Suicide Studies, 2022, 3(1)

INTERVIEWS WITH SUICIDOLOGISTS

John Connolly & David Lester

In the 1990s and early 2000s, John Connolly interviewed a number of those working in the field of suicidology about their professional and personal life. An effort has been made since then to obtain transcripts of the interviews, after which David Lester has edited them. They were then returned to those interviewed to be edited and approved by them. Some of those interviewed were deceased, and I have noted in a footnote that they did not edit their interview.

The process has been long and laborious. Transcripts prepared by John's secretaries were not always complete or made sense. Those sent as recordings have not always been clear enough for David to make transcripts. David has been slow in working with the transcripts, and those interviewed have not always edited their interviews in a timely fashion!

But we have made progress at last. This book presents all of the interviews in one volume. The majority are transcripts from John's interviews. Most were edited by the person interviewed, and a few people updated the information in the interview. A few interviews were lost, including mine. If you were interviewed by John, and your interview is not in this volume, please let me know (david.lester@stockton.edu).

Two recordings of interviews were unintelligible. For Brian Mishara, Brian and I have recreated the interview now in 2021. For the other unintelligible interview, it has proved to be impossible to contact the person. For my interview, I have recreated it, again in 2021. One individual declined to have the interview included. In addition, I requested one individual who was not interviewed by John to respond to my questions which were based on John's interviews. Michael Kral's interview is also included.

The following are the interviews.

Alan Apter
Margaret Battin
Alan Berman
Jan Beskow
Unni Bill-Brahe
Silvia Sara Canetto
Yeates Conwell
Diego De Leo
Thomas Ellis
Robert Goldney
Keith Hawton
Herbert Hendin

David Jobes
Ad Kerkhof
Cheryl King
Michael Kral
Antoon Leenaars
David Lester
John Maltsberger
John Mann
Ronald Maris
Israel Orbach
Antapur Venkoba Rao
M. David Rudd
Isaac Sakinofsky
Armin Schmidtke
David Shaffer
Morton Silverman
Steven Stack
Yoshitomo Takahashi
Kees van Heeringen
Mark Williams

INTERVIEW WITH ALAN APTER

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

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

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

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

Dr. Connolly: What years are we talking about?

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

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

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

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

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

Dr. Connolly: And that left a lasting impression?

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

Dr. Connolly: Do you have brothers and sisters?

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

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

Prof. Apter: No.

Dr. Connolly: Why were you attracted to psychiatry.

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

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

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

Dr. Connolly: Your religion would be more secular?

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

Dr. Connolly: Were you a devout family?

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

Dr. Connolly: Tell me about that.

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

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

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

Dr. Connolly: To all over the world?

Prof. Apter: All over the world.

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

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

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

Prof. Apter: No. I couldn't say that.

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

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

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

Prof. Apter: No, unfortunately.

Dr. Connolly: Do you play any musical instruments?

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

Dr. Connolly: What are your other recreations?

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

Dr. Connolly: Were you good?

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

Dr. Connolly: How many children do you have?

Prof. Apter: I have three.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: Do you ever go back there?

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

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

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

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

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

Dr. Connolly: Did military life appeal to you?

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

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

Prof. Apter: Sure. From my unit.

Dr. Connolly: That is very disheartening.

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

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

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

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

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

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

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

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

Dr. Connolly: Tell me about that.

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

Dr. Connolly: Did you have a personal analysis?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: What else are you involved in?

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

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

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

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

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

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

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

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

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

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

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

INTERVIEW WITH 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

[1] Original interview 2000; updated 2021.

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.

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 ALAN BERMAN

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

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

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

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

Dr. Connolly: What about your parents?

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

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

Dr. Connolly: What about your early school years?

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

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

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

Dr. Connolly: What about religion?

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

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

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

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

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

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

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

Dr. Connolly: What are your values?

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

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

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

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

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

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

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

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

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

Dr. Connolly: You inhaled?

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

Dr. Connolly: Where did you study psychology?

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

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

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

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

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

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

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

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

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

Dr. Connolly: What about your graduate years?

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

Dr. Connolly: Tell me about your doctorate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: How did you meet your wife?

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

Dr. Connolly: Any children?

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

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

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

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

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

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

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

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

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

Dr. Berman: Which one? Name one?

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

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

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

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

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

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

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

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

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

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

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

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

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

INTERVIEW WITH JAN BESKOW[2]

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

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

Dr. Connolly: How many of you were there?

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

Dr. Connolly: Where did you come in?

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

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

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

---

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

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

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

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

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

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

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

I was born in the countryside, and I like nature. Another memory from my early childhood, during my sick period, I struggled very much with the concept of death

because, when you are lying there alone in a room for month after month, apart from your friends, you ended up having a very strong religious conviction. One day, about ten years later, I was burdened with anxiety and feelings of guilt, and I talked to a priest about these problems. He said, “You have not a proper feeling of guilt. You must go away and come back to me when your guilt feeling is more genuine than you have today.” I went out of the church, and I never back again. But, nevertheless, I have always been interested in existential problems, and this has of course been of useful for my work as a suicidologist.

Dr. Connolly: Which church did you belong to?

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

Dr. Connolly: Where was your medical school?

Dr. Beskow: It was in Uppsala.

Dr. Connolly: Why did you choose medicine?

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

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

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

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

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

After coming to Uppsala where I did my medical studies, I lived with a friend of mine who also studied medicine. There were three rooms in our apartment, and one of the rooms was rented by a Hungarian refugee, a boy who had great difficulties finding his place in the Swedish society. He developed suicidal ideation, and eventually he died by

suicide. He took a boat to the Island of Gotland and, on the way there, he threw himself in the water. We knew that it may happen. Before he went on the boat, he had a small feast for us at a restaurant and gave us gifts. Earlier, we tried to talk with him and to seek help for him, but it was impossible to find any way out of this situation. Of course, this also has influenced me. I had a primary responsibility in this affair. There was no conflict between us, but I had little idea of what to do about his suicidality. Of course, with us living there, you always raise questions of what should you do and what should you have done. You can find things you could have done better and so on. That had an impact on me.

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

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

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

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

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

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

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

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

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

Dr. Beskow: The plan was to do a retrospective psychological autopsy study. We wanted to focus on male suicides because suicide is most common among males. I had 150 men from Stockholm and the surrounding district and 110 men from the North of Sweden to compare suicides in regions with high and low suicide rates. It was a very ambitious study. I visited all these 250, either in person or by telephone. For about two or three years I was going over the country. I had a flat in Stockholm, but I was traveling all over this big country. You learned very much sitting in the homes, speaking with the relatives and hearing how they discussed the man who died by suicide. I also had a social worker who collected information from the medical records and if they had any data from crime and welfare records. It took time. I started in 1969, and I was ready to write it up in 1979. That was an interesting time. It was hard work, and I added two researchers (two dissertations) to help me. One, Dr. Ulf Åsgård studied 104 female suicides from Stockholm and he is now an associate professor here in Stockholm. Another investigated 58 youngsters under the age of 29, and another who investigated 85 elderly people in Gothenburg. In total we investigated suicide in young and old men and women and got a total picture of suicides in Sweden.

Dr. Connolly: What about your current research?

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

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

You have quite a lot of people who are depressed. You have many people who have suicidal thoughts, and who can't manage their life. Compared with these numbers, there are not many who are attempting and even fewer who are dying by suicide. In accidents, it is physical abilities which cannot be managed. There is another car suddenly

coming up, there is child running out into the road, and you do not have enough time to avoid him. That's the same for the suicidal person. You have threats, you have situations which you have difficulty managing, and sometimes the psychological abilities make it impossible for you to manage. The theoretical picture is roughly the same for accidents and suicide. Therefore, I think it's quite correct to call suicide or a suicide attempt *psychological accidents*. Suicide in people who are healthy and sitting quietly is rare. Suicide is always accompanied by psychiatric distress or some type of psychiatric disorder. If you study cancer, some people choose suicide when they get their diagnosis of cancer or when they have much pain. They have become depressed. People who are not depressed do not choose suicide.

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

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

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

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

Dr. Beskow: I think that one of the most important developments is the research by Mark Williams and his collaborators. Of course, he is not alone, and he has taken ideas from

different fields but in a very good way. He has outlined a way to understand the suicidal situation in a way that is more substantial than and more in line with the facts. It is revolutionary in suicidology. He is building on ethology and evolutionary theory and on sound natural science experiments. He focuses on how people get into the suicidal situation.

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

If you study people who are frightened of spiders, they see them more quickly in a picture of nature than other people do because they have a genetic disposition for observing threats. That's very good. But, if the fear is too strong, it can be dangerous for them, and these people who have these negative perceptions have a tendency to identify themselves as losers. It has to do also, of course, with their background.

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

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

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

I am very interested in public health. I have worked administratively with suicide prevention programs in Sweden. But it has been very difficult to know what you can teach people. We know warning signals, but the problem with warning signals is that they

are very general. A lot of people have them. But I hope that it's possible to find ways for public education to use this.

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

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

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

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

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

have their own children, and I count them all (11 in total) as my grandchildren, and I have some responsibility for them all.

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

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

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

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

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

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

If you are frightened of looking at your own death, you will never be able to look at the possibility of the death of the earth, of *homo sapiens,* and you need to do this in order to increase your level of awareness. We may not change rapidly enough to solve the

cultural and technological problems of our time. I see most of the psychiatric distress has to do with anxiety and depression. Every man has the capacity to adapt to very different situation and increase his level of understanding. But you must be able to confront death.

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

INTERVIEW WITH UNNI BILLE-BRAHE

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

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

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

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

Dr. Connolly: It was a big adventure?

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

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

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

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

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

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

Dr. Connoly: What about children?

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

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

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

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

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

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

Dr. Connolly: What was the EU project?

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: The difference between depression and sadness.

Dr. Bille-Brahe: Yes

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

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

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

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

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

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

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

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

Dr. Connolly: That project will continue?

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: The Website might help.

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: Do you go frequently to concerts?

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

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

Dr. Connolly: What about literature and philosophy?

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

Dr. Connolly: Are you a religious person?

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

Dr. Connolly: What about your spiritual values?

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

Dr. Connolly: A kind of secular spiritualism?

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

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

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

Dr. Connolly: But your family background was Christian?

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

Dr. Connolly: Have you achieved that?

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

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

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

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

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

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

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

INTERVIEW WITH 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.

References

Azrin, N. H., & Foxx, R. M. (1971). A rapid method of toilet training the institutionalized retarded. *Journal of Applied Behavioral Analysis, 4*(2), 89-99.

Canetto, S. S. (1991). Gender roles, suicide attempts, and substance abuse. *Journal of Psychology, 125*, 605-620.

Canetto, S. S. (1995). Elderly women and suicidal behavior. In S. S. Canetto & D. Lester (Eds.), *Women and suicidal behavior* (pp. 215-233). Springer.

Canetto, S. S., & Feldman, L. B. (1993). Overt and covert dependence in suicidal women and their male partners. *Omega--Journal of Death and Dying, 27,* 177-194.

Canetto, S. S., Feldman, L. B., & Lupei, R. A. (1989). Suicidal persons and their partners: Individual and interpersonal dynamics. *Suicide and Life-Threatening Behavior, 19,* 237-248.

Canetto, S. S., & Hollenshead, J. D. (1999-2000). Gender and physician-assisted suicide: An analysis of the Kevorkian cases, 1990-1997. *Omega--Journal of Death and Dying, 40*, 165-208.

Canetto, S. S., & Hollenshead, J. D. (2000-2001). Older women and mercy killing. *Omega--Journal of Death and Dying, 42*, 83-99.

Canetto, S. S., & Sakinofsky, I. (1998). The gender paradox in suicide. *Suicide and Life-Threatening Behavior, 28*, 1– 23.

Cato, J. E., & Canetto, S. S. (2003). Young adults' reactions to gay and lesbian peers who became suicidal following "coming out" to their parents. *Suicide and Life-Threatening Behavior, 33,* 201-210.

Cato, J. E., & Canetto, S. S. (2003). Attitudes and beliefs about suicidal behavior when coming out is the precipitant of the suicidal behavior. *Sex Roles, 49 (9/10),* 497-505.

Coleman, D. (1992). Withdrawing life-sustaining treatment from people with severe disabilities who requst it: Equal protection considerations. *Issues in Law & Medicine, 8*(1), 55-79.

Coleman, D. (2002). Not dead yet. In K. Foley & H. Hendin (Eds.), *The case against assisted suicide: For the right to end-of-life-care* (pp. 213-237). Johns Hopkins University Press.

Ganchrow, J. R., Steiner, J. E., & Canetto, S. (1985). Behavioral displays to gustatory stimuli in newborn rat pups. *Developmental Psychobiology, 19*, 163-174.

Hendin, H. (1994). Seduced by death: Doctors, patients, and the Dutch cure. *Issues in Law and Medicine, 10*(2), 123-168.

Hendin, H. (1995). Assisted suicide, euthanasia, and suicide prevention: The implication of the Dutch experience. *Suicide and Life-Threatening Behavior, 25,* 193-204.

Kass, L. R., & Lund, N. (1996). Physician-assisted suicide, medical ethics and the future of the medical profession. *Duquesne Law Review, 35*(1), 395-425.

INTERVIEW WITH YEATES CONWELL[3]

Dr. Connolly: Where were you born?

Dr. Conwell: Wilmington, Delaware.

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

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

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

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

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

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

Dr. Connolly: How did the household operate?

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

Dr. Connolly: What about books and music?

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

Dr. Connolly: What about religion?

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

---

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

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

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

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

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

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

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

Dr. Connolly: How were your early school day?

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

Dr. Connolly: Did your teachers inspire you?

Dr. Conwell: Not at that stage in life.

Dr. Connolly" What about Australia?

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

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

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

and elsewhere. We flew crossing the equator twice and getting a certificate! An eye-opening experience for a 12 year-old.

Dr. Connolly Have you been back there?

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

Dr. Connolly: Did you see the outback?

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

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

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

Dr. Connolly: Any reading in those days?

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

Dr. Connolly: Music?

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

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

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

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

Dr. Conwell: Not until two years into college. I went to Princeton University looking for a liberal arts education, but medicine didn't crystallize until my sophomore year when I took a

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

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

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

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

Dr. Connolly: Tell me about university.

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

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

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

Dr. Conwell: My interest in suicide didn't stem come that. It came through my interest in geriatric psychiatry and late-life mood disorders, and then suicide as another perspective on understanding that set of illnesses in older people. I realized that the situations that suicidal older adults find themselves in are very much like the situations of the people I was caring for after strokes, fractured hips and hospitalizations - facing institutional care and nursing home care. Those two lines of experience came together to form my initial interest in suicide. The great majority of older people who are suicidal and who take their own lives do so because of the diagnosable and treatable psychiatric conditions, depression in particular. Over time, however, my understanding of suicide in the elderly has become more nuanced.

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

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

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

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

Dr. Connolly: Were there any memorable teachers?

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

Dr. Connolly: And then?

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

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

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

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

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

Dr. Connolly: Was Yale an eye-opener?

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

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

Dr. Conwell: At Yale one did a full year of medicine as an intern, so there was no psychiatry that year. In my second year at Yale-New Haven. I worked with Larry and Craig, watching what they did, which was very influential - seeing clinical research conducted in such a seamless way with good patient care being provided in an evidence-based fashion. Asking questions informed by observation of patients, searching the literature, being able to test hypotheses in the course of routine clinical care. As a second-year resident, I was able to work with them on some research that they were kind enough to include me in as co-author, relating to lithium augmentation for treatment-resistant depressed patients. Then it was a very busy time for the next couple of years. I started to look at late-life depressive disorders so stayed at Yale on a geriatric psychiatry fellowship for an extra

year after completing my residency. I worked with Craig on his unit looking at issues like the age of onset of depressive disorders. Older people who develop a first episode of depression in the second half of life have a phenomenological and perhaps a pathogenetically different disorder than those who have a recurrent depression in later life. Most of my work at that point was descriptive phenomenology, looking at symptom patterns, which led ultimately to the decision to study suicide as a set of behaviors that stood out as having a distinct profile in later life, and was epidemiologically distinct, yet closely related to depressive disorders.

Dr. Connolly: What did you do after Yale?

Dr. Conwell: I moved in 1985 to the University of Rochester. I had looked there already at their geriatric psychiatry fellowship, but I stayed at Yale. I was eventually persuaded to go to Rochester though and it wasn't a hard sell because they had such a strong geriatric medicine and psychiatry program. There was another fellow at Yale, Ron Miller, whom I knew quite well, a fellow who had received his geriatric medicine training at Rochester at the Monroe Community Hospital. MCH was established by Frank Williams and was a premier geriatric medicine teaching facility at the time. Frank went on to become the second director of the National Institute on Medicine after Gene Cohen had established it. Therefore, there was the attraction of an established geriatric psychiatry program very closely connected with a wel- developed geriatric medicine program. There was a lot of attention to experience with and sensitivity to the special needs of old people.

Dr. Connolly: How about your current research?

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

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

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

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

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

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

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

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

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

Dr. Conwell: As a geriatric psychiatrist I see the impact of ageism everywhere here in the US. I think older people as a class are very vulnerable to discrimination although it is couched in other terms. So while I don't have any trouble with the concept that there are plenty of situations in which it is reasonable and rational to want an early end to one's life, at the same time, that perspective is easily distorted by a set of biases against older people that could very easily lead on everybody's part, including the older person, to a belief it is

almost an obligation to end one's life early, the right thing to do and the easiest solution, when what we as a society ought to be doing is grappling with the our inability to provide adequate care and resources to keep people well.

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

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

Dr. Connolly: How influential has your work been?

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

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

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

Dr. Connolly: Are you married?

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

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

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

Dr. Connolly: How did you meet?

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

Dr. Connolly: Tell me about the kids.

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

Dr. Connolly: What are your family origins?

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

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

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

INTERVIEW WITH DIEGO DE LEO

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

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

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

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

Dr. Connolly: Maybe they have something in common?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. De Leo: Yes.

Dr. Connolly: Has there been culture shock?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: What about music?

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

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

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

Dr. Connolly: What about modern composers?

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

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

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

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

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

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

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

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.[4] 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

[4] Updated in 2021.

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 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 ROBERT GOLDNEY

Dr. Connolly: You are Australian born?

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

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

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

Dr. Connolly: Do you have siblings?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prof. Goldney: No.

Dr. Connolly: Why did you choose medicine?

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

Dr. Connolly: You had no regrets?

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

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

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

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

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

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

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

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

Dr. Connolly: And now you are a Professor?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: Do you teach a lot?

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

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

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

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

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

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

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

Prof. Goldney: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: You mentioned interests other than suicidology.

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

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

INTERVIEW WITH KEITH HAWTON

Dr Connolly: Where you were born?

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

Dr Connolly: What was your family background?

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

Dr. Connolly: Did you have any siblings?

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

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

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

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

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

Dr. Connolly: Were you always an avid reader?

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

Dr. Connolly: What about music?

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

Dr. Connolly: What about your religious background?

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

Dr. Connolly: Are you a churchgoer?

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

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

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

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

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

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

Dr. Connolly: Were any of your teachers influential?

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

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

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

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

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

Dr. Connolly: Tell me about your research.

Dr. Hawton: In 1976 I started our Oxford monitoring system for attempted suicide in which we collect information on everyone who presents to our local general hospital following intentional self-poisoning or self-injury. That has become an incredibly rich database. There has been a theme of work running through it, which has been largely epidemiological. Some other areas of my research have come partly from my interests in the psychology of suicidal behavior. I think that's an area I could have developed further and still might do. Our recent research in media influences on suicide developed because of an opportunity to carry out a project that has become one of the landmark studies in

the area. Much of my work of late has concerned treatment and prevention of suicidal behavior. I have covered a broad area - perhaps a bit too broad. Suicidal behavior is multifactorial so that to focus on only one line of work is unnaturally constricted and not in keeping with the full picture of suicidal behavior.

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

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

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

Dr. Connolly: What else?

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

or aspirin overdose, the numbers of liver transplants, and the numbers of people taking large overdoses. That is perhaps one of the most rewarding pieces of work we have done.

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

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

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

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

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

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

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

information base that the Finns have had. The Finns have been able to take an approach which is based on really sound knowledge about what seems to contribute to suicide.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Hawton: The Academy started off with the aim of providing an organization for researchers in order to facilitate research. That is a laudable aim. Unfortunately, it became caught up in issues which deflected the organization from that initial aim. I support the notion of providing an opportunity for researchers to get together, to present their work and to exchange ideas. I ran a similar smaller project like that in the UK – a meeting once a year of researchers to discuss research methodology. It's very exciting and invigorating and a tremendous way to generate ideas. The idea of doing it at international level is good. It can be seen as elitist, but I don't see it that way as long as the organization brings in up-and-coming researchers and provides a forum where they can hear more experienced people talking about research, where they can be given advice about research, and so on.

I see that as very valuable. Some people value the journal that comes from the organization, the *Archives of Suicide Research*. Initially I questioned whether we needed another journal in the field? Now I think it is justified, and it should be a forum for doing exactly what I have been talking about, allowing people to examine the methodology of suicide research and to provide high quality examples of suicide research. Unfortunately, such a journal is always going to be competing against the needs of researchers to get their publications into the more important journals, particularly now that many countries, including ours, are judging research output through the citation impact of the journals in which we publish. But I support the overall aims of the Academy, and I hope they can be achieved.

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

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

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

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

Dr. Connolly: You are a teacher too.

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

Dr. Connolly: You work on cognitive therapy?

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

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

Dr. Connolly: You also researched into yuppie flu.

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

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

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

very positive about the way clinical work was developing. We would argue, however, about sharing the housework!

Dr. Connolly: You enjoy sports.

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

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

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

Dr. Connolly: What other interests do you have?

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

Dr. Connolly: What about art?

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

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

Dr. Connolly: Are you looking forward to retirement?

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

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

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

INTERVIEW WITH HERBERT HENDIN[5]

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

Dr. Hendin: The project I am most engaged on is called the suicide databank. The object of that project is to get information from therapists who are treating patients who kill themselves. It's like a psychological autopsy study except that the informants, rather than being relatives, are therapists who have been involved in treating patients at the time they killed themselves. We have been doing psychological autopsies for about eleven or twelve years, and we have published three or four papers on this topic, and two more are about to come out. I think that our study provides a dimension that is missing from psychological autopsies studies that depend upon relatives because, very often, the relatives do not know what was going on with the suicidal individual. In contrast, the therapists have often seen the patient the same day or a couple of days before their suicide, and they have been treating the patient for a period of time. We have the therapists fill out questionnaires with clinical, psychodynamic and demographic questions and, in addition, their own reactions to the suicide. We can, therefore, look into what impact the suicide had on the therapist. Although that was not our original purpose, it is something that the therapists really wanted and insisted upon, and so we modified the project in order to do that. One paper has been published in the *American Journal of Psychiatry* and another is about to come out in the next few months.[6]

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

Our foundation funds research done by other people, but we do a few projects internally. I just came from Hungary where we have been engaged for the last four years in a suicide prevention project. The actual work is done by the Hungarian investigators, but we helped shape the project. Hungary has had, over the last hundred and twenty-five

---

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

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

years, the world's highest suicide rate. It is not the highest now, but it is still very high (close to 30 per 100,000 per year). The project is in a rural province in Hungary that has a suicide rate twice the Hungarian rate (55). We are educating the community and the doctors about depression in order to improve their treatment of depression with a view toward seeing if we can prevent suicide attempts and suicide in this high rate region. We are using the rest of the province (which has two hundred thousand people) as a control to see what happens.

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

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

Dr. Connolly: Is Ireland represented in that group?

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

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

Dr. Hendin: I think it was nice because countries in Europe, particularly Eastern Europe doctors, can't make a living, and so they come for training to America and they never go back home. You know we're happy to have them here, but it's a terrible loss for their home

countries. The doctors in Hungary go to work for pharmaceutical companies because they can make twice the money that they can make any other way, or else they go to England or America and they don't come back. I knew Kevin a little bit when he was in New York. We played tennis a little, and I knew his wife always wanted to go back to Ireland. There was an increase in youth suicide in Ireland, and that was one of the reasons that seemed to sway him.

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

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

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

Dr. Hendin: New York.

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

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

Dr. Connolly: Tell me about school?

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

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

Dr. Connolly: Do you have brothers and sisters?

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

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

Dr. Hendin: The reading in college was unique. I don't think there's any college that gives you a well-rounded and liberal arts education like Columbia University. They have a two-year core curriculum. You start with ancient civilizations and go to modern times. They don't do what most colleges do, which is let you take a course in this and a course in that, etc. It's a core curriculum that everybody has to do for two years, and they've maintained it even in the fifty years since I graduated. That curriculum stimulated me because, when I was in medical school, I used to re-read the books that we had to read in college that I thought had maybe gone over my head in college! I still have as a hobby reading about Greek civilization. I'm interested in Greek mythology, Greek history and Greek literature. History is one of my interests, and American history is a strong interest of mine.

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

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

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

Dr. Connolly: What about your religious background?

Dr. Hendin: My father left Russia before the revolution. He was a young communist in Russia, and his brother, who was 19, was arrested when the anarchists in Russia set off a bomb. Everybody was arrested who was a radical. His grandfather had inter-married into a Jewish family. If I identified him with any religion, it would have been as Jewish, but he was the way communists were in those days - very much an atheist. He had the Marxist idea that religion is the opiate of the people, and so I was not raised in a religious

tradition of any kind. My father was very active politically. He went back to Russia in the 1920's as head of a communist delegation, but he was the only one that spoke Russian. He heard from all the Russians how terrible things were; that; if you had any kind of political dissent. you were sent off to the gulags. He became very anti-communist as a result of that. He became a communist under Tsarist Russia where almost anything looked better than the Tsar. It turned out that communism wasn't good. He remained what you would call a socialist. He ran for Congress on the socialist party ticket and came very close to winning in 1932. That was the year that Norman Thomas, who was the head of the socialist party in America, won several million votes. But the socialist party had no chance in America. Franklin Roosevelt adopted all of their good ideas, and so they were not going to go anyplace.

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

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

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

In medical school, I can't say there was any one teacher who influenced me. The most significant thing that happened to me was that I had an elective in my second year of medical school. and I wanted to do something with suicide. I had a patient during a psychiatry elective who seemed to have everything going for her. She was a very attractive woman, came from a very well-connected family, and was very suicidal. I was very struck by her as a patient, and I wanted to learn something about suicide. The head of the department was a political figure, running around the country campaigning to become president of the American Psychiatric Association, which he eventually did. He said that he didn't want to take on suicide because he was doing an experimental study of EEG's. He wanted me to be an assistant on that project, but I said no. If there was a person who influenced, it was the deputy chairman of that department who was very nice

and really ran the department. He told me to come back and see him the next day. He told me that he liked the idea of what I wanted to do, and I should see a doctor in the department who ran one of the wards to get started on the project. It was on the tip of my tongue to say that he had heard what the chief had said - that I couldn't do that project - when I realized he had heard and he was telling me to do it anyway! I just kept quiet, and he assigned me to this doctor who was not a teacher of mine in a sense of taking classes, but who encouraged me. It was a project looking at every attempted suicide that came into the hospital over a long period of time. That's how I started and, naturally, I published a paper on that before I finished medical school. When I came back as a fellow, I did further work on that project. By the time I was 25, I had published two papers on attempted suicide in those patients. That deputy chairman has remained a friend for a long time. He encouraged me and made it possible for me to do things that I could never have done. The doctor to whom he assigned me was the same. He did not try to use me as an assistant for his research but encouraged me to do my own research. That's how I got started doing research.

Dr. Connolly: Did you undergo psychoanalysis?

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

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

Dr. Connolly: Were you in military service?

Dr. Hendin: I was in military service during the Korean War, after medical school and before my internship. That's the reason I got to Staten Island. I was hoping to go to Korea or at least to San Francisco to get out of New York. The government sent me a check for 15 cents to

cross on the ferry to Staten Island, and 10 cents for the bus. It must have cost them at least $1 to make out that cheque for 15 cents, but that's what they did.

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

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

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

fibrosis raises 130 million dollars a year, and yet there are only 125,000 people in the country who have cystic fibrosis. We have 30 thousand people who kill themselves each year in America and, if you take all the depressed people at any one time, you are talking about 10 million people.

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

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

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

Dr. Connolly: What age is that?

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

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

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

In 1956, I had bought some paintings from an art gallery on the left bank in Paris. We went back to that gallery but, unfortunately, the owner had died three months before. Her two daughters were running the gallery in the same place where it had been in 1956. It looked nicer because, back then, it had a mustier look - the way galleries used to look. They weren't so conscious of being clean and nice. They just showed the paintings. It

was nice to visit the family there and tell them my story. I was sorry I missed their mother by a few months, but one of the things I enjoyed doing in Paris was going back to places I had been, just to see what they were like now. In New York, the odds of a store being there 50 years later are nil. It couldn't happen.

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

Dr. Hendin: We were initially called the American Suicide Foundation back in 1986, and we took no position or interest in assisted suicide or euthanasia. Then, along came Derek Humphrey and Jack Kevorkian, and the public became interested in assisted suicide. People called us up and asked, "You're the American Suicide Foundation. Are you for it or against it?" I was asked to look into the problem of assisted suicide and euthanasia. If you had wanted to know about the issue, you had to go to the Netherlands which was the only place that was practising assisted suicide to any degree. When I went to the Netherlands, I was concerned only with the fact that I had a grant to study suicide among older people. I was very struck that older people, when they became ill, often became depressed and suicidal. I was very much afraid that the Dutch would be putting to death older people who were ill and depressed, but who could be treated. That was my concern. It never occurred to me that they weren't giving good care to people generally who were terminally ill. In my country, care was poor for terminally ill people, and I assumed that it had to be better in the Netherlands. That was my concern. They sensed that I didn't have a fixed position on assisted suicide, and they were certain that I would be persuaded of the merits of their system. So they gave me access that they don't give to foreigners, and they put me in touch with doctors who were practising assisted suicide regularly. They would present their cases to me, and I would see what was going on.

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

I spent hours with a woman who had lost her son to cancer and wanted to die. One doctor volunteered to be involved in her suicide. She told him that, if he wasn't going to help her now with suicide, she was going to it by herself. He asked for some consultants, but they didn't even want to see the case. The doctor was, in my opinion, succumbing to emotional blackmail. If a woman tells you that she is going to kill herself unless you help her, but you know that people recover from acute grieving even without treatment, you

don't have to assist her suicide. Nobody is ever happy who has lost a child, but she would not necessarily have been suicidal.

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

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

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

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

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

any time since he was married. I saw him the day before he died, and he told me how grateful he was to have those six months

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

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

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

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

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

Dr. Hendin: Yes. I was married when I was young and divorced when I was young. I was single from 27 till 40. I married again when I was 42, and we have now been married for about

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

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

Dr. Hendin: You need treatment centers to test one treatment against another treatment versus combining the two treatments to see if they work better than either separately. We don't have a good system of evaluating the treatments that we have, and the number of people who kill themselves is not large enough that you can draw any conclusions. You need a wider population base, and that's why you need this network. Our foundation can persuade the government to set up a network, but it will take 4 or 5 years. If enough people put enough pressure on Congress, eventually Congress will give you the money that you need only because they have a constituency and they want to remain popular or they want you to go away.

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

Prior to the last decade, we saw cases that were not treated medically and could never get better. But I have seen a smaller number of cases where you see that a treatment didn't work unless you didn't solve a psychosocial problem. If you solved that problem, the medication suddenly worked. I'll give you one example of what I mean. A patient was referred to me by another patient whom I had seen 30 years ago. She was 70 years old, and her 38-year-old son had developed multiple sclerosis a year or two ago and was going to a faith healer in Germany rather than accepting the new medical treatments which seemed to be slowing down the multiple sclerosis. She became depressed because she was unable to persuade her son to get medical treatment. She was going to a psycho-pharmacologist, but she didn't have confidence in him, and she hadn't responded to the medication that he has prescribed for her. I saw her four or five times. From what I could see, the psycho-pharmacologist had prescribed the correct medication and increased it somewhat because it hadn't worked up to that point. She told me that she saw him for

forty minutes the first time, and subsequent visits lasted five minutes just to renew the prescription. That’s how the people who do psychopharmacology practice. In the first interview, he had asked for the whole story but, as she finished, he said to her, “Do you have any children?” That meant he hadn’t listened to her. He had decided she was depressed, he decided on the medication, but he really wasn’t listening. She was furious with this doctor and, in some way, she was not going to let this medication help her no matter what it was. I suggested to her that she go back and see him and tell him what had pissed her off. She did that, and she recovered immediately. I let her stay on the medication for a month or two. He called me and was very grateful that I hadn’t told her to stop going to him. That’s what I mean about a psychosocial situation.

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

INTERVIEW WITH 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 AD KERKHOF

Dr. John Connolly: Where were you were born?

Dr. Ad Kerkhof: In 1952 in Holland.

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

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

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

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

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

Very much later, and after many years of clinical work, I became aware that my mother had a narcissistic personality disorder, and my sister as well. They had zero empathy and no self-reflection. In my mother's family there were more females with this disorder, and so it seemed to be hereditary. I wonder whether my father had features of autism spectrum disorder. He never had any friendships or good relations with another

person. He never had any relationships at all, not with my mother, nor with his children. In my father's family autism was abundant.

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

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

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

Dr. Kerkhof: Yes,

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

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

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

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

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

Dr. Kerkhof: Certainly.

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

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

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

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

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

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

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

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

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

Dr. Kerkhof: No. Not really!

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

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

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

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

Dr. Connolly: Are they still alive?

Dr. Kerkhof: Both my parents have died.

Dr. Connolly: You went on to university?

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

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

Dr. Kerkhof: I had this psychologist who was a priest, Han Fortman, a very famous man and a very nice man, a professor of cultural psychology. I read all of his books, especially about

Buddhism and Hinduism. He also told us about the role of projection in religion. He was very inspiring. I also studied mathematics. My grades were good, and the professor provided me with an opportunity to give workshops in statistics to first-year students. When one of the teachers became ill and had to be replaced, I was asked to give his lectures. So, there I was at 20, lecturing in statistics before an audience of 300–350 first-year psychology students.

Dr. Connolly: After university, what was next?

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

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

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

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

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

Dr. Kerkhof: About ten times. India is a fascinating country because it's so different. In India, if you walk on the street or watch television, you have a new experience every five minutes. You have unexpected encounters with a totally different culture. It is a challenge to understand why people do things and a challenge to live in that culture. My six months

there was a wonderful experience because, then I had to adapt, to live in completely different surroundings and still find ways to interact in a way that was agreeable to me and for others.

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

Dr. Connolly: How long have you been married?

Dr. Kerkhof: 21 years now.

Dr. Connolly: Children?

Dr. Kerkhof: Two girls aged 7 and 6.

Dr. Connolly: Are they spoilt?

Dr. Kerkhof: A little bit, yes!

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

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

Dr. Connolly: Is your wife a psychologist?

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

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

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

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

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

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

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

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

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

Dr. Connolly: What led you to clinical psychology?

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

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

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

Dr. Connolly: Are you successful?

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

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

Dr. Kerkhof: 35

Dr. Connolly: How did that affect you?

Dr. Kerkhof: It was awful. I had the opportunity to discuss it with my colleagues from the clinic, and it made me much more aware of the danger. We (myself and the psychiatrist who was treating her with pharmacotherapy) came to the conclusion that we had done everything we could. We had evaluated her suicide risk, and we had given her the proper

treatment. She had been admitted several times, and so the risk was always there. I really did not feel guilty afterwards but, still, it was awful.

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

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

Dr. Connolly: What are your main conclusions?

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

Dr. Connolly: You became a professor in Amsterdam?

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

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

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

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

Dr. Kerkhof: Yes

Dr. Connolly: It's a double bind?

Dr. Kerkhof: Yes

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

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

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

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

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

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

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

Dr. Kerkhof: We had until very recently no National Suicide Prevention program in Holland. The Government decided that it was not necessary. They said that suicide is a mental

health problem, and they left it to mental health clinicians to do a better job. But we have had a decrease in suicide by 25% since 1984.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Dr. Connolly: That would be murder.

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

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

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

Dr. Connolly: What about living wills?

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

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

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

Dr. Kerkhof: Who says that?

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

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

Dr. Connolly: You have been involved with IASP?

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

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

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

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

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

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

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

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

Dr. Connolly: What about your own death?

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

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

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

INTERVIEW WITH 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.

INTERVIEW WITH MICHAEL KRAL[7]

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?

---

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

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 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.

.

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 ANTOON LEENAARS

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

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

Dr. Connolly: Which persuasion was that?

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

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

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

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

Dr. Connolly: What was his business?

Dr. Leenaars: He had a greenhouse business which, as you know, in Holland is quite an enterprise. In our region of the Netherlands, my father was the only one with a greenhouse business. His main crop was tomatoes – we even had grapes. It was a happy childhood there.

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

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

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

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

I was, as a young teen, still very much involved in the Church. I was the head altar boy, the president of the youth club and all of those kinds of things. But there was another part of me that was a bit of the juvenile, nothing criminal, just teen mischief. One of my favorite stories about high school concerned a teacher in grade 13 who knew nothing about chemistry. It was the first year that they had a new chemistry book, and she would do these equations but make mistakes. I would put up my hand and correct her and

she would order, “Go to the office.” I would get hauled to the office and asked, “Why are you here?” [My calculations were always right.] This happened repeatedly, and the students in the class loved it. They would laugh! Later on in high school, I started reading everything. I even read the *Iliad* and the *Odyssey*, but I was also going out and drinking with my friends. I had two major girlfriend relationships. One lasted for about two and a half years.

In my last year of high school, I took a special history course on using personal documents to understand people’s lives, and I realized then, how different the textbooks were from what people were really experiencing - like slaves in the old South of the U.S. This teacher, Mr. Dan McMaster [who later was one of the guests of honor at my PhD party] did a marvelous job at introducing us to what people really said. He was a true teacher - rare, I think.

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

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

Dr. Connolly: Did your parents despair?

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

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

fortunate chance event. It's the best education that I ever had. In fact, I have now sent my oldest daughter there, who is studying psychology.

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

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

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

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

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

Dr. Leenaars: Yes. One of the things about Bill that was really helpful was that he allowed me to do what I wanted to do. He did not force me to do his research. I thought of a different way of studying suicide notes; others have called it, "novel." It is a theoretical-conceptual

analysis. Bill said, "This is a wonderful idea. Go with it." That was unique because most of the professors wanted you to do their research. Nobody spoke about suicide at the university, but I did my dissertation on suicide notes. [*Dank U* to Ed Shneidman and Norm Farberow.] There was, in fact, hardly any discussion of suicide in graduate schools or in the medical schools in Canada. [Is it different now?] There was a document that came out entitled, *Suicide in Canada,* and the psychologists and psychiatrists who were interviewed said that they knew everything there was to know about suicide. "Is that true?", I wondered. In those days, it was believed that suicide was depression and depression was suicide. All was simple. Was it?

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

Dr. Leenaars: My relationship with Shneidman developed, and we visited him, many times a year, at his home with wonderful picnics in his backyard, under a marvelous very large Birch tree. [Ed and his wife, Jeanne, called me, "son", a mixed blessing. I found a 'father' in Ed for whom I was yearning.] Ed would barbecue, and I would meet a whole host of people who were "Who's who" in the fields of psychiatry and psychology. These were wonderful experiences because we would sit and talk about the patients I was seeing who were suicidal. These later on became important cases in my forthcoming book on psychotherapy, *Psychotherapy with Suicidal People,* for which Ed was the consultant. There are case consultations with him on almost every one of the patients whom I discussed. It is a precious trove of clinical insight. We would spend hours talking, and he would also ask, "What about you?", addressing the counter-transferences. He was the best case consultant ever. I should mention one other master clinician, Dr. Terry Maltsberger, who influenced me greatly. He is a Harvard professor, and we edited book together, *Treatment of Suicidal People.*

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

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

Dr. Leenaars: I should go back to my career a little bit. Before I finished my doctorate, I got a job at the Windsor Board of Education. I worked in that position for about three or four years, but it was also where I started developing a deeper interest in suicide and especially postvention. I graduated in 1979, and in 1980 I got a phone call from one of the Superintendents. One of the kids in grade 6 or 7 had killed himself and the superintendent said, "You know about suicide. Please go to the school and do something". Now, I had had conversations with Ed about postvention, and so we did one. I think that it was one of the earliest suicide postventions in schools. Truthfully, many of

things that I did back then are still what I advocate today. Susanne got a job with the same school board a year later, and we started doing work together on suicide prevention in schools. Later we produced an edited volume called, *Suicide Prevention in Schools.* It was, I think, one of the first books on suicide prevention in schools. However, an opportunity opened for me to get a position at the University of Windsor and so I left the school board. They were saddened; they even had me hire my replacement. To this day, I continue a relationship. I also see many teachers in my private office.

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

Dr. Connolly: Why did you leave the university?

Dr. Leenaars: Because of my private practice. A beginning professor is very limited. For example, we were allowed $200 for Xeroxing per year, and now I spend that sometimes in a week. In private practice, I could make three or four times as much money as I could in academia. I liked working with patients, letting them tell me their stories and assisting and helping them. I am person centered, not mental illness centered. The opportunities in private practice are unique. My patients are still teaching me. I remember so many of them. For example, Justin was a four-year-old boy who had attempted to kill himself by hanging. When I first met Justin, he still had the rope marks on his neck. I recently wrote up his case in my psychotherapy book. Of course, I wasn't just seeing suicidal people because I believe one has to be more than just a suicidologist in a clinical practice. One has to see a wide array of patients. One has to know people generally, and the suicidal person specifically. [The nomothetic and the idiographic.] Besides, seeing only suicidal patients would burn you out. One can only see a few highly lethal suicidal patients in one's practice at a time.

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

Dr. Leenaars: No. On the contrary, after I left the university, I started doing more research. I had more time to do research. I started writing more books. At the university, we were confined to classes and sitting on useless committees. When I left the university, my curriculum vitae exploded. My studies with David Lester increased as well as my studies on suicide notes. At this point, I started developing a collection of suicide notes which included Ed's 700 notes, but now my collection is over 2,000 suicide notes from around the world. I take an ecological view. The private practice allowed me to have time to set aside for research and writing. I always set Fridays aside for my writing but you have to understand that people cancel, and there isn't another patient waiting for you until the

next hour. I had all these hours, on occasion, to write and proof read, so I ended up having more time and started writing and editing more books. I even became the first and founding Editor-in Chief of the international journal, *Archives of Suicide Research.* In 1989, I received the Shneidman Award for my research, which was a wonderful gift. I appreciated that recognition. [Just in 2001, I was honored with the International Association of Suicide Prevention's prestigious biannual Erwin Stengel Award, for outstanding research in suicide prevention.]

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

Dr. Leenaars: Probably my major administrative and programmatic effort was the Canadian Association for Suicide Prevention. There was already an attempt at the Canadian Association for Suicide Prevention (CASP), but it disintegrated. There were many reasons, and CASP ceased to exist after a few years. There was talk among us to resurrect it, and a distress center, Suicide Action in Montreal, did a marvelous job in getting people from across Canada to meet to try to resurrect this association. As I left for the meeting, I remember saying to Susanne, "I think that they'll elect me as the Vice-President," and when I came home she said, "Well, did you get elected Vice-President?" I said, "No," and she said, "I'm so sorry for you." I said, "I'm President." It, I think, was the Shneidman Award because that gave me visibility and was useful to the new association. I put a lot of energy and time into trying to re-make the association. The new Board voted to dissociate CASP from the old beginning - too much internal system-destructive strife. We had the first meeting at a university in Toronto, and I realized quickly that it was a mistake because people did not stay together after the meeting. We needed to talk. We needed to work as a whole. Thus, I decided that our next meeting would be at Lake Louise in the Canadian Rockies, because it is a majestic setting and more isolated. People stayed at the location. We talked, ate, and played together. It worked, and Lake Louise is now the spiritual home of suicide prevention in Canada. There is an old hotel there. It was one of the first winters that Chateau Lake Louise was open, and it cost us almost nothing to stay there – maybe $80 a night, whereas now it is $500 a night. It also snowed, and so people were stuck there. It produced a wonderful alliance. Building up the Canadian association took a lot of work and time. It was due to many of us.

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

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

I also became very involved in the American Association of Suicidology after being awarded the Shneidman Award. Someone once asked me, "Why don't you become

president?" I thought, "But I'm not American"; yet, I became the first non-American president of the AAS, which was a wonderful opportunity. I am still the only non-American president of AAS, an honor.

Dr. Connolly: Tell me about your private practice.

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

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

Let me back up. By this time, I also started doing other research because I realized that, although suicide notes were really important, research on them alone would limit me. As a result, I began, for example, doing research on gun control with David Lester. We also did comparisons between Canada and the United States because the Canadian government had put out a document called *Suicide in Canada*, but it should have been called *Suicide in Canada based on American Data*. I conducted research to show that our rates and patterns were different. At the same time, I met with George Domino and we showed that the attitudes in Canada and the U.S. were different. We looked at a whole array of issues, trying to take ownership of suicide in Canada, because the bureaucrats seemed to be interested in simply taking the American point of view. Canada had to own the problem. We had to set our own priorities. We had a meeting in 1990 with Perrin Beatty, the Minister of Health, which, by the way, is the last time anyone in suicide has ever met with a Minister of Health. Suicide in Canada is still a taboo topic. I'm blacklisted by the Government and the bureaucrats, but so were subsequent CASP presidents and the association itself.

Dr. Connolly: Blacklisted in what sense?

Dr. Leenaars: The Canadian government didn't want to address the problem of suicide. We don't have a national policy, and it's not a priority. I think that there's a taboo in Canada much different from your experience in Ireland. Suicide used to be glossed over in Ireland, but it's glossed over much more still in Canada. We're back where you folks were in the 1980's in terms of addressing the problem of suicide. In February of this year, we had the first meeting of researchers and practitioners, to set research priorities. This was

recommended over twelve years ago, in 1990, to the Minister, Perrin Beatty. Now, the President of the association is still struggling to get a national policy on suicide. The government is still refusing to meet and discuss it. Perhaps ten years from now something will be done. So far there's no money made available for the priorities that we proposed. As for *Suicide in Canada*, the document that the Government produced, there were wonderful recommendations made, but not one of the recommendations has ever been implemented. They are great at producing documents in Canada but not at doing anything. Similar problems occurred in Canada with drug reforms in the 1970's and mental illness. Of course, it may not simply be a taboo about suicide, but also mental illness in general. It may also be bureaucratic ineptness or prejudice and bigotry. What I do know is that there is stigma in Ottawa!

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

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

Let me talk a little bit more about my interest in Aboriginal people. A unique opportunity presented itself for me in 1990 to go to the Arctic. I remember flying out first to Yellowknife, near Great Slave Lake and then Rankin Inlet, which is on the Hudson Bay. I then went to Iqaluit on Baffin Island, the capital of Nunavut. And I flew for a day trip up above the Arctic Circle to Pangnirtung, the hamlet of "Pang." You fly in through this fjord. Many people there still have a traditional hunting and fishing lifestyle. I travelled to more of the Arctic. [It was like I was in a dog sled crossing the barren North.] However, I want to give you an idea about Pang. I was there in early September, and suddenly there was a snow storm. The plane could not land. There were no hotels in those days in Pang, so where was I going to stay. Fortunately, I had earlier met and was taken in by the minister of the Anglican church, and I offered to make dinner. So I went to the Great Northern Store which is the Hudson Bay Company. I bought 1.5 lbs. of hamburger, 2 cans of tomato sauce, and noodles that I needed for a spaghetti dinner. I also bought bread and peanut butter. It cost like $ 44.95! [A carver said, "Groceries are more expensive than Inuit carvings."] I started making supper and this Inuk girl, around 10 or 11, came in and said, "That smells good." of course, I understood and said, "Well you know, there's plenty". I continued, like a naive *qablunaats* (*kadluna, "whiteman"*). "Would you like some? But you first have to ask your parents". She looked at me and said, "I'm an Inuk". I had an "Ah!" experience; I knew my mistake right away. Among these peoples, they respect their children to make good decisions so, if the child makes a decision, they will respect it. It is a cultural tradition. It is the ethic of non-interference. Well, of course, word spread, and she was not the only one at the table. By the beginning of the dinner, I had twelve kids sitting around the table, and I was feeding them. It is truly a collective community. During the conversation at dinner, the girl asked, "Where are you from?" I described my home in Windsor, Ontario and the peach trees in my

backyard. We, I related, were just picking the peaches before I left, and she said to me, "I've never seen a tree before."

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

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

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

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

INTERVIEW WITH DAVID LESTER[8]

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

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

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.

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.

.

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 JOHN (TERRY) MALTSBERGER[9]

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

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

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

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

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

Dr. Maltsberger: My brother still has it.

Dr. Connolly: You visit quite frequently?

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

Dr. Connolly: Has that always been the case?

Dr. Maltsberger: Pretty much. Sibling rivalry

Dr. Connolly: You grew up in Texas?

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

---

[9] This interview was not edited by Dr. Maltsberger before he died.

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

Dr. Maltsberger: Maybe

Dr. Connolly: What about your religious background?

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

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

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

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

Dr. Connolly: Why?

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

Dr. Connolly: There is a famous story about Evelyn Waugh, the English writer. Somebody asked him why he chose to convert to Catholicism rather than to the Anglican faith and he said

it is better to be with something that is absurd and consistent than something that is absurd and inconsistent.

Dr. Maltsberger: That's correct.

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

Dr. Maltsberger: I go to Mass every Sunday.

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

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

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

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

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

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

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

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

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

Dr. Maltsberger: Probably.

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

Dr. Maltsberger: But it is fun to go back

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

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

Dr. Connolly: What about Henry James?

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

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

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

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

Dr. Maltsberger: I was in my second year at Rice University but, while it was a great improvement over South West Texas, at that time it was a technical school. It was an engineering school, and people who were interested in and wanted to study liberal arts were very much a minority. My father had not allowed me to have any other choice. He thought that I was very good at science, and he thought that I should have a scientific training and maybe become an engineer if I wasn't going to be a cattleman. I was there under his thumb in some way, but I was restless. At the beginning of my second year, a

visiting professor came from Princeton University- Willard Thorp. Professor and Mrs. Thorpe were from a type of people that I had never known and teachers that I had never known. He came to teach a few courses, but he also reached out to the graduate and undergraduate students. He organized all kinds of things for us. We had worked up a program in which different scenes from Shakespearian plays were played out at different places on the campus. The architecture of that place was a sort of renaissance architecture in some respects, with balconies in places. I remember that, among other things, we had the balcony scene from Romeo and Juliet played by undergraduates, and the whole place turned out for this. It was a year of tremendous excitement. There were other theatricals. They would invite the students to their home for parties, and it was enormously stimulating. I loved both of them and, when the time came for them to go back to Princeton University, I went with them and stayed.

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

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

Dr. Connolly: What about your medical school years?

Dr. Maltsberger: They were glorious. I loved medical school. I arrived at medical school late one summer - it must have been late 1955 or 1956 - and one of the last polio epidemics was raging in Boston. There were a great many sick children, and the medical students were volunteering in the hospitals to help nurse the people. It was a very dramatic introduction to very sick people, and a very immediate lesson that one could be useful. It did wonders for my self-esteem to get a medical training. I made friends that I still have, and there was a wonderful warm feeling of congeniality. There were only about 100 people in my class. We all lived together and had our meals together and, unlike some medical schools, it was not competitive. It was collaborative, and we helped one another. It was a wonderful time of my life. We worked very hard and drank too much on the weekends. When I arrived at medical school, I thought that maybe it would be psychiatry for me.

Dr. Connolly: Why was that?

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

I felt that, if I had a medical degree, I would see the great panorama of life, the life that I would not see from a library stall if I became a literature teacher. Medicine led off into so many directions so that it couldn’t be a mistake, and it wouldn’t be a trap. I went to medical school, and I was very interested in psychiatry from the beginning, although the rest of it was enormously interesting to me too. In succession, I was going to

be a neurologist (very briefly - I quickly gave that up) and then a pediatrician. By the time I was near graduation, I was very tempted to go into surgery, and I was offered an excellent position at Massachusetts General Hospital to train in surgery. I was very tempted and, when I turned it down, they were very disappointed. The Chief Resident said that, if you want to study psychiatry, I suppose you will, but don't you think it is terribly vulgar?

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

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

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

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

I decided there was nothing else to do except to take it to Dr. Semrad. He had a policy of always keeping his door open unless he was with a patient, so that you could see what he was doing or if he was busy. He was working on papers at his desk, and he told me to come in and, in my best intellectual Harvard Medical School manner, I began to present this case. I was trying in the way that I had been taught to keep the affect out of it and, as I got on to describe how she would cut herself, I began to lose control of myself and began to cry. I felt so humiliated and so ashamed and, when I recovered myself a little bit, he said, "I can see how much this patient matters to you. You care for her. I am

not sure, but I think if you will show the patient what you have just shown me, she will stop cutting."

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

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

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

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

Dr. Connolly: You have published a great deal?

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

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

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

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

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

Dr. Connolly: What are you currently writing?

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

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

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

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

Dr. Maltsberger: There was another teacher whose name was Ives Hendrik. He was an eccentric person, an old curmudgeon, an irascible man, who had the most remarkable capacity to

get close to a patient and to tune in empathically with the experience of all kinds of people - psychotic people, neurotic people. He taught me how to interview patients, and he was a magician in what he could elicit.

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

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

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

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

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

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

INTERVIEW WITH JOHN MANN

Dr. John Connolly: Where you were born?

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

Dr. Connolly: Where did your parents come from?

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

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

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

Dr. Connolly: Has the Holocaust had an impact on you?

Dr. Mann: It certainly has. We had a large family which was reduced significantly in size and, although I didn't experience it myself, it was very difficult for my parents to re-start life afresh in a new country.

Dr. Connolly: What did your parents tell you about it?

Dr. Mann: Not much. They were in a concentration camp for the last year and a half of the war and, like a lot of people who had that experience, they didn't talk about it. I think this is true for a lot of Holocaust survivors. It wasn't until they got much older, after I was grown up and married, that they came to terms with the idea of talking about it. It might have been different in other families, but we didn't discuss it much.

Dr. Connolly: Were you a religious family?

Dr. Mann: Yes. My grandmother and my aunt also survived and came to Australia, and my grandmother always remained observant. My aunt is somewhat traditional, and my parents a little less so. I grew up in a somewhat Orthodox Jewish environment.

Dr. Connolly: Where do you stand with religion now?

Dr. Mann: I'm still observant. We have an Orthodox Jewish household.

Dr. Connolly: Going back now to the early days in Australia, what was your schooling like?

Dr. Mann: I went to an Australian government day school, and we had religious studies in the evenings and on Sundays. Then I went to Melbourne Boys High School and then to Melbourne University. There is no college system in Australia. You go straight to medical school. I trained at the Royal Melbourne Hospital clinically, and I did my residency training there. I did internal medicine first and then psychiatry.

Dr. Connolly: What kind of reading did you do in your adolescence that shaped your thinking?

Dr. Mann: I read a lot of books. I read all of the Waverley novels when I was about 12 or 13. I found one, and I was so fascinated by it that I read the whole series. I read fairly widely. I was quite interested in English literature. I think medicine was really a way of just making a living.

Dr. Connolly: What about music?

Dr. Mann: Everybody seems to have a musician in their family as far as I can tell, but there were no musicians in my family. I never learned to play a musical instrument, and I was kicked out of the school choir because the chap standing next to me sang flat! I never pursued anything in the realm of music.

Dr. Connolly: What drew you into medicine? There are far easier ways of making a living.

Dr. Mann: That's true, but we were so young in those days. You had to decide what your career was going to be when you were in 10th grade, and in 10th grade you really don't have much idea what you wanted to be doing. When I was a kid, about 6 or 7, I was fascinated by the Flying Doctor Service in Australia. A lot of kids grew up wanting to be firemen, but not me. I decided I wanted to be a Flying Doctor. It seemed exciting - flying a plane and doing medicine. It stuck in my head, and I didn't think about a career except when I had to make a choice of going into the humanities (which gave you a choice of law, economics or business) versus the sciences (which were medicine, dentistry or engineering). I went for the sciences, and I followed the pack as it were. The best students generally went into medicine, except for a couple of geniuses in my year who became mathematicians. The rest of us didn't think we were smart enough to take a chance on mathematics so, like me, mostly went into medicine. I had never studied biology at school. In my last year at high school, I did two math courses, English, physics and chemistry, and so I had no idea what biology was like. I found out pretty fast though.

Dr. Connolly: What did your parents think of your choice of career?

Dr. Mann: They were pretty happy. It seemed like a sound way of making a living. My father in particular was happy because he had been a lawyer in Poland. He specialized in international law. He was a very gifted man. He was the best graduate they had had for a decade at Warsaw University, and he quickly advanced. He was invited to join a firm that practiced in international law, and he traveled all over the world at a relatively young age.

He worked for foreign governments in Poland and then, when the war came and he had to re-locate to a new country, his law degree was worth nothing because it was from a different country with different laws. He had to start law over again in Australia as a student, and he remembered that. He always said to me, doctors have a portable profession. It's the same profession everywhere in the world. So he was happy with my choice.

Dr. Connolly: How many of you were there in the family?

Dr. Mann: I was an only child because, by the time my parents got through the war, they were a bit older, and it was hard for them to have kids. They were rather poor at the time.

Dr. Connolly: What impressed you at medical school?

Dr. Mann: The Australian system at that time involved a 6-year medical school program. You did two years of all the basic specialties. The first year was an introduction to biology, organic chemistry and medical physics; the second and third years you did anatomy, physiology and biochemistry. So we had a very good grounding in the basic sciences. That really helped me because we learned the subjects by looking at pivotal papers. We got an idea of the scientific process that led to the answers. I had a marvelous lecturer in physiology, a chap who is famous in Australia but unknown elsewhere called Roy (Pansy) Wright. Pansy Wright was a legend in Australia. He was a brilliant physiologist, had a lot of publications, and became very involved in upgrading research in Australian Universities, trying to reduce the brain drain. The bulk of Australia's best talent left and went overseas. He gave lectures that I found really exciting and that got me interested in research. I still carry round in my head many of the basic principles that he taught, and I still find them useful in thinking through research design and experimental methodology. The professor who taught much of the biochemistry course, also by analyzing key papers and how the researchers carried out their experiments, was also a big influence. I found the clinical subject matter disappointing. It seemed a bit disconnected from the basic science subjects like physiology and biochemistry. What's exciting about today is that gap has now vanished. We have much more of a translational relationship possible in medical research.

Dr. Connolly: Were there any other stars in Melbourne or Australia?

Dr. Mann: There were very talented clinicians. My first clinical instructor was a woman called Priscilla Kincaid Smith who was the discoverer of analgesic nephropathy and one of the early people to pioneer the use of anti-inflammatory agents and steroids in the treatment of renal disease and the use of the renal biopsy to establish what the exact diagnosis was, rather than just relying on general renal function tests. She is one of the greats of clinical nephrology. She was President of the World Nephrology Association. I found her combination of clinical skills and medical research interests very stimulating. When I

graduated, I was very interested in research but, of course, you have to go into the trenches for a while because of your clinical training.

Dr. Connolly: Which trenches were you in?

Dr. Mann: I started with internal medicine, and I loved it. It never crossed my mind to do psychiatry. My original intention was to do cardiology, and then I became more interested in the brain and neurology. Then I did a psychiatry rotation as part of my training, and I found that so interesting. I thought, in regards to the brain, “That’s where we should be looking. That’s the raison d’être of the body - to keep the brain happy.” The brain is by far the most sophisticated and challenging part of us, and it seemed neglected, like an orphan.

Dr. Connolly: What year are we talking about now?

Dr. Mann: I finished medical school, and I started my residency in 1972. I did three years of internal medicine, of which one year was devoted to psychiatry. After that, I decided I was going into a different track. I did the boards in internal medicine and passed those, and then I did psychiatry.

Dr. Connolly: That was all in Australia?

Dr. Mann: Yes, all in Australia at the Royal Melbourne. When I was doing psychiatry there, was a tradition in those days that people did what was called an MD, a Doctorate of Medicine, which is like an MD/PhD. In the Anglo Saxon world, you graduate from medical school with a Bachelor of Medicine and Surgery or an MBBS. I decided to do a doctorate. Actually my boss in psychiatry encouraged me to do it. I did a doctorate in neurochemistry because he felt that was a good idea. I was a bit intimidated by the idea because I had never been a star at the bench. I grew up in the tradition of trying to do the experiments in organic chemistry and physiology, but essentially using last year’s laboratory book from somebody to make sure the quality was ok. We all did it. It reminds me of an old joke. “My mother has been serving us leftovers for so many years now that nobody can find the original meal.” I think the laboratory books were like that. We had been copying laboratory books for so many years in our medical school that nobody could find the original laboratory book where the experiment was actually conducted. There was a chap in Melbourne at another hospital who had trained with Leslie Iverson at Cambridge University in neurochemistry and monoamine oxidase, and he was kind enough to show me the ropes.

Dr. Connolly: What was your thesis on?

Dr. Mann: It was on monoamine oxidase in psychiatric disorders, in platelets, which was all the rage at the time. I made a significant little change in strategy- I went and also obtained brain tissue. I was convinced that we couldn’t keep doing research in platelets - we had to

get at the brain and have a look. I got some brain tissue and measured monoamine oxidase, types A and B, in the brain, and I was convinced that that was the way to go.

Dr. Connolly: What was your first publication?

Dr. Mann: My first publication was almost unrelated to psychiatry. It reported a hyperosmolarity state induced by lithium treatment that I published in conjunction with the registrar in endocrinology who was my registrar when I studied endocrinology during my medical training. He went on to become Dean of the Medical School. He was the brightest medical graduate we had since World War II. He and I published the article in the *British Medical Journal*. That was the first.

Dr. Connolly: And you never looked back. How many publications have you got to your credit now?

Dr. Mann: I'm not sure. Perhaps three hundred and counting.

Dr. Connolly: What colleagues then, apart from this registrar, made an impression on you?

Dr. Mann: I owe a significant debt to Brian Davies. Brian Davies was a Welshman who trained at the Maudsley and became the first professor of psychiatry in Australia. He was a quiet and understated person, and it was often difficult to know what he was thinking, but he was a superb diagnostician without explaining how he arrived at his diagnosis. He was also a phenomenologist and methodologist, and he was into double-blind studies - there are very few people in Australia who were doing them at that time. I think that's why he encouraged me to go to the laboratory. He believed in reducing problems to simple elements that you could test and, while sometimes these models seem naive and over simplistic, at least they provided you with a model that you could disprove. You could find inconsistencies in them. It wasn't so complicated that you could never fail to explain an experimental result. Here you could fail to explain the experimental result because it forced a certain precision. That has been very valuable in trying to do psychiatric research for, otherwise, you never make any progress because you never really disprove your model - you just keep tinkering and fiddling around with it so that it still explains the result. You feel that you are moving in the right direction, but you might be really going round in circles. I owe him a lot. Then there was a very fine clinician who worked on the inpatient unit and who taught me a lot about clinical psychiatry and diagnosis and psychodynamic formulation and how to understand the patient.

Dr. Connolly: What was your first brush with the reality of suicide?

Dr. Mann: Like everybody, I had a patient who died by suicide when I was a resident. It was a big shock. I remember it was a young mother with post-partum depression, and we thought we had succeeded with our treatment. We were wrong because we sent her out on a day pass, and she went out of the hospital to the tallest building on the university

campus and jumped off the top. That was pretty upsetting because she had a little baby. It was quite a shock.

Dr. Connolly: Did you get much support from your colleagues then?

Dr. Mann: Yes. People were very understanding. I had had to deal with disappointment and death in my medical training before. What I found far more moving was when I was a medical resident on a very busy in-patient and out-patient unit. We had a system where the in-patients were taken care of by the same attending physicians that took care of the out-patients and, as a resident, you looked after your patients and then you did two half-days a week with the out-patients. I had a chap who had a bleeding ulcer, and he bled to death. I was called from the out-patient department to run to the unit, and he was obviously bleeding. He looked really pale, and his blood pressure was hardly measurable. I put in two IVs running with saline. I called for blood, and they sent down a couple of packets because we had already blood typed him. I was kneeling on the bed, straddling him, and squeezing the two bags of blood with my hands to try and get the blood into him faster through these big-bore IVs, and he said to me "Doc, I'm dying." I said, "No you're not; hang in there." He died in front of me. That was terrible. I went to the autopsy. He had this massive ulcer with a big vessel right in the middle of it. Those two deaths, even 30 years later left an impression.

But I had no particular interest in suicide. I was interested in depression and mood disorders and lithium and mood stabilizers. Lithium was discovered by John Cade in my department. The first lithium clinic was established in our department, and I inherited the lithium clinic that had been started by John Cade. I got into suicide only because of this postmortem brain research. After finishing my degree, I went to New York thanks to a job offer from Sam Gershon, who was an Australian running a research unit at New York University. I met him at an international scientific meeting to celebrate John Cade's retirement. They invited some of the great names – Mogen Schou, Frank Aide, Sam Gershon and some other people. I was the third author on a paper from our department. I went up to Sam Gershon during one of the breaks, and I said to him, "I'm interested in spending a year or two in the States, just to see what it's like overseas, before settling down." I had an appointment at The Royal Melbourne and Melbourne University, and he said, "Sure; no problem; come and work for me." He knew that Australians were relatively non-neurotic and hard-working, and the low salaries paid to fellows wouldn't bother us. I said, "It sounds great; terrific." I had never heard of New York University, but I was willing to go there. I had the idea that I was going to do lithium research, but I found out, from one of his young protégés, Baron Shopsin, that Sam had got a divorce and part of the divorce agreement was that Baron Shopsin took over the lithium clinic. So Sam said, "Why don't you talk to the other fellows, find out what they are doing and work out your own research project." I found that amazingly unstructured. In Australia, any job that you took in the medical academic world had been occupied by somebody else for the previous 120 years, and so the job description was really clear-cut. To be told that you're starting a job, and you can do anything you like, just tell me when you've

worked it out, was quite disorganizing. I talked to the other fellows, figured out a few research projects and went on from there. We were only there for a year or two.

Dr. Connolly: You are married?

Dr. Mann: My wife is a fifth-generation Australian. She is also Jewish. Her mother's family came out on the first fleet of free settlers, and so they are famous. They played a role in the early days of Western Australia and Melbourne and Victoria.

Dr. Connolly: In those early days, would there have been a large Jewish population in Australia?

Dr. Mann: There has never been a large Jewish population in Australia, but there were Jewish convicts on the first fleet. In Tasmania, which was called Van Demons Land in those days. The convicts built a synagogue. There weren't many Jews, but they played a big role because Australia's first Governor General, when it became independent at the start of the 20th century, was Sir Issac Issacs who was Jewish. I never felt that there was any anti-Semitism in Australia, but there was obviously some prejudice.

Dr. Connolly: Did you encounter any of that in your school days?

Dr. Mann: No, not particularly. I went to the Royal Melbourne Hospital annual dinner for the attending medical staff at the Melbourne Club, a club which did not permit Jewish members! When the Governor General was Jewish, he was automatically invited to become a member, but he saved them the trouble by saying that he didn't want to be a member. Golf is big in Australia, and the annual doctors' golf outing was in a club that had no Jewish members. (It may sound funny to Americans that Australian doctors have a golf tournament.) Coming to New York was an eye opener, a heterogeneous city of tolerance that was a long way ahead of Australia and Melbourne. Australia was very homogenous in the days when I was there. It was pretty much all Caucasian and, when my kids arrived in the States, my three-year-old daughter had never seen anybody who wasn't white. One day, she pointed and said, "How come that man over there is brown?" We came from a very homogenous country with a society where things were done in a particular way. There wasn't a lot of innovation, and there wasn't a lot of tolerance for change in those days. (Australia is very different today.) The United States was the exact opposite. It was an absolute cauldron of bubbling activity, vitality and constant innovation, with a variety of people from different countries. The variety of emigrants and the tolerance for emigrants was much different in the United States because they had had a steady stream of emigrants throughout their history, whereas Australia had a bunch of people who came out in the early days, after which emigration slowed down. It was very controlled. There was a surge after World War II, but they were called "New Australians." There were New Australians and Old Australians. There was a clear sense of where you fell into society. My wife still has that prejudice in her although she doesn't realize it. When I mention my Australian identity, she'll immediately tell you that I was

born a couple of weeks after my mother landed in the country. I'm a New Australian whereas she is a fifth generation Australian.

America was a real eye opener. Of course, in Australia we had all sorts of prejudices about Americans. We thought Americans were rash, superficial, materialistic, uneducated, not very cultured, and did a lot of things that were silly. When I first arrived in New York, I thought, all the streets are numbered because they couldn't figure out names. It's been a long process of been humbled because soon I realized that you can tell the block of the dwelling from the street address, so it's really brilliant. It's a lot more user-friendly than our system with all the names because you have no idea where the street is from its name alone. With their system, it's a grid, and everything makes perfect sense.

Researchers don't read old papers and give proper acknowledgement to the people who came before you. That's not universal, and there are lots of people who are very careful about those things. Americans will spend the money necessary to get the right answer to a question, and much of the rest of the world doesn't seem willing to invest the resources to solve a problem. It's true for social problems as well as scientific problems. Americans are willing to put resources that other countries would not in order to get the right answer, the right solution or the right product. They are not afraid of innovation, and they reward hard work. In Australia, the academic scene has changed a lot. When I was there, there was a leisurely pace. I remember coming back to visit my old in-patient unit, and I couldn't find anybody. I asked one of the nurses, "Where are all the doctors?" and the head nurse reminded me of morning tea! I had forgotten. We used to take breaks for morning tea and afternoon tea. I had completely forgotten about that and, if you worked too hard there, people were suspicious. There was something a little odd about you.

Dr. Connolly: You came to America for two years?

Dr. Mann: I came for two years, and I realized shortly after I arrived that I was about a year behind on where the scientific frontier was. People were talking about methods and findings that I had never heard of. Of course, I realized that they are hearing about this because they talk to each other all the time. They go to conferences where the research is discussed, and they know what is going on. After I caught up I realized that being in the States (and maybe it's the same in Europe) you were at the epicenter of what's going on. If a person did a big study, it was important, and you heard about it on the grapevine. You didn't design experiments, as I was doing way back in Australia, without having much idea about what was going on except for what was published in the literature. By the time something is published, a lot of other work has already happened. You might not want to design the experiment that way if you knew about it. There was an enormous advantage to being in touch with what was happening in the field.

I was still planning to go back, and then I had a few fortunate breaks. I started getting into postmortem brain research because the medical examiner's office was across the street. It's in the NYU Medical Campus. By walking across the street, I could start collecting brain tissue. I happened to share an office with Mike Stanley, and that's how

we got into this research. He got the idea that, if you want to study depression, get the brains of people who commit suicide. I started collecting the brains of people who committed suicide, I started reading the literature, and I realized that only about 60% of these folks are depressed. What is wrong with the others? There's a serotonin abnormality but, in reviewing the literature, you could see the abnormality was there regardless of whether the suicides were depressed. People in the UK and Sweden had clinical information on the patients who died by suicide and, when I divided them into depressed and non-depressed, I saw that the serotonin deficiency related to suicide regardless of the diagnosis. I realized that we may be trying to study depression, but we're actually studying the pathophysiology that's related to suicide. Around the same time, I became aware of the work of Marie Asberg and Lil Traskman-Bendz at the Karolinska Institute with CSF 5-HIAA. It was a different approach and a different method but the same thing, Serotonin was related to suicide independent of psychiatric diagnosis.

Dr. Connolly: Where do you go from here?

Dr. Mann: We have learned an enormous amount by looking at the brain directly. The suicide research on the brain has revitalized postmortem studies and given them an enduring place in psychiatric research in terms of understand the details both at a neuro-circuitry level as well as at a cellular level - the molecular components that go wrong in psychiatric disorders. Post-mortem studies are going to be an indispensable part of that process now. That was very exciting, not to mention the huge amount that was learned about the precise things that have gone wrong in depression and in suicide, right down to the gene expression level. That's been very exciting. The post mortem work is valuable for many reasons, but it also gives us a scientific basis for designing brain-imaging studies. Designing brain-imaging studies without the post mortem work is guesswork but, if you have the post-mortem data ahead of time, then you can see which receptors and which enzymes are altered, and you can then make your imaging studies much more specific. Of course, the great question is: do you see the same thing in the living patients at risk for serious suicide attempts or suicide that you see post-mortem in people who have died by suicide. Are there serotonin and other receptor abnormalities present in our patients and can this form part of a biological diagnostic or screening for risk system, just like Priscilla Kincaid Smith with renal biopsies? We need to get to the biopsy level. There is no biopsy in the brain for psychiatry, but there are brain scans, so we need to get to that level. Hopefully, that will also inform us about medication selection and prognosis, in addition to helping us diagnostically. I believe that treating people empirically with drugs that take 6 or 8 weeks to work, without knowing what kind of biochemical abnormality they have, is unsatisfactory. We need to get to the point where you do an assessment, maybe brain scans, genetic profiling or a combination, and you can say, you are an SSRI responder, you are a norepinephrine drug responder, you need an Alpha II adrenergic receptor antagonist, or you need CBT or DBT because medications aren't going to work.

Dr. Connolly: How far away is this?

Dr. Mann: I think the next generation is going to be practicing differently from the way that we do.

Dr. Connolly: Changing the subject, you're President of the International Academy of Suicide Research.

Dr. Mann: I'm the President-elect.

Dr. Connolly: How do you feel about that organization?

Dr. Mann: I think that it is a very important organization that needs to be totally revamped. It's important because there is no other international organization for suicide researchers, and we need to enhance our dialogue. We need to take a more international view of what we're trying to accomplish. We have to stop inventing the wheel in each of the countries in which we're working, and so we need to improve that organization. It's an organization with relatively few members, and there are more talented investigators outside it than inside. Everybody agrees that there are a lot of people who need to be involved with it.

Dr. Connolly: Have you been involved with IASP?

Dr. Mann: I have been to a few of their meetings. I think that it does a very fine job. It has been doing to some extent what the Academy should. I belong to the organization. I'm a very big supporter of it, and I think it plays a crucial role because it also brings in all of the hotline people, crisis intervention people and suicide-survivor support-group people, and it casts a broader net. It is a forum where you can have a dialogue between the basic researchers, the clinicians, the family support groups, individuals and so on. I think that's very important.

Dr. Connolly: Tell me about your involvement with the American Suicide Prevention Foundation..

Dr. Mann: I'm very involved with that. It is probably the major source of funding for suicide research. The Foundation is dedicated to that task, and that's important. A third of its money goes to overseas investigators. It has a very fine scientific advisory board that has a lot of people from overseas and from the USA. It's growing significantly. We give about a million dollars away for research projects, and about the same amount is spent on educational types of activities. The amount of funding hopefully will be going up progressively. It's grown a lot in the several years that I have been associated with the Foundation. I'm very enthusiastic about that because it publicizes the importance of supporting suicide research to the general public and to people who would like to donate money to support it.

Dr. Connolly: We have a branch of the Foundation in Ireland now. Kevin Malone is working hard at that.

Dr. Mann: I'm very proud of Kevin. He spent quite a bit of time with us in the United States and has gone back to Ireland. There may have been a number of Jewish convicts on those ships that were sent to Australia, but there were a heck of a lot of Irish. The British treated the Irish badly. I didn't fully grasp this when I was in Australia because, just as my parents didn't talk much about their experiences in World War II, the Irish didn't talk much about the bad experiences that brought them out to Australia either. I went to school in Australia, and I had the classic education. I went to one of the better schools in the country, and they told us practically nothing about what happened to the Irish in Australia. The most famous guy is Ned Kelly who was not representative of the Irish in Australia. It wasn't until I read the book "The Fatal Shore" that I learned about the past. I went and talked to Kevin Malone, and I said, "This is really shocking." I read a lot more about Irish history. Australia had a difficult relationship with England, which is a polite way of putting it.

Dr. Connolly: It's to become a Republic soon, isn't it?

Dr. Mann: Australians are very independent minded. If the government tells you, "This is a good idea," they'll vote against it just because the government said it was a good idea. They had a referendum for Australia to be a Republic. Ninety percent of Australians think Australia should be a Republic and that having the Queen as the head of state is an idiotic idea but, because the government supported that, they voted it down.

Dr. Connolly: That's the Irish element!

Dr. Mann: Absolutely! If a government is consistently giving you a very bad time, you develop a culture of attempting to defeat the government and its machinations. That has become part of the Australian character along with other interesting characteristics - a self deprecating sense of humor and a strong antipathy towards privilege. Australia is highly egalitarian.

Dr. Connolly: What about the issues like assisted suicide and euthanasia?

Dr. Mann: Assisted suicide or euthanasia of people with terminal illnesses is something I am fundamentally opposed to. I believe that the goal for those individuals should be to relieve their suffering, not to kill them. A lot of people who develop a fatal illness will, in the initial phases of that illness, feel that they want to die. It may be a progressive illness, and there is a sense of pessimism and grief that they experience. If you follow these individuals for a longer time, after a while, they begin to evolve in their reaction to their illness. They begin to think, "I've got a certain amount of time left, and there are certain things I'd like to do constructively." They begin to learn to use the terminal phase of their

life in a more constructive fashion. This is not surprising when one looks at the stages of grief. First there's disbelief, then there's the sense of anger and loss, and then there's reconstruction. People with fatal illnesses can get to that stage. If they're not in a clinical depression, the evolution of the grief reaction to the illness can result in an evolution of their thinking, wishes and desires.

The second thing is that we know that, for people with conditions that involve a lot of pain, pain management is sadly lacking in a lot of settings. If we stopped worrying about the person becoming addicted to opium when they've only got a year or two or less to live, then we'd do a much better job of relieving their suffering. If you can relieve their pain, they're not going to feel the same way about wanting to escape from life. I see that as an area where medicine can play a constructive role in people's lives. That's the attitude we should have. I think the business of society legalizing assisted suicide tends to obscure these points. I remember Everett Koop, who was the Surgeon General, say, "Doctors, we're in the business of saving lives. Whether or not to end people's lives is a decision for society, not a decision for the medical profession". There's a lot of truth in that.

Dr. Connolly: Remember the old saying, "Thou shalt not kill."

Dr. Mann: Every patient deserves the maximum we can help them achieve in quality of life. There has to be a sensible assessment of what they want, what their families want and what the prognosis is. Then we try and design a treatment to give them the very best result for them in their circumstances. That's not always major surgery.

Dr. Connolly: That's right. It's amazing what the hospice movement has done.

Dr. Mann: Yes. My father is still alive, but my mother died in our home. She didn't want to be in a hospital, and so we nursed her at home. When it was too much for us, we got some help at home. That should be the goal for everybody. Everybody should try to die at home. It's much better than being in hospital if you have the right support system. The last place you want to die in is a hospital.

Dr. Connolly: What about recreation? What do you do to relax?

Dr. Mann: I'm a runner. Running is big in Australia, but I took up running because my brother-in-law, who is a GP in Australia, is a runner. He conned me into it by taking me as an assistant to the Boston Marathon when he ran it. I now run regularly, and that's relaxing. Australia is big on sport, and I love sport. I'm a big fan of lots of sports, and I like to play them.

Dr. Connolly: You're pretty fit?

Dr. Mann: I think so, more than average. I took up golf because my two sons are playing golf. I play with them on a Sunday morning at 6.30 am - just 12 holes. It's fun, and it doesn't

take too much time away from the rest of the family. We have a good time together. I like a lot of sports. My dad was a big sportsman. That might sound funny for a Jewish man from Poland, but he was nationally ranked in table tennis, he won the national toboggan championship, and he was in the top volleyball team in the country.

Dr. Connolly: Is your father still alive?

Dr. Mann: Yes. He'll turn 95 in two weeks.

Dr. Connolly: And sound in limb and mind?

Dr. Mann: As a matter of fact, the only medications he takes are vitamins. That's not bad.

Dr. Connolly: What about theatre and music and reading?

Dr. Mann: I still read a lot. My daughter is doing a PhD in Medieval English so the reading tradition is being carried on. We go to the opera and the ballet which in New York is great. And I'm a painter.

Dr. Connolly: Are you really?

Dr. Mann: Yes. Oil paintings. I like to do portraits mainly. I had an orthodox upbringing, and you're not supposed to be an artist. I started by drawing famous Rabbis, and I went and studied with the art teacher of my wife's aunt, a Frenchman. I learned portrait painting and then landscapes. I've got a few paintings at home. I don't have as much time to do that as I used to. I really haven't painted anything for a while. Time is precious. Harry Truman, the United States former President, had a wonderful saying – life was all about deferring things that are urgent in order to concentrate on things that are important. I think it's an important principle for us in medical research. I try to tell my students to think of an important question. You can publish lots of papers and you can do lots of research, answering little questions, but try and think of an important question and it'll be worth it.

INTERVIEW WITH RONALD MARIS

Dr. Connolly: Tell me about your early school days.

Dr. Maris: I grew up in the Midwest. I'm not sure I can make much of my early school days. They were uneventful with the exception that I had scarlet fever as a young child. My father created a lot of problems since he was an alcoholic.

Dr. Connolly: What books did you like to read?

Dr. Maris: I read a lot, mainly adventure stories.

Dr. Connolly: Was your family religious?

Dr. Maris: Yes and no. My grandfather and my uncle on my father's side were very religious. We talked about life and death a lot.

Dr. Connolly: What about school?

Dr. Maris: I was a good student. I was very involved in art. I did a lot of drawing during my senior year in high school. I went to the University of Illinois which was in my home town. I never really thought about going far away. I majored in chemical engineering, and I earned good grades. But I had doubts about majoring in chemical engineering. I wanted a more liberal education, and I switched to English and philosophy. The major change that I made at university was that I decided to give up my athletics scholarship in track and try to go to Harvard Divinity School. I did go to Cambridge (Massachusetts) in 1958.

I enjoyed it there, and I loved Cambridge. Although I did not see myself having a career in religion, I was in fact a Methodist Minister for five years. I was ordained as a Methodist Minister and had two churches, and that was an important part of my life.

` Then I came back to Champaign, Illinois, and got a Masters degree in Philosophy, focusing on British linguistic philosophy. Again, I decided to switch interests, after I got my masters, to social and behavioral sciences. Almost by accident, I read Durkheim's book on suicide as a Master's student, and I decided to do theoretical and epidemiological work on suicide in Chicago. I got a grant from the National Science Foundation to do that for my Ph.D. dissertation.

That was my first work on suicide. I don't really know why I picked suicide. I had been interested in Durkheim, and he was a social philosopher who happened to write about suicide, Jack Gibbs once said that if Durkheim had written about stuttering, there would be a huge literature on the sociology on stuttering. So it was somewhat accidental. I taught for a year at Arizona State University (in 1966), but I was very unhappy in the southwest. A couple of months after going out there, I got a job in at Dartmouth College in Hanover, Hampshire, to teach sociology.

I went up there for two years and decided that I wanted to do more clinical and psychiatric work in suicidology. At that point I had only an epidemiological and statistical understanding of suicide; so that was a crucial juncture in my development.

In 1968, I left Dartmouth College and went to Johns Hopkins Medical School where I stayed for five years. I started with a post-doctorate fellowship in suicide prevention and suicidology, and then I stayed on for four more years as an Associate Professor of Psychiatry. I ran the MD/PHD program in behavioral science. I created a program where students got both degrees in six years. I ran that program for four years, and I received an NIMH grant to study suicide. I went back to Chicago and did another survey study of suicide there. I received a lot of supervised clinical training in the Johns Hopkins Psychiatry Department, and I took a clinical internship in Los Angeles at the Suicide Prevention Center where I worked with Ed Shneidman, Robert Litman and Norman Farberow. I stayed at Johns Hopkins Medical School until 1973, but I have continued to take post-doctorate fellowships in psychiatry. In 1971, I had a World Health Fellowship in West Berlin; in 1980, I had a fellowship to go to Austria to study with Professor Ringel who was still alive. Recently, in 1993, I took a year off and went to Pittsburg to study psychobiological suicidology with Dr. John Mann.

In 1973, I got tired of living on soft money and research grants, and I got a chance to be a tenured Full Professor at the University South Carolina, and I have stayed there ever since. I became Chairman of their Sociology Department in 1973, and I was chair of the department for eleven years. I created the Center for Study of Suicide in 1985, a state agency in South Carolina where we trained masters, Ph.D.'s and a variety of other students in suicide prevention.

During part of that time I was President of the American Association of Suicidology (in 1981) and Editor of their journal (Suicide and Life-Threatening Behavior) for 16 years (1981-1995). I did a lot of writing – for example, an original monograph called Pathways to Suicide (Johns Hopkins University Press) based on my Chicago research. I edited a book on the assessment and prediction on suicide (Guilford Press, 1992). I still do some of work on philosophy, like the issue of rational suicide. I travel quite a lot, I have been fairly active in international suicide prevention associations, and I'm a member of the Scientific Advisory Committee of the American Foundation for Suicide Prevention.

Dr. Connolly: Are you still involved in foreign travel now?

Dr. Maris: It has declined. I had become tired of travelling. For a while I worked with Professor Ringel and other people in Europe, including Michael Kelleher in Ireland. I attended Michael's conference in Ireland, one in Greece, and one in Israel with Israel Orbach.

I am a member of the International Academy for Suicide Research, but my understanding is that their organisation has faltered. I have been a co-author of books, both with Dr. Rene Diekstra and for the International Association for Suicide Prevention.

Dr. Connolly: Can we just go back a little bit now. In your student years, who made you interested in suicide?

Dr. Maris: Indirectly Durkheim. I started off reading Durkheim, and he was a major influence in terms of thinking very critically about philosophical issues, such as whether suicide is ever appropriate or not? Durkheim talks about that. At Johns Hopkins, I did a lot of psychoanalytic training. Several of my teachers were psychodynamically-oriented, such as Avery Weisman, Seymour Perlin, Ben Riggs, and Jerry Motto. These were the people that I worked with during my fellowship years. I also spent some time with a fairly eccentric character in Germany, Klaus Thomas, a hypnotist.

Dr. Connolly: Did you practise hypnosis?

Dr. Maris: No, but I visited Dr. Thomas one summer night, and he was putting people to sleep for therapeutic purposes. Erwin Ringel was another major influence in my life. I spent about a year working for Katschnig and Ringel. John Mann has also been very influential in my life regarding the biology and the neurochemistry of suicide. I also had Seymour Perlin for a fellowship, and I worked with Brian Tanney in Alberta for a year.

Dr. Connolly: What about in Divinity School?

Dr. Maris: In Divinity School I studied primarily with Paul Tillich, the German theologian. I was there when the really famous professors were there -- George Ernest Wright, a Professor in the Old Testament, and Kristen Stendahl, a Professor in the New Testament, as well as professors in Greek and Hebrew studies. Paul Tillich was a major influence in my life. While I was there, I also took philosophy courses at Harvard.

Dr. Connolly: What about Popper?

Dr. Maris: Not much, I knew about him, of course, as well as Ayers, Russell, Wittgenstein and Nagel.

Dr. Connolly: Popper and Wittgenstein didn’t get on very well did they?

Dr. Maris: Wittgenstein was a rich, eccentric man, but I don’t really know their interpersonal history.

Dr. Connolly: Actually, Wittgenstein spent sometime in Ireland!

Dr. Maris: Did he? Interesting! I remember him working with Russell. Norman Malcolm, who was a philosopher at Cornell, who went over to Ireland to write a book about Wittgenstein. Wittgenstein had a safe in his apartment and a lawn chair, and the students would come in and there was no place for them to sit, so they would sit on the floor. He had a phobia of his manuscripts burning up. He wrote only two books in his life, the Tractatus Logico Philosophicus, which had seven propositions and, when he finished it,

he figured it solved all philosophical problems, so he quit philosophy. He built a house for his sister and then he wrote his second book, Philosophical Investigations.

Dr. Connolly: Did you have do military service?

Dr. Maris: I never went into military service. My father was in the military, as were my brother, my brother-in-law and my uncle. My early kidney disease disqualified me. I took the physical but failed. Not that I would necessarily had to serve because at the time I was involved in my graduate studies and, if you were a student, you could be deferred on that basis.

Dr. Connolly: Were you disappointed about that?

Dr. Maris: I was a little disappointed because military service was the norm at the time. It was the thing to do, and I was an athlete. But I failed the urinalysis test. I was somewhat disappointed, and I felt that I wasn't like my father or my brother (who is now a Business School Dean in Ohio). On the other hand, I was close to being a conscientious objector at the time because I had religious views that I had difficulty reconciling with war.

Dr. Connolly: Has that grown or lessened as you have got older?

Dr. Maris: I think it has grown. I don't hunt or fish anymore because I can't kill animals. I'm not a vegetarian, although two of my daughters are. But I just can't justify killing for sport. So in that sense it has grown. On the other hand, I'm not naïve about the fact that there are complex issues involved. I wrote an essay as a college student about a soldier who had the opportunity of killing his enemy, and I let the soldier be killed because he could not pull the trigger.

Dr. Connolly: How old were you then?

Dr. Maris: I was probably about 18 or 19.

Dr. Connolly: Speaking of such dilemmas, what about assisted suicide and euthanasia? Oregon has just legalised assisted suicide.

Dr. Maris: I am very sympathetic to some assisted suicides. On the other hand, I think that most suicides are inappropriate. I don't have a major aversion to helping people die. We shouldn't abandon people when they are dying. If my internist and I talked about my illness and, if I felt that there was no reasonable way to live my life, then I would hope that I might be permitted to die with his help, much as someone might have an abortion. We shouldn't be abandoned in our time of real need. If I asked my physician for a lethal overdose, I would hope that he would be willing to help me die, after certain conditions were met. We are all going to die anyway. No one is getting out alive.

Dr. Connolly: Many people are worried about the slippery slope argument and the possible pressures put on people to commit suicide.

Dr. Maris: That's a real concern. I have read most of the arguments. I have read Herbert Hendin's book and his argument that physicians, on their own authority, make life and death decision about the needs and interests of their patient, often without consulting them. I remember Kevorkian would not remove the carbon monoxide mask from his client, Hugh Gale, even though Gale wanted to stop the procedure. On the other hand, there is a danger that a woman may need an abortion but ends up torturing herself because she can't go to a clinic and get it done safely.

I would hope that, just because I felt the need to die, that I would not have to do it alone in some dingy hotel room, with nobody there, using a method which might just mutilate me. Some people really need to die, and many people need help in doing so. I have been fairly close to Derek Humphry over the years, and I have talked to Derek about the fact that most of the objections to assisted suicide have to do with religious issues. As I have become older, I have become less religious in the conventional sense. Most people don't believe in killing because they think it's God's role to make that decision. I don't believe that. I'm not sure anymore that there is even a God in any doctrinal sense.

Yet, I am very spiritual, very concerned, very sensitive, and very worried about things that are ethical. But I would never not help somebody because it was "against God's will." That just does not make any sense to me.

Dr. Connolly: There is very interesting statement from a Bishop in Scotland who published a marvellous tract on morality, exploring it all.

Dr. Maris: Probably you could discuss intriguing moral issues with him. One of the things that initially attracted me to the Christian religion was its morality and ethics. But you can have those without the theology. Even in philosophy the arguments about the existence of God were just web-spinning logic.

For example, when I was President of AAS (in 1981) I wrote a paper on rational suicide which caused me a lot of trouble. Basically I said that, under certain conditions, I thought that suicide could be appropriate. Most of the people in the organisation would not endorse that view of suicide. Suicide is a fascinating subject and a very important matter. We ought to exhaust all our nonsuicidal alternatives and, even if there is no God and no after-life, you should still want to have the fullest life you can. In fact, that there may be no after-life might even make life more precious.

Dr. Connolly: Yes indeed! A friend of mine used to have a reoccurring nightmare, and he would wake up terrified. He realized that, when he died, if there was a God, he would know but, if there wasn't a God he would never know.

Dr. Maris: I think that's true. It's more terrifying that there may be <u>no</u> God or Hell. The fact that most people are terrified by that possibility is an indication that the belief in God is a comfort. There is concern that your consciousness might be annihilated, and we spend 60

to 80 years developing our soul and our spirit and our mind and then they are just gone. What a waste!

Dr. Connolly: Maybe the alternative is even worse -- survival of the mind for ever.

Dr. Maris: Certainly. Living forever would not be marvellous.

Dr. Connolly: But I expect that the controversy about rational and assisted suicide is going to rage on for some time.

Dr. Maris: It will. We will probably see it waxing and waning. We have already seen Oregon pass an assisted suicide law, and then the federal government rescind it in effect by controlling narcotics licences. California and the state of Washington have come very close. Several other states have put propositions on the ballot which have narrowly failed to pass. I predict that there will be more of those attempts to pass legislation and set up suicide assistance centers as opposed to prevention centers where those worried about dying or wanting to die can go. On the other hand, every time you get a Humphry or a Kevorkian making the news, a reaction is generated which sets the liberal cause back. So you end up often going backwards.

Dr. Connolly: Assisted suicide certainly raises great emotions.

Dr. Maris: It certainly does. On the other hand. I can empathize with people who are opposed to abortion. It's an extremely difficult issue, particularly when you have a fetus that has no thoughts, no rights and no power. It's similar to the position of young children. Children have very few rights and little power. So somebody needs to be an advocate for unborn children. On the other hand, there are situations where life becomes a little too precious in some respects. Death is something that can be pornographic. I was watching a Discovery Channel nature movie, and you see that there is death all the time in nature. Animals eat each other, and big fish eat little fish. It's an everyday, ordinary activity. Yet, with humans, we get bent out of shape about the unique importance of a particular human life. Of course, if it was my life or your life, then that's a different story. The death of others is all around us, but premature death can be unfortunate.

I think most suicides are premature in a sense that, eight to ten weeks later, the suicides themselves would have changed their minds, if they could have, and, if they would have treatment, they might have not even wanted to die.

INTERVIEW WITH ISRAEL ORBACH[10]

Dr. Connolly: Thank you very much for agreeing to this interview. First of all, I would like to explore a little bit about your early background - where you were born, family life and so on

Dr. Orbach: I was born in Russia. My family were Jews living in Poland and fled Poland at the beginning of the 2nd World War. When I was two years old, we came back to Poland and then to Germany, to a refugee camp. From there we went to Israel in 1948, and so I grew up in Israel. I went through the same course of development as any other Israeli - high school, the army and the six-day war. I came to the United States after I received my BA in psychology in Israel.

Dr. Connolly: What are your early memories?

Dr. Orbach: I was raised by my Grandfather and my Uncle and Aunt. My earliest memories are from the refugee camp in Germany. As a child, it was a great time for me. I wasn't aware of course at three-years-old of the history of the family. I learnt about it much later. We were a rich family that lost, not only part of the family, but all the property we owned. I have memories from Israel. I grew up in Israel in a small village, with immigrant Jews from Yemen. I remember that I was very scared by these little dark-skinned kids. I had never seen anything like it before. But, all in all, it was great childhood.

Dr. Connolly: What were the influences on you there?

Dr. Orbach: It was my Grandfather who was a very loving, warm, wise person. We had a wonderful relationship. I was number one for him among all the grandchildren. He has guided my life until today. A very powerful person but so warm and so loving. He was the person who influenced my life more than anybody else, more than teachers, more than friends, the army. Nobody else stands out.

Dr. Connolly: Did you have a religious upbringing?

Dr. Orbach: Yes. He was orthodox. The entire family was orthodox. The family that remained from the holocaust lived together in one court, and it was great. We had a kibbutz-style life. We shared a lot of things and even some of the properties. We had a small farm which belonged to the entire family, and everybody took his share in the duties. There was an atmosphere of cohesion, warmth and protection and, as a childhood, it was great.

Dr. Connolly: What about music?

---

[10] Dr. Orbach's death in 2010 prevented him from editing this interview.

Dr. Orbach: There was no music. Nowadays, I have very simple tastes in music. I don't listen to classical music. I don't understand it, unfortunately. I read a lot. I like literature.

Dr. Connolly: What do you recommend?

Dr. Orbach: I read a lot of Israeli literature, and I just completed a book on the relationship between a man and Israel which portrays Jewish emigrant from Iraq confronting the different protocols in Israel and the independence war which was one aspect of what we went through in Israel through the liberation and the conflict. The book brought up the social conflicts for emigrants who come to Israel.

Dr. Connolly: How old were you when you became aware of the holocaust?

Dr. Orbach: I always knew something about it inside. It was intuitive. In spite of the happy childhood and the good family experience, there was always something there that was sad. My parents and aunts and uncles would speak about the life in Poland. They were very affluent, and they lost everything. They lost family members including my grandmother and some of the children who stayed behind. There was always a tone of bereavement in the family, and I think I got more conscious of things and more aware around the age of ten.

As a child, we were aware of the situation which was always in danger. When we came to Israel, it was in the middle of the independence war in 1948. I remember the war in 1956, and in 1967 I took part in the war as a paratrooper. The sense of having to defend ourselves, of being surrounded by enemies, was always there. In my experience, this was stronger than the awareness of the holocaust, which came much later.

Dr. Connolly: Tell me about your early years at school?

Dr. Orbach: I went to sixth grade in a village, a low-grade school. All the students were children of immigrants who were hassling every day for bread and really didn't have time to devote themselves to the education of their children. After sixth grade, I went to another school in a nearby city which was a different world. They were different kids, and they looked more like Israelis then myself. They spoke with a different accent than mine, and I was very apprehensive and afraid at the beginning. I merged very quickly into the school, and I became a very good student. This was for two years. Then I went to yet another city, to Tel Aviv, to a very prestigious high school, very competitive. It wasn't easy to get into this school. It was tough, but I met many kids from different backgrounds. They were sharp and intelligent. The teachers were very demanding but, on the other hand, it was a very enriching school. The student that sat next to me was Hanoch Levin who later became the best Israeli play-writer ever. This was a great experience, knowing him and listening to his wonderful compositions. It gave all of us perspective on our own narcissism. Our teacher right away recognised his great talent and encouraged him. He came from a very poor family and would not have been able to complete school if it had

not been for this teacher. All in all, the influence of this school was great. I learned how to think, to integrate and to analyse

But, in terms of education and interests, I was a self-made person. All of us carry our own dreams.

Dr. Connolly: Is it there you developed your love of literature?

Dr. Orbach: Well, I haven't mentioned this, but I wrote poetry since the age of 10.

Dr. Connolly: You still do?

Dr. Orbach: No. I quit when I met this friend Levin because I saw that, if I would be a poet, I would be a very mediocre one, so I stopped then. At the age of 16 I stopped writing.

Dr. Connolly: You didn't believe in what Bernard Shaw said, that if a thing is worth doing, it's worth doing badly!

Dr. Orbach: Right. I didn't believe it.

Dr. Connolly: After high school, then what?

Dr. Orbach: After high school, the army is mandatory for all Israeli kids. I got drafted into into the paratroopers. They were two and a half very tough years.

Dr. Connolly: Was that a time of war?

Dr. Orbach: It was before the war. There was no war in 1962 or 1963. I was an enlisted soldier and didn't make it to an officer rank.

Dr. Connolly: What did the military experience do for you?

Dr. Orbach: It's basically mental strengthening and provides a sense of identity. It helps you make transition from adolescent to adulthood. It puts tremendous responsibilities on you. It teaches you how to be with other people, and how to relate to other people; the necessity of being together at times of stress; to adjust to the most difficult situations; and knowing that, no matter how bad it is, it goes away after a while when you get adjusted. The experience was that every day you learn more about life in terms of your ability to cope and to survive and to be able to sustain yourself in stress and being proud of being able to do it. Of course, it brings you close to other people, to your friends, to your mates in the army, to your peers. You have the sense that what you are doing in the army is not only for your yourself, but also for your friends in the army. You learn to be together and to work together.

Dr. Connolly: To be a team. After the army, what then?

Dr. Orbach: Before the army, I met my future wife Esther. We met in Ruth's Movement. I fell in love with her right away. We went out for three years while I was in the army and then, right after the army, in 1965, we got married. I was 21 years old, and she was 20 years old.

Dr. Connolly: Could you afford it at the time?

Dr. Orbach: Yes we could. She came from a rich family. Then I started to go to the university for my BA. I knew then that I wanted to study psychiatry.

Dr. Connolly: Why?

Dr. Orbach: It's difficult to say what made me do that. For a long time, I considered a career in teaching or in literature until I met a writing journalist before I got married. I knew that I would not be able to make a living from writing and, all of a sudden, it hit me that I was interested in psychology. It was the best profession for me, loving people, listening to people, liking to help and liking to be helped.

Dr. Connolly: Which university did you go to?

Dr. Orbach: I went to Bar-Ilan University which is near Tel Aviv. It was a young university, founded in 1955, and it was a great learning experience. Every day I would go to the university and come home and think about the next day. I knew that this was what I wanted to do and that this was the right choice for me. Then came the six-day war. I participated in the war. I was in Gaza, and I hit a mine with the vehicle that I was in and lost consciousness. So my participation in the war was quite short. Then I graduated.

Dr. Connolly: What was the system of psychology in that university?

Dr. Orbach: It was the only university that we had at that time with clinical psychology, and there were some teachers who came over from the United States with a strong clinical, dynamic, psychoanalytical method.

Dr. Connolly: Not behavioral?

Dr. Orbach: No behavioral psychology, although we covered behavioral psychology in some courses in experimental psychology. We had a very good basis for research, but it was the only university to expose students also to dynamic approaches. It was soft psychoanalysis, and not the pure psychoanalytic approach. At that time, there was no PhD in psychology. I had an offer to come to Boston and to do some work with Jewish youth in Boston for Israel. I decided to combine this with my studies. We moved to New York. and I was accepted to several places. I choose Yeshiva University, and this is where I got my PhD.

Dr. Connolly: Tell me about your thesis?

Dr. Orbach: I spent a long time thinking and trying to do a thesis on freedom of choice and decision making and the way a person constructs his life. Then my supervisor left the university. So, I did a dissertation on an idea that came up in one of the seminars that I took on aggression. I studied aggressive behavior and a fear of retaliation. How does the fear of retaliation affect your aggressive behavior? What I wanted to do was very quickly finish my dissertation and go back home. Part of the education was also an internship which I did at Albert Einstein School of Medicine, a tough place. I was exposed to very good people and a variety of approaches and gained quite a lot of experience. Then we stayed one more year in the United States to pay all our debts before we got back to Israel. I worked as a chief psychologist in St Mary's Hospital in New Jersey for one year, and I loved it. I felt there my studies had provided me with some tools, insights and courage that I could use.

Dr. Connolly: Which of your teachers made most of an impression on you, either there or in Israel?

Dr. Orbach: In Israel, it was more the atmosphere of learning than any one particular teacher. At Yeshiva University, I was influenced by a number of people, one of them being Morris Eagle who was a psychoanalytic therapist. But it wasn't so much the people as what they offered. The dominant approach at the time was the interpersonal approach. I learnt from one professor not to give up your personal intuitions and your unique way of looking at things in favor of a specific method or a specific approach. Be yourself in the way you approach people, in the way you see things and in the way you explain things. I was most influenced by him, not by using his point of view or approach but in being able to be myself.

But there is one story I must tell you which is related in a way to being awarded the Dublin Award. When I was in school going for my PhD, one of our classmates committed suicide. A beautiful girl, Susie. Of course, we felt bereaved, and we felt guilty. We wanted to do something about this, so we decided to establish a hotline. None existed at that time. I am talking about 1971 in New York. The head of our program got in touch with Shneidman and Faberow. For us, they were only names in the field, and they had got together and established a hotline. We, the students, took turns on our hotline and, when my turn came, I was sitting and chatting with the supervisor. The telephone rang, and I got paralyzed. I couldn't lift the telephone and talk to the person on the other end of the line. The supervisor was Joseph Richman, and he looked at me and looked at the phone. I looked at him and looked at the phone, and finally he picked up the phone. The next time it rang he put his hand on my shoulder, and I picked up the phone, and this is how I started my career as a suicidologist - being paralyzed by the telephone for the hotline and being really helped and supported by Joe Richman.

In the area of suicidology, I was strongly influenced by Richman's family perspective and, of course, Shneidman's emphasis on the phenomenological, subjective

perspective. Also, Charlotte Ross and the way she translated theoretical ideas into practice in an artistic way.

After I worked as a psychologist in New Jersey and came back to Israel, I felt guilty for not being there for so long, five years. I had missed the Yom Kippur war. I wanted to do something, and so I volunteered to work in a school for disturbed children. This is where my career in suicidology started because, on the first day, my first meeting in the school was with a 7-year-old who she told me that she was going to kill herself. I was shocked and didn't know what to do. I went to the principal and told him that this 7-year-old girl wanted to kill herself. He said really, but what about this one and this one and this one, and so on. It was a school for disturbed children, and so he knew much more about suicide in children than I did. This is how I got into suicide. I was bewildered by the fact that such young children talked about wanting to kill themselves in the way that adults talk.

Dr. Connolly: What is the youngest suicide you know of?

Dr. Orbach: The youngest suicide that I know of (but I did not come in direct contact with) was a 9-year-old girl who hung herself from the handle of the refrigerator which says a lot about the determination and the energy she put into killing herself. And a ten-year-old boy who burnt himself. He left notes that he was going to kill himself A lot of what I know about suicide and the way I work today in therapy was influenced by those experiences with the kids. When I first started to study about suicide, we didn't know what death means to them and how it is related to suicidal thoughts. I was also intrigued by the fact that I would sit in the room with a child and talk about life and her wishes to kill herself and then, half an hour later, I would see her playing with other kids, seeming to be very happy. You couldn't tell that this was a suicidal child. I was intrigued by how the state of mind could change so quickly and what does it mean that she is so happy playing in the yard but, when she is with me, she is talking of trying to kill herself.

This is where some of my first ideas about suicide started to develop, as well as what I learned from books, conferences and other people. The first thing I learned is that, when one is suicidal, one is not always suicidal. The state of mind consists of a matrix of different things, and one can have moments of happiness and be busy at work and carry on a relationship with family, and then, at times, a suicidal process takes place and this state of mind takes over. This led me to develop one of my first theoretical conceptions about suicide which I called *mental attitude tendencies*. Attitudes towards life and death are different facets with aspects such as attraction to life, repulsion by life, attraction to death and repulsion by death. All these facets and processes take place in all of us, but they have a different profile in the suicidal person. I started to study this in suicidal children. For these four tendencies, I made up stories which I believed measured each of these dimensions. The children had to complete these stories, and the way they completed them provided an insight into the degree they felt attracted to life or repulsed by life, attracted to death or repulsed by death. This was guided by the idea that the suicidal person is a whole person, and different states of minds or reflections of the soul take him to this situation.

I realized that one major difference between suicide in young children and adolescents on the one hand and adults is that the youngsters' suicidal behavior is strongly related to family processes. This is where I learned a lot from Richman. You cannot always see the destructive dynamics that go on in the family when you study the child alone. You have to study the suicidal child in the context of the family. Suicidal behavior in the youngster is an index of the suffering of the entire family. People have written about the dispensable child, the scapegoat child. One of my theoretical conception was that suicidal children and adolescents are pressured to resolve unsolvable problems, usually family problems. The pressure is to resolve something that cannot be resolved, and they are blamed for not being able to resolve it. This brings them to a state of despair, hopelessness and helplessness.

I'll give you just one example. I had started to get a reputation that I work with suicidal children, and so I made it my responsibility to talk about the issue - that very young children can kill themselves. I came out very strongly against psychologists and psychiatrists who denied the existence of suicidality in young children because children don't have a concept of death. I never understood this idea - why not having a realistic concept of death does not enable them to commit suicide. It could be just the opposite. If they believe that there's a life after life, then it's easier to commit suicide because you believe that you will go on living. This is what I call attraction to life and to death which is a facilitator of suicide. A young child of 9 came to me for treatment and talked about suicide and wanting to die. I tried to find out why he wanted to die, what was wrong, what was bad, and what was he suffering from. He couldn't tell me. He kept making suicide attempts. Then I learned that his sister had made several suicide attempts and threatened suicide a year and a half earlier. The parents went to a psychologist, and he suggested that they buy a dog for attachment and love. She stopped talking about suicide but, a few months later, her younger brother started talking about suicide. After working with him for a few months and getting nowhere, I decided to meet with the family. I discovered that there was a divorce issue in the family in which the father wanted to divorce the mother. The mother was terrified by the idea, but she didn't do anything about it. She started to encourage, I believe unconsciously, the children to talk about suicide and about death. When they talked about death and suicide and wanting to kill themselves, she said, "I cannot talk with you about this. Please go to bed." She used the kids as messengers to the father. "Listen, if there is going to be a divorce, there is going to be a suicide in the family". The children participated in this without knowing. This I call an unsolvable problem. We developed a scale that measures the experience of unsolvable problems that an adolescent faces, and we did some research on this.

Dr. Connolly: Are you still on this journey?

Dr. Orbach: I took a turn in my career, a radical turn. I started focusing most of my research on non-mainstream research. I don't focus on the risk factors and correlates or the epidemiology of suicide behavior. I try, the best that I can, to get to the heart of the matter, so to speak, into the inner dynamics and the inner world of the suicidal person. One of the questions that bothered me and directed my research is that we all have these

risk factors. What are the additional processes that we don't look at that make the difference? This is what guides my interest, my curiosity and my research. This is how I came to talk about attraction to death as a facilitator of suicidal behavior. My focus is not on the risk factors, but on what makes suicide possible in terms of the inner state of mind and the inner world.

Most of my research ideas come from the clinic, from the therapy room, and from my experience with working with people and what I observed there. This is how I got to study the issue of the body in suicide because, time and again, I saw that the way that the patients are speaking about their body must be meaningful in terms of the suicidal state of mind or the suicidal process. I came across stories about not feeling pain and being able to sustain physical pain. I started to think about what role does this have in suicide. It's not a cause of the suicide. But being numb, being able to sustain physical pain, believing in life after life and viewing death in a positive way may make the difference between suicide and no suicide. If you don't like your body, if you don't have any pleasures from your body, if you feel detached from your body, and if you can tolerate physical pain, then it's easier, at a certain moment, to carry out an aggressive action against yourself.

Dr. Connolly: Does this aspect of suicidology get enough attention?

Dr. Orbach: No, but I was given an award for this research.

Dr. Connollu: Congratulations.

Dr. Orbach: Thank you. I get a lot of mail from young psychologists, young therapists and young researchers who show a lot of interest in this, and there are a lot of studies going on with it now. The four dimensions scale has been translated into Japanese, French and Italian. The body issue gets a lot of interest from young people who are not yet used to thinking about the major risk factors and correlates of the risk factors and correlates of depression and are ready to do research in a different way. I am particularly proud about this award because part of this award is about my non-mainstream research.

We have just completed a series of studies which constructed a scale of mental pain. Shneidman defines mental pain mostly as an outcome of frustration of the most important needs. Different people define it in different ways. We went to people and asked them to tell us stories about what mental pain is. We analysed the narratives until we got a scale of 45 items yielding nine factors of different aspects of mental pain. We have now started to use the scale. This allows us to measure to mental pain and to confirm Shneidman's concluding remark about suicide - that suicide is an outcome first and foremost of intolerable mental pain in the psyche.

Dr. Connolly: How do you relate your community research with the biological aspects of mental pain?

Dr. Orbach: Mind and body go together. Suicide starts with biology, and then biological processes and psychological processes go together. You can approach it from either side,

and I approach it from the soul side, the mind side. But the first thing I do, when people come to me for depression or for suicide, is to send them to a psychiatrist for medication. I try to persuade them to take medication. I think my work is easier if can we alleviate some of the pain. You cannot work in a dynamic way with a person in pain. I think that we should work together. What comes first? We know that biology comes first but, later on in life, what influences us? I think it biology is less relevant.

Dr. Connolly: You've done some teaching all over the world, haven't you?

Dr. Orbach: Yes. First of all, I teach at my university, and I love teaching. But suicide is not my only area. I have a great interest in unconscious processes, and I have a book on unconscious processes which they sell here for $225. This is why I don't sell many of the books! It's not worth $225; $25 is enough.

I am a personologist. I have taught theories of personality for many years, and I teach clinical methods and supervise young students. I can say that I have quite a wide perspective in looking at suicide from a more general theoretical standpoint. This shows in some of our work. A series of studies we undertook and still do about suicide from the perspective of self-psychology and about suicide from a perspective of relational-psychology. This helps me a lot. I love teaching, and I love talking!!

Dr. Connolly: What do you learn from your students?

Dr. Orbach: I learn from my students. As a matter of fact, this is also related to suicide and to my work in suicide and also meeting with parents and educating teachers about suicide prevention. I tell parents that the prevention of suicide is to hug your child every day, as long as he lets you, and to teach him something new about life every day. To enhance the problem-solving ability and the love of the self, the body and life itself is antithetical to the suicidal process. I cannot tell you at this moment any specific thing that I learn from my students, but I love listening to them. I love listening to their fresh perspectives and their paradoxical ideas; sometimes to things that I have been thinking about for years and here come the first-year students of psychology with the answer. I think life itself is an ongoing experience of learning, and you can learn something everyday from everybody.

Dr. Connolly: Tell me which of the suicidologists in the world you most admire?

Dr. Orbach: Ed Shneidman is my bible. I am not a little Ed Shneidman, and I am not a second Ed Shneidman. We don't think alike, and we don't agree on everything. He doesn't like that! We had an ambivalent relationship for many years, but now we are good friends. I was captured by his insight, by his ability to see through and summarise complexities in one sentence. I think he has a great interest in people. I wouldn't say that he always gets along with people, but he is so perceptive and so sharp, and I particularly like his approach because of his phenemological and subjective perspective - trying to see things from the perspective of the other. He emphasises the narrative approach. I didn't learn that from Shneidman. I learnt that from one of my teachers in school, but this is one of

the reasons why I like Shneidman's approach. His insight is incomparable. I have never heard anybody show such deep understanding of human beings.

Dr. Connolly: Anybody else in the suicidology field?

Dr. Orbach: Richman in his work with families and seeing suicidal behavior from the family perspective. I learnt a lot, a lot from him.

Dr. Connolly: Who are the up and coming stars?

Dr. Orbach: I think maybe David Jobes who combines an objective formal research into the narrative approach, trying to get to the heart of the matter, to the soul. I like the work of Thomas Joiner, but I don't like him at all! I like when somebody is able to capture the complexity the inner complexity, not just studying a variable and its relationship to other variables. One other person I was influenced by later on is Terry Maltsberger and his dynamic approach, his psychoanalytic approach. He is relating to the suicidal person with whom he is sitting. I am less enthusiastic about the pure behavioral cognitive approaches.

I have just completed a book in Hebrew that I am going to publish in English on my three or four years work with suicidal individuals in the course of therapy. I lay out my approach in therapy which is so much in contrast to the behavioral cognitive approach. My approach is the empathic understanding of the suicidal wish. Trying to be with the person in his suicidality is a way of reducing, first of all, his isolation and his being misunderstood, while respecting his pain and even his death wishes; not agreeing but respecting. Basing the therapy on a very strong alliance; being with the other and being affected by him; and working together out of the suicidal state of mind. I think my book will demonstrates this.

The way a person constructs his worldview and himself is related to language. Suicidal people use a suicidal language which has some effect probably on their suicidality and their general state of mind. I work with children, but I have noticed how many similarities there are between very young children and the older suicidal person. I believe there is some basic characteristic of suffering and wanting to live and wanting to die. Trying to understand the different cultures and different languages teaches you about differences and similarities in regard to understanding suicide.

Dr. Connolly: What about the future of suicidology?

Dr. Orbach: I am pessimistic, very pessimistic. I think we will have more programs, and we will be more efficient and there will be better drugs, but it will not eliminate suicide because suicide is part of the human condition. I think that as the world gets more populated, there will be more suicide. I must say pessimistically that suicide is one of nature's way to deal with over-population.

Dr. Connolly: Which brings up the issue of euthanasia and assisted suicide. What are your views on that?

Dr. Orbach: I can talk about different feelings that I have about this issue at different times. Sometimes I feel the person should hold on to life because things may change, except in very extreme situations. But sometimes I feel that the pain is so great and the future is so bleak, so why not? I don't have a definite stand on this. It depends on where I am at a particular time and on a particular day. There's something in me that wants to say "No" to it. But sometimes you see such suffering that you ask yourself what would you do? What would I have done?

Dr. Connolly: Are you a very religious person?

Dr. Orbach: I am not a very religious person. I am not religious in the sense of ritualistic ritual. On one hand, I can say, speaking rationally, that I can't believe in God. On the other hand, there is something in us as human beings that needs and wants God. The very fact that sometimes I find myself very angry at God means that I believe in God. I think religion is a basic need, and I would like to believe in this spiritual person, but it's very difficult.

People can get to a point of wanting to end their lives. So many authors who wrote about the holocaust have committed suicide, and I wondered about this. Was it a delayed reaction to the Holocaust? At a time of weakness, does the memory come out and is there a sense of failure, of not being able to make a difference? Wars go on, atrocities go on, traumas go on. People suffer all over the world. These authors make it a mission in life to bring about a change, and maybe they feel that they have failed. I don't know anything in their personal life that would cause this

Dr. Connolly: You're a grandfather?

Dr. Orbach: Yes. I love being a grandfather. That's a great experience. I have, I think, a wonderful relationship with my grandchildren. They love me. I love them. We can't wait to see each other! It's such a pleasure to be with them, to learn with them, to try to teach them. It's so much simpler to love grandchildren than children. You know the joke that, if we'd known this, we would have started with the grandchildren! Both me and my wife Esther have a different relationship with each one of them, something unique. We have them over in turns each week. One of them stays with us for the weekend. This where I come back to my old loves of writing and storytelling because one of things I like to do is to sit with them and make up stories together.

Dr. Connolly: Do you write the stories?

Dr. Orbach: No. My last book is, in a way, a story. It's a popular book. It's maybe a professional, popular book. There is a little bit of me as a writer in this last book. It's called *The Killer's Cry*. It's a story of a suicide and my experience of working with this woman. How I experienced it and how I understood what was going on.

I like so much what I do, and I am so busy with what I do. I like the research. For me, research is also storytelling. You start with a question, and you end up with two questions. I love it. I love doing the research and the therapy, and I combine the two.

But the grandchildren brought up in me the poetic aspect of writing and of storytelling, of being a child again.

INTERVIEW WITH ANTAPUR VENKOBA RAO[11]

Dr. Connolly: First of all, where you were born? Tell me about your family and the influence they had on your development in childhood.

Professor Rao: Let me start somewhere in the middle and work from there. I started at the Madras Medical College in the year 1915 where I earned my MBBS. I married my classmate soon after our graduation. She won the blue ribbon at the Medical College as the best outgoing student. We had a difficult time to start with, which is why she had to find a job. She worked as a demonstrator in the Department of Physiology, and that enabled me to pursue my clinical studies in general medicine. She has been a great support to me, mentally, economically and domestically, and we have collaborated on scholarly publications.

We had three children, and we lost one of them in an accident this year. One of them is a doctor. She is a Professor of Pathology in the Medical School in Chennai, and our son-in-law is a pediatric surgeon. Our son passed the Indian Administrator Service exam, but he is a bit of a rebel and disinclined to be in the service. He studied literature and is presently Professor of English Literature in the Central Institute of English and Foreign Languages. He has his PhD, and he spent quite a long time in the United States. His wife is also a teacher of English literature in Somas College, and they have a daughter. My son is a very good writer and has published many books in English.

After I passed my postgraduate examination in general medicine, the Director of Medical Education promised me a post in general medicine in Chennai, but I turned it down. He said there is a vacancy in the Mental Hospital. You can work there for two months and I will find you a job in general medicine afterwards. I am still waiting!

I spent three years in Madras Mental Hospital and, after three or four years, the Director of Medical Education suggested that I switch to psychiatry. I finished five years of training in psychiatry and earned a DPM (Psychiatry) from NIMHANS, Bangalore. I transferred to Madras in 1962 to organize from scratch the Department of Psychiatry in the Medical School. It became the Institute of Psychiatry. At the same time, I did research, and I worked on a PhD at Madras University. I was the first clinician to get a PhD in research. Clinicians never have time for a PhD, and it is mostly non-clinicians do it.

My chief research interests in Madras when I started organizing the department were depression, suicide, the history of psychiatry, and biological psychiatry. My wife and I collaborated on research on stress and other topics. We also organized a number of international conferences in Madras, including a World Federation of Mental Health Conference. For one study, we followed up a sample of depressed patients for ten years, and the paper was published in the *British Journal of Psychiatry*. My department became a post-graduate center for training in psychiatry, and a number of my students are

[11] Dr. Rao was not able to edit this interview before his death in 2005. The transcript from the original recording that I was given was poor, and so I had to cut much of the material.

working all over the world - in the USA, the UK, Ireland and Australia. It gives me satisfaction to see my students all over the world and doing very well.

Dr. Connolly: Why did you decide to specialize in suicide?

Professor Rao: When I was in Madras, a colleague of mine, a professor of forensic medicine, asked me one evening about the son of a friend of his who was very depressed. He was a college student. I didn't see the boy, but I told him that, from what he told me, he seems to be a very depressed boy. He should treat the boy's acute depression as a psychiatric emergency and seek treatment. I said why don't you bring him and I will treat him? I realized the importance of psychiatric emergencies, and I collaborated with this professor of forensic medicine for about two years on autopsies of suicides, not psychological autopsies but regular autopsies. We published the first paper on suicide in Madras, I gave him first authorship. I was the second author although I should have been first author. We studied suicides by poisoning, drowning, hanging, etc.

From then on, I studied attempted suicides and completed suicides. I was very lucky to have had clinicians in the hospital who cooperated with me, and they gave me free access to attempted suicides. At the same, I was training the students and clinicians in our weekly clinical society meetings in the hospital. I was able to introduce a number of general physicians, surgeons and other specialists to psychiatric care.

I came across a report that depression was rare in non-European countries. But we have all sorts of depression, so I began to study depression in the 1970's. When I presented my observations on 30 cases of depression at conferences, there were barely twenty people in the audience to listen to the paper. I started collecting cases and followed them up for nearly ten years - what happens to them, the course and the outcome of depression - and that was published. I also studied topics such as general paresis and the history of psychiatry. A couple of years ago, a publisher in India wanted me to write a book on psychiatry for undergraduates, and that has done well and recently been translated into Hindi.

Psychiatrists do not see most attempted suicide. Cases of poisoning go to the alcoholism wards for detoxication. Others are placed in the medical wards. I published a paper on 100 consecutive cases of women with burns. I collaborated with the plastic surgeon to whose unit the burns cases are taken. They suffer so much from burns that it is very difficult to talk to them.

I edited the *Indian Journal of Psychiatry* for nearly eight years. I was the founder and president of the Indian Association of Psychiatry, and organized many conferences including one for the World Psychiatric Association in Delhi.

Dr. Connolly: I just want to go back a small bit now to your medical school days and ask you which of your teachers made an impression on you.

Professor Rao: We had wonderful teachers in those days who taught us very sound clinical methods, teachers in pathology, anatomy, and physiology.

Dr. Connolly: But not in psychiatry?

Professor Rao: there was no department of psychiatry in the medical school when we were studying medicine. The professor of mental diseases who was in the mental hospital used to come and teach a couple of classes. That was all. We did not have any exposure to psychiatry.

I consider psychiatry to be the most fascinating specialty. One of the things which has interested me in the last 20 to 25 years is examining the Indian classics and scriptures to show how they are relevant to the understanding of mental health and treatment methods, especially psychotherapy.

It gives great joy when you help a patient. They never forget it. If you've been in practice for more than forty years, you see three generations I have treated the grandfather, the son and the grandson. Recently, somebody said, "Sir, you treated my father, and you treated my wife," and here was the son getting treatment. I think in no other specialty can you get this type of a satisfaction. Patients become attached so much more to you.

Dr. Connolly: What made you go into medicine in the first instance?

Professor Rao: There are no doctors in my family. My family wanted to send at least one boy to the medical college. My grandfather had other ideas for me, but my father said that I would do medicine.

Dr. Connolly: You have done a great many studies on religion and psychiatry. Were you always a very religious person or was that something that developed over the years?

Professor Rao: I have been interested in religion for the last twenty-five years because I feel that, with that background, you can pursue the patient's problems much better.

Dr. Connolly: Was your father a very big influence on you growing up?

Professor Rao: Yes, He was of great help to me, a very great help. He was very insistent that I get through all the examinations and become a doctor, even though every family has difficulties supporting a big family. In my early childhood, I used to spend most of my vacation time with my paternal grandfather. He has a very impressive personality. He owned a big farm and had many comforts, which in those days was a luxury. He influenced me more than my father did. They were religious people, going to the temples and praying.

Dr. Connolly: What about brothers and sisters?

Professor Rao: I have one brother who studied psychiatry. He passed away last year. He was a very heavy smoker, and he had emphysema and heart failure. I have two sisters. Both are married with children. One of my other brothers is a veterinary surgeon, now retired, and

one other is an engineer involved in the construction of houses. We have good family relationships, with no in-law conflicts.

Dr. Connolly: What about the big issues in psychiatry today, like euthanasia and assisted suicide?

Professor Rao: I have written a paper or two on the topic. The laws on this in India are still being debated. At the moment, it is being practiced unofficially, without being legal.

Dr. Connolly: In your lifetime, you have seen enormous changes in India, politically and economically. Can you talk about those a little bit? When you were born, the British were ruling India, or thought they were.

Professor Rao: There have been a lot of changes. When I entered psychiatry. people used to go abroad for training in psychiatry, such as to the UK. Now we have our own teachers who have been trained by us, and our former students are now chaired professors. Psychiatry has grown enormously. Fifty years ago, our association had only thirteen members! Today, we are about 3,000 strong in the Indian Psychiatry Society. That's a small number for a big country like ours. We don't have enough have manpower with psychiatric training to meet the demands of the public. Community psychiatric has come a long way, but there still is stigma attached to seeking treatment.

Dr. Connolly: What is the future for psychiatry?

Professor Rao: The future for psychiatry is very bright. More brilliant and intelligent people have chosen psychiatry, but unfortunately the workload is so heavy that there is little time for the research. Basic research is suffering because very few people are interested. Everybody wants to be a clinician. We don't have good teachers to teach neurophysiology and anatomy which are very important with the changing concepts in psychiatry, especially studies of the brain. Some people complain about psychiatry becoming neurology. There is nothing new about this. One of the definitions of psychiatry was that it was neurology without the science!

INTERVIEW WITH M. DAVID RUDD

Dr. Connolly: Where were you born?

Dr. Rudd: I was born in Beaufort, South Carolina. Both my parents were from North Carolina. My Dad was a Marine at the base in South Carolina. I was born there, but I was raised in Texas, in the Dallas/Fort Worth area, from about age 5.

Dr. Connolly: How many of you were there in the family?

Dr. Rudd: Three. I am the youngest. I have an older sister and an older brother.

Dr. Connolly: You father was a Marine. Was he away from home a lot?

Dr. Rudd: No. He fought in the Korean War, and he retired when I was 3, after 21 years of service. We moved to Arlington, Texas, where I lived until I went away to college. He worked as an executive for an aircraft-manufacturing firm that he eventually owned. When I was in junior high school, he took over this company. They manufactured what are called stabilizing bars for aircraft - computer generated bars that go on the wings to balance the plane. He had contacts in the military because of his military service.

Dr. Connolly: What about your early days?

Dr. Rudd: At elementary school, I was pretty active in athletics, and from third grade on I was a football player and a baseball player, but I also loved to read.

Dr. Connolly: What were you reading?

Dr. Rudd: Pretty much everything I could get my hands on. As a six-year old, I read more than anyone had ever read. At my little elementary school, you got points for reading. It was a fascinating program, but I loved to read. I have instilled that love in my children. They too have always loved to read.

Dr. Connolly: Do you have much time for reading now, aside from suicidology?

Dr. Rudd: No, not outside of my field. I don’t do as much reading but, whenever I do, I like to read history and presidential biographies, which are a fascinating way of learning history. But, as you know, it is difficult to read outside of your field when you’re stretched a little thin.

Dr. Connolly: Tell me a little about your mother.

Dr. Rudd: My father died this past year from cancer. My mother still lives in Arlington, and she is currently an administrator at the University of Texas. During my childhood, my Mom

was a stay-at-home mother, a housewife. She started working when I was in junior high school. She went back to work and eventually went to college part-time. It took her 10 or 12 years to get her degree, which she finished in 1984, and then she became an administrator. She's in good health and doing pretty well, but it's been a tough year after my father's death. They were together for fifty years.

Dr. Connolly: Were you close to your father?

Dr. Rudd: I was a pretty independent kid, and I was probably a little closer to my mother than I was to my father. My Dad spent 21 years in the Marines, and you know there was a Marine persona. Then he was a businessman, and so there was less intimacy in his relationships.

Dr. Connolly: What about religion?

Dr. Rudd: I'm a fairly religious person. We were raised Presbyterian, and we were consistent in terms of our involvement with the church. There wasn't much intensity in our involvement outside of some of the ordinary rituals and religious practices.

Dr. Connolly: What are your religious practices now?

Dr. Rudd: I am a member of the Methodist church, and I am very involved in the weekly programs. Our children are involved in Sunday school, and we're educators for the Bible school program. I'm involved in some of the men's program, and I volunteer with an organization called Mission Waco in which we provide pro bono services for homeless. That is an outgrowth of my faith.

Dr. Connolly: What does your faith mean to you?

Dr. Rudd: It's a foundation for my life, providing a fundamental set of core values.

Dr. Connolly: What part does it play in your work?

Dr. Rudd: I was trained as a scientist. I went to the University of Texas in which psychology is a scientist/practitioner program. I see myself as a scientist, but I'm also driven to do some of this work as a function of my values. I see it as a service in many ways to my fellow man.

Dr. Connolly: And what are your core values?

Dr. Rudd: They are for the most part pretty traditional core values, consistent with a Christian perspective in terms of general notions of love, commitment and grace.

Dr. Connolly: What of your family?

Dr. Rudd: Both sides of my family were from North Carolina, outside of Raleigh-Durham. There is a long history on both sides of the family of being tobacco farmers, so I tell people we did our part in the tobacco settlement law suits that generated enormous sums of money in the United States. My grandfather on my mother's side was the first to go to college and get a degree. My father went to college part-time in the service but, once he took over the company, he didn't have time to go back to school and finish his degree.

Dr. Connolly: Have you traced the family tree?

Dr. Rudd: My brother has done some genealogical work, but we've never traced it back beyond the immediate grandparents on both sides.

Dr. Connolly: How about high school?

Dr. Rudd: I went to Sam Houston High School, and I was the only member of my family to go there because it was the poorest high school in town. We lived on a street that was the dividing line between the richer high school and the poorer high school. In Texas, sports are a big deal, and I was a football player. My brother and sister went to Arlington High School, which was wealthier and known to have a better academic reputation. I had planned to go there, but I attended the spring training for football there, not knowing that I wasn't supposed to do that until I actually entered the school. I was disqualified. I ended up going to the Sam Houston High School, which had predominantly minority students, so that I could continue to be involved in athletics. That had a profound influence on me in because I was exposed to so many minority students.

The school had a lot of African American and Hispanic students, and it helped me grow and develop as a person in many ways. I came to see diversity as being a critical issue in understanding people in the work that I now do professionally. It had a large impact on me, and it was something that broadened my understanding and perspective about people.

I was extremely active at school. I had a lot of friends, and I was very active athletically and academically. I was the president of my class. I excelled academically and graduated in the top ten in my class, which laid the foundation for college.

Dr. Connolly: Did any of your teachers there inspire you?

Dr. Rudd: The one teacher I remember is my first-grade teacher who inspired me to read so that I developed a joy for reading that persists. In junior high school, I had a math teacher there, Mr. Tyner, and he was a wonderful man. He helped me learn how to think. I maintained a peripheral connection with him throughout the years, and he attended my wedding. He died the following year from an aneurysm at a relatively young age.

Dr. Connolly: What books do you remember from that period?

Dr. Rudd: I read a lot of philosophy (such as Spinoza) and European fiction (such as Dostoyesky and Cervantes).

Dr. Connolly: That must have been unusual in your school?

Dr. Rudd: It was, but there was a core group that was academically able.

Dr. Connolly: Did you get any flack for your academic interests?

Dr. Rudd: Not really. I think a part of it was that I was athletic and that buffered the ridicule.

Dr. Connolly: You came to philosophy at an early age.

Dr. Rudd: I did, and I chose to go to a fairly good private university where I could pursue my academic interests.

Dr. Connolly: What subjects did you pick at college?

Dr. Rudd: I went to Princeton University in New Jersey which was a fair distance from my home. That was a big move for me. The university where I now teach is just a couple of hours from where I grew up, and I thought seriously about attending there and was planning to, until I met an alumnus of Princeton University. They had a college open house at my high school, and they had representatives from a couple of Ivy League schools there. I met an alumnus of Princeton University and developed a relationship with him. Part of what developed the relationship was that I played athletics as well. I got very interested in Princeton and applied there and also to a couple of other Ivy League universities. It was a tough transition. It was a very intense school, and I wasn't used to working that hard to do well. I didn't really have to work very hard where I had been in order to do well, and it was a little bit of a struggle for the first year.

Dr. Connolly: Did you have some influential teachers there?

Dr. Rudd: There were two. I met John Darley who is a well-known social psychologist in my first year at Princeton and then John Jemmott who was a health psychologist there. Jemmott is now at the University of Pennsylvania now, and Darley is still at Princeton. I was in some small seminars with eight to ten people, and I developed a good working relationship with them and started doing research as a sophomore. I had to do both a junior project and a senior project, and I developed a love for psychology.

Dr. Connolly: What was the research on?

Dr. Rudd: I did a literature overview of attributional theory for my junior thesis, and an experiment for my senior thesis that is comparable to a master's thesis. We did a study on pain perception, and we looked at pain tolerance. We had people submerge their hand in

ice water as a measure of pain tolerance, and we looked at the measure of pain tolerance relative to anxiety, depression and general attributional style. Therefore, from the very beginning of my exposure to psychology, I was involved in this notion of pain perception and pain tolerance. It's very consistent with the work I do today.

The one person I haven't mentioned yet is my wife whom I met when I was 13 years old in junior high school. Initially, she rebuffed me, but I persisted, and we started dating when I was 14. We continued all the way through high school, but we went to different universities. She went to the University of Texas in Austin, and I went to Princeton University. That was a difficult decision for us to make, but it clearly was the right decision. We had talked about getting married throughout our college years, and we decided that we were going to get married when I had finished. The University of Texas in Austin has one of the better psychology departments, and so I applied only to the University of Texas. I was admitted, and we got married the summer before I started there.

Dr. Connolly: What did she do at college?

Dr. Rudd: Her undergraduate degree was in deaf education and communication, and she was a deaf education teacher for seven years. When I started graduate school that first year, she taught full-time and also finished her master's degree in deaf education. I haven't mentioned the way that I paid for school. I was as an athlete, and I had opportunities for scholarships to pay for my undergraduate education. I decided not to pursue athletics as one of my primary interests, and Princeton, as an Ivy League school did not offer athletic scholarships. They offer need-based scholarships. My family did well enough that I as not qualified for these. I accepted a military scholarship from the Army, and so my undergraduate schooling was paid for by the Army which meant that, when I finished, I would have to go into the service. I delayed that by going to graduate school.

Dr. Connolly: What years are we talking about?

Dr. Rudd: I graduated from high school in 1979, from Princeton University in 1983, and finished at the University of Texas in 1987.

Dr. Connolly: What were your graduate years like?

Dr. Rudd: The psychology department at the University of Texas is an empirically driven program and so, from the very beginning, I did research. There were a couple of people that I worked with there. One was Ira Iscoe, a wonderful man and a guiding influence in my life. He was very much a thinker, and he was clinically involved as well. I worked hard there, full-time, twelve months a year for 4 years. We didn't take the summers off, and so I was able to progress rapidly through the program. One of my best friends was getting a doctorate in computer science, and we are still close. It was a competitive program, and you had to work hard to move through the program. As part of that, I did a practicum placement at the Houston Child Guidance Center, and I started working with

the new suicide program there. I was doing an outcome study of family intervention for suicidal adolescents and their families, and that's where I first became involved with suicide as an issue

Dr. Connolly: Why did you pick that topic rather than any other?

Dr. Rudd: I didn't know that the adolescents were suicidal. I was interested in a program they had on extended family therapy. I watched a couple of the sessions, and it was fascinating. There were four or five therapists, and they would bring in, not just the parents, but the grandparents, aunts and uncles and anyone that was thought of as a family member. They had extended family intervention. They sometimes used psychodrama and other techniques as a part of this. You could never this do today because of cost issues. I picked that as a program to work with, and it soon became very clear that the vast majority of the cases were young people who were suicidal. I became really interested in that, and we did an empirical study and published several articles. My dissertation developed from that project, and that set the stage for the work that I would do after that.

Dr. Connolly: So you got your doctorate?

Dr. Rudd: I got my doctorate. I hadn't done any military service yet, so it was understood that, when I finished my degree, I had to go into the Army to pay back my scholarship. I did my internship in the Army at a hospital out in Calfiornia.

Dr. Connolly: Was it a culture shock going from university to an institution like the military?

Dr. Rudd: It was. Even as an undergraduate, I did not understand how the military worked. My father had been in the military, so I had some sense of what it means to be in the military, but not in a realistic way. It was a difficult transition, but as an officer you are accorded a certain amount of flexibility which you're not allowed otherwise. For the first couple of years, I functioned purely as a psychologist. I worked in a hospital surrounded by medical personnel, and so I was buffered. But after I did my internship, I went to Fort Hood in Texas where I was a division psychologist. I worked with a combat unit for the last couple of my years in the service, and that was very much a real military experience. Prior to transition, I had basic training which was a unique experience.

Dr. Connolly: Was it a mistake to join the military in terms of your development and research?

Dr. Rudd: No. I look back on that as a valuable experience. In the military, you're given an enormous amount of responsibility very quickly. I had a tremendous amount of responsibly and opportunity to do a lot of different things. I worked with people in that hospital setting whose psychopathology was fairly severe. It was a unique experience. I ended up applying for and getting an NIH grant for five years in which I was able to do a randomized-controlled trial that I couldn't have done anywhere else because the military

has a structure that provided an opportunity to do a randomized trial on service members. In the military, you don't have to worry about issues such as where the patients are and insurance coverage. We had a fair amount of control over the patients.

Dr. Connolly: Was it published?

Dr. Rudd: We did a comparison of inpatients versus outpatients in a hospital setting. The outcome was comparable for both groups in terms of treatment success. We did a long-term follow-up with high-risk individuals, and we found that the effects persisted. But the more significant finding was that we were one of the first researchers to demonstrate that outpatient care for high-risk patients was just as effective as inpatient care.

Dr. Connolly: How long were you in the military?

Dr. Rudd: I was in the military for five years. It was originally supposed to have been for four years, but I was there for part of the first Gulf War. I was due to get out the month before the war started, but they have a mandatory retention policy for times of war

Dr. Connolly: Did you get to go to the Gulf?

Dr. Rudd: I didn't go to the Gulf. We were on and off the tarmac! We were supposed to go. They deploy units in pieces, and they deployed medical units. We were ready to deploy when the ground war started, but the ground war lasted only 100 hours. They already had medical assets in place from other units. My time during the war was spent evaluating large numbers of people for months on end who did not want to deploy for psychiatric reasons.

Dr. Connolly: Why did you leave the military?

Dr. Rudd: I had never intended on staying. I had always wanted to be an academic. I had done it as a means of supporting myself through college. I found it to be a good experience, and I had a history with my father. I felt it was an admirable thing to do. But the opportunities for psychologists were limited. I would have been doing for another twenty years what I was doing in those first four years.

Dr. Connolly: You were married. Was it disruptive to family life?

Dr. Rudd: My wife was pursuing her career. We had discussed what we wanted as a marriage, and it wasn't disruptive. We didn't have any children - we had made a conscious decision to wait for more stability before having any. Afterward, we ended up staying in that area. I was an adjunct faculty member for Texas A&M College of Medicine. I used to train the medical students on the military base, and I met the new chairman of psychiatry at the college about two years before I got out, Jay Burke. He had been a division director at the National Institute for Health, and he was recruited to build the department. I was applying

for academic positions, and he and I had developed a good relationship. He offered me a job, and my wife and I decided to stay. I moved to the Scott and White Medical Center at Texas A&M College of Medicine which was an integrated health science center. I worked in a medical department of psychiatry for almost eight years after that. During that time, my wife Loretta went back and got a Masters degree in administration. She wanted to move into administration rather than be an educator. We decided to have kids. My son Nicholas was born in 1994 and my daughter in 1997. During that time my wife completed her Masters in administration. She did a fabulous job, but having children after twelve years of marriage was a challenging transition.

Dr. Connolly: What kind of Dad are you?

Dr. Rudd: I like to think I'm good Dad. I love being a Dad. There is nothing more important in the world than to be a Dad. It was the best decision I ever made. I look back on that, and I'm thankful that we were able to have kids. We waited twelve years without a lot of thought that it might not have worked out the way we wanted to, but we are blessed to have two beautiful children who are healthy and happy kids.

Dr. Connolly: They are re-educating you.

Dr. Rudd: They are. They change your life in dramatic ways - what you do in terms of commitment of time and your working schedule. We used to do pretty much what we wanted to do. If we wanted to go somewhere, we could. If we wanted to work and if I wanted to write, we could. Now we have to be careful how we schedule our time. How much time I spend away from home is a critical issue for me and my wife. You become involved in things you would never have been involved with in terms of school and activities related to school. I coach some of my son's teams, and my daughter takes dance lessons. They both do music and other activities, and so it really keeps you jumping.

Dr. Connolly: What are your tastes in music?

Dr. Rudd: As a youngster I was a classic rock fan. Over the years I have transitioned to jazz and classical music, but I still enjoy the same rock music. It brings back good memories - of high school days and the energy that comes with that.

Dr. Connolly: Do you play an instrument?

Dr. Rudd: I don't. I played guitar when I was going to grade school, and I stopped because the fellow that was teaching me told my mother that I didn't have any musical abilities! So I stopped. I really regret that now. We have gotten both children involved in music fairly early. It's so critical. My son is a wonderful piano player. He didn't enjoy it for the first few months, but he loves it now and spends a lot of time doing it. I wish I had done that more intensively as a youngster because, although I enjoy music, I can't actively participate.

Dr. Connolly: You are still working in the psychiatric department in a medical school?

Dr. Rudd: I left Texas A&M after about eight years.

Dr. Connolly: What research did you produce while you were there?

Dr. Rudd: I did a lot of research in terms of outcomes, looking at differentiating attempters, repeated attempters and ideators, and a number of predictive studies. I wrote a primary treatment book and an edited book with Tom Joiner on suicide science. That's where I met Tom. He was an intern at the VA where I did some rotations and teaching. He went to Princeton four years behind me and went to the University of Texas four years behind me, and so we have those connections. We started collaborating on different projects in his internship year, and we have maintained that friendship and collaboration. I've worked with Tom Ellis, and I did a post-doctorate fellowship at the Beck Institute in 1995 and 1996. I became very interested in cognitive therapy, and we revised our treatment model to incorporate cognitive therapy and theory for suicidal individuals.

Dr. Connolly: Tell me about your research with the Air Force.

Dr. Rudd: While doing some training, I met Dave Jobes at AAS, back in the 1980s and developed a friendship with him over the years. The Air Force contacted me because they were interested in doing some training. They formed a working group a couple of years ago to develop a program to manage suicidal behavior and train clinicians to do that. Dave was the lead on that while I was more peripheral. I became a little more active two years ago. I really enjoyed it, and we have a couple of projects planned, including a retrospective review of their case files on suicide cases, trying to better understand the critical points for intervention for suicide, looking for opportunities missed. As a part of that we are looking at the issue of what is a reasonable target suicide rate. We are not going to be able to prevent every suicide but, for the others, can we identify them and see what opportunities exist for intervention?

The major reason why I left that position at Texas A&M was that I was doing too much clinical care. I wanted to have more time for academic activities. To do that, I had to take away time from my kids and my family, so I decided to look for a full-time academic position. I had been a clinician first and an academic second, and I wanted it to be the other way around. When my wife went back to do her doctorate, I found a position as a professor at Baylor University. I have been there for five years now, and my wife finished her doctorate last year. She also got NIMH funding, and she's having great success with her research program.

INTERVIEW WITH ISAAC SAKINOFSKY

Dr. John Connolly: I would like to start off with your early life -- where you were born, your family etc.

Dr Isaac Sakinofsky: I was born in Cape Town, South Africa. My parents were from Latvia and Lithuania, Baltic states of Eastern Europe, and they came independently to South Africa, my father to escape pogroms and my mother because she was an orphan who happened to have relatives in South Africa. First, she emigrated as a young teenager to Israel to stay with relatives. Then as a young woman she moved to South Africa to connect with other relatives. She and my father met and married in their 20s, and I was the first born of four children, three boys and a girl.

Dr. Connolly: How long did you live in South Africa?

Dr. Sakinofsky: Until my mid-thirties, when I emigrated to Canada, including a four-year sojourn outside South Africa doing postgrad training in London. My childhood was not very remarkable other than that I grew up in a working-class neighborhood, Woodstock, where my father ran a small store and where many boys my own age were ruffians. We lived there in South Africa during the Apartheid era, a time when the racial groups were segregated, as you know. Racism often extended to other forms of xenophobia. Because we were Jewish, we children had to face the obligatory anti-Semitism from some of our peers and sometimes from a few of our teachers. I was called names such as "Jew boy", and subjected to other intended insults and that sort of thing when I was in the local elementary school. I had a few fights with people about it.

In high school (S.A.C.S.) my parents sacrificed to pay the private school fees, but I did not encounter overt anti-Semitism from my peers. A fair-sized minority of the students were also Jewish, only they came from the more affluent homes in the upscale suburb where the school was situated. Some of my cousins had attended this school before me, done well academically and distinguished themselves in rugby and cricket. Some of them had gone off to World War II, and their war exploits had brought honor to the school. I too played the obligatory summer and winter sport at SACS but, unlike my cousins, I was pretty undistinguished as a rugby footballer or cricket player. However, I did immerse myself in the school magazine and was an editor and contributor for years. I loved English literature, and one time an English teacher even predicted that I would be a writer one day. Unfortunately, he was wrong as far as writing fiction is concerned.

As a day scholar, I went home to Woodstock at the end of the school day, where I tried to blend in to the community with everybody else, while the family, myself included, at the same time continued to observe the major Jewish holydays and traditions. My hard-working parents, although they tried to be observant, were not Orthodox. My mother kept a kosher home, but both parents worked in their store on the Sabbath, for instance. Their main goal in life seems to have been to ensure that we children would grow up having had the good education for which they never stood a chance. But I wasn't sure myself at that point what I wanted to do when I grew up. For some years I wanted to

be a writer and regularly contributed short pieces for the school magazine, but I can remember times when I also wanted to be an architect - probably the usual toying with different career images of themselves to which adolescents are prone. I suppose the critical determining influence on my ultimate choice of career was that I had a boyhood hero, an uncle of mine, who was awarded the MBE in World War II for pulling a pilot out of a burning plane and helping to operate on him while the plane was at risk of blowing up. He was quite a hero, and he undoubtedly influenced me indirectly to become a doctor, somebody who saved lives in a spectacular way. But I also had another much-loved uncle (my mother's only brother), who had a bad heart and, as a medical student, I frequently found myself called upon by the panicking family during his cardiac crises of pulmonary edema. Helpless myself, I "held the fort," trying to preserve calm and pervade reassurance – in which I had little confidence – while we all waited for the real doctor to come and give him intravenous aminophylline. Poor man, my uncle - I saw him die during one of these acute attacks, unable to get his breath because of pulmonary edema.

During clinical years in medical school I discovered that I liked taking social and personal histories and the opportunity to get insight into people's lives, and I was intrigued by the interplay between an individual's life stressors and the medical disorders that they were suffering from. At that time, there was a resurgence of research interest in psychosomatic disorders. I found the psychodynamic theories of psychophysiological disorders extremely compelling, but of course they have lost much ground over the years.

Dr. Connolly: Was your family religious?

Dr. Sakinofsky: My parents were believers and tried to keep the Jewish traditions, but they also had to make a living, and sometimes the two came into conflict. If he were truly Orthodox, my father would have closed his business on the Sabbath, but we didn't. We kept it open except for the Jewish New Year and for the Jewish Day of Atonement (Yom Kippur). I wasn't sent to a *cheder* school, but my parents hired a Hebrew tutor for me once a week, Mr. Rosen, a nice man, who taught me Hebrew and Jewish history. Like most Jewish people who had immigrated from Eastern Europe, my parents tried to preserve some of the traditions in the family and to pass them on to us. In addition to the High Holidays, they observed other Jewish holidays such as Passover, and we used to have wonderful Sedorim, which are the two nights of recounting the story of the Exodus from Egypt while eating a dinner that includes symbolic foods, such as hard-boiled eggs (new birth) and salt water (tears and suffering). Jesus attended a Seder, as depicted in Leonardo da Vinci's famous picture, *The Last Supper*. Because my mother kept a kosher home, it meant she had to buy three sets of dishes, one for meat dishes and the other for dairy and a third for the Passover. I also remember, when I was about ten, taking some chickens down to be kosher slaughtered for my father, and I saw the chickens (whose throats had been cut) clucking around for some time after. This made such a traumatic impression on me that for many years I did not eat poultry until long after I was married. To this day, chicken is not a preferred meat of mine, to be avoided if possible.

Dr. Connolly: Have the spiritual aspects affected your life?

Dr. Sakinofsky: Spirituality? Well my belief in God was seriously challenged by World War II and the Holocaust. It affected our family directly in that my father's entire extended family was wiped out in Latvia. Our best information was that they were rounded up with all the other Jews and taken into the forests on lorries, where they were machine-gunned to death after being made to dig their own graves. I never believed that the Determining Force behind our world was similar to a human being in form, but rather an abstract presence that we cannot imagine. But it seemed reasonable that there had to be some creative force that set in motion the process we call evolution, and which eventually designed humans, animals and everything else. All this was, of course, before I encountered the ideas of Stephen Hawking, but even his explanations to my mind, do not account for all the facts, not that I am an expert on his ideas. Of course, in my work as a psychiatrist, I take great care not to allow my own theories to be imposed on my patients.

Dr. Connolly: What is your experience of the Holocaust?

Dr. Sakinofsky: As I mentioned, my experience of the Holocaust is quite personal because my mother had lost her siblings, and my father lost his parents and several brothers and sisters and their entire families. He had no information about them after the Nazi Occupation and, after the war, the Red Cross found no trace of them. I remember him sobbing when that news was received. For some years after that, my parents nourished the hope that at least Tamara would have survived, the infant child of his favorite brother, perhaps fostered or adopted by neighbors, but we never found any evidence to sustain this wisp of hope. I have. of course. visited Yad Vashem in Jerusalem and the Holocaust Museum in Washington, DC and seen the visual evidence of the mass murders that took place.

In a North American city there is a professor who, in spite of everything, denies that the Holocaust occurred, and a historian who wrote a book about Holocaust-deniers such as he, has been sued for libel by him. This is quite mad. The professor in question suffers from a form of delusional thinking, I am afraid, the delusion of denying the Holocaust in the face of the abundant historical evidence and testimony that exists. I think the Holocaust has left a deep imprint on me and has tested my beliefs in a protective Deity who protects the innocent and punishes the guilty. I believe that, as a child, my innocence was stolen from me, along with the family experiences I might have had, and I developed a need to see that justice is done. Personally, I am somewhere between a believer, an agnostic and an atheist depending on which frame of mind you catch me in.

Dr. Connolly: You had a very serious illness this past year.

Dr. Sakinofsky: Yes. It wasn't very pleasant. I had angina and had myself investigated. My cardiologist showed the coronary angiogram to a surgeon who recommended an operation, so I had the bypass operation, and I was quite phlegmatic about it. Whatever the outcome, I was resigned to it. I remember waking up in the ICU and looking at the

ceiling and registering the fact that I was alive. I was quite surprised that I had survived. I felt I had bought myself more time, and I owe that to the doctors, especially to the woman surgeon who agreed to operate on me when another surgeon would not.

Dr. Connolly: As an adolescent, did you read widely?

Dr. Sakinofsky: Yes, I read quite a lot, everything I could lay my hands on - the classics, good fiction.

Dr. Connolly: What books stand out?

Dr. Sakinofsky: Well I read all the novels of Charles Dickens and other classic English writers. I read books by Dostoyevsky and Tolstoy. Among contemporary writers I enjoyed all the works of C.P. Snow for their psychological insights.

Dr. Connolly: Have you read *Finnegan's Wake*?

Dr. Sakinofsky: Oh, yes. But it was difficult.

Dr. Connolly: You graduated from Medical School in South Africa?

Dr. Sakinofsky: I went to school and university in Cape Town, South Africa. After I qualified in medicine, I decided I wanted to be a psychiatrist, and trained in psychiatry also at the University of Cape Town. At this level I was much influenced by a respected teacher, Henry Walton, and his wife, Sula Wolff, who had both trained at the Maudsley and who later emigrated to Scotland to join Maurice Carstairs in Edinburgh (coincidentally, on the *Pendennis Castle*, the same ship and the same time that my wife and I and our infant daughter were traveling in to join the Maudsley as a registrar). After being exposed to these two Maudsley alumni I determined to augment the training I had in the relatively small psychiatric center in Cape Town at the time, and decided to go to a world-class center where I could be sure that I would get a first class training in Psychiatry, which was the Institute of Psychiatry of the University of London, known as the Maudsley.

So, after I graduated from medical school and did my internship, I went into psychiatry. Psychiatry in Cape Town was just developing at the time, and the head of the department was actually a neurologist, trained in London at Queen Square, very elegant, precise and impeccable both in his social manner and his professional conduct. In those days, neurologists customarily also treated psychiatric patients, and the department was thus called a Department of Neurology and Psychiatry. Some of the faculty to whom I owe a debt of gratitude for what they taught me as a registrar included Frances Ames, Jim McGregor and Harold Cooper. Then Henry and Sula Walton joined us. He was an ex-South African, and she was originally of Viennese origin, possibly a child refugee from Europe, and they had met at the Maudsley. Henry later became a professor at Edinburgh University jointly with Bob Kendell, and Sula Wolff became a world-renowned child psychiatrist. The chief in Cape Town, Sam Berman, taught me some very useful basic

neurology – that I have never regretted – and I had to learn to type (for which I am also eternally grateful) to prepare the new patients' case notes in advance for his ward rounds. He absolutely insisted on it and would not accept anything handwritten. Frances Ames taught me empathic psychotherapy and later, Henry Walton taught me a whole other set of psychiatric skills. Soon after Henry arrived the department was split into departments of neurology and psychiatry, but I continued to learn from both as senior registrar. Later, after I completed a doctoral thesis on the social and cultural determinants of psychiatric illness (of which a major portion was analyzing the comparative inter-racial rates of attempted suicide), I left Cape Town for the Maudsley where I was privileged to study with renowned individuals such as Sir Aubrey Lewis, Michael Shepherd, and S. H. Foulkes, ultimately serving as senior registrar (chief resident) on the professorial unit of Lewis and Shepherd.

Dr. Connolly: What year were you at the Maudsley?

Dr. Sakinofsky: I was there between 1962 to 1965,

Dr. Connolly: What were the influences on you in the Maudsley. Who was there at the time?

Dr. Sakinofsky: Professor Michael Shepherd was one of the people who interviewed me for admission to the Maudsley, and his unit was my first placement. Shepherd was the Reader in Psychiatry, considered to be a very critical thinker, a widely published epidemiologist and psychopharmacologist, much respected, but rather aloof and intimidating. Anyway, as a registrar, I remember the first six months as a time of major adjustment, and I got a real workout in the competitive climate. You can imagine the anxiety everyone felt. It was so very competitive at every level, and everybody tried to outshine everybody else, but once you were past the first six months and less likely to be let go, you heaved a huge sigh of relief. I remember one poor fellow who was not allowed to go on after six months and who killed himself. It was scary, to say the least, but the learning curve among the junior staff was almost vertical. On the other side of the coin, there were checks and balances. We had our Junior Common room where the registrars spent a fair amount of time, and where some collegial bonding took place, which helped to counter the anxiety. It was also a place where useful information was shared and where one was exposed to a high level of discussion of intellectual issues, not only about psychiatry but also about contemporary affairs. It was a veritable cauldron of social and professional learning and, sometimes, I wondered whether I was learning more from my peers than from my teachers. I also look back with great pleasure on the group visits to the opera and theatre that were organized from time to time by one of us, Oscar Hill, a polished and urbane man to whom we all should have been more grateful. On the PU (professorial unit) we registrars met Friday mornings for a case conference. The anxiety of the presenting registrar would be over the top, just trying to meet Sir Aubrey's exacting expectations. Having probed the presenter's depth of knowledge Lewis would go around the room addressing a probing question to each of us in turn, like Socrates, debating our (to us) pathetic answers from the vantage point of his Olympian intellect and

total mastery of the literature. I had never before in my life encountered anybody approaching Lewis's intellectual stature, nor have I since - definitely a man to be looked up to and emulated, if one could.

From Lewis and Shepherd, I moved off the PU to study group psychotherapy with S. H. Foulkes, one of the numerous German-Jewish refugees whose flight from Europe enriched British psychiatry. Foulkes was one of the pioneers of group psychotherapy that came out of trying to manage large numbers of soldier-patients with "battle fatigue" in World War II. I observed him conducting groups, and he supervised my groups for about a year. I attended some of the meetings of the group psychotherapy society that he had started and over which he presided, and I remember we were served Pym's Number One drinks and dainty sandwiches. But I had already gained some experience of group psychotherapy from Henry Walton in South Africa who had himself trained under Foulkes at the Maudsley. Henry was pretty impressive to watch in action. Then, as I neared the end of my term, I had a phone call from Michael Shepherd that he could arrange for me to work in suicide research in Chichester with Peter Sainsbury, but I was on the point of returning to South Africa and, to my great regret, I had to decline. I had met Sainsbury a few times and regarded him extremely highly, but duty called.

Dr. Connolly: Why what made you do that?

Dr. Sakinofsky: First of all, when I went to the Maudsley, I had a fellowship from the South African College of Physicians and Surgeons that was conditional on returning to South Africa to teach for at least three years. Secondly, I had family business to attend to. My father had died about a year before I went to London, and I had to make sure, as the eldest child, that my mother and siblings would be all right. So I rejoined The Department of Psychiatry in Cape Town as a senior lecturer. I taught there for exactly three years to fulfil my obligation, and then circumstances permitted me to move to Canada.

It was 1967 and, at the time, I was actually in charge of the Department, the acting head, while the Professor, Lynn Gillis, was on his sabbatical year in America. One evening I got a phone call from the registrar on duty at the hospital, Dr. Tockar, who told me that I had better come to the hospital because the Prime Minister, Dr. Verwoerd, had been brought in by ambulance after an attack and was dying and, in another ambulance, his alleged assailant had also been brought in and needed a psychiatric evaluation. So I went across, and I knew this was going to be fun and games because this was South Africa at the height of the Apartheid Era, and Dr. Verwoerd was known as its intellectual architect. When I arrived, security officers and police were milling around the accident and emergency department of the Groote Schuur Hospital (the same one where Christiaan Barnard did the world's first heart transplant). The room where the alleged assassin was being held was crowded with police, military police and non-uniformed security, possibly about 50 of those guys in there. There was no hope of getting a decent interview with the man, so I had to say, no way, you know you don't do psychiatric interviews with an audience of 50 people and, therefore, the room needs to be cleared. So there was a bit of a standoff with the security people but, with the support of the hospital administration,

eventually the room was cleared, leaving Tockar and myself alone with the patient. We were able to complete and record the interview, but I needed time to mull it all over before releasing our findings, and so a press conference was arranged for the next day. However, the police did arrest the patient (Demetrios Tsafendas) immediately after our interview and took him away to prison and pre-trial while their own psychiatrist started his evaluations. It was clear that he was ultimately going to trial for the murder of Dr. Verwoerd. A handful of psychiatric colleagues from UCT and myself were enrolled as expert witnesses for the defense and gave evidence at the subsequent high level trial that he was psychotic and unable to plead, and ultimately this viewpoint was upheld by the court. Naturally, there were government psychiatrists who believed he was competent, but their thesis did not prevail. Tsafendas was found unfit to plead by reason of insanity. Subsequently, several books have been written about it, and my evidence has been transcribed in some of those books. The assassination took place not long after the Kennedy assassination so, in preparing for the trial, I wanted to get as much material about the Kennedy assassination as I could, and I approached the U.S. consul's office, and they were very helpful. I discovered, incidentally, no doubt because of my involvement in the case, that the F.B.I. had opened a file on me, so you could say that I earned a certain notoriety but, in spite of that, I then had an offer of a job from the Albert Einstein University, New York, and about the same time one from McMaster University in Canada. Based on the specious logic that Canada lay somewhere culturally between Britain and the United States, I decided on moving to Canada. A good friend of mine had also vouched for me at McMaster and, knowing that he and his wife were living in Toronto, only an hour away, also made the choice easier.

Dr. Connolly: How did you get into suicidology?

Dr. Sakinofsky: When I made up my mind to become a psychiatrist I determined that I would focus on the severely distressed at not "the worried well." Even when I was still a registrar in Cape Town, I was asked to see and treat such people. A few of my erstwhile professors asked me to treat their wives who had attempted suicide or were thinking of it. I did have a medical student who took her life, with devastating effect on me, and I developed an even greater determination to improve my skills with suicidal people. I think she had gender confusion in a country where homosexuality was kept in the closet at that time. She used to run well, was an athlete and worked well at her medical studies. She then took a break from her psychotherapy to prepare for her exams and died in her room in the medical student residence with a blanket around her and an empty bottle of tablets. I went through the aftermath of that, my first patient suicide. As Kreitman once remarked, you can count the suicides but not those whose lives you may have saved. I think there have been some of those too, judging by letters I have received from patients or their relatives over the years. At the end of the day, when you look at what you have done in this world to justify being here, we need memories like that, because that's all that matters.

Dr. Connolly: You save one life, you save them all?

Dr. Sakinofsky: Yes.

Dr. Connolly: You have published a lot on what suicidology's future is?

Dr. Sakinofsky: Some, but not as much as I would have liked. I always had jobs that were pretty burdensome clinically and loaded with administration. I think it would have been better in Canada if we had a different healthcare funding system - more salary-based and less fee-driven.

Dr. Connolly: What publications are you most proud of?

Dr. Sakinofsky: It's hard to say which ones. We just finished a study which is going to be in the next issue of SLTB that I'm quite proud of. It is a study of suicide in the Canadian Armed Forces among peacekeepers. You have to understand that peace keeping is very important to Canada ever since Lester Pearson was the Prime Minister. Pearson was very active in the United Nations and believed that the United Nations should keep the peace in the world and that Canada should play its part. Canada was always regarded as a fair and unbiased country, a good country to find peace-keepers for the trouble spots. Then there was a rash of newspaper stories that Canadian peacekeepers in Bosnia had committed suicide, and it was the horrors of peacekeeping that were responsible, and so I was asked to come back to independent research and put together a team, which I did - scientists with first class experience in epidemiology, biostatistics and psychological autopsies. Our findings were presented in a report to the defense authorities and over public television (CPAC).

Dr. Connolly: Where is suicidology going from here?

Dr. Sakinofsky: The $64,000 question. I think increasingly we are making neurobiological advances in suicidology. But the complete picture has got to be biopsychosocial and is still elusive. Even in the presence of severe mental illness, no matter how hopeless they may feel, most people would see that they do have alternatives to suicide and would preferably choose one of those alternatives. The minority do choose suicide because of their thinking processes. So it is understanding the cognitive process, and why the cognition goes towards suicide in one person and away from suicide in another, that is the enigma that I personally would have liked to have spent a long time researching. I've got patients with not much adversity in their lives really but who are or have been very suicidal.

Dr. Connolly: This would link up with the biggest issue this year, that of physician assisted suicide or physician assisted dying?

Dr. Sakinofsky: Physician assisted suicide? Well that's different. The suicides that I try and prevent are suicides in people who have had unbearable conditions and who have been

suicidal in the past, but fundamentally they are ambivalent. They seek us out to help them make it possible for them to go on living in a healthier or better state. I don't get involved with people who attempt suicide to kill themselves, genuinely failed suicides, unless they are suffering from potentially treatable illnesses that would make them change their minds if they recovered from them. I do not hold the utilitarian view that people's lives belong to the state. They belong to the person. I've seen enough suffering to take a humane and compassionate physician role. I think there are situations where they can be assisted and should be assisted.

Dr. Connolly: But could you assist anybody in that way?

Dr. Sakinofsky: Myself? No, I don't think I could but, on the other hand, I don't know how I might react if it was a dear one suffering terribly, and no one else would help. You cannot say what one would do under those circumstances until you are actually in that position. Even famous suicidologists, like Nico Speyer, a famous Dutch suicidologist, took their own lives when confronted by inordinate predicaments.

Dr. Connolly: He's a Dutchman.

Dr. Sakinofsky: One time he was a big name in suicidology. Ringel, Austria's leading suicidologist and secretary of IASP is another name that comes to mind.

Dr. Connolly: Yes, I had felt very let down by the sub-group who were kind of heroes in my time.

Dr. Sakinofsky: No, I don't judge, you see.

Dr. Connolly: Are you involved with AAS?

Dr. Sakinofsky: I've been involved with AAS; I've been going to their meetings, but I have not sought office.

Dr. Connolly: What about your interests in art and music?

Dr. Sakinofsky: I enjoy music - classical music and some jazz too, but I don't enjoy jazz as much. I didn't have a musical background at home. My parents were too involved in the harsh realities of making a living in a strange country. It was only in high school and when I was a medical student that I started going to classical concerts with friends. Not being able to play an instrument has always been one of the lasting regrets of my life.

Dr. Connolly: London was wonderful for musical concerts, wasn't it?

Dr. Sakinofsky: London was, yes, I liked concerts there.

Dr. Connolly: Do you now have much contact or any contact with South Africa?

Dr. Sakinofsky: No. My mother emigrated to Canada together with my sister and her family in 1997, and she died in Canada. I had a brother in South Africa and have made the occasional visit. My wife has been back more often; she has many of her family there.

Dr. Connolly: Have you been back there since the change of government?

Dr. Sakinofsky: Yes. It is a very beautiful country.

Dr. Connolly: What do your children do?

Dr. Sakinofsky: My daughter has a human resources company that she started herself, and she hires people for quite large organizations. I'm very proud of her. She has an MBA from the University of Toronto and is a fine young woman in, the way she relates to people. and she is an excellent mother and wife and daughter. My son is a lawyer but burdened by problems of physical health.

INTERVIEW WITH ARMIN SCHMIDTKE

Dr. Connolly: First, tell me about your formative years, your family and your early education.

Dr. Schnidtke: I was born in East Prussia in the last years of WW II. In the last months of war, my mother fled with me to a region of Germany near to the border with France, and later to a separate independent state called Saarland where I grew up in a relatively small city. My early education was in a humanistic high school, what we call Gymnasium. After my military service, I started my studies at the University of Saarbrücken, at that time a very multi-cultural university with a strong French influence. We had a lot of French professors, and my first professor in psychology was a Swiss professor, Professor Ernst Boesch, who was interested in developmental psychology and cognitive psychology, a former student of Professor Piaget, and co-working with UNESCO. As a result, we became familiar with international research and international connections. For example, I wrote my first master's thesis half in German and half in French and, for this master's thesis, I had to test French and German students in summer camps in their respective languages to see whether changes of national stereotypes are possible through personal contacts. After I finished my studies, I accepted a position as an Assistant Professor at the University of Mannheim, a university specializing in life-span development and economics.

Dr. Connolly: Tell me about your family.

Dr. Schmidtke: One of my early and also later interests comes from my mother's family because my grandfather was once a director of a daily newspaper, one of the bigger newspapers in the country and, later, an editor and owner of a newspaper and printing company. Still today one can buy in antiquarian bookshops famous photos made by him So I became familiar in my early years with all the things associated with newspapers and their production, the writing, making photos, the printing, the selling, and dealing with the distribution. I grew up between Linotypes, Heidelberger printing machines, and I very much enjoyed it. I never lost this interest, and it led to my interest in the influence of mass media and especially on the influence of the press on changing human behaviour. We used to talk about it nearly every day. It was our life at home.

The joy in teaching came also from my mother's side of the family, because I grew up in a family with very emancipated females, all teachers. For example, my grandmother was one of the first teachers for vocational training in Germany, and at that time it was very difficult for women to become such a teacher. She dared to go to court during emperor's time to make this possible. As you may know, in Germany in the last years of the past century, it was, for example, not allowed for women to study some disciplines such as medicine. So my main interests came from two sides, teaching and the media.

From my father's side came the interest in economics. He was a producer of paper products and, for example, already very early he was thinking to replace plastic bags with paper bags.

Dr. Connolly: Tell me about your thesis.

Dr. Schmidtke: My main interest at that time was in pure methodology because I was trained in mathematics, statistics and experimental methodology. My master's thesis dealt with testing the limits and learning potential of feeble-minded children with culture-free test procedures. I had to use different methods to assess the subjects' intelligence potential. Therefore, I standardized and edited the first German version of Ravens Culture-Free Matrices Test (CPM). In some statistics books, one can still find statistical tables developed by me, for example, for kurtosis and excess of distributions.

After I finished my studies at the University of Saarbrücken, I went to the University of Mannheim where I was offered a position as assistant professor and lecturer. The University of Mannheim at that time was very methodology orientated, and so I taught methodology, statistics and experimental methodology. The head of the department, Prof. Groffmann, was also interested in life-span development, and this interest shaped my work later in suicidology because I was asked to test if one can use statistical methods (time-series analyses) for the prediction of the development of suicide rates. This was my first connection with suicidology, and I became interested in the behavior itself and tried to apply behavior analytic psychological methods to suicidal behavior. I worked at the University of Mannheim from 1972 to 1982 and, after the early sudden death of my boss, I then moved to the Central Institute of Mental Health in Mannheim, belonging to the University of Heidelberg, a WHO collaboration center, as Deputy Head of the Department of Clinical Psychology. There I got into contact with Professor Heinz Häfner, who used to be an WHO adviser, and with health officers at the WHO office in Copenhagen, especially Dr. John Henderson who used to be the WHO adviser for Psychiatry at WHO/EURO in Copenhagen and with the WHO Headquarter in Geneva (Dr. Faria). Our main interest was on imitation of suicidal behavior, and we started to do more suicide research in this field.

We did research on, the so-called Werther effect. We performed studies on the sociological background of suicide attempters and on learning theories of suicidal behavior. In 1984, we planned, together with Professor Häfner, to launch a major suicide project on how we could improve the situation for suicide attempters in Europe. I worked with Dr. John Henderson in Copenhagen, Professor Nils from Denmark, and Peter Kennedy from York, UK. We started this project in Mannheim and, in the first two years, we planned it from Mannheim. This project, the WHO Multicentre Study on Suicide Attempts, stimulated a lot of research and resulted in more than 10 books and several hundreds of papers from various cooperating researchers (and also stimulated many careers). We had a lot of contact with old and young researchers, the contacts and friendships lasting until today (with Professor Kerkhof, Professor Faria, Professor Soubrier, Professor Fekete, and Professor Wasserman).

In 1986, I got an offer to become the Head of the Department for Clinical Psychology and Psychotherapy at the University of Wurzburg, and we transferred parts of our project in 1989 to Wurzburg. When people visited me in Wurzburg, they were always astonished that I am also responsible for clinical wards, the ward for behavior

therapy and the ward for psychotherapy, and for the training of the doctors and psychologists in psychotherapy.

Dr. Connolly: I am amazed by this because I did not realize, until Ad Kerkhof told me, that you had a very full clinical and administrative role in the department. I began to wonder how you can be so prolific in your research and in your publications. How is it done?

Dr. Schmidtke: How is it done? Sometimes people laugh and say that I am the inventor of the 25-hour day. At work, I have a good team, longstanding and very motivated. We are well organized, and everybody enjoys the combination of research and the clinical work. It is my opinion that suicide researchers should not lose contact with patients. You can't understand suicide in your ivory tower only from figures and graphs and from files. You have to deal with patients or else you will lose the ability to understand the patients and to build hypotheses for your work, or you work in a way that we call armchair psychology. I always enjoy having contact with patients and to be responsible for them while doing research. Sometimes people are astonished, asking how I can treat patients if I am so interested in methodology. I believe that a good clinical psychotherapist must also be a good researcher. Treatment of a single person is clinical research. You have to build a hypothesis, you have to test your hypotheses, and you have to think about intervention and treatment and how to control your efficacy. Every single patient is like an experiment. This has been my experience especially in suicidology. This kind of thinking also prevents you from becoming dogmatic. As a result of this combination, we always had a lot of foreign postgraduates from other European countries, including Hungary, Turkey, Norway, Armenia, Poland, Italy, and Austria.

Despite the workload, which is sometimes heavy, I wouldn't give up the research for the clinical work. We have a good reputation for our work, and I think that the department has a good reputation because of this combination of tasks. I enjoy it, but sometimes I am asked how can you cope with suicidal persons? I think that, if you have the right strategies, it is easy. You mustn't lose your patience or your sense of humor. You have to find good coping strategies.

Dr. Connolly: All of us who work with suicidal patients have had a patient who has taken his or her own life, which is very traumatic and can be quite devastating for the therapist. What sort of mechanisms do you have inside yourself for coping with this?

Dr. Schmidtke: It was sometimes not easy to lose a patient, especially young patients. One of my principles was that every therapist needs supervision and has to be controlled. I speak on a continuous basis with my assistants, and we have them under continuous supervision. On a daily basis, I have a colleague supervisor, and we talk about our cases. We speak about the cases to see if we have made mistakes and at which point of time we should have worked in another way We also had, in addition, an external supervisor for our department. Professor Fred Kanfer, from Illinois, who comes in at least once a year to talk about problems. We were also the first German unit to invite Professor Marsha Linehan to visit, with funding from the Germa Research Foundation (DFG), in order to

learn about the treatment of suicidal persons. Her strategy at that time was not yet named DBT, was very new, and a little bit strange perhaps for the old German schools of treatment. I also learned from my mentor, Professor Häfner, who said, during a lecture, that to be humanistic means to accept that a patient has the right that sometimes he should be heard against his will. That is really humanistic thinking, and I always act in this way. I teach my students to think always in the interests of the patient, and not to think in terms of revenge or because you are exhausted with such cases. If you go home at evening and you wonder if you have done the wrong thing, then you did the wrong thing. It is better to act in the interests of the patient even if the patient doesn't like you at this point. You don't always have to be liked by the patient. We lose some patients despite all our efforts. We should accept that we are not master of all lives We should accept our inability. We talk about these problems with patients, and we tell them at the beginning of therapy that we can't control everything. We do also not want to control everything.

Dr. Connolly: Your research covers a wide range of topics in suicidology. What are you most proud of?

Dr. Schmidtke: I think we can be proud of our research on the imitation of suicide behavior. The basic idea goes back to the early 1970's when we started to think about behavior therapy and learning theory-based therapy. But I must say I am also very proud that we very early detected that the papers of Jerome Motto, David Lester, David Phillips and Marsha Linehan could have a big influence in suicidology, and we are to obliged to the German Research Foundation which funded us 1987 to be able to invite Professor Linehan to visit long before other people wrote about her work. We were able to see the relevance of this kind of therapy for the treatment of suicidal patients. Later we also got funding from DFG to invite Professor Phillips and Dr. David Clark. One result of our research was that our group received the first Hans-Rost Price from the German Association for Suicide Prevention (DGS) in 1988 (later on also a second), and we are, up to now, the only Germans to have received the Stengel Award from IASP.

Dr. Connolly: You mentioned one of your mentors earlier on. Who are your other mentors, the people who most influenced you?

Dr. Schmidtke: One of my first mentors was my first professor, Professor Ernest Boesch, a pupil of the development psychologist, Jean Piaget, who trained me to think in a scientific clinical way. His calm and sophisticated manner in dealing with clinical problems also impressed me. I liked him very much. He trained me not to think or act in a dogmatic way, but to formulate a hypothesis, then test this hypothesis, and depending on the results formulate a new, improved hypothesis. Later there was Professor Heinz Häfner in Mannheim, a German psychiatrist. I was very impressed with his clear thinking and his strategy for dealing with problems. He taught me how to cope with scientific methodological problems, and I learned a lot from him. I also learned a lot from Professor David Philips whom I like very much. One of my first books I read was *Why People Kill Themselves* from David Lester which was very impressive. (At this time, we

nearly had not German scientific books on suicidology). I am very proud that I have been able to publish with him. I obtained this book first when it came out in 1972, and it was one of the first books about suicidology I read in my life. I never thought that later I would be able to be able to publish with David. I think these were my main teachers.

Another person who later influenced me was Terry Maltsberger. I admired his clear thinking and strict methodology. Beside the scientific influences, another person whom I admired was John Henderson at WHO. I met him first in 1983, and I was impressed by the way he dealt with people from various international backgrounds and organized meetings and research. I always wanted to emulate him.

Dr. Connolly: When did you first become involved with IASP?

Dr. Schmidtke: Very early. In Germany, since the 1970s, we had a yearly meeting, but no German association existed. These German meetings were organized by the late Professor Pohlmeier, and the international meetings by Professor Ringel, an Austrian professor, and also Gernot Sonneck. I had the opportunity when the director of the psychiatric clinic in Kassel invited us to a lecture, and I met Professor Ringel. This was my first contact with someone from IASP. In 1973, I had the opportunity to get funds from my university to visit, along with some of my students, Dr. Sonneck's center in Vienna. The first congress I officially visited was the IASP Congress in Vienna organized by Professor Ringel and Professor Sonneck, and Ijoined the IASP as one of the early members. I later became co-editor of Crisis, when Professor Pohlmeier was the chief editor.

Dr. Connolly: You soon got very actively involved with IASP?

Dr. Schidtke: Not really. I have been on the scientific committees of some IASP Congresses, but I never took on an official position in IASP because I was involved in German and USA associations. For example, I was chairman of the German Association of Suicide Researchers, and this position was a part of the German Association for Suicide Prevention. I was a member of several AAS working groups and the first international representative in the AAS directory. In Montreal, I was asked to run for the position of Vice-President of IASP but, at the time, I was already Secretary of the International Academy for Suicide Research (IASR), and I had been asked to run for the Presidency of the Academy (and was then elected). I did not want to confuse positions. Thus, I was more engaged in other organizations than in IASP itself.

Dr. Connolly: You are now President of the Academy.

Dr. Schmidtke: Yes.

Dr. Connolly: Congratulations.

Dr. Schmidtke: Thank you

Dr. Connolly: The Academy, in its structure and its running, has caused a certain amount of comment and controversy. It is often seen as an elite group. What are your views on that?

Dr. Schmidtke: Yes. I have heard these objections. The Academy was founded mostly by IASP members as an association for suicide researchers and their needs. Some researchers thought that they needed a special organization for researchers because some of the problems that researchers face and have to discuss are not connected with the problems of more general politically-oriented associations, such as the Samaritans or lay people engaged in suicide prevention, who are not interested primarily in doing research. Ideally, it should be an association of people in the field who are good researchers, perhaps the leading people in their countries, who want to promote suicide research and prevention, and want to distribute their knowledge about suicide research and prevention. The Academy also created a more scientifically-orientated journal. This does not mean that the organization is exclusive. I think the various suicidology organizations have different aims and goals. I see them as complementary and not as enemies.

Dr. Connolly: During your term as Secretary of the Academy, the Diekstra controversy rocked the boat a little bit. Was that a difficult time?

Dr. Schmidtke: Yes, it was a difficult time for the Academy and all persons who were involved. When I took over the Presidency, I inherited the problem with the so-called scientific misconduct of one member. The case is open at the moment, the member is suspended, and a committee will give advice on how to deal with the case. Since nobody thought, at the creation of the Academy, that such a case would ever arise, there are no formal rules in the Academy's constitution for dealing with such a situation. In addition, a few people concluded that there is something wrong with the Association when such a case is possible, which is not the case.

Dr. Connolly: You yourself published with Diekstra, as did many members of the Academy

Dr. Schmidtke: Yes. René also influenced me, and I regard him as a friend. I admired his bright ideas, his enthusiasm and his ability to deal with problems. We had several contacts when he worked at WHO Headquarter in Geneva. I published books together with him, and I also used his ideas, especially about imitation, and one of my assistants tried to write her dissertations with René. I was very surprised when I first heard from the accusations, but I wanted to keep the matter very calm. It is not my way to act in a histrionic way to a crisis and to promote arguments. I always say to myself wait and see also the other side of the coin. You have to try to understand why people do this, what normally not belongs to their character and you should not sentence them without hearing them. Everybody has a right to be heard and one should also bear in mind the reasons why people are so eager and over-persistent.

Dr. Connolly: What about the future in your research? Where do you go from here?

Dr. Schmidtke: One of my teachers used to say that, if you read more, you don't have to think so much. This is true. Sometimes I have the impression that some researchers in our field try to invent the wheel again and again, always saying the same thing. You see their work and say that this was already published twenty years ago without having any effect. Some feel that it is a pity that money is spent on such research.

Research in this field can also be very narrow and rigidly. During one period, only social factors are studied, during another period only biological factors. During one period, only pre-natal factors and in another period only early stages in development are studied. I saw these effects in comparing suicide research in the former German Democratic Republic. Suicide research dealing with socioeconomic factors was nearly non-existent, despite their high suicide rates (never published). We need a more comprehensive holistic view for the field. I think we need to get away from what is called type A research (domain research), which means to look in the field and collect only data. We have to develop theories, then hypotheses and then test them – type B (doctrine research). Without type B research, we can't develop valid methods of treatment. There are not many studies showing the effect of treatment or prevention efforts, and the results of the research is not very overwhelming. One question we have to resolve is why is our theoretical knowledge is not put into practice and why is it not effective? Is this too complicated? Don't people like to deal with research results or logical thinking about it?

We also have to bear it in mind that there are not only some external factors which are important, but also biological, psychological and sociological factors. Life is too complicated to be seen only as unidirectional or dependent only one variable.

Dr. Connolly: What do you do to relax?

Dr. Schmidtke: People ask me when do I relax. For example, I am collecting old maps, and I am often asked why are you collecting old maps? To collect old maps is really interesting because you can see, on old maps, the quality of the development of the brain and thinking, as in the development of a child. The very old maps are very egocentric based. No north, no south. People were standing in the middle of the map and deciding where to

go. If there was a church with two towers, they painted two towers and you had to go in that direction. Later the maps developed in a more symbolic way. Every map has the north on the upper side and south on the lower side, and you can see the development of the brain and of the thinking. I very much enjoy this.

I used to engage in sport. I participated twice in the so-called Nijmegen march, and I was champion of the army reserve in skiing in Saarland.

Dr. Connolly: Do you still ski?

Dr. Schmidtke: Yes, but very carefully. I'm older, and so the risk of injury is greater. I used to take longer runs.

I also read lot. I still write for non-scientific journals, and I sometimes take and publish non-scientific photographs, as I used to when I worked for journals during my studies. That is still relaxing. I always used to learn beforehand about the region or city where I go and look around, and I enjoy that. It is fun when you go somewhere, and you can discuss with the local people about their history.

Dr. Connolly: Other than scientific books, what have been the most important books that have interested and impressed you. I often feel that psychiatrists would be better off spending far more time reading novels and literature than reading textbooks of psychiatry.

Dr. Schmidtke: Yes, that is true. I was impressed by French literature because I had to read a lot of it in school, but I really can't say that one special book influenced me. If I choose one German writer, it would be Heinrich Heine who had to go into exile to France. Sometimes he was a little bit cynical, but I liked his view of life behind the curtains, describing reality. He was not liked at the time, and he is not liked very much today, but I think he was one of the writers who really impressed me. I like him especially for his poems. I was also very much impressed to read Uncle Tom's Cabin. Such books can influence you, and that book made me think about fight for the human rights.

Dr. Connolly: What about music?

Dr. Schmidtke: I have a daughter who is now in her 20's. She likes pop music and has always taught her father how to appreciate this. I was always up-to-date with this music, and I really like it. I also like operas, operas with suicides. It is always very interesting to see the suicidal development on stage. I like Mozart, and I have a collection of all of Mozart concertos.

Dr. Connolly: Has religion played any part in your life?

Dr. Schmidtke: Religion is very important for me. I grew up in a very religious household. My mother had what we call in Germany a special license to teach religion, which meant that she could teach religion in schools. My grandfather had many connections to priests and

monks, and so we often had such guests in our house. I think religion plays a big role in our life. I am not a church worker, but I am religious in a certain sense.

Dr. Connolly: Would you say religious or would you say spiritual in a secular sense?

Dr. Schmidtke: No. In a certain sense, I am religious. It is a very funny thing, when I had my training in psychotherapy, what we call the week of self-assessment, self-encounter, one of the trainers in the self-encounters said, if you are narcissistic, if you think you have to fight against certain systems and you are offended, go for a walk during the night and look at the sky. See all the stars and think about your inferiority. That is a good thing to keep you modest, and sometimes I do it.

Dr. Connolly: You mentioned your daughter. What other family members do you have?

Dr. Schmidtke: My son studied also psychology and media, but he is working for a publishing company. We call him a work and economy psychologist. My daughter is more creative, and she used to take photographs. So we are still all connected to the press. There is a saying in Germany that, if you have color in your veins, you will never lose it. This is sometimes true.

Dr. Connolly: Printers ink.

Dr. Schmidtke: Printers ink, yes. It is strange. I was never forced to do anything, and I never forced my children to do anything. It came from them. I never wanted my son to study psychology. It was his own decision, and he likes it, but he doesn’t do any clinical work as I am doing.

INTERIVEW WITH DAVID SHAFFER[12]

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*.[13] 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.

---

[12] This interview was not edited by David Shaffer.

[13] X-linked *agammaglobulinemia* (XLA) is a primary humoral immunodeficiency characterized by severe hypogammaglobulinemia and increased risk of infection.

Dr. Connolly: Did you read a lot at that time?

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 MORTON SILVERMAN

Dr. Connolly: Tell me about your early years.

Dr. Silverman: I was born in 1947. My parents moved within a year of my birth from New York to New Jersey. My father was a Board-certified clinical psychologist and held a number of academic and teaching positions. My mother was an educational psychologist with expertise in school psychology. I remained in New Jersey until I went to college.

Dr. Connolly: How large is your family?

Dr. Silverman: I have an older sister who has cerebral palsy and a younger brother.

Dr. Connolly: What is the impact of your birth order?

Dr. Silverman: Having an older sibling who was intellectually challenged placed me in a different position. In some ways, I became the older child in terms of expectations such as performance and responsibility. Yet, in other ways, I was number two in the family. my sister being the eldest child. I also have a younger brother. I guess one could make a case for me having the middle-child syndrome.

Dr. Connolly: What formative events happened during your childhood?

Dr. Silverman: My younger brother had quite a number of illnesses, and I remember that there was great concern about his health and welfare. He was in and out of hospitals with one problem after another - allergies and illnesses. Other than that, my life was very stable. We moved when I was approximately a year old, and then we moved when I was six to the home where I grew up.

My father was an academic and a clinical psychologist with a private practice. He published a number of books on family therapy and psychotherapy, as well as being an accomplished poet.

My mother went back to school when we were growing up and has her Masters in school psychology and completed her coursework for her doctorate - what we call in the United States, “all but the dissertation.” The message I got growing up was to be very sensitive and to be responsive to those less fortunate then myself, especially to individuals who had mental disorders or other types of mental disabilities.

My parents were very active in associations that dealt with developmentally- and intellectually-challenged children because my sister was developmentally-challenged. My parents were very active, both clinically and in professional organizations, with an emphasis on special education and caring for people who had special needs. My mother earned her state licensing certificate as a school psychologist, and she was focused on students who needed special accommodation. A lot of my upbringing, a lot of the dinner table talk, and a lot of activity at home, emphasized exercising sensitivity and the

recognition that many others were not as fortunate and had needs to be identified and addressed.

Dr. Connolly: Was it a religious household?

Dr. Silverman: Yes. My father came from an Orthodox Jewish home, and my mother came from an Orthodox/Conservative Jewish home. I was brought up in a conservative Jewish tradition. We observed the Sabbath on a weekly basis and also most religious holidays. I attended Hebrew school a few afternoons each week, and I was bar mitzvah, as was my younger brother. We had a very strong Jewish identity.

Dr. Connolly: What about now?

Dr. Silverman: The same. My wife grew up in a Reform Jewish family, and we have always been members of a Jewish synagogue. We brought up our children to have a very strong Jewish identity, and they too have all had religious training – bar mitzvah and religious high school confirmation classes. It's always been a very important part of our family lives.

Dr. Connolly: What influence does your religion have in your daily work?

Dr. Silverman: It provides some balance, some sense that there is more to life than the day-to-day frustrations and headaches. There is a saying in the Talmud, which is a sacred Jewish book of writings, that translates something like, "If you save one life, it is like you have saved the world." I came upon that phrase four or five years ago and, when I saw it, it immediately resonated with me and helped me. I like what I do and why I do it, and this perspective helps to validate and support what I do - the time and effort and the sacrifices that I make for my work because, as with any other profession, we have to make choices and sacrifices. We have to weigh alternatives - to do this or to do that - where you are putting your time and energy - balancing between one's chosen vocation, family life, friends, recreation and personal activities.

Dr. Connolly: Getting back to your childhood, what did you read back then?

Dr. Silverman: I loved reading murder mysteries and comic books. I particularly like murder mysteries because of the challenge of figuring out who did it and how and when, and trying to solve the mystery before the last page reveals all.

Dr. Connolly: That was your first step in research!

Dr. Silverman: I guess so. I also enjoyed reading adventure books, stories of heroes, of people who had ambition, or who had a view of something and went out and did it. Just in the last year, after a long illness, I have started reading adventure books again - true stories of people who had to fight the odds, who have had to pick a path that is not the usual path

and who challenged themselves and did things that other people have not done - sailors fighting against hurricanes, how to survive on Mount Everest after sudden avalanches, and other challenges such as that.

Dr. Connolly: Were you athletic in your youth?

Dr. Silverman: Not really. If this ever gets into print, my kids will probably laugh and say, "Daddy, 'Not at all' is what you really should have said," and that's probably true. I never broke a sweat and never was interested in doing so. I enjoyed playing basketball more than anything else and a little baseball, but I have no athletic coordination and no ability in that arena. I just didn't have what it takes to be athletic. Basically, I remain unathletic.

Dr. Connolly: What university did you go to?

Dr. Silverman: I went to Franklin and Marshall College which is in Lancaster, Pennsylvania, with the intention of being pre-med. Back in high school, I had decided that I wanted to be a doctor. At the time, Franklin and Marshall College was one of the premier, small liberal arts colleges with a strong pre-med curriculum.

What I found was that Lancaster in those days was an isolated community, very different from anything I had experienced before. I had grown up in the city, and I always enjoyed the benefits of public transportation, theater, museums and shopping and being part of something big. When I started at Franklin and Marshall, I found myself out in farm country at a small, all-male school. I knew this in advance, but it did not sink in until I got there. I was very unhappy.

I was fortunate enough to get good enough grades and to have a strong enough high school record that I was in a position to transfer. I left Franklin and Marshall at the end of my first year and transferred to the University of Pennsylvania which was in Philadelphia, a big city and an urban campus - a larger school with more options. During my orientation week as a sophomore, I met my wife-to-be. She was starting as a freshman and, since I was a transfer student, I was expected to participate in orientation for new students. We didn't spend a lot of time together during the ensuing three years, but we knew about each other and were aware of each other's activities through our mutual friends.

At the end of my fourth year at college, we reconnected and, as they say, the rest is history. We have been married thirty years. In hindsight, the education I got was fine, but the fact that the school provided the opportunity for us to meet was the best thing that happened to me.

I graduated from college as a psychology major with some pre-medical courses. This was 1969, and the Vietnam War was raging. The competition to get into medical school was fierce because it was the only deferment from active military service for young men. A number of my friends and classmates, who would have otherwise gone on for Ph.D.'s in biology, chemistry, physics, or one of the other sciences, were all applying to medical school.

I was placed on a number of waiting lists, but I did not get accepted at first. I used my science background to secure a position as a junior high school science teacher back in northern New Jersey, in the junior high school that I had attended as an adolescent. I returned there as a science teacher and reconnected with some of the teachers who had taught me eight or ten years earlier. I taught in the public school system for a year and then reapplied to medical school. During that year, I courted my wife-to-be, and we were married in July 1970. I was accepted to medical school and went to medical school in Chicago in the Fall of 1970, and received my MD degree in 1974.

Dr. Connolly: You didn’t serve in the forces?

Dr. Silverman: No. Being a science teacher in an inner city was considered to be a sought-after profession in high-demand, especially in underserved and disadvantaged neighborhoods. I was fortunate to receive a military deferment so that I could teach science in a junior high school in Newark, New Jersey. I then went to medical school and fell in love with surgery. I had always known in the back of my mind that I liked psychology, but I fell in love with surgery, in particular, neurosurgery. I finished my required clinical rotations and saved up all my vacation time so that I had six months’ vacation. We went to London, and I pursued a medical student rotation at the Maudsley Hospital Neurosurgery Unit and a rotation in cardiology at St. Bartholomew’s Hospital. My wife was working on her advanced degree, and she would spend her time at the reading room of the British Museum while I went to work. I was convinced that I was going to be a neurosurgeon. I found it exciting, stimulating and at the forefront of medicine - uncharted territory. However, at the Maudsley, I was working with Murray Faulkner, whose area of expertise was temporal lobe epilepsy. There were many people suffering from temporal lobe epilepsy who were medication resistant, and they would be referred to Professor Faulkner whose expertise was in removing temporal lobes to cure the epilepsy.

There was a Psychiatry Registrar assigned to Professor Faulkner’s team because part of the evaluation and work up prior to a decision to undergo surgery included a psychiatric assessment to be sure that the individual was an appropriate candidate - that they understood the procedure and understood the possible side-effects. I found myself spending more time with the psychiatric registrar who was doing the interviewing than I was with the surgeons, although the surgery was interesting and fascinated me. I wanted to learn more about these patients’ histories - how they struggled with the illness and had come to this point where other treatments had failed.

I came back to the United States for my fourth year of medical school and, although I was still interested in surgery, I decided to focus on psychiatry as my fourth-year clinical elective. In 1974, medical school clinical rotations did not require psychiatric training. It was an elective rotation. I guess there was a part of me that was resisting pursuing psychiatry because of my mother’s and my father’s vocations. There was a part of me which resisted following in the footsteps that I was “genetically environmentally destined” to pursue.

In any event, I did a rotating medical internship at Cook County Hospital that was one of the largest public hospitals in the country - a very famous hospital in the United

States- and then I entered a psychiatry residency at the University of Chicago. We had decided to stay in Chicago since my wife was a graduate student at the University of Chicago, pursuing her Ph.D.

Dr. Connolly: On what topic?

Dr. Silverman: It was on the relationship between the artist and the audience during the French revolution, exploring whether the reactions of the audience and art critics, the patrons, and the people who were attending the concerts and salons alter the artists' work, their views of themselves, their productivity, and the types of artistic endeavors that they pursued. After I finished my Psychiatry Residency and was a junior faculty member in the Department of Psychiatry at the University of Chicago, we moved to Paris for one year. My wife received a fellowship to finish her dissertation, and her primary sources were in Paris. At that point, we had a two-year-old daughter, and we spent a year in Paris – a "time-out" for me overseas.

One of the most significant events during my residency involved my mentorship with the Chairman of the Department of Psychiatry at the University of Chicago, Daniel X. Freedman. Danny was the Editor-in-Chief of the *Archives of General Psychiatry*, which was the premier research-oriented psychiatric journal in the United States. During my residency the residents met on a monthly basis for a journal club at his home, where one resident each month would select an article to read. The resident was asked to present the article, discuss it, and reference all the relevant literature. I presented an article which I still remember exactly - on post-partum depression. Pretty soon afterwards, Danny called me into his office and told me that he was looking for an editorial assistant to help him with the journal, and so I began working with Danny as a Special Assistant to the Editor-in-Chief of the *Archives of General Psychiatry*. This was one of the few defining professional experiences in my life. I worked with him, mainly on weekends, for a few years as his Special Assistant and had access to all the authors that published in the *Archives* and all the submitted manuscripts. I saw all the reviews that came in, and I watched him make decisions about what needed to be done to the manuscripts, make decisions about what needed to be published and why and when and how. I would sit in his office while he was on the phone with people from around the United States and around the world talking about the science of psychiatry. I became hooked on pursuing editing and publishing.

After I finished my residency, I stayed at the University of Chicago as an Assistant Professor of Psychiatry and also as a staff psychiatrist at the Student Counseling Service. I had worked there during my residency training as well, and I found a clinical area that I enjoyed - which was working with young adults. I had that clinical assignment, my academic career and also work on the journal. As we were planning our year in Paris, Danny put me in touch with the World Health Organization, and I was able to serve as a Temporary Adviser for the re-review of International Pilot Study on Schizophrenia, I was given charts to review and abstracts, in order to confirm diagnoses as they prepared to publish the results. That was a great experience to work with Norman Sartorius, Assen Jablensky, and Richard Day. It was a great year.

I wasn't there full time. I used to go and come from Geneva on a part-time basis. The exposure to the World Health Organization and their activities in the areas of mental health and substance abuse opened my eyes to a larger public health world perspective that I hadn't seen before. When I returned to the United States the following year, I began working at the National Institute of Mental Health in Washington, D.C.

I was hoping at that point to focus on public health. I was there for seven years and, while I was there, prevention became a hot topic and an area of research that was just beginning to be supported. Within a few years of my being at the National Institution of Mental Health, they created the Center for Prevention Research, which was a brand-new program in mental health. I became the first director of the Center.

I was the Director of the Centre for Prevention Research for a number of years and started some prevention research programs looking at preventing depression and fetal alcohol_syndromes. Subsequently I became the first Associate Administrator for Prevention in the Alcohol, Drug Abuse and Mental Health Administration, a public health branch of the U.S. Public Health Service that no longer exists. At the time I oversaw the prevention activities for the National Institute on Drug Abuse, National Institute on Alcohol and Alcohol Abuse, and the National Institute of Mental Health. It must have been around 1984/1985 when I started interacting with Mark Rosenberg at the National Centers for Disease Control and Prevention (CDC) who was very active in developing prevention programs for behavioral problems

Soon after I began that position, the Secretary for Health and Human Services started the Secretary's Task Force on Youth Suicide, and I became the representative for my agency to participate in these activities. This is when I met, for the first time, Bryan Tanney, Richard Ramsay, Lanny Berman, and Ron Maris.

I found that the field of suicidology was the perfect intersection of my interests in Public Health, prevention, and addressing a problem that we could do something about. The challenge was finding or looking for the disorders, settings, or disfunctions that were amenable to interventions and prevention.

I could probably summarize the next 16 years by saying I stayed with it, because of my ongoing interests in saving lives, the challenges, and the hope for making a difference. I still believed it was the right thing to do, and the right place for me, so that's how I got to be in this field.

Dr. Connolly: You've done a lot of research?

Dr. Silvernman: I don't know that I have done a lot of research. My major contributions are as a synthesizer, disseminator, and thinker in the field. I don't do hands-on research. I have tried to translate prevention approaches from other fields, such as preventing motor vehicle accidents, and apply them to the problem of suicide - looking at models for prevention to see which models are applicable to suicide. I try to read broadly and think broadly and then make that knowledge transfer to this field.

Dr. Connolly: You've been editor of *Suicide and Life-Threatening Behavior* for how long?

Dr. Silverman: Five years. The other significant thing in my career is that I had the honor to serve as a consultant to the Federal Steering Group that developed the National Strategy for Suicide Prevention. Developing national strategies have been a passion of mine since 1993 when Richard Ramsey and Bryan Tanney asked me to participate in the UN/WHO Regional Expert Workshop in Canada. That was the first time that a group of international experts got together to develop guidelines for developing and implementing national suicide prevention strategies. I had the opportunity then to help formulate the general principles. That's something I am very proud of.

Dr. Connolly: Tell me a bit about your present position?

Dr. Silverman: I'm a husband and father of three kids - that's my avocation! But that's not really a job - that's the fun part. My real job is Director of the Student Counselling and Resource Service at The University of Chicago. I have been doing that for fourteen years. The Counselling Service has a staff of twenty clinicians who work with me, providing a full range of psychiatric services to a university community of about 10,000 students. It is a very demanding, but also a very gratifying, job to do. I'm also an Associate Professor of Psychiatry at the University of Chicago. I teach in all four years of medical school. I mainly teach about the assessment, treatment, and management of suicidal behaviors, and I supervise and train psychiatric residents.

Dr. Connolly: What is the future of suicidology?

Dr. Silverman: We need to devise better interventions, techniques and tools, and become able to better identify those at risk. Also better ways of helping, better understanding of what the biological and non-biological contributions to self-injury might be.

Dr. Connolly: One other issue we should look at is the issue of assisted suicide and euthanasia.

Dr. Silverman: How do I address that? Recently I was asked to comment on a special issue of a journal where the focus was on "hastened death." I am concerned about the evolution of the terminology in this area. What I am concerned about is the tendency to smooth over, by the use of terms, an activity or a decision that I have difficulty with.

I don't think that we can label something with a euphemistic term, like "hastened death," to make it more palatable. I have very ambivalent feelings about this area. I personally, and professionally as a physician, could not participate in a physician-assisted suicide - that process whereby I would assist someone in terminating their life rather than letting natural events take their course. I find that very difficult to deal with as someone who has been trained to preserve life, to do whatever I was capable of to ameliorate people's pain and distress. I don't think I am the best person to comment on this subject because I don't see myself as a participant.

I can intellectually understand that there are cases where it maybe (emphasize *maybe*) be a humanitarian thing to do to shorten someone's pain and suffering. I

personally haven't been involved in these situations, and I don't think I would feel comfortable being in these situations. It's not something that I would want to be part of.

Dr. Connolly: Is there anything else I should have asked you?

Dr. Silverman: The only other area in which I have made a major professional investment is the issue of standards of care. I have spent a lot of time trying to clarify the standards of care in the assessment, diagnosis, treatment and management of suicidal patients. I teach about this, and I think about this, and I am trying to raise the level of the standard of care so that problems are addressed and dealt with appropriately and consistently.

Dr. Connolly: Do you do much legal work?

Dr. Silverman: I do some around the issue of standards of care in treatment and assessment

Dr. Connolly: What about music in your life?

Dr. Silverman: That's a great question. I was a clarinet, saxophone, and bassoon player. I played all these instruments in high school and through college. I was also a bass drum player for a marching band at the University of Pennsylvania. Unfortunately, although I still listen to music, my playing days were over by the time I began medical school.

Dr. Connolly: What music do you listen to?

Dr. Silverman: I listen to some blues and classical music, but I mainly listen to jazz, particularly piano jazz, more than anything else.

Dr. Connolly: You mentioned your children. What are they up to?

Dr. Silverman: My daughter, 24, is a graduate of Harvard University, and she is a legislative assistant in Washington, focusing on the environment. I've a 19-year-old son who's a freshman in college, and I have a 14-year-old son who's still at home.

Dr. Connolly: Will any of them follow in your footsteps?

Dr. Silverman: I don't think so. My daughter is following in my footsteps to the extent that she believes in doing something for others and not just for her own self-interests. She is working for the common good. My son is very interested in international relations and international conflict and how to resolve conflict. I don't know yet about the passions of my 14-year-old son.

INTERVIEW WITH STEVEN STACK[14]

Dr. John Connolly: We might just start off by asking you about your early life. You were born in America, I presume?

Dr. Steven Stack: Yes, on December 20, 1947.

Dr. Connolly: Tell me a bit about your early days then.

Dr. Stack: I don't really remember much about anything at all until about age five. I remember painting a fence with my father at our first house back in Rhode Island. I remember making lots of mistakes. He gladly corrected them with his big brush.

I spent much of my childhood studying for exams and trying to do my best in school so I would be able to go to college. My mother would not allow me to have any friends inside our house. She was not open to having anyone but family visit us. I had little contact with non-kin outsiders. I am first generation college. Money was always in short supply and so there was always considerable tension in the household. I would escape to the town library to study. My prized possession was my coin collection, but it fell victim to the family's financial situation.

Dr. Connolly: What did your father do?

Dr. Stack: He was a skilled metal worker. In the booming economy of the 1950's he was offered a white-collar job for the first time as a safety engineer at Sikorsky Aircraft. The family moved from Warwick, Rhode Island, to Stratford, Connecticut. However, there were cutbacks circa 1963, and he was the last to go in his small department. He ultimately went "back to the bench," as he put it, and remained a skilled factory worker until he retired. He often worked two jobs to support our family, including four children.

Dr. Connolly: What about brothers or sisters?

Dr. Stack: I have two sisters and one brother. I'm the second oldest. My older sister entered the US Navy after high school. She aspired to become an RN and a Navy nurse. Sadly, she became disabled as a result of a tragic event and received an honorable discharge. She was a Vietnam era disabled veteran with a 100% disability. She passed away from a pulmonary disorder at 63. She was buried in Arlington National Cemetery with full military honors. My youngest sister is an attorney in Virginia. My brother is retired from the U.S. post office.

Dr. Connolly: Tell me about your childhood. What did you read?

---

[14] The original interview, like all of the others, was in 2000 or thereabouts, but Steven modified this version in 2021.

Dr. Stack: I have always loved the outdoors, and I read a lot of books about 19th century mountain men, fur trappers, and native Americans. I liked their cultural traditions and their battles to survive in harsh conditions. My favorite book was *Traplines North*.

Dr. Connolly: What about music?

Dr. Stack: I loved playing percussion instruments, mainly the drums. I started in sixth grade and played all through junior high school and high school. I was in the concert band, jazz band, and marching band. At college, I was in marching band for three years.

I have a small stream of work on music and suicide. The most notable piece was one linking country music to urban suicide rates. In a sample of 49 large cities, the greater the radio market share of country music, the higher the white suicide rate. (Blacks were not country music fans.) That got me and my coauthor, Jim Gundlach, our 15 minutes of fame-- phones rang off the hook for 2 weeks. There was coverage in Newsweek, USA Today, CNN, the British press, etc. Willie Nelson called us "academic coneheads" in a Time magazine article. Ouch! But it was good to get his attention. Ten years later, we received the Ig Nobel Prize in Medicine for this work. The Ig Nobel, not the real Nobel. This was presented at Harvard University. Each year it goes to the authors of a study that, at first, makes you laugh but, afterwards, makes you think. We had been nominated every year-- the competition was tough, but we finally nabbed the award! We thought we were onto something, with a future as media stars, and we did additional papers on the media and suicide. However, articles on heavy metal, opera, and blues music and suicide were all published but attracted little or no media attention.

Dr. Connolly: What was your religious background?

Dr. Stack: I was a Catholic.

Dr. Connolly: Was it a religious household?

Dr. Stack: Yes, pretty much. Both of my parents were Roman Catholic, and I went through First Communion and Confirmation. My younger brother and sister both went to Catholic elementary school.

Dr. Connolly: Are you still a religious person now?

Dr. Stack: Somewhat. I go to church between 0 to 3 times a year, mostly during weddings, funerals, and Christmas. Maybe I would go more if they switched back to Latin. The Mass in English is not as meaningful for me.

Dr. Connolly: Tell me about your high school days.

Dr. Stack: My high school days? I remember studying for a lot of exams, I still have nightmares about walking to a class and there was an exam that I forgot about. I proudly played board #3 on the chess team, I was in the Latin Club, and I was in track for three years.

Anyway, I did pretty well at my studies-- I won an award ($50.00) for scoring the highest in a school-wide algebra test. I also won a big trophy for a project I presented at a county science fair. I scored the highest in the senior class on the Level II SAT mathematics achievement test.

Dr. Connolly: How did your nightmare end?

Dr. Stack: In those dreams I say, "Wait a minute. I'm not a student anymore. What am I doing here?" and then I wake up.

Dr. Connolly: What was your choice of career?

Dr. Stack: My mother told me that I could be a priest or a mathematician. I ruled out being a priest, I so that left me as a mathematician. At the university, I majored in math for a couple of years. I had always done well at math until my fourth semester of calculus when I got a "C." I had never got a "C" before in anything, so I thought that either I should drop out of college or change major. I switched to English, and I got my degree in literature, primarily because I had a couple of professors that I really liked. I loved American literature and still read the work of my favorites including Hemingway, Faulkner, O'Neill, and Tennessee Williams-- including their biographies. I tried to get a job as a high school English teacher, but I didn't get anywhere-- there was glut of English teachers in 1969. I did get one interview and they offered me the job at the end of the interview. I said I would like an evening to think about it, and they looked strangely at me but said ok. I called them up the next day at 9 o'clock in the morning and I said, "I'll take it" They said, "Sorry, you can't have it anymore. If you really had wanted it, you would have accepted it yesterday."

So, I stayed in school another year and received my first master's degree (in education, with a minor in sociology). I became fascinated with sociology and the study of structured inequality. However, I could not continue for a second year of grad school to work on a second M.A. degree in sociology because I was broke. I hit the job market and with my M.A. in education, I was able to find a job. They needed someone who was certified to teach in in both mathematics and English, a rather odd combination. That was me! I taught high school for just one year so I could save money and get back to earning an advanced degree in sociology. I made contact with some counter-cultural students who liked me and asked me to be faculty advisor to the school's "Hearty Eaters Club." That was really fun. Then, with my savings to get me started, I went back to my element-- the university-- and got my masters and PhD in sociology over the next five years. Being a professor typically involves working 60 or more hours a week, but I liked the freedom in deciding which days and hours and at what location I would do the work. You don't have those choices as a high school teacher.

Dr. Connolly: This was all around the time of the Vietnam War?

Dr. Stack: Yes. I was really terrified at the thought of going to war. I took my physical and, at the end of the physical, the sergeant said, "Your eyes are bad, but not bad enough." I thought, "Oh, no. I'm going to Vietnam. I'm dead!" But it turned out that I would be drafted only if there was an emergency. I was classified I-Y. That was just a step above 4-F.

Dr. Connolly: Did many of your friends have to go?

Dr. Stack: I never really had very many personal friends in high school. It was a working-class high school, and a good number of kids went to Vietnam. I don't know if any of them got killed, but one of them lost his leg, and the star basketball kid was shot in the head. It was pretty sad. My two close friends, who majored in the sciences and went to Johns Hopkins, did not go. Neither was pro war to put it mildly.

Dr. Connolly: You mentioned a sociology professor who was a big influence in your life. Tell me about that.

Dr. Stack: The main influence was Rosalio Wences, and he became my role model. He was very interested in inequality, including the predictors of income inequality (the subject of my MA and PhD theses). However, he left the university to become president of a university in Mexico, which was where he was from. Dr. Ken Neubeck became my PhD advisor. He also was keenly interested in structured class inequality. In those days I had little interest in suicide studies or even in deviant behavior, a broader area of sociology that includes suicide.

Dr. Connolly: What about the graduate program?

Dr. Stack: I was married, and my ex-wife was often suicidal. In my years as a graduate student, I was teaching 2 or 3 classes, often in the evenings at a neighboring university as well as on the main campus of the University of Connecticut. I was a full-time graduate student at the same time, so those were the years of my life when I was rather overworked. We had a couple of kids. I didn't have much time to develop friendships with the other graduate students. It seemed that many of the other students were enjoying themselves. I remember that, one year, I had a seminar that started at one o'clock, and I was teaching from nine to twelve, sixty miles away at Central Connecticut State College. I had barely enough time to get in my car at the end of teaching three hours to make it back to my three-hour seminar as a student. I would eat a sandwich in the car and drive at the same time. That was the busy schedule I had during those five years in Connecticut.

Dr. Connolly: Was your wife's depression the first experience you had of depressive moods in others?

Dr. Stack: Yes.

Dr. Connolly: How many kids did you have?

Dr. Stack: We had three: 1972, 1975, and 1978.

Dr. Connolly: How old are your children now?

Dr. Stack: (in 2021) Jimmy was born in 1972, so he will be 49 this year; Timothy was born in January 1975, he is 46; and Johnny will be 43.

Dr. Connolly: What are they doing?

Dr. Stack: Jimmy went to a school of public health at the University of South Carolina to work on a MA degree, but he didn't finish. In 2001 he worked for a water company and tested water samples for the county. He now (2021) works in a lab and tests blood samples from pets and humans for various diseases. Timothy was (2001) a computer analyst, but he switched to a career in the military. He is now a Captain in the National Guard. He holds a MA degree in Public Administration. He is currently in charge of an armory. Johnny received an MBA degree in business administration. He works at Geico and is in charge of a group of analysts. They are all pretty good kids, now men, actually. John is married.

Dr. Connolly: You describe yourself as rather shy. Where does that come from?

Dr. Stack: My mother was very shy. Part of my shyness is probably genetic.

Dr. Connolly: What is the most important element in your life?

Dr. Stack: I would say it's almost a tie between the love of my life, my second wife Barbara (we have been married now [in 2021] for 20 years) and my work. But, of course, Barbara comes out first! I am pleased and proud now to have published in the top scholarly journals and my work has proved to be valuable to others-- according to Google Scholar it has been cited over 15,500 times. Much of my work has been on suicide, especially media impacts, and religion, but I have also done some good work on the death penalty.

Dr. Connolly: Tell me about that.

Dr. Stack: Looking at the most publicized executions (about 20 of them), I found that there were 30 fewer homicides in the month of those executions, which is especially significant if you are one of the people that didn't get killed. The paper was published in the "number one" sociology journal, *American Sociological Review*, back in 1987. I didn't get into the politics or ethics of whether capital punishment should be abolished or not.

Dr. Connolly: You have carried out some research on copycat suicide.

Dr. Stack: Yes. I have about twenty papers on that subject. An article (*Suicide & Life-Threatening Behavior*, 2005) reviewed 419 findings contained in 55 studies. I tried to explain why some studies find a copycat fact, and the single most important factor is whether or not the suicide story is about a celebrity. I determined that research based on stories concerning the suicides of celebrities were 5.47 times more apt than other studies to find an apparent copycat effect. However, over sixty percent of the findings found no increase after a widely publicized suicide.

Dr. Connolly: What do you think of the media guidelines that have been published around the world, as in Ireland and New Zealand?

Dr. Stack: I published a critique of the work on media guidelines and suicide last year (2020) in *Social Science & Medicine*. There are actually only a few studies that rigorously test aspects of the guidelines to see if presumably dangerous stories (ones that violate a guidelines), are actually any more dangerous than stories that don't violate the guidelines. The most rigorous study was done by David Phillips way back in 1979. He found that controlling for the sheer amount of coverage given to the story, all aspects of story content regarding guidelines (e.g., detailed mention of the suicide method, lack of a source of help, etc.) made no difference in predicting an increase in suicide. The few more recent studies often find that specific guideline violations have no effect on suicide rates following a story. Sometimes the findings are counter-intuitive. In an Austrian study, media coverage that included mention of a source for help (e.g., crisis line number), were followed by an increase in suicide, abd not the expected decrease.

Dr. Connolly: A lot of the guidelines say no pictures.

Dr. Stack: The study by David Phillips found that the controlling for the sheer amount of coverage given to a suicide story, the presence of a picture made no difference in the rise in suicide rates. Curiously, the Phillips study is often not cited in the relevant literature.

Dr. Connolly: How big is the sample you need to study for a reasonable conclusion?

Dr. Stack: My research and that of Philips is based on the whole nation of three hundred million people or on a large state such as California which has tens of millions of people. Phillips and I report a 2% increase in the number of suicides after a publicized suicide story in the nation as a whole. Using small samples, the change in the number of suicides, if any, may be too small to be statistically significant.

Dr. Connolly: What's your world view now of sociology's contribution to suicidology?

Dr. Stack: Sociology has focused on forces outside of the individual (e.g., trends in unemployment, divorce, marriage, religiousness, immigration, fertility) as predictors of suicide rates. This is in contrast to psychiatry which has an individual, intrapsychic focus stressing internal constructs such as genes, brain chemistry and mental disorders.

Dr. Connolly: Who are the bright, emerging, shining stars in suicidology?

Dr. Stack: Within sociology, currently (2021) the rising stars include Seth Abrutyn of University of British Columbia and Anna Mueller of Indiana University. There are many sociologists who publish one or a few papers on suicide, while most of their work is on other topics. Fred Pampel, a demographer at University of Colorado, is a case in point. Bernice Pescosolido at Indiana University has some papers on suicide that are widely cited, but she is known mainly for her work on the sociology of mental health. Jack Gibbs had a few outstanding papers on suicide, and a book on status integration theory and suicide, but he is mainly a criminologist. Zhang Jie, a sociologist at State University College at Buffalo, has published over one hundred papers on suicide. They are related to his strain theory of suicide. David Lester has published hundreds of papers which test aspects of a sociological approach to suicide. He often links suicide rates to unemployment, birth, divorce and other rates. There are an increasing number of persons who publish work on sociological factors and suicide rates, but who are not sociologists. For example, Keith Hawton is a star overall, but has some work on sociological topics. Thomas Joiner's work actually borrows from the Durkheim concept of social integration in his concern with the similar but also different concept of "belonginess." However, writers in the area of the interpersonal theory of suicide and belonginess often fail to cite Durkheim and much of the work on family and religious integration – which are related to "belongingness."

Dr. Connolly: Have you met Keith Hawton?

Dr. Stack: I met him in 2000 for the first time. We currently (through 2020) see each other at IASP, IASR, and ESSSB meetings.

Dr. Connolly: He is here at the moment (2001).

Dr. Stack: I met him again yesterday (2001). I congratulated him on his award, and he thanked me for sending him some of my papers for a review he is writing.

Dr. Connolly: How long have you been involved in AAS?

Dr. Stack: Since 1978. I was honored to receive both the Shneidman (1985) and the Dublin (2003) awards for my research contributions.

Dr. Connolly: What are you working on at present?

Dr. Stack: Currently (it's 2021) I have a paper just published in *Suicide & Life-Threatening Behavior* on the link between social distancing and suicide rates in 43 large cities. It used census data on suicides and flu deaths for 1918, the year of the peak in the Spanish flu epidemic. I was able to get recently published data on the details of various physical

distancing measures in the cities from a team of researchers. They were not interested in suicide, but on deaths from the Spanish flu. I found that for every 10 unit increase in days of distancing (lockdowns, school and business closures), there was an increase of 2.9% in the suicide rates. I also have a conditional acceptance for a paper on a 20-year review of the sociological work on suicide. I read 4,000 abstracts and many full articles on suicide. It's a follow-up to my pair of reviews for sociological research on suicide for 1980-1996, both published in *Suicide & Life-Threatening Behavior* in 2000. Those two reviews proved useful to many researchers, receiving 729 and 470 citations each.

Dr. Connolly: You presented a paper a few years ago at an IASP Meeting.

Dr. Stack: Yes. Currently, I have regularly attended the IASP meetings. I have been giving papers – usually 2-3 per meeting. I was honored to be a plenary speaker for the Asia-Pacific IASP in New Zealand, as well as the meeting in Tokyo.

Dr. Connolly: What else are you working on?

Dr. Stack: I am preparing a paper to be read at the annual meetings of the Society for the Scientific Study of Religion in 2021. It deals with the mediators of the link between religiosity and death by suicide. I explore the mediators with data from the National Mortality Followback Survey. It has data on 20,000 deaths including close to 1,800 suicides. The mediators dealt with include psychiatric factors such as depression, hopelessness, and anxiety, and a range of social factors such as marital status, income, job demotion, unemployment, as well as other conditions such as physical disability and illness preceding death by suicide. The main idea here is the extent to which, if any, religiousness will still predict lower odds at death by suicide once all these covariates of religiousness are teased out.

I've also been looking at the question of why some people publish more than others.

Dr. Connolly: David Lester must be the leader of the pack?

Dr. Stack: Yes. He's the most published psychologist, as well as suicidologist, in the world. We are actually doing a paper on gender and research productivity (citations, articles) among the most prolific suicidologists (those with over 70 papers on the subject of suicide as indexed in the Web of Science). These 110 researchers typically have few and often no sole authored papers in their most cited works. Much of the work comes from a core of clusters of researchers such as those centered around John Mann of Columbia University and Keith Hawton at Oxford.

I have a license to use a data set from the National Science Foundation on 40,000 PhDs. I published the first paper to systematically look at how children of different age groups affect research productivity of scientists. It is now (2021) one of my top 20 most cited papers. It came out in *Research in Higher Education* back in 2004 (321 cites). It explores the effect of children and their ages, marital status, the status of the university,

etc. on number of reported articles by each of the 40,000 PhDs. I have published about a dozen papers on predicting research productivity.

My top twenty most cited papers (of 345 publications) contain five that have nothing to do with suicide. One of my top 20 most cited works (according to cites in Google Scholar) is a paper on predicting visits to pornography web sites using data from the General Social Surveys (356 cites). My most cited paper assesses marital status as a predictor of happiness (with 867 citations). Sometimes I think I might get back into happiness studies which might make me happier in my old age? I never published anything else on pornography or happiness. Unlike most researchers, most of my papers (my most cited ones) are sole authored. A few of the most cited papers in suicide studies by others have 200 co-authors. This reminds me of the old joke, something like, how many professors does it take to install a light bulb?

Dr. Connolly: What about the future of suicidology generally?

Dr. Stack: I'm not sure. I am not very conversant with the research that is being published on suicide in psychology and biology journals. I stick mainly to sociological research. Now (in 2021), there seems to be a great deal of attention to some topics while others are neglected. For example, there are now hundreds of studies on suicide in the military. However, the military is just one occupational group of 630 groups covered in the Bureau of Labor statistics. Most occupations have never been studied in suicidology. That seems very odd.

Other strange and curious patterns exist. There are now thousands of studies on "suicide prevention," but they focus on behaviors short of actual deaths by suicide. Many of the suicide prevention studies should probably be re-titled "suicide attempt prevention" or "suicide ideation prevention" or "depression prevention." It may be a well-kept secret that most people who actually die by suicide have no history of a suicide attempt.

Another major problem in recent research is the lack of investigations of major national trends. During 2000-2016 the suicide rate increased substantially by over 30% in the USA. However, in most of Europe the suicide rate has declined-- about 22% in most nations, on average, over the same period according to WHO data. It would seem important for suicidologists to endeavor to understand why the rates in Europe are going down, down, while in the USA our rates going up. Possibly the USA could learn something from an analysis of what accounts for the big drop in Europe and, perhaps, import that understanding to address suicide in the USA. However, there needs to be caution here. Understanding long term trends in suicide may have little or nothing to do with the typical efforts at suicide prevention such as 1-800 crisis call lines and text lines. Major shifts in what sociologists call integration and regulation can go on behind the scenes (sometimes "upstream factors," so to speak), affecting mass rates of suicide-- either upwards or downwards.

Dr. Connolly: You have done some research on religion and suicide.

Dr. Stack: My first major article on religiousness and suicide was in *Journal of Health & Social Behavior*. It is one of the top journals in sociology and public health. I was very happy when I get that article in print back in 1983. Today (2021) it's one of my top 20 most cited pieces (317 cites according to Google Scholar). I developed a theory focused on religious commitment to a few core beliefs (e.g., life after death can assuage all manner of suffering-- divorce, unemployment, depression). The theory was supported using data from a large number of nations and their suicide rates. It has surprised me, as a sociologist, how few papers had been published on religiousness and suicide in the last century. More recently, in 2011, Augustine Kposowa and I found that such commitment predicted suicide acceptability in a large sample of persons in the World Values Surveys. However, measures of other aspects of religiousness-- religious coping, church attendance, and attending social events with co-religionists also predicted lower levels of suicide acceptability. That article has been cited in 184 other papers. One might say that some researchers are "bringing God back in," so to speak.

Dr. Connolly: That's fascinating. About twenty-five years ago, church attendance on Sundays was roughly 95%, and now it's down to about 40%.

Dr. Stack: That's exactly what I documented in the United States in a paper in the *Journal for the Scientific Study of Religion* in 1983. I looked at the period of 1950 to 1979, and I found the same thing. Church attendance among Catholics was cut almost in half and suicide rates were up, especially among young people. The fall in church attendance in the United States was disproportionately among Catholics. Protestant attendance remained pretty much the same.

Dr. Connolly: What are your views on physician-assisted suicide?

Dr. Stack: I'm basically neutral.

Dr. Connolly: Well, we have covered a lot of ground here, haven't we?

Dr. Stack: I like talking about my work.

Dr. Connolly: More than about yourself? David Lester and I are doing this book of interviews, getting more personalized accounts from people in the field.

Dr. Stack: David has been trying to get me to finish my autobiography. I have about 150 pages, and one of my goals is to finish it. I have one chapter finished and one in draft form. I haven't worked on it for about 20 years and that's something I would like to do when I get the time. The longer I wait the more material I'll have!

Dr. Connolly: It's amazing that some people write their biography at the age of 25.

Dr. Stack: Life's not over then!

Dr. Connolly: It's hardly started. What do you feel about eternity?

Dr. Stack: As long as I am there with Barbara, eternity will be good.

INTERVIEW WITH YOSHITOMO TAKAHASHI[15]

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.

---

[15] It was not possible to get Dr. Takahashi to edit this interview.

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 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 consttitute 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.

INTERVIEW WITH KEES VAN HEERINGEN

Dr. John Connolly: First of all, I would like to explore your early background. You were born, of course, in Holland?

Dr. van Heeringen: I was born in Holland in 1955. I spent my childhood in Holland and attended secondary school there also. Then I decided that I wanted to study medicine, and I applied to the University in Amsterdam, which was very near to which we lived. There is a system in Holland which accepts only about 1,700 people at university to study medicine; there is no room for the others. You get a number, and it is a sort of lottery. Only the numbers between 1 and 1,700 can start studying medicine. We learned from friends of our family that it was possible to study medicine in Belgium where there is no limitation on the number of students. So I applied for a place at the University of Gent, and I studied medicine there.

Dr. Connolly: Were you an only child?

Dr. van Heeringen: No, I have two sisters, one older and one younger.

Dr. Connolly: Was there much sibling rivalry?

Dr. van Heeringen: It was not always easy to live in a house with two sisters.

Dr. Connolly: What sort of an influence did your parents and relatives have on your subsequent development?

Dr. van Heeringen: I think there are two major issues. The first thing is that my mother was a nurse, and she worked in a hospital, first in England and then in the Netherlands. She stopped working when the children came, but I inherited the wish to take care of people, which I also notice in my two sisters. One is an art therapist, and the other is a nurse for young, mentally-handicapped kids. So the three of us went in that direction. The other influence is more general in that my parents have been very supportive in accepting what I wanted to do and creating the possibilities for me to do what I wanted to do. I was 18 years old when I had the opportunity to go to Gent, which is about 250 kilometers from home. They were very supportive and there was no question about whether would it be possible or not. They just said, "Go and do it."

Dr. Connolly: What did your father do?

Dr. van Heeringen: My father died five years ago - just before the Gent Symposium, which I organized. He had been ill for about two years, and we knew that he wouldn't be able to make it to the conference, which he would have enjoyed very much -- the opening ceremony and things like that. Unfortunately, we had to say goodbye to him a couple of weeks before the conference started. He was an accountant. He studied economics at the

University of Amsterdam. He was born in 1921, and he first studied to become an accountant. He always wanted to get a university degree in economics, and so, when he was about 40, he went back to university and started studying again. He had a room in Amsterdam where he stayed during the week. He worked during the day, and then in the evenings and nights he studied economics. He was very dedicated to that.

Dr. Connolly: In your formative years what interested you in literature and music?

Dr. van Heeringen: There is not very much that I remember with regard to reading. I have always enjoyed music very much, but not reading.

Dr. Connolly: Tell me about your music then.

Dr. van Heeringen: I play guitar -- not as much now as I used to simply because I don't have the time to do it. I have played in different bands, rock music in secondary school and then during my years as a student at the university in a band. I was also part of an orchestra which performed on different occasions during the academic year. I have always enjoyed playing modern rock-like music, and I still do.

Dr. Connolly: Do you like modern composers?

Dr. van Heeringen: My preferences are rather broad. I like opera very much - Puccini and others. I like good old jazz music. Then in terms of modern music, I like some English music, but I am not very much into American music at all.

Dr. Connolly: What about religion?

Dr. van Heeringen: I was brought up in a rather religious home. My parents were both very religious - Protestant, which is the most common religion in the area in which we lived. I wish there had been more discussion between my parents and us about religion. One of my sisters still goes to church and lives in the same way my parents did, while myself and my younger sister never go to church. That has been a difficult issue, especially for my father who would have liked very much that for us to follow in that direction.

Dr. Connolly: Yet you have a great number of spiritual values and humanistic values. What shaped those other than formal religion? Were there any influences, philosophical or otherwise?

Dr. van Heeringen: No, I wouldn't say so.

Dr. Connolly: You went to medical school. Did you enjoy those years very much?

Dr. van Heeringen: Yes, I did.

Dr. Connolly: What led you to psychiatry?

Dr. van Heeringen: Well, that is a strange story. What I actually wanted was to become a pediatrician. In the penultimate year of studying medicine, you have to plan the internships that you want to do during the last year. This is to prepare yourself for becoming a GP, a pediatrician, internal medicine, or whatever else you want to do. I composed my internships based on the idea of becoming a pediatrician. I didn't choose psychiatry as an internship, but I did include neurology. My supervisor at the neurology ward where I worked for a couple of months was a psychiatrist and, after two weeks, he called me into his office and said, "You have to do psychiatry. You are a psychiatrist." This was a totally new idea for me. I checked with the administration of the university whether it would be possible to change my program of internships. The least I could do was take an internship in psychiatry just to get the flavor of it, and so I did that. I worked for a couple of months in a psychiatric ward in the general university hospital, and indeed I noticed that I liked it very much, not that I always liked the people, but I liked the approach, the problems, the way you can deal with these problems and the different approaches that you have for tackling these problems. So I changed my plans.

Dr. Connolly: You were obviously a good listener, even then

Dr. van Heeringen: I worked for a couple of months in the psychiatric ward, and it fitted. I felt fine, and apparently it was the other way round as well, because the head of the department of psychiatry asked me to stay. He offered me a position so that I could take the training in psychiatry. When I finished my training, he asked me to stay in the hospital, then they asked me to become a member of the staff, and then to be a professor of psychiatry.

Dr. Connolly: You became a professor of psychiatry at a young age.

Dr. van Heeringen: Quite young, yes, due to, I don't know what. Working hard?

Dr. Connolly: And brilliance?

Dr. van Heeringen: I don't know if you could call it brilliance. I wouldn't use that word. It is something that sort of evolves when you like your job - an excellent combination of doing clinical work, seeing patients and doing research. That combination is excellent.

Dr. Connolly: What proportion of your work is clinical work?

Dr. van Heeringen: Too much! Officially we have an 80-20 division: 80% clinical work and 20% research, but we also have to do teaching, management regarding the hospital, meetings and many other things.

Dr. Connolly: Do you enjoy teaching?

Dr. van Heeringen: Yes, very much.

Dr. Connolly: What first awakened your interest in research?

Dr. van Heeringen: My first involvement in suicide research was a pure coincidence again. My boss at that time gave me the opportunity to do a follow-up study of suicide attempters. There was no history of research in our department. Nobody did research. He was asked to join in a multi-center study, and he came to me and asked me whether I would be interested in doing that study in our hospital. I accepted it in 1986.

Dr. Connolly: What did that research entail?

Dr. van Heeringen: It was a one-year follow-up study of attempted suicide patients - a naturalistic description of what happened to these people and also a randomized control trial to study the impact of a specific intervention. All of the patients who were seen at the A&E Department for a suicide attempt were sent home after the medical, internal and psychiatric evaluation. The experimental group were referred for outpatient mental health care after their suicide attempts and, in case they didn't show up for the appointment, we sent a community nurse to their houses to talk to them to try to understand the reasons why they didn't take up the treatment. Then the nurse tried to match their needs with the opportunities for mental health care. The idea was to improve compliance with aftercare in attempted suicide patients. That was the main aspect of the study, and I had to coordinate the follow-up, collect the data, carry out the analysis and write papers about it.

Dr. Connolly: What was your thesis?

Dr. van Heeringen: In this study we collected baseline information on all suicide attempts who were admitted to the Emergency Department. This was built up into a database on characteristics of suicide attempters and their attempts. We decided to continue this monitoring after the actual intervention study stopped, so we collected, and are still collecting, information on suicide attempts. Therefore, I got involved in what you can call an epidemiological study of attempted suicides. My thesis was about epidemiological aspects of attempted suicide - age, gender, marital status and employment status. That is one reason for my being involved in suicide research. There is another reason as well

Dr. Connolly: What?

Dr. van Heeringen: At the beginning of my training as a psychiatrist I did liaison work seeing people with psychiatric or emotional problems in the General Hospital, and one of the patients that I met was on the physical rehabilitation ward. She was a young girl, 15 years old, who had jumped in front of a train in a suicide attempt and lost her legs. She was trying to learn to walk with prostheses. I had many talks with her because I was intrigued by the problem. It was summer, and we have this summer city festival in Gent. I was

sitting on a terrace and looking at young, nice-looking girls with nice legs walking around and wondering how is it possible that a young good-looking girl can jump in front of a train and get mutilated in that way, particularly because she told me about the reasons why she did it. She left school one hour earlier than she should have just to meet her boyfriend, and she was seen by an uncle standing on the street with this boyfriend, talking to him. The fact that this uncle saw her made her take her bicycle, struggle through the meadows to the railway line, and jump in front of a train. It was such a trivial reason for her to do it. I got involved with this girl in a therapeutic way, and I had many discussions with her, talking about the reasons why people do this.

Dr. Connolly: Was she mentally ill?

Dr. van Heeringen: Apparently not. So that was another reason for me to become intrigued by the problem. That is one of the reasons why we started collecting data on suicide attempters - to try to understand who they are and why they do it. My interest was in finding out whether anybody can attempt suicide, but now I don't think that everybody can do it.

Dr. Connolly: You are part of the WHO/EURO multi-center parasuicide study. Tell me a bit about that.

Dr. van Heeringen: I can tell you why it has been important for me to join the group. It has put our work on the European map of suicide research. It was a major vehicle to achieve that. It was an opportunity to meet many nice colleagues and make some good friends with whom we communicate quite often about research and methodological problems.

It also allowed me to organize the European Symposium in Gent two years ago which was due to the fact that I got in touch with many other people and made friends who got to know me, the kind of work I do, etc. This is partially related to having joined the multi-center study.

Dr. Connolly: The organization of the conference is a big undertaking. We never realize what it entails until we actually do it. We take it very much for granted. I've had the experience. Yet I want to go for the IASP Conference in 2005. It is crazy. Perhaps I should see a psychiatrist?

Dr. van Heeringen: There are many difficult problems that you have to solve in organizing a conference like that. On the other hand, it is very satisfying. You tend to forget the negative things and the problematic things and remember the good ones.

Dr. Connolly: Going back a little bit in your career then, which psychiatrists and colleagues were the most use to you in your development and your progress through the system.

Dr. van Heeringen: Well the first one I have to mention is Keith Hawton. I probably met him for the first time at the European Symposium in Bologna (Italy). At that time, I was preparing for my oral examination and making up my mind about writing my thesis. I

already knew that it was going to be on the epidemiology of suicidal behavior. He knew a lot about the methodological issues regarding epidemiological studies and so I made an appointment and went to Oxford to discuss possibilities of doing a PhD with the data that we had collected. After that we met again on other occasions. He is now a very good friend of mine. I see him as a teacher for me, and the relationship evolved into a very good friendship.

Dr. Connolly: What did you learn from him?

Dr. van Heeringen: Methodological issues. As I told you, there was no history of research in our department and, in fact, in psychiatry in Belgium. There was nobody with any knowledge of how to set up studies, what things you have to look for, how you can avoid methodological problems and things like that. He gave me a very basic knowledge of how to design the studies.

Dr. Connolly: Tell me a bit about your current research and your current interests.

Dr. van Heeringen: I established in 1996 what we call the Unit for Suicide Research, which is located in the Clinical Department of Psychiatry which is good because the research and clinical work stimulate each other. The research can be good for the clinical work, and we need patients for our research. The work that we do can be divided into three main issues. The first is epidemiology which includes monitoring studies like the WHO Study which I do for the Flemish Government. We also monitor attempted suicide in several other hospitals in Flanders. We have also studied specific risk groups, for instance, homosexual youngsters.

The second part of the work is the development of prevention programs. The first program was for secondary school students in which we developed a program, not for the students, but for the teachers. We organized meetings with small groups of teachers and had them sitting around a table with local mental health care professionals from community mental health centers so as to establish personal contacts between teachers and mental health care professionals - training teachers how to recognize suicidal pupils and things like that. There have been several other prevention programs. Now we are involved in a broad regional suicide prevention program in Flanders, and we are also involved in the development of specific prevention activities through schools, GPs, and the police.

The third area is what we call the psychobiology of suicidal behavior, looking at the psychological and biological risk factors and the relationship between the two. This is what I find particularly interesting, and what is very nice about this kind of research is that you meet researchers with different backgrounds, such as nuclear medicine people, radio-pharmacists, psychiatrists, and psychologists, and you take a multi-disciplinary approach to the study of risk factors. We tend to talk different languages as psychologists or as biological psychiatrists, but we are actually talking about more or less the same things.

Dr. Connolly: Where do you think the future of suicidology research lies?

Dr. van Heeringen: In what we are doing. It sounds very self-confident, doesn't it? It is all happening in the brain. There is a growing insight into what is happening in your brain between hearing or experiencing something and reacting to it. We all know about risk factors like interpersonal problems, or unemployment, etc., but on the other hand we know that not all people who have interpersonal problems or who are unemployed become suicidal. There are individual differences in information processing, and we are now beginning to see where these individual differences are located, which biological and psychological mechanisms are involved. I am sure that this will provide opportunities for new approaches.

Dr. Connolly: Which brings us quite naturally then on to the problem of transferring research findings into clinical practice, which is something that comes up at all of these meetings. What would you say about that?

Dr. van Heeringen: The general idea of course is that clinicians or mental health professionals should have evidence-based guidelines on what to do, but one of the problems in managing suicidal patients is that there are so few evidence-based guidelines. This is one of the challenges for us in the coming years -- to develop such evidence-based guidelines. There is a great need for collaborative large studies of suicidal patients and the effects of psychotherapeutic or psychopharmacological approaches. We have to be very confident as researchers or as opinion-leaders that we have good evidence for what we are telling people.

Dr. Connolly: Regarding the setting up of suicide prevention programs in schools and working with government departments, how successful have you been? One of the problems with school-related programs is that they don't get accepted with great enthusiasm, and then they gradually get whittled away and lost. There is no continuity there. How do you achieve that?

Dr. van Heeringen: We don't. I told you about the program we developed for schools to bring together teachers and mental health professionals. We did get a grant for developing the program and conducting a pilot study which took us about three years, from developing to testing, but after that the grant stopped. We have kept talking to the minister of health about the necessity of developing a prevention program. We have epidemiological data showing the increase in attempted suicide, especially among young people. About three years ago, she finally decided to develop plans for a regional suicide prevention program, and she made money available, including a little bit for our research center, but especially for the community mental health services. Every center should have a half-time suicide prevention person responsible for the region. This half-time person is responsible for contacting police, schools and emergency departments in general hospitals, and anybody else who could be involved in the prevention of suicide. That was a way that we could integrate the prevention program that we had developed for schools. About a year ago,

the Flemish Minister of Health Policy determined that the prevention of depression and suicide should be one of the five health targets. We are currently involved in developing a broad prevention program which incudes work in the schools.

Dr. Connolly: You have been involved with IASP for a long time. How important is the Academy, IASR?

Dr. van Heeringen: I think it is important. It is very important to have an academy as a platform for discussion, exchanging experiences, exploring methodological problems and trying to find solutions, a platform where you can consult colleagues and also a platform for the presentation of preliminary data from studies. I think it can be very helpful to have an academy like that.

Dr. Connolly: I agree with that entirely as long as it doesn't become remote and as long as it doesn't stop the kind of communications that can take place at the general meetings of IASP. To move on, you have published quite a lot?

Dr. van Heeringen: Yes, quite a lot, but not as much as I want to.

Dr. Connolly: You are still young, not like some of us. What are you most proud of having produced?

Dr. van Heeringen: The *International Handbook of Suicide and Attempted Suicide* for a couple of reasons. It was a pleasure producing it, working with my former teacher and now friend. It was a good experience, and the response has been quite good.

Dr. Connolly: You have also done a lot of work with Ad Kerkhof.

Dr. van Heeringen: I have indeed worked with Ad in a very productive way. We have just produced a Dutch book on treatment strategies, a very practical book for mental health professionals in Belgium and Holland.

Dr. Connolly: I saw the book. We ought to set up a little group to look into translating books like that because so much is published in languages other than English which unfortunately never gets into broad circulation.

Dr. van Heeringen: That is a good idea. A third book was published in 2001 called *Understanding Suicidal Behaviour* which is about the suicidal process approach and the consequences of this approach for the treatment and prevention of suicide. There are some intriguing biological and psychological data supporting the process approach.

Dr. Connolly: We might finish by getting back to more personal things, your marriage and that kind of thing.

Dr. van Heeringen: That might be interesting for the reader. One of the reasons I stayed in Belgium and did not go back to Holland was because I met my wife while studying medicine. Of course, it is very nice to live in Gent. Then the children came - they are now 12 and 14 - lovely kids. Of course, I am sure that everybody will tell you that when you have to do clinical work, teaching and research, and you have your family, there is always a conflict between priorities.

It is not always an easy life for your family to understand why you are so involved with something that has to do with work. The first time that happened was when I was writing my PhD thesis. My wife doesn't have a university background, and so she was not familiar with the huge amount of work involved in producing a PhD thesis. I had to spend all my holidays, weekends, evenings and nights sitting at a computer. Sometimes she was ready to throw the computer out of the window.

That was at the beginning of my research career, but now she has seen the results that have come out of it. The next major thing was the Handbook which took us about two years to prepare. Again, that took all my weekends, nights and evenings, and it was very time consuming, but by that time she understood. She was more confident that it was not an escape from the family but was well necessary to produce a good book.

I have been working very hard for the last ten years, and now I feel the rewarding aspect. Two years ago, I received the first Dutch suicide prevention prize, which was nice. When the books come out and are well received, it feels like a return of the investment, and that keeps us going.

Dr. Connolly: What about relaxation and hobbies. You mentioned music. What else do you like to do in your spare time, if there is such a thing.

Dr. van Heeringen: Sometimes there is. I used to be a bit of a sportsman. I played squash quite seriously, and then I switched to tennis. I go to the movies and go out with friends, and I enjoy good food.

Dr. Connolly: And wine

Dr. van Heeringen: And good wines. Absolutely. And travelling, which is also a nice part of the research. If you only do clinical work, there is no opportunity for you to go to Australia, New Zealand, or to America.

Dr. Connolly: Is there anything else you would like to add?

Dr. van Heeringen: In the end the most important thing is the suicidal person. You can talk about the benefits of doing research and travelling and things like that but, in the end, it is the patient that we are all thinking about. That is what I like very much -- the combination of clinical work, seeing patients, and doing research. Many of the research questions are phrased by patients, and it is by listening to them that you can focus your attention on what we have to study.

Dr. Connolly: I think that is a lovely point to end on. How do you feel about being interviewed like this?

Dr. van Heeringen: I like it.

Dr. Connolly: It is something we don't get a lot of experience of in our jobs, but I also like interviewing people.

Dr. van Heeringen: I get a lot of requests from newspapers and magazines for interviews, and sometimes I am a bit reluctant to talk about suicide because we are all aware of the potential media effects of such articles. Sometimes you get questions from journalists which are difficult to answer if you take into account the potential negative effects of talking about suicide.

Dr. Connolly: That's true, and I am in that position quite a lot in Ireland at the moment. I suppose you are damned if you do and you are damned if you don't. If you don't talk to the journalists, they are going to talk about suicide anyway but, if one co-operates with them, one can at least have an input and try to minimize the bad impact.

Dr. van Heeringen: A crucial aspect with regard to interviews with the media is that it gives you an opportunity to point out that help is available. In that sense the media can be very helpful in increasing the access to appropriate treatment.

INTERVIEW WITH MARK WILLIAMS

Dr. Connolly: Where were you born?

Dr. Williams: In North Wales, in a little town called Mancot, Hawarden, just over the border from England near Chester. My father was a minister in the local Presbyterian church there - his first church after training. I was born the third child in a family of five. My father moved around, first to Aberystwyth in West Wales and then when I was 8, to Stockton.-on-Tees in 1961, so most of my memories of childhood come from Stockton-on-Tees in the north of England, an industrial area. We were there in the 1960s, and it was an exciting time for the family. I left there in 1970 when I went to Oxford to read Psychology and Philosophy.

Dr. Connolly: Tell me about those early days.

Dr. Williams: The years in Stockton were characterized by a slow start. I felt from the outset that the move to England was for me a good one. I felt that this was real life. Life in Wales had been quite isolated. Aberystwyth is a beautiful place, but isolated. My family and myself all felt isolated, I think. Despite feeling that it was a good move in one sense, it was also a strange move from a gentle rural community to an industrial community that was more violent. There were bullies in school, especially for new kids, and I had a Welsh accent so was a target. After a while there, I was moved to a Church of England school. My parents, quite rightly, thought that I needed protection! It was a much gentler school where I felt I could be myself. That school was a rescue. I could see myself as having a future. It was a much more academic school too.

Dr. Connolly: Were there hardships in being the son of a minister?

Dr. Williams: There were advantages and disadvantages. You did get bullied. I was unfortunate in that my first teacher in Stockton was rather sarcastic about religion. I was only 8 at the time, and it was difficult to tolerate her remarks. When I went to the church school, it was not unexpected for people to have a religious background. Another advantage of being the son of a minister was you get an immediate circle of friends. You mix with a lot of people of all ages who are moving through the house all the time. It's a good preparation for later interactions in life. There's a regularity to the week and to life, although I've rejected a lot of the strictures about 'not doing things on Sundays', there's a sense of belonging to a community and a foundation to life which never leaves you, even if you want to leave it.

Dr. Connolly: What spiritual values did you acquire?

Dr. Williams: I was aware of the sense that all the people around me, parents and grandparents, were aware of a Presence and a Power in the universe which they called God, and at times in my life I have too. They prayed to God which gave meaning to their lives and to

the tragedies in their lives. That possibility, the sense of there being a rumor of God through the ages and in this family, was very palpable, even as a child.

Dr. Connolly: What about now?

Dr. Williams: Through the ups and downs, I've ended up reconnecting with the religious side of life. As a teenager I thought I would follow my father into the ministry. But it didn't happen. Later on, when I was at Cambridge, I got the same calling, and I eventually trained and got ordained as a non-stipendiary minister in 1989. This meant I continued as a psychologist but assisted with church services and pastoral work.

Religion is about the daily and weekly practices and the commitment to an organization, to a body of scriptures and of knowledge, a way of doing and believing things. The spiritual side is an inner life. For me that was much enlivened by becoming a student of Buddhist practices through my experience in psychology.

Even with people who practice religion, you can make a distinction between going to church as a habit versus going to church as a personal nourishment. Studies of religiosity often don't make that distinction. There are, of course, spiritual experiences outside of church, and these days often there is *more* spiritual experience outside of church. The church has been rightly criticized for killing off spirituality and focusing on organization. If spirituality is like a river running through our lives, the church has sometimes tried to divert this river into its own channel and then to restrict access to that water to those who do and think certain things. The church needs to release the river back onto the land.

Dr. Connolly: What did you read as child and adolescent?

Dr. Williams: I wasn't a great reader of novels as a child. I was more interested in philosophical books. As with many people who get into philosophy, as I did later, it's the philosophy of religion that they get intrigued by, that you can think seriously about issues such as the existence of God. The idea that you can argue about this, especially for people brought with a religious faith, is a great revelation because you feel like you are going back to basics and not just having to take things on authority. It's a very liberating thing to read that sort of book. The Philosophy of Religion, John Hicks's book of that title, was one of my earliest life-changing books. Then I looked for any book I could find on philosophy. There's a book by A. D. Woozley called *The Theory of Knowledge* which explores how we know something is true or not and that was a very influential book in my adolescence. I was trying to think things through for myself having been brought up in the church where we had to take things on authority. It was very liberating to read things through for myself.

Dr. Connolly: How did going to the Anglican school work out?

Dr. Williams: My parents had always been very ecumenical, not worrying about which denomination. My mother started off as an Anglican. Her father was a missionary and

became a bishop in the church in Africa. My father was brought up in the Presbyterian church but, then when it came to the early 1970s when the Presbyterian church was going to unite with the Congregational church, my father was a big supporter of the union between different churches, and he would have to liked to see more progress towards uniting of the churches instead of splitting apart.

Dr. Connolly: Were there any influential teachers?

Dr. Williams: We had interesting drama teacher. He was actually the biology teacher. He was not much good as a biology teacher. He just read from the textbook and expected us to take notes. But as a drama teacher he was excellent. There was also a guy called Tom Moffit who was a religious instruction teacher, and he was one of the people who introduced me to philosophy. We went through Plato and definitions of what 'good' and 'virtue' meant, and that was a wonderful eye-opener.

My father had been a conscientious objector in the Second World War and been sent to work as a forester in South Wales. It was a difficult time in that his bosses were people who thought that he should be fighting in the war. He had studied Latin in school but, when he came out of the forestry, he went Cardiff University to read classics and found to his surprise that he could read Latin fluently. He died three weeks ago, so he is much in my mind at the moment. Even up to his death, he was reading the Latin bible daily. He gave me this sense of excitement about the layers of meaning in a text and even these days, as I take services in the churches around Oxford, it's very meaningful to me, the way in which metaphor, parable and language combine in the text. The text has multiple meanings and exploring these is fascinating.

In the last 10 years, I've become interested in Buddhist practices, and you can see parallels between the ancient Christian and Buddhist texts - the sense that they were discovering and trying to express the same sort of truths about acceptance, accepting yourself as you are now, not yesterday or as you hope to be tomorrow. They both explore the nature of love, gentleness and compassion towards yourself and each other. Those issues are profoundly expressed in Christianity and other religions too. Now, I am interested in how to use the best practices and theories, without a religious connotation, in psychotherapy and in our work with patients.

Dr. Connolly: What about music:

Dr. Williams: Music was always important to me., I used to sing in the choir at both school and the church, singing both secular and religious music. I play the organ and the piano, and I write a bit of music (I've never told anyone outside the family of this before!) The music in the church helps to make the service meaningful for people because it involves your whole body and goes way beyond poetry.

Dr. Connolly: You're a very private person and a public person. How do you separate the two?

Dr. Williams: Trying to be just myself as best I can in every moment in whatever any domain that I find myself in – family life, public life, my work, conferences and so on. I used to keep my public and private lives very separate. My religion and spirituality were part of my private life, psychology was part of my public life. Over the last 10 years with the exploration of mindfulness meditation as a personal practice and as a therapeutic practice, this separation can no longer be sustainable. I have had to come out of the closet. That's given me some pause for thought because I'm not naturally an evangelist about my religion. I have always kept them separate, and now they are not so separate.

Dr. Connolly: Tell me about university.

Dr. Williams: In my university years, I was involved in the National United Reformed Church Youth Movement and was quite involved in running camps for children. For example, we used to take children from Liverpool to North Wales, with canoeing and other activities with them for a week. I did that for a few years, and that was organized by the church.

In my undergraduate university days, I read philosophy and psychology.

Dr. Connolly: Why psychology?

Dr. Williams: I really wanted to read philosophy, but I wanted to apply to Oxford University because my brother was there. At that time, I was thinking of being in the ministry which would have meant going to Cambridge to train for three years. I didn't want to go to Cambridge for six years. So I applied to Oxford. But at Oxford, you can't just do philosophy on its own. You have to do it with something else, and psychology seemed to me to be the most interesting option.

I didn't want to do theology because I thought I'd do that. In those days, the church did not take 21-year-olds to train for the ministry because they thought that was too young. They asked me to go out and do something else first, and then go into the ministry. I thought that training in clinical psychology was a good thing to do. That training involved three more years at Oxford, and then I got an offer to do a doctorate on depression with John Teasdale at the Department of Psychiatry at Oxford.

I wrote to the church to ask them about postponing for a second time, and they encouraged me to go for the PhD. They said, 'You can do theology at any time'. But after 9 years (undergraduate, clinical training and doctorate), I thought that my initial impulse to go into the church must have been a mistake. I was so much into psychology and enjoying it that I decided that *that* was my career path. I applied for and got a job as Lecturer in Applied Psychology at Newcastle University helping to teach the clinical psychology course there.

Dr. Connolly: Tell me about your doctorate.

Dr. Williams: It was on psychological models for the treatment of depression, and I looked at the learned helplessness model of depression. I started by trying to replicate an existing study that Seligman had done in which he had given people unsolvable problems in one phase

of the experiment and demonstrated that that made them helpless for other tasks such as a shuttle box in which they had to move a lever to avoid a noise coming on in 5 seconds. I couldn't replicate his experiment. In fact, some participants reacted to the initial failure by doing *better* than the control group and some reacted by doing worse. My thesis became a study of why people react to failure in these different ways - some do better but some give up. We looked at how people attributed their failure, their expectancies and how important the task was. The thesis derived and tested a model to account for the difference. That was published in *Behavior Research and Therapy* in 1982.

Dr. Connolly: You haven't mentioned your mother yet.

Dr. Williams: My mother was a very loving person who you were always sure of. She brought up 5 children and was a minister's wife, so she was very busy. She had gone to university but had given up after a year because her own mother was ill, and she went back home to care for her, but by then, she had already met her future husband at university. They married a few years later. She was a feisty person, unlike my father who was a pacifist. Her two brothers had been killed in the war, and she was going to get Hitler back in the only way she knew how. She went into the land army. She was intelligent with immense resources of courage. She is still alive, but in 1987, just a few months before they were due to retire, she had a major stroke which left her without being able to speak, and she still can't sixteen years later. Yet, she kept going. She's carried on, riding for the disabled, fallen several times, broken her hip and had to go into a nursing home. But she found a way of embroidering with her left hand and has done amazing embroidery. Doing that and watching Sky Sports from wherever cricket or tennis is being played throughout the world, she gets by and has become a source of support for many people despite the fact that she's in a wheelchair all day and can't speak.

Dr. Connolly: What about your siblings

Dr. Williams: I've got an older sister and an older brother and then two younger sisters. My older sister is a radiographer in Bath, my older brother was a schoolteacher and then headmaster and is now chief executive of the Dorset Connections Service which looks after kids post-16 who are at risk of dropping out of education. My younger sisters are an eye nurse, and the youngest, a social worker, who has just been ordained and become a missionary.

Dr. Connolly: What was psychology like when you were an undergraduate?

Dr. Williams: It wasn't what I expected. You could choose 4 areas out of 10, and I chose behavioral disorders, social psychology, developmental psychology and perception. I found it really fascinating, although it was a bit of a shock. I hadn't done any biology since the 5th form, and my first essay for my tutor was on the role of the hypothalamus in the regulation of thirst in the rat! So my first few days at Oxford were spent in the Science Library trying to find out where the hypothalamus was, trying to understand its

role and writing the essay. Latin, English and history for A levels wasn't a great preparation for learning about the hypothalamus!

There were people there who were very inspiring. John Hutt, for example, talked about ethology, how to observe the behavior of animals in their natural habitats, how to write an ethogram. We studied Piaget and other developmental psychologists as you would expect. To me, this combination of neuroscience and behavior was an excellent grounding for later understanding the psychological problems in patients. Observing without judging behavior rather than making inferences.

For example, we learned that the early diagnosis of autism involves observing behavior carefully. When the child puts the hand of their parent on the door handle to get the parent to open the door for them, but not looking at the parent during this, people had thought that the child was 'using an adult as an object'. We were taught to not merely make inferences, but to observe carefully. What you actually observe is that the child is averting their gaze rather than looking. We know that gaze-aversion is one of the things that both animals and humans do when they are over-anxious. Seeing the gaze-aversion in autistic children led to new understandings of autism and the chronic over-arousal from which children with this diagnosis can suffer. What happened to the theory is perhaps not the issue for me. The issue was the method of discovery, which was about close observation rather than rushing to make unwarranted inferences.

Dr. Connolly: So who else was there?

Dr. Williams: Jeffrey Gray was a lecturer and a hero to many of us because of the way in which he managed to transcend the animal/human divide with his series of anxiety studies. He later went to Hans Eysenck's chair at the University of London's Institute of Psychiatry. Lawrence Weiskrantz was the Head of the Department, a neuroscientist who discovered blindsight among other things. He discovered that when people are cortically blind, there is another pathway to the visual cortex which allows them to reliably discriminate which side an object is that you show them. They cannot see, in the sense of experiencing seeing, but they show by their behavior that they are seeing at some level. He also did some early work with Elizabeth Warrington showing that people with amnesia actually could remember some things, but they weren't aware that they were remembering. He was fairly influential on many of us. Later on, Gordon Claridge came to Oxford bringing his psycho-physiological theories of schizophrenia.

Among my peers, there were people like John Duncan who is now at the Cognition and Brain Sciences Unit, Sue Blackmore who is now interested in parapsychology at the University of Bristol, and Jane Wardell who became Professor of Health Psychology at the University of London.

Dr. Connolly: What about the philosophers?

Dr. Williams: My tutor in philosophy was John Kenyan who was a Humean and interested in the theory of induction. Other philosophers who taught us were Geoffrey Warnock – a clear thinker. Peter Strawson's lectures on the introduction to philosophy were the most

complicated lectures I have ever listened to in my life, and I did not understand a word of them. A. J. Ayer was also around at the time, and I remember going to one incomprehensible seminar with him. He was a great proponent of logical positivism. It was a time when Oxford was still pretty dominated by analytic philosophy in which philosophy was really the philosophy of language. A lot of that was pretty dry, and I found it relatively dry myself as well. It was only recently that I came across a book which made sense of this, a book by Brian Magee who was both a philosopher and a broadcaster, called *Confessions of a Philosopher* which is his autobiography. He talks about analytic philosophy in Oxford and how dry and disappointing it was to him. Reading his book, I thought that is precisely what I felt but hadn't articulated. It's a wonderful book.

Dr. Connolly: You were nine years altogether in Oxford, and then you went to Newcastle. That must have quite a transition.

Dr. Williams: It was a big change. We had one child and another one on the way when we moved there, and another born when we were there. My parents by then were living in Newcastle-upon-Tyne, and my wife's parents were living in Stockton-on-Tees, so we thought we were moving back home, as it were. It didn't particularly feel home to us, but I was very glad of the three and a half years I spent in that job because the head of the clinical psychology course, a man called Peter Britton, was a very good mentor. He was very sound in his judgement and very good at explaining things. And he introduced me gently to the business of being a lecturer and a supervisor for the clinical course. He gave me the opportunity both to do clinical work and to do research. Although I didn't stay there long, being with Peter Britton gave me a very good solid foundation for later on.

Also, it was a time when I started getting seriously interested in cognitive therapy which hadn't been part of my original training as a behavior therapist in Oxford when I was doing clinical training because it was only just emerging in the 1970's. I explored it along with several colleagues, like Jan Scott who was a junior lecturer in psychiatry at that time in Newcastle. We saw patients and then went to workshops and met Beck when he came over to Britain and gradually got into cognitive therapy. It was out of those early workshops that my first book, *The Psychological Treatment of Depression* came, because I found that there wasn't a book that really comprehensively reviewed all the available treatments for depression. There was Beck's 1979 book, but that didn't go into the behavioral side. In order to teach my students, I brought together these treatment techniques in that book, which came out in 1984. Newcastle was good in giving me the time to do that. An opportunity to do full-time research came up at Cambridge as a post-doc in the MRC Applied Psychology Unit, and I moved there in January 1983.

Dr. Connolly: Again, a different world from both Newcastle and Oxford.

Dr. Williams: A very different world. I went there for a three-year stint thinking that three years would be good so get research underway. It is very difficult for young lecturers to get research up and running. I was very grateful that, in Newcastle, some lecturers there had

incomplete data and asked me to help them complete the data gathering and analyze the data and they gave me my place in the publication. Without that, I might have floundered. When I went Cambridge, it was explicitly to give myself quality time to get research underway. It was at Cambridge where Fraser Watts and I began to look at the using experimental cognitive psychology to investigate underlying psychological processes in emotional disorders.

Dr. Connolly: How long were you there?

Dr. Williams: Nine years.

Dr. Connolly: Then you moved on?

Dr. Williams: Then I moved on to North Wales.

Dr. Connolly: What about the publications in Cambridge?

Dr. Williams: Well, it was there that I started being again interested in suicidal behavior.

Dr. Connolly: What awakened that?

Dr. Williams: It was probably because we were interested in psychological change. I picked up a theme that had come out of my PhD: why do some people react to adversity in a catastrophic way while other people react without a catastrophe. Suicidal behavior is something which is very catastrophic, but often, a few weeks after a suicide attempt, some people seem back to normal. I wanted to understand the psychological processes underlying emotional crises and how the crisis resolves.

When I was doing memory testing, I wanted to know whether their memories were biased. If you gave people a cue word that was positive, maybe, I thought, it would take them a long time to retrieve happy memories. This was the memory bias that had been found in depression but had not ever been looked for in suicidal people. Perhaps part of the black despair of the suicidal crisis was contributed to by this inability to retrieve anything positive from the past so that your past seems like a string of failures and disappointments.

We discovered that some of our patients didn't seem to be able to do the task at all. They came up with over-general memories, memories that summarized a number of events instead of a specific event. At first, we thought that perhaps they didn't understand the instructions, but it reminded us of a phenomenon that we found in cognitive therapy. Very often in cognitive therapy, after you know the person quite well and they've disclosed a lot of things to you, they still have difficulty in coming up with specific events in their past. There is a lot of 'general memories' rather than specified particular memories.

In cognitive therapy workshops I would advise novice cognitive therapists always to be specific. If somebody says, 'I've got no friends', ask them gently which friends

have left them and which friends are still around. Be specific, name them, ask whether X or Y is still there. If people say ‘My life is falling apart’, at some point, ask for specific information.

It seemed we were discovering this same phenomenon using the cue word test. It turned out to be a very important finding because although this seems a subtle memory problem, it impairs problem-solving. It seems to be much worse in those who have a history of trauma. If people have had a trauma, particularly sexual abuse in the past, then it seems to affect their memory years after the trauma and, even when they are not thinking about the trauma, the trauma has impaired other aspects of memory, making it over-general, which then impairs their current ability to solve completely unrelated problems. We first published those results with suicidal people in 1986, since when it has been replicated in depressed psychiatric patients, those with PTSD, Vietnam veterans, children who have been through the Bosnian war, and many other groups.

Dr. Connolly: And after Cambridge back to Wales?

Dr. Williams: Back to Wales, another big culture change. We lived in Anglesey, off the coast of North West Wales, and worked at Bangor University, on the mainland. This part of Wales has consistently been one of the parts of the United Kingdom with the highest unemployment for the last seventy years. It is in the bottom 25% of Europe in terms of social deprivation. Yet it is stunningly beautiful, as is the rest of North Wales. The mountains are beautiful, the fields are wonderful, and the sea is incredibly clean, but that beauty hides an immense amount of rural poverty. It is linguistically a very Welsh-speaking area, and both my children and my wife and I learnt Welsh. That was a challenge. We didn’t *have* to speak Welsh, because the University welcomed English speakers, but we wanted to do so.

We found the community and the university very warm and welcoming, and we were privileged to be there. Of course, we changed church as well because it was the Welsh Anglican church rather than the English church into which I had been ordained, with bi-lingual services. But only once have I managed to preach in Welsh. It was when I was on sabbatical, and I had the time to prepare a Welsh sermon. I would have done it again if I had more time, but it was not to be.

Dr. Connolly: What were you doing then in your years there at the University in Wales?

Dr. Williams: I was director of the clinical psychology course for the first six years I was there. We set it up as a three-year doctoral course, and it was the first professional doctorate in clinical psychology in the UK to be approved by a university and get up and running. Bangor was very proud of being the first one to do this.

After six years in 1997, I left the course to set up a research institute and also became Pro-Vice-Chancellor for research, helping to navigate the university through the Research Assessment Exercise for 2001, helping departments prepare their submissions. The research institute was called the *Institute of Medical and Social Care Research* and brought together psychologists, social anthropologists, public health physicians, and

health economists to look at both public health aspects of community and social level interventions as well as individual treatments for mental health issues as well.

Dr. Connolly: In all of this time, your children were growing up. How many children do you have?

Dr. Williams: Three.

Dr. Connolly: What kind of a father are you?

Dr. Williams: What would they say? I think quite a busy father, a father who takes an interest in what they are doing whether they're succeeding at it or not. A father who hugs his children. We have a boy and two girls, and they hug me back and are sensitive to what they are feeling. They, in turn, are sensitive to what I am feeling.

Dr. Connolly: What career paths have they mapped out for themselves?

Dr. Williams: My son decided to do philosophy and mathematics and went to Christchurch College in Oxford and then stayed on to do a BPhil which is the professional post-graduate philosophy degree they do there. He has decided to go to St Andrew's to do his PhD where there is a very good mathematics and philosophy department. My middle daughter has gone to Liverpool, John Moore's University, to do applied computing technology, and she graduates next year. My youngest daughter decided to read English and she went to Worcester College in Oxford, and she has got another year to do in that.

Dr. Connolly: What age were they when you took holy orders?

Dr. Williams: My son was 11, my daughter was 9 and my youngest daughter was 6.

Dr. Connolly: How did they react?

Dr. Williams: I think they were quite intrigued. But it was hard too. I had to be away quite a lot when I was training. I had to take weekends away, and that was hard as that was my family time. But once I was ordained, I stayed at home more. When I got ordained, they were there in the Cathedral cheering me. They were quite involved in the Church themselves - in Sunday school and in the Young People's Group. None of them are as involved now as they were then, but I don't feel particularly worried about that and have no interest in pressuring them to seek church life or a religious life. It will happen in its own time if it's meant to happen.

Dr. Connolly: You are in the Anglican Persuasion?

Dr. Williams: Yes, by accident. I sort of fell off my bike into the Anglican Church for family reasons when we moved to Cambridge. It was a bit of a bind on a Sunday morning to get

the children into the car and go into Cambridge for the Reformed Church services because we lived 3 miles outside Cambridge. We thought it seemed much easier to go to the local parish church in the village which was just a walk up the road. That's how we started worshipping in the Anglican Church. It wasn't high principle - it was really a matter of convenience.

Dr. Connolly: Tell me about your journey back to Oxford.

Dr. Williams: I was 50 in 2002. When we had been in Wales a few years, I realized that coming to the age of 50, I had to make a decision whether North Wales was going to be the place that I spent the rest of my life. Probably not. I felt that I had one more move in me before I retired. As Pro-Vice-Chancellor and also head of the research institute, my life was pulling me in two different directions. I wanted to continue the research, but my life as a Pro-Vice-Chancellor was about helping the administration of a large institution, handling large budgets and being at regular meetings to help problem-solve at a management level. I enjoyed both these sides of my job, but I realized I was going to have to make a decision.

When I was finishing off my Pro-Vice-Chancellor role, people would mention that 'the next thing for you is a Vice Chancellorship somewhere'. People started mentioning me to head-hunting agencies, and there were e-mails from head-hunters about jobs that were coming up to lead various universities. How to decide? I realized, on the way home from work several times, if I had two things to read in my briefcase that evening and one of them was a document from a funding council and the other one was an academic paper, that I would always read the funding council paper first in order to leave the academic paper as a treat for afterwards, to be done for enjoyment rather than for just something I had to read. I realized that what I really enjoyed doing is research. But if I went back into psychology department somewhere, there's all the teaching and admin commitments that take you away from research. But there was one scheme that I thought I would explore and, if I didn't get that. then I would become an administrator. That was a very generous scheme called Principal Research Fellowships from the Wellcome Trust. You have to write a 5-year Program Grant and if you're successful in that, and you pass their interview, they will give a University the funds to employ you for ten years to do pure research.

I had, during my time at Bangor, started down this path of relapse prevention for depression using mindfulness meditation. I had continued my research on autobiographical memory in depression, and I had stayed with research in suicidal behavior. Here was an opportunity maybe to write a proposal for the Welcome Trust to bring together my interest in memory, my interest in relapse prevention using mindfulness and my interest in suicidal behavior.

I wrote a grant, which brought these three things together and submitted it to the Wellcome Trust, sponsored by Oxford University because of the ground-breaking research of Keith Hawton and his group in the Centre of Suicide Research there. Keith was very welcoming of the proposal and has been a tower of strength throughout the whole procedure, as was the Head of Psychiatry, Guy Goodwin, and the Head of

Psychology, Oliver Braddick. I decided to ask for joint sponsorship between experimental psychology where I had been in the 1970's and psychiatry where I had been for my PhD, and to apply to go back to Oxford to do this ten-year program of research. It took eighteen months to write the grant. I submitted it and, a year later, was successful. The Wellcome Trust funds my post, two post-doctoral researchers and a post-graduate research assistant, a cognitive therapist, Melanie Fennell, a PhD and a research coordinator.

Dr. Connolly: When did you started in Oxford?

Dr. Williams: January 2003. This is the beginning of a huge adventure. It's a huge adventure. It's a high-risk strategy because you never know whether your experiments will work. We're using techniques that haven't been used before in this group, using mood induction procedures, taking people who are recovered from depression or from suicidal behavior and who are back to normal. We know that they are vulnerable, and we are trying to predict who will relapse and who will show later suicidal behavior. We are going to use a mindfulness approach which helps people to distance themselves from their suicidal thoughts, allowing their thoughts to come and go rather than trying to suppress them or escape from them. We hope to see if the mindfulness that worked so well for relapse prevention in people with three or more episodes of depression can be transferred to this suicidal group.

Dr. Connolly: What are your views on assisted suicide and euthanasia?

Dr. Williams: I have great respect for those countries, such as the Netherlands, who make provision for people who genuinely feel at the end of their life and at the end of their tether. I think that making a general principle that something like that should *never* be done is not necessarily always going to be the most loving thing to do for people. I believe that the most loving thing to do in any situation has to be judged in that situation. 'Situation ethics' is important here. There are occasions when you've got to set your principles aside and do the right thing. I think sometimes we get caught up in principles and forget that the right thing has to be done. I think that's true in euthanasia, and it's true in assisted suicide. Having said that, I cannot imagine myself in the situation in which I would want to give up with a person and suggest that to kill themselves was the best option.

There is a view within Buddhism that says, 'While you're still breathing, there is more right with you than wrong with you.' Given that most people in those situations of being in despair or having a terminal illness do not want to kill themselves suggests to me that the wish to kill yourself comes from a sense of hopelessness rather than the objective reality of the physical pain or the mental anguish. It may be that the very act of trying to deal with their pain and their anguish, mental or physical, has actually trapped them even more. They're like an animal caught in a trap that, by struggling, has made the trap tighten even more. Often people get caught up in their inner voices. As Marsh Linehan pointed out, when people say, "It would be better if I'm dead," how do they know? You

can’t get evidence about what will happen after your death! So I will always try to work with people to see what value there is in whatever life remains to them rather than knowingly declare that their life is no longer worth anything.

Dr. Connolly: We have this problem with the terminally ill in great pain that the measures that we take to alleviate that pain and give them some comfort and dignity is going to shorten their life.

Dr. Williams: We know that some measures shorten life in many cases, and there is an important distinction between intending to alleviate suffering and intending to shorten life. I want to work with the person to see how much of their sense of wanting to go was coming from a sense of their own worthlessness and their own depression and their own helplessness rather than the inevitability that their life was at an end.