Jeff Goodfellow (00:00:00):

I have two poems on youth issues. Don't call me lead. Don't call me lead. Dad just don't call me lad. Got my hair on my bowls, dad. Then you've got, or had I made in years old, man. And I'll sinker. I'll swim. Just uncle me, lad, dad. My name is James or just Jim. And now that I vote, dad, my party is green. Get away with those flags. Dad, red and blue are both mean you can roll up your sleeves, dad and slip on your tie. You can wrap my guilt trips. That'll sit in your eye. Y'all grow some plants, dad, but I'm keeping it cool for, it's not a plantation. I'm not such a fool. I just can't find a job. Dad. Year 12 was a waste. Two friends who just died, dad too much of a taste. Yeah, I get that doll. Dad don't do much good, but don't call me lad. Dad I'd work. If I could now mellowing out, man. It's I'm grind is just wild. So don't call me lad. Dad. I'm no longer a child. So don't call me lad. Dad. I'm no longer a child.

Speaker 2 (00:01:08):

[Inaudible]

Jeff Goodfellow (00:01:10):

If a tougher Robbie rubber gloves, these hidden. So the plastic bag of glue and couldn't find it. Then once he slipped on, on strike, sorry, lock up hard and tight. You're right. Then he had to fight, but he was struggling near the glue is not to go wrote up joints. Five papers, slow, choked and cough till he let go. But crave distraction then spotted hash on coal red Ash during Beckwith teenage dash split up deals to score the cash, but so much worry when casual work would come along, he'd pack the cone of his water. Bong sneak away, but not for long young red-eyed Robbie, slightly safer guitar wrote songs and lyrics and the bar wanted peace. Just like he star. Can you imagine then made his fingers. Strum a tune worked at arm each afternoon and three months was not too soon, but he could move it. The joints and bongs, not enough at age 18, all life seems tough. And when the going got too rough, he dropped the tablet. First trip was good. The speed was right. It barreled him through day and night. Set him up without a fight, but lift him reeling. Now five years further down the track, poor Robbie stretched down on his back on a script, scrolled out by a local quack. He's body's cold. He won't be back. Thank you.

Speaker 3 (00:02:46):

Wow. Please give it up for Jeff Goodfellow. What a fitting way to start this session. Thank you. Being here on Sunday morning. And Jeff is part of the peppering of poets that has been happening right across the festival, the Adelaide festival of ideas. And you can find his book in the festival of ideas, bookshop, it's called waltzing with Jack dancer, a slow dance with cancer published by Whitefield press. It features his daughter, grace as well, and it's about his survival from throat cancer. And on that note, let's give it up again. [inaudible]

Speaker 3 (00:03:31):

And it's full of really beautiful evocative imagery as well. So take a look at his book images by Randy Larkin, welcome to sick, screwed up or just lazy. And as you reach into your bags and pockets, can you pop your phones on silent? I'd be really grateful for that. And also if you're a Twitter freak, the hashtag is a F O I a F O I. It's a way to continue the conversation parallel to the festival and we'd love your participation there. My name is Natasha I'm from ABC radio national, our host, our program called all in the mind, I'm a science and health and culture sort of journalist. And from the title of our session today, you know that our speaker doesn't hold back. His intellectual punctures. The theme for the festival this year is planning for uncertainty and perhaps one of the greatest and most uncertain things is that trajectory from birth into adulthood.

Speaker 3 (00:04:33):

And if you're a parent, you know about that, you know about that anxiety, I imagine, but life is uncertain. And in the last few years, we've certainly seen that mental health, particularly the mental health of our young people has been put front and center in the public conversation, not the least because of psychiatry, Patrick McGarry's role as Australian of the year. Last year, there was the getup campaign, which very loudly mobilized around the issue in the lead up to the last federal election. But for some though the mental health needs of our young people are still not being responded to adequately for others were responding in the wrong way. And Jon Jureidini wants to take us, I think, back to basics because how we talk about how we think about the minds of young people today is causing him considerable concern. And he has some expertise.

Speaker 3 (00:05:27):

He's a child psychiatrist at the women and children's hospital and professor in the disciplines of psychiatry and pediatrics at the university of Adelaide. So he has a long career working with young people on some of their anxieties, distresses, and the chaos of that time of their life. He also trained in philosophy. So he brings a deeper framework to this conversation. He's a spokesperson for the organization or network called healthy skepticism who take aim at misleading pharmaceutical drug promotion inside and outside of the medical profession. He's also chair of siblings, Australia, and organization advocating for individuals with ill and disabled siblings and to illustrate he's a man of many hats and causes. He's also chair of the Australian Palestinian partnerships for education and health. So he's a great polymath. And can we please give him a warm welcome this morning? [inaudible]

Jon Jureidini (00:06:30):

Thank you. As a part of the getup campaign that Natasha has told you about. Earlier this year, we were told that 750,000 young Australians are locked out of mental health care that they desperately need. That means that five young people in every classroom are desperately sick and that's something that I have healthy skepticism about. I have no doubt that there are many young people who are troubled and suffering and that this might be quite dangerous for them. They might be using alcohol in a dangerous way. They might be experiencing significant physical impairments, fatigue, distress, and so on, and they might be very unhappy, but none of that means that they're sick. Distress demands, explanation and sickness is unexplained a tree for the suffering of young people. And the archetype, when we think about sickness, what comes to mind for most of us, when we're thinking about somebody being sick are the cases like heart attacks or cancer or whatever where there's some, something very obvious and overt that goes wrong with the body that may or may not have a treatment when it does the treatments often quite dramatic in its impact on the person's wellbeing.

Jon Jureidini (00:07:59):

That kind of archetype does have it play habits place within psychiatry, or it did have syphilis field psychiatric hospitals a hundred years ago by the identification of the spiral Cade and its treatment. We eliminated a whole range of psychiatric illness. And there's a huge amount of energy in psychiatry. I think, which hopes that one day we'll be able to replicate the syphilis story somewhere else in psychiatry. But we haven't yet. And I don't think the prospects are particularly promising. So most of what we call sickness is not really like heart attacks or cancer or syphilis. And I want to spend a little bit of time talking about why we think of ourselves as sick. What, what contributes to that? The first thing is that there's a repertoire of symptoms available to us. On average, each of you will have had 30 odd symptoms in the last week or not personally, I've had several this morning whether they are physical

symptoms like headaches or upset stomachs or psychological symptoms like axed or despondency, they tend to come and go throughout the week and we give them more or less attention, according to our circumstances at the same time we have feelings, emotional feelings, sadness, anger, and fear and so on.

Jon Jureidini (00:09:34):

And each of those has a bodily manifestation. So we're experiencing churning, stomach sweatiness fatigue, whatever it is that might be a somatic manifestation of our ordinary emotional feelings. And then there's, I think if this is a particularly modern thing the idea that everything we experience in our body is medical in the domain of doctors. So that, I mean shyness would be a recent example of something that has a very intense medic experience associated with us. I don't think anybody ever really thought I was any kind of illness or disease, but increasingly over the last decade or so has been co-opted into, into disease structure. Now all of those symptoms and experiences that come and go tend to have a fairly transitory effect unless we're in some kind of altered state of arousal. And that might be something that's brought on by tiredness or by emotional distress or by intoxication.

Jon Jureidini (00:10:46):

And in those circumstances, those little feelings that we hardly notice in our body might become a focus for our attention and the pre our preoccupation with the may lead to their persistence. And then there's a range of social forces that have an impact on how we interpret those bodily experiences and, and experiences in our, in our minds and in our machines. So I'm not going to have time to go into a range of the, of the broad social first forces that shape our investment in newness, but just to talk a little bit about some of the new diseases that we doctors have made available for you throughout the lifespan starting from gastroesophageal reflux disease in infants through attention deficit disorder in children irritable bowel syndrome, chronic fatigue syndrome, all of these conditions, which when defined very rigorously might not include terribly many people, but pretty much available for anybody who wants to join the club.

Jon Jureidini (00:11:57):

If you take them a little bit more loosely and I'd probably want to add to that list depression, as we understand it today now in English the term depression was applied to the very severe disturbance that very few people had that resulted in hospitalization and a great deal of disability. And, you know, 50, a hundred years ago, that was what depression looked like. It was something that was really talked about except amongst people who were hospitalized had very high suicide rates and very high levels of dysfunction associated with it. But what we talk about when we label something, depression today is quite different from that. And but the difference is kind of hidden and we have to go to other cultures to see that spelled out more clearly. And in Japanese culture, the term that was used for that severe form of depression was something that didn't lend itself to be used to describe the much lower level feelings of, of distress and suffering that we use the label for analysis ADI, and the effect of that was quite dramatic. Antidepressants didn't take off in Japan. And it wasn't until somebody somewhere probably in marketing came up with the notion that apparently translates roughly to cold of the soul. And this term was something that Japanese society could embrace in much the way it, same way that as society embraces the concept of depression as something that everybody can have and that we mustn't be ashamed of, and that there are good treatments for, and that life can be made better for you all acknowledge our depression and and traded appropriately.

Jon Jureidini (00:13:54):

Another social force that I think is really important in shaping the epidemic of, of mental illness is our own intolerance of uncomfortable feelings. Our intolerance of suffering our intolerance of ordinary unpleasant feelings. And, you know, actually only takes you two weeks to get a diagnosis of depression. You don't have to feel bad for very long to get that diagnosis. And there's this whole idea of, of pursuit of happiness as an end in itself. And in fact, I think the thinker in residence who's coming to Adelaide this year makes makes it his business to have us all pursue happiness. And there's a a wonderful book by Barbara. I can write called smile or die which talks about the, the pressure on people to be happy. And in particular, she was somebody who had breast cancer and really got the message that many people with cancer get, which is that you know, the kind of Lance Armstrong view of it, that if you, if you're a good enough person and you're strong enough and you're positive enough, you cancer will go away.

Jon Jureidini (00:14:59):

And if you ha, if it happens to kill you, that's because you haven't tried hard enough. And I think I can, Reich's work is a, is a wonderful antidote to that kind of thinking, but it also taps into this idea that happiness is an end in itself, something that we should pursue. And I, I think that's a, a real misperception of what it is as an emotional state. And happiness is a marker. It's something that, that that we experience in certain circumstances in life. And it's not something that we pursue for its own side, what we should be pursuing is a good life, whatever that is. And that's probably the subject of another whole series of seminars, but and, and if we pursue a good life and we're successful and lucky in our pursuit of a good life, then for large periods of our life will feel happy.

Jon Jureidini (00:15:49):

But part of a good life is also to feel sad and miserable and upset and angry and all of those other feelings. And, you know, I'm not advocating joy in suffering or any sort of extreme Calvinist approach to life. But I am saying that we have to be much more open to and accepting of uncomfortable and unpleasant feelings and not just in ourselves, but also in our children. And most of us have had the experience in parents of getting panicky about our children, feeling the slightest bit unhappy and feeling that it's our obligation to make things right for them. And maybe that's not the kind of parenting that they always need. [inaudible].

Jon Jureidini (00:16:33):

So with that background in mind, I want you to imagine a child who's in you know, I want to go back now to that the idea of us having a range of symptoms that are available to us from our body's feedback from our bodies all the time, and that if we're in a state of what you might term disarray, that is some kind of intoxication or unhappiness or anxiety or distress that we're in, we're inclined to become preoccupied with those symptoms, whether they're coming from our body or coming from our emotions or from our mind. And if you imagine a child who's in some kind of a predicament, maybe her parents are fighting a lot, and she's very uncomfortable about that. And you know, children have a really limited number of ways in which they can tell us that things aren't right in their life.

Jon Jureidini (00:17:24):

And ideally we'd like this little girl to come to somebody and, or go to her parents and say, look, I can't be you fighting anymore. And it makes me sick. And it gives me a tummy tuck when you do it, and I want you to stop, but most kids can't do that. And maybe the Tommy act doesn't go away when they do. But but let's imagine that that it's a tummy act for this girl. It might be behavior problems for another child,

or it might be withdrawal and apparent depression for a third child. And this will go it becomes increasingly preoccupied with her tummy pain, which is very real and very distressing to her. And if things go for, if the cards fall in a certain way, she finds herself in an emergency department or in a doctor's surgery.

Jon Jureidini (00:18:13):

And the doctor gets worried about the pain that she has and investigated extensively. And we've got an illness. What we have is something it's a series of symptoms, which would be better thought about as symptoms of a predicament actually being interpreted as symptoms of a newness. And it's not until somebody can grasp the meaning of those symptoms that this is a gut sack that's brought on by mum and dad fighting. And that doing something about mom and dad fighting is the intervention that's needed. It's not until that happens, that we've really explained what's going on for the little girl. We can put all kinds of labels on her experience, but they don't constitute explanations.

Jon Jureidini (00:19:01):

So I'm suggesting that a lot of mental health, mental illness is socially determined. There's nothing very controversial about that. And it's not, of course, just mental problems that are socially determined. And it doesn't mean that something's not real if it's not. So if it's socially determined, if we tag for example type two diabetes of which there's an epidemic in our society that's quite clearly socially determined. It's very much related to obesity, which in turn is very clearly related to poverty and deprivation and pour you out of the more likely you are to be a base. So, and, and those social things are, are those social factors are things that we should be doing something about, but that doesn't mean that we don't have to treat diabetes. When somebody presents with diabetes, we need to trade it. And you might argue that all of the things I've said about the social determinants of mental illness amount, to the same thing, that when somebody presents with some kind of mental illness, then that needs to be traded on its merits, independent of whether it's been caused by social factors or not.

Jon Jureidini (00:20:09):

But there is a significant difference because diabetes explains what the person who has diabetes is suffering from it's, it's quite straightforward to give an explanation of how the person with diabetes comes to experience all of the range of symptoms that they have. Depression on the other hand at bet explains nothing. And at best it describes now depression as a description can be a relatively benign label. If somebody goes to the doctor and the doctor says, I think what you're experiencing could be described as depression. And this is a condition that's quite common in our society, and it tends to last weeks rather than months. And you've had it for several weeks now, so you can expect it to go away relatively soon, but why don't you come back in a couple of weeks and let me know how you're going with it.

Jon Jureidini (00:21:10):

That's it might sound like nothing, but it's actually has a name it's called watchful waiting, and it's the recommended treatment for mild to moderate depression. And that's a very relatively benign process because what's being acknowledged there is that depression is a description of the person's experience in much the same way that attention deficit disorder is not a bad description of a pattern of inattentiveness and overactivity and impulsivity, but it's when these descriptions masquerade as explanations, that things become dangerous. And and the trouble with most of our mental health labels or categories, is it by an explanatory and I think that, that the risk of, of using a non word that they

constitute an explanations and unexplained nation is different from an error. It's not that you've got the explanation wrong.

Jon Jureidini (00:22:24):

It's also different from uncertainty, which is the theme of this festival because an unexplained nation actually to a certain extent, represents an intolerance of uncertainty, the need to come up with something, a liable for, for the experience. And it has, it has some cousins and explanation, I think, and perhaps the one of them is the philosopher Frankfurt wrote an essay some years ago called on. And and he it's, it's a really worthwhile little book to read and what he tries to capture with the notion of and distinguishing it from from lies is the idea that it's there is inherent in it, a reckless disregard for the truth. And I think that that the that the problem with our psychiatric labels, our unexplained Satori psychiatric labels is there in authenticity. And I want to say a little bit more about that, but in a little while, but to summarize where I'm up to at the moment, I think sickness is an unexplored nation or an, a tree for most young people's distress. So where do we go looking for something that might do better as an explanation?

Jon Jureidini (00:23:58):

I have gone to a poem by Philip Larkin, which is well known and begins. They you up your mom and dad. And I prefer the notion of bang fact up to the notion of being sick as an attempt to explain young people's distress. I apologize for the use of the crude term, but it captures in a way that no other term I can find a difference between two sort of apparently mutually contradictory processes that are going on the first is the sense that, that Lakin's talking about. It's not just mum and dad obviously, but a whole series of life circumstances and, you know, intoxication and head injuries, and a whole range of things can, can have the effect. And this is what's been done to you or been done to the young person. But the other sense of it is of having fact up of having done those things, which we ought not to have done and left undone, those things, which we ought to have done and getting right.

Jon Jureidini (00:25:15):

What's the contribution of those two different senses of that term, I think is a big part of the work that we do in making sense of our suffering and distress and unhappiness. And you might think that with young people the it's more, they're going to tend more towards focusing on what's been done to them and not taking responsibility for their contribution to it. But if I just re recall an experience that I had on yesterday, when I went into the hospital to see a young person who'd been admitted apparently with depression, I came from a very abusive background and whose onset of depression had been brought about by the fact that he'd been a heavy drug user and abruptly stopped using drugs, and now was confronted with all of the things that have been hidden by his use of drugs. And some of those things related to how much trouble his parents were in and how frightened and impotent he felt in the face of that.

Jon Jureidini (00:26:23):

And, but his take on what he was going through was that he had filed that he was being aggressive at home which he was that he was behaving in a way that was unpleasant for his mother, which he was but a more sort of mature understanding of what was happening was to see him as having been screwed up by his circumstances, not as was being constantly told to him by police and all the other people who were involved, that he had screwed up and was responsible for the distress and unhappiness in his family.

Jon Jureidini (00:27:06):

So one common way that young people screw up is by attacking overdoses. And and to try to w when I'm teaching about the importance of explanation in understanding and dealing with young people's distress, I use a kind of case example of a 16 year old go who lives with a mother and younger brother in what appears to be a happy and functional family. Who's taken an overdose that's moderate, moderately, severe, and has ended up in hospital. And when asked why she took the overdose, she says, I broke up with my boyfriend. And of course, that's not an explanation because hundreds of girls have broken up with their boyfriend every day. And most of them haven't taken a serious overdose. And so I get the trainees to ask me questions about what they think that, that might aluminate provide an explanation of why the is behind in this way.

Jon Jureidini (00:28:09):

And the first set of questions that they tend to ask are about her mood and her depression, and pretty quickly, it's established that she's matched the criteria for a moderately severe depression. And I asked him whether that's an explanation and some of them think that it is, but most of them, but that's not really because they know that I'm not going to like it. If they say I got it is. And so the next set of questions, I tend to ask her about the nature of the breakup. And I make it that the breakups been relatively benign, that the they've been together for six months. It's been a nice relationship. He's been kind to her but he doesn't want to be in a serious relationship. You know, it's all about me. It's not about you kind of thing. So there's not been anything particularly toxic about that Brian cup, and that doesn't explain why she's become suicidal.

Jon Jureidini (00:29:03):

And we, we plug away for a while and eventually it comes out that or somebody gets expresses an interest in where dad might be in the process. And it turns out that the parents divorced when she, when the goal was two years old, dad disappeared from the scene and had no contact with her until she was 11 or 12. At which time she, he, he made tentative attempts to come back into a life and my gradually built a relationship. And then about the time that she started up with the boyfriend, he got a transfer into state, again, interrupting their relationship. And so now we have an explanation don't we, because we can see that the breakup with the boyfriend, which is troubling, but a relatively benign process in a young person's life, resonates with the abandoned and experience that she's had from a father.

Jon Jureidini (00:29:52):

And so, whereas on the one hand, if we went down the mental luminous line, we'd be able to say, well, she's depressed. And people who are depressed often make suicide attempts, and we can give her some treatment for her depression, whether that's drugs or cognitive behavioral therapy or something. And she might've got better. She might've done really well with that process. But I think the alternative process, which is to come up with an explanation for her suicide attempt and for her to stress that doesn't amount to a medical label, but amounts to a story about the relationship that she had with a father and what went wrong with that and how that was recapitulated in a relationship with a boyfriend has, has potentially has a different set of outcomes. And you know, the, the outcome that it had had in this case was that the mother said something like well, she burst into tears actually and said, I, now I kind of see it.

Jon Jureidini (00:30:47):

I always thought, you know, your father was a did. And it was a good thing that he was out of your life, but now I can see how difficult that was for you. And perhaps I shouldn't have said all of those awful things about him and, you know, the, the fact that the mother's response to the child's overdoses, warm and supportive in that way then means that the family had discharged. You know, maybe there's some psychiatric follow-up organized, but I'm feeling kind of confident that this experience has set the young person up for growth rather than, and you know, that, that we know that people can grow and develop out of crises. Now the fact that I use that case for a teaching example gives it away. It, doesn't not really because it's not usually as straightforward and as dramatic as that.

Jon Jureidini (00:31:40):

But it is the case that people come to us with a fairly limited repertoire of themes. Everybody's got a different story, but the themes are relatively limited and prominent Adelaide real estate agent once explained to me that the only two forces that control the world, I fear and grade. And I think Melanie Klein actually said something quite similar to that. But if you, if you substitute hunger for, for grade, I think most of the people who come to see me are generally frightened frightened of something or hungry for something, usually relationships of some sort, and they're in pine. And I have as a product of that, or going along with that, some level of disarray arousal, they don't feel emotionally and physically and physiologically as they would want to. And so that, that's the kind of, th those are the kinds of themes that I've got to work with.

Jon Jureidini (00:32:42):

I don't have to start from scratch. I know the kind of territory that I'm likely to encounter, but if I respond as a lot of conventional psychiatric and psychological practice does just to the pain and the disc arousal which is a very understandable response, cause nobody likes to see somebody in pain and we want to waste suffering. But if I respond just to that then I might be offering analgesia at the expense of understanding. And whereas the, the project that I'm advocating might in many cases, prolong the pine that people are experiencing. But it might be with the added benefit, oh, of immunizing people against further difficulties and distress later in life. And actually now there's increasing concern about the role of psychiatric drugs in injustice, why there's very little doubt that many psychiatric drugs whether they're prescribed ones or ones that you buy in the pub we're on the street microwave pine in the short term, and do a good job of that.

Jon Jureidini (00:34:02):

And I enhanced functioning in the short term and they do a good job of that. And many of them have few side effects for many of us who take them, but there is increasing concern that that might not be the outcome in the longer term that one of the reasons why there's more depression around and more recurrence of depression might be that we're treating it earlier and more frequently with antidepressants, which while I may reduce and shorten that episode of depression may predispose us to further episodes of depression. Now that's by no means proven it's something to worry about rather than something to necessarily act on, but it does anyway fit, even if it's not a a physiological effect, it does fit with the idea that avoiding pine might not be the best long-term strategy. It might be a better short-term than long-term strategy.

Jon Jureidini (00:35:05):

So this might make some people puke, but what I think the psychiatric enterprise is about, and the psychological enterprise is about providing a safe, validating environment in which our patients can with

our help come to some kind of authentic account of where they are and how they got there. Now it's not the, that just any story we'll do when I, when we set out to develop a narrative with our patients about who they are and how they got there. It's, it's it's got, we, we have to strive towards an authentic story. And what is an authentic story? Well, that's something that perhaps our novelist, a better place to judge then than a therapist, but it's, it's not very different from the scientific process where we develop a hypothesis and we test it and we improve it and we enhance it, and we're always trying to make better sense of the circumstances.

Jon Jureidini (00:36:21):

And the, the narrative task is to bring that all together into a coherent, cohesive and meaningful story. And that I think is something that we must always be treating with the same kind of skepticism that I advocated at the beginning of my talk, we should direct towards drug treatments and conventional psychiatric assessments. That the story that I come up with with my patient needs to be always interrogated and re-examined to see whether it's not just something that suits me and them to avoid some kind of conflict, but it actually the best and most authentic story that can be developed for that person at that time. So my conclusion is that what helps us survive in an uncertain environment when things don't go well for us is not so much good drugs good diagnosis, but good stories. Thank you.

Speaker 2 (00:37:42):

[Inaudible]

Speaker 3 (00:37:43):

Fantastic presentation. Aren't the kids who get John as a psychiatrist, lucky beings. I think that you take that care [inaudible],

Speaker 3 (00:37:53):

But you take that care and time to unravel the complexities of a story. We have microphones. I really want to optimize the time to get as many of you who would like to add comment or ask a question involved here. We have microphone there. And I think we have one up the top. Is that right? Can someone just let me know that? I think that's right. So feel free to, I'm just going to cut straight to questions. I think why don't we do that? I mean, I've got zillions, but you'll have just as many zillions, if you could keep them fairly brief and concise and put a question mark on the end, that'd be great. And if a few of you queue up, what I might do is do them in batches of two, so we can get as many comments and input as possible.

Speaker 3 (00:38:33):

So please, thank you. Hello. I do have a question. It as I was listening to your talk, John, I was thinking a lot about learned optimism and optimistic kids, which of course is the work of our incoming thinker in residence in Adelaide. And my question is I think I heard you mentioned the term immunization, immunizing kids against depression, and thinking about, you know, it's not just the stories that these kids have that they bring with them, but also the skills that they have, which shapes and determines their responses to these stories. And so my question is, you know, is there a lot of complimentary nature of what you've discussed this morning and also concepts such as learned optimism? Thank you. Go for it.

Jon Jureidini (00:39:28):

I'm sure there's some, I mean, I'm sure that, to some extent it's talking about the same thing in different ways, but I think that there's an important difference. Because I think that that learned optimism as an, again, as an end in itself is missing the point. What I think we need to teach kids is all of the cognitive and moral skills that they need in order to be able to manage in an uncertain environment. And the more skills they have and the more positive qualities they have in the more positive experiences they have, if that happens to be matched by a sympathetic environment, the more optimistic they'll be. But to think that somebody who has been abused and neglected and and has a bad school experience and then encounters adversity can overcome that through some through being taught, to be optimistic. I think misses the point and type has over some very important cracks.

Speaker 3 (00:40:41):

Hm. Thank you. Could you just clarify my understanding of it? I interpreted your, your criticism of traditional psychotherapies is that they're more descriptive than explanatory, but then, and the problem is that is that they're using a descriptive technique and then forming treatments from that. Whereas your solution seems to be more explanatory, but you didn't really elaborate on the treatments that you would be able to implement with. So you have an explanation that is actually quite psychodynamic dynamic, I would think coming from childhood and he didn't really elaborate on how you would use that information to then adequately treat a client. Good question.

Jon Jureidini (00:41:27):

Well, any treatment is part of a treatment package and the most part of that package is all of the non-specific stuff. It's you know, that shared by good therapists, whether they are doing cognitive behavioral therapy, giving drugs or doing psychoanalysis and that's something to celebrate because we can all bring that into our work before we get started on what we think is the important bit, but which evidence shows probably isn't the most important part. For me, the bit that I try to add to that nonspecific part of it is I guess, psychodynamically oriented some of the time, but it might also be. So

Speaker 3 (00:42:12):

For the benefit of the collection collective here, remind us what psychodynamic is.

Jon Jureidini (00:42:19):

Well, I guess psychodynamic is about trying to make sense of your current circumstances by understanding the forces that have shaped those circumstances. But, but the, the actual therapy that I do might be quite behavioral, it might be setting somebody tasks today. Fat, I think that two things might happen as a result of me setting somebody a task. The first thing is that they might do that task and it might benefit them and they might feel better and stronger and more a sense of mastery, and that will enable them to get on with their life in a more effective and satisfying why. The second thing second possibility is that might not go as well as that, in which case I'll come back and tell me about it, and I will understand better what's causing their difficulties and together we'll enhance our understanding of that. And that will generate the next level of intervention, whether that is mutual sort of development of a story, or whether it's setting about some behavioral task or whether it's medicating or doing family therapy or whatever it is that the modality sames, the best match between what I can do and what might be helpful for the person.

Speaker 3 (00:43:42):

So, John, where does your medical heritage, oh, psychiatrists have a medical degree, your doctors, and then you tack on the psychiatry bit where does the medical degree fit into all of this?

Jon Jureidini (00:43:53):

Well, in the setting, in which I work with people who are sick and sometimes dying than being a doctor, I think is an enormous asset in that situation to be able to sort of respond with equanimity in the face of horrible situations and that generalizes out of, I think the direct medical setting into the horrible suffering that some of the people that I see experience. So I think having been trained as a doctor has been enormously beneficial to me in my work. But in terms of the individual interventions that I use I'm not sure that apart from the very occasional bit of prescribing, I'm not sure that any of those things pertain directly to being a doctor. Except I suppose in the things that I don't do. And I mean, I'm well placed, I think, to spot the in psychiatry because of my conventional medical psychiatric training. So I think that's an important asset

Speaker 3 (00:45:00):

And he's a psychiatrist in the room. I mean, it, it flies in the face, your whole argument flies in the face of the predominant argument and public health message. Now that that mental illness is a disease. It does. And we'll come to that, please. Thank you, Dr. Giardini. Thank you so much for your inspiring lecture and for exposing the as a mother of an almost 14 year old girl who has recently written about the four different ways that she's attempting or thinking about killing herself. And who's been diagnosed by a private psychiatrist as suffering, depression and anxiety, severe depression and anxiety, and has also presented at the women's and children's hospital emergency department. And seeing the psychiatrist there having waited eight and a half hours to be admitted and being kept for six hours and told she didn't belong there. Please tell me, I want to know, I need to know cut the. I want to know who's going to listen to my child's story. Who's going to help her work out her story. I'm a resourceful parent as is my husband. We have financial resources. We've tried the private and the public system helped me cut the. I need to know where to go next. Thank you.

Speaker 3 (00:46:31):

Thank you for that question, John. And it's you know, there's a sensitivity here, isn't there because you haven't met the daughter, your daughter,

Jon Jureidini (00:46:43):

And I work at the women's and children's hospital. Look, I think you've just got to keep trying until you find the person who can well, I, I don't think it's appropriate for me to list places for consultation. I think it's sorry,

Speaker 3 (00:47:07):

Just to generalize this, this is, this is a story that we hear over and over again from parents who feel despairing about their children's expression of extreme distress and, and some, and there's an incredible amount of fear around suicide and the prospect of suicide. There's a lot of fear and concern and, and in many families cases, grief about losing a young one. And so there's a sense of urgency about, about many of the public health campaigns that we we see about helping people help their children get help. So you can understand the desperation that people feel when they found habit at emergency way meant to put you on the star. Not at all. I have a great deal of respect for you and your lovely family. I taught your children primary school, but indeed when the public system, the public hospital tunes my

child away and refuses to read what she has written about the dark place that she lives in and the four different ways that she's going to kill herself, then I feel very disparate. Thank you. But trying to generalize this, and I understand thank you for your follow up comment. There is a sense of urgency, and I wonder if that's why we've become much more focused on the medical treatments available and the medical explanations for young people's suffering, because it seems like a much more straightforward, less complex path trajectory to give them support.

Jon Jureidini (00:48:44):

I think that's right. I mean, I think where we are somewhere between appropriately respectful and inappropriately intimidated by suicide, know the number of young people of high school age under 18, who killed themselves in south Australia each year is less than four. And while every one of those deaths is a tragedy that obviously is extremely damaging and distressing for the families involved. It's not the case that there, there are young people killing themselves all over the place, but we often respond to young people's distress as though the only line of intervention. Well, our, our approach to intervention needs to be dictated by what's the safest thing to do from the point of view of suicide. And in trying to ensure safety from suicide. I see young people whose freedom is taken away whose family's capacity is undermined, whose own autonomy is, is destroyed, freedom being taken away.

Jon Jureidini (00:49:55):

Well, if detained to hospital, because people think that if in a psychiatric ward, then they're not going to kill themselves, which is psychiatric wards answer is Onpro, but probably it's not unreasonable to expect that while you're in the psychiatric ward, you are a bit safer from suicidal behavior, but you've got to look beyond that 24, 48, 72 hours of the person's going to be in there and think about what's the overall impact on that young person's life. And there are times when my job in the emergency department is back up the staff to say, this person is suicidal, but the best thing to do to do for them overall is to send them home with their family and to accept that there is some risk associated with that, but that the risks associated with that, or outweighed by the risks associated with hospitalizing, the person or whatever, intentionally terrifying for a family though. And so families aren't who are

Speaker 3 (00:50:51):

Dealing with a very volatile situation

Jon Jureidini (00:50:54):

And families should never be made to manage that on their own. We should always be offering support and, and services and intensive follow-up, but we mustn't be. That's why I say we have to be respectful of the risk of suicide, but we mustn't be intimidated by it because I think we sometimes make bad decisions because we're scared and we're not prepared to tolerate the fear and uncertainty that's associated with that. And, you know, a good psychiatrist, clinician is somebody who can take the right risks. And if we're risk averse, I think we do more, more harm than good, which is not related at all to the case. That was just right. But what you've

Speaker 3 (00:51:37):

Said is that we need to back up and we need to provide support services. And the concern for many parents is that there just aren't enough support services. So they, they revert to emergency at times of

Jon Jureidini (00:51:48):

Emergency, maybe, maybe for some people was those resources and those services don't reside best within the medical system. Maybe there are other places where that support and resources can, can be found. And, you know, we know that all of those, I mean, it's difficult to think about this when you're in the midst of an acute emergency and it's difficult for anybody to make good decisions in those circumstances. But the majority of times when our young people come to us in distress, it's not actually an emergency. It's something that needs to be taken seriously and dealt with, but it's not an emergency. And there is time to do things in a different way and doing things in a different way, might range from one end of saying, I'm just going to sit with this. I'm going to tolerate the fact that everybody feels really bad and it's frightening.

Jon Jureidini (00:52:38):

And I'm probably not going to get any sleep tonight through to there's somebody I know in my family or in my community who I think it would be really good for my son to talk to through to this is something that exceeds the capacity of my extended family, friends, and resources, and I need to go for professional help, but I just think we jumped to there too quickly. And I absolutely agree that we professional psychologists, whatever have to do a much better job in this territory. I'm not shy. I'm not for one minute suggesting we abolish psychiatry. There are, the problem is that we can flight to populations. When people talk about in that quote about people desperately needing a mental health care that they're locked out of, there are people who desperately need mental health care that they're locked out of, but that's from the one or 2% of the population who have major mental illnesses.

Jon Jureidini (00:53:35):

And I think on average that we psychiatrist and the mental health system do more good than harm for those people. But then there's another 20% who were identified in community surveys as having psychiatric problems or disorders or diagnosis. And there's not a blind bit of evidence to show that I'm any better at dealing with those people than a GP or a counselor or somebody else's mature and thoughtful and helpful. And so we do need to strengthen mental health services, but we need to strengthen mental health services for the people who absolutely need them. Not for the people who think that might help

Speaker 3 (00:54:12):

Lots to talk about there. And we're going to come to you now. Thank you. Thank you, John. My name's Leslie, and I'm actually a rural GP. So I've jumped in just at the right moment here. There's a few things I'd like to see is that, that out of the city, the resources that the mental health resources often are not available so often I'm dealing with it on my own, and it may be a suicide. You know, people threatening suicide. There's a few things that you said, you talked about watchful waiting, but I must say I've got to do active watchful waiting. Cause I have a short time to, sorry it was happening. There's a few resources that we have available to us. I have a single sheet that young people can put themselves in the middle of the universe and they can actually identify any stresses, roundabout them. And it's on one page and it's very quick and you don't need to ask any questions. They actually write it out and show you exactly why they are, where they are. The other thing that seems to be occurring is boredom and sleep deprivation are increasingly, sorry, not sleep deprivation, slip sleep disorders seem to be becoming increasingly identified as other stressors. And I wonder if you could comment a little bit on that the hyperstimulation of our young people today.

Jon Jureidini (00:55:26):

Yes. I mean, I think the, the first point you made really illustrates what I was saying before. You're one of those people that, that people can come to with their distress and you can help them. And it's not just the piece of paper that you give them, it's you providing the safe, containing environment in which they take the piece of paper and then go away and do whatever it is that they do with it. And that can be replicated throughout the system by mature well-trained professional people who don't need to be psychiatrist and don't need to be dispensing medication or cognitive behavior therapy or any other packaged intervention. Your comment about boredom, I think is, is a really interesting one. Because I don't think our young people have enough opportunity to be bored. I think that this is part of the same package as the intolerance of unpleasant feelings.

Jon Jureidini (00:56:24):

There's always something available to distract you. You can always get out your iPhone or play a computer game or watch television or, and, and the, the value of being pushed to reflect that people of my generation grew up with is no longer so readily available. And of course there are lots of advantages to that, but I think there are, there are dangers and disadvantages as well in terms of sleep. I agree with you, absolutely. That sleep is, is a really important issue. And often sleep is presented as a symptom of psychiatric disorder, but it's a very potent, you know, it's one of those things that disarray sleep disturbance is one of those things that disc arounds us and gives us a different perception of our bodily experiences in the way that invites us to present it as an illness. And you just have to look at sleep deprived, new mothers, and the ease with which they can attract diagnosis of postnatal, depression, or postnatal anxiety, and how that medical condition can be Morag miraculously cured by a few good nights late.

Speaker 3 (00:57:44):

So sleep disordered, rural doctors as well. Cause we have to go up in the middle of the night too. So we've got, we've got about two and a half minutes and I'm under strict guidance to finish this on time. So what I'm going to do is just get the two of you to ask your questions and then we'll come to John for final wrap, if that's okay. Thank you. Thanks John. Half of the population of females, most of whom will need to, well, we'll have already faced the issue of contraception, huge, massive chemicals, coursing through their bodies, the easiest option, or one of the easiest options is the three-year implant like Implanon. My daughter chose that option. And sometimes, sometime afterwards, she changed from a bright, bubbly, incredibly competent person, never anxious bone in her body to sudden onset anxiety, fear and loss of self-belief.

Speaker 3 (00:58:33):

This decline resulted in her admission to a psychiatric ward where there was no separation whatsoever between short and long term patients. She said it cured me and it broke me sometime later. She tragically suicided. When I asked her doctor, if there was any history of any connection between psychosis and high progesterone levels, she said, yes, of course, that's why Depo-Provera was taken off the market. What would you advise to your daughter to all the women facing decades of contraception issues where seemingly the simplest option is highly chemical, highly potential, and four other mothers have approached me with similar consequences in situations. All right. So thank you for, for that. And I'm sorry about to hear about your daughter. What we might do is just pause if you don't mind. And we'll just consider that, that question. Thank you.

Jon Jureidini (00:59:33):

I mean, I think, I think what you, apart from the moving nature of your question, what it illustrates is how bad we doctors are at collecting information about adverse drug reactions and how bad we are as a community at doing that. And how important it is that every individual who has a story like this one is somehow heard by the system and that information is collected together because one individual case tows is very little, but when we collect together these cases we can learn. And and then we can prevent further disasters from happening, which

Speaker 3 (01:00:12):

Is the case that often parents are the ones that do that data collection. If only there was a way to sort of filter that experience. And in some ways the internet has become a repository for that experience, but it's not always extracted and collided in a way that science can interpret. So thank you for that. And a final question. Thank you.

Speaker 5 (01:00:33):

Thanks Dr. Jon I'm instructor of medicine my, this, my problem will drive for a long drive and sometimes I've I was thinking about an event that happened Peter twenties, years back, and sometimes what I studying my goal, my mind goes other places basically thinking of my studies. So I'm not giving artists proper concentration that I could 10 years, years back. How can you overcome this problem?

Speaker 3 (01:01:15):

Did you were having trouble hearing what we might do because I have to wrap the event? It's just, it's a quite resonant space as well. We might just get your questions separately at the end, if that's all right. Is that okay? Thank you. Sorry about that. Unless someone did hear and can interpret for me. No, sorry. Hold that thought. Look, thank you for attending Jon Jureidini. Thank you for being a guest speaker at this year's festival. Hmm.