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COMMENTARY

Addressing the missing stair: Conversion culture in mental health ecosystems

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Abstract

The author wants to direct attention to the persistent otherisation of queer/trans people in mental health ecosystems that breeds conversion culture – a system of values that looks at gender/sexual diversity as a less preferred outcome. While outright and tell–tale forms of conversion efforts continue to be flagged, outlawed and held accountable, a wider paradox is exposed: Do majority cis-het psychotherapists go along with anti-conversion practices because they truly believe them to be unethical and violative?

After a critical review of literature on micro–aggressions, the author argues that conversion culture persists despite bans — in mental health classrooms, training spaces, clinical interactions — even if it does not take the shape of overt conversion attempts. It can also seep into psychotherapy talk and foster negative healthcare experiences. Conversations about conversion therapy must therefore percolate deeper to address care frameworks in terms of mental health curricular and training realities in which pro-conversion attitudes and mindsets may get shaped, legitimised and perpetuated.

Keywords: *conversion culture, framing and frameworks, micro-aggressions, mental health ecosystems*

Introduction: defining conversion culture in mental health ecosystems

Conversion therapy offered by mental health professionals over time, targeting gender and sexually minoritised (GSM) populations has persisted across the globe [1, 2]. Its history of legitimisation using frameworks rooted in mental health discourse begs the question of whether there is a culture, a system of values, enabling such outcomes in mental health ecosystems. I use the term "conversion culture" in this article to identify and describe this system of values and practices, having first used it earlier in a similar context [3].

Conversion culture in mental health ecosystems may be defined as a broad umbrella of beliefs, norms and practices around gender and sexual diversity — that privilege gender/sexual normativity, being cisgender and heterosexual by default, as a desirable and deemed-to-be psychologically comfortable goal for all service-users [4, 5]. In parallel, gender/sexual diversity is framed as an undesirable outcome or one that warrants being challenged or questioned before being accepted (for instance, see [6]). Such *framing* is not always on the lines of direct pathologisation of gender/sexual diversity, which makes it harder to pin down in psychotherapy practices [7,8,9]. Rather, it is a bent of mind, a systematised way of approaching psychotherapeutic work with GSM service-users from a gaze of otherisation or suspicion towards the authenticity of their gender/sexual diversity. This may manifest itself in diverse ways: undue resistance to validating gender/sexual diversity in clients and equating validation with negative consequences, often marked by active detachment from the political nature of gender/sexual diversity [10], lack of acknowledgement of historical harm perpetrated by psychotherapeutic ignorance of gender/sexual diversity [4,5], and advocating for "best interests" of GSM persons without paying due heed to their needs and aspirations of care and the routine onslaught of dominant social systems in frustrating those needs and aspirations [10].

Conversion culture as a value-orientation in mental health praxis is certainly more subtle and nuanced than openly coercive attempts to change one's gender identity or sexual orientation. It can be masked as sustained well-intentioned effort to protect service-users from political propaganda surrounding gender/sexual diversity [9,10]. Under the garb of best interests, it can encompass varied propensities to delegitimise gender/sexual diversity of service-users through micro-aggressions, leading to negative mental healthcare experiences. It may also manifest in legitimising the frictions of such diversity with dominant social institutions and cultural values instead of countering those frictions [5,11]. The underpinning agenda remains that self-actualisation of gender/sexual diversity is presented as an outcome to save the individual, towards which a continuous flow of interventions must be directed. It is also undeniable that psychotherapists get to spend much more time with their clients compared to psychiatrists as the latter follow a pharmacological model of care. As talk and sustained talking is the edifice on which psychotherapy often premises itself [12], it is important for psychotherapists to take note of how their interactions with GSM service-users may be shaped by conversion culture.

The presence of conversion culture is like a missing stair, which is recognised and well-tolerated within mental health ecosystems. It is sometimes even bypassed to direct attention to alternative non-pathologising care frameworks, but never directly addressed or spotlighted.

Conscious 'framing' in psychotherapy-based interventions

When it comes to talk-based mental health interventions, framing is the thin line that separates conversion-focused talk from talk that is oriented to alleviate distress for GSM users without stigmatising them and attempting to change their gender/sexuality.

Framing as a behavioural science principle is relevant here as it pertains to how information is presented that can significantly influence people's perceptions and decisions [13, 14]. Framing is also implied in how one attempts to resolve dominant frames with alternative possibilities. For example, Crenshaw [15] understands the experiences of marginalisation of black women through a multi-dimensional lens, highlighting unique struggles and challenges, and not simply a summative experience of their gender and race-based discrimination. Even for gender-diverse youth, the dominant framework of merely normalising their identity position may be extended more meaningfully to cover interventions that affirm their sense of self and experiences [11]. Framing may therefore be indicative of value-positions and biases, intentionality and consequent actions.

As such, psychotherapy frameworks can be *framed* to suit the norms and dictum of conversion culture, while being conveniently posed as value-neutral and agenda-free. This is a major flaw in psychotherapy frameworks, which depend heavily on the inter-subjectivity of dialogue and meaning-making; the clarity of intent and commitment to social justice by mental health professionals becomes paramount in this regard. In a report on conversion therapy [16] continuing in India despite a ban imposed by the National Medical Commission in a circular to state medical councils, a practising advocate observes:

> *The NMC circular to State Medical Councils banning conversion therapy is the document that comes closest to saying what kinds of acts or methods can constitute conversion therapy in India. But even this is exclusive because it lays down what conversion therapy is but does not address how even established medical and psychological treatment modules like talk therapy, Cognitive Behavioural Therapy (CBT), or any kind of 'cleansing', 'healing', or psycho-religious rituals also constitute conversion therapy.*[16]

Conversion therapies have never existed in a vacuum in psychotherapy contexts. They have been defended with rationale, legitimised by the same psychotherapeutic frameworks which continue to form the backbone of research and evidence-based treatment for many mental health conditions at present [11,17]. This points to the persistent reality of how the language of established psychotherapy frameworks can be manipulated to change, question or challenge sexual orientation or gender identity, framing them as undesirable outcomes. Such tweaking of therapeutic language and intervention design needs to be read in conjunction with the pervasive negativity and stigma already existing towards GSM subjects, where routes for positive identity formation are prematurely foreclosed [18, 19]. The negativity and stigma are also internalised [19, 20] so that clients from GSM positions may not always be able to present with consolidated, stable and positively achieved identity positions. Such clients may even desire conversion to gender and sex normativity as a route to avoid minority stress and internalised shame and guilt that come to be associated with it. In a mixed method inquiry for documenting trans-affirmative mental health practice, spanning three cities in India, 34.5% of mental health professionals were consulted by trans and gender-diverse service-users on their own accord with conversion therapy requests [21]. Herein, the role of the psychotherapist becomes paramount in how they frame their intervention and whether they are led on by conversion culture and messaging to work against gender/sexual diversity as a non-pathological outcome.

Conine, Campau and Petronelli [22] foreground how frameworks of applied behaviour analysis have been misapplied to design and disseminate conversion therapies. Capriotti and Donaldson [23] also call for a need to frame behaviour analytic interventions towards the goal of liberation of gender and sexually minoritised subjects, while accepting accountability for historical harm perpetuated through wrongful use of such interventions in enabling curative violence [24].

On the other hand, D'Angelo [25] can be observed to vouch for deeper psychoanalytic exploration of trans identification of youth to safeguard them from potential harm of gender-affirming interventions, drawing in his reasoning from de-transitioning testimonials and the pivotal assumption of Gender Dysphoria as an outcome of secondary psychopathology.

> *Currently, we have no screening tools or protocols to determine in which individuals' gender dysphoria is a carrier for another psychosocial or mental health issue. Similarly, we have no reliable way of predicting which young people will be helped by transition and which will not. The best, and arguably only, tool we have is detailed psychotherapeutic exploration that extends over a long enough period to allow significant, previously unknown or unconscious issues to become available for reflection.* (25: p. 7).

Interestingly, D'Angelo [24] himself acknowledges: "Any intervention, including psychotherapy, can be misused to exert undue influence and impose a preferred outcome." (24: p. 7). Ironically, he also delineates in the same paper how psychotherapy may be utilised to align individuals with their unwanted gender rather than their desired gender.

> *Psychotherapy provides a space in which patient and therapist can question the assumptions and regulatory*

> *discourses that underpin why certain qualities, behaviours, identities and sensibilities are associated with particular body configurations, types of dress, gender signifiers, etc. They may question whether transition is truly gender expansive or whether it perpetuates those very norms that the young person finds oppressive. Thinking critically about these gender norms invites young people to generate heretofore unimagined ways of embracing gender diversity that are arguably safer than gender-affirming interventions* (24: p. 7).

In a critical analysis of gender-exploratory therapy similar to that of D'Angelo [25] and its value orientations, Ashley [26] raises a series of questions to clinicians to reflect on the ethics of the psychotherapy praxis. I find their concluding position particularly useful with respect to the argument that I am making:

> *When you begin from the premise that trans identities are suspect and often rooted in pathology, your therapeutic approach soon becomes indistinguishable from conversion practices. As a scholar of conversion practices, the uncanny resemblance cannot but give me pause.* (26: p. 478).

The focus seems to be primarily on prevention of gender-affirming medical interventions, which may sometimes be outside the expertise and professional scope of psychotherapy itself, especially as the *International Classification of Diseases,* 11th revision (ICD-11), recently published by the World Health Organisation [27] has shifted Gender Incongruence out of mental and behavioural disorders and incorporated it as a condition pertaining to sexual health. The regret rate after undergoing gender-affirmation surgery is estimated to be less than 1% in a systematic review, which is even way lower than regret about having children [28].

The American Psychological Association's (APA) resolution on Gender Identity Change Efforts [6] cautions professionals against dissemination of misinformation regarding gender-diversity including claims for cure; however, given the political situation in the United States in the present, that negatively targets gender-affirming healthcare for trans and gender-diverse youth and adults along with normalising discrimination and prejudice through executive orders [29], the APA Guidelines seem to have been sidelined, and conversion culture has political sanction to operate freely.

Without addressing conversion culture, mental health ecosystems are absolved of their structural biases and sanctified in the public domain. However, there is substantial evidence that both service-users and professionals from the margins continue to grapple with differential treatment in these spaces. I shall take that up below.

Findings from a relatively recent Trevor Project survey engaging more than 40,000 LGBTQ+ youth in the United States (aged from 13-24 years) highlight that 10% of the surveyed youth have been subjected to conversion therapy, with 3% reporting instances of such treatment by healthcare professionals and 78% reporting exposure to such treatment below eighteen years of age [30]. In fact, there exist no legal safeguards against minors being enrolled in conversion therapy programmes in thirty states of the United States, with 29% of LGBTQ+ youth between the ages of 13-17 years living in states with no state legislations or policies in place for prevention of conversion therapy [31]. This also exposes a bigger paradox: if conversion therapy bans need to be in place for the practice to be stopped by mental health professionals and the broader healthcare fraternity, what does their ethics of care look like without external accountability mechanisms?

Micro-aggressions as modern-day artefacts of conversion culture

In order to probe how frames of reference for gender/sexual diversity in psychotherapy contexts can be traced back to conversion culture, microaggressions are a potent source of evidence, as stated earlier.

Micro-aggressions encompass common subtle verbal and non-verbal, negative exchanges that are directed at individuals of minoritised status or marginalised position/s. Pioneering work in this area was conducted by a noted African-American psychiatrist, Chester Pierce, who defined micro-aggressions as "black-white racial interactions [which] are characterized by white put-downs, done in an automatic, pre-conscious or unconscious fashion" [32]. Sue later expanded the concept to apply to gender and sexually minoritised communities as well [33].

Micro-aggressions in clinical relationships reek of negative bias towards minoritised populations. They can rob service-users of their autonomy in bringing forth their felt experience of oppression to the therapist's chamber. Further, if the psychotherapist comes from a dominant social location with respect to LGBTQ+ clients (the overwhelming demographic of mental health professionals being cisgender and heterosexual), the therapeutic encounter itself can become a source of stress. This can again foster a sense of marginalisation, where the client may feel misunderstood or invalidated.

Shelton and Delgado-Romero used focus-groups to explore micro-aggressions experienced in psychotherapy by LGBTQ+ clients, which resonates with the scope of the current article [9]. Certain kinds of sexual orientation microaggressions featured in the findings are telling in terms of (a) assumption that sexual orientation is the cause of all presenting issues, (b) avoidance and minimising of sexual orientation, (c) expressions of heteronormative bias, (d) assumption that LGBTQ+ individuals need psychotherapeutic treatment, and (e) warnings about the dangers of identifying as LGBTQ+. Looking at these micro-aggression themes, it is not far-fetched to suggest that such psychotherapy can have conversational sequences/dialogue chains in moments of psychotherapeutic inquiry that nudge

the service user away from embracing their gender/sexual diversity, or make their gender/sexual diversity pass multiple litmus tests even though overt, forceful attempts to alter gender identity or sexual orientation may be absent. This observation can also be extended to Mizock and Lundquist's work on missteps in psychotherapy with forty-five TGNC (transgender and gender non-conforming) participants from diverse racial/ethnic compositions and socio-economic backgrounds [8]. The sample comprised twenty-one participants who self-identified as Male-To-Female (MTF) or transwomen (both or either), seventeen participants who self-identified as Female-To-Male (FTM) or transmen (both or either), and seven genderqueer or genderfluid participants. Although the work did not bring in the lens of micro-aggressions explicitly, the clinical errors that came out of exegesis fit the operational and theoretical understanding of micro-aggressions. The following thematic categories became apparent in their work: i) Education burdening (reliance on client to educate the psychotherapist on transgender issues), ii) Gender inflation (overlooking important aspects of client's experience beyond their gender-identity/presentation) iii) Gender narrowing (imposition of prescriptive and preconceived notions of gender on transgender clients) iv) Gender avoidance (keeping gender out of bounds in psychotherapy work with transgender clientele) v) Gender generalising (assumption of a universal transgender experience) vi) Gender repairing (perception of non-normative gender identity as something to be fixed, which of course is a manifestation of an assumption of pathology/abnormality), and vii) Gate-keeping (pertaining to control of access to gender-affirmative medical resources).

A provocative study by Anzani and colleagues tried to examine the question of whether micro-aggressions were reflected in psychotherapist's assessments of lesbian or transgender women relative to heterosexual women [34]. What sets this study apart from other relevant literature is its focus on direct observation of therapist's response to client's disclosures of gender/sexuality, rather than premising itself on narrative experiences of LGBTQ+ clients- which is why the author found it important to include it in the current analysis. The sample consisted of 135 licensed psychotherapists, of whom 25 were cisgender men and the rest were cisgender women. They were exposed to an audio file of a woman client's introduction in the first session of therapy in three versions: as a transgender woman, as a lesbian woman and as a heterosexual woman. They were then asked to evaluate the clinical utility of ten questions (5 neutral and 5 micro-aggressive questions) for determination of a clinical impression. A repeated measure, ANOVA, was used to explore the likelihood of queer clients being at the receiving end of micro-aggressions. Results confirmed the hypothesis that participants indeed considered micro-aggressive questions as necessary/relevant when informed about the queerness of the client. Such processes could be extremely detrimental in a psychotherapeutic setup that draws heavily on emotional exchange between the clinician and the client from a marginalised social group.

This also becomes more evident in a qualitative study involving interactional experiences of LGBTQ+ service users (N=10) in Kolkata, India, where negative perceptions of clinical authority are predominant, marked by themes of invalidation by professionals, professional partnering with families of service-users to further injustice, and lack of professional competence to deal with LGBTQ+ issues [35].

Auditing conversion culture in mental health ecosystems in India and abroad

Ranade et al [21] in their mixed method, multi-site study in India on trans-affirmative clinical practice, observed that amongst 165 mental health professionals, 63% reported not having studied transgender mental health as part of their formal education in a wholesome manner; 78.2% reported the need for training on mental health of trans and gender-diverse individuals. There was also lack of consistent exposure to international and national clinical guidelines for working with this population.

Some of the earlier studies in India, concerning clinician's attitudes towards LGBTQ+ individuals, confirm Ranade's findings [21]. In a study on attitudes towards homosexuality among Indian psychiatrists (N=190), some participants had raised concerns regarding exposure of children to same-gender attracted colleagues [36]. Sappho for Equality compiled a comprehensive good practice guide for gender-affirmative care in India with a team of medico-legal experts, where attitudinal barriers from healthcare professionals are highlighted as a major concern, rooted in discernible gaps in knowledge and training coupled with a lack of standard communication protocols [37].

A by-product of conversion culture is also how mental health ecosystems are designed to exclude professionals and trainees who may be from gender/sexual margins themselves. Kottai points to the lack of positive sexuality curriculum in mental health training in a premier central government Indian tertiary-care setup along with lack of a support group for LGBTQ+ trainees on campus [38]. He further elaborates on his experiences of exclusion and terror where his marginal gender/sexual experiences became a site of mockery, bullying and otherisation:

> *There was immense scrutiny and control on the way I talked, dressed, emoted and behaved in the mental health institution... A senior psychiatry student eager to probe my sexual preferences constantly quizzed me on the hostel's public spaces, blatantly violating my fundamental right to privacy. The academic space was [so] bruising and intimidating that even the junior students used to mock me by [mimicking] my tone of voice and speech*.

Some studies based in other geographies also point to similar findings around microaggressions faced by LGBTQ+

trainees in mental health ecosystems. Bryan [39] delineated the types of microaggressions faced by LGBTQ+ students in counsellor training programmes in the United States which included themes of invalidation of experience by both faculty and peers, assumption of heteronormativity of trainees, as well as in case studies and role-plays, assumption of pathology, derogatory slurs and hate speech, environmental micro-aggressions (such as negatively biased representation in textbooks and absence of gender-neutral facilities), misgendering and even social isolation and expressed reluctance of cisgender heterosexual peers to deal with LGBTQ+ clients to name a few. Closer in time to this study, Pollock and Meek [40] in their online survey of 43 lesbian and gay students in counsellor educator programmes (participants were not geographically restricted), also evidenced negative experiences of being subjected to verbal harassment, stereotypical thinking and even physical abuse.

How does the discourse add up?

Conversion culture is deeply enmeshed within the ethos of mental health ecosystems, with a huge impact in terms of negative and discriminatory healthcare experiences for GSM service-users that can negatively impact help-seeking behaviours of an already underserved population. There is an urgent need to amplify such experiences in these ecosystems and demand accountability. This needs to be achieved both from secondary data and first-person accounts involving service-users, service-providers and other stakeholders from GSM communities to break the myth of non-judgemental objectivity that is projected by these ecosystems. The author believes this projection maintains the cis-heterosexual status-quo that is upheld by socio-politico-religious incentivisation of dominant worldviews, while sidestepping the needs, visibility and voices of GSM communities. And it is these roots that need to be struck in the interest of psychotherapeutic liberation of LGBTQ+ individuals within these ecosystems, be it as service-users, professionals, trainees, faculty and the like.

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