our hypotheses regarding the role of gender norms (including women's socialized low entitlement and women's socialized deference to male authority) in women's decision to seek suicide with the assistance of Kevorkian. Because of the nature of the data, the findings of our study raised more questions than they provided answers. We need more research on what leads people to seek an assisted suicide, specifically, research on why older adult women die by suicide at high proportions only when the suicide is assisted.

Dr. Connolly: It's a resurrection of the ancient Indian custom of suttee.

Dr. Canetto: In some ways, yes, women's assisted suicide is like a suttee by Hindu widows. And in other ways it is not.

In suttee, women are burnt alive on the funeral pyre of their deceased husband. Some have argued that suttee is a choice. The meanings and social consequences, for Hindu women, of widowhood, make it obvious that suttee is not a choice. For example, being a widow is considered an aberration in Hinduism. Women are supposed to die before their husband, or together with him, never after. It is believed that a husband dies before a wife because of sins she committed in this or in a previous life. According to Hindu beliefs, via suttee a widow can be redeemed from the presumed sins. Via suttee she can also bring great fortune to herself and her kinship. Therefore, when widows do not resist suttee, it is because they have been culturally inducted into it; because they have been socialized to believe that suttee is their duty. And also, likely, because they know that the alternative, life as a widow, would be dreadful. Like Hindu widows, the women whose death was hastened by Kevorkian appear to have been culturally inducted into the idea of assisted suicide as a virtue, and even a duty, when older, affected by chronic illnesses and disabilities, and in need of care.

At the same time there are important differences between suttee and assisted suicide. In the many documents we examined for the Kevorkian study, we found evidence that the women whose suicide was assisted by Kevorkain were concerned about being a burden, and that these concerns played a role in their assisted suicide. By contrast, based on the literature on suttee I have reviewed, a subjective sense of being a burden is not what drives widows to suttee. What drives widows into suttee is the belief that being a widow is the consequence of sins they committed; and the belief that widows can and should erase the sins via suttee. For sure, Hindu society views Hindu widows as undeserving of resources. The killing of widows via suttee is how Hindu society prevents widows from accessing the resources of the family they married into--the resources that widows also contributed to with their labor. Widows may be driven to suttee also by the horrendous life that widows are forced into, including being banned, without possessions, to an ashram, a widows' house. Bottom line, in Hinduism, widows do not have good life choices, only a "good" suicide "choice." Still, there are accounts of widows being physically forced into their husband's funeral pyre.

In addition to research on women and assisted suicide, I have done research on women and on so-called "mercy killing," using data from The Hemlock Society. How I obtained access to the data is an interesting story. I met Derek Humphry, one of the founders of The Hemlock Society, at a AAS conference. He told me that The Hemlock Society had data on euthanasia and on mercy killing. I asked whether the data were available. He said that I could ask the society to send them to me, which I did. Once I received the data I decided, with Hollenshead, my student and co-author, to examine the profiles of the mercy killers and the mercy killed. We found that the mercy killers were typically men and the mercy killed, women. Evidence that the mercy killed had a wish to be killed was absent or questionable. For example, a statement like "Please help me," had been interpreted by the mercy killer as a death request, according to The Hemlock Society data. In The Hemlock Society data there were indications that some of mercy

killed had felt discouraged by their condition; but from that to wanting to be killed is another story.

Via the mercy killing study, as via the assisted suicide study, I sought to understand how things might differ when the suicide is brought about by the individual versus when the suicide involves assistance by others; and how gender and cultural issues might play into unassisted and assisted suicide. So far, nearly all cases of assisted suicide in Oregon, as in Michigan via Kevorkian, involve people of European descent. Why is it that ethnic minorities are nearly absent among those dying of physician-assisted suicide in the United States? An hypothesis that I have proposed, including in the Kevorkian assisted-suicide article, is that U.S. ethnic minorities distrust institutions in general, and physicians specifically, based on their negative experiences. Many U.S. ethnic minorities have to fight to live. They have no particular investment in fighting to die sooner. They have to fight to get adequate medical care. Their problems and concerns are related to insufficient and inadequate medicine, not to excessive medicine.

Dr. Connolly: What is your own personal view about the legalization of assisted suicide and euthanasia?

Dr Canetto: My initial view on assisted suicide and euthanasia was that they are and should be a personal decision. Why not allow people to determine the time of their death, and do it with technical assistance, with medical assistance? People choose whether or not to marry and whether or not to have children. Why not choose also when and how to die?

Once I started reading more broadly about the topic, particularly the writings of Coleman, Kass and Lund, and Hendin, and once I better understood how internalized oppression can contribute to diminished entitlement to life, my views evolved beyond my initial naïve individualist and libertarian perspective on assisted suicide and euthanasia. What I learned from Coleman is that it is a form of ableism to endorse assisted suicide in response to a wish to die by people with disabilities, when suicide prevention is the social and professional response to people without disabilities who express the same wish. As I said, my perspective has matured as a result of readings about the privilege and about the elitism of the "right to die" discourse.

In fact, I have become quite concerned with initiatives to legalise assisted suicide. I am concerned about the impact of legalization on individuals from socially devalued and economically disadvantaged groups, especially women and people with disabilities. Women and people with disabilities are socialized into lower entitlement. They are also particularly likely to internalize the view of being undeserving. In the United States, there is not universal access to medical care so financial concerns. Diminished entitlement to care have more impact on access to medical care in the United States than in countries with a national health insurance, like the Netherlands. In the United States, it is only if you are well off or if you have had sustained and well-paid employment with benefits that you can access medical care without medical care being a threat to your financial resources.

Another concern I have about the dominant, individualistic, choice- and autonomy-narrative of assisted suicide is that it does not consider the interpersonal and the power dynamics of medical decision making, particularly when the person is seriously ill. Choice and autonomy in medical decisions are difficult to attain even when

the individual has resources and is in relatively good health. They are a fiction when the person has limited resources and is seriously ill. Also, physicians have control and authority over information regarding prognosis, treatments, and their appropriateness. How they frame the information influences the medical decision. Furthermore, medical decisions regarding persons who are seriously ill are typically made in consultation with, or by family members. Family members bring their own needs, emotions, and agendas to the situation. For example, they may be demoralized by the severity of their relative's illness and may wish to avoid the anguish of caring for someone who will not recover. So medical and family caregivers may end up steering the sick individual toward assisted suicide because of their own, rather than the sick person's discomfort with the illness and the disabilities.

Oregon's assisted suicide law has been hailed as a model statute with strong safeguards, such as the requirement that the person making the assisted-suicide decision is free from undue outside influences. However, for all the reasons I described, assisted suicide is difficult to regulate, including because the safeguards are hard-to-impossible to implement. The legalization risks, in my view, outweigh the legalization potential benefits. Legalized assisted suicide is particularly dangerous for individuals who are economically disadvantaged and socially devalued. As the data indicate, the most vulnerable to seeking a hastened death out of internalized oppression, including concerns about being a burden, may not be individuals from the most economically and socially disadvantaged groups. In the United States, women of European descent are more likely to die of assisted suicide than women of African descent. I think society should provide support and care to individuals who are older, seriously ill, and/or have disabilities, and are concerned about being a burden, not the means to hasten their death.

Dr. Connolly: Where do you think suicidology is going?

Dr. Canetto: It is exciting to see suicidology taking a global perspective; that at a conference like this one, people from around the world dialogue about suicidology. For too long dominant suicidology's sense of what is normative suicidal behavior has implicitly been based on a standard that represents the experience of a very narrow set of humanity, people from industrialized countries. Suicide patterns however vary greatly by country and region. For example, the male to female (M/F) suicide ratio is not as large in low-income countries as here in United States, where men are more likely to kill themselves than women by a ratio of 4:1. If you take into account all countries in the world, the M/F suicide ratio is closer to 2:1. It is exciting to see that dominant suicidology is changing its organization and priorities as a result of input from a broader set of experiences; that it is going beyond the experiences and the priorities of high-income, Anglophone countries.

Dr. Connolly: Have you ever married?

Dr. Canetto: Yes, I was married, and I have a daughter, Sara, who was born in 1997. She's six. I was 6 month pregnant when I traveled from the United States to Australia for the International Association for Suicide Prevention conference in Adelaide.

Dr. Connolly: That must have changed your life quite a bit.

Dr. Canetto: Yes - in positive ways. It's been wonderful to be a parent. For most of my life, I had no interest in being a mother. In fact, for many years I was not interested in children, including professionally. At Northwestern University I specialized in clinical gerontology. When I turned 40, however, I wondered if I would regret not having a child and thought I should consider the idea. I conceived within a month.

My daughter Sara has been a total joy. She is smart and affectionate; open and curious. She speaks, without an accent, Italian and English; and can read Italian and English. She is very adaptable, physically and psychologically. Even as a small child, she ate a diversity of foods and slept anywhere and under all sort of conditions. She is open to new people and to new experiences. She has travelled with me just about everywhere I have gone. Her first flight was at two months of age. We went to Chicago where I was presenting a paper at the annual APA meeting. I had submitted the paper for consideration for presentation at the conference prior to being pregnant. Sara attended APA conference sessions at two months.

What motivates and energizes me are ideas and understanding the diversity of people's lives and experiences. It has been easy to be Sara's parent because she is so open to the world. She is a big thinker; she loves to learn, and she loves books. She is a fabulous child. It has been wonderful to see the world through her eyes.

Dr. Connolly: What part has music played in your life?

Dr. Canetto: I listen to different kinds of music, but I prefer classical music. I also like some Italian pop music. I used to go to classical-music concerts, but now I do not do that as much. I now give priority to activities Sara is interested in. When I take her to live concerts or to musicals, I introduce her to the music and/or the story prior to the event. I listen to the radio a lot, mostly news. I like National Public Radio. When I work, the radio is often in the background. I don't like to work in silence.

Dr. Connolly: Do you plan to stay in the United States?

Dr. Canetto: I have spent most of my life in the United States but my formative years were in Italy. I am at home and a stranger in both places. I think that I will continue to spend part of the year in the United States, at least as long as Sara is in the United States. At the same time I am thinking about ways I can spend more time in Italy. Before Sara was born, I did not visit Italy every year. Now I go every year because I want Sara to be in Italy during her formative years so Italy can be her home, culturally and affectively.

Dr. Connolly: What interests and hobbies do you have?

Dr. Canetto: I had a horse for many years. I rode both English and Western style. I kept my Colorado horse, Tessa, through the first couple of months of pregnancy and then sold her. Tessa had become a skittish horse. She had developed a fear of plastic bags, which unfortunately are not uncommon on the ground or flying in the wind. During my first two months of pregnancy, she threw me off twice. I realized that riding was not a good idea during pregnancy; and also that I would not have time for Tessa once I had a child.

Indeed, now I am always busy with academic work and with Sara's care. I do not think that horses are going to be part of my life for a while.

I also like skiing. I love the speed, the elegance, and the physical challenges of skiing; being in the mountains in the winter, whether it snows or whether it is sunny. Skiing is relatively accessible in Colorado. I am an advanced skier. I am very comfortable on skis even when I have not exercised recently. Sara has been skiing since she was three. She is already a good skier. Sometimes she skis with me, and sometimes she takes lessons and skies with her instructor and peers. Skiing will likely continue to be a shared activity.

Dr. Connolly: Do you have any musical talent yourself?

Dr. Canetto: I played piano for many years. I do not have a piano at home now. I spend time at the computer keyboard.

Dr. Connolly: You're not ready to exchange one keyboard for another?

Dr. Canetto: I am not ready to exchange the computer keyboard for a piano. I would rather have access to both kinds of keyboard at this point. I was recently promoted to full professor. In the coming years, I expect to spend lots of time at the computer keyboard, writing papers. As for piano playing, who knows when I will do that again.

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INTERVIEW WITH THOMAS ELLIS

Dr. Connolly: Where were you born?

Dr. Ellis: I was born in a small town in northeast Texas called Kilgore, population about 10,000. I grew up in an intact family with 4 sisters. I was the middle child. We were lower middle class with a Catholic upbringing. A pretty unremarkable upbringing.

Dr. Connolly: What did your father do?

Dr. Ellis: He had a few occupations. He was a newspaper reporter. The region where I grew up is in the oil fields in north east Texas, and he did some work in the oil fields, and eventually he became an office manager for an oil products distributor that took care of gasoline, oil, tires and batteries for the entire area. My mom was a homemaker who worked in educational resources after the kids got older.

Dr. Connolly: Tell me about your early schools.

Dr. Ellis: I went to Catholic parochial schools up until the 6th grade and then public schools after that for junior high and high schools.

Dr. Connolly: You were practicing Catholics?

Dr. Ellis: Yes.

Dr. Connolly: Are you still Catholic?

Dr. Ellis: Fair weather. For a long time, I was a recovering Catholic which is to say that I wanted nothing to do with Catholic church but, since my wife and I have had children, we thought that it was important to give them some experience in a religious context, and so we had returned to the church. We are not what you would call devout. We have mixed feelings about the beliefs, but we participate in the services.

Dr. Connolly: What about your early schooling?

Dr. Ellis: It’s interesting that, although I did reasonably well in school, I wouldn’t say that I was that great of a student. In high school, I was more interested in getting a job so that I could buy a car. It was always assumed that I would go to college, but I didn’t give much thought to it. I didn’t do much serious reading until I got into college. I started out as an engineering major. I had several uncles who were engineers and one taught in engineering department at the local college. It seemed the natural thing for me to go into engineering. It lasted about three semesters, with average grades, and then I discovered psychology. I liked it a lot and decided to change majors.

Dr. Connolly: How did you discover psychology?

Dr. Ellis: I made a friend who had a philosophical bent, and we had a lot of conversations about philosophy. He introduced me to Eric Fromm, and I read some of his works. I found it very exciting. I had never had any exposure to psychology or philosophy.

Dr. Connolly: What interested in Fromm?

Dr. Ellis: It gave me a framework to understand human unhappiness. My high school experience was fairly typical, although that particular culture had a lot of bravado and hostility and not much intimacy. There was a lot of bullying. To have a good time, the kids would go out drinking. For me, it was not a hospitable environment.

Dr. Connolly: Were you bullied?

Dr. Ellis: No, I never was, but there an atmosphere that it could happen. There fights on the school grounds. I didn't perceive my classmates as being particularly happy. Fromm's emphasis on the effects of the social structure made a lot of sense to me. It helped me have a framework to help me understand things that puzzled me. It validated my experience.

Dr. Connolly: What happened after you changed majors?

Dr. Ellis: I'm grateful to one of my professors, the Dean of the Engineering School. He was also a family friend. I spoke to him about changing majors. I was worried about disappointing him, but he was supportive and understanding. The same was true for my father. I was worried he would see psychology as a soft area as opposed to hard-nosed engineering. But he was great also. I look back at that as a time of anxiety, but also relief that I had support for my decision.

Dr. Connolly: Tell me about your teachers in college.

Dr. Ellis: The Dean I mentioned was one of my professors, and he was a role model as a human being. He had a wonderful balance between the hard-nosed science of engineering but also the human quality. Later I switched out that college to go to the University of Texas which is a huge university – 55,000 students. You became a face in the crowd there. I can't say that any one professor there struck me. I just tried to finish the course work.

In graduate school, the director of the doctorate program at Baylor was another similar character in terms of his basic human qualities. He was not that well published. His approach was very common sense, humanistic and client-centered.

Dr. Connolly: What was your thesis on?

Dr. Ellis: This was in the late 1970s when the Doctorate of Psychology (Psy.D.) program was brand new. Baylor was only the second university in America to adopt this training model which was intended to focus more on the practice of psychology in contrast to the more research-oriented PhD programs which produced strong researchers but not strong clinicians. Looking back on it, I took a big chance since it was not a well-established

degree, even though Baylor is a well-established university. They did not require a dissertation at that time.

I was very naïve when entering graduate school. I thought that all I wanted to do "help people." I thought of research as being esoteric and often irrelevant to clinical work. I thought it would be a waste of my time at graduate school, which is why I chose the Psy.D. program. I didn't have good advising that would have set me straight.

I did do an independent study paper under another professor who got me excited about scholarly work. He had come from the University of Michigan. He talked about making presentations at the American Psychological Association convention. He had journal articles. He opened my eyes that this would be a rewarding thing to do. I took an elective course, an independent study with him. I wrote a paper on social class and schizophrenia. I came up with the idea that the correlation between social class and schizophrenia might not be so related to income as it was to occupation. I built on ideas of Karl Marx that our work and productivity is a central part of our identity and being healthy. It was the quality of work that the lower classes do that had an impact on their mental health. I submitted it to 5 journals, but I never got it published.

Dr. Connolly: How were your college years?

Dr. Ellis: I was very bookish. I focused on my studies. My first couple of years in college, I was working part-time to help pay tuition, and so I didn't have a lot of time.

Dr. Connolly: What kind of jobs?

Dr. Ellis: I started to work at 12 as a newspaper carrier. I had a paper route in high school. Later in high school, I went to work in the mail room at the paper. In summers, I had different kinds of jobs. The hardest job I ever had was "hauling hay" which involved baling hay in the fields. It's very hot in Texas in the summers. I worked one summer on a loading dock at a transport center. In college, I spent some time building fences. A great education and a great motivator to finish school. I do take pride in that, feeling good about knowing what hard work and physical labor is like, and work that doesn't pay very well.

Dr. Connolly: What degrees did you get?

Dr. Ellis: I received an associate's degree in electrical engineering from Kilgore College, a BA in psychology from the University of Texas at Austin, and then the Psy.D. from Baylor. My pre-doctoral internship took me to West Virginia at the West Virginia University Medical Center in Morgantown for the first 6 months where I spent some time in a minimum-security federal prison working with the inmates. Then I moved to Charleston which is a three-hour drive away for the second half of my internship year. I worked there in the medical center in the department of psychiatry. Then they hired me to be a faculty member but also to run a state-wide training center that the university was just setting up on contract with the state department of health. For the first 7 years of my career, in addition to seeing patients and teaching psychiatry residents and psychology interns, I was also running the training center that provided staff development services for state

hospitals and community mental health centers around the state. That's when I also got started in suicidology.

Dr. Connolly: What turned you into a suicidologist?

Dr. Ellis: It's a very unremarkable tale. I needed a research focus. I remember feeling clinically underprepared about knowing what to do with the severely disturbed individual. I felt at a loss. People were calling me doctor and I felt that I should know more what to do. That was particularly true for suicidal individuals. I didn't find the literature to be that helpful in terms of specifics, and there were a lot of unanswered questions. I thought that if I wanted to do research, I wanted it to be relevant and impactful. I wanted it to be in an area that was in need of new ideas and new discoveries. Suicide really fit that bill both in terms of my own needs as a clinician but also for the field in general. I remember very clearly the day I made that decision.

Dr. Connolly: Had you had experience of suicide in your practice?

Dr. Ellis: I had not. I had no personal or professional experience with suicide at the time.

Dr. Connolly: What about experience of other kinds of death?

Dr. Ellis: Not at all, other than my grandparents. I was quite fortunate in my childhood. I remember my grandmother's death, feeling very sad. I was quite young at the time, maybe 7 years old. I coped with it like any child would. I don't think it affected what I was pursuing. It was perhaps more my high school experience, thinking that kids ought to get along better than this, and it ought to be more than this.

Dr. Connolly: What was your first research?

Dr. Ellis: The first thing I did is one of the things that I'm most proud of. To become a better clinician, I sought out advanced training in cognitive therapy. This is where I learned more specifically what to do in psychotherapy. I was especially interested in cognitive therapy because of the empirical foundation that it had. Not only proposing ideas and theory, but also testing those ideas and getting good data. But with the exception of Aaron Beck's writings, there was not really much there that was applying cognitive theory and techniques to suicidal patients. I wrote a paper, an overview, and found that there was a fair amount of research at the time that indicated that there was some cognitive characteristics that were reliably connected with suicidality. It goes all the way to some of Shneidman's writings – cognitive rigidity and dichotomous thinking. Then Neuringer, who studied under Shneidman, did a series of studies that reinforced the idea that people who were suicidal were thinking in very restricted ways and not engaging in very good problem-solving. I gathered up this literature and proposed that cognitive therapy was consistent with this research. I started to target these vulnerabilities directly, much as Beck's cognitive therapy had targeted depression, such as negative filtering. That paper was published in 1986. The editor of *Professional Psychology* told me the

paper was so unusual that he had 5 different people review it . I look back on that as something I'm proud of.

Then, in that vein, we did a study of psychiatric inpatients. I got two groups of individuals, pretty well matched, one with suicide attempts or severe suicidal ideation and one who had not been suicidal. Both groups were moderately depressed. We administered a series of cognitive instruments to them and found a couple of things. One was consistent with Beck's earlier work, which was that the correlation between depression and suicidal ideation was fully mediated by hopelessness. We also administered the irrational beliefs test which has 10 subscales, and only one of those subscales came out significantly different between the two groups. It's the one that measures the extent to which the individual believes that their happiness is a product of events themselves as opposed to their interpretation of events. The suicidal group was more convinced that they were at the mercy of circumstances. The circumstances made them upset and made them depressed. That fit very well with the hopelessness construct. They felt less able to do something about this. The control group thought that this was a state of mind and that they could learn how to cope with the situation in a manner that would make them feel better and to be happier. This was a central construct of cognitive therapy. I saw that as a good preliminary indication that cognitive therapy was a promising approach for suicidal patients. I've pretty much been on that path since then.

Dr. Connolly: Tell me about your later work.

Dr. Ellis: The next study we did was looking at neuropsychological functioning in that same population to see if the difference had some organic basis. It was not a sophisticated study, but the two groups did not differ much, but we did find a significant amount of subtle neuropsychological dysfunction but no difference between the groups. In the process, it became very clear that there were major definitional problems with the issue of suicidality. It became clear that we were looking at a very heterogeneous group. To write a cognitive therapy treatment manual for suicidal patients, there are too many varieties of suicidal patients. That got me interested in the varieties of suicidality. We did a couple of studies using cluster analysis to break out sub-groups of suicidal individuals. It's very difficult research to do. We contributed some interesting preliminary ideas. However, I found that the cluster analysis is only a descriptive statistic. It does not have a lot of power in getting good consistency across populations. Thomas Joiner's work on taxometrics is the way to go. We need large samples to do that kind of research, and I didn't have access to those kinds of resources. That was interesting work. It was gratifying in some and frustrating in other ways. We didn't come up with any definitive answers that would translate into treatment implications.

It was at that time that I became interested in what we might be able to offer to the general public in terms of cognitive therapy principles for suicidal individuals. In the mid-1990s, Cory Newman and I teamed up to write *Choosing to Live* which is a self-help book based on cognitive therapy principles. That was a very interesting and enjoyable collaboration with Cory, worked with Aaron Beck. We were very pleased with that book. We got a lot of nice comments from people who read the book and also practitioners who recommended the book to their patients. The book is still in print.

In working with psychiatry residents, I've had a few occasions when residents would lose patients to suicide. Knowing that I worked in that area, they would come to me to talk about this. These were very bright, mature and responsible physicians, and they would be beside themselves, very sad and upset, doubting their abilities. I became interested in the issue of how you debrief students, interns or residents after they have lost a patient to suicide. The literature didn't have much to say about this. I read Bruce Bongar's view that one needed to be careful about this because, if there were a lawsuit brought, then what you say in supervision could be taken into court. That was a real quandary because the students were very distraught and, because they were distraught, they would make statements like, "This is my fault. I really screwed up." These statements would be very hazardous in court. The literature didn't have much to say about this. We did a national survey of psychology internships and psychiatry residencies, asking them about their training practices in suicide risk assessment and intervention, and also their postvention policies and procedures as well. Regarding training, we reinforced what Bongar and others had found before, namely that training in suicide risk assessment and intervention was by no means universal. There were significant gaps, especially in the level of training in journal clubs, supervision, seminars and in-depth workshops. The more intensive the training became, the less often it was endorsed by training programs. Most training programs had no policy at all when it came to debriefing. We got comments from the participants that the survey itself was thought-provoking, and they were looking into making changes in their policies and procedures as a result. That came out in 1998.

Dr. Connolly: You started talking about this last piece of work by saying that it wasn't important enough to talk about. Why?

Dr. Ellis: It was just a survey. It didn't break new ground except to give us a sense of what was going on.

Dr. Connolly: What else are you doing?

Dr. Ellis: The main thing is a book I'm editing now looking at different viewpoints on cognition and suicide. Since I started writing about this, we've seen more people looking at different aspects of cognition and suicide, such as problem-solving and over-general memory. It was important to bring that together and synthesize it. I have been fortunate to recruit some very top people to write chapters or this book. My dream team. Greg Brown from Aaron Beck's center, Albert Ellis and I are co-writing a chapter on Rational Emotive Behavior Therapy, Lisa Firestone is writing on the cognitive aspects of voice therapy, David Jobes is doing the same based on Shneidman's work, Israel Orbach is writing about body image and self-destructive behavior, Mark Williams is writing about autobiographical memory, a chapter on Marsha Linehan's dialectical behavior therapy, and there's a chapter on perfectionism. It'll be a 2006 book, published by the American Psychological Association.

Dr. Connolly: What about your involvement with AAS?

Dr. Ellis: AAS has been a tremendous boon to me personally and in my career. 1988 was my first conference. It's such a tight-knit and receptive community. From the beginning, I was impressed by how much I was welcomed into the organization. There's a genuine interest in ideas. There are disagreements, but it is a healthy atmosphere for exchanging ideas. It's been a wonderful place for me to learn and also to field test my ideas.

Around 1996 I helped get the listserve started and then the website. The listserve is a place to exchange ideas. I've enjoyed seeing the diversity. I worried that it would be dominated by researchers or survivors or crisis interveners. That has not happened.

Dr. Connolly: Tell me about your life outside suicidology

Dr. Ellis: I was single for quite a while. I was focused on my career. I got married in 1992 when I was about 40. My wife and I have two sons; the older got his degree in computer science and is living with his wife in Florida; the younger is a junior at the University of Texas and hopes to get a doctorate in physical therapy.[2] Being a father was an experience in balancing for me. It taught me so much about life, especially having children, understanding what a daunting task it is to be a parent, how stressful and rewarding it is. It has provided a balance to the professional side and a tempering. If I hadn't married and had children, it would have been easy to get detached or irrelevant, getting involved in the technicalities of research without a grounding in real life. It's also made a big difference in my psychotherapy practice. I'm much more tolerant now about human foibles and shortcomings.

Dr. Connolly: Are you a good father?

Dr. Ellis: I'd like to think so. It's something that I do take pride in. I'm very involved with the kids. My wife and I share the parenting. I enjoy being with them and teaching them and learning from them. I've been impressed how my parenting style has evolved, especially with the second child, which is probably pretty common. There is less hovering and, as a result, less strictness. Being a strict parent is largely a result of anxiety rather than being mean or rigid. The older child has benefitted from the younger child because we give him more freedom too.

Dr. Connolly: Any community involvements?

Dr. Ellis: I was involved with the state mental health association for a number of years. The mission of that group is largely around de-stigmatizing mental illness and promoting the availability of services. I worked with them both on the local and state levels.

Dr. Connolly: What about assisted suicide?

Dr. Ellis: A very important issue that I think will become increasingly important. As medical technology advances, we are going to be faced with the tension between the quantity and the quality of life. I'm glad to see a little bit of softening in the suicidology arena. In the past, there has been a knee-jerk response that any kind of suicide is bad. James Werth's

[2] Updated in 2021.

presentation was interesting in that the definitional issue of suicide versus hastened death. I believe that there is a place for assisted suicide given appropriate safeguards, and that is the sticking point. We have a lot to learn about assessing whether an individual is making a well-reasoned decision about ending their lives. At the same time, there are horror stories about the death experiences of people who are kept alive and who are not offered assistance in dying – kept alive by artificial means, in terrible pain, with debilitation because of the illness. We have to find a middle road.

Dr. Connolly: What about the slippery slope argument?

Dr. Ellis: I worry about that too, more now that there are reports from the Netherlands. I don't have any answers, but we have to stay flexible and open-minded. What concerned me early on was the categorical rejection - that we can't go there, that we can't contemplate the possibility that someone might make a rational decision to hasten their own death. We've seen some softening there. The slippery slope is a real danger, but there is a danger of a paternalistic approach to medicine that the person's death is in the hands of doctors. That's a problem as well.

Dr. Connolly: What do the next ten years hold for you?

Dr. Ellis: That's a tough question because, having made a recent career change, it's too soon to say. My first job lasted 24 years. From 1978 to 2002, I was at the place where I did my internship, West Virginia University. Because of medical economics, the environment changed over the years. We were called on more and more to do lots of clinical work in order to finance the medical center. That was hampering my ability to do scholarly work. I was recruited by a near-by university, Marshall University. They were starting a brand-new PsyD program which took me back to my roots. I could make a contribution there and have more time for writing and research because I would not have clinical responsibilities. I am getting this book done, but the teaching load is quite significant. So it's too soon to tell whether it will work out the way I had hoped.

What I'm really interested in looking into from a research perspective is the possible overlap between health psychology and suicidality. I've been impressed in working with some of my patients who seems to have an under-developed sense of self care, almost a disregard for their physical or psychological and emotional well-being. Once, a patient came in soaking wet for her session. I made a comment about whether she had forgotten her umbrella, and she got this puzzled look on her face as if so say, No. Why would I have an umbrella." She was diabetic and morbidly obese. She didn't eat right or exercise. She was losing her eyesight. And here she was soaking wet. She was also severely suicidal and had been hospitalized several times. Being in a medical environment for such a long time, I really developed an appreciation of how much health psychologically and behaviorally driven. I'm interested in exploring whether there might be continuous cognitive variable that would pertain to both health-risk behavior such as smoking, seat-belt usage and safe sex, and extending all the way to deliberate self-harm behaviors and suicide. It's only an idea, but I'd really like to look at it in a formal way. It would have implications for how we intervene in psychotherapy and in a preventive way, teaching children that your body is important, your happiness is important. and you are

worth caring about. People subjected to child abuse were given messages that they were not worth caring about. You are worse than that, you are worth abusing. That might play out over the life span in terms of health-related behaviors and severe cases of suicidality. That's what I hope to.

Dr. Connolly: There are lots of things we haven't talked about. What about music?

Dr. Ellis: Blues jazz and classical and rock-and-roll. I have a diverse appreciation. I love music. It's important for people to get their world views validated. One of my favorite sayings about blues music is that blues music is not about being sad, it is designed to pick you up. Blues music makes you feel good.

Dr. Connolly: Is there anything you'd like to add?

Dr. Ellis: The real challenge in suicide prevention is remaining hopeful. Suicidality, individually or as a public health problem. Is complicated and hard. It is possible to get discouraged as the suicide rate does not decline dramatically. We lose patience from time to time. I feel optimistic. Things are happening in psychotherapy and in the medical arena. The body and mind are not separate things, and we separate them at our peril. There's reason to stay hopeful.

Note added in 2021. I left Marshall University to join the faculty at Baylor College of Medicine in Houston, where I served as Director of Psychology and Director of Suicide Research at the Menninger Clinic. There I pursued research in several suicide-related areas, including a demonstration of the superiority of the Collaborative Assessment and Management of Suicidality (CAMS) over usual care with psychiatric inpatients (Ellis et al., *Psychiatry Research,* 2017). I retired in 2017. A summarization of my research can be found at www.bcm.edu/people-search/thomas-ellis-21079.

INTERVIEW WITH DAVID JOBES

Dr. Connolly: Where were you born?

Dr. Jobes: In Cleveland, Ohio, 45 years ago.

Dr. Connolly: Tell me about your early days.

Dr. Jobes: I'm the third of 3 boys. My father, who passed away this summer, was an electrical engineer. He went to the Naval Academy in Annapolis and served briefly during World War Two. My mother and father were a classic World War Two blind-date romance and married a few months later. They were married for 57 years.

Dr. Connolly: What did your father die from?

Dr. Jobes: He had prostate cancer. We felt fortunate because he had spent 25 years in remission. He had a recurrence about a year and a half ago. He handled a number of chemotherapies very well. He was remarkably resilient. He was 82. He was a very influential person in my life, and we had a good relationship throughout my life. He was very intelligent and a family man. My growing up years in Cleveland were unremarkable. My parents built their home. My mother was a stay-at-home mother. Participated in the PTA and did volunteer work. It was a very traditional 1950s American family. Growing up, we did a lot of family activities. My father was a hiker, and so would go on hikes on the weekends. My brothers and I were interested in sports.

Dr. Connolly: What sports in particular?

Dr. Jobes: Martial arts. I did judo and karate, and I did Little League baseball, basketball, soccer, and football.

Dr. Connolly: What are the ages of your brothers?

Dr. Jobes: My oldest brother is 8 years older, and the other 5 years older. It was two-tier family. They were closer. When the second brother went off to college, there was just me and my parents, and the three of us got on well. It was a nice time.

Dr. Connolly: What about religious influences?

Dr. Jobes: My father was raised as a Catholic, and my mother was Presbyterian. There was some degree of controversy in my father's family for marrying out of faith. The resolution was that we raised Unitarian. We went to the First Unitarian Church in Cleveland where there was incredible music. Most of my religious education was eclectic because the Unitarians are into serving the world. I learned about Buddhism, Islam, Buddhism, Judaism and Christianity. Sunday School had specific classes on the world's religions.

Dr. Connolly: Have you remained involved in religion?

Dr. Jobes: I've circle through various phases of religious orientation. I've always considered myself as spiritual. My wife of 14 years is Catholic. Our boys are baptized Catholic, and we go to a Catholic church., although I have not converted. Formal and informal religion has been one of the influences in my life. When I was in high school, we did a course in transcendental meditation. My father was a meditator and the whole family meditated. I college, I was very involved in martial arts, and there was a spiritual component to that.

Dr. Connolly: Does spirituality enter into your work?

Dr. Jobes: Being a suicidologist is a lot about my interest and excitement in life, in our blessings and how rich and fulfilling life can be. The more I study suicide, the more I am mindful of what it means to be alive and what the gifts of life are. When I look into the darkness of what suicidal people wrestle with, I try to bring them back into the light. You can't help but be preoccupied with the things that make life worth living. For me, that is a very spiritual thing. I have a deep emotional feeling about working in this field and about preserving life, not in a dogmatic or rigid way, but giving people a second chance.

Dr. Connolly; How was school?

Dr. Jobes: Pretty unremarkable. I went to public school. I enjoyed school and was a chronic under-achiever. I could always do better, but I did so-so work. In graduate school, that became an issue because I had to do better. But in grade school, I did well enough. I got decent, but not stellar grades. I was more interested in my friends, girls, and sports. When I went to college, I was not academically preoccupied.

Dr. Connolly: What about reading?

Dr. Jobes: Mostly I was reading autobiographies, especially about great sports legends. Because of my size, I couldn't play football or basketball, I became a runner and was involved in cross-country and track and field. That became a big part of my identity. I ran the half mile and the quarter of a mile. It required a lot of training and a lot of running. I was dedicated and disciplined in that.

Dr. Connolly: What about music?

Dr. Jobes: When I was in middle school, I played French horn and was very interested in classical music. My father was in the Cleveland Orchestra chorus. We went to the symphony and the theater. As an upper-middle class family, we were relatively well cultured. We went to the Cleveland art museum, and I was involved with art at school. I had some pieces exhibited in the children's exhibition at the Cleveland Art Museum. I sang in choirs all through middle school and high school. When I played the French horn, I became quite accomplished and had to decide what to do next. I stopped because I got braces. Later I switched to rock-and-roll, but I still like classical music.

High school was a wonderful time for me. I had a close-knit group of friends. I did not have significant adolescent crises. In my work with adolescent suicides, I notice

that I got through those years with very little tumult. I can't take much credit for that because I came from a relatively stable family. It was impactful for me to be the youngest of three boys and to watch my older brothers, to see the choices they made, their successes and mistakes. I was very much an observer. I used that in the decisions that I made and how I lived my life as a teenager. I was socially active. I had girlfriends, and I was fairly popular. I enjoyed high school.

Dr. Connolly: Were there any teachers that influenced you?

Dr. Jobes: I had a series of really good English teachers who were good at teaching us how to write, especially grammar and syntax. They were excellent in teaching us to develop ideas and how you would write about them well. Because I write a lot now, that was a significant part of my history – to be blessed with them. I relish and love writing. Being an academic has not been problematic because writing is an important part of that.

Dr. Connolly: Tell me about college.

Dr. Jobes: I started out in my freshman year at Miami University in Oxford, Ohio, which is a small liberal arts school in southern Ohio. I was unhappy there. I had an adolescent crisis of sorts. It was not a good fit for me. It was focused on fraternity and sorority life for which I was not suited. When I was 17 in high school, I wanted to do Outward Bound. I took a 28-day course in the Colorado mountains. I was interested in mountaineering, rock climbing and high-altitude camping. You do a three-day solo experience, fasting and keeping a journal. I earned my own money to go on Outward Bound; I worked in a bookstore as a clerk. In my senior, we had senior projects and a group of us went out to Yosemite National Park and spent three weeks mountaineering.

Oxford, Ohio, is pretty flat, and there was no mountaineering possible. I decided that I wanted to go to the University of Colorado. Boulder has a strong pull for climbers. I gave my parents an ultimatum. Colorado or no college. They were very wise and patient. They were Great Depression kids, and they insisted that I had to partly pay for what I wanted to do. So, in the summers, I painted houses. That summer before I went to Colorado, I had my own paint company and crew. We could make good money in the course of three months. I moved to Boulder for my sophomore year; it was tricky time managing the cost of tuition and I changed colleges three times, which was a very unorthodox way to go to college. I was happy in Colorado, but it was expensive to be out-of-state. The tuition was very high. I didn't know anybody, so I got into the climbing community, and we did sheer face granite wall climbs. I became very accomplished at rock climbing, but I missed a lot of classes.

I did eventually get excited about some of my courses in a way that I wasn't in my freshman year. I took liberal arts courses, philosophy, and psychology courses. I loved both, especially philosophy. I thought about a double major. I had a good sophomore year, but it got too expensive. Colorado is a big state school, it was well-funded, with pre-eminent people in philosophy and psychology. I had John Searle who was a visiting professor from Berkeley and was a world-famous analytic philosopher. I took a philosophy of science course with him, a very important class for me, because he stressed intentionality, mentalism, and early stages of cognitive science. He was a

powerful, persuasive, and compelling professor. In suicidology, we are so often focus on intentionality. Suicide is psychologically intended, and so his work has relevance. And there are philosophical issues in suicidology everywhere you look.

I had a philosophy professor from England, and I sat down with him to talk about a career in philosophy. He said to me, “Don’t even bother. It’s a waste of your time. It’s a dying field. If it’s a choice between philosophy and psychology, choose psychology because there’s no future in philosophy.” I was crushed, disappointed and crest-fallen and ultimately followed his advice.

Dr. Connolly: What after Colorado.

Dr. Jobes: I went to Ohio State University, which made a lot of sense because a lot of my friends from high school were there and living together. Ohio State has a very good psychology department. I was drawn to industrial, organizational and applied psychology. My father was into that too. He left his job as an electrical engineer and got into personnel work and worked for TRW, a big corporation with government contracts. He was in the first wave of applied psychological—organizational development—on the business personnel side of things. He influenced my move toward that.

They had a quarter system there and, in my first quarter, I did horribly. I almost flunked calculus. I got a D in my first exam in anthropology. It was a disaster. I was very unhappy there. I had a girlfriend back in Colorado. My parents were very concerned about me. It did not work out well with my old friends. We led a decadent life. I came close to dropping out or withdrawing from that quarter. I went home and my parents sat me down and said that this won’t do. Get your act together and do better. That was a wake-up call for me. I went back and did much better. Part of the deal was that I would go back to Colorado for my senior year. I got a job and they helped out with the tuition. In that junior year, I was academically strong and very happy.

I went back to Boulder the summer after my junior year. I got a job in a Mexican restaurant as a prep cook. I made 25 gallons of guacamole a day. I still like it. In fact, I’m a connoisseur of guacamole. I took my statistics course that summer which had been a problem for me at Ohio State. My senior year went well, but my oldest brother was diagnosed with Hodgkin’s Disease and my middle brother was in a car accident. My best friend from kindergarten was killed in a car accident. That was impactful because I had never had someone close to me die. It was a rough year, but I did well academically. I squeaked in Psi Chi, the national honor society for psychology.

My brother was treated successfully. He had both chemotherapy and radiation. This year, he had a recurrence on non-Hodgkin’s lymphoma and is getting chemotherapy right now. We feel blessed. That’s 25 years of remission.

Dr. Connolly: What about graduate school?

Dr. Jobes: I played catch-up and did as well as I could, but I had not what was needed to get into a graduate program in clinical psychology. I went back to Cleveland and through family friends got a wonderful job working in a children’s hospital as a recreational therapist which was a glorified “job” where I play with young kids all day. Children who had spina bifida, muscular dystrophy, and so on. I worked there for a year and a half. I had to make

up for my lack of research experience, so I worked as a research assistant for a professor at Case Western University in Cleveland in a gerontology laboratory studying perceptual psychology. I was financially solvent. I was living at home. My grandmother came to live with us. I had some friends still in Cleveland. It was a good time in my life.

I applied to 8 graduate Ph.D. programs and got totally shut out—not even one interview. I was devastated. One of the Ph.D. programs was in Washington, DC (where my brother lived) and after being rejected I asked them if I could switch my application to their Master's program. They admitted me. I moved to Washington and rented a room in a family's home where I could ride my bike to campus at American University. My first semester was the hardest one of my life because, as a chronic under-achiever, I couldn't get away with only having a promising potential. I had to show up and really apply myself. I did after some initial floundering. At AU I met Lanny Berman who was my professor for psychopathology. I was very impressed with him, but everyone said that he didn't work with Master's students only the clinical doctoral students. That first year, I was persistent because he was my ticket into the doctoral program. I would go to his office every week, and he would turn me away. I would bring him a cup of coffee and I persisted. Finally, I convinced him that he should give me a chance.

We moved very quickly to this project that ended up being my master's thesis. It was a wonderful project. We published it. I presented it at my first conference at AAS in 1984. Bob Litman was the discussant which was a dream come true since he was one of the founding fathers of American suicidology. I had an incredible time at that AAS conference and met all these important people that I had read about. Lanny was very involved. He was president-elect at that point, and so he could introduce me to many people. I was very impressed with the people I met in the field. I came back from that conference via Los Angeles and stayed with friends. I was invited to stop by the Los Angeles suicide prevention center. I spent a couple of days there including time with Normal Farberow and I met Ed Shneidman! I was very impressed with what they were doing. That was 20 years ago, and I've gone to every AAS meeting since. I've grown up in AAS. My link with AAS and Lanny was pivotal because, a year after I did my thesis, the Centers for Disease Control was doing a project on the criteria, and I was invited to present my thesis research.

Dr. Connolly: Tell me about your thesis.

Dr. Jobes: It was a simple study using vignettes of equivocal cases in the presence of psychological intent. It was a simple study, but it underscored the importance of the psychological intent in suicide aspect in the certification of suicide. Mark Rosenberg was at the CDC and Patrick Carroll were keen on developing criteria that would help medical examiners do their job better as it related to suicide manner of death certifications. As a lowly graduate student, I had the best data about how medical examiners thought about this. I was invited to the CDC and went to a series of meetings on this issue as a graduate student with these influential people within the world of medicolegal certifications of death. I had an incredible experience working with this group. I was publishing papers, and I applied for doctoral programs. I got into the clinical program at American University to continue my work with Lanny and I continued to work with medical examiners and on legal investigations, the forensic aspect of suicide.

But this wasn't exactly what I wanted to do. I was interested in clinical aspects of suicide. I had some influential professors at American University, particularly Margaret Rioch who was a close friend of Harry Stack Sullivan and Morris Parloff who was a major luminary at NIMH. In graduate school I did some Tavistock groups that were very influential. It did extremely well in grad school. I was working in a psychiatric hospital as a psychology technician doing evening shifts and going to school during the day. I was publishing papers. I never aspired to an academic route, but after working with Lanny, I developed a passion for suicide prevention and found myself, surprisingly being drawn to the field and immersed in it, loving it, and feeling that I could make a contribution. I was well mentored. Lanny was generous and thoughtful about raising me in the field. He promoted me and was never threatened by my success. There were things I wanted to do as he had done, and there were things that I wanted to do differently. Lanny was well connected, and so I met Jerry Motto, and other founders of the field. I went into therapy, and that was a huge influence. I wanted to know what that experience was like. I went twice a week for five years and immersed myself in self-exploration.

In my fourth year, I did a summer traineeship at the V.A. hospital in DC, and it was a fantastic experience. They encouraged me to apply for an internship at the V.A. I did so and I remain affiliated with V.A. to this day. I did an clinical externship at Catholic University in the Counseling Center where I would later get a job. My dissertation was also a study of medical examiners' manner of death decision-making. I always saw myself as a clinician, but a friend told me about a job at Catholic University which was a joint appointment at the Counseling Center and the Psychology Department. I interviewed for it and got it. I was there for 8 years. In my first year, I was teaching a graduate course, seeing 14 patients, and supervising two trainees who were each seeing 8 patients. I was directing the group therapy program. I was 23 and was working like crazy. After my second year there, I became the Director of the Training Program and worked on two books on adolescent suicide.

I met my wife at college, and she would come to DC on business while I was at graduate school. She worked for credit unions and came to DC to lobby and for national meetings. We would get together. I was a poor graduate student, and she had an expense account, so we had wonderful times together. We were always dating other people. In my second year at Catholic, we finally weren't dating anyone else, and we realized that we had potential. Six months later she moved to DC. She enrolled in law school by night at Catholic University and worked for the Credit Union National Association by day. We commuted in the morning at 6 or 7 in the morning and stayed on campus until 10 at night. We did that for 4 years. It was a productive time for me because I did research and wrote it up in the evenings. After her second year at law school, we got married. We both worked really hard and kept the same work schedule.

It was at that period, 1988-1989, that the director of the agency said he wanted us to do a better job of identifying and tracking suicidal clients. That was the beginning of the Suicide Status Form (SSF) that I've been working on for 16 years since. It started off modestly. With a small grant from AAS we surveyed clinicians to see what they did when they identified suicide risk. We found out that they did not use assessment tools or psychological tests. They simply ask questions. That become my central line of work, clinical suicidology. Can we develop an assessment tool that is both qualitative and quantitative, that has open-ended responses and Likert-type scales, good psychometrics?

Psychologists and mental health professionals prefer interviews, but assessment tools have a role. We are on the 3rd iteration of the SSF, and we have had 16 or so papers on it. That brings me to the present day, professionally speaking.

I was very involved with AAS. David Clark got me involved even more with helping plan the divisional structure for AAS. For better or worse, it was a significant structural reorganization of AAS. I presented every year at AAS. I was moving up into the hierarchy of the organization. I was on the board. My professional life was blossoming.

The 8 years in the counseling were 3 years too long for me. By the 5th year, I was Associate Director and Director of Training, but I wasn't on a tenure track. It was becoming clear to me that I would happier as a full-time academic with a part-time practice. I was stressed and not happy.

Dr. Connolly: What is the most important thing you have to say?

Dr. Jobes: I feel so fortunate to have such good mentors, father and father figures, and guidance and support. I've worked really hard. What I have to say is, that in the course of that, I've been a good student, especially of the suicidal patients whom I've seen. If I've been able to make contributions, it is as a clinician-researcher, because I'm not a natural researcher. I've listened closely to what my patients have said, especially the suicidal patients. The success that we've had with the Suicide Status Form and, more recently, with the Collaborative Assessment and Management of Suicidality (CAMS), has made me aware that the need of suicidal people is profound. The clinical responses they receive is sorely inadequate, at least in this country, but it's not exclusive to us. I've been spending more time in Europe and going to international meetings, and it's not all that different in Europe. Where I think my contribution has been is providing a road map to form a viable therapeutic alliance and optimizing the potentiality for a suicidal patient to find their motivation to want to live their life. That is a profound thing, and a lot of clinicians do not have a clue about it. I'm not overly cynical or pessimistic about these things, but I do a lot of training and I travel all over the United States and Europe. I talk to clinicians about how they work with suicidal patients. It strikes me that they are asking a lot of the wrong questions, and they are engaging these patients in a non-productive way. There's too much of a power struggle between the clinician saying "No, you can't do this" and the patient saying "Oh, yes I can! Who the hell are you to tell me that I can't do this; it's my life?" and then the clinician says, "I'm the doctor and we'll commit you to a hospital if you don't say the right words. We'll make you sign a no-harm contract!" This dialogue is stupid. But this is probably a pretty standard conversation between clinician and a suicidal patient. Suicide contracts are not consensual. They are not mutually agreed upon. A person in a position of power is saying, "You say the magic words or you'll go to a hospital." "I'll call the police."

In my estimate, there is a lot of foolish things that we find ourselves doing in working with suicidal patients. They are not very helpful. There is an overreliance on medications as the primary treatment when there is hardly any empirical support for that. I'm not opposed to medication; half of my case load takes medication, but I don't see it as primary. It is secondary or tertiary to good psychotherapy. In the VA hospital where I worked for many years and where I consult now, veterans sit in the clinic for 2 or 3 hours

in the mental hygiene clinic to meet with their psychiatrist for about 15 minutes. They walk into the office and look into their doctor's eye trying to find a relationship, and they walk out with a slip of paper for medicine. You can see their disappointment in their eyes. We know from the compliance literature that they may not fill the script, or they may not take the medicine prescribed, and they probably won't come to the follow-up appointment. This is because they are looking for a relationship! This is the problem in our field. The therapeutic relationship is the most healing force. What the CAMS protocol how we engage in a relationship with a suicidal person around the topic of suicide is key; the way we can best do that is to look into their psychological suffering and the link to the prospect of suicide. That is engagement is inherently alliance forming. Good assessments are interventive. The CAMS protocol is a joint enterprise where you and I sit down together with my patient and we go through the assessment together. We are working off the same sheet of music, so to speak. We are working together to understand how it is for you that you are thinking about ending your life? As we go through this joint action, this joint enterprise, we try to make sense of this suicidal struggle and in so doing the patient is trusting me more. In turn I feel less threatened by you. We're also talking about treatment, about how to keep the patient out of the hospital. Ever since the enlightenment period in Europe, there was a common notion was that mentally ill people need asylum. That wasn't a bad idea, but it was abused over time. From our data it is so clear that suicidal people need a means of escape, to escape their suffering, and that is a perfectly reasonable—a legitimate and understandable goal. The CAMS protocol asks: how do we give you sanctuary, comfort, safety and succorance without you having to end your life? How do we figure a way to keep you safely out of the hospital and stable enough to be seen on an outpatient basis? Let's get out of the business of no-harm contracts, with you promising me that you won't kill yourself. Let's spend much more time on what you are going to do than on what you are not going to do should you get lonely, hopeless, isolated or desperate. Let's spend time talking about that. In turn, what role am I going to play as your clinician in that, and when can you contact me? When can and should we make a life-saving connection? And when can you handle the crisis on your own? Let's spend time negotiating all that!

I had this incredible experience when I became president of AAS. We themed the conference *Toward the Year 2000: Collaborating to Prevent Suicide*. People thought it was a brilliant idea. It was a conference theme that people could actually rally around. How many conference themes does one actually think about, that actually shape the conference? It was a theme that every division and every suicidologist could relate to – the idea of collaborating. As president, I wanted to build bridges between AAS and AFSP along with SPAN. There was a history of those organizations not working closely or in an integrative way. I learned that from my patients. Working with my patients was more desirable than being in conflict or in competition or being in power struggles.

Giving the AAS Presidential address was a huge moment in my professional career. It was the most anxiety-inducing speech I ever gave. It was a watershed experience of relief and recognition. People came up afterwards and gave me a hug, invited me to Europe. This simple notion was really wildly popular. That was a few years ago. The last five or six years have been the richest of my life.

My wife Colleen and I have had two boys, ages 6 and 8. I'm incredibly happily married to a wonderful person who understands me and importantly keeps my feet on the ground in a way that I really need, she tolerates me and supports me.

I'm now board certified. I'm a full professor. I've definitely arrived. It's been very impactful for me to go to international meetings in the last few years, meet the European suicidologists and getting that take on things. I love the international meetings because they are so clearly different. Americans are so insular in the way that we think about everything, both geopolitically and within our field. It was refreshing to see the integration between neuroscience and psychology. We are so polarized into psychiatric and psychology camps.

Dr. Connolly: Tell me about your map for the next few years.

Dr. Jobes: The next ten years? Five years is easier to talk about. I'll round out what we started. My collaboration with the Air Force has been powerful.

Dr. Connolly: Tell me about that.

Dr. Jobes: I am one of two civilian consultants to the Air Force, along with David Rudd. It comes in part from the work we've done in research clinics with the CAMS protocol. We have some good data on using CAMS in real world Air Force clinics, retrospectively. The protocol correlated with more rapid decreases in suicidal ideation in 4 to 6 weeks. An unexpected finding in our research was a much lower use of medical services: Emergency rooms, primary care, and clinical services. We have the best data for Air Force clinical mental health treatment of suicidal risk. The Air Force is a small enough world that you can do programmatic initiatives and have a big impact on a finite population, and actually study it. It's been an honor to have worked with them. The work has set the stage for a prospective study, a randomized clinical trial using the CAMS protocol. Marsha Linehan will be a consultant for that. She has been a great inspiration to me. She has been very generous with her time. She is an expert on randomized controlled trials (RCTs). So I'm focused on obtaining an NIMH grant for a prospective RCT study. This will be the next big thing. The need for clinicians to have something they can use is so pronounced. I hope to write a book, train others, and develop software.

Dr. Connolly: What are your views on end-of-life issues and euthanasia?

Dr. Jobes: There needs to be much more clinical emphasis on creating motivation for suicidal people to want to live, as well as respecting the decision-making of suicidal individuals. If you want to be in treatment, then let's do treatment. We should negotiate a period of time for that to occur and, frankly, I don't want to work under the shadow of suicide. As my patient, I want you to consider what you can do instead of suicide and see how that works in terms of ameliorating your suffering and pain. If you have one foot in the land of treatment and one foot in the land of dying, then I'm not interested in working with you. I want to work with people who are interested in giving treatment a fair chance because you can always kill yourself later. And I don't mean this flippantly or provocatively. I mean it in a strategic, thoughtful, forthright manner.

There's no dispute. People can kill themselves. Tens of thousands of people around the world do it all the time. The real dispute is whether suicide is the best thing to do? But if it is the best thing to do and I am a clinician and you are in my office, why are you here? If you are here, then part of you is not yet convinced that this is this is the best thing to do, so let's work with that and do this work in a finite, structured and specific way. I'm going to ask a lot you as my patient to find ways of doing things differently. I'll show up and help you find other ways of coping. But I'm going to make you aware that you can't kill yourself according to law, because the law says that, if you are set on suicide in an imminent way, then I have to put you in the hospital whether you like it or not. It's not reasonable for you to expect me to break the law. But then one of your options is to not be in treatment so this conflict is avoided.

It sounds flippant and uncaring, but I don't mean it that way. I mean it to be very caring. Clinicians fail to be forthright about what the deal really is. They need to create a framework in which the patent can say, "I'll try that." I want in good faith a real commitment to giving this idea a go and doing my level best to work with that. And the clinician in turn must also say that they will commit to this kind of work, doing everything in their power to collaborate with the patient to help make your life livable. If it doesn't work, then it can be heartbreaking. In my experience, clinicians often fail to negotiate at the forthright and honest level. They get into a position where they feel blackmailed by the patients, use a power trip over the patient with the threat of hospitalization. Power struggles don't work for me. I don't like them. I believe suicidal people deserve a second, third, or fourth chance that they yearn for. At the end of the day, if they have thought that they have done everything in their power to make their life viable and they have turned over every stone, and they still want to kill themselves, who am I to say that they can't do that?

Dr. Connolly: That's very different from assisted suicide and euthanasia.

Dr. Jobes: My father just passed away, he suffered tremendously for six weeks. My feelings about assisted suicide are evolving. Mercifully, he went very quickly, but he suffered a lot. He was talking a lot about the business of assisted suicide and facilitating assisted suicide, but he wanted to live to his natural last moment. For my part, I am preoccupied with people who are alive, suicidal, and seeking treatment. But for those who clearly not interested in living and enduring incredible suffering and pain, who am I to say that you can't have some control over your end-of-life process? Even Ed (Shneidman) has said: "I reserve the right to pass judgment on every suicide, except my own." Or something along these lines.

INTERVIEW WITH CHERYL KING

Dr. Connolly: Let's start at the beginning. Where do you come from?

Dr. King: I was born in Detroit, Michigan. I am currently at the University of Michigan in Ann Arbor, Michigan, so I have landed close to where I began. In terms of training over the years, I circled the mid-western states. I was raised in the Detroit metropolitan area, then attended the University of Michigan as an undergraduate. I completed my doctorate in clinical psychology at Indiana University. From there I moved to Madison, Wisconsin where I did some teaching in the Department of Psychology at the University of Wisconsin and directed a early intervention program for the State Office of Mental Health. This program was federally funded for the prevention of child abuse. Then I came back to Michigan for a post-doctoral fellowship at the Lafayette Clinic in Detroit and from there joined the faculty at the University of Michigan. Along the way, I was out of the workforce twice when my children were born.

Dr. Connolly: Can we go back to your childhood?

Dr. King: I'm the third born child in my family, with two older brothers and a younger sister. My mother was trained as a high school teacher, but mostly stayed home with us. My father was in business. He was a CPA, Certified Public Accountant, who, after one or two years of working for another company, opened his own business in the metropolitan Detroit area. This was an accounting and financial advising firm.

When my siblings and I were grown, my mother went back to school and trained as a counselor, but the rest of my immediate family is all in business. My oldest brother and younger sister are CPAs, and my other brother was a manufacturer's representative. So, I'm the black sheep among the children of the family, although my interests aligned with my mother's interests. Nevertheless, in my home growing up, the conversations at dinner were usually about business -- the stock market. They certainly did not expand to any topics related to mental health, psychology, academics or suicide prevention.

Both of my parents grew up on farms in rural Michigan, and they were both the first persons in their families to go to college. They met in rural Michigan and moved to the city. They aren't living any more.

I had a very easy childhood. I thought that being third born was a gift. Neither too much attention, nor too much anxiety about what I was or wasn't doing. I got to just grow up. One of my brothers is only 10½ months older than I am. In terms of my parents' styles, they balanced each other out very well. I definitely received a gift from each of them. My father was extraordinarily easy-going, an eternal optimist. My mother was a more anxious person but also engaging, smart, and a perfectionist. They were very different people. I don't know how they survived together but we, as kids, got the best of what each had to offer.

Dr. Connolly: What was their religious background?

Dr. King: Catholic, but not on both sides. My father's family was Catholic, my mother's family was Methodist. They grew up in rural Michigan, only about 10 miles from each other, but

in totally different communities. My mother's family goes back to the *Mayflower*. They have it all tracked. Very English. My father's family was Polish and German, and they were living in an ethnic community where some of the older people spoke Polish or German and most of the people were Catholic. They met in a high school that served these two very different communities in the rural area.

At that time, if you were married in the Catholic Church, your spouse had to become Catholic. My mother converted to Catholicism when she married my father, but she would not allow us to go to Catholic schools, which was fine. We were not begging to go. It was a liberal Catholic upbringing. It was a blend, but we did go to a Catholic church while growing up. We were regular church goers. We had our first communion, we had out confirmation. I was married in a Catholic church.

Dr. Connolly: Do you consider yourself Catholic now?

Dr. King: I do. I went to church this Easter, but I'm not a regular attender. Weddings and funerals, Christmas and Easter, and sometimes in between.

Dr. Connolly: Tell me about your schooling.

Dr. King: I went to public schools. It was in a metropolitan area (not downtown) -- a populated suburban area. My high school had 2,200 students. The community was reasonably well-to-do, at least middle to upper-middle class. Fairly homogeneous, mostly European descent so it wasn't very integrated as an urban area might be. I always did extremely well at school. I loved school. I was born to be a student, and I'm a professor now. I had years when I never missed a day for illness. I had some really excellent teachers.

Dr. Connolly: Tell me about them.

Dr. King: I liked best the teachers who were the toughest. They allowed me to work at my own pace so I could go further if I wanted to. There was the regular classroom material, and then you could keep working ahead going into other areas. I had an English teacher in 6th grade who would let us work ahead in reading. I would get bored, and I would get in trouble to have something going on. I would stay after school to work off demerits. I had no traumas in school and academics were easy. I always had boy friends in school which made it more interesting. In junior high and high school, I was involved with cheer-leading and then baton twirling.

I had a great teacher in the 10th grade of high school who taught me how to write. I got back my first paper and it was minus, minus, minus. She had me write draft after draft and I learned how to write. I never wanted to go into mathematics because I could never see its practical use, at least at that time. What was I going to do with calculus and differential equations? But it came easy to me, and I loved problems, and so the mathematics classes were a lot of fun.

Dr. Connolly: What about reading?

Dr. King: I read all the time. Just novels. Non-fiction was too tedious. The classic and biographies. I loved biographies like of Margaret Mead.

Dr. Connolly: What novels stand out?

Dr. King: I loved *The Agony and the Ecstasy*. Leon Uris novels. The Dune trilogy. *The Lord of the Rings*.

Dr. Connolly: What about music?

Dr. King: I loved rock-and-roll and still remember watching the Beatles when they played on the Ed Sullivan show. I was about ten when I bought my first album, and it was a Bob Dylan album. I was born in 1955 in Detroit. So, perhaps it's not surprising that I grew up with Motown. Stevie Wonder, Diana Ross and the Supremes. And then it was the Beatles and Bob Dylan. Joan Baez. Joni Mitchell. Cat Stevens. I love female vocals, but I also loved rock-and-roll groups.

Dr. Connolly: Tell me about college.

Dr. King: After high school I want straight to college at the University of Michigan, a big university. That was exactly what I wanted. My parents suggested that I go to a small private school, but I only applied to the University of Michigan. I liked the opportunities there. The chance to get away. I grew up in Birmingham, Michigan, which wasn't a small town, but it was very homogenous. I wanted to go somewhere with more variety and more excitement. My parents never put any pressure on me academically. They never pushed or recommended that I do any particular thing in college. I was one of 4 children in my family, and it was important for my mother to be fair and careful to not have anything different for one of us. Academics came easier for me than for my siblings, but one didn't note that in my family. I sometimes didn't even show my parents my reports cards because I didn't want it to be an issue. This worked with the culture of the family.

I loved the University of Michigan, but I could probably have adapted to any place. I liked the chance to pick from all those courses and have lots of freedom to explore new relationships, activities and places. I didn't know what I wanted to do as a career and considered different possibilities. My mother probably influenced me into mental health because that fitted more with her teaching. She thought about the world with a psychological perspective.

I graduated in 3½ years. I never intended to. At that point, I was getting married, I didn't have any money, and I didn't need any more credits. So I graduated. I thought of law, medical school, speech and audiology, but I liked the social sciences and, specifically, psychology best. I also had enough credits in psychology to graduate. The University of Michigan had an Outreach Program where you could obtain more practical experience. I did a placement in the state psychiatric hospital and one in a disadvantaged impoverished elementary school. I also did a semester placement called *Institution and the Child* where I drove out to a residential treatment facility once a week to spend half a day there. As part of the courses, we journaled our experiences and insights. I found these experiences fascinating, and they definitely stimulated my interest in applied psychology.

Dr. Connolly: Did your marriage early interfere with your academic career?

Dr. King: Not really. I've been married 28 years. We were young enough and not set in our ways. I didn't go straight to graduate school. When I graduated, I worked as a therapeutic parent in residential treatment with adolescents for about a year and a half before I went to graduate school. A fabulous job, underpaid, and one of the hardest things I've ever done in my life was to leave, even though when I left it was the right thing to do, the right time. I learned from that position how much we didn't know about how to intervene with these youth, and how much I needed to go to graduate school to do what I really wanted to do. I was the therapeutic parent for a group of boys who had emotional problems or who had been removed from their homes. They had a mix of severe disturbances and histories of child maltreatment – schizophrenia, physical abuse. I worked with the same 6 or 7 boys the entire time. I was their "parent" from when they got out of school until they went to sleep. Helping them to learn how to use the buses, wash their clothes, cook, shop. We ate dinners together. I learned a lot from them and the entire experience, even though it was so difficult to leave them.

Then I went into a PhD program in clinical psychology at Indiana University in Bloomington.

Dr. Connolly: What does your husband do?

Dr. King: He's a PhD in biochemistry and microbiology. He is at the University of Michigan as a research scientist in immunology and microbiology. He works in the laboratory and manages a Biosafety Lab in the medical school. We went to Indiana University because we thought it had good opportunities for my husband and me, my family was close, and we love the Midwest. We picked Indiana because of the opportunities and we loved the feel of the place and the culture. Bloomington is a beautiful town and campus, and it is more liberal socially, as are all the three universities towns we've lived in. We had very little money, and we started living in an old turquoise trailer that the university had scheduled for demolition, until we bought a house for $19,000 (in 1978)-a white frame house with garage and a beautiful yard, about 700 square feet, which we remodeled a bit. It was in a lovely community with a park across the street, and just a mile and half walk to the campus. My oldest daughter was born in Bloomington, after I had finished all of the academic coursework for the PhD. After she was born, I worked part-time from home on my dissertation for a couple of years.

Indiana University is very strong in psychology. The department has its own building and a strong faculty across core areas of psychological science. The faculty provided very strong research training, and that was what enabled me to be an academic psychologist, which was the best fit for me. I had a mentor who was a lot of fun and very caring. He wasn't a famous scientist or even perhaps the strongest scientist, but he was smart and creative, and he gave me a lot of room to do my own thing. And, he was always there to help, which was a good match for my style. When my daughter was born, he never hassled me about my family responsibilities. He just met with me regularly and made sure I never completely buried my work. My husband commuted to Indianapolis

and worked there for a year before he started a graduate program at Indiana University in his area of study.

Dr. Connolly: Tell me more about your teachers.

Dr. King: Indiana had an unusual amount of course work for a PhD. The educational philosophy there was that, no matter what area of psychology you were training in, you should be a strong psychologist across the board. We had three years of course work. A lot of the courses were not in clinical psychology; I took courses in animal learning, cognitive science, social psychology, developmental psychology (which was my minor in my PhD), the scientific method and 4 courses in statistics, together with all of the other graduate students, studying in different areas of psychology. Some of the people who had a strong influence on me were not necessarily in clinical psychology.

Eliot Hearst, well known in the learning field, was fabulous. He made us think so carefully and critically. He never let us get away with the smallest logical error. All his exams were essays, long exams where you had to figure something out. It was good training in terms of the exercise of sharp thinking, the scientific method, justifying your statements, moving away from content to learning how to think and how to analyze. A lot of people can't teach that, but he did.

In clinical psychology, Dick McFall, a clinical psychologist, taught us basic clinical psychology and psychopathology. I remember him for the clarity of his thinking. He would take a complex problem and break it down so that you would know it forever. I've been very lucky with teachers, but I don't remember ever having a professor that I didn't learn from. I took whatever resources they gave me and rode with them.

Dr. Connolly: What was your dissertation on?

Dr. King: My dissertation focused on social skills and communication in young boys with attention deficit and hyperactivity disorder. Nothing like my research focus now. I completely changed areas after I was out of the work force when my second daughter was born. My research in graduate school reflected my advisor's influence and my clinical experience as an undergraduate. I also did a preliminary study with a second advisor, Dick Aslin, on babies' reaction to different facial expressions. I think of myself as a developmental psychopathologist.

After the second year and qualifying exams, we spent the entire summer reading the classics in clinical psychology followed by a written exam and then an oral exam. I wanted to do a dissertation in the child psychopathology area, and my advisor had worked on ADHD and he guided me to that area. I reviewed the research one summer and decided to focus on how they interact with peers. I was too ambitious in that study. After working through getting permissions from schools, I screened kids in grades 2-4 in several schools to identify kids with ADHD. I video-taped them in a real-life game situation in which they joined kids who were already playing a game and observed their behaviors if someone went out of turn. I video-taped about 50 groups, each of 3 kids. It was a long process. I learned what not to do and to not be too ambitious in a research study.

Dr. Connolly: The babies came along in the middle of that.

Dr. King: I had all of my dissertation data collected. My oldest daughter was born in 1981. I bought a computer so that I could work on my dissertation at home. I didn't go on internship with my classmates; rather, I took an extra year. My husband and I both had teaching assistantships, and we both taught part-time. I finished my dissertation when my oldest was two. Then we moved to Indianapolis where I did my internship. My husband was still working on his dissertation, and the internship gave me an opportunity to broaden my clinical child training. Bloomington was a small town, whereas Indianapolis is an urban area with a large medical school and a choice of clinical training rotations. I did 4 or 5 rotations, so I was able to gain a strong experience in the different kinds of work that clinical child psychologists could do.

Dr. Connolly: What was life outside of work in Bloomington?

Dr. King: We had good friends in our graduate programs, although these programs were small. I had 9 classmates and my husband had 5. We spent a lot of time with them. We had a weekly soccer game. We did a lot together - swimming in the quarry, camping in the hills and woods.

Dr. Connolly: What was next?

Dr. King: The University of Wisconsin in Madison, one of my favorite cities. My husband had a post-doctoral fellowship at the McArdle Cancer Institute, and I had a job as the state department of mental health, co-directing an early intervention program. I also did some part-time teaching at the university. We were there a couple of years. Before leaving, I was appointed Acting Director of Children's Mental Health for the State of Wisconsin. I left this position when my second daughter was born. I decided that I was too young to be a bureaucrat.

Then we moved to Michigan near where my family lived. My husband was offered a job at Wayne State University. After a year, I had a post-doctoral fellowship in adolescent suicide prevention at the Lafayette Clinic in Detroit, and that is when I moved into suicide research, but with no good reason other than opportunity. The clinic was state funded. I went back ¾ time (30 hours a week). The post-doc was with Alan Raskin who had left NIMH and was in semi-retirement. I did clinical work on the inpatient unit with suicidal adolescents and descriptive research on these adolescents. I started teaching in the child psychiatry training program, and then the University of Michigan, Dearborn campus, offered me a position as a visiting professor for a year. Then, a faculty position opened up at the University of Michigan, which was an especially strong match for me. They needed someone in child and adolescent clinical psychology, who had worked with acutely suicidal adolescents, to work on the adolescent inpatient unit and help other faculty develop a research program related to adolescent suicide. They were also looking for someone to teach evidence-based short-term adolescent psychotherapy. I took the job in 1989, and I've been there ever since.

Dr. Connolly: Tell me about your first suicide.

Dr. King: I haven't had a suicide among my patients yet. I've known of individuals who have died by suicide who have been on our unit, because we try to keep track of patient outcomes. Early on, we had a suicide on our unit, a teenage girl on 15-minute watches, who hung herself on a cord above the ceiling tiles. She didn't die but had to live in a nursing home afterwards. There was a major lawsuit with a huge settlement. I felt the weight of it. They asked me to do the postvention for the staff. One of the nurses who found the girl changed jobs.

Dr. Connolly: What was your research at that time?

Dr. King: When I began as a faculty member in the Department of Psychiatry, it was suggested to me that I integrate my research with my other work, which appealed to me. I decided to do descriptive research on suicidal adolescents. Why are some depressed adolescents suicidal and not others? How does the family fit into this? How could we recognize if they were using alcohol but not telling us? I had students helping me and also some nurses on the unit. My work became better over time.

Dr. Connolly: What is your best work?

Dr. King: After I was tenured, I built upon my prior research and clinical experiences and moved to intervention research. This was in 1998. Because I decided to pursue NIMH funding, I realized I had to increase my scientific rigor. And, I wanted to develop a supportive intervention for adolescents hospitalized for suicide risk that would be adjunctive to the more usual treatments of medication and psychotherapy. I received funds from Ronald McDonald's House charity to develop and conduct a large preliminary trial, realizing that the intervention may or may not pan out. The findings were promising. Now I have a large grant from NIMH, and I'm in the middle of a 5-year intervention trial. I moved to a different level, and I'm comfortable with that. Perhaps someday we will fund a center for suicide prevention. It can be an unbelievably strong professional experience to put grant applications together with a collaborative group of interdisciplinary colleagues. I worked on at least one day and night on it for 10 weeks. It involved bringing together the strongest scientists at my university whose work had relevance to suicide prevention to form a team.

Dr. Connolly: Tell me about your involvement with AAS.

Dr. King: A good friend, Mary Leonardi, is from Michigan and was the first president of the Michigan Association of Suicidology (MAS). I want to the first MAS meeting around 1988. I met Jay Callahan and Steven Stack, and they talked me into going to my first AAS meeting, in San Diego. I've missed one since. The people who influenced me to stay in AAS were David Clark and John McIntosh. They talked me into being the program chair for the New York City conference in 1994 when John was president. Then, David Clark persuaded me to be on the board. It snowballed, and after serving as program chair and secretary, I became president. For 7 years, I was dedicated to AAS, and it took a lot of my time. I'll always come to AAS.

Dr. Connolly: Where will you be in 10 years?

Dr. King: I don't know. I'm not especially ambitious in terms of additional goals. I don't expect to leave the University of Michigan. It has been a nurturing place for me, enabling me to develop my interests and program of research. And, I continue to be involved in the broader professional community. I am president-elect of the Association of Medical School Psychologists which is in the American Psychological Association (APA). I'm also on the Council of Representatives of APA now, and I'm probably somewhat over-extended, particularly as some of these activities are far removed from the problems that are of primary interest to me.

I still do my clinical teaching. I have a large research team, graduate students, post-doctoral fellows, honor undergraduate students. I have a strong commitment to research mentoring. I help people design studies, read their drafts. I wear a lot of hats. I'm the chief psychologist in my department and director of the child and adolescent psychology training program, in addition to the national organizational work. Because I'm also involved 50% of the time leading a major 5-year study involving several hundred acutely suicidal adolescents, that involves risk management as well. I have never been bored with my work activities.

Dr. Connolly: What are the biggest problems facing suicidology today?

Dr. King: Impoverished thinking. Getting into ruts with paradigms. Financial pressures that keep people from thinking broadly because they are chasing grant funds or chasing reimbursement for clinical services. We seem to be going down the same path and not thinking broadly. We need theoretical models, and we want them to be parsimonious, but we don't want to hold onto them beyond their usefulness. Someone comes up with a new idea and then, for 10 years, everyone is testing that model. Only some people are good at thinking outside the box and creating new models.

Dr. Connolly: Psychiatrists seem to have a narrower view of the medical model than other areas.

Dr. King: Psychiatrists are having an identity crisis these days, and suicide is more complicated than neurology or genetics. The DSM-IV system does not fit very well with children and adolescents. Nor is it helpful in understanding suicide. It is a way of describing some of the risk factors. I work full-time in the medical school, so I live with that model. You can use it as a tool but not be bound by it.

If someone wants to develop a long-term intensive treatment for suicidal patients, no one is going fund it because it seems to be unfeasible. We could spend 20 years studying short-term interventions that may be funded, but none of them may work.

Dr. Connolly: What about assisted suicide and euthanasia?

Dr. King: At the other end of the lifespan, I have mixed feelings. I have a lot of problems with assisted suicide because there is such an interpersonal component to it. I don't know how one can be neutral in assisting someone in suicide. You may be colluding with their

notion that they are a burden or suggesting to the person that it’s a good idea. As for euthanasia, you can talk about it but, if you had to face it, you might change your mind. Both of my parents suffered from debilitating illness for so many years. My mother struggled with cancer of undefined origin for 8 years in which she was never without chemotherapy for more than two months. In the end, she died from the treatments as much as from the cancer. The last years of her life were not of high quality. My father was a double amputee later in life. He had major heart disease and strokes and, when my mother passed away, he came to live with us for the last 1½ years of his life. My father was an optimist and never complained. They suffered so much, and yet they were strong people. I could see how other people might make a different choice. It might have been their religion or that they were so connected with family. They couldn’t imagine leaving before you had to.

INTERIVEW WITH DAVID SHAFFER[3]

Dr. Connolly: Tell me about your background.

Dr. Shaffer: I was born in South Africa. My father was an enterprising man who left school when he was thirteen. He supported all of his family, and he became very wealthy, acquiring a whole lot of companies which he would purchase cheaply and then develop them. He was a big risk taker, and he had a terrible temper. He was an enormous man and quite a character. I adored him. My childhood was dogged by illness because, as I subsequently found out much later on in life when I was in my middle fifties, that I had been born with an inborn agammaglobulinemia.[4] I have never been able to make certain types of immunoglobulins, and that has rendered me very prone to infections all of my life. Now I get replacement immunoglobulins, and it has changed my life. A lot of my childhood was spent being very overprotected. I was always falling ill, always getting a fever, and spending a lot of time in bed. They used to think it was tonsillitis and that they should take out my tonsils one more time, My father knew nothing about modern medicine and believed in wearing lots of sweaters, avoiding drafts and wearing a scarf around your neck to prevent sore throats. I remember that it was during the war that sulfur drugs had just been introduced, and they gave me sulfadiazine, and I remember becoming calcimined. Luckily, I survived.

Dr. Connolly: Let's talk about other influences at that time. What was your about religious background?

Dr. Shaffer: My father came from a religious Jewish background. His father had never worked. He had a bookshop, and he played chess, but I don't think that he was gainfully employed. The bookshop had been bought for him by my father. My grandfather came from a very religious background. A that time in the 1930s, there was a very strong anti-religious feeling in Judaism. Religion was regarded as a sign of primitivism and as reflecting a lack of education. I did go to the synagogue for my bar mitzva, but I didn't go back much after that. I was frightened by the man who taught me for my bar mitzva because sometimes I would forget to put on my hat. He was on a high platform, and he would point down to me like the Lord, pointing to my bare head. I would scuffle around looking for my hat to put on. Occasionally I would drop my prayer book, and this seemed equally sinful. I always felt that it was an unappealing religion, particularly if you were living in South Africa at that time. It was so elitist, and also Jews were subject to a lot of anti-Semitic remarks. My mother read the news every week, and she had many Trotskyite friends, and that aspect of the 1930s was present in the house, but my father was strictly a businessman who spent his spare time racing horses.

Dr. Connolly: Did you read a lot at that time?

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[3] This interview was not edited by David Shaffer.
[4] X-linked agammaglobulinemia (XLA) is a primary humoral immunodeficiency characterized by severe hypogammaglobulinemia and increased risk of infection.

Dr. Shaffer: Yes. I read a lot, but not terribly elevated stuff. Enid Blyton and the usual stuff that kids read but, in my adolescence, I read an enormous amount, mainly novels.

Dr. Connolly: Does anyone stand out as being particularly important in your development?

Dr. Shaffer: In adolescence I was very influenced by John Galsworthy and I found that E. M. Forster was very moving and rather sentimental. And William Faulkner, phenomenally involving consciousness and trying to record that. Galsworthy and Forster are very similar, and they both showed the contrast between privilege and social responsibility.

Dr. Connolly: What about James Joyce?

Dr. Shaffer: I could never understand much of Joyce,

Dr. Connolly: You probably have to be Irish to understand him.

Dr. Shaffer: Possibly, but I certainly enjoyed Graham Green and read all of his novels. In fact, *Brighton Rock* is a book I will always remember because, when I did my first suicide study, one of the boys who died was reading *Brighton Rock* and had it next to his bed when he was discovered. I don't know if you remember how it ends. There was a boy about to die by suicide and leaving his suicide message on one of those self-record wax gramophone records that they used to have on fair grounds. That is probably way before your time.

Dr. Connolly: Tell me about your adolescence.

Dr. Shaffer: I had missed a lot of school. I had another health complication, osteochondritis on my back, and so they put me in plaster and bed for a year. I had a tutor who would come and teach me, but I found it very difficult to go back to school. I found it unpleasant. The South African system was brutal to everyone, not just blacks. I remember the way we used to learn Latin was that everybody used to form a semi-circle. You put your hand out and then you declined or conjugated and, if you got it wrong, then you'd get the cane. It was fairly routine for the teacher to walk up and down between the desks randomly hitting us. There was also a military cadet corps including rifle shooting. We had to wear shorts, not long trousers, even up to the age of 18, and there was this lieutenant who would swipe you across the back of your knees if you missed the target. This was at the very best school in Johannesburg. It was an unpleasant atmosphere. I missed more and more school, and eventually they sent me away to Switzerland to go to school. My mother took me to school there, and my father followed a week later. His plane crashed, and he died. I joined my mother in London briefly and didn't get back for his funeral. I've never been back much to South Africa, except for the occasional vacation. When my mother died, I didn't go back even then. It was a place that I hated.

Dr. Connolly: Have you got any family ties there now?

Dr. Shaffer: My sister remained there, but my brother left as well. I went to a school in Switzerland which was a wonderful experience. We lived in a village and the great thing about Europeans at that time is that they treated teenagers like grown-ups, and the English was not that different from that spoken in South Africa. I remember the wonderful way in which you were treated as if you were a grown-up by the French, Italians and Spanish and the great feeling of confidence and joy that it gave you. I can remember the feeling of liberation of being in Europe and being away from South Africa and from England because, although England was not quite as bad, it touched on it.

The school I was at was a bit of a bummer. It was up in the mountains, the teachers weren't that good, and there weren't enough people there to really have competitive classes. After a while I started worrying about my future. I went down to Geneva one day, and I heard a lot about the International School there. I went to see the headmaster and he said that, if my parents would agree, then I could go there. I sold the idea in a letter to my mother, and she agreed. I transferred, and I had a wonderful life in Geneva, probably the best years of my life. My ambition was very much to become either a journalist or a politician. I was very left-leaning at that time, but then I had an incident.

I'd been driving a car for a long time, since the age of twelve. My father used to let me do things like that. Then I had a scooter, and then I got a car when I turned the right age, seventeen. I went to get my test but, on my way back, I ran into a lady who was on a bicycle and who was drunk at the time. It was a fairly shocking experience for me. She turned out to be fine. I followed her to the hospital, and she had discharged herself. After that incident I became interested in Catholicism at that point of my life, and I was interested in how you could be blame free, by which I meant forgiven. I used to occasionally think that the most forgiving people must be the people who understand why you do things and that perhaps the closest that you could get to true goodness was to be a shrink because the maybe you understood why people did things. At the time I thought that I ought to be a doctor. I went to University College Hospital (London}, and they asked me what kind of doctor I wanted to be. I told them I wanted to be a missionary doctor. I got in and did well,

I had a beard which got me into trouble from time to time. I had a series of fantastic girlfriends, and then I decided to become a pediatrician. I did my house jobs in Great Ormond Street and UCH, but there were some things about being a pediatrician which I found to be very awkward. The most difficult thing was encountering the kids who were always great. No matter how sick they were, they never seemed to know it. They hardly ever demonstrated fear, and it was great fun on the pediatric ward. All the kids would get high in the evening which kids tend to do. The nurses were nice, the kids were nice, and it was enormous fun. But I found it very harrowing to deal with very frightened parents who were very dependent on your information. I found it difficult to assume the role of telling parents what to do and giving advice. I found their dependency very difficult, and I continue to find that aspect with dealing with people very difficult.

Anyway, I decided that pediatrics wasn't for me. I had been assigned to one clinic, an assignment which was given always to the most junior member of the department at UCH. I was intrigued by the fact that there were so many competing ideas which were contradictory of one another, and I enjoyed the kids and their parents. I decided to drop pediatrics. Phillip Graham who was at Great Ormond Street with me at the time had just gone to the Maudsley, and he told me how great the Maudsley was, how

stimulating it was, what great people there were, and how fantastic Aubrey Lewis was. I interviewed, and I got a taste of my own medicine because I was interviewed by Michael Shepherd who, in his disdainful way, said "What do you want to do if you do psychiatry?" I said I would like to be a child psychiatrist. He said, "A child psychiatrist. What do you think a child psychiatrist can do?" He had a look of mock horror. He seemed truly appalled by my choice. I was sure that I would never get in, and so I left feeling that I had screwed up the interview, but I was offered a job. I came to admire his good sense of humor, and there were a lot of good people at the Maudsley. It was a terrific period. Aubrey Lewis was about to retire, I worked for Michael Gelder who was standing in for him, and they were fantastic people.

Dr. Connolly: It was a golden age for all of them.

Dr. Shaffer: It was terrific! it was wonderful. It was before Dennis Hill came in and screwed the whole thing up! It was a golden age of supreme skepticism, very hard thinking, a lot of emphasis on phenomenology, a lot of emphasis on classification, and a lot of skepticism about treatment. I found that a great relief, because what I found unsettling is when you keep resorting to the same model and the same explanation for everything. That is why I can't imagine how people can do pure practice or be psychoanalysts because they are always having to resort to the same explanation. It was quite a relief to get into the field of research where you didn't have to have any answers. You just have to have some questions, and eventually something may come of it. In order to do your academic degree, you had to have a research project. I had been at a seminar on youth suicide and that area seemed to be full of nonsense because it seemed that suicide was excessively rare in children and to lesser extent in adolescence, yet all the writing at that time was about what there was in adolescence that made you suicidal when what needed to be written about was what in childhood and adolescence protected you from being suicidal. I felt a lot of pleasure at being confronted with something that one could have a go at.

I got a small grant, £200 pounds, and I decided to do a psychological autopsy study. There had never been one on children who died by suicide. There had only ever been one study before, by Eli Robins. I would do one on all the children under the age of 15 who had died by suicide in England and Wales. The Registrar General gave me permission, and they started sending me coroner's records. It turned out there were only about three such suicides a year. They taught you at the Maudsley that good sampling was the most important thing. I remember that Michael Rutter used to tell me that the discrepancy in the results between different studies was almost always a result of the samples rather than by the method of the measurement that was used. I bought a tape recorder. a bit bigger than yours, and I would go from village to village, town to town. The Registrar General had said, I think very sensibly, that it would be wrong for me to interview the families, but what I could do was examine their NHS records, their school records and speak to their General Practitioners and their school teachers.

There were thirty suicides altogether who died in that time period. The coroner's records and the police reports were marvels. They would run anything from 30 to 150 pages, and they were full of interviews and very accurate recordings of activities and so on. I learnt a lot from that research. The first observation was the great frequency of aggressive and assaultive behavior in the kids. A surprising number of them had been

arrested or had been in trouble, often for fighting. Of course, now research is pointing to the twin underpinnings of suicidality and aggression. The second thing that was very interesting was that I they were all big kids. I did have post-mortem heights and weights and, when I plotted them on a height-weight curve, probably over 85% were over the 90th percentile, so they were precocious physically. In other words, they were physically advanced, suggesting some biological mechanism at work. The other interesting thing that emerged from that study was the little boy who died with *Brighton Rock* at his bedside in which the hero dies by suicide at the end of the novel. There was another little girl who died, and she had a tabloid newspaper next to her with the news about Stephen Ward. She died by suicide the day that he died by suicide. He was a romantic figure for some people

I had to go back to one town three times, and I said to the old GP, who used to go for a walk with me whenever I was there (we would sit on top of the hill with a cemetery below), and I asked him why on earth have you so many suicides in this town. He said, “Oh, it’s the weather, it’s the rain.” It dawned on me subsequently that one was witnessing an epidemic. The three things that I took away from that little study were communication, the strong relationship to aggression, and the curse of physical precocity. I don’t know that I have learnt a hell of a lot more since then.

I then came to America and eventually got back into suicide because people were talking so much nonsense about it. We did a $2 million study, and I don’t think I learnt anything more than I did from that tiny study of 30 people. In a way it showed Michael Shepherd to be right, that if you have a total sample or a fully representative sample, you are going to go a long way to making real discoveries. It was a terrific way to get launched at the Maudsley. I remember that, one day, Michael Rutter had organized a seminar for people, and somebody was ill and he asked me to talk about suicide. I had it clear in my mind, and I delivered a talk with five minutes preparation. At that point, I was really enjoying doing research, and I never really looked back on it.

Dr. Connolly: What lead you to go to the United States?

Dr. Shaffer: I had run through all the money my dad had left me, and the salary was lousy. I was a spoilt kid, brought up in great luxury. It was in 1977 when inflation was running at 35%, and I was keen to make a bit more cash. I had been earning about £700 a year, not a lot, and I was quite keen to be my own boss. I loved Michael Rutter, and he taught me basically everything that I know. He taught me how to think. I have more respect and affection for him than anyone else I know, but I felt it would be great to be a chief. I kept getting offers from America, but Mike would put me off them. Then I got an offer from Columbia University, and he said, “Well I can’t put you off this one. It’s good.” Columbia University had been a very psychoanalytic place for a long time, but they had suddenly appointed a new chairman at the New York State Psychiatric Institute (which was the Maudsley of the United States), a psychobiologist who was looking for somebody to do research in child psychiatry. Back in the 1970’s, there were hardly anyone in that field in America. There were about four or five people at the most. There was Rutter, myself, and a few other people, but not many. It wasn’t a highly competitive field. I applied for the chair at Great Ormond Street, but Phillip Graham got that. I didn’t really want to leave. I liked living in London, but it was an attractive offer.

Dr. Connolly: Have you regretted it?

Dr. Shaffer: I have regretted it at a personal level because I don't think that there is anybody quite as stimulating or as interesting as the English or the Irish. They think differently. There are a lot of negative things about the English. They have some of those qualities that I disliked in South Africans, that ready ability to denigrate and to express their competitiveness in a very hostile fashion. They are very intolerant.

Dr. Connolly: Some people say Aubrey Lewis was such a case.

Dr. Shaffer: Possibly, although I am not sure about that. I think Aubrey Lewis loved to see people do well, and he took real pleasure at his work. He helped develop an amazing number of people. He was cruel at times. He wasn't very considerate to other people's feelings but, in some ways, that was a compliment because he felt that people could take it. He took real pleasure at their success.

There have been several good things in my life. One of them was going to boarding school, especially the boarding school in Geneva. The other was arriving in New York and realizing that they understood that people lost their temper, that people would say things in a heated moment, but nothing was fixed, and that perfect behavior was not expected. I found that an enormous relief because there was always that feeling in England of blotting your copy book in some way.

There were good things about going to New York but, on the other hand, it is an ugly place. I have never really strayed very far from other Brits, and most of my friends are English, including my two wives and my current girlfriend.

Dr. Connolly: You were in New York City at the time of 9/11.

Dr. Shaffer: Yes, I was. I was on the telephone at the time. I have this office way up town about nine miles from the Twin Towers, but you can see them from my office. I was speaking to somebody, and he said that news had come over the radio. I looked out the window, and there was this enormous pool of smoke coming out of the buildings. I broke off the conversation. It was very disconcerting. We immediately converted the auditorium into a television room, and everybody gathered there.

It wasn't frightening for me, but it was for some people. Everybody cancelled their appointments they had, but you couldn't make use of the free time. Your mind wasn't able to do that initially. My first reaction, before one had any idea about how many people had been killed, was how infuriating it was that those beautiful buildings had gone. I remember driving down the West Side Highway on my way back home, because I live down near there, and seeing the Empire State Building and thinking how tacky it looked. I compared it with how a mother who loses a child might turn against a sibling as an inadequate replacement.

The next day was equally confusing. People started getting nervous. I initially cancelled going to India because I thought I couldn't make it. Then I found out that airplanes were starting to fly again. The main initial reaction was of terrible disorganization and then, after about five or six days, one became aware of all the people

who were missing. Outside all of the hospitals in New York, they placed photographs of all the people who were missing, and the people who were looking for them, and how to contact them. Each one was very moving. You might just come across one on a lamp post. As you drove past Bellevue Hospital, the pieces of paper covered the whole block, and the same thing was happening at St. Vincent's Hospital. The other notable thing was the fury induced by the television with its repetition and inability to put it into context. There was a wonderful editorial in *Private Eye* about how televised news has to be continuous whereas, in fact, news is episodic. The other infuriating side was that it was taboo, and to some extent it is still taboo, to say that this is the consequence of Israel. The Chief Mullah in Afghanistan said that you can blow us all up if you like, but as long as you go on having a large presence in the Gulf and as long as you go on being partial to Israel, it's going to keep on happening.

I was quite glad to leave for India. The misery and depression started to set in about six days afterwards when you started to hear that there was no chance of people surviving.

Dr. Connolly: Did you lose anybody personally?

Dr. Shaffer: No. I didn't lose anybody personally, but everybody knows people who did lose someone. It affected mainly the business world. The Business School at Columbia University was very badly affected. Many of their professors were lost.

Dr. Connolly: You mentioned you had two wives?

Dr. Shaffer: Yes. I married two girls, two English ladies, both of them considerably younger than me. I now have a girlfriend who is thirty years younger than I am. I find it very difficult to deal with very dependent people, including worried parents, people who are out to please you, and people who work in your department. I have always felt much more comfortable with people who will tell you what they really think, who will debate you every inch of the way. I feel much more secure in that kind of setting where people question what you say rather than just accepting it. Both of my wives were like that. They gave as good as they got! My girlfriend has the same style. It is not a comforting style to be married to because it's clearly not a caring environment.

Dr. Connolly: Have you got any children?

Dr. Shaffer: I have got four children, two by each marriage. My oldest son is a doctor, a dermatologist, and my second son owns a bar on 23rd Street. He was doing quite well, but it was recently closed down because of fire regulations. My 3rd son is still at high school, and I have a daughter who is my youngest. I love them all.

Dr. Connolly: Were your divorces traumatic?

Dr. Shaffer: Divorces are terribly traumatic, unbelievably traumatic, the most traumatic moments of one's life, much worse than death. I rarely see my first wife since being divorced, even though we share two children who I see all the time. The divorce from my second wife

was also very traumatic too. My kids are still living with both of us, and so we do see each other a lot, and speak to each other several times a day, but there were frightening aspects of getting divorced.

Dr. Connolly: What about the future of suicide?

Dr. Shaffer: Obviously, I have tended to stick to a rather simplistic view about suicide, because it is so easy to fudge things and to be sloppy and to say that suicide is caused by all these different factors. In fact, those fluffy models don't actually help you think. They stop you thinking. So, for heuristic purposes, I adhered to model of suicide as the symptom, although there were reservations about that because the big unanswered and maybe unanswerable question is: how does suicide get into the repertoire of your thoughts? Clearly, it's not in the repertoire of everybody's thoughts. It takes an illness for the thought to be acted upon although it is a perfectly logical thought. I stuck to the notion that the real truth about suicide is that it's not accessible to everybody, that you have to be sick to do it. I think that it took a couple of years to dawn on me that the suicide rate was no longer not going up, but that it was actually falling. It's taken an amazing amount of time for that to be broadly accepted. People are so geared to the journalistic notion that, to be interesting, something has to be getting worse. The fact that it is getting better is interesting, and, if it really is due to the very wide spread use of SSI antidepressants with their very low side-effects and their very broad action (because they reduce anxiety, irritability, and emotional responsiveness as well as reducing depression), then those are all the characteristics of kids who are driven to kill themselves. Therefore, it would not be surprising that many pediatricians would be reinforced for using them because they find that a lot of their patients are a whole lot better on those medications. They are prescribing them more and more, and that it is having an effect on suicide rates.

Yet it's still being resisted by lots of people. It's an interesting situation where paper after paper is coming out by pediatricians who are outraged at the appalling behavior of their colleagues giving out these dangerous medicines.

Dr. Connolly: Not of course by David Healy recently?

Dr. Shaffer: David Healy occupies a special position!!!

Dr. Connolly: He comes from Ireland I might add.

Dr. Shaffer: He just got fired from Toronto. I think he was unfairly criticized, by people who had conflicts of interest. They bought pressure to bear on his department.

I once took an imipramine, one 25 milligram tablet. It was after my mother died, and I noticed I was getting more and more sensitive. I was taking people's glances and comments amiss and feeling left out. I thought that maybe I'm depressed, and so I took one imipramine. It completely knocked me out. I don't know how anybody could survive it. I never took another one, and it had a dramatic effect on my thinking,

Dr. Connolly: What about assisted suicide?

Dr. Shaffer: I had a horrible event occur to me when I was a pediatric registrar. There was a little three-year-old boy who was a monster physically. He had enormous facial deformities, and he came in with pneumonia. He was a vegetable mentally, and he had some weird syndrome which is normally not compatible with life. I remember we were told that we shouldn't be too aggressive with antibiotics, and the boy succumbed. I will never forget the devastation that that mother felt and showed. That was a very scary event for me. The worst thing about being a pediatrician is telling parents what's best for them. Nothing gave pediatricians more pleasure than to take a failure-to-thrive kid, who wasn't breast feeding well, away from mother, give it to the Sister on the ward and see that the Sister could make the baby take food perfectly. We're better than mothers. Mothers are our natural enemies, and you are out there being a gladiator for the babies. That is still a very pervasive approach. I detected evidence of that in some of the presentations here at the conference, and it's still present in many child psychiatrists. It's so far from reality and from helpfulness.

One is impressed by the fact that, in the Finnish National Study where 4% of the suicides were found to have some form of cancer, 4%, and I'm not sure whether any of them were terminal. In a New York study, they looked at the method of suicide recommended by Derek Humphry's book *Last Exit* which had rarely been used (a plastic bag plus the whatever sedative you take) and found that it was now very popular. There wasn't a single suicide who had a physical illness. I think it's another example of physician arrogance. If somebody is a vegetable, then you assign responsibility to the relatives. If they are not a vegetable, you keep your mouth shut and do your best.

Dr. Connolly: What about the future of child psychiatry?

Dr. Shaffer: It has changed because of enormous economic pressures. Fortunately, that is flushing out the awful influence of psychodynamic theory. I am not questioning psychodynamic theory because there is much to support it, but I'm questioning its relevance to mental illness. Now, you're allowed to see a patient only ten times. I suspect that psychiatrists will be called upon much more than they have been, because they are going to be the only people who are educated in a modern fashion. Unless there is a revolution in who is allowed to prescribe, it's going to be much more medication dependent, especially as the effectiveness of psychotherapy is challenged. My fear is that it will end up being like tuberculosis before the war. If you were a TB doctor, you were the best. The great physicians of the country were TB doctors, and the master surgeons were all people that could do wonders with the lung. Then, all of a sudden, it became a mug's game. All they had to do was prescribe a pill, and the whole notion of TB treatment as an art died. Psychiatry as an art may die, it may simply merge into family practice and, from the public health point of view, that's wonderful.

INTERVIEW WITH MICHAEL KRAL[5]

David: Where were you born?

Michael: I was born in Toronto, Canada in 1956

David: What are your family origins?

Michael: My parents came from the Czech Republic. They escaped with my mother's parents and brother in 1950. It was a harrowing escape, and they had to run across a lot of land and hills. My mother was Roma (Gypsy) and I look like her.

David: Tell me a little bit about your early life.

Michael: I lived in Toronto until age 8. Then we moved to Montreal where my father got a job with someone who had the Canadian franchise for Holiday Inn. My family started out as poor, but with my father's new job, he started making much more money. He moved up the ladder and ended up forming his own company when the owner retired. His company bought the Holiday Inn franchise. I learned to speak French there.

David: What does your brother do?

Michael: I have a younger brother who, for about 20 years, had a vineyard. He sold it last year when he retired. He moved with his wife to a smaller city in Ontario on the St. Lawrence River.

David: What about religion?

Michael: I became an atheist when I was 15 and attending a Jesuit-run Catholic high school. I am still that.

David: Did you have any inspiring teachers at the Jesuit school?

Michael: My high school Spanish teacher. He was kind, and we played music together, in. and out of class. I also liked learning Spanish.

David: What books did you read in those school years?

Michael: I cannot remember what books I read. I was not a very good student, and I hated school until I went to graduate school. I found it boring. and I was not interested in the structure.

David: What music did you like?

Michael: When I was a teenager it was heavy rock, including Led Zeppelin and Jimi Hendrix. Then I got into jazz and acoustic guitar, listening to bands like Oregon and guitarists like

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[5] I added this interview because of Michael's unique work on suicide in the Inuti.

Ralph Towner, Bruce Cockburn, Derek Gripper (later), and Michael Hedges. I taught myself guitar and became pretty good, even though I never read music. I played electric guitar in bands since I was 17. In Winnipeg we had a great band that played Blues Brothers etc. and had a horn section.

David: What were your first experiences with death and dying or suicide?

Michael: I decided to study suicide after volunteering in a crisis center as an undergraduate. My only experience with suicide was when I was about seven years old. I was walking home from school and near my house there was a bunch of people looking at a house. I saw men taking a wrapped-up body into a coroner's car. Someone told me that the woman living there had killed herself, and that she had two small children. I still remember the scene.

David: Tell me about your undergraduate university.

Michael: My undergraduate space was the University of Guelph In Guelph, Ontario. I was a bit lost at first, being a first-generation university student. I graduated with a major in psychology.

David: You went to graduate school twice. What motivated you?

Michael: I did my first PhD in clinical psychology at the California School of Professional Psychology Los Angeles. Those were great years, and I enjoyed clinical work. I never was planning to be a professor, but I was very interested in my dissertation research. My dissertation compared, experimentally, three theories of social desirability with one another. Social desirability is when, on a clinical scale, people deny having problems. The three theories complemented one another. I never published it. I had some great teachers there, my favorite one being, of all things, my statistics professor who was very conceptual. I eventually went to Windsor and rose to be a tenured Associate Professor Psychology at the University of Windsor.

My second PhD was much later in medical anthropology from McGill University in Montreal. I got a position on the faculty at Yale University in anthropology. Yale offered the position to me after I did not get into their PhD program because their graduate school does not allow someone who already has a PhD to get another one

David: What were the reasons for the second degree?

Michael: What interested me in anthropology was that I had started doing research on suicide among Inuit in Arctic Canada, Nunavut. I wanted to see how anthropologists did research, and I was reading a lot of anthropology at the time.

David: Were there any memorable teachers in undergraduate or graduate days?

Michael: I liked a few professors at the University of Guelph as an undergraduate. I persuaded one to teach a course on hypnosis, and other students took it with me. Another taught the

history of psychology, and I was interested in that. Later, when I was a faculty member at the University of Windsor, I edited the *History and Philosophy of Psychology Bulletin*, a newsletter/journal of the Canadian Psychological Association (CPA). I was very involved in that section of CPA.

David: What motivated you toward studying suicide in the Inuit and other indigenous groups?

Michael: I started working with Inuit after I went to a conference of the Canadian Association for Suicide Prevention in Iqaluit, Nunavut in 1994. I knew that Inuit had a high suicide rate, but I did not realize that Arctic Indigenous people have perhaps the highest suicide rate in the world. At that conference, I had been asked to lead a panel on suicide research in the north. I was the only non-Inuit person on the panel. The audience was mostly Inuit with headphone translation between their language of Inuktitut and English.

We asked the audience what they thought was important to know about suicide. Many Inuit spoke. They had three major issues. What is it like for Inuit to be unhappy and happy? What is the communication like in families and in general? And what about suicide --why is the youth suicide rate so high, and what can be done to prevent it? We asked them how we should get this information. That was my first lesson in community-based participatory action research, which I had never heard of before.

At the end of the conference I was sitting with a group of people, Inuit and non-Inuit, most of whom had been at the session. I told them that I took notes and that we could have a project. Did they want to do it? There answer was yes. An Inuit woman said she would organize an Inuit steering committee, and I went south and organized a multidisciplinary research team of academics across several universities who did research with Inuit. We worked together for about 3 to 4 years and then applied for a federal grant. We got the grant, and that was our first study, asking the questions the Inuit gave at the conference. The Steering committee recommended two Inuit communities. One had a very high suicide rate and the other a low one. By the time we got the grant, they had reversed their suicide rates. Before I went north, I had phone conferences with members of the youth committees in each community. These committees were common, made up of young people getting together do put activities together for the youth. They helped design the study, as did the Steering Committee and the researchers. I have been doing participatory research in the same Inuit community for 25 years now.

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David: What is next??

Michael: Now I am beginning to do research on Roma (Gypsy) mental health in the Czech Republic. I have a research team in Prague.

David: You recently published two books: Tell me about them.

Michael: Yes, I published two books in 2019, and before that I had edited several. One book was on my research with Inuit, called *The Return of the Sun: Suicide and Reclamation among Inuit of Arctic Canada* (Oxford). It is historical, looking at the imperialism/colonialism by the Canadian government in the 1960s and 1970s. This changed the Inuit completely. It has had negative and positive effects, but the negative ones include changes in family

relationships. These changes have not been good. I think this is behind the youth suicide epidemic. My other recent book is called *The Idea of Suicide: Contagion, Imitation, and Cultural Diffusion*. It is my cultural theory of suicide. Suicide is not caused by distress, perturbation, psychache, or risk factors. They merely motivate the person to do something about their problems. Suicide is caused by the idea of suicide, the decision to take one's own life in response to the distress, etc. Ideas are cultural, and the idea of suicide is internalized by vulnerable people from their culture. Suicide is scripted in method and reasons across the world. These books fit into the critical suicide studies framework.

David: How did you get to your present position?

Michael: In the past, I have been a faculty member in departments of psychiatry, psychology, and anthropology, and now I am in a School of Social Work at Wayne State University. It is the best fit for me because a number of faculty members in the school do community-based research which I have been doing for decades. I was not liked at the Department of Psychology at the University of Illinois because of this. The psychologists there were very biological and hard-nosed.

David: You've also been involved in the development of critical suicidology. Tell me about that that? What motivated that and what does it entail?

Michael: Several years ago, along with a few other people, we started the Critical Suicide Studies Network. We published an edited book on critical suicidology, and we have had three international conferences, in the Czech Republic, England, and Australia. We are now all over the world. Critical suicide studies look beyond psychopathology and the individual. It includes political, subjective, social justice perspectives. For me, this is the future of suicidology, looking beyond where we have been.

David: How influential has your work been?

Michael: Has my work been influential? I do not know, but I hope so. With my colleague and friend in my Inuit research, we met with the people running the First Nations and Inuit Health Branch of Health Canada. They had tried suicide prevention, and it had failed trying to train Inuit from different communities in white suicide prevention. We told them that, when two communities organized suicide prevention themselves and put together their own activities, then the suicide went way down. The government people put together a new policy for Indigenous suicide where they give money to Indigenous communities to develop and run their own programs, based on our work and that of psychologist Michael Chandler at University of British Columbia. Michael also found that, when Indigenous communities have control over a number of things like education, health, police and cultural centers, their suicide rates are much lower. The government is putting together the new policy which is exactly what Native people have wanted, to be in control of their lives. I am proud we did this.

David: Ten years from, where will suicidology be?

Michael: I think suicidology has been stuck in the same place for a long time looking at risk factors and mental health. I'm enthusiastic about the potential of the critical suicidology perspective.

David: There's a life outside work. Are you married?

Michael: I am married with no kids. My wife is a professor of history at Wayne State University. She got her PhD at Yale when we were both there. Her research has been on Indigenous-French families in the Detroit area in the 18th century, and she published a book on that in 2020.

David: What are your current interests and hobbies?

Michael: I play guitar and I'm taking online banjo and jazz bass lesson (online because of Covid-19). I have a sailboat. I like to read, and I write. I am writing about how social work, community psychology, and public health are intertwined, on the mental health of MSW students, on Indigenous suicide prevention and well-being, on teaching a university course on suicide, which I do at Wayne State University and did at the University of Illinois. In the Department of Psychology at Illinois, my course on suicide was the most popular course, and this was a huge department.

INTERVIEW WITH DAVID LESTER[6]

Avatar: Where were you born?

David: In London, England.

Avatar: What are your family origins?

David: On my mother's side, I am half Irish and half English. On my father's side, I am Ukrainian Jew, but I never learned about that side of my family. I've always labelled myself as English, being raised as a Londoner.

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

David: It was an unhappy, even dreadful marriage. For the three years before my father left, they did not talk to each other. I was their messenger boy.

Avatar: Do you remember those early years vividly?

David: No. I assume that they were traumatic because I remember almost nothing. Any memory of those years is shaped by my mother's stories about them.

Avatar: Were you spoiled by your parents?

David: I guess so. As an only child, I got all of their attention, but I'm not sure that I always got my own way.

Avatar: What about religion?

David: My mother was Anglican and my father Jewish, but neither parent followed any religious customs or practices, so I was raised to be an atheist, which I am. However, I like Zen Buddhism, and I sometimes label myself as a lapsed Zen Buddhist.

Avatar: How were your early school days?

David: Elementary school days are a blur, but I went to a private school at the age of 11 (King's College School, Wimbledon) and that was an excellent school.

Avatar: Did you have any inspiring teachers there?

David: Yes. At 16, I choose to specialize in physics, chemistry and mathematics, and the next year and thereafter, we were taught by two great science teachers. Mike Smith, in particular, was great. He trained us to work independently, which served us well at Cambridge University, and he covered the first university year of physics. He wrote a textbook on physics for high school students and he had me help him with footnotes, etc.

[6] John did interview me, but the interview was not in the transcripts or the audio recordings sent to me.

Avatar: What books did you read in those school years?

David: I read a lot, but what? The traditional schoolboy books (like Billy Bunter), but by high school years I was reading the classics, especially Dostoyevsky and Tolstoy. There were three books that had a huge impact on me in high school and college years: Thomas Hardy's *The Mayor of Casterbridge*, Ivan Goncharov's *Oblomov*, and Nikos Kazantzakis's *Zorba the Greek*.

Avatar: How did they impact you?

David: *The Mayor of Casterbridge* made me fear that I might make a wrong choice at some point in my life which would ruin my life. It created great anxiety. Oblomov sits on a couch and does nothing until he falls in love. Once the woman says she'll marry him, he goes back to his couch. I stopped reading after that for two years. I chose to have my own experience rather than vicariously through books. And Zorba? I loved the book and the movie, and it urged us *to live*, the antithesis of Oblomov.

Avatar: Did you ever make the wrong choice?

David: Sometimes, I think that every major choice was the wrong one. But here I am, and it all sems to have turned out ok, so maybe I never made the wrong choice.

Avatar: What music did you like?

David: We had a great music teacher at King's College School who introduced us to classical music. He would show us the stories and scenes in music like the *William Tell Overture* and Tchaikovsky's *1812 Overture*, and he took us through Beethoven's *Grosse Fugue*. I bought the complete set of Beethoven's symphonies on vinyl.

Avatar: Have your tastes changed over the years?

David: I still like classical music, but I love AC/DC, and I like the rolling Stones. I've seen both in concert.

Avatar: When did you decide to study suicide?

David: The psychology department at Cambridge University was purely experimental psychology. One day, I was in the library, and someone must have donated *Clues to Suicide* by Edwin Shneidman and Norman Farberow. I picked it up and read the pairs of genuine and simulated suicide notes at the end. It seemed obvious to me which were genuine, and I had tears in my eyes. At graduate school in America, at Brandeis University, we were the last group of students to be allowed to choose our dissertation topics. When I was asked, I said *suicide* without giving it any thought.

Avatar: What were your first experiences with death and dying or suicide?

David: None with suicide, but I was born in 1942 and slept for 3 years in an air raid shelter in the living room, so I'm told. My mother says that I listened for the airplane engine noise and the warning sirens. I seemed to have been very anxious. If I had become a physicist, those early years would have been irrelevant. But as a thanatologist (studying the fear of death and life after death) and as a suicidologist, that experience has Freudian significance.

Avatar: Tell me about your undergraduate university.

David: If you were at King's College School, you went to Cambridge or Oxford Universities. Otherwise, the school was not interested in you. I was sent to Cambridge University, and assigned to St. John's College. I got a college scholarship and a government grant to pay for it. I went as a physicist but panicked after 1½ years. The only alternatives were the social sciences since they aren't taught in the school and so you aren't 4 years behind the other students. I chose psychology without any knowledge of what it was about. I tried to read a psychology book from the 1920s which was in the local public library, but my Director of Studies told me to read Hans Eysenck's books instead. I've always been grateful to Eysenck for showing me that my choice might not be so wrong after all.

Avatar: Were there influential teachers there?

David: Absolutely not! College life was horrendous. The living conditions were primitive and very restrictive. The university had the worst system of education ever developed. We attended lectures that could have been typed out and given to use to read. There was no interaction with the lecturers, no question and answer. Two lecturers, one in mathematics and, later one in psychology (Oliver Zangwill), never even looked at us. Luckily, King's College School had taught us to be independent. There were two good lecturers in psychology: Richard Gregory and Alan Watson, both without PhD degrees. Alice Heim supervised my senior thesis (on the Shaw Blocks Test, an intelligence test) and became a friend. When I went back to get my second PhD (in the department Social and Political Science on suicide), I stayed with her.

Avatar: You emigrated to America after your BA. Why?

David: The precipitating cause was that I fell in love with 17-year-old American, whom I wanted to marry. Her wonderful parents sponsored me as an immigrant (so I never had visa problems). We never married, and I knew that before I left, so the other reason was to get away from my parents and from depressing England.

Avatar: Where did you go to graduate school?

David: I was accepted (with no guaranteed financial support) to Berkeley in human engineering. But I saw an ad for Brandeis University, and applied there too. I was awarded a Charles Revson Fellowship (of Revlon Cosmetics fame) which paid for tuition and all my expenses. What a fortuitous and wonderful choice!

Avatar: Were there any memorable teachers in your graduate days?

David: I was fantastically lucky. There was Abraham Maslow of course, and I became his teaching assistant. He introduced to the beautiful theory of personality (theory of the mind) of Andras Angyal. George Kelly retired to Brandeis, and we had a Austrian psychoanalyst, Walter Toman, who presented a rational version of Freudian theory. Toman converted me to psychoanalysis, at least his version. Those three formed the basis for my own theory of the mind.

Avatar: What were your first research?

David: At Brandeis, I flourished. I had a rat laboratory and published a lot on exploratory behavior in rats (and later got a small NIMH grant). I developed my first fear of death scale and published the first article on the fear of death (and later on suicide) ever in *Psychological Bulletin*. For my dissertation, I focused on aggression in suicidal individuals, and I put together 5 or 6 studies for the dissertation.

Avatar: What were your fist jobs?

David: I taught for two years at Wellesley College, but then I was recruited by Gene Brockopp to be a director the suicide prevention center in Buffalo. I was there for two years, and that stimulated my career in suicidology. We published a journal (*Crisis Intervention*) sent free to suicide prevention centers and suicidologists, I wrote my first review of the suicide literature (1897 to 1969) published as *Why People Kill Themselves*, and much more.

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Avatar: What next?

David: I missed academia. I saw an opening for a new college, Richard Stockton State College, applied and became the coordinator (chairperson) of the psychology program. That was a fantastic job.

Avatar: Why not somewhere more prestigious?

David: After a private school and Cambridge University, I was done with prestige. Stockton University (as it called now) provided me swift promotion (Full Professor at age 33) and the freedom to publish whatever I wanted to. I did not have to focus only on prestigious journals and major works. I could do whatever I liked.

Avatar: You've published over 2,800 articles and notes. Why?

David: I used to get defensive when asked that question. A dear friend and colleague at Wellesley College, Ward Cromer, one day said, "David, why you just say, 'because it's fun?'" It is. I've had fun. And when people ask me why I publish so much, I answer back, "Why don't you publish more?"

Avatar: Tell me about your current research?

David: I'm old now, 78 as I answer these questions. My creativity has dried up. But I still like to play with ideas. I've just published a psychological autopsy study on 72 famous suicides, and an editorial on why suicidologists should support climate change policies. Those were creative and fun.

Avatar: How influential has your work been?

David: At graduate school, I used to go to the Countway Library in Boston to read the articles on suicide from 1897 to the present for my review. (I tried to read *everything*.). I would go into the basement, pull the bound journals off the shelves and blow the dust off them. "Your papers will soon be here too," I said to myself. Instead, we do a literature search online, and there so many articles on suicide that no one checks anything more than a couple of years old.

But, my 4 books reviewing the literature from 1897-1997 have helped lots of researchers. From the articles they cite, I know they used those books. Second, for some reason, I have acquired collaborators from all over the world, as Bob Goldney once said of me, from A to Z – Austria to Zimbabwe. Even today, I have two teams of collaborators in Iran, one team in Turkey, two in Italy, one in England, and more. By also publishing in journals from around the world, I may have encouraged researchers in those countries. Stephen Platt once chided me for publishing in a Czech journal, but I told him that, maybe, a Czech student would read that article and be stimulated in his or her research.

Third, my work on restricting access to the means for suicide was ground-breaking at the time, even though those early papers are rarely cited anymore .Fourth, I have focused a lot of my research and writing on minorities and the oppressed: African-Americans, Native Americans, Jews in the Holocaust, immigrants, the Roma (gypsies), etc. Fifth, our book on crisis intervention by telephone, developed initially at the suicide prevention center in Buffalo, became the manual for crisis counselors. And finally, often my paper, even if it was a one-page note in *Psychological Reports* (a no-no if you are at a prestigious university) was the first paper on that topic in suicidology. I hope I have stimulated others in their research careers.

Avatar: Ten years from, where will suicidology be?

David: My book in in 2019 entitled *The End of Suicidology* has a gloomy outlook. I think suicidologists will be reinventing the wheel, especially if they ignore what has been done in the past. And with no one to review the research and theory since I stopped in 1997, they won't know what was done in the past. I was amazed at the ideas to be found in obscure publications during the period 1897-1997. Raoul Naroll's work was not to be found in journal articles, and his book had the weird title of *Data Quality Control*! Today, there are hundreds of "predatory" journals whose articles are not listed in the abstracting services, and I am sure that a lot of creative research and ideas are appearing in those journals.

Most of the theories of suicide from the last 20 years have been combinations of previous ideas, and not very original. The major theory from that period is Thomas Joiner’s Interpersonal Theory of Suicide, 16 years ago, and some of it is not new (thwarted belonging) and some of it does not apply to every suicide as claimed by Thomas (perceived burdensomeness). There was a recent review claiming that we still cannot predict suicide in individuals with any degree of accuracy or usefulness, and scholars, like Cas Soper, argue that we never will be able to.

Avatar: What is your position on assisted suicide?

David: It’s here and here to stay. I’m am in favor of assisted suicide, especially as set up in states such as Oregon. My wife and I have living will in which we reject the most intensive treatments for serious illnesses (such as major surgeries and transplants), and I can imagine deciding to hasten death if the palliative care fails me. I do not trust medical doctors to make the correct decisions for me. And as for psychiatrists, I have written scathing reviews of psychiatry.

Avatar: There’s a life outside work. Tell me about it.

David: There wasn’t much until I retired. While I was working, I built up a collection of maybe 3,000 books, some of which I read then, and which I read now in retirement – especially detective and spy stories. I began traveling while I worked, and my wife and I combined conferences abroad with tours of those countries. We travel as much as possible in our retirement. I’ve visited way over 100 countries by now. And we have always liked, and still do like, movies in theaters – not on the television or a laptop or smart phone.

Avatar: Are you married?

David: Many times. I’ve had three wives, all of whom were colleagues and with whom I published. Each was appropriate for the time, but I’ve been married to Bijou for 35 years now, and she had a tremendous impact on my life.

Avatar: How?

David: We met because I needed an econometrician to write a chapter in my book on the death penalty. (We always tell others that the death penalty brought us together!) Research on the deterrent effect of the death penalty was done by economists, and I didn’t understand their statistical analyses. I asked Bijou to write that chapter. I had been a hermit up to that point. Bijou took me to buy a suit and sent me off to conferences, first to AAS in San Francisco in 1987 where I met Steven Stack. People, like Ronald Maris, came up to me and said, “So you are David Lester,” and Ron invited me to be on the editorial board of *Suicide & Life-Threatening Behavior*. In 1994, married to Bijou, I published 116 scholarly articles and notes.

Bijou and I wrote a lot on suicide together, partly because I was able to take some of the concepts from economics and work with her to apply them to suicide: suicide rates

as a random walk (from the stock market indices as random walks) and the natural rate of suicide (from the natural rate of unemployment), for example.

Avatar: Tell me about your kids.

David: I have one biological son. Both his mother and I are psychologists so, of course, he became a lawyer. He and his wife run a website (indeed, *the* website) on world trade law (www.worldtradelaw.net). They have two sons, Andrew and Sean who are in high school. I have two step-children, Andy and Cindy, and Andy has three kids with whom I'm very close (Tyler, Julian and Natalie). But there are no psychologists or economists among them.

INTERVIEW WITH YOSHITOMO TAKAHASHI[7]

Dr. Connolly: Tell me about your early days.

Dr. Takahashi: When I was in high school, I wanted to study Japanese literature, but I changed my mind. I wanted to contribute both to myself and to society. I was interested in the work of Sigmund Freud and in myself. I lost two of my god friends to suicide, and I did not know why they died by suicide. I wondered why I did not catch their cry for help. That made me interested in psychiatry. I applied for medical school. After finishing medical school, I pursued a career in psychiatry.

Dr. Connolly: Tell me about medical school. Which teachers there impressed you?

Dr. Takahashi: There were many. [He mentions two.] As I said, I am interested in myself. Whenever I saw patients and asked them questions, those questions would come back to me. I am a mystery to myself. After finishing medical school and my internship, I was given the chance to work for a newly-founded medical school which is located in Yamanashi prefecture, about 100 kilometers west of Tokyo. There were not enough staff there at first, and so we had to work very hard. Mount Fuji is there, and part of the foothills are located in Yamanashi. There is a dense forest at the foot of Mount Fuji, the sea of trees, and people believe that, once you enter that forest, it is impossible to get out. It is hot-spot for suicide. When I was at the medical school there, I treated the patients who attempted suicide in that forest, but who were rescued. Among them, some lost the memory of the act. They had amnesia. That also led me to become interested in suicide prevention.

I applied for a Fulbright Scholarship, and I was given the opportunity to study in the United States for one year. I want to the University of California in Los Angeles, and my supervisor was Edwin Shneidman which was a great opportunity. I saw how a progressive suicide prevention program worked, and I watched Dr. Shneidman work with dying patients. It was a tremendous experience for me to stay in the United States for a year, 1987-1988.

Dr. Connolly: Tell me more about your relationship with Shneidman.

Dr. Takahashi: I had read most of his books before arriving at UCLA. When I was given a chance to study in the United States, I chose UCLA. It was very kind of him to accept me as a foreign student. That was his last year, and he retired just as I left Los Angeles. I was his last student. He let me sit in the consultation room when he saw patients. Of course, he asked the patients for their permission. It was a very interesting experience.

Dr. Connolly: Tell me about his theory.

Dr. Takahashi: Shneidman did not like the ICD or DSM diagnostic systems. He always said that we have to understand each human being over the life course. Shneidman did not like seeing see a patient at one point in his life, assigning a diagnosis and prescribing a

[7] It was not possible to get Dr. Takahashi to edit this interview.

medication. Shneidman wanted to understand how the patient came to this point and developed this response pattern, his background and personality traits. I really liked that idea. Mental health professionals should have this attitude. Shneidman said that people die by suicide and accept death in a manner that is consistent with how they lived. He didn't like Kübler-Ross's idea that people pass through 5 different stages of dying. People die as they live. I like that idea. We have to know the whole background of the person in order to understand why that person develops a particular psychological problem.

Dr. Connolly: Does that work in Japan?

Dr. Takahashi: The basic idea fits. I always say that that there are more similarities than differences in different cultures. We often focus on the differences, and that strengthens cultural stereotypes. Even in suicide, there are more similarities. I am often asked what are the characteristics of Japanese suicides. Japanese suicides have similar risk factors, psychiatric disorders and prior history of attempted suicide, predominance of males, older age, lack of support and accident proneness, and so on. I don't want to emphasize the differences.

Dr. Connolly: Sometimes we can learn from the differences.

Dr. Takahashi: Too much focus on the differences runs the risk of overgeneralization. But we do notice that Asian people in general complain about physical symptoms more when they suffer from depression. If we focus on mood and affect, we may miss the depression.

Dr. Connolly: When did you finish medical school?

Dr. Takahashi: 1979.

Dr. Connolly: When did you go to California?

Dr. Takahashi: 1987.

Dr. Connolly: What were you doing between those times?

Dr. Takahashi: First, I finished the residency in psychiatry. I was interested in doing research in electroencephalography, but then I became more interested in humans as a whole and not just millions of brain cells. Nowadays, mainstream psychiatric research is in molecular biology. Most professors of psychiatry do not see patients but are more interested in research and submitting papers to top journals like *Cell* or *Lancet*, a tragic state of affairs.

Dr. Connolly: What research did you do?

Dr. Takahashi: Mostly neurophysiology.

Dr. Connolly: Where were you born in Japan?

Dr. Takahashi: I was born in Tokyo.

Dr. Connolly: Did your parents have a strong influence on you?

Dr. Takahashi: Japanese parents often tell you what you should or should not do in the future. My parents always let me do what I wanted to do. They let me decide my direction. My father wanted me to be a lawyer, but he never forced me. When I chose my career, he supported me 100%.

Dr. Connolly: What did your father do for a living?

Dr. Takahashi: He was an ordinary office worker. My mother was a housewife.

Dr. Connolly: Do you have brothers or sisters?

Dr. Takahashi: I have a sister.

Dr. Connolly: What about spiritual values in your home?

Dr. Takahashi: That is a difficult question. I am an ordinary Buddhist. We did not go to the temple often or pray. We are told that we should get along on good terms with other people. We should not disturb the harmony with others. We have to learn what position we are in. To be too independent is not good, but to be too dependent is not good. We must know our position in society. We have to do our best. We have to thank others. We cannot achieve anything without the help of others. We cannot achieve on our own. But our philosophy and teaching are not very specialized.

We feel that our destiny is decided by an invisible power. Sometimes we have to stop and listen. Maybe we are given an assignment by this invisible power, and we have to follow that. It sounds very primitive. As I said, I lost my two best friends in high school and college, tragic events, but maybe that experience led me to pursue a career in psychiatry. I was given a chance to help suicidal patients and to study with Shneidman. Rather than deciding on that journey, I was destined to follow that path. I meet many people at AAS and IASP who are interested in suicide prevention, and I feel as if my batteries are recharged.

In Japan, suicide is thought to be something that we have to accept. If someone wants to die by suicide, who has the right to prevent it? This attitude is very strong. But at AAS, the enthusiasm here is very encouraging for me.

Dr. Connolly: How did your school deal with the suicides of your friends?

Dr. Takahashi: It was 40 years ago, and they did nothing. Classmates got together and cried. We were not offered any help at that time. Suicide is a taboo, hush-hush topic. It was thought that only time can heal the wound, and so we were left alone. They still think that way. They think that, if you try to educate students about suicide prevention, it will be very dangerous. It will wake up a sleeping tiger.

Dr. Connolly: Going back to your childhood, did you read very widely?

Dr. Takahashi: Yes, I liked reading. Dostoyevsky, Truman Capote, Solzhenitsyn, Saul Bellow and so on.

Dr. Connolly: What about philosophy?

Dr. Takahashi: I liked fiction more.

Dr. Connolly: What about music?

Dr. Takahashi: I like ordinary music – the Beatles, the Carpenters, easy listening. I love movies. I see about 100 movies each year, especially European movies.

Dr. Connolly: Tell me about your suicide research.

Dr. Takahashi: Japan's population is about 120 million, and there was an increase in suicides in 1998 to more than 32,800 suicides annually. The suicide rate is 25 per 100,000. This is a serious problem. Suicide is more three times the number of traffic accident deaths. There is a strong stigma toward psychiatric disorders, and people are unwilling to seek help from mental health professionals. This makes it very difficult for us to start interventions at an early stage. The rate is very high in middle-aged men. The economic situation has not been very good in Japan. There has been a high unemployment rate, and the suicide rate has been increasing in parallel with the unemployment rate.

Suicide as a result of overwork is a Japanese phenomenon. A series of cases appeared in the 1990s. There was a famous case in 1991, and the parents asked the company for an explanation about the overwork situation before he died by suicide. The company did not comply with their request. The parents filed a lawsuit which was appealed all the way to the Supreme Court which, in February 2000, supported the plaintiff's claim and approved the claim of 168 million Japanese yen (about 1½ million US dollars). The Supreme Court said that prolonged work hours and suicide were closely related and that companies are fully responsible for having a safe working environment for employees. In addition, companies are responsible for taking proper measures as early as possible if employees suffer from physical or mental disorders. In 1996, the Ministry of Labor stated that standard work hours should be kept according to the law. That is 1,800 hours each year, but many people work 3,000 hours. If there is overtime, the companies have to pay. In 1999, the criteria for psychiatric disorders and suicide were revised. They set up specific criteria. Since then, the number of claims for compensation has increased dramatically. In 2000, proposals for mental health care in companies were developed.

In Japan, it is believed that suicide is something that we have to accept and that we cannot do anything to prevent it. Finally, in 2001, The Ministry of Health and Welfare started a comprehensive suicide prevention plan. They set up a special committee.

Dr. Connolly: Are you on that committee?

Dr. Takahashi: Yes. They established a consultation network. People who suffer from depression typically do not go to a psychiatrist directly because of the social stigma. They often complain of physical symptoms and go to their general practitioner, but the general practitioners do not have proper knowledge about psychiatric disorders. We now try to educate the general practitioners to diagnose psychiatric problems and intervene properly. In addition, we set up research and education for different groups of the society.

The government moved in a systematic way for suicide prevention, like Finland and, provided research funds. It is a three-year, 300 million yen project, which is not a large amount. I hope that they will continue. Suicide prevention cannot be achieved in a short period of time. I am worried that, after a short period of time, they will stop. I am concerned that no one from the Ministry of Health and Welfare as attended this conference. Perhaps suicide prevention is not enough; they must improve basic mental health services which would result in suicide prevention.

Dr. Connolly: What other papers have you published?

Dr. Takahashi: One on suicide prevention for young children and one for middle-aged men at the workplace. The most serious problem is the elderly. Japanese elderly constitute 17% of the total population but account for 26% of the suicides. The elderly population is growing rapidly. In 15 years, ¼ of the Japanese population will be over 65 years of age.

I am also interested in the media and suicide. I collaborated in a study with Armin Schmidtke and Sandor Fekete to compare how the mass media report suicides. Unfortunately, the Japanese media sensationalizes suicide. They focus on suicide pacts, and family suicides (father/child and mother/child). After political scandals, occasionally a politician involved chooses suicide, and this is reported. A popular singer died by suicide in 1986 which was sensationally reported. Afterwards many youngsters died by suicide, almost all jumping from a high building as she did.

Dr. Connolly: What about the Internet?

Dr. Takahashi: Recently, one man and two women in their 20s used carbon monoxide from charcoal for suicide. They had recruited one another to die by suicide together. They had never met before. It was a new phenomenon, and the mass media jumped on this and labeled it as a cyber-suicide pact. In the next month, more suicide pact suicides occurred in young people. Eventually the mass media lost interest, and the number of cyber-suicide pacts declined.

I am interested in why people choose to die suicide in the same place, such as Mount Fuji, or using the same method. Perhaps they want to die in a beautiful place and, because many other people have died by suicide in the same place, they can share the experience. Mount Fuji is also perhaps a symbolic tombstone.

Dr. Connolly: Do you have a suicide prevention association like AAS in Japan:

Dr. Takahashi: Yes, but very weak. We try to coordinate between the professionals and the volunteers. However, the mental health professionals do not think that the telephone

volunteers are effective and that the service does more harm than good. I do not think so, but other psychiatrists and psychologists do. The volunteer counselors at the telephone suicide prevention center in Tokyo (Inochi no Denwa) are trained for two years. We teach them about psychiatric disorders and how to communicate over the telephone. It is a good education. Even after they stop being counselors, they go back into the community and become resources for the community because they have this knowledge.

Dr. Connolly: What is your opinion about assisted suicide and euthanasia?

Dr. Takahashi: I'm completely against it. How can you decide that a person is terminal, that they have, say, six months to live? That is based on statistics. It does not apply to each individual. My father had a myocardial infarction. It was thought that he would die soon, but he survived 8 years. Physicians make mistakes, so who can decide that a person has 3 or 6 months to live? In addition, people's wish to die fluctuates. People who want to die often are depressed. If we successfully treat the depression, then they may choose to live. We have to offer help so that they accept a natural death. As Herbert Hendin has mentioned, many physicians do not have the proper training or experience to make informed decisions.

Why do they ask a physician to help? I don't want to play the role of an executioner. If euthanasia was legalized, we would have to be very careful that a situation doesn't arise as in Germany before World War Two when many people were killed, such as criminals or people with genetic defects. There is the possibility of a slippery slope. I am very worried about that. As a physician, I want to value life. I try to see what the source of pain is for my patients. They may say that they want to be killed, but what is behind that? For example, they may not want to become a burden for their family.

Dr. Connolly: Where do you think that the breakthrough in suicidology will take place?

Dr. Takahashi: Many say biological studies, but I doubt it. Maybe I'm a Shneidmanian. Now, I'm more interested in clinical service rather than research. I am frustrated that many people do research for research's sake with little application for clinical practice. In research, even if you get consent from the patient, I feel uneasy about it. People who do research should see patients, should see the pain of the patients. If they don't, then they should not do research.

Dr. Connolly: Tell me about your family Are you married and do you have children"

Dr. Takahashi: Yes, I'm married with two children. My daughter is 23 years old and majoring in computer science at graduate school. My son is a student and wants to become a veterinarian. When my daughter entered junior high school, we had a celebration, and she wanted a Macintosh computer. It was very expensive, but I thought it was an investment for the future, and now she majors in computer science. My son wanted a puppy and now he wants to become a veterinarian. It's very simple.