**Fractured narratives of psy disciplines and LGBT rights movement in India: Critical questions**

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**Abstract**

The day before the Honourable Supreme Court commenced hearing on the curative petition on IPC 377, Indian Psychiatric Society (IPS) issued an official statement that homosexuality is not a mental pathology. In the year 2014, a year after the top court criminalized homosexuality, the then IPS president had termed it as a pathology for which treatment need to be sought. By examining articles published in flagship journals in psychiatry and clinical psychology in India on LGBT rights, position statements by professional bodies, international and national developments in human rights mechanisms and drawing from personal experiences we argue that psychiatry’s voice for human rights protection of marginalized people has been akin to whispering sweet nothings in tune with juridico-penal system. In turn, clinical psychology appears to huddle with the medical without raising voice against coercive and traumatizing practices within mainstream technocratic psychiatry.

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*“An unexamined life is not worth living.”*

*-*Socrates

Same sex desires, referred to as homosexuality in popular discourse is again in the limelight as the five-member constitution bench of the Honourable Supreme Court of India struck a sharp blow to section 377 of the IPC which prohibited sexual acts ‘against the order of nature’. The top court observed that “what nature gives is natural” terming 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 LGBT individuals applied *locus standi* by directly approaching their constitutional court for protection of fundamental rights. In all former cases they were represented by NGOs or other organizations on their behalf. On July 10, 2018, the day before the Supreme Court started hearing the curative petition, the IPS (Indian Psychiatric Society) issued a position statement saying that homosexuality is not a mental illness to be treated (2). In contrast, in 2014, a year after the Supreme Court recriminalized homosexuality, the President of IPS had publicly announced that homosexuality is unnatural for which psychiatric treatment need to be sought (3). Mainstream psychiatry in India appears to be singing to the tune of juridical- penal system to decide whether homosexuality is a disease or not.

The panorama of political struggles for decriminalization and depathologisation of same sex love and the concomitant developments in psy disciplines[[1]](#endnote-1) illustrate that voices of resistance to inequality and injustice in psy disciplines have been fairly muted and marginal. Realignment of psy disciplines with the spirited fight for LGBT rights evolved only after it was discussed, debated and actively pursued by a broad range of disciplines and stakeholders. Hence psychiatry’s emerging progressive voices are akin to whispering sweet nothings as it has done little to lend its voice for the victims of marginalization. History of psychiatry is replete with similar stories in relation to racism, slavery, and gender bias.Metzl tells the story of how civil rights era anxieties about racial protest catalyzed associations between schizophrenia, criminality and violence (4). Davies compiled evidence against psychiatry’s claim to be 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 (5). Psychiatry’s history and its evolved methodologies compel us to radically rethink what kind of science is psychiatry (6) and critically examine its relationship with its publics.

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

Homosexuality has a long history of pathologisation by mainstream psy disciplines of psychology and psychiatry. Same sex desires and behaviours have been represented as a psychiatric disorder worldwide as the diagnostic manuals of ICD (International Classification of Diseases) and DSM (Diagnostic and Statistical Manual) classified it as a diagnostic category. The book *Psychopathia Sexualis* (1886)written 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 (7). Homosexuality was a disease category in the DSM until 1973 when it was struck down as a disease nomenclature by just a nay vote. Ego-dystonic homosexuality continued as a disease category in the manual till 1987 when it was removed from the DSM. ICD, another widely used manual published by the WHO retained the classification of homosexuality as a disease until 1993 when it dropped the classification of ego-syntonic homosexuality from the manual. But even after LGBT rights have been accorded the stature of human rights by international human rights laws, ICD-10 still carries ‘ego-dystonic homosexuality’ (F 66.1) as a diagnostic category (8). Voices from the ground reveal that psychiatrists and psychologists put clients on potent antipsychotic medicines and psychotherapies including aversion therapies respectively. Deliberations are still going on for declassification of disease categories related to sexual orientation in the forthcoming 1CD-11 (9).

**LGBT movements and human rights mechanisms: International scenario**

Article 1 of the Universal Declaration of Human Rights adopted in 1948 by the UN General Assembly states that All human beings are born free and equal in dignity and rights. People with queer sexual identities have employed Universal Human Rights to challenge laws that segregate them to critically engage with psychiatrisation of sexual identities. It was in the year 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 criminalized consensual sexual relationships between adult men. After hearing Toonen’s plea, in 1994, UN ruled that the said law violated his human rights by subjecting him to arrest and detention just because he is a homosexual (10). The UN also observed that the law reinforced stigma and prejudice in the society at large against LGBTs. This marked a watershed moment for equal treatment of queer people worldwide leading to the repeal of the offending law in Australia. 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, in a historic speech on LGBT equality in New York, UN Secretary General exhorted the world community to tackle violence and discrimination against LGBT people. Recognizing the fact that Human Rights violations targeted towards people due to their actual or perceived SOGI constitute an entrenched global pattern of serious consequences, International Panel of Experts in International Human Rights Law on SOGI adopted Yogyakarta Principles on the application of international human rights law in relation to SOGI in the year 2006. 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. The first formal intergovernmental debate on this issue was initiated at the UN in 2012 and then UN High Commissioner for Human Rights Navi Pillay called for a systematic response to homophobic violence and discrimination. In 2013, office of the UNHCHR launched Free and Equal (11), a global campaign to raise awareness against homophobia, transphobia and associated discrimination and violence. The then UN Secretary General termed LGBT discrimination as the biggest human rights challenge of the 21st century where love attracts hate. The US Supreme Court ruling legalizing same-sex marriage in 2016 was another milestone in the fight for equality and human rights by LGBT people worldwide. In 2017 in its first report, 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 destigmatize sexual orientations to promote respect and understanding that sexual orientation is “part of the natural state to be human”. The expert expressed concern over LGBT people being forced into conversion therapy by mental health professionals across the globe. The report noted the fact that transgender and intersex people still fall under the International Classification of Diseases (12). Psychiatry is being accused by user-survivors and scholars for 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 disguised to think that all states of mind are invariably caused by neuro-chemical imbalances and can be rectified through medicines (13). Reflecting in similar vein against individualization 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 contaminate 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 than psychiatry’s oft-quoted chemical imbalance, the report warned that power and decision-making in mental health are concentrated in the hands of “biomedical gatekeepers” representing biological psychiatry (14).

**LGBT rights in India: Pressure groups & judicial activism**

In India, LGBT rights movements have provided critical leadership in gaining visibility for the minority community in recent times thanks to regular pride parades happening in almost all major cities and increasing number of rights-based NGOs across India. India witnessed the first public interest litigation challenging constitutional validity of section 377 of the IPC which criminalizes homosexuality in 1994. In the years to come the police across the nation were engaged in vigorous enforcement of the penal section resulting in brutal violence against LGBT community including the infamous arrest of 9 people associated with Bharosa trust and the raid and seizure of safe sex aids like condoms and instructional videos by Lucknow police in 2001. 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 harassments to help LGBT people seek treatment almost failed.

The Delhi High Court in 2009 struck down Section 377 terming it as unconstitutional violating fundamental rights. Hearing appeals against this judgement the Supreme Court in 2013[[2]](#endnote-2)overruled the judgement passing the baton of responsibility of decriminalization to the Parliament of India. Cognizant of this fact, Shashi Tharoor, MP had 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 (15). Expecting the apex court to live up to the ideals of equal rights enshrined in the constitution, a curative petition was filed which was accepted by the top court for a back-to-roots, in-depth hearing. The Supreme Court has played a vital role in framing positive public opinion about LGBT community in recent times. The apex court touched upon sexual orientation when it was termed as a core constituent of right to life, equality and privacy when it ruled for right to privacy as a fundamental right in 2017(16). Another progressive move by the top court was in 2014 when transgenders were accorded the right to gender expression. The court emphatically said, “recognition of transgender 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 (17).

It is in the context of shifting narratives about homosexuality among world human rights bodies and the apex court that the IPS came out with an official position statement supporting decriminalization. The official position statement mentions that “IPS recognizes 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 decriminalization of homosexual behavior”.

**Responses to LGBT rights among psy disciplines in India**

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

Research in mainstream psy disciplines also tended towards quantitative studies on sexuality, often measuring pathological variables like depression and anxiety in the LGBT community unmindful of the lived experiences, social sufferings and the distress that emanates from the interfusion of socio-political and psychiatric systems in which their lives are enmeshed. This further contributed to pathologisation and framing of social suffering as a mental illness to be treated. ECTs, antipsychotic medicines and aversion therapies rained on LGBT clients deepening the psychological divide with the rest of the mainstream society. Framing queer sexualities as mental illnesses and treating them is common among both psychologists and psychiatrists in India (18). The IPS President’s statement itself is an attestation of this fact where it calls for a “very radical stance to stop considering homosexuality as an illness [by Psychiatrists]” **(**19)**.** Even as we write, ego-dystonic homosexuality is a diagnostic category in ICD-10 which is a widely used manual in psychiatric settings in India. Many psychiatrists hold on to the ego-dystonicity clause without probing the reason for the same- the societal stigma and disapproval that the person faces on account of queer sexual orientation (20). A distorted picture of homosexuality is widespread in medical textbooks leading to biased attitude of medical professionals with respect to homosexuality (21). Asking the ‘patient’ to meet the commercial sex workers to try sex with opposite sex has been evidenced by Kalra (22). While Sarin (23) stipulated that psychiatry unflinchingly contributed to the negative view of homosexuality, improving the response of mental health professionals towards homosexuality was emphasized by Chandra (24). At a conference in Kolkata in 2017, the present IPS President Dr. Ajit Bhide spoke about concerns and dilemmas in dealing with sexual expressions of persons living with psychosocial disability.[[3]](#endnote-3) The relevant excerpt of his speech is extracted herein below:

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 sterilization. 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 realize 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 (25).

**Methods**

In the context of all these debates we have undertaken a study of the flagship journals published by the All India professional bodies of psychiatrists (Indian Psychiatric Society) and clinical psychologists (Indian Association of Clinical Psychologists), viz., Indian Journal of Psychiatry and Indian Journal of Clinical Psychology. In this paper all the articles published in both journals before and after the landmark Delhi High Court judgement which decriminalized homosexuality in 2009 are analysed temporally and synchronically to see how homosexuality and queer issues are depicted and discussed therein. We found a total of 11 articles dealing with this issue in the *Indian Journal of Psychiatry*. *Indian Journal of Clinical Psychology* has not published any article on this topic. All the 11 articles were put to content analysis to determine the purpose of each study and to see how ‘homosexuality’ is talked about in these articles as to whether as a disease or a natural variation. Analysis is extended to find out whether quantitative or qualitative research methodology was employed in these studies.

**Discordant notes: Homosexuality in *Indian Journal of Psychiatry***

A literal ‘coming out’ of the closet was noticed among Indian psychiatrists after the landmark judgement of Delhi High Court in 2009 triggering a host of discussions in the psychiatrist community. Hereafter, articles on homosexuality skyrocketed in the flagship psychiatry journal with opposition to homosexuality dropping quickly. There are, in total, 11 articles published on queer issues in Indian Journal of Psychiatry, out of which 9 came out after 2009. Only two articles had been published before 2009, the year in which homosexuality was decriminalized in India. The first one, published in 1979 deals with the treatment of 4 males for homosexuality by anticipatory avoidance conditioning technique, a form of behavior therapy (26). 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 evidence of the development of heterosexual interests, stating that one of the patients was happily married. In the 1970s and 80s, men with ego-dystonic homosexuality often came to Indian psychiatrists for help and behavioral techniques were used in treating such persons. It is to be noted that clinical psychologists are the main providers of behavior therapies aversion therapies (27). The second study published in 1982 involved cases of 32 males who were diagnosed under ICD-9 as cases of homosexuality. Personality tests (MMPI and Rorschach Inkblot test) were employed to find the causal correlates of homosexuality. The study concluded thatearly childhood experiences and homosexual seduction were etiological factors that contributed to the conditioncreating the notion that there was a specific “cause” for homosexuality and if that “cause” could be found, then a “cure” could be administered (28). Individuals who sought treatment were referred to as ‘patients’ in these articles whenever they were referred to. Hereafter the topic of homosexuality was under a state of complete dormancy for around three decades in the Indian Journal of Psychiatry until 2008 when an article interrupted the silence by offering a new treatment algorithm for homosexuality (29).

Our analysis found that post the 2009 verdict on decriminalisation, discourse of the psychiatrists take a U-turn as some articles published in the IJP support the cause of homosexuality. The first article to come out in IJP after the Delhi HC ruling was in 2010 which offered a comprehensive account of the existence of homosexual behavior in ancient India citing many examples from mythology to claim that it is a normal sexual variation to be acknowledged, accepted and depathologised (30). Another article threw light on the continued pathologisation by ICD-10 in the form of ego-dystonic homosexuality. Human rights sensitization and attitude change amongst the medical professionals is felt by the authors to be important to focus on people’s humanity than sexual orientation aligning closely with UN resolution on the issue in 2011 (31). Kalra (32,33) brings forth an important point of continued medicalization of homosexuality by psychiatrists employing conversion therapies in the form of prescribing antipsychotics in the treatment of homosexuality by giving false promises to the clients. Several instances of unethical treatments by psychiatrists using religion as a tool to dissuade clients from homosexuality are illustrated in the articles. Psychiatrist’s role is designated by the author to be that of a facilitator in coming out helping the family too in that process. Rao & Jacob in 2014 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. This is the only article which cited developments outside the medical arena: recognition of LGBT rights by United Nations Human Rights Council (34).

In response to the above rights based arguments, Varghese counteracted them by arguing that it is difficult to accept the stance that homosexuality is a normal psychosexual development (35). 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 it is abnormal because of the statistical minority they make up. In 2016 an editorial was published with gay rights as the title vouching for LGBT rights (36). The last article to appear was on existence of homosexuality in ancient times in Tamil Nadu (37).

**The troubled relation between Psychiatry and the marginalized**

Scholars and activists from fields like critical psychiatry, critical psychology, anthropology, disability studies, gender studies and developmental 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 (38,39,40). 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 (41). These in effect enforce social control, oppression and silencing of people living on the edges. Of late, counter-narratives of user-survivors of psychiatry or the experiencing experts have been emerging (42). India is also witnessing a spurt in first person narratives of mental illness (43,44,45). Historically, the psychiatric diagnostic categories relay, reflect and export political and social norms where diagnoses in reality become nothing short of social judgements rather than scientific medical assessments. In the 19th century, American psychiatrists diagnosed drapetomania as a frightening condition that affects African slaves characterized by an intent and feeling of running away from their masters. This was a legitimate diagnosis then and the treatment prescribed was whipping. If the ‘patient’ was still recalcitrant, amputation of both big toes was indicated as treatment. Diagnostic categories like kleptomania, drapetomania, atypical theft offender disorder illustrated how diagnoses serve to promote the interests of those who are in power. When stealing becomes a disease for upper class social power is entrusted to mental health professionals akin to the police or religion (46). The inclusion of homosexuality under psychiatry’s fold is the most recent example of psychiatry’s political leanings. Meghana Rao foregrounded how suicides are **increasingly being depoliticized by rechristening it as a mental health problem by premier mental health institutions like NIMHANS pushing into oblivion the economic, political and gendered aspects of suicide (47). Priebe reminds us** that psychiatry’s abstention from political involvement is a major mistake for the profession and for people with mental disorders (48).

***Indian Journal of Clinical Psychology*: Diffidence and silence**

Our analysis of articles published in the Indian Journal of Clinical Psychology has revealed complete silence about LGBT issues. We found that not a single article dealt with homosexuality or queer issues in their flagship journal Indian Journal of Clinical Psychology. There has been not a single press statement or position statement seeking to make the professional body’s position clear. There have been many occasions where psychologists proclaim that they can cure homosexuality**.**  In early 2018 a psychologist from Kerala posted many videos on YouTube claiming that he can ‘cure’ homosexuality thereby attracting many ‘patients’ (49). A prominent LGBT support group had to finally step in to counter this self-proclaimed healer. Neither the IACP nor its Kerala chapter intervened in the case.

**Clinical Psychology curricula, training systems and practice: Towards a ‘pathological’ consciousness?**

The latest syllabus prescribed by the Rehabilitation Council of India for the 2-year M. Phil course in clinical psychology demonstrates how divorced is psychology from the social sciences (50). The 6 theory papers are titled Psychosocial Foundations of Behavior and Psychopathology, Statistics and Research Methodology, Psychiatry, Biological Foundations of Behavior, Psychotherapy and Counseling and Behavioral Medicine. Prima facie, half of the syllabus is strictly an import from mainstream psychiatric science, viz., 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 be neuropsychiatry is mirrored by psychology disabling the clinical psychologists from appreciating social and contextual factors while defining mental disorders. Topics which are central to every social science such as intersectionality, justice, freedom, equality etc. are weeded out at a juncture when mental health is increasingly being talked of as a human rights, disability rights and developmental issue by activists and scholars. Recent developments in mental health studies marked by alternative paradigms in psychology such as user-survivor movements, mad studies, disability studies, etc. remain out of bounds for clinical psychology.

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 prioritized as the keystone for clinical psychology research. The syllabus doesn’t have a single mention of the word qualitative. The standardized psychological tests are often loosely employed to diagnose psychiatric diseases decontextualizing distress, disability and suffering enmeshed in socio-politico-economic conditions. In a provocative article titled *Numbering the mind*, Jacy Young excavates the impact of widespread use of questionnaires to 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” (51). 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 understanding of lived experiences.

Going deeper into the syllabus a marriage between psychology and medicine is palpable in most of them. The bulk of the paper on psychotherapy and counselling is devoted to behavioural therapy and physical therapies which rests mostly on the positivist paradigms of objectivity characterized by measurable goals and outcomes.On the same page, the paper ‘Behavioural Medicine’ in effect wedded behavior and medicine. In effect these relays to the 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 socio-cultural aspects of disability and treats disabled people as objects amplifying their exclusion than emancipation (52).

**Sexuality, pleasure and clinical psychology**

The term ‘sexual’ appears only with reference to sexual disorders and dysfunctions in the syllabus recasting everything related to sexuality as pathology making it difficult to dialogue across disciplines that locate sexuality at the intersection of pleasure, human rights, sexual citizenship, morality, ethics, bodily autonomy and dignity**.**

**Mainstream psychology: Creating another asylum of knowledge?**

In the name of scientific inquiry, mainstream psychology continues to shift its gaze from constructive language to problem language of symptoms. While the first author 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 accusing him of not maintaining professionalism. This is the extent to which psy professionals are trained to be away from ‘others’ to remain in an island of self-proclaimed asylum of knowledge. Even reading newspaper 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 (53). Tanya Luhrmann in her classic ethnography examined closely the training of psychiatrists in American medical schools. She reported that psychiatry students find the whole training to be bruising where the relationship with the senior doctors is guarded and mistrustful. Doctors are taught ‘doctor manners’ on how a doctor should look and behave. Psychiatrists harbour anxieties of 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 recognize the sufferings which are resonant with their struggles (54).

Talking on the basis of 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 (55). Psychology, by mirroring mainstream psychiatry, is now a discipline where objectivity is the expected normal. It is significant to note that Supreme Court has not quoted even a single scholarly work on LGBT issues in India by a psychologist or psychiatric social worker in its judgement on IPC 377. Taking cognizance of the fact that 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 [reading down of Section 377 of IPC] 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).

Our Supreme Court has been able to take up a progressive role to bring 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 violations of psychiatry with courage and conviction we find a complete absence of voice of clinical psychologists, at least with respect to the articles in their flagship journal**.

**Modernity’s new normal of violence and violations**

We would like to share an emblematic story of what is famously known as the Machang Lalung case (56, 57) which serves as a prototype in demonstrating the everyday violence by psy disciplines. There is poetic justice when NCERT XI standard political science text book uses this case to teach about fundamental rights.

A young man named Machang Lalung was only 23 when he was arrested by police in 1951 and was lodged in a premier psychiatric institution. As per the hospital version the police were intimated that he is fit for trial after 16 years, i.e. in 1967 and once again after a long gap of 49 years in 1996, but, allegedly, the police didn’t respond. Hence the institution found no other option other than to “rehabilitate” him for 54 long years until National Human Rights Commission had to pitch in to free him at the age of 77. This is where the hegemonic positioning of psy disciplines with the wider public in effect breeds cruel systems that widen the distance between the psychological experts and their subjects; the ‘experiencing’ experts. Conducting strictly according to established procedures, interventions got limited to waxing-waning official correspondences with the “concerned” authorities, viz., police. In order to conceal and censure dereliction of duty by the state, psychiatry and psychology easily aligned with it 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.

**Conclusion: Need for a critical perspective in psy disciplines**

Taken together, in the case of LGBT rights in India the mental health system appears to have blindly followed the state and judicial order until its stand was questioned by the judiciary and rights mechanisms. There is a dire need to reverse this trend where mental health scholarship aids the public and the judiciary to expand their consciousness on sufferings of marginalized groups. RPWD Act 2016 is a rights based anti-discriminatory law with penal provisions. It has many affirmative clauses such as reservation of 4 percent of jobs for disabled including mentally ill. 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. After the recent floods derailed Kerala, psychologists have rallied behind to provide mental health services for the affected. But no psychologist has spoken against the widespread environmental damage and loss of natural capital caused by indiscriminate quarrying, sand mining, tribal dispossession, massive deforestation due to predatory capitalism resulting in man-animal conflicts etc. in the context of Kerala even though researches have established that climate change increases mental health problems including suicide (58). Individual interventions by psychologists tend to be couched in a psychological language targeting disaster victims even though the disaster has significant political ramifications to be called a human-made disaster.

Stories of oppression, violence and human rights violations abound. Contemporarily, Honourable Supreme Court has been hearing crucial cases such as that of constitutional validity of section 497 of IPC on adultery that discriminates women which essentially pose mental health implications. The recent trend has been of the courts taking proactive measures. In August 2018 the apex court restrained the media against interviewing minor rape victims, observing that it has a serious impact on their mental health. There is a sheer lack of interest on the part of clinical psychologists and psychiatrists in bringing the ethics question into their ‘sciences’. Are their actions helping the poorest, the most vulnerable? If not, what is preventing them from denying cognitive justice (59) to themselves?

It is the overwhelming positivist tenets of psychiatry that mute transformative vision held by ethics and morality. We hope that psychiatry and clinical psychology would turn the analytical lens 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. Dainius Pūras[[4]](#endnote-4), himself a psychiatrist,actively involved for the past 30 years in transforming public health policies and services with special focus on 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 (60).If psychiatry wants to be really called as modern and progressive, it needs to include all the discourses and incorporate various points of view. Varied perspectives on healing, art and philosophy applied to suffering get drained in the midst of hyper-technical psychiatry which fails to tap the full range of human diversities. 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 psychological theories and praxis which would enable for a radical re-construction of people’s sufferings other than sugarcoating them.

Scholars in critical psychology have exhorted for decolonialisation of psychology mainly through three approaches: indigenization, accompaniment, and denaturalization. Indigenization approaches to decolonization seek normalization of indigenous forms of knowledge and practice as legitimate that mainstream science devalues or treats as illegitimate (61). Watkins moots the idea of psychosocialaccompanimentfor a paradigm shift in mainstream psychology through psychic decolonization of its practitioners to achieve an ethical foundation for research leading to transformative action enabling psychologists to empower the marginalized through social and environmental justice orientation and sustained attention to social roots of suffering. Drawing from liberation psychology, an alternative model has been presented in responding to oppression against coping which remains fundamental in mainstream psychology literature. It emphasizes on building critical consciousness of oppression and de-ideologisation of unjust status quo realities leading to paradigms of collective action as strategies for ensuring well-being (62). Denaturalization approaches to decolonization seek to disrupt both oppressive ways of being and the forms of knowledge that masquerade as natural standards in hegemonic psychological science. e.g. interrogating androcentric character of conventional standards within psychology such as “deficit model” accounts of women’s experiences (63).

Clinical psychology needs to put effort in enabling people to narrativise their experiences through stories for failure to tell a story is a terrible experience in itself because “the lives between normal and abnormal are often too personal” (45). Stories of suffering have no exceptions, no distinctions, as pain transcends all**.** To act as a powerful conscience builder for the psy disciplines let us invoke the legal maxim *audi alteram partem.*

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**Notes**

1. *Psy disciplines*refer to disciplines like psychiatric nursing, psychology, psychiatry and psychiatric social work which directly engage with study of mental health issues and its treatment. [↑](#endnote-ref-1)
2. For an expansive account of jurisprudence related to homosexuality in the Supreme Court of India see Naik,2017 (64). [↑](#endnote-ref-2)
3. Speech at the session titled *Ajeeb dastan hai yeh, kahan shuroo kahan khatam* at Pleasure, Politics and Pagalpan: National conference on Sexuality, Rights and Psychosocial Disability on 13 May 2017 in Kolkata. [↑](#endnote-ref-3)
4. Dainius Pūras 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. [↑](#endnote-ref-4)