Leonardo Tondo: Interviews with Pioneers

Hagop Akiskal

On art and science

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Biographical notes[1]

"We have lost a friend, an erudite, and a maestro" reported the Lebanese newspaper *Orient le jour* on January 26, 2021[2] about the passing of Hagop Souren Akiskal (Armenian: Յակոբ Սուրէն Ակիսքալ) in La Jolla (USA) surrounded by his wife Kareen and his close family. He was born in Beirut, Lebanon, in 1944 in an Armenian family who had survived the genocide (1915–1916) and moved to Lebanon. He received his medical degree at the American University of Lebanon in 1969 and completed residency training in psychiatry at the University of Wisconsin in Madison. He then worked for several years as a clinician and mood-disorder researcher at the University of Tennessee, Memphis, where he founded an outpatient mood disorder clinic. He was senior science advisor at NIMH from 1990 to 1994, before moving to the University of California in San Diego where he was professor of psychiatry and director of the international mood center to the end of his career. He was a great admirer of U.S. for allowing a young Armenian-Lebanese doctor to gain access to the top posts of the academic medical system. He said to have inherited literary and medical gusto from his mother's and mathematical precision from his father's lineage. Both traits certainly helped him in his brilliant career.

During his adolescence he met Kareen in Lebanon and they later married in the United States. She was the companion of his life, his deep love, and his great professional partner. Thanks to their passion for art and their extraordinary cultural background, they explored the mysterious and fascinating world

[1] Biographical information is based on: [a]. Sani G, Perugi G, Vázquez GH, Tondo L. Transitions: Hagop Souren Akiskal. J Affect Disord. 2021; 284: 201–202. [b] Ban T. Cetcovich-Bakmas M. In memoriam of Hagop Souren Akiskal. INHN, February 2021. [c] Carta MG, Colom F, Erfurth A, Fornaro M, Grunze H, Hantouche E, Nardi AE, Preti A, Vieta E, Karam E. In Memory of Hagop Akiskal. Clin Pract Epidemiol Ment Health. 2021; 31; 17: 48–51.
[2] Karem É, Hantouche É, L'ami, l'érudit et le maître. Orient le jour. 2021; January 26.

of artists, understanding and describing the profound relationships among mood disorders, creativity and art. Both were very much involved in the artistic world and would fly to Europe at any possible occasion.

Hagop was a very innovative researcher and a critical clinical observer. His early experiences in substance abuse and student health stimulated his career-long interest in mood disorders. He had a strong respect for the efforts of young researchers probably thinking of his own experience of having received much attention from the academic sites in the US when he was an obscure, young Armenian-Lebanese doctor. For this reason, he never declined to reply to an email sent by young researchers, encouraged their ideas, and often checked with them about their progress. They included investigators from the Balkans, Brazil, China, Japan, Europe, Australia and Lebanon and of course from the USA. In a famous interview with Paula Clayton in 2008, Akiskal says he learned a lot from the Italians, including two of his closest collaborators Giulio Perugi (1956–) and Franco Benazzi (1957–2009). His generosity in responding to young people and in accepting their contributions to the journals he edited were sometimes criticized but were deeply rooted: he said once that he rarely saw anyone smile in his family because of the ordeals they had lived; his reaction was to offer hope.

Hagop followed Emil Kraepelin's (1856–1926) approach to psychiatry, strongly believing in the unitary nature of mood disorders for the very humane reason: "to bring smiles to the faces of people… I never saw a smiling face when I was growing up. People were all talking about genocide, how much pain they had that and could never give up." Thanks to his acute clinical ability, deep humanistic interest and original thinking, he coupled high quality research and clinical care. At the age of 29, he reached international notoriety with his integrative hypothesis of depressions.[3] Subsequently, starting from his clinical experience, he conducted seminal studies on the diagnosis of mood disorders, recognizing cyclothymia as part of the mood-disorder spectrum,[4] challenging the sterile but well-established notions of characterological disorders, hysteria, sociopathy and the abused diagnosis of borderline personality disorder.[5] During an international congress in Rome, he dismissed the socio-psychological interpretation of the borderline personality disorder saying: "a person with borderline personality is just lacking lamotrigine." However, the concept of bipolar spectrum, echoing Emil Kraepelin would not be recognized by the DSM-5 which, instead, clearly separates depression from bipolar disorder. Moreover, he revolutionized the concept of chronic depression,[6] considering it a treatable mood disorder, belonging to the bipolar spectrum, a concept that he revitalized and classified in a new original fashion and recognizing more bipolar subtypes by taking into account temperament, family history of bipolar disorders or antidepressant-induced hypomania or mania.[7]

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[3] Akiskal HS, McKinney WTJr. Depressive disorders: toward a unified hypothesis. Science. 1973; 182: 20–29.
[4] Akiskal HS, Djenderedjian AM, Rosenthal RH, Khani MK, Cyclothymic disorder: validating criteria for inclusion in the bipolar affective group. Am J Psychiatry. 1977; 134: 1227–1233.
[5] Akiskal HS. Subaffective disorders: dysthymic, cyclothymic and bipolar II disorders in the "borderline" realm. Psychiatr Clin North Am. 1981; 4: 25–46.
[6] Akiskal HS. Dysthymic disorder: psychopathology of proposed chronic depressive subtypes. Am J Psychiatry. 1983; 140: 11–20.
[7] [a]. Akiskal HS, Pinto O. The evolving bipolar spectrum. Prototypes I, II, III, and IV. Psychiatr Clin North Am. 1999; 22: 517–534.

Temperament was one of his main interests and with Kareen Akiskal he brought it back to modern life from classical Greek psychiatry to the point of developing a largely used self-rating scale, the Temperament Evaluation of Memphis, Pisa, Paris and San Diego Interview (TEMPS-I) to address five affective dimensions of temperament.[8] Hagop's concept of temperament described sub-threshold characteristics which even in absence of full-blown disorder, could be sometimes either maladaptive, or beneficial to the individual.

He followed the inductive reasoning of traditional research in clinical psychiatry starting from close observations of patients to develop more general considerations. He refused the idea of untreatable patients and struggled in many ways to find the best possible way to take care of them. They included patients with treatment-resistant depressions, mixed features or chronic mood disorders.

He was a highly fertile writer of articles in psychiatry, editor of several academic journals, as well as a skilled and very effective lecturer in innumerable meetings all over the world. He was perfectly able to lecture in several different languages (Armenian, English, French, German, Portuguese and Spanish).

Akiskal received many awards, including the *Gold Medal for Pioneer Research* (Society of Biological Psychiatry), the German *Anna Monika Prize for Depression*, the *NARSAD Prize for Affective Disorders*, the *Jean Delay Prize for International Collaborative Research* (World Psychiatric Association), the French *Jules Baillarger Prize* and the *Italian Aretaeus Prize* for his research on the bipolar spectrum. In 2003, he received the *Ellis Island Medal of Honor* "for exceptional national humanitarian service." He also was nominated *Foreign Member of the French Academy of Medicine* and received the *Gold Medal of the Order of Medical Merit of First Degree* by the president of the republic of Lebanon in 2011. When his wife Kareen asked him what to do with all his awards (probably 50 or 60) he replied: "Throw them in the thrash. Now it's time for my students and the young generation to bring novelty and honor to psychiatry."

About the interview

Hagop and Kareen had invited me to spend a few days at their home in Memphis. I stayed for four days, and we enjoyed lively discussions on creativity and psychopathology. Both passionate art enthusiasts, they collected biographies of contemporary artists, exploring their temperaments and the nuances of bipolarity within their work. Their large, Spanish-style house had been transformed into a gallery, adorned with art and antiques, primarily selected by Kareen Aksikal. Many of these pieces

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[b]. Akiskal HS, Mallya G. Criteria for the "soft" bipolar spectrum: treatment implications. Psychopharmacol Bull. 1987; 23: 68–73.

[8] [a]. Akiskal HS, Maser JD, Zeller PJ, Endicott J, Coryell W, Keller M, Warshaw M, Clayton P, Goodwin F. Switching from 'unipolar' to bipolar II. An 11-year prospective study of clinical and temperamental predictors in 559 patients. Arch Gen Psychiatry. 1995; 52: 114–123. [b]. Akiskal HS, Placidi GF, Maremmani I, Signoretta S, Liguori A, Gervasi R, Mallya G, Puzantian VR. TEMPS-I: delineating the most discriminant traits of the cyclothymic, depressive, hyperthymic and irritable temperaments in a nonpatient population. J Affect Disord. 1998; 51: 7–19.

originated from Kareen's family home in Beirut, while others were curated from shops in Paris and Memphis. Kareen especially loved browsing antique stores, which she considered particularly fascinating in Memphis.

Their warm, welcoming hospitality reflected their Middle Eastern roots. As an example of their kindness, two years prior, I had driven cross-country from Los Angeles to New York with three friends. Hagop and Kareen invited us to stop by and stay for a couple of nights. Due to a series of miscalculations (in the era before GPS), we ended up arriving from New Orleans well past midnight after being stopped for speeding in Mississippi. Despite the late hour, they welcomed us as though it were 7:30 in the evening. Appetizers were set up in the den, followed by a sumptuous dinner, and we spent hours conversing with great enthusiasm.

During my current visit for an interview, we met twice, sitting comfortably on the sofas in their spacious living room, sipping tea. I remember it as one of the most informal and relaxing interviews I've ever conducted.

Memphis, November 13, 1989 (revised in 1996)

Kareen Akiskal (KA) participated at the interview[9]

LT: How did you become interested in the relationship between creativity and depression?[10] Unlike other studies on this topic your approach has been based on the identification of "soft" psychiatric disorders in the creative process.

KA: Well, I was involved with artists because I had an art gallery and I used to observe not only their work and their lifestyle but also their temperaments through time. When I was living in Paris I was again very much surrounded by creative people, but mainly writers and musicians. In time, I noticed that their behavior changed much sometimes from day to day or from month to month and I started being puzzled and asking myself: "What makes an artist? What temperament makes an artist? What can be an artistic temperament? Is there a common denominator? Is there a common temperament applicable to all artists, not only painters but also other creative people including writers?" I discussed this question very often with Hagop and I told him that I had an idea of designing a questionnaire. He helped me to put it in the right scientific terms. The questionnaire was conceived in Turin and Venice;

[9] References are given for topics and may have been published after the interview.
[10] [a]. Akiskal KK, Akiskal HS. The theoretical underpinnings of affective temperaments: implications for evolutionary foundations of bipolar disorder and human nature. J Affect Disord. 2005; 85: 231–239. [b]. Akiskal HS, Akiskal KK. In search of Aristotle: temperament, human nature, melancholia, creativity and eminence. J Affect Disord. 2007; 100:1–6.

in fact, we started the questionnaire in Venice. I don't know if Venice helped as a catalyst in inspiring us, however in the midst of this wonderful artistic atmosphere the questionnaire was designed but not completed because it took us almost two years to make it as perfect as possible.

HA: If I may add something, Kareen was quite unhappy that day and maybe she was unhappy because she was restless for something to be created. She didn't rest until we had initiated the first draft of the questionnaire.

KA: I felt restless.

HA: She was restless and not unhappy because we were not doing this [the questionnaire] and when we started, she was finally satisfied.

KA: Maybe my restlessness was a sort of an initiation to some creative work.

LT: Was that feeling related in some way to anxiety?

KA: Well, that's what you would call it, but I wasn't really anxious, I wanted to do it , it was just like writers who want to write. They cannot help it; they just want to write.

LT: Did it happen after a visit to a museum or after being exposed to much art? And I say this thinking of the Stendhal syndrome,[11] something that you might describe as a mixed state.

KA: Maybe, in fact, we were intensely exposed not only to artwork, I mean, Venice itself, when you look around is an open-air museum. Indeed, Italy is an open-air museum.

HA: Kareen was so eager and so restless and had all the intuition about it. Somehow it took Venice to put these two temperaments of ours together to come with the initiation of the questionnaire. You know, I somehow had the structure and the method but I wasn't sure about it. It was an enormous task and I was working, searching for the best way to do it.

[11] A state induced by enjoying art too much and that would cause agitation, fainting, lightheadedness and in some cases psychotic symptoms. It was described for the first time by the writer Marie-Henry Beyle (pseudonym: Stendhal; 1783–1842) who experienced it in Florence in 1817. As a psychiatric syndrome it was described by the Florentine psychiatrist Graziella Magherini when several people with the same symptoms were brought to a psychiatric ward directly from the Uffizi in 1979 (Innocenti C, Fioravanti G, Spiti R, Faravelli C. La sindrome di Stendhal fra psicoanalisi e neuroscienze [The Stendhal syndrome between psychoanalysis and neuroscience]. Rivista di Psichiatria. 2014; 49: 61–66. Italian.)

KA: I had too many questions which for years had stopped and started in my mind and I wanted finally to try to touch some of the answers. This is such a mystical subject – creativity – and it is still a mystery. Through the ages people have tried to understand why some people are wonderful artists and others are not. The subject was already fascinating and I understand when you say that a person may become manic after going to a gallery or a museum. I personally can say, and I know I have observed the same in many people, that some somehow become restless when they come out of a museum – I think nobody remains insensitive; everybody has some sort of reaction. Even when people react negatively to some modern art, it's also a strong reaction and something inside changes.

LT: Do you think that there is a correlation between affective disorders, bipolar illness and creativity?

HA: Well, we knew that there should be some connection because of other reports in literature. It was obvious that creativity could not be associated with schizophrenia, since that is destruction of any kind of harmony in the psyche and art without some harmony would be impossible. Also, the connection with manic depressive illness did not make sense because the extremes of mania and depression themselves could actually destroy art rather than lead to art.

LT: You thought there was an association between mood and creativity but manic depressive illness was too disruptive. So, were you looking for connections between softer expressions of mood disorders and creativity?

HA: Yes, exactly, something like cyclothymic or hyperthymic temperaments, but also others less intense but nevertheless able to induce activity and shifts in the mood. That was basically the hypothesis on which we worked. So much was said about mania, depression and creativity that we thought that we would find at least some of that connection, and yet we did not find it, neither in the Paris study nor in the blues study in Memphis.

LT: Can you describe the blues study?

HA: After we had begun the Paris study, and we had interviewed many artists, about 18 writers, poets and painters, we came to Memphis. I was just returning from the airport to my office and it was about 12:30 AM or so but I remember the exact intersection — Airways Boulevard with Lamarr — that I heard a song on one of the Memphis radio stations: "I woke up early this morning/the blues were walking all around my bed/I went to eat my breakfast/the blues were all in my bread." I immediately

knew that the singer had endogenous depression. I went to see my assistant and asked: "Jerry, you must find this person." She just couldn't do it, which is remarkable because she is usually good at this type of thing. The reason was that there are so many stations that play the blues in this area that it was just impossible. However, someone finally directed us to Dr. David Evans at Memphis State University who is professor of Ethnomusicology. He could finally trace the song for us. Kareen and I then had the idea that this would be an excellent opportunity to adapt the questionnaire that she had developed, for the blues study. Maybe she can tell you better why she thinks the blues singers would have been an ideal group of people.

KA: This was a group of artists who had absolutely no musical information; who didn't even know the musical notes. They couldn't read music and they couldn't learn professionally. Usually they had heard good music from their grandfathers, grandmothers, uncles and aunts who had a piano in one of their relatives' houses or had received a guitar as a present. This was their only access to a musical instrument and so they had somehow initiated themselves just trying and putting their feeling in the instrument. This was the most interesting part for me because creativity was just there at the end of their fingers, touching the musical instrument. Whatever they were feeling, they were already playing or singing, the lyrics were coming out spontaneously, a very primitive type of music, a form of creativity which was so vivid and performed while the feeling was expressed at the same time. It was a sort of transport to an art form just at the same moment. I don't know if it is clear but when you feel the blues you already play the blues or you already sing the blues with the right words to express your feeling.

LT: You speak of a relationship between the blues and the feeling, in other words, the mood. You said that blues means depression and at the same time you sing and actually you feel the urge to express your feelings; the two moments do not seem to belong to depression attitude, though.

HA: I think that's very interesting. What about the person who sings the blues? People who are blue are unable to do anything. So, what about the temperament? There must be a special temperament that has the blues but can put the blues into an artistic expression; there must be something about their accompaniment. This is what we tried to study. We felt that all these people who get down don't accomplish anything; but if these people were able to sing it in the most original way, it must be something about their temperament.

KA: Besides what they have inherited.

HA: And besides the musical talent of course. There was something about temperament which permitted them to express the blues and what we found is that these people were not only experiencing the blues. One of the singers said: "I'm the blues"; you can't sing the blues unless you have, or you are, the blues. Obviously, they are experiencing the blues but they were also very restless people; they had very little need for sleep, they could have two jobs, they could go on for days without needing much rest, womanizing and traveling a lot. They were very restless. We felt that this restlessness had a lot to do with a mixed state.

KA: It was an actual mixed state. At the same time, they were feeling the blues which is a depressive down, but they had the necessity to express it which is the manic high.

HA: Actually, one blues singer who knows absolutely nothing about psychiatry told us that in order to be really creative, it is worth being blue and being high, it is a kind of a mixed state and we need to have both in order to create and sing the blues. He said you cannot sing the blues if you are down, you must have a down feeling but you must be high in order to execute it: he himself used the term "mixed state."

LT: Do these singers use drugs to get their highs?

KA: They love drinking.

HA: Now this is interesting. There is an older generation of people in their fifties and sixties who use conventional drugs like alcohol but they don't use drugs like young people.

LT: Would this suffice to support the idea of a relationship between alcoholism and affective disorders?

HA: I would personally say that alcohol is used either because they are too excited or they are too down, they use it in both occasions and therefore they use it all the time.

KA: Or also they use it to lose their inhibitions before any performance. To start performing they need a few drinks. It can be therapeutic in the beginning but as singing is somehow related to a mixed state, alcohol can be antidepressant because they feel the blues and as soon as they feel high, they need more energy and drink more which eventually would make them feel more depressed.

HA: As you see, Kareen has developed psychiatric expertise; she realizes more than most psychiatrists that alcohol gives mixed states. I wish we could teach this to American psychiatrists.

KA: That alcohol puts people in a mixed state is also true with American writers. Initially I did not want a question on alcohol in the questionnaire but then I wanted to see the relation between alcohol and creativity and, surprisingly, we found something.

HA: Actually, we left the question for reasons concerning the way research is conducted, you cannot ask intimate history of alcohol use or abuse, unless it is freely mentioned. We really didn't ask but it came out, and Kareen is right, alcohol was important.

KA: In developing anything, more than cyclothymia, I think creative people need a mixed state.

HA: That may be so, but although your insight is very good, I would say you need both cyclothymia and mixed state to get a good artist. You cannot develop a mixed state unless you are bipolar and if you don't have the bipolar temperament, alcohol might not produce a mixed state.

KA: No, at the moment of creating, at the moment of writing you are in a mixed state.

HA: The creative moment may be like a mixed state but you must have a certain temperament so that you develop a mixed state, either spontaneously or with the help of alcohol.

KA: It is like having stage fright but at the same time it's important to perform well. This is also some sort of a mixed state.

LT: This feeling seems more related to anxiety than to depression.

HA: Anxiety might easily be part of the mixed state.

LT: When you speak about mixed state, are you speaking of the admixture of depression and mania or the rapid succession of them?

HA: The rapid succession of mania and depression could be quite disruptive; I'm talking about the two being together for some length of time, a few hours, part of the day, a few days perhaps. Also, rapid succession would be disruptive and prolongation would also be very unpleasant. In those people who may become creative, mixed states can determine the discharge of energy and that will cause depression at the same time, rather than interlocking them hopelessly together for weeks.

LT: And if you succeed, you would feel better.

HA: Obviously, although all this is very hypothetical.

LT: What kind of results have you gathered so far?

HA: The blues study is based on 24 blues singers and it shows that approximately two thirds have cyclothymic or hyperthymic temperaments and that alcohol abuse is quite common. These are people in their fifties, sixties and seventies. We have not analyzed all of the study findings so I cannot give you all the results. Nevertheless, maybe 40% had depression of clinical significance that lasted at least a few weeks. Also, remarkably, their first-degree relatives have higher rates of suicide and homicide compared to controls.

LT: Is not this in contradiction with your saying that creativity is not related to bipolar disorders?

HA: I said that it is related to manic-depressive illness but being manic-depressive is not creative because being manic or depressive in the classical sense is too disruptive. What we have found is primarily a temperament associated to creativity. For these people, bipolarity was sufficiently mild that they could self-treat with alcohol or with their own lifestyle.

KA: Or with their music. The music was beneficial not only to them but also to the people around them.

HA: We're not dealing here with manic episodes but with adaptive temperaments.

LT: Kay Jamison[12] claims that from her analysis of writers and poets[13], 38% of them were actually bipolar. Is there a methodological problem with diagnosis between your data and hers?

HA: There are two possibilities: either she's using different criteria for diagnosis or she is using the concept of manic-depressive in a general sense. An alternative explanation might be that in special artistic subgroups there are no full-blown manic-depressives. It would seem to me that would be a

[12] Kay Redfield Jamison (1946–) is a clinical psychologist, Professor in mood disorders and psychiatry at Johns Hopkins University School of Medicine, and writer.
[13] Jamison KR. *Touched with Fire: Manic-Depressive Illness and the Artistic Temperament* (New York; Free Press Paperbacks) 1994.

relatively small number because the more full-blown manic-depressive you become, the less likely it is that you will have the necessity to be creative. You need a smaller dose than the full-blown manic-depressive syndrome. Well, at least we didn't find this in our study, not a single case of bipolar I disorder, the closest would be that they had a bipolar II disorder, but most of them were cyclothymic or hyperthymic.

LT: A possible explanation could be that Kay Jamison refers to information collected through biographies of the artists while you have directly interviewed them. Also, even Jamison's artists might have started with a mild form of mood disorder and only later on develop a full blown condition. The same for your group that might eventually develop the condition.

HA: This could certainly be a possible explanation.

KA: They all have fluctuations of mood but they were handicapped when they were too down or too high, but they all had these swings.

LT: This issue of temperament and its relationship with the overt expression of a mood disorder is fascinating and makes me think of the neo-Kraepelinian movement that you have started in the States and that reintroduces Kraepelin's[14] ideas in psychiatry.

HA: I think I can start earlier than that. I would say basically it goes back to why I became a psychiatrist. Initially I was fascinated by literature, philosophy, genetics, neurology; those were the fields which attracted me and naturally someone interested in such a broad array of things is interested in psychiatry because it deals with all these things, but although I was fascinated by Freud – as most young people would be – I found practitioners who spoke that language to me hopelessly lost.

LT: What language do you mean?

HA: The language of Freud or any of his followers. I felt that the language they were using did not agree with the rigor of medicine in some sense. Psychiatry seems to be somewhere between literature and red molecules and psychoanalysis was closer to literature than to the molecules. Yet even at literary level, it wasn't flexible enough. You can think of literature being flexible and very soft but at the same time the psychodynamic theory had rules and regulations. It wasn't as free ranging as

[14] Emil Kraepelin (1856–1926). German psychiatrist.

literature was and psychiatry seemed to be in this kind of shape. I would have hoped for psychiatry to have the truthfulness of literature. Literature, in a truthful way, describes human subjective experience, yet it is also scientific; if you try to reduce it to molecules, that is hopelessly removed from subjective experience. Therefore, I was between these two experiences when I started studying psychiatry. What I brought with me was my knowledge of descriptive and phenomenological psychiatry. I want to make a distinction between these two because they are often confused: descriptive would mean objective, phenomenology by contrast would mean capturing subjective experience as faithfully as possible and that would be like Jaspers (1883–1969)[15] or Schneider (1887–1967).[16] These two concepts should not be confused, the objective description would describe the behavior of the patient, the phenomenology would describe as faithfully as possible how the patient was experiencing what he was experiencing. It is the mixture of the two, in my view, that really gives the rigorous description of psychology, which 20 years ago was misunderstood, as I think it is still today. You see we tend to use descriptive and phenomenological psychiatry in this country synonymously and they are not synonymous. However, in those days descriptive was synonymous of Kraepelinian which meant paying no attention to the patient as a person and that was obviously quite undesirable. Someone who was descriptive was thought to be someone who really was interested only in putting the patient in hospital, giving him medication or ECT,[17] disregarding the subjective experience, the person and all that and it was considered very negatively. Even to this day there is this kind of attitude.

LT: And how did you become a great supporter of Kraepelin's ideas?

HA: I was quite tormented by the existing ways of thinking in American psychiatry in those days. I even decided to leave psychiatry a few times – perhaps decided is a strong word – I even thought that then I should quit psychiatry because it was in this hopeless conflict between the subjective and the objective. In fact, the existing systems of explanation of mental illnesses were obviously quite inadequate. Anybody who walked into a mental hospital knew that psychodynamic theory could not explain or treat most of the disorders and the same was true for behavioral malfunctioning. Psychodynamic treatments were useful for relatively minor disorders and yet we also knew that the biological interventions could reach a certain level but they would not go too far leaving patients with continuing disabilities. There was obviously some kind of need to develop an approach that made use

[15] Karl Jaspers. German-Swiss psychiatrist and philosopher.
[16] Kust Schneider, German psychiatrist.
[17] Electro-convulsive therapy. Invented by two Italian psychiatrists, Lucio Bini (1908–1964) and Ugo Cerletti (1877–1963) in 1937.

of objective information and in a sense I developed as a psychiatrist because I wanted to explain to myself what was happening. I was in a way educating myself by learning the various approaches but I really felt that the foundation had to be one that had to be not only descriptive but also phenomenological. It was absolutely necessary to have objective descriptions of behavior as well as the subjective experience of the patient side by side and it was an absolute must to replace the pre-formed ideas of any particular theory. This approach can be considered atheoretical but also adhering to the theory that empirical description is the first step in any scientific inquiry. Around that time, something very interesting happened which has to do with the politics of our department – I mean at the University of Tennessee. Initially we were in an inpatient unit and it was easy to describe the patient objectively as well as gaining access to their subjective experiences in that unit. Everything was so classical there with the illness of moderate or extreme severity but after six months that inpatient unit was closed and we were left with essentially an outpatient clinic in which patients who had been discharged from the hospital were routinely followed. As time went by and we received other patients referred from the community, we observed that the majority of patients would not meet the easily definable objective criteria of mood disorders. They all fell below the threshold and things were pretty messy for a while because there was no structure to understand these patients. Moreover, the existing literature in psychiatry from a descriptive and phenomenological point of view was primarily developed from inpatients with psychotic disorders and it was quite inadequate to deal with the disorders we had to deal with. In addition, the classical literature in a somewhat marginal way also described the temperament and its effect with very brief descriptions often no longer than two pages. However, there was the hope in the classical tradition that ultimately the major psychotic disorders had to be understood in one way or another. It occurred to us that patients we were seeing in the outpatient department were somewhere between the two extremes, mainly that they had not yet developed the extreme psychotic intensity of the illness but they were somewhat beyond just the temperamental disturbances. Kraepelin had observed temperamental disturbances among the relatives of the manic depressives but they were not really sick; their temperaments were adapted for them and something which Schneider described in his psychopathic personalities which really are synonymous with the personality disorders today. As we were studying these patients on an outpatient basis, we had an excellent opportunity to prospect the research and we borrowed the technology from Washington where they had studied primarily classical forms. They had introduced descriptive psychiatry for the classical forms and what we did was to use that technology for the prospective evaluation of families with these ambiguous affective disorders. The latter constitutes something like 40 to 50% of our

psychiatric patients so in a sense it was the bread and the butter of the psychiatrist. We then began publishing our results on these mild mood disorders and they quickly captivated the interest of American psychiatrists as they could suddenly see that descriptive and phenomenological psychiatry had something to offer. Most psychiatrists were practicing in their offices and were seeing this kind of patient on whom the more traditional approaches, whether it was psychodynamic theory or behavioral approaches or group psychotherapy or major biological interventions, were not very appropriate. They were mostly doing some form of psychotherapy and counseling with these patients but they really didn't know how to conceptualize these ambulatory disorders because really there was very little literature on them. I think that was where our work was very useful in convincing American psychiatrists that descriptive and phenomenological psychiatry was useful to show that the most common type of patient with which they were having difficulty day after day could be conceptualized along descriptive and phenomenological lines and understanding the temperament. We showed how useful it was and when to use medication, when to withhold medication, what kind of medication to give, sometimes in small doses. This is another thing that I want to emphasize: much of the pharmacological literature, especially in this country, had come from studies in centers or State hospitals, in inpatient units, in university hospitals where they had used huge doses because those patients were very psychotic and treatment refractory so they needed to be treated with large doses. So, a psychiatrist diagnosed affective illness and even if it was ambulatory, they were using these mega doses and the patients got worse. This is part of the reason that today we have so many rapid-cycling patients. We started noticing these things in the '70s, these large numbers of patients who were becoming rapid-cyclers and then by the end of the '70s, there were so many and this was because the psychiatrists had used these big pharmacological guns [*especially antidepressants*] for relatively mild affective disorders.

LT: Many psychiatrists, mainly here in the States, don't believe that antidepressants can play a role in the induction of rapid cyclicity.

HA: The reason they don't believe it is because primarily they don't follow up the patients long enough or if they do, they are excluding the type of patient who is most likely to become rapid cycler. For many biologically oriented researchers, bipolar illness means bipolar type I which is less likely to develop rapid cyclicity. It is more the bipolar type II disorder patients who are cyclothymic in their temperament and tend to have a more accelerated course and switch into mania. It's easier to see the rapid cyclicity on this population but for many biological psychiatrists bipolar II disorders are not

bipolar at all; they are personality disorders or they are considered unipolar depressives because they don't follow them long enough to see the bipolarity. Therefore, in a sense the ambulatory focus that we have had over a long period of time has permitted us to notice a great deal about not only the patients' descriptive status, objectively characterized, and their subjective experiences but also their temperament, the life events that happened to them, the marriages they have, or the interpersonal relationships they have. All this is really a way of bringing together all approaches that really are unique to psychiatry: the ability to consider not only the disease but also the person and how a given treatment influences its course. This perspective is in some way unique to psychiatry, although I would argue that all of medicine should look at things this way but in the present time of high-tech medicine, the person is "lost." In a peculiar way, one can say that in the high-tech time of psychiatry maybe we are losing the person also in psychiatry unfortunately.

LT: Are we really losing the person in the sense that we are not interested in the human being in front of us?

HA: Years ago, I would have said that the psychodynamically oriented psychiatrists were perhaps the greatest sinners against psychiatry because they really were too narrow in their perspectives and biological psychiatry was in a way a liberating movement. Today I would say that the high–tech biology that has come from psychiatry has almost forgotten the person as if psychiatry is only a technical approach; simply we have gone to the other extreme. So, it seems to me that if we focus on ambulatory mood disorders, we cannot go to these extremes. I mean if you deal with the extremely psychotic patient, you are tempted to leave everything just to molecules. If you deal with very mild adjustment disorders, you are tempted to stay with dynamics alone, but if you deal with the intermediate degree of mental illness, which is the most common, and what most psychiatrists are doing, you really need to follow a course where all these approaches, descriptive, phenomenological, dynamic – although I would prefer to call it interpersonal – behavioral, cognitive, and pharmacological become extremely important.

LT: Would you support the integration of all these diverse perspectives?

HA: I began my career in that sense. When I was working with Bill McKinney (1937–2022)[18] and after being exposed to a large dose of primate behavior, I had the chance to observe monkeys in the

[18] William McKinney. American psychiatrist who studied developmental psychiatry and the social relationships of the rhesus monkey as a possible model of depression.

laboratory in Wisconsin college and to observe how they developed looking at the various theories of how they get depressed after separation. I kind of looked at the existing human literature and then we wrote two papers with McKinney;[19] one was on the relevance of the basic biological animal models to human depression and the other was how the various data from the human studies could fit together and afford some kind of interaction between various psychological and biological factors. I actually began my career developing such a theoretical approach but I had to put it aside for a while because I was interested in a descriptive and phenomenological approach. As our outpatient work progressed in the mood clinic, it was quite obvious that we had to come back to this integrative approach whereby all these structures had to interact in the long run to understand the patients and to treat them. I want to add just one more thing here. A subspecialty approach to psychiatry in my opinion is extremely important. We need to have clinics in psychiatry that specialize in one group of disorders rather than in several. When I was in training, inpatient psychiatry was biological and outpatient psychiatry was psychodynamic. That doesn't make sense to me because the same disorder was treated in one way in the inpatient setting and in another way in the outpatient one. To me, that didn't make sense. The patient should have been treated with all the weapons that were applicable – this is in a way Kraepelinian. But at the same time, it is an approach following Adolf Meyer's (1866–1950)[20] views because it looks at long distance course. Of course, Meyer was one of Kraepelin's students but he also was influenced by the psychodynamic approach. It's remarkable, although we talk about the Kraepelinian and Meyerian psychodynamic psychiatry, that they all really looked at psychiatric illnesses being very suspicious of the concept of disease. Now, with the cognitive revolution that has taken over clinical psychology, the view of depression is clearer because what makes you depressed is not the life you have, it's the way you react to it and your reaction is due to these attributional biases that you have which are part of your long-term tape.

LT: Are you referring to the cognitive style?

HA: Yes, the cognitive attributional style. Psychodynamic theory has long said the same thing more or less – that you have a certain character structure that cannot adapt to certain kinds of stress and breaks

[19] [a]. Akiskal HS, McKinney WT Jr. Depressive disorders: toward a unified hypothesis. Science. 1973; 182: 20–29. [b]. Akiskal HS, McKinney WT Jr. Overview of recent research in depression. Integration of ten conceptual models into a comprehensive clinical frame. Arch Gen Psychiatry. 1975; 32: 285–305.

[20] Adolf Meyer. Swiss-born psychiatrist who became the psychiatrist-in-chief at the Johns Hopkins Hospital in Baltimore, U.S. Famous for his integrative view of psychiatry where all the biological, social, and psychological factors had to be considered in a patientt.

down. Or you are sensitive to certain kinds of key events, like losses, but this sensitivity is a longitudinal characteristic of yours and the same thing with biological psychiatry, you have vulnerabilities which are in your genes or your chemistry that you carry in you. Kraepelin had the genius of ascribing it to your temperament but this is a very old concept, it goes back to the Greek and Roman psychiatry that derived illness from the four humors that constituted the temperament. So, what I'm saying is that the notion of a clinic actually goes back to these notions of longitudinal study rather than studying an illness in its various phases and saying psychotic patients act like this and neurotic patients need psychotherapy; to me this was crazy. I felt that we had to have different categories of illness which have severe and mild phases and that by having a clinic, such as a mood clinic, we should study the same patients whether they have congruent or incongruent delusions, whether they were manic or depressed or they were becoming depressive or and between episodes they were just hyperthymic. I felt that we had to do all these things on the same patient. That's why I feel that the notion of a mood clinic is so central and in psychiatry there are many people who are opposed to it, they think that sub-specialization is a very narrow interest and therefore the skills of the psychiatrist would atrophy. On the contrary, I believe that we need all those general skills to be applied to each particular disorder. So, I would say that to the extent that we have been able to influence American psychiatry, if I may boast a little bit, what we did was the correct thing to do, establishing mood clinics which in a sense were Kraepelinian but at the same time were all these other things. All this really helps us to understand the longitudinal course of these disorders to the extent that there has been resistance to this concept. We still have this amorphous way of studying mental illness which at its worst is not only a problem for the psychodynamics of psychiatry but for biological psychiatry as well. Similarly, the studying of MHPG [21] or some other chemical in depression is not going to discover anything because as long as you don't know the patients' history, that knowledge is useless; it is so heterogeneous that it will be diluted. Adding family history may help, at least some kind of genotypical knowledge, some colleagues do that but the majority of researchers don't look at genotypes. It seems to me that there are some very important methodological problems in American psychiatry that are not being looked at as rigorously as they could be and so I think the notion of a mood clinic is an absolute must for any kind of research on mood disorders.

[21] 3-Methoxy-4-hydroxyphenylglycol (MHPG) is the major metabolite of norepinephrine in the brain. The measurement of its excretion was considered useful for the understanding of depression or bipolar disorder but the results were inconsistent.

LT: You were discussing different aspects of bipolar illness.

HA: Temperament is basically what you are when you are born. It's an interaction between your genes and the environment.

LT: And in your view what is its relationship to personality?

HA: Temperament is what you are born with as a result of your constitution. It is a matter of your genes reacting with the intrauterine environment and that's your temperament at that point and leads to personality. Personality is a more general term, now I use character and character disorder and personality disorder in a different way. We must distinguish between someone who has a temperament or a personality which is adapted or opposed to having a disorder. Disorder means that is has become maladapted. In a sense, every temperament or personality has its own virtues and liabilities and it is like everything else in the human being made for some evolutionary end: high energy, low energy, too much sleep, too little sleep. All these things are part of one's temperament that gives some adaptive roles or some disadvantages. It depends on their environment so in a sense each temperament finds itself moving into a hidden environment where its adaptive skills are most useful. This often happens autonomously. I view a mental illness in part as a mismatch between temperament and the environment in which one happens to find oneself. Most people are smart enough to move away, but often there are very big mismatches between the temperament and the environment and there is a breakdown. That temperament is not adapted to the environment. Personality disorder in part arises when somebody develops these episodes, let us say depressive episodes and they develop a great deal of interpersonal difficulties after the episodes which eventually crystallize into more maladaptive behavior. That is called personality disorder and it seems to me that the best example of this is border-line; it is quite clear from all the available studies that the diagnosis of borderline almost always follows affective episodes rather than disease. Now I doubt if many of the concepts of personality disorder precede major mental disorder. In the anxious cluster, it is very hard to distinguish between an anxiety disorder and a neurotic disorder and a personality disorder; this is due to the fact that neurotic illnesses begin very early in life so the personality and the neurotic constitution is very much intermeshed with a personality and the anxious constitution is intermeshed with neurosis itself. If you find that panic patients are more dependent, it doesn't mean very much because that is part of their illness. By contrast I think that the evolution of schizotypic or paranoid personality in schizophrenia is up in the air because it has yet not been possible to follow up a sufficient large number of schizotypes

and show that they breakdown into schizophrenia; all the findings have been correlational or have been on the relatives so I don't know about that.

LT: With regard to the affective literature, is there any evidence to confirm whether the temperaments precede or not the actual disorder or if any kind of personality disorder exists before affective episodes?

HA: There are four prospective studies that have given rise to similar findings which are contradictory in some ways. The first study was done by Lindegård in Göteborg[22]. It's an epidemiological study and what he found was basically that the primordial personalities of the depressives could not be distinguished from sub-affective disorders. In other words, what was measured in one instrument as personality was in another instrument measured as subclinical symptoms. This is very interesting because it links with some of the work that Jules Angst (1926–) [23] is doing, studying brief recurrent depression which begins very early in life [24]. Angst is actually showing that there is something called brief recurrent depression which begins very early in life and it could be that the so-called personality style of the depressives is the result of these relatively mild symptomatic states. Angst still has not found much personality disturbance as such in the manic-depressive term. He saw that the persons with unipolar depressive illness were similar to the anxious patients but those with bipolar disorder did not seem to have any abnormality. Then Hirschfeld (1943–2023) [25] who studied the relatives of affective individuals, found that between those who had a breakdown into depression and those who did not, there is not much difference in the personality.[26] This was particularly true for the young whilst the elderly with some neurotic depression which had originated in their forties were more likely to be neurotic individuals. If depression begins at age 16 you were less likely to have the involvement of personality. Basically, these three studies are remarkable in not showing any major differences in personality. Why is that? In part it is true and in part it is because they are not measuring temperament which none of them measured and the two temperament relevant to manic-depressive illness are

[22] [a]. Nyström S, Lindegård B. Predisposition for mental syndromes: A study comparing predisposition for depression, neurasthenia and anxiety state. Acta Psychiatr Scand. 1975; 51: 69–76. [b]. Nyström S, Lindegård B. Depression: Predisposing factors. Acta Psychiatr Scand. 1975; 51: 77–87.
[23] Jules Angst. Swiss psychiatrist known for his longitudinal studies on depression and manic-depressive illness.
[24] [a]. Angst J. Recurrent brief depression. A new concept of depression. Pharmacopsychiatry. 1990; 23: 63–6. [b]. Angst J, Merikangas K, Scheidegger P, Wicki W. Recurrent brief depression: a new subtype of affective disorder. J Affect Disord. 1990; 19: 87–98.
[25] Robert MA Hirshfeld. American psychiatrist.
[26] [a]. Hirschfeld RM, Klerman GL, Lavori P, Keller MB, Griffith P, Coryell W. Premorbid personality assessments of first onset of major depression. Arch Gen Psychiatry. 1989; 46: 345–350. [b]. Hirschfeld RM. Major depression, dysthymia and depressive personality disorder. Br J Psychiatry Suppl. 1994; 26: 23–30.

hyperthymic and cyclothymic. These patients lack insight so a self-administered questionnaire is not going to indicate any abnormalities. The other possibility is that the findings are true, a lot of personality disturbances that are observed are actually nonclinical phenomena. Mainly after many episodes you develop a great deal of interpersonal differences that crystallize into the so-called post-morbid personality.

LT: Can we go back to the different bipolar expressions that you meant before? Do they go into what your describe as bipolar spectrum?

HA: The concept of the bipolar spectrum started very simply in the way that we observed that there were many individuals who had an extremely psychotic depression that was considered schizophrenic at onset yet who had a very classical brother or sister. It was quite clear that these extremes have to belong to the manic depressive spectrum. Of course, Kraepelin observed that, but many people doubted it but he didn't have these kinds of relations to back it up. Now there's a study from Europe – I forget the author – who found the same thing looking at siblings where one is schizophrenic and one is classical manic-depressive. There are lots of such families and then there was the Gershon (1952–)[27] study which showed that schizoaffectives came from manic depressive families of a more extreme form.[28] That was one of the observations; the other we had was that the bipolar type II patients were often in the families of manic-depressives and some of these although not all of them, ended up becoming bipolar type I. The third observation was that the cyclothymics whom we studied came from manic-depressive families and prospectively one third of them became full-blown depressive or manic. Then the most unbelievable thing happened; we were studying this temperament which was part of the bipolar spectrum according to these data and we had to treat these people with lithium because they were cycling. We then observed that we could see manic-depressives from different parts of the family. Here was the patient who was manic-depressive; the father had never been treated for anything, the father's mother and sister had been manic-depressive – now you would say that the manic-depressive illness was transmittable – there's nothing else on the other side of the family.

[27] Elliot S. Gershon, American psychiatrist, professor of psychiatry and human genetics at the University of Chicago, U.S.
[28] [a]. Gershon ES, Hamovit J, Guroff JJ, Dibble E, Leckman JF, Sceery W, Targum SD, Nurnberger JI Jr, Goldin LR, Bunney WE Jr. A family study of schizoaffective, bipolar I, bipolar II, unipolar, and normal control probands. Arch Gen Psychiatry. 1982; 39: 1157–1167. [b]. Goldin LR, Gershon ES, Targum SD, Sparkes RS, McGinniss M. Segregation and linkage analyses in families of patients with bipolar, unipolar, and schizoaffective mood disorders. Am J Hum Genet. 1983; 35: 274–287.

Obviously, the father was passing something and then we talked with the father and found that the father was an extremely successful businessman and it occurred to us that there was something there in his temperament that was adapting. This was not even leading to illness and that was the whole link with the creativity, so that in making the manic-depressive spectrum, we not only included the most extreme forms of the illness which had the extreme psychotic forms but we almost discovered the theory. Some of those patients were not even schizophrenic, they had recurrent mania and became chronic. There was that extreme which was not very common but there were patients with recurrent manias, with delusions of inventive genius who never recovered and became chronically manic. Obviously, they were not really in any form or shape schizophrenic forms. Then there were the schizophrenic types with mood oscillations; at the other extreme there were the milder ambulatory cases plus their relatives who only had different temperaments; there was nothing wrong with them except that they were a little bit temperamental and some of them were very successful. To me, the most interesting observation is that we actually had a rather important person to examine who was telling us he was dysthymic and who had never been treated except with some psychotherapy. When we saw him in his fifties, he mentioned he was having some difficulties, he was telling us that his father was manic-depressive, his brother was an extremely successful businessman, parties all the time, sleeps very little and was very successful, obviously hyperthymic. He was saying. "Why do I have the worst part of my father's illness – a depressive fall in a low-grade chronic patient – but my brother has the milder form of the mania in a chronic way and then he was manic-depressive?" To me, this is a very interesting phenomenon: two brothers received the same genes, yet one has a depressive temperament and the other one the hyperthymic. Basically, the bipolar spectrum comes from this basic idea I was telling you about the mood clinic. Kraepelin had some ideas about this but he was studying mostly the psychotic and other spectrums because he was working in a mental hospital. Instead, we were working in an outpatient ambulatory setting where we had the chance to observe everybody who came from the hospital and their relatives and all these patients were seen longitudinally and prospectively over time and we had a chance to interview and their relatives who were not sick. There was a philosophy in our clinic that we would not treat anybody unless the family members agreed to come because we felt that we needed their support for the sick individual so we had a chance to observe these relatives. So, it was this longitudinal approach with family history which was an application of Kraepelinian psychiatry. However, the setting had never been examined and I believe that because most American psychiatrists were struggling with this kind of person, on whom there was

very little data from systematic studies. I feel that our approach to these interesting patients really was very convincing to the American practitioner that Kraepelinian psychiatry had a lot to offer.

LT: Before you mentioned something about the difference between European and American psychiatry. Would you develop this point of view?

HA: It seems to me that European psychiatry, after having made brilliant discoveries in the last two hundred years, has somehow lost interest in its own discoveries and in this century especially after the Second World War. Maybe the war was such a shattering experience that people were no longer able to study these things or I am not exactly sure what happened. Maybe all the talents went to the United States at the time. I don't know but somehow European psychiatry did not continue, probably with the exception of the British and the Scandinavian who continued some of the European tradition. Another possible explanation is that European psychiatry is so hierarchical that it discouraged young people from entering the field and that the system of academic promotion in Europe further discouraged the young. So that the excellent traditions in European psychiatry could not be continued. It is not the tradition which is important; it is the ability to build on the tradition and come up with new ideas. The traditions were excellent but by themselves didn't lead to the next step of encouraging young people to challenge existing traditions and go forward. I think that that is true in the United States – as I have learned here – where you have the opportunity as a young investigator to disagree with the existing system. You may be totally wrong but people will let you explore your area. If you're wrong you change your idea or continue in the wrong way and nobody pays any attention to you after a while. However, if you have the chance to discover something, then people would take you very seriously and you can publish in the leading journals. So, people give you the opportunity to deviate from the classical knowledge and come up with new ideas, they give you the chance which I think European psychiatry is not perhaps giving. That's why I think the marriage between Europe and the United States would be very good.

LT: Might be your opinion influenced by your personal experience coming a foreign country?

HA: Coming from a foreign country to the United States was both exciting and at the same time difficult. Perhaps the difficulties help but they also handicap to some extent. I would say that it is a really hard question to answer because it’s so subjective in the one case but I would generally say that Americans are interested to know about other things – they do not get particularly unhappy if you do not agree with classical ideas. Actually, I would say that there is almost an encouragement to do so and

that innovative ideas can find some fertile ground on which to grow. Ultimately, however, the system is sufficiently conservative as not to let something too crazy to continue. There is some balance and some harmony but I think that there is greater flexibility and freedom to explore experiment and adventure if not viewed as being entirely negative, provided that it has some good rationality. I would say that on the whole my experience in the United States has been very positive from this point of view. Of course, not being born in this country has its own difficulties, problems of adjustment and so on, but perhaps being a psychiatrist, being very familiar with the language and to some extent with the culture – I went to America as a boy – I think that helped me to integrate into American life and eventually psychiatry. At the same time there was the capacity to observe from the outside. One could observe from the outside as well as from the inside which could be quite a useful perspective. It is somewhat of a problem from a personal point of view because it is not so pleasant to be both an outsider and an insider, but despite those difficulties, I think it gives a unique perspective for an observer.

LT: How did you end up here in Memphis?

HA: Should I answer that? The answer is very simple. I was told by the Dean of my medical school that, of the various places I applied to, I should come to Memphis. I asked him why and he said you have not moved away from your family at all and it could be easier for you to adjust to life in Memphis. He said that if I didn't like it, I could always move but by that time I would have adjusted to American life. He also told me that American psychiatry was kind of too much up in the air in most places and that in Memphis although it was not the greatest, not so famous, at least it was more solid. Memphis was not following any special fad, it was just ordinary classical psychiatry.

LT: Was it a more neutral place?

HA: It was indeed more of a neutral place; this was the idea. Actually, I didn't like Memphis that much, I left and went to Wisconsin but by mentor, Bill McKinney told me the same thing, that Memphis was more of a neutral ground that I could come here and be perhaps freer. I was once at Johns Hopkins and I was asked the question: "How come your work has been so influential in the field? You didn't go to Hopkins or Harvard; what is the secret of your success?" My answer was exactly because I hadn't been to all those places and I meant that sometimes for some temperaments, if there is an existing system of knowledge which is adhered to very rigorously, that could be a handicap. All those places have traditions and maybe traditions are not so good after all. I wanted a change or it

was too narrow, so I feel that here in this more neutral ground, I could develop on my own. I'm quite grateful to some of the people in my career like Dr. Winokur (1925–1996).[29]

LT: After so many years, what's your opinion of Memphis?

HA: I think that Memphis has been slow in developing but I think Memphis should make more use of its talents but it does not.

LT: I remember that years ago you mentioned what Memphis gave you besides the easiness that you found in the academy here. This place is not a big city; there are no special attractions but it gave you the possibility to concentrate better on your work.

HA: I think I said that more for Wisconsin which really was so cold in the winter that there was nothing else to do but to read and write. Medicine in Wisconsin was intellectually very attractive and in the long run I could have been quite powerful because there was so much excitement intellectually that one didn't know which way to go. Memphis was calm and there was relatively little to do culturally so that was a lot of time to work. That could be true but you must never forget that this was possible simply because my wife-to-be Kareen and I had met and I was being exposed to Europe and it wasn't just Memphis. Memphis was just the place where I used to live in the United States. I think that in these days air travel is so easy that it really doesn't matter where you live because there is so much movement that you can really be exposed to everything. There is literature, art, entertainment but early I wasn't constantly being exposed, politically exposed, to Europe. I would have got rather lonely and I was always in contact with the Washington people who encouraged what I was doing and that was very important because you can get pretty lonely. Finally, I must say that I had excellent colleagues who really were in the clinics with their continuous support and I really feel that that is the most important thing in a scientific world for somebody to have young students who can share and experience the patients' problems. The best thing in my opinion is to learn from a student and I would say this as a last point perhaps which should be of interest to a European. I once had a student and on the last date I was telling him that I was going to give him an A-plus. I asked him why he thought I was giving him an A-plus and he said: "Well, I have done the things you wanted me to do" and I told him that would earn him maybe a C. He said: "Well, I am very systematic and I read a lot"; and I said: "That would give you a B"; then he said: "Well, perhaps, I worked overtime and I participated in studies and I did

[29] George Winokur. American psychiatrist, expert in classification and genetics of mood disorders.

more than was required of me"; and I said that would give him an A minus and he still didn't know why I was giving him an A plus. He couldn't think of the answer and so I said: "I am giving you an A plus because you often disagreed with me, you just didn't take my word, you wanted to really challenge me." I think you as a European can take this message – I think this is in a sense very interesting because the European academic system, in literature, in philosophy, the European intellectual tradition as a whole even when outside the academic field is very much like this – it comes from Greece. Tradition is the debate and intellectual tradition has been very free in Europe and that is what makes the European thought so attractive – academically it's not so free which could be perilous so we have adapted some of the traditions. So perhaps you need to have a re-organization of tradition in Europe.

LT: Near the end of our interesting conversation, I really wonder what kind of temperament would help to become a successful psychiatrist and scientist.

HA: That is a tough question. Is this sociology? Is this medicine or physiology? What field is this? The ultimate question of how can people achieve their best potential is the kind of work my wife and I are trying to do. I don't know that there is an ultimate answer but I remember something she told me a long time ago. The ultimate challenge is combining art and science together – that really was something we should do together. Maybe the work we're doing together is that. If you look at it that way, then art is more intuitive and, in a sense also science is, but intuition is not enough, you need facts. I think it is a combination of the intuitive and the systematic, they are incompatible in a sense the two together but you need that kind of combination.

LT: I was trying to imply, considering that you are a successful psychiatrist and scientist and in view of the fact that temperament is so important in order to find your own resources, how would you describe your temperament?

HA: I would really think that introspection is a very careless method of scientific impulse and I will not answer the question.

LT: You mean that answering this question would require an introspective effort?

HA: Yes, that would mean that I have such great capacity of observation that I cannot interrogate myself. I don't think there is a magic formula. It has all to do with genes, with upbringing, with politics, publicity, chance. Of course, we've been talking about this all along, so there is no magic

formula but it's a combination of these things which is really hard to define. I feel that I would be doing injustice to the work I have done in my career which is to have systematically carried out studies on a large number of people, to answer this question because I have not studied this so I would not like to look at myself and answer this.

LT: The scientist comes back and speaks.

HA: I think that's a good way to finish our conversation. I have not known you very long but I have a sense that this might be a sort of philosophical book. You know what the best thing about this interview was? I thought the notion that European intellectual tradition and academic tradition are so far apart. I think that's the problem with Europe.

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