In Conversation With: Associate Professor Shuichi Suetani and Emeritus Professor Sidney Bloch | Release Date: 27th November 2024

Case Scenarios written and provided by Emeritus Professor Sidney Bloch

Scenario 1: An unnerving clinical encounter
(Discussed in episode | 2:40)

I am in my third year of training and have had the opportunity so far to treat people with a diverse range of mental illnesses.
But today I participate in an entirely new clinical scenario.
A student in his early 20s (as am I) ---let's call him Jim—has been referred to our Psychiatric Centre in the most unorthodox way. We might even describe it as dramatic.

He has been cautioned by the police who observed him "loitering" in a locale where homosexuals are known to gather and instructed to get into treatment without delay or face criminal charges. The law in the State of Victoria is unambiguous: male-male and female-female sexual acts are prohibited. (it would take another 12 years for the law to be repealed).

Jim is terrified about the repercussions of a criminal conviction for himself, and the impact on his family, none of whom is aware that he is gay. He resents the coercion imposed by the police that has landed him in a psychiatric hospital and suspicious that conversion therapy, a procedure he knows is designed to change sexual attitudes—is likely to be imposed.

I am at a loss as to how to approach the situation and what action to take. Fortunately, the head of the unit and my supervisor is one of the country's top experts in the field of sexuality, including the treatment of what is referred to as "sexual deviations" by the World Health Organisation.

I complete my assessment as sensitively as I can. I conceal the tension I feel about how to fulfil my role as a health professional. I cannot find any evidence of a disturbed mental state. On the contrary, he is progressing well in his studies, enjoying family life, and nurturing warm friendships with fellow students. I nervously wait to present my "findings" to the team. Meanwhile, I ask fellow trainees whether they have experienced a situation like the one I am facing. They have not and feel unqualified to proffer advice.

At the ward-round the next day, Jim is reassured by the chief that although we appreciate his anxiety at the prospect of receiving psychiatric treatment, we do have his interests at heart and will refrain from intervening without his consent.

We raise various options, including aversion therapy which he has read about, and fears. How does Jim feel about the issues that have emerged the discussion? Obviously perplexed.

"Why don't you consider the options we have discussed today and discuss them in greater detail with Dr Bloch?" Just what I feared! Me, a total novice?

I spell out the potential benefits and risks of the approaches we have covered. Surprisingly; at least to me, Jim expresses his willingness to try aversion therapy.

I sense that the recent confrontation with the police, the current harsh legislation against male-male sexual activity, and the shame he would bring upon his conventional family were he to disclose his sexual proclivity have combined to sway him to "convert".

Our psychologist, Tom, who has had considerable experience of applying conversion therapy, assumes responsibility for its administration. He is keen for me to observe the procedure and so determine its utility for myself.

Although Tom is impressively gentle and empathic, his repeated application of electric shocks when Jim is shown photographs of explicit homosexual scenes but not doing so when he views heterosexual acts unnerves me. However, I find myself surprisingly becoming inured to what I have previously regarded as a noxious procedure.

Following the first treatment session, I share my mixed feelings about the therapy with my consultant. He directs me to an article recently published in the prestigious *British Journal of Psychiatry* by Dr John Bancroft, a leading researcher on sexual disorders and their treatment. I rush to the library. There it is—a pilot trial of 30 to 40 sessions of aversion treatment, each session lasting 60-75 minutes, carried out in 10 homosexual men. "Painful electric shocks" were delivered to the "patient" while viewing photographs of men whenever he had an erection. Seven men have changed their "sexual attitudes", but only transient. They have dissipated totally. An effective outcome has ostensibly occurred in only one case within the one-year follow-up. I question within myself the use of this mode of treatment when change is so negligible.

(Footnote- John and I enjoyed a warm colleagueship when I took up a position in Oxford in 1975)

I also dip into two novels a colleague has recommended which embodies themes germane to Jim's situation. I hope thereby to gain a richer understanding of the inner life of the homosexual. I find James Baldwin's *Giovanni's Room* (1956) and Christopher Isherwood's *A Single Man* (1965) particularly illuminating, in fact much more than the very few scientific articles that have been written.

Meanwhile, it is doubtful whether Jim has undergone any change in attitude towards his sexuality. At the cessation of the program. He declines a follow up appointment though we do invite him to contact us at any time should he wish to see us.

A movement in the homosexual community calling for a respect of their human rights is growing apace in parallel with our work with Jim. Many psychiatrists express their support although it takes another four years (1973) before the American Psychiatric Association (APA), the first professional organisation to declare that homosexuality is not a mental illness and therefore does not require any treatment; help is only necessary in the case of people who are in turmoil as they grapple with their sexual orientation. A few years later, the APA scraps this qualification as well and deletes all references to homosexuality in its classification. The WHO makes the same changes in their classification.

This radical shift, after over a century, has not been matched by 37 nations which continue to regard same-sex physical relations as illegal and offenders liable to imprisonment: even worse, the death penalty many be applied in some nations like the Sudan, Iran, Saudi Arabia, and Yemen. Certain religious communities view homosexuality as sinful, some resorting to exorcism and other practices of similar ilk to eradicate the "abomination".

I feel utterly relieved that I shall probably not have to treat another case like Jim. Indeed, we members of the ANZ College of Psychiatrists, have disseminated our position widely in the hope that prejudice and discrimination will soon be a distant memory.

In reflecting on Jim's story, I asked myself what have I learned from his ordeal? Several crucial lessons come to mind (not necessarily in the order below).

- First, it behoves me to harness as much empathy as I can when a person has undergone an experience like that of Jim.
- Second, it is all too easy to rationalise the utility of a treatment even when the scientific evidence for its effectiveness is meagre.
- Third, the ethical dimension (principles like respect for autonomy, justice, at first, and do no harm) of an intervention invariably takes precedence over other aspects.
- Fourth, the humanities (literature in Jim's case) complement the sciences when attempting to understand patients and their problems.
- Fifth, psychiatric practice always takes place in several contexts, among them, historical, social, political, philosophical, and legal; and they all need to be considered.

- Finally, I value Jim's story as I reconnoitre through the complexities of the human condition to enhance the hallmarks of good clinical practice, especially sensitivity and compassion.

Scenario 2: The vague boundaries of psychiatry
(Discussed in episode | 8:21)

A basic question on what constitutes a mental illness has arisen throughout my career. Thus, what was regarded as a psychiatric condition for decades e.g. homosexuality was deleted from a cardinal classification over half a century ago. New conditions have been delineated, others modified, all with dubious rationales e.g. Oppositional defiant disorder in children, autism spectrum, ADHD in adults, personality disorders and gender dysphoria or incongruence.

I have struggled to determine whether a proportion of people I have treated warrant a clinical diagnosis. For example, a religious couple with marital problems invoked verses from *Ephesians* in the New Testament but contradicted each other in how they should be interpreted. The husband averred that adherence to verses in chapter 5 would improve the marriage: "Wives, submit yourselves unto your own husbands…For the husband is the head of the wife …

His wife was adamant that a later verse embodied the more significant injunction: "Husbands, love your wives even as Christ also loved the church …."

I was inclined to suggest that their parish priest was more likely to counsel them to interpret these verses.

A young Jewish student was urged by his Rabbi and his parents to consult a psychiatrist when he predicted that a mere few months dedicated to the study of sacred Hebrew tracts would result in his elevation to incontrovertible scholarly status.

I felt out of my depth in both cases although I was stuck with the possibly that he was manifesting a grandiose delusion.

Scenario 3: How to cope with this limited knowledge base
(Discussed in episode | 13:02)

I have learned to do the best I can to help patients and their families, both clinically and scientifically. I decided on a primarily academic career regarding the latter, participating in a series of research projects, and teaching medical student and trainees in psychiatry about the challenges facing them.

An associated commitment has involved gaining informed consent namely, to convey

honestly about what we can and cannot do for our patients; we have eschewed the temptation to offer more that we can. This has led to other ethical responsibilities which I have had the pleasure to teach the next generation. My textbook, *Psychiatric Ethics,* has been through 5 editions and been a mainstay in educational programs.

Scenario 4: Grappling with the intrinsic complexity of psychiatry
(Discussed in episode | 17:02)

The above episodes and several others I encountered raised the thorny issue of a lack of fundamental knowledge which persists to this day. I still grapple with the question whether the psychiatric glass is half full or half empty. I sit on the fence! I surmise that it is both. For example, Autism has been a conundrum since it was first described in substantial detail in 1943. We have learned about its clinical nature but are far from identifying its cause. On the other hand, significant research has been carried out in renowned institutes, especially on genetics. Many other examples come to mind. Knowledge has accumulated but wide gaps therein persist e.g. the dearth of biomarkers which could pave the way for strategies to determine causes and treatment.

Impulsivity—a mixed blessing
(Not discussed during episode | Provided for your reflection)

I was about to wind up my training in Melbourne when I had the good fortune to be offered a senior training position in the Maudsley Hospital in London, arguably the most distinguished centre of psychiatry in the UK. I couldn't believe my luck. Advanced training was usually reserved for newly fledged psychiatrists who had graduated at the Maudsley. An English colleague teasingly speculated they wanted to keep the Aussies happy by appointing one of us from time to time. Whatever the case, I was excited at the prospect of renowned clinicians and researchers enriching my insights the vagaries of the mind.

I came to respect-- beyond measure -- one of them for his erudition and openness to new ideas. Sir Denis Hill (see below) soon became both model and mentor (and remained so throughout my career). I met Sir Denis in Oxford a few years later when he was appointed a visiting Fellow, and I was working there as a junior consultant. I had the privilege of interviewing him for a journal I was then co-editing. You can obtain an impression of the man from his replies to a wide array of questions I posed. My favourite was the appeal of "stumbling" on a new way of looking at things—serendipity and beyond.

As a mere colonial, I was out of my depth in many spheres, but this did not deter me from expressing my views. We call it *Chutzpa* in Yiddish! Perhaps a means to overcome my interloper status? Perhaps my life-long tendency to act impulsively along the lines of my

home-made adage: “When in doubt, *do*”? However, I had not learned adequately that one can get into deep trouble by overstepping the mark.

I was embarrassingly oblivious of the mark on at least two occasions, both soon after my arrival at the Maudsley.

The first was triggered by my attendance at what was called the “Supportive Clinic”. My predecessor had pointed out helpfully that my chief task was to encourage, boost the morale of, and instil hope in the patients. They had been long term, committed attenders. I would have a few dozen to look after about eight on average, each Monday afternoon.

I quite enjoyed chatting with them about whatever they wished. Apart from this relatively superficial encounter, I was instructed to repeat prescribing the medication they had been taking, usually for years, which ostensibly served to maintain their link with the hospital. Year after year, my predecessors had adhered to this program. I was however beginning to sniff a rat. I wondered if we had fostered their dependency on the clinic. Were we possibly doing them a disservice? Might they cope just as well under the care of their family doctor and as a member of one or more occupational therapy groups?

I shared my initial concerns with Sir Denis. Not so impulsively, but certainly premature. After all, I had only attended a couple of sessions. I sensed he was taken aback by my comment about the possibly nurturing dependency. Oh dear, had I overstepped the mark? I quickly reiterated the pleasure I had had meeting the patients and getting to know them, albeit in a limited way.

I was utterly relieved when Sir Denis replied: “Let me mull over your concerns; we can then delve into your views more thoroughly”. The dénouement was not only a relief, but also most gratifying. A task force was set up to review the purposes and procedures of the Supportive Clinic. The result – key changes were made to mitigate the risk of dependency and other untoward issues raised by the group. I was immensely relieved that I hadn’t been sent back to the colonies.

My second impulsive act did not end as productively or as harmoniously.

I had been assigned to another clinical team in addition to that of Sir Denis. I was welcomed warmly and particularly chuffed that the junior trainee I was to supervise was a charming fellow South African. He put me in the picture regarding the current patients. I was raring to go. But again, my keen sense of anticipation got the better of me. Harold presented a follow up report of a 30-year-old senior nurse who had been a patient in the hospital for almost two months. Jane had barely improved despite participating in therapeutic ward programs and taking anti-depressant medication. The more I heard Harold elaborate on her lack of progress, the more it seemed to me that scanty attention was being paid to the psychological and interpersonal challenges she had been grappling with since her

graduation a decade earlier. When the consultant determined that we should increase the dose of her medication slightly and review her mental state the following week, I asked him what role psychotherapy had played during Jane's two month stay in hospital. An innocent enough question I thought, but given that I barely knew her, I soon detected that my comment was interpreted by the consultant as veiled criticism. The outcome this time was my transfer to another clinical team. Surely, I had blown it; my presence at the Maudsley was under a cloud, and a very dark one too. My mood was equally dark. A few weeks passed during which I was on my "best behaviour". Then, lo and behold, I bumped into the psychiatrist with whom I had crossed swords. To my utter delight, I heard him say in friendly fashion: "I have reflected on our encounter in the ward round and suggest we meet up to chat about it". The exchange we held was probably the most valuable I had all that year. He taught me a lot about colleagueship and not rushing to a clinical judgement. At the same time, he agreed that Jane had probably not been offered the opportunity to divulge repressed feelings –they were too painful and shameful. Whew. I expressed my appreciation for his invitation to examine what had transpired and his honest feedback. We conversed periodically about clinical matters thereafter, always to good purpose.

Did I rein myself in thereafter? Not enough, but two years of personal psychotherapy on the couch a few years later enabled me to look deeply into myself and gain insight into the underlying dynamics of my impulsivity.

Confronting a horrendous desecration of psychiatric ethics
(Not discussed during episode | Provided for your reflection)

While working at the Maudsley, I stumbled on the horrendous allegation that psychiatrists in the former Soviet Union were involved in diagnosing human rights activists as mentally ill and treating them forcibly in mental hospitals. Unlike my insensitivity to the ethical dimension inherent in Jim's aversion treatment, I shuddered at the thought that colleagues in my profession were participating in this blatant misuse of psychiatry.

On this occasion I was primed to learn more.

And so, I did—to the extent of co-writing *Russia's Political Hospitals*—the first evidence-based account of the practice. It created quite a stir internationally and won a prestigious prise from the American Psychiatric Association. Another outcome was my contribution to a 15-year campaign to bring the abuse to an end.

My involvement led to psychiatric ethics attaining a prominent place in the profession and in my career, including publishing the first textbook on the subject and playing a central role in devising the foundation code of ethics of the ANZ College of Psychiatrists and its regular updates.