**LGBTQIA+ rights, mental health systems and curative violence in India: Call for a metanoia**

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**Abstract**

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

*‘*“The formulation of a problem is far more often essential than its  
solution.”  
 -Albert Einstein

The death by suicides are almost always followed by front-staging of awareness generation about depression and its treatments by mainstream mental health professionals (1, 2, 3 ). The same vigour and vitality are absent in foregrounding the toxic landscapes of oppression, discrimination, disadvantage and deprivation that lead marginalized people to end their lives. Such disproportionate biomedical analysis of deaths by suicides are only ameliorative in scope that it is limited to widespread sloganeering about prevalence of ‘mental disorders’ and the need to seek expert ‘treatment’ . The consequence of such diagnostic analysis of breakneck speed is that mental distress which stems from social structures that make some people less human or non-human gets reified preventing transformatory change (4, 5). Given that psychiatric diagnoses lack robust explanatory power compared to other medical disciplines, it is hard to differentiate among distress, difficulty, disturbance and depression because no objective, bodily malfunction is identified in psychiatric diagnoses. Mental health professionals make socio-moral judgements about (un)acceptable ways of thinking, feeling and behaviour leading to misrecognition, misdiagnosis and overdiagnosis when meaningful responses to social injustice get diagnosed as mental disorders. (6, 7). Outlining the major limitations of aprioristic psychiatric diagnoses, scholars within psychiatry itself have argued that it is improper to use the term ‘comorbid’ in psychiatry as most of the psychiatric ‘diagnoses’ are not ‘diseases’ with a conclusive etiological factor but syndromes without definite etiology (8, 9). However, the issue of lack of scientific objectivity is brushed under the carpet in the popular discourse as mainstream psychologists and psychiatrists struggle to (re)claim their space within medical science preventing a human rights model of mental health. The plethora of webinars, social media posts and media articles by mainstream mental health professionals comprise of a linear, singular, simplistic, biomedical narrative that frame suicide as stemming from psychological disorders situated within the person to be treated with psychopharmaceuticals and individual therapies. These biased, psychocentric categorisations with an overstated focus on the individual causal factors at the cost of structural causal factors of suffering don’t give phenomenological quality, thus medicalizing mental health (10). This fear of social context among the mainstream mental health systems, comfortably erases the chronic unjust world that dominates the disruptive fabric of everyday life of people living in the margins of the social, thereby amplifying the voices and visibility of ‘expert’ mental health professionals . Psychiatric knowledge production and practice are vast and heterogenous with varied ontological, epistemological, axiological and methodological standpoints fraught with ambiguity in conceptualizing mind, mental health and ‘mental illness’. Very few mental health professionals are sensitive to acknowledge these alternative facts to press for a transformative and value-based change in dealing with mental suffering. Writing on psychiatry’s myopia of the social, cultural and the psychological, Braslow, Brekke and Levenson (2020) poignantly states that “clinical psychiatry has failed to systematically address the reality of mental illness as a liminal object, its multilevel nature, and how it is lived in everyday life” (11).

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

The death by suicide of Anjana Hareesh, (12, 13) a bisexual student from Kerala in May 2020 who underwent forced conversion therapy at the hands of mental health professionals in connivance with her family, provides a window to the world of our mental health systems that perpetuate domineering narratives of individualized, ameliorative interventions without voicing for transformative change of oppressive (colonial) institutionalized structures, like heteronormativity that systematically cause distress and harm to marginalized sections of people. A doctor, who terms homosexuality as “genetic mental disorder” and uses electric shock to treat gay and lesbian people, was summoned by a Delhi court in December 2018 (14). There are reports of curative violence on LGBTQIA+ people with hormone therapy, conversion therapy with ‘consent’ and prescribing psychopharmaceuticals for ‘depression’[[1]](#endnote-1) which are direct and implicit indictments that same sex intimacy is pathological to be set alright (15, 16). This needs to be read within the context of 2018 Supreme Court verdict which decriminalized not only same-sex love but also instructed mental health professionals not to pathologise LGBTQIA+ people cognizant of the tyranny of mental health systems in oppressing them. The apex court directed the mental health fraternity to think beyond the individual and initiate social change so that people with diverse sexualities thrive in a barrier-free environment (17).

Even though a miniscule number of mental health professionals have spoken aloud against unethical practice of conversion therapy within their fraternity (18), the mainstream Indian mental health community has been silent about the need to bring an LGBTQIA+ anti -discrimination law and a ban on conversion therapy[[2]](#endnote-2) signifying prioritization of ameliorative change that blames the victim for systemically induced suffering. History is repeating itself as mental health professionals largely remain out of the scene in speaking boldly for the realization of equal rights for LGBTQIA+ people (19). The position statements issued by the professional associations (Indian Association of Clinical Psychologists, Association of Psychiatric Social Work Professionals, Indian Psychiatric Society) (20, 21, 22) fall short of precocious reflection and proactive actions in striving for transformative change that shifts values and power relationships. Instead, they appear to be strategic and reactive actions to escape the moral and intellectual embarrassments caused by transgressions of their fraternity. It was only in 2018 the Indian Psychiatric Society came out with a statement asking its members to ‘stop considering homosexuality as an illness’ for the first time (23). Reports also suggest that there are divisions amongst the medical fraternity in India even now as to whether to consider homosexuality as an illness or not (24). In contrast, as had happened in the past (25, 26, 27, 28), human rights bodies and queer rights networks have demanded transformative policy changes to build an inclusive, free and equal society. e.g. a queer group approached the High Court of Kerala for a ban on conversion therapy after their complaints to the state mental health authority and health secretary were not responded to (29, 30). The UN Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity (hereafter SOGI) in his report called for a ban on conversion therapies citing experiential accounts of torture in the hands of mental health professionals including India (31).

**Resistance to transformative change: Queerphobic space-attitude administrative complex in Indian mental health systems**

One of the most unique directive in the judgement of the Supreme court was that it instructed the state to disseminate its landmark judgement widely so that the public becomes aware that it is natural to be different and that people of diverse sexualities enjoy constitutional protection as equal citizens. Justice R F Nariman wrote: “Union of India shall take all measures to ensure that this judgment is given wide publicity through the public media, which includes television, radio, print and online media at regular intervals, and initiate programs to reduce and finally eliminate the stigma associated with such persons”(17, 32). Most often, it is the popular discourse of heteronormativity that causes anxiety and confusion among parents regarding their children’s diverse sexual orientations leading them to consult mental health professionals (33) who find fault with LGBTQIA+ people’s brains and minds exhorting them to convert and ‘adjust’ with oppressive systems that breed distress (34, 35).

Unfortunately, there has been no such awareness campaigns in the country (36). Most people take what the doctors say into face value rather than what the Supreme Court said. Doctors are experience-near entities with lot of local authority compared to the Supreme Court, which slips as an experience-distant mechanism whose verdicts don’t generally percolate down to laypersons. A report published in June 2020 shows that the families, immediate acquaintances, religious leaders and alternate healers are important actors in addition to the medical establishments in perpetuating curative violence[[3]](#endnote-3) against LGBTQIA+ people in India “that aims to enforce conformity to binary norms of gender and sexuality or to suppress the expression of transgression in matters of gender and sexuality” (37). Rights based aSOGI chronic stress, , curative violence It is here that awareness campaigns on the Supreme Court judgement hold immense value to usher in communicative justice (38) and transformative change.

None of the government run mental health institutions including the three mental health institutions under the Government of India has initiated LGBTQIA+ rights-based awareness campaigns as directed by the top court when lack of awareness about sexualities in itself remains a critical factor for a non-inclusive environment (even at their own homes) that forces queer individuals to end their lives. This alignment with the queerphobic attitude of the state[[4]](#endnote-4) not only fails mental health institutions in their legal duty but also in their moral responsibility of atonement for notorious contribution to the oppression of LGBTQIA+ people by framing same-sex love as pathological (39) . The dominance of biomedical technocratic psychiatry at these institutions focusing on individual-level analysis at the cost of socio-political analyses compounds its troubled relationship with LGBTQIA+ people. For example, sexual orientation and gender identity intersect with gender, caste, class, disability, equitable access to employment, housing, education and health care to produce a wide array of social determinants of mental distress. The report submitted by the UN Independent Expert on protection against violence and discrimination based on SOGI in 2019 exhorts for recognition of intersectional nature of compounded discrimination and exclusion to promote multisectoral analysis and action programmes. The need for public policy to “mainstream LGBTQIA+ issues across wider programmes, such as health, education, employment, housing, poverty reduction, food security and access to justice” is emphasized (40). Nakkeeran & Nakkeeran (2018) supplies insight in understanding health inequity in the context of disability, mental health, SOGI as they mandate an inclusive social arrangement that celebrates difference for achieving health equity (41). A recent review article suggests that “a public policy targeting stigmatization of sexual minorities could impact positively on national suicide levels” as countries with low levels of LGBTQIA+ acceptance were found to be associated with higher suicide rates (42).

**Unwillingness to unlearn: Biocommunicability in mental health awareness**

The analysis of the websites of state-run mental health institutions which are the most vital public interfaces shows that mental health awareness gets restricted to individual specific disorders, symptoms and epidemiological surveys (e.g. the National Mental Health Survey). None of the legislative provisions of various rights-based, user-centric, affirmative mental health-related human rights mechanisms such as UN Convention on Rights of Persons with Disabilities[[5]](#endnote-5), Rights of Persons with Disabilities Act 2016[[6]](#endnote-6), apex court rulings around gender identity-sexuality-mental health axis, report of the UN Independent expert [on protection against violence and discrimination based on SOGI](https://www.ohchr.org/EN/Issues/SexualOrientationGender/Pages/Index.aspx) presented to the Human Rights Council, Bali declaration by persons with psychosocial disability and cross disability supporters,[[7]](#endnote-7) Yogyakarta principles on SOGI,[[8]](#endnote-8) National Human Rights Commission advisories [[9]](#endnote-9) etc. are available for public dissemination on the websites of the institutions under the ministry of health and family welfare, Government of India (43, 44, 45).

Taking the above said fast forward, it appears that resistance to even comply with Supreme Court’s order to create awareness about its judgement on same sex love that has the potential to improve the well-being of queer Indian citizens as a whole, stands testimony to a highly medicalizing tendency in mental health institutions. This is how neoliberal psychiatry tries to promote a particular way of  
understanding about mental health by dictating terms and conditions of not only treatment but also communication, which Kate Holland refers to as biocommunicability (46). Biocommunicability instils specific role for different actors to adopt about health knowledge posing a barrier to the development of  
multiple perspectives including that of the users of the services. “[T]he privileging of biomedical authority and patient–consumer models of biocommunicability serve the interests of policymakers in neoliberal governmental contexts in emphasizing the role of experts and individuals, and mainly eschewing the role of  
governments and social forces, in contributing to and addressing mental health challenges” (46). In the case of mental health, the prioritization of biomedical model of mental health (consisting mainly of psychiatric epidemiology, symptoms of disorders and individualized treatments) in awareness campaigns serves the purpose of biocommunicability where there is a lack of recognition of the fact that a person is constituted not only by the  physical body but also by the social and political body. The mental health communication on the websites of state run mental health institutions and the awareness posters don’t inaugurate an interactive, intersectional, preventive and promotional view of mental health as they comfortably ignore the upstream socio-structural determinants of mental health (47, 48, 49, 50, 51, 52).Exploring biocommunicability through public health discourse in one newspaper, Briggs and Hallin (2007) supplies caution:   **“**If the emergence of new forms of biomedical knowledge in laboratories, clinical trials, marketing departments, and other sites is indeed transforming “the politics of life itself,” then its projection as “news” warrants scrutiny for its role—along with that of pharmaceutical advertising—in shaping which aspects of this process will jump scale to become central features of public discourses and political imaginaries” (53). The resistance of mental health professionals to talk about LGBTQIA+ issues and mental health in the language of human rights in India contribute to hegemonic biomedical model in popular mental health communication. However there have been efforts by queer and disability right activists to offer alternative demedicalising countervoices to mainstream psychiatry's curative violence on LGBTQIA+ people in the form of social media campaigns, e.g. #QueersAgainstQuacks[[10]](#endnote-10) campaign in 2016 employing name and shame strategy and sharing of personal experiences. Sincere efforts by queer-friendly mental health professionals have also contributed to the counter- narratives to mainstream mental health practice by coming up with queer affirmative counselling modules (54).

**Queer constituencies and psy disciplines**

How we define a problem is of paramount ethical importance as it has far-reaching implications in mental health practice. “How we define a problem shapes the questions we ask, the  
methods we use to answer those questions, and the way we interpret those  
answers. And all those things affect the types of interventions we will consider” (55). Associations between mainstream psy fraternity and queer constituencies need to be viewed with caution particularly when it has become fashionable on the part of mental health fraternity to talk about LGBTQIA+ issues loosely in contemporary times situating the issue within the medical/health constituency without harnessing social and political support for multisectoral transformatory policy change. My research on community mental health programmes in Kerala found that these programmes don’t implement a rights-based, intersectional approach towards queer issues. Instead, they adopt a technocratic mode that seeks to absorb LGBTQIA+ persons as “patients” in need of their ‘expert treatment’. The coordinator of the programme, a government psychiatrist, told me, “LGBT population is not coming out in the open even though they have support groups. They need to approach us so that we can offer mental health services”. This rendering attests the fact that LGBTQIA+ issue is tackled as a medical problem rather than a human rights problem by the psychiatrist at the community mental health programme. The typical response is to provide ‘help’, which is individualized “therapy or interventions that strives to  
change disadvantaged individuals so that they can better adjust to unjust social  
conditions” (56). Such siloed interventions are only ameliorative than transformative in nature where the focus is limited to people affected by the system but not the system itself steeped in exclusionary tendencies.

**Need for a transformative change in mental health systems**

The most critical challenge before the decriminalized queer Indian people is that of enjoyment of equal rights which will not be possible if mental health professionals harbouring colonial queerphobia continue to hold on its medical authority and power with regard to LGBTQIA+ people. Without a mind of its own, the colonial medical knowledge framework in India is cisgendered, cissexual and heteronormative. The medical fraternity themselves have evidenced that their curriculum and strict dress codes are LGBTQIA+ discriminatory (57, 58). Such noncohesive registers of sexuality in medical colleges are potent to create queerphobia and ‘diseased love’ narrative concerning non-heteronormative intimacies among doctors and other health professionals which in turn negatively impact the lives of LGBTQIA+ people (59). Rianna Price in her article titled “*Medical Imagination: Homosexuality in the Indian Journal of Psychiatry. 1970-1980***”** which analyses the medicalization of homosexuality in post-independence India found that the “references section of the IJP articles predominantly relies on western medical journals and sources when creating a frame of reference for their own work. The seminal work of British psychiatrists, such as MacCulloch and Feldman, who wrote ‘Aversion Therapy in the Management of 43 Homosexuals’ (1967) is referenced and discussed within the text itself, as is the work of Richard Bancroft” (60).Commenting on Price’s work, Lucy Threadgold presses the point that the article “reminds the reader of the domination of western views in psychiatric and LGBTQ+ histories, showing the understanding of the influence these had and still have in academia” (61). This provide a strong case for raising awareness among the medical fraternity themselves about same-sex love and sexual diversities from a value-laden, decolonialised, human rights perspective. A doctor writing on the deep neglect of narrative medicine in India presses for an “adequate broadcast of native, home-grown perspective and stories regarding health care”(62). There is  
limited involvement of caregivers and service-users in planning, design, control and execution of mental health  
services in India reflecting on a need to shift from provider-centric to user-centric model of care (63).

**Conclusion**

Until and unless the mental health systems explicitly shift its hegemonic biomedical narrative and align with the human rights discourse on LGBTQIA+ issues advocating policy/social change, will continue to address systemic problems at an individual level without appreciating “how persons respond to contexts and how they can exercise power to change those contexts” (55). In the face of inertia to offer systemic solutions by the mental health systems, LGBTQIA+ groups should push for disengagement of mental health systems from addressing LGBTQIA+ issues through individualized medical solutions. As it has been proven beyond doubt that sexuality is a political and moral issue, shouldn’t mental health systems and awareness campaigns talk politics, social conflicts and human rights violations that pose critical challenges to mental health rather than acting as extended arms of the queerphobic state? Many lives could be saved if the gap between affirmative human rights mechanisms and their strict implementation could be bridged. Anjana Hareesh’s confrontation with the brutal conversion therapy is an outgrowth of the sheer diffidence of mental health systems to address oppressive political structures while seeking to improve personal experiences, reductionistic awareness campaigns being an example. This amounts to double violence that benefits the mental health economy that creates customers out of structural violence and human rights violations. It is high time that value-neutral, colonial, acontextual, apolitical, ahistorical and positivist psychiatric knowledge production and practice is resisted in defining every state of mind and every social problem as a psychiatric problem. To materialise this,we require a new psychiatric theory and praxis which is value-laden, decolonialised, contextual, political, historical and critical in defining mental health problems and solutions, for, political action is paramount in curing sickness. Rudolf Virchow, father of modern pathology puts it emphatically; "Medicine is a social science, and politics nothing but medicine at a larger scale".

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# Notes

1. This report published in 2020 offers a window to the experiences of LGBT people who have suffered in the hands of mental health professionals themselves. The following are some of the relevant excerpts: ““A Kerala-based psychiatrist who practises conversion therapy said, on condition of anonymity, that his patients “undergo the treatment willingly” as it’s “easier to live as a heterosexual individual”. According to him, many of his patients now have a family and children. But he admits that many of them return due to marital discord and are on endless medication for depression.A Hyderabad-based sexologist is equally confident. He offers different programmes tailored to ‘the severity of queerness’. “You can fix most homosexuals with hormone therapy. Psychiatric interventions have been successful in most cases I’ve treated. For example, testosterone injections can reverse same-sex desire to a great extent while some people respond to behavioural therapy.”” [↑](#endnote-ref-1)
2. There is a ban on conversion therapy in 5 countries, viz., Malta, Brazil, Taiwan, Ecuador and Germany. [↑](#endnote-ref-2)
3. In addition to conversion therapy, curative violence within the psychiatric establishment include behaviour therapies, electroconvulsive therapies, prescription of psychiatric drugs, sexual corrective surgery on intersex babies, corrective rape etc. “[C]urative violence is broad enough to include all forms of violence against LGBT+ people, since the very act of othering members of non-normative gender and sexual minorities instantiates the concomitance between violence and cure”(37). [↑](#endnote-ref-3)
4. When the Supreme Court judgement in 2013 recriminalised same sex love, it had passed the baton of responsibility of decriminalisation to the Parliament. Cognisant of this fact, Shashi Tharoor, Member of Parliament from Kerala, introduced two private member bills in the Lok Sabha which were not even allowed to be taken up for debate due to majoritarian resistance. A very recent instance which exposed the Indian government's queerphobia was when the Delhi High Court which is hearing case on gay marriage was told by the government in September 2020 that gay mariage is against Indian culture . See this report for details on the case. **Mandhani, A.** ‘Same-sex marriage not a part of our culture’, says top govt lawyer, opposes plea in Delhi HC. *The Print*. 2020 14 September. Available from: <https://theprint.in/judiciary/same-sex-marriage-not-a-part-of-our-culture-says-central-govt-opposes-plea-in-delhi-hc/502232/> [↑](#endnote-ref-4)
5. UN Convention on Rights of Persons with Disabilities (UNCRPD) has given a whole new transformatory language to speak about mental health care. The shift from mental illness to psychosocial disability as envisaged in the UNCRPD is a paradigm shift from biomedical model to the social model of mental health. It has moved the mental health discourses from the sole territory of the psychiatric infrastructures to every other stakeholders including those who are suffering from psychosocial disability. Even though India is a signatory to UNCRPD the government and the mental health systems in India have not welcomed UNCRPD wholeheartedly. The state report on implementation of UNCRPD which is to be submitted every year was submitted by India after a long gap of 10 years in 2018. The UNCRPD is available from <https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html> [↑](#endnote-ref-5)
6. Rights of Persons with Disabilities Act is an outgrowth of India’s ratification of UNCRPD. [↑](#endnote-ref-6)
7. Bali declaration by Transforming Communities for Inclusion- Asia Pacific adopted in 2018 at Bali, Indonesia calls for the implementation of UNCRPD for all persons with psychosocial disabilities. See the link to read the full text. <https://transformingcommunitiesforinclusion.wordpress.com/2018/10/01/full-text-of-the-bali-declaration/> [↑](#endnote-ref-7)
8. Yogyakarta principles, adopted in 2006 at Yogyakarta, Indonesia are a set of standards on the application of international human rights law with regard to sexual orientation and gender identity. See the link for more information. https://yogyakartaprinciples.org/ [↑](#endnote-ref-8)
9. # National Human Rights Commission came up with a human rights advisory for Protection of the Rights of LGBTQI+ community in context of COVID-19 pandemic on 19th October 2020. It can be accessed here: <https://nhrc.nic.in/sites/default/files/Advisory_for_the_Protection_of_the_Rights_of_LGBTQI%2B_Community_0.pdf>

   [↑](#endnote-ref-9)
10. #QueersAgainstQuacks was launched by Humsafar trust in 2016. For a nuanced understanding about demedicalising discouses in social media campaigns, see Tenneti, S. Discourses of (De)Medicalization in Social Media Awareness Campaigns on Homosexuality and Mental Illness. Peace Prints: South Asian Journal of Peacebuilding.2019; 5(1). Available from: <https://www.academia.edu/43853871/Discourses_of_De_Medicalization_in_Social_Media_Awareness_Campaigns_on_Homosexuality_and_Mental_Illness>

    [↑](#endnote-ref-10)