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COMMENT

# Evolving jurisprudence on conversion therapy: Reconsidering ethics in mental health systems

**SUDARSHAN R KOTTAI, RAJALAKSHMI RAMPRAKASH**

***Abstract***

*Since the Delhi High Court judgement (2009), reading down IPC 377 that criminalised homosexuality, the Indian judiciary has been at the forefront of invoking constitutional morality to uphold LGBTQIA+ rights. In contrast, the mainstream mental health systems have failed to uphold human rights and protect LGBTQIA+ people ethically, except for a few position statements. Though the Supreme Court directed the mental health fraternity to exercise utmost sensitivity to LGBTQIA+ issues, they have not risen to the occasion. The absence of gender affirmative guidelines and failure to put in place punitive action against those practising conversion therapies set apart Indian mental health systems, in stark contrast to international mental health associations. Here, we review landmark judgments and the actions of professional mental health bodies regarding LGBTQIA+ rights in India, from 2009 to 2022 — especially those regarding conversion therapies and the discriminatory medical curriculum — to examine the deepening crisis of public health ethics.*

***Keywords:*** *conversion therapy, mental health profession, judiciary, ethics, LGBTQIA+ rights*

Authors: **Sudarshan R Kottai** (corresponding author — sudarshan@iitpkd.ac.in), Assistant Professor, Department of Humanities and Social Sciences, Indian Institute of Technology Palakkad, Palakkad, Kerala 678623, INDIA; **Rajalakshmi Ramprakash** (rajalakshmi.r@phfi.org), Assistant Professor and Research Scientist, Ramalingaswami Centre on Equity & Social Determinants of Health, Public Health Foundation of India, Bengaluru, Karnataka, INDIA.

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*The capacity to suffer is, clearly, part of being human. But not all suffering is equal, despite pernicious and often self-serving identity politics that suggest otherwise.*

> - Paul Farmer, On suffering and structural violence: A view from below. 1996.

In the past two decades, the Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual + (LGBTQIA+) rights landscape has been marked by increasing demands for equal rights by LGBTQIA+ activists, allies, scholars [1,2,3,4] and international human rights bodies [5,6,7]. There is a demand for ending discriminatory policies against LGBTQIA+ individuals and bringing a ban on the notorious conversion therapy, "an umbrella term to describe interventions of a wide-ranging nature, all of which are premised on the belief that a person's sexual orientation and gender identity, including gender expression, can and should be changed or suppressed when they do not fall under a so-called 'desirable norm'" [8]. LGBTQIA+ rights started moving away from a state of legal stasis after the landmark judicial pronouncements in the Delhi High Court (HC) judgment in 2009 that decriminalised homosexuality [9], the Supreme Court (SC) judgment in 2014 that recognised transgender people as the third gender [10], and the 2018 judgment, which read down Section 377 of the Indian Penal Code that criminalised consensual same-sex relationships [11]. In short, these judgments went far beyond the mechanics of law, foregrounding the right to love for queer people. They also called for collective responsibility, especially among mental health professionals, in tackling prejudice and discrimination rooted in oppressive structures of gender binarism and heteronormativity.

Cognisant of the role of mental health disciplines in oppressing LGBTQIA+ people by pathologising same-sex behaviour, the SC issued a slew of directions to mental health professionals to — a) ensure protection against harmful medical and counselling practices that view sexual orientation and gender identity as medical conditions to be "treated" or "cured"; and b) to adopt progressive professional practices that enable freedom from discrimination and

stigma, protection of human rights and equal social participation of LGBTQIA+ people [11: pp 86-111].

In this article, we analyse the responses of mental health systems post the 2009 judgment, focusing specifically on conversion "therapy". We collected all judgments of constitutional courts in India from 2009 to 2022 on the issue of LGBTQIA+ rights, conversion therapy and the discriminatory medical curriculum. We also reviewed the position statements issued by professional organisations of clinical psychology and psychiatry in India from 2009 to 2022 on their official websites. We draw on the recent understanding of conversion therapy, and judicial pronouncements nationally, and compare them with developments internationally. Our findings reveal that the mainstream mental health systems have failed to take prompt and serious action in putting an end to conversion "therapy". We observe that they continue to maintain a regressive stance, serving the exploitative systems that render LGBTQIA+ lives unequal, miserable and invalid [12, 13]. Taking this forward, we express our concerns on the ethics of mental health systems in India and discuss corrective actions, including the scope of a public apology as a first step towards social justice.

## LGBTQIA+ rights and conversion therapy

As same-sex desire was considered to be a mental disorder, various techniques, tools and interventions to "treat" and "cure" it — known collectively as conversion therapy — bloomed and continue to be practised in India [13, 14]. Conversion therapy has been severely critiqued by LGBTQIA+ survivors, medical/mental health professionals and human rights advocates on the grounds of a lack of efficacy and ethics globally.

Firstly, mental health professionals must accept that same-sex attraction is natural, and the denial of that "disrobes the individual of his/her identity and the inherent dignity and choice attached to his/her being" [11: p 109]. Hence, the claim of a "cure" for sexual orientation is quite baseless and unscientific. The Yogyakarta principles [15,16] termed conversion therapy as medical abuse and exhorted states to take measures to curb the same. Further, the UN-appointed Independent Expert's first report applied international human rights law while submitting that conversion therapy violates equality, personal integrity and autonomy as it targets a specific group, exclusively based on sexual orientation and gender identity (SOGI), making it a discriminatory practice. The expert also termed "conversion therapy" as violative of the prohibition of torture and ill-treatment, of the right to health, the rights of the child and the right to freedom from non-consensual medical treatment [7]. Regarding the so-called "efficacy" of conversion therapy, the claim of success based on the ability to engage in heterosexual contact is questionable, as the existence of heterosexual behaviour before treatment was disregarded in conversion treatment studies which clubbed bisexual people with homosexual people as research participants [17, 18]. Most importantly, the harms caused through conversion treatment by mental health professionals include long-lasting physical and psychological damage, "corrective" rape, severe pain (through electric shocks, nausea-inducing or paralysis-inducing drugs), suicide, self-blame and feeling of dehumanisation (through use of anti-LGBTQIA+ epithets and slurs) [8, 19].

Haldeman, in 1994 pointed out that the appropriate focus of the profession of psychology is "what reverses prejudice, not what reverses sexual orientation" [17: p 226]. Some countries including Brazil, Ecuador, Germany, Malta and New Zealand have criminalised conversion therapy. The Psychological Society of South Africa came up with a position statement in 2013 that provides a framework for mapping lived experiences of LGBTQIA+ people. Its Council ratified the Practice guidelines for psychologists to work with LGBTQIA+ people in 2017 [20]. Despite these international developments, mainstream mental health professionals in India continue to employ conversion therapies reflecting discriminatory attitudes to homosexual, bisexual and transgender people [21, 22]. It took until 2020, for the Indian Association of Clinical Psychologists (IACP) and Indian Psychiatric Society (IPS) to issue position statements on conversion "therapy" [23, 24]. These statements have not been followed by any firm action on the ground, such as a ban on conversion therapy, delicensing practitioners from adopting the practice or even a formal apology statement. At last, the Madras High Court banned conversion therapy in 2021.

There is no information on the harmful effects of conversion "therapy" even on the websites of central government-run mental health institutions. The continuing apathy to ban conversion therapy and support the human rights of LGBTQIA+ people stands against every principle of healthcare ethics — autonomy, informed consent, beneficence and non-maleficence. Updating developments in the field and educating peers about the growing evidence is a major component of systematising medical ethics. That said, we also acknowledge the contributions of some mental health professionals who have challenged regressive majoritarian positions displaying a strong sense of justice. A few articles published by psychiatrists in the *Indian Journal of Psychiatry*, [25, 26, 27], post the 2009 Delhi HC judgment, have sought progressive initiatives to usher in transformative change. It was in 2014 that the immediate past president of IPS shockingly suggested that homosexuality is pathological and needs to be cured [28]. Expressing protest over this contention, a senior member of the IPS demanded posting of the official position on homosexuality on the IPS's members-only online discussion forum. When that was not done, he resigned [29].

## LGBTQIA+ jurisprudence post-2018: An overview

This section analyses some landmark cases of the High Courts decided after the 2018 SC judgment on LGBTQIA+ rights.

***(a) Queerala and Anr vs State of Kerala and Others: HC of Kerala, 2021* [30]**

In 2021, a petition was filed in the HC of Kerala by a transman and an NGO working for LGBTQIA+ rights to ban conversion "therapy". The state, in its counter-affidavit, pleaded ignorance of the existence of conversion therapies [30: p 4]. This was a lame and shocking defence as there have been many reports, research studies, first-person narratives and deaths by suicide due to conversion "therapy" in the state, eg Anjana Hareesh/ Chinnu Sulfikar's death by suicide [31]. The counter-affidavit submitted by the Kerala State Mental Health Authority, a statutory body, stated that "Conversion therapy though unscientific, is not on the list of prohibited procedures" [30: p 13]. Both these positions expose the sheer callousness of the state mental health systems on this vital issue.

At the outset, the submission of the IPS Kerala chapter to the HC looks progressive but a closer analysis reveals lack of co-presence and empathy towards LGBTQIA+ people even after the ban on conversion therapy by various countries and international human rights mechanisms. It states:

> *LGBTQ+ community, like any other individual, may be vulnerable due to stigma, bullying, family and society pressures etc., so seeking psychiatric help could help them pre-empt associated problems and treat them by pharmacological and non-pharmacological therapy* [30: p 9].

The use of the phrase "LGBTQ+ community, like any other individual" is symbolic of the insensitivity to the unique life stressors that the LGBTQIA+ community go through due to their disenfranchisement by the state and society, including their own families, which very often become an important source of violence [32, 33]. Also, we see the absence of any public health initiatives to inform the parents and public about the "normality" of all sexualities as an affirmative public health action that can prevent a cascading effect of pathologisation by families, religious healers, and mental health professionals.

***(b) Queerythm and Dhisha vs National Medical Commission and Others, HC of Kerala, 2021* [34]**

In line with the SC judgments in 2014 and 2018, the petitioners prayed for the court to issue a writ of Mandamus to the state authorities to revise medical textbooks and curricula containing remarks that stigmatise the LGBTQIA+ community as pathological, criminal or perverted. The forensic medicine syllabus for MBBS categorises "sodomy", "lesbianism" and oral sex as sexual offences, and "transvestism" (cross-dressing) as "sexual perversion" [34: p 43]. Two MBBS students in 2018 foregrounded the discriminatory information on LGBTQIA+ people in their textbooks which include references that puberty is a period where attraction towards the opposite sex develops. They reported that cross-gender homosexuality and ego-dystonic homosexuality appear in standard psychiatry textbooks and that forensic medicine textbooks refer to homosexual people as criminal, psychologically imbalanced and as those who pose socio-moral problems [35]. The Kerala HC termed it a serious issue and issued a notice to the National Medical Commission (NMC) for urgent action. The fact that the National Medical Commission and Undergraduate Medical Education Board are respondents in the case speaks to the ethical code of keeping up with the scientific evidence produced globally, and reveals the inertia in bringing much-needed change into medical education even after the SC judgments on the subject.*

***(c) S Sushma and Seema Agarval v/s Commissioner of Police and Others, HC of Madras, 2021* [36]**

This case arose from the elopement of lesbian lovers and the consequent filing of an FIR by the police due to family disapproval. The couple filed a lawsuit to quash the said FIR. A Madras HC judge, aware of the need to use his institutional power to bring about change and educate the public, took several bold steps including:

- bringing the parents and petitioners together for a discussion, mediated by a queer affirmative psychologist;
- interacting with four queer and allied individuals , including a transperson-cum-MBBS student to understand their lived experiences and perspectives;
- himself convening an interaction with the queer affirmative psychologist to understand sexuality and queer relationships;
- issuing a slew of directions banning conversion therapy and initiating many affirmative actions.
- asking the government of Tamil Nadu to revise the police conduct rules to deem any harassment against LGBTQIA+ people or people working for their welfare as misconduct.

The HC required the state to provide regular updates on the policy changes it has enacted.

It was much later, in February 2022 that the NMC recommended a penalty for instituting conversion therapy, terming it as professional misconduct [37].

From the three cases we have discussed above, the role of the judiciary in protecting the rights of LGBTQIA+ individuals becomes evident and emphasises the need for other state actors such as mental health professionals, police, and the educational system to make serious changes in their policies. Yet, the mental health systems, as the narratives above illustrate, have been the cause of denial and delay of justice even after witnessing many first-person accounts of conversion therapy [38, 39]. That for every single step towards justice, the aggrieved person has to go through the onerous and costly exercise of approaching the courts reflects the state of inertia within the mental health professional bodies and statutory bodies. One cannot always rely on the constitutional courts to take a progressive stand

and strike down every form of injustice, as is clear in its equivocal stand on marital rape in India [40], and the recent striking down of *Roe vs Wade* on abortion rights in the USA [41]. The silence of mental health systems on such crucial issues puts undue pressure on the judiciary, the public and the aggrieved community. A major role should have been taken on by the mental health professionals who have been direct witnesses. The HC's observations and directions to the NMC and Rehabilitation Council of India (RCI) regarding conversion therapy and the discriminatory language in medical textbooks must be implemented through solid, actionable mechanisms to protect the fundamental rights of LGBTQIA+ people.

## The inertia of mental health systems: Failure to adopt best practices

The Office of the United Nations (UN) Independent Expert on protection against violence and discrimination based on SOGI had submitted a report on conversion therapy to the UN General Assembly in 2020 [7]. The Government of India, NMC, RCI, and the largest professional organisations of psychologists and psychiatrists (IPS and IACP) refrained from making submissions. "Given the persuasive evidence that practices of 'conversion therapy', including its most heinous forms, exist in every corner of the world, the Independent Expert is perplexed by the lack of interest of certain States in engaging in a process that was designed to address an issue that deeply damages millions of persons under their jurisdictions", the report noted.

The belated position statements of the IACP and the IPS are bereft of directives for concrete action such as cancelling the licences of professionals engaging in conversion therapy, or a grievance mechanism for people to report such instances. They fail to educate society on the structural violence, need for civil rights, equality and acceptance to usher in mental health support among LGBTQIA+ people. This amounts to just lip service in contrast to the transformative role of the landmark court judgments, and almost always appear to align with conservative social morality and the state's positions.

In April 2022, the Madras HC directed the state to conduct a training programme for sensitising school teachers in dealing with issues of LGBTQIA+ children [42]. The same court expressed shock over the National Council of Educational Research and Training (NCERT) pulling down the transgender manual from its website and the government arbitrarily transferring its authors [43]. We don't come across such empathetic statements and compassionate solidarity from the Directors of state-run mental health institutions. The silence around state-sponsored violence on LGBTQIA+ people in these institutions also reveals their non-recognition of the relationship between state policies and mental health and the consequent need to engage in resistance and advocacy for transformative policy changes. Even after the SC, in 2018, called upon mental health professionals to act as agents of social change by adopting steps to ensure LGBTQIA+ people are accorded equal human rights, RCI, NMC, National Institute of Mental Health and Neurosciences (NIMHANS), IACP and the IPS have not taken steps to either develop a queer and trans affirmative mental health curriculum within mainstream mental health training or to include it as part of an ethical code of conduct. The Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender Nonconforming People, published by the World Professional Association for Transgender Health (WPATH), was first published in 1970 and is currently in its 8th version [44]. NIMHANS published a manual on Mental Healthcare of Transgendered Persons in India for practising psychiatrists in 2021 [45], more than 50 years after WPATH and six years after the NALSA judgement on transgender rights. The manual, although praiseworthy, appears to be authored solely by psychiatrists, foreclosing the opportunity for the members of the transgender community and queer mental health professionals to be part of a guideline which is about them.

While saying this, we do appreciate the tireless work of feminist, rights-oriented mental health practitioners who acted ethically by persistently questioning, challenging and often changing mainstream mental health practice in support of LGBTQIA+ individuals and communities [46, 47].

As Cvetkovich, in *Archives of Feeling* asserts, archives

> *"… must preserve not just knowledge but feeling. Lesbian and gay history demands a radical archive of emotion in order to document intimacy, sexuality, love, and activism—all areas of experience that are difficult to chronicle through the materials of a traditional archive.* [48; p 241].

## Towards a transformative mental health practice

The long-festering problem in mainstream psychology and psychiatry has been the overstated focus on repairing individual pathology without diagnosing social pathologies, thereby contributing to the further oppression of people living on the margins of society. Instances of psychiatry acting as a political agent of the state in deflecting attention from state human rights violations and violence are not just historical facts [49, 50] but complex everyday realities that undergird "modern" mental health practice [51, 52]. The private troubles that are told and retold in the clinic are divorced from the larger milieu in which the person lives, consisting of communities, politics, personal identity, economy and state policies. This social amnesia and fear of social context in psychological theory building, research and practice [53] demonstrate its intimate relationship with colonialism, capitalism and neoliberal governance, eg experiences of the farmers' mental distress are divorced from the political, economic and local contexts in the mainstream mental health discourse [54].

Mental health practice almost always maintains an eerie silence regarding the need for transformative socio-political change, thus invoking coping with social injustice and systemic violence at an individual level. Systemic issues like multiple levels of marginalisation, social exclusion and

discrimination co-construct mental health problems and such systemic problems need systemic solutions instead of individual-level interventions [55, 56]. A thorough understanding of the LGBTQIA+ spectrum is yet to emerge even in the most progressive associations. For instance, gender incongruence, as defined in International Classification of Diseases-11 (ICD-11), is still seen within the confines of sexual health rather than as an identity issue, thus conflating gender identity and sexual relationship. It is useful here to press into service research on the collusion of psychology with the apartheid government in South Africa in pathologising LGBTQIA+ people [49].

This paper shows that postcolonial mental health systems in India have failed to validate and archive experiences of LGBTQIA+ people to apprise other stakeholders, including the public and the judiciary about the anguish that constitutes their everyday experience. Failure to challenge, question and curb a harmful practice like conversion therapy, which is their responsibility, stultifies the spirit of natural justice. This points to the breakdown of ethics in failing to account for the trauma of LGBTQIA+ people.

As mental health problems in LGBTQIA+ people chiefly emanate from upstream sociopolitical factors such as state disenfranchisement and abandonment, mental health professionals have the ethical duty and responsibility to intervene to change those factors instead of subjecting the person to innumerable therapies to make them adjust to an unjust world. A recent *Lancet* editorial, titled "When therapy is not therapy", states that psychiatry's "past role in promulgating enduring stigma of LGBTQ+ people gives it a responsibility to oppose conversion therapy" [52]. In light of this, we need to ask: Should the mental health systems not have educated and informed the judiciary, rather than waiting for the reverse to take place?

We believe in Deepa Pawar's concept of "mental justice" as suggesting the way forward. "Mental Justice is when individuals and communities can access their rights of development, opportunities, participation, leadership, and other rights in a dignified and non-discriminatory manner that the Constitution safeguards" [57]. The steps towards mental justice could start in the form of a nationwide helpline for addressing trauma for conversion therapy victims. A public apology by mental health associations for the injustices meted out in the name of conversion therapies could be another step. In 2021, the American Psychiatric Association and the American Psychological Association tendered a landmark apology for their legacy of systemic racism against people of colour [58, 59]. Offering lucid insights on taking the blame in healthcare which resonates with the principles of medical ethics, a philosopher posits that an apology marks the acknowledgement of fault or the desire to prevent harm and to understand the harm in totality [60].

It is also essential to break the existing silos to collaborate with the public, activists, scholars and mental health professionals from the LGBTQIA+ community and other marginalised sections to produce bottom-up knowledge laying a foundation for intersectional, cross-movement advocacy to advance social justice. Mental health practice should take cognizance of the intersections in social locations of individuals and groups including gender, SOGI and caste [61]. In dealing with LGBTQIA+ mental health, it is imperative to challenge structures that pathologise and discriminate, including the mental health systems and the state, to implement inclusive therapeutic practice. Homophobia/biphobia and transphobia and all discrimination based on SOGI needs to be framed as a public health problem by the mental health systems to bring lasting well-being to survivors of such violence, rather than charitably gifting individualised mental health services to them.

As Martin Luther King reminds us, "Injustice anywhere is a threat to justice everywhere".

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COMMENT

# Global Mental Health Movement: Need for a cultural perspective

**NIDHI SINHA**

***Abstract***

*The present commentary reviews the goals and differing positions on the Movement for Global Mental Health (GMH), with a distinct emphasis on the cultural differences in the understanding of the aetiology of mental health issues. The proponents and advocates of GMH support its intentions and primary agenda of scaling up mental health services, especially in low-income and middle-income countries where the prevalence of mental health disorders is continually rising. However, many cultural psychologists and sociologists critique the movement for universalising psychiatric symptoms, as this universalisation could actually suppress local voices and might also undermine the significance of culture and political and psychosocial predictors which may contribute to mental health challenges. After discussing the pros and cons of the GMH movement, this commentary concludes with a conceptual analysis of the GMH position and offers predictions about its future discourse.*

***Keywords:*** *global mental health; GMH; mental illness; culture and mental health*

Author: **Nidhi Sinha** (imnidhis@gmail.com), PhD Fellow (Psychology), Indian Institute of Technology, Hyderabad, INDIA.

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## Introduction

Mental health issues make a substantial contribution to the global health burden, as indicated by World Health Organization (WHO) health statistics, 2017 [1]. According to the World Health Report of 2001, it is expected that one out of four individuals in the world are, at some point in their lives, susceptible to mental or neurological disorders [2]. Globally, there has been an increase in depression by 18.4% from 2005 to 2015 [1]. Worldwide, mental health comprises up to 13% of the total disease burden, and at least two-thirds of all the people with mental illness fail to receive any treatment, especially in low-resource countries [3]. Despite the availability of various effective treatment strategies and