

LGBTQIA+ rights, mental health systems, and curative violence in India

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Abstract

This commentary examines the space-attitude-administrative complex of mainstream mental health systems with regard to its responses to decriminalisation of non-heteronormative sexual identities. Even though the Supreme Court, in its 2018 order, instructed governments to disseminate its judgment widely, there has been no such attempt till date. None of the government-run mental health institutions has initiated an LGBTQIA+ rights-based awareness campaign on the judgment, considering that lack of awareness about sexualities in itself remains a critical factor for a non-inclusive environment that forces queer individuals to end their lives. That the State did not come up with any awareness campaign as mandated in the landmark judgment reflects an attitude of queerphobia in the State. Drawing on the concept of "biocommunicability", analysing the public interfaces of state-run mental health institutions, and the responses of mental health systems to the death by suicide of a queer student, I illustrate how mental health institutions function to further anti-LGBTQIA+ sentiments of the state by churning out customer-patients out of structural violence and systemic inequalities, benefitting the mental health economy at the cost of queer citizens on whom curative violence is practised.

Keywords: LGBTQIA+ rights, conversion therapy, mental health, sexual identities, social justice.

Today, our view of genuine reality is increasingly clouded by professionals whose technical expertise often introduces a superficial and soulless model of the person that denies moral significance.

-Arthur Kleinman, *What Really Matters: Living a Moral Life amidst Uncertainty and Danger*

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Deaths by suicide are almost always followed by front-staging of awareness generation about depression and its treatments by mainstream mental health professionals (1, 2). The same vigour and vitality are absent in foregrounding the toxic landscapes of oppression, discrimination, disadvantage, and deprivation that lead marginalised people to end their lives. Such lack of analysis of suicides among the marginalised leads to widespread sloganeering about the prevalence of "mental disorders" and the need to seek expert "treatment". The consequence of such a hasty diagnostic analysis is that mental distress which stems from social structures that make some people less human or non-human is ignored and transformatory change stalled (3,4). Given that psychiatric diagnoses lack robust explanatory power compared to other medical disciplines, it is hard to differentiate between distress and depression because no objective, bodily malfunction is identified in psychiatric diagnoses. Mental health professionals make socio-moral judgements about (un)acceptable ways of thinking, feeling, and behaviour, leading to misdiagnosis, and overdiagnosis of meaningful responses to social injustice as mental disorders (5). However, the issue of lack of scientific objectivity is brushed under the carpet in the popular discourse as mainstream psychologists and psychiatrists struggle to (re)claim their space within (medical) science by denying a human rights model of mental health.

A plethora of webinars, social media posts, and media articles by mainstream mental health professionals frame suicide as stemming from psychological disorders situated within the person. Such linear, simplistic biomedical narratives propose psychopharmaceuticals and individualised therapies as solutions. These psychocentric categorisations overstate individual causal factors and understate structural causal factors, resulting in medicalisation of social suffering (6). This fear of social context amongst mainstream mental health systems comfortably erases the chronically unjust world that dominates the everyday life of people living on the margins of society, thereby amplifying the visibility of "expert" mental health professionals. Psychiatric knowledge production and practice are vast and heterogeneous with varied standpoints, fraught with ambiguity in conceptualising mind, mental health, and "mental illness". Very few mental health professionals are sensitive enough to acknowledge these alternative facts to press for a transformative and value-based change in dealing with mental suffering. Writing on psychiatry's myopia on the social, cultural, and the

psychological, Braslow, Brekke, and Levenson poignantly state that “clinical psychiatry has failed to systematically address the reality of mental illness as a liminal object, its multilevel nature, and how it is lived in everyday life” (7).

LGBTQIA+ rights, heteronormative mental health systems, and conversion therapy

The death by suicide in May 2020 of Anjana Hareesh¹ (8), a bisexual student from Kerala who underwent forced conversion therapy at the hands of mental health professionals in connivance with her family, provides a window to the world of our mental health systems. These systems perpetuate domineering narratives of individualised, ameliorative interventions instead of advocating for transformative change in oppressive institutionalised structures, which cause distress and harm to marginalised people. A doctor, who termed homosexuality as “genetic mental disorder” and used electric shock to treat gay and lesbian people, was summoned by a Delhi court in December 2018 (9). Reports published in 2020 highlight curative violence on LGBTQIA+ people in the form of hormone therapy, conversion therapy with “consent,” and the use of psychopharmaceuticals for “depression” which are direct and implicit indictments that same sex intimacy is pathological and must be “corrected” (10,11). Eunjung Kim employs the phrase, “curative violence” to interrogate the depiction of cure as a universal good that often results in violent effects. Writing within an Indian context, Tenneti notes that “curative violence is broad enough to include all forms of violence against LGBT+ people, since the very act of othering members of non-normative gender and sexual minorities instantiates the concomitance between violence and cure” (12). A Kerala-based psychiatrist who practises conversion therapy said that his patients ‘undergo the treatment willingly’ as it is “easier to live as a heterosexual individual” (10). He claims that “many of his patients now have a family and children. But... they return due to marital discord and are put on endless medication for depression.” The same report goes on:

A Hyderabad-based sexologist is equally confident. He offers different programmes tailored to ‘the severity of queerness.’ “You can fix most homosexuals with hormone therapy. Psychiatric interventions have been successful in most cases I’ve treated. For example, testosterone injections can reverse same-sex desire to a great extent while some people respond to behavioural therapy” (10).

These reports, published in 2020, need to be read within the context of the 2018 Supreme Court verdict, which not only decriminalised same-sex love but also instructed mental health professionals not to pathologise LGBTQIA+ people, taking cognisance of the tyranny of mental health systems in oppressing them. The apex court directed the mental health fraternity to think beyond the individual and initiate social change, so that people with diverse sexualities can thrive in a barrier-free environment (13).

Even though a miniscule number of mental health professionals have spoken out against the unethical practice of conversion therapy² within their fraternity (14), the mainstream Indian mental health community has been silent about the need to bring an LGBTQIA+ anti-discrimination law and a ban on conversion therapy², signifying prioritisation of ameliorative change that blames the victim for systemically induced suffering. History is repeating itself as mental health professionals largely remain silent on the subject of the realisation of equal rights for LGBTQIA+ people (15). The position statements issued by the largest professional associations of clinical psychologists and psychiatrists (Indian Association of Clinical Psychologists and Indian Psychiatric Society) (16, 17) fall short of critical reflection and proactive action towards transformative change that will shift values and power relationships. Instead, they appear to be strategic and reactive actions to escape the moral and intellectual embarrassments caused by transgressions of their own fraternity. It was only in 2018 that the Indian Psychiatric Society came out with a statement asking its members to “stop considering homosexuality as an illness” for the first time (18). Reports also suggest that there are divisions amongst the medical fraternity in India even now as to whether or not to consider homosexuality as an illness (19). In contrast, as had happened in the past human rights bodies and queer rights networks have demanded transformative policy changes to build an inclusive, free, and equal society (20,21). For example, a queer group approached the High Court of Kerala for a ban on conversion therapy after their complaints to the state mental health authority and health secretary went unanswered (22, 23). The UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity (hereafter SOGI), in his report, called for a ban on conversion therapies citing experiential accounts of torture at the hands of mental health professionals, including in India (24).

Resistance to transformative change: Queerphobic Indian mental health systems

One of the most unique directives in the judgment of the Supreme Court was that it instructed the state to disseminate its landmark judgment widely so that the public becomes aware that it is natural to be different and that people of diverse sexualities enjoy constitutional protection as equal citizens. Justice RF Nariman wrote: “Union of India shall take all measures to ensure that this judgment is given wide publicity through the public media, which includes television, radio, print and online media, at regular intervals, and initiate programs to reduce and finally eliminate the stigma associated with such persons” (13, 25). Unfortunately, there have been no such awareness campaigns by the state in the country (26).

A report published in June 2020 shows that the families, immediate acquaintances, religious leaders, and alternative

healers are important actors, in addition to the medical establishments, in perpetuating curative violence against LGBTQIA+ people in India “that aims to enforce conformity to binary norms of gender and sexuality or to suppress the expression of transgression in matters of gender and sexuality” (12). Most often, it is the popular discourse of heteronormativity that causes anxiety and confusion among parents regarding their children’s diverse sexual orientations, leading them to consult mental health professionals (27) who find fault with LGBTQIA+ people’s brains and minds, exhorting them to convert and “adjust” to oppressive systems that breed distress (28, 29). Rights-based awareness generation about SOGI is significant in mitigating catastrophic multiplier effects of queerphobia such as discrimination, chronic stress, mental health issues, curative violence, and suicide. It is here that awareness campaigns on the Supreme Court judgment hold immense value to usher in communicative justice (30) and transformative change.

Not one of the three central mental health institutions under the Government of India (Central Institute of Psychiatry, Ranchi, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Tezpur, and National Institute of Mental Health and Neuro Sciences, Bengaluru), has initiated LGBTQIA+ rights-based awareness campaigns on the judgment as directed by the top court. This, in spite of the fact that lack of awareness about sexualities is, in itself, a critical factor in maintaining a non-inclusive environment within families and even among mental health professionals which in turn, forces queer individuals to end their lives. In this time tested alignment of the mainstream mental health systems with the State’s queerphobic attitude³ – evidenced again by the instance in 2020, when the Delhi High Court, hearing a case on gay marriage, was told by the Government of India that gay marriage is against Indian culture (31) – mental health institutions not only fail in their legal duty but also in their moral responsibility of atonement for their notorious contribution to the oppression of LGBTQIA+ people by framing same-sex love as pathological (32). Pillay et al, writing from another colonial context, while foregrounding the collusion of psychology with the apartheid government in South Africa in framing queerness as pathology make a very potent point. “[The] reactive impulse to the politics of the day appears to relegate the [psychology] profession to that of conservative follower rather than liberal leader when it comes to addressing matters of social justice or science. Psychology would do better to proactively map out its own path based on value-based praxis that enables social action” (33). The dominance of biomedical technocratic psychiatry at these colonial asylum-turned mental health institutions, focusing on individual-level analysis at the cost of socio-political analyses, compounds their troubled relationship with LGBTQIA+ people. For example, sexual orientation and gender identity intersect with social justice, public policy, caste, class, disability, equitable access to employment, housing, education, and healthcare to produce a wide array of social determinants of mental distress. The report submitted by the UN Independent

Expert on protection against violence and discrimination based on SOGI in 2019 exhorts recognition of the intersectional nature of compounded discrimination and exclusion to promote multisectoral analysis and action programmes. The need for public policy to “mainstream LGBTQIA+ issues across wider programmes, such as health, education, employment, housing, poverty reduction, food security and access to justice” is emphasised (34). Nakkeeran and Nakkeeran provide insight in understanding health inequity in the context of disability, mental health, and SOGI as they mandate an inclusive social arrangement that celebrates difference for achieving health equity (35). A recent review article suggests that “a public policy targeting stigmatization of sexual minorities could impact positively on national suicide levels” as countries with low levels of LGBTQIA+ acceptance were found to be associated with higher suicide rates (36). Yet the apex mental health institutions continue to sugarcoat suffering through ameliorative interventions at the individual level.

Unwillingness to unlearn: Biocommunicability in mental health awareness

The analysis of the websites of the three central mental health institutions under the administrative control of the Government of India, which are the most vital public interfaces, shows that mental health awareness is restricted to individual specific disorders, symptoms, and epidemiological surveys (eg, the National Mental Health Survey). None of the legislative provisions of various rights-based, user-centric, affirmative, mental health-related human rights mechanisms, such as the UN Convention on Rights of Persons with Disabilities⁴, Rights of Persons with Disabilities Act 2016⁵, apex court rulings around the gender identity-sexuality-mental health axis, reports of the UN Independent expert on protection against violence and discrimination based on SOGI presented to the Human Rights Council, the Bali Declaration by persons with psychosocial disability and cross disability supporters,⁶ Yogyakarta principles on SOGI⁷, and National Human Rights Commission advisories⁸ are available for public dissemination on the websites of these institutions under the Ministry of Health and Family Welfare, Government of India (37,38,39).

This resistance to even complying with the Supreme Court’s order to create awareness about its judgment on same sex love (13), that has the potential to improve the well-being of queer Indian citizens as a whole, stands testimony to how professional mental healthcare is promoted as the only determinant of mental health in mental health communication. Structural violence, legal violence and other power imbalances escape the gaze of mental health practice, reinforcing the colonial attitudes of suppression, profit-making and victim blaming that reconfigures LGBTQIA+ rights issues as individual mental health problems in connivance with the queerphobic state architecture. Thus,

discourses on the mental health systems fail to frame same-sex love as a human rights policy issue that demands interventions at the socio-structural level. This is how neoliberal psychiatry tries to promote an individualised understanding of mental health through mental health communication, which Kate Holland refers to as biocommunicability (40). Biocommunicability acts as a barrier to the development of multiple perspectives about health, eg macro determinants of health including social determinants of health, social justice, structural discrimination and human agency. “[T]he privileging of biomedical authority and patient–consumer models of biocommunicability serve the interests of policymakers in neoliberal governmental contexts in emphasizing the role of experts and individuals, and largely eschewing the role of governments and social forces, in contributing to and addressing mental health challenges” (40). The prioritisation of biomedical models of mental health (consisting mainly of psychiatric epidemiology, symptoms of disorders, and individualised treatments) in mental health awareness campaigns serves the purpose of biocommunicability, where there is a lack of recognition of the fact that a person is constituted not only by the physical body but also by the social and political bodies. The mental health communication on the websites of state-run mental health institutions and the awareness posters discourage an interactive and preventive view of mental health as they conveniently ignore the socio-structural determinants of mental health (41,42,43,44). Exploring biocommunicability through public health discourse in one newspaper, Briggs and Hallin caution:

If the emergence of new forms of biomedical knowledge in laboratories, clinical trials, marketing departments, and other sites is indeed transforming “the politics of life itself,” then its projection as “news” warrants scrutiny for its role — along with that of pharmaceutical advertising — in shaping which aspects of this process will jump scale to become central features of public discourses and political imaginaries (45).

The resistance of mental health professionals to talking about LGBTQIA+ issues and mental health in the language of human rights in India contributes to a hegemonic biomedical model in popular mental health communication. However, there have been efforts by queer and disability right activists to offer alternative demedicalising counter voices to mainstream psychiatry's curative violence on LGBTQIA+ people in the form of social media campaigns: for example, the #QueersAgainstQuacks⁹ campaign in 2016, employing a name and shame strategy and sharing of personal experiences. Sincere efforts by queer-friendly mental health professionals have also contributed counter narratives to mainstream mental health practice by coming up with queer affirmative counselling modules (46) and rights-based awareness campaigns, eg the Youth Wellness Club at LGBRIMH Tezpur led by a faculty member in the department of clinical psychology initiated a book club to celebrate pride

month in June 2021, with children's books that critically examine sexual, gender and relationship diversities¹⁰.

Queer constituencies and psy disciplines

How we define a problem is of paramount ethical importance, as it has far-reaching implications in mental health practice. “How we define a problem shapes the questions we ask, the methods we use to answer those questions, and the way we interpret those answers. And all those things affect the types of interventions we will consider” (47). Associations between the mainstream psy fraternity and queer constituencies need to be viewed with caution, particularly when it has become fashionable on the part of the mental health fraternity to talk about LGBTQIA+ issues loosely in contemporary times, situating the issue within the medical/health constituency without harnessing social and political support for a multisectoral transformatory policy change. My research on community mental health programmes in Kerala revealed that these programmes don't implement a rights-based, intersectional approach towards queer issues. Instead, they adopt a medicalised approach that seeks to absorb LGBTQIA+ persons as “patients” in need of their “expert treatment.” The coordinator of the programme, a government psychiatrist, told me, “LGBT population is not coming out in the open even though they have support groups. They need to approach us so that we can offer mental health services.” This statement attests to the fact that the LGBTQIA+ issue is tackled as a medical problem rather than as a human rights problem by the psychiatrist at the community mental health programme. The typical response is to provide “help,” which is individualised “therapy or interventions that strives to change disadvantaged individuals so that they can better adjust to unjust social conditions” (48). Such siloed interventions are ameliorative rather than transformative in nature, where the focus is limited to people affected by the system but not the system itself, which is steeped in exclusionary tendencies.

Need for a transformative change in mental health systems

The most critical challenge before the decriminalised queer Indian people is that of enjoyment of equal rights, which will remain a distant dream if mental health professionals harbour colonial queerphobia and continue to define and dictate LGBTQIA+ people's identities and life course within the medical framework. The colonial medical knowledge framework in India is cisgendered, cissexual, and heteronormative. The medical fraternity themselves have evidenced that the medical curriculum and dress codes strictly followed in medical colleges are discriminatory towards LGBTQIA+ people (49,50). Such non-cohesive registers of sexuality in medical discourses are likely to breed queerphobia and “diseased love” narratives concerning non-heteronormative intimacies among doctors and other health professionals, negatively impacting their approach to

LGBTQIA+ people (51). Rianna Price, in her article titled "Medical Imagination: Homosexuality in the *Indian Journal of Psychiatry*, 1970–1980", which analyses the medicalisation of homosexuality in post-independence India, found that the "references section of the IJP articles predominantly relies on Western medical journals and sources when creating a frame of reference for their own work. The seminal work of British psychiatrists, such as MacCulloch and Feldman, who wrote 'Aversion Therapy in the Management of 43 Homosexuals' (1967) is referenced and discussed within the text itself, as is the work of Richard Bancroft" (52). Commenting on Price's work, Lucy Threadgold presses the point that the article "reminds the reader of the domination of Western views in psychiatric and LGBTQ+ histories, showing the understanding of the influence these had and still have in academia" (53). This provides a strong case for raising critical awareness among the medical fraternity themselves about same-sex love and sexual diversities from a value-laden, decolonialised, human rights perspective.

Conclusion

Until and unless the mental health systems explicitly shift their hegemonic biomedical narratives and align with the human rights discourse on LGBTQIA+ issues, advocating policy/social change, they will continue to address systemic problems at an individual level without appreciating "how persons respond to contexts and how they can exercise power to change those contexts" (46). In the face of inertia by the mental health systems in offering systemic solutions, LGBTQIA+ groups should push for disengagement of mental health systems from addressing LGBTQIA+ issues through individualised medical solutions. As it has been proven beyond doubt that sexuality is a political and moral issue, shouldn't mental health systems and awareness campaigns talk about the politics, social conflicts, and human rights violations that pose critical challenges to mental health, rather than act as extended arms of the queerphobic state? Many lives could be saved if the gap between affirmative human rights mechanisms and their strict implementation could be bridged. Anjana Hareesh's confrontation with the brutal conversion therapy is an outgrowth of the sheer diffidence of mental health systems to address oppressive political structures while seeking to improve personal experiences, reductionist awareness campaigns and public interfaces of mental health institutions that withhold key information like the Supreme Court judgement being examples. This amounts to double violence: one that benefits the mental health economy even as it creates customers out of structural violence and human rights violations. It is high time that acontextual, apolitical, and ahistorical psychiatric knowledge production and practice is resisted in defining every state of mind and social problem as a psychiatric problem, and social and political action is recognised as paramount in curing sickness. Rudolf Virchow, father of modern pathology puts it emphatically, "Medicine is a social science, and politics nothing but medicine at a larger scale".

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Notes:

¹Anjana Hareesh was forcibly taken by her family members and given psychiatric treatment without her consent, including forcible injections and incarceration at various mental health facilities. She had taken a brave stand against family and psychiatric institutional violence which resulted in malicious campaigns against her lifestyle and support groups. For more on her see; <https://countercurrents.org/2020/06/justice-for-anjana-hareesh-sahayatrikas-statement-on-the-queerphobic-coverage-of-her-life-and-death/>

²Conversion therapy is banned in five countries, viz, Malta, Brazil, Taiwan, Ecuador and Germany.

³The Supreme Court judgment in *Suresh Kumar Koushal v Naz Foundation* in 2013 recriminalised same-sex love, and passed the baton of responsibility of decriminalisation to Parliament. Cognisant of this fact, Shashi Tharoor, Member of Parliament from Kerala, introduced two private member bills in the Lok Sabha, which were not even allowed to be taken up for debate due to majoritarian resistance.

⁴The UN Convention on Rights of Persons with Disabilities (UNCRPD) has provided a whole new transformatory language to speak of mental healthcare. The shift from mental illness to psychosocial disability, as envisaged in the UNCRPD, is a paradigm shift from the biomedical model to the social model of mental health. It has moved the mental health discourses from the sole territory of the psychiatric infrastructures to every other stakeholder, including those who are suffering from psychosocial disability. Though India is a signatory to UNCRPD, the government and mental health systems in India have not welcomed UNCRPD wholeheartedly. The state report on implementation of UNCRPD, which is to be submitted every year was submitted by India after a long gap of 10 years in 2018. The UNCRPD is available from: <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html>

⁵The Rights of Persons with Disabilities Act, 2016, is an outgrowth of India's ratification of UNCRPD.

⁶The Bali Declaration, Transforming Communities for Inclusion – Asia Pacific, adopted in 2018 at Bali, Indonesia, calls for the implementation of UNCRPD for all persons with psychosocial disabilities. See the link to read the full text. <https://transformingcommunitiesforinclusion.wordpress.com/2018/10/01/full-text-of-the-bali-declaration/>

⁷Yogyakarta principles, adopted in 2006 at Yogyakarta, Indonesia, are a set of standards on the application of International Human Rights Law with regard to sexual orientation and gender identity. See the link for more information. <https://yogyakartaprinciples.org/>

⁸National Human Rights Commission (NHRC) came up with a human rights advisory for the Protection of the Rights of LGBTQIA+ community in the context of COVID-19 on October 19, 2020. (See: https://nhrc.nic.in/sites/default/files/Advisory_for_the_Protection_of_the_Rights_of_LGBTQIA%2B_Communit

y_0.pdf). In December 2020, NHRC's core group on LGBTQIA+ communities recommended that the government should sensitise the medical fraternity, law enforcement agencies and the general public about the recent Supreme Court judgments to protect the rights of the community in the context of increasing incidents of violence, blackmail and extortion post Supreme Court verdict in 2018. See Chauhan (54).

#QueersAgainstQuacks was launched by Humsafar Trust in 2016. For a nuanced understanding of demedicalising discourses in social media campaigns, see Tenneti, S., 'Discourses of (De)Medicalization in Social Media Awareness Campaigns on Homosexuality and Mental Illness.' Peace Prints: South Asian Journal of Peacebuilding.2019; 5(1). Available from:<https://www.academia.edu/43853871>

Discourses_of_De_Medicalization_in_Social_Media_Awareness_Campaigns_on_Homosexuality_and_Mental_Illness

¹⁰See: <https://www.facebook.com/LGBRIMH/photos/a.2254413954579015/4217835108236880/>.

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A writer's suicide: On creativity, mental health, gender and ethics

URMILA G

Abstract

The correlation between creativity and mental illness has been at the centre of ongoing debates for quite some time. This has its roots in the Romantic era (late 18th to mid-19th century), when

melancholia and madness were considered to be the signs of creativity and genius. Because of this, writers like Virginia Woolf, Sylvia Plath, Anne Sexton, Charlotte Perkins Gilman, and many other prominent creative minds have been represented in popular narratives as having reached the heights of their creative careers while struggling with their mental health. This paper addresses the need for moving away from Romantic era notions of the relationship between madness, genius, and melancholia that reinforce the inseparability of the writer and the text, thereby trivialising the real causes and effects of mental illness.

The paper also addresses the need for a health humanities intervention within the Indian literary public, using examples from the existing narratives on the late Malayalam writer Rajalakshmy — an established woman writer in the 1960s — who died by suicide in her mid-thirties. This paper will also reflect on the author's own experience of reading and working with Rajalakshmy's writings over the years.

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