

OREGON HEALTH & SCIENCE UNIVERSITY

ORAL HISTORY PROGRAM

INTERVIEW

WITH

George Saslow, M.D., Ph.D.

Interview conducted December 12, 2003

by

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SUMMARY

The interview begins in mid-stream, with Dr. George Saslow recounting his earliest employment as a teacher, a career he began in college as a way to help defray the cost of tuition. He has been teaching ever since and continues to teach even now, beyond his ninety-seventh birthday, in the psychiatry residency program at OHSU. He even teaches fellow members of the Psychiatric Security Review Board, a unique institution that determines the treatment and supervision of criminals who have used the insanity defense. Saslow talks about the Board and its successful record of reintegrating the mentally ill into the community.

The conversation then turns to a consideration of the failings of psychoanalysis. Saslow recounts early experiences which led him away from the work of Freud and fueled his interest in psychotherapy. One of these experiences was as co-therapist, with Erich Lindemann, of the survivors of the horrific Cocoanut Grove fire in Boston in 1942. Saslow goes on to describe the strengths of psychotherapy and its interview techniques. He shares his opinions of several post-Freudian analysts as well as nonanalysts, and notes that the current teaching of psychiatry focuses perhaps too narrowly on the physiological basis of mental diseases.

One of the early leaders in group therapy, Saslow has had many opportunities to use group therapy techniques. As psychiatrist for the scientists at Los Alamos Scientific Laboratory during the years of the Manhattan Project, Saslow was often called upon to provide group counseling to the small community; he talks about a few of the incidents that occurred during his time there and the challenges he faced. His early training as a physiologist led him to apply scientific rigor to his own theories about psychiatry, and his research into interview techniques used new tools such as audio and video recordings and two-way mirrors to assess different methods.

Saslow becomes very candid when discussing the creation of the Department of Medical Psychology at UOMS. He talks about his falling out with Dr. Joseph Matarazzo, and about the impact that the rift had on both departments. He mentions a few of the faculty members who helped him in his work here at the Medical School, including Dr. Howard "Hod" Lewis and Dean David Baird.

Saslow talks at length about his early education and career, giving credit to several key individuals who encouraged him in his studies and contributed funds for his education. He also talks about his father, a Menshevik and supporter of presidential candidate Norman Thomas, about his wife Julia and their long relationship, and about his young granddaughter, Sarah Saslow Brown, who at nineteen already has her pilot's license and flies an air-ambulance for Aero Air.

Asked if he would do it the same way all over again, Saslow affirms that he has not yet tired of the work he enjoys so well.

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Site: History of Medicine Room at OHSU
Begin Tape 1, Side 1

SASLOW: I taught my way - earned my way through college at Washington Square College, a new college at New York University in downtown Manhattan. I had a part-time teaching job, which paid for my expenses. And later on, after I got my Ph.D. – while getting my Ph.D. in physiology at New York University, I was teaching all the time. I taught elementary biology and advanced biology and physiology at Washington Square College. And where else? And I taught medical students at Harvard Medical School, second-year medical students, while I was there for a while.

And when I came here, I continued teaching all the time. I thought it was important to continue to do that. I would meet with the residents every day, once we got residents. We started with zero residents. I would meet with them every day, and we would discuss various questions that they had.

ATKINSON: And your ninety-seventh birthday was last Friday.

SASLOW: Yes.

ATKINSON: To my knowledge, you haven't stopped teaching yet.

SASLOW: No. I'm teaching fourth-year residents, once a week, on Wednesdays, together with two other members of the faculty. And, in a way, I do some teaching at the Psychiatry Security Review Board. I'm the – there's one psychiatrist member, and I've been there for about seventeen years.

ATKINSON: And you had a captive audience at Pittock Mansion at your birthday party last week, and you were teaching them.

SASLOW: Yes, that's true.

ATKINSON: You were telling us about work you've just read in the JAMA.

SASLOW: Yes, and how it reminded me of my close connection with medicine, which I thought always belonged together with psychiatry. And I was on the executive committee of the Department of Medicine at Washington University Medical School. And when Dr. Lewis invited me out here, he put me on his own executive committee in the Department of Medicine. I met regularly with them.

ATKINSON: I'm going to break a second (interruption).

SASLOW: And we read various books together in Dr. Lewis's department and discussed them.

ATKINSON: So you had a fair hand in teaching residents and faculty in the department of medicine as well as in psychiatry.

SASLOW: Yes. I was always interested in the connection, so I was interested in that article in JAMA, which demonstrated that the same parts of the brain are activated whether you are in physiological discomfort or emotional discomfort. That was an important confirmation of something I have been thinking and doing for many years.

I was actually invited by the Commonwealth Fund to New York when they read a paper I wrote in which I related personality characteristics to hypertension. Of course, we had a wonderful hypertension clinic as a source of patients, and I was – I had published I think one of the first papers which related personality styles and characteristics to hypertension, which was later substantiated by many other people. But on account of that publication, the Commonwealth Fund invited me to set up a clinic of comprehensive medicine in the Department of Medicine, with the condition – it was called Medicine D. They had three clinics, A, B, and C. This was called Medicine D. And the condition that they wanted Barry Hood, the chief of medicine, to agree to, which he did, was to have all of his second-year residents in internal medicine rotate for three months through that clinic, and they did that, in the Clinic of Comprehensive Medicine. And the chief residents in a number of other services heard about this, and they began to ask to come, and they did.

This was all at Washington School of Medicine, St. Louis, Missouri.

One of the important members who came was Sam Guze, who was in his second year of internship. He became interested in psychiatry and later became chair of the department and then vice president for health affairs of Washington University. He was a close friend of my - he and his wife were close friends of my wife and myself. He, unfortunately, suddenly died unexpectedly of a ruptured spleen last year. He just bled to death very quickly.

ATKINSON: So you started earning your keep, or at least your education, when you were fifteen, or so, as a teacher.

SASLOW: Yes.

ATKINSON: And have taught nonstop since.

SASLOW: Never stopped, right.

ATKINSON: When you look back on your career, do you think of yourself as principally a teacher?

SASLOW: Yes. I always did, and more of a teacher than a doctor, but a doctor as well. I'm even a teacher in the Psychiatric Security Review Board, because I insisted, when I accepted the nomination to be a member of that board, that I would not behave the way psychiatrists had in the past, when they were the only ones who decided whether a mentally ill person should be placed in a hospital or treated in a particular way. I resolutely refused ever to be the – to chair a set of hearings on the ground that other people ought to share in that decision, because it was impossible to predict dangerousness of mentally ill patients, and we had no medicines at that time.

So I really functioned in an educational way in the Psychiatric Security Review Board, which is an amazing institution in itself. It was created by people interested in mental health: a judge, a psychiatrist – now, I forget if there was somebody else. And the point of its creation was that a mentally ill person who, while mentally ill, committed a crime should not be treated as a criminal but should be placed under the long-term jurisdiction - for example, if somebody was murdered by such a person, for life under the jurisdiction of the Psychiatric Security Review Board for care and treatment.

And many of them improved tremendously during the period of being under the jurisdiction of the Psychiatric Security Review Board. They could return to the community. There was a very low rate of recidivism of crimes on the part of such people as were placed under the jurisdiction of the Psychiatric Security Review Board.

So it's a unique institution in the United States, and has been imitated in several states and several other countries. It has an excellent record of very low recidivism and reintegration into the community of people who previously were never given a chance. It's an extraordinary – it probably couldn't be done again.

ATKINSON: Why not?

SASLOW: There isn't the leadership in the legislature. The legislature has become extraordinarily polarized and conservative and is not – not measuring up to its responsibilities for care of the mentally ill.

ATKINSON: But, to your knowledge, there are no inroads to dilute or overthrow the PSRB.

SASLOW: No.

ATKINSON: And you have found that the other members of the board are good students of psychiatry?

SASLOW: Yes. They ask me questions about new medicines, for example; experiences I've had with people who, although diagnosed as being schizophrenic, nevertheless have been able to function in the community. So it's been an important teaching opportunity there, as well.

I don't know where to go on from there.

ATKINSON: Let's talk about psychotherapy a little bit. You're well known for a number of reasons in the world of psychotherapy. One of them is your own research, which we'll get to, but another reason you're a fairly notorious character in the world of psychotherapy, to those who know you, is that you've been – you've had a kind of antipathy to psychoanalysis, about which you've been pretty outspoken over the years. Could you talk about that, why you believe as you do about psychoanalysis?

SASLOW: While I was at the Harvard Medical School - because Freud's work was widely admired in the Boston area, almost everybody who went into psychiatry wanted to go into psychoanalysis. The Rockefeller Foundation made a fund available so that residents in psychiatry in the Boston area could have an experience of psychoanalysis and decide what to do about it. Well, I was one of the people who benefited from that fund in my third year as a resident at the Massachusetts General Hospital Department of Psychiatry, which was a very small department with one small ward for about twenty-four patients.

I had a year of psychoanalysis with one of Freud's coworkers named Hans Sachs, a very well educated man, very well versed in English literature, such as Shakespeare's literature, for example, which he would talk about. At the end of that year, he thought I would not need any psychoanalysis further. And that was very different from what happened later on when I met people on returning to Harvard after an absence of ten or twelve years. There were people who'd started analysis about the time I did who were still in analysis.

Now, the reason I did not go into analysis was not only that Hans Sachs said it was – I would learn nothing more from it, though I benefited to some degree, learning some things about my feelings about my father, who died during that year. I attended a meeting of the Psychoanalytic Association and was astonished to find that four or five people would rise up, announcing their ideas about the origin of an addiction such as alcohol addiction. Each of these persons would present a different hypothesis. It never dawned on them to decide to set up a plan for comparing these hypotheses, something which I was used to thinking about because I got my Ph.D. in physiology, where you thought about such things. I decided that psychoanalysis had little to do with science - and Freud himself decided that at some point - and I saw no reason for going on in that. That was one thing which had to do with my interest – the kind of interest I had in psychotherapy.

And then, as it happened, on account of the – well, of the possibility at Harvard of your reducing some of your regular requirements, say of so many months in surgery, and so on, you could arrange during your fourth year to have an elective period of a number of months during which you explored possible fields you might want to go into. I talked with the man who had invited me to come back to medical school, Dr. Cecil Drinker, the dean of the school of public health, who was interested – when he found out I'd had two years of medical school at the University of Rochester and had never finished because they objected

to my getting married - at that time, you weren't supposed to get married as a medical student.

Dr. Drinker, when I was getting ready to complete my third year and thinking of my last at Harvard, he asked me – he pointed out to me that I was one of the few people interested in psychiatry – who might be interested in psychiatry who'd already had a basic training in a biological science such as physiology. And he said, There are practically no psychiatrists in this country who have had any basic science of any kind, so you might be able to make a useful contribution if you were to go into psychiatry, and so why don't you try and see what it's like.

So I tried to see what it was like by making contact with Eric Lindeman, and as I watched him interview people, I became absolutely fascinated by the way in which he conducted an interview, listening, picking up nonverbal communications, and so on, and that's how I got hooked on psychiatry.

My next big experience in psychotherapy had to do with the Coconut Grove fire, which occurred in 1937, this tremendous fire in which over five hundred young people died, charred to death, because somebody had closed the exit door of the Coconut Grove restaurant. When I came in the next morning to work as a resident - there was a big open square between the outpatient entrance to the Mass General Hospital and the inpatient wards, and in that tremendous space there were five hundred or so charred bodies from the Coconut Grove fire.

Eric Lindeman was asked to be responsible for dealing with the families, the survivors of those who had died. He asked me to help him. And so the two of us were by no means enough. We had to invite all sorts of other people to help us. There weren't enough nurses to deal with the grieving families. And so we spent a tremendous amount of time working with grieving survivors, teaching other people to work with them. At that time, Eric Lindeman wrote a paper, which became very famous, on how to deal with bereavement. It became the standard for many years about how to do that.

And so I saw no place for psychoanalysis in any of that and drifted farther and farther away into the direction of psychotherapy. It was a kind of – it was curious how Eric Lindeman himself was trained as an analyst, but he wasn't really very psychoanalytic in his thinking. He was a very skillful and sensitive psychotherapist from whom I learned a great deal about how to do psychotherapy emphasizing the cognitive aspects, which I did ever after that.

ATKINSON: Expand on that some. Tell us what you think the key ingredients are for effective psychotherapy.

SASLOW: That's a hard question to answer.

ATKINSON: Well, you mentioned cognitive aspects. Could you say more about what you mean by that?

SASLOW: Well, the – I think the work I was most influenced by was Aaron Beck's work on cognitive psychotherapy. The general point was that whatever thoughts you have also affect you physiologically and emotionally. Underlying those thoughts are a series of autonomic thoughts, and underlying those are a series of strong beliefs to which you have given allegiance without realizing what they meant. And you slowly learn to identify the way you were thinking, the way your body and your emotions were being affected by the way you were thinking, and the underlying automatic thoughts which would come up, and you learned how to pay attention to those, how to verbalize those, and how to consider alternative ways of dealing with those thoughts, feelings and emotions.

That's the essence of cognitive psychotherapy, and I found that extremely effective and useful in dealing with many patients. I've taught many residents how to use cognitive psychotherapy, and I've used it myself, mainly in treating my own patients. I've not used any psychoanalytic methods; I haven't found them helpful.

ATKINSON: From your long experience working with patients, doing many interviews for teaching purposes, the research you've done, what other things besides the cognitive area, these deep and automatic and long-lasting beliefs and thoughts that people have, what other things have you found are critically important?

SASLOW: Well, the way one reacts to a patient one is seeing for the first time always seemed to me important, and for that reason, I obtained Dean Baird's consent to have a Saturday morning class for second-year students, in which I always interviewed a patient I'd never seen before. And the class would join with me in watching the way the interview developed when you were faced with a person you had never seen before and whom you needed to listen to, to understand.

Well, I found that a very important teaching experience, and one which demanded a great deal of me in the way of listening attention and definition of the way a person looked at his or her own life. And these interviews were remembered by people for many years. The – what's his name? The recent chief of ophthalmology, what was his name?

ATKINSON: Fritz Fraunfelder(?).

SASLOW: Fraunfelder. He never forgot those interviews. They made a tremendous impression on him as one listened to a patient that one had never seen before and made some kind of meaningful relationship with them in less than, say, thirty minutes. And, of course, I became very skillful in doing that, as I did it for many years. I had done it at Washington University for about twelve years, too.

ATKINSON: You repeatedly mentioned the importance of listening, paying attention. What else? What else counts in that first...

SASLOW: Well, you pay attention to nonverbal signals, you pay attention to the way a person moves and the way the face changes in its expression as the person listens to you and you listen to the person. All of these I learned to pay attention to by watching Eric Lindeman interview. He was extraordinarily sensitive in those ways.

ATKINSON: Going back to psychoanalysis, do you think that any of the Freudian ideas or post-Freudian ideas in analysis have any relevance? Have any of them stood the test of time, if not experiment?

SASLOW: The main thing that I think Freud's experience still is meaningful about is the importance of early experience in later development. Now, it's turned out that a lot of the notions about the way in which early experiences influence adolescent and adult behavior cannot be supported. A lot of research by child psychiatrists, in England, especially by Dr. Rutter—a lot of that research in England showed that you could not predict adolescent and adult behavior from early childhood unhappy experiences. The kind of school a person went to made a tremendous difference, the kind of peer relationships made a tremendous difference, often negating the nature and content of early experience.

But, nevertheless, Freud was the first person to draw attention to that possible connection, and that had a lot to do with your earliest experience with your own parents. I thought that was a valuable contribution, but not in quite the way that he had – he had overemphasized it. Nevertheless, it was a new idea that the illnesses didn't come from, as had been thought at one time in the nineteenth century, constipation, for example. It was a very different idea.

ATKINSON: Any other ideas from analysis that have held up and proven useful over time?

SASLOW: Well, there have been a lot of contributors after Freud.

ATKINSON: Who stands out?

SASLOW: One of them was a man named Eric Erickson, who came from Denmark. He tried to relate Freud's ideas about various stages of emotional development, such things as he called the anal stage, and things of that kind. He tried to relate those to the culture in which the person grew up.

Eric Erickson was the person who emphasized the way in which a person's personality was very much influenced by the culture in which he grew up. He spent time with some Native American Indians, like the Sioux, for example, to become familiar with the way in which culture shaped personality. And so, although Erickson has been ignored by psychoanalysts, his views have been used as very important in paying attention to the way in which culture influences personality development. It's very important that you grow up in

Culture A or Culture B or Culture C as to what you become. And we're seeing that in Warm Springs right now, right here in our own state.

ATKINSON: Are there other post-Freudian analysts whose work you think highly of, besides Erickson?

SASLOW: Oh, there's a number of English psychoanalysts who emphasized the attachment relationship between a child and a parent. People like Bowlby and Winnecott. These had a great influence in adding to Freud's ideas. And his own daughter, Anna Freud, who emphasized what she called the functions of the ego in regulating the initial drive states that Freud emphasized so much. These all have been very influential subsequent to Freud.

At the moment, I'm listening to a lot of that in the teaching of fourth-year students by the person in charge. Dr. Schweby was trained as a psychoanalyst at the Menninger Clinic, and so she introduces these fourth-year residents to these post-Freudian ideas. They read chapters in a book dealing with Freud and Beyond, it's called, and they discuss the new ideas since Freud. There are a lot of them. Psychoanalysis is nothing like what it was when Freud died. It's very different.

ATKINSON: Regarding some nonanalysts, one of your contemporaries is Albert Ellis. I think he just celebrated his ninety-third birthday. I'm curious what you think of people like Ellis and Carl Rogers.

SASLOW: Well, I knew Carl Rogers better, and I thought very highly of his – what did he call his way of working with patients? I don't remember, do you?

ATKINSON: Unconditional positive regard?

SASLOW: Yes. I was at a conference with Carl Rogers somewhere about 1959. At that time, practically no research was being done on psychotherapy. There was Rogers' view. What was Ellis' view called? He had a name for it. Rational?

ATKINSON: Exactly.

SASLOW: Rational emotive therapy.

ATKINSON: A kind of cognitive therapy.

SASLOW: Yes. I thought both of those views had things to offer, and I paid attention to them, used whatever of them I could incorporate into my way of doing things, and I value them. I think they made important contributions to psychotherapy. But psychotherapy research was in its infancy in 1959. We didn't know how to do it.

ATKINSON: Some people have characterized some of your research on psychotherapy as behavioristic. I don't know if you agree with that label, but I'm curious what you think of folks like B. F. Skinner.

SASLOW: Well, Skinner, whom I met a couple of times, pointed out I was the only resident in the Boston area who did not go into psychoanalysis. None of them had the courage not to. He thought it was worthy of comment that I did take that step.

I didn't think that Skinner's way of looking at psychotherapy had very much to offer. It was too ritualistic and automatic.

ATKINSON: In your work with residents over the years, have you noticed that there tend to be any common pitfalls or problems that residents trip up over when they're learning psychotherapy?

SASLOW: Well, recently, it seems to me there's been a very disadvantageous change in the opportunities residents have to learn – (coughs)

ATKINSON: Do you want to take a break and take a sip of water?

[tape stopped]

ATKINSON: Take your time.

SASLOW: Residents in recent years have spent more and more time on knowledge of neurotransmitters and use of medication rather than listening. They have not been given adequate opportunities to learn by listening, and so a number of them have, really, very little experience with individual psychotherapy of any kind, or family therapy, which I also thought very important and introduced to the residents through Virginia Satir, from California, and group therapy.

I thought they needed all of those experiences, and I introduced all of those, but they have all vanished on account of the overemphasis in neurotransmitters and medication. And so I think they often finish their training ill equipped to use psychotherapy skillfully, unfortunately.

ATKINSON: So you think it's a matter primarily of shifting values as to what is considered important?

SASLOW: What to give time to. Yes, I think that's happened. I think it's rather destructive and does not produce psychiatrists of the quality we should like.

ATKINSON: So if you were in charge of the residency curriculum today, you would, obviously, want to alter that.

SASLOW: Yes, but I don't know whether I'd be able to, on account of the tie-up with funding of residencies. When I came here, Dean Baird's attitude, and the attitude of the faculty of the medical school, was not to accept any federal funding for residencies, because if you could accept it, you could also lose it. And on account of accepting federally funded residency stipends, the residents have to rotate a certain number of months in the VA hospital, and they have a certain number of months...

[End of Tape 1, Side 1/Begin Tape 1, Side 2]

SASLOW: ...rotation and an outpatient rotation. But that is planned in relation to the funding and not in relation to what the residents need to learn, unfortunately.

So I think I would change quite a great deal. But whether - I would want to change a great deal, I should say, but whether I'd be able to, in view of the federally funded things, I don't know. When I came out here, there was no federal funding for any resident, there was no residency program. I came out here alone.

ATKINSON: So the biggest problem you see in residents acquiring knowledge of psychotherapy is that they lack sufficient opportunity to practice those skills. They don't see enough patients for the purposes of psychotherapy.

SASLOW: And they can't practice the various kinds of psychotherapy which I mentioned, such as family therapy, couples therapy, and group therapy, all of which I think are very important for them. I introduced all of those when I was here by the use of one-way windows and bug-in-the-ear transmission so I could call attention to something that a patient said, such as a parent had recently died, and the resident paid no attention to finding out what had happened. I could, through the bug-in-the-ear technique, draw attention to that and invite the resident to consider what to say. That one-way window technique was abolished, the bug-in-the-ear stopped being...

ATKINSON: What's important? What makes family therapy useful, as opposed to individual therapy?

SASLOW: Well, Virginia Satir demonstrated that very convincingly. She was one of the first persons to use family therapy. I invited her here to demonstrate to us how she did it, and one of the first things she demonstrated was that the first person that you called upon to say "What are the problems I see in our family?" was the youngest child, if the child was able to speak, was old enough to speak. She would start, not with an adult, but with the person who was the youngest in the group and move from there up the scale of age as people defined the kinds of problems they saw in their family. And it often turned out that those problems were being verbalized for the first time in the hearing of all of the members of the family, and that was extremely useful. And she demonstrated how she would then get the family members to interact with each other about what they had just been hearing from one another. That turned out to be very important in bringing the family together.

And sometimes we would invite some members of the family to come out of that one-way room while they listened to how the remaining members talked with each other. That was a very useful technique. We also used – we used the visual method. There was a lot of television with people watching interviews and paying attention to the way in which - while you watched somebody in an interview, they might suddenly do something like that [demonstrates] but not comment on it. You would play that back and say, What thoughts do you remember or feelings do you remember having at that moment? And you would increase their awareness of what was happening to them by the use of such visual techniques.

That also was abandoned when I retired. Of course, I retired unable to carry all of these things on continuously, because in my time there was a mandatory retirement in the country when you were sixty-five. And when you were an administrator at this medical school, like a chairman of a department, and you were approaching sixty-five, you were told you would soon have to retire. Some years later, in the Clinton administration, that mandatory thing was abolished.

So I retired quite, in my view, prematurely, because I'm still active. I got bored to death after doing nothing for a year, and then I responded to the invitation to go down to UCLA, where I spent five years creating a new residency program that they needed - which is still actively going and is highly valued – and a new third-year clerkship, which they needed, because the California legislature at that time had decided that the medical school at UCLA needed to be enlarged. It turned out they were mistaken, but that's how those programs got started. I had a fine time down there.

ATKINSON: What particular advantages do you see for group therapy versus individual therapy? What's good about group?

SASLOW: Well, the awareness that other people have problems such as you have is a very important one. The beginning of empathetic awareness of the problems that other persons have comes out very strikingly in group therapy and is very moving for the persons present.

Psychodrama is another way of doing group therapy which makes people aware of what others are experiencing. And we used the man I invited out from St. Louis, Leon Fine, who was doing psychodrama, which was suddenly disapproved of at the St. Louis State Hospital. I invited him to come out here and finish getting his Ph.D., which he did, and he introduced group therapy to our whole department. He made a tremendous impact on everybody.

ATKINSON: You were one of the earliest leaders in academic psychiatry to begin to pay attention to group process as an important therapeutic modality. You got involved in sensitivity training experience.

SASLOW: Yes. I was psychiatrist for the entire sensitivity training organization in Maine. I was their psychiatrist for a whole summer, and I dealt with a lot of the problems which occurred there to members undertaking sensitivity training who experienced emotional distress, and sometimes psychosis. So that was a useful function which gave me a lot of experience with a different kind of group of people not ordinarily defined as patients, people active in ordinary life, people in business and professions and so on.

And it was because of that experience that later on I was suddenly asked by the president of Washington University to go out to Los Alamos and be the psychiatrist there after they'd had some disastrous community experiences. I was the only member of the psychiatry department at Washington University who'd ever had training with groups, like T groups. There wasn't anybody else there to do it. And so for over ten years, I was psychiatrist during the Manhattan Project at Los Alamos, going out once a month on the Santa Fe Chief. There were no planes to get at that time, close to World War II.

ATKINSON: That must have been a remarkable time. Tell us about it.

ASLOW: Well, you were not allowed to be cleared beyond a certain point, but you had to deal with the emotional problems of scientists working on the Manhattan Project.

For example, in one setting in Maryland, where particle theoretical physicists worked - there were about six theoretical physicists in the country who knew enough about high-pressure - about theoretical physics to be useful to the project. One of these men was an alcoholic who, in an alcoholic state, nearly beat his wife to death, and himself became psychotic. I would suddenly get a call to fly out - to get out to Los Alamos immediately to decide could this man ever be restored to function. They needed his functioning in theoretical physics. So I got out to Los Alamos to size up this man's ability to function. I didn't understand the theoretical physics that he was using, and it was a difficult job to decide, how do you tell whether he's ready to return to work. That would be one of my assignments.

On another occasion, a man who had been a fullback on the Purdue football team - he weighed over two hundred pounds, and, as we see it now, he would have been labeled a manic-depressive today. He was in a manic state. He decided that if we had the atomic bomb and Russia was on our side, Stalin ought to know about it, and he was going to tell Stalin about the atomic bomb. Obviously, that could not be permitted. General Grove, who was in charge at Los Alamos, said this cannot be permitted.

I was asked to come out there immediately, and I flew back with this man and two security guards, who had a higher clearance than I did, in a small private plane, from Los Alamos to get him hospitalized on the psychiatric ward at Barnes Hospital in St. Louis. There was no medicine at that time to deal with a maniacal state that was effective, and the only way I could prevent him from ruining all of us by ditching the plane was to keep him talking all the time. So I kept him talking all the time, and he did not kill all of us.

We got into St. Louis, drove through red light after red light to get him hospitalized as soon as possible. I was never allowed to see him alone until he had stabilized again, which took several months before he could be released from the hospital. That was another unusual experience.

Still another one occurred when a man who had been on the Pacific front, a surgeon who had grown up in Illinois and had had malaria several times, was assigned to Los Alamos as surgeon. He was a very pleasant man, highly regarded. He was trying to deal with a soldier who, in driving on the still-unfinished roads from Los Alamos to Albuquerque, was drunk, had a terrible accident, was brought back to Los Alamos, and while he was being treated by the surgeon for whatever injuries he had suffered, he kept on bringing up saliva from his lungs and making the operation more and more difficult. The surgeon suddenly lost control of his temper and, with a wet towel, beat him to death in full view of everybody in the surgery.

Of course, in a community numbering only two hundred people at that time at Los Alamos, every one of whom was invested in research – no wives, no dependents, no children could be there for a while – this became immediately known, and the whole community was in such distress, I was asked to go out immediately and deal with their distress. That was another unusual experience.

ATKINSON: Through group discussion?

SASLOW: Dealing with the entire community. And, again, I was the only person in the department who'd had any experience working with groups of people who were not psychiatric patients. I had to deal with the distress of the entire community. That was another extraordinary experience.

ATKINSON: So you gathered everyone in the community?

SASLOW: We met with everybody. I had some very interesting meetings. And it was several years later that an internist, Loren Blaney came out, and he took over the responsibilities of completing the treatment of patients after I had decided what he could do that would be helpful to them. He and I began to work together. And after a number of years, the restrictions on Los Alamos began to be lifted; the families could come, I didn't need to work any longer with all the teachers in the school. I was the only one who was available for a while. But Los Alamos, when the restrictions were finally lifted, became an ordinary city and they functioned in an ordinary way.

ATKINSON: Had you made that recommendation? Had that been your observation, that part of the peculiarity and difficulty for those scientists was the lack of families?

SASLOW: They came to recognize that themselves, that it made a lot of difference if family members could be present. And so I no longer was the only person dealing with all of these problems.

ATKINSON: Is it a good idea - based on the Los Alamos experience, do you think it's a good idea to cluster or cloister a group of scientists of that sort off in the middle of nowhere for projects? Does it make sense, in light of your experience?

SASLOW: It's hard to answer that. The Soviet Union did exactly the same thing. It had a lot to do with the way the people in charge felt about betraying secrets. I don't think they'd listen to anybody else; they were too worried about somebody learning their secrets. And, in fact, there was a tremendous amount of betrayal of American secrets to the USSR, because it wasn't very long after we had developed the atomic bomb that we learned that they had too. It took only a couple of years, on account of the spy information which they got. But I had nothing to do with that.

ATKINSON: When I first met you, in 1969, you were very much involved in a different sort of project that involved group work, and that had to do with groups you had inspired the development of around the state for primary care physicians. You had a cohort, a man that you worked with. I believe his name was Robert Daugherty.

SASLOW: Yes. He was an internist.

ATKINSON: Yes. And I believe the idea was to improve the sensitivity of physicians.

SASLOW: We met regularly with physicians in each of the counties where there was a county medical association. We invited questions, we interviewed people that they suggested we interview, we talked about interviewing, and it was really a statewide enterprise. It was a very worthwhile idea.

ATKINSON: And that went on over several years.

SASLOW: Over a number of years, right.

ATKINSON: And, from your point of view, did make a difference in the quality of practice of some of the doctors.

SASLOW: Yes, and the way people looked at the mentally ill and at psychiatry in general, sure. It was a very important combined effort of internal medicine and psychiatry.

ATKINSON: And it went on for several years, but then...

SASLOW: I forget what happened. I don't think Daugherty died. I guess he just lost interest. I'm not sure about what happened. Maybe I just had something else to do.

ATKINSON: Dr. Kendall has told me a story of another way in which your group skills became of use here in some consultation around some problems in the Department of Medicine. You apparently met with faculty for some time to do some troubleshooting?

SASLOW: It had to do with the kind of persons they would like to choose as chief residents, what the criteria were. We read a book together about psychotherapy – I forget what its name was – and we discussed the criteria that they would like to use, and we all found that very useful.

I was used to being a member of the Department of Medicine because I had been at Washington University. It was part of my interest in medicine and psychiatry as belonging together, so that was not unusual for me. And John Benson thought it was very helpful to the Department of Medicine. He came the year after I did and was a member of that group.

We haven't talked about the research on interviewing that I did.

ATKINSON: Would you like to?

SASLOW: That needs to be discussed.

ATKINSON: Let's do it.

[tape stopped]

SASLOW: I became interested in psychiatric interviewing while I was in my third year residency at the Mass General Hospital. As soon as we got into the war I tried to enlist, but I was rejected because of two experiences that the U.S. Army had had at that time in North Africa. There was a tremendous increase in asthma in that desert climate, and I had asthma. I'd had it for a number of years; and there was a tremendous increase in psoriasis disabling people with weeping psoriasis so they couldn't function. For those two reasons I was rejected and I was assigned to examine people at the draft board at first. Later on, I was assigned to Washington University to train doctors, because we needed doctors very badly in the accelerated medical school programs of that period.

Well, while I was still at Mass General Hospital, I worked with – I came to know an anthropologist named Elliott Chappell, and we were both interested – we became interested in the fact that the psychiatric interview had never been carefully studied, so we devised a particular plan for studying the psychiatric interview. What had become possible at that time was a series of relatively small long-playing records, so you could record a conversation while it was going on and listen to it, and you would have included in it what you had said as well as what the other person had said.

We devised an experimental procedure for studying the interview, which is something like as follows: It had several periods in it. In period one, you invited the patient to talk about what he or she was doing there, and every time that they spoke, you encouraged them

to keep talking. After they had done that for about twelve minutes, as they continued talking, you suddenly shifted your behavior, and you simply didn't respond while they made another twelve or so statements or twelve or so minutes passed. Then you returned to your period one behavior where you were very encouraging for another twelve minutes; and then, when that period was over, every time they spoke, you interrupted them for twelve times. And then, when that period was over, in the fifth and final period you again listened encouragingly.

And you were recording all of that behavior quantitatively, and you were recording it on that disk. And so you became aware that patients differed very remarkably as they went through this experimental interview. Depending on their psychiatric diagnosis, you could pick up schizophrenics as being very different from people who were depressed and people who were anxious, and so on. So it became a very useful method for identifying different groups of mentally ill patients, and we applied it in a number of hospitals and in a number of settings over a number of years.

I spent fifteen years studying the psychiatric interview, and it was one of the first funded projects of the National Institute of Mental Health, which had been established in the late – in 1959, or something. That's a long period for studying the psychiatric interview, which had never been studied before.

ATKINSON: Were there certain diagnostic groups of patients who were more responsive to the variations?

SASLOW: Oh, yes, they had different – you could identify them differently, right. That's why that was the usefulness of the interview. That was the first time any such device had ever been thought of.

I don't remember more about that, except people who've worked with me, like psychologist Matarazzo and his wife, Ruth Matarazzo, and another psychologist, Jeanne Phillips, they moved with me from Washington University to the Mass General to work on this interview, and then they came out here to Oregon to work with me. They joined the department.

ATKINSON: Let's talk about that. You mentioned collaborating with an anthropologist and then psychologists. One of the things that I found very impressive about the department during your time as chair is that you had a very broadly-schooled faculty. You had people from the social sciences and from psychology, you had a pharmacologist in addition to people trained in psychiatry. You, yourself, were double-degreed and had your Ph.D. in physiology. We have a narrower faculty base now. We aren't, as a faculty, so broadly schooled. Have we lost something?

SASLOW: I imagine we have.

A major error I made in relation to that broadly-schooled idea was this: I came to the conclusion at a certain point that psychology had now advanced enough as a facility related to medicine and to psychiatry to deserve a department of its own. I therefore recommended that Joe Matarazzo become the head of a new psychology department. The dean went along with that.

It then turned out that no sooner had that happened that Matarazzo revealed that he was – he had really been deceiving me all along. He had a kind of totalitarian mentality. He insulted all of the members of his own department; he humiliated them publicly before each other. Half of them left the department and joined ours or went into some other department at the medical school, and it was a disaster. It took years before that could be undone.

I've never become comfortable with him again since, because one day in a parking lot - in the old parking lot on the gravel near the Doernbecher Hospital, he asked me some question. I said, "Well, we'll discuss this with the whole department." I was used to doing that. And he said, "You are mentally ill if you believe in working with your whole department." I never forgave him for that, and I've never had anything to do with him since.

[End of Tape 1, Side 2/Begin Tape 2, Side 1]

SASLOW: ...all of his own department, not only just me. And, apparently, no other medical school in the country followed that model because of his behavior, which became widely known through the psychologists who left. There were a number of very capable psychologists, and they made it widely known what he was like. He recently was – he was elected by some kind of scheme as president of the American Psychological Association, and he won some kind of award and recognition, which they would find incredible.

ATKINSON: Well, I hadn't planned to open up this Pandora's box, but...

SASLOW: Well, there it is.

ATKINSON: It's very interesting, what you say. The rumor, of course, the thing that most of us have heard over the years, is that the formation of the medical psychology department was a consequence of the falling out between you and the Matarazzos.

SASLOW: No, it was not.

ATKINSON: And the idea that it was your...

SASLOW: It was my idea.

ATKINSON: ...brainstorm to found a separate department is a revelation for me to hear.

SASLOW: That's true, that's exactly what the sequence of events was.

ATKINSON: And so at the time you formulated the idea of a separate department of medical psychology, you and the Matarazzos were still on good terms.

SASLOW: Yes. We were working together on the interview research. And his wife tried to remedy the breach between us, but I would hear nothing of it.

ATKINSON: So it was after the separation of the departments that things went sour.

SASLOW: Right.

ATKINSON: And Dr. Ruth Matarazzo did try to be a peacemaker.

SASLOW: Yes. And I wasn't – in view of what he had done to the rest of the department, to many of the members of which I felt closely allied, like Jeanne Phillips and Fred Kanfer and others...

ATKINSON: John Marks.

SASLOW: John Marks. They were people well known in their own right.

ATKINSON: Vince Glouden.

SASLOW: None of them had anything to do with Joe after that, so I didn't feel it was just myself.

ATKINSON: And that beach has never been repaired and never will be, you think?

SASLOW: Not as far as I'm concerned. I'm not comfortable in his presence, because I don't know what language to use for his deceptive behavior. He would like to pretend it never happened. And, for all I know, maybe he doesn't even remember it. But his behavior with all the people in his department tells you the story...

ATKINSON: Yes.

SASLOW: ...of why I can't stand him. I'm afraid I'm very unforgiving. I won't enter the realm of the forgiving.

ATKINSON: Well, while we're on the subject, is there anybody else on your list of...

SASLOW: Nobody.

ATKINSON: Your A list of, not enemies, necessarily, but people for whom you don't have high respect?

SASLOW: No, not particularly. I've enjoyed most of my associations in whatever fields I've worked in.

ATKINSON: Let's go back to things we were talking about earlier for a moment. We talked about the fact that when you look back on your career you see yourself first and foremost as a teacher, and we've talked a lot about the main area of psychiatry where you have made your finest contributions, namely, in the study and practice of interviewing and psychotherapy. Is that parallelism significant? In other words, do you think that teaching is a pretty important aspect of psychotherapy?

SASLOW: Absolutely.

ATKINSON: Do you think it's fundamental?

SASLOW: Yes.

ATKINSON: I'm not trying to lead you, but...

SASLOW: I do think it is.

ATKINSON: So that the enterprise of doing psychotherapy you think may be a special case of a teaching-learning relationship?

SASLOW: Yes. In a very complex area. I find that particularly true when I think of the hearings I've attended of the Psychiatric Security Review Board. Helping those people find a place in the community, to me, is extraordinary. It's an achievement.

ATKINSON: You're speaking now of times when you actually interview...

SASLOW: Well, when we have a hearing and learn what is happening to a patient. The patient is always at a hearing; his family can be at a hearing. The hearings are public. The doctor is present, unless he's on vacation. Or maybe a social worker, maybe a family member. They're very impressive, these hearings, they're very open. And they're not subject to the usual legal rules of what's admissible as evidence. You can pay attention to things like hearsay, and so on, because these are not legal proceedings. They're proceedings designed to find out, Can this person live in the community.

ATKINSON: There has been a whole development over the last twenty years, as you know, of something that some people call psychoeducational programs, training chronic schizophrenics to live in the community more effectively by...

SASLOW: We have a long list of those through the Psychiatric Security Review Board. I have a very gifted schizophrenic patient who's a gifted pianist, for example. There are people like that, and in the past, we refused to pay any attention to that once the label schizophrenia was attached to them. It's not necessary for them not to live.

ATKINSON: And going back to your early comments about cognitive therapy, Beck's work, we now have manualized approaches to cognitive behavior...

SASLOW: I have used those...

ATKINSON: ...manuals for patients and for the psychotherapist.

SASLOW: I've used those in teaching residents. As their supervisor I've used some of the manuals. The cognitive behavior approach to therapy has been well recognized by the Association for the Advancement of Behavior Therapy, of which I was one of the original members. There's a move now to change the name from the Association for the Advancement of Behavior Therapy to the Association for the Advancement of Cognitive Behavior Therapy because cognitive behavior therapy has been found extremely effective in a great variety of mental illnesses: obsessive-compulsive disorder, anxiety disorder, depressive disorder, and even schizophrenia. We never used to think of the possibility that I could have a person as a patient who was a gifted pianist and also a paranoid schizophrenic. Clozeril made the difference in his life.

ATKINSON: Do you see any paradox in the fact that you came to psychiatry via advanced training in one of the, quote, hard sciences, physiology, and yet found yourself in psychiatry, pursuing a career in which your interest was more in the humanistic and behavioral aspects of our field rather than the hard science aspect? Do you see that as paradoxical in any way?

SASLOW: I'm not uninterested in the advances and knowledge of neurotransmitters. I think those are important discoveries. They have a very important place. It made a tremendous difference, for example, when in 1954, thiorazine was discovered in France. It was the first time schizophrenic patients could live outside a hospital. No, I would not think that nonrelevant at all. But it has to be placed in a broader context of empathic listening, cognitive understanding, community participation, and group life. You can't overemphasize the chemical aspects of psychiatric treatment any more than they can be overemphasized in medicine. Medicine is broader than that.

ATKINSON: It sounds like a pretty good credo for what residents need to learn.

SASLOW: I think it is. If I had to do it over again, if I could start over again, I would try to include a lot of the things we've talked about. Again. They proved extremely valuable to them; they never forgot them. I would get comments from residents in different parts of the country for years about the ways in which they had found what we had learned together useful to them for their own maturing as persons and as psychiatrists.

ATKINSON: So, the details may change and deepen, what we know about neurotransmitters or manualized cognitive therapy may evolve, but the fundamental truths about human nature and what people are like and what they need from us go on.

SASLOW: Right.

ATKINSON: So, if you lived your life over, you would want to pursue the interesting paths that you did pursue that you've been talking about?

SASLOW: Sure.

ATKINSON: You'd be happy to do it all again?

SASLOW: I'm not tired of them.

ATKINSON: And if you couldn't have the career you've had, what would be some alternate careers that you might pursue instead? Any favorite fantasies?

SASLOW: Well, before I became interested in psychiatry I thought I would end up doing research on human beings in internal medicine. That was my original idea.

ATKINSON: What sort of things?

SASLOW: That's not a bad alternative.

ATKINSON: What kind of research?

SASLOW: I didn't know. But it had nothing to do with behavior, at that time, anyway, as far as I remember thinking.

ATKINSON: Was there a time when you were, let's say, in the Ph.D. program in physiology where you had envisioned a different kind of career?

SASLOW: No. I didn't know what would happen, and there was a special reason for that. This was the period, about 1929, of the tremendous depression in the United States, and in the biology department in which I was teaching and getting my degree, there were about thirty members. I think about – over twenty of them had achieved tenure at New York University and they were summarily fired.

I became very upset about that, and that's when I decided I didn't want to be in that department. I protested strongly about it, and then I was fired for protesting, because the chairman was a man who had been denied admission in medical school, and he was very revengeful against anybody who had actually gone through medical school, and I'd had two years of medical school by that time, and he didn't like that, especially when I protested his decision to deprive of tenure over twenty members of the department, a number of whom were well known for research they had done in places like the Woods Hole Research Laboratory in Massachusetts. So, I wasn't going to continue on that pathway.

I protested to the chancellor of New York University about what this man had done, and he told me that if I had had children – and to that time I had not had – he would not have agreed to let me be fired. What he recommended instead was that I go on a two years' leave with full salary, no obligation to the department, and that would be his recommended compromise solution.

So I spent a year at Cornell doing research with somebody I'd come to know there on work I had started on the effects of caffeine on muscle while I was a physiologist at New York University. I spent a year doing that. Then I spent a year at the University of Rochester in the department of physiology continuing that research, and that was when I published a paper from there that the dean of the Harvard School of Public Health had to review, that it raised the question, Have you ever thought of returning to medical school? And I said I had thought about it but I couldn't afford it. He said, Well, we can help afford it if you'll take three years to finish, and you can have a salary of two thousand dollars a year while you do research in the fields you and I are both interested in, which was lymphatic profusion.

And so I was – he simply walked with me over to the admitting office of the department of medicine at Harvard. In those days, you didn't have any SATs, you didn't have to take any tests. He just walked you over as one man in charge. He was a professor of pharmacology. And the slight number of examples they had of people who had Ph.D.s who were over thirty years of age – I was then thirty-one – they had failed to achieve medical school; they couldn't take it. He decided, despite that, to give me a chance.

And so I was admitted on the Harvard School of Public Health dean's recommendation and this man's acceptance. That's how I got to finish medical school. I had to review my anatomy, all of which I'd forgotten. It took three years, and I finished.

ATKINSON: You are a voracious reader. Over the last few years, you've recommended reading to me spanning a breadth of subjects from evidence for homophilic behavior in the animal world to early Ireland and its preservation of classical Western values through its literature and learning, and a million things in between. What are you reading these days?

SASLOW: Oh, there's a South African author, whose name is spelled C-o-e-t-z-e-e, Coetzee, who's recently won a Nobel Prize. I'm reading everything of his I can get. He's a fascinating writer. I've also read a number of things by people who've come from China and written about Mao's great Cultural Revolution, and various other kinds of things going on in China. I've read about how people behave who come to America from Bengali, India. So there's a wide range of things I'm interested in, still, as well as in music and in plays.

ATKINSON: George, what have we left out? Anything from your review of the taped interview with Joe that you had on your agenda that you'd like to talk about that I haven't asked?

SASLOW: There was one thing I remembered wanting to mention that was not in that interview. While I was finishing high school at this excellent, highly regarded Boys High School in Brooklyn, New York - I was one of the youngest students because I'd been skipped several times. That was the only way the public school system in Brooklyn knew how to deal with a bright youngster. So I was skipped twice, which meant I was always the youngest and the shyest and the least socially experienced of all my peers. I could never play on a football team or a basketball team. But – and I was selected to be the valedictorian at the graduation exercises of Boys High School.

But during my third year, and before I finished, I was – I forget how this began. I would be accompanied in walking from the high school to the elevated station where I would take the train to go home - I would be accompanied by a teacher of English named Polk, P-o-l-k, he came from Germany. He was a poet, a playwright, and a dramatist. He encouraged me to take a part in a play, for example. That never had dawned on me.

As we walked along, he began to ask me what my plans were when I graduated. I told him the only plan I had was paying attention to what my mother was saying, namely, that I'd have to go to work right away, and she thought I'd better become a bookkeeper. That would be a possibility. And he said, You are bright enough that you would make a contribution to our society. You have got to think beyond that. I think you ought to go to college. I said, I can't afford to go to college. I haven't any money. And he encouraged me to think about that.

I talked to my mother about it, and she wrote to her sister. She had a sister in Chicago who had a small grocery business. And the sister sent a check for seventy-five dollars for me to register for one night course at Washington Square College, a newly-formed college in New York University. It is now their biggest college, but it was then a new college.

And so I – with that check, I went to Washington Square College to register, and there I met the dean of the college, a newly-appointed dean, and he looked over my record and said, You ought not to just take one course, you ought to register for a four-year college course. And I told him I can't afford it. He said, You could have a part-time job teaching biology, and that will pay for it, and I will help you with other expenses.

It turned out that his father – his name was Munn. His father was the president of the University of Rochester, which had just built the first new medical school in this country in two decades, in Rochester, with the aid of Rockefeller Fund money and Eastman Kodak money. Dean Munn offered me this opportunity to earn my keep by teaching biology at Washington Square College.

I was very shy and very embarrassed about depending on that help. I wouldn't tell him when I had a sweater that was full of holes, and he would suddenly give me a sweater as a gift, for example, at some particular – it might be my birthday, it might be Christmas. He and I would walk up and down Fifth Avenue – he lived way up near the park up there on

Fifty-Seventh Street in a beautiful four-story house - and he would talk with me about what I should be doing as I planned for the next years of my life.

Well, it was through him that when I finished college in 1926 he suggested – I had no idea what I was going to do next, and he suggested visiting Rochester, and I was admitted to medical school there. I was the youngest student in a class of twenty-four. There were students from different countries. Among the students were four women, very unusual in those days. Every one of them became a well-known professor later on. And I kept on knowing some of them for a number of years.

So this teacher, Mr. Polk, was extremely influential in shaping the whole of my life. I just realized that the other day when I was thinking about the fact that I hadn't even mentioned him.

So, here are people ready to help you in all sorts of extraordinary ways. I don't know how common that is. But there are people like that around, I guess.

ATKINSON: Anything else that you'd like to – that's occurred to you since watching that other tape?

SASLOW: Just one other thing is some things I learned about my father during that year I spent in psychoanalysis. He never talked about his life, but he was very unusual in that - for example, on a shelf above the sink in the kitchen in New York where we lived there were four or five books in Russian. Very few people knew Russian in those days. You had to be highly educated. I never found out where did he ever learn Russian. He was distributing Russian pamphlets in the period of a couple of years just before the 1905 attempted revolution in Russia, and he decided that his life was at risk, and that's when he and his young wife – I think he was thirty-four and she was something like twenty-nine – that's when they came through Ellis Island to the United States. I was born in 1906.

He was a member of – he was a strong opponent of Lenin's views and of the Bolsheviks. He was a member of a group called the Mensheviks, which meant social revolutionary. When the revolution finally occurred in Russia, they killed all the social revolutionaries. He would have been killed. He took me to meetings of the Socialist party held in Brooklyn at a time when Norman Thomas ran for president. Even my younger son, Steven, remembers going to a meeting to hear Norman Thomas when he was quite an elderly man. So my father was very different from other Russians. He never talked about what that difference came from; I never knew.

ATKINSON: And, so far as you know, his formal schooling?

SASLOW: I have no idea. He never talked about it. People didn't talk about those things in those days, and I wasn't very interested in hearing. I was a typical first generation new American. I wanted to have nothing to hear about – nothing to do with the old culture, except I joined him in going to these meetings. I remember that. So he was really a different

kind of man than the usual Russian, too, evidently, and very different from my mother, who was very traditional.

He died in the very same year that I was having another of numerous episodes of pneumonia while I was a chief resident at the Mass General Hospital. I was in the hospital at the time he died, and I couldn't go to his funeral. I have had, all told, eight or nine episodes of pneumonia on account of inefficient treatment of asthma, until I was down at UCLA and for the first time received proper and effective treatment. I've never been in the hospital again after that last time, which was 1975. So I've been very lucky, and I've been very well since.

I've had an aortic aneurysm, which stopped just above the bifurcation of the kidneys, so I have a plastic thing in. And what else have I had? I've had a GI bleed of the – my right iliac artery, which is connected to the bottom of the aneurysm and suddenly ruptured, and I nearly bled to death and needed about ten transfusions, but I survived that. So I'm in fairly good health at the present time. My blood pressure is being carefully watched by an excellent geriatric physician, trained here partly and at Good Sam. Dr. Patricia Newton. You know her?

ATKINSON: Very well.

SASLOW: She was my wife's doctor, and she's mine.

Those are the only things I remember I never thought about while talking to Joe Bloom. I don't think I can think of any more.

ATKINSON: A couple of things. You mentioned Julia. I'm not sure – I don't recall from the other tape whether you talked about Julia much. How you met, how your lives professionally intertwined over the years. Do you want to comment at all?

SASLOW: Well, through two people that I had been tutoring, who lived in southern New Jersey when I was at college, two brothers named Immermen, whom I had been tutoring while I was a college student, I was invited by them in the summer the end of my third year to vacation with them in southern New Jersey. That's where I first met Julia. She was staying with some friends that she had known at Hunter College for a long time, a whole family. The father in the family was a doctor who had come from Russia and was practicing in southern New Jersey. He was a very fine man, then in his eighties, a Dr. Jaffe.

I was very shy about girls. I'd had no experience with them, practically. Julia and I began to know each other and be interested in each other, and when the vacation period was over, we both were returning to college. In those days, it was safe to hitchhike back, and we hitched a ride back. A man gave us a ride almost to New York. I guess after that we kept on communicating by letter nearly every day for a long time.

Then, when I graduated from college, there came this unusual opportunity to go to medical school at the University of Rochester. She was working as a social worker and thought she'd be uncomfortable staying in New York while I was in Rochester, so after I was there for a while – I forget how long – she came and got a job proofreading for Eastman Kodak for a very excellent woman editor of their chemical journals. She didn't know any photographic chemistry, but she was a wonderful proofreader. So for the next two years she was in Rochester, working there while I was there. We would meet often, and we finally decided we'd get married.

At that time, the University of Rochester faculty decided that medical students ought not to marry, and so I had to make a choice between not marrying or giving up medical school. Many of my student colleagues and a number of the interns and residents at Rochester posted letters in our men's locker room disagreeing with the faculty stand on marriage, so I decided I would defy them, so I left to get married...

[End of Tape 2, Side 1/Begin Tape 2, Side 2]

SASLOW: I lost support from Dr. Munn at that time, and we came back to New York. We got married when we were both twenty-eight, and we were married ever since. After we'd had our – we had two sons and two daughters, and after they had grown beyond the necessity of her to be a fulltime mother, she decided to get a degree in psychology, and at sixty-three she got a Ph.D. from the University of Oregon and spent the next years working in the counseling service at PSU. And at St. Vincent Hospital she conducted group therapy until, because of hearing loss, it became impossible for her to hear the group, and she then stopped. But she had a long working career as a psychologist.

ATKINSON: And very much shared your interest in psychotherapy, individual and group psychotherapy.

SASLOW: Yes. And we often worked together with patients and couples and families. Yes, we did that. That was a very long, happy period in our lives.

ATKINSON: The archivists here at the library would probably appreciate it if I asked you, looking back on the years here, who stands out in your recollection? Who were the people who were most effective in the school, who helped you and the department grow, who you found it most interesting to collaborate with, who you learned from?

SASLOW: I would say Dr. Howard Lewis was extremely influential and helpful. So was John Benson, whom I'd first met at Harvard when we both taught second-year medical students.

And Dean Baird himself. I had hundreds of requests to make to him as I set up a new department in a place which had not ever had a psychiatry department. I had people working part-time on various kinds of jobs on the campus to learn work skills when they no longer needed to be patients. I had them working in the community, for example. I had to find out,

if there was an accident out there and they were injured, what liability would we have. I had hundreds of questions like that to raise with Dean Baird. He could answer most of them, but, when he couldn't, he would ask his assistant, Dr. Holman - who then became his successor dean - at the next meeting of hospital administrators in the West to find out how did they look at this, and always the answer came back it's okay to try.

So Dean Baird and Dr. Holman and Dr. Lewis, they were the ones who had tremendous beneficial effects on what I was doing here. I could not have done it without them.

For example, when I first came out here, there was one ward for psychiatry for about twenty-four people. It had a wall running down the hall, and on one side of that wall there rooms that could be locked, for suicidal patients, and at the end there was a room about half of this size which could be an exercise room for those patients; and there was a small nursing station staffed by nurses three times – what do you call it?

ATKINSON: Shifts.

SASLOW: Three shifts, for five patients, because they were so unused to dealing with psychotic patients. And then, on the other side of that wall, there were a number of very beautiful, brand new tubs with wonderful chrome fittings for the hot and cold baths which were used before thorazine came into use and electric shock was overused.

Well, we had to get rid of all of those things. And there was a rule of the state legislature that when a new structure was built, for the first two years, if you needed to change something because there was some kind of error that had to be corrected, you couldn't spend more than ten thousand dollars on it. So Dean Baird carefully arranged for a series of moves to get rid of those tubs, get rid of that exercise room, get rid of that nursing station, to break down that wall over a two-year period in a series of moves, each costing less than ten thousand dollars (laughs).

So we ended up with a room for a resident, which there wasn't before; a room for a psychologist, which there wasn't before; a room for a chief of nursing, which there wasn't before; and a completely open ward. That was another innovation which we could introduce through Dean Baird. So I had a lot of help from him.

There was only one time that he did not go along with me. I think I mentioned that in the interview with Joe Bloom. There was one person I wanted to appoint, and he said, I can't approve that, and I can't tell you why, because it's a matter of confidentiality. It turned out that he was justified. I found later on through some other source – I forget who that was – this person had been deceptive about something and had a bad credibility record. That was the only time Dean Baird didn't go along with something I requested, out of hundreds. That's quite a record.

Now, in my own family, you may have noticed one of our two granddaughters is a pilot. She's only nineteen. She's just gotten a fulltime job on the airlift – what do you call it? The Life Flight for injured people, you know. At nineteen, she's one of the – she took Margie Boulé up in a plane. Margie Boulé wanted to talk with an early woman – a woman pilot. She's one of the two or three youngest pilots in the United States. Her name is Sarah Brown, Sarah Saslow Brown, and she was featured in the Oregonian the other day in a long article by Margie Boulé. She never went beyond high school. She was home schooled.

She is – I think she's just finished – she's going to be working for an associate's degree in aviation, I think. You can do that even though the school is down in Florida and she's in Hillsboro. They can do that through the Internet, I think. She's going to do that. So she's quite a remarkable young woman. A delightful granddaughter.

We've been happy in our granddaughters, too. We have two of them.

ATKINSON: We may be done.

SASLOW: Okay. That would be nice (laughter). Do I have to come back?

ATKINSON: You've been a good sport.

[End of interview]

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