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LGBT MENTAL HEALTH: THE WAY FORWARD

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[4]

INTRODUCTION

India, in its National Health Policy 2017, envisions reaching the entire population in a comprehensive integrated manner by achieving universal, quality and affordable health coverage. Such a mandate would, therefore, necessarily include within its ambit citizens who are lesbian, gay, bisexual, and transgender (LGBT).

A major impediment to realizing such universal coverage for LGBT citizens is the stigma and discrimination they face in health care institutions and other contexts, because of their non-mainstream sexuality and/or gender identity. Such stigma and discrimination persists against gay, lesbian and bisexual persons despite international medical consensus (WHO 1992) that homosexuality is not a pathology but a normal variant of human sexuality. In the Indian context, three editorials (Rao and Jacob 2012, Rao and Jacob 2014; Rao et al. 2016) in the Indian Journal of Psychiatry reiterate that homosexual orientation is a normal variant of human sexuality, urge the mental health fraternity to challenge the widely prevalent prejudices in society and abandon unethical and unscientific practices such as conversion therapy/ reparative therapy for persons of homosexual/bisexual orientations or transgender identity. The Mental Healthcare Act, 2017 has also emphasized that no person shall be discriminated on the basis of sexual orientation or gender while accessing mental healthcare services from government institutions.

Moves towards abandoning the old psychopathological model are also evidenced in proposal of the ICD-11 Working Group on the Classification of Sexual Disorders and Sexual Health to reposition gender diagnoses by moving them out of "Mental and Behavioural Disorders." to "Conditions Related to Sexual Health" and renaming "Gender Identity Disorder" to "Gender Incongruence" (Drescher 2016).

Despite these official positions, stigma and outdated perceptions of LGBT issues are pervasive among healthcare providers, including mental health professionals, and are reflected in failure to provide unbiased and clinically competent care to members of these communities.

This situation of LGBT people and health care is further complicated by the legal scenario. India has two mutually contradictory Supreme Court decisions, the 2013 ruling (*Koushal vs. Naz Foundation and ors.* 2013) that upholds criminalisation of same-sex behavior *vide* Section 377 IPC and the *NALSA vs. Union of India and ors* (2014) ruling that upholds transgender rights and declares that discrimination based on sexual orientation and gender identity is unconstitutional. These legal ambiguities further the ambivalence that exists among the healthcare fraternity about LGBT communities: some fear that providing medical care can be viewed as abetting criminal activities, and others fear that procedures such as

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emasculation that are part of gender affirmative surgical procedures will place the providers in conflict with the law.

NEED FOR LGBT-AFFIRMING MENTAL HEALTH SERVICES

While non-normative sexual orientation and gender identity are not, by themselves, mental disorders, there is substantial evidence of higher prevalence of mental disorders among lesbian, gay and bisexual persons, attributable to minority stress (Meyer, 2003). Experiences of hostile and prejudiced social environments, expectations of rejection, having to conceal one's identity, and internalised prejudice, are among the factors contributing to stress for LGB (and by extension transgender and intersex) communities who experience themselves as minorities in a society that is heteronormative, cis- and binary gendered. Additionally, issues such as the criminalization of homosexuality and the heightened vulnerability to violence can magnify the minority stress faced by LGBT individuals.

Some of the issues we have encountered among LGBT clients seeking mental health care in the Indian context include: loneliness, inability to disclose one's orientation or identity, rejection or fear of rejection by close family members upon disclosure, marriage pressures - often intensified by parents when they find out their child is non-heterosexual, double-stigma related to being HIV positive and of a gender/sexual minority, and experiences of harassment, bullying and violence based on gender, sexuality or gender expression. For individuals who are transgender, a major source of distress arises from the incongruence of gender with assigned-sex. This distress, called gender dysphoria, requires diagnosis by a psychiatrist to enable them embark on procedures to realign body and mind, such as through endocrine therapy and surgical procedures for genital reconstruction.

There is, thus, a strong need for mental health providers to provide therapeutic support to LGBT individuals in need. In the context of transgender persons, this need has been formally articulated by the Government of Odisha in its draft Transgender Policy (SSEPD 2017) that mandates that transgender persons have access to quality health care facilities, goods and services, that government and private hospitals and facilities should develop transgender inclusive policies on registration, treatment, admissions, investigations and other medical services to prevent discrimination, harassment, abuse or exploitation while providing health care services, and that psychological counseling services to Transgender persons with regard to their gender transition especially during pre-operative and post-operative period.

HOW TO BE AN LGBT-AFFIRMING MENTAL HEALTH CARE PROVIDER?

i. Adopt a human-rights approach

There have historically been many human rights violations in the mental health profession, when it comes to services for LGBT persons. These have included unethical and unscientific practices such as electro-convulsive and other aversion therapies to try and change sexual orientation (India Today 2015, Patra 2016): practices that some psychiatrists engage in to this day.

A human rights based approach to mental health care for LGBT persons is needed because of the bi-directional nature of the two, i.e. human rights violations can adversely impact mental health, and conversely, respecting human rights can improve mental health (Mann et al. 2016).

Some elements of the client-provider relationship are listed below:

- **Respect client goals:** Respect for a person is widely considered to be one of the fundamental principles of bioethics. For some, it may involve primarily expressions of care, attention to needs, and an empathic response, whereas for others, the important aspect of respect may be providing information and allowing them to make autonomous decisions recognizing their individuality (Dickert and Kass 2009). A cautionary note: some LGBT clients, as a result of pervasive homophobia or transphobia, may state a desire to change their sexual orientation or gender identity. In such a situation, it is for the provider to explain to the patient that these cannot be changed by external intervention through any scientifically valid means. Needless to add, forceful application of conversion therapies is unethical (Patra 2016) and must not ever be attempted.
- **Respect need for confidentiality:** Considering the highly stigmatized nature of non-heterosexual and transgender identities, it is vital for mental health providers to respect their clients need for confidentiality. Special caution and attention to confidentiality needs to be taken when working with children, adolescents and young adults who may not have shared their concerns about sexual orientation or gender identity with their parents. Children and adolescents are particularly unlikely to share their intimate feelings with clinicians unless their wishes and sensitivities are recognized.
- **Unlearn personal biases:** Even providers who do not view homosexuality or alternative genders as pathological are sometime not free from biases. Towards providing an affirmative service, it is important that the mental health professionals unlearn their personal biases around gender roles, gender identity, sexual orientation, notions of 'normal' vs. 'abnormal', etc.

ii. Know your terminology: Terminology around LGBT issues is evolving and not always available in medical textbooks and guidelines. A partial glossary (Orinam 2014) is appended for ready reference. Terminology around clinical diagnoses is also evolving, as mentioned in a previous reference to term gender incongruence and gender dysphoria replacing the previous term gender identity disorder.

iii. Know the current best practices in psychiatric/counseling care of LGBT clients: The "Guidelines for Psychological Practice With Lesbian, Gay, and Bisexual Clients" (APA 2012) provide psychologists with a frame of reference for the treatment of lesbian, gay, and bisexual clients and basic information and further references in the areas of assessment, intervention, identity, relationships, diversity, education, training, and research. In the Indian context a guide to gay-affirmative counselling practices has been published by Ranade and Chakavorty (2013) from the Tata Institute of Social Sciences.

The World Professional Association for Transgender Health Standards of Care, 7th Version, provides clinical guidance for health professionals to assist transsexual, transgender, and gender nonconforming people in primary care, gynecologic and urologic care, reproductive options, voice and communication therapy, mental health services (e.g., assessment, counseling, psychotherapy), and hormonal and surgical treatments (WPATH 2011). In the Indian context, a good-practice guide to gender-affirmative care has been published recently (Sappho for Equality 2017).

iv. Learn about Legal versus Medical determination of gender identity: The Government of India, as per Hon'ble Supreme Court's NALSA judgement (April 2014), provides for legal recognition of gender identity based one's self-identification of one's gender as man, woman or transgender/third gender, without hormonal therapy or surgical process. The legal recognition process involves gender identity (and name) change affidavits, similar to name change process. Such a legal recognition may not require a clinical diagnosis of gender dysphoria or gender incongruence. In contrast, medical procedures such as endocrine therapy or genital reconstruction procedures sought by some (but not all) transgender persons, will require clinical determination of gender dysphoria. Psychiatrists should be aware that any insistence on hormone and surgical procedures for legal recognition of gender identity is not required by the government: further such insistence would be deemed illegal.

v. Establish links with community networks for two-way referrals: Many LGBT individuals facing distress on account of their sexual orientation or gender identity seek support from existing community collectives and networks. These networks would benefit greatly from knowing of LGBT-friendly psychiatrists to make referrals for individuals needing professional intervention. Conversely, individuals who first reach out to mental health professionals may benefit from peer support available on an ongoing basis. Make an effort to learn about such peer groups and networks in your area.

HOW TO BE AN LGBT- SUPPORTIVE PSYCHIATRIC ASSOCIATION

i. Advocate for LGBT content in professional training: LGBT issues in psychiatric curricula are currently limited. There is a dire need to go beyond diagnostic criteria for gender diagnoses, and include LGBT-relevant content in undergraduate, post-graduate and continuing-medical education. Professional associations such as the Indian Psychiatric Society and its Odisha chapter can play key roles in advocating for inclusion of such content.

ii. Advocate for adopting standard guidelines for LGBT mental health care: There is a need to collate existing best practices to develop standard guidelines for LGBT mental health care in the Indian context. In the context of transgender mental health care, it is important to factor in cultural specificities such as identification as a 'third' gender (associated with hijra communities), that are absent in international diagnoses.

iii. Expand the network of LGBT-friendly psychiatrists: Currently most psychiatrists exposed to LGBT issues and clientele are located in urban areas. There is an urgent need to include LGBT-focused training among practitioners in rural areas as well, and build linkages with existing resources such as the Adolescent Reproductive and Sexual Health (ARSH) clinics in the government system so as to cater to the needs of LGBT individuals in rural areas.

TERMINOLOGY: A PRIMER (excerpted from Orinam 2014)

We provide here some basic concepts relating to sex, gender, sexuality and gender identity relevant to mental health professionals, as we have noted confusion even among clinicians, around these terms.

Sex: The assignation of an individual as male, female or intersex, typically made at birth, based on externally visible body parts, anatomy, tissues and/or chromosomes.

Intersex: Intersex conditions may sometimes be identified at birth based on ambiguous genitals. In other cases, they are identified through karyotyping (analysis of chromosomes) to reveal XXY [Klinefelter syndrome], XO [Turner syndrome] and other conditions. Apart from these, there are other conditions such as Androgen Insensitivity Syndrome where cells of an XY foetus do not respond, or respond only partially, to androgens and the individual develops with female anatomy. The proportion of people whose bodies differ from male or female body norms has been estimated to be about one in 100 individuals as per a review of several studies. (Blackless, et al. 2000)

Gender: Refers to socio-cultural attributes and behaviors typically associated with one's sex assigned at birth. Gender-associated expectations are often imposed on individuals without their consent. Both children and adults are encouraged or coerced to perform in ways consistent with the gender expected of them.

Gender identity: A person's internal sense of being a man, a woman, neither of these, both, and so on. It may or may not be aligned with the sex assigned at birth. Two terms to note here are: the terms *cisgender* refers to those whose sex and gender-identity are aligned. The term *transgender* refers to people whose sex and gender-identity are non-aligned. They may be binary, identifying as men or women, or they may embrace a gender-queer or other non-binary identity. For yet others, gender identity may be fluid, or even absent.

Gender expression: The ways in which a person manifests masculinity, femininity, both, or neither, through appearance, behaviour, dress, speech patterns, and more—that is, masculine, feminine, androgynous, agender, etc. The cultural expectation is that one's biological sex, gender identity, and gender expression will align in stereotypical ways: that someone who is male will identify as a boy/man and have a masculine gender expression, for example.

Sexual orientation: It describes the pattern of a person's **sexual attractions** based on their own gender and in reference to the gender of the people they are attracted to. Terms such as *heterosexuality* (exclusive attraction to the other gender) and *homosexuality* (exclusive attraction to the same gender) are concepts denoting extremes of a continuum of attractions. Other orientations include *Bisexuality,* refers to attraction to more than one gender. *Pansexual,* refers to attraction to people regardless of their gender. *Asexual*, refers to being not sexually attracted to anyone and/or no desire to act on attraction to anyone. Asexual people sometimes do experience romantic attraction and not sexual attraction. *Questioning* refers to *a* term used by someone who is unsure of or exploring their sexual orientation.

Sexual identity: How one identifies. Sexual identity may or may not be aligned with sexual orientation. Terms such as gay and lesbian (identity terms corresponding to homosexual orientation) or **straigh**t (identity term corresponding to heterosexual orientation), have gained currency in recent years. However many people do not identify with these terms.

Sexual behavior: Refers to the actual sexual acts performed by the individual. These may or may not be aligned with sexual orientation or identity, may vary over time, may be situational, subject to social pressures, etc. Thus, for example: *a heterosexually oriented person* may be abstinent for religious or other reasons, *a homosexually oriented person* may engage sexually with a spouse of the other gender, having been forced into marriage, a person may be *bisexually oriented* and engage sexually with just the one individual with whom he/she is in relationship with.

Transgender: All persons whose own sense of gender does not match with the gender assigned to them at birth. In the Indian context, it includes trans-men and trans-women, genderqueers and a number of socio cultural identities, such as kinnar, hijra, ranga, maichiya, aravanis, jogtas, etc. whether or not they have undergone sex reassignment surgery or hormonal treatment or laser therapy, etc.

Hijra: Individuals assigned male at birth who reject their 'masculine' identity in due course of time to identify either as women, or "not-men", or "in-between man and woman", or "neither man nor woman". Hijras have a long tradition/culture and have strong social ties formalized through a ritual called "reet" (becoming a member of Hijra community). There are regional variations in the use of terms referred to Hijras, for example, Kinnars (Delhi, Rajasthan, and Odisha), Aravanis and Thirunangais (Tamil Nadu).

Eunuch: Originally, this term referred to males who had been castrated/emasculated. In India, this term is commonly used to denote Hijras. But all Hijras are not eunuchs, nor are all eunuchs are Hijras. The Ministry of Social Justice and Empowerment, Govt. of India, recommends not using this term for hijras or other transgender people, and many hijras consider this term inappropriate.

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