FRANK J. AYD, Jr.

Interviewed by Thomas A. Ban

Washington, DC, July 19, 2001

TB: This will be an interview with Dr. Frank Ayd, Jr., one of the pioneers of neuropsychopharmacology., for the Archives of the American College of Neuropsychopharmacology. We are in Washington, DC, at the Biltmore InterContinental Hotel. It is July 19, 2001. I am Thomas Ban

TB: Frank, we’ve known each other for a long time.

FA: That’s correct.

TB: I’ve followed your work since I started my residency in psychiatry at McGill in the late 1950s. What I would like to do now is go through your life and achievements. Let’s start from the very beginning: Tell us where you were born, brought up and something about your education and early interests.

FA: Well, Tom, I was born in Baltimore, Maryland, and I’m the son of a doctor. I had two doctors before me in our family. My father was a doctor, and, my grandfather, who was first a pharmacist but became later a physician. He was very interested in pharmacology. My father, originally, was a general practitioner but, ultimately, became a pediatrician and was fairly well known for his work in that area. My father had quite an influence on me. He was a very kind, soft-spoken man. I became an avid reader, partly, from his example and by his encouragement. I’m the oldest of five children. I have a brother, who became a Jesuit Priest, and as a Jesuit, ultimately, became president of one of the Jesuit schools and universities in Pennsylvania. I have another brother, who became an assistant to the mayor of the city of Baltimore. I have two sisters, who married and had families; they’re in the real estate business. So, you get an idea of the family. It’s a strong family. We all see each other fairly regularly, because we all live in Baltimore. I went to grammar school, a Catholic grammar school, in Baltimore, a Jesuit high school in Baltimore, and a Jesuit college in Baltimore. I also went to medical school in Baltimore. So, every bit of my education was in the city of Baltimore. I graduated from the University of Maryland when World War II was on. And, when I graduated from medical school, I, like all graduates, was given time, before called on active duty, to get some training in medicine. So I did an internship in a Catholic hospital in the city of Baltimore. And, when I finished that internship, I had applied for a residency in pediatrics. Now, you see my father’s influence, his example. And, the Navy gave me time to do all these before I started on active duty.

TB: Can we go back a little?

FA: Sure.

TB: What year did you enter college?

FA: Let’s see. I entered Loyola College in 1938 in Baltimore.

TB: What did you major in?

FA: Well, actually, I took a Bachelor of Arts degree, after I took science courses in biology and chemistry. At that time, I was not sure about whether I was ever going to go to medical school. I just wasn’t sure then. Truthfully, I was toying with idea that I might become a Jesuit Priest, and it was not an easy decision to make. I did make it, anyway.

TB: What made you decide to enter medical school?

FA: Well, I guess, in part, was the example of my father and the other doctors I had met through my father. I also had a conviction that I didn’t have a real vocation for the priesthood that has proven to be correct. I made my decision while at a Jesuit retreat house with my class before graduation. The retreat conductor or master was a priest from England, a very well known British philosopher. He looked somewhat like my concept of Ichabod Crane, physically. And, he started that retreat with an opening statement, which I have never forgotten. The statement was, “Gentlemen, there are two things in this world, God and yourself. Everything else is extraneous matter to be used by you for your salvation or your condemnation.” That was his opening remark of a two and a half day meditation on what your vocation would be. That convinced me that I really didn’t have a religious vocation. It was good for me. So, I immediately applied for medical school. The war was on. They needed more doctors. So, I was admitted.

TB: By the time you entered medical school you were married, weren’t you?

FA: My wife was a freshman a year after me, when I was a sophomore. And, I fell in love with her and she fell in love with me and we got married after two and a half years, because we couldn’t get any time off from school. And that was the beginning of the marriage that has lasted now fifty-seven, going on fifty-eight years. As you well know, it has been a very fruitful marriage; if you thought, there are twelve children. We now have thirty-two grandchildren and sixteen great grandchildren and two more on the way. And, we are all still staying together. Raising those kids, educating them was a challenge to work hard, get the money to pay tuitions and everything else. But, I have no regrets about that.

TB: I saw somewhere that you were active in the student body while in College. Is this correct?

FA: Oh, yes. I was very active in the student body and became in my senior year, the president of the student council at Loyola. That got me involved in the relationship between students and faculty and gave me some training in negotiating. It was worth the time and effort I put into it.

TB: Then, after College you entered medical school.

FA: Yes, I got to medical school.

TB: When did you graduate from medical school?

FA: 1945.

TB: And, what did you do after graduation?

FA: Well, I did my internship in St. Joseph’s Hospital and then I started my pediatric residency at the University of Maryland’s university hospital. But, then I was called up to active duty, because they needed more men. I, initially, was assigned to surgery in the Bethesda Naval Hospital. It was a big mistake; I have no manual dexterity, whatsoever. And, I said, “Oh, my Lord.” Fortunately, the commanding officer of the hospital was Admiral Hogan, who was Catholic. I’d met him on retreats down at the retreat house of the Jesuits, so I had no hesitancy going to his office and asking if I could see him. It was my first real introduction to how the military protects their big officers when his secretary said, “Well, who are you”? And, I said who I was. And she said, “Well, I don’t know. The Admiral is pretty busy. I don’t know if he’d have time to see you or not.” And, I said, “Well, just tell him it is Frank Ayd from Loyola.” She, begrudgingly, said “all right”. About fifteen minutes later, she came out and said, “follow me.” I went into Admiral Hogan’s office, and, we exchanged greetings. Then, he said, “What’s your problem”? And after I told him he said, “Well, we don’t have any pediatric services in the Navy right now. We have, what some people might call babies, but those are psychiatric patients.” Then, he said, “I’m going to send you up to Bainbridge”. Bainbridge was a naval base very close to the VA Hospital at Perry Point that was understaffed. This was at the time when the nationwide program started in which doctors were being sent to military bases and then loaned by the army or by the Navy to VA hospitals. It was a great experience, Tom, because there were about two thousand psychiatric patients and only eight doctors in the whole hospital that included the superintendent, the assistant superintendent, an internist, a surgeon, a dentist and a radiologist. So, you could figure out, that left two “psychiatrists” to take care of the psychiatric patients. You were pretty much on your own but you were given every opportunity to learn and practice. When I went there, Tom, to be perfectly honest, I had no ambition to become a psychiatrist. But, after six months there, I began to realize that there’s something very intriguing about psychiatric patients. Let me give you one of my experiences. It was a bitter cold winter night, and as you might know, Perry Point chucks out into the Chesapeake Bay. I was the officer of the day and I got a call from someone from one of the wards, telling me that a patient had escaped from the shower. My immediate response was, “I wouldn’t worry about him. It’s so damn cold. He’ll be back in another fifteen minutes.” All of those attendants, actually, were farmers and when they couldn’t farm, they worked at the hospital. And, he said, “Doc, you don’t know these people. If we don’t find him, he’s going to be an icicle.” So, we started the search and found him. He was pretty blue and pretty hypothermic, but he revived and that was it. He could have died. And, you would think that the pain that was caused by the cold would make him come indoors. It didn’t. So, I began to wonder about what makes these people so different.

TB: It was a real learning experience, much more than anyone could convey in a class.

FA: Oh, yes. I had another patient who stuffed herself with newspapers and then ignited the papers. I got called over, and, when I arrived she was just sitting there responding to his hallucinations, and was not complaining of any pain or anything else. He had, I guess, twenty percent of his body badly burned; second and third degree burns. And, I didn’t have to give her opioids or anything else for pain. He never complained of pain. So, I learned that schizophrenics have decreased pain sensitivity. That was for me a very important observation. So, I began to become extremely interested in schizophrenia.

TB: Did you decide by that time that you would become a psychiatrist?

FA: Yes, I did decide by that time.

TB: Can you remember the different treatments you used in those days?

FA: Oh, yes. Bromide was still used and we had patients get bromism from being overdosed with bromides. Barbiturates were used a lot. Paraldehyde was also used a lot. I hated the smell of it. We used in those days insulin as well. We had our share of fatalities with insulin. If you had experience with insulin coma therapy you know that you have to be extremely careful because you can easily induce severe, perhaps, irreversible hypoglycemia.

TB: So, you became involved in treating psychiatric patients with drugs and insulin coma?

FA: That’s right. And, then, of course, I got involved with ECT. I tell you, Tom I was convinced that ECT was a great treatment. When I was doing my internship I had seen some patients who got ECT and I saw the kind of “awakening” that Oliver Sachs described with L-DOPA in Parkinsonism after three or four treatments with ECT. And, at Perry Point, I seized the opportunity to get experience at administering ECT.

TB: Was ECT at the time still administered without muscle relaxants?

FA: What you needed was a couple of strong men to hold the patient down and a very firm pad under the back to arch it to reduce the risk of spinal compression. You, also, needed a rubber mouthpiece to keep the cheeks from being damaged or the jaw dislocated. We didn’t have at the time a safe, short acting barbiturate that could rapidly induce anesthesia. That was introduced after I was out of Perry Point. I was already in practice when I was asked by a company to take a look at an IV anesthetic, which they said, on the basis of animals studies, was of short duration and rapidly induced anesthesia. It was sodium barbital. I administered it to a series of patients prior to ECT, and it seemed to work.

TB: Are we talking about the early 1950s?

FA: That’s correct, yes.

TB: What did you do after Perry Point?

FA: Well, Tom, by this time, I had children. I had to get out and get more money than the Navy was paying me. That was for sure. To increase my income, I went into practice. But it takes a couple of years to start a practice; to become known by your colleagues and get referrals. So, I, also, had some GI Bill of Rights for education I could capitalize on. So, I went back to the University of Maryland. It happened that I liked, very much John Kranz, the pharmacologist there. And, I took the course, John Wagner, a pathologist was offering in neuropathology. It was a one-year course and I used to go down to attend the course during the day and see patients in my office at nights.

TB: So, by 1951, you had opened your practice?

FA: That’s correct.

TB: Did you also have an academic appointment?

FA: Oh, yes. Even while I was at Perry Point, I taught psychology at the Catholic University in Washington, DC. Then, my alma mater, also, asked me if I would head up a small department in psychology. And I did that for about two or three years, I think, until they got a full time man with a PhD in clinical psychology.

TB: Didn’t you present your first paper in those years?

FA: Yes, it was around that time. My first paper in a medical journal was my first report on chlorpromazine. I presented it at the Southern Medical Association’s annual meeting, which happened to be in St. Louis that year. It was the first paper on chlorpromazine in this country presented at a national meeting.

TB: Didn’t you publish a couple of articles prior to your paper on chlorpromazine?

FA: Oh, yes. I had already published before in one of those throwaway magazines. They were commentaries, on topics, as for example, “The Lack of Pain Sensitivity in Schizophrenics,” and things of that sort.

TB: Didn’t you got involved in the care of psychiatric patients in a general hospital setting in those years??

FA: Oh, yes, absolutely.

TB: Weren’t you one of the first in the United States who practiced psychiatry in general hospital setting?

FA: That’s correct, Tom. That is correct. And, again, I was very fortunate that the first hospital, a general hospital, that allowed me to have psychiatric patients admitted to my service, was St. Joseph’s in Baltimore, where I had done my internship. My father had been on the staff at that hospital, I don’t know for how many years, he was probably for forty years there. So, the nuns were very gracious and the chief of medicine, of course, trained me during my rotating internship. And I started doing ECT there and admitting inpatients. That was feasible. In those early days when chlorpromazine came along I had to train the nurses and the interns, and, also, had to educate everybody about that psychiatric patients are not as dangerous as people might think they are. It worked. There was only one suicide I had over ten years on my service at St. Joseph’s, Bon Secour’s, St. Agnes’, and, Mercy Hospitals. All these were Catholic hospitals, where I had admitting privileges. And, one also learns fast. I had a patient, a very cunning patient whom I had on suicide watch. I had a nurse assigned to the patient to watch her, constantly. Well, when it was quiet on the ward, as night began to set in, she asked for a drink of water. The nurse gave it to her and then she dropped the glass on the floor. The nurse went out to get a mop. When she came back in, the woman had gone out the window, and she died. Most of the patients who were admitted were depressed patients, who were not seriously suicidal. If they were, we had extra precautions taken for them. Many of them, I gave ECT, because I was convinced of the value of ECT, particularly, in suicidal patients.

TB: So, you used ECT extensively? Weren’t you a member of an ECT Society in those years?

FA: Oh, yes. It was called the Electroshock Research Association. It had many very fine people. I who met in that Association. Lothar Kalinowsky and David Impastato from New York, Howard Fabing from Cincinnati, George Ulett from St. Louis. I, actually, went to Howard Fabing and Doug Goldman in Cincinnati to spend with them a week. As you know, Doug Goldman, was a board certified internist, psychiatrist, and electroencephalographer. These were wonderful people to be literally tutored by. I’d stayed in their home; they opened their door and welcomed me in. So did Lothar Kalinowsky who couldn’t have been kinder to me.

TB: So, you were taught ECT by Kalinowsky?

FA: Oh, yes. I watched him and he taught me different techniques with respect to electrode placement and so on.

TB: I suppose this happened before he wrote his classic text on ECT.

FA: Yes, a few years before that. . It became clear to me that administration of a muscle relaxant was very desirable, because you could avoid fractures. And it was also clear that it was preferable to administer it with a short acting rapidly metabolized anesthetic. As I mentioned it before I did a clinical study with sodium barbital before, and, I presented the results of that study at an annual meeting of the Electroshock Research Association. It was well received. I got one of the two prizes of the Association for my paper.

TB: How did you get to the idea of giving a muscle a relaxant prior to ECT?

FA: Well, I had met Bennett later at an APA meeting in San Francisco, and we ended up becoming friends. He had just started his pioneering work with succinylcholine around that time and, I watched him administer the substance a couple of times. He had me do it under his supervision. It was marvelous to see how it worked. If you gave it too quick, the patient would stop breathing on you, and, that could be frightening. So you have to be very prudent in the administration of it. But, it mixed very well with barbital sodium. It focused my attention on drug-drug interactions, because if you didn’t do it right, instead of helping you could harm the patient and scare yourself. That’s for sure. I felt it was important that patients get this combined treatment prior to be given ECT. I took sort of interest in this treatment and went out, talked and wrote about it.

TB: How did you get involved in psychopharmacology?

FA: Well, I was in private practice, OK? And, in private practice, you make a commitment to a patient that you are going to provide the best possible care you can provide that will offer them alleviation from the suffering that is so concomitant with psychiatric disorders. We had a definite effective treatment for depressed patient in ECT. So, I thought if we could use succinylcholine with barbiturates we could make ECT an even safer treatment. As it was why not to try other drugs in the treatment of psychiatric patients. It so happened, that a Squibb representative, who used to call on my father, came to see me. I was using my father’s office at the time, because I didn’t have enough money coming in to pay the rent for somebody else’s office. We started chatting and he asked me what I was doing. I told him what I was doing, and about my interest in using medication in treatment. So, a couple of weeks later, I got a phone call from Squibb, from a doctor at Squibb, who wanted to come down to see me. That sounded interesting. He came to see me with a product he called mephenesine that had muscle relaxing properties. He was looking for someone who would be willing to explore it, as a possibility of using it as an anxiolytic, muscle relaxant in the treatment of neurosis. So, I thought, well that sounds interesting. And after reading the information they had on the animal data they had, and found that it looked reasonably safe, I said, OK. I did a study with the substance, and, found that it was practically a dud. It had some sedative properties, but did nothing really in alleviating the kind of tension that the severely ill psychiatric patient has. So, I gave a narrative report on my findings to the company that was never published. They told me right off the bat that based on my report, plus of one other person’s report, they had decided that there was no market for this compound. But, that identified me as someone who is interested in working with new drugs. It’s amazing how the word gets around in the industry. And, the next drug that I ever agreed to do a study on was chlorpromazine. I got a phone call from a Dr. Bill Long. Bill Long’s Jesuit brother was a principal at the high school that I attended and he mentioned to Bill Long my interest in drugs. And, Bill called me that he had a drug from Rhône-Poulenc in Paris and would like talk to me about it. So he came to Baltimore, and, I’ll never forget it, he had samples of 10 mg. tablets of chlorpromazine with him. You’d have to give a full bottle to get some effects from it. But, I tried the drug and had initially some unhappy experiences with it. The first patient I gave chlorpromazine was in a general hospital. He was a very tense, obsessive-compulsive guy. I put him on a relatively low dose but still in two days he got jaundice. The nurses called and said, “Your patient is yellow”. I went in to see him right away. I was never convinced that, actually, chlorpromazine was responsible for his jaundice because when we admitted him to the hospital for his obsessive-compulsive disorder, he, also, had fever, and some malaise. So, we just withdrew the chlorpromazine and waited until the storm blew over. It cleared up spontaneously. . But, then, I had a patient, whom I had been seeing by then for about two years, and ten days after I put her on chlorpromazine when she came back to my office, Tom, she was as jaundiced as she could be. So, I said, “Oh, Mary, how long have you been like this”? And, she said, “Oh, it’s almost ten days, doctor”. I said, “You stopped the medicine, didn’t you”? And she replied, “Oh, no, no, it’s helping me and you’ve been so kind trying to help me, I just kept taking it”. I learned one thing right off that you don’t necessarily have to discontinue chlorpromazine when a patient gets jaundiced. In fact, I kept her on it because she had some very imminent relief. I had known her for long enough that I could see definite changes in her condition. And, she agreed to continue on the medication. The family also agreed. We never altered the dose, and the jaundice went away. She continued to improve, and, then, finally, the chlorpromazine was stopped.

TB: So, you got your chlorpromazine directly from Rhône Poulenc. Most investigators in the United States got it from Smith, Kline & French. It seems that the first patients you treated with chlorpromazine were not schizophrenics.

FA: They weren’t. You don’t see that many schizophrenics in private practice. I had at the time just gotten admitting privileges at Taylor Manor hospital, a private psychiatric hospital. Most of the private patients don’t go to be treated in private hospitals for schizophrenia, unless they are very wealthy, because they would need to stay there a long time. Most of the patients admitted to private hospitals are bipolar, hypomanic or manic patients Schizophrenic patients are admitted mainly for a short time to control their agitation and aggressive behavior, or that sort of things.

TB: When was your first paper on chlorpromazine published?

FA: It was in 1955.

TB: By the time you published your paper on chlorpromazine you probably started your studies with reserpine?

FA: Yes.

TB: Where did you get the reserpine from?

FA: I got it from CIBA.

TB: From CIBA?

FA: Yes.

TB: By that time, of course, they knew that you were interested in drugs?

FA: Oh, yes, yes. I’m trying to think, now, who contacted me first. I believe it was Jack Saunders. But it could have been someone else from the medical department of CIBA. Saunders, ultimately, left them and went to Rockland State Hospital to work with Nathan Kline. Reserpine was not as dramatic a drug as chlorpromazine. It took time to take effect. It, also, frequently caused unpleasant side effects, gastrointestinal disturbances, vomiting and, so forth. Many patients just wouldn’t take it, consistently. Yet, if you had a patient, who tolerated it and took it faithfully, it was very definitely a positive drug. It was nowhere near as positive as chlorpromazine, in terms of antipsychotic effects.

TB: You were among the few who reported on both, chlorpromazine and reserpine. You might have been the only one in the USA who reported on both.

FA: Nate Kline had reported on both as well. So did Al Kurland at Spring Grove State Hospital in Baltimore. Al did a study on chlorpromazine about the same time I was doing mine but he did not get on the program in St. Louis where the first chlorpromazine studies in the United States were discussed. And, then, outside of Maryland, Doug Goldman was doing a study with chlorpromazine in Cincinnati. As a matter of fact, Doug attended the meeting in St. Louis and in a discussion of my paper, he got up and asked me if I’d had encountered any agranulocytosis with the drug. And, I said, “No, I’ve heard that that it occurred in Europe, but I’ve not had any trouble with it”. It turned out that he had two cases. I had some patients who developed agranulocytosis on chlorpromazine as time went on. Doug was a very astute observer.

TB: You were among the first to publish on chlorpromazine in North America. The first, I think, was Heinz Lehmann.

FA: Yes, it was Heinz’s paper from Canada the first, and, subsequently, I presented my paper. Then, a paper was published in the JAMA. It was written by someone in Texas, I can‘t remember his name now. He got published first, but my presentation preceded his publication. And, of course, Fritz Freyhan, at Delaware State Hospital, and Bertrum Schiele were working with the drug also. In a very short period of time there were many people working with chlorpromazine. It really exploded.

TB: There were much less people involved with reserpine than with chloorpromazine.

FA: Very few people did much with reserpine, because there was a big controversy over whether or not it produces depression. . I mean, there were lots of people who did become depressed on reserpine but this didn’t alarm me, because I was never sure that it was really drug induced. In my office, of course, I was concerned whether it would be safe to give ECT to depressed patients whose hypertension was treated with reserpine. That’s when I called on Lothar Kalinowsky and David Impastato in New York, and Leo Alexander in Boston. What became evident to me was that depression often carries with it hypertension, and as soon as the depression goes away, the hypertension disappears without any particular treatment for it. As a matter of fact, I did a follow up study on a large number of patients, who allegedly had reserpine induced depression and the follow up showed that there was no substance to that. There were many people who took reserpine as a prophylactic medication even though they were well, and did not become depressed again. There was a long hiatus after they stopped taking reserpine before their next depression started. So, they were having cyclic episodes of depression. On the other hand, if the patient is vulnerable to depression, it’s possible, that reserpine could bring vulnerability for depression to a reality. The results of treatment with reserpine were not sufficiently good to justify the risk of using it. So, it fell by the wayside, as you know. However, it’s still on the market after fifty years as an antihypertensive. And, if you look into the data, it did not cause an unusually high incidence of depression among the people who were treated with it. So, it’s not a bad drug, but it’s not a desirable drug.

TB: Did you use yourself reserpine in low dose in hypertensive patients in your practice?

FA: Yes, and it worked. I never had any problem with depression in my patients treated with reserpine.

TB: You used to report adverse effects with psychotropic drugs before anyone else but had no trouble with reserpine. .

FA: Correct. Nate Kline gave me the name, “Dr. Side Effect”.

TB: Oh, did he?

FA: Instead of “Dear Friend”, he used to write me, “Dear Side Effect, I’ve just read your latest report. Is that all you’ve got to do is to look for side effects”?

TB: You published a couple of reports on the side effects of chlorpromazine?

FA: Yes. I reported on jaundice with chlorpromazine. I also reported on the gastrointestinal and vascular side effects of reserpine.

TB: I think you also reported on fever in chlorpromazine treated patients.

FA: Oh, yes. I tried to report, honestly, everything I saw. In fairness to the patients, you have to make these things known, so the other doctors can say, “Look, there is a risk with this, and, get their informed consent for treatment”

TB: You also reported on generalized hypersensitivity to chlorpromazine.

FA: And, of course, I reported very early on extrapyramidal symptoms with the drug. I had one patient, a young woman with bipolar disorder, who was put on chlorpromazine for her euphoria, agitation and irritability, and developed a very acute dystonic reaction. I filmed her. You can’t convince people about some of these reactions, without showing them. I filmed this patient and sent my film to Smith Kline & French. They looked at it and sent it to their consultants, but none of them had seen this reaction before. They got all kinds of opinions that it was hysteria, some kind of toxicity, and what not. And, then, Smith Kline arranged for me to go to the annual meeting of The American Academy in Neurology in Atlantic City, and to present the film there to a committee of five expert neurologists. They agreed that it was a dyskinetic reaction, but they didn’t know what caused it. But, even after that many people thought that it was a hysterical reaction in a neurotic woman.

TB: In the late 1950s, in addition to your practice were you not also the acting director of a psychiatric service in a general hospital?

FA: Yes, I became Chief of Psychiatry at Franklin Square Hospital..

TB: Your work in those years was recognized nationally.

FA: I think that’s correct.

TB: You received a distinguished service award….

FA: Oh, yes, I had gotten that.

TB: You were recognized as the Outstanding Young Man of the Year.

FA: Yes. Well, it so happened, that I was nominated for it. It started with a newspaper report after a presentation I had made in Atlantic City at an APA meeting. The Associated Press covered the event. Then, the executive director of the Mental Health Society in the United States, a former newspaper man from Oklahoma, contacted Nate Kline, Henry Brill and myself about testifying in Washington, at a congressional hearing, on psychiatric illnesses and their treatment. I agreed, and the three of us went to Washington and testified. I got a lot of publicity because I took the position that if one wants to save money in patient care one would need to use chlorpromazine. I pointed out that successful use of chlorpromazine costs so many cents a day whereas untreated illness costs so many dollars more a day. I, also, made a plea for the coordination of activities in drug treatment. I felt that the government should collect, analyze and summarize the data on drug treatment and the findings should be taken into consideration in handling the problems of the psychiatrically ill. We do that for diabetics and we do that for epileptics. Why can’t we do it for psychiatric patients? To make a long story short, they appropriated the money that was needed for the establishment of the Psychopharmacology Service Center. And, then, Jonathan Cole was appointed as the first director of PSC.

TB: You had been involved in studying many drugs including methylphenidate. Could you tell us something about your research with them?

FA: Well, in so far as methylpenidate is concerned, my dad was a pediatrician, and like all pediatricians, he had his share of ADHD kids. And he did what most pediatrician did, treated them either with a sedative drug, like liquid diphenhydramine, or methylphenidate. Regarding diphenhyrdamine, I often wondered how much of its effect was due to its alcohol content, and how much was to the sedative effects of the drug. In so far as methylphenidate was concerned I was contacted because people knew that I was interested in working with drugs, and also because they thought that I could get patients from my father. So, I did a study with methylphenidate and showed that it was effective not only in children and adolescents but also in some adults. As you know, there are adults who have ADHD. I had some among my patients. In appropriate doses methylphenidate is clearly an effective drug, even if not for all, but for a substantial proportion of ADHD patients.

TB: Did it create for you any problem in working with children?

FA: You know, I did a residency in pediatrics.

TB: Yes.

FA: And beside that I also saw pediatric patients with my father. He did house calls. He was a real old time family doctor who was a specialist in pediatrics. And, then, I saw my share. When I started to work with methylphenidate, I had no trouble getting patients, because a lot of the pediatric guys in town knew me as a resident in pediatrics before the Navy called me up. And, I just called a couple of them and said, “You know, I need some patients and there will be no charge for the medication and for my service”. Well, you know what that meant; I got a lot of referrals. It didn’t take very long to see that methylphenidate helps. I also recognized soon that it has less risk for abuse and dependency than amphetamines. I became very convinced about that. You might remember, some years later; I think you were with WHO at that time, Sweden raised concerns about the dangers of methylphenidate. I remember the meeting held in Geneva that dealt with the Swedish concerns. Leo Hollister was there, representing the United States, along with, I think Sid Cohen.

TB: Yes. Then you also did some research with meprobamate in the 1950s.

FA: Yes, I did. I used meprobamate primarily in epileptic children. I was asked to study whether meprobamate has anticonvulsant effects. So I did a study and found that it has some anticonvulsant effects in epileptic children. The seizure rate would go down, but it would depend on the type of seizures the kid had. It was not a very potent drug for severe and frequent grand mal seizures, but, for minor epileptic episodes, it could be beneficial. I say, could be, because some of these children can go for weeks without having a darn thing even if they’re taking a placebo. Meprobamate so, in my judgment, is an effective drug and has helped lots of people. I’m not talking now just about epileptics; I’m talking about people with anxiety states or co-morbid anxiety and so on; it would alleviate anxiety. Unfortunately dependency on meprobamate became a real problem because doctors used it like candy. You can’t do that with the kind of drug meprobamate is. The limitations of meprobamate became more and more apparent with the advent of chlordiazepoxide. When Librium (chlordiazepoxide) was released for clinical use, it was quite clear that it would be a real competitor of Milltown (meprobamate). Nevertheless my first paper on chlordiazepoxide was a report on my negative findings with the drug although it was effective in controlling some of the symptoms of my patients.

TB: So you had a practice that allowed you to study drugs in all kinds of psychiatric populations.

FA: Yes, I had a practice in psychiatry that was kind of a general practice in psychiatry. I had some training in pediatrics, so I wasn’t too concerned about children. I, also, had enough sense to know that if something was out of my area of expertise.

TB: There were very few people in those years studying drugs in children.

FA: That’s true. There were very, very few people doing it, very, very few. I never identified myself, deliberately, as a psychopharmacologist in pediatrics; although, I’ve done my share of it and I’m still doing some work in children.

TB: And, you, also, did some early work with perphenazine in the aged, right?

FA: Oh, yes, yes, that’s right. My first paper on perphenazine was on its’ value in the elderly. Perphenazine was an interesting compound. So, was thioridazine, which on a milligram for milligram basis was a very weak drug but it didn’t cause much extrapyramidal signs. It is not true that it is totally free of EPS If you gave the right dose, you could make patients stiff as a board. So, on the other hand, chlorpromazine had more sedative effects than thioridazine, caused more EPS, weight gain, hypotension. And what was the difference between those two drugs? It was a difference in the structure of the side chain. Thioridazine was introduced before perphenazine. Another phenothiazine introduced before perphenazine was Compazine, a very good antipsychotic drug.

TB: Prochlorperazine?

FA: Yes, prochlorperazine..

TB: In Canada it was available as Stemetil.

FA: Stemetil, that’s right. So, at any rate, then along came perphenazine. It had all the assets of chlorpromazine but did not have as much anticholinergic and sedative effects. Unless you gave a fairly high dose, you didn’t get much in the way of EPS and so on. It looked as a substance that is going to be a good drug for the elderly, because you’re not going to get the cardiovascular side effects that you would get with with the other phenothiazines available at the time. And, it was compatible with medications that elderly people took for co-morbid medical illnesses, such as diabetes, hypertension, cardiovascular disease, etc. After doing the original work I suggested to Schering, the company that had perphenazine, that we put together a team to study it. And with their authorization I put together the team. I called Nate Kline, and got him involved, and I got also Bert Schiele involved. It was the three of us. I gathered enough data for submission to the FDA. Then we had a meeting in New York and we presented all the data we had. Perphenazine differed from the other phenothiazines by its side chain and became a very widely used drug. But still, it didn’t have quite the kick for the schizophrenic patient or the severe manic. So, that led chemists to twist things further around, and with a fluoride atom added, to synthesize fluphenazine.

TB: So, you were much aware of structure activity relationships and tried to translate even minor molecular changes into clinical effects.

FA: Right. And, I gave a paper at the 1st CINP congress in Rome on Structure Activity Relationships with Antipsychotics. I covered twenty-three different antipsychotic drugs.

TB: Did you work with all available phenothiazines for clinical studies at the time?

FA: Oh, yes, with all the available ones that could be studied.

TB: In 1956, you went overseas to visit some European centers in psychopharmacology. How was that arranged?

FA: There were seminars organized by European pharmaceutical companies, like May & Baker in England, Rhône Poulenc in France, and CIBA, Geigy, Roche, and Sandoz in Switzerland and they invited experts from the USA to participate. I was invited to meet also with their personnel and I met with personnel from each one of the companies. These were pharmacologists, physicians, who were dealing with other doctors and getting them involved in clinical investigations and what not. We were advising them as to possible clinical applications of compounds based on animal data .I was convinced, Tom, that there was a dire need for better communications between psychiatrists in the world, not just in the United States. You were in Canada. You know, that sometimes, what you call schizophrenia would have been called mania in the United States or vice versa. And, as a matter of fact, there was a study done involving patients in London and in New York, which showed that there was good reason for saying that this is a problem. And, in the course of having lunch with these people at these different companies, I brought up this concern of mine. There has to be some kind of an international organization so that when a guy in Switzerland says, “This is schizophrenia”, and presents his criteria, it’s comparable to the criteria that we might be using in Baltimore, Maryland, and so forth. Because, to read an article that says, this drug is good for schizophrenia, to me, meant nothing, because there were no real criteria for the diagnosis of schizophrenia. After I finished my stay in Europe, I came back home, and, subsequently, I got a phone call from Switzerland about having a symposium in Milan, to discuss the possibility of establishing a college in the field. I was honored for being invited and I attended it. It was a very good meeting. Out of that meeting came the CINP.

TB: So this symposium took place about a year after you returned from your trip in Europe attending seminars organized by drug companies? Am I correct?

FA: You are correct.

TB: You already met on your first trip many people from different European centers.

FA: That’s correct. I got to know, pretty much, the leading people in Europe.

TB: Can you mention a few by name?

FA: Well, Paul Kielholz, Jules Angst and many others. I talked with these people, had dinner with them, so I was learning about what they did and returned home optimistic about what was going on.

TB: If I remember correctly you went to Milan, on your second trip to Europe, with you family.

FA: We went to Rome, first.

TB: You went to Rome, first?

FA: That’s correct.

TB: Could you tell us more about that second trip?

FA: Yes, I’m proud of it, Tom When the invitation came for the Milan meeting I realized that the date of the symposium was just around the time when one of my daughters, Theresa was supposed to have her First Holy Communion. So I told my wife, Rita, I don’t know whether I can accept the invitation. Then I got a date for the Holy Communion that did not conflict and I accepted the invitation to attend. Well, that was in the fall, and this was to be the next spring. On Christmas Eve, the pastor of my parish had a heart attack and died. So, my wife said, “What are we going to do”? I said, “We’ll wait until the new pastor is appointed and see what happens”. So, the new pastor was appointed and I went down to see him and asked him when he thought the First Holy Communion was going to be and he said, “Don’t ask me. I don’t expect to be here more than six weeks. I’m a temporary pastor, as far as the Cardinal, or the Archbishop is concerned”. Sure enough, about six weeks later, the new pastor was officially appointed. I went down to see him and he was going to change nothing, so the Holy Communion was going to be on a date that would conflict with the symposium. So, after I came home and told that to my wife she asked, “What are you going to do”? I said, “I’m going to write a letter to the Holy Father”. She said, “What are you going to do that for”? And, I said, “Well, he’s the Bishop of Rome and he would be the one who would have to authorize her First Holy Communion in Rome”. So, my wife said, “You think he’s going to answer”? I said, “All he can do is say, ‘No’”. Well, weeks go by and no answer and it is Holy Week, now it is three weeks before the meeting in Milan. I was in Los Angeles addressing pediatricians on the use of psychotropic drugs for behavior disturbances in children, when I was handed a message, “urgent call, call your wife immediately”. So, I stopped the lecture and went out and called my wife and she said, “We’ve heard from the Pope”. We should be in Rome on Good Friday. This was Tuesday before, and I was in Los Angeles. And I said to her, “Meet me in New York. I’ll change my ticket and we’ll go over”. We arrived there, Good Friday, as requested. And, of course, you don’t do anything on Good Friday, but Holy Saturday morning, we went to the Vatican. I presented the credentials that had been sent over by the Apostolic Delegate from the Swiss guards, and we met the man from the Secretary of State’s office, who is now one of my closest friends, and he told us of the arrangements. Now, that the Pope agreed to my daughter making her First Holy Communion in Rome, we are to be his guests for a week. For Easter Sunday, we had special seats up in the left cannonade there and our daughter was to make her First Holy Communion on Wednesday. It would be in St. Peter’s at the altar of St. Pius X, who’s the patron saint of first communicants, and mass would be held by the Carmelite Fathers, since Theresa was a Carmelite. Everything was carefully thought out. Before the First Communion we were to have an audience with Pius XII, but the night before, we got a phone call from his secretary saying, “Have to cancel for tomorrow, because Prince Rainier and Grace Kelly are coming”. And, of course, heads of states are given priority. So, we were brushed aside. Two days later, we, then, had a proud audience with Pius XII and he gave my daughter his zucchetto, his little white hat. He had tremendous interest in medicine, Tom. He wrote more on medicine than any Pope in the history of the church. And, I told him I was going to Milan, and wanted this First Holy Communion in Rome. And, so, he was interested in what’s this meeting about in Milan, and I told him. Well, he said, “Once over, let me know what’s happened”. So, I said, “OK”. So, before we got to Milan we got an invitation to his birthday party. We had a great time. And the next day we got off to Milan for the meeting. I’m human, Tom. To me, that was the most exciting thing that had ever happened to me and, obviously, I told people about it.

TB: So, you went from the Pope to the psychopharmacology symposium organized by Garattini that lead to the founding of the CINP. But wasn’t there also another meeting, independent of the one in Milan, where the need for an international organization was discussed?

FA: Well, yes, there was one that was supported by CIBA. The one organized by Garattini was a scientific symposium where I gave a paper on the Use of Antidepressants in Children.

TB: Can you tell us something about the other meeting, the one sponsored by CIBA?

FA: It was organized by people in Europe, who were active in the field of psychopharmacology. Paul Kielholz played a big role in it. I don’t know whether Jules Angst was there. I think he was, but I’m not sure. And the professor from Vienna, what is his name, was also there.

TB: Hans Hoff

FA: Yes, Hans Hoff, from Vienna.

TB: What about Otto Arnold?

FA: Yes, Arnold was there.

TB: Frank Fish?

FA: Yes, Frank Fish from Liverpool was there. .

TB: Michael Sheppard?

FA: Oh, yes, Mike Shepherd was there. Many of the leading psychiatrists of Europe were there. Still, it was not a scientific meeting but a meeting to discuss whether to have an organization that would set up standards in the new field, etc, a kind of organization as the ACNP here is now. It was decided that there is a need for such an organization and, what is his name, was asked to help setting it up.

TB: Ernst Rothlin?

FA: Yes, Rothlin. There was then, another, meeting that was held in Switzerland during the time of a congress…

TA: The 2nd World Congress of Psychiatry.

FA: That’s it. You got it. The founding meeting of the CINP was held in a restaurant at the railroad station.

TB: The dinner, at the Zurich railway station, was organized by Rothlin. He hand picked a number of people and invited them to attend.

FA: Exactly. I give a major paper at the Congress, and attended Kuhn’s historical paper on imipramine, but was not invited.

TB: Did you attend Nate Kline’s psychopharmacology symposium at the Congress?

FA: Yes. People by that time were beginning to realize that we could not go ahead in a haphazard way any longer in psychopharmacology. It was worse than the Tower of Babel. And that was not good.

TB: So, you participated in the 2nd World Congress of Psychiatry in 1957, listened to Kuhn’s first paper on imipramine and attended Nate Kline’s symposium at the Congress, but were not invited to attend the founding meeting of CINP.

FA: And, Heinz Lehmann, Fritz Freyhan, Doug Goldman were not invited either.

TB: But then you attended the 1st Congress of the CINP in Rome.

FA: Oh, absolutely, in Rome.

TB: I’m sure you remember, very well, the meeting in Rome, because it had important…

FA: Well, it was very important because the Pope addressed the Congress, and, in a sense, strongly endorsed psychopharmacotherapy. He strongly endorsed the concept that psychiatric patients are ill. That mental illness is not imaginary, etc. To have a world leader, with his influence, say these things was very, very important.

TB: How did the Pope get invited? Did you have anything to do with that?

FA: How did he get invited?

TB: Yes, how did he get invited?

FA: Exactly who invited him, I don’t know, because I was not at that meeting in Switzerland at the railroad station, you see. However, I knew he was going to address the Congress because I had my own contacts at the Vatican. The Holy Father had a policy of writing his own speeches. He seldom used a speechwriter. He was a very educated man. To a certain extent, he had some obsessive features. And, I was asked to provide reprints of some of the better articles in the field, so that he would have a picture of what psychopharmacotherapy was all about. I provided those. He wrote his paper. He gave his paper in French. So, I couldn’t follow him very well, but it didn’t take more than a couple of hours to have an English translation. After that, I saw the Holy Father a couple of times. At one of my audiences with him, he asked me if I’d be interested in working at the Vatican. And I asked, “What am I going to do as a psychiatrist there?” To make a long story short, the answer was, “Well, I want the Vatican to be looked upon as a place that knows what’s going on in the medical world, in the scientific world, that people see that we are not sitting up somewhere. I would like you to teach for us; we have the Vatican radio and you could broadcast on the Vatican radio.” So, I said, “Well, your Holiness, you know, my wife and I are expecting another child”. He said, “I understand. You talk to your wife and let me know what your decision is”. So, I prayed about it, talked about it and made a decision that I would take the job. Now, it was not a full time job in the sense of ten hours a day or anything like that. The programs were taped often in advance. And, so, classes were set up. I taught on Mondays and sometimes on Wednesdays. Then, I would leave Thursday and Friday and go off to anywhere from Sweden to Greece, Turkey and what not. I still had a lot of expenses to take care of and I was, also, invited to lecture at almost every medical school in Europe, Tom.

TB: Weren’t you also a professor at the University of the Vatican?

FA: Yes, I was the first layman appointed to the faculty of the Pontifical Gregorian University in Rome. The University was founded 400 or 500 years ago by Pope Gregory, and that’s why it’s named Gregorian University. The students there come from all over the world. There are seventy-two languages spoken, including the different dialects, in the student’s body. It’s quite a place. The students are either ordained priests working on getting their doctorate in Canon Law or Moral Theology, or seminarians, personally selected by their Bishop, who pays their tuition, pays their travel and their room and board. You get the best education and it costs you nothing. And, they are very carefully selected. They’re men with a vocation.

TB: What did you teach?

FA: I taught two courses. One was called Modern Medical Moral Problems, and the other one was Pastoral Psychology. Now, the men, getting their doctorate in Canon Law, for example, are basically becoming religious lawyers. OK, they’re going to uphold the law of the church and so forth. For example, the Vatican has a marriage court, so that people who want to have their vows annulled can appeal to their Bishop and from their Bishop, it can go on to Rome and the marriage court reviews all the data and they make a decision. Obviously, the question is often, was the person capable of making a valid contract? And, so, what are the criteria for a valid contract, whether it’s marriage or whatever? So, that was basically the kind of thing that I had taught.

TB: So, this is how you got involved in law?

FA: Yes.

TB: Didn’t you get a doctorate in law later on?

FA: I have four honorary doctors of law and one honorary doctor of science degree.

TB: Is this how you got the one in law?

FA: That’s right. I don’t think anybody would have given me an honorary doctor in law, before I started doing this work. The whole issue, Tom, was, that these men needed to know, pretty much, what psychiatry was thinking about in certain areas. As you know, in the United States, for example, there were conflicts between psychoanalysts, represented by a known Catholic priest, who protested a sermon by the Bishop, and complained to the Cardinal. What happened was that the guy said to the Cardinal that he wanted the Bishop to stop what he was doing or otherwise he was going to leave. Now, the rumor is, that at that point, the Cardinal said, “I just accepted your resignation”. And, these were the kinds of things. I was, also, there at a time when the Vatican Council was going on and I ended up consulting to Council Fathers on issues that interested them. The purpose, Tom, of the Vatican radio program was to let the world know that the Vatican is keeping abreast of developments in medicine. For example, on the 100th anniversary of the Red Cross, I did four 15 minutes programs, on the history of the Red Cross. At the end of each program, listeners were urged to make a donation to the Red Cross. During that period, the United Nations put out a series of postage stamps for the world to unite “against malaria”. Every member of the United Nation countries issued a postage stamp for the world to unite “against malaria”, and I was asked to do a series of programs on malaria. I’ll never forget that, Tom, when Father Thomas O’Donnell, an Irish priest, who was head of the Vatican radio, called me into his office and said, “Frank, I want you to do four programs on malaria”. I said, “Father, that’s impossible. I know a mosquito is involved and I know that we can treat it with a few things, but that’s about all; I could say it in five minutes”. He says, “You’re going to do four fifteen minute programs”. That’s the way he managed it. So that turned out to be a Godsend for me, because I had to go looking into the history of it. Surprisingly, the American library had nothing in their bookshelves that was worth anything on the subject but in the British library I came across a book written by a British historian that was called “The Fever Bark Tree” that was a story of quinine and how the Jesuits brought it back from South America to Rome. Of course, in that period of history, malaria was very common in Rome and threatened many people on the Vatican Council and many religious men. It was an interesting and very informative book. These are the kinds of things that I learned from that book. Thomas Sydenham gave quinine to a couple of members of a family who had fever, thinking that it was, perhaps malaria. Well, they never got any better. He wrote the most scathing denunciation of the drug that I’ve ever read in my life. He really blistered it, you know. At the time I was in the Vatican the birth control issue was on. People from Planned Parenthood were lobbying at the Vatican Council, and there were a great number of press people there. Well, as a member of the American Association of Science Writers, I had my press credentials and was able to attend a good number of cocktail parties, and, ended up becoming involved in birth control. I wrote a book on oral contraceptives, in which I showed that’s it’s really not a contraceptive, but a pill that aborts the fetus. Since the Pope had to make a decision about what is going to be the official position of the Catholic Church in that matter, prominent obstetricians and psychiatrists, including Lopez-Ibor from Madrid, were consulted.

TB: Lopez-Ibor?

FA: He was one of the psychiatrists. There were a couple of psychiatrists from England. But anyhow, the church didn’t sit back doing nothing. They did something and, as you know, the Encyclical was finally publicized. I served on a committee for that, along with a Jesuit theologian from Massachusetts, a lady theologian from Maryland, and another well-known Jesuit, whose brother is a well-known internist in the United States, who spent his priestly life just with medical moral problems. The four of us were on a committee, reviewing and commenting, “This is good; this is not quite clear” and what not. In a sense we were proofreaders or peer reviewers. It was very educational. So, I can tell you one thing, which is the absolute truth, I was never bored in the three years I was there.

TB: You were also involved in publishing a journal.

FA: Well, it was not a journal; it was a newsletter.

TB: Newsletter?

FA: Medical Moral Newsletter.

TB: But wasn’t there also a Magazine?

FA: Oh, yes, but I didn’t start that. I wrote articles for the Magazine of the Palatine Fathers, a religious group that started in Italy and are now all over the world.

TB: So, you started the Medical Moral Newsletter.

FA: Yes, the Medical Moral Newsletter.

TB: That was in 1964, right?

FA: That’s correct.

TB: And, I think you continued with it until quite recently.

FA: That’s correct. About three years ago, I stopped it. I got to the point I couldn’t handle it.

TB: Could you tell us something about that newsletter?

FA: Well, it was, originally called The Medical Moral Newsletter for Religious. You know, there were so many changes going on from heart transplants to in vitro fertilization. In fact, right now, stem cell research is becoming the “in thing” in this country, and believe me there are many theologians looking into that. Well, anyway. I started that because, in the interval, between sessions of the Council, the priests would go back to their diocese, and some of them asked me to keep them informed if anything comes up in the medical field while they were away. And, I said “sure”. So, I sort of started sending them mimeographed information. And, they liked it very much. So, I thought, well, why don’t I just start this The Medical Moral Newsletter for Religious. Many dioceses bought it for their archives or for a library that they would maintain for priests. Surprisingly, I had a number of divinity schools and seminaries from various religious denominations, the Protestants, the Episcopalians and so forth that bought subscriptions. And, I covered everything you would want to cover in that kind of thing. I liked to write something stimulating, occasionally. I did an issue on the intrauterine devices, how they work, and on the first page, I had all the different devices. Some of them looked like the Bishop’s cruiser. And, that got a big sale. It was a very enjoyable life. It was great for my family. I brought my wife and the twelve kids over to the Vatican and we all went over on the same plane. We were the first family that was that size to fly on the same plane across the Atlantic. Pan Am arranged for all kinds of photographs taken of us, leaving Baltimore, arriving in Italy and so forth.

TB: Were all the twelve kids born between the mid-1940s and the end of the 1950s?

FA: Yes, the youngest was three years old at the time we arrived. I carried her around on my shoulder most of the time.

TB: We talked about the birth of the CINP. We talked about your life in the Vatican. We also talked about the congressional hearings in the United States which led to the establishment of the Psychopharmacology Service Center, but we have not talked yet about the founding of the ACNP, an organization you had been involved with very much.

FA: I was very much involved in the founding of the ACNP. The idea came from Ted Rothman, who was instrumental in organizing the first meeting. He was a psychoanalyst and not a psychopharmacologist, but he was seeing patients who were given all these drugs and felt that there was a need for knowing a little bit more about them. I’ll give you an illustration how some psychanalysts felt about the new drugs in those years. At the New York Academy of Sciences, I gave a paper on chlorpromazine and my experiences with it. The discussant of my paper was a past president of APA who used to be at Yale. He thought that my paper was very erudite, interesting and informative. And, then, he got to the punch line, and said, “I have one word of advice to you people in the audience. Hurry up and prescribe this stuff while it still works”. At any rate, the idea behind the founding of ACNP was to get better communication between psychiatrists, pharmacologists, industry, and physicians, in general. I played a role, also, in the founding of the British College of Psychopharmacology. It was acknowledged in one of the books of David Healy.

TB: It’s interesting that Rothman, a psychoanalyst, was the one who got the idea of founding a society that was to become ACNP.

FA: Rothman had a very good relationship with the medical director of Geigy, and he got those people to put up the money to pay for the travel and foot the bills for the hotel and meals of the organizing group at a weekend meeting. From the very beginning, so, there were a few psychopharmacologists involved. Nate Kline was there; I was there; Heinz Lehmann was there, and other leaders in the field. But we had very few pharmacologists and I thought that we should have more of them. So, lo and behold, at the next meeting, we had Brodie there. What a mind that man had! At that time he was working on determining the presence of drugs in plasma and serum, and he told us, “We’ve got to work on determining drugs in the blood because otherwise we don’t know whether the drug is in the body”. He championed that area of research, and, we established a sub-committee that consisted of Jonathan Cole, Brodie and myself, that focused on that issue. So, before long, we were getting into such issues as hormonal kinetics and pharmacokinetics, and so on. And, that, to me, was the important thing. The College should be a College, a source of information, a source of stimulation. That was my position.

TB: During those years, you had been intensively involved in educational activities, weren’t you?

FA: Yes, I was.

TB: You made a film, sometimes in the late 1950's on physical therapies?

FA: Well, I did a couple of films, Tom. I think the one, you may be referring to, was the series on Medical Horizons. It was sponsored by CIBA Pharmaceuticals and was on prime time television on Sundays. It covered, initially, medicine and surgery, and not psychiatry. All the programs came from hospitals. I was contacted by CIBA to do a program on psychiatry because they didn’t want to be criticized for boycotting psychiatry. But, they, also, had run into people who told them, “No, you can’t do this on television because of confidentiality and so on”. A physician from CIBA came to Baltimore to see me and we talked it over. I thought it will be a wonderful opportunity to educate the public, so I agreed to do it out of my office. Now, my wife will tell you, she didn’t think that was a good idea, mainly, because they had to set up all the equipment in the living room. My office was a wing to my house. And, we had the children running around, you know. And, the kids always brought their friends in. Actually, to do it, they had us build a special tower about a mile and a half up the road on a hill, so they could beam it off better. And, they had all this equipment and the kids were just fascinated. But we ended up that the whole front of my house had to be redone after the program was over. My office had punched holes in the wall to get the cameras and little microphones through. I had no idea how much was involved in a national TV show. They had these huge trucks in my driveway to beam the stuff up to the tower on the hill, which beamed it out to the rest of the United States. I had, beside myself, two psychologists working for me, then. I had also two trained internists, who had interest in psychiatry, and two psychiatrists working part-time working for me. In one segment we had the mother interviewed first and, then, the child, then, the psychologist giving the child some tests and so forth. Then, I had a big job, doing the first ECT on television anywhere in the world. And, that took some courage, because, first of all, I had to give the patient some succinylcholine. Well, that’s, as you know, tricky. I did it deliberately in an elderly patient because elderly people were considered to be not good candidates for ECT. Then, of course, I used amobarbital sodium to induce anesthesia. Patient was interviewed before treatment, and then again before going home to show that it can be done in the office. And, finally, we had a patient who had had lobotomy; a very intelligent, attractive woman, who came in and talked to the neurosurgeon. The neurosurgeon explained how it was done and so forth and so on. Then there was an interview with me on who should be seeing a psychiatrist and why. The attitude toward psychiatrists, like myself, who were doing physical methods of treatment was not good in those years. After the film was completed CIBA invited to dinner a large number of psychiatrists and not one showed up. Then people watching the film noted that the patient did not have a grand mal seizure after given ECT. I got phone calls and nasty letters that I’m a fake, and that I faked this stuff. And I wrote back and said, you have no idea what succinylcholine and amobarbital sodium does. The lobotomy part was very well received. Several neurosurgeons and psychiatrists contacted me with favorable comments.

TB: It’s a great film.

FA: Well, I’m not sure whether I did get my message across in the film.

TB: You did several other films as well.

FA: Yes, in 1961 I also did for Merck Sharp and Dohme, a film called, Recognizing the Depressed Patient, in which, I interviewed a number of my patients.

TB: Recognizing the Depressed Patient was also published.

FA: Yes, and it sold a hundred and fifty thousand copies. It was a best seller.

TB: Was it translated into any other language?

FA: It was translated by Jean Delay into French. There was also a German translation but I did not see it. And there was a Spanish one translated by Lopez-Ibor. They’re collectors’ items today, if you can find them. Anyway, the film, Recognizing the Depressed Patent was shown and won first prize in an International Film Festival on scientific films. And I was very grateful to all those patients who let themselves be interviewed before camera. I, also, had another film, Tom, which has been very successful. It was on Drug Induced Extrapyramidal Reactions that was made available, I think, in ten languages.

TB: While doing those films you were involved in research.

FA: Oh, yes. I never stopped doing research in those years.

TB: You were involved primarily in clinical investigations and survey research.

FA: Oh, yes. Well, I did a survey on Drug Induced Extrapyramidal Reactions. It included 33,775 patients. It wasn’t a one week or a one month survey. Those people were surveyed over a period of years. And, I’m proud of the fact, Tom, that, I published the findings of that survey in JAMA so that my colleagues, who are not psychiatrists, can be informed about what we psychiatrists are doing, and that we psychiatrists are physicians.

TB: Well, you were one of the few who tried to communicate at the time that we psychiatrists are physicians.

FA: Oh, yes.

TB: Was not your paper in JAMA one of the most frequently cited papers?

FA: Yes, that’s correct. On the 100th anniversary of JAMA, they did an analysis find out the 150 most frequently cited papers of the journal and my paper was number 20 on the list. It was also the only paper on the list that was written by a psychiatrist. It got a tremendous reception and a recent survey showed that’s still a very, very frequently referred to article.

TB: And, then, in the mid-1960s you started your International Drug Therapy Newsletter.

FA: The International Drug Therapy Newsletter was started after a very strenuous tour of the Orient, Australia, New Zealand, Fiji, Japan, Hong Kong and Singapore. It was a very strenuous tour. I think it was a British epileptologist who arranged it, a very well known one, but I cannot recall his name now. But, at any rate, we met in Tokyo. My first stop was in San Francisco. I did something at the medical school there, then went over to Honolulu and did two stops there, at the Army hospital and at the medical school. Then, from there I went to Guam and met with some neurologists there. From Guam, I went to Tokyo, from Tokyo to Singapore, from Singapore to Perth, Australia, from Perth to Melbourne, from Melbourne to Brisbane, from Brisbane to Sidney, and from Sidney to New Zealand. I made several stops in New Zealand. It was summertime there but it was snowing at the top of the mountain.

TB: Was it Mount Cook where you went?

FA: That was the sightseeing place. I stopped there. It was beautiful.

TB: You were in Auckland also, I suppose.

FA: I was in Auckland.

TB: In Christchurch?

FA: Christchurch.

TB: And, Dunedin?

FA: Yes. I covered all of Australia and New Zealand. Anyhow, in Melbourne, John Cade was my host and John is or was a very devout Catholic. He’s dead now, as you know. I hit it off with him just like that. I learned, from the horse’s mouth, so to speak, everything I had ever wanted to know about lithium. We really covered the subject.

TB: So, the International Drug Therapy Newsletter was born after that trip.

FA: It was born after that, yes. As I said it before it was a very strenuous trip and my colleague, the epileptologist was older than I was. We were not long enough in any one place to really adjust, so he decided to stay and rest in Melbourne. In fact, I think he may have even gone in the hospital for a couple of days, just to be checked. And, I had a marvelous time just going around in those glass bottomed boats and seeing all those beautiful corals and fishes. But you can’t do that all day long. So, one night I woke up and began thinking about what I’m doing here. So I had the typewriter that John Cade loaned me. It was a portable typewriter. So, I wrote a little thing to myself. I wasn’t in a hypomanic state or drinking. I’m gifted with energy and I have a way of organizing things. I sent the piece to John. He wrote back and thought it was pretty good. So, with that encouragement, I decided to embark on what was to become The International Drug Therapy Newsletter. It was very interesting, the reaction to it. Gerry Klerman with whom I had been good-friends for many years, wrote me a letter, which I saved, saying, “Frank, I’ve read the first issue of this International Drug Therapy Newsletter of yours. It’s good, but, I’m not going to subscribe to it, because it’s going to be out of business in a short time. You’ll run out of ideas”. So, I said, “OK”. So, to make a long story short, twenty-five years later I sent Gerry a lifetime subscription free. It’s still in business.

TB: It’s still in business?

FA: Oh, yes. Lippincott Williams and Wilkins bought it from me. If you’re getting older you have to be careful with your time. It was a lot of work to keep all those records of subscribers who paid and hasn’t paid straight. It is lots of work.

TB: And you wrote the Newsletter without any help.

FA: I wrote the whole thing.

TB: You wrote the whole thing.

FA: Occasionally, a colleague would come to my rescue if I got sick and couldn’t get an issue done, so I would, occasionally, invite somebody, whom I thought could do much better tha me on one or another topic. I asked Bob Post or Fred Goodwin or Leo Hollister and so forth.

TB: Was it distributed worldwide?

FA: Yes, but primarily in the United States. But I had subscribers from Canada, UK, Switzerland, Australia, and New Zealand.

TB: So, it was distributed all around the world.

FA: Yes, but things were getting increasingly difficult because drug companies started to send out reports on their meetings, and others have started their own little things. When I started the newsletter it was the only newsletter.

TB: Yes.

FA: And, then, Drug Alert was put out by John Powers and some other publications.

TB: You gathered in the Newsletter all the important events in neuropsychopharmacology monthly.

FA: I tried to.

TB: And you reviewed the material you gathered critically.

FA: Well, there’s also another thing I do, Tom, and I’ve been doing it for some years. I write for Psychiatric Times.

TB: Yes.

FA: I write an annual report on the highlights of the APA meeting.

TB: Your writings have an important impact on the field.

FA: I hope it has. I hope it has.

TB: After launching the Newsletter, you organized a very important meeting dedicated to the history of the field

FA: The Discoveries of Biological Psychiatry.

TB: The Discoveries of Biological Psychiatry.

FA: And, Donald Klein at this meeting, so kindly referred to it at the end of his presentation yesterday, saying, “I couldn’t have done this without Frank Ayd’s support”.

TB: Yes.

FA: But, my idea, Tom, was, why not get the guys who have made these discoveries, while they’re still alive, together in one place to tell their story themselves. And, I proposed this to Dr. Taylor, because the hospital would have to be sponsor for it. I knew that it wasn’t going to be an inexpensive venture, to say the least, because we had to bring in John Cade came from Australia, Lopez-Ibor from Madrid. We had…

TB: You had Pierre Deniker from France.

FA: We had Hugo Bain from CIBA. We had Albert Hofmann, the LSD man from Switzerland. And, then, I had my professor in pharmacology, John Krantz, who’s a great lecturer, tell the story of Indoklon, which was never a great replacement for ECT but still gave hope that there could be some alternatives.

TB: You, also, had the amphetamine story told.

FA: Yes, the amphetamine story told by, what’s his name, the fellow from California. I can see his face in front of me…

TB: Chauncey Leake. You, also, had Tracy Putnam there. He gave the diphenylhydantoin story. What happened to him?

FA: He’s still alive, but I understand he’s quite feeble now. I would think he would be, because, after all, that’s forty years ago, almost, now. No, that’s thirty-one years ago, thirty-two. Well, I was anticipating the possibility that anticonvulsants will end up being mood stabilizers. Tom, I remember this guy, Dreyfus, the big investor guy, who claimed that he was cured of his instability by taking Dilantin. And, this got a lot of publicity. He felt that he had found something that could help a lot of people like himself. And, he assembled in Florida some of the top people in business. And in the middle of that meeting, when everybody was just relaxing, television announced that the son of one of the participants, an internist from the Mayo Clinic, had just won the Nobel Prize. And, I’m telling you everyone felt like it was his son. It was quite a celebration. Out of that meeting came a full day symposium on Dilantin at the ACNP meeting in San Juan. Dreyfus came and told his story. He also drew up grant money for various studies done at Hopkins, at Columbia and so forth, most of which did not hold out much promise for the drug.

TB: Going back to the meeting on Discoveries in Biological Psychiatry, you had Frank Berger there.

FA: Yes, Frank told us his meprobamate story.

TB: Then you also had Joel Elkes.

FA: Joel Elkes, yes.

TB: He had the firs department of experimental psychiatry and done the first double-blind cross-over study with chlorpromazine.

FA: Yes, the first double blind study with chlorpromazine. But, you see, I had to know all those people. I had to know, not only what they did, but who they are, what kind of speakers they are.

TB: You also had Paul Janssen there.

FA: He did the haloperidol story.

TB: The butyrophenone story.

FA: Oh, yes, that’s right.

TB: It was in 1970, right?

FA: Yes.

TB: And, you published a book on it with Barry Blackwell.

FA: Yes, Barry and I edited the book.

TB: It was probably also a best seller.

FA: Oh, yes. It’s out of print now, but I have the copyright to it and I’m planning to reprint it, sometime, when I find the time.

TB: I am using it very extensively. It is an excellent source book.

FA: That’s right. It’s very authentic.

TB: Yes, when people tell their own story.

FA: When I wrote to these very well known guys I told them if they want to be on the program they must arrive couple of days ahead with their manuscript.

TB: To be able to publish the book promptly?

FA: The book was published two weeks after the meeting was over. Barry would edit the chapters as we got it from them. When they presented their papers they already had the edited version in hand. And on Sunday night, after the meeting was over, I sat up with a guy from Lippincott till about three in the morning, finishing off the final touches. It was a lot of work.

TB: In the early 1970s you became involved in drug delivery systems.

FA: Absolutely.

TB: You recognized the importance of giving neuroleptics in long-acting depot preparations. Would you like to talk about that?

FA: Well, you know, if a drug is going to be beneficial to someone, the person will have to take it by a particular route and you might enhance the benefit by by-passing some metabolic pathways if given parenterally instead of orally or by a deep intramuscular injection instead of subcutaneously. Actually, the story of depot preparations is an interesting one, Tom. I did the first study on fluphenazine for Schering and the company was doing quite well with the success of the drug. This might have been the reason that Charlie Revlon was buying up Schering stocks. Schering wanted to stop this and the only way they could do it was to merge with another company. So they merged with White Laboratories. I knew White Laboratories very well, because they were predominately a pediatric pharmaceutical company, and my father had contacts with them. They produced a lot of vitamin preparations for children. It turned out that those vitamin preparations came from Squibb. So, anyhow, to get Revlon out of the picture, the merger between Schering and White Laboratories was finalized. The agreement was that Schering would continue with fluphenazine at an adult dose whereas White, being known as a pediatric pharmaceutical company, would market a low dose of it. Well, shortly thereafter, Squibb, which had already developed a way of producing a depot formulation, said to White Laboratories, we want the rights to fluphenazine and if we don’t get it we will not produce the other stuff for you any more. Basically, that’s what it was. So, that happened. So, then, they developed a depot formulation of the drug. The first one was the enanthate that worked for two weeks. And, then with some more structural manipulation they got the decanoate that lasts from four to six weeks. That was the beginning of the depot formulations. Now, there are close to twenty-seven or twenty-eight different depot preparations of antipsychotic drugs available, and you’re going to see some of the atypical depot preparations in the not too distant future.

TB: The availability of drugs in depot preparations is very important for developing countries, like India. They use them, probably even more extensively than we use them in the Western World.

FA: Oh yes. But depot preparations also have their drawbacks. There are inconveniences associated with them. I mean, either a nurse has to go to the patient or the patient has to come to a clinic. So, the clinic has to operate on schedules that people can come, say at night, because they can’t get off from work without losing their job, to get their shots, usually. So, a lot of things are involved in it. I envision that eventually we will see olanzapine, risperidone, ziprasidone available in depot preparations. Clozapine, I think, would not be available because it would be too risky.

TB: You were also director of research and education at the Taylor Manor, and professor at...

FA: West Virginia; University of West Virginia. Tom, to be perfectly truthful, that was never intended. The young fellow, I had known for some time, who became chairman there had an accreditation visit shortly after he took the job. And, there he was, a young man, about thirty-five with all the residents without senior people, so to speak. So, the question was raised, where are your old people? I don’t have any he said. He was asked why he is not getting some senior people in to help out. So, he called me and asked me if I would come down and help him. So, I went down and the agreement was that I would teach a certain number of hours every month. Usually I went down either Wednesday and be there Thursday and Friday and came back Saturday morning, or go down on Sunday evening and be there Monday and Tuesday and come back Wednesday. That worked fine and I was pleased. They were pleased. I’m still, officially, on the faculty and still get invited to graduations and all the faculty ceremonies, but in fact I haven’t been there to teach for the last few years.

TB: You became emeritus at Taylor Manor in 1987, I think, and when you became emeritus they changed the name of the library of the hospital to…

FA: Oh, yes. You know, I’d been admitting patients to that hospital since 1951. I built that hospital’s reputation, even before I became the director of professional education and research. And, to show their appreciation Dr. Taylor said to me, “I’d like to name the library the Ayd Professional Library at the hospital”. They had a little ceremony, and put a plaque on the wall. So, a number of doctors from Washington came and we had a very pleasant luncheon. It was nice. I felt very glad about whatever I’d done to help them and their patients.

TB: ACNP also recognized your contributions. You were recipient of the Paul Hoch Award.

FA: The College has given me two awards.

TB: The other one was the Distinguished Service Award.

FA: That’s right. That’s correct.

TB: But, the same year when you got the Paul Hoch, you got also another distinction, The Open Mind Award.

FA: Yes, from the Janssen Research Foundation. That year, it was Pierre Deniker and myself who got that award. Since then, Hans Hippius, and the fellow who was in New York and now is back to Holland…

TB: Herman van Praag.

FA: Yes, Herman van Praag, he also got it. I don’t know if it has been given since that time to anyone else.

TB: Then, The Psychiatric Times gave you also an award.

FA: Yes, yes, they did. They gave me The Lifetime Achievement Award.

TB: You got it in the early nineties.

FA: Yes, and they gave Paul Jannsen the same award also that year, and, to somebody else as well, but I’ve forgotten who it was.

TB: In the mid 1990's you were listed among The Best Doctors in America.

FA: Yes. I don’t know how that happened. I think, they wanted me to buy a copy of their book. Still, it’s an honor somebody thought I deserved to be listed.

TB: Then, in the mid-1990s, you also got The Distinguished Professor Award from The Center of Psychiatry.

FA: That’s right. Tom, I’ve been blessed. There’s no question about that; I’ve been blessed. As a Catholic, for example, I was honored to become a member of The Holy Name Society, and, to my knowledge, I’m the only psychiatrist that The Maryland Holy Name Society awarded this honor. And, then, I got from the Palatine Fathers, the Saint Vincent Palatine Award for service to the church and the state. These things always come as a surprise to me.

TB: They were well deserved.

FA: Well, you know, when it happens, you’re grateful that it happened. But I have a duty to teach my children don’t let pride become a big item.

TB: Now, all through those years, you did practice and saw patients

FA: That’s right.

TB: And, you said that at the beginning you had your practice in your father’s office.

FA: Oh, yes, that’s was only for about a year.

TB: And, then, you moved into...

FA: I moved into a wing of my home. I bought an old country home, tore down the barn, and got the ground for my wife and the children. Then, I built a wing on. It took about eight months for them to dig out the foundation, run in the water and all that sort of stuff. Then I moved immediately full time into the office. And, the office was set up in such a way that there were two floors. In the basement we had beds where I could give ECT. And, then, on the other side of the basement there were four offices for interviewing patients that the psychologists and social workers could use. On the first floor there was a big reception room, my office, offices for two psychologists, or internists, or whoever was working at the time with me. And then we had storage place for the records of the patients.

TB: Did you have usually two psychologists working with you?

FA: Yes.

TB: Did you also have psychiatrists working with you?

FA: Yes.

TB: How many?

FA: Well, it varied. It really varied. I had a very fine board certified psychiatrist from Argentina who was very fluent in English. He was a distinguished looking and soft-spoken man. He worked for me until he died. He died, prematurely of cardiac arrest. And, then I had a fellow, whom I’d met in a strange way. You know, I’m a Catholic and I have never charged widows and so forth. And, God has been good to me, so I pay Him back any way I can. I used to go to the Bahamas, once a year, and donate a month of my time to the church and outpatient clinics there. And, I also help in the psychiatric hospital. These things were my way of saying, “thank you.” I’ve lost my train of thought. What was the question before?

TB: We talked about your office, about people who worked for you, and that one of the psychiatrist working with you that you met while donating your time to the Church in the Bahamas.

FA: He was a board certified psychiatrist who was also donating his time to the Church. He was down there with this wife and two children, and he wanted to go into private practice. So I gave him a job. His wife was expecting their third child, then. So, we gave them the third floor of our house to live up there. He would be on call twenty-four hours a day.

TB: So, you usually had at least one psychiatrist to cover for you when you were away, right?

FA: No, actually when I was away, Taylor Manor Hospital covered for me.

TB: Oh.

FA: They had people on duty twenty-four hours a day. I have almost forgotten but I also had a fellow working with me, who ultimately became a neurologist. During his residency he got married and his wife was expecting a child. So he needed some extra income. He did physical exams in the office.

TB: And all through the years you have been doing clinical investigations in your practice.

FA: Lately I’ve been involved more, as a consultant, than in actual research. You get to the point in this business, so to speak, Tom, that you begin to put together which way the wind is going to blow with one or another particular compound. For example, I had a tremendous experience with the depot neuroleptics, so Squibb had me go to the Orient, and I gave lectures in Singapore, Hong Kong, Tokyo. They, also, had me in Australia to give some seminars on depot neuroleptics, setting up the clinics and that sort of things. It is important how you set up the clinic, how you schedule the appointments and how you consider the patients. Doctors can be cruel people, Tom, and I’ve witnessed this in clinics, you know, where patient comes in to get a depot injection and some guy pulls the dress up and pulls the pants down while the patient is menstruating. You know, it’s a terrible thing to do. And that creates hostility on the part of the patient, and, boy, you try to get them back – it’s impossible. Now, for example, recently at a meeting of one of the pharmaceutical companies that has an atypical neuroleptic to be studied in a depot form, I listened to their plans and said, “You’re going down the wrong road. This isn’t going to work”, and pointed out, that you need to schedule things properly and for this you’ve got to have nurses who understand this; you’ve got to train people; it’s not just a matter of injection; you’ve got to know how to use the needle that it wouldn’t hurt. These are very simple things that apply to all of the depot neuroleptics.

TB: So, lately you have been more involved in research as a consultant. Which were the last drugs you were actively involved with as a clinical investigator?

FA: I worked with zimelidine. That was an unfortunate story. It was a very good antidepressant drug, and, then “bingo”, something that you could not predict from animal data happened. Before it was released for clinical use, Tom, they brought together a remarkable board of experts to advise them. Leo Hollister, Bob Post, Malcolm Lader, I, and many others were there. The company wanted to be a success without any risk to the patients whatsoever. They had had a couple of other drugs that had backfired on them, so they were really touchy about this thing. And, they brought us all to Sweden and treated us very graciously. There were no holds barred on the data. We saw all of their data and it was the consensus that it was a good drug and, as you know it was marketed, but unfortunately it produced neurotoxic effects

TB: So it was zimelidine the last antidepressant you were involved with as an investigator. What about antipsychotics? Which was the last antipsychotic you were directly involved with as an investigator?

FA: Well, the last one would have been clozapine.

TB: Clozapine.

FA: I got involved with clozapine in a strange way. Warner Company in Bern, Switzerland, a small pharmaceutical company, invited me over to give a talk on antidepressant drugs. I wondered why because they didn’t have any antidepressant, to my knowledge. And, I went over and after I gave my lecture they showed me data they had on a new compound that they thought to be an antidepressant drug, and they wanted me to do a study with it. So, I brought back with me the data and after studying what I got carefully I wrote them back and said, I’d be willing to do a study. And the drug turned out, Tom, to be a very effective antidepressant in a certain dose-range. I had seen no serious adverse effects with it until ninety percent through the study. It looked very good, then, “bingo”, a fatal agranulocytosis occurred in an elderly woman. And, of course, I reported it to Warner. The drug turned out to be a predecessor of clozapine. So, shortly after that, they merged with Sandoz and Sandoz got all the derivatives of this compound. And, I ended up being consulted by Sandoz, quite frequently. I’d fly over to Basel, Switzerland for a weekend, or for three or four days. This is how I got involved in a small study with clozapine.

TB: From early on you were frequently one of the first to describe one or another adverse effect of a new drug. Didn’t you write something about akathisia and suicide recently? Were you the one who thought first that there was a possible relationship?

FA: No, I was not. I was the first to say that people who say that are wrong. What happened, Tom was, that there were a number of letters to the editor on akathisia and suicide based on very weak scientific data. I wrote a rebuttal to some of these letters that was published. Just recently, I published an issue of the Newsletter on extrapyramidal reactions with the various atypical antipsychotics, and the fellow, who wrote it for the Newsletter, brought up the issue of potential suicide because of akathisia. I wrote a rebuttal to that and it’s been published. If you’d like to see it, I’ll send you a copy.

TB: I knew you wrote on the topic and I should have read it.

FA: Well, the difficulty is that both, akathisia and suicidal ideation are common and statistically you are going to have X number of persons who have suicidal ideation and akathisia together.

TB: So, you don’t think that there is a relationship between them.

FA: There isn’t. There isn’t any. Now, it’s possible that akathisia make some people so uncomfortable that they act impulsively, but this is not necessarily a suicidal action induced by a desire to die.

TB: In the middle of the 1990's you became involved in writing a book in collaboration with some people...

FA: John Davis, Sheldon Preskorn, Phillip Janicak and myself, yes.

TB: It was on The Principles of Psychopharmacology.

FA: The Principles and Practice of Psychopharmacotherapy. The third edition just came out. It’s been very successful. The second edition is now translated into Russian and, now, there are negotiations to have it come out in Chinese and Japanese. It’s been a very successful book. It’s very practical and fairly comprehensive. If you pick up a copy of the latest edition, the foreword to it was written by Jonathan Cole and Jonathan was very, laudatory in his comments on the structure of the book, its coverage in terms of comprehensiveness, and its clarity of presentation. It’s a good book for practitioners. Whether we’ll have a fourth edition, who knows?

TB: It seems to be very successful. And the same applies to your Lexicon that is also very successful.

FA: The first edition of the Lexicon was quite successful. The sales of the second edition have been a delight. And, the reviews of it have been, I think, very objective and laudatory.

TB: The Lexicon covers psychiatry, neurology and neuroscience. It is really more than a Lexicon. It’s like an encyclopedia.

FA: Well, Floyd Bloom was a peer reviewer of it. He’s a very busy man, editor of Science and he was the first to comment that, “This is no longer a Lexicon. This is an Encyclopedia”. And, I took a poll of other people whose opinion I respect and there were many of them who agreed with him. There were a few dissenters who felt that in the minds of people this was established as a Lexicon and if we try to change it to Encyclopedia it’ll confuse people and they will not be inclined to buy the third edition and five years of labor will be going down the drain.

TB: You had an editorial board. But, it seems to be that you did most of the work.

FA: Editorial boards have perspectives but if you respect the people on the editorial board enough to have them on the board, you ought to respect their judgments, unless it’s so way off beam. And, I picked some psychiatrists because of their broad experience and some very bright, young psychiatrists. I didn’t expect them all to be expert writers. They could write some things or call my attention to something, and they were very helpful. I’m grateful to them; I tell you that. But, basically, the writing is mine.

TB: How long did it take you to write it?

FA: Five years. The second edition took five years. It has a thousand new entries in it, and the size of the book increased from 500 to 1200 pages.

TB: One of the reviewers of the book said in his review that no one else could have done this, and it’s true.

FA: Well, I’m glad to hear you say it’s right.

TB: Could you mention some of the people who might have had an impact on your professional development?

FA: Tom, there are very many that I could name, but will pick out for you just a few. One of them was Paul Jannsen. He is clearly a great pharmacologist. Paul Janssen is not a psychiatrist, but he’s a genius. He’s got a gift. Paul and I met under strange circumstances at an annual meeting of The American Academy of Chemistry in New York. He was presenting a paper on How To Cure It All and I presented a paper on Structure Activity Relationships. I didn’t meet Paul before but I knew who he was, by reputation. And, after he delivered his paper I went over and talked to him; we ended going out to dinner and that was the beginning of a very valuable friendship, for me anyway, and I hope for Paul also. I’ve spent many hours with Paul at his home and at meetings. Another person I would like to mention is of course Heinz Lehmann. Then Malcolm Lader is also one.

TB: Just one more question. Do you think your expectations at the beginning of your career to bring back psychiatry into medicine are fulfilled?

FA: We’re not a hundred percent there, but we’re getting there. I mean, there’s no question about it. Look at what Representative Kennedy had to say yesterday about the attitude of people toward a person who has a physical illness vs. the attitude of the public toward a person who has a psychiatric illness. The stigma is still there. There’s no question about that and we’ve got to eliminate that. We’re getting closer to it all the time. We’ve got to educate the public. That’s one of the reasons, in fact why I did that television show on ABC many years ago. . I didn’t get paid for that. I had a lot of headaches because of it, because I was trying to run a practice and they were running wires through my house.

TB: Do you think we are moving in the right direction?

FA: Yes, we are moving in the right direction.

TB: Is there anything else you think that should be mentioned?

FA: No. I think we have a right to be proud.

TB: I think we are proud, lucky and thankful to you that you were willing to share all this information with us. Thank you very much.

FA: You’re more than welcome.