



Theme: 'Psychiatry's legacy and future with the LGBTQ+ community'

The Psychiatric Eye

The London Division e-Newsletter

It may be getting dark and gloomy as the festive season approaches but London still remains vibrant and full of diverse people which makes our city a truly international and popular place to work. It's with this in mind, that this Winter edition discusses LGBTQ+ within mental health.

Our Chair Dr Hughes sends us a positive message about the College incorporating its first celebration of Pride month and highlights LGBTQ+ issues as being included in other events offered to members and trainees.

Dr Zambon gives us a global perspective of LGBTQ+, pointing out positive changes in declassification of disease categories relating to sexual orientation, although sadly there are still countries that criminalise same-sex relationships. Dr Claudius-Adeniyi and Staff Glenda Boutell explain how mental health services are working to reduce stigma on wards and through better education of staff. Even mental health tribunals must ensure that their panel members get training on LGBTQ+ as outlined by Dr Rutherford and Judge Fyall. Dr Coffin and Prof Veale explore the OCD condition where people have obsessional fears and thoughts about being gay. Drs McLaughlin, Jones and Lapraik write about an innovative mental health "first aid course" to promote mental health awareness in the LGBTQ+ community and we extend our congratulations to them for winning our best themed article prize.

We have 3 stocking-fillers; Drs Marsh and Powell's enthusiastic feedback about this year's General Adult Faculty annual conference, an interesting book analysis of "The Single Man" from Dr Devan and a wonderful review of Anthony Gormley's exhibition at the Royal Academy of Arts.

Lastly, the editorial committee would like to wish all our readers a wonderful Christmas and prosperous New Year! Happy reading!

Stephanie Young and team.



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Chair's Message

Dr Peter Hughes

Chair of the London Division Executive Committee

Welcome to this edition of the London Division newsletter which is themed around LGBT+ issues.

This year the college celebrated Pride month for the first time and we had rainbow lanyards at the International Congress. Professor Dinesh Bhugra, Dr Susham Gupta and I gave a presentation at the Congress on LGBT and mental health. So this edition is timely and highlights the particular challenges faced by this community in London.

In other matters, the Division is proud to have had a medical student- led pan London PsychSoc event at the College. This was a very successful event and hopefully will be the beginning of an annual tradition and also a spur to recruitment. We had a Choose Psychiatry event in September with a fantastic programme. Special thanks to the moving lived experience account of Laurie Dahl. We move forward with more and more events that we hope will inspire the psychiatrists of London and others to choose psychiatry. Inspiring a new generation of psychiatrists and recruiting into our field remains one of our most important core objectives.

Other future ventures include holding a London awards event, further StartWell courses, and work on supporting International Medical graduates.

I have just finished reading all the essay submissions for our annual London division competition and it heartens me to see the academic skills, professionalism, passion for mental health and soul of our medical students and foundation doctors. It has been an unenviable task to attempt to select the winning entry.

We have inspiring members of the executive and Choose Psychiatry committee but need everyone's passion and commitment to move forward the agenda to champion excellent mental health care and prevention in London.

We welcome the new members to the executive especially Diane Goslar -our service user representative.

I thank Jen Edwards and her colleagues for their ongoing sterling support for the Division in every way.

As Chair of the London Division, I invite you to read, digest and enjoy this newsletter. I invite you to be part of the work of the London Division to make mental health better for us all in our global capital city.



Outside the NHS; Innovative ways to promote mental health awareness amongst the LGBTQ+ community

Dr David McLaughlan, Dr Amelia Lapraik and Dr Lydia Jones

Over recent years there have been several headline grabbing moments of progress for the LGBTQ+ community, such as legalization of same-sex marriage, however behind the headlines levels of poor mental health remain worryingly high. A recent report illustrated that 52% of LGBTQ+ people had experienced depression in the last year, and 61% had anxiety¹. This far exceeds the 16% of the general population in England who are estimated to have a common mental health problem, such as anxiety or depression². Reasons put forward to explain this increase are myriad and include bullying, parental rejection, discrimination and fear of violence.

Whilst there is a clear need for LGBTQ+ people to have access to mental health support it seems mainstream services might not be reaching this demographic. Almost one in four LGBTQ+ people report witnessing negative remarks about LGBT people from healthcare staff, with one in seven reporting they have previously not sought mental health care due to fear of discrimination.

Given these alarming statistics a mental health first aid course was developed, aimed specifically at the LGBTQ+ community. It was hoped it would not only offer support to those struggling with their mental health but also reduce stigma around discussing these topics, break down barriers to accessing care and help develop a more informal peer-to-peer support network.

The course was delivered on site at an LGBTQ+ swimming club before their training session. Using this outreach approach, we were able to engage with a significant proportion of members (over 50% who went swimming that day). Participants were taught the signs and symptoms of common mental health conditions as well as coached on skills such as active listening and brief intervention strategies. Participants were given the opportunity to engage in role-plays addressing common mental health concerns within the LGBTQ+ community, such as anxiety disorders and substance misuse.

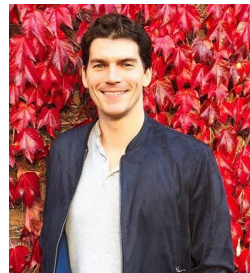
Information was given regarding useful services to signpost people to; with a focus on those that had an understanding of the specific health needs of LGBTQ+ people. Participants were encouraged to share their new skills within the LGBTQ+ community.

Since delivering this course, there has been significant demand from other LGBTQ+ sports clubs within London and such an outreach programme could be delivered via a wide range of LGBTQ+ groups/clubs. With one in eight LGBT people aged 18-24 reporting they've attempted to take their own life in the last year such interventions really could be life-saving.

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'Geo, are you all right?'

Dr Karrish Devan

Psychiatry has a complicated legacy with many population groups, no group more so than the LGBTQ+ community. This was made clear to me recently when I was reading 'A Single Man', a novel published in 1964 by the British-American author Christopher Isherwood. Film fans may recognise the title from the Academy Award-nominated 2009 film starring Colin Firth. In either form, it is a nuanced exploration of how institutional and social stigma can drastically affect an individual's mental health.

The novel is set in the early 1960s and follows George (Geo), a lecturer who is suddenly bereft after the traumatic death of his partner, Jim. The two lived together but kept their relationship secret from almost everyone around them. Isherwood depicts, in exquisite detail, the events of the day during which George plans on killing himself. George teaches, works out, goes to the shop whilst the grief hits him in waves. We get strong clues about George's premorbid personality from the book. He is stoic and mysterious in public, but endlessly happy in private with Jim. George cannot share his grief with many of the other people he interacts with. His sorrow must remain hidden, because his partner was a man. Isherwood's prose is captivating, outlining the deep existentialist battle that has led to George's suicidality. The novel ends tragically, but in a different way than the reader likely expects.

To understand George's isolation and inability to be open about Jim, his situation is best framed by prevalent attitudes at that time. 'Homosexuality' was then listed in the DSM, under paraphilias (abnormal sexual desires), and was not removed truly until the 1973 edition^[1]. Thus, many 'out' people faced significant social and institutional stigma, including Isherwood himself. In the book, Isherwood further implicates the mental health field, when George speaks about how his neighbour likely views his sexuality:

'Out comes her psychology book—bell and candle are no longer necessary. Reading from it in sweet singsong she proceeds to exorcise the unspeakable out of George. No reason for disgust, she intones, no cause for condemnation. Nothing here that is wilfully vicious. All is due to heredity, early environment (shame on those possessive mothers, those sex-segregated British schools!), arrested development at puberty, and/or glands. Here we have a misfit, debarred forever from the best things of life, to be pitied, not blamed. Some cases, caught young enough, may respond to therapy.'^[2]



Image:
Isherwood (left) with W.H Auden, 1938. [3]

To go forward as a profession we have to be mindful of our history and how it impacts the communities we wish to engage with. I believe that ‘A Single Man’ is a strong example of how sociocultural stigma, reinforced by the field of psychiatry, failed many LGBTQ+ people in the 1960s and is a legacy that we must still face today.

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LGBTQ+ Group - tugging at the conscience of 21st century mental healthcare

Dr Olusegun Claudius-Adeniyi and Staff Glenda Boutell

With the hitherto societal criminalization of alternative sexual identities and preferences over the years, Lady Helen Mirren recent declaration of the antiquation of binary gender was a strong voice in the support of the LGBTQ+ cause. The psychiatric community was also complicit in the criminalization agenda as the norm for over a century was to pathologize alternative sexual identities and preferences. The Stonewall riots of 1969 served as the catalyst that broke this norm and challenged the unacceptable traditional view by the psychiatry profession. The slow pace of change was highlighted by the fact that it was only in 1973 that the American Psychiatric Association (APA) removed homosexuality from DSM-II. It took over 30 years thereafter for the US Supreme Court to ban sodomy laws in 2003. And the Royal College of Psychiatrists only issued a position statement on how the mental health workforce can work with this category of clients in 2019.

Psychiatric inpatient wards are now mostly same-sex oriented with most Trusts providing policy guidance on management of LGBTQ+ patients. This by itself is a challenge for those with or without gender reassignment and made worse by the continuing animosity, lack of cultural sensitivity, conscious and unconscious bias by healthcare workers. Various studies have emphasized the vulnerability of LGBTQ+ patients and their preponderance for higher risk of common mental health problems, which far surpasses that of the general population. The Stonewall Trust report of 2018 titled "LGBT in Britain", identified major depression, panic disorder, generalised anxiety disorder, suicidal thoughts and attempts, self-harming behaviour and drugs and alcohol misuse as predominant.

The ingrained stigmatisation of the LGBTQ+ community by the psychiatric profession has continued to create a system characterised by unequal treatment, inappropriate curiosity on the part of staff, outing without patient consent, prejudice and discrimination, intrusive and irrelevant questioning (e.g. about transition and so on) and undue pressure on patients to access services to change or suppress their sexuality. The impact of the stigmatization is

so strong such that about 19% of patients find it difficult to out their sexual orientation when seeking medical attention while about 14% have completely avoided treatment for fear of discrimination.



The future lies with the mental health services actively tackling homophobic, biphobic and transphobic discrimination in healthcare settings. There is active need for strong implementation of equality and diversity training for staff with special coverage of their duties to the LGBTQ+ group under the Equality Act 2010. There is a need to embrace widespread implementation of the Sexual Orientation Monitoring Information Standard via provision of training and guidance to practitioners. Bearing in mind that those who may have experienced inhumane treatments to "cure" their sexuality may still have a mistrust of psychiatry, the government should as a matter of priority bring forward the implementation of comprehensive proposals to end the practice of conversion therapy, including any form of psychotherapy that aims to change patient's sexual orientation or to suppress gender identity. Medical and nursing education should devote appreciable time to the study of LGBT health and their peculiar mental health needs.

The aim is to create a mental health workforce that can provide LGBTQ+-inclusive care. All mental healthcare providers should develop an attitude of zero tolerance to bullying and harassment of this vulnerable group with clear compliant procedures put in place. Overall, psychiatric interventions need to be inclusive, accessible and affirming to support engagement and improved outcomes. Commissioning of services needs LGBTQ representation to reflect the diversity of mental health service users.

Thus, despite some progress, the journey to social acceptance and equitable mental healthcare for the LGBTQ+ group remain unattained.

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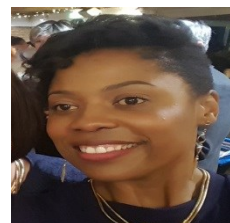
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Am I Gay? The difference between “Homosexual OCD” and exploring one’s sexual identity

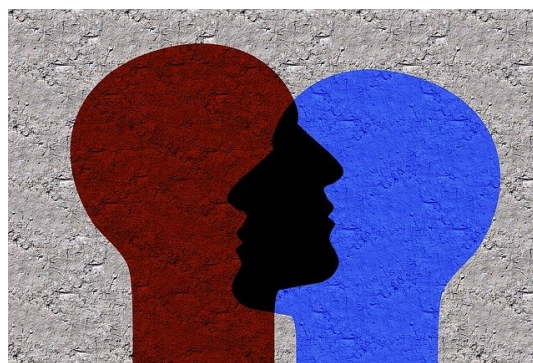
Dr Jessica Coffin and Professor David Veale

Obsessive Compulsive Disorder (OCD) is characterised by both obsessions and compulsions. Obsessions are recurrent unwanted intrusive thoughts, doubts or images. They are distressing and usually senseless. Compulsions, on the other hand, are repetitive behaviours or mental acts which the person feels driven to perform. They have the aim of “undoing” the obsession (e.g. washing), or verification (e.g. mental reviewing or physically checking), or trying to feel “just right”. Some patients with OCD experience intrusions of a moral, religious, violent or sexual nature. These intrusions are almost always ego-dystonic - that is they are inconsistent with the patient’s values or beliefs.

Some people with OCD may have obsessional fears, images and doubts about being gay, when they are not. This is informally known as homosexual OCD (H-OCD). At one level, the patient “knows” that the intrusions are senseless – for example, they have never had any sexual feelings for anyone of the same sex, and they have no desire to enter into a homosexual relationship. These individuals are not homophobic and have no ill feelings against the gay community. However, they are deeply ashamed of such thoughts and images. This may be because they are concerned about hurting loved ones in the future (such as an existing or potential partner or children) or because they are anxious about whether they are living an authentic life. These anxieties may lead the patient to “check” whether they are gay e.g. by watching homosexual or heterosexual porn to check if they become aroused; to avoid gay media or people (for fear of confirmation of their anxiety) or even end a heterosexual relationship (for fear of hurting their partner). When triggered, patients with H-OCD may also monitor their “groinal sensations”, which may lead to further confusion if they are anxious or slightly aroused.

H-OCD should not be confused with people who want to explore their sexual identity. These individuals would benefit from seeing an appropriately trained counsellor. People with OCD however report on being counselled with comments such as - “Well, maybe you *are* gay; How do you know you're not in denial? What if culturally you

can't accept that you are? Is your sex life with your partner not satisfying? What if you are just bi-sexual? What would be so bad about that?” This has led to severe distress and deterioration in their symptoms of their OCD, as it acts to confirm their anxieties may be true.



Cognitive behaviour therapy for someone with H-OCD involves developing a good understanding of their problem and how their interpretation of such thoughts (e.g. “If I have this thought, it must be true”), and the way they respond (through avoidance and compulsive behaviours), maintains the OCD. It is important for the therapist to normalise intrusive homosexual thoughts, as something we all experience. However, their occurrence does not indicate latent homosexuality, any more than intrusive images about pushing someone in front of a train on the platform means a person really want to murder them. The therapy for H-OCD is in no way similar to “conversion therapy”, which has no place in modern psychiatry. In fact, the homosexual content of the OCD is not discussed in therapy, as it’s unhelpful and only provides temporary reassurance. Therapists purposefully avoid discussions regarding whether the patient could be gay or not; however, providing emotional support to the patient when experiencing such doubts is imperative. OCD is a debilitating yet treatable condition. It is essential for assessing clinicians to make every effort to distinguish individuals with normal doubts about their sexual identity from those suffering with OCD, in order to provide the right approach.

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Psychiatry and LGBTQ+ community: a global perspective

Dr Amanda Zambon

Psychiatry, the area of medicine that deals with mental health, focuses on alleviating struggles of the mind, helping people to develop adaptive skills and, occasionally, curing illnesses. At the same time, psychiatrists are often doctors who branched out from the classic medical-surgical career path due to their interest in humanity. However, considering psychiatry as an area of medicine that addresses sexuality and gender issues can lead to a dangerous misinterpretation that these issues would need to be fixed or “cured”. I personally have come across mental health professionals who suggested a referral to the gender clinic for non-binary clients, despite them having no dysphoria or feelings of not being accepted.

Nevertheless, psychiatry welcomes with open arms the discussion about human sexuality, in all its colourful presentations. It was a psychiatrist named Robert Spitzer who in 1973 was fundamental for homosexuality not being classified as a disease in the Diagnostic and Statistical Manual of Mental Disorders¹. The World Health Organization in the newest International Classification of Diseases (ICD-11) proposed a Declassification of disease categories related to sexual Orientation, discarding “transsexualism” in favour of “gender incongruence” and moved it from Mental and Behavioural Disorders into the new “Conditions related to sexual health” chapter².

These changes in classification were significant towards de-pathologising human diversity and contribute to a slow and steady process of social inclusivity.

In Brazil, my country of origin, psychiatrists and psychologists have been advocates of LGBT rights since 1980’s, when other minorities also started the fight to

be heard and to have equal rights, after more than two decades of dictatorship³.

Brazil has come a long way since then, criminalising the prejudice against the LGBT community under the racism law in 2019 and being the centre of one of the biggest Pride Parades in the world. Unfortunately, there are still many concerning facts. Brazil is the country where the most trans people are killed in the world, with 167 people being killed in 2017 - 2018 (followed by 71 in the same year in Mexico and 28 in the USA)⁴. In September 2019, the mayor of the city of Rio de Janeiro banned and recalled a comic book that displayed a homosexual kiss between two male superheroes. This act was then revoked by the Supreme Federal Court of Brazil, who considered the act as censorship.



Page of the comic book 'Avengers: The Children's Crusade' Jim Cheung/Reproduction

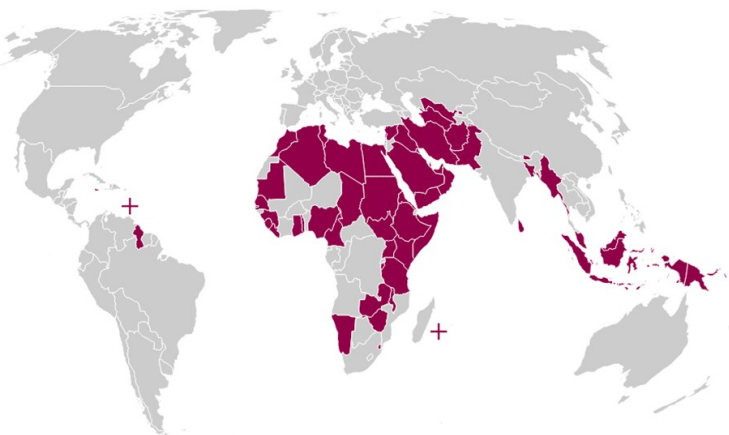
To be part of a minority in traditional societies, especially being part of LGBTQ+ community,

To be part of a minority in traditional societies, especially being part of LGBTQ+ community, is to opt for authenticity and self-actualisation in spite of other people’s fears. Nevertheless, stigmatised minorities face adversities and are at higher risk of mental health issues (known as “minority stress”). The level of effort and stress one needs to face in order to reach their authentic self internally and externally depends on factors based on the individual and the dominant social rule. These factors notably correlate with cultural aspects such as morality, history, political-economic scenarios and prevailing religion.

Unfortunately, the mix of factors that make up for a society to frown upon the LGBTQ+ community is still not uncommon. There are 72 jurisdictions in the world that criminalise private, consensual, same-sex sexual activity, with almost half of them being part of the Commonwealth, six having the legal possibility of death penalties (UAE, Qatar, Pakistan, Mauritania, Afghanistan) and six having imposed death penalties (Iran, Northern Nigeria, Saudi Arabia, Somalia, Sudan and Yemen)⁵

Filter Countries by...

Criminalises LGBT



Psychiatry requires practice based on empathy and a judgement-free environment. It needs to remain open minded to help those who struggle with their inner selves, even in those cases where the people who struggle are the oblivious majority.

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Could training for Mental Health Tribunal Members about LGBTQ+ also benefit clinicians?

Dr Joan Rutherford and Judge Carolyn Fyall

'Whilst awareness and understanding towards transgender people has increased in recent years, transgender people are highly likely to experience prejudice, discrimination and harassment in their daily lives...., some may be particularly concerned about their previous name and gender assigned at birth being unnecessarily revealed in court' - Equal Treatment Bench Book, chapter 12 (1)

It's therefore important for mental health tribunal members to ask appropriate questions at a tribunal hearing; this anonymised scenario has been used at mandatory tribunal training.

Do read and consider what you would do in this scenario, either as the clinician or if you were a tribunal member:



Ms A, a 25 year old woman, is currently detained on Section 3 following a first presentation of psychosis. She experienced paranoid delusions and voices commanding her to kill herself, but has responded to medication and her symptoms are much improved. Unescorted home leave is successful, she is compliant with medication and accepts she has been unwell.

The medical report details Ms A's transgender history. At age 11 she was referred to a child gender identity clinic after insisting she should not be a boy. Medication delayed puberty to allow her time to decide. She adopted a feminine presentation from the age of 12 and began cross-hormone therapy at 18. She is currently prescribed Gonadotrophin Releasing Hormone (GnRH) by injection every three months and oral estradiol 4mg daily. Ms A is yet to decide on gender reassignment surgery.

The Responsible Clinician wants Ms A to attend an inpatient psychology assessment to clarify her thoughts about gender identity; without this is unwilling to discharge the Section. Ms A is incensed by this suggestion and is making an application to the Tribunal for discharge.

The social circumstances report states that Ms A was doing well in her life until a few weeks before admission, with no previous mental disorder. Ms A's family have supported her through her gender transition. A diligent student, she achieved an upper second class degree at university and is a successful marketing consultant.

Ms A's legal representative asks to speak with the tribunal panel before the hearing. Ms A is distressed that the reports contain information about her gender identity. She has been through the correct legal process of changing her birth certificate to female, feels that her transgender history is irrelevant to the Tribunal, and wants the information removed from reports and not referred to in the hearing on the basis that it is a breach of her right to a private and family life.

You may now wish to compare your thoughts with the themes discussed by tribunal members:

- Is the RC's plan and reasoning for psychological treatment appropriate?

No, according to the Royal College of Psychiatrists position statement (2) about conversion therapy

- Has the RC read the evidence in the social circumstances report, and does that affect the RC's opinion?
- In Ms A's case, is her transgender history relevant to the issues that the Tribunal has to consider?
- Does Section 22 of the Gender Recognition Act prevent the RC from disclosing information for discussion at the tribunal hearing?

The Equal Treatment Bench Book suggests that this should be considered very carefully:

'Where a person has applied for, or obtained a Gender Recognition Certificate (GRC), section 22 of the Gender Recognition Act 2004 (3) makes it an offence for someone who has obtained 'protected information' in an official capacity to disclose that information to any other person. Protected information is information about a person's application for legal recognition of their 'acquired gender' (as gender identity is referred to in the GRA) or, if they have legal recognition, their transgender history. Section 22(4)(e), gives a limited exception in that it is not an offence to disclose protected information if the disclosure is 'for the purpose of instituting, or otherwise for the purposes of, proceedings before a court or tribunal.'

- If the RC does attempt to discuss Ms A's transgender history when the Tribunal considers this unnecessary, should there be a warning that this might be a criminal offence?

What is your decision?

Usually, tribunal members decide to exclude the transgender history. Making a decision on the statutory criteria, this tribunal discharged Ms A from Section 3.

NB. Since the GRA came into force on 4 April 2005, more than 4,900 people in the UK have been granted a full GRC (4).

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Conference Watch : Faculty of General Adult Psychiatry Annual Conference Manchester 2019

Dr Will Marsh & Dr Jennifer Powell

In October we attended the General Adult Faculty annual conference, which was held over two days in the Midland Hotel, a calm Manchester oasis. Things kicked off with an introduction to the new order; recently elected Chair Dr Boland enthusiastically welcomed us to the city with reference to its 'Madchester' and brit-pop musical heritage. We found his verve to be well placed, given the variety of topics presented and debated.

Challenges to normative practice were frequent. Prof William's plenary encouraged us to reframe Treatment Resistant Depression as Difficult to Treat Depression¹; not just a lesson in semantics but an alternative patient-centred model for those that do not respond to initial pharmacological management.

Dr Monkton Smith presented her research² that counters the typical narrative of intimate partner homicides as impulsive 'crimes of passion'. Rather they are predictable, planned and determined; her homicide timeline³ is designed to help professionals risk assess this more confidently.

Epidemiologist Prof Pickett spoke movingly about the correlation between widening income inequality and worsening mental health⁴. The session on social exclusion and poverty reinforced the need to consider broader social structures in our work.

Most provocative was Jo Watson and Dr Johnstone's call to 'drop the disorder'. They argued that the current functional illness model is a charlatan that privileges 'biological aspects'. Dr Johnstone's alternative framework encourages practitioners to think and ask "what happened to you"⁶ rather than "what's wrong with you?"

The arts and culture club was opened by Professor Oyeboode who described the multi-faceted talent of Anton Chekhov; not only a renowned writer but also fellow psychiatrist. He was followed by Dr David O'Flynn who recounted the fascinating story of the rescued art of former patients of the Netherne Asylum, now collated as the Adamson Collection.

Finally, a lively masterclass on antidepressant withdrawal made clear the term 'discontinuation syndrome' is outdated. It provided food for thought on how to adequately taper off medication⁷, even if evidence for the levels of withdrawal symptoms may have recently been overstated⁸.

The event passed in a blur and we left on a high, inspired by the forward-thinking tone of the conference. To us, this was evidence that our speciality is no stone rose; rather it is keen to grow and flower and face the uncertainty that we as clinicians must learn to tolerate in our day-to-day clinical practice.

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Culture Vulture: Anthony Gormley, Royal Academy of Arts (21 Sept-3 Dec 2019)

Dr Julia Topp

As I strode across the expansive courtyard of Burlington House, my eyes were drawn to a small lump of black metal lying on the ground which on closer inspection was the life-sized form of a newborn baby (Iron Baby 1999). Thus, the Anthony Gormley Exhibition at the Royal Academy of Arts begins before even entering the gallery.

This new exhibition aims to provide 'a series of encounters that heighten our attention to our bodies and our surroundings'. It features sculptures, mostly in metal but also stone, wood, pottery and even bread, ranging in size from those that can fit on a shelf to others that fill entire rooms. And you can get close – no 'do not touch signs' here!

Slabworks (2019) consists of 14 stacks of steel oblongs which at first glance appear to be building-like constructions but as you move between them are revealed as human forms. It's incredible how with just a few metal slabs, Gormley can trigger the recognition of a human presence some lying, some standing, some hunched.

Clearing VII (2019) is made from 8km of aluminium tubing coiled and then allowed to expand until restricted by the floor, ceiling and walls. It looks like a giant child's 3-D scribble! You can cross the room by picking your way through the loops and each time someone brushes against one there's a metallic clank.

You emerge through this vertical maze into one of the smallest rooms where, in contrast, there's an almost hushed reverence. Standing in the centre is a single life-sized sculpture of a person bowing their head (Subject II 2019) constructed from small Cuisenaire-like metal rods. The experience is almost spiritual.

Matrix III (2019) consists of 21 intersecting steel mesh cages (each the average size of a European new-build bedroom) suspended from the ceiling and filling a

massive room. From a distance it looks like an ominous, sharp-edged rain cloud. As you walk underneath it and look up, your eyes struggle to perceive distance. You can't enter the last room. The floor is covered in clay and seawater (Host 2019) and as you peer in through an opening you are struck by the stillness and how you suddenly feel physically very cold. This is a just a small glimpse of what's on offer in this incredible exhibition. Days later I'm still re-living the experience!



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Dr Julia Topp
ST4 Higher Trainee

Facetime: Professor Michael King on LGBT issues in psychiatry



Michael King is Professor of Primary Care Psychiatry in the Division of Psychiatry, Faculty of Brain Sciences, at UCL. He is a psychiatric epidemiologist, and trialist with the UCL PRIMENT Clinical Trials Unit. Among his research interests are the stress and stigma faced by gay and lesbian people and the role of religious and spiritual beliefs in mental well-being.

How did you come to be involved in psychiatric epidemiology?

After training in medical school in New Zealand, I came to the UK to pursue primary care training, but once I'd done a lot of that, I realised that mental health was what GPs were doing, so I did training in psychiatry at Maudsley. This was in the 80's, and in that era you could hardly not get involved in research! My research initially was in primary care mental health, and that's an obvious place for epidemiology. It's reached its apex at the moment with big data, particularly with clinical data sets. I thought studying populations was the best way to address prevention, particularly in common mental disorders.

Among your many research interests is the stress and stigma faced by gay and lesbian people. How did that interest come about?

That arose in the 80's, when I was working in what was then called a general practice research unit at Maudsley. The issue of HIV and AIDS came up: what was happening and where was it, and what was the psychiatric fallout from that? So I got interested in that and in the wider field of not just HIV, but the obvious stigma and discrimination, both in that time but also in previous

decades and centuries, against LGBT people. Back then, practically nothing was being researched on this because it was still very stigmatised.

Did your own identity play a part in your research aspirations?

About being gay myself, that's an issue that people raise. I think it's quite interesting when you're a gay psychiatrist. I grew up in New Zealand in a very repressive time. I don't think my research was generated by my own sexuality, because I'd come out and come to terms with it anyway, and I'd never sought any psychological help. But I think sometimes I've been targeted, e.g. "You would say that, wouldn't you, because you're trying to promote some sort of gay activism". That's quite a burden when you're trying to research something. I think that's an interesting take on it, because if a psychiatrist from an ethnic minority studies areas to do with racism or discrimination, or women look into women's issues, that would be seen as appropriate. But when gay or lesbian people examine this issue, it's some kind of "activism", so there's always been a strange discrimination within the profession on that, too. It's died down, now, because all discrimination seems to be dying down, but I've always found that quite an intriguing issue.

We may like to think society is less discriminatory towards queer people, these days. To what extent does stigma persist?

I think it's much bigger than people realise. People think that it's much better now, and I think it is, in terms of the law leading the situation: so The Equality Act and equal marriage; those sorts of things are huge steps forward. But from research we know that young people growing up are still suffering similar rates of discrimination and mental health problems as they were even back in the 80's or before, which really puzzles us, because we would have expected the minority stress to have declined somewhat. But at school age and college age, it's still taking a very long time to diminish. It seems, from a lot of research around the Western world, the attitude of your parents matters a lot. But maybe we're dealing with parents in their 40's, who aren't the youngest generation, who are more accepting.

So there may still be a standoff between the young people growing up and their parents. We just don't know. But rates of suicide and depression are still high, much higher than we would want for young lesbian, gay, bisexual and trans people.

What role has psychiatry played in LGBT stigmatisation?

I think it's been key, unfortunately, and I say that being part of the profession, myself. Not just psychiatry, though. Psychoanalysts and psychologists were leaders of treatment of homosexual people from the early 20th century onwards. Psychiatrists were part of that, but they didn't particularly lead. And many of the behavioural treatments were dreamed up and discovered by psychologists. I think down to all mental health professionals. But eventually the diagnoses were done away with. We've managed to stop many of the so-called conversion therapies that were promulgated mainly by spiritual groups or private psychotherapists. I don't think these therapies were ever part of major psychiatry or psychology organisations. The therapies caused tremendous damage, with no effect on the person's sexuality. Luckily, practice of these therapies has declined, at least in this country. But we don't know in other countries, like China or India or even South America, exactly what's going on.

The WHO will recognise in ICD-11 that trans-related and gender-diverse identities are not conditions of mental ill health. In the future, what role will psychiatrists play in the lives of trans people?

I think the role will be much less, because it's not going to be a diagnosis, and it has been removed already from some of the diagnostic classifications. I don't think that means people won't need some support when they're going through transition or receiving guidance. I think psychiatrists could have a role, there. But I don't think psychiatrists are going to be a key gatekeeper anymore. I don't think it will be the same requirement for people as it has been. Maybe that's a good thing, because to some extent, psychiatry did stigmatise trans people by its presence. The area of trans children is a much more difficult one, and there's a lot of controversy about that; whether there should be medical interventions at such young ages when young people may change their minds later, and we just don't know enough about the natural history of that.

What areas are most important for future research?

One of the key things I would do is understand the natural history of discontent with gender, or feelings that your gender identity is at odds with that assigned at birth. That would be very important. The other important thing is to understand much more about sexual orientation. It's quite obvious that it's much more of a spectrum than we've heretofore thought. It's a sort of political thing: "gay", "straight", all that stuff. What appears to be coming from most recent studies with young people is there's a certain flow and flux along a spectrum. It's much more likely that sexuality is on a spectrum, as most things in nature are. It would be really helpful to understand that more. To understand that many people have sexual responsiveness to the same or other sex, and it doesn't classify them as being a certain type of person for their lives.

Interview by Dr Sachin Shah, General Adult Psychiatry Trainee, SWLSTG

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We're looking for a new member to join the PsychEye newsletter team! Enthusiasm, creativity, and interest in writing and editing are vital.

Please send us an e-mail if you're interested in getting involved!

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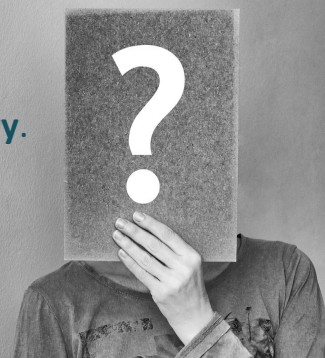
Congratulations!

Congratulations Dr David McLaughlan, Dr Lydia Jones and Dr Amelia Lapraik for winning the best article of the Winter 2019 Edition for their article on 'Outside the NHS; Innovative ways to promote mental health awareness amongst the LGBTQ+ community' - read all about it on page 3.

Theme for next edition of The Psychiatric Eye:

With another set of UN climate talks coming to an end our next issue turns to focus on the climate emergency and **Environmental Sustainability in Psychiatry**.

- How should we change our practice?
- What innovations will be important?
- How will this affect our patients?
 - and any other thoughts



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