Framing Queer Mental Health: from deviant subjects to knowledge producers

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Within the public health discourse as well as within psyche disciplines (disciplines related to the study of mind and behaviour, including psychology, psychoanalysis, psychiatry, psychiatric social work, psychiatric nursing), mental health of queer persons has traditionally been framed in clinical terms. We are familiar with the history of pathologicalisation of homosexuality, wherein homosexuality was seen as a form of mental illness, often connected with traumatic childhood experiences or absence of appropriate role models - a cold and distant father and an over indulgent mother. While the idea of homosexuality as mental illness has undergone a lot of change in the past few decades within the psyche disciplines, in clinical terms, the idea of pathologicalisation has been replaced by the public health idea of the homosexual as risk for certain kinds of sexually transmitted illnesses. Transwomen and hijras were added to the group of 'populations' considered to be at high risk for HIV/AIDS in the Indian context in the National AIDS Control Policy III, 2007-2012 (NACO, 2007). Thus while homosexuality ceased to be pathological since the 1980s, the MSM (referring to a behavioural as opposed to an identity category) and the transwoman, particularly the sex-worker transwoman or male sex worker, re-entered the clinical, although this time not as a medical deviant/pathological but as persons whose 'risky behaviours' needed medical intervention and correction. This conception of 'at risk' population/group, is based on the notion of the deficient individual (for instance, by way of a 'promiscuous' lifestyle) and attributing the same to all persons belonging to that group.

What came next is the 'vulnerability' model that foregrounds the role of social structures and inequalities in making some groups more vulnerable to illness. The vulnerability models of health and mental health suggest that experiences of violence, victimisation, criminality, restricted life opportunities can seriously compromise well-being. From this lens one would argue that at one point in the history of HIV interventions in India, populations considered to be at highest risk for HIV i.e. MSM, transwomen, female sex workers and injectable drug users were groups, all of whom were associated with criminality based on their behaviours, sexual or otherwise, and their occupation. This core idea
of the vulnerability model is reflected in other ways of thinking about distress and well-being, for instance the sexual minority stress model proposed by Meyer that refers to psychological distress that is a result of the stigma, discrimination, violence experienced by sexual minority individuals as a result of their sexuality. Minority stressors are conceptualized by Meyer as internalized homophobia, that refers to the ‘gay person’s directing negative societal attitudes towards the self, leading to a devaluation of the self and resultant internal conflicts and poor self-regard’ (Meyer and Dean 1998, p.161), stigma that relates to expectations of rejection and discrimination, and actual experiences of discrimination and violence (Meyer 1995). Studies using the minority stress framework have suggested higher rates of depression, substance use disorders and suicide and self-harm among LGBTQ populations (Sivasubramanian et al. 2011; Cochran et al. 2003)

More recently, studies informed by the syndemics theory that describes clustering of a range of psychosocial health and mental health problems, have suggested a co-occurrence of psychosocial health conditions (depression, frequent alcohol use, and victimisation) among MSM and trans women in India (Chakrapani, 2015).

Whether individualising distress and locating it within individual psyche or viewing it as an interplay of a range of psychosocial disadvantages, all of the above are ways of talking about health and mental health of queer and trans persons in clinical terms that are often a combination of the risk-vulnerability logic of understanding mental wellness and illness among minority/marginalised communities. I would like to draw attention to the fact that these epidemiological descriptions and explanations of mental illness and distress among LGBTQ co-exist with a rich, burgeoning discourse of lived experiences day-to-day anxieties, challenges and celebrations of living, negotiating, surviving and thriving while existing outside the norm of naturalised heterosexuality or the gender binary. These include for instance, daily challenges of trans persons figuring out which public toilet or security queue to use to avoid violence; the extra cognitive and affective work that a queer person does while entering a new space - a college campus or a workplace of figuring out who to and whether to come out and who and what will they stand to lose by coming out or the everyday negotiation done by the young lesbian woman to resist pressures of heterosexual marriage.

This kind of writing about one’s own experiences as a Queer/Trans person in the form of first person narratives, anthologies or biographies has been used as a tool for making visible lives and realities that have been hitherto invisibilised/erased/silenced, as also a tool to challenge ‘expert’ narratives and knowledges about our lives. The idea of experiential knowledge has challenged misrepresentation within academia as well as public policy and has enabled solidarities within the queer/trans communities as also with allies and with family members and peers. Experiential accounts are useful to build empathy and understanding across difference and reduce isolation/loneliness/alienation.

There is of course the challenge with use of experience as knowledge - that of fetishising what is seen as a non-normative/minority experience, as also of that experience being co-opted by dominant interests.

Apart from offering experience as knowledge, queer and transpersons, starting from the point of experience generate critical knowledge by interpreting experience to talk back to, talk with or negotiate with existing paradigms of knowledge that are steeped in ideas of naturalised heterosexuality and binary understanding of gender. When doing my study from which I developed an analysis on growing up gay’ in urban India, I attempted to pose a challenge to existing discourses of child development and life span studies from a queer perspective. One of my propositions was that most conceptions of childhood within western psychology, imagine the child to be growing up within families and within the domestic/private sphere unmoled by exigencies of public life. This notion of the happy, innocent, pure childhood is somewhat destabilised when discussing the deviant child, the orphan child, the refugee child, the child in conflict with law or in need of care and protection. Even in reference to the deviant child, who is seen as ‘vulnerable’ and in need of state protection/correction/control, the norms of heterosexuality and gender binarism are firmly in place through for instance, institutions meant for boys and girls and a complete erasure of queer or trans possibilities. The other challenge I posed in the book is to the idea of life stages within life span studies that divides the life span from birth to death and prescribes certain milestones to be achieved for each life stage. A cultural psychology critique of life span studies has already posed critical questions of whether the life span can be neatly divided into early, late childhood, adolescence and young adulthood, when in fact majority girl children in India, for instance, receive extensive training in their natal homes in becoming good wives and mothers, and their life experiences at the parental home, such as primary responsibility for sibling care, exposes them early to the role of motherhood.

Sarawathi (1999), therefore, states that “adolescence is the invention of a technological, industrial society that is marked by a discontinuity between childhood and adulthood” (p. 214).

Speaking from a queer and trans experience to propositions of life span studies, one may ask the primary question of whether the prescriptions of normative development apply to queer and trans lives that may follow a fairly imaginative life schedule and may particularly deviate from the social calendar of birth, education, job, marriage, children and so on. What happens to the linear notion of time within growing up/ developmental psychology literature, when one looks at Queer Time (Halberstam, 2005). What would the developmental milestones be like for a lesbian woman who after a decade of heterosexual marriage steps out of it? What about achieving of prescribed milestones for the trans person who finally at the age of 40 is able to live their life in their own gender and leave behind the gender assigned to them at birth? Would they be seen as having delayed development?

The other example I use to talk about queer perspective informing praxis is the work I have been doing with a group of us on making the queer and trans experience count in mainstream counselling or therapeutic work. When I and Shruti first wrote about Gay Affirmative Counselling Practice , it was motivated by the fact that while there was rampant harmful practice around in the form of conversion/ reparative treatments to cure
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homosexuality and pathologize gender identity disorder, there was also a lot of ‘neutral’ practice i.e. the claim by the clinician that the client’s sexual orientation does not matter to me and that it is entirely client’s private matter. We therefore started from a point of saying that being neutral in a homonegative and trans-prejudiced world is simply not an option and that it causes as much harm and hence an affirmative stance towards nonnormative genders and sexualities is the only acceptable form of support. In our initial formulation, which has undergone changes, we primarily set out to point to heteronormative and gender binary assumptions in a seemingly neutral space of counselling, for instance the mental health professional keeping a photograph of their child on their desk, keeping volumes of marriage counselling in their consulting room, having two columns for gender or having a question on marital status in their intake forms with a total absence of any queer/ trans inclusive image, resource in their clinic. This we acknowledged was a reflection of the mainstream training and curriculum within the psy disciplines. Since doing this work for the first time in early 2010, we have subsequently developed and are in the process of working on specific training inputs, especially for cis-het mental health care providers such as understanding gender and sexuality as social structures, self-reflexivity, morality and sexuality, paradigms informing queer affirmative counselling practice and so on. I think these kinds of efforts have the potential to frame situated and inclusive conversations around queer/ trans mental health.

End Note
1 Of course the homosexual man.

References:


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