

ARTICLE

Fractured narratives of psy disciplines and the LGBTQIA+ rights movement in India: A critical examination

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Abstract

In 2018, a day before the Supreme Court of India commenced hearing the curative petition on Section 377 of the Indian Penal Code (which criminalised “carnal intercourse against the order of nature”), the Indian Psychiatric Society (IPS) issued an official statement that homosexuality is not a mental pathology. In 2014, a year after the top court recriminalised homosexuality, the then IPS president had termed it as a pathology requiring treatment. By examining articles on LGBTQIA+ rights published in two flagship Indian journals in psychiatry and clinical psychology, position statements by professional bodies, and international and national developments in human rights mechanisms, we argue that psychiatry’s voice for human rights protection of the marginalised has been akin to whispering sweet nothings in tune with the juridico-penal system. In turn, clinical psychology appears to huddle with biomedical psychiatry without raising its voice against coercive and traumatising practices within mainstream technocratic psychiatry. We seek to explore the troubled relationship between mainstream psy disciplines and LGBTQIA+ persons characterised by psychological evasion: failure of mainstream psy disciplines to take up sensitive, socio-political issues like same sex love in a broader human rights framework leading to individualisation- pathologisation complex which further side-lines persons living on the margins of society.

“An unexamined life is not worth living.”

~Socrates

Background

Same-sex desires, referred to as homosexuality in popular discourse, reappeared in the limelight when the five-member constitution bench of the Supreme Court of India struck down

key provisions of Section 377 of the Indian Penal Code (IPC) which prohibited sexual acts “against the order of nature”. The top court observed that “what nature gives is natural”, terming the denial of right to sexual orientation as “irrational, indefensible and manifestly arbitrary” and in violation of Articles 14, 15, 19 and 21 of the Constitution (1). It was the first time LGBTQIA+ individuals applied *locus standi* by directly approaching the constitutional court for protection of their fundamental rights. In all previous cases, they had been represented by non-governmental (non-profit) organisations (NGOs) or other organisations acting on their behalf. On July 10, 2018, the day before the Supreme Court started hearing the curative petition, the Indian Psychiatric Society (IPS) issued a position statement on homosexuality not being a mental illness requiring treatment (2). In contrast, in 2014, a year after the Supreme Court recriminalised homosexuality, the president of the IPS had publicly announced that homosexuality is “unnatural” and that those uncomfortable with their orientation could seek psychiatric treatment (3-4). Mainstream psychiatry in India appears to be dancing to the tune of the juridical- penal system on whether homosexuality is a disease or not.

The panorama of political struggles for decriminalisation and depathologisation of same sex love and the concomitant developments in the psy disciplines¹ demonstrate that the voices of resistance to inequality and injustice in the psy disciplines have been fairly muted and marginal. Mainstream psy disciplines with their dominant medical models of homosexuality exhibited inherent heterosexism limiting its engagement with LGBTQIA+ persons in human rights-based research and advocacy efforts (5). Walters (2005) puts it straightforwardly: “Biological research and social science research are at the end of two opposite poles as the social scientist tries to locate sexualities on a continuum whereas biologists yearn to fix identities” (6). Writing in 2008 on the hesitance of psychologists and psychiatrists in undertaking rights-based research on LGBT youth in India, Parekh submitted that “as far as the research on lesbian, gay, and bisexual individuals in India is concerned, the situation is almost the same as it was in 1980s” (7). On the contrary, anthropologists, philosophers, critical theorists, and queer rights activists have been proactively engaged in generating an alternative knowledge base countering the dominant medicalisation narrative of the psy disciplines (8-13). Hence, psychiatry’s emerging progressive voices are akin to sweet

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nothings as it has done little to lend its full-throated support to the victims of marginalisation. The history of psychiatry is replete with parallels in relation to the struggles against racism, slavery, and gender bias. Metzl tells the story of how civil rights era anxieties about racial protest catalysed associations between schizophrenia, criminality, and violence (14). Davies compiled evidence against psychiatry's claim to being an objective science that is value-neutral and apolitical, thereby sidelining lived experiences and diverse sociocultural contexts which mediate in complex ways to shape each person's unique experience (15). Psychiatry's history and its evolved methodologies compel us to radically rethink what kind of science psychiatry is, and critically examine its relationship with its publics (16).

The troubled relationship between psychiatry and the marginalised

Scholars and activists from fields such as critical psychiatry, critical psychology, anthropology, disability studies, gender studies, and development studies have drawn attention to psychiatry's skewed tilt towards individual attribution of psychosocial disabilities, whereby social suffering and structural violence are "diagnosed" as "mental illnesses" to be individually "treated" with medicines and psychological therapy algorithms (17-18). People living on the margins have a troubled relationship with mainstream psychology and psychiatry as their "differences" are framed as "pathological", in need of psychiatric/psychological interventions, disregarding critical factors of culture and experience (19). These, in effect, enforce social control, oppression, and the silencing of people living on the margins. Of late, counter-narratives of user-survivors of psychiatry or the experiencing experts have been emerging (20). India is also witnessing a spurt in first-person narratives of mental illness (21-24).

Historically, the psychiatric diagnostic categories relay, reflect, and export political and social norms where diagnoses translate into nothing short of social judgements rather than providing scientific medical assessments (25). In the nineteenth century, American psychiatrists diagnosed drapetomania as a frightening condition that affected African slaves and was supposedly characterised by the intent of slaves to run away from their masters. This was considered a legitimate diagnosis and the "treatment" prescribed was whipping. If the "patient" was still recalcitrant, amputation of both big toes was indicated (14, 26).

Diagnostic categories such as kleptomania, drapetomania, and atypical theft offender disorder illustrated how diagnoses serve to promote the interests of those who are in power (27). The inclusion of homosexuality within psychiatry's fold is the most recent example of psychiatry's political leanings. Rao foregrounded how suicide is increasingly being depoliticised by rechristening it as a "mental health problem" by premier mental health institutions such as the National Institute of Mental Health and Neuro Sciences, Bengaluru, pushing into oblivion the economic, political, and gendered aspects of suicide (28). Priebe reminds us that psychiatry's abstention

from political involvement is a major mistake for the profession and for people with mental disorders (29).

Diseased love: History of pathologisation of same-sex love in psychiatry

Homosexuality has a long history of pathologisation by the mainstream psy disciplines of psychology and psychiatry. Same-sex desires and behaviours have been represented as psychiatric disorders worldwide as the diagnostic manuals—the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual (DSM)—classified them as a diagnostic category. The book *Psychopathia Sexualis* by psychiatrist Richard Krafft-Ebing evidences the way in which medicine created the sexual "other", the sexual deviant, when it concluded that homosexuality is a "mental illness" (30).

Homosexuality was a disease category in the DSM until 1973, when it was struck down as a disease nomenclature by just one "nay" vote. Ego-dystonic homosexuality continued as a disease category in the manual until 1987, when it was removed from the DSM altogether. The ICD, another widely used manual published by the World Health Organization retained the classification of homosexuality as a disease until 1990 when it dropped the classification of *ego-syntonic* homosexuality from the manual. However, even though LGBTQIA+ rights had been accorded the stature of human rights by international human rights laws, ICD-10 still carried "ego-dystonic sexual orientation" (code F 66.1) as a diagnostic category (31). Research presenting voices from the ground reveals that psychiatrists and psychologists put clients on potent antipsychotic medicines and psychotherapies (including aversion therapies), respectively (32).

LGBTQIA+ movements and human rights mechanisms: The international scenario

Article 1 of the Universal Declaration of Human Rights adopted in 1948 by the United Nations (UN) General Assembly states: "All human beings are born free and equal in dignity and rights." (33) People with queer sexual identities have employed Universal Human Rights to challenge laws that segregate them and to critically engage with psychiatrisation of sexual identities. It was in 1991 that Nicholas Toonen, a gay man from Australia, complained to the United Nations Human Rights Committee about the repressive law in his country that criminalised consensual sexual relationships between adult men. After hearing Toonen's plea, the UN ruled in 1994 that the said law violated his human rights by subjecting him to arrest and detention just because he was homosexual (34). The UN also observed that the law reinforced stigma and prejudice in society at large against LGBTQIA+ persons. Consequent repeal of the law marked a watershed moment for equal treatment of queer people worldwide. The UN held that no country is entitled to discriminate against people on the grounds of sexual orientation and gender identity (hereafter SOGI).

In 2010, the UN Secretary General exhorted the world community to tackle violence and discrimination against LGBTQIA+ persons. Recognising the fact that human

rights violations targeted at people due to their actual or perceived SOGI constitute an entrenched global pattern of serious consequences, the International Panel of Experts in International Human Rights Law on SOGI adopted the Yogyakarta Principles on the application of international human rights law in relation to SOGI in the year 2006 (35).

The UN had its first formal report and adopted the first resolution on widespread discrimination, acts of brutal violence, torture, kidnapping, and even murder based on SOGI in 2011(36). The first formal intergovernmental debate on this issue was initiated at the UN in 2012, and the then UN High Commissioner for Human Rights (UNHCHR), Navi Pillay, called for a systematic response to homophobic violence and discrimination (37). In 2013, the office of the UNHCHR launched *Free and Equal* (38), a global campaign to raise awareness against homophobia, transphobia, and associated discrimination and violence. The then UN Secretary General termed LGBTQIA+ discrimination, where love attracts hate, “one of the great, neglected human rights challenges of our time” (39). The US Supreme Court ruling legalising same-sex marriage in 2015 was another milestone in the fight for equality and human rights by LGBTQIA+ persons (40). In 2017, the first report of the UN-appointed Independent Expert on protection against violence and discrimination based on SOGI, titled *Diversity in Humanity, Humanity in Diversity*, exhorted the medical sector to depathologise and destigmatise sexual orientations to promote respect and the understanding that sexual orientation is “part of the natural state to be human” (41). The expert expressed concern over LGBTQIA+ persons being forced into “conversion therapy” by mental health professionals across the globe. The report noted the fact that transgender and intersex persons still fall under the International Classification of Diseases. Psychiatry is being accused by user-survivors and scholars of pitching a large tent of “patients” to be “treated” for all social ills, which Nikolas Rose refers to as creation of “somatic individuality” whereby people are persuaded to think that all states of mind are invariably caused by neurochemical imbalances and can be rectified through medicines (42). Reflecting in similar vein against individualisation of social problems, another report presented by the UN Special Rapporteur on Right to Health in the UN General Assembly last year was critical of psychiatry for its overdependence on medicines and the “biased” use of evidence, which contaminates knowledge about mental health. Citing power imbalance (in the face of growing inequalities, emergencies, and discrimination) as the major hindrance in progress in mental health care rather than psychiatry’s oft-cited scapegoat—chemical imbalance—the report warned that power and decision making in mental health are concentrated in the hands of “biomedical gatekeepers” representing biological psychiatry (43).

LGBTQIA+ rights in India: Pressure groups and judicial activism

In India, the LGBTQIA+ rights movement has provided critical leadership in gaining visibility for the minority community in recent times, thanks to regular pride parades being organised

in many cities and the increasing number of rights-based NGOs across India. India witnessed the first public interest litigation in 1994, challenging the constitutional validity of Section 377(44) of the IPC. In subsequent years, the police across the nation were engaged in vigorous enforcement of the penal section, resulting in brutal violence against the LGBTQIA+ community, including the infamous arrest of nine people associated with Bharosa Trust and the raid and seizure of safe-sex aids such as condoms and instructional videos by the Lucknow Police in 2001(45). Around the same time, the union health ministry was grappling with India’s high burden of HIV infection—second only to South Africa—and its attempts to convince the police to do away with harassment to help LGBTQIA+ persons seek treatment almost failed.

The Delhi High Court, in a 2009 verdict, struck down Section 377, terming it as unconstitutional and violative of fundamental rights (46). Hearing appeals against this judgement, the Supreme Court in 2013² overruled the judgment, passing the baton of responsibility of decriminalisation to the Parliament of India (47). Cognisant of this fact, Shashi Tharoor, Member of Parliament, introduced two private member bills in the Lok Sabha in 2015 and 2016. Faced with majoritarian resistance in the Parliament, these bills were not even allowed to be taken up for debate in the Lok Sabha (48). Expecting the apex court to live up to the ideals of equal rights enshrined in the constitution, a curative petition was filed; this was accepted by the court for a back-to-roots, in-depth hearing. The Supreme Court has played a vital role in framing positive public opinion about the LGBTQIA+ community in recent times. The apex court touched upon sexual orientation when it was termed as a core constituent of the rights to life, equality, and privacy, when it ruled for right to privacy as a fundamental right in 2017 (49).

Another progressive move by the top court was in 2014 when transgender persons were accorded the right to gender expression. The court emphatically said, “recognition of transgender persons as a third gender is not a social or medical issue but a human rights issue,” paving the way for right to self-identification of one’s gender identity (50). LGBTQIA+ rights activism was successful in mobilising an otherwise apathetic community of mental health professionals in the 2013 Supreme Court case, which had otherwise remained out of the scene until the Delhi High Court’s landmark verdict. For the first time, an intervention was filed by a group of 13 mental health professionals in 2011, among whom more than 10 were psychiatrists (51). The involvement of non-medical mental health professionals such as psychologists and psychiatric social workers in the issue has been marginal in comparison to that of psychiatrists.

It is in the context of such shifting narratives about homosexuality³ among world human rights bodies, critical psy fraternity, and the apex court that the IPS came out with an official position statement supporting decriminalisation of homosexuality (2). The official position statement reads: “IPS recognises same-sex sexuality as a normal variant of human

sexuality, much like heterosexuality and bisexuality. There is no scientific evidence that sexual orientation can be altered by treatment." The brief one-page position statement ends by declaring "IPS supports decriminalisation of homosexual behaviour".

Responses to LGBTQIA+ rights among psy disciplines in India

The professional bodies of psychiatrists and clinical psychologists—the IPS and the Indian Association of Clinical Psychologists (IACP)—were profoundly silent on this issue until the courts got involved. There were no position statements, press conferences, or articles in their flagship journals supporting depathologisation of queer sexualities until the 2009 Delhi High Court ruling decriminalising homosexuality.

Research in mainstream psy disciplines also tended towards quantitative studies on sexuality, often measuring pathological variables such as depression and anxiety in the LGBTQIA+ community, unmindful of the lived experiences, social sufferings, and distress that emanates from the interfusion of sociopolitical and psychiatric systems in which their lives are enmeshed. (52-56). This further contributed to pathologisation and framing of social suffering as a mental illness to be treated. Electroconvulsive therapy, antipsychotic medicines, and aversion therapies rained on LGBTQIA+ clients deepening the psychological divide with the rest of the mainstream society (57-58). Framing queer sexualities as mental illnesses and treating them are common among both psychologists and psychiatrists in India. The IPS President's statement itself attests to this fact where he calls for a "very radical stance to stop considering homosexuality as an illness [by psychiatrists]" (59).

Many psychiatrists hold onto the ego-dystonicity clause without probing the reason for the same—the societal stigma and disapproval that a person faces on account of their queer sexual orientation (60). A distorted picture of homosexuality is widespread in medical textbooks, leading to a biased attitude of medical professionals with respect to homosexuality (61). Asking the "patient" to meet commercial sex workers to sample engaging in sexual acts with the opposite sex has been evidenced by Kalra (62). Sarin (63) stipulated that psychiatry unflinchingly contributed to the negative view of homosexuality, while Chandra (64) emphasised the need to improve the response of mental health professionals towards homosexuality. At a conference in Kolkata in 2017, the present IPS President, Ajit Bhide, spoke about concerns and dilemmas in dealing with the sexual expressions of persons living with psychosocial disabilities. A relevant excerpt of this speech is presented here:

This is a much-neglected area. I have been witness to forced ablation of ovaries in a woman who presented with extreme sexual longing. One of my friend's sister suffered from mental illness. Her parents, with the passive support of my friend, had to prepare her for sterilisation. Later, when I used to meet her, she used to tell me, "I have no husband, I will not be able to bear a child". She had no say in the decision. She was deprived of love, sex, pleasure, and intimacy. Denial is the main problem even within mental health circles. The crying need for intimacy

is totally neglected. We need to look back and realise how we, as mental health professionals, have denied basic rights to our clients, how insensitive we have been. In the homosexuality case, after removing it from DSM, ICD had still retained ego-dystonic homosexuality. It has to do away with gender identity disorder also, to accommodate the rainbow of desires (65).

Methods

In the context of all these debates, we have undertaken a study of two flagship journals published by the all-India professional bodies of psychiatrists (IPS) and clinical psychologists (IACP)—*Indian Journal of Psychiatry (IJP)* and *Indian Journal of Clinical Psychology (IJCP)*. In this paper, all the articles published in both journals before and after the landmark 2009 Delhi High Court judgment are analysed temporally and synchronically to see how homosexuality and queer issues are depicted and discussed therein (Supplementary Tables 1 and 2).

The *IJCP* has not published any rights-based article on this topic. We found a total of 17 articles dealing with this issue in the *IJP*. The content of all 17 articles was analysed to determine the purpose of each study and to see how "homosexuality" is talked about in these articles—whether as a disease or as a natural variation. Parekh's study in 2003 had foregrounded huge gaps and silences about homosexuality in clinical psychology and psychiatry literature in India (66). Our analysis is extended to find out whether quantitative or qualitative research methodology was employed in these studies. This paper deals only with the engagement of the dominant, mainstream psy disciplines (psychiatry and clinical psychology) with LGBTQIA+ issues in India.

Discordant notes: Homosexuality in the IJP

A large-scale "coming out of the closet" was noticed among Indian psychiatrists after the landmark 2009 Delhi High Court judgment, triggering a host of discussions in the psychiatrist community. Thereafter, the number of articles on homosexuality soared in the flagship psychiatry journal, with opposition to homosexuality dropping quickly. There are, in total, 17 articles published on queer issues in the *IJP*, out of which 12 came out after 2009. Only six articles had ever been published before 2009, the year in which homosexuality was decriminalised in India. The first one, published in 1979, deals with the treatment of four males for homosexuality by anticipatory avoidance conditioning technique, a form of behaviour therapy). It describes the application of electric shocks to create aversion towards same-sex desires. Two personality tests were employed to assess the personality dynamics of these individuals in a pre- and post-test experimental framework. They were followed up for 5 to 10 months post intervention. The authors found that "they are completely free of their homosexual behaviour and have developed heterosexual interests. One of them is married and happy" (67).

"In the 1970s and 80s, men with ego-dystonic homosexuality often came to Indian psychiatrists for help, and behavioural

**Supplementary Table 1:
A bird's eye view of articles published in Indian Journal of Psychiatry on homosexuality from 1979 to 2018**

Author/s	Title of the article	Year of publication (reference number in main text)	Crux of the article
Sakthivel LM, Rangaswami K, Jayaraman TN	Treatment of homosexuality by anticipatory avoidance conditioning technique	1979 (67)	Deals with the treatment of four males for homosexuality with anticipatory avoidance conditioning technique. It describes the application of electric shocks to create aversion. Results showed "improvement in their shy-ness, tension, tendermindedness (assertive) and in their anxiety level".
Pradhan PV, Ayyar KS, Bagadia VN	Homosexuality: Treatment by behaviour modification	1982 (69)	Focuses on "treatment" outcomes of 13 homosexual patients employing behaviour modification techniques. Depression was treated with antidepressant drugs.
Pradhan PV, Ayyar KS, Bagadia VN	Male homosexuality: A psychiatric study of thirteen cases	1982 (70)	Clinical study of 13 homosexual patients. Early childhood experiences and homosexual seduction were identified as "etiological" factors that contributed to homosexuality.
Mehta M, Nimgaonkar Deshpande S	Homosexuality - a study of treatment and outcome	1983 (71)	It is a case study of treatment of five homosexual patients. Claims to have been successful in reorientation.
Jiloha RC	A case of unusual sexual perversion	1984 (72)	Gives a psychodynamic explanation of a patient's homosexuality.
Sathanarayana Rao TS, Avasthi A	Roadmap for sexual medicine: Agenda for Indian Psychiatric Society	2008 (73)	Mentions the existence of a standardised manual for treatment of homosexuality published in 2000. Reminds that management guidelines are absent for gender identity disorders. Calls for integration of sexual medicine with other branches of medicine.
Kuruville K	Indian contribution to behavior therapy	2010 (68)	Documents excessive reliance on aversive techniques in the treatment of homosexuality.
Kalra G, Gupta S, Bhugra D	Sexual variation in India: A view from the west	2010 (74)	Focuses on the ancient scriptures that had depicted homosexuality; takes the stance that it is not abnormal and calls for the need to re-evaluate the role of psychiatrists with regard to this. Mentions psychiatry's role as a means of social control.
Sathanarayana Rao TS, Jacob KS	Homosexuality and India	2012 (75)	Calls for research into context-specific issues of LGBT persons. Human-rights sensitisation and attitude change amongst psychiatrists towards homosexuality emphasised.
Kalra G	Breaking the ice: IJP on homosexuality	2012 (77)	Notes that the trend in psychiatry has shifted from employing aversion therapies to prescription of antipsychotics in the name of conversion therapies. Reports instances where mental health practitioners bring religion into the scene to profess that homosexuality is a sin.
Kalra G	A psychiatrist's role in "coming out" process: context and controversies post-377	2012 (76)	Vouches for facilitation of coming out to be an important role of the psychiatrist in which referring clients to support groups becomes vital. Opines that non-judgemental attitude and confidentiality assurance are crucial in the process.
Raveesh BN	<i>Ardhanareeshwara</i> concept: brain and psychiatry	2013 (78)	By detailing the philosophical foundations of the <i>Ardhanareeshwara</i> concept and the biological causes of ambiguous genitalia, it argues that bisexuality is a silenced sexuality. Alerts the readers to high risk for anti-homosexual bias in psychotherapy with LGBT clients.
Sathanarayana Rao TS, Jacob KS	The reversal on gay rights in India	2014 (80)	Brings a detailed discussion about the history of IPC Section 377 and progressive developments such as LGBT rights laws and same-sex civil partnerships and marriages around the world.
Verghese A	A fresh look at homosexuality	2014 (81)	Disagrees with the argument that homosexuality is a normal psychosexual development. Citing studies of structural differences in the brain, it argues that homosexuality is an "aberration" in the psychosexual development caused by genetic and psychosocial factors, that is "not normal" because of the statistical minority homosexuals make up.
Prajapati AC, Parikh S, Bala DV	A study of mental health status of men who have sex with men in Ahmedabad city	2014 (79)	The objective of the study was to study the mental health status of men who have sex with men and their determinants using a General Health Questionnaire (GHQ). Results signalled a high risk of psychiatric illness in the population. Prevalence of psychiatric morbidity was found to be 52.9%.
Somasundaram O, Tejus Murthy AG	Homosexuality - leaves from antiquity: lesbian, gay, bisexual, and transgender population: a Tamil perspective	2016 (83)	Traces the existence of homosexuality in Tamil Nadu in ancient times.
Sathanarayana Rao TS, Rao GP, Raju MSVK, Saha G, Jagiwal M, Jacob KS	Gay rights, psychiatric fraternity and India	2016 (82)	Editorial endorses LGBT rights.

Supplementary Table 2: Articles published in <i>Indian Journal of Clinical Psychology</i> on homosexuality from 1982 to 2018			
Author/s	Title of the article	Year of publication (reference number in main text)	Crux of the article
Rangaswami K	Difficulties in arousing and increasing heterosexual responsiveness in a homosexual: a case report	1982 (84)	Describes “treatment” of homosexuality by behaviour modification.
Nammalvar N, Rao AV and Ramasubramaniam C	Modification of homosexual behaviour: a case report	1983 (85)	Describes “treatment” of homosexuality by behaviour modification.

techniques were used in treating such persons” (68). It is to be noted that clinical psychologists are the main providers of behaviour therapies and aversion therapies. The second and third study published by Pradhan, Ayyar, and Bagadia in 1982 involved “thirteen patients diagnosed as suffering from homosexuality as defined in the ICD-8”. The first study focused on the outcomes of behavioural modification “treatment”. For the second study, personality tests (Minnesota Multiphasic Personality Inventory and the Rorschach Inkblot test) were employed to find the causal correlates of homosexuality to conclude that early-childhood experiences and homosexual seduction were “etiological factors” that contributed to the condition, creating the notion that there was a specific “cause” for homosexuality and that if that “cause” could be found, then a “cure” could be administered (69-70).

One study each, published in 1983 and 1984, dealt with treatment outcomes of homosexual “patients” and psychodynamic explanation of a patient’s homosexuality respectively (71-72). Individuals who sought treatment were referred to as “patients” in these articles. Hereafter, the topic of homosexuality was under a state of complete dormancy for around three decades in the *IJP* until 2008, when an article interrupted the silence by setting an agenda for sexual medicine in the IPS. It mentions the existence of a standardised manual for “treatment” of homosexuality and the absence of such a manual for gender identity disorders (73).

Our analysis found that after the 2009 verdict, the discourse of the psychiatrists took a U-turn as some articles published in the *IJP* supported homosexuality. The first article to come out in the *IJP* after the Delhi High Court ruling was in 2010. It offered a comprehensive account of the existence of homosexual behaviour in ancient India, citing many examples from mythology to claim that “homosexual behavior has existed for centuries indicates that the ‘normal variation’ is part of human nature” (74).

Another article threw light on the continued pathologisation by ICD-10 in the form of ego-dystonic homosexuality: The authors considered important human rights sensitisation and an attitude change amongst medical professionals towards a focus on a patient’s humanity rather than their sexual orientation, aligning closely with the UN resolution on the issue in 2011 (75). In an article published in 2012, the psychiatrist’s role is designated by the author to be that of a facilitator in coming out, helping the family too, in that process (76). Kalra brings forth an important point of continued

medicalisation of homosexuality by psychiatrists employing conversion therapies in the form of antipsychotics prescribed in the treatment of homosexuality and giving false promises of a cure to clients. He has illustrated in the article, several instances of unethical treatments by psychiatrists using religion as a tool to dissuade clients from homosexuality (77). The article by Raveesh published in 2013 endorses affirmative psychotherapy taking cognisance of high risk for anti-homosexual bias in psychotherapy with LGBTQIA+ clients (78). A study of mental-health status of men who have sex with men (MSM) ⁴ in Ahmedabad city in 2014 concluded that psychiatric morbidity was high among the MSM population (79). Rao and Jacob in the same year stated that people with homosexual orientation don’t have any objective psychological impairments but the distress is caused by societal non-sanction of their sexualities by the predominantly heterosexual world around them (80). This is the only article that cited developments outside the medical arena: the recognition of LGBTQIA+ rights by the United Nations Human Rights Council.

Varghese counteracted the above rights-based arguments by arguing that it is difficult to accept the stance that homosexuality is a normal psychosexual development (81). He argues that it is an “aberration” in the psychosexual development caused by genetic and psychosocial factors, citing studies of structural differences in the brain. Further, he suggests that homosexuality is “not normal” because of the statistical minority homosexual persons make up. In 2016, an editorial was published with “gay rights” in the title, vouching for LGBTQIA+ rights (82). The last article to appear was on the existence of homosexuality in Tamil Nadu in ancient times (83).

Diffidence and silence: The *IJCP* and its treatment of homosexuality

Our analysis of articles published in the *IJCP* has revealed a complete silence about LGBTQIA+ issues. We found that not a single article dealt with homosexuality or queer issues from a rights-based perspective in the flagship journal of the IACP. There are only two research papers (published in the 1980s) to date in the journal, both of which discuss the behavioural modification treatment of homosexuality, deeming it pathological (84,85). There has been not a single press statement or position statement seeking to make the professional body’s position clear even though there have been many instances of psychologists proclaiming that they can cure homosexuality. In early 2018, a psychologist from

Kerala posted many videos on YouTube claiming that he could “cure” homosexuality, thereby attracting many “patients”. A prominent LGBTQIA+ support group had to finally step in to counter this self-proclaimed healer. Neither the IACP nor its Kerala chapter intervened in the case (86).

Clinical psychology curricula, training systems, and practice: Towards a “pathological” consciousness?

The latest syllabus prescribed by the Rehabilitation Council of India for the two-year MPhil course in clinical psychology demonstrates how divorced psychology is from the social sciences (87). The six theory papers are titled Psychosocial Foundations of Behaviour and Psychopathology, Statistics and Research Methodology, Psychiatry, Biological Foundations of Behaviour, Psychotherapy and Counselling, and Behavioural Medicine. Prima facie, half of the syllabus is strictly an import from mainstream psychiatric science: Psychiatry, Biological Foundations of Behaviour, and Statistics.

Neuropsychology and psychometric testing have become the centre of clinical psychology’s theatre, increasingly gravitating towards preoccupation with IT-enabled psychological testing. The quest of psychiatry to become neuropsychiatry is mirrored by the curriculum of clinical psychology which disables clinical psychologists from appreciating social and contextual factors while defining mental disorders (88-90). Topics such as intersectionality, justice, freedom, equality, and so on, central to every social science, are weeded out at a juncture when mental health is increasingly being talked of as a human rights, disability rights, and development issue by activists and scholars (91-92). Recent developments in mental-health studies, marked by alternative paradigms in psychology such as user-survivor movements, mad studies, disability studies, and so on, remain out of bounds for clinical psychology. The term “sexual” appears only with reference to sexual disorders and dysfunctions in the syllabus, recasting everything related to sexuality as pathology and rendering difficult dialogue across disciplines that locate sexuality at the intersection of pleasure, human rights, sexual citizenship, morality, ethics, bodily autonomy, and dignity (87).

It is also pertinent to note that the research methodology paper is now termed “‘Statistics’ and Research Methodology”. The special mention of “statistics” in the title implies an attempt to speak the language of strict science by getting rid of qualitative research paradigms. Quantitative research is prioritised as the keystone for clinical psychology research. The syllabus doesn’t have a single mention of the word “qualitative” (87).

The standardised psychological tests are often loosely employed to diagnose psychiatric diseases, decontextualising distress, disability, and suffering enmeshed in socio-political-economic conditions. In a provocative article, Young excavates the impact of widespread use of questionnaires on the relationship between psychology and wider society. Even though questionnaires limit engagement with a wide spectrum in the process of research, the results are used by psychologists to make far-reaching generalisations and

comments reducing “the complexity of mental life to a manageable and readily communicable numerical form” (93). We would like to clearly state here that we are not against statistics or statistical research to understand mental state or any other health problem, but this overreliance on them has serious repercussions in the understanding of lived experiences.

Going deeper into the syllabus, a marriage between psychology and medicine is palpable in most of the topics in the prescribed papers. The bulk of the paper on Psychotherapy and Counselling is devoted to behaviour therapies and physical therapies, all of which rest mostly on the positivist paradigms of objectivity characterised by measurable goals and outcomes. On the same page, the paper “Behavioural Medicine” in effect wedded behaviour and medicine. In effect, this relays to trainees that psychology speaks the language of medicine. The book *Disability and Psychology: Critical Introductions and Reflections* explores the troubled relationship between psychology and disability and contends that psychology ignores the sociocultural aspects of disability and treats disabled people as objects amplifying their exclusion rather than their emancipation (94).

Mainstream psychology: Creating another asylum of knowledge?

In the name of scientific inquiry, mainstream psychology continues to shift its gaze from constructive language to the problematic language of symptoms. While the first author of this paper was a trainee clinical psychologist at a central government institution, he was reprimanded for being friendly with library staff and class IV employees at the institution, viewed as not maintaining professionalism. This is the extent to which psy professionals are trained to stay away from “others” to remain as an island of a self-proclaimed knowledge asylum. Even reading newspapers was a matter of violation of established norms in the institution. There were strict instructions on how to dress, talk, and present oneself in front of patients.

At a global level, eminent psychiatrist Arthur Kleinman, writing in 2012, called for rebalancing academic psychiatry to include social and community studies within a broader humanistic biosocial framework (95). Tanya Luhrmann in her classic ethnography examined closely the training of psychiatrists in American medical schools (96). She reported that psychiatry students find the whole training to be bruising: the relationship with senior doctors is guarded and mistrustful. Doctors are taught “doctor manners” on how to look and behave. Psychiatrists harbour anxieties about losing their medical skills as there is nothing so medical about psychiatry, making it imperative for the psychiatrist to act as a doctor and assert herself to be a “psychiatric scientist”. Diagnosing the patient has become more important than understanding the patient. The conflict of interest between psychoanalysis and biomedical psychiatry lies in the question of whether to understand a person as a broken brain or to recognise the sufferings that are resonant with their struggles (96).

In a critical literature review on construction of professional identity of psychiatrists in India, Bayetti, Jadhav, and Deshpande observed that psychiatric training and practice in India continue to operate chiefly in an instrumental fashion. Absence of interpretative social science training generates a professional identity that predominantly focuses on the patient and his/her social world as the site of pathology (97). In the notorious Machang Lalung case, the 23-year-old Machang had been arrested in his village in Assam on a charge of “grievous harm” in 1951 and detained for 54 years in a prominent mental health institution as an undertrial prisoner until he was released by order of the National Human Rights Commission. The Commission found four more prisoners at the same institution languishing there for 32 or more years (98, 99).⁵ This serves as a chilling example of the everyday violence by psy disciplines, whose hegemonic positioning with the wider public effectively breeds cruel systems that widen the distance between psychological experts and their subjects, the “experiencing” experts. There is poetic justice in the National Council of Educational Research and Training Class XI political science text book’s use of this case to teach about fundamental rights (100).

Psychology, by mirroring mainstream psychiatry, is now a discipline in which objectivity is the expected normal. It is significant to note that the Supreme Court has not quoted even a single scholarly work on LGBTQIA+ issues in India by a psychologist in its judgement on Section 377. Taking cognisance of the fact that the mental-health sector has often reflected the societal prejudice regarding homosexuality, the Supreme Court instructed mental-health professionals to initiate social change also as a part of “treatment.” Justice Chandrachud wrote:

Mental health professionals can take this change in the law [the reading down of Section 377] as an opportunity to re-examine their own views of homosexuality. Counselling practices will have to focus on providing support to homosexual clients to become comfortable with who they are and get on with their lives, rather than motivating them for change. Instead of trying to cure something that isn’t even a disease or illness, the counsellors have to adopt a more progressive view that reflects the changed medical position and changing societal values. There is not only a need for special skills of counsellors but also heightened sensitivity and understanding of LGBT lives. The medical practice must share the responsibility to help individuals, families, workplaces, and educational and other institutions to understand sexuality completely in order to facilitate the creation of a society free from discrimination where LGBT individuals, like all other citizens, are treated with equal standards of respect and value for human rights (1).

The Supreme Court has been able to take on a progressive role to bring in social changes by speaking to us in a value-based and philosophically tuned language, instilled with potent ideas of justice. Even though some psychiatrists have spoken critically against the violations perpetuated by psychiatry

with courage and conviction, we find a complete absence of such voices among clinical psychologists, at least with respect to the articles in their flagship journal. Stories of oppression, violence, and human rights violations abound. Contemporarily, the Supreme Court has ruled in crucial cases, such as that of the constitutional validity of Section 497 of the IPC on adultery (which discriminates against women), that essentially pose mental health implications (101). The recent trend has been of the courts taking proactive measures. In August 2018, the apex court restrained the media from interviewing minor rape victims, observing that it has a serious impact on their mental health (102). Yet there is a sheer lack of interest on the part of psy professionals in bringing the ethics question into their “sciences” thereby failing to think subjectively and proactively. Unable to break the silos of science, clinical psychologists fail to capture the experiences of the weakest and most vulnerable. It is the overwhelmingly positivist tenets of psychiatry that mute the transformative vision held by ethics and morality. This, in effect, obliterates experiential knowledge and denies *cognitive justice*, as Visvanathan puts it (103).

The Rights of Persons with Disabilities Act, 2016 is a rights-based anti-discriminatory law with penal provisions. It has many affirmative clauses, such as a reservation of 4% of jobs for the disabled, including the mentally ill (104). But how many of us are informed about this? Mental health interventions are not only about treatment but also about empowering people as individual citizens with equal rights. Varied perspectives on healing, art, and philosophy applied to suffering get drained in the midst of hypertechical psychiatry, which fails to tap the full range of human diversities. As an example, after the recent floods derailed Kerala, psychologists have rallied to provide mental health services for the affected (105). However, no psychologist has spoken against the widespread environmental damage and loss of natural capital caused by indiscriminate quarrying, sand mining, tribal dispossession, and massive deforestation due to predatory capitalism in the context of Kerala. This is despite the fact that they cause man-animal conflicts and climate change, which researchers have established increase mental-health problems, including suicide (106).

Individual interventions by psychologists tend to be couched in a psychological language that targets disaster victims even though the disaster has significant enough political ramifications to be called a human-made disaster (107). Dainius Puras⁶, himself a psychiatrist, who has been actively involved for the past 30 years in transforming public-health policies and services, with special focus on the rights of persons with psychosocial disabilities and other groups in vulnerable situations, invokes human rights as an essential tool to strengthen the practice of medicine. He noted that paternalistic medical interventions are being imposed arbitrarily, disregarding one’s human rights, needs, and agency (108).

Scholars in critical psychology have pressed for the decolonialisation of psychology mainly through three

approaches: indigenisation, accompaniment, and denaturalisation. *Indigenisation* approaches to decolonisation seek to normalise and legitimise indigenous forms of knowledge and practice where mainstream science devalues or treats them as illegitimate (109). Watkins moots the idea of psychosocial *accompaniment* for a paradigm shift in mainstream psychology through “psychic decolonisation of its practitioners.” The aim is to enable psychologists to empower the marginalised through social and environmental justice orientation and “sustained attention to social roots of suffering” (110). *Denaturalisation* approaches to decolonisation seek to disrupt both oppressive ways of being and the forms of knowledge that masquerade as natural standards in hegemonic psychological science, for example, by interrogating the androcentric character of conventional standards within psychology, such as “deficit model” accounts of women’s experiences (111).

Conclusion: The need for a critical perspective in psy disciplines

Taken together, these discussions show that, in the case of LGBTQIA+ rights in India, the mental health system appears to have unquestioningly followed the state and judicial order until its stand was questioned by the judiciary and other rights mechanisms. There is a dire need to reverse this trend to one where mental-health scholarship aids the public and the judiciary in expanding its consciousness on sufferings of marginalised groups. At the same time, we do realise that what we have highlighted are generic trends with respect to mainstream psy disciplines in India. It is understood that there need not be a linear relationship between judicial pronouncements and changes in attitudinal stances within the mental-health disciplines.

We do not ignore the fact that there have been sincere efforts on the part of queer feminist researchers, queer-friendly mental-health care providers, and doctors who have continued to voice their resistance to mainstream teaching/training, knowledge production, and practice of psy disciplines (112-115), suggesting that psy disciplines and practices are not a homogeneous entity that continue to exist in a vacuum. However, the voices of the dissenters and their critiques largely go unheard in the dominant public and academic discourses as a matter of skewed power relations. Notably, the critical voices within mental-health disciplines are dominated by psychiatrists, which points to the apathy of non-psychiatric mental-health professionals in taking up such touchy social issues.

We hope that mainstream psychiatry and clinical psychology turn their analytical lenses from chemical imbalances to power imbalances while dealing with mental health issues. To tap the micro-geographies of privilege and poverty, it is imperative to employ qualitative methodologies. If psychiatry really wants to be called modern and progressive, it needs to include all the discourses and incorporate various points of view. There is a dire need for clinical psychology to look at mental-health

issues from a social-justice lens so that the wide gulf between activism and academia is bridged. There is a felt need to radically deconstruct clinical psychology theories and praxis to enable a radical re-construction of people’s sufferings other than sugar-coating them.

Clinical psychology needs to put effort into enabling people to narrate their lived experiences through stories, for the failure to tell a story is a terrible experience in itself. As Pinto says, “the lives between normal and abnormal are often too personal” (23). Stories of suffering have no exceptions and no distinctions, as pain transcends all. To act as a powerful conscience builder for the psy disciplines, let us invoke the legal maxim of *audi alteram partem* or “Listen to the other side.”

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Notes

- ¹ “Psy disciplines” refers to disciplines such as psychiatric nursing, psychology, psychiatry, and psychiatric social work, which directly engage with study of mental health issues and their treatment.
- ² For an expansive account of jurisprudence related to homosexuality in the Supreme Court of India, see Naik Y. *Homosexuality in the jurisprudence of the Supreme Court of India*. Switzerland: Springer International Publishing; 2017.
- ³ This paper dwells only on the treatment of sexualities by the IPS.
- ⁴ The usage of the phrase “Men who have sex with men” is only deployed in the paper as and when quoting from other research papers. We are aware that it is offensive and politically incorrect to use the term.
- ⁵ As per the hospital version of the events, the police were intimidated that Machang was fit for trial after 16 years—in 1967—and once again, after a long gap of 49 years, in 1996; but the police allegedly did not respond. The institution found no other option than to “rehabilitate” him for 54 years until the National Human Rights Commission (NHRC) stepped in to free him at the age of 77. The fields of psychiatry and psychology easily aligned with the dereliction of duty by the state by being silent. This culture of silence of the psychiatric institution is tantamount to gross violence and brings to the fore its connivance with the state architecture.
- ⁶ Dainius Puras is currently serving at the UN as its Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and has authored over 60 scientific publications covering issues such as public health, mental health, public health policy, disabilities, and prevention of violence.

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