In Memoriam Peter Gaszner (1939–2017)

Thomas A. Ban and Andrea Tone

On July 25, 2017, Peter Gaszner, a close friend and a member of our International Network for the History of Neuropsychopharmacology, passed away.

Peter Gaszner was born in 1939, in Bekescsaba, Hungary. He received his MD from the University of Debrecen, Hungary, in 1963, and earned diplomas in neurology, psychiatry and clinical pharmacology in 1957, 1970 and 1980, respectively. He was trained in psychiatry in the Department of Psychiatry at the University of Pecs. During the 1980s, Dr. Gaszner became Director of Psychopharmacology at the National Institute of Neurology and Psychiatry of Hungary and Professor of Psychiatry at Semmelweis University and during the 1990s, he served as Vice President of the European College of Neuropsychopharmacology. Dr. Gaszner was Founding President of the Hungarian Psychopharmacology Society and Founding Editor-in-Chief of *Neuropsychopharmacologia Hungarica,* the journal of the society (Salzman 2011).

All through his professional career Peter was involved in research. In the 1970s his research interest was focused on atropine coma therapy and on epilepsy and anticonvulsants (Ban 2011; Faludi and Ban 2001). In a series of studies conducted in the early 1980s in normal subjects, in collaboration with Elemer Szabadi and Christopher Bradshaw, he demonstrated differences in peripheral anticholinergic activity among tricyclic antidepressants. They had also shown adrenergic blocking effect with neuroleptics (Gaszner, Szabadi and Bradshaw 1980; Szabadi, Gaszner and Bradshaw 1980, 1981). In the 1990s, Dr. Gaszner was a member of the international team which demonstrated the efficacy of reboxetine in major depression (Ban, Gaszner, Aguglia, et al 1998). At the time he was Visiting Professor in our Division of Psychopharmacology at Vanderbilt University, in Nashville we collaborated in developing a Composite Diagnostic Evaluation of Hyperthymic Disorders to study the therapeutic profile of drugs used in the treatment of mania (Gaszner and Ban 1998).

On December 15, 2004, Peter Gaszner (PG) was interviewed by Andrea Tone (AT) at the annual meeting of the American College of Neuropsychopharmacology (ACNP) in San Juan, Puerto Rico. His edited interview (see below) was first printed in volume 8 of ACNP's Oral History Series (Ban 2011; Salzman 2011).

Thomas A. Ban

INTERVIEW

San Juan, Puerto Rico, December 15, 2004

Andrea Tone: We're at the 2004 Annual Meeting of the ACNP, my name is Dr. Andrea Tone, and this morning I have the pleasure of interviewing Dr. Peter Gaszner. Thank you for agreeing to be interviewed.

Peter Gaszner: It is my pleasure to be here.

AT: Tell us a little bit about your background and upbringing and how you got interested in medicine.

PG: Are you interested in my personal background or in my research activities?

AT: Both.

PG: Both, OK, let's try. As you know I'm from Hungary. It had a great impact on my life that in 1956. I was involved as a young soldier in the uprising against the communist regime and Soviet occupation. I was 18 years old at the time of the revolution and when I graduated from high school it created difficulties for me to continue with my education. My father was a physician and he wanted me to continue with my studies. He was not determined that I become a physician, because he thought that the life of a doctor was very difficult, but he thought I should study whatever I was interested in

AT: What did you want to be before the revolution?

PG: I wanted to be a chemical engineer. It's very interesting to think back, because I am a clinical psychopharmacologist now. In someway I returned to my first love. Of course, I am a psychiatrist first. To make a long story short, eventually I entered medical school in Debrecen, a city in Eastern Hungary, a very at-

tractive university town. As soon the "communists" found out that I entered university, they tried to have me kicked out from medical school. You might have heard that after the revolution we had a few very rough years with lots of punishments, executions and so on. As time passed, life became a bit easier. It was my good luck that I was able to continue with my studies, and, finally, in 1963, graduate from medical school.

AT: Can I stop you for a second? This is a really fascinating story that I think people will be interested in. The Communist Party and their representatives, actually, went to the medical school, or what happened?

PG: Yes, they did. It was a very difficult period of my life and it continued to be rough even after I got my diploma. There was an opening in the department of psychiatry at the Medical School in Debrecen, and the chairman was ready to hire me, but I could not get the appointment, and not only because my past, but also because I was not a member of the Communist Party, or of the Young Communists Organization. Fortunately, the Chairman of the Department of Psychiatry at the Medical School in Pecs, a city in Southern Hungary, made it possible for me to become a resident, first, and, later, a psychiatrist in his department. After completing my residency, I got my certification first in neurology, then in psychiatry, and later on also in clinical pharmacology. It was not possible to get a diploma in clinical psychopharmacology in Hungary, in those years. It was a great disadvantage for me that I did not join the communist party. To compensate for it I had to work very hard.

AT: But, they didn't pursue you, or try to kick you out of the field? They left you alone?

PG: No, I was able to get my PhD in Pecs and move to the National Institute of Neurology and Psychiatry of Hungary, in Budapest. I have been with the Institute now for about 25 years. I also received my Doctor of Science degree from the Hungarian Academy of Sciences and became the first psychiatrist appointed to a committee of the Academy. The Hungarian Academy of Sciences is a 150 years old prestigious institution.

AT: Can you tell us a little bit, to sort of set the stage, what psychiatry looked like at this time? Can you tell us what it meant to be a psychiatrist, the role of biological psychiatry within psychiatry and how other doctors viewed psychiatry?

PG: Hungarian psychiatry was prevailingly biological. It had strong ties with the German school of psychopathology. But, 70 or 80 years ago, before the Communist regime, it was also inspired by Freud and we had several excellent psychoanalysts. Many of them immigrated to the United States before World War II. Psychiatry was transformed during the communist regime. It was entirely biological. Psychotherapy, I don't know why, was prohibited in those years. When I was young, as I told you, I was dreaming about to become a chemical engineer and after I became a psychiatrist, I tried to realize my dream by becoming a clinical psychopharmacologist. I was one of the first clinical psychopharmacologists in Hungary, and the founder of the Hungarian Association of Psychopharmacology. Later, I became also the founder of the Journal of the Association. By now Neuropsychopharmacologia Hungarica has become an international journal. Although I'm a psychiatrist and psychopharmacologist, I'm combining pharmacotherapy with psychotherapy in my practice. I'm the head of a psychiatric service at the National Institute of Psychiatry and Neurology of Hungary. It is the largest clinical service with 140 patients at the Institute and also in Hungary. My service is designated as the psychopharmacology service of the Institute. Yet, I spend most of my time at work doing psychotherapy.

AT: I didn't know that.

PG: I believe that pharmacotherapy together with psychotherapy works better than pharmacotherapy alone.

AT: So, biology can be enhanced in tandem with an emphasis on environmental inputs?

PG: Exactly. Our patients with major depression or schizophrenia are treated with a combination of pharmacotherapy and cognitive therapy.

AT: So, someone with panic disorder would get exposure to psychotherapy at the same time that they might get an anxiolytic.

PG: Yes. Panic disorder is one of the common diagnoses in Hungary these days. We are treating patients with panic disorder with serotonin uptake blockers together with psychotherapy. I have a feeling that all of our patients respond favorably to our combined treatment.

AT: That's wonderful. So, just for the record, I want to make sure that people, who are viewing this videotape, get this correctly; you are working at the National Institute of Psychiatry and Neurology of Hungary?

PG: Yes. I am 65 years old and intend to work three or four more years before retirement. I like very much what I'm doing.

AT: That's good. Tell us about some of the earliest work that you did and take us through your career, what you see as the key contributions that you've made to the field.

PG: Are you asking me about the clinical research I did?

AT: Right.

PG: It might be interesting to have it on record that I did my research always at nights because during the day I was busy attending patients. During the day, we have to do our clinical job because in Hungary because we are very short of psychiatrists.

AT: Could you get funding from the government for your research? Probably getting funding from industry wasn't possible.

PG: No, I could not get funds from the Hungarian government. The Hungarian government was always very poor never had funds in the communist era, nor in the past 15 years. The democratic government we have in the past 15 years does not spend enough money for the health service. The entire health service, and, especially psychiatry, is under-funded. To do research, I had to collaborate with colleagues in the United States, Western Europe and Eastern Europe. Usually the money for the research is coming from the United States and Western Europe.

AT: Going back to when you started your career and you're doing your research at night; I have this image of you by a tiny little lamp on the table, which may be misleading. What were the kinds of questions you were most interested in and how were you able to do your work?

PG: I was involved in six different areas of research. Chronologically, I was interested first in atropine coma therapy in psychotic, and especially schizophrenic patients. It is a treatment modality that is no longer in use. But about 35 years ago when we still did not have effective drugs for treating psychotic patients, it was very useful.

AT: Was chlorpromazine available to you in Hungary?

PG: Today, every drug is available in Hungary.

AT: But in the late 1950s and 60s?

PG: We had chlorpromazine, but not as much as we needed. To be able to do our job we had to use ECT and atropine coma therapy. Atropine coma therapy was effective and had virtually no side effects. Atropine was given intravenously. One of the difficulties of atropine therapy was, and I found this out early in my research, that patients widely varied in their sensitivity to the substance. For some patients, I had to administer as high as 1,000 mg of atropine sulphate to induce coma, whereas for some others 10 mg was sufficient.

AT: If I understand what you're saying correctly, this was a method you pioneered as an alternative because of the political reality of not being able to get enough antipsychotics. Let me ask you: Did you continue to use it, even after the new drugs became available?

PG: When I transferred to the National Institute in Budapest some 25 years ago I stopped using atropine coma therapy. By then we had enough psychotropic drugs in Hungary.

AT: OK, that's what I was wondering.

PG: But truly, we never really had enough money to pay for psychiatric drugs. Western pharmaceutical companies gave us drugs free of charge in the hospital.

AT: How did you get them?

PG: Representatives of the companies came to see me in my office at the Institute, and, offered their drugs.

AT: So, even under Communism, the companies were allowed to have offices in Hungary? This is very interesting.

PG: Yes, it was a very interesting situation. If we hadn't been given drugs free, we wouldn't have been able to treat our patients. This is the situation even today. The new atypical antipsychotic drugs are extremely expensive. We can't afford to pay for them. But if we can get them free of charge in the hospital, we can use them treating our patients.

AT: In hospitalized patients?

PG: Yes, and after discharge the patient can continue on the same drug. That is good business for the drug companies.

AT: Right. That's very interesting. Sorry, I interrupted you. You were saying you had six different projects and we were talking about the first.

PG: In 1979, I went to England to work in Manchester with Sir David Goldberg and Professor Elemer Szabadi in clinical psychopharmacological research. I was involved in the development of a new method to study the peripheral effects of antidepressants and neuroleptics with the employment of psychophysiological tests, such as pupillometry, galvanic skin resistance, and others. Then, in the 1980s, I went to work with Tom Ban in Nashville. I was there for the first time in the mid-1980s for six months, but I kept on going back every year after that until the mid-1990s.

AT: This was at Vanderbilt?

PG: Yes, it was at Vanderbilt in Nashville. I was working there also with Mike Ebert who moved since that time to Yale. And, as you know, Tom Ban is now in retirement. I am very sorry that he is no longer in Nashville.

AT: Yes, we all are.

PG: With Tom Ban we worked on the development of a new polydiagnostic methodology.

AT: The CODE system?

PG: Yes, the CODE system, the Composite Diagnostic Evaluation System.

AT: How does that differ from DSM?

PG: The DSM, and also the ICD, is a classification in which diagnoses are based on the consensus of experts, whereas in the CODE the diagnoses are based

on many of the different classifications in the past and present, including the DSM and ICD diagnoses. It gives a profile of the diagnoses included in the system. CODE-DD, the composite diagnostic evaluation of depressive disorders is based on 25 diagnostic classifications, and CODE-HD, the Composite Diagnostic Evaluation of Hyperthymic Disorders, I was especially involved with, is based on 16 diagnostic classifications.

AT: I can't tell you the number of people who have sat in your seat, who have told me, during this meeting and at previous meetings that DSM is so flawed that it almost makes no sense to use it as a diagnostic tool and, yet, people do. Why aren't we all using CODE?

PG: That's a very good question. Everybody is criticizing consensus-based classifications, but keep on using them. We also founded an International CODE Collegium, and a CODE Institute. I'm currently the president of the Collegium, and I'm also the Director of the Institute. I was also involved with the clinical development of reboxetine about 15 years ago. The drug was only recently marketed for the treatment of depression. It was an Italian company that developed originally reboxetine. Then, reboxetine went to Kabi and recently it belongs to Pfizer. I have known from the beginning that it's a very effective antidepressant. Still it took many years before it was marketed and even now it's available only in some countries.

AT: That tells you a lot about how marketing and industry shapes what people prescribe and what patients receive.

PG: Exactly. Drug companies are concentrating more on their profit and less on new drug development. Another area of research I have been involved with is clozapine, the first atypical antipsychotic. It was introduced about thirty-three years ago in Hungary and I have been using it since that time. It is my favorite antipsychotic drug. By now, I treated more than 1,000 patients with clozapine. It is the largest cohort of clozapine treated patients in one center in the world! Agranulocytosis is a very dangerous side effect.

AT: Tell us…

PG: From the more than 1,000 patients I treated we had only 2 patients with agranulocytosis and they are still alive. Of course, they are no longer on clozapine, but they are still alive. I believe it's genetically determined who will develop agranulocytosis. As you probably know about 35 years ago several clozapine treated patients developed agranulocytosis in Finland. As a result, clozapine was almost taken off the market. But, luckily it was rescued. In the USA, Herb Meltzer is the leading researcher involved with clozapine and I have been collaborating with him for some time.

AT: I didn't know that.

PG: He's now at Vanderbilt in Nashville.

AT: Yes, he's been a big fan of history and this endeavor. Can you tell why there was a need for a new kind of antipsychotic?

PG: The main advantage of atypical antipsychotics is that they don't cause extrapyramidal side effects at regular doses. If we are using them in higher doses so, they may induce Parkinsonian manifestations and other CNS side effects. Another advantage of atypical antipsychotics is that they don't cause suicidal ideation. I first learned this from Herb Meltzer. This is very important for me because for some time Hungary had the highest suicide rates in the world.

AT: I didn't know that. What time frame?

FG: In the 1980s, we had nearly 50 suicides per one hundred thousand inhabitants, which was the highest in the world. Actually, the East Germans had higher suicide rates than we, but when they realized how high they suicide rate is they stopped doing statistics on suicides in East Germany. We had no single suicide in our clozapine treated patients. The drug seemed to be even effective in suicide prevention. I also think that the danger of agranulocytosis is highly exaggerated.

AT: How do you explain the Finnish report?

PG: The Finnish and the Hungarian languages are related to each other but it must be a genetic difference between Finns and Hungarians with regard to clozapine induced agranulocytosis. Herb Meltzer and I thought that we should look into this matter and I might be able to answer your question sometime in the future.

AT: Do you think it might be genetic?

PG: Yes, I think so.

AT: I think we were up to four or five areas of your research.

PG: The area we have not covered as yet is social psychiatry. We are conducting a rather unique research project in social psychiatry. Let me give you the background to it. Hungary used to be a very large country compared to the Hungary of today.

AT: It was part of the Austro-Hungarian Empire.

PG: Yes, we lost the first and the second world wars and, because we lost the wars, we lost about two-thirds of our territory. Hungary became very small and lots of ethnic Hungarians are living in neighboring countries. In our research, we are studying anxiety in the Hungarians who are returning to Hungary from Slovakia, Romania, Yugoslavia, and Serbia because they had difficulties living in those countries. The governments in those countries are not very friendly

towards ethnic Hungarians. They are coming to live in Hungary without jobs, money, or housing and their life in Hungary might even be worse than it was in the country they left. Their anxiety is usually very high. Many of them become schizophrenic, depressed, or even suicidal.

AT: So, ultimately, this can be traced back to their response to this unique stressful situation?

PG: Yes. Hungary is a poor country. We have no money for refugees. We would like to improve their lives, but it has not been possible as yet.

AT: Did you, at any point in your career, think about leaving Hungary when it became possible to do that?

PG: Twenty-four years ago, when I was working in Great Britain, I was invited to stay, but I did not want to live there.

AT: This is Manchester?

PG: In Manchester. The same situation arose in Nashville fourteen years ago when Tom Ban invited me to stay in Nashville and work with him. When Tom went to Toronto, he invited me to join him there to work with him, but I did not go. It is a curious situation, because life in Hungary can be very hard, but still I want to live in Hungary.

AT: Have you ever read the Unbearable Lightness of Being?

PG: No, I did not.

AT: A couple of final questions and, then, I'll ask you to add anything on. I interviewed at CINP, Eva, who practices psychiatry in Czechoslovakia.

PG: Are we talking about Eva Ceskova? She is s a very good friend of mine.

AT: Yes. She had a lot of interesting things to say about mental illness under Communism.

PG: Did she talk about psychiatric abuse?

AT: She mentioned a little bit of it but felt it was exaggerated.

PG: I went several times to Russia, and was aware of psychiatric abuse there. I also know of psychiatric abuse in some of the other Eastern European countries, but in Hungary we had no psychiatric abuse. Hungarian psychiatrists were always very honest. But even in Russia it was created by the Government and not by psychiatrists by declaring that people who are against the Soviet regime are mentally ill. It was not entirely the fault of Russian psychiatrists.

AT: When we talk about psychiatric abuse, how were people being treated when abused?

PG: ECT was the treatment of choice.

AT: Punitively, to punish them?

PG: No. Russian psychiatrists diagnosed dissenters as paranoid, because whoever was against the Communist government must have been paranoid. It was not a wrong diagnosis on purpose. Some honestly believed that this was the case.

AT: I understand what you are saying. What about patients who were schizophrenic, and not because they thought Communism was wrong, would they be treated, also, with ECT?

PG: Yes.

AT: But, were they properly treated?

PG: Yes, the Russians had problems obtaining psychotropic drugs; they had no money to buy them.

AT: And, western countries weren't allowed to set up offices in Moscow?

PG: I don't know.

AT: Let me ask you, what advice would you give someone who's new to psychiatry and they turn to you and ask you about ECT?

PG: I used ECT extensively thirty-five-forty years ago, because we had no other treatment options. Today, ECT is quite popular again, but I am using it very seldom.

AT: Why?

PG: Because drug treatment and psychotherapy work perfectly well in combination. I don't need ECT for the vast majority of patients; I am using ECT only for patients with major depression who don't respond to treatment

AT: Now, someone like Max Fink would argue that we should do ECT instead of subjecting patients to more and more antidepressants.

PG: Max is a friend of mine and he told me that ECT is dying and it is true.

AT: Why?

PG: We don't need ECT; we can treat patients with antidepressants and antipsychotics combined with psychotherapy. I have virtually no or very few treatment failures if I am using combined treatment with drugs and psychotherapy.

AT: Do you think it maybe harder in the United States, in particular, for psychotherapy to be integrated into patient's treatment? Often, the doctors are writing prescription because they have five minutes only to spend with their patient. They're not going to be able to do psychotherapy.

PG: That's a very good question. That's a problem. The doctor has no time for psychotherapy. They should have time so. The doctors on my service are doing psychotherapy. It is possible to do psychotherapy in fifteen minutes. We are also using group therapy. It is more economical.

AT: Groups of four or five?

PG: At least ten.

AT: Here at ACNP, we have a lot of sessions devoted to smaller and smaller parts of the brain. If you think about the future, do you think psychotherapy will return out of necessity?
PG: No. I don't think so. The future is in genetic research. In the future, we should be able to examine patients, and based on their genetic make-up suggest specific drugs that will work immediately.
AT: So, we don't need psychotherapy in the future?
PG: We won't need psychotherapy in the future. Let me tell you about a patient I consider my greatest professional success. The patient was an economist. His mother was schizophrenic, his sister was schizophrenic and there were also other schizophrenics in the family. He was schizophrenic as well. First, I treated him with haloperidol, because we only had haloperidol at the time and he was not responding to treatment. Then, clozapine became available, and I treated him with clozapine. After a few weeks of treatment with clozapine he became symptom free. He has been on clozapine now for 33 years and during these years he has had no symptoms of schizophrenia. He got his PhD, then his DSc. He became first a respected teacher. Then he was appointed as chairman of the department of economics at his university. Today, he is the President of a university in Southern Hungary. About eight years ago, he told me that his university would like to appoint him president but I told him at the time he should not accept is because it's a very hard job. He therefore refused the job at the time. But, two years ago, he was approached again and this time I told him, OK, and he accepted it. I consider it as the greatest success of my life.
AT: You have four children.
PG: Yes.
AT: One of them with my name.
PG: Of course, you know Andrea. Three of them are physicians and the youngest one started medical school, but changed her mind and went to study economics.
AT: Oh, that's wonderful.
PG: It happened because of her boyfriend.
AT: Men will do that to us; derail our best intentions. Do you have anything you'd like to add? This has been a wonderful experience.
PG: Thank you very much for inviting me.
AT: Thank you for joining us.
PG: Thank you.
AT: It was wonderful.

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