In Conversation With… Associate Professor Shuichi Suetani and Emeritus Professor Sid Bloch – Part 2

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Host (00:01):

Hi there. Welcome to Mental Health Professionals Network podcast series MHPN's aim is to promote and celebrate interdisciplinary collaborative mental health care.

Shuichi Suetani (00:19):

Welcome to this episode of MHPN Presents in conversation with, my name is Shuichi Suetani. I'm a mid-career psychiatrist based in Brisbane, Australia, and I'm joined by a late career psychiatrist Emeritus Professor Sidney Bloch. Hi Sid, thank you for joining me.

Sidney Bloch (00:39):

Oh, look, it's a pleasure and I'm very pleased to be able to do this.

Shuichi Suetani (00:42):

This is our second podcast conversation. Last time we had a chat on MHPN Presents In Conversation, we talked about the things that have inspired, sustained, and challenged Sid in his psychiatry career. In today's conversation, we will be talking about something a little bit different, some of the transformative experiences in Sid's longstanding career, what they meant to him then and what they mean to Sid now. You will find hyperlinked on the podcast landing page, some of the scenarios or stories really, which Sid has written for this podcast. And we'll be talking about these scenarios in this conversation. Let's get started, Sid. So maybe I wonder if you could tell us about the scenario number one.

Sidney Bloch (01:37):

Okay, fine. Just to say the word scenario is a bit vague, but as you were saying, it's a story, a narrative. And my way of thinking about working in the field is that you learn every day from yourself, from your patient, from your colleagues, and also you undergo certain experiences calling them scenarios which leave their mark and teach you a huge amount about yourself and about your work. I've actually even used the word transformative sounds a bit highfalutin, but some of these cases, some of these scenarios are truly that they've made me think and look at things quite differently to their advantage. So you want to start with scenario one. When I thought about scenarios at your invitation, a few came rapidly to mind, and this one probably came right at the beginning because I've thought about this a lot Now. This happened in my third year of training, so this goes back decades and I can see this guy in front of me.

(02:40):

And in essence, I'll make it brief because people can read the story in more detail. I'm asked to see a young man of my own age, a student, I'm a student, a trainee, and why are you here? I won't go through all the detail of it, but I discovered that the police observed him or noted that he is loitering, that expression that was used very widely and he's obviously in trouble with them because it's an illegal practice, homosexuality. So I think, gee, what am I doing here with this lovely young man who's committed a quote illegal act? Why a psychiatrist? Anyway, we get talking and he certainly expresses some concern that he's there in a psychiatric setting. He's never told anybody about his sexual practices other than partners. He might've picked up and we go on talking and I assess him in quotes in the way I would assess anybody, except I'm extremely sensitive to what the hell's going on.

(03:51):

And I do ask myself, am I the right person? But when I finished that assessment and I go and talk to, I won't mention names, but one of the leading human sexuality experts, very well known, has written a lot about this. And he's not at all puzzled or worried that we are treating him or trying to help him. He gives me advice and I go back to him. Anyway, cut the story a bit short. They decide, not me, because I've never heard of the treatment called aversion therapy. A lot of people who listening to this may know something about it, but this was a fairly novel treatment for sexual disturbances. Sexual deviation was called, in essence, there is my psychologist colleague with a whole number of slides. Some are homosexual in nature, some are heterosexual, and when he sees the homosexual, they randomly displayed on a screen, and as you know, when the homosexual sees apply, they come up, he gets a shock.

(04:52):

I was there. I was not all that perturbed. I have to say, and I'm not ashamed of this because I was following, if you like advice and guidance and the treatment goes through a number of sessions, and as far as I can understand, well this is a recommended treatment. And then lo and behold, I opened up the most recent journal of the British Journal of Psychiatry, and I see an article, a pilot study from Oxford on this very treatment in 11 people, and I won't go to that because people could read it up their want, but it's written by John Bancroft, who is, again, a very noted person in the field. And rather coincidentally, I land up in Oxford a few years later and I'm there for 13 years, and so is John, more or less. So we've become colleagues. But given that my own boss said, look, this is a bonafide treatment, and Bancroft's paper says we're going to do a full study.

(05:49):

This was a pilot. So that was the end of that if you like. Now you might say, well, what's so special about that? But later when I go to work in England and I'm getting more of a sense of the real difficulties I had at that time, but which I was not aware of, that really hurt my sense of conscience because I thought

surely I should have picked up on the fact that there I was giving a pretty barbaric treatment to somebody for a non illness. And as you know, it wasn't more than a few years later that the American psychiatric decided homosexuality was no longer a sexual deviation or disorder, and it was scrapped from the DSM. So there I was treating somebody who didn't even have a disorder. From then on, my ethical sensitivities mushroomed like nobody's business, lots of other things occurred in this context of working in situations where I'm unsure of myself. I've got to think through and it worries me what I'm doing.

Shuichi Suetani (06:59):

Can I ask you, Sid, I guess we're probably talking about 60 years ago now, is that right? 1960's?

Sidney Bloch (07:06):

You don't have to remind me. I'm not asking your age! Cor blimey!

Shuichi Suetani (07:11):

Yeah, but like you said, a long time ago, but 1973, I think you said American Psychiatry Association declared that homosexuality is not a mental illness. Before that happened when you were a trainee in psychiatry, it was accepted that it was a mental illness. I guess what's striking about what you just said was people were trying to help this young man get better, even though when we think about it now, what an awful thing to do. But at the time, 60 years ago, these were people who are trying to help people. And I guess the question is the nature of psychiatry is that the concept of mental illness changes all the time depending on all sorts of stuff. And I think homosexuality is a good example of that. You talked about your ethics, ethical senses, mushrooming after this instant, looking back now 50, 60 years later, how did that help you be more aware of this fact?

Sidney Bloch (08:21):

Okay, this is a very important question for me because I became super sensitive to lots of things where the boundaries of our field were blurred and they remain blurred. And I know that the current big dilemma for us is transgenderism, let's call it that, but where young people, as young as four years old, five years old, believe they're in the wrong body. And we as a profession, and the college of psychiatrists have struggled immensely with this. I was involved in trying to bring out a so-called position statement. What do we think about this? Is it a condition? Is it a part of nature that there's variance in sexuality and sexual expression? And we haven't sorted that out. It's outlawed in about 30 states of the United States, so that's totally political and ideological and whatever. You know "this is unnatural, and it's we don't want it. We want to get rid of it."

(09:19):

Initially it was called transgender dysphoria because dysphoria is a Greek word simply for discomfort. And then that was changed by the world psychiatric to incongruence, which is a complicated word. So it means your gender and your sexuality are not the same, you feel the other gender. So these sort of things happen all the time. During the course - between that, my original episode we discussed and the current one, which is still with us, I don't think it's going to change in the near future at all - I got involved with similar things about boundaries. I'll just give you one or two examples. So one was a professor, a middle aged, two adolescent children, and he believed he was in the wrong body. He is a male, lived a male, never disclosed. I was the first person he told this to, ashamed, burdened, and all the rest of it.

(10:17):

He thought if he told his wife, the marriage would collapse, all the rest, all the other devastating things that might follow. Frankly, I did not know what to do with the span because he wasn't asking me to give him the ticket, go and do whatever you want to do. So after a couple of sessions off he went, I said, come back anytime. I never saw him again because I just felt it was beyond my province. And the other case is really horrible. So here's a young man, he's about 21. He looks like a corpse. Why? Because he's been starving himself. So the obvious diagnosis would be a variant of -

Shuichi Suetani (10:54):

Eating disorder.

Sidney Bloch (10:55):

- of an eating disorder, that's right. Anorexia nervosa. And that's how he was being seen. But also he was undergoing a lot of tests for cancer and other serious physical illnesses. Anyway, he comes into our ward, we get called in. This is part of our psychiatric role in the general hospital. To cut that story short, although a terribly important story for me and for our team, he does not reveal his problem, which is transgenderism the same thing, right? So he born a boy and all the rest Catholic family, one son had been divorced of three children. He felt it would be horrible for his parents and the family to get to know. So he acted out his discomforts in, well, more than that by starving himself. And I think he was really suicidally in many ways. So who did he finally reveal this to? The humble fifth year medical student, same age, roughly.

(11:55):

Lovely student who obviously gained confidence. And then he told the truth about this other thing. The medical student was nonplussed, didn't know what the hell to do. Confidentiality comes into the story, but in the end, we didn't yank it out of him, but he came and said, look, I'm in trouble because I'm just a humble medical student, and guess what? I'll call him William. William has told me this. In the end, William did not give us permission to treat him and see his family because we thought of family therapy just to help everybody. And he left us. We said the usual thing, call us anytime. I wrote him twice saying, look, we're still here. A year later, I get a call from another hospital. We've got a patient called William. He looks like he's going to die. We believe he was treated at your place, et cetera, et cetera. The fellow was still in the most dreadful trouble. So it's an example of where the boundaries are so difficult and social attitudes and prejudice and all the rest of it.

Shuichi Suetani (13:02):

So it's kind of going straight to story five, which is the vague boundaries of psychiatry. I guess. You talk about things like operational defiant disorder in children, autistic spectrum disorder, ADHD in adults, and it could be in children as well, I guess, where it's difficult to know what's normal and what's abnormal, if you like. So I guess they are on spectrum, but as a psychiatrist, you feel like you need to have a binary answer of yes, that's a mental illness, or no, it's not. And you reflect on that. You talk about how sometime you wonder maybe a proportion of people that you have treated in your professional career, did they even have a clinical diagnosis? And that's something that I think about pretty much every day, I think. I kind of think, yeah, yeah, for sure. And how do you navigate that? How do you kind of go through these spectrum disorders? But I have to say, all the psychiatric disorders are on spectrum.

Sidney Bloch (14:09):

The word spectrum is a Pandora's box. I don't believe in it actually. Autism, you know, Americans came up with this idea of spectrum. In my way of thinking it is a range of variants of the way in which autism in this case can present. Partly it's severity, so the worst end of the spectrum, no language. And I've met some of those in adulthood. Oh, terrible. And then an easier way of living with this is that you do have language, but you are socially very fearful and can't cope with close relationships. So I think spectrum's become an unhelpful term, which basically says, I think he's on the spectrum. I've heard this so many times from friends. My wife keeps talking about, we go out and we meet somebody. She says, I'm sure he's on the spectrum. She's not a psychiatrist and so on. And I said, what do you mean?

(15:02):

She said, well, and she gives her criteria. She's not a fool. And she's read a fair bit. Of course, you read about all this in the general media, newspapers and so on, films. So how the hell do we as an expert group, which I don't, we are experts to a degree, but not in everything. So the vague boundaries is one area where we are really up against it. So the example I give in scenario five is this ODD, oppositional defiant disorder. I dunno what the hell it is. I've not worked as a child psychiatrist, but I volunteer at a primary school. I teach reading and writing just in my retirement. Lovely thing to do, by the way. I'd recommend it highly. And some of these kids, they're just not like the other kids. But there's no way that I can say, oh, look, I think there's a tinge of something. But ODD, it's a behavioural disorder. No biomarkers, nothing, right? Autism is better to find. I've got colleagues in Boston who do phenomenal work on genetics of autism, and we don't need to go to that now. But autism will be definitely, I think, cracked at some point. We will know more. Biomarkers will come up, and I feel confident that we ought to be working with autism. It's within our boundaries, but the actual boundary is sometimes vague.

Shuichi Suetani (16:28):

Can I ask you, so I'm going to pick up on couple points that you've made, and one is, do we need the biomarkers or biological proof for something to be a psychiatric diagnosis? So that's question one. And question two is, given how subjective it is, is it our job to say someone's abnormal as opposed to -

Sidney Bloch (16:55):

I'm shocked that you use the word abnormal. It's almost as bad as using the word insane. You mentioned the word binary.

(17:02):

We cannot live with binary type diagnostic entities. There's no sharp allergy. We've already discussed that a bit earlier. I can't answer your question very well. Biomarkers, typify good medicine, right? I gave a talk at the Royal Children's on psychiatry. Is the glass half full or half empty, and I said, it's half empty because we have no biological underpinnings. And so a lot of the kids we see, we can't be sure what the hell's going on. We try our best. And so in the end I said, what do you guys think the chairman said? Well, fortunately in paediatrics, the glass is half full. Oh, why? Because they can take conditions like diabetes or whatever it might be, a lot of diagnoses except the ones we are talking about today, autism. And they can say, look, this child has quite marked whatever it is. The result of that pursuit is that we can do something a little more scientifically, in fact, entirely scientifically.

(18:05):

So I think we struggle like crazy, and I would love more biomarkers. Look, you've worked with schizophrenia. I've worked with schizophrenia. Do we have a biomarker for it? It was first described in 1880 again in 1911. It's now 2024. And what is schizophrenia? Some people say it's this type of

psychosis, and other people say it's something else. It would be great to have something to examine and look, take dementia, Alzheimer's. So 1906 a Lewis Alzheimer in Munich says, I followed this patient for five years. I've looked at their brain and they've got absolutely classical features. And of course, a hundred plus years later, those features still prevail in Alzheimer's. But we have some way of detecting Alzheimer's nowadays with fancy neuro imaging and so on. And we can say, oh, it starts much, much earlier. But by then it's, it's pretty late when we find it clinically.

Shuichi Suetani (19:05):

Do we actually need to diagnose people to help people?

Sidney Bloch (19:09):

Well, I, as you may know, worked in the psychotherapy arena for most of my time. Family therapy, individual psychotherapy group, I loved working, psychologically speaking. And most of the time I did not make diagnosis. Typical example, I'm working in Oxford. A student comes in, GP referred, she's struggling, she feels inadequate, blah, blah, blah. What am I going to say, she's got a personality disorder, that's rubbish. Has she got a depression? Obviously she's very sad about a situation, but I treated this, I'm thinking of this particular person, for a year and a half in weekly psych therapy. I got to understand her. She got to understand herself. There was a commonality, there was a terrific communicative relationship emotionally and in every other way. And in the end, she did rather nicely. Her self-esteem was boosted, but I never gave her a diagnosis. I didn't see the point of labelling her.

(20:11):

But I can remember women with postnatal depression, right? Everything seems fine. There's no history in the family. And a few days after the birth of the baby, who was perfectly normal, starts crying and tearful and couldn't sleep, suicidal, all the rest of it. I needed a diagnosis. Absolutely. I knew that in this scenario, you kill yourself. And I had a patient who killed a child, a baby, two of them, another transformative experience. Could I have prevented that happening? I mean, it was devastating thing you no doubt have had similar experiences. But if I had known much, much better that postnatal depression is a serious disorder, sometimes it's worse than other depressions. I often tell my students or have told them, there's no such thing as depression because they want to label. I say, you put depression on this person. What does it mean? It's a symptom. It's a feature, clinical feature.

(21:11):

Go into it, understand it. Sometimes it's diagnostically important, like postnatal depression. Absolutely. And sometimes as with the students, I'd say it's a disadvantage to put a label on. So we work in a bloody complex field. All I can say, once upon a time, I was terribly interested in children and I wanted to be a paediatrician. And I applied for jobs in the paediatrics field and the psychiatric field, guess, which I didn't get. They didn't want me, although I felt very suited to it. That's why I volunteer at the school. So I went to psychiatry and I've enjoyed, I've valued the whole experience. My point is there are very different sorts of things and psychiatry, I think it's the most demanding. I don't mean in terms of prognosis and the suffering that we see, although that's bad enough. It's more what we've been talking about, the vagueness of concepts, diagnoses, boundaries, you name it.

Shuichi Suetani (22:13):

I guess we can probably pick on one more topic to talk about before we finish, but I want to come back to that question about is the glass half full, or half empty?

Sidney Bloch (22:26):

Naughty! I can answer it.

Shuichi Suetani (22:29):

Well, something that you've mentioned in the past is we know so much more than we did 60 years ago. We've got the genetics understanding of some of mental disorders, I guess, but the gaps process, so knowledge has accumulated, but wide gaps processed with what we know and how we can help people suffering with, I don't even know, mental illness or mental distress or whatever. And I guess one of the reasons might be that what you just talked about, sometimes it's not helpful to label people in psychiatry. Other times it might be helpful to label people. But it's really hard to do science when everything's so grey.

Sidney Bloch (23:21):

I think half the glass, it's not too bad, and the other half the glass, it is tough. Look, I'm going to ask you a question. You are asking me so many questions. Have you been stuck with this idea that we've made little progress, or are you pretty optimistic or hopeful that we are making steady progress? I mean, you've been around for a bit now, so you've seen things and you've read the literature, and you've worked with people.

Shuichi Suetani (23:46):

No, that's a really good question. Oh gosh. So I think it depends on the day. Yeah. So some days I feel like, yeah, we are getting somewhere. And I think about things like psychedelic psychotherapy for people with trauma. I think about how much we've been able to help people with ADHD in the recent years. I think about all these kinds of exciting new stuff that's happening in the field. And I think maybe we are getting somewhere, but sometimes I read journals from 20 years ago,

Sidney Bloch (24:27):

Don't do that!

Shuichi Suetani (24:29):

But then there are papers that are talking about the same thing that we talk about today.

Sidney Bloch (24:35):

Oh, look, I'm going to help you.

Shuichi Suetani (24:38):

Yeah?

Sidney Bloch (24:38):

Not solve your problem. I think we've made huge progress in lots of areas. And you mentioned genetics, call it genomics. Look, the advent of the genome has really been phenomenal. And the other big area of course, is neuro imaging. And you could do so many sophisticated tests. Now, we didn't have those things, you know once upon time, skull x-rays, all we could come up with. And gee, I mean, familial studies. They were crude and really not particularly illuminating. So there are many things where we're

doing a much better job. And I would include the psychotherapies as well. I trained in those. When I started off, I felt pretty optimistic that using certain skills, technology, strategies, let's call them, you could help a lot of people. Huge amount. That's been shown. We have outcome studies in all these areas and we're doing pretty well.

(25:43):

So there's some areas that are big, big, big that we are just stuck. I would regard schizophrenia and related psychosis as an example. I wish we had just an inkling. Look, you wouldn't have wanted to be labelled schizophrenia in 1951 prior to the first antipsychotic. They weren't ideal drugs. But gee, now we've got depot, we've got a whole range of drugs. You mentioned psychedelic drugs. Who knows at the moment, I dunno whether psychedelics are going to solve trauma or any other big problems, but gee, I'm glad they're around because at least we can put them to the test. One vital thing, another transformative thing. Tim Beck, founder of CBT. Everybody knows about Beck who died not long ago at age a hundred. He's one of my heroes. Why? Because he thought that Freud had a lot to offer, and he thought that Freud's ideas about depression actually were fairly solid.

(26:48):

But put it to the test, that was his favourite phrase. So he began to try to unravel depression. He was a psychoanalyst in early training, and he never quite gave that up actually. But as the years went by 1957 and beyond, CBT was refined more and more and more as psychotherapy, right? Look, we all think CBT helps huge amounts of pathology and of people. I mean, without CBT today, I think I'm not going to treat somebody with thrice weekly psycholytic psychotherapy. It's not necessary. It doesn't work in that sort of way. But Freud's concepts of defence mechanisms and the whole range of things, the importance of dreams, gee, that's half full stuff. You don't have to be a Freudian. I'm not a Freudian in the strict sense, but there's some concepts that I value so highly that I teach them and I try to see how they can help me and they lead to other ideas.

(27:47):

I'm a great believer in shoulder on the shoulder. There are many, many people who sit on the shoulders of Freud. Now Freud, it was strong enough to carry these people, and we've learned a huge amount from lots of people, lots of research. So getting back to progress, and it's the half glass. Forget about the glass. It's a bit of a tricky one. I would rather be ill today and I'd rather my grandchildren be ill today than they were before 1943. What happened in 43? Leo Kanner, who is a, well, a sort of paediatrician really in John Hopkins, he writes a paper, long paper, 11 cases. I've got this paper, I treasure it. And each is very carefully described. And then he gives it a name, which is not autism, but it almost amounts to autism. That was the first time anybody had described a child and not called them mentally retarded or an idiot, or those ghastly derogatory labels that we put all the kids into.

(28:56):

We dumped them there. So autism took a hell of a long time to ripen. But Beck, when I interviewed him, I asked him a number of questions, but one that was troubling me, I said, your CBT was called CT cognitive therapy. Why the hell is it called CBT, cognitive behavioural? He said, I didn't give it the name. Psychologists were getting bored with behavioural therapy and they borrowed my cognitive therapy model, and they thought they better add the behaviourism. So it's their fault. But he was quite happy with that because he felt they did link up quite well. And then I said, look, the other thing that really bothers me is that I'm reading now the literature. You said depression in 1957, but now you use it for personality disorder and everything under the sun post PTSD. That's bad news, isn't it? That's called panacea. That means, oh, I'll use this model for everything under the sun.

(29:59):

And then he repeated this thing. Somebody up in Brisbane is willing to put my model to the test for something that they're struggling with. Go ahead, but treat the patients sensitively. It's not a mechanical treatment. Measure the outcome as accurately as you can. So he was very much the scientist, but he was also the humanist. And I think that's where the glass is sort of half fullish because I think a lot of us have the skills now, which we are taught and trained to be humanistic as well as try this drug and that drug. I hope so anyway. And this is one reason why I like to do what I'm doing now, to exchange ideas about where we are, what advances our field and what holds it back. I don't think there's a lot of things that hold it back. That's the positive thing. And I think as I've been intubating with some examples, there are quite a few things that are bringing us forward. So I think we should end on a hopeful note because it's justified

Shuichi Suetani (31:07):

For sure. Yeah, we progress by testing ideas, I guess, and that's what we are doing.

Sidney Bloch (31:12):

And we have a much more sophisticated way of testing ideas. Can you imagine in the old asylum days. Mind you think of lithium, what a giant of a man he was. But he worked with Guinea pigs in his kitchen, but he was aware of the size.

Shuichi Suetani (31:30):

Well, look, thank you so much, Sid, and I think it's a good place to finish today. So thank you for joining us on this episode of MHPN Presents In Conversation With. You've been listening to me, Shuichi Suetani and -

Sidney Bloch (31:47):

Sidney Bloch.

Shuichi Suetani (31:48):

We hope you enjoyed this conversation as much as we have. If you want to learn more about Sid or myself, or if you want access to the many resources we would refer to, go to the landing page of this episode and follow the hyperlinks. In addition, on the landing page, you will find a link to a feedback survey, MHPN values your feedback. Please follow the link and let us know if you found this episode helpful. Provide comments or suggestions about how we can better meet your needs. You can also provide us with a star rating. Stay tuned for future episodes in the series or listen to other podcasts. Thank you for your commitment and engagement with interdisciplinary person-centred mental healthcare. So it's goodbye from me, Shuichi and -

Sidney Bloch (32:40):

Me, Sidney Bloch, and Shuichi, thanks for the opportunity. I think you make a very good interviewer. I think you should chuck over psychiatry and go into the ABC. Try to help them.

Shuichi Suetani (32:50):

Dunno about that, Sid. Well, thank you.

Sidney Bloch (32:52):

No you are very good.

Shuichi Suetani (32:52):

Thank you very much.

Host (32:55):

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