

QUEER AFFIRMATIVE COUNSELLING PRACTICE (QACP)

A RESOURCE BOOK FOR MENTAL HEALTH PRACTITIONERS IN INDIA

Ketki Ranade / Shruti Chakravarty / Pooja Nair / Gauri Shringarpure

mariwala health initiative

Queer Affirmative Counselling Practice (QACP)

A Resource Book for Mental Health Practitioners in India

PRESENTED BY
Mariwala Health Initiative

CITATION
Ranade, K., Chakravarty, S., Nair, P., Shringarpure, G. (2022). Queer Affirmative Counselling Practice - A Resource Book for Mental Health Practitioners in India, Mumbai: Mariwala Health Initiative

COPY EDITOR
Smriti Nevatia

DESIGN & ART DIRECTION
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www.anujakhokhani.com

ILLUSTRATIONS
Parth Pawar [pg 34, 82, 392]
Shubham Bose Roy [pg 162, 204, 304]

TYPEFACES
Besom by Gatis Vilaks, Krisijanis
Boston Traffic by Vic Fieger
Roboto by Christian Robertson
Ultra & Special Elite by Astigmatic

ICONS
Flaticon

PRINTED BY
Trikkon SK [Instagram: @trikkon_sk]
Printed in Mumbai

PUBLICATION DATE
May, 2022

PROJECT COORDINATOR
Aashima Sodhi

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Publisher: Mariwala Health Foundation

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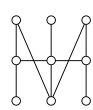
ISBN
978-81-947894-0-6

This book is dedicated to the many QACP course participants, across different cities and towns, who participated wholeheartedly, shared generously, co-created safe space for each one of us in the QACP classrooms, and set an admirable example of mental health practitioner self-reflexivity.





director's foreword

In 2014, India took a major step toward gender equality with the National Legal Services Authority (NALSA) judgement by affirming the right to self-identification of gender and in 2018, the Supreme Court read down Sec 377 and decriminalised sex between consenting adults. Both judgements referenced the need to address stigma, discrimination and the right to health. LGBTQ+ activism has tirelessly pushed for changes and rights such as this judgement and NALSA, but the mental health community has a long way to go in this matter.

While the Mental Health Care Act (2017) called for non-discrimination on the grounds of gender and sexuality, the Indian Psychiatric Society (IPS), widely considered an apex body, took until July 2018 to issue a statement saying homosexuality is not an illness. Despite this position, homonegative and transnegative attitudes and practices continue to dominate mental health in India past 2021. This ranges from conversion practices and institutionalised violence against LGBTQI+ folx to unchanging medical curricula and discrimination against queer-trans mental health professionals. While the law mandates 'queer-friendly' and discrimination free mental health services for the LGBTQI+ community, is this enough to make amends for history and entrenched pathologisation of queer-trans identities?

While 'queer-friendly' services and approaches may not be actively transnegative or homonegative, the lens would still be markedly cis-heterosexual, because the psy-disciplines are moored in the

roots of structural gender and sexual oppression. To illustrate, when the IPS shared its position on homosexuality, the IPS President stated “Some individuals are just not cut out to be heterosexuals…” This is an incomplete, incorrect and harmful gaze.

To systemically counter this legacy of violence and discrimination - mental health practice must be informed by and centre the needs of queer-trans folx. Implicit bias and inequity has been built into the psy-disciplines and needs to be dismantled in approach, curricula and practice. This is what we mean when we say this that there is need to shift from being queer friendly, to being queer affirmative.

To that end, MHI reached out to our Chief Advisor, Dr Shruti Chakravarty, a queer mental health professional to address this need. A core team of queer/trans mental health practitioners of KP, Shruti, Pooja and Gauri came together to develop a training for qualified practitioners. Apart from being queer-trans, this core team were all part of feminist movements where knowledge from the margins of gender and sexuality and queer-feminist politics gave direction on how to make therapeutic work affirmative and responsive to queer/trans clients.

The first QACP course was launched in February 2019 in Bombay, in less than 6 months after the judgement. In the very first year, 100 MHPs from across 8 cities completed the QACP course. We moved the course online during the pandemic and till date 350+MHPs have been trained across 40+locations. Three years since the first

QACP course, we are publishing the Queer Affirmative Counselling Practice Resource Book that has emerged from these trainings so that practitioners can have access to queer-affirmative curriculum to educate and inform themselves on responsive and responsible practice with the LGBTQI+ community.

However, in the same breath, it is important to acknowledge that our restitution and responsibilities extend beyond the therapy room. To be queer affirmative is to also challenge this pervasive structural violence in institutional, societal and individual settings.

This is why, I am proud to say that the QACP cohort made up of those practitioners who have completed the QACP course, has displayed consistent allyship towards the LGBTQI+ community. In 2019, after the death of Chinnu Sulfikar/Anjana Harish due to conversion therapy, members of the QACP cohort advocated within their formal associations to put out statements against conversion therapy.

On The International Day Against Homophobia, Biphobia, and Transphobia (IDAHOBIT) 2019, the QACP cohort circulated a petition against Conversion therapy that was signed by 1200 MHPs. During Pride Month 2020, several MHPs of the QACP cohort created resources on LGBTQI+ mental health and the need and importance of queer affirmative practice. Such was the volume of their work that MHI released a new tab on our website (https://mhi.org.in/qacp/) dedicated solely to QACP. This tab now hosts over 100+ videos, podcasts, articles, infographics, petitions & formal statements, lists of (150+) queer affirmative practitioners, peer supporters and queer-trans organisations and collectives. It is a one-stop resource for LGBTQI+ mental health. Pride Month 2021 continued to see the creation of more resources by the QACP cohort. In the Madras High Court Judgement on LGBTQI+ rights in June 2021, the court appointed MHPs were also members of the

QACP cohort. We documented their insights and learnings from this process into a report (Building Allyship: The Mental Health Community & LGBTQI+ Rights).

Thus, in these 3 years since the judgement came out, we have had some important milestones. The QACP course did not remain a 6-day course but through its participants, the QACP cohort, it took on a life outside the classroom, in the real world pushing for social change and justice. In just 3 years, we have gone from asking through whisper networks on who is a 'safe' MHP for the LGBTQI+ community to openly requesting for queer affirmative practioners. For all the years of absence or harmful practice in mental health, the LGBTQI+ community has relied on its own strong support systems. These support systems are as necessary and critical as formal mental health support. So, other than QACP, MHI has courses on peer support practice in partnership with queer collectives all over India and more, recently, in partnership with the Ministry of Social Justice and Empowerment in Kerala.

We have moved from the innocuous LGBT-friendly to a sharply political stand of queer affirmative. This journey makes us proud and also humbled by the queer labour that goes into such work. Without a doubt, where we are today with QACP would not have been possible for what came before us- the years of activism and relentless push for rights by queer-trans communities and collectives. We hope that this QACP Resource Book will contribute to not just direct therapeutic work that is responsive to queer/trans clients but also more activism - not just on queer-trans issues but to dismantle structural casteism, racism, ableism and other systemic forms of discrimination in health systems and beyond.

Raj Mariwala
Director

con-tents

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About the Authors

Ketki Ranade/KP,[1] PhD, (genderqueer; pronouns: they, them) is faculty member, Centre for Health and Mental Health, School of Social Work, Tata Institute of Social Sciences (TISS), Mumbai. They have worked for almost a decade as a mental health service provider with queer and trans clients, and developed community mental health programmes in low-income urban settlements and institutions such as the Beggar's Home and Family Court in Pune and Bombay. Since 2010, KP has been teaching at TISS in areas such as clinical social work, mental health law, policy and advocacy, queer affirmative mental health interventions, and research methodology. They have conducted research and published extensively in the area of gender-sexuality and mental health, and also served on committees of the Ministry of Social Justice and Empowerment, GOI, to develop status and planning documents for trans inclusion. They continue to advocate for queer and trans inclusion in institutions of higher education. KP was part of the faculty for the QACP Course between 2019-20. They were a member of the Bombay-based LABIA – A Queer Feminist LBT Collective (2010-21), and have learnt all that they know about queer feminist politics and solidarities from this collective.

Shruti Chakravarty, PhD, (cis woman; pronouns: she, her) has 20 years of experience in the non-profit sector, as a mental health practitioner, researcher, trainer, and social worker. Her areas of engagement have been mental health, gender and sexuality, from a rights-based perspective. She has an independent therapeutic practice

About the Authors

based in Bombay, has in-depth experience working with LGBTQ+ clients in the therapeutic space, and has co-authored a training manual on Gay Affirmative Counselling Practice. She has completed her PhD on the subject of queer intimacies from Tata Institute of Social Sciences. Shruti is Chief Advisor at Mariwala Health Initiative (MHI), and a faculty member of their Queer Affirmative Counselling Practice (QACP) Course.

Pooja Nair (cis woman; pronouns: she, her) has been part of the non-profit sector for over a decade. She has worked as a researcher, documentation consultant, trainer, and counsellor. She has an MPhil from Tata Institute of Social Sciences, and has worked in the areas of life-skills training, curriculum development, feminist theory, gender, sexuality, violence, and child sexual abuse. Pooja is a faculty member of Mariwala Health Initiative's (MHI's) Queer Affirmative Counselling Practice Course, in addition to practicing independently as a psychotherapist.

Gauri Shringarpure (cis woman; pronouns: she/her) is a queer mental health practitioner with a private practice in Thane. She is an experienced gender-sexuality trainer, having conducted trainings in colleges, and for the National Service Scheme (NSS). She is a positive psychology practitioner, and active in conducting workshops on mental health and self-care. Gauri is also a consumer behaviour consultant and researcher, with over 20 years of experience in the field.

CHAPTER 1

Setting the Scene: An Introduction

This introductory chapter is to give the readers a sense of who we are and why we have developed a course, and now this resource book, on Queer Affirmative Counselling Practice (QACP) for mental health practitioners (MHPs) in India. This chapter will also engage with the questions of how, which relate to the process and method adopted in developing the QACP course, and to what readers may expect from this book. All of these questions are deeply intertwined, since our location – who we are – intimately informs and is informed by the why (rationale), how (process), and what (content) of this book. We must acknowledge at the outset that very few people are granted an opportunity wherein who they are can be completely reflected in why, what, and how they create. It is in the context of this opportunity that a section on our relationship with our funder-partner (and publisher of this resource book) is included in this chapter.

The QACP Resource Book is the result of a six-day QACP Course that was conducted between February 2019 and February 2020 in the cities of Mumbai, Bangalore, and Delhi, with more than 100 practitioners from over ten cities participating in the courses.

1.1 Who are we? Locating the authors



My birth/legal name is Ketki Ranade. I identify/disidentify with it as much as I identify/disidentify with the gender assigned to me at birth. I identify (without any "ambivalence" there) as a genderqueer, non-heterosexual person, use the pronoun they and the name KP, in as many professional and social contexts as I can. My gender-sexuality location has influenced the ways in which I have occupied spaces within the psy disciplines, as trainee, as mental health practitioner, researcher, activist, and now academic.

Amidst (mainly) invisibility in my social, as well as professional training milieus, I first encountered the "abnormal homosexual" in need of treatment at the Behavioural Medicine Unit of a premier mental hospital and teaching institution in the early 2000s, where I was a trainee. This traumatic encounter led to some of my initial research work on "conversion treatments"[2] meted out to homosexual men in India. This was the first in a series of engagements aimed at exposing institutionalised homoprejudice and harmful practice towards queer clients within the clinic. Looking back, I see some of this work that I started as a young (I was 23), queer, mental health professional as coming from a place of anger and anguish. However, as a therapist working with queer and trans clients for almost a

decade in an NGO-run clinic, negotiating a range of harmful practices existing in the mental health field even as I worked towards healing and support, I also came across many accounts of compassionate, empathetic and supportive counsellors. These were people trained in the same curricula that was steeped in homoprejudice; yet they were challenging it in their everyday practice and making an effort – in the absence of queer affirmative training or supervision – to be supportive of their gay and lesbian clients. This inspired the task of collating good practices among mental health professionals that are affirmative of their gay clients. In many ways, the QACP course and this book develop further on this foundational work on Gay Affirmative Counselling[3] that I worked on between 2009-13. The affect associated with this work, for me, moved on from anger and anguish to a spirit of co-creation, solidarity and allyship, along with a continuing critical engagement with (at times posing challenges to) the mainstream psy[4] disciplines and practice.

The healing energy this work demands comes also from two other projects I have been involved with in the recent past: one, a study[5] about the journeys that parents and siblings with gay and lesbian family members undertake in making sense of non-heteronormative sexualities; the second, my book titled 'Growing Up Gay in Urban India'[6] that documents narratives of young gay and lesbian individuals growing up in the 1980s and early '90s in the cities of Bombay and Pune. Moreover, my friendships within queer communities and collectives have given life to this work: through my membership of LABIA – A Queer Feminist LBT Collective, in Bombay; and through the young queer and trans students I meet in my classrooms at TISS, besides the many generous practitioner-participants of the QACP course.



I was first introduced to feminism in 2001 as part of my Master's degree at Tata Institute Of Social Sciences (TISS). It was also at the same time that I started realising I was not heterosexual. In a quest to understand myself better I stumbled upon two feminist collectives in Bombay – Forum Against Oppression of Women and Stree Sangam – through both of which I was introduced to the autonomous women's movement, the queer movements, and the progressive politics that shaped my identity as a queer feminist activist. I identify as lesbian, more specifically butch cis lesbian. My lived reality, intimate relationships and gender expressions are different from those conventionally expected of a person assigned gender female at birth. I am also a queer affirmative MHP – my politics as well as lived reality inform the therapeutic values and interventions in my practice.

These three identities of mine (activist, lesbian, MHP) are important to me and, over the years, have begun to fit well with each other. I strive to understand realities by examining the power relations that exist in our social locations, identities and structures. Being assigned gender female at birth as well as being lesbian places me at certain margins, from where I can challenge these power hierarchies. These identities mean, further, that I am aware of my own positions of privilege – of being cisgender, urban, English-educated, able-bodied, assigned Hindu at birth, and from a savarna caste background. What I bring to QACP and to this resource book is my perspective, my lived reality and my therapeutic work, which means that I situate the analysis of power in the centre of the frame. It is not an equal world when it comes to gender-sexuality, and I have dedicated 20 years thus far in wanting to change that equation: I am a trainer and researcher; I have co-

published research studies, papers, an anthology of queer writing, and the Gay Affirmative Counselling Practice (GACP) training manual; I am Chief Advisor at Mariwala Health Initiative and have completed my PhD (on queer intimacies) from TISS.

I had no idea, when Mariwala Health Initiative first approached me in December 2018 to work on LGBTQ+ mental health, that it would turn into this phenomenal journey. I had been a trainer in Gay Affirmative Counselling Practice for several years, and was actually looking to hand over these trainings on gender-sexuality and mental health to younger trainers. What happened instead was that I had to go looking for a team of people who might be interested in furthering this! I approached KP since they had been key to developing GACP, and were an academic in the area of mental health with many years of teaching and training experience. And I approached Gauri and Pooja who, as MHPs, had both training experience and mental health knowledge. This core team of four persons was politically aligned and queer/trans. I did not want to lose sight of another goal – to mentor and train younger people on sexuality-gender and mental health. So I approached two MHPs who were queer/trans identified to begin training with us. This was how our core group of four faculty and two trainee-trainers emerged, and in 2019 we delivered the QACP Course as one team. Thanks to my activism, I have been steeped in collective politics. How a diverse team of people can professionally engage with each other, using the principles and values of collective functioning, became an endeavour from which I learned much. The process of QACP and the writing of this book have been stupendous for me, bringing together my identities with my work.



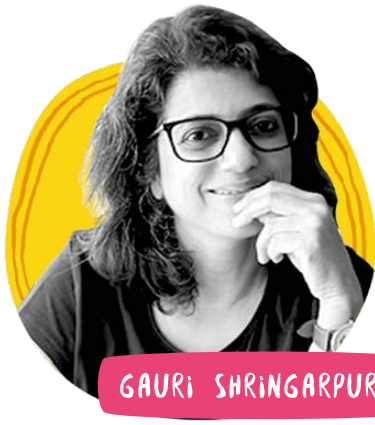
Becoming part of QACP has been the culmination of an incredibly arduous journey – over 12 years in the making, or perhaps this lifetime thus far. I have put into this course everything I have and everything I know: my identity as a femme lesbian; my studies in feminist theory and research; my training as a counsellor; my experience as a person living with mental health challenges. Funnily enough, this is nothing compared to what I have gotten out of it – a recognisable shape and form to my own self. I have, for long, carried within me a sense of not being "authentically" queer because of my gender, gender presentation, and life choices. I am a cis woman and my gender expression is "very" feminine, and how can that exist for anything except male consumption? I have lost count of the times I have asked myself if I was queer enough. I use the term rehabilitable to describe someone like myself, suggesting that all hope is not lost: I can still return to the heterosexual fold. I remember thinking in college that if I was attracted to masculine women, maybe that meant that I was just a different kind of heterosexual, a hybrid perhaps! Many life decisions and life circumstances made the possibilities of living a queer life rather dim.

So here I was, a confirmed homosexual (to myself), but with no clue that I could actually live a queer life. Questions of validity and authenticity are not just struggles for and of identity, but may also be barriers to shaping a life of your own choosing. In the world of compulsory heterosexuality, the struggles of gender-conforming cis and queer persons are often of a different kind – especially if you are a cis woman who has struggled with sadness often. We (the QACP core team) have described such a struggle, or effort, as a labour of

love. This description has multiple meanings for me. The project has been a labour of my love for and with my partner as well. Shruti and I have loved and fought each other through the entire process. The work we have done together at QACP has been our love language, our love letters to each other. Our love drove this process, nourished it, sustained it and, may I say, was tested by it too!

An important reason for my being part of this endeavour has been my own experience in therapy with an affirmative and feminist practitioner. There was definitely skill, my therapist is eminently qualified, but the magic came from somewhere else – from a core of values and ethics, and a consciousness about the ways in which power shapes us and also of how we wield it. Everything I know about Queer Affirmative Counselling, I have learned from her. She has held me steadfastly on this long road home. She has saved my life and, more importantly, helped me carve out a life I now want to save.

Making normative decisions that are socially rewarded, come at deep personal and psychic costs. My mental health reached a crisis point about seven years ago. The only way I stayed afloat was by getting into therapy and surrounding myself with a handful of people who held me up (during each episode). My journey to becoming a counsellor began as a user of mental health services and navigating the world as a person living with mental illness. My privileges and access to whisper networks in the queer community led me to an 'LGBT friendly' (queer affirmative was not part of our lexicon yet) therapist because of a sneaky suspicion that my sexuality had something to do with my distress. I sometimes reflect on how years of activism and scholarship has led us to the current times where queer people feel strong enough to demand affirmative mental health services from the very establishment that colluded in pathologising and medicalising our lives.



I jokingly call myself "the youngest queer" in the QACP core team, and the more I reflect on this term the more do the various dimensions of queerness and being queer emerge in my awareness, like an inexhaustible wellspring. My journey as an "out" (to myself) queer person began some 10 years ago (I was 38), when I fell madly in love with a woman – and reading Nivedita Menon's 'Seeing like a Feminist' forced me to look at my sexuality squarely in the eye. It was a final acknowledgement of a part of myself that I had either intellectually denied in my lucid and "free" moments, or had not had time to examine while growing up. The first thing that hit me then was the lost time. In QACP, we talk about queer time, and having lost almost four decades of my life ignoring my non-heterosexual identity felt like a personal let-down. Self-acceptance was a bittersweet experience for me.

Acceptance of one's queerness, or "coming out" to oneself, as some call it, is in a sense a birthing of sorts. Suddenly the world takes on a new hue; familiar things, people, places take on a new meaning. My experience of the gap between my chronological age and the time elapsed since that moment of self-acceptance (which I half-jokingly call "queer age") was at once liberating and a source of despair. When I look at my "queer age", I realise that time flew past me without making my queerness known to me, not so much because of my inability to recognise it but because I lived in a world that just did not reflect my reality. That world was a cis-het, academics- and livelihood-driven middle class world, where there was no room for exploring the non-normative. In the absence of a mirror validating this part of my self, the possibility of a life that was not a cis-het-normative one

remained unknown to me – which also points, essentially, to a gaping hole in how lives are generally framed and which lives are considered valid. The world we live in zealously guards the cis-het illusion, and so the question of making queer lives visible arises only when a queer individual experiences their self as valid. Attempting to break through the illusion comes with the cost of risking your physical and mental safety. Many queer lives just don't sprout, because it is so daunting.

Only after I came to the point of acknowledging my sexual identity was I able to let myself live a more authentic life and to access queer spaces, whether through being part of a queer feminist collective or through conducting trainings on gender-sexuality. Being roped in by Shruti for QACP went a long way towards holding my experience as a queer individual. It was only when I experienced my life as possibility – as a life that could not just be lived by me but also celebrated by others – that I was able to come out of the woods. QACP has been my course correction, my way of wiping the mirror to make the reflection of queer lives crystal clear. The project has been a balm for me, a warm space that allowed me to make up for my "lost" time, not just for myself but also towards the queer community. My background in research and mental health afforded me the thirst to explore myself further, and bring those insights into QACP spaces. It has been a fantastic process of collaboration, co-creation, trust, commitment and, above all, love.

*(*While I am not a big fan of labels, labels do serve a huge purpose in queer lives: in keeping with this insight, I currently identify as bisexual and use the pronoun *she.)*

As reflected in our personal notes above, all of us are trained mental health professionals, with some of us engaged in counselling practice, research, teaching, activism, and advocacy in mental health. We are also all queer/trans-identified, and are engaged with queer and feminist spaces locally and also connected to queer rights movements nationally. Most of us have used mental health services at some point

in our lives, and for many of us our lives depend on access to queer/trans affirmative mental health services. Thus, all of us occupy multiple loci within the world of mental health and gendersexuality. We are "mental health experts" by virtue of our disciplinary training and we are "experiential experts" primarily through living as queer/trans persons – but also because of our critical position on the power associated with knowledge "expertise". Some of us may identify as mental health service users and may live with invisible forms of disability. These multiple locations all inform our perspectives on QACP and help us to bring ideas of social justice, feminist therapy, critical psychology, and mad studies into what has traditionally been a value-neutral space within mainstream mental health praxis.

The authors would like to acknowledge that several more individuals have contributed in co-creating parts of the content, including Neeta Chakravarty, Sailee Shringarpure, Shweta Mahajan, Sameera Jahagirdar, Aanchal Narang, Ranjita Biswas, Deepa Vasudevan, Poushali Basak, Mridul Dudeja, Aryan Somaiya, Vinay Chandran, Raj Mariwala, Devanshi Vaid, Amalina Kohli Dave, Aparna Joshi.

1.2 Why the QACP course – and this resource book?

Several factors motivated us to put together the QACP course and, subsequently, this book:

1. The foremost of these was the longstanding history within mental health sciences of pathologising same-sex sexuality, as well as transgender identities, which resulted in harmful practices such as conversion treatments to "cure" homosexuality and "transgenderism". Even today, most mainstream mental health curricula and training in India carry traces of this pathologising impulse; ideas of compulsory heterosexuality and cisgenderism continue to dominate the thinking and practice of the psy

disciplines. Hence the urgent need to create curricula and training materials that would speak to and of lives that lie on the margins of the mainstream understanding of gender-sexuality.

2. Then there was the felt need to make visible the lived realities of queer and trans persons, and to bring these individuals into the mental health classroom not as museumised others, or even as abject figures, but as full persons living ordinary and extraordinary lives embedded within the contexts of family, work, friendships, intimate relationships, and communities.
3. The changing socio-legal context in India with its paradox of, on the one hand, the decriminalisation of homosexuality and passing of The Transgender Persons (Protection of Rights) Act, a heightened media inclusion of LGBTQ+ issues, corporate India speaking the language of gender-sexuality diversity and inclusion, mental health professionals claiming to be LGBT-friendly, and on the other hand a political milieu of increasing anxiety and insecurity for all minorities, including gender-sexuality minorities. In the context of hypernationalism combining with homonationalism, and with a market economy that frames queer and trans subjects as consumers of medical and psy technologies and services, the QACP course raises critical questions, such as: Is queer affirmation possible in the absence of social justice? Can a practitioner claim to be queer affirmative while maintaining a status-quoist stance on structures of gender, sexuality, caste, race, class, religion?
4. We believed that within this paradox there existed a window of opportunity to work towards a discrimination-free health and mental health care system. For instance, in the Supreme Court judgement decriminalising homosexuality (by reading down IPC Sec 377 in September 2018), the judges emphasised the role of MHPs in providing mental health care to LGBTQ+ persons

and creating awareness and understanding about sexual diversity among families, in workplaces, and in educational institutions. National-level MHP bodies have responded favourably to the Supreme Court's call and, more recently, several MHP associations have condemned the use of conversion treatments aimed at "curing" homosexual and transgender persons.[7] We were therefore of the view that a QACP resource book at this time was likely to be received with more enthusiasm and openness than ever before.

5. Finally, this book has its origins in a research project in which two of the authors were involved, more than a decade ago, which documented good practices in counselling gay, lesbian and bisexual clients. A total of 25 counsellors from the cities of Mumbai, Pune, Bangalore, Kolkata, Chennai and Sangli were interviewed to reflect on and develop a local understanding of Gay Affirmative Counselling Practice (GACP). We built further on that rich experience to develop the QACP course and this resource book.

1.3 What to expect from this resource book

The primary aim of the QACP course and now of this book is to aid reflexivity among MHPs – primarily around gender-sexuality, but also with regard to other axes of power and privilege in social life. We believe that training and curricula within the psy disciplines, and the resulting supervision, tend to be based on normative ideas of gender-sexuality. Hence, for instance, while narrating client distress due to a relationship break-up in your supervision group, it is most likely that others in the room, including the supervisor, will perceive this break-up as being between two persons of "opposite" genders.

It is this very pervasiveness of heteronormativity – and reflexivity about it, that this book hopes and aims to achieve. Needless to say, then, that QACP is not a new model of counselling practice, but is, rather, about developing a queer/trans perspective, and shifting from a harmful and neutral practice to an informed and affirmative one.

The QACP course can broadly be divided into three major focal points – further divided into seven chapters for the purposes of this resource book. The first part (Chapter 2) focuses on understanding the social construction of normative gender and sexuality. The aim of this chapter is to get participants, particularly those who are heterosexual and cisgender, to appreciate how ideas of normative sexuality (heterosexual) and gender (cisgender), continually confused with "normal" and "natural", are constructed through complex social processes.

The second part of the course (Chapters 3, 4, 5) is focused on creating locally relevant knowledge for therapeutic issues such as stressors unique to living as a queer/trans person in India, working with the families of queer and trans persons, working with queer and trans couple issues, gaining perspective on understanding interpersonal violence within queer relationships. This part of the course also elaborates on the historical understanding of ways in which non-normative genders and sexualities have been pathologised within the psy disciplines, and provides insights into ways of shifting from harmful to neutral to affirmative practice. Some basic principles/tenets that a queer affirmative practitioner must follow are also laid out.

The third focal point of the course (Chapters 6 and 7) is to critically examine concepts within existing models of counselling practice that are informed by heteronormative and cisgender binary assumptions, and altering these to make them more responsive and affirmative to the psychic and interpersonal struggles of queer/trans clients.

The **primary aim of the QACP course** and now of this book is to **aid reflexivity** among MHPs – primarily **around gender-sexuality,** but also with regard to **other axes of power** and privilege in social life.

Finally, the course critically examines clinical frameworks related to suicide and self-harm as well as representation of gender-sexuality within the diagnostic systems of the psy disciplines. In this chapter, we also reflect on the idea of 'recovery' from a neurodivergent and a queer affirmative perspective.

This book only partially addresses the mental health concerns of transgender/nonbinary/gender non-conforming persons. For instance, the role of MHPs in the medical transition of trans persons is a significant area on which we have not been able to elaborate, while we do believe that this a serious gap in mental health knowledge in India that needs to be addressed soon. We do list a range of resources related to trans mental health in different sections of this resource book. We often use the hyphenated "gender-sexuality" because we see the two as closely linked. It is precisely the assumption that there are only two kinds of bodies, which produce two biological sexes which in turn produce two genders and one sexuality, that lies at the heart of the social construction of cisgenderism, gender binarism

and heteronormativity. Hence the term *gender-sexuality*. This in no way implies that we do not make a distinction between sexual orientation and gender identity. In this book, *queer* has mainly been used to refer to non-normative/non-heterosexual sexual orientation, and trans, transgender persons, nonbinary, gender non-conforming persons have been used to refer to non-normative gender identities. Where we use queer/trans we use the term to point to the commonality of experience and challenges that may be faced by individuals either because of their non-normative gender or sexuality location, or both. When we refer to the specificity of experiences based on either gender or sexuality, we use *trans person* or *queer person*, respectively – and separately.

Minority stress is an important framework that we use to encompass the experiences of stigma, prejudice, discrimination, and their effects on the psychic world of the individual subjected to these in the context of their minority location. Hence we have, at times, used the terms sexual minorities and gender minorities to refer to queer and trans persons. The use of the term *minority* here is not so much about numbers as it is about a position of marginality vis-à-vis a majority where the latter conforms to gender-sexuality norms. The logic of numbers ('how many queer and trans persons are there in India?') and the suggestion by one of the Supreme Court Justices, while re-criminalising homosexuality in India in 2013, that this is a 'miniscule minority', is as flawed as it is dangerous. We would therefore like readers to note that when we use minority here, we refer neither to absolute numbers nor to percentages with regard to the population of queer and trans persons in India.

1.4 The intended audience/readership of this resource book

This resource book has been written primarily for counsellors, MHPs, students of psychology, social work, mental health and counselling courses, for mental health activists and advocates, as well as for LGBTQ+ activists interested in the mental health concerns of queer and trans persons.

In addition, professionals working with children and young persons on personality development, social and emotional learning, life skills education, as well as teachers, educators, school and college principals, would be able to draw lessons from this book to better understand children and young persons with non-normative gender-sexuality expressions and identities, and thus to intervene as first responders for mental health issues associated with bullying of and violence towards trans and gender non-conforming children. Similarly, human resource professionals working towards LGBTQ+ inclusive workspaces, and motivated to create safe spaces for queer and trans employees, may be able to draw some lessons from this resource book.

This book may be used in two ways–

1. Practitioners may want to consult it for enhanced awareness about ways in which gender-sexuality enters clinical conversations, and its relevance in making therapeutic formulations or plans for intervention. They may use the suggested resources to enhance their knowledge of queer/trans-related stressors, as well as of the basic tenets of affirmative practice. They may consult ideas provided here while dealing with crises such as suicide, self-harm as well as partner violence among queer and trans clients. They may want to use this book to reflect on whether their practice is

neutral or queer affirmative, and on how to make family therapy or cognitive behaviour therapy more responsive and affirmative for queer clients.

2. Practitioners, trainers and educators may draw upon the information, perspective and learning exercises presented here in order to devise and conduct training and capacity building sessions for various constituencies.

1.5 The How of the QACP course – thoughts on methodology and pedagogy

Teachability-Learnability

Describing methodology begins, ideally, with unpacking the assumptions that underlie the project. Knowing these assumptions helps in understanding the project's value base, and provides a critical lens with which to examine its contents, besides helping ensure transparency with regard to its motives.

It could be deemed, in some ways, an act of audacity for a few queer/trans-identified MHPs to come together in order to tell cisgender, heterosexual people that it is possible to work as therapists with queer/trans clients without pathologising their clients' distress. Just what, then, led us to believe that persons who had not experienced certain specific forms of oppression would be able to support the journeys of pain and growth of those who had? That those trained under traditional paradigms would be able to push themselves and question the very institutions and disciplines that granted them credibility and legitimacy? That understanding the inner world of a marginalised person, and becoming their support system was possible even for someone who had never experienced oppression due to the axes of the body and gender binaries and of

heterosexuality? And that they could provide said support from the locations they occupied as cisgender, heterosexual persons?

Looking for long answers to these questions is perhaps a project for another day, because so much of the work was a product of robust and rigorous training methods, facilitation, and participation. However, before any of that happened, what we were counting on was that the ethics and responsibilities that marked our vocation as MHPs would become the bridge that allowed for these exchanges. We embarked on this course believing that it was possible for a cis-het practitioner to be part of a queer/trans client's journey in a meaningful way – with the significant caveat that this would not be possible unless the practitioner worked hard to compensate for their lack of the wealth of what we call lived experience.

The course design is the result of a great deal of collective thinking, brainstorming, and creating together, by persons who, among themselves, have as much diversity as commonalities – diversity in terms of age, experience, skills, perspectives, strengths, as well as different gender-sexuality locations.

Some of the broad guiding principles we adhered to in the writing of this book:

1. We were keen to **maintain a balance between information (knowledge), perspective and skill**. We did not want the book merely to provide information on, for instance, different gender and sexuality identity terms and their differences, or simply to list common health and mental health problems among queer and trans persons. While we do believe that information is one of the important cornerstones in developing competence as a queer affirmative practitioner, we think that the gender-sexuality perspective is equally vital. A sharpening of this perspective helps the practitioner to critically evaluate the information they receive, and even to decide what kind of information is relevant. We wanted to give primacy to the practitioner's being able to formulate critical questions

for effective practice: after all, the most important thing is translating the perspectival learning and information into skilled practice. We have attempted to give each of these three aspects its due.

2. Closely connected to the idea of such a balance are the **issues of method and pedagogy** – how is the content delivered? Some of the pedagogic tools we employ, both in the QACP course and in this book, include:
    - The traditional lecture method, and an extensive reading and resource list aimed at enhancing knowledge and sharpening perspective.
    - Engaging with lived experience – an aspect of methodology deliberately chosen to enable participants to engage with the content on an affective as well as cognitive plane, and also to appreciate the nuances and complexities of living life as a queer/trans person in a world that erases these lives or even their possibility.
    - Lived experiences were brought into the classroom, and will be drawn upon here, through the medium of films, case vignettes derived from the clinical practice of the authors, and personal experience sharing by the trainers/authors; self-disclosure has been used in the QACP trainings as a pedagogic tool to enhance both authenticity and empathy in the training room.
    - Self-reflexivity is as much a perspective as a skill, and we believe it to be one of the core competencies of a queer affirmative practitioner. This resource book contains a range of individual and group exercises designed to facilitate self-reflection, not only around gender-sexuality but also on power and privilege in social life as much as within the therapy room.
    - Working in groups, and collective learning, have been built into the development of the QACP

course by and among the trainers, and throughout this book there are similar opportunities for co-learning through a number of group discussion exercises.

- Much of the QACP classroom learning has been co-produced by the trainers and course participants. We have had participants who are counsellors and who identify as queer and trans; there were others who were family members of queer/trans persons – a mother, a grandmother, an aunt, a sibling; besides many ally practitioners. Several of them have shared their personal stories, learnings from queer/trans clients in their practice, insights into how these clients have changed them as practitioners, and so on. We attempt to bring some of this co-created knowledge from the QACP courses into this resource book.

3. Some of the perspectives that have informed the QACP course, and this book, include **ideas from critical psychology, mad studies and feminist therapy**. Some examples of the ways in which these have inspired the framing of the course and of this book are:

- While QACP engages with distress experienced by queer and trans persons, and affirmative ways to respond to the distress, it does not frame queer and trans mental health in clinical terms alone. Thus, for instance, there is no session in the entire course on the prevalence of mental illnesses among LGBTQ+ communities. This is not to deny the vulnerabilities of queer and trans persons to a range of mental distress and illness, but to frame this distress within larger material-social contexts. This book discusses minority stress at length, framing it within the contexts of structural violence, discrimination, and exclusion. Such a perspective means that while individual distress is addressed, the individual

is not blamed or held solely responsible for their psychosocial distress.
- The course does not have a "deficit focus" – which means that it does not treat being different/non-normative, and the struggles that ensue in leading such a life, as a personal tragedy. There is an equal emphasis on the pleasures of being queer/trans or, as some would say, the "gift" of being queer. Queer well-being and resilience are important themes for us, and we explore them here in the contexts of queer communities, families of choice, doing relationships outside of heteronormative scripts, and so on.
- Feminist therapy principles of equity, inclusiveness, respect for diversity, intersectionality, and the therapeutic not being divorced from social justice, are some of the other guiding perspectives that inform this book.

1.6 Our relationship with our funder-partner

When Mariwala Health Initiative (MHI), one of the leading grant-making and advocacy organisations for mental health in the country, with its vision of tying therapeutic work to social justice, and making quality, rights-based therapeutic services available and accessible to all, chose to initiate work on queer/trans mental health, they approached us, and trusted us to develop and deliver the QACP course and the resource book. Finding an initiator and funder to support work such as QACP – that is critical of mainstream psy-centred ways of thinking about and doing LGBTQ+ mental health work, that is uncomfortable with an uncritical celebration of the sudden boom in "rainbow products and services" (including mental health services) would have actually been next to impossible at the time we began. QACP work has gained much credibility and acclaim since. But then,

the beginnings to these endeavours are always the hardest part. From the outset, in providing funding as well as administrative support to this work, the team at MHI demonstrated queer/trans affirmation: sensitivity in handling issues such as pronouns; working to avoid using the dead names still present on the documents of trans persons, even as these were needed for administrative purposes like bookings and payments; sharing deadnames only on a need-to-know basis, issuing certificates to course participants in names that were authentic to them and not the ones on ID documents, and so on. They made accommodations for disabilities, both visible and invisible, and were responsive to a range of diverse needs through this very intensive process of developing and implementing the QACP course and of writing this resource book. MHI also provided full administrative and publicity support. This gave the QACP team the luxury of focussing on the curriculum development without the encumbrances of logistical management. The comfort of the faculty and participants was taken into consideration while booking accommodation and travel. No cost was spared to ensure that the environment was conducive to learning. All these factors move us to consider MHI more as partner than funder.

In 2020, when the COVID-19 pandemic engulfed the globe, MHI urged us to adapt the course to an online medium. MHI continued to provide full administrative support as well as publicity via all its social media platforms to the course. By October 2021, the QACP course had completed 10 batches with 350+ MHPs trained across 40+ cities in India and 3 South-Asian countries.

What was most heartening and freeing was the trust that MHI placed in us for developing and delivering a course that aligned with their values and politics. That trust made the process of creating this curriculum an energising and enriching one. MHI has been a co-traveller on this journey, holding us through thick and thin; and having our backs. Through our work on QACP, the course and this resource book, the authors and MHI have continued to commit to the larger goal of social justice. ●



Illustration: Parth Pawar (@artwalahoe)

Reflecting on Normative Gender-Sexuality

Normal is simply the Normative. Inequality doesn't have a life of its own: there are forces that sustain it. Social norms escape scrutiny. The gaze on the margins means that the oppressors are not queried. It is crucial to turn the gaze to the oppressor/powerful forces that are complicit in creating and maintaining the inequality and the margins.



CHAPTER 2

Reflecting on Normative Gender-Sexuality

What Makes the "Normal" Possible; the Possibilities of the "Normal"

On opening a resource book on queer affirmative counselling, one might expect to find, right at the beginning, definitions of queer/trans – Who is queer/trans? What makes them queer? What are some of the emotional problems that queer persons face? What needs to be done about it? – and so on. That an initial chapter in such a resource book would, instead, spend considerable time and thought in understanding normative ideas of gender and sexuality might belie expectations. After all, what is there to "understanding" when it comes to heterosexuality, and the cisgender-binary system of men and women? We could, of course, talk about the ways in which rigid gender roles and expectations oppress women, and men too! And we could talk about marriage, and sex that occurs within and outside it, but what would all this have to do with queers or, indeed, with counselling them?

We believe that in order to work with non-normative gender-sexualities, we must first

interrogate the normative. What do we mean by the normative, and why interrogate it? Is the normative "natural", or is it "socially constructed"? And how does the normative affect us all? These are some of the questions that this chapter will address through a series of experiential and self-reflective exercises.

At a cursory glance, the sections in this chapter might look like a collection of experiential techniques that could be part of a workshop. Let this resemblance not discourage the reader, or in any way undermine this chapter's significance. The contents of this chapter comprise, in fact, the foundation of all Queer Affirmative work. It is our firm belief that Queer Affirmative work, or work with persons who have historically been considered "abnormal", does not begin by understanding this "abnormal", but by unpacking what is "normal" – and through this process, questioning the very need and basis for the classifications of normal and abnormal, legal and illegal, "pure" and "sinful". As Mental Health Practitioners (MHPs), through training and practice, we are oriented to focus on the abnormal, while the normal functions only in peripheral and largely hidden, ways – it escapes similar scrutiny. And yet, it informs every single act of conceptualising the abnormal. In this chapter, and throughout this book, this insidiousness of the normal – "normal" bodies, genders, sexualities – is continually questioned. Its role in defining and controlling lives from the wings is brought out onto centre stage for all to see. Too often, LGBTQ-"friendly" practices/trainings/therapies/therapists miss this fundamental point, of how the

In this chapter, and throughout this book, this **insidiousness of the normal** – "normal" bodies, genders, sexualities – **is continually questioned.**

normal operates, focusing only on what lies outside its purview, without questioning how it was created in the first place, or the role of the "abnormal" in maintaining the idea of the "normal".

This chapter is meant to help MHPs reframe their understanding, to move from the received notion of normal gender-sexuality to that of normative gender-sexuality. In deconstructing the normative, we also bring to light the forces and social institutions that create, maintain, and benefit from it. If we do not know who the beneficiaries are, and what benefits flow from normative gender-sexuality, we cannot truly understand what happens to those who do not conform, or what losses they accrue, or the ways in which their psychic worlds are affected. Inequality doesn't have a life of its own – there are factors that sustain it.

We urge the reader to begin at the beginning, for the sake of a sound values- and ethics-based foundation for Queer Affirmative work. This chapter will provide analytical frameworks to understand the construction of the normal, and proceed from there to what lies outside of this construct. We believe any other entry point would, unfortunately, be one that pathologises and medicalises queer/trans lives and identities.

→ ***Note that this chapter is deliberately in the "training manual" format – activity-based, with instructions. Trainers/facilitators/ teachers who engage with gender-sexuality topics can use these powerful exercises in their own settings.***

Since we are of the opinion that any training on these topics must start from examining the normal, this particular set of exercises is experiential and thought-provoking, meant to lead participants gently into reframing their views on gender-sexuality. As an individual MHP reading this chapter, do make sure that you complete each exercise in the order given: the importance of this cannot be emphasised enough. Please read the 'Objectives', 'Probes', 'Instructions' and 'Takeaways' in order to build your learning through self-reflection.

2.1 The "Charmed Circle" under the spotlight

an exercise in understanding normative gender-sexuality[8]

OBJECTIVES

To understand gender-sexuality as socially constructed.

To uncover the mechanisms through which normative gender-sexualities emerge as "natural" and "normal" in society, in any given time and space.

MATERIALS

Large board and chalk, or white board and markers.

ACTIVITY AND INSTRUCTIONS

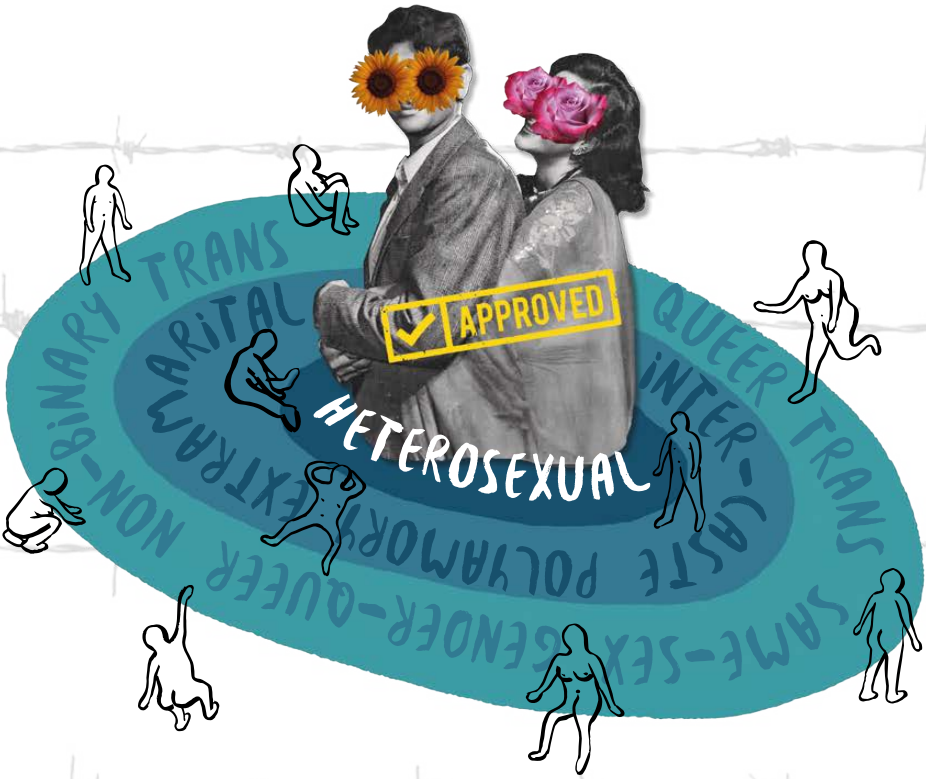
In order to unwrap normative gender-sexuality, we start with a few basic questions. These are opened up one by one by the facilitator for responses from participants.

1. What, according to you, is considered by society to be normal/appropriate/ acceptable sex?

→ ***Note: Facilitator emphasises that it is not the participant's personal opinion about "normal" sex being elicited here, but their thoughts on what society thinks of as normal/appropriate/ acceptable sex.***

Facilitator may consider using the following probes:

- What kind of sex is seen as normal/acceptable?
- Who having sex with whom is thought acceptable? What should the nature of the relationship between persons having sex be, in order for society not to frown upon them?
- When and where (place) should this appropriate sex be had, in order for it to be seen as normal?



Points to be covered in discussion:

- **The nature/kind of sex** considered "normal" – involving the penis and vagina, where the penis penetrates the vagina (everything else that happens in the sexual encounter being in order to facilitate peno-vaginal penetrative sex); the man on top position.
- **The nature of the relationship** – married couple
- **The when of the sex** – may refer to time of day, as at night, or in the dark; may (also) refer to purpose – procreation.
- **The where of the sexual act** – in the privacy of the bedroom/home, and so on.

2. Who can marry whom in our society?

→ ***Note: Participants are encouraged to think about the wider social acceptability of marriages, and not merely the constitutional provision of any adult citizen being legally able to marry another of the opposite sex.***

Points to be covered in discussion:

- **The role of religion**, caste, community, *gotra*, region, language, food, in determining who can marry whom, and which kind of marriages enjoy social legitimacy (can discuss "love jihad", exogamy).
- **The practice of arranged marriage** in Indian society, and also the popular adjacent idea of marriage as a relationship/contract between two families and not just between two individuals.
- **The gendered expectations** of the two individuals who are to marry: age (man older than woman), physique, appearance (man taller, stronger than woman; woman fairer, shorter, dainty, pretty, submissive etc.); sexual initiation by the virile man, and the woman's hesitation, innocence, virginity; education and income – both higher for men.

CHARMED CIRCLE

Introduce the idea of the "Charmed Circle" as described by Gayle Rubin (1984) in her seminal essay 'Thinking Sex: Notes for a Radical Theory of the Politics of Sexuality' to refer to the socially sanctioned, acceptable forms of sexuality.

↓ **SOCIALLY SANCTIONED GENDER-SEXUALITY WITHIN THE CHARMED CIRCLE**

BINARY CISGENDERISM:

- Every child at birth is assigned one of the two recognised genders (based on the appearance of their external genitalia);

- And is expected to conform, lifelong, to this assigned gender, of either man or woman

HETEROSEXUAL SEXUALITY:
- A cis man and cis woman having peno-vaginal sex with each other, within marriage, for procreation;

- In a marriage between social equals that has social approval; premised on monogamy – the "together forever" model of marriage;

- Between able-bodied, able-minded persons

- Seen as pure, normal, natural

After being introduced to the idea of the charmed circle, participants are encouraged to discuss where they learned some of the rules that govern normative gender-sexuality expressions and ways of relating. Some discussion points could be: **How explicit are these rules? Where do they come from? Where did we hear these ideas for the first time? In what other spaces do they get reinforced?**

It may be useful to reflect that even though all of us come from varied backgrounds, with considerable diversity among us in terms of genders, age, education, language, region, religion, caste, and so on, we are nevertheless informed by a common pool of knowledge about socially acceptable forms and socially defined rules for normative gender-sexuality.

Further questions could also be asked, such as –

3. What are some of the social institutions that uphold the charmed circle?

Points to be covered in discussion:
- **Religion** – as one of the institutions that dictates what is considered "pure" v/s "sinful" sexuality.
- **Caste** – as one of the institutions that regulates sexuality, particularly through the institution of marriage, and consequently regulates "purity" of lineage.
- **Family and marriage** – as social institutions that govern individual sexual conduct: often, family is used as a tool by the institutions of religion and caste to maintain and reproduce the unequal social order.
- **Law** – as a tool used by the

state to lay down rules about appropriate sexual conduct; breaking of such laws may have serious consequences: the colonial-period law, Section 377 of the Indian Penal Code, criminalising same-sex sexual activity, that first appeared as a statute in 1860 and was finally read down only in 2018, could be discussed as a case in point.

- **Education** – reinforcing the social and public discourse of appropriate sexual conduct through visibilising cisgender heterosexual lives alone, thereby indicating that only this form of gender-sexuality exists.
- **Science/Medicine** – as a powerful tool that adds the dimensions of naturalness (as is meant to be in nature) and normality (as opposed to deviant, abnormal) to the idea of cisgender heterosexuality, which would otherwise have been just a set of socially prescribed norms (The role of men of science and medicine in defining and regulating the "normal" – right from assigning sex and gender to a newborn, to attempting "cure" of homosexuality, to certifying dysphoria in trans persons – is discussed in some detail in the following chapters.)

With all these powerful forces and institutions creating, maintaining and governing the charmed circle, the next logical question is –

4. What exists outside the charmed circle?

A simple answer to this would be: Anything and everything that is thought of/fantasised about/practiced outside of monogamous, heterosexual marriage, and is meant for pleasure and not just for producing babies. In other words, a great deal lies outside the charmed circle.

Participants could be encouraged to consider, and mark on a diagram representing the charmed circle, what kinds of sex lie outside it, starting with cisgender heterosexual persons who may fall just outside for engaging in sexual acts such as masturbation, or being – for instance – in an inter-religious marriage, and going on from there to include those who are

the farthest from the circle (non-cis/non-het) and, in that sense, most on the margins.

Nature of relationships – immediately outside the circle, for instance, would be premarital sex between a man and a woman who are committed to each other and plan to get married soon; then, live-in heterosexual relationships; then, heterosexual married relationships that are inter-religious/inter-caste but with minimum taboo, such as Hindu-Jain, Hindu-Sikh, Brahmin-Kayastha marriages, with Hindu-Muslim marriages much further out.

Other kinds of cis-het relationships that would fall well outside the circle include open relationships, polyamory, extramarital sex, commercial sexual transactions, and so on. Sexual relationships among same-sex/trans/genderqueer/nonbinary/intersex persons would be placed even further; even when some of these have a normative appearance – especially if the individuals pass, or almost pass, as cis-het – fear of discovery imbues their situations with both precarity and marginality.

Nature of sex – well outside the circle would be sex for pleasure alone; masturbation; oral sex and anal sex even if within marriage; sex involving toys, objects, pornographic imagery; group sex.

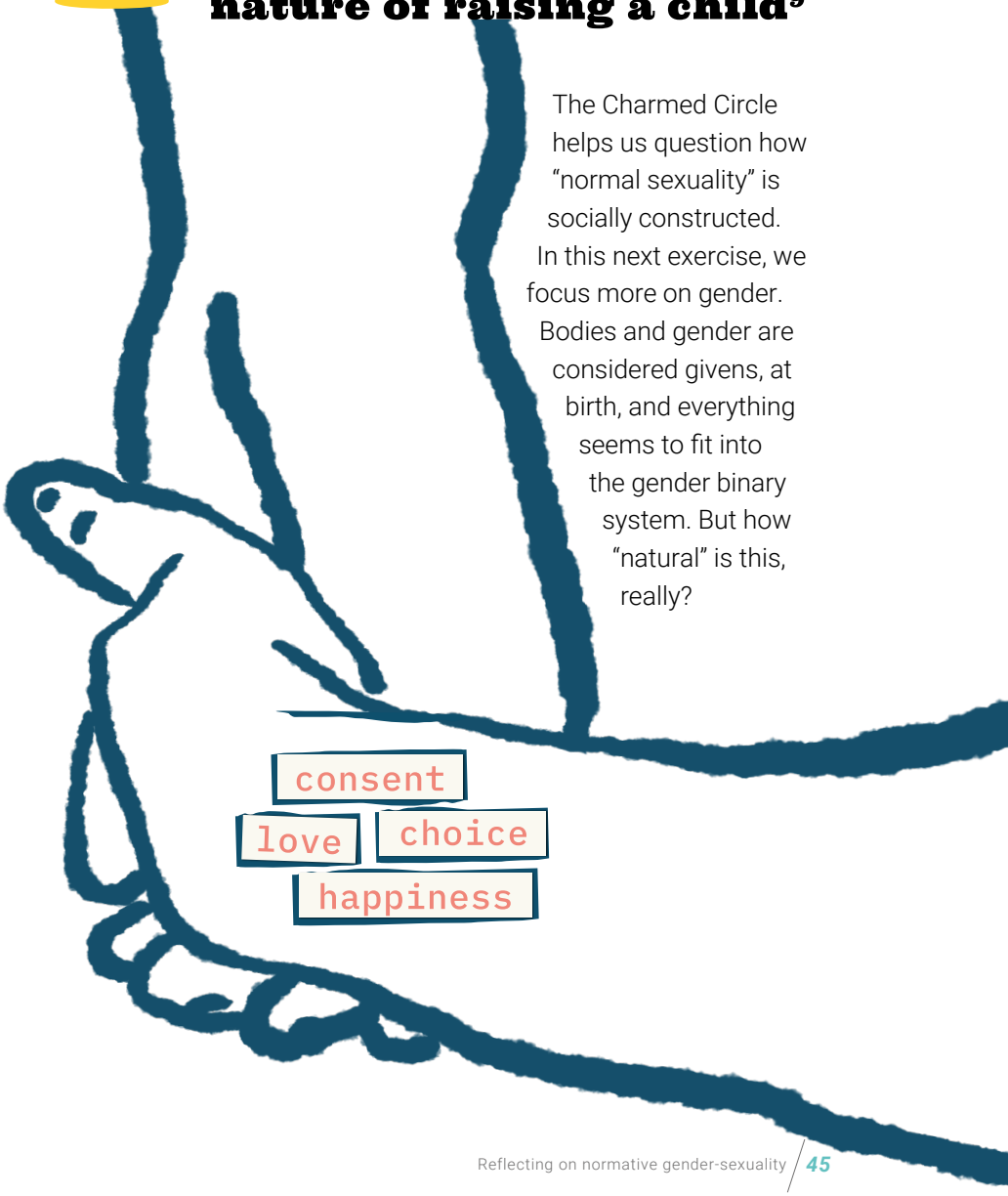
TAKEAWAYS – POINTS FOR WRAPPING UP DISCUSSION

1. There is a clear power centre that determines and regulates what kinds of sexualities and gender expressions may be welcomed into it.
2. This centre, or charmed circle, shapes normative gender-sexualities through a mechanism of reward-punishment, i.e., sexualities and genders that fit in and belong to the centre are rewarded with social acceptance, which enhances social capital, support, legitimacy; those that lie outside the centre risk invisibility, illegibility, and illegitimacy.

3. While not everyone outside the circle faces the same consequences, there is a sexual hierarchy that decides the place of an individual's sexuality in the privilege-disadvantage ranking. In other words, the closer one is to the circle's centre, the fewer are the disadvantages.

2.2 Examining the gendered nature of raising a child[9]

The Charmed Circle helps us question how "normal sexuality" is socially constructed. In this next exercise, we focus more on gender. Bodies and gender are considered givens, at birth, and everything seems to fit into the gender binary system. But how "natural" is this, really?



OBJECTIVES

To recognise how the body (sex), gender, and gender socialisation are deeply entwined.

To recognise that the process of fitting people into the gender binary starts at birth.

To ask the critical question about whether fitting into the boxes of sex and gender is a need of the child, i.e., is it necessary for the child's healthy development? What does the child need to be happy, and develop a positive sense of self?

MATERIALS

Chart papers and art supplies like markers, colour and sketch pens; whiteboard and markers for the facilitator to use for debrief, if needed.

ACTIVITY AND INSTRUCTIONS

Divide the group into four small groups.[10]

Each group has the same task: to raise a child up to the age of eight years. The genitals of this child who has been entrusted to your care are covered. Thus, you have no knowledge of the genitals of this baby.

Each group must reflect, and then present their ideas, about the following questions:

- ***How would you raise a child if their genitals were under wraps and you could not know their sex?***
- ***What are some of the barriers you would face?***
- ***How would you work around these?***

The groups take 20-25 minutes each to answer the three questions and prepare their presentations. In the debrief, each group has about 10 minutes to share its points.

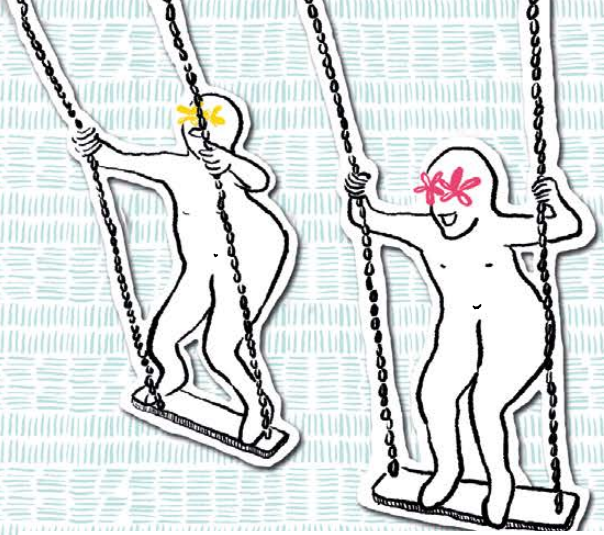
[10] Technique for dividing a large group into smaller groups: If participants need to be divided into, say, four groups, go round the room with the first participant saying "1", followed by the next participant saying "2", then "3" and then "4". Continue round the room, with participants repeating 1,2,3,4 aloud, till each of them has a number. Then all those with the same numbers come together to form the smaller groups.

PROBES:

1. What were the reflections on the process of this exercise? What parts were easy to do and where did the parents/ caregivers struggle/find it challenging?
2. What actions would parents/ caregivers take with respect to their own lives (would they make changes, communicate certain messages through action and example?)

TAKEAWAYS

1. Raising a child is, in so many ways, a project of engendering the child.
2. The role of the "social" in child-rearing – how, the minute you find you are raising a child who does not conform, this puts you in an adversarial relationship with social and formal institutions like (extended) family, the school, neighbourhood, community, and the State – all for the sake of something as fundamental to all our identities as gender.
3. How the body (sex), gender, and gender socialisation are deeply entwined.
4. The process of fitting people into the gender binary starts at birth.
5. Values like consent, agency, choice, resilience, and so on, can be part of conversations on child-rearing only when we think outside the charmed circle.
6. Once parents/caregivers who are raising the child are actively made to understand that they do not know the sex of the child, there is a marked shift – trying to focus on the child's needs rather than on their gender.
7. A child's needs are met through love and nurturing, and these should not be linked to their gender.
8. Since raising a child is so much about engendering the child, having a child who does not conform might get framed as parental "failure".
9. The intent here is not to advocate for "gender-neutral" parenting but to understand these several points, and also to know that assertion of gender is something all children will do; that you may



raise the child in any manner, yet they will at some point assert and communicate their own sense of their gender. The important question is whether there is space for the child to communicate this, and to be believed and affirmed.

10. When a child is gender non-conforming and communicates this through resisting gendered ways of having to look, of dressing and of play, how we respond is critical – whether as adults in general, as parents, as teachers, as school counsellors, as child mental health professionals.
11. Some common responses are: hoping that it's a passing phase; thinking children don't know what's best for them; assuming that if we intervene and "correct" the child's "wrong" ideas at an early age, we can help them adjust to their assigned gender better, and so on. (Some of these responses are akin to conversion treatments aimed to "cure" gender non-conformity, and the transgender identities discussed later in this book.)
12. An affirmative response would be willingness to make the gender journey of the child with them, with the child taking the lead and the adult making an effort to be attuned to the messages from the child – believing and affirming these as they go along.
13. If the child expresses distress while navigating this journey, or specifically with their body, then the need is to provide support to the child, including getting help from a trans affirmative therapist.





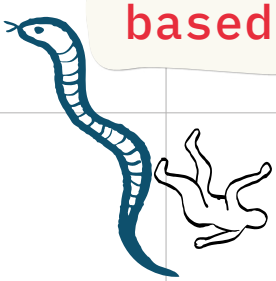
2.3 The Power-Privilege Walk

The *Charmed Circle* exercise highlighted how sexuality is socially constructed, and showed us which social institutions are invested in maintaining the unequal social structure. The charmed circle also introduced the idea of how bodies and genders are a social project. The subsequent exercise, on examining the gendered nature of raising a child, helped us to reflect on how deeply the gender binary is entrenched in our parenting, family systems, and social institutions. In the following exercise, called *The Power-Privilege Walk*, we widen our understanding about social inequalities and structural hierarchies: all of us occupy multiple social identity positions, and several of these may be linked with social privileges or marginalities. The power walk is a simulation exercise which makes clear how social inequalities are based on social identities.





The power walk is a **simulation exercise** which makes clear how **social inequalities are based on social identities**



OBJECTIVES

To simulate the experience of power-privilege, marginality, social inequalities and structural hierarchies.

MATERIALS

A. A set of eight social identities and locations, as given below, on individual PPT (Power Point) slides:

1. ***Brahmin cis man, lawyer, lives in Delhi, heterosexual, single, 29***
2. ***Blind cis man, heterosexual, studies at IIT, affluent family, 22***
3. ***Hijra living in Bombay city with other members of the Hijra community, engaged in sex work, 52***
4. ***Blind cis woman, born in a Dalit family, heterosexual, lives in village with family, 23***
5. ***Trans man, working as a waiter in Chennai, heterosexual, 29***
6. ***Bisexual cis woman, living with female partner, Muslim, works as travel agent, 33***
7. ***Cis woman, married, has bipolar disorder, lives with spouse in Ahmedabad, 44***
8. ***Lesbian cis woman, sports teacher in Nagpur, single, 33***

B. A set of eight folded chits, each marked with a number from 1 to 8.

C. A set of situation statements, as given below, printed on a sheet of paper:

1. ***You are able to move through the world without fear of sexual assault.***
2. ***You have access to basic amenities.***
3. ***You can drink at a bar late at night.***
4. ***You feel confident that your parents would financially help/support you if you were going through financial hardship.***
5. ***You can show affection for your romantic partner in public without fearing ridicule or violence.***
6. ***You can wear the clothes you want to wear.***
7. ***You are able to call the police or go to the police station when in trouble.***
8. ***You are likely to get the job you want because of an association with a wealthy person.***

9. *You have never been groped in public by a passing stranger.*
10. *You would be able to bring a romantic partner home.*
11. *You can keep your hair at any length you want.*
12. *You are not embarrassed about drawing attention to yourself in public.*
13. *You can whistle at home or in public.*
14. *You would be able to buy property jointly with an intimate partner.*
15. *You are reasonably sure you would be hired for a job based on your ability and qualifications.*
16. *You could take a week-long holiday from work.*
17. *You can get a passport made.*
18. *You feel you can go to a doctor with ease, whenever you feel the need.*
19. *You had the option of saying no to kitchen tasks like cooking while growing up.*
20. *You have chosen, or would be able to choose, a profession based on your own preferences.*

ACTIVITY AND INSTRUCTIONS

Eight volunteers line up in a row at one end of the room, standing next to each other. Each person is given a chit with a number (materials set B) that is not revealed to the rest of the group as yet.

The rest of the group also pick numbers by self-assigning numerals 1 to 8 through a process of rotation, going around the room.

Then the PPT slides with identities (materials set A) are projected, for each participant to match their number with the specified social identities and locations given under it.

Next, the situation statements (materials set C) are read out, one by one, to the whole group. With every statement, each volunteer standing in the line or seated has to assess if their answer would be a yes or a no for them, in that identity. If the answer is yes, those standing take a step forward, those seated mark themselves +1.



STATEMENT 1. You are able to move through the world without fear of sexual assault.

If a participant answers yes to this statement, for themselves in the assumed identity, then they take one step forward. If the answer is no, they remain in their place.



STATEMENT 1. You are able to move through the world without fear of sexual assault.

If a participant answers yes to this statement, for themselves in the assumed identity, then they mark +1 in their notebook. If the answer is no, they just put a zero, or leave it blank.

- Continue this process till all statements have been read out.
- Next, ask all participants to observe the volunteers who began by standing in an even row, and note how they are all now at different places. Ask each seated participant to total their points and call out the totals. Ask the group to note how widely the totals vary.
- Now ask each standing participant to read out the chits with their assigned identities, and have the group at large observe which identities moved ahead and which did not; which identities had higher totals and which did not.
- Ask everyone to return to their places for the discussion.

Probes:

Q. Which identities were left behind?

Q. Why do you think some identities went ahead and others were left behind?

Q. What did the chits represent?

(**A.** Social identities and social locations – these are structural/ systemic, arising out of the social structures in which we live.)

Q. What did the statements represent?

(**A.** Resources, opportunities, facilities.)

Q. What was the objective of the activity?

(**A.** To develop awareness about how a person's social location and identity enable or limit their access to resources, as well as their mobility, opportunities, and self-expression.)

TAKEAWAYS

1. All volunteers started off at the same spot but ended up at different places, based on their social identities and locations.
2. Social identities and locations are linked with power and social capital, which – more than inherent abilities and capacities or the lack thereof – provide individuals with access to resources, opportunities, mobility, freedoms and choices.
3. Thus, the ability to do certain things such as whistling in public or drinking at a bar or taking a vacation or bringing one's partner home are not simply matters of individual achievement or capacities but are linked to access to opportunities and resources that the social location brings with it.
4. In each situation, different social identities and locations, such as age, gender, sexuality, education, class, caste, ability, geographical location, religion, contribute to increasing or reducing the individual's power in that situation.
5. A knowledge of social locations and associated opportunities – or their lack – helps MHPs to understand better their clients' lived realities and associated challenges.



2.4 Mapping our own sexuality journeys

The first three exercises focused on social structures, and the inequalities present due to sexuality and gender and other social locations. In this next exercise, we explore how these social structures connect to the individual. While growing up, individuals are imbued with ideas about sexuality, acceptable behaviour, gender markers. This shapes our experiences, and also the way we view the world. Looking back and tracing one's own sexuality journey is a starting point for questioning, unlearning and re-learning some of our notions of sexuality. Since conversations around sexuality are not encouraged in private or public domains and are also neglected in curricula, self-awareness and insights into one's own ideas about propriety, morality, shame, guilt may not get explored by MHPs in an intentional way. Such exploration is, however, especially important before therapists may truly claim to provide a non-judgemental space while engaging with clients on issues of gender-sexuality.

OBJECTIVES

To reflect on our own notions of sexuality.

To trace our own sexuality journeys.

MATERIALS

PPT (Power Point) slides; sheets of paper to note down responses.

ACTIVITY AND INSTRUCTIONS

A set of four sexuality-related questions are projected on a screen. Participants are given 30 minutes total to reflect on these questions. A group discussion follows in which each question is addressed, and participants are encouraged to share their reflections and points of view.

The questions for reflection are–

1. What messages did you receive about sexuality while growing up? Where did these come from?
2. What incidents related to sexuality made you uncomfortable, ashamed or morally outraged?
3. What sexuality norms have you broken? What were the consequences, or what would the consequences be, if people were to find out?
4. Which sexuality norms would you like to break?

→ ***Note: The same set of questions may be used to enable participants to reflect on their gender journeys.***

After answering these questions, plot your own position on the Charmed Circle, and reflect on your experiences of privilege, and the times when you might experience a loss of these in that position.

→ ***Note: Facilitator to reiterate that the purpose of the exercise is self-awareness and reflexivity, and therefore it is not essential to share answers with the larger group. However, voluntary sharing (only if the participants feel ready to share) is encouraged, as it helps in the process of learning and reflecting, both for the participant who is sharing and for the other participants. Ensure that it is a space which is safe, where confidentiality will be maintained.***

Each question is taken up in turn, and responses sought from participants. Themes around sexuality are discussed.

Some themes for reflection –

1. Sources of messages around sexuality from figures of authority: Participants may share experiences where parents, extended family, teachers, and so on, propagated socially sanctioned ideas of sexuality: the taboo around sex before marriage; the importance of virginity; woman as the nurturer, man as the provider; sex outside the marital context being dirty. Reiterate the systems that uphold these structures: family, marriage, education, law, religion, science.

2. Messages from peers/any form of media: When did participants come across the word "sex" (as referring to sexuality) being used for the first time? Was it used in a good way – to mean something good, pleasurable, evoking curiosity, anticipation? Or in a bad way – implying something shameful, wrong, unfit for discussion, to be avoided? When did the participant use the word for the first time themselves?
3. Earliest feelings associated with sex: Was there shame? Fear? Participants' opinions about the reasons for these feelings.
4. Experiences that reiterate and cement these notions: Allow sharing of life experiences which served to shape participants' ideas about gender-sexuality – for instance, the persistence of cis male privilege in everyday life and otherwise – power, claim to property, primary decision making; media representations that foreground normative gender-sexuality; the social consequences of challenging or breaking norms.
5. Experiences around consequences of breaking sexuality norms: Participants may talk about how they managed to go against some sexuality norms, and how family and society reacted. They could speak of the impact of these reactions on their lives. (It would help to remember that such personal sharing could be painful, and the importance of holding space for the person sharing.)
6. Struggles while attempting to break norms: For those who wish to share, the journeys of their struggles could briefly be traced. Allow such sharing to be free-flowing. The objective is to recognise the hurdles that people are bound to encounter in the process of breaking norms.
7. Instances that forced you to question norms around sexuality: Encourage participants to share instances when they felt the need to question norms, either because of something happening to themselves, or due to others' experiences and feeling empathy for the latter.

→ ***Note: Experiences related to sexual abuse might get shared during this exercise, and the facilitator would need to be able to engage sensitively with these disclosures. Other ground rules can be worked out in discussion with the participants, for instance, about trigger warnings, taking breaks if the sharing gets overwhelming, and so on.***

TAKEAWAYS

1. Heterosexuality is constructed; messages to train you to be a "good" boy or girl, from a good/respectable family, start from a very early age.
2. "Bad"/"shameful" sexuality is also constructed, alongside the "good" and "pure" kind. This includes messages about what you should never want to be/become.
3. Shame and morality govern the rules around sexuality, which other/stereotype/stigmatise/marginalise those who don't fit in.
4. There are consequences to not following these rules of respectable sexuality; the punishments may come from various sources and are of different kinds.
5. Awareness and reflections about one's sexuality journey help at two broad levels – therapists become more consciously aware of their beliefs around sexuality-morality, including their own prejudices, stereotypes, and so on; and by engaging empathetically with their own journeys and possibly struggles around sexuality, they are able to draw on these to empathise with their queer clients.

2.5 "Sexuality Talk" in the Clinic

We follow up the mapping of our sexuality journeys with discussions of case vignettes that draw upon various sexuality themes.

Notions about sexuality are deeply entrenched in the psyche. An MHP's response in the therapy space on matters of sexuality will significantly depend on internalised ideas of sexuality norms. A scripting approach to sexuality, which includes cultural, interpersonal and intrapsychic scripts, was introduced by Simon & Gagnon (2003) to reconceptualise sexuality as a social process rather than as a biological imperative. The sexual script is a useful approach to uncover the process by which the "normalisation" of reproductive heteronormativity, and the pathologisation of that which is not heteronormative, occur. For the purposes of this exercise, we will focus on unearthing internalised sexual scripts, with their inherent do-s and don't-s – to help practitioners become more reflexive and affirmative in addressing non-normative sexualities and genders.

→ ***Note: As all trainers are queer-identifying MHPs, the broad outlines of the cases are drawn from personal realities and narratives shared by clients in the course of therapy. Since these cases are meant only to be illustrative, they have been tailored towards demonstrating common sexuality-related notions and scripts that MHPs might bring with them into their clinics.***

An MHP's response in the therapy space on matters of sexuality will significantly depend on internalised ideas of sexuality norms.

OBJECTIVES

To bring to the fore real-life gender-sexuality themes to help identify biases and prejudices around sexuality.

MATERIALS

A. PPT (Power Point) slides with cases, and questions for reflection.

B. Printouts of the case details (as given below).

ACTIVITY AND INSTRUCTIONS

The group is divided into four or five smaller groups, with five or six participants in each sub-group.
Each group is assigned one of the six cases, given below, along with this set of questions–

1. ***What are some of your first thoughts about this situation?***
2. ***Have you come across a similar scenario in your personal or professional life? If yes, what were your thoughts/feelings then? If no, was it difficult to imagine the scenario now?***
3. ***Were you able to empathise with the client? With whom was it easier, and with whom was it more difficult, to empathise? What do you think are some of the barriers to empathy and understanding in this case?***
4. ***What do you imagine would be some of your challenges in working with this client?***

The groups are given 30 minutes each for an internal discussion.

Each group first reads out the case assigned to it, and then presents their group discussion points based on the four given questions.

CASE 1

Swati, a 39-year-old married woman, has sought an appointment with you because of distress related to her marital situation. She says that her husband would like to come for a couple of sessions as well. However, she has come alone for the first session – in which she reports that she and her husband Ravi, have been married for nine years and have a 5-year-old son. For some three years, Swati had taken a break from full-time work to be a full-time home maker and mother. She re-joined work about a year and a half ago, and was happy to be back at work; she reports that she has been managing the juggle between home and work pretty well. However, in the past few months, there have been a lot of fights and tension at home, mostly related to Swati's working over several weekends and not giving enough time at home. Swati says that she had been feeling disconnected from her husband, and things reached a crisis when Ravi checked her phone and found romantic and sexually explicit messages between her and a colleague from work. Swati says that Ravi, in his anger, talked about divorce, but she tried to assure him that their relationship and their son were very important to her and she was willing to put in all the work needed to make things work. Swati also says that she was not looking for a relationship but the thing with her colleague just happened – and that though she tried to resist the new relationship, she feels like she has fallen in love all over again. She says that Ravi has been struggling over the last few weeks – oscillating between anger, pain, his dependence on Swati, and willingness to negotiate the open marriage that Swati is proposing.

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION

(likely responses from participants)

What will happen to the child?
The idea of an open marriage when there is a child in the equation evokes anxiety, given that anything other than a typical family with a mother and a father in a marriage is deemed to be an unstable and unhealthy environment for a child. Mental Health training and references within psy curriculum also tend to reiterate this idea, further deepening the therapist's conviction of its truth.

Encourage the group to reflect on what they consider a "stable" family environment.

"She wants to have her cake and eat it too!"
Swati's being unable to take a stand, and wanting the best of both worlds, might come up in the discussion. Her wanting to continue the "affair" and also keep her marriage going could come up for debate.

Let the group reflect on how deeply entrenched certain ideas of marriage are, and on how these notions could impact the framing of the client's problem, and therefore of the therapy. It could also be useful to interrogate the language about relationships outside of marriage – for instance, terms such as pre-marital/extra-marital/promiscuous. Discuss how marriage is the pivot or reference point for all other relationships. In this context, how does Swati's experience get framed? Does the therapist's ideas about marriage as an institution allow them to look at Swati in a non-judgemental fashion?

How is Ravi tolerating all this?
Point out that it is easier to empathise with the person doing the normative thing – in this case, Ravi. Sympathy towards Ravi might surface; with the feeling that he has got a raw deal. Heteronormative scripts, and the therapist's own ideas about masculinity and views about marriage, could form a barrier to empathising with Swati.

Is there the possibility of an unconscious alliance between the therapist and Ravi – who come together in assigning blame to Swati? Discuss the idea of the man in the marriage "allowing" such "promiscuity" on the part of his wife.

Swati seems emotionally unstable.
Swati could get labelled as having a problem, possibly a personality disorder, for falling in love with someone else while being a mother and being in a marriage. This view is problematic: mainly because it pathologises what is perceived as a non-normative sexual/relational expression for a married woman and mother; also because it forecloses any possibility of growth for Swati and Ravi, as individuals, as a couple, as parents, as a family.

Encourage a sharing of spontaneous normative responses from the group. This is important because:

- the therapist must work to put aside spontaneous thoughts and ideas that could impede forming a healthy working relationship with the couple/client(s).
- an awareness that the couple is possibly being subjected to normative, snap judgements outside of the therapy room would help the therapist to explore the feelings of the clients in response to this – feelings of shame, guilt, being trapped, and so on. Exploring and reflecting these feelings and their source back to the client would be an important therapeutic tool.

CASE 2

You work as a counsellor on a helpline that also provides email- and chat-based mental health support services. You receive the following email from a woman who is 33 years old: 'My neighbour and I are very close. We both moved to the city 10 years ago. We have been living next to each other since then. We were both new to the city and found lot of support in each other to cope with the struggles of a big city, especially as single women. About 6 months back, one afternoon, we were cooking together in her kitchen. She was teaching me how to make besan ke laddoos. I am not quite sure what happened but we ended up hugging and kissing each other. And now we just can't stop! In the last 6 months we have given ourselves to each other fully. We have explored and discovered each other's bodies and we can satisfy each other thoroughly. I just can't wait to find time with her alone. The intensity between us is growing. She taught me to orgasm you know. We laughed so much in the beginning because I had no idea what she was talking about when she said "clitoris". But she showed me. My fingers, her fingers, her mouth… I discovered myself and I am in heaven. I am 33 and this is the first time in my life that I am experiencing so much sexual pleasure and I know now that I will never feel this kind of pleasure with a man. I have had two boyfriends in the past, both were serious relationships. I nearly married one of them. Do you think I am lesbian/ bisexual?'

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION *(likely responses from participants)*

What is the main point of this email?

Is the last sentence to be taken as the primary point of focus? Is this email to be read as sent by a client unsure of her sexuality and distressed as a result? After all, this mail has come to a counselling service.

By focusing on the final line, do we completely miss out on the whole aspect of sexual pleasure and discovery?

If the case gets discussed with the main focus being the writer's confusion about her sexuality – Encourage the group to reflect on the tone and intent of the email; and to realise how not acknowledging and validating the experience narrated amounts to minimising the client's reality.

The narrative is very explicit. Normative ideas about desire in the common imagination influence how women's desire is viewed by society; who is supposed to pleasure whom and in what way. Some group members might find the description too bold and explicit.

Discuss the feelings this explicitness evokes: if there is discomfort, what does that tell us about our level of comfort with thoughts about sexual desire and pleasure?

Why is she writing an email which is so descriptive? Is there a hidden message? In society at large, acknowledging women's experience of pleasure, or their own articulation of it, is not sanctioned and is often discouraged. Consequently, the descriptive nature of the communication could get interpreted as a distress call, or as the client's attempt to communicate something beyond the obvious. If we, too, have internalised this attitude, it could be a challenge to take the email for what it is (a declaration of a liberating sexual experience), instead of trying to read more into it.

The group could reflect on the fact that the email space might be the only safe space where the client is able (perhaps anonymously) to speak about topics that are taboo, and how a simple validation of her experience could go a long way in making her feel safe about sharing more, and also about continuing to explore her sexuality.

CASE 3

At a party with colleagues, most of them counsellors from your supervision group, and a few other mental health professionals from your city, the conversation turns towards clients who come with unusual relationship- and sexuality-related concerns. One counsellor is talking about a couple in their early 40s who have explored BDSM, and how it has been a great experience for them. This counsellor reports that – to her surprise – the man talks about the pleasure he experiences from being tied up and being the "subordinate" in the bedroom. And the woman speaks of having joined an online community of people who share a safe space to explore BDSM further and to support each other. At the party, these revelations are followed by discomfort, sniggers, and some jokes about kink and couple swapping.

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION *(likely responses from participants)*

Conversation around BDSM evokes discomfort.
Generally speaking, any sexual behaviour other than the heteronormative kind, sometimes described as "vanilla sex", is viewed as deviant. In such a scenario, BDSM is also usually viewed as deviant behaviour. Nor does it help that BDSM is still listed as a diagnosable condition in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and International Classification of Diseases (ICD).

In the event that the group, too, considers BDSM as deviant, steer the conversation towards consensual sexual experiences – and their special

relevance in BDSM. Inadequate understanding of a range of diverse sexual practices could lead MHPs to being judgemental about client's preferences – which could create a barrier to establishing a meaningful working relationship with clients such as this couple and working competently with them.

What are the ethics involved in such casual and callous conversations about clients?
The incident described reflects how BDSM is viewed by society, and how this may then creep into the therapy space in ways that are not only disrespectful but voyeuristic.

Point out the voyeuristic nature of the casual conversation in the narrative, with MHPs sniggering and joking as they are made privy to one counsellor's clients' non-normative sexual preferences – which also constitutes a breach of confidentiality.

How could the man agree to be the "sub"?
"Acceptable" sex has prescribed roles for the man and for the woman. Indicate the meanings made of being a "sub" in the act.

Encourage conversation around how the act changes in meaning depending on whether the man or the woman is the "sub". Discuss how, in the absence of an affirmative understanding of BDSM, or due to a normative understanding of gender roles in sexual acts on the part of the MHP, BDSM may be read only through the lens of woman's sexual oppression and man's sexual perversion.

CASE 4

Reshma is a 32-year-old corporate trainer. She lives in a rented apartment in Pune. About a year ago, she was laid off along with a few other employees, as part of serious job cuts in her company. Reshma is the sole earner in her family and has already taken loans for buying a house as well as for paying for the hospitalisation of one of her parents. She has been severely distressed ever since she lost her job. One of her friends recently suggested to her that becoming a high-level escort would be one of the fastest ways to earn money and manage her debts. Reshma has since started escorting, and also does some freelance corporate training work. She has been struggling with her new profession as an escort, and is constantly worried about what would happen if people got to know. She has been very anxious, has difficulty sleeping, complains of low energy, and feels low all the time. She has come to you for help.

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION *(likely responses from participants)*

(Why) is there discomfort around Reshma's choice of profession?

Bring out how only certain professions are considered "appropriate" professions; how professions involving the body (escorts, sex workers, bar girls) for sexual services are judged. Also point out how easily an individual's choice of profession gets linked to their "character"; how the integrity of the body becomes an aspect of morality. The biases that the therapist carries about professions such as working as an escort could emerge as a significant barrier to empathising with the client as well as to being non-judgemental during therapy. Assert that sex work is work, and a livelihood

option that a person has the right to choose.

Explore common biases that prevent certain kinds of work from being seen as valid work/vocation/profession – and how, if chosen, they can seriously impact the woman's social position. The group could question why it is that while they uphold the values of autonomy and self-determination when engaging with clients, they might find themselves holding back when it comes to a client choosing such socially stigmatised professions.

Reshma had no option, her life situation demanded she make this choice.

Certain professions, such as sex work, are granted legitimacy/sympathy only when there appears to be a valid justification for choosing these. Thus Reshma's choice could be seen as justifiable only because of her difficult circumstances.

One thread of discussion could be around how the client would be viewed if her circumstances were not dire (loss of job, parent's hospitalisation), and she chose this profession "just" to earn money, like with any other livelihood option. The therapist's position regarding this will determine how heard Reshma feels in therapy.

Reshma's anxiety is because of her profession and the stigma attached to it.

Explore how "low on energy" can be read as depression, guilt, fear, depending on how the practitioner views the profession of being an escort. This will determine the nature of intervention: will it be in the direction of helping Reshma work through her guilt and shame by placing the guilt/shame at the door of the prevailing societal structures, and thereby empowering her to make self-aware choices, or will it be about trying to help her process the shame by encouraging her choose another more socially acceptable profession?

Guide the group to discuss the role of client agency and empowerment in making decisions.

CASE 5

Ankit is a 14-year-old boy studying in the 7th Std in a suburb of Mumbai. He has always been very fond of one of his older cousins, and they share a close bond. The cousin, 15, as someone popular in his school as well as among other kids in the neighbourhood, is a role model for Ankit. One night when staying over, this cousin makes sexual advances towards Ankit; after this, whenever they meet and get a chance, they are sexually active with each other. One day Ankit's father catches the two of them and brings Ankit to you, a counsellor, saying that he thinks his son is being raped by this cousin.

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION *(likely responses from participants)*

While both boys are minors, the older boy has definitely taken advantage of Ankit's adulation. Sexual experiences between minors are often construed as "inappropriate", because they have not attained the legal age of consent, 18 years. If Ankit's age becomes a central point of discussion, it would be important to explore the agency of a minor in sexual matters. The age of the cousin would also be in focus. For instance, if the cousin were 21, this whole scenario would be viewed differently.

Discuss the age issue in the context of the father alleging that the cousin is raping Ankit. Encourage discussion with respect to children exploring their sexuality at an earlier age, and draw out views regarding this. Examine how the premium attached to "innocence" during childhood is one of the major barriers in discussing childhood sexuality.

The father's alarm on learning about the Ankit and his cousin is justifiable.

How consent works with minors, and how adults read it, are core aspects here. So is adults' proclivity to control children's sexuality.

The father's allegation of rape could be discussed taking into account evidences of Ankit's consent in the act ("whenever they meet . . . each other"). What constitutes abuse could also be discussed: can a sexual act between two consenting individuals be seen as abuse? It might be worthwhile to initiate conversation around how we, as adults, refer to children's sexual encounters – observing that terms like "exploration" and "play" are often used, suggesting a tendency to be dismissive of and in denial of children's agency to experience physical intimacy.

If the father has alleged rape, reporting this would be necessary.

Unfortunately, under POSCO (The Protection of Children from Sexual Offences Act, 2012), it is mandatory to report all cases of sexual exploration/ experiences between minors. This is a legal requirement, which needs an ethical resolution. Each MHP needs to figure out for themselves their ethical stance on reporting children to authorities. The answers to these ethical dilemmas would lie in how each MHP views the sexual agency of children.

CASE 6

Rosanna is a 28-year-old married woman who has been referred to a marriage counsellor by her gynaecologist. Rosanna has been married for four years and has a 3-year-old daughter. Recently the couple visited their gynaecologist, as Rosanna has been refusing to have sex with her husband. The husband wanted to know if there was any biological/hormonal reason for this. Rosanna reported to the doctor that she does not feel and has never felt attracted to her husband, and gets no pleasure in sexual relations with him. She had a girlfriend before marriage, and she got into this marriage after her girlfriend was forcibly married off. She tells the doctor that she feels attracted to other women in her building, to film heroines, even to her sister-in-law – but knows that there is no possibility of anything happening with any of them. She says that she masturbates and satisfies herself whenever she feels aroused. Rosanna would like her husband also to do the same whenever he feels aroused, and not trouble her for sex. The gynaecologist has referred the couple to you.

AREAS FOR DISCUSSION AFTER THE GROUP PRESENTATION *(likely responses from participants)*

Rosanna has a very young child; friction with her husband over sex could spiral into a "broken family".

Point out the way practitioners dismiss and minimise any non-normative sexuality-related facts, in a bid to "save" marriages. And flag the common notions about "healthy child upbringing" as pitted against the "broken family". Draw out any moral discomfort MHPs might feel around the wife's behaviour, especially considering that the couple have a child. Discuss where our popular ideas regarding what kind of home/family environment is best for children have originated. Also, note whether Rosanna's anguish is picked up by the group.

The only valid intimacy is between a man and a woman. Rosanna's not feeling like having sex with her husband (considering she's been married for four years and has a child and is therefore societally certified as a heterosexual) is likely to be seen as a sign of sexual dysfunction or some other medical condition. The explanations sought for the refusal to have sex are always biological by default. Hence the husband's insistence on finding the "reason" for the wife's lack of interest in sex with him. In the process, the possibility of their being in a mixed orientation marriage, where the husband is heterosexual but the wife lesbian, may get completely overlooked.

Discuss what is understood as "normal sex", and whether this is confined to peno-vaginal sex. Encourage the group to tease out normative notions of sexuality from this narrative. Initiate a conversation about women's sexuality and choices – including whether it is acceptable in the context of a marriage for the wife not to feel attracted to her husband.

TAKEAWAYS FROM THE CASE EXCERPTS AND DISCUSSIONS

1. We unwittingly carry our biases into our clinics, and though we are trained to be non-judgemental as MHPs, our own ideas of morality, appropriateness and normativity in matters governing sexuality and gender could – perhaps unconsciously – slip in, into our clinics and our practice. These biases are of course pervasive in our social contexts, including in mental health curricula and classrooms.
2. We might well question the very idea of therapist non-judgementality. We may wish, as affirmative practitioners, to claim a self-reflexive stance instead, one that means we are constantly aware of our own ideas of gender-sexuality and beliefs about what is acceptable and what is not – and are able to reflect on the ways in which these views might affect our work with our clients.

2.6 Reflecting on the linearity of body, gender, sexuality

The earlier set of exercises helps reflect on normative sexualities and normative genders. What about bodies? Are they constructed too? In what ways? This exercise also helps us to reflect on the politics of naming – who gets to label whom?

OBJECTIVES

To understand how the connections between body, gender and sexuality are socially constructed

To reflect on the politics of naming and the value of self-determination.

MATERIALS

White board and markers.

ACTIVITY AND INSTRUCTIONS

The exercise is conducted in an interactive lecture style.

The facilitator draws two columns on the board. The left-hand column is labelled 'Normative'. The facilitator asks the participants to answer the following questions –

NORMATIVE

1. How many types of bodies does the normative offer?
Participants say boy and girl; male and female.
PROBE: Facilitator asks participants to reflect on the body, or sex, with reference to a child. Other than the gendered male/female, there doesn't seem to be any way of describing the body. Facilitator suggests 'body with a penis, and body without a penis.' So the normative offers only two types of bodies, which are also supposed to be able-bodied.

2. How many types of genders does the normative offer?
Participants say male and female again. Or man and woman.
PROBE: How is this gender determined? Based on the genitals of the baby – a body with a penis is "assigned" male; a body without a penis is assigned female. Who assigns? Doctors – as they are considered the experts, who look at the external genitalia and divide bodies into two kinds and assign them genders accordingly. Gender is, then, "assigned" to you – which means it is given to you at birth, based on your body.

3. How many types of sexualities does the normative offer?
Only one – heterosexual.
The body that was assigned a gender is expected to grow up in that gender and be attracted only to the "opposite" gender. A man and a woman. You are allowed to feel desire only for the "opposite" gender.

4. How many types of intimate/sexual relationships does the normative offer?
Only marriage, which is considered possible only between a man and a woman, who are then expected to produce a child together, thus repeating the cycle – bringing up the child, who is expected to have a normative gender-sexuality.
The facilitator summarises that what the normative does is to collapse all these categories: it says that your body = to your gender = to your sexuality. It creates a binary for bodies as well as for gender; and sexuality is possible only within these binaries.

Next, the facilitator labels the right-hand column 'Non-Normative', and asks the four questions again, one by one.

NON-NORMATIVE

5. How many types of bodies does the non-normative offer?
Bodies are multiple. Bodies are as diverse as there are people, but the gendering of bodies into a binary is a social construction that keeps out the diversity of bodies and genders. We know that apart from the male and female sex based on external genitalia, there are variations in sexual anatomy, reproductive organs, hormones, chromosome patterns – and some of these variations are broadly included under the identity of intersex. We have much to learn from people with intersex variations about bodies. Intersex is not a separate or third "type" of body or sex. Intersex variations tell us that the available, normative definitions/understanding of bodies as being of only two kinds limits our understanding of the diversity of bodies and sexes.

6. How many types of genders does the non-normative offer?
Again, multiple. Gender is determined by the felt experiences of the individual, and not by the gender that is assigned at birth based on whether or not the body has a part resembling a penis or a vagina.
PROBE: What does cis gender mean? The term describes the gender of those individuals who identify with the gender they were assigned at birth. For instance, if someone was assigned female at birth and grew up and continues to experience her gender as female then she is cis female/cis woman. Basically, if the gender assigned at birth and the gender you identify with match, then it is called being cisgender.
PROBE: What does trans gender mean? The term refers to those individuals who do not identify with the gender they were assigned at birth. For instance, if someone was assigned female at birth and experiences their gender as male, he might use the gender label 'man' or 'trans man' for himself. Basically, if the gender assigned at birth and the gender you identify with do not match, then it is called being transgender: trans man, trans woman, transgender are some of the labels people may choose for themselves based on their own

NON-NORMATIVE

experiences. Some people identify as nonbinary. This means that the available, normative definitions/understanding of only two genders just does not fit their personal experience of gender. Hence, under the non-normative column, gender is not one, two or three, but is self-determined, and there can be many genders. Gender is based on lived and felt experiences rather than socially constructed boxes.

PROBE: What would the body of a trans woman be? Is this question relevant? Why do we need to know? This need to know again arises from the thinking that assumes just two kinds of bodies and two kinds of genders. A trans woman would have been assigned the male gender at birth; she might or might not have undergone any changes in her body. Irrespective of whether she has sought medical transition to change her body, she is a woman because she knows and says that this is her gender.

7. How many types of sexualities does the non-normative offer?

Multiple.

PROBE: How can we best define lesbian? "A woman who loves a woman" is the traditional definition. Can we now learn to say: a woman-identified person who is attracted to (an)other woman-identified person(s). They need not be cis women.

PROBE: What is the sexuality of a trans man? It could be anything from heterosexual, to gay, to queer. If a trans man is attracted to women-identified persons, he might self-identify as heterosexual, or might not (for instance, he might call himself queer).

8. How many types of intimate/sexual relationships does the non-normative offer?

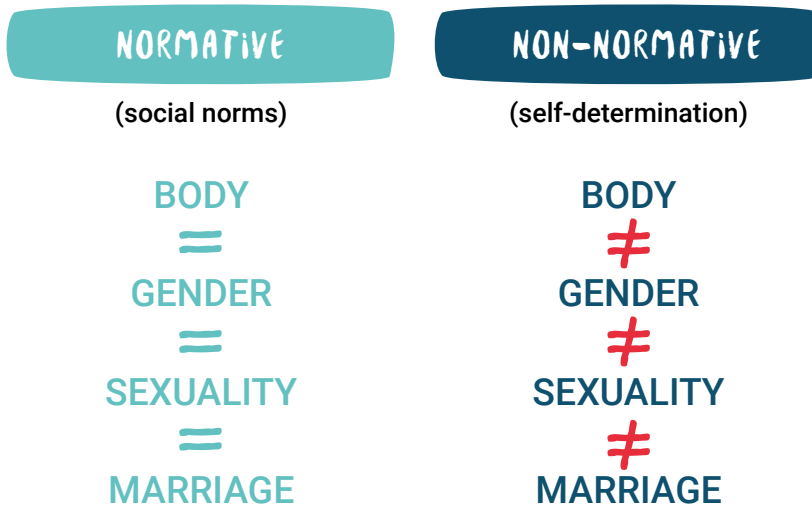
Multiple. Relationships need not fit the normative script of marriage or, indeed, coupledom, but are defined by the people involved in them.

PROBES FOR THE EXERCISE, OVERALL:

1. Why do we know so little about non-normative genders and sexualities, experiences and lives?
2. Whose responsibility is it to educate the normative persons?
3. Why should the burden of identities and labels be placed on already marginalised groups? All bodies, genders and sexualities are natural but only some get constructed as "natural'" and therefore, "normal".



The normative makes a linear association between bodies, genders and sexualities. The body = gender = sexuality equation is socially created, and is not based on the lived realities and felt experiences of non-normative persons. Unfortunately, it is not self-determination but the socially determined script that becomes the basis for people's identities. Very many lives are invisibilised by this social script which restricts bodies and genders to only two kinds, and sexuality to only one kind.



trans gay lesbian queer non-binary

2.7 The politics of labelling

THIS LOPSIDED NATURE OF LABELLING AND ITS IMPACT ON NON-NORMATIVE LIVES, MUST BE RECOGNISED BEFORE WE SET OUT IN SEARCH OF LABELS.

How do we understand labelling at QACP? Why is it that we don't share with you a list of labels and terms that queer/trans people use? Why do we take you through this journey of naming the normative? This is a deliberate choice.

The normative never has to define itself in any way. It is backed by social structures and scripts. It just falls under the label of "normal" and is not even considered a gender-sexuality label. A majority of people would not even know what cisgender means, and normative people almost never have to say, 'I am heterosexual.' This power imbalance is what we at QACP want MHPs to engage with. Unless we engage with this politics of labelling, our curiosity and our interest in knowing more labels and definitions just adds up, in fact, to *othering*. Our knowledge about labels needs to be situated within the unequal structure of naming. Who gets named? How do they get named? Who does the naming? What meaning do such acts carry? These are crucial questions of which to remind ourselves. Not every label/naming is equally valued. The normative has the power to "other" the non-normative, while never needing to name itself because it carries within it the power of the "normal". This lopsided nature of labelling and its impact on non-normative lives, must be recognised before we set out in search of labels. Just knowing a hundred different labels that queer/trans people might use for themselves without recognising the inherent power difference is not useful.

None of which is to say that the labels that queer/trans people use to define themselves and their experiences should be disregarded! Labelling is essential to give a name and meaning to experiences that are otherwise forced out of view. The question we need to ask is: whose need is it to have the label? Is the MHP asking for labels because they want to slot and categorise the non-normative client? Or are MHPs willing to engage with labels that clients and queer/trans communities use for themselves in order to visibilise their realties? Labels are powerful, without a doubt, and are discussed further in **Chapter 5** *(see 5.3 – 'Tenet 1: Knowing and using queer affirmative language').*

It is important that cis-het practitioners recognise heterosexual, cis man, cis woman, married as identity labels, too, just like gay, lesbian, trans, and so on. Additionally, queer identities must explicitly be labelled as normal. This needs to be done in order to give legitimacy to stigmatised identities, and is one of the ways in which the power of the normative can be redistributed.

EXERCISE

A Day in the Closet

Why this exercise?

Heterosexuality is woven into everyday life in such a way that those with this kind of sexuality are often not even aware of the ways in which their sexuality plays out. Is sexuality only about our attraction, feelings, desire? If we are heterosexual then what are the many ways in which this gets expressed in our daily living, even without our realisation?

OBJECTIVES

To reflect on the everydayness of heterosexual expressions, and how these are normalised.

MATERIALS

The exercise is more effective when done with another person with whom participants can discuss their observations.

ACTIVITY AND INSTRUCTIONS

Please follow the instructions, for one whole day from morning to night. Make notes at the end of the day about your reflections. You may also make notes through the day. Repeat the same exercise on a festival day, or during a family function.

Live this day just like any other regular day, doing all your daily chores, work, usual social and familial interactions, and so on. The only thing different today is that you will not make any reference to your sexuality or your sexual/relational life. For instance, in your conversations (no talk about husband/wife, in-laws, children) or dress/grooming (no markers of marriage either in dress, or by means of a wedding ring, *mangalsutra, sindoor*, bangles, or any other jewellery that marks marital status). This means that you don't initiate nor do you respond to other people if the conversation is about relationships/sexuality. Also observe how many times other people make a reference to their sexuality and/or marriage while talking to you. Observe what kind of information they share about their relationships and make a note of this.

PROBES:

1. Did you have to change your daily behaviour, thoughts, speech to be able to do the exercise?
2. How often and in what circumstances did you have to silence/check yourself?
3. What are your thoughts/feelings about this exercise?

TAKEAWAYS

1. Understanding the extent to which sexuality (heterosexuality) is a part of our daily life.
2. Understanding the extent of the visibility of heterosexuality.
3. Empathy for the experiences of queer persons, who must often live their relational and sexual lives in silence.

Conclusion

The main intent of this chapter was to help us recognise that "normal" gender and sexuality are not naturally occurring phenomena but are constructed through a complex web of institutional and social processes. Heterosexuality and the "two bodies equals two genders" system are the products of this social construction. All other types of bodies, genders and sexualities are rendered as the "other" – the unnatural, abnormal, pathological, in need of a "cure" to become "normal". Social institutions play a crucial role in maintaining the norms of heteronormativity and body-gender binarism; and the process of socialising us to fit these norms begins right at birth. By the end of this chapter, we should be able to shift our understanding of the "normal" to the normative, i.e., that which fits in with the social norms; and to understand bodies, genders, sexualities and experiences which are excluded by the same social norms and pushed to the margins as non-normative. Non-normative people and lives are, then, marginalised by social norms, making gender and sexuality matters of social inequality and systemic oppression.

As MHPs we must become alert to, and account for, our own lack of knowledge and our prejudices towards this gender-sexual "other". The set of exercises given in this chapter was a starting point towards that end.

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Illustration: Parth Pawar (@artwalahoe)



What does it mean to live as a queer/trans person?

Knowledge that is considered valid is created by the oppressor. It is inadequate and harmful. We must recognise that lived experiences is valid knowledge- day-to-day experiences and struggles with oneself, with peers, with families of origin and with society at large. Learning from the margins about the margins is the only way to equip oneself as an MHP.



CHAPTER 3

What does it mean to live as a queer/trans person?

3.1 Learning from lived experience and clinical experience

In the last chapter, we asked you to examine your own social locations and, if these were normative, then to recognise the privilege embedded in them – and how that shapes your understanding about queer/trans lives. In this chapter, we aim to bring to you knowledge from the margins of the Charmed Circle.

Knowledge in general, and particularly within the psy disciplines, is usually knowledge by and about the dominant. Since the psy disciplines engage, primarily, with the deviant, they do create knowledge about those of us who are on the margins – knowledge

created by the dominant about the margins. In this chapter, as we bring you knowledge of lives as lived and experienced by persons on the margins of normative gender-sexuality, we encourage you to reflect on the question: Which kind of knowledge may be considered valid knowledge? For too long, matters of gender-sexuality have been viewed from a cisgender and heterosexual lens. The knowledge about queer/trans lives generated in the mainstream is often a reflection of stereotypes and prejudice against queer/trans persons and is, therefore, not only incomplete and incorrect but potentially harmful (to queer/trans persons). Mainstream mental health curricula rarely represent the realities of LGBTQIA+ communities in valid and authentic ways. If this is so, then where do we learn about lives on the margins? We learn it from the lived realities and felt experiences of people on the margins, and we recognise this as valid knowledge. We learn from knowledge generated by queer/trans people; from knowledge drawn from queer/trans lives, politics and struggles.

This chapter is rich with information about queer/trans people's lived realities. We have relied on personal experiences, the authors' clinical (therapy process) experiences of working with queer/trans clients and their families, as well as on existing research on queer/trans mental health. This information has been presented in ways that may be used as conceptual tools to inform therapeutic practice with queer/trans persons as well as to sensitise other MHPs and students of mental health sciences.

The knowledge about queer/trans lives generated in the mainstream is often a reflection of stereotypes and prejudice against queer/trans persons and is, therefore, not only incomplete and incorrect but potentially harmful (to queer/trans persons).

3.2 Unique Life Stressors (ULS)

common therapeutic issues while working with queer and trans individuals

In this section, we engage with some common therapeutic issues that arise while working with queer and trans individuals. These are unique to our lives as queer and trans people living in a cis-heteronormative society, and thus quite distinct from those faced by people who more comfortably inhabit the cis-heteronormative world.

While examining the lives of queer and trans people, it is important to take into account their position in society and the impact that has on their lives. LGBTQ+ individuals and communities can validly be described as belonging to a minority in terms of their gender-sexuality locations: they are, in the main, forced to live their lives based on the societal norms laid down by the dominant social groups – which in this context means those who uphold the norms of cisgenderism and heterosexism. Such a minority is consequently subject to a number of stressors – the nature of which may be understood further through the Minority Stress Theory put forth by Ilan Meyer.

Meyer (1995) studied the impact of minority status and minority identity on the mental health of sexual minorities. *Minority stress* can be described as the "juxtaposition of minority and dominant values and the resultant conflict with the social environment experienced by minority group members" (p. 39). In his pathbreaking study on the impact of minority stress on the mental health of gay men, Meyer talks about three aspects of minority stress: internalised homophobia; expectations of rejection and discrimination; and events of actual prejudice. He points out that even before a queer individual comes out to their self, dominant notions prevalent in society about the unacceptability of homosexuality are already deeply entrenched

Such a minority is consequently subject to a number of stressors – the nature of which may be understood further through the **Minority Stress Theory** put forth by Ilan Meyer.

in them. Such socialisation manifests as internalised homonegativity, especially during the "coming out" period. The individual finds it hard to shake off the belief that they have some fundamental internal flaw when it comes to their sexual orientation.

The social stigma associated with a minority status is reported to have rather a detrimental effect on mental health, more so when it comes to sexual minorities. Citing numerous psychological and sociological studies, Meyer says that the stigmatised minority's perception of non-acceptance in their social interactions leads to a state of insecurity – and, often, hyper-vigilance – in social situations, adding that **'a high level of perceived stigma would lead minority group members to maintain a high degree of vigilance – expectations of rejection, discrimination and violence – with regard to the minority components of their identity in interactions with dominant group members' (Meyer, 1995, p. 39).**

It is important to note here that this constant monitoring of one's own emotions and behaviour can prove extremely exhausting.

Belonging to such a minority also means living in the shadow of the fear of being discriminated against, and of expecting physical and/or emotional abuse from the dominant group. This in itself is a major stressor, with which minority members must chronically grapple.

Until September 2018, homosexuality was criminalised in India. Hence not just social sanction, legal sanction too was completely absent for queer individuals, who were perforce pushed to live lives that were hidden, inauthentic, fearful and restricted. Even today, despite the Supreme Court's reading down of


REFUSING EQUAL RIGHTS
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ABANDONEMENT
FRAGILE RELATIONSHIPS
NO SAFE HOME SPACE
REFUSING EQUAL RIGHTS
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QUEER PEOPLE HAVE TO MAKE
SEXUALITY
THE LOSS OF PRIMARY SUPPORTS LIKE
HEALTHY ACCEPTANCE OF ONE
QUEER SEXUALITY
NEGATIVE
FAMILY, OF HETEROSEXUAL PRIVILEGES, AND LOSSES
VIOLENT RESPONSES, WITHHOLDING RESOURCES AND PRIVILEGES,
INVISIBILISING GENDER-SEXUALITY, UNSUPPORTIVE SOCIETY
DEPRESSION, ANXIETY, JEALOUSY, SUSPICION

the notorious Section 377 of the Indian Penal Code, social sanction is far from being a reality. Given the fact of minority stress, it is not surprising that queer individuals live with certain unique stressors emerging from their sexual minority identity. Mental health support may, then, routinely be sought for issues such as low self-esteem, anxiety, self-doubt, homonegativity, paranoia, fear of violence, experiences of discrimination and, in general, the inability to lead a meaningful, fulfilled life.

It is therefore imperative for an MHP to keep the minority stress framework in mind while addressing the mental health concerns of queer and trans individuals.

MHPs must recognise that–

- Neither is queer sexuality nor is being trans a problem in itself, nor is it true that being queer/trans in itself leads to mental health problems.
- Living life as queer/trans people is difficult due to the external, heteronormative environment that upholds and reinforces the two body-two gender-one sexuality system.
- This system results in queer/trans people experiencing prejudice, exclusions and stressors that are unique to them owing to the social context of gender-sexuality that exists around them. Cisgender-heterosexual (cis-het) persons are not subjected to the same stressors, as their sexuality and gender fit the social norms.
- An understanding of ULS helps MHPs build knowledge about the psychic experiences of queer and trans persons. It is also a useful framework in which to situate certain specific mental health concerns of queer/trans people, and is a departure from the traditional "deficit" framework of the psy disciplines that locates the source of distress, or the "problems", within the individual.
- In order to understand ULS better, we suggest doing the following exercise. Please note that this has been written out in an activity format so that it may be used in workshops on Gender-Sexuality. As an individual practitioner, you could simply read the scenario and answer the given questions.

EXERCISE

Inversion Scenario

→ ***Note: We use the gender binary language of "man" and "woman" here – as we are primarily seeking, through this scenario, to highlight issues faced by cisgender queer persons.***

Imagine a time 1000 years ago/ in the future. You live in a country of 10 million people. 95% people here are homosexual. Most of them marry people of the same gender. The average age of marriage is 22-28, and most families have one or two children. The state insurance covers the use of medical technology for childbearing. Parents raise their children on story books such as the one about the love between Cinderella and Snow White; and bring them up to become normal, healthy homosexual adults. Religious leaders promote homosexuality and condemn any heterosexual behaviours as sinful. There are laws punishing

OBJECTIVES

To introduce participants to the lived realities of queer individuals.

To illustrate that these realities are a function of the oppressive social systems in which we live.

MATERIALS

Printout of the "Inversion Scenario" for the trainer; white board and markers.

ACTIVITY AND INSTRUCTIONS

Have participants close their eyes and listen attentively.

Read out the Inversion Scenario once.

Ask the group to answer the questions that are put up in three columns on the board.

any kind of heterosexual conduct. Medical foundations are putting in lakhs of rupees into research aimed at finding and eliminating the "straight gene", and to find a cure for heterosexuality.

You are a 32-year-old woman/man, who has always been attracted to people of the opposite gender. Despite several attempts at getting rid of these feelings, you have an intense inclination towards persons of the opposite gender. You work in a hospital as a counsellor that has a policy against the hiring of "perverts" such as yourself. In this institution, most people are either married to, or have steady relationships with, people of the same gender. The institution provides insurance cover and all partner benefits to homosexuals (married or in partnerships).

You have heard of reports on the internet that as many as 5% of the people in the country are heterosexual, but you haven't personally met anyone like yourself. You suspect that there must be others but, just like you, they all probably have to remain in the closet for fear of being "found out". The only place where you sometimes see heterosexuals is in movies, where they are used for comic relief.

REFLECT ON THE FOLLOWING QUESTIONS –

- Would you be at a disadvantage in such a society?
- What are the challenges you would face in this society?
- Which social institutions would be barriers for you?
- What would be your feelings/emotions in such a society?

YOUR NOTES

Allow about five minutes for reflection, and list all the responses to each of the questions under the relevant heads. Some answers that typically emerge:



CHALLENGES	SOCIAL INSTITUTIONS	FEELINGS/ EMOTIONS
No friends	Family & marriage	Loneliness
Hidden life	Law	Sense of alienation
Double life	Religion	Not belonging
Pretending	Workplaces	Fear
Fear of losing one's job	Media portrayals	Feeling inauthentic
Fear of being found out	Medical and Psy disciplines	Shame
Marriage pressure		Guilt
Violence		Anxiety, worry
Discrimination		Humiliation
Finding partner/s		Suicidal ideation
Nowhere to seek help for distress		Isolation
Not being able to share my truth		Worthlessness
		Hopelessness
		Feeling trapped
		Helplessness

REFLECTIONS –

1. The challenges were a direct result of the social norms that promote only a certain type of reality. Here, homosexuality was the social norm that pushed heterosexual people into the margins.
2. Social institutions work in collusion to maintain what is "normal", and pathologise and punish heterosexual realities in different ways.
3. Mental health and well-being were negatively affected because of societal responses to heterosexuality rather than caused by something internal to the individual.

YOUR NOTES

→ ***Note: We did not ask cis-het practitioners to imagine themselves as queer in order to build empathy for queer lives. We simply asked them to imagine having a marginalised identity in a society that stigmatises that identity. When the social systems became negative or hostile towards heterosexuality, mental health was immediately seen as being affected. Before this, heterosexuality had not been experienced as being wrong or abnormal.***

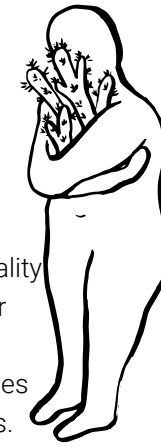
The most important takeaway of this section is simply this: the source of the distress related to sexuality actually comes from rigid social norms. MHPs must recognise this and actively work towards locating the source of distress outside the individual client. It is important to place responsibility on various social structures, and help clients recognise that their distress isn't stemming from who they are inside but how they are made to feel about something that is innate and natural to them.



We now discuss, in two separate parts, some detailed examples of Unique Life Stressors (ULS) for queer and trans persons. The first part elaborates on stressors on account of non-normative sexuality, and the second on non-normative gender expressions and identities. Please note that these stressors, while distinct at times, could also be overlapping for queer and trans clients.

It is unlikely that clients themselves would be able to pinpoint these stressors in their lives in these same terms. They are likely to speak to their counsellors about feeling depressed, ashamed, disgusted, or dirty; they may tell you that they are not being able to concentrate on their studies, or not being able to hold down a job. They may talk about getting teased, bullied, or beaten. Making possible links between the problems articulated by the client and the unique life stressors related to their gender-sexuality is the responsibility of the queer affirmative practitioner.

UNIQUE LIFE STRESSORS IN QUEER LIVES[11]



1. **Difficulties with self-acceptance**
   Queer people grow up in a heteronormative society, which stigmatises and rejects non-heterosexual sexualities. Having a healthy acceptance of one's sexual identity is, then, an often tumultuous journey that many of us have to make. Homosexuality and/or bisexuality are perceived as perversion, as pathology, or as phases that will pass. The understanding and opinions held by the heteronormative world about non-heterosexual sexualities is, frequently, also what queer people believe about themselves. Reflections of non-normative realities in a heterosexually constructed world are rare to come by, which further cements such beliefs. We refer to this as *Internalised Homonegativity/ Bi-negativity* – which describes the sense of guilt, hatred, shame, anger, denial, suicidal ideation, low self-esteem, self-doubt, confusion, neglect, repulsion, feelings of having done wrong, feeling different, feeling dirty, and similar negative feelings that clients have about their own sexuality or sexual behaviour.

Reflections of non-normative realities in a heterosexually constructed world **are rare to come by,** which further cements such beliefs.

CLIENT EXPERIENCE 1

I am a lesbian. I try very hard to stop but I always seem to prefer girls. I have tried sleeping with men on many occasions in the hope that I will start liking it. But, since college days, I am like this. I have done my Master's degree and for the last four years I am working in a reputed company. I am scared that if they come to know about these feelings of mine, I will lose my job. I hate this addiction to girls.

QACP VIEWPOINT

Many queer people's narratives reflect such internalised homonegativity. It is the responsibility of the counsellor to be alert to these feelings of non-acceptance in their clients. In this example, believing that her sexuality is an addiction, and wanting to stop feeling as she does, are indications of the client's discomfort with her sexuality. When clients are unable to accept themselves, it becomes the priority of the practitioner to ferret out and address these negative feelings during counselling.

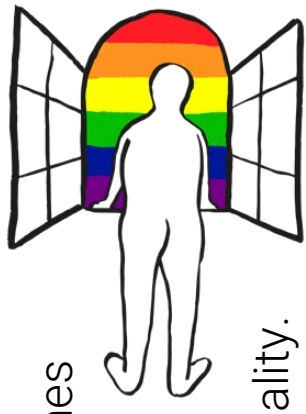
YOUR NOTES

CLIENT EXPERIENCE 2

I cannot bear it anymore. Please help me change. I want to be normal again. My religion does not allow men to have sex with other men. My parents are finding a girl for me. So I cannot go on like this. Please do something and change me. As a man, I want to learn to have sex with women only.

QACP VIEWPOINT

Lack of self-acceptance also manifests in clients seeking counselling support in order to "convert" to heterosexuality. QACP asserts that trying "to cure homosexuality" is inherently flawed, and that Conversion Therapy is a harmful and unethical practice. Such a practice stems from the faulty belief that homosexuality can be "treated" so as to fit the heterosexual standard. While some clients might benefit from more information, affirmative messages, and acquiring a sense of community through meeting more individuals like themselves, many others may continue to remain conflicted and express a desire to change. Affirmative practice would include validating that conflict and the feelings arising from it; it would focus on exploring the sources of the conflict and help clients work through these. Often, the client seeking out a therapist in order to "cure" their homosexuality is linked to an immediate stressor in their life – for instance, the painful break-up of a same-gender relationship, after which feelings of shame, rejection and being "bad" could resurface. Or the reason for seeking conversion treatment could be increased marriage pressure at home. Addressing some of the underlying issues that may have motivated the client to seek to cure their homosexuality could help them work towards self-acceptance. **Chapter 5** (see 5.3 – 'Tenet 5: Facilitating self-acceptance')



In a heteronormative society, heterosexual people never have to come out and tell others about their sexuality; it is already a given. The process of coming out becomes unique, then, to queer people, when they are forced to acknowledge their own difference in the face of the mainstream and more acceptable sexuality.

2. Coming out

Compulsory heterosexuality refers to the assumption that all human beings are born heterosexual – an assumption widely held in our own socio-cultural context. Consequently, non-heterosexual sexuality must first be discovered by the person themselves, before it can be revealed to others. This process is called "coming out". Coming out happens at two levels: coming out to self means realising 'I am not heterosexual'; coming out to others means revealing to them that 'my sexuality is different from heterosexuality'. In a heteronormative society, heterosexual people never have to come out and tell others about their sexuality; it is already a given. The process of coming out becomes unique, then, to queer people, when they are forced to acknowledge their own difference in the face of the mainstream and more acceptable sexuality.

CLIENT EXPERIENCE 3

I was very scared to tell my mother but she was already suspicious and so I told her that I am homosexual. She locked herself in the bathroom and cried all night. Next day she told my father, who beat me up. One day, my mother caught me talking on the phone to my girlfriend. She went and insulted her in front of the teachers and other students. My girlfriend was asked to leave college after my mother outed her like that. My parents took me to a psychiatrist, who started giving me medicines that made me feel drugged. I was only 18, but my parents started asking relatives for a prospective husband for me. Finally, I ran away from home. This was five years back.

QACP VIEWPOINT

As is apparent from this case, the consequences of coming out are unpredictable and could be violent. Coming out requires careful consideration and readiness on the part of the queer individual. Coming out should not be viewed as necessary or framed as a goal in the counselling process unless it is something towards which the client expressly wishes to work. For a long time within LGB mental health discourse in the West, the idea that coming out is an important milestone to achieve a synthesis of one's sexual identity, and is essential to lead a healthy and happy life, has been very popular. This idea has been widely challenged.[12] We understand, increasingly, that coming out is not merely an intra-psychic process but a contextually situated one, where the individual assesses the safety and consequences of their decision to come out (Ranade, 2018). Thus, the client's coming out must not be seen as a marker of success by queer affirmative therapists.

YOUR NOTES

Critical points to remember when clients consider coming out to others:

- Every queer person constantly has to evaluate who they can come out to, and how much and what they would want to reveal about themselves. Often, queer people find they have to come out to the same people, multiple times.
- The final decision on how, when and to whom the client comes out must be made by the client alone. Telling others about someone else's sexuality without that someone's explicit consent or knowledge is called "outing" a person. Outing a client is unethical practice. In the case under discussion, the client's mother outed her daughter's girlfriend. Outing is often done to shame, or publicly humiliate the person. Counsellors need to be alert to how being outed, or the fear of being outed, can have serious mental health consequences.
- Coming out can sometimes have violent consequences because of the stigma associated with homosexuality – forced marriage, house arrest, stopping the person's education, separation from partner, besides the emotional harm caused by rejection, denial, and being shamed.
- Preparation and strategising on how and whom to come out to can minimise the risks to some extent, and enhance client preparedness.
- The process of coming out is different for different people. The counsellor can facilitate this process by helping the client to work on other issues such as the guilt and shame they might associate with their sexuality, which are known to be barriers to coming out to oneself as well as to others.
- As already emphasised, the final decision about when and how to come out, and to whom, is always the client's. A decision not to

come out is not necessarily a sign of some sort of "incompleteness", nor does it imply the lack of an "authentic" queer identity.



3. **Invisibility**

Heterosexuality is visible, accepted, and celebrated. Queer sexuality, on the other hand, is invisible, deemed unacceptable, stigmatised. Heterosexual privileges awarded to married heterosexuals include the affirmation of their togetherness, their never having to hide their relationship, their being acknowledged as a husband-wife couple at all times, their possibly having an extensive support system as well as social capital in the form of relatives and friends, with access to familial resources and material benefits.[13] Queer people, who typically lack these privileges, may be pushed to lead double lives, hiding their sexuality from other people in order to escape violence, avoid being shamed, and so on. Invisibility could also mean having no queer-affirming people or spaces that might mirror their own realities. Not having access to resources that affirm one's existence results in feelings of isolation, and a deep sense of loss for lacking what everyone else around one seems to take for granted.

Queer people, who typically lack these privileges, may be pushed to lead double lives, hiding their sexuality from other people in order to escape violence, avoid being shamed, and so on.

CLIENT EXPERIENCE 4

Every time I go home, my mother starts the same topic – 'Beta, I found a wonderful girl for you. Why don't we go and meet her? You are now 28, how much longer will you delay your marriage?' And it is not just her but the relatives, neighbours, my colleagues, my friends, they all keep trying to fix me up with some girl. Sometimes I just want to tell everybody that I am gay and now please find me a boyfriend! But that is not possible. That is a dream world. If I tell my parents, they will try and find me a girl even quicker. All this lying and hiding – it has begun to cause me a lot of stress.

QACP VIEWPOINT

This gay man's narrative reflects how queer people may be forced into a dual existence, often having to lie actively, or make up a "pretend life". Not having enough information, not knowing other people like oneself, not having support for one's relationships – these are all consequences of an invisibilised existence. The loss of primary supports like family, of heterosexual privileges, and losses in terms of education and livelihood also feature prominently in queer lives. It is important to recognise that the QACP practitioner may be the first person to have knowledge about their client's sexuality. Therefore, acknowledging the invisibility, isolation and sense of loss, and then affirming and validating the client's sexuality and life choices, become crucial.

YOUR NOTES

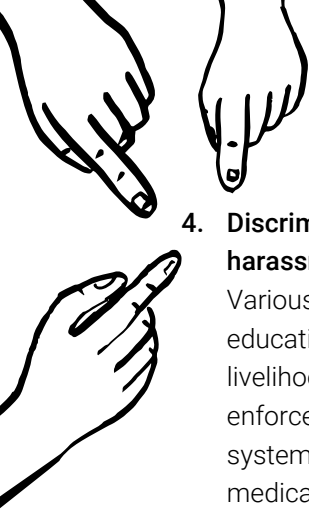
CLIENT EXPERIENCE 5

My girlfriend is receiving an important award but I am unable to get a front row seat next to her because we have no way of proving that we are a lesbian couple, that we are together. She is somewhat famous so she can't talk about her sexuality, and us, because it will impact her career. So her parents, siblings, even her extended family that she does not care about, are getting front row seats, but I – I, who am her partner – has no place. I am just with the general crowd, because no one knows we are a couple. We are "just friends". It is such a prestigious moment for her, I am so proud of her and yet I have to sit far away, just like one among the crowd. instead of being able to sit by her side at such a moment of celebration.

QACP VIEWPOINT

This client's sexuality and her love for a woman are invisible to the heteronormative society around them. Because they are two women, they are assumed to be "just friends" – both, their sexuality and their couplehood, are erased. As a result, they are kept apart, unable to share this significant moment together. Because heterosexuality is so visible and validated, other sexualities get relegated to the sidelines, often with severe consequences for queer clients. This invisibility and its negative consequences is something to which the QACP practitioner must be alert, in order to help clients process the ensuing distress. It is important to validate the unfairness of the situation, and the accompanying sense of loss to which the client is subjected because of compulsory heterosexuality.

YOUR NOTES



4. **Discrimination and harassment**
Various systems such as educational institutions, livelihood spaces, law enforcement and legal systems, hospitals and the medical system, and – not least – families, can become sites of harassment if the non-heterosexual sexuality of a person becomes known. Discrimination is manifested in the form of violent responses, such as withholding resources and privileges, curtailing access and mobility, refusing equal rights.

CLIENT EXPERIENCE 5

You remember when I had told you that five years back my girlfriend and I started living together at her parents' place. I used to go over often to meet her and stay the night in her bedroom, and slowly- slowly I just moved in. Her parents knew, of course, that she's queer, and they knew that I was her girlfriend. They never said anything negative about us living together. My GF has a younger brother. A couple of years back he fell in love. His GF used to come over to meet him often and spent time in his room, but she never stayed over. Then they got married. They are a wealthy family and had a lavish wedding. His entire room was renovated to make it into a couple bedroom. When she first came, she was welcomed in typical "bahu" style, lots of rituals took place, and the family jewellery along with a new car was gifted to her. We all settled into a routine of living together. Next month is their first marriage anniversary. The whole family is gearing up for a huge celebration. All day long we are busy discussing the logistics and arrangements, guest lists, menu – and everyone is running around to make sure that the event is a big success. I know I should be happy, it is such a happy occasion, but I am beginning to feel suffocated. I don't feel like living in that house anymore.

QACP VIEWPOINT

The client's emotions are primarily a response to the discrimination she is facing as a lesbian and in being part of a couple that is not really valued or even seen for what it is in the heteronormative household. There is ample recognition of heterosexuality, but only a tacit and silent tolerance of queer sexuality. Validation and celebration are not accorded similarly to both couples. It is important to recognise that not awarding the same status to all sexualities is systemic inequality. Clients are likely to have experienced some form of harassment and discrimination on account of their sexuality – without any redressal, or even so much as an acknowledgment of such treatment. Discriminatory experiences may take overt forms such as violence, bullying, denying a job or promotion or housing, or it could take covert forms such as the one described in the case under discussion, where there is no outright disapproval, yet there is some amount of denying and erasing of the queer relationship. MHPs can support clients by acknowledging the discrimination and unfairness that emanates from being outside the Charmed Circle, and help clients work through feelings which may range from deep despair and a sense of being wronged to anger and rage. Being able to articulate these feelings and having them validated by the therapist can in itself be empowering for clients. At times, clients may wish to make certain choices or initiate actions to address the discrimination, and the therapist can help them work these out as well.

YOUR NOTES

5. **Relationship issues**

   Heterosexual marriages give sanction and legitimacy to a relationship between two people. Rarely do any other relationships ever get the same affirmation and validity as marriage. Therefore, queer people have to wrestle with their romantic, sexual relationships not being considered serious enough and/or with the threat of separation from their partners. QACP takes into account these associated losses.

   Marriage also promotes a long-term, single partner model of relationships. QACP recognises that queer relationships (also several heterosexual relationships) do not necessarily follow the same trajectory. Relationships may be multi-partnered, open, non-monogamous. They may be short-term. The couple may not necessarily live together. There are no rigid definitions as to what a relationship means. A person may be in a relationship with a man as well as with a woman at the same time, or at different points of time in their life. There are negotiations and boundaries that each person in the relationship decides on, with each other. QACP practitioners must guard against inadvertently pushing their clients towards building relationships along the lines of marriage. Instead, they must recognise that the counselling space may be the only place where the client's relationship is valued and validated.

   Queer relationships, like any other, face interpersonal problems. Communication and compatibility issues, disagreements, fights, and sometimes even physical violence, are a part of intimate relationships. Fear of losing one's partner, jealousy, suspicion, and abandonment, are other emotions that clients may bring to the session and that would need to be addressed. Additionally, the issue of how out to be as individuals and as a couple may be a cause of discord.

   Particularly for queer people who are in heterosexual



marriages, living a dual relationship is an additional stress. Their married spouses may not be aware of their other relationships. This may cause guilt. Health risks for the married spouse may also be an issue to which QACP practitioners need to be alert. Being married to heterosexual people brings its own set of problems between queer couples. Not being able to visit the partner where they live with their spouse, or the unmarried partner being unable to deal with their partner's marriage, have been reported as problems by clients. Clients also find it harder to give up their married partners for fear of not finding another relationship (see **Chapter 4** for in-depth discussions on queer intimacies).

QACP practitioners must guard against inadvertently pushing their clients towards building relationships along the lines of marriage. Instead, they **must recognise that the counselling space may be the only place where the client's relationship is valued and validated.**

CLIENT EXPERIENCE 7

M and I have been friends for a long time now. We did our postgraduation together, after which she left for the USA to do a PhD. I started teaching in a college in Bombay and soon met A, who was also a faculty member there. We got along well and soon started dating each other. It has been a happy two years with him. Last summer, M came back from the USA and has been looking for work in India. She has had a lot of free time and we have been spending much of this time together. In the past few months, we have discovered this intense attraction for each other. Neither of us has named it as anything, but we both know that it is as much sexual as it is emotional and intellectual. It is like two women who are best friends being in love, perhaps. A has noticed this, and has been quite upset. Last week I told him about M and I, and he is devastated. I have assured him that my relationship with M does not change how I feel about him, but he is very upset. On the other hand, M, too, is asking me to make up my mind about A, and where he stands in my life. I am feeling torn.

QACP VIEWPOINT

The situation that the client describes is indeed a complex one and can be emotionally taxing for all three persons involved. Counsellors have to deal with similar issues with bisexual clients, as well as clients who want to be in open/multiple-partner relationships. In these situations, QACP practitioners do not pass moral judgements; they empathise with the dilemma of the client – assuring the client that being attracted to, or being in love with, two persons at the same time – in this case, a man and a woman – is normal. It may have emotional consequences for all involved, which will need to be understood. The QACP practitioner tries to create a safe and non-critical space for the client to work through her emotions as well as issues of transparency, communication with partners, and taking responsibility for decisions about the relationships.

UNIQUE LIFE STRESSORS IN TRANS LIVES

'Every Day in the Life of a Transman'[14]

"I wake up every morning wishing that some miracle happened the previous night, and I have woken up as a man – but well, I haven't been lucky enough for this miracle to happen. In the morning I detest using the washroom to pee as I want to be able to stand and pee and not sit and pee. I hate bathing because that means that I need to touch areas of the body that I don't like, and I don't want to have them. While getting ready I need to ensure that I look man enough to be able to travel safely in a train in the general compartment, otherwise I have these men always trying to figure what I am on the basis of my body.

I have choices to make that most people won't even think about for a second, while making my CV. When I am looking for a job, I need to figure: what do I write as my gender? Do I disclose my gender? And if I do, will I get a job? And even if I get the job, will I be subjected to abuse at my workplace? I need to decide whether I have to tell everyone in the office, or do I need to tell only the HR.

If everything goes well and none of this happens, I still need to answer the curiosity of my employer and my colleagues…

Questions about whether I have breasts or not? Do I get my period or not? How do I have sex? How my penis is a penis but might not be the "real deal", and how I might apparently never be able to satisfy my partner. Whatever

contd.

decisions I take, I have to prepare for the consequences. Well, if I am fortunate enough in my personal life then I might get someone who loves me but I still need to explain to them that during sex I don't like my chest to be touched or I don't want to see myself in a mirror or take so many pictures with you because, well, my beard has not grown out properly and I don't want to look feminine even for one moment. I will still need to explain to you why on some days I use the ladies' washroom as I fear for my safety, and on others days I feel like I just have to use the men's washroom. I need to explain to you that I absolutely love movies but going for a movie is an absolutely pain-inducing experience as I again need to pick which security queue to go to – the men's or women's? Whichever I choose, I get stared at anyway."

[14] *Narrative written by Aryan Somaiya, transman, practicing psychologist, and co-founder of Guftagu Counselling and Psychotherapy Services*

REFLECT ON THE FOLLOWING QUESTIONS –

- Which of the concerns or challenges in the narrative were things that you had never thought about before?
- What are the daily stressors and challenges of living this life – the unique life stressors?
- Which are some of the social institutions that would be barriers for the person in the narrative?

POINTS FOR DISCUSSION – HAVE YOU THOUGHT ABOUT THESE AS CHALLENGES BEFORE?

- Using the toilet, taking a bath, looking in the mirror, taking pictures, waiting for one's beard to grow out.
- What clothes to wear and how to dress so as to be read as a man: going for movies, to malls, using public toilets, train compartments – any public place that has gender-segregated queues/utilities; being looked at with the gaze of people "trying to figure out your gender".
- Putting down gender identity on one's CV; figuring out the process of coming out in one's workplace; answering uncomfortable questions about one's body – being at the receiving end of voyeuristic questions about one's body and anatomy.
- Communication about boundaries related to one's body with partner, especially in the context of intimacy and sex.

YOUR NOTES

Daily stressors, challenges and social institutions that pose barriers

1. **Gender dysphoria**
   Alienation and isolation are common day-to-day experiences in the lives of persons with non-normative sexualities and genders. Specifically in the lives of trans persons, who experience body- and gender-related dysphoria,[15] the distress that arises from alienation from one's own body is a major unique life stressor. Other queer persons, too, talk about alienation from straight friends or family members, or caused by the "straight talk" that pervades our social lives – however, when it comes to trans persons, the sense of alienation from one's body and dysphoria with specific attributes/parts of the body can be extremely challenging, as seen clearly in the narrative, **'Every Day in the Life of a Transman'.** The unique life stressor of 'self-acceptance', discussed earlier, takes on a different meaning here. A trans man, as in the narrative, may have no difficulty in accepting the fact that he is a man – the distress comes from elsewhere: from a body that feels "not right"; from people who refuse to see him as the man that he is; and from the social structures that divide all humans into only two possible categories – man and woman, with an insistence on specific attributes being necessary for fitting into one of these two boxes. This social superstructure, of cis-binary gender, is upheld and reinforced by every social institution including family, marriage, state and law, medicine and science, education, and so on.

2. **Passing**
   Passing[16] refers to a transgender person being correctly perceived to be of the gender they are, or identify with, and not being perceived as a transgender person or as a person with the gender identity assigned to them at birth.

   As apparent from the **'Every Day in the Life of a Transman'** narrative, the

need to be read/seen as belonging to the gender that you are can be a daily struggle. Decisions related to clothes, hair, accessories (watch, belt, shoes, jewellery, make-up), binders, packing (for trans masculine persons), stuffing the bra/using breast prostheses, tucking (for trans feminine persons), on an everyday basis – so as to be recognised, seen and not be misread/misgendered – is a major stressor unique to trans persons. Not only does passing enable gender affirmation and reduce dysphoria, but in an intensely transprejudiced and hostile world, passing may also be as much about avoiding the violence that may occur because one is read as not fitting neatly into one of the gender binary boxes. It is important to note that even for binary trans persons who are able to pass, the fear that their transness may be discovered can be a chronic stressor (instances of violence against trans persons being stripped or assaulted to "check" if they are a "real" man or woman are not uncommon).

3. **Coming out**

Decisions related to coming out as transgender to family, friends, or at the workplace, constitute another major stressor. Many trans and gender non-conforming children (TGNC) face "correction" efforts – family members, teachers, and other adults in their lives try to get the TGNC child to fit

THIS SOCIAL SUPERSTRUCTURE, OF CIS-BINARY GENDER, IS UPHELD AND REINFORCED BY EVERY SOCIAL INSTITUTION INCLUDING FAMILY, MARRIAGE, STATE AND LAW, MEDICINE AND SCIENCE, EDUCATION, AND SO ON.

the gender expression and roles associated with their birth-assigned gender. Most TGNC children are, actually, coming out to these adults by defying these correction efforts and asserting their own gender, even though the language of coming out as transgender may be learnt by these young persons only later in life. As implied in the trans man's narrative, coming out about one's gender identity is complicated, and usually involves assessing the environment for safety. Often, considerable psychic energy is spent in thinking about coming out and its possible or likely consequences. Not asserting, or being unable to assert, one's gender, and being misgendered in the process, could have immense psychic costs too.

4. **Gender transitioning**
   This refers to the process of changing one's gender presentation or sex characteristics to match with one's inner sense of gender identity. Gender transitioning is an extremely personal and individualised process: some transgender persons may emphasise that they never really embraced or identified with the gender expressions or roles of the birth-assigned gender, and hence do not talk about their process of gender assertion as "transition" at all; other transgender persons may see, as part of "transitioning", their whole journey of discomfort with the assigned gender, and of exploring their gender identity through self-reflection, connecting with community, accessing therapy, looking up trans-related resources – information, life stories, role models, and so on. Gender transitioning may include social, medical and legal transitioning.[17]

5. **Misgendering and trans-erasure**
   Misgendering refers to using a wrong form of address, usually a pronoun, that does not correctly reflect the gender of the individual being spoken about or addressed. This may be done in other ways, too, such as continuing to use someone's deadname (which refers to given/

assigned name, to which the person does not relate, as with the gender assigned to them at birth), wilfully refusing to acknowledge the gender of the person, and so on. Closely linked to misgendering is the act of trans-erasure – which means to ignore, deny, minimise or even refuse to acknowledge the existence of transgender persons. This is one of the commonest and most distressing stressors in the lives of trans persons, taking the form of active discrimination, or manifesting in a range of micro-aggressions. Mental health professionals, too, continue to engage in such behaviours. And there are grimly ironic instances where MHPs insist on using the deadname of, and wrong pronoun for, a trans person who is seeking a certificate for Gender Dysphoria to be able to go ahead with his/her/their medical transition (a certificate mandated in India for seeking gender affirmative therapy services), just because his/her/their legal documents may still reflect the deadname and the birth-assigned gender.

6. **Discrimination and violence**
As seen in the context of sexuality, violence and discrimination in private and public spaces are common in the lives of trans persons too. Right from their early years, trans persons have to struggle against constant attempts – by parents, at home, by teachers, in school, by playmates and friends – to "correct" their gender presentation. Apart from social correction, with instructions on gender-appropriate ways of dressing, walking, talking, and so on, many TGNC children and young persons face correction efforts from professionals such as school counsellors and child psychiatrists/mental health professionals, who are supposedly "helping" the child to fit into the birth-assigned gender. The bullying of TGNC children and young persons in school and college as well as violence within family are well-documented in India **(Nevatia et al.,** 2012; **Menon et al.,** 2019). One result of

Apart from social correction, with instructions on gender-appropriate ways of dressing, walking, talking, and so on, many TGNC children and young persons face correction efforts from professionals such as school counsellors and child psychiatrists/mental health professionals, who are supposedly "helping" the child to fit into the birth-assigned gender.

this is that trans persons may get pushed out of educational systems as well as family homes at an early age. This often means fewer years of formal education, lack of access to familial resources and social capital, lack of access to vital documents related to one's citizenship and educational qualifications. All of these together lead to reduced life opportunities for trans persons.

Apart from surviving the strictly gender binary institutions of family and education, discrimination could well continue at workplaces in hiring, promotion, lack of suitable accommodation for trans persons, trans-hostile environments and colleagues, and so on. Trans persons could suffer lack of access to trans affirmative health and mental health care services that may be necessary for some as part of their medical transitioning, or for a host of other trans-related health and mental health complications – for instance, mental health issues stemming from dysphoria, gender correction efforts, bullying and abuse; health issues related to the prolonged use of tight binders, or avoiding using public toilets for long hours and dealing with effects such as urinary tract infections; or, for instance, the health and mental health consequences of an unregulated use of hormones.

Diversity under the umbrella of queer and transgender identities

In concluding this exploration of unique life stressors, we would like to reiterate that the term transgender is used as an umbrella term to include a range of non-cisgender identities. Similarly the term queer is used as an umbrella term for a range of non-heterosexual identities. It is necessary, therefore, to bear in mind that there is a great deal of diversity within queer and transgender communities: the experiences of one transgender person cannot be generalised to represent all transgender communities; nor can any queer or transgender individual validly claim to speak for an entire community of queer or transgender persons. The one thing that all persons who self-identify as transgender have in common is that they do not fit comfortably into the gender assigned to them at birth. As a practitioner, it is important to educate oneself about the spectrum of gender and sexuality identities that one might encounter in one's practice, and about the unique life stressors specific to each identity and lived experience.

Hijra and *Thirunangai* are part of a range of culturally located identities that have historically been the most visible transgender identities in India for those who identify as transfeminine/trans women, or as belonging to the *third gender*. In recent times, we have also seen an increase in visibility for binary transgender persons, i.e., transgender persons who self-identify within the binary of men and women. Transmasculine persons, who have been not as visible or well-represented in the Indian context traditionally, are now collectivising and asserting their rights, and giving voice to their experiences with the medical establishment and with law enforcement agencies, within families and educational institutions, and so on. Transgender persons who are *nonbinary, genderqueer, gender non-conforming*, are still poorly represented in India, and their unique life stressors are therefore less well-known. We discuss the stressors experienced by a nonbinary person through a case example in **Chapter 6** (Section 6.2.3) of this resource book.

EXERCISE

Debate

OBJECTIVES

To highlight some issues pertaining to trans lives.

MATERIALS

Printout of the statements to be read out by the trainer (see 1-9 in the following pages).

ACTIVITY AND INSTRUCTIONS

(The primary objective of this exercise is to engage with and debunk some of the most popular misconceptions about being transgender, along with widely prevalent transnegative attitudes in society, through setting up a debate.)

Divide the participants and the training room into two sides.

Read out the statements one by one, asking one group to take an "Agree" stance, while the other group is asked to "Disagree".

The groups are given 5 minutes after each statement, to discuss their points among themselves, and then each group presents its main arguments, which the other side refutes. A free-flowing debate of 5-10 minutes is allowed for each statement.

After each segment of discussion and debate, the facilitator sums up the popular misconceptions and trans negative ideas that came up, and replaces these with trans affirmative perspectives – adding to the points that the "Disagree" group might not have made.

→ ***Note: The debate format can be helpful in training/teaching sessions. In this instance, it allows participants to engage with transprejudicial ideas commonly present in society and within their selves, as well as to think simultaneously of ways to shift from those positions and ask themselves what a trans affirmative stance would look like.***

STATEMENTS AND POSITIONS:

1. Misgendering and using deadnames while interacting with a trans person is not such a big problem.

SOME COMMON ARGUMENTS FOR THE MOTION

- You will always be 'ABC' (deadname) for me, no matter what. I will love you the same.
- Shalini or Sachin, how does it matter how I call you? It does not matter to me.
- I have known you as Shalini (deadname) for 20 years. We have been childhood friends, how can you expect me to start calling you by another name now? How can you insist that I change the way I have saved your number in my phone book?
- You have been my daughter for 30 years, now you suddenly want me to start saying "he"?!
- All your documents are with your birth name, for the purposes of this company we recognise you only by your birth name and will call you only by that name.
- We know about your gender and will address you as you insist on being addressed at home, but what is the need to use your "new" name and gender pronoun outside the home?

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

- If a transgender person in your family, your clinic, your classroom, at your workplace, among your friends has asked you to use a certain name and pronoun for them, then listening to their name and pronoun, acknowledging that you have heard, and using those consistently are ways of showing the person that you see and hear them for who they are and you do not doubt or challenge their gender reality.
- If you use any of the excuses expressed to misgender a trans person, or to continue using their birth name, which may be a deadname for them, then you are saying that you do not see, value, validate the person's gender identity or their struggles to assert their gender; and that by invoking a past history, you are trying to fit the person into the birth-assigned gender, which has possibly been suffocating and erasing of their gender identity.
- If due to force of habit, or since as a cisgender person you do not have to think too much about pronouns and birth names (cis privilege), you do end up misgendering or deadnaming someone, it is important that you see this as a mistake for which you need to apologise. If it is an honest mistake and you are genuinely sorry, you are unlikely to keep repeating it.
- Affirming gender identity in a private context and misgendering in a public one (for instance, parents misgendering their child when with extended family) is erasing, distressing, and conveys to the TGNC child/young person or adult that their parents are ashamed of them. A trans affirmative stance would also suggest that counsellors may want to know if the trans person themselves has asked to be addressed differently within private/safe spaces and public spaces, which could be about the person figuring out to whom, where and how much they want to be out.
- Many trans persons may undergo legal transition, i.e., change their gender and name on their legal documents; many others might choose not to, or not be able to. In any case, social recognition (name, pronoun) at the workplace or in any other

public or private context has nothing to do with legal transition and should not be contingent upon legal changes in documents.

YOUR NOTES

2. SRS[18] needs to be classified as an elective surgery just like other cosmetic procedures, and not as an essential surgery.

SOME COMMON ARGUMENTS FOR THE MOTION

- Since SRS is not life-saving like a cardiac procedure, it should be considered elective, not essential.
- Since SRS is not like plastic surgery performed to correct or repair damage due to accidents or birth defects, but involves cosmetic procedures such as breast implants and vaginoplasty, it should be considered similar to other cosmetic procedures.
- People seeking SRS have mental health issues such as dysphoria and not "real" health, i.e., life and death issues. SRS may therefore improve quality of life (elective) but is not about saving life (essential).

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

- Who decides what is life-saving? Is keeping the vital organs of the body running the only way to qualify life-saving? What about a trans person who feels that his life is on hold, or in pause mode, and can start only when he is able (through the help of medical

transition) to live as the man that he has always been? Would SRS for this person not be life-saving and therefore "essential"?

- The range of medical procedures that are part of the Gender Affirmative Therapies (GAT) for transgender persons may on the surface resemble "cosmetic" procedures –but what is cosmetic and what is essential is determined by the intent in using that procedure and not by the procedure itself. For instance, if mastectomy for a cis woman suffering from breast cancer is not seen as cosmetic, why then should top surgery (mastectomy) for a trans man suffering from gender dysphoria be seen as cosmetic? In both situations, the intent is therapeutic – to alleviate pain and suffering: in the first instance, that of the cancer patient, it is about removal of tissue that is malignant; in the second, it is about removal of tissue that causes distress and anguish and forces the person to live in a sex and gender that is not theirs.
- There is no hierarchy between physical health and mental health, or the suffering of the body and the mind. Even if one were to consider for a moment the distinction made by modern medicine between mortality and morbidity, with "essential" seen as that which prevents mortality, would not preventing the suicide of a severely dysphoric trans person through providing them GAT make GAT an essential procedure?

YOUR NOTES

→ ***Note: There are several reasons why this debate between essential and elective is important. Firstly, to affirm that gender dysphoria can be severely debilitating, and that access to quality, affordable treatment for it needs to be read as an inherent part of the right to health – a fundamental right under the Indian Constitution. It follows from this that it becomes the duty of the state to provide treatment for gender dysphoria, denial of treatment for which becomes an offence when such treatment is seen as an essential service under the umbrella of trans health. Secondly, when a surgery is classified as elective, it is seen as a choice by the patient and is therefore often not covered under insurance policies or subsidised procedures, making it unaffordable for many.***

3. Medical interventions for treatment of gender dysphoria are intrusive, irreversible and harmful for health.

SOME COMMON ARGUMENTS FOR THE MOTION

- Why can't trans persons be helped to cope with dysphoria through other psychological mechanisms, why undergo these intrusive and dangerous medical procedures?
- Each person has a masculine and feminine within themselves and we all have to embrace these. A transgender person can be helped by asking them to do the same.

SOME COMMON ARGUMENTS AGAINST THE MOTION

👍 THE TRANS AFFIRMATIVE POSITION

- GAT as treatment for gender dysphoria is a well-researched and established process globally. Instead of forcing trans persons to live in the gender they were assigned at birth, attention could more helpfully be focused on strengthening the protocols for GAT in India and ensuring adequate information, counselling, and the meaningful participation of trans persons in their own treatments; better training for all GAT professionals (counsellors,

psychologists, psychiatrists, endocrinologists, gynaecologists, urologists, plastic surgeons, voice therapists, and so on); enhancing access to these treatments, making them affordable; improving quality, and so on.

- While talking about medical interventions and their harmful effects on health, the default notion is always about physical health. Mental health needs to be considered at par with physical health, and the debilitating mental health ramifications of continuing to live in a body and gender with which one does not identify need to be taken into account.

YOUR NOTES

4. Seeking to live as a transmasculine person is a strategy to step into a position of power, of the sort enjoyed by cis men.

SOME COMMON ARGUMENTS FOR THE MOTION

- In a society such as ours, with son preference and so much social power and privilege on the side of men, it is likely that some tomboys may want to start living like men and undergo medical procedures to become men.
- By doing this they can escape the life of women – cooking and cleaning for the husband, looking after the household, caring for children and the elderly without appreciation or payment. Instead, they can order their mothers and wives around by becoming men.
- Whether transmasculine persons automatically inherit the social

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

position and power of cis men, and whether they are able to exert this power in all social institutions –marriage, family, workplaces, social/public spaces – is highly questionable. Even if a trans man were to pass as a cis man on most occasions, transmasculine identity is not a result of a pre-meditated strategy to grab power; it is a response to and a struggle to deal with dysphoria and a sense of incongruence between the way one's gender is read and the gender that one is.

→ ***Note: Vihaan (2018) discusses transmasculinity as subordinated/oppressed masculinity, as opposed to the hegemonic masculinity that is made possible not just by gender (being a cis man) but by caste and ability as well. The precarity and vulnerability of transmasculine persons has been discussed in the section on unique life stressors as well.***

5. A real transgender person is one who has had surgeries and now belongs either to the male or to the female sex.

SOME COMMON ARGUMENTS FOR THE MOTION

- Anyone who has not had surgery and other medical procedures to change their sex and gender is faking being transgender. These could be perverts, cis men who are faking it in order to have access to all-women spaces such as hostels, toilets, the ladies' compartment on trains, or to fraudulently benefit from governmental schemes for transgender persons.
- Sex can be only of two kinds – male and female. Transgender persons are actually people trapped in the wrong bodies, which can be changed through surgery, so that they can alter the sex they are born with to become the "other" sex. Hence, real transgender people are those who have had "sex change surgeries".

- Enduring the pain and suffering involved in undergoing multiple medical procedures is what makes a transgender person "real transgender".

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

- There are no "fake" transgender persons, just as there are no fake men or fake women.
- Sex is a label assigned to a person at birth based on factors such as genitals, chromosomes and hormones. Gender is another label assigned to a person at birth based on the medically assigned sex and carrying distinct, socially expected/determined attributes, norms, roles for men and women. Sex and gender should not be medically or socially determined, but self-determined instead. Self-determined sex-gender is valid and is the reality of that person; it is not for others to judge as being "real" or "fake".
- Self-identified transgender persons can and do identify as trans man/transmasculine/FtM (female-to-male) or as trans woman/transfeminine/MtF (male-to-female), i.e., they identify within the gender binary: these identities are valid not because they fit within the gender binary, but because the individuals concerned self-identify as transgender. They may undergo GAT or not, or undergo some procedures that fall under GAT and not others. Gender transitioning – socially, medically, legally – is an intensely personal journey, and not for anyone else to label valid or invalid.
- Finally, there are many trans identities that do not take on terms that fall within the gender binary – even if these individuals choose to undergo surgery, they may have no desire to fit within the male-female binary.

YOUR NOTES

6. Intersex is the same as transgender, or *hijra*.

SOME COMMON ARGUMENTS FOR THE MOTION

- Anyone who is not born male or female is intersex or *hijra* or transgender. These are different names for the same person – someone who is neither a man nor a woman.

SOME COMMON ARGUMENTS AGAINST THE MOTION

👍 THE TRANS AFFIRMATIVE POSITION

- "Intersex" refers to variations in the development of sex characteristics that do not fit the typical norms of male or female. There may be a variation in the chromosomes, hormones or reproductive anatomy, which may be apparent at birth or become known later in life. So intersex variation is about sex development and nothing to do with either gender or sexuality. Intersex persons like anyone else can be cisgender, or transgender, or heterosexual, homosexual, bisexual, pansexual, and so on.
- "Transgender" refers to gender identities and expressions that are incongruent/incompatible with the birth-assigned sex-gender. Thus, the transgender identity is about gender, and not about sex development or sexuality. Transgender persons, too, may be heterosexual, homosexual, bisexual, pansexual, and so on.
- "*Hijra*" is a socio-cultural identity/way of being, primarily in South-Asia, and refers to persons who are assigned the male sex-gender at birth; whose gender expression and identity may be feminine/woman; and who may identify as "third gender", outside the binary of man and woman.
- Unfortunately, due to pervasive ideas of binary sex-gender and a complete lack of discourse around diversity in sex-gender, there is an extreme degree of ignorance about these realities not just in the general population, but also among medical professionals. Policy and law makers also share in this ignorance – which is why these varied identities are often misunderstood or conflated even in law and policy in India.

7. All trans people are heterosexual.

SOME COMMON ARGUMENTS FOR THE MOTION

- We have seen stories in the media about trans men and trans women marrying each other, or trans women marrying cis men.
- We know of someone who has undergone sex change and become a man so that he can marry his childhood sweetheart, a girl from his school.
- The only thing wrong with transgender persons is that they are born in the wrong body, otherwise they are normal like other heterosexuals.

SOME COMMON ARGUMENTS AGAINST THE MOTION



- "Transgender" is an identity term that is used to describe the gender identity and expression of a person and does not refer to sexuality – to sexual attraction, desire, fantasy, sexual behaviour or sexual identity. Thus, a transgender person may be heterosexual, homosexual, bisexual, pansexual and any other way in which being sexual may be defined.
- There is nothing "normal"/"abnormal" about being a heterosexual or cisgender person.
- The very idea of heterosexuality in the traditional sense applies to binary gender, i.e., a man and a woman. Marriage, too, in India, is seen as possible only between a man and a woman. Popular culture and media in their attempts to be trans-inclusive have reported primarily on heterosexual marriages between binary transgender persons, i.e., a trans man marrying a trans woman, but we rarely see media coverage of stories of two trans men or two trans women in intimate relationships, which does not mean that such relationships do not exist.
- It is a common misconception that two lesbian cis women, who want to marry each other, and who seek social recognition or wish to escape social ostracism, use medical transitioning as a

way for one of the women to undergo surgery and "become" a man. Transgender persons who seek to transition medically are doing so to bring more congruence between their felt gender and their body, not to find a legal loophole to marry their partner.

YOUR NOTES

8. Gender-neutral instead of gender-segregated public utilities, such as toilets and security queues, would be unsafe, and a public nuisance.

SOME COMMON ARGUMENTS FOR THE MOTION

- Men's toilets are unhygienic and dirty. Gender-neutral public toilets would mean a health hazard for women.
- Gender-neutral public utilities can become a breeding ground for violence and sexual assault against women, and would in general be unsafe for women.
- There would be logistical difficulties about whether male or female staff would manage these utilities (maintaining toilets, checking in security queues).
- Not enough privacy in a gender-neutral toilet for any gender.

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

- Gender segregation in our society has a long history steeped in protection of women against violence as well as the protectionism and moral panic associated with a free intermingling of "men" and "women". All of this is strongly rooted in ideas of caste-patriarchy, and maintaining the sanctity of the institution of marriage and family. It is these same ideas that enable violence against women in public and private spaces and act to reinforce gender segregation. Thus, the intermingling of all genders (in train compartments, toilets, security queues) is not the cause of violence against women, nor can strict gender segregation work to prevent such violence. Also, when we think about protecting women from violence perpetrated by men in public spaces, it is useful to ask if we are also thinking about the protection of trans women – and is this even a consideration in our planning of public spaces and utilities?
- Gender neutrality in public spaces lessens the sharp divide between the "two genders" and thereby opens up possibilities for persons who do not fall strictly within the gender binary to be able to occupy these spaces without the constant fear of being outed, or of facing violence. For trans binary persons, too, there is much less pressure to pass as a man or a woman in gender-neutral spaces, which have far less policing of gender per se.
- Gender-segregated utilities do not exist in most households. Men and women use the same toilets, bathrooms, beds, etc. What about hygiene, safety, health hazards in our homes? Is it not possible for everyone to extend lessons about health and hygiene from private spaces to public spaces too?
- Some gender-segregated public utilities, for instance in public transport, are a result of hard-won battles by women's movements in this country. Therefore, since caste-patriarchy or violence against women is unlikely to vanish anytime soon, gender-neutral spaces could co-exist alongside already existing gender-segregated spaces.

- In all-women or all-men spaces, particularly toilets, there is often the assumption that people do not need privacy when amongst persons of their own gender. This may not be true for many cisgender persons, and is definitely untrue for transgender persons – who, in gender-specific toilets, have to face gender policing and the constant intrusive gaze of cisgender persons. We know of trans persons regularly avoiding the use of toilets altogether when away from home for several hours, leading to a range of health complications in the long run.
- Some creativity (outside the gender binary systems) around designing, and some extra resources, may need to go into thinking about how to ensure better privacy for everyone in gender-specific as well as gender-neutral toilets.
- Apart from public utilities and public spaces that are gender-specific, gender "marking" is present in our day-to-day lives in multiple ways – specific colours for specific genders, specific clothes, toys, sports, school uniforms, and so on. Moving from a position of gender-designated clothes, colours, hobbies, uniforms, to self-determined choices in these would make life far more interesting for cis as well as trans persons.

YOUR NOTES

9. Egg or sperm freezing as a reproductive option for transgender persons before they start on their medical transition is an unnatural and unnecessary procedure.

SOME COMMON ARGUMENTS FOR THE MOTION

- When transgender persons have voluntarily given up the sex and gender into which they were born, what is the need for sperm or egg freezing?
- Even after genital surgery, trans men or trans women cannot really achieve the reproductive function of the sex into which they have transitioned. They have themselves opted for this surgery. What is the need then for them to have biological children?

SOME COMMON ARGUMENTS AGAINST THE MOTION

THE TRANS AFFIRMATIVE POSITION

- Transgender persons like everyone else have sexual and reproductive rights, which, among other things, includes the right to have a biological child through the use of medical technologies such as sperm/egg freezing, surrogacy, and so on.
- Information about these procedures and the reproductive options available should be an essential part of GAT-related counselling; it is best to discuss fertility-related options and take decisions early on, before starting hormone therapy or surgeries to remove/alter reproductive organs.[19]

YOUR NOTES

Section 3.2 aimed to throw light on the particular stressors that queer/trans people experience, and debunk some commonly held misconceptions about trans persons. It is important that MHPs arm themselves with this knowledge, so that they are more readily able to identify distress and its sources. We also spoke of how ULS is a useful framework with which to approach the mental health concerns of queer/trans clients. The next section provides conceptual tools with which clients' concerns may be formulated in an affirmative manner.

3.3 The emotional landscape of a queer/trans individual

The context of affect

As practitioners, irrespective of the therapeutic approach used, we all are presented first with affect. We understand that the doorway to any therapy is through the emotions of the client. Addressing emotions is the fundamental step towards managing distress. While it is undoubtedly important to identify the emotions that clients are experiencing, it is equally important to understand the context in which these emotions are experienced. Therefore, keeping in mind the unique life stressors of queer individuals as points of reference is imperative while doing affirmative work. This context of affect would determine how we, as practitioners, respond to our queer clients and their unique life concerns.

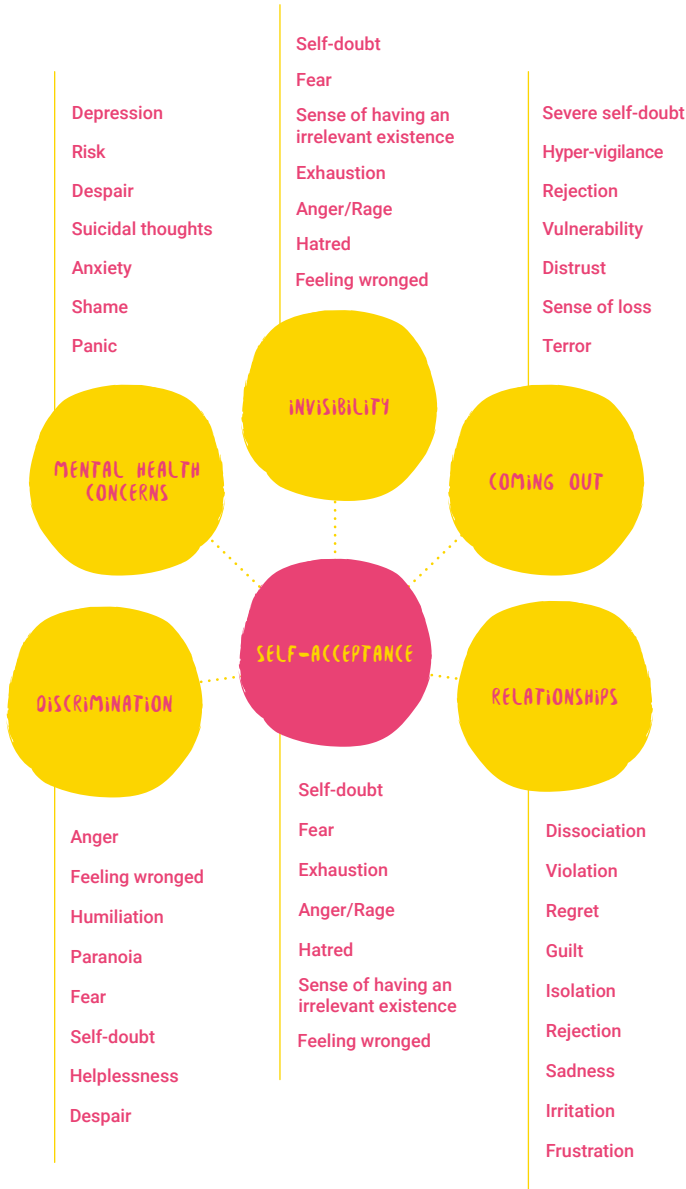
The ULS matrix

In Section 3.2, we discussed several of the Unique Life Stressors (ULS) of queer and trans individuals. We would like, at this point, to flesh out the concepts discussed thus far, and elaborate upon the interplay of the various stressors and the ensuing dynamics, to make evident the individual's intra-psychic experience. It is important to extrapolate the intellectual understanding of the

ULS to the lived realities of queer persons by building a bridge to their emotions.

Let us begin developing this matrix by unpacking each stressor – starting with ***self-acceptance***. Self-acceptance is often the first stressor that must be navigated, a process that has no stipulated or prescribed time-frame. To many, self-acceptance or coming out to self is a long and arduous journey, where a person might even take the better part of their life to come to the point of accepting their sexuality and/or gender. This is particularly so because of being surrounded exclusively by heteronormative representations through the growing up years and after; with no space given to scripts that might mirror alternative realities.

Once self-acceptance does happen, the stressor that comes up next is ***invisibility***. Self-acceptance brings about a heightened perception of the disparity between one's lived reality and the predominantly cis-heteronormative world. Moreover, any attempts at living an authentic life are continually thwarted by structures mandating a certain type of societally "acceptable" life. Despite having accepting one's own reality, then, the individual faces erasure – or the constant threat of erasure – by family and society alike. As a consequence, there is a strong likelihood of self-doubt creeping in, compelling the person to re-negotiate their self-acceptance. After the struggle to re-establish a sense of certainty about their sexual identity, the queer individual may draw on their internal strength in order to come out to people they trust – family members, or close friends. Such a decision is usually arrived at after an intense mental back-and-forth to ascertain the trustworthiness of those people, and concerns of personal safety. This coming out is, unfortunately, not a one-time process. The list of people to come out to increases, and with each addition to the list a new series of mental calculations commence. Coming out is, then, a continuous process – also to the same people many times. It is not uncommon to find that family members are unwilling to accept the realities of the queer person, and erasure


Depression
Risk
Despair
Suicidal thoughts
Anxiety
Shame
Panic
Self-doubt
Fear
Sense of having an irrelevant existence
Exhaustion
Anger/Rage
Hatred
Feeling wronged
Severe self-doubt
Hyper-vigilance
Rejection
Vulnerability
Distrust
Sense of loss
Terror
MENTAL HEALTH CONCERNS
INVISIBILITY
COMING OUT
SELF-ACCEPTANCE
DISCRIMINATION
RELATIONSHIPS
Anger
Feeling wronged
Humiliation
Paranoia
Fear
Self-doubt
Helplessness
Despair
Self-doubt
Fear
Exhaustion
Anger/Rage
Hatred
Sense of having an irrelevant existence
Feeling wronged
Dissociation
Violation
Regret
Guilt
Isolation
Rejection
Sadness
Irritation
Frustration

of these realities becomes a practice. All too frequently, this having to come out repeatedly is both traumatic and exhausting, and threatens to create self-doubt once again.

→ ***Note: Please reflect on how various stressors have the potential to force queer people into the zone of self-doubt time and again.***

Coming out, by its very nature, translates to visibility – and visibility is a double-edged sword. While, on the one hand, it can mean validation, it may, on the other, invite ***discrimination***; given the hierarchies of society's Charmed Circle, the latter is more prominent than the former. Discrimination can take various forms, ranging from withholding resources to extreme violence. Sites of discrimination are present across all the systems that we have discussed previously as being those that uphold the Charmed Circle. It is not difficult to imagine, therefore, the frequency of instances in which queer/trans individuals face discrimination. Needless to say, resilience and strength notwithstanding, the intensity of discrimination can be so overwhelming that there is always the possibility of the individual's forcing oneself to self-correct, self-censor, and self-harm.

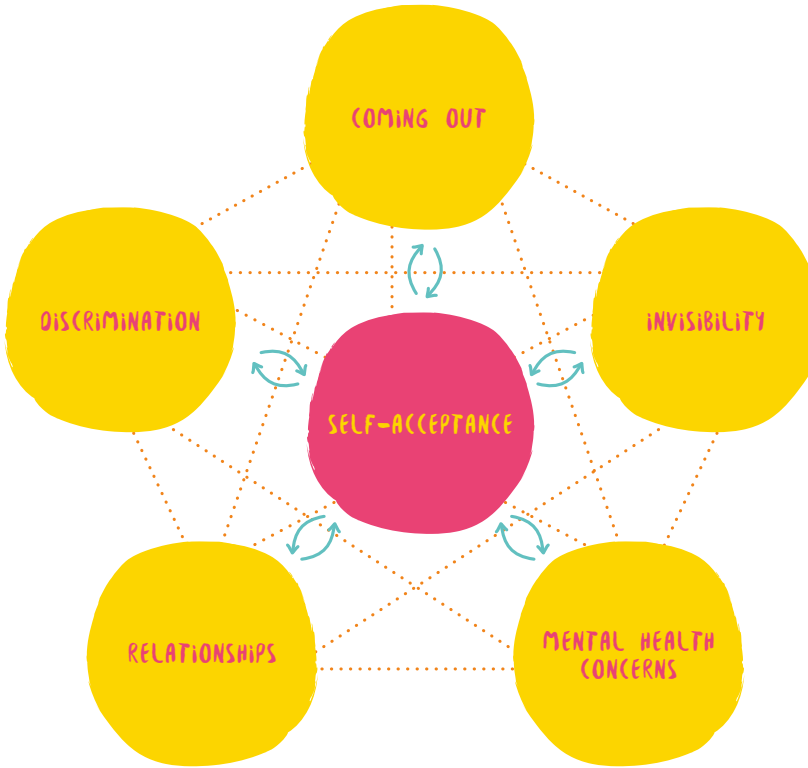
Relationships for queer/trans persons, relationships – that form the crux of a meaningful life – tend to be fraught with uncertainty and risks. (Relationship-related issues are dealt with in greater depth in the next section as well as next chapter.) In the queer context, it is essential to look at both, relationships with family, friends, and in society at large, as well as relationships with intimate partners.

From all our previous discussions, exercises and cases, it is amply evident that heteronormative society poses challenges at every step of queer existence. Families and friends cannot be assumed to be supportive at all times. Assessing how safe each relationship is within the family is exhausting in itself, especially if the individual has to live under the same roof as their family. Living on a daily

basis with the risk of being outed can be traumatic. The same risk applies to friends, especially because of overlapping relationships and spaces. Safety assessment in relationships thus tends to take precedence over other attempts at strengthening bonds. Trust is the first casualty in many such cases.

It is easy to assume that intimate relationships would be less traumatic, considering that the risk of being outed is largely mitigated. However, queer intimate relationships come with their own set of challenges. This is especially true when the partners are at different stages of being out. For example, if one partner is more out than the other, there are bound to be expectation clashes, often leading to misunderstandings and conflicts. Since both persons experience the stressors (albeit in varying degrees) unique to queer persons, resolution of conflicts may not be easy. Seeking informal help is often not possible because, unlike with heterosexual relationships, there are likely to be very few persons who would be invested in helping to preserve the queer relationship in the first place. It would be good to note here that other stressors such as self-acceptance, coming out, invisibility, discrimination, and related mental health issues, all play out in queer intimate relationships in one form or another. For instance, when partners are at different stages of "out-ness", the less out partner is always vulnerable and at risk of being outed (deliberately or inadvertently) by their partner,

It is easy to assume that intimate relationships would be less traumatic, considering that the risk of being outed is largely mitigated. However, queer intimate relationships come with their own set of challenges.



perhaps ridiculed for not being "bold" enough to be totally out, or taunted for being not queer enough – with any of these occurrences having the potential to dent the fragile space of self-acceptance that the partner currently inhabits. It is not surprising, in such circumstances, for a queer individual to feel pulled towards the Charmed Circle, making self-acceptance a renewed struggle.

Mental health concerns

Given the various stressors described here, ***mental health concerns*** are likely to crop up. Depression, anxiety, panic attacks, low self-esteem, low confidence, self-harming tendencies, suicidal ideation – these are just some of the issues that queer persons face from time to time. And then the stigma attached to mental health conditions makes queer people

The ULS matrix helps us recognise that **the appearance of the stressors in queer lives is not linear**, and that the presence of one stressor does not mean absence of another.

all the more vulnerable. Doubting themselves and their experiences could be a natural fallout of compromised mental health.

The ULS matrix helps us recognise that the appearance of the stressors in queer lives is not linear, and that the presence of one stressor does not mean absence of another. All the ULSs can exist together at all times (degrees may vary). It is important to be aware that all stressors are also linked to each other in subtle ways that the therapist could sometimes miss. The ULS matrix shows us the inter-connectedness of the ULS, and their contribution toward the ***fragility of queer lives*** becomes clearer.

The emotional landscape of a queer/trans individual

The ULS matrix can also help us recognise the emotional world of the queer person. For each stressor, try to list the emotions your queer client is experiencing when faced with that stressor. The client comes to a therapy space laden with an entire emotional baggage – acknowledging these emotions and appreciating their context is imperative for a practitioner doing affirmative work. Some of the emotions that are likely to get mentioned are listed in the following chart. Please note that these lists are by no means exhaustive, and may be added to during the exercise.



1. The stressors are not linear in their presentation but are inter-linked in complex ways, all present simultaneously and always, in the lives of queer people. It would be apt to call them "Unique Lifelong Stressors".
2. As all the stressors exist together at any given point, the negative emotions linked to them also exist together at the same time.
3. This context of affect underscores the vulnerability of a queer individual.
4. As the ULS are a manifestation of systemic oppression arising from unequal structures, the ULS Matrix along with the accompanying emotions may be referred to as the psychic experience of an unequal structure.
5. It is, therefore, important to recognise the unique power and responsibility a therapist holds as probably offering the only space where the queer client can be their authentic self, much like an oasis in a desert.

The particular significance of this section has been its bringing together the theoretical and experiential aspects of the Unique Life Stressors of the queer/trans individual. It aims to help the MHP identify the emotions the client is experiencing, and the possible sources of these emotions, which in turn can aid in addressing specific distress points in therapy – thereby enhancing, to a great degree, trust and empathy in the therapeutic engagement.

3.4 Working with the families of origin of queer persons – common therapeutic issues

After a discussion of unique life stressors and the ways in which these inform the emotional landscape of a queer person, we will look at the relationship of queer persons with their families of origin/natal families in this section. We would have liked to discuss therapeutic issues in the familial context across the life course of the individual, but realise that this would by itself be a subject for a complete resource book or training course. For now, and for purposes of this section, we aim to give readers some insights into common therapeutic issues and themes that emerge at a few significant ages and stages of the queer person's and their family's lives. We discuss the experiences of the queer child within the family, an awareness of which we suggest is vital not just to understand the growing up experiences of the individual concerned but for therapeutic work with children, young persons, as well as adults. We also discuss here some common issues that queer adults face within their families. Finally, we provide a glimpse into some of the therapeutic issues that emerge with queer older adults in caregiving positions vis-à-vis their parents. Relationships with siblings are only marginally touched upon here. The themes we discuss here are based on existing research, our clinical experiences with our clients, as well as the authors' own personal experiences. We do not claim that these are universal or even exhaustive, or that they speak for the experiences of all families. We are, here, only initiating conversations on some familial dynamics involving queer persons, and some therapeutic themes to which QACP-trained practitioners may want to be attentive while working with queer clients and their families of origin.

A queer child growing up in a heteronormative family unit

From a biological perspective, the emergence of sexuality is associated with puberty, hence most discussion about sexuality (heterosexual sexual awakening) coincides with discussions of adolescence as a life cycle stage. As a result, childhood sexuality remains minimally understood unless the discussion is about childhood sexual abuse. In this scenario, the question, 'how does a child's sexuality affect their experiences of childhood and growing up?' may often be seen as irrelevant. We try to address this question here, and hope to show its relevance for therapeutic work not just with children but with adults too.

Sexuality is not just about sexual behaviour or sexual attraction. **Sexuality as experienced in the day-to-day is also about your relationship with your "self" and body: it's as much about the kind of clothes you like to wear; the way you keep your hair; the accessories you choose to wear or not; the way you carry yourself; the way you see yourself – self-image, body image; and it is also intimately linked to your gender presentation and expression.** Many queer children and young people talk about *feeling different* from their peers right from their early years, while many speak of same-gender attractions even in their pre-pubertal years **(D'Augelli,** 1996; **Savin-Williams,** 2005). Research suggests that many queer children report gender non-conformity during childhood, often manifesting in areas such as clothes, grooming, play, hobbies, choice of playmates. This is not to say that these children identify as transgender in childhood or in later years, nor is it to suggest that all queer people are gender non-conforming. However, non-adherence to the gender scripts/codes by some children marks them as being different from an early age and makes them more vulnerable to bullying and name-calling as compared to their more gender-conforming queer counterparts, whose "deviation" may manage to escape attention until their same-gender sexual attraction surfaces **(Ranade,** 2018). Speaking in developmental terms, queerness may often be present during

childhood, and deeply affects the child's engagement with themselves and the world. Researchers studying the effects of discrimination and exclusion have compared sexual minorities with ethnic and religious minorities, and have concluded that there are many similarities between these groups in terms of facing group victimisation, concerns about group stigma, being excluded from membership in social groups, aggression towards one's group from the majority community, and so on **(Allport,** 1954; **Martin,** 1982). However, one major difference is that sexual minorities are minorities even within their own families. Most of us are born and grow up in heterosexual families with heteronormative role models **(Ranade,** 2008). When it comes to other kinds of marginalisation, a child in such a family is instilled with a minority identity at an early age and does not have to find this for themselves. Thus a child in a Dalit household or a Muslim family would know from early on what it means to be Dalit or Muslim in a caste-Hindu-majority society. In fact, family members and, often, neighbours/communities would be invested in equipping the child from early on about how to make sense of, cope with, and even resist minority-related stress in everyday life. For instance, a Muslim child whose schoolmates refuse to eat from their tiffin would know what this means, be able to name this experience – and, most importantly, if the experience is new, they would be able to go home to adults who could explain, and help the child deal with the experience. This child is unlikely to feel left alone to make sense of the overwhelming experience of being excluded; moreover this child is unlikely to believe that they deserve to be excluded because of who they are.

By contrast, a queer child is not introduced by their parents to the possibility of being queer, but must discover it on their own while growing up in a heteronormative world (see 3.2 – 'Unique Life Stressors (ULS)…' for the "Inversion Scenario" exercise), with parents or siblings not functioning as role models to help consolidate the minority identity. In figuring all of this out, a queer child may often not be able to count on

parental (or any adult) support for protection from bullying, rejection, exclusion and violence. Many queer children and young adults thus navigate the difficult journeys of growing up without having a safe home space to which they can return **(Ranade, 2018).** In developmental terms, these childhood experiences of not being able to turn to an adult for solace are extremely significant, and could lead to heightened loneliness and a sense that parents, and by extension other adults and the world at large, cannot be relied on for help. A lack of identification with family members, a sense of alienation and lack of cohesion with the family unit, tends to have a significant emotional impact on children.

Research suggests that childhood experiences of departing from family/peer norms in concrete ways – such as atypical gender expression, and sexual interest in individuals of the same gender – may be experienced by the child not as a "good" difference but a "bad" one **(Savin-Williams,** 2005). This could cause feelings of being misunderstood, isolated, shamed, which the child may internalise as rejection, as being unlovable. Cisgender, heterosexual parents of queer children on the other hand are likely to be entrenched in culturally, publicly and institutionally upheld norms of compulsory heterosexuality and are therefore likely to be unaware of the "felt difference" of the child and the daily struggles that follow from this.. As a result, they are not able to support, buffer, or mediate the struggles of the child, and may feel at a loss rather than attuned to their queer child. Some parents do talk about having known/"suspected" the truth from early on, particularly if their child was gender non-conforming, and yet having hoped that it was a passing phase, or having been overwhelmed and lacking information – or a support system – themselves.

Some parents who know early on that their child is queer even try to change, or "correct" the child, and seek to "cure" the child's queerness, which serves only to disrupt the parent-child bond further, and

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to confirm to the child that they cannot trust their parents. Such a disrupted parent-child bond, with its ensuing lack of mutual attunement, need not be restricted to childhood; it often continues throughout life, with the child choosing to cut emotional ties and not share much about themselves – about their queer self, relationships, heartbreaks, stressors, celebrations, or suffering. Thus, the inability to make space for gender-sexuality diversity can often mean a *lost opportunity* for growth, togetherness and intimacy, both for queer children and for their parents.

This is not to paint a deterministic, bleak picture: of course, many parents and queer children do talk about the opportunities they had to find their way back to each other and embrace their differences and celebrate diversity. Our attempt is to point to the intrapsychic and interpersonal struggles that queer children and their families often undergo in the child's growing up years. And also, to point to the vital role of therapists and counsellors in helping queer children and their families heal from attachment injuries and from the early disruption of the parent-child bond.

We present a few experiential narratives of queer persons talking about their childhood and growing-up years, excerpted from the book by one of us, 'Growing Up Gay in Urban India – A Critical Psychosocial Perspective' **(Ranade,** 2018).

childhood as a scary time

"When people talk about childhood as this carefree time – best years of their life with no worries and lots of play and laughter – I am filled with a deep sense of disconnect with this image. when I think of childhood, I think of it as a scary time… when everyone thought it was ok for them to comment on all my ways of being, my gestures, way of walking, talking, clothes, how much and when is it ok for me to be upset and cry… as a young boy you have very little control on what can happen to you, you know.

So when I think of my childhood, I think of it as a time I never ever want to revisit again."

[Prelude, Chapter 3 Exploring Early Years: Childhood and Adolescence of Young Gay and Lesbian Persons, p. 59]

uprooting the child from school and sending to an army school to correct the child's gender non-conformity

"I was sent to a military school after 5th std. It was an only-boys school. I didn't like the environment there at all. There was extreme discipline there. We used to have a khaki dress, half pant and half shirt. I didn't like that. At St. Andrews (earlier school) it was ok to wear anything, even casuals…"

[Mansoor, 33, about the time he was in the 5th Std., p. 74]

being bullied in school

"All the time… this whole time, maybe from the 6th or 7th standard onwards, I was feeling alone because I could not talk to anyone about it. I wanted to come back home and tell because I was in tears so many times, I just wanted to tell that this is what was happening in school, can you help me?"

[Avinash, 28-year-old gay man, about the time he was in school, p. 80]

Queer adults and their families of origin

In India, marriage and reproduction are not really seen as optional. It is through marriage and, subsequently, having children, that an individual can assert adulthood within their own family of origin, extended family, as well as society in general. By being married in the right way (matching of class, caste, religion and, of course, the appropriate gender) and reproducing, the individual fulfills a familial but also larger social duty, thereby achieving social legitimacy for themselves and their family unit. In this sense, ***queer adulthood is a socially failed project to begin with.*** Many of the cases and client experiences shared in this book underscore the point (for instance, in 'Client experience 6' given earlier in this chapter, the client talks of how the same-sex couple is not treated on par with the newly married heterosexual couple in the same household).

Queer people will often tell you that their being invited to attend family occasions – a wedding, the naming ceremony of a child, housewarmings, and so on – gets clubbed, verbally, with the formal invitation card to the parental unit,

whereas the married siblings of the queer person receive separate invitation cards, as the household of the married sibling is socially legible as a separate unit while that of the queer single or coupled person is not. This is irrespective of the chronological age of the queer person. Thus, an "unmarried" queer person, even at the age of 50, would still be seen as part of the parental unit and, in that sense, would have "failed" (socially) to become an adult. There are many lessons here for developmental psychologists and family therapists to rethink our conceptualisation of ideas such as "individuation" or "launching of young adults" (one of the stages of the family life cycle), and other markers/milestones used to define adulthood within our cis-heterosexual-dominant disciplines.

Thus an "unmarried" queer person, even at the age of 50, would still be seen as part of the parental unit and, in that sense, would have "failed" (socially) to become an adult.

Most queer people have faced or will face heterosexual marriage pressure, and often this becomes the point that pushes them to consider coming out to family; many may, also, seek counselling support at this time. Thus, negotiating heterosexual marriage pressure as well as decisions regarding coming out – whether to come out, to whom, how much to tell, weighing the likely consequences – are significant themes in the relationship of a queer adult with their family of origin. In this section, we discuss some of the consequences, both of coming out and of not doing so. Some may choose not to come out but to move out of the parental home to a bigger/faraway city/country that affords the anonymity that enables them to live out their life as a queer person. Moving out may be done under the

pretext of better educational or employment opportunities; **(Ranade et al.,** 2016) and physical and emotional distance from family may be maintained to cope and survive. This can be stressful for the queer person, and have an impact on their family relationships.

For those who do come out, there are different kinds of challenges. To understand some of these, let us summarise here the findings of a qualitative study conducted with 22 family members of gay and lesbian persons in Mumbai **(Ranade et al.,** 2016). Family members comprised parents (12 mothers and 4 fathers, as well as an aunt) and siblings (4 sisters and a brother). There were more mothers and sisters than fathers and brothers in the study; there were instances where the queer person had come out to the mother but not to the father. Research does suggest that cis-heterosexual women in general are less hostile towards homosexuality than cis-heterosexual men are **(Herek,** 1988). And one study indicates that same-gender parents have a greater difficulty accepting their grown-up children's homosexuality, i.e., mothers find it more difficult to accept lesbian daughters and fathers have a harder time accepting gay sons – because the same-gender parent perhaps sees the child's homosexuality as a result of their own failure in communicating to and instilling in the child the "appropriate" gender-sexuality role and identity **(Rosen,** 1992).

Thus, negotiating heterosexual marriage pressure as well as decisions regarding coming out – whether to come out, to whom, how much to tell, weighing the likely consequences – are significant themes in the relationship of a queer adult with their family of origin.

Some of the major findings of the **Ranade et al.,** (2016) study hint at therapeutic issues that could be particularly significant in working with queer clients' families of origin:

- The initial responses of most participants were shock, disbelief, denial, withdrawal and silence. The loss and bereavement framework of **Kubler-Ross** (1973) has been seen as useful for understanding the initial reaction of those parents who experience an intense, irreversible sense of loss on learning of their adult child's homosexuality. This loss is the loss of the heterosexual script and idealised future they had imagined for their child **(Savin-Williams,** 2005). In the study, the parents' age range was 45-82 years – some said they hadn't heard the words *gay/lesbian/queer* before, and did not know what these meant. Others spoke of feeling overwhelmed and of having many questions: Is my son likely to get HIV? Who will look after her/him after I am gone? Will she meet someone who will be with her for life? What does the life of a gay person look like? What about when she/he is old? Is there any possibility of change/cure? Will she go to hell/will God punish him? Most parents interviewed talked about looking for answers by talking to their family doctor, or to a counsellor, psychiatrist, priest, spiritual guru, reading books, looking for information on the internet, and so on. It was interesting that some participants said they had met counsellors who allayed some of their fears and held them through the confusion, while suggesting that they must keep the doors of dialogue open and not shut their child out. Similarly, a priest told an anxious mother that she should not worry about how God sees homosexuals – that that was an issue to be settled between her lesbian daughter and God, and not for the mother to agonise over.
- One of the major learnings from the study was that the pre-disclosure relationship between the parents and child was very significant to

in determining the course of events after the initial shock had worn off.

- What helped the parents in moving towards acceptance was engaging with their adult child and learning more about the latter's queer self, challenges and pleasures, and getting more involved – meeting their queer friends, going for events such as the Pride March, meeting other accepting parents, attending parent support group meetings. Meeting their grown-up child's partner was a turning point for many parents. In fact, most parents viewed queer relationships from a heteronormative lens and wanted their queer child to "settle down" with one person. More complex relationship situations – such as having multiple partners, or a partner currently in a heterosexual marriage, or a partner with children from a previous marriage, or a partner's being genderqueer or nonbinary – made it more challenging for parents to accept or make sense of their queer child's relationships.
- Some parents talked about using areas of non-conformity in their own lives as a reference to make sense of their queer offspring. For instance, parents who had undergone divorce and faced stigma, and parents who had married across community and religion divides and suffered disappointment or rejection from their own parents, used those

Most parents viewed queer relationships from a **heteronormative lens** and wanted their queer child to **"settle down" with one person**.

experiences to build empathy for their queer child.

- Acceptance was, we found, a complicated thing. There were parents who said, 'We love our child unconditionally, but we do not accept homosexuality', or 'I accept it now, but if I had a choice, I would not have chosen this', or 'I accept because I know that this cannot be changed', or 'I accept, but I don't want her to tell our extended family.' There were parents who felt guilt for not having been there enough for their children during the latter's growing up years – for instance, a mother who felt she did not do enough to protect her child who was sexually abused while growing up said, 'Now no matter what he does, I will stand by him.' There were also parents who had religious or moral dilemmas. One mother asked, 'I can see the love and attachment between them, it is really special, but which religion allows this, tell me?' Acceptance is thus a layered and complex process, changing with time.
- Compared to the parents, the siblings of queer persons responded with less angst and were far less overwhelmed. There was more familiarity with the idea of queerness, and easier acceptance. They were more likely to come out to their own friends about their sibling's sexuality, be more validating, and also make more space in their life for the queer sibling – including cutting off friends and partners who were homo-prejudiced. In general, the queer individuals' relationships with their siblings came across as more egalitarian; also, siblings had fewer expectations than parents did – sisters and brothers did not see their queer siblings as extensions of themselves, which was possibly why they were less affected than most parents were.
- Coming out as a family was another significant theme, with parents often finding it difficult to come out to their own siblings or to the extended family about their queer offspring.

A QACP practitioner has a significant role to play at each point in the life of the queer adult and their family

1. In supporting the queer person in their decision about whether to come out, in planning the coming out, and anticipating as well as being prepared for possible responses.
2. By holding the family through the initial response period (possibly a phase of shock, denial, despair) that can be intense; the practitioner may, at this time, be the only link between the parents and their grown-up child, with whom the former can talk about the experience – holding and validating feelings on both sides at this point can open up the possibilities of listening to one another.
3. Through always bearing in mind that being queer is not a tragedy, an accident, a catastrophe facing the family – that it is about making space in the psyche and within the family for diversity and difference, which can be challenging, causing pain and, maybe, stretching the boundaries of the family system, but is also an opportunity for growth for all, as individual human beings and as a family.
4. By simultaneously supporting the family, and providing information/resources – reading materials, films, support group suggestions, while countering prejudice/misinformation about homosexuality from the parents' dominant cultural contexts.
5. Through exploring parental negative emotional responses – shock, shame, disgust, failure, loss, despair, and so on; and enabling the parents to see that these responses come from an internalised heteronormative script, that of the Charmed Circle, so that if they are experiencing grief, it is not because their child has died, but because their idea of what the child should be has been altered; allowing for the vital space and time the parents need in order to make these connections and work through their discomfort.
6. In assisting the family at large in rethinking their notions of family (which may not be very different from the parents'

ideas) so as to make sense of and make space for their queer family member; families may move from their initial position of shock and despair to learning to accommodate the queer individual, and may move even further towards eventual acceptance and even pride.

7. By making the therapy space safe and non-judgemental, where – at least initially – separate sessions are held with the parents for them to be able to explore their internalised ideas about sexuality, gender, morality and so on; putting the queer person in conjoint sessions with parents while the latter may still be working through their internalised homonegative ideas would be counterproductive and could well traumatise the queer person further.
8. Through actively discouraging parents from seeking conversion/curative treatments, and providing all available information on the harmful effects of these.

An important theme that emerges from research on lesbian and gay intergenerational family relationships is ***ambivalence***, wherein there is a simultaneous presence of positive and negative affective dimensions in the parent-child bond **(Reczek,** 2016). There could be overt ambivalence – overt approval and overt disapproval – for instance, cracking jokes or making comments that are homo-prejudiced, while accepting queerness at the same time. Then there is covert ambivalence – overt acceptance from parents and yet veiled disapproval (as also shame), for instance, ***'I accept you for who you are, but why do we have to tell this to everyone?'***

Another form in which ambivalence is displayed is in what is termed the "glass closet" – here, the same-gender attraction/relationship of a family member is an open secret – everyone knows, yet no one acknowledges or engages with it **(Sedwick,** 1990). So, a closet, but made of glass, hence transparent. "Glass closet" also describes the situation in which an individual – perceiving heightened homo-negative attitudes among their family members (which could be due

to religious beliefs, conservative political beliefs, toxic ideas around masculinity, traditional notions of the institution of family, and so on) – does not come out to them, yet is able to live their life as a queer person without hiding much but without stating anything explicitly. For instance, living with a partner whom the family knows about but who continues to be referred to as a "friend" (implying a non-romantic/non-sexual relationship) by both, the queer person and their family.

On the other side of the glass closet is what many queer persons refer to as *multiple/ repeated coming out* to parents. This is often in the context of parental denial – as when the queer person has told their parents about being queer, and after a couple of months the parents come back with a marriage proposal (or they might call off the marriage pressure, but act as if the coming out did not happen – and refuse to acknowledge the queer parts of their child's life).

Overall, parental ambivalence is experienced as unfair treatment, or ambiguous standing in the family fold, and can considerably increase the queer adult's distress. Ambivalence is likely to be at its highest when the queer person first comes out to their parents, and may be a significant therapeutic issue for counsellors working with the families of queer persons.

We have been discussing queer adults coming out to their families, and the complex ways in which families make sense of and respond to this coming out. A good deal of research in the Indian context indicates that many queer people face violence within families when they voluntarily come out, or when they are outed (someone discloses their sexuality without their consent), or when family members unexpectedly "find out" in some other way. Violence includes house arrest, control and policing, forced separation from partner, forced marriage, physical and sexual abuse, seeking "remedial treatments", making the queer individual leave the family home, pushing them to suicide **(Fernandez & Gomathy,** 2001; **Joseph,** 2005; **Ghosh,** 2011; **CREA,** 2012; **LABIA,**

2013). In all these situations, QACP practitioners need to be equipped with the necessary crisis intervention tools (see 4.3 – 'Community as resource') and have on hand a good list of resources and referrals for various services such as shelter homes, emergency and casualty services, police help, lawyers, crisis counsellors, and so on.

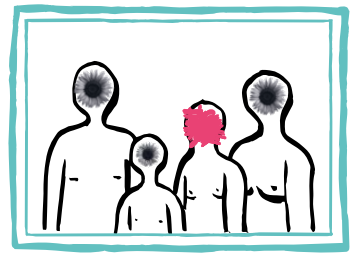
Older queer adults as caregivers for families of origin

Research suggests that in most families, "tolerance" is a common response for accommodating gay and lesbian kin within the family. Complete acceptance is less common, and – over a period of time – so is complete intolerance **(Seidman,** 2002).[20] In this context of tolerance and chronic ambivalence, the task of caring for elderly parents has many layers of complexity. Caregiving can be stressful for anyone: it may last anywhere from a few weeks to years, and often takes a toll on the caregiver's emotional, physical and material well-being.

With respect to queer adults as caregivers for their elderly parents/siblings, therapists may want to keep certain unique considerations in mind:

- In order to live a full and open queer life, many queer adults decide to live without contact with or support from their family networks. As a result, when such an individual finds themselves having to act as caregiver to a member of their immediate family, they are likely to be relatively isolated from familial resources – from the human as well as social capital of the extended family. They may experience an erasure of their gender-sexuality when they do come in contact with uncles, aunts, cousins whom they may have avoided for many years of their lives.
- In the context of caregiving, it is common for one of the siblings of the person needing care to be expected to take over as primary caregiver. This is often the sibling who is perceived to have "no family responsibilities" of their own, particularly no children or elderly in-laws. This assumption can be hurtful for the queer person.

- A queer person could simultaneously be in a caregiving position for a biological parent or sibling as well as for a partner, or a queer friend, or a member of their family of choice **(Family Care Giver Alliance,** 2015). At such times, the deeply entrenched pulls of family ideology may make the setting of boundaries very difficult for the queer person. Elderly parents or siblings may refuse to see that families of choice or friendships in the life of the queer person might be as (or more) significant for them as their families of origin – and that the responsibility, or commitment, of the queer person towards this chosen family is as valid and real as that towards blood/natal family. These other commitments may be seen by family of origin as "secondary", and having less validity than filial duty **(Tafseer,** 2015).
- Such erasures, or invisibilising of a queer person's gender-sexuality and their relational intimacies, can be a real stressor in the life of an older queer person, and therapists may want to stay alert to this. These erasures are often subtle, and may not scream of homoprejudice, and yet they are there.



Research suggests that in most families, **"tolerance" is a common response** for accommodating gay and lesbian kin within the family.

CLIENT EXPERIENCE 8

A 45-year-old genderqueer client, K, spoke of getting a call at 5 AM from their sister to say their mother was likely having a stroke, and that the sister was going to get her admitted to a nearby hospital. They immediately rushed to the hospital, an hour-long drive from their home, and spent the whole day there, talking to doctors, waiting for test results, and so on. By evening, it was clear that it was not a stroke and the mother was now stable – however, the doctor wished to keep her overnight for observation. K stayed on with their mother till she had had her dinner and taken her medication. It was decided between K and their sister that K would now leave and, if necessary, the hospital would call the sister, who lived 10 minutes' walk away. At this point, however, the sister insisted that K stay the night at their parents' house, also a 5-minute walk from the hospital, as the sister did not want their father to spend the night alone at home. There was no question of the sister staying with the father to keep him company, as she had her "own home" to go to – with a husband, two children, and in-laws. All K wanted to do was go home and curl up with their partner of 10 years after having had a very stressful day, yet being able to say this to the sister was difficult. K said in their counselling session, *'I was absolutely convinced that I was not being unreasonable. I really wanted to go home. Besides, my dad is in perfect health and I did not see the need to spend the night there; and yet setting that boundary was so difficult. When I did say that I am going home, it made me look aggressive, unreasonable and selfish… all this with a sister to whom I have been out for many years now.'*

- Caregiving often involves disruptions in the lives of the caregivers, non-queer or queer. These may include changes in routine; less time available for oneself and for partners and friends; having to visit parents/family of origin more often, temporarily moving in with, or closer to, one's parents, or have parents (or other persons needing care) move in with one. Such disruptions can be challenging enough by themselves, but when exacerbated by queer erasure or invalidation, the emotional toll can be severe. Therapists may want to be attentive to this additional stressor, and work with the queer client to figure out strategies for assertion, boundary setting, as well as self-protection and self-care.
- Finally, caregiving in the context of vulnerability, illness, pain, debility, is likely to evoke many emotions on both sides. There may be fear, sadness, worries related to mortality; irritability, frustration, anger related to physical discomfort and pain. All these can become fertile soil for old hurts to surface, and a history of "perceived" and "real" wrongdoing to re-emerge. QACP practitioners may want to be alert to the complex emotional landscape of the queer client and their family. They may work with the family members, with all the caregivers involved, or with the individual client on short-term goals such as division of labour – who does what, when – figuring out roles, boundaries, material resources, etc. Working on such short-term goals may help avert immediate crises, better manage tasks at hand, and thereby reduce resentment and enable communication. Long-term goals – of exploring unresolved issues, addressing and letting go of histories of hurt, making amends, seeking forgiveness, looking for reconnection may also be picked up by clients for individual or family work.

Conclusion

The experiential knowledge of the authors, their clients, and the queer and trans communities to which they belong, has been presented in this chapter in various forms that include first-person narrative, simulated and empathy-building exercises, the debate format, and research literature to introduce certain lived realities of queer and trans persons. These realities represent day-to-day experiences, besides challenges and struggles with oneself, with peers, with families of origin and with society at large. The primary aim of this chapter has been to build insight into the complex emotional worlds of queer and trans persons that MHPs can learn from and that would guide their praxis.

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Learning from and about Queer Relationships

Intimacies on the margins exist. There is a hierarchy that results in devaluing queer-trans kinships and thrusting meanings drawn from heterosexual cisgender marriages. There are no models or reflections of queer-trans intimacies in the mainstream. Queer-trans intimacies are done very differently and that has to be understood, held and valued. This can lead to reimagining all intimacies and kinships.



Illustration: Shubham Bose Roy (@shubnam.jaan)

CHAPTER 4

Learning from and about Queer Relationships

In the previous chapter, we learnt from those on the margins about their lives. We continue to do this work in the present chapter, with a focus on queer/trans people and their kinships. We look at intimate relationships, queer families, at engaging with children, and with the queer community.

4.1 Queer/Trans intimate relationships, and therapeutic issues

It is important to view the intimate relationships of queer/trans people against the social backdrop of heteronormativity and cisgenderism.

Having an intimate relationship is important to nearly everyone, whether the relationship has the sanction of family and society; or is known, shared and



→ ***Note: Although we make use of the terms "couple" and "partner/s" in this section, please note that not all clients use these terms for themselves. Please be alert to the terms clients use for themselves and for their relationships, so as to use those in sessions with them.***

celebrated only in some safe spaces; or is completely furtively lived – a secret, shared only between the partners. Needless to say, the ways in which each such relationship is lived – and each one's possibilities – would vary vastly.

When it comes to queer relationships, one of the unique aspects is that for many queer young people, it is through falling in love and being in an

intimate relationship that they meet another queer person for the very first time. This person then becomes the source of validation for one's queerness and for reducing one's sense of isolation, often acting a companion in getting to know more about the queer community and discovering queer resources – films and books and people. The meanings of such a "first" relationship are likely, then, to be somewhat different from the Bollywood ideas and depictions of "first love"; it could even mean survival itself. Another unique aspect is how the reality of being in a queer relationship makes one's own queerness more visible and less deniable to oneself as well as others: this can be a source of joy and strength, but could also be stressful in contexts where being visible comes with a range of potentially distressing consequences.

Queer relationships are of all types. Some people may aspire to a marriage-like relationship, others may try to figure out their own scripts. **What is important to remember is that queer relationships are impacted by various social hierarchies – as we have seen already, not all couples, intimacies, or relationships are equally valued.** The script of monogamous, "forever" marriages devalues/erases the diversity and multiplicity of how a large number of other intimacies are experienced. The particular diversity of queer relationships derives, also, from the wide range of individual identities and journeys, besides different sets of negotiation with social norms **(Chakravarty,** 2020). An MHP's current knowledge may be inadequate to address queer relationship concerns because of the heterosexual values embedded in their curricula and training, as well as in prevalent theories and research on mental health of LGBTQ+ populations **(Adams et al.,** 2009). Practitioners need to equip themselves with additional knowledge so that:

The script of monogamous, **"forever" marriages devalues/erases the diversity and multiplicity** of how a large number **of other intimacies** are experienced.

1. They are alert to heterosexual bias, and learn not to dismiss or minimise relationship concerns that don't fit with normative notions of marriage and family **(Garnets et al.,** 2008).
2. They are able to identify the unique relationship stressors that have an impact on queer/trans intimate relationships **(Green & Mitchell,** 2008).
3. They are able to address, in therapy, the stigma arising from societal sources, and help couples/partners have more meaningful relationships **(Addison & Coolhart,** 2015; **Alonzo,** 2005; **Mereish & Poteat,** 2015).

Therefore, in order to work with queer couples, we must gain insights into the unique struggles they face. The following sections elaborate on some of these.

4.1.1 Unique relationship stressors

We list here a set of different intimate relationships that involve queer/trans people. Please note that this is not an exhaustive list. There are as many possible kinds of relationship as there are people, and several unique ways in which couples live out their relationships. However, all queer couples undergo a unique set of common stressors because of the wider social context. The following exercise will help to understand this.

OBJECTIVES

To help in understanding the diversity of queer and trans intimate relationships, as well as the stressors – both interpersonal and structural – that queer/trans couples experience.

MATERIALS

A. A set of relationship realities, listed as follows:

1. *Cis man and intersex cis woman, in a heterosexual marriage*
2. *Two gay cis men, in a monogamous relationship for 23 years*
3. *Cis woman living with cis man, in an intimate relationship; the cis woman also in a long-distance intimate relationship with a trans woman*
4. *Nonbinary person, female assigned, in a relationship with trans man who has not medically transitioned*
5. *Bisexual cis woman in a relationship with lesbian cis woman*
6. *Trans man and trans woman, both post-transition, in a heterosexual marriage*
7. *Trans man and straight cis woman living together, in a monogamous relationship*

B. Two sheets (Sheet 1 and Sheet 2 with columns) per relationship reality as listed in 'A', per participant.

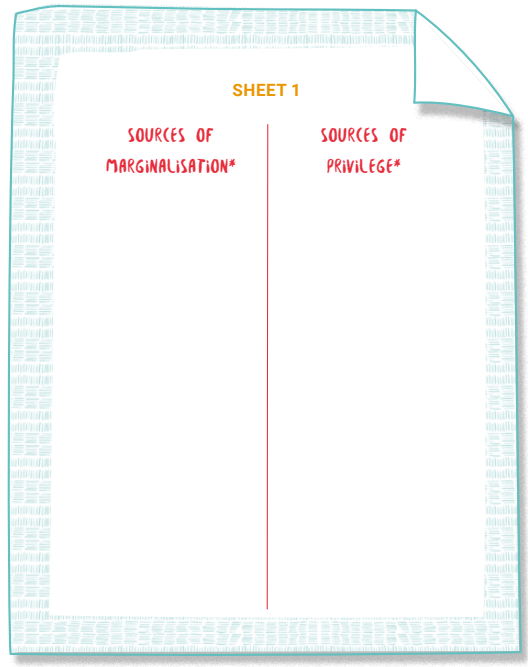
ACTIVITY AND INSTRUCTIONS

Fill both Sheet 1 and Sheet 2 ('B') for each of the seven given relationship reality statements ('A').

→ ***Note: Each relationship might pan out in different ways: you are allowed to assume different factors, and base your answers on those. For example, in relationship 3, the cis man may or may not know about his partner's other, long-distance relationship. And this knowledge or lack of it would operate differently in terms of stressors. Try to imagine the nuances and complexities of each person and their realities.***

SHEET 1

Think of each person's as well as each couple's position vis-à-vis the Charmed Circle. Put down your thoughts with respect to the given sub-heads–



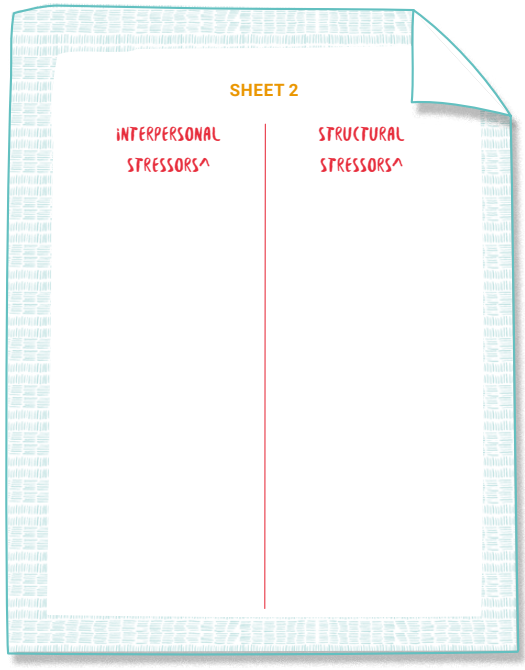
*Sources of marginalisation and of privilege refer, respectively, to the structural disadvantages and advantages that each person in the couple would have.

FOR EXAMPLE

IN RELATIONSHIP 1:
The cis man would have privilege because of his gender, while the intersex person would be marginalised on account of her body if she is not read as a normatively feminine woman.
A heterosexual marriage would be a source of privilege for both, but within the marriage the cis man would have greater gender privilege.

SHEET 2

List the stressors each couple would face–



^Interpersonal stressors would be what the individuals face between each other; structural stressors would be what each couple faces together, because of how the Charmed Circle operates.



IN RELATIONSHIP 3:
The trans woman might feel jealous or insecure, as the cis woman with whom she has a relationship lives with a cis man partner – this would be an interpersonal stressor. The trans woman's relationship with the cis woman could get erased and the cis woman's relationship with the cis man be far more visible because a cis-heterosexual couple is more socially acceptable – this would be a structural stressor. Of course the interpersonal and the structural dimensions are usually linked, and so the jealousy may be heightened because the trans woman feels she is in a relationship that must compete with a socially sanctioned relational reality.

IN RELATIONSHIP 4:
It would be important to reflect on the structural stressor that arises from how society perceives the genders of both persons. Both persons could be read as "women", thereby erasing their felt genders. This could cause each person intense stress and dysphoria. If society responds to them on the basis of their assigned genders, then their couplehood could also be erased – slotted as a "friendship" between two "women". Individual gender being erased as well as couplehood being erased are structural stressors that might cause significant damage to each person as well as to their relationship. Interpersonal stressors could arise from dysphoria/discomfort to do with certain body parts. The naming of body parts is gendered; it can trigger dysphoria. The couple would need to figure out what terms they would like to use for specific parts of the body, to refer to each other's erogenous zones. Apart from language and naming, the couple may want to figure out which body parts are okay to touch, or look at, and which are not. The MHP would do well to know about these ongoing negotiations among the couple, while they deal with erasure and other structural stressors.

TAKEAWAYS

1. The diversity of intimate relationships is not only about "how" relationships are lived, but also arises from each individual's sexuality-gender identities and journeys.
2. Additionally, the complexities of class, caste, religion, ability locations may also function as stressors in relationships.
3. Stressors impacting the relationship often have social sources. Thus, being alert to, and distinguishing between, individual/ interpersonal/social stressors is important.
4. Intimate relationships and the people within these often experience stigma, erasure, isolation, and structural powerlessness. We have conceptualised this as "the context of deprivation", elaborated on in the next section.

4.1.2 Queer intimacies – the context of deprivation

No social sanction or legal sanction

All queer/trans couples are forced to exist in a social context that does not provide any social or legal sanction to their intimacies. No partnership rights are available. This also means, that all such couples function in a resource-scarce environment with limited sources of support or none. This could be reflected not only in young queer/trans persons being denied access to material resources from their natal families, but also in a serious lack of emotional and social support. Therefore, these couples have to hold these relationships for themselves, in contrast to cis-het couples who have ample social and legal sanction, rights and privileges – with entire families, friends, even the law courts invested in keeping the relationship/ marriage together.

Erasure of intimacies

In a visibly heteronormative society that upholds cisgenderism, intimacies and relationships that don't fit the dominant norms tend to get erased. People who are comfortably part of the mainstream are either unaware of, or unable to validate, queer/trans intimacies. While heterosexual marriages remain hyper-visible in the everyday social realm, queer/trans relationships find neither social visibility nor place. Queer couples often have to pretend that they are "not a couple", or that they are siblings/cousins, or "just friends" or colleagues, which completely erases the truth about their mutual intimacies. Years may go by without the couple being accorded its rightful recognition.

Withholding of resources by the Charmed Circle

If the truth of their relationship becomes known, queer couples are often separated, and the individuals frequently forced into heterosexual marriages. Or else, the couples are ignored; their realities not taken on board. Their emotional and material

needs, not being recognised, go unmet. In multiple instances, once the couplehood becomes known, violence towards the couple intensifies; scrutiny and surveillance increase. There may be deliberate attempts to ignore, demean, and end the relationship. These violent behaviours often go unaddressed because of the power of the Charmed Circle – which makes it possible for queer and trans relationships to be brushed aside, or even punished, as "shocking", "unthinkable", "disgusting". The couple's individual lives and the stories of their togetherness are unlikely to attract interest or empathy. Attempts to value or celebrate queer couplehood are extremely rare, while couplehood via heterosexual marriage continues to be enthusiastically celebrated: and this kind of discrimination seems to be here to stay.

Lack of representation and of role models

Given the invisibility surrounding queer/trans lives, even looking for love and potential partners becomes a major challenge. And when queer/trans persons do succeed in finding partners, the couples function in a situation marked by scarcity of representation: often, they do not know other couples like themselves; they may not have access to other queer/trans people, or community. Marriage is a readymade social script that heterosexual people can follow. No such scripts are available for queer/trans couples. Where can they turn, to find possibilities for queer couplehood?

The heteronormative script as reference point

Related to the lack of queer/trans representation is the not infrequent phenomenon of non-normative couples who end up following the heteronormative script, with its specific power dynamics and gender roles – and while this may be seen as replication, it is important to note that the replication does not carry, at all, the power of the normative, or acceptance into the Charmed Circle.

Let us consider these examples–



COUPLE 1: A lesbian couple that tries to follow the husband-wife marriage script. One of them, who happens to be more masculine-presenting, performs the gender roles of earning money and doing the "outside" jobs. She is the "husband". The other partner manages the domestic sphere and slots herself in the role of "wife". The two have "married" each other through enacting marriage rituals privately, in a temple.

COUPLE 2: A cis-het couple that does not follow the marriage script. They are unmarried, and not very conventional about their gender roles, sharing roles and tasks equally.

Which of these couples will have more social privilege? Would the queer couple that is "married" have social recognition and sanction? Would they be recognised as a couple by society? If yes, would their relationship be taken seriously, or are they likely to be harassed in various ways? Would the unmarried cis-het couple face similar harassment? Would they be able to pretend that they are married, and be believed?

These examples should make clear to us that even if a queer couple follows the normative script, this still does not bestow on them the power that the normative carries. It is extremely important to recognise this fact, because it has implications for how we might understand conflict, and even violence, between partners (see 4.1.3 below – 'Intimate Partner Violence (IPV) and queer relationships' for a more detailed discussion).

In order to do affirmative work with queer/trans clients, it is critical to understand and apply all these aspects of the context of deprivation, as this would have a bearing on assessment, problem formulation, and intervention planning.

4.1.3 Intimate Partner Violence (IPV) and queer relationships

This section is meant to help the practitioner work with clients on issues of violence in queer/trans relationships. We attempt to describe what a Queer Affirmative lens might look like when addressing **Intimate Partner Violence (IPV)**.

Mainstream approaches to violence

The standard approach to IPV relies on the binary understanding of cis man as perpetrator and cis woman as victim, which comes from the historical feminist analyses of patriarchy and violence. The general recognition of such violence as pervasive took a long time and was hard-won. The women's question in India was raised in multiple spaces and through various forms of collective action for social change **(Kumar,** 1993) – including, among others, the Indian freedom struggle, the anti-caste movement, as well as movements centred around access to education and for protection from various forms of violence.

The mobilisation around violence against women in India has highlighted sex-selective abortion, rape, dowry-related abuse, sexual harassment in public spaces and workplaces, domestic violence in the marital context, and so on. These campaigns foregrounded the oppressed status of women in society; the fact that violence against women had systemic roots; that it was not simply about individual victims of crime or misfortune. Violence against women was about power and its abuse, and patriarchy helped maintain the subordination of women and supremacy of men. Feminists have thus described violence perpetrated on cis women as both a manifestation and a tool of patriarchy.

However, we would do well to understand that feminist

analyses of power need to be applied differently when we consider lives lived on the margins of cisgenderism and heterosexuality, because here we are no longer talking about violence perpetrated by a cis man on a cis woman. Queer theorists have pointed out that the gender binary, as well the assumed heterosexuality of the cis man and cis woman, cannot capture the realities of LGBTQ+ persons.

Perspectives on domestic violence

The psy disciplines have traditionally viewed intimate partner violence as bi-directional too, without accounting for the structural inequalities between cis men and cis women.

→ ***Note: The following is not an exhaustive list of perspectives on IPV, and includes just the ones commonly used to plan interventions. There is detailed literature available on these approaches, both in print and online.***[21]

1. Michael P Johnson's Typology of IPV– classifies IPV into four discrete types, based on coercive control as well as aggression: (1) intimate terrorism (2) violent resistance (3) situational couple violence (4) mutual violent control.
2. The Life Cycle approach to domestic violence– looks at violence against women in each stage of life (such as childhood, adolescence, adulthood).
3. The feminist and social work approach to IPV– sees violence as an instrument to control women: violence against women is described as "patriarchal terrorism"; the violence against women of oppressed castes is a manifestation of similar social control by the dominant castes.
4. The family conflict viewpoint– regards violence as a response to occasional conflicts in the family, and as episodic rather than systemic occurrences.

A QACP approach necessitates an engagement with structural vulnerabilities (vulnerabilities that can be traced back to structural hierarchies) when we try to understand violence.

Queering the approach

Building on the ways in which we have understood the specificities of queer and trans struggles, we find that existing mainstream (and other widely used) models cannot simply be replicated – or used un-critically – for the sake of intervening in instances of IPV among queer couples. Working with queer couples on IPV would require a structural understanding, both of violence and of the particular vulnerabilities of queer persons. It is important to recognise that the therapist/practitioner may be functioning in an absence of scripts that would help them understand many of the inter-personal dynamics of queer relationships. The practitioner must, then, start with building an awareness of these scripts.

It is particularly important to take into account the absence of the cis-heterosexual man in the equation. This has implications for assessing levels of threat, risk, harm, violence. Violence in queer/trans intimate relationships cannot be viewed through the lens of structural power alone, because queer/trans identities do not derive power in the way cis-heterosexual persons do from the institutions and systems of marriage, law, heterosexuality and the gender binary. Cis-heterosexual men also have access to social and material resources that accords them more systemic power, something that cannot be accessed by other genders and sexualities.

A QACP approach necessitates an engagement with structural vulnerabilities (vulnerabilities that can be traced back to

structural hierarchies) when we try to understand violence. It would be crucial to reflect on whether violence in a queer/trans relationship is being understood and analysed using cis and heterosexual frameworks, because a tendency to do so definitely exists. Please reflect on the exercise (see 4.1.1) that details the sources of marginalisation as well as the stressors, both interpersonal and structural, that have an impact on queer/trans couples. The resulting precariousness and vulnerabilities must be taken on board as we attempt to engage with IPV in these contexts.

Both MHPs and social workers are urged to use a queer lens rather than a heteronormative lens to respond to violence in queer/trans relationships. When a practitioner works on IPV with queer and trans persons, they should know that the work of helping the client unlearn harmful patterns of behaviour and learn to take responsibility for one's actions will remain incomplete without factoring in existing vulnerabilities. When we keep in mind the context of deprivation (see 4.1.2), we realise that queer persons and relationships, more often than not, have no alternative spaces in which to address their needs and concerns, which ends up putting undue strain on already disenfranchised persons – possibly leading to various kinds of vulnerabilities and conflicts that have their source outside the interpersonal.

Another aspect that needs to be borne in mind is how the legal systems function, and how the long history of criminalising queer people has resulted in a certain defencelessness. The cases discussed later in this book (see 7.1 Revisiting mental health care emergencies from a queer lens – reframing suicide and self-harm) offer only a tiny glimpse into how queer and trans persons have been at the receiving end of violations by the police and legal systems. There are also fact-finding reports by groups like People's Union for Civil Liberties on the violence experienced by LGBTQ+ people at the hands of the State **(PUCL-K,** 2001).

None of this is to condone violence in queer/trans relationships – but to caution how, if a mainstream lens is applied by a practitioner, they would very probably be adding to the marginalisation and discrimination of already disenfranchised persons.

At this point of our discussions in this resource book, we need to develop a deeper and more nuanced understanding of masculinity and femininity, which are otherwise rigidly tied to two types of bodies and roles in society. The familiar examples of violence from a cis-het context are unlikely to aid any queer, contextual reading of a given situation, because certain actions that constitute violence may not be perceived as such – threatening to "out" a partner, misgendering a partner, invalidating a partner's gender identity, and so on. For instance, when a cis partner tells a trans man partner that he is "not a real man", what is happening is that misgendering is being used as a tool to erase, hurt and humiliate. This transprejudiced, transnegative statement is a form of verbal abuse.

Since knowledge of relationships on the margins is so scarce, it may happen that the practitioner resorts to mainstream ideas to assess the situation. This also runs the risk of seeing conflict in a queer relationship as violence, and intervening accordingly, or reading violence as conflict and then attempting couples' counselling – using a systems approach that operates on the principle of circularity (the idea that a couple's interpersonal difficulties are a result of interactional patterns co-created by both persons) – instead of perceiving that the situation is linearly caused, by the actions of one person affecting the other person. In situations of interpersonal violence such a circular approach would be contraindicated. For example, the threat to "out" a partner at the workplace or to family puts the person's life and livelihood, both, at grave risk. This has to be understood not as conflict but rather as threat, and intent to cause harm. It is abuse of

the power that derives from knowledge of the vulnerabilities of the queer or trans partner.

There is the further possibility that an assessment of the situation based on cis-het scripts, combined with existing vulnerabilities before law and State, could mean a complete lack of access to redressal mechanisms for aggrieved queer and trans persons.

Thus, reframing IPV through the QACP lens is to provide additional tools to the practitioner for understanding and assessing situations using the framework of structural vulnerabilities and queer/trans contexts before planning interventions.



4.2 Doing kinship differently

The dominant norms of kinships are designed such that they push out people who don't fit well into the Charmed Circle. As a result, queer/trans folks seek out and create kinships that are better able to affirm their queerness, and are more meaningful. Their engagement with family of origin can be complex and challenging. These traditional sites of support are, often, no longer able to offer queer/trans people what they need. Prevailing family structures and rituals end up invisibilising these non-normative family members. This section includes some powerful lessons on how kinship may be reimagined – and on the resilient ways in which these new kinships are formed and held despite the looming, everyday context of deprivation. The examples that follow – about chosen families, queer parenting, and the queer/trans community as a resource – throw light on just some of the ways in which modes of kinships may be, and are being, reframed and actualised.

4.2.1 Chosen families

We start by reading this personal narrative by one of the authors about her experience of creating a chosen family for herself.

For me, chosen family got consolidated as a lived reality when my couple relationship began to end. Typically, a love relationship breaking apart is seen as "the end" for the couple. The word "ex" indicates that the couple is no longer a couple and it is possible they may never meet again. The usual attempt is to separate the two lives as much as possible. And the losses are immeasurable. You leave not just the person, but maybe a space you shared with them, kids or animals you cared for together, family and friends and social ties you had in common, stuff you did together. All this is usually lost or even viciously withheld or guarded by one or both partners.

When my couple relationship was ending, it was no doubt painful. For almost 10 years, I had seen myself as being in a joint unit with my partner, with not just our lives but our identities interlinked. I had the choice of leaving them, because the pain was too much. But there was also the recognition by both of us that leaving each other's lives would be a mutual deprivation. Yes, my couple relationship may have ended, but I wanted this person in my life. We worked hard at trying to separate the elements and emotions that ended if we were not a couple from – more importantly – the elements and emotions that continued even without our being a couple. This was where the chosen family bit began to emerge. What was the function this had? What meanings do I attribute to it?

contd.

I liken my chosen family to a cocoon. It is a safe space. It is nurturing. It helps us grow and thrive. And it is transforming for those involved. Other elements slowly began to emerge: affection, harmony, connectedness, rootedness, mutual respect; and being considerate of differences, demonstrating care and support, laughter, dependability, kindness, collective care, critter love.

I began to separate out my needs, and to expand the circle of people who could meet them. My chosen family consists, now, of my ex-partner, their current partner and my girlfriend. And between us, four adults, we have a dozen dependents – two dogs, nine cats and one human child. These four people think and feel similarly about the cocoon that we are trying to create, and each one adds to the elements and emotions listed above. And, most importantly, this chosen family is an open space for more people to join in. What keeps us together is not any structure, but the meanings we painstakingly make with each other. These meanings come from our feelings and our ethics. And from the shared recognition that all of it takes time, years... and it takes hard work. We all struggle, we fail, we also celebrate, and through it all we hold each other to make it work and to keep reworking it.

I was initially averse to the term "family", given the critiques many of us have of families as hetero-patriarchal institutions perpetuating unequal power structures. I preferred terms like bubble, cocoon, unit. But I also began to realise just how much we internalise what families are supposed to mean. On account of our sexualities and genders, queers often move apart from natal families – move away physically, or grow apart simply because we can't share our real selves with them. But our need for

contd.

belonging continues: where, then, do we find the roles and functions that families are supposed to play? Therefore, I now believe that despite our critique of what families are and do to us, it is possible to subvert notions of family and create relationships in ways that meets the varied needs that we expect families to meet. What is powerful about chosen families is that such families are not thrust upon us at birth – because we choose them, we can negotiate in a more willing manner how to be with each other.

REFLECTIONS

- Meanings are made, negotiated, reworked, and held, in the absence of a social structure that provides validation. Each person in the equation is continuously working to make and hold multiple meanings.
- The entry or exit of people, besides a range of other life situations, keep affecting the unit; meanings are therefore reworked over and again.
- It takes years to construct and consolidate these processes and relationships. And yet it is important not to lose sight of their fragility in the face of social forces, which continue to deny validation.
- The values and ethics that are important to the people in the unit are paramount.

YOUR NOTES

4.2.2 Children of queer adults

Obviously, queer/trans folks have children. They have children either from heterosexual marriages, or they have children with their queer/trans partners, or they may have adopted children as single people or as couples. The point is, unlike the popular belief that queer/trans folks "cannot have" or "do not have" children, there are several of us who are parents and have found ways to queer our parenting. We have also found ways to communicate with our children about our lives without the burden of shame and discomfort; there is much here from which the mainstream can learn.

This particular section is divided into two parts: the first has pointers on how to engage with children on matters of gender-sexuality; the second discusses how queer/trans parents could be supported.

Talking to children about gender-sexuality

1. The exact words and precise language to be used are not the primary concerns, although we often get stuck on the issue of wanting only to know what words to use. It can actually be counterproductive to use some standardised or universal terminology that can alienate the child. The appropriate articulations would depend on many aspects of the context – age, region, spoken language, and other specificities of the child's and carers' environments.
2. What is needed before having the actual conversation is to have an awareness of the affect (emotions) underlying the communication. This is important, because we

Unlike the popular belief that queer/trans folks "cannot have" or "do not have" children, **there are several of us who are parents and have found ways to queer our parenting**

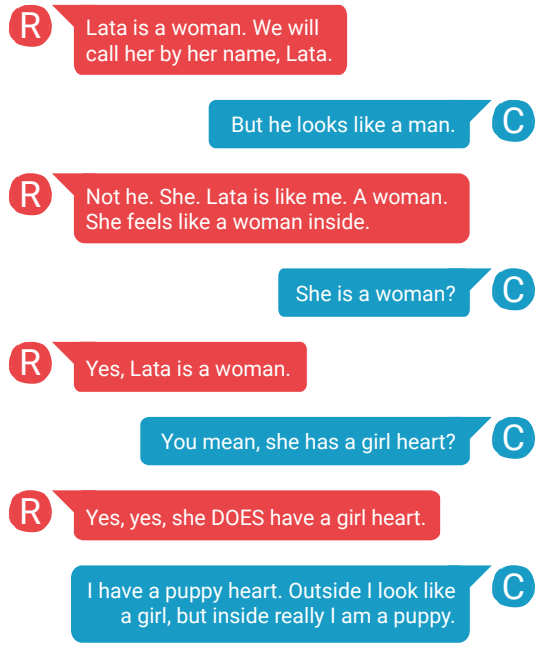
know that children respond to affect. Often, they are also far more perceptive than adults give them credit for being: if your words sound correct but your emotions and attitude convey shame, disgust, hesitation, fear, then the most perfect sentences will not make up for the messages being conveyed by way of the shame and fear.

3. Adults should, therefore, first examine their own emotions and feelings around talking about sexuality and gender, as well as their own prejudices. Only after such self-examination can they be ready to work on how and what matters of gender-sexuality to communicate to children.

A set of conversations between children and their adult carers follows. Please note that these are all based on actual conversations. We have drawn on examples from our own lives and from other queer/trans parents.

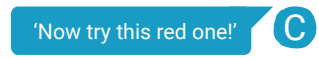
EXAMPLE 1

A cis woman mother **(Reena)** was keen to help her six-year-old child **(Charu)** understand her trans woman friend's (Lata's) gender identity. Lata had not accessed any medical transition, and her gender might have been read as man/masculine.

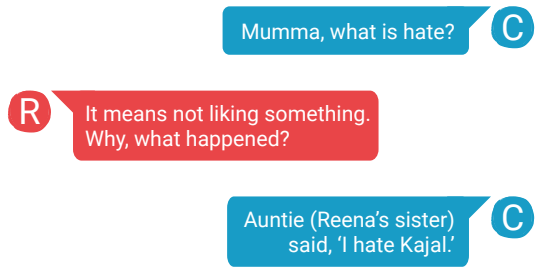


In this example, the six-year-old found a way to make sense of the gender of her mother's friend by saying that she herself had a "girl heart". Also, since there was no shame attached to this conversation, Charu went on to make the conversation about herself, just like any six-year-old might.

This lack of shame and discomfort was evident when, one day, Lata was trying on Reena's sarees, and Charu piped up and said,



Another day, Charu had a different experience regarding her mother's lesbian partner (Kajal).



Reena tried to comfort her little one, saying that it was because Auntie did not know Kajal very well, and that they would become friends when they had met a few times. Though Charu may not have known the word "hate", she must have felt its intensity in the way her aunt spoke. And that brought her crying to her mother. Charu and Kajal had a great bond and spent a lot of time together. Charu was also extremely fond of her aunt. She had to realise at an early age that these two adults she cared about took pains never to meet each other. Reena and Kajal, the queer parents, had to put in extra labour to help the child process the feelings that arose because the straight adult was not willing to work through her homonegativity about her sister's sexuality.


Lata is a woman. We will call her by her name, Lata.
But he looks like a man.
Not he. She. Lata is like me. A woman. She feels like a woman inside.
Yes, Lata is a woman.
She is a woman?
You mean, she has a girl heart?
Yes, yes, she DOES have a girl heart.
I have a puppy heart. Outside I look like a girl, but inside really I am a puppy.

EXAMPLE 2[22]

A trans man **(Piyush)** is approached by his girlfriend's five-year-old niece **(Shona)**.

S Are you a girl or a boy?

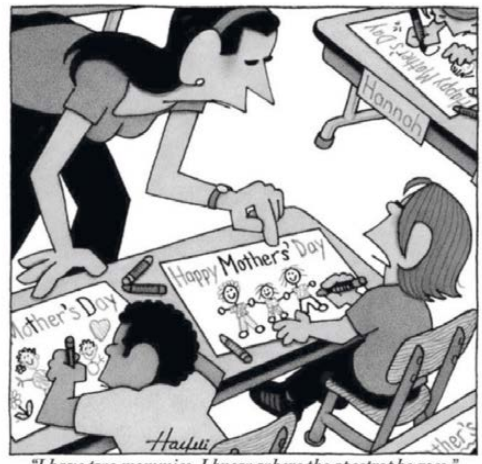
I have the brain of a boy, heart of a boy and body of a girl. P

S Brain of a boy, heart of a boy, that is two. Body of a girl, that is one. Two is more than one, that means you are a boy.

Again, in this example, the child found a way to make sense of Piyush's gender. What is important to note is the matter-of-fact way in which her question was answered.

[22] *Shared by Aryan Somaiya, transman, practicing psychologist, and co-founder of Guftagu Counselling and Psychotherapy Services*

Credit: William Haefeli/The New Yorker

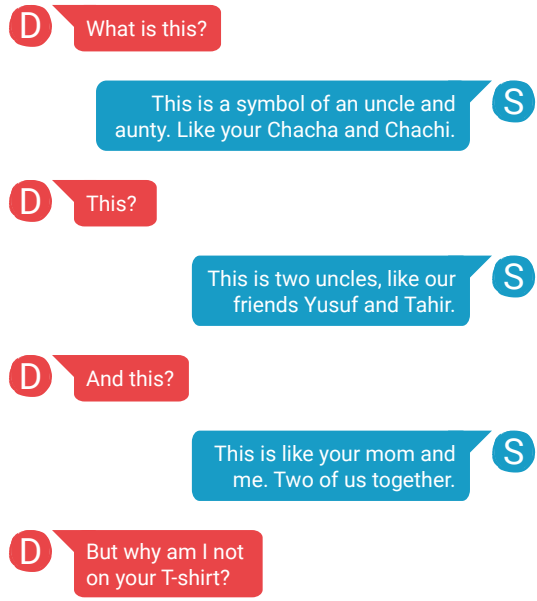


"I have two mommies. I know where the apostrophe goes."


Are you a girl or a boy?
I have the brain of a boy, heart of a boy and body of a girl.
Brain of a boy, heart of a boy, that is two. Body of a girl, that is one. Two is more than one, that means you are a boy.

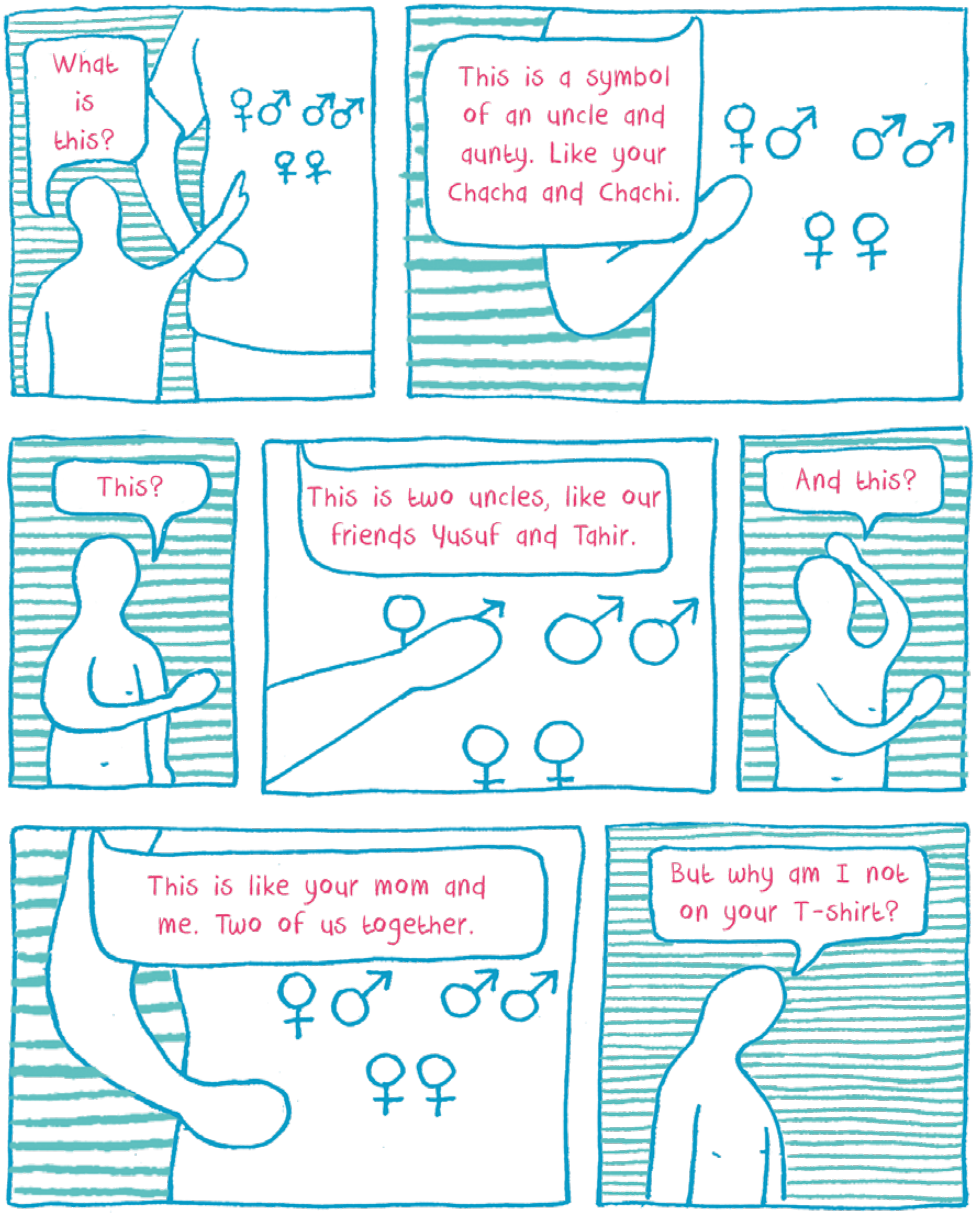
EXAMPLE 3

A queer woman **(Shabana)** was wearing a T-shirt with symbols representing different couples of various genders. An eight-year old **(Dhriti)** pointed to each symbol, and a conversation ensued.



This example demonstrates how having two women as her mothers is not a matter of much concern for Dhriti. Because her reality – her "normal" – is presented to her without shame, she internalises it without effort. In time she will very likely have to respond to tough questions from her peers, but her parents are preparing her for how to cope with those eventualities, which also counts as queer labour by queer parents.

Queer parents are often role models by dint of their very being. As Sailee, the 17-year-old daughter of one of the authors says, ***'Mumma was never affected by what others said to her. I saw she was always so strong. She did not let it bother her. I also learnt to be like her.'***


What is this?
This is a symbol of an uncle and aunty. Like your Chacha and Chachi.
This?
This is two uncles, like our friends Yusuf and Tahir.
And this?
This is like your mom and me. Two of us together.
But why am I not on your T-shirt?

EXAMPLE 4

A teacher **(Neeta)** who is open and aware of gender-sexuality issues was teaching pronouns. When the third person neuter gender pronoun "it" came up, a **student** hesitantly asked

S What pronoun to use if a person is not a he or a she?

Neeta was quick to answer, with much ease,

'You have raised an important question. Good! There are transgender people, and you have to ask them which pronoun they want you to use for them, and you must use that. Some people may not feel a "he" or a "she". Then you can use the pronoun "they". Sometimes you may see someone who looks like a man but inside she may feel like a woman. So *she* is a *she*. It is most important that you use the pronoun which the person wants. Is that clear to everyone?' N

This teacher had just introduced 10- to 12-year-olds in her Grammar class to ideas of self-determination, diversity, and trans and nonbinary gender! When you are queer-affirming, and support queer/trans people, such affirmation becomes second nature.



Queer parenting

How do we typically view queer parenting? Through feminist critiques of parenting, we know how quickly, in conversations about any adult woman and her sexuality, her capacity to "mother" or raise children is brought into question. When we extend this mainstream attitude to queer/trans realities, we can see how queer/trans parents (if they are out, of course) would fall under even greater scrutiny in this regard.

When engaging with queer/trans parenting, what are the useful questions and reflections that we might have as practitioners ?

1. The practitioner must examine why queer/trans people tend to be viewed as irresponsible, and as incapable of being trusted with the care of dependents. Is this disgust masked as concern? Are familiar arguments invoking lack of "stability" actually a cover-up for homonegativity and transnegativity?
2. It is highly essential to check with ourselves if our view of queer parenting is through the lens of *deficit*. Do we see queer parenting as a space that "lacks" what a child needs? Can we work past this lens of deficit to look at the ways in which queer parenting might be working in favour of the child? If the unit consists of "chosen family", it might actually be a space with an abundance of carers and role models. However, to appreciate these potential strengths and resources, we must first explode the myth of the two-parent, mother-father format of "the ideal family". If we uncritically uphold the cis-het family system here, we do a serious disservice to our queer/trans clients and their dependents.
3. Can the practitioner be a true ally to the parent in supporting them through the process of building resilience in their children? It is important to remember that both, queer/trans parents as well as their children, are likely to have a

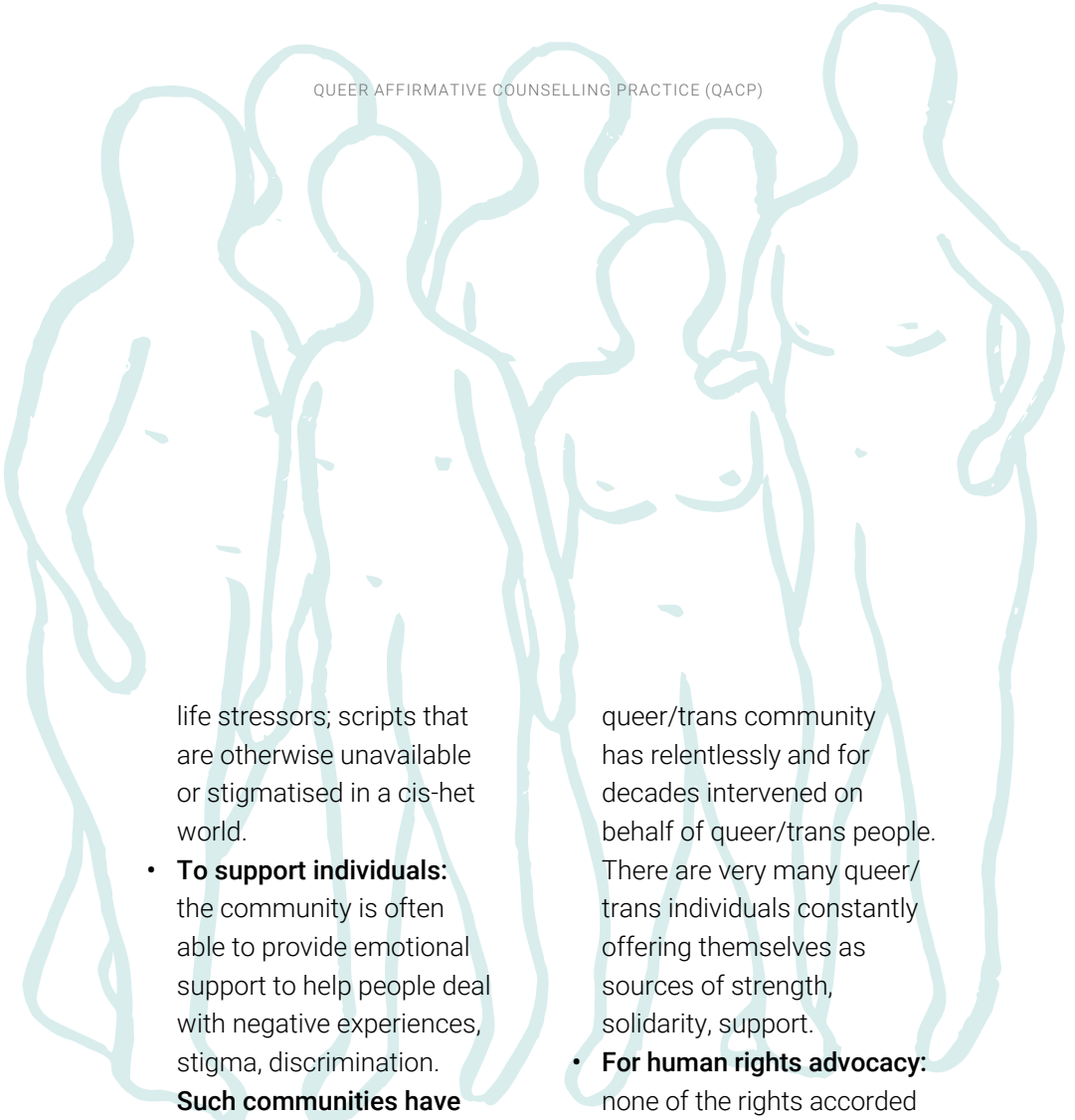
relatively greater awareness and experience of the world as hostile or unwelcome. Can the practitioner draw upon this experience while working with the client on coping, or on building resilience?

4. To recall our exercise on the gendered nature of raising a child (see 2.2) – a significant takeaway there was that when thinking outside the Charmed Circle, we are better able to focus on what children need – love, care, structure, consistency.

4.3 Community as resource

It is of utmost importance that cis-het practitioners learn to recognise queer/trans communities as a resource for their queer/trans clients. Far too often, the larger cis-het society is unable to provide any representation or validation for the lived and felt experiences of queer/trans individuals. Historically, therefore, communities have had to step in, in a variety of ways–

- **To support queer/trans journeys:** the wider community becomes an important space in which individuals are able to explore their identities. This is where they are able to finally glimpse an authentic self and then work towards consolidating it. The community does the critical work of normalising queer/trans lives for individuals.
- **To educate:** communities provide role models/role modelling with which queer/trans people can connect or find resonance, and which they can emulate, as well as scripts on how to "be" as a queer/trans person, how to be in relationships – scripts about love, desire, sex; scripts for how to cope with



life stressors; scripts that are otherwise unavailable or stigmatised in a cis-het world.

- **To support individuals:** the community is often able to provide emotional support to help people deal with negative experiences, stigma, discrimination. **Such communities have also undertaken crisis intervention on a huge scale: helping queer/trans folks get out of violent homes; preventing forced marriages; offering support after sexual assault; following up on legal cases; helping couples relocate; standing up against police brutality.** That is just a small set of examples of how the wider queer/trans community has relentlessly and for decades intervened on behalf of queer/trans people. There are very many queer/trans individuals constantly offering themselves as sources of strength, solidarity, support.
- **For human rights advocacy:** none of the rights accorded to queer/trans people could have been won without decades of advocacy at all levels. Queer/trans folks have put their lives out in the public domain to push for change. Legal, social, medical, media, mental health – take any social institution, and you will find that it is designed to serve the Charmed Circle. Any push for change, then,

has always had to come from within the marginalised communities. Additionally, pushing for diverse realities to be included has been labour done by them – for instance, making Pride marches disability-friendly to include disabled queer/trans individuals.

- **For possibilities of living:** these communities are, then, often the only space where possibilities of living emerge for queer/trans persons – finding others like oneself, finding love, finding support, finding ways of being. Given the context of deprivation surrounding queer/trans people, community offers possibilities for an individual to survive, perhaps even thrive; it makes visible possibilities of a future for oneself.

This framing of ***Community as Resource*** is critical for MHPs at all times. Clients might not always report positive experiences about their engagement with community, but this does not mean that community should be disregarded. It is important to remember that the queer/trans community is not a monolith. There is diversity within the queer and trans communities (see 5.3 – 'Tenet 3: Avoiding assumptions and respecting diversity').

It is also important to know that community is not something "out there" or "far away". It is not like some housing society to which one may send one's clients! Community is made up of people, spaces, resources – and meanings. MHPs must recognise that community may not be continuously accessible, nor is continual engagement a necessary condition for a sense of community. For instance, a lesbian woman may have been part of a queer support group in college, but her work may have caused her to move to a smaller town and she may not know of any queer groups there. It might seem that she now lacks community, but her earlier experiences of community may be enough for her to feel 'I am not alone.' Therefore, MHPs must be innovative, and work closely with their clients to figure out what community might mean to them and how it can be accessed.

What should therapists do?
Create a data base of community groups in their area, be aware of queer events, be familiar with queer resources (see 5.3 – "Tenet 6: Knowing about – and engaging with – resources and community").

- **Assess the client's readiness:** clients may not be ready to access community, possibly due to internalised stigma, or even because of earlier disappointments with community – such as a gay man who has faced body shaming at a party, or a butch lesbian who has been at the receiving end of negative comments about her masculinity. It is crucial to recognise that queer/trans communities do not exist in isolation and are likely, therefore, to have members who have internalised normative ideas of body, gender, and sexuality, and who may act based on these normative notions. It is therefore important to work with the client so that they have a more realistic perception of queer/trans communities and do not get disillusioned because of a few instances such as the ones mentioned.
- **Leave information with the client:** it is best that you provide the information you have about groups and events without any insistence that the client join, or attend – just let the information be available to them.
- **Work with clients who are open to accessing community:** creative ways may be required to connect clients to community. For instance, a 35-year-old gay man was extremely unsure about accessing community through gay parties, as he felt he was too old to party. However, he did feel lonely – he did not know any other gay men, and was surrounded by straight colleagues and friends among whom he found no space for his own realities. The counsellor suggested that he attend a Pride march in order to get a sense of the community, but the client was fearful about being 'seen in a march like that'. The counsellor then worked with the client to explore

what might be possible. Finally, both agreed that the best way would be for the client to stand at a bus stop that was on the route of the Pride march. This way he could be an anonymous bystander, while having the opportunity to witness queer celebration. The impact of this experience on the client was immense. From the safety of the bus stop he was able to witness queer people in the thousands, in all their diversity, and this gave him a deep sense of community; it also strengthened him by reducing some of the shame he felt, and encouraged him to attend a support group meeting.

- **Hold even their brief experiences of community interaction for the client:** as mentioned, access to community is not always continuous. For many reasons, this tenuous connection could be broken: the loss can feel like erasure; the client may feel bereft. The MHP plays a very important role here, of holding and helping to strengthen even the client's brief brush with queer realities – experiences that may not seem significant from a normative time perspective but which, for a queer/trans client surviving in a context of deprivation, could well function as a lifeline.
- **Crisis Intervention with community support:** Typically, in therapeutic practice, MHPs do not engage directly with crisis intervention. However, an MHP may have to intervene if a violent situation arises when their client's sexuality becomes known. MHPs need to know some basic crisis intervention steps in order to support clients in their preparations to escape from violent homes, for instance. The following Do-s and Don't-s have been put together by community groups with decades of crisis intervention work behind them.

DO-S

Take all your relevant ID documents and educational certificates with you.

Leave your cell phone and your SIM card at the location from which you are running away.

Write a letter and post it to the police station nearest to your home, stating that you are above 18 years of age and have left home of your own free will. Send a copy of this letter to your home address as well. You can say in the letter that you are leaving because you are facing domestic violence. Ask a trustworthy ally to post the letters from a location unrelated to where you are going to be.

Contact a local LGBT group/ community organisation prior to running away, so that they can advise you about shelter homes/ safety steps/lawyer contacts.

DON'T-S

Do not take any valuables or cash that are not your personal property from the house. Families are known to register police cases alleging theft.

Your phone and the SIM can both be traced, and your whereabouts tracked. Buy/use a new phone and SIM card after you leaving home. Do not use the new phone or card to call family members, or any other persons to whom your family has access.

Don't send these letters from any area around where you might be taking refuge. Do not say anything about your sexuality or gender. The mention of domestic violence can prove useful: the PWDVA (Protection of Women from Domestic Violence Act, 2005) can help to intervene in cases involving female assigned persons, and may be interpreted to include trans men and trans women as well.

Do not run away as a last-minute option. Escape from violent spaces requires sound planning, with the help of community.

Conclusion

Chapters 3 and 4 presented some of the lived realities and felt experiences of queer/trans people, in order to help MHPs gain information and insight into these lives lived on the margins. This chapter focused on kinship, offering insights into how dominant Charmed Circle norms can impact queer/trans intimate relationships, along with conceptual tools that are needed so that client concerns can be framed and responded to in affirmative ways. The chapter also outlined newer ways in which intimacies and kinships can be reimagined – these, too, are useful frameworks to bear in mind.

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Some Core Ideas of QACP

There is a history and legacy of violence against queer-trans folx by the psy-disciplines. Interrogating “neutrality” and “objectivity” - and recognising them as a tool to maintain inequality is critical. Affirmative practice is about doing the extra in order to account for the gap that these systems of power have created by applying knowledge and perspectives learned from the margins.

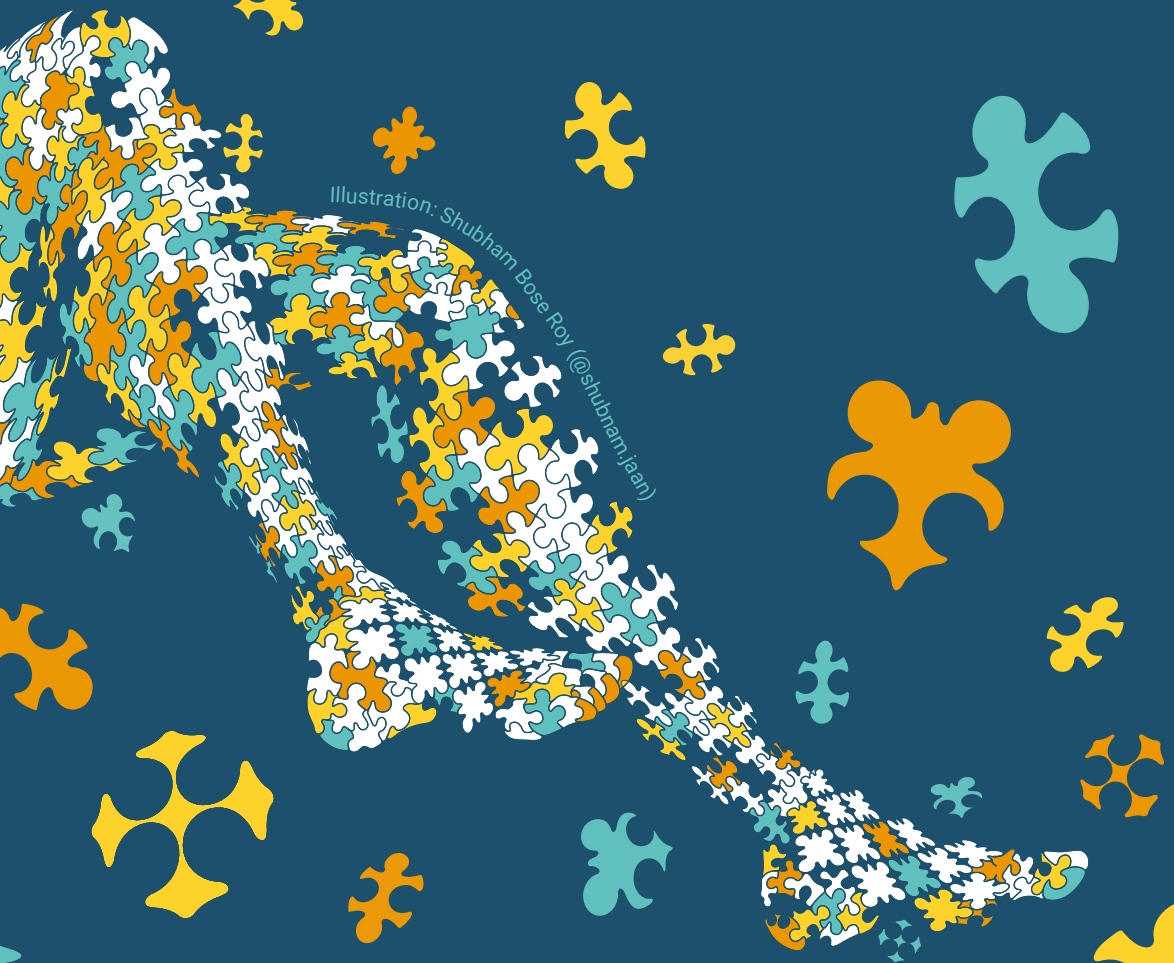


Illustration: Shubham Bose Roy (@shubnam.jaan)

CHAPTER 5

Some Core Ideas of QACP

Having examined the social construction of normative gender-sexuality, and the many ways in which non-normative lives are lived on the margins formed by this construction, we now move towards defining the foundations of QACP. One of the foundational pillars for QACP work is to uncover the historical engagement of the psy disciplines with queer and trans issues. The first section of this chapter examines this engagement in detail. Subsequently, we try to answer the question: what makes counselling queer affirmative? And in responding to this, we also make some distinctions between queer affirmative, "neutral", and "queer friendly" mental health work. Finally, we discuss some tenets that QACP practitioners can use as guiding principles in their practice with queer/trans clients.

5.1 Pathologisation and medicalisation of the queer and trans subject: A historical account

This section is broadly divided into three sub-sections. The first engages with the relevance of understanding the historical engagement of psy disciplines with non-normative genders and sexualities. The second focuses on providing a historical account of the journey of the "homosexual" and "trans" person within Euro-American diagnostic and treatment frameworks. The final sub-section dwells on the questions: How have Indian mental health sciences and professionals responded to changes in Euro-American mental health praxis vis-à-vis LGBTQ+ persons? And what have been the local contexts of these responses?

5.1.1 Why engage with histories of pathologisation of "homosexuality" and "transgenderism"?

One may argue that history is about things that are in our past. What is the need, then, to rake up the past, particularly if it is unpleasant or violent? As long as it has changed, and we no longer repeat the same mistakes, it may seem best to bury the past and move on towards more evidence-based, scientific practice in the present.

There are two questionable assumptions underlying such an argument–

1. That the past and present can be disconnected from one another – that it is, in fact, best to disconnect them if the past has elements of coercive, violent praxis that is embarrassing for today's practitioner of the discipline.

2. That the discipline itself and its practitioners are now completely cleansed of the traces/ways of thinking that were historically central to them, and that neither the discipline nor its practitioners today have any role to play vis-à-vis their histories – which means there is no question of collective responsibility and accountability, or of righting a historical wrong.

We suggest here that engaging with histories of the ideas and practice of a discipline provides us with insights: into some of its core values and beliefs; into the functions that the discipline may have served in a social order at any given time; and into the contexts of its development. Most importantly, such an engagement also teaches us something about change – when, how, and who makes it possible? A study of history is not only a study of what happened in the past, but is as much about how that past connects with the present and, possibly, the future.

Exploring the histories of the psy disciplines vis-à-vis the queer and trans subject is, then, an attempt to discover how non-normative genders and sexualities have been looked at within those disciplines, and the ways in which they have been sought to be "treated" or "managed" over the years. Drawing attention to the historical pathologising of queer and trans persons – within psychiatry, psychoanalysis, psychology, and psychiatric social work – thus becomes an exercise in underlining these oppressive legacies and uncovering the gaze(s) through which we, as queer and trans persons, have been viewed and treated within these disciplines. Moreover, it is an exercise that helps us identify and locate the continuation of these pathologising tendencies within the psy disciplines and their practice in contemporary times.

Chapman et al. (2019) suggest that in historical studies the relationship between the past and the present can be framed either as clear-cut progress or as total discontinuity. We are interested, here, in interrogating both: the tendency to refer to past treatments of homosexuality as

almost barbaric – condemned by the profession/discipline today, with no claim to connection or continuities in contemporary practice; and the other side of the coin – the impulse to claim progress, and the scientific temperament, by pointing to the long way that the discipline has come from understanding homosexuality as "perversion" and "deviance" to seeing it as a normal variant of human sexuality.

Another question that arises while studying the history of a discipline is that of whose story is being centred, and whose left out. In this section, we draw on some of the "left out" stories – of work and writing by queer/trans mental health professionals, activists, and our allies from within the psy disciplines, to offer a critical commentary on the mainstream psy disciplines.

While we focus here only on the history of the queer and trans subjects within these disciplines, we wish to state that a study of gender-sexuality histories across time and space enables us to understand the wider socio-political-scientific project of the production of the "abnormal", which sheds light both on the management of this abnormal and on the consolidation of the "normal". Without knowing this history, we run the risk of believing the ahistorical (read "timeless") story of naturalised reproductive heteronormativity, and binary ideas of bodies and genders, as constituting the only forms of sex-gender-sexuality – a story that often continues to be uncritically retold in the curriculum, training, research and practice of the psy disciplines.

Exploring the histories of the psy disciplines vis-à-vis the queer and trans subject is, then, an attempt to discover how non-normative genders and sexualities have been looked at within those disciplines, and the ways in which they have been sought to be "treated" or "managed" over the years.

5.1.2 Pathologisation of Homosexuality – shifts in position within western medicine and the psy disciplines

Studying the history of the pathologisation of homosexuality in western medicine is of relevance to us as practitioners in India to the extent that our disciplinary training, research and practice is influenced by these Euro-American models and their historical trajectories.

Drescher (2015) suggests that in 19th century western societies, as power shifted from religious to secular authority, same-sex sexuality – like many other "sins" – began to receive greater scrutiny from the law, medicine, psychiatry, sexology and so on, with the result that '… religious categories like *demonic possession*, *drunkenness,* and *sodomy* were transformed into the scientific categories of *insanity, alcoholism,* and *homosexuality*' **(Drescher,** 2015 p. 568). 'Psychopathia Sexualis' by Krafft-Ebing, published in 1886 and considered to be one of the first texts on sexual pathology, is an important starting point with reference to the European context. Krafft-Ebing listed a range of sexual diseases and perversions including sadism, masochism, fetishism, nymphomania, satyriasis, homosexuality, voyeurism, exhibitionism – basically every sexual aspect that was not part of legally and religiously sanctioned marital reproductive sexuality.

One of the ways to examine this history of pathologisation is in terms of what was considered to be the site of this pathology at different times. Some early writings focus on the physical body as the site of pathology, or on what has been called by Steinach and Lichtenstern (in **Schlich,** 2010) the somatic theory of development of homosexuality. Austrian physiologist Eugen Steinach

described a surgical technique he used in 1917 in an attempt to cure homosexuality – this was a unilateral castration performed on a homosexual man, with testicular tissue from a heterosexual man transplanted into the castrated patient. Steinach and his colleague Lichtenstern believed they had found *'… signs of female germ cells in the testicles that they had removed from homosexual patients. Logically enough, only organs from definitely heterosexually oriented men came into consideration as transplants to cure homosexuality'* **(Schlich,** 2010, p. 113). **Silverstein** (1991) notes that at least 11 men were operated on in this manner between 1916-21. Four decades later, another form of surgical intervention, this time a neurosurgical one called hypothalomotomy, came to be used in Germany to treat sexual deviations. In 1962, Roeder **(Silverstein,** 1991) introduced this technique; since then, 75 men considered sexually abnormal were subjected to hypothalomotomies. Both these surgical interventions suggest a belief that homosexuality was understood as being located in the genitals or in the brain of the homosexual person. There have been other theories postulating biological origins for homosexuality – for instance, hormonal imbalance theories, including prenatal hormone imbalance, with suggested treatments including injecting adult male homosexuals with androgens, or correcting abnormal sex hormone levels in the prenatal period to prevent the development of homosexuality.[23]

While biological theories about the causes of homosexuality were popular in the early part of the 20th century – and some of these, especially hormonal treatments, are used even in contemporary times to "cure" homosexuality – psychoanalytic influences on the study of the abnormal mind and sexual impulses brought about a decided shift from the body to the psyche, along with the interpersonal and the familial domains, as more legitimate sites of inquiry.

Sigmund Freud's views on homosexuality have been controversial in that they have been used to justify their own



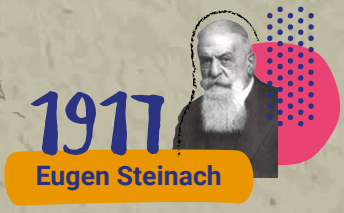
1886
Krafft-Ebing

'Psychopathia Sexualis' by Krafft-Ebing, published in 1886 and considered to be one of the first texts on sexual pathology, is an important starting point with reference to the European context. Krafft-Ebing **listed a range of sexual diseases and perversions** including sadism, masochism, fetishism, nymphomania, satyriasis, homosexuality, voyeurism, exhibitionism – basically every sexual aspect **that was not part of legally and religiously sanctioned marital reproductive sexuality.**



1948
Alfred Kinsey

Another important figure of this time was **Alfred Kinsey, who published two volumes: 'Sexual Behaviour in the Human Male' (1948),** based on interviews with 10,000 American men; **and 'Sexual Behaviour in the Human Female' (1953),** based on interviews with 6,000 American women.

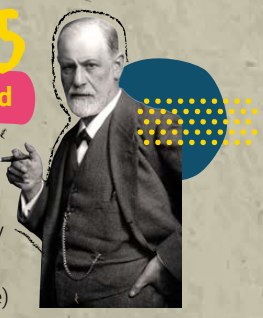


1917
Eugen Steinach

Stienach first to use a surgical technique to attempt cure of homosexuality. Performed a unilateral castration on a homosexual man and transplanted testicular tissue from a heterosexual man into castrated patient. Silverstein (1991) notes that at least 11 men were operated between 1916 – 1921.

1935
Sigmund Freud

Letter to mother of a homosexual man (shift from pathology being located in the body/brain to psyche)





1957
Evelyn Hooker

It has been argued that the declassification of homosexuality by the APA was not so much about scientific evidence and consensus but more about the social, moral and political contexts that made it difficult to continue to assert the view that homosexuals were deviant and diseased persons. In addition to the gay liberation movement, civil rights struggles and the women's movements of the 1960s and '70s that were influential in American society, the work of a few medical and mental health experts also shaped public and scientific opinion. Among the most influential was **'Adjustment of the Male Overt Homosexual' (1957), a study by Evelyn Hooker.**

1973
American Psychiatric Association (APA)

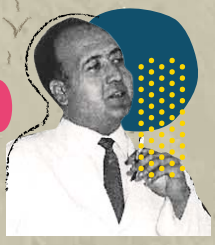
We know that the **American Psychiatric Association (APA) removed homosexuality from its list of mental disorders in 1973.** However, what is less well known about this decision is that it was severely contested, being eventually arrived at through a process of referendum – with 58% voting in favour of declassification of homosexuality from the list of disorders in the DSM, and 37% voting against.



1962
Irving Bieber

Homosexuality: A psychoanalytic study of male homosexuals. Studied 100 homosexual men and concluded that the cause of homosexuality was a combination of over-protective mothers and detached rejecting fathers. This research was used as proof of homosexual pathology during the declassification debate.

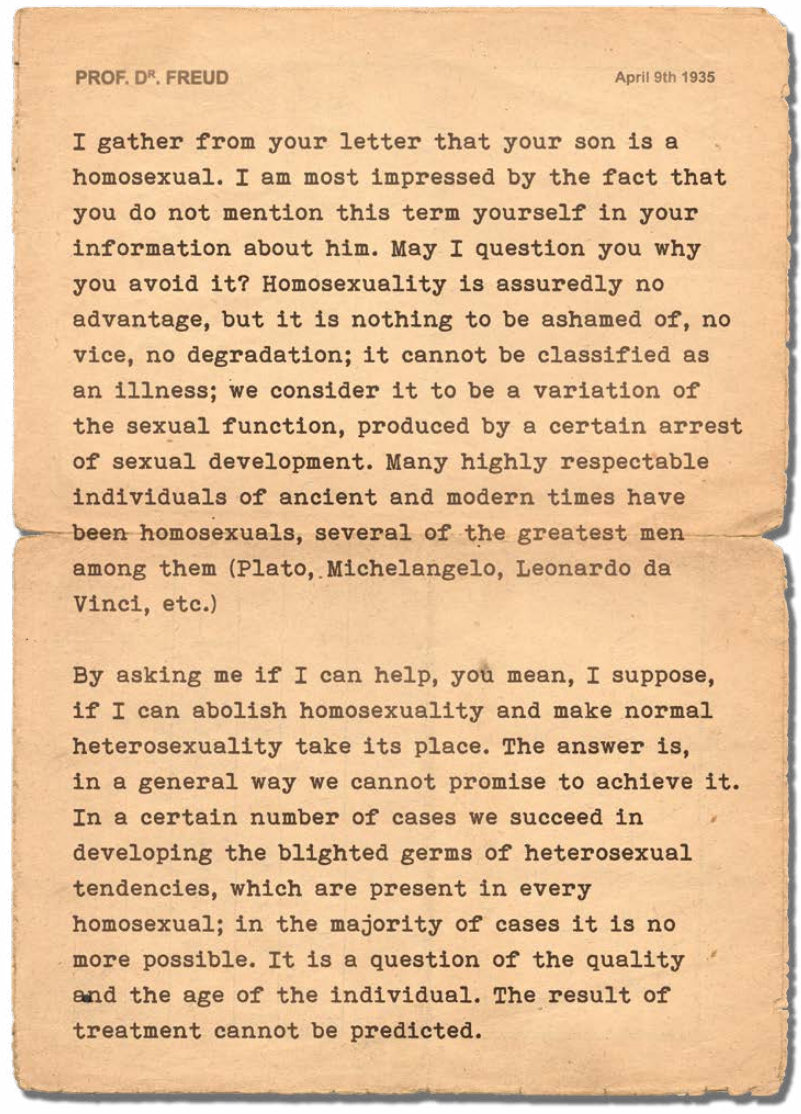
1962
Fritz Roeder



New technique of hypothalamotomies, experimented with 75 sexually abnormal men

stands by both detractors and supporters of the position of homosexuality as pathology. Freud, in his earlier work, considered that all human beings were bisexual and that it was through the successful resolution of the Oedipus complex that they achieved adult heterosexuality.

FREUD'S LETTER TO A MOTHER[24]



PROF. DR. FREUD

April 9th 1935

I gather from your letter that your son is a homosexual. I am most impressed by the fact that you do not mention this term yourself in your information about him. May I question you why you avoid it? Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation; it cannot be classified as an illness; we consider it to be a variation of the sexual function, produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.)

By asking me if I can help, you mean, I suppose, if I can abolish homosexuality and make normal heterosexuality take its place. The answer is, in a general way we cannot promise to achieve it. In a certain number of cases we succeed in developing the blighted germs of heterosexual tendencies, which are present in every homosexual; in the majority of cases it is no more possible. It is a question of the quality and the age of the individual. The result of treatment cannot be predicted.

[emphases added]

This letter can be read to assert that Freud does not pathologise homosexuality but calls it a 'variation of the sexual function', and makes reference to famous historical figures who were homosexual, thereby according respect to this form of sexuality. Yet he also says that homosexuality is an 'arrest of sexual development' implying the individual is "stuck" in some sense, and "lacks" something. There is also a definite suggestion about conversion treatment in the letter.

Rado (1940), a psychoanalyst himself, opposed Freud's view of constitutional bisexuality, claiming instead that everyone was born with a heterosexual drive, and that homosexuality was not instinctual but rather a phobic response to heterosexuality. This idea of homosexuality as a phobic response, which is itself the result of childhood (sexual) trauma and neglect, is popular even today among clinicians and laypersons alike – the idea has, in fact, survived across geographical boundaries and a timespan of decades. **Bieber** (1962), another psychoanalyst, who conducted a study with 100 male homosexuals and heterosexuals, concluded that homosexuality was the result of a pathogenic family with a domineering mother and a detached and distant father. Bieber's work was extremely influential and was used as one of the key arguments against the depathologisation of homosexuality.

With the emergence and growing popularity of behaviourism in psychology, learning theories came to be used to explain the pathology of homosexuality: it came to be seen as the result of faulty learning, such as early sexual experimentation with persons of the same sex; or the idea that a solo boy child growing up with several girls learns girly ways, lacks a male role model, hence grows up to be a feminine boy attracted to masculine men. Behaviourism also suggests that faulty learning can be unlearnt and corrected through behavioural techniques to counter-condition homoerotic responses. Some techniques that have been popularly used for orgasmic reconditioning include pairing aversive stimuli

such as electric shocks, or convulsion- or nausea-inducing drugs, with the presentation of same-sex erotic visual material in the therapy session, followed by the presentation of heterosexual erotic material that is not paired with aversive stimuli. The aim of such therapy is that the homosexual patient, through paired associate learning, makes a link between the aversive stimuli and their own homoerotic response to same-sex erotic material and, over a period of time, develops an aversive response in place of an erotic response to same-sex erotic material. Other kinds of behavioural interventions include masturbatory reconditioning, wherein a homosexual patient is asked to masturbate to sexual images and fantasies that he is comfortable with and then, just before the point of orgasm, to shift the mental image/fantasy to a heterosexual one.

Thus – from suggesting that homosexuality has organic, physical causes in the form of pathology in the genitals and/or parts of the brain, through locating homosexuality in the more subtle interpersonal, psychic domains of pathological attachment, childhood conflicts and developmental arrest, to finding its causes in faulty learning – the journey of the homosexual patient in the clinic over the course of the last century has seen many shifts, including the one towards depathologisation, to which we shall come.

Curiously, as we have seen, much of this history of pathologisation has had homosexual men as its primary focus. Critical writings about homosexual women under the medical gaze are, for much of the period we have discussed so far, scarce. **Terry** (1990), reports on the 1930s New York Committee for the Study of Sex Variants that did focus on lesbian women; the committee that carried out this study sought to distance themselves from the public stigmatisation of homosexuality, and chose the term "sex variant" over the derogatory "sex deviant". The explicit purpose of this committee was a prophylactic one, in that they sought to prevent the spread of sex variants in society. In order to achieve this goal, it sought

to study differences between lesbians and heterosexual women by studying their bodies and their minds. **Terry** (1990, p. 323) notes:

> 'Psychiatrists used psychoanalytic methods to study lesbians... Pathologists studied their skin complexion, fat distribution, coarseness of hair, of teeth, and commented on the overall facial and bodily structure of each subject. Radiologists took x-rays to determine cranial densities of the skull and "carrying angles" of the pelvis in order to identify anomalous gender characteristics. A dense skull was presumed masculine. "Graceful" and "delicate" pelvic bones were feminine. Endocrinologists measured hormonal levels... Gynaecologists and obstetricians examined to look for indications of sex variance. Their focus was on evidence of "female-to-female" sex play... Sketches of genitals and breasts were drawn in order to document particular characteristics of sex variance which appeared on them.'
>
> (Terry (1990, p. 323)

The core assumption of this study was that homosexuality was linked with the gender expression of the person, such that all homosexual men were assumed to be effeminate and lesbian women to be manly. The solution was stricter reinforcement of gender norms and roles within the family, and by society in general.

Another recently published study on the history of psychiatric treatment of lesbian and bisexual women in England **(Carr et al.,** 2019) records that lesbian women, too, accessed mental health services in distress and despair because of struggles with their sexual orientation, isolation, and social ostracism.

Treating Homosexuality

Depending on each conceptualisation of homosexuality, treatments prescribed have differed. A range of techniques and tools used to "cure" homosexuality are clubbed together under the term "conversion therapy". The term "reparative therapy" has also been used to suggest that pathological sexualisation was in need of "repairing" **(Nicolosi,** 1991). More recently, the term "curative violence" has been used to refer to these treatments that subsume a range of surgical, biological, psychoanalytical, behavioural as well as religious methods to cure homosexuality *(see* ***Ranade,*** *2015, and* ***Tenneti,*** *2020, for more details on forms of conversion treatments used in India).*

Conversion treatments have been labelled a form of medical abuse (the Yogyakarta Principles, 2007) and have been critiqued severely on the grounds of both efficacy and ethics. Among the main critiques is the question, **What is being sought to be converted/cured?** There are two kinds of queries inherent in this question. One is an ontological query: **'Why fix what ain't broken?'** In other words, it is the task of the scientific community first to prove that homosexuality is a pathology or an illness, and only then can it validly attempt to prove the efficacy of a "treatment". The second inherent query concerns the claim of a cure: **is it a cure for sexual orientation? is it about instilling new/heterosexual behaviours that were previously absent? is it about the cessation of homosexual behaviours? or even about the homosexual patient faking being cured, in the face of severe pressure and shame from the psy establishment and the institution of family?** Most research studies claiming "success" for conversion treatments report such success in terms of the homosexual person having been able to initiate heterosexual behaviours, including getting married and having a child.

Another question that the critiques of conversion treatments dwell upon is – **Who is sought to be cured?** This is

an important question; a review of conversion treatment studies indicates how, in several of them, the composition of the sample itself was unclear, such that bisexual persons were clubbed with homosexual persons and success was claimed based on the fact that participants were able to engage in heterosexual sexual contact – but the question of whether the participants were already engaging in such contact prior to treatment was never asked *(see* ***Haldeman,*** *1994;* ***Serovich et al.,*** *2008, for review of research on conversion treatments).*

A major shift in the critique of conversion treatments occurred when researchers and activists began to ask questions about the harm caused to those subjected to these treatments, which has included suicide, self-harm, self-hate, guilt, shame, a sense of being dehumanised, internalised homonegativity, lowered self-esteem, and so on *(see* ***Smith et al.,*** *2004 for experiences of patients subjected to treatments of homosexuality).* The move towards flagging conversion treatments as harmful has been useful in shifting the

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conversation from medical efficacy to a social critique of so-called treatments that degrade homosexuality and uphold heterosexuality as a superior way of being.

Depathologisation of Homosexuality in the DSM (Diagnostic and Statistical Manual) – what made this possible?

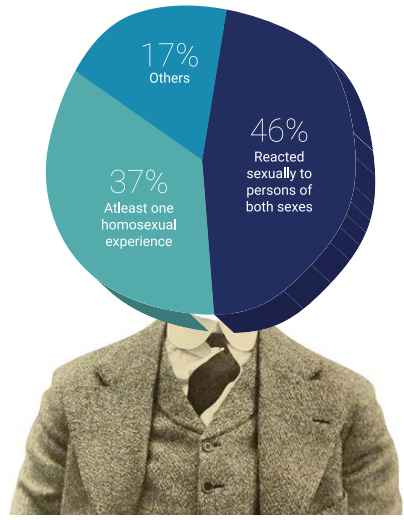
We know that the American Psychiatric Association (APA) removed homosexuality from its list of mental disorders in 1973. However, what is less well known about this decision is that it was severely contested, being eventually arrived at through a process of referendum – with 58% voting in favour of declassification of homosexuality from the list of disorders in the DSM, and 37% voting against.

> Whereas homosexuality per se implies *no impairment in judgment, stability, reliability, or general social or vocational capabilities,* therefore, be it resolved that the American Psychiatric Association deplores all public and private discrimination against homosexuals in such areas as employment, housing, public accommodation, and licensing, and declares that no burden of proof shall be placed upon homosexuals greater than that imposed on any other persons. Further, the American Psychiatric Association supports and urges the enactment of civil rights legislation at the local, state, and federal level that would offer homosexual citizens the same protections now guaranteed to others on the basis of race, creed, colour, etc. Further, the American Psychiatric Association supports and urges repeal of all discriminatory legislation singling out homosexual acts by consenting adults in private.
>
> *APA Position Statement on Homosexuality [Chair, Robert Spitzer]*
>
> **[emphases added]**

It has been argued that the declassification of homosexuality by the APA was not so much about scientific evidence and consensus but more about the social, moral and political contexts that made it difficult to continue to assert the view that homosexuals were deviant and diseased persons. In addition to the gay liberation movement, civil rights struggles and the women's movements of the 1960s and '70s that were influential in American society, the work of a few medical and mental health experts also shaped public and scientific opinion. Among the most influential was 'Adjustment of the Male Overt Homosexual' (1957), a study by Evelyn Hooker. Hooker compared two groups, matched in terms of age, IQ and education – one comprising 30 exclusively homosexual men, and the other with 30 exclusively heterosexual men – who were administered three psychometric tests: the Rorschach; the Make a Picture Story Test (MAPS); and the Thematic Apperception Test (TAT). Judges who were considered experts were asked to identify the homosexual respondents from the results. Two-thirds of the research participants in each group were judged to have average or better adjustment, and the **judges were unable to distinguish between homosexual and heterosexual subjects. Hooker concluded that there was no association between homosexuality and psychological maladjustment.** This study is significant not only because it showed that there was no scientific basis for considering homosexuality to be pathological, and that the attribution of psychological deviance was in fact a sign of social prejudice widely prevalent among the psy disciplines and its practitioners; but also because it used scientifically rigorous methodology to arrive at its conclusions.

Another important figure of this time was Alfred Kinsey, who published two volumes: 'Sexual Behaviour in the Human Male' (1948), based on interviews with 10,000 American men; and 'Sexual Behaviour in the Human Female' (1953), based on interviews with 6,000 American women. Kinsey found that 46% of all male subjects had "reacted" sexually to persons of both sexes, while 37% had had at least

Alfred Kinsey (1948) 'Sexual behaviour in the human male' and 'Sexual behaviour in the human female'



Sample size:
10,000 American Male

Sexual Response Scale



0 Exclusively heterosexual
1
2
3 Equally heterosexual & homosexual
4
5
6 Exclusively homosexual

IN MEN

10% RATED >3

11.6% RATED 3

IN WOMEN

6% RATED >3

4% RATED 3.2 *(Previously married)*

7% RATED 3.2 *(Single women)*

one homosexual experience. He mapped sexual responses on a scale of 0 to 6, with 0 for exclusively heterosexual and 6 for exclusively homosexual, 3 being equally heterosexual and homosexual. 11.6% of white males in the sample were given a rating of 3, and about 10% had been predominantly homosexual for at least three years between the ages of 16 to 55. 7% of single and 4% of previously married women were given a rating of 3.2. 6% of the women were predominantly homosexual in experience and sexual response. Kinsey's reports made the stunning revelation that not all of America was having marital, heterosexual, reproductive, vanilla sex – and that many more women and men than had been previously imagined had same-sex fantasies and sexual contact. This, clubbed with studies like that by Hooker – and a vibrant gay rights movement with activists crashing psychiatry conferences and organising sit-ins at these meetings, demanding to be heard and rejecting expert narratives about their lives and their loves – paved the way for the APA referendum on homosexuality.[25]

The declassification of homosexuality, or its removal from the APA's list of disorders, did not mean that homosexuality was depathologised overnight in people's minds or, indeed, in the practices of the psy disciplines. If we look at the journey of homosexuality as a diagnosis in the DSM then we see that it first appeared in DSM-I (1952) as 'sexual deviation' within the sub-category of 'sociopathic personality disturbances' alongside transvestism, paedophilia, fetishism, sexual sadism, and so on. In DSM-II (1968), it continued to be diagnosed under sexual deviation until it was deleted from the classification in 1973 – but was replaced by 'Sexual Orientation Disturbance', which was later replaced by 'Ego Dystonic Homosexuality' in DSM-III (1980). Ego-dystonic homosexuality meant that the homosexual person was deeply distressed by their sexual orientation and wanted to cure/change it. This diagnostic category was critiqued on the grounds that the distress arising due to homosexuality was more to do with society than with the individual, indicating social

dystonicity rather than ego dystonicity. Another argument against this label was that if this were a valid category of experience, was there also such a thing as ego-dystonic heterosexuality? Finally, in DSM-III-R (1987), the category of ego-dystonic homosexuality was dropped. Other classification systems of mental illness followed suit: the International Classification of Diseases (ICD) by the World Health Organization (WHO) removed homosexuality from its classification in 1992.

5.1.3 Pathologisation of homosexuality: The story in India

While Indian psy disciplinary training and practice are otherwise significantly influenced by mental health praxis in the USA and Europe, including following the DSM and the ICD for assessments, treatments and training of professionals in India, the declassification of homosexuality did not have any major impact on mental health praxis in India. In fact, the issue of gender-sexuality – which was always a marginal concern for the Indian mental health professional or educator – did not come up for any substantial discussion even after the depathologisation of homosexuality in the Euro-American context. Parekh (2003) conducted a study to understand the extent to which sexual minority concerns were represented in mainstream research publications by MHPs in India. This study revealed that, **of the 829 papers published between 1974 and 2000 in the Indian Journal of Clinical Psychology, only two were on the subject of homosexuality. Similarly, there were only four research papers related to homosexuality published in the Indian Journal of Psychiatry in the 1982-95 period.** These papers, despite the depathologisation of homosexuality in 1973 and then

again in 1987, were all case studies of homosexual patients and the outcomes of conversion treatments. More recent Indian studies **(Kalra,** 2012; **Ranade,** 2015) that document conversion treatments for homosexuality reveal how some practitioners have used the trope of Indian culture to justify "treating" a homosexual man, since he must carry forward his family's lineage and therefore must be able to get married and impregnate his wife. This cultural argument has even been offered as an example of socio-culturally responsive practice that justifies ignoring international standards of care for LGBTQ+ persons.

LGBTQ+ activists in India have over the years made several efforts at initiating a dialogue on queer mental health, including documenting practices such as conversion treatments. In 2001, Shaleen Rakesh,[26] a gay rights activist, approached the National Human Rights Commission (NHRC) in order to file a complaint on behalf of a young boy who had been administered aversion therapy and non-prescription drugs to "cure" his homosexuality: the NHRC cited Section 377 of the IPC and refused to address the violation.

The situation in India seems to be slowly changing now, and it does appear that mental health praxis with regard to homosexuality, like in the West, is responding more to socio-legal changes than to any significant shifts in scientific research or opinion. **Kottai** (2018) suggests that the stance of professional bodies, particularly the Indian Psychiatric Society (IPS), towards homosexuality, has been significantly influenced by the responses of the Indian courts in the matter of decriminalisation of homosexuality. **Ranade** (2018) states that it was a couple of years after the Delhi High Court – in a major boost for queer rights in India – first decriminalised homosexuality that the Indian Journal of Psychiatry (IJP) started to publish some papers, including an editorial in 2012 depathologising homosexuality and calling for more research on LGBTQ+ issues. However, after the 2013 re-criminalisation by the country's apex court (based on a legal challenge to the Delhi High Court judgement), the IJP chose to publish a letter to the editor

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titled 'Fresh Look at Homosexuality', in which the writer, a member of the IPS, pathologised homosexuality for being non-procreative **(Varghese,** 2014). A similar sentiment was echoed by the IPS President in January 2014, in sharp contrast to the editorial published in IPS just two years earlier. Finally, a day before the Indian Supreme Court decriminalised homosexuality in 2018 (in response to review and curative petitions), the IJP issued a public statement against the pathologisation of homosexuality. Then, in 2020, the Association of Psychiatric Social Work Professionals, the Indian Association of Clinical Psychologists, and the IPS as well, issued statements condemning conversion treatments aimed at curing homosexuality. These stands were in response to the death by suicide of a young queer woman in Kerala who was subjected to forced institutionalisation and psychiatric treatment for her bisexuality.[27]

While it is true that institutional responses to queer mental health in India have been significantly influenced by which way lawmakers, or the government of the day, have swung, individuals have stood their ground in resisting the pathologisation of homosexuality. For instance, in 2010, when the Delhi High Court verdict decriminalising homosexuality was being challenged in the Supreme Court, a group of 13 MHPs filed a petition in the Supreme Court in favour of decriminalisation, arguing that living as a criminal in society has serious mental health consequences for homosexual persons, and that decriminalisation would go a long way in reducing stigma and discrimination and

improving the mental health of LGBTQ+ persons.[28] Interestingly, when the section criminalising homosexuality was finally read down in India by its apex court, the judgement called upon MHPs and counsellors to support LGBTQ+ persons in their struggle for self-acceptance, and to help their families, workplaces, educational and other institutions to understand sexuality and thus help create a discrimination-free society for all **(Kapoor et al.,** 2018).

Finally, to conclude the Indian story, we would like to underscore that while decriminalisation and depathologisation are key steps in the journey of homosexuality within the psy disciplines in India, it is necessary to bear in mind that–

1. Conversion treatments for gender-sexuality continue to exist in India, despite the outcry by LGBTQ+ activists and MHPs over instances such as the suicide of the young person from Kerala mentioned earlier.
2. In the context of HIV/AIDS, some groups within the queer/trans spectrum, such as men who have sex with men (MSM), trans women, and sex workers from within the LGBTQ+ community, are seen as high-risk groups – and while this has meant state-supported targeted interventions to address their vulnerabilities, it has also opened the door for a re-pathologisation of some queer/trans lives.
3. Curriculum and training within the psy disciplines as well as the medical curriculum are still far away from change. The Medical Council of India, which revised its MBBS degree curriculum (graduate training in medicine) in 2018, after 21 years, still includes 'unnatural sexual offenses', 'lesbianism', 'fetishism' under 'sexual offences' in its forensic medicine literature. Medical textbooks in India carry a range of homoprejudiced and transprejudiced ideas.[29]
4. The development of a queer and trans affirmative mental health curriculum, and its mainstreaming within the training for psy disciplines, are therefore urgent needs in the Indian context.

5.1.4 Pathologisation of "transgenderism"

Historically, medical theories of sexuality conflated transgenderism and homosexuality, such that homosexuality was seen to be a result of "gender inversion", i.e., having a gender opposite to the gender assigned at birth. For instance, German lawyer Karl Heinrich Ulrichs argued in the 1860s that men like himself, who desired other men, might be male by birth but identified as female to varying degrees. Krafft-Ebing in **'Psychopathia Sexualis' (1886)** used a framework of varying degree, or severity, of cross-gender identification to describe gender-variant individuals – 'from individuals who had a strong preference for clothing of the "other sex", to individuals whose feelings and inclinations became those of the "other sex", to individuals who believed themselves to be the "other sex" and who claimed that the sex assigned to them at birth was wrong. Krafft-Ebing characterised this last group as especially disturbed, and saw their "delusion of transformation of sex" as a form of psychosis' **(Beemyn,** 2014, p. 9).

German physician and sexologist Magnus Hirschfeld coined the term transvestite in 1910. Transvestite comes from the Latin trans or across and vestis or clothing – to refer to individuals who are overcome with a 'feeling of peace, security and exaltation, happiness and well-being… when in the clothing of the other sex' **(Beemyn,** 2014, p. 9). Hirschfeld, who was a gay man himself, saw transvestism as distinct from homosexuality and, based on his study with 17 cross-dressing persons, asserted that transvestites could be of any sexual orientation but most were heterosexual from the standpoint of what we refer to, today, as the gender assigned to them at birth. Some of the earliest recordings of genital transformation surgeries at the Hirschfeld Institute of Sexual Science that date back to 1922 include the removal of the penis and reconstruction of the vagina.



TRIVIA

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It was only later in the '30s that a breakthrough in hormone studies – showing that "male" hormones occurred naturally in women and "female" hormones occurred naturally in men – challenged the dominant theory of two separate, mutually exclusive biological sexes. Before this discovery, the medical understanding was that male hormones could be given only to men and female hormones only to women, but now hormonal treatments for cross-gender identifying individuals became possible. During the years of the Second World War, the Hirschfeld Institute was burned down and Hirschfield, being a Jew – as well as gay, and a sexologist – had to flee Germany. He died in exile two years later.

In 1950s and '60s America, two opposing views existed regarding transgender gender identities. One was propagated by endocrinologists such as Harry Benjamin, who proposed hormonal and surgical interventions for transgender persons to get their bodies to match their minds, i.e., their felt experience of their gender; the other involved psychological interventions aimed at changing the mind to match the body that was seen as "naturally given" at birth. Benjamin referred to those who wanted to change their sex as transsexuals, distinguishing them from transvestites. He pioneered sex change interventions for transgender persons, and wrote a book based on his clinical insights,

'The Transsexual Phenomenon' (1966) – even as mainstream medical psychiatric opinion of the time was against irreversible surgeries for what they saw as essentially a delusional disorder to be corrected. The latter school of thought viewed gender reassignment surgeries as being nothing short of a mutilation of what were, to them, "natural"/"normal" bodies, and these ideas persist in contemporary times as well, within the psy disciplines. Biologist and trans woman Julia Serano has pointed out that when it comes to transgender persons' experience of their gender, if the clinician believes that the physical sex is 'real and primary' and the 'external, anatomical sex is most relevant and immutable' (p. 132), then the inner experience – the mental state – is seen as irrelevant, secondary, even unstable and faulty. Treatment programmes based on these assumptions are aimed at examining and "correcting" the transgender person's mannerisms, gait, hand gestures, voice inflection, besides colour, play and playmate preferences, and at strictly reinforcing gender norms, roles and expression through individual psychotherapy, parental therapy **(Green & Fuller,** 1973) and behaviour modification **(Rekers et al.,** 1974). Such corrective treatment, when aimed at gender non-conforming children, is justified in particular through the motive of avoiding a 'devalued future in the form of adult homosexuality or transsexuality' **(Pyne,** 2011, p. 83).

John Money, a psychologist at Johns Hopkins University, and Robert Stoller, a psychoanalyst at UCLA, are important figures in the discussion on transgender gender identities. In 1955, it was Money who advanced the idea of gender as being distinct from biological sex and, going further, used the term "gender identity" as well as articulating the idea of gender congruence, wherein a person's gender identity, gender roles and symbolic manifestations of gender are in harmony. Stoller, in 1968, made the distinction between gender identity and role in order to describe the former as an intrapsychic phenomenon and the latter as a behavioural and socially prescribed idea **(Bullough,** 2003). Money courted

considerable controversy through what, for decades, was known as **"the John/Joan case"**. This was the case of David Reimer who, in 1966, as an eight-month-old infant, had had a botched-up circumcision (meant originally to treat some condition), resulting in his having no penis at all. Money persuaded the parents that David could be reassigned as female, with surgical (removal of testes), hormonal and psychological treatments – and later claimed that David had been successfully turned into a "girl", Brenda. In the several publications where he cited this case, Money never revealed that David had rejected his gender treatment – in fact, at age 14, Reimer refused to see Dr Money anymore, threatening suicide if he were forced to continue the treatment. That was when his parents explained his medical history to him. Reimer immediately ended the hormone treatments he had been forced to undergo to stimulate female sex traits, and began taking hormones to bring about male puberty. At 15, with a different medical team, he sought a mastectomy, testosterone therapy, and a phalloplasty. The David Reimer case is important to bear in mind not just because Money purportedly engaged in a range of involuntary and abusive treatments to enforce a specific gender identity on a young child, but because it once again sparked the nature-nurture debate with respect to sex and gender. The fact that David was never happy as a girl, and reassumed his identity as a boy through medical and social re-transitioning, has been used by the proponents of the "gender is inborn" theory. Money's claim that David had successfully transitioned to being Brenda was used to support the theory that gender identity was all about nurture (upbringing), not nature (inborn traits), and that strictly adhering to and reinforcing gender roles and expression in keeping with the birth-assigned gender was the key to treating all children with gender non-conformity as well as those with atypical sex anatomies, i.e., persons with intersex variations.

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TRIVIA

In the late 1980s, Ray Blanchard, a psychologist, coined the term autogynephilia to refer to transsexual persons who, he stated, were essentially heterosexual men of a certain kind – who, typically around puberty, begin to experience cross-gender arousal in response to imagining themselves as women.

kind – who, typically around puberty, begin to experience cross-gender arousal in response to imagining themselves as women. This cross-gender arousal was a form of paraphilia that eventually became the primary factor driving these individuals to transition physically, to female. Another type of transsexual, according to Blanchard, was the "homosexual transsexual", who was feminine from a very early age and was, as an adult, attracted exclusively to men. Transsexual women belonging to this latter group were thought to be a type of feminine gay man who ultimately transitions to female in order to attract heterosexual men. Blanchard viewed all transsexual women as being sexually motivated in seeking gender transition. **Serano** (2016) aptly called these ideas a serious trans invalidation, essentially through the sexualisation of trans women.

Transgender gender identities in the DSM

In 1980, seven years after the declassification of homosexuality as a form of mental illness, two diagnoses relating to gender dysphoria in children, adolescents and adults appeared in DSM-III: gender identity disorder of childhood (GIDC); and transsexualism (to be used for adolescents and adults). In DSM-III-R **(APA,** 1987), a third diagnosis was added: gender identity disorder of adolescence and adulthood, non-transsexual type. In DSM-IV **(APA,** 1994; 2000), this last diagnosis was eliminated, while GIDC and transsexualism were collapsed into one overarching diagnosis, gender identity disorder (GID),

with different criteria sets for children, and for adolescents and adults. In DSM-V (2013), with a view to destigmatising transgender gender identities, the diagnostic label of GID was replaced with Gender Dysphoria, a change in nomenclature that was hailed by professionals and trans activists as a positive move towards depathologisation – seen not just as a change in language from disorder to dysphoria, indicating distress but not mental illness, but also as a welcome means of challenging the conversion treatments carried out citing GID as a mental disorder among trans and gender non-conforming children and adolescents.

Even so, several trans activists point out that this change in nomenclature does not, in fact, change much for trans persons. **Serano** (2016) states that the biggest problem is not so much about the pathologisation of trans identities – because in order to access insurance for gender affirmation services, trans persons need to have a certified diagnosable condition – as it is about being labelled as having a mental disorder.

From this label follows the tag of mental inferiority, which, just as it has been used to legitimise racism and sexism, has also been used to invalidate trans persons, and so the very fact that gender dysphoria continues to be a diagnosis within the DSM implies that trans people are still considered disordered.[30]

Trans persons' experiences have historically been challenged by cis male doctors, who have labelled them as mentally unstable, confused, incompetent, suffering from psychosis or neurosis, and hence not able to speak validly about their own experiences, identities and personal histories. Another transprejudiced diagnostic category that persists in the DSM-V is "transvestic disorder" (see 7.2 – 'Revisiting clinical diagnoses from a queer affirmative lens'). By contrast, the move in the new ICD-11 **(Drescher et al.,** 2016) to place transgender gender identity under the category gender incongruence, removing it from mental and behavioural disorders altogether and shifting it instead to a chapter on sexual health, is a much more welcome move.

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In the Indian context, as was the case with homosexuality, trans identities have been very little discussed within the psy disciplines. However, in the last decade with its major socio-legal shifts with respect to transgender rights in India, the medical and mental health sectors are being pushed to acknowledge some of these realities. Also, following the Supreme Court judgement (popularly known as the NALSA judgement)[31] in response to a petition filed by transgender activists in 2014, several state governments in India have been taking steps to ensure transgender rights and welfare in areas such as employment, education and health – including accessible and affordable gender transition services. Subsequently, the **Government of India passed the Transgender (Protection of Rights) Act, 2019[32] under which welfare schemes for transgender persons are being planned at the national level as well.**

However, there are still no clear guidelines or protocols regarding transgender physical health or mental health in India, either from government agencies such as the Indian Council for Medical Research (ICMR) or the Ministry of Health and Family Welfare (MoHFW), or from the country's professional MHP associations. Gender transition services are available at several private gender clinics and in some public hospitals in different parts of the country, but without any standard protocols and therefore without any accountability on the part of care providers. Attempts at developing models of care for trans health and medical

Trans persons' experiences have historically been challenged by cis male doctors, who have labelled them as mentally unstable, confused, incompetent, suffering from psychosis or neurosis, and hence **not able to speak validly about their own experiences, identities and personal histories.**

transition are being made,[33] though these are isolated efforts, as yet. Medical and psy training and curricula continue to be trans-ignorant – and, at times, transnegative.

Health care providers who are aware of guideline documents such as the Standards of Care for the Health of Transsexual, Transgender and Gender Non-Conforming People, Version 7 by the World Professional Association for Transgender Health (WPATH, 2011) do not necessarily follow – and may lack training in – these. For instance, the MHPs, who come in at the first step when a person seeks medical transition, play a gatekeeping role, in that they get to decide who may and may not transition, and who might make the transgender client jump through several hoops before they get a "certificate" from the psychiatrist stating that the

person is "psychologically fit" to access further interventions. In such situations, the rationale put forth by MHPs is that medical transition is irreversible and expensive, and hence they need to be certain about client preparedness. While this may be a sound argument, many MHPs, while conducting the clinical assessments, in fact operate from stereotypes about trans persons while being guided by binary gender beliefs along with doubts about the mental fitness of "such" persons. In the absence of training on trans affirmative care, and given their ignorance about trans lives, MHPs being seen as experts/final authorities on the experiences of trans persons can cause more harm than good. After all, transness as a sign of a disordered mind is a view that was firmly embedded in the psy disciplines for decades. While MHPs trained in gender affirmative care do have a significant role in assessing the psychosocial context of the trans person – such as figuring out their social support systems, educating the person on the transition process, and helping them have realistic expectations from it, poorly trained and transprejudiced MHPs could end up invalidating the experiences of trans persons, increasing instead of alleviating gender dysphoria.

There has been anecdotal evidence in India about MHPs insisting that trans women wear a sari or salwar-kameez when they come for consultations; if the trans woman is wearing trousers/ jeans with a t-shirt, for instance, she is not perceived as feminine enough by the cis-heterosexual

In the absence of training on trans affirmative care, and given their ignorance about trans lives, MHPs being seen as experts/final authorities on the experiences of trans persons can cause more harm than good.

doctor – who then subjects her to yet more questioning, and asks her to come back for more sessions, until she has been able to convince the said practitioner of her femininity.

> 'I can't tell you how many times that I've heard different trans women say that when they first visited some psychiatrist or therapist about transitioning, they were told that they were obviously not a "real" transsexual because they didn't come in wearing a dress and makeup. Because cisgender women always wear dresses and makeup, right?' **(Serano,** 2016, p. 135)

> '… it is well documented that many gatekeepers have based their recommendations for sex reassignment on whether they considered the trans woman in question to be physically attractive and/or willing to dress and act in a hyperfeminine manner.' **(Serano,** 2016, p.139)

> 'For accessing hormone treatment, they require your mental health to be "assessed" and for two psychiatrists to certify you as having gender identity dysphoria (a lot of psychiatrists still write "gender identity dysphoria"). Depending on your psychiatrist, this could take any amount of time, in some cases, even years. We are left at the mercy of doctors who know very little about us. In most cases, they try to convince us that we should continue to live in the same bodies, they warn us about the consequences of "sex change".' **(Gee Imaan Semmalar, in Revathi,** 2016, pp. 197-198)

That last quote, by Semmalar, is significant for the Indian trans communities not just in the context of difficulties in accessing gender affirmative therapies (GAT) but also given the fact that the new Transgender (Protection of Rights) Act, 2019 has made medical transition mandatory for those trans persons who wish to transition and change their legal documents to reflect Male/Female based on their lived gender, and not the gender they were assigned at birth [Section 7 (1), Transgender (Protection of Rights) Act, 2019]. With the law that is meant to protect transgender persons' rights relying on the medical and mental health fraternity to have the "expertise" to provide GAT as well as enable trans persons to seek legal transition and assert their gender identities, the training of MHPs and other health care professionals in trans affirmative care has become more urgent and vital than ever before.

Finally, what happens when a trans person diagnosed with a mental disorder, possibly severe and chronic in nature, seeks medical transition services? Does the current training for MHPs in India equip them to care for such a client/patient? Is clinical supervision available for those MHPs who may be new to this area of work? Are Indian laws that equate an "unsound mind" with legal incapacity, i.e., with lacking the capacity to take decisions, a barrier for trans persons suffering from mental illness to be able to access



TRIVIA

The new Transgender (Protection of Rights) Act, 2019 has made medical transition mandatory for those trans persons who wish to transition and change their legal documents to reflect Male/Female based on their lived gender, and not the gender they were assigned at birth [Section 7 (1), Transgender (Protection of Rights) Act, 2019].

gender affirmative care? Can the new Mental Health Care Act be used to advocate for the rights (particularly the right to mental health care, including access to gender affirmative care) of transgender persons living with mental illness diagnoses? These are some of the more significant and urgent questions in the Indian context around trans mental health care in the context of gender affirmative therapies.

5.1.5 What do these histories say about the psy disciplines?

1. The classification or declassification of something as mental illness is as much a socio-political and legal endeavour as it is a "scientific" one. In fact, scientific consensus and evidence-based research may not always be neatly separable from the socio-political.
2. In the absence of biomarkers, the classification of mental illnesses is arrived at using statistical computation. Hence the name 'Diagnostic and Statistical Manual' (remember the bell curve – the normal probability curve in first year Psychology class?). The meanings of "normal"/"abnormal" become linked, then, to what are seen as statistical norms/averages, where the uncommon, or the minority, are viewed as deviations from the common or majority norms. We know, however, that outside of statistics – in real life – "normal" is understood as much more than merely average or common: normal becomes ideal and desirable; and the abnormal, that which is in need of correction.
3. With respect to the declassification of homosexuality and of transgender identities, we may claim major progress from the time when genital/brain surgeries were

carried out as cures for homosexuality, and trans persons were thought of as delusional; yet it is important to highlight certain continuities – that which does not change with the changing socio-legal milieu – within the psy disciplines.

4. The core values of the psy disciplines that are tied to the average-normative, dominant discourse around gender-sexuality remain intact – those of the cisgender, reproductive heterosexual family unit, as does their functioning to provide stability to the Charmed Circle through control of whatever lies outside it.
5. What has changed, then, is that a few non-normative gender-sexuality identities have been accommodated as non-pathological, while a range of non-peno-vaginal, non-reproductive sexualities continue to be pathologised (see 7.2 for discussion on sexual dysfunction and fetishistic disorders). Homosexuality per se is not treated as a mental illness, and yet homosexual "lifestyles", i.e., those of gay men who do not follow the rules of marriage-like, monogamous relationships, are medicalised under the sexual risk discourse, as are queer and trans sex workers. Similarly, young queer and trans persons (while not being labelled mentally ill per se) are seen as belonging to the high risk category for mental illness and suicide.
6. The historical shifts in the scientific position on homosexuality or transgender identities, discussed in this section, certainly help us to argue against harmful practices aimed at "curing" these "conditions". However, such depathologisation does not automatically, or by itself, translate into affirmative practice.

5.2 What is Queer Affirmative Practice? – from harmful, neutral, to queer affirmation

In this section, we describe the foundational principles and values of Queer Affirmative Counselling Practice. We explain, further, why "affirmative" is a deliberate and political choice of word, and how it is different from, say, "queer friendly mental health practice".

Why Queer Affirmative Counselling Practice?

1. **Historical wrongdoing, and complicity in harmful practice**
   Queer affirmative counselling practice begins with an acknowledgment of historical wrongdoing, and taking collective responsibility, as MHPs, to make right what has demeaned and caused harm to gender and sexual minority communities for so long. An affirmative practitioner must actively engage with and challenge (through practice, research, teaching, advocacy, and in other ways) the dominant narrative of gender-sexuality within the discipline that grants them the credibility and authority to speak on matters of mental health. It then becomes necessary to interrogate and be reflexive about the power that accrues to us from our discipline's knowledge creation process, curriculum, training and practice, supervision, and which grants us as MHPs our "expert" positions.

   Though pathologisation has been challenged the world over, many MHPs trained in keeping with the traditional paradigms continue to stigmatise queer/trans individuals. Even today, there are MHPs who claim to help "cure" "unnatural" sexual desires, and gender identities and expressions. This is why we invoke collective responsibility, and suggest that QACP practitioners

should attempt to influence professional bodies and associations that regulate practice and curricula.

2. **Structural inequalities and systemic failures**
   Being a queer affirmative counsellor becomes vital against the backdrop of a systemic culture of silence and shaming of queer/trans persons – and the lifetime of experiences of dealing with homonegativity, prejudice and ignorance that the client brings to the counselling space. Those living on the margins carry with them experiences of discrimination at the hands of multiple systems and institutions that are not invested in their lives or well-being. In a world that upholds heteronormativity and the binaries of body and gender, affirmative counselling is cognisant of the inequalities that result, and of how these affect the well-being of a queer person.

   As we have discussed, practitioners, too, internalise prejudices as part of being socialised in normative systems. These prejudices can enter therapeutic work and can cause damage. There is a need to deconstruct and challenge the grip of social institutions over individual lives, because these institutions are geared to maintaining the status quo. In QACP, we urge that therapeutic work must be informed by these links between the personal, social and political.

3. **The particularity of queer struggles**
   Working with queer/trans clients means, among other things, that the practitioner must put in extra effort to understand the specific stressors that the community experiences. The nature of the stress and distress experienced by persons from stigmatised communities (more often than not, minorities) is of a different kind.

   'In developing the concept of minority stress, researchers' underlying assumptions have been that minority stress is **(a)** unique – that

In a world that upholds heteronormativity and the binaries of body and gender, affirmative counselling is cognisant of the inequalities that result, and of how these affect the well-being of a queer person.

is, minority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people require an adaptation effort above that required of similar others who are not stigmatized; **(b)** chronic – that is, minority stress is related to relatively stable underlying social and cultural structures; and **(c)** socially based – that is, it stems from social processes, institutions, and structures beyond the individual rather than individual events or conditions that characterise general stressors or biological, genetic, or other nonsocial characteristics of the person or the group.' **(Meyer,** 2007, pp. 243-44)

It is important never to lose sight at any point of the agency and strength with which the client comes to you. Their struggles necessitate reserves of great resilience. Recognising and respecting agency may come more easily when we work with the privileged; it is harder when it comes to working with the marginalised because of our tendency to deny them personhood. It is imperative, also, to acknowledge how unfair it is that so much of a person's energy should be spent wholly on resistance and survival, and how much harder it is to thrive in such a context.

4. **The need to acknowledge and participate in queer labour**[34]

As affirmative practitioners, we must recognise the

queer labour that several queer/trans folks do in order to push for a just world. This is our opportunity to acknowledge that it is the tireless efforts of activists, many from the community itself, that fuel the push to change oppressive systems; that the victories have not been simply a function of time, but have involved struggle and sacrifice. The declassification of homosexuality from the DSM and the reading down of Section 377 of the Indian Penal Code (see 5.1.3) are prime examples of how systemic changes have been the product of radical and collective action by the oppressed communities. Being affirmative therapists would mean joining in this queer labour.

What is Queer Affirmative Counselling Practice?

1. **Taking ethical responsibility; demonstrating a willingness to make amends**
   Because we live in a world that is built on the hierarchies of heteronormativity, the gender binary and the body binary, we must resolve, as ethical practitioners, to stand with those who do not fit into the normative gender-sexuality moulds. The practitioner also needs to deconstruct their own locations of privilege vis-à-vis the queer/trans client.

   A continuous effort at educating oneself is an important aspect of affirmative work. In today's times, there is a great deal of information both on the internet and offline; and plenty of access to varied knowledge/learning platforms. The only word of caution would be that the practitioner apply the lenses of rights and of self-determination in order to discern which materials are useful. Being ready to learn also means that those practitioners who happen to occupy space in the centre of the Charmed Circle admit that neither will their texts nor their contexts readily provide them with knowledge of lives on the margins. The practitioner will have to go out looking for this.

The practitioner recognises that a willingness to make amends will have to be demonstrated within therapeutic work as well as outside of it. What such amends could look like will become clearer as we go along. Since the practitioner is part of a larger community, they must make all possible efforts towards advocating for the rights of queer and trans persons – for instance, sensitise and train their colleagues and peers to adopt affirmative stances.

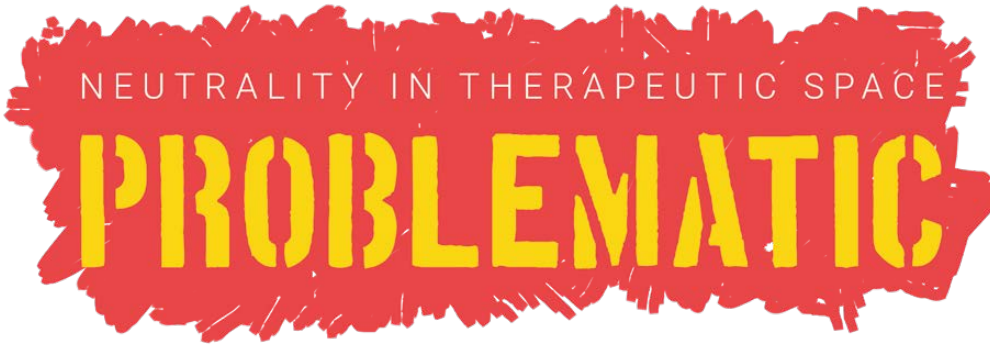
2. **Recognising neutral practice as non-responsive at best, and damaging at worst**

Neutral practice with marginalised communities is a denial of the structural inequalities and of the therapist's own locations of privilege. A non-critical upholding of "values" such as neutrality and impartiality incorrectly assumes a sameness and uniformity in societies. In our therapy space, what we are engaging with is the psychic experience of an unequal structure. This experience is shaped by the context of deprivation, loss, shame, stigma and inauthenticity in which the queer/trans person lives. Practice that is non-cognisant of these realities is, then, non-responsive to the psychic wounds and therapeutic needs of the queer/trans client.

The more we unpack these concerns, the more we see that what we know and practice as "neutral" is in fact that which upholds the normative.

Neutrality in the therapeutic space is problematic.

The ideal of therapeutic neutrality inevitably results in maintaining existing unequal relations. This ideal is detached from a world that is arranged hierarchically in every possible way. Every social structure is based on inequality, be it gender, sexuality, caste, race, class, ability. These are all significant social determinants of mental health.



Moreover, impartiality is a dangerous position to hold when working with marginalised groups (in this case, the queer/trans communities), because the practitioner who echoes normativity in the therapeutic setting fails to attend to those concerns of the client that have their origins in social hierarchies.

Langdridge (2017) says that 'the moral ideal of impartiality is not only an impossible fiction but also ideologically pervasive for the way it justifies the notion of the impartial or neutral decision-maker, whether this is within the public sphere of politics or the private arena of counselling and psychotherapy. There are consequently many dangers with the notion of a moral ideal of impartiality, not least the silencing of individuals and groups whose needs do not conform to the universal as constructed. It is here where we see the loss of the particularity of the lesbian, gay, bisexual, transgender or queer subject, and the silencing of their specific needs.' (para 5)

Practice which is not affirmative may also miss subtle forms of internalised shame and homonegativity that affect the client's quality of life, even as the client remains possibly unaware of

their presence and impact. For instance, a client's request for conversion treatment for themselves often stems from internalised homo/bi/trans negativity, and if a neutral MHP were to take the request at face value, they would risk offering conversion treatment using, as justification, therapist neutrality and respect for client self-determination. And in this way, the so-called neutral therapy would turn into harmful intervention. Affirmative work thus requires the therapist to be the person who shines the light on internalised homo/trans negativity.



Audre Lorde

Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare.

Holding space in the context of the scarcity of validation and support

In Audre Lorde's words,[35] 'Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare.' Queer persons experience lack of validation, erasure, and negative messages, which – almost invariably – affect their sense of self and self-worth. Recognising these realities, the practitioner needs to hold space for the queer client to be able, safely, to be their self. One of the MHP's chief responsibilities, then, is to institute and promote a regime of self-care that goes beyond aspects of routine, and works towards preserving and celebrating the sense of self that finds such scarce sanction and validation from the mainstream.

TAKEAWAYS

1. There is a necessity for affirmative practice – as opposed to a "neutral" approach.
2. Neutral practice can cause damage; because it upholds the normative, it will never account for lives that lie outside the norm. "Neutral" practice, then, does not equal providing a "No Harm Zone".
3. When mental health is viewed from a lens of social inequality and injustice, MHPs need to become advocates for equality and justice as well.
4. Even if we are progressive practitioners, we must take on the responsibility of interrogating the discipline from which we derive our credibility, influence and power.
5. Queer Affirmative Practice is as much about social change as it is about therapeutic work with individuals and groups. The binary between therapy and social change is exploded/collapsed when a queer affirmative lens is applied to therapeutic work.

Moving towards being queer affirmative

The following list, which describes different kinds of practitioners, can help practitioners locate where they themselves might currently be, and explore how they might move towards being queer affirmative practitioners.



- Genuinely accepts that people's gender-sexuality are their business, and that the MHP should have no say in the matter.
- 'It does not matter to me who you sleep with, it won't change a thing in my treatment'.
- 'Your gender is your business and I have nothing to say about it'.
- 'I am a modern, liberal person and hence accepting of you; however, I cannot do much to change curriculum, training, or the beliefs of my colleagues or of our professional association'.



- Does not try to convert/cure queer clients.
- Has heard that queer people actually exist only very recently, perhaps only after the Supreme Court verdict on Sec 377.
- Has accepted that among their clients, there are likely to be some who are queer/trans.



- 'I am open and want to learn, hence I believe I am queer affirmative'.
- 'I am open and very curious about the "issues faced by queer people", hence I am queer affirmative'.



- 'I have a lot of queer/trans friends and I know what some of their problems are; I use this social learning to support my queer and trans clients'.
- 'My brother is gay/my daughter is lesbian; I think I understand the pain that queer people go through, as well as what their families face. I use my personal learning in supporting my queer and trans clients'.



- Claims, and is committed to, the identity of a queer affirmative therapist, and communicates this identity to clients and fellow professionals.
- Self-reflexive about their own social location, personal beliefs, and professional training and practice.
- Works to deconstruct the influence of heterosexism and cisgenderism in psy knowledge systems and practice, and in the lives of queer and trans clients.
- Educates themselves about standards of care, protocols and guidelines for working with LGBTQ+ clients.
- Adopts a critical psychosocial approach that views individual distress as systemic and structural, and not as intrapsychic alone.
- Engages with queer and trans communities to build knowledge from their lived experiences, and to build solidarities and friendships – thereby diversifying their own social circle.
- Advocates for the rights of queer and trans persons, in and outside the mental health system.

5.3 Tenets of QACP: thumb rules for becoming a queer affirmative practitioner[36]

A number of guidelines on therapeutic work with queer and trans clients have been brought out in the last decade.[37] In India, unfortunately, there have been no standards of care or guidelines developed by any of the MHP associations or by the relevant Ministry. The tenets of QACP that we propose here are based on our clinical and research experience with queer/trans persons; specifically, some of these tenets are the result of a study that two of this book's authors undertook so as to document good practices among counsellors, psychologists, psychiatrists, with regard to their LGB and MSM (men who have sex with men) clients in different parts of the country **(Ranade & Chakravarty,** 2013).

The experiences of this QACP resource book's authors as users of mental health services have also contributed to our conceptualisation of these tenets.

The QACP tenets are broad guidelines that will help to–

1. Modify the MHP's existing practice in order to make it inclusive of and responsive to queer/trans lived realities.
2. Demonstrate the MHP's alliance with their queer/trans clients, and help create a safe therapeutic space where clients experience an affirmation of their realities.



TENET 1

Knowing and using queer affirmative language

Language is the primary tool through which counsellors reach out to their clients. Listening to clients; empathising with their issues; helping them express themselves, get in touch with difficult feelings and experiences, and work through these; looking out for the best possible options for clients, or even providing information: language is central to all these processes. And language is, of course, not free of context. Thus, if the context assumes that heterosexuality is the "only", "natural", "normal" form of sexuality, and homosexuality is "abnormal", then this assumption will get reflected in the language used as well – because this language will be limited by a narrow understanding of sexuality and gender. It becomes the task of the queer affirmative counsellor to identify and eliminate such heteronormative biases in language, where they exist, in their communication with clients. *The queer affirmative counsellor may also want to think about adopting – as part of a new language – new terms that convey inclusion, respect and trust.*

What is queer affirmative language?

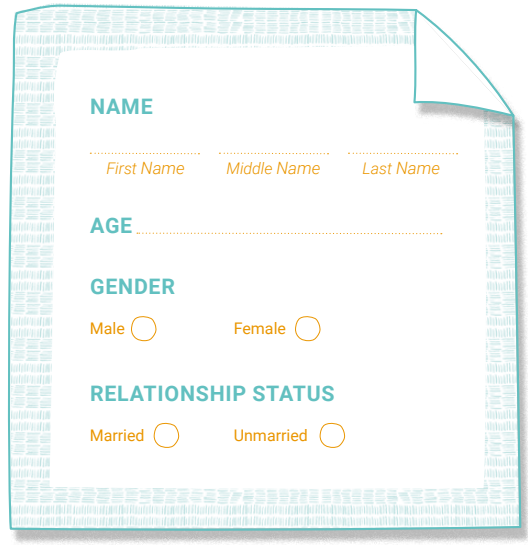
- Language that eliminates heteronormative and cisgender biases, is non-stigmatising, non-pathologising and non-derogatory towards queer and trans individuals (this refers to both verbal and non-verbal communication).
- New terms, new words and new language, learned or formulated so as to be inclusive and respectful of the experiences of queer and trans individuals.

The next section helps us reflect on how our usual language is steeped in Charmed Circle assumptions, and is often derogatory and stigmatising. Additionally, much of the language used by MHPs is also steeped in pathology. A few scenarios have been devised to aid our reflections.

REFLECTIONS ON THE LANGUAGE OF NORMATIVE ASSUMPTIONS

SCENARIO 1

This is an example of an intake sheet at a private counselling centre, in which details about all new clients are recorded. When we look at the sample below, it may seem at first glance like any regular intake proforma that collects basic background information. ***But it is important to ask oneself: 'Does this sheet reflect the experiences/ realities of all my clients?'***


NAME

First Name Middle Name Last Name

AGE

GENDER

Male Female

RELATIONSHIP STATUS

Married Unmarried

Consider a 42-year-old client, who identifies as male and has been living with his male partner for the past 12 years:

- How would he answer the question on relationship status?
- How would he feel ticking the "unmarried" response to that question?
- Would this question erase/invisibilise a part of his life?
- Based on his answer of "unmarried", would it be valid for the counsellor to assume that he is not in any romantic, sexual relationship?
- Would that assumption be a true reflection of the client's lived reality?

Consider a 33-year-old trans woman who has not transitioned, medically or socially:

- How would she answer the question about gender?
- Does the question allow for the client's realities?
- Would this question make the client feel excluded?

Consider a 22-year-old woman who identifies as bisexual. She is the daughter of a well-known media personality:

- How would this person feel about having to put down her middle name and last name?
- Would she feel safe coming out, knowing that her full name would reveal her family identity?



A 24-year-old woman has come for her first counselling session. As part of the initial assessment, she reveals that she has finished her postgraduate education in computer science and works at an IT firm. She seems very confident and is articulate about her problems. She elaborates on her reason for seeking help, saying that for a while now she has been unable to concentrate and has frequent spells of crying, feelings of loneliness, an inability to sleep, and gets irritated easily. All this has been affecting her work, and so her team leader has asked her to get help. She confides that all these problems started after a break-up. On hearing this, the counsellor spontaneously says, 'So when did you break up with your boyfriend?'

- In the given scenario, did the client say that she had been in a relationship with a man?
- Why does the counsellor assume that when the client says, "break-up", it must be with a "man"?
- Does this have anything to do with the counsellor's assumption that all her clients must be heterosexual?
- Would using neutral terms such as "partner" be more inclusive, at least until the client has started to use some terms to describe that relationship in more detail?



Amit and Shamir met at a film screening organised by a gay rights NGO in the city over a year ago. Shamir had just come to the city from a small town nearby, in search of a job, and Amit was the first "out" gay man he had met. 'It was love at first sight,' says Shamir. Today, they are at a fancy restaurant to celebrate the first anniversary of their being together. After a romantic dinner, the waiter hands out a feedback form to them. The form asks, among other things, for the customer's wedding anniversary date. 'It's ironic,' says Amit, 'that while we are celebrating our love for each other today, we must still leave this space blank.'

- Do most of us generally assume that all people around us are heterosexual?
- When we hear the words "marriage" or "relationship", do we always assume these as being between a man and a woman?
- How do these assumptions of ours alienate and invisibilise the reality of queer and trans people?



Mohan is a 28-year-old trans man who is meeting his family doctor for his monthly testosterone shot. The doctor, who has known Mohan since the latter's childhood, fondly refers to him as "Mohini" and uses feminine pronouns for Mohan throughout their interaction.

- Why is the doctor not using the name "Mohan" and the male pronouns for his patient?
- Is the doctor continuing to assume Mohan's gender based on his knowledge of Mohan's assigned gender at birth?
- Do you think that the doctor would start referring to Mohan with the appropriate name and pronouns once Mohan has completed his medical, surgical transition? Is self-determined gender as a basis for name and pronouns not valid enough? Is medical intervention a necessity for one's gender to be seen as valid?
- What does misgendering and erasure do to a person?

Stigmatising and derogatory language

Derogatory terms and words to refer to "deviations" from normative sexual and gender expressions are aplenty in the English language as well as in the regional Indian languages. This is not to say that there are no celebratory or affirming words. Those exist as well, but may not be as accessible to memory or commonly in use as the words used to taunt, poke fun at or humiliate individuals with different gender and sexual desires and expressions.

Most of the derogatory terms are used for men. Some terms such as *"ganda kaam"* (doing bad things) in Hindi or *"vait vichar"* (bad thoughts) in Marathi are used to refer to sex in general as a "bad thing", as well as, more specifically, to sexual attraction or sexual acts between male-identified persons.

Many queer and trans clients would have grown up with such taunting expressions being flung at them in their families, homes, at school, among peers, in public spaces, and so on. Sometimes, clients may use some of these terms, such as "homo", to describe themselves or their desires. This may reflect the client's internalising of the negative connotations attached to queer sexuality in their social context, or it may simply be the result of not knowing any other words or terms for same-sex sexuality – the only readily available words being derogatory in tone. **It is important for a queer affirmative counsellor to be aware of these terms and the cultural meanings that they carry.**

Hatred, disapproval, disgust, and other such intensely negative responses can be conveyed non-verbally as well. So, while the language used may not necessarily be derogatory, non-verbal cues may well carry stigma. Queer and trans clients often describe having had such experiences in their interactions with other health care providers – such as simply being ignored, or the health care professional avoiding eye contact with them, avoiding touching the patient during a physical examination, asking them to speak from a distance, and so on. Such acts rob the patient of dignity; if the

counsellor finds themselves behaving with queer or trans clients in similar fashion, this would clearly indicate their discomfort with queer and trans realities. This points to the need to be continuously self-reflexive about one's own prejudices.

Language that reflects pathology

From the discussions on the history of the pathologisation at the start of this chapter, we learned how the psy disciplines played a significant role in slotting non-normative genders and sexualities as abnormal.

Consider the following:

CLIENT

I realised I was lesbian in Class 7, when I saw that my other friends are "normal".

COUNSELLOR'S THOUGHTS

This statement implies that the client sees heterosexuals as "normal" and, by contrast, being lesbian as "abnormal". It may also mean that the client uses the word "normal" to refer to heterosexuals; she may not think it appropriate to refer to them simply as "heterosexuals" because people are about more than just their sexuality. It may, then, be important to find out how the client feels about referring to herself or to people like herself as "homosexual". This could throw some light on whether the client is experiencing some internalised homonegativity.

The counsellor might start by asking the client a simple question: **'You mentioned that your friends are normal. What do you mean by that?'** In this manner, a counsellor could proceed to explore the client's perceptions about "normal" and "abnormal" sexuality, and reframe these by providing an alternative, affirmative framework.

Learning new language, and the deliberate use of queer affirmative language

1. ***Using respectful language for all sexualities and genders.*** To be able to use respectful language authentically, MHPs need to show a willingness to work at unlearning their own prejudices. We are not taught to value all sexualities and genders equally, and our biases can and do slip out. With time and effort, MHPs can learn to affirm queer and trans clients through using respectful, affirming language in credible ways.
2. ***Using gender neutral, open-ended language.*** MHPs must remain aware that queer and trans clients are constantly at the receiving end of stigma – and so may not come out about their gender or sexuality in early sessions. One way for the MHP to convey that their therapeutic space is affirming would be to use neutral terms for gender, sexuality and relationships – for example, use the pronoun they until the client uses gender-specific pronouns, speak of "relationship" instead of "marriage".
3. ***Using the terms and pronouns that the clients use***. MHPs must be alert to the names, pronouns, and the gender, sexuality and relationship labels that clients use to describe themselves and their realities. This includes using the pronouns that clients use and not referring to their assigned gender, or their assumed gender based on the counsellor's reading of their outward appearance.
4. ***Building a vocabulary of language that queer and trans communities are using for themselves.*** New terms are constantly emerging, and MHPs need to keep abreast of these (for instance, in Tamil, *thirunambi* and *thirunangai* are respectively used as respectful identity terms for trans man and trans woman). Please use the terms being coined by communities on the margins, who represent your clients, rather than those being supplied by medical or mental health experts. It is all right to ask clients the meaning of a particular term, and what meaning it holds for them; however, to depend solely on clients for learning about queer and trans communities without making any effort to educate oneself

would be unfair to the clients we serve (see 2.7 – 'The politics of labelling').

5. ***Supplying affirmative language to clients;*** helping them to find language that feels affirmative to them. Clients may not have access to affirmative terms for themselves. Therefore, supplying affirmative terms, labels, descriptions can help clients affirm their own realities. It might be useful to employ a stance of tentativeness while supplying terms in order to assess if clients are comfortable with them or whether these terms evoke discomfort, shame, or any negative affect due either to internalised stigma or to other things specific to the context of the individual.
6. ***Using "normative" (or equivalents) to refer to the mainstream/ power centres***, instead of the loaded descriptor "normal people".
7. ***Deadnaming is bad practice.*** A deadname refers to the name that the person was assigned in their infancy, but which does not reflect their gender or their felt reality. When you know the client's chosen name, never use their old, assigned name. That name is not their name. Even if you have knowledge of that name from

Hatred, disapproval, disgust, and other such intensely negative responses **can be conveyed non-verbally as well.** So, while the language used may not necessarily be derogatory, **non-verbal cues** may well **carry stigma.**

their documents (not all trans clients seek/have completed legal transition), please do not say it. If the name must be mentioned in forms due to rigid protocols, for instance hospital records, or insurance cards, please explain this to your client and seek their consent to enter that name while assuring them that you are fully aware it is their deadname and you will not be use it in the therapeutic sessions.

8. ***Foreground the client's gender and sexuality in sessions.*** Non-acknowledgement through language occurs in clients' everyday lives within families, at workplaces, even among friends. Very many clients may have no other comfortable spaces or opportunities for sharing significant aspects of their queer/trans lives, feelings and experiences with anyone else. Therefore, MHPs need to be alert to any references, however fleeting, that clients make about their sexuality and gender. Clients may not elaborate on these further unless they sense your willingness to engage with their realities.

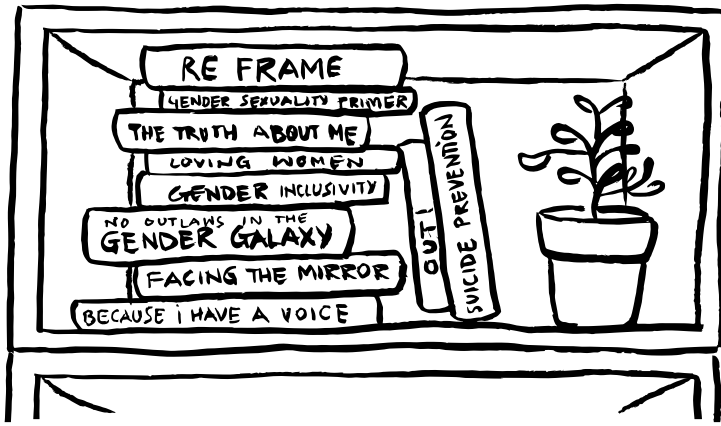
TENET 2

Having – and publicising – a queer affirmative setup

A significant aspect of the counselling process is its physical environment. The physical space in which counselling takes place, like the attitudes counsellors carry within those four walls, has an impact on the client. In QACP, importance is given to making the counselling setup a queer and trans inclusive space.

Counselling spaces tend, like other spaces, to be heteronormative by default; a supposedly neutral space is likely to be focused on the heterosexual. How does this happen?

1. Images and messages found in counselling rooms and clinics usually refer only to heterosexual couples and lifestyles.
2. Even when spaces have no explicit heterosexual messaging by way of wall posters, and so on,



books (with titles like 'A Handbook of Marital Therapy'), magazines, even the newspaper lying around in the reception area, could reflect back to clients the predominantly heterosexual realities of our world.

3. Photographs of the MHP with family members, such as typical heterosexual family images of husband/wife and child/children, reinforce heteronormativity.
4. Marriage markers worn by the MHP can also make the client feel estranged, as might religious idols/symbols displayed in their office – given how most religions consider homosexuality unacceptable.

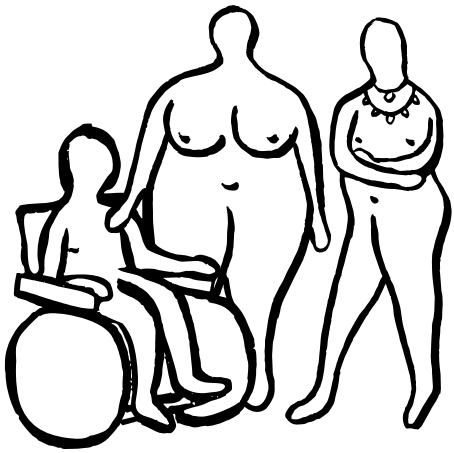
This counselling space could, then, feel as alienating to a queer or trans client as does the world outside. Consequently, the client may end up expecting the same sort of harsh judgments about their sexuality and gender realities in this space too. This is why **QACP advocates that counselling spaces should exhibit, at the outset, a queer/trans inclusive and affirming atmosphere – one that clearly conveys that queer and trans clients are welcome and safe in this setup.**

The other aspect of a queer/trans inclusive counselling setup is reflected in the attitudes of the people within that space. **QACP practitioners need to ensure that the staff they employ have a basic understanding of related issues**; that they are trained not to stare at clients who do not follow gender norms and not to ask them intrusive questions; that they know they must not

gossip about clients; that they do not insist on complete and full details such as name and address for their records. Everyone needs to remember that queer and trans clients are often faced with very real, negative consequences if they are outed, and every precaution is necessary to ensure their safety (see also **Tenet 7:** 'Confidentiality').

Setting up and publicising a queer affirmative space–

1. ***Put up posters in the counselling room to indicate that people across a range of gender-sexuality identities and relationships are welcome here.***
2. ***Add books on queer and trans subjects*** to your bookshelves.
3. ***Keep queer and trans friendly magazines*** in the reception area.
4. ***Print brochures that include queer- and trans-related information.***
5. ***Advertise on your CVs and visiting cards*** that you are a queer affirmative practitioner.
6. ***Advertise on your social media*** by following queer and trans handles, and posting queer affirmative news.
7. ***Use inclusive intake sheets/forms that ask open-ended questions*** about name, pronouns, sexuality, gender, and relationships.
8. ***Train any attending staff to be sensitive*** towards these issues (particularly gender presentation, which is often the most visible marker of non-normativity).



TENET 3

Avoiding assumptions and respecting diversity

This tenet is true for counselling in general. Good practice would automatically mean that we do not make assumptions about our clients. However, when it comes to queer

and trans realities, ingrained prejudices and stereotypes could lead us to make assumptions about our clients' gender, sexuality, relationships, sexual behaviours. The following quiz is meant to help us avoid some common traps:



A woman with short hair, wearing a full-sleeved shirt, full-length trousers, closed shoes, and carrying a helmet and a sports jacket, walks into your room. She is accompanied by another woman, who has longer hair and is wearing trousers with a sleeveless T-shirt. In an attempt to establish rapport with them after they tell you that they are a couple, you–

1. Ask the person with short hair if she is the husband, and the woman with her the wife.
2. Refer to one person in the couple as "he" and the other as "she" based on their appearance.
3. Ask them to tell you more about butch-femme dynamics.
4. Mirror the language and terms they use to refer to themselves and to each other.



Do not assume that all couple relationships involve a "man" and a "woman" and follow the prescribed script for gender roles. **Nor do most lesbian couples use the terms "husband"/"wife"** to define their relationship, so option 1 is ruled out. Also, do not assume, even if there is an apparent difference in the gender expression between both persons, which option 2 indicates, that one identifies as "butch" (more masculine-presenting) and the other as "femme"(more conventionally feminine) – these terms that surface in option 3 are part of long-held stereotypes about lesbian relationships in the popular imagination. **The fact that queer people do not have a heterosexual script or established relationship models to follow allows for a good deal of diversity in their lives.** This diversity may be seen in the identities they choose for themselves, and in their gender expression, relationships

and sexual behaviour. **Making assumptions, or trying to fit all queer people into stereotypical boxes, is a fatal flaw that QACP counsellors must avoid.**
Option 4 shows that the counsellor is keeping an open mind and allowing the clients to inform them about their lives. Good practice includes providing room for voluntary disclosure, as well as simply seeking clarification from clients about their genders, sexual orientations, sexual behaviours, and experiences.



Your client is well-built and muscular, keeping himself fit by working out at the gym every day. He enjoys watching and playing football, and refers to himself as an "alpha male". He makes it obvious that he prides himself on his masculinity. In his second counselling session, he tells you he is versatile but doesn't know how to communicate this to potential sexual partners. You are not completely sure what "versatile" means, and so you–

1. Clarify to your client that you are unsure, and ask if he can help you understand what the word means.
2. Taking into account that he is talking about sexual behaviour, wait a while for more cues that might help you understand.
3. Tell him to use an easier word like "top" or "active" instead of "versatile" because you conclude that being so masculine he must not be desiring penetration.
4. Ask him if "versatile" is a dressing style.



Given the range of diversity that exists within queer communities, it would be best to ask the client politely what a particular term might mean. This would convey to the client that you are making a genuine effort to learn about and understand their life experiences. Option 2 is another possible response – but given that the meanings of words and terms may be fairly varied, depending on the class and language

Good practice includes providing room for voluntary disclosure, as well as simply seeking clarification from clients about their genders, sexual orientations, sexual behaviours, and experiences.

backgrounds of the client, it is perhaps a better strategy to clarify things right away rather than risk misunderstanding. Option 3 is completely avoidable, based as it is on an assumption that masculine men do not desire being penetrated. Option 4 would indicate to the client that your knowledge is limited, which is likely to impede rapport-building.



Your client is a 45-year-old gay man who has been in a relationship with his male partner for eight years. He tells you that he has met a much younger man, with whom he is having sex. It makes him feel alive and young again, and he wants to rent an apartment for his current lover so that he can visit this lover regularly. He asks for your opinion, and you tell him that–

1. He should be more sensitive towards his partner of eight years, and stop the fling with the younger man at once.
2. He should reflect on the boundaries and negotiations he has with his long-term partner, and make the decision accordingly.
3. He should not risk his long-term relationship, especially considering that he is now 45.
4. The younger man will not be able to give him the love and companionship that he receives from his older partner, and so he should not spend so much time away from the latter.

QACP ANSWER OPTION 2

Relationships are not all black and white, and this is may be truer of the queer/trans community – whose members do not necessarily follow the socially prescribed scripts of marriage and monogamy, or of lifelong relationships. A couple might not be living together, for instance. Persons involved in a relationship negotiate with each other about the boundaries and definitions of that relationship, as option 2 suggests. Relationships may be long-term or short-term; monogamous or non-monogamous. **Given that the values advocated by marriage dictate long-term and monogamous relationships, counsellors should beware against inadvertently steering their clients in that direction** – which is what option 3 does. Neither should any moral judgements – as seen in option 1 – be made about clients' choices. And nor is it for the counsellor to place a greater value on permanence and companionship, and minimise the sexual aspect, as seen in option 4.

→ ***Note: To avoid making assumptions, the first step is to recognise the insidious ways in which our prejudices play out, and how we might often not even be aware of our biases or stereotypes about queer/trans people. We need to recognise, particularly if we come from cis-het identities and contexts ourselves, that we are likely to make therapeutic formulations in a very cis-het way. Therefore, being alert to our normativising impulse and tracing it to its source can help keep this tendency in check.***

QUIZ SITUATION 4

Your client, who is 23, tells you that she feels she is attracted to women, but she is not sure. What should she do? You–

1. Tell her to have sex with a woman so as to know for sure whether she is attracted to them.
2. Ask her to concentrate on boys while she is still unsure, so that her feelings towards women can be controlled.

3. Inform her that many women her age go through such a phase, and she should wait for it to pass.
4. Explain that discovering one's sexual identity is a process, and she should keep an open mind, read up more, and maybe meet some people from the queer community, in order to understand herself better.

QACP ANSWER  OPTION 4

Just as heterosexual people can know they are straight without having sex, lesbian/bisexual women can know they are attracted to women even without having to sleep with one, which rules out option 1. Trying to ensure that someone does not become lesbian, given that she is still unsure – as in option 2 – is an indication of one's own prejudice. Option 3 is another stereotype, that homosexuality must be a passing phase. Option 4 is the only one that reflects the genuine belief that any sexuality is possible and all sexualities are natural. **Coming out is a process, and there is no quick formula for an unsure person to figure out if she is indeed a lesbian or not.**

 QUIZ SITUATION 5

Javed tells you in his fourth session that he wants to stop being gay, and wants you to help him change his sexual orientation. You will–

1. Tell him that you cannot help him change, and he should stop coming for further sessions.
2. Show him pictures of nude women and ask him to masturbate while looking at them.
3. Explore the reasons behind his request, and help him accept his sexual orientation.
4. Try to find out the causes of his homosexuality so that you can assist him in changing.

QACP ANSWER OPTION 3

Very often, clients are unable to accept their own homosexuality and may request help in changing themselves. **QACP advises that the use, or supporting the use, of any method that attempts to "change" or "cure" sexual attractions or orientation, as in option 2, is unethical.** However, sending clients away without addressing an expressed need, as in option 1, also risks damaging them. As for option 4, trying to find causes for homosexual orientation is to uphold the belief that something went wrong to make the person deviate from the heterosexual norm; asking queer people why they are homosexual is like asking straight people what caused their heterosexuality. Option 3 is the only appropriate response.

Understanding and respecting diversity

Connected to the need to guard against assumptions and misconceptions is the issue of diversity. The tendency is to see heterosexual individuals as "whole people" with multiple identities, roles, and social affiliations – and not merely in terms of whom they have sex with. We think of them as Tamilian, Maharashtrian, Hindu, Christian, old, young, educated, unemployed, upper caste, poor, rich, artists, engineers, dusky, fair, and so on. However, when it comes to queer and trans people, the entirety of their being often gets reduced to the sexuality or gender "deviation", which is further (mis)understood due to our exclusive reliance on the stereotypes fed to us by various social institutions.

Most queer/trans persons living in India may have certain common experiences – for instance, some form of homo/trans prejudice, stigma, discrimination, based on their sexuality and/or gender. Various such prejudices were highlighted in **Chapter 3** (see 3.2 – 'Unique life stressors…') and are discussed throughout this resource book. However, this is not to say that any two queer/trans individuals have identical experiences, or that they would have the same resources and mechanisms for coping with similar experiences.

Many forms of sexuality exist all around us, too, although the most valued and thus socially validated form is that of heterosexuality, within marriage, and associated with procreation. The famous old *'Hum do, hamaare do'* ('We two and our two') family planning slogan represents the most visible form of sexuality. Yet all of us are likely to know of the many other ways of relating sexually that exist all around us.

Developmental psychologist Savin-Williams coined a set of four propositions that help us take on board the diversity within queer and trans people's lives, and realities about sex, gender, sexuality, sexual acts, relationships, values, perspectives and social locations.

PROPOSITION 1: WE ARE SAME.
This acknowledges that there is a sameness between heterosexual and queer/trans folks on very many counts.

PROPOSITION 2: WE ARE DIFFERENT.
This acknowledges the differences between heterosexual and queer/trans folks that we, too, highlighted in **Chapter 3** (see 3.3 – 'The emotional landscape of a queer/trans individual').

PROPOSITION 3: WE DIFFER AMONG OURSELVES.
This acknowledges the diversity that exists within the queer and trans communities. LGBTQIA++ – or, as it is sometimes referred to in jest, the "alphabet soup" – is indicative of a wide range of identities within the queer/trans communities.

PROPOSITION 4: WE ARE EACH UNIQUE.
This acknowledges that even among persons identifying in the same manner in terms of gender-sexuality, each one is a unique individual with their own unique set of realities. We cannot assume a sameness between two trans women, for instance, simply because both are trans women – any more than we may assume a sameness between two cis women or two cis men simply because of their gender.

TENET 4

Challenging the misinformation that clients have



This tenet amplifies the need for QACP counsellors to take an educative stance in counselling sessions. Very often, queer and trans people grow up surrounded by silence about their realities. They have little information, limited access to resources, and distorted media representations of themselves. As a result, clients may lack information, be confused, or even have inaccurate notions about queerness or about LGBTQ+ communities. They might come with misinformation related to sexual acts and behaviour, sexuality, gender identity and expressions, medical/health issues, legal rights, societal attitudes.

EXERCISE

Identify the misinformation

1. Rehmaan, 28, tells his counsellor, 'I am not having sex. Why should I wear a condom? I only do *masti* (fun/enjoyment) with men. I penetrate them anally.'
2. Shobha, 16, tells her counsellor, 'My family doctor told me that I am lesbian because of hormonal imbalance. He gave me some pills to take every night.'
3. Victor, 41, tells his counsellor, 'Why did God make me like this? Only I am like this. There is no one like me in this world. I am a freak because I am attracted to men.'
4. Sneha, 28, tells her counsellor, 'It is only after coming to this NGO that I met so many feminine boys and trans persons like me. Before this I thought that my hidden feelings of being a woman and always wanting to be one were because I grew up among so many sisters.'

QACP VIEWPOINT

1. Rehmaan is misinformed when he says that he is not having sex – he appears to believe that having sex refers only to peno-vaginal penetration, and perhaps views any sexual activity in the absence of vaginal penetration as "*masti*" or fun, not "real sex". In a context where not much knowledge about sex and sexual acts is available, many people believe that the correct way to have sex is for the penis to enter the vagina. ***This is a myth: there is no one "correct" way of having sex***. Yet, against the backdrop of campaigns around safe sex that tend to focus only on man-woman sexual relationships and promote the use of condoms solely for peno-vaginal penetration, it is not surprising that Rehmaan genuinely believes penetrating men anally is not sex – and that he is not at risk for STIs and HIV. **As a QACP practitioner, not only will you have to tell the client about how having sex may include a variety of sexual acts, you will also need to explain the health risks of unprotected sex, whether vaginal or anal.** Some male clients, while engaging in sexual acts other than peno-vaginal sex, may believe them to be inferior, less valid, not as significant as sex with a woman. Such a belief could reflect internalised homonegativity; and the counsellor can help the client appreciate experiences of "*masti*" as valid and pleasurable sexual acts.

2. Shobha has been misinformed by her doctor that her sexual orientation is the result of a hormonal imbalance. He has gone further and prescribed medication to "correct" this so-called imbalance and, thereby, her sexual orientation.

If you are a heterosexual practitioner, please answer the following questionnaire–

WHAT IS THE CAUSE OF MY HETEROSEXUALITY?

1. Hormonal Imbalance
2. Genetic Defect
3. Very strict family atmosphere in childhood
4. Child sexual abuse
5. Sins of last birth
6. Lifestyle choice

QUESTIONS FOR REFLECTION–

- Have you ever looked for a cause for your own heterosexuality? If not, why not?
- Did you find the cause after attempting this exercise?
- How did you feel while trying to find the cause of your heterosexuality?

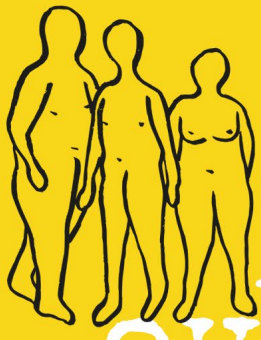
This exercise was meant to help us better understand how the notion of locating causes for sexual orientation is a meaningless endeavour. Asking queer people for the cause of their sexual orientation is just like asking straight people why they are heterosexual. As QACP practitioners, we must understand that ***all consensual expressions of sexuality are equally natural, and part of the rich diversity present in human sexuality.*** **In this case, the counsellor would have to explain to Shobha that her doctor is incorrect, and offer her new knowledge and resources to help her acquire a new belief that tells her how being lesbian is normal and is not something a doctor can change.**



we are
SAME



we are
DIFFERENT



we differ
AMONG
OURSELVES



we are
UNIQUE



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3. When Victor feels he is the only man who is attracted to men, he is misinformed. He does not know that there are many like him and that his desires are normal and valid. His sense that God created him a freak reflects the isolation and loneliness to which many people are subjected, in a heterosexually constructed world. **A QACP counsellor would inform the client about support groups, websites and other resources that visibilise the presence and normalise the existence of other sexual minorities.** The counsellor would also need to take into account the stigma that many religions attach to homosexuality, and help Victor through his feelings of guilt and self-revulsion.

4. Sneha had internalised the misconception that her desire to live as the woman she feels she has always been had something to do with having been brought up among sisters, i.e., she used to think having too much feminine influence and an inadequate amount of masculine influence must have caused her transness. She seems to be questioning this misinformation already, since meeting other trans persons and gender non-conforming persons. **The counsellor may want to offer Sneha the insight that gender is an aspect of the self that is self-determined – that if she knows and says what her gender is, if she knows that she is a woman, then irrespective of the gender she was assigned at birth and regardless of how many sisters or brothers she had, she is a woman.**



A couple of case scenarios follow, to help us reflect more deeply:

CASE SCENARIO 1

A 21-year-old girl tells you that she is attracted to a girl in her tailoring class. Her parents have been exploring marriage prospects for her. She does not know what to do. You tell her that–

1. She should think about what her family will go through if she allows these feelings to continue.
2. Such feelings are wrong, and she should focus on boys instead.
3. Her feelings will go away in some time, and she should concentrate on learning tailoring.
4. Being sexually attracted to a person of the same sex is normal, and she can use the counselling session space to work through her options.



Do not pathologise non-heterosexual attractions or behaviours. These are normal and valid expressions of sexuality. Believing that homosexual feelings are a passing phase (option 3), or that the client can control and stop such feelings (option 1), stems from the belief that heterosexuality is the only acceptable form of sexuality and that any other expression of sexuality is "abnormal", wrong and must be "corrected" (option 2).

CASE SCENARIO 2

Your client is a 19-year-old girl who tells you one day that her hostel roommate is lesbian and that this makes her uncomfortable. You tell her that–

1. Anybody in her place would feel uncomfortable, as her roommate must be hitting on her all the time.
2. If she is uncomfortable, she must change her room at once.
3. She is feeling uncomfortable because we all have a very negative image towards gay people, and perhaps getting more information, or understanding that lesbianism is also a valid form of sexuality, may help her deal with her discomfort.
4. She does not deserve to feel uncomfortable because of certain people who choose such a lifestyle, and she must report the matter to the authorities at once.



Homonegativity exists in many of us, because of the stigma attached to homosexuality and the belief that heterosexuality is the only normal and natural expression of sexuality. Options 1 and 4 stem from stereotypes that lesbians are hypersexual, or that they choose their sexuality at will. Whereas the fact is that homosexuality is as innate as heterosexuality – and, like heterosexuals do not feel attracted to every person of the opposite sex, lesbian women too are not attracted to every woman they encounter. Option 4, further, encourages moral policing and surveillance – reinforcing the idea that because the client is heterosexual she is entitled to interfere with, even report to the authorities about, her roommate's sexual orientation. Option 2 is not one that QACP would advocate, either, because it does not help the client deal with her discomfort about homosexuality.

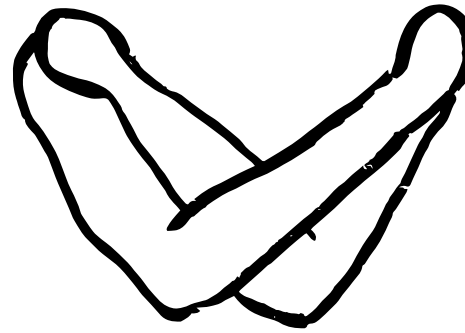
The exercises we have done can help us identify some kinds of misinformation, and ways of addressing them. QACP practitioners must–

- Avoid confirming or validating misinformation.
- Explore the source of the misinformation, and then supply the client with new knowledge and information.
- Increase the client's access to queer and trans affirming materials like books and films, resources such as websites, organisations, support groups and – should the client require medical assistance – genuinely queer and trans friendly general physicians, or specialists such as gynaecologists, psychiatrists, dermatologists, and so on.
- Build a data bank of locally available resources that they can give their clients (see Tenet 6 below).

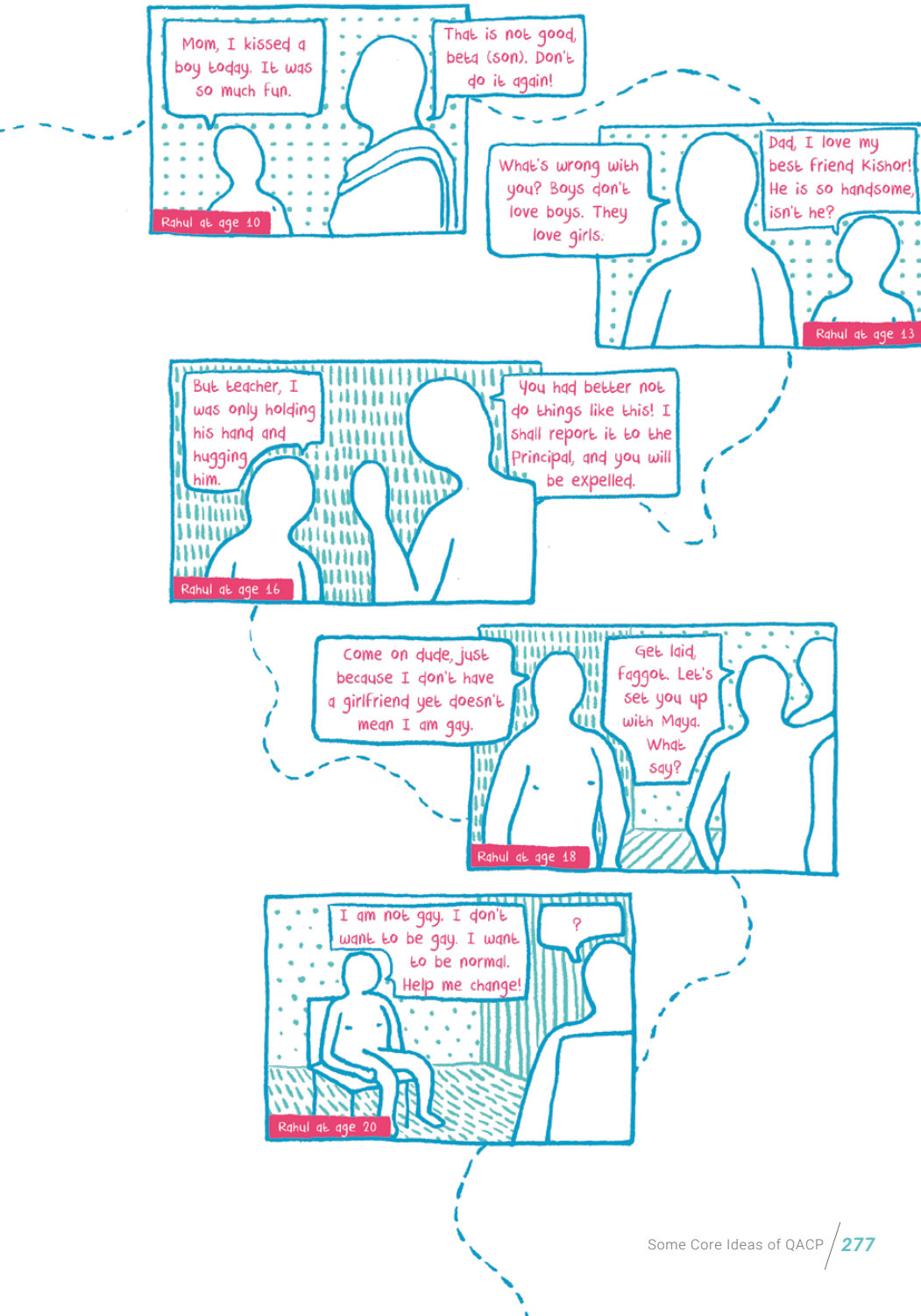
TENET 5

Facilitating self-acceptance

This can sometimes be the most important tenet of QACP, and is an overall goal of counselling. It perhaps becomes more crucial with queer clients, given how the historical prejudice and culture of shame and silence to which they are subjected impedes self-acceptance.



An illustrative story of internalised homonegativity –



Rahul's story demonstrates how every exchange with significant persons in his life has been negative when it comes to queer sexuality. Every successive interaction succeeds in making Rahul more and more ashamed of himself and his desires, until he reaches a point where he does not even believe that it is possible to be gay and normal at the same time. Many clients come in with varying shades of self-hate, denial, shame and guilt around their sexuality. **The counsellor may be the first person who can break the chain of negativity and affirm the client's sexuality in a positive manner.** This would be a starting point towards self-acceptance by the client.

To facilitate self-acceptance successfully, QACP practitioners must be aware of the various processes that act as impediments in the client's journey towards this goal. The 'Unique Life Stressors (ULS)…' and 'The emotional landscape of a queer/trans individual' sections in **Chapter 3** (see 3.2 and 3.3) enabled us to recognise several internal and external barriers to self-acceptance: isolation, invisibility, denial, shame, guilt, lack of role models, lack of support, and so on.

Growing up with distorted images of oneself, or in silence and shame, can make it extremely difficult to develop an integrated, "whole" self. Accepting oneself as one is, in the face of opposing social attitudes and cultural imagery, is no easy task; finding oneself worthy and feeling proud of oneself seems even more arduous. Yet it is a core goal to strive towards in QACP.

Research studies have documented the stages that queer individuals typically go through in the process of self-acceptance. A denial of one's feelings of attraction to people of the same sex is common – individuals might try to avoid these feelings by wishing them away, seeking distractions, and so on. Eventually, while they might learn to live with the feelings, acting on them could be associated with intense shame and guilt. Comparisons with the experiences of cis-het friends are likely to be frequent, and unhelpful. A sense of being "the only one" with such desires,

and fears about being "abnormal", may plague the individual. The person might seek information, and search for reading materials on same-sex sexuality, to try and make sense of their feelings and desires which do fit into the heterosexual script that is assumed to be universal. They may come across prejudiced information and continue to experience turmoil until they find safe spaces that normalise their reality and provide them with affirmative information. Getting in touch with community, real or virtual, is often a milestone. Meeting others like themselves and being able to explore their sexual attractions and desires enables a person to develop some comfort in their own skin.

Every individual does not necessarily experience all the stages described, or encounter a set of responses that runs completely parallel to Rahul's in the story; nor do the stages and responses follow any fixed sequence. Many persons say that when they first heard the word "gay", they knew instantaneously that it fit them perfectly. ***How sexuality is experienced by different individuals reveals considerable diversity and fluidity.*** Similarly, self-acceptance is not a singular, fixed point; it may be an ongoing process for most people. Some clients who have come out to themselves and to their family members may yet be struggling with self-acceptance in the context of their spiritual or religious beliefs. Some may find it difficult to come

ACCEPTING ONESELF AS ONE IS, IN THE FACE OF OPPOSING SOCIAL ATTITUDES AND CULTURAL IMAGERY, IS NO EASY TASK; FINDING ONESELF WORTHY AND FEELING PROUD OF ONESELF SEEMS EVEN MORE ARDUOUS. YET IT IS A CORE GOAL TO STRIVE TOWARDS IN QACP.

out to their friends, or colleagues, even if the circumstances do not seem hostile – they may struggle with internalised shame and self-censorship, and expect to encounter discrimination or stigma even in apparently safe situations.

The counsellor's role in facilitating self-acceptance:

1. A counselling space is often among the first few spaces where individuals are able to talk openly about their queer desires. And so the responses that clients receive here are vital to their future journey. If clients experience prejudice, discomfort, stigma, then their process of self-acceptance is likely to receive a severe setback and they may feel driven further into the closet. On the other hand, **if the first such interaction is validating, where the client feels accepted, is assured that they are not alone** – and that their feelings are not pathological, and is given information on resources for queer/trans people, then their journey of self-acceptance is likely to be quicker.

An illustrative story

David, a third-year-degree student, takes little part in social activities. He is good at academics and always gets good results. He prefers to sit alone and study, rather than mix with other students. He has often been the target of a gang of boys in his college. This gang regularly teases and taunts him about being a "weirdo" because he does not have a girlfriend and barely talks to girls. Within the family, too, David avoids family functions, and having to meet relatives. Concerned about his behaviour, his parents bring him to a counsellor for help.

The counsellor first builds trust with David, and helps him articulate some of his problems. David confides in her about what he considers to be "shameful" and "embarrassing" events. For instance, when he was 15, he was attracted to a boy in the neighbourhood. When he tried expressing his feelings to this boy, the latter insulted and humiliated him badly. The boy called David a *chhakka* (derogatory term used to insult effeminate males) and stopped speaking to him. Since then, David started avoiding boys, afraid of being humiliated again if he developed similar feelings towards another boy. The counsellor then helps David to deal with the feelings of shame and embarrassment he associates with his first sexual attraction, and this is the beginning of his dealing with the homonegativity he has internalised due to his first negative experience.

2. Mirroring is another important process in the development of the self. All of us need to see positive images of ourselves being reflected back to us by significant persons in our lives such as family members, friends and neighbours, besides people in society at large. However, most queer/trans persons tend to be deprived of this experience in their growing up years, especially when it comes to aspects of themselves that are not in conformity with prevailing norms. This lack of positive images can cause considerable trauma to the developing self. **Providing, in the counselling space, affirming, validating experiences of mirroring to queer/trans clients with respect to their sexual and gender expressions is thus very important.** It may provide the client with an emotionally corrective experience that is vital to self-acceptance.

3. **Encouraging clients to place the onus of their problems outside of themselves, and on the homoprejudiced society they inhabit, is useful.** From where is your

client's distress coming? From the social rules that are not made for your client's experience. Not fitting in creates distress – the source of which lies in the social structures that fail to account for the realities of queer/trans persons. Helping the client make this connection is a crucial step forward.

4. A therapeutic group is another effective strategy to enhance self-acceptance in clients who have a high degree of internalised homophobia. **Group sessions can help to reduce the isolation that clients may have faced while growing up. They also provide safe ventilation spaces.** Listening to each other's stories of struggle and resilience can be cathartic as well as healing. **Such group sessions, if conducted by a skilled counsellor, can become spaces for emotionally corrective experiences, a sense of cohesion, and a feeling of community and mutual support among its members.**

5. Counsellors, just like doctors, are seen as being in a position of authority. Clients and their families ascribe considerable power to the counsellor. Thus, **when a counsellor offers basic information about queer sexuality and trans lives that is non-pathological, normalising, affirmative, and informative about resources for queer and trans people, the fact that all this information is coming from an "expert" helps both clients and their families to better accept the non-normative sexuality of one of the family members.**

6. Homoprejudice, stigma, discrimination, internalised homonegativity, and difficulties with self-acceptance – this forms a vicious cycle. The more the number of negative life events and experiences of violence and discrimination related to one's sexuality, the more the individual is likely to be isolated; to feel ashamed, inadequate and unsupported; and to face greater difficulties with self-acceptance. **It is**

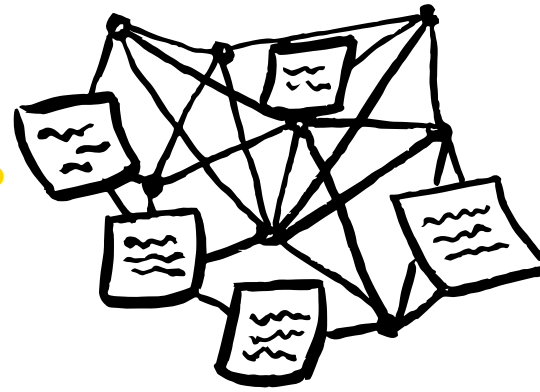
important that counsellors recognise this cycle and help clients make the links between their experiences of stigma and their mental health situation in counselling sessions. Making these links explicit for queer clients is an important component of QACP.

7. Providing resources about – and connecting clients to – community (see Tenet 6 below).



TENET 6

Knowing about – and engaging with – resources and community



Three main reasons to do so–

1. **Counsellors who not only know of but also engage with, both resources and community spaces, become better acquainted with the problems their queer/trans clients typically face, and with other services for queer/trans individuals.**
   It is useful for counsellors, especially if they are cis-het, not only to read books and watch films with queer/trans themes, but to make the effort to meet and get to know various queer/trans individuals at, say, NGOs and drop-in centres. This helps the counsellor to be more educated and informed about queer/trans lives – which is particularly important for the cis-het counsellor who tends to be exposed only to cis-heterosexual models of living and who needs to gain more familiarity with queer/trans lives, relationships, modes of socialising, political positions. Interacting with queer/trans individuals outside of the clinic/counselling space offers the counsellor a chance to acquire a more nuanced understanding of issues their clients might bring up in sessions. In order to be a QACP practitioner, then, it is important that counsellors do not rely solely on their clients to educate them about queer/trans realities and concerns.

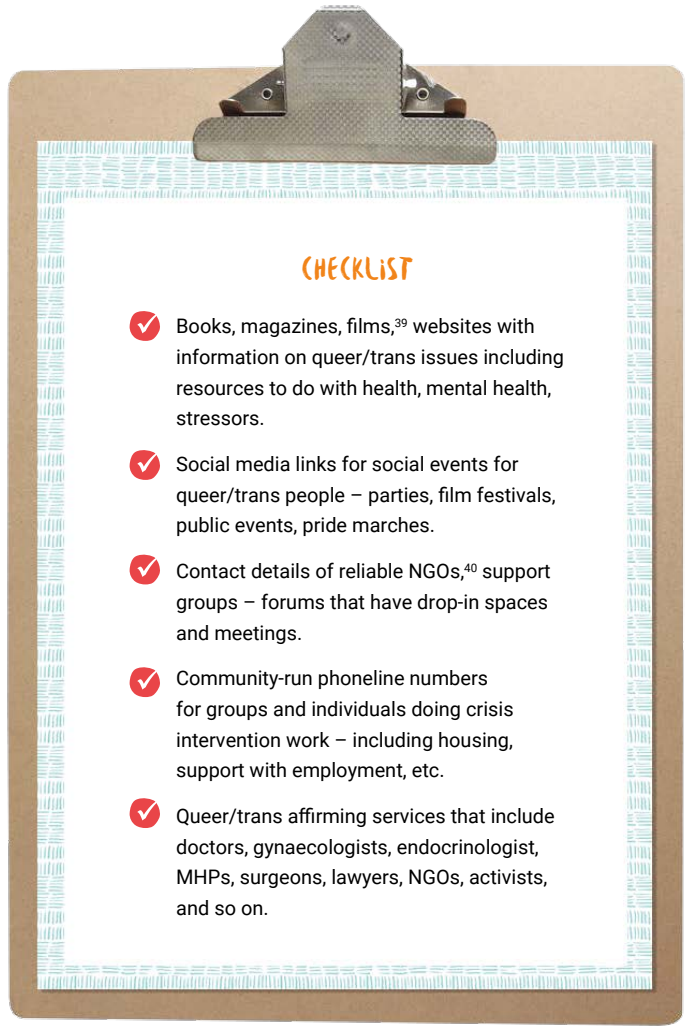
2. **If a counsellor is able to put queer/trans people in touch with relevant resources, this could be of significant help in reducing the client's sense of isolation.**
   Many queer/trans clients come into counselling spaces feeling there are no others like themselves out there – a feeling that deepens their sense of

isolation and may intensify internalised homo or trans negativity. One of the first steps towards self-acceptance is knowing that there are others like oneself, living lives that seem happy – persons who are proud of their sexuality; or have navigated gender journeys; and who deal with issues similar to one's own – such as how to tell family, friends, employers, how to seek information about gender transition, how to find partners, and so on. The knowledgeable counsellor can introduce clients to accessible and helpful resources.

3. **Knowing about resources and services for queer/trans individuals would help counsellors to make better referrals and provide more effective services to their clients.**
   Most clients seeking counselling help do not have single needs, i.e., they are probably looking for more than a resolution to one problem, or conflict. Besides dealing with emotional distress, they may also be looking for spaces to meet other people like themselves; they may want to leave their parental homes and be looking for a self-sustaining job, or for housing; they may be in search of information to pass on to parents or friends that could help with their coming out process; they may need to find queer/trans friendly (and, if possible, affirmative) doctors for information on gender affirmative therapies, or other health issues. A QACP practitioner recognises that most heterosexual people have several services as well as social spaces that cater to their multiple needs, and hence these may not come up in counselling. Even if some do, the counsellor may know about "standard" support systems for heterosexual people such as family, peer group, colleagues, school/college/office, legal mechanisms, and so on. However, the same legal, material, social resources may not be available for queer/trans clients. Hence the QACP practitioner

must make efforts to find out about geographically convenient resources and holistic services for queer/trans clients, in order to be able to make appropriate referrals and offer necessary information. This would mean networking to build a database of services.

Resources[38] that the QACP practitioner should make themselves familiar with, and be able to suggest:



TENET 7

Maintaining confidentiality

Confidentiality is an inherent part of counselling ethics. However, it becomes an additional concern for queer/trans persons, because–

1. The societal stigma towards queer and trans people heightens the possibility of violent consequences towards them if confidentiality is breached and clients are outed.
2. Queer and trans communities, like most other marginalised and minority communities, are often close-knit. Hence information tends to circulate quickly, and breach of confidentiality regarding various personal matters can cause the client avoidable distress.
3. Most cities and towns have a limited number of mental health care providers that are friendly and accessible to queer/trans folks. This means that most people access the same limited number of clinics/therapy centres. The mental health care provider would need to be mindful of this while fixing back-to-back appointments for queer/trans clients, using examples from other clients' lives in therapy sessions, and so on.



A couple of case scenarios follow, to help us reflect more deeply.

CASE SCENARIO 1

A 15-year-old girl, Tahira, began meeting her school counsellor weekly after her teachers noticed that she was missing school often, doing poorly in studies and being sullen and bad-tempered. After about a month (and with the client's consent) the counsellor arranged a session with Tahira's parents in order to enlist their support in helping their daughter follow a routine. Three weeks later, when the client had began to trust her counsellor, she revealed that she was in love with Neha from the same class. They had been best friends for two years, but now Neha had found a new best friend and had stopped eating lunch with Tahira or meeting her after school. Earlier, Tahira and Neha would go for walks in the park after school, just by themselves. They would hide among the trees, hold hands, sometimes even kiss. Tahira said she had seen Neha and the other girl hugging in an empty classroom at break-time. She was really sad and did not like to see Neha having so much fun with her new friend, and that was why she had begun to hate coming to school.

The counsellor addressed Tahira's hurt, and continued to work with her after this revelation. She began to encourage Tahira to tell her parents about the friendship with Neha. When Tahira refused, she told Tahira that as her counsellor it was her duty to inform the girl's parents. She added that she would also inform Tahira's teachers, so that they could support Tahira in dealing with her feelings better.

The next thing Tahira knew was that her parents had been summoned and they had taken her out of school. No one at school knew what became of Tahira after that; it was rumoured that her parents had sent her away to live with her grandparents.

QUESTIONS FOR REFLECTION–

1. Did the school counsellor breach client confidentiality? If yes, in what ways?
2. Is the counsellor responsible for what Tahira's parents did after she told them about their daughter?

THE QACP VIEWPOINT:

In several school mental health set-ups, counsellors may be expected to report "sensitive" issues that come up in the counselling sessions to the school authorities. Counsellors may themselves think it to be in the best interest of the child to inform parents and teachers about issues related to sexuality. However, what the counsellor in this particular scenario did not take on board was that **given the stigma and lack of acceptance around queer sexuality, revealing such information to significant adults without the consent or readiness of the client herself could have dangerous consequences.** Families, schools, and persons in positions of authority wield considerable power, and can withhold basic rights and freedoms from their wards in order to "correct" or "punish" what they consider deviant behaviour. When queer/trans individuals are outed, they often face severe negative responses, such as physical violence, house arrest, forced marriage, stopping of education, sexual assault, institutionalisation – to list just a few common responses. The client must feel ready, and the counsellor needs to feel confident about working, over a period of time, with others who are significant in the client's life, to create a space of comfort and to prepare the client, before any intimate knowledge is shared. At all times, however, the client must be allowed to make the final decisions about what to tell whom, and when, and the counsellor must not try to influence these decisions in any direction.

CASE SCENARIO 2

An 18-year-old boy, Raja, identifies as a man who has sex with men (MSM). His counsellor had built a good rapport with Raja, who had confided in him about being in love with a 38-year-old guy who worked as a waiter, and how he, Raja, would wait at 7 pm every evening for this man to leave the restaurant and would follow him home. Then Raja would be up again at 6 am, to follow the man to the restaurant. Raja said he did not have the guts to approach this guy and was quite content, for the time being, just to watch him for those 20 minutes every day. The counsellor then worked with the client on the possibility of expressing his feelings to this man, and on thinking through the possible consequences.

Now the same counsellor had another client who identified as MSM and who was working with the former to work up the courage to approach someone to whom he was attracted. The counsellor, without naming Raja, shared with this other client Raja's story of being attracted to and following the man who worked in a restaurant.

In the next session, Raja was very angry and upset with the counsellor, accusing him of ruining his life and revealing everything about him to the community. The counsellor tried to reassure him, saying that he had not revealed Raja's name, but kept him anonymous. Raja told the counsellor that the latter had broken his trust, and so he was never coming back – or going to any other counsellor ever again, because they always gossiped about people like him.

QUESTIONS FOR REFLECTION:

1. Did the counsellor break confidentiality?
   - If yes, in what way do you think he did so?
   - If no, how do you think the information got out and reached Raja?

THE QACP VIEWPOINT:

In order to protect his client, the counsellor did not reveal Raja's name or other identifying details. So the counsellor did think about confidentiality, and kept his client's identity anonymous while sharing the story with another client. But he did not take into consideration that **queer communities are often closely-knit, which makes it easier to identify people despite the lack of obvious details.**

In this case, what really happened was that the second client knew of the man who worked as a waiter at a restaurant. When the counsellor told this client that another client of his was in love with a waiter, this client remembered his friends telling him about a waiter in a restaurant many community people frequented, who was 'just like us.' This made it easy to check who was following him, and that was how Raja's identity was revealed.

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Protocols around confidentiality

Breaking confidentiality

In the event of harm to self and others, if confidentiality needs to be broken, whom will the MHP contact? "Next of kin" is the usual answer, and this is always assumed to be the natal or marital family. However, with queer/trans people, families can be the most unsafe space. Therefore, whom to contact in the event of needing to share confidential information is a discussion that must be had with the client early on. MHPs must be willing to recognise that kinship outside of natal family and marriage often represents the closest bonds that queer/trans people have – and might constitute the only safe people to whom concerns about the client can be taken. The traditional systems tend to rely on natal and marital families, which queer clients may not have, or from which they may be estranged. Therefore, identifying whom the client nominates as next of kin is crucial.

Shared confidentiality

Often, in institutions, as in the context of the school in Scenario 1 above, there are protocols about what content is to be shared with whom and in what context. The contexts are usually about supervising psychiatric medication, being on guard in cases of likely self-harm or suicide, and so on. Discussing

these protocols with your client could be important. Clients are often compelled to hide different truths about themselves in different settings. Therefore, assessing the client's safety before revealing any information to authorities or family members as per the demands of protocol becomes necessary.

Breaking confidentiality is a matter of the MHPs own ethical stance. Existing institutions, systems, policies and protocols cater to a cis-het world and fail to take everyone's lived realities into account. MHPs are, then, bound to face barriers while making a decision regarding breaking confidentiality. What is important is that MHPs remain aware at all times about the possible serious consequences for a queer/trans client and do their best to think of other ways around the situation. The Mental Health Care Act, 2017, can be a useful tool: the Act has an important provision on 'Nominated Representative', a person nominated by somebody, to make decisions about their mental health care and treatment in the event that the nominator is going through a mental health crisis and is unable to decide certain things for themselves. This nominee need not be a family member, in which event the provision can be used by the MHP to make a case for not contacting the client's natal or marital family.[41]

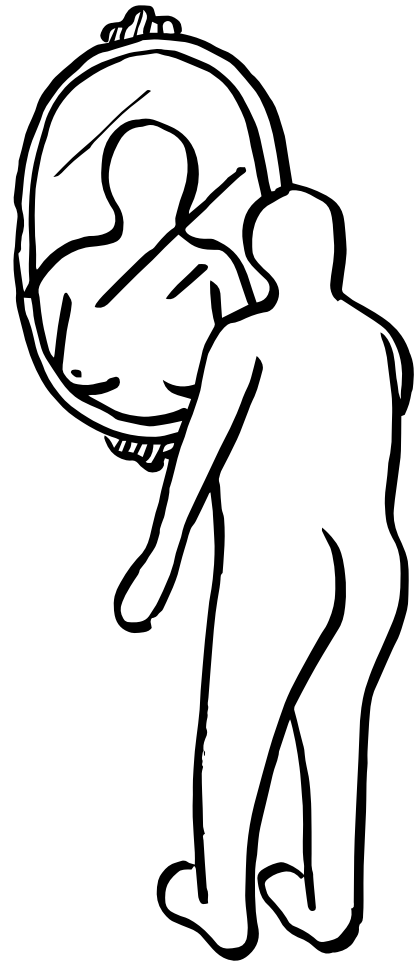
TENET 8

Self-awareness and enhancing competence

Self-awareness on the counsellor's part is vital in all counselling processes. Knowing about one's own biases and inadequacies, and seeing oneself as fallible – and therefore open to correction, change and growth – lie at the heart of this tenet.

With respect to working with queer and trans clients, the MHP needs to–

- **Reflect on one's own gender-sexuality journeys** – taboos, and ideas of propriety, morality, disgust: where do these come from? what has changed? what was responsible for these changes? (for self-reflexive exercises discussed earlier, see 2.4 – 'Mapping our own sexuality journeys').
- **Ask oneself** – not limiting oneself to issues of gender-sexuality, although these can be significant – **'what does the client evoke in me? and what do I evoke in the client?';** reflect on what aspects of their life and realities are easy to empathise with, and where empathy becomes difficult; think about what evokes judgement, and when is one's struggle to keep from judging at its most intense.
- **Recognise one's own locations of power and**



privilege with respect to gender, sexuality and other social locations.

- **Become aware** of and challenge internalised homonegativity/ transnegativity and prejudices.
- **Be willing to change personal beliefs,** and manner of professional practice.
- **Recognise that "therapeutic neutrality"** with regard to queer and trans clients **can often be harmful.**
- **Be attuned to the client and their life experiences:** when a client comes in with previous experiences of discrimination within mental health systems (and, of course, in the world at large), building trust with the counsellor/therapist as well as in the process of therapy may be challenging for them; there could be other issues such as being closeted, fear of being outed, and so on; and it becomes important to bear in mind that the client's mistrust need not be framed in normative fashion as a "trust issue" that extends to all their other interpersonal relationships.
- **Recognise one's share in the collective responsibility for stopping harmful treatments** of every kind and for promoting an affirmative approach.
- **Think about one's own levels of comfort/ discomfort** in disclosing one's gender-sexuality location to clients – queer or non-queer: when, why and how such disclosure happens are important questions on which to reflect; for many "out" queer and trans therapists, who regularly get community referrals, this may not be something they engage with actively in their sessions, as most clients are likely to know about their gender-sexuality identity already; for those of us who identify as queer/trans and are not out, and do not wish to be out in professional contexts, these are particularly important considerations in our work with queer/trans clients; for those of us who identify as cisgender and heterosexual, it is important to think about what it means to come out as "cis-het" to our queer and

trans clients – to reflect on how this acknowledgement might aid or hinder therapeutic alliance, and what it means for cis-het MHPs to identify as allies.

Enhancing competence

One aspect of enhancing one's competence is to build knowledge. It is important that MHPs educate themselves about good practice, standards of care, and other such existing guidelines in order to work with queer and trans clients. Being aware of ethical, clinical dilemmas while working with marginalised groups, knowing about grey areas, i.e., areas where professional consensus has not been reached, and updating oneself about research in those areas – all

It is important to think about **what it means to come out as "cis-het"** to our queer and trans clients – to reflect on how this acknowledgement **might aid or hinder therapeutic alliance, and what it means for cis-het MHPs to identify as allies**

this is important for enhancing one's competence. Being aware of policy and legal provisions with respect to queer and trans persons nationally and regionally is another crucial aspect of knowledge building.

In addition to building professional expertise, it is vital to learn from the lived experiences of queer and trans persons through actively engaging as allies with these communities, and to acquire social learning not just through having queer and trans persons as clients but through expanding one's social circle to include queer and trans persons as friends, co-workers, peers, trainees, students, and so on. QACP advocates against relying solely on one's clients to educate oneself – which is not to suggest that learning from clients is not welcome, but to remind ourselves that the burden of educating the care provider cannot be placed entirely on the client, who has a right to an affirmative mental health care service when in need or distress without having to put in the labour of educating their counsellor/MHP.

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TENET 9

Affirmative practitioners as advocates



Therapy is usually about what the client brings to the MHP in sessions. Mental health care for clients from marginalised and minority communities, however, includes participating in their struggles for dignity, equality, inclusion, and social justice. Is it enough to be a therapist who engages with queer/trans clients in a therapeutic space but is otherwise not aware of, or connected to, any of the larger struggles that contribute to each client's distress? For instance, the widespread opposition to The Transgender (Protection of Rights) Act, 2019, which discriminates against trans communities more than it protects them – is it enough to attempt to address the distress such laws evoke in trans clients, or do MHPs see themselves as participating in broader campaigns to promote social justice? We take the position that queer affirmative therapists are advocates of social justice, who demonstrate their commitment to anti-oppressive practice in different ways. These could include micro-level actions, such as offering to talk to persons at the client's workplace about his medical transition and the accommodations that may be required to be made there; or macro-level actions such as filing petitions in the courts challenging discriminatory legal provisions.



Holt N. R.

I think you have to wear a lot of hats. Like I am helping clients navigate how to change their name and what to expect with hormones and who the best surgeons are and so I am wearing medical, legal, mental health [hats] a lot of times.'
(Holt et al., 2020, p.10)

Conclusion

In this chapter, we have tried to discuss some of the foundational ideas that inform QACP. In addition to providing a historical overview of queer and trans identities within the psy discourse in the west as well as in India, we have attempted to explain, with some precision, what constitutes QACP – how it is an amalgamation of perspective, knowledge and skills. The perspective and the knowledge are drawn from the margins; the nine tenets are meant to guide us on how to modify our skills so as to be responsive to queer/trans realities. The following chapter provides more in-depth discussions on the skill(s) of queer affirmation, and shows us – through a series of case studies – how to operationalise, in affirmative ways, the perspective we have thus far gained and the tools we have learned to use.

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Illustration: Shubham Bose Roy (@shubnam.jaan)

Reframing Therapeutic Approaches through a Queer Affirmative Lens

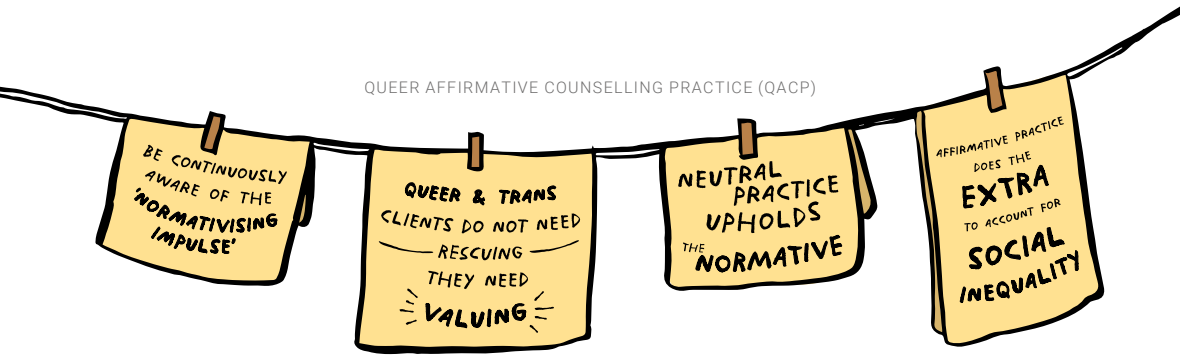
Our first responses to a client's concerns may come from a neutral/normative space. Awareness of this possibility, and a deliberate attempt to make our responses affirmative, are crucial. It is possible to take any approach in mental health and 'queer it'. This means becoming responsive to realities of queer/trans clients, demonstrating affirmation and furthering a social justice agenda.



CHAPTER 6

Reframing Therapeutic Approaches through a Queer Affirmative Lens

In this chapter, we focus on the application of the knowledge and perspectives discussed in the previous chapters. This chapter brings together that learning – about unique life stressors, relationship stressors, the tenets of QACP, as well as the differences between harmful, neutral, and affirmative practice, and other key ideas – and explores how it may be operationalised in counselling practice. It must be reiterated that queer affirmative practice is not a new approach to counselling; rather, it offers a perspective and tools to modify our current practice so that it becomes more responsive to the realities of queer/trans clients and furthers the social justice agenda for gender-sexuality minorities.



6.1 Learning the skill(s) of queer affirmation

In this section we consider five individual case studies and two cases about couples. Through these, we highlight the skill of queer affirmation – we try to understand the unique life stressors and come up with an intervention plan using the tenets of QACP. We also, deliberately, examine what "neutral practice" could look like in each case, and what kind of reframing may be done using a queer affirmative lens.

With this in mind, please read the following case studies and respond to these questions about each case –

1. What are some of the unique life stressors affecting this client?
2. What would be your intervention plan? (Think about the tenets from which you might draw.)
3. In the given scenario, what do you think would constitute neutral practice, and what would make for affirmative practice?

→ ***Note: Please refer to the concepts of ULS (see 3.2), emotional landscape (see 3.3), unique relationships stressors and context of deprivation (see 4.1) and tenets of QACP (see 5.3) to formulate the therapeutic concerns and make your interventions affirmative. Please use the probes given after each case to help think through the formulation of the problem and the intervention plan – and add your own points to each probe.***

CASE 1

School management has referred a 14-year-old student to you for not sticking to the school's dress code. This student insists on wearing trousers under the pinafore, and often tucks the pinafore into the trousers. The student does not wear the shoes that are part of the girls' uniform, but shoes with shoelaces like the boys. Teachers have also complained that the student acts like a boy and refers to themselves in the masculine gender.

PROBES

1. What is the gender experience of this student likely to be?
2. How would you demonstrate an openness towards the student?
3. What is the school's understanding of the problem?

YOUR NOTES

THE QACP RESPONSE

UNIQUE LIFE STRESSORS	INTERVENTION PLAN
Discrimination	Demonstrate openness to knowing the student's chosen name (if they have one apart from their birth name) and the pronoun by which they wish to be addressed, and assure them that their/his gender will be affirmed in this counselling space every single time.
Invisibility	Focus on strategising with the student about how his gender could be affirmed in different ways outside of the counselling room as well, and explore whether he would be comfortable with trying out some of these strategies. For instance, having you, the counsellor, address him in front of others using his preferred pronoun and chosen name. And having a few other students who support him do the same. Also, are there some teachers who might allow him to tuck his pinafore into his trousers and sit for class?
Violence related to gender "correction"	The student is very likely to know what he wants, and is also likely to have a good sense of some of the barriers and possible consequences. Support the student's exploration and articulation of these.
Possible misgendering	Focus on strategies to combat bullying – whether systemic, or interpersonal (by peers),
Possible coming out and social transition	

while exploring ways in which the student feels he can stand up for himself.

Focus on identifying support systems within the school, as there might be some teachers/ clerical or other staff/senior students who would stand by him. Similarly for life outside school – to whom does the student feel close? Who else might be in his corner?

NEUTRAL PRACTICE	AFFIRMATIVE PRACTICE
Formulation of the problem: as a discipline issue (refusal to follow school rules, dress code)	**Formulation of the problem:** as being about the rigid gender norms that cannot accommodate the student's gender experience and expression.
The young person's best interest framed as: a student's needing to follow rules in order to avoid disciplinary action	**The young person's best interest framed as:** the need to uphold a person's self-determined gender; validation of the student's gender experience by asking him for his name and pronouns.
Focus: on helping the student to adjust to the requirements of the school, such as the gendered uniform–	**Focus:** on collaboratively identifying strategies to face the consequences of not being cisgender, including punitive actions by an unyielding school management and system–

The child's parents or guardians are likely to be viewed as the natural **support system**, and be brought in to reinforce school rules and to discipline the child.

The support system will be identified by the student. No assumption will be made that parents or guardians are naturally supportive and therefore ought to be involved. The MHP will strive to help strengthen supports that the client identifies.

Advocacy action: none

Advocacy action: The MHP may need to *gauge whether school management and staff are open to conversations on gender, and to making systems responsive to a range of gender experiences,* such as having gender-neutral uniforms. Actions to be taken could range *from holding sessions with teachers on gender beyond the binary, to developing an anti-bullying policy* within school that includes a section on bullying based on non-normative genders and sexualities. The MHP would do well to *update themselves on recent legislation for transgender rights in India, specifically with regard to the sections on non-discrimination in educational institutions,* and foreground this in an awareness session with the school management, teachers and other stakeholders.

CASE 2

I am Naina – 27 years old, and single. I have mostly dated guys. I once fell in love with a girl in my college. She was my junior. I thought that could become a serious relationship. I was crazy about her and did not care that the whole college was gossiping about us. The sex was fantastic. It didn't last, but it gave me an opportunity to explore my sexuality. I realised that I was bisexual. I think it's good to be bisexual. You don't really need to come out to anyone. And look at me, I could always pass as straight. I mean, I could always date or marry a man. I could always continue to have sex with women on the side. I am thinking of getting married. Am I complicating things for myself?

PROBES

1. What is Naina's gender presentation likely to be?
2. How does she understand bisexuality?
3. What are your thoughts about her being able to access Charmed Circle realities?

YOUR NOTES

THE QACP RESPONSE

UNIQUE LIFE STRESSORS	INTERVENTION PLAN
Self-acceptance	Validate all Naina's sexuality experiences, but definitely explore her relationship with a woman, as she is unlikely to have had much opportunity to speak of it.
Coming out to self	Explore what she means by 'I think it's good to be bisexual.' Is there any internalised bi-negativity that requires unpacking?
Invisibility	Help her work through the complications she feels she might be getting into: • by helping her recognise the negotiations she might need to make in the marriage in order to be more authentic about her sexuality (as she would be read as heterosexual in the marriage, and her desire for women might thereby come to be erased). • by working with her to prepare herself for the loss of Charmed Circle privileges, if she feels that marriage might complicate matters for her and that she should therefore not get married.

NEUTRAL PRACTICE	AFFIRMATIVE PRACTICE
Formulation of the problem: as the client needing support to make a decision about getting married	**Formulation of the problem:** as the norms of sexuality not having the space to accommodate her specific experiences.
Focus: on weighing the pros and cons consequences of getting or not getting married, suggesting a choice between two equally socially valued positions–	**Focus:** on collaboratively working through the complications of either decision by situating her struggle within the social norms of marriage and recognising the erasure of non-heterosexual desires and experiences–
This would not only be far from the truth, it would be an individual-focused intervention with no discussion of structural realities.	The MHP *would help strengthen the client's ability to cope with all that non-normative experiences bring.* This would mean *validating Naina's experiences of her sexuality,* including her desire for women; exploring with her *the meanings of the word "bisexuality"; introducing her to resources and support groups.*
It would also shift attention away from Naina's having said, of her relationship with a woman, 'I was crazy about her . . . The sex was fantastic' and 'I realised that I was bisexual'. In other words, what bisexuality means to Naina might not receive enough attention, let alone validation.	*Explore what 'I am thinking of getting married' means for the client* – is it a foreclosure of her identity as a bisexual woman? Since she does say she could 'continue to have sex with women on the side', *help her*
And what might be worse (going from neutral straight into harmful practice) would be the framing of these assertions	

as part of the "confusion" that modern young women like Naina supposedly undergo when they are uncertain about marriage and commitment, or when they haven't yet met "the right man".

This approach might push Naina towards a normative decision, while allowing her desire for women to become erased within a heterosexual set-up.

think through possible barriers, or challenges to accessing her bisexual self in a heteronormative institution such as marriage. Also, *discuss whether she has thought about disclosure to her spouse.*

CASE 3

A 33-year-old gay man, working in a corporate set-up, tells the MHP that he finds it hard to take the lead in group settings and is particularly uncomfortable doing presentations. He says he has many ideas that he would like to bring to the table but is unable to claim that space. He confides that he often feels that everyone is staring at him and he might "get caught", because some mannerisms of his will reveal to people that he is gay.

PROBES

1. What are the client's ideas about the masculinity of gay men?
2. What is the predominant emotion the client has brought into the session?
3. How real is the possibility that his sexuality will become known at his workplace, and what might the consequences be?

YOUR NOTES

THE QACP RESPONSE

UNIQUE LIFE STRESSORS	INTERVENTION PLAN
Self-acceptance	Help the client work through his internalised stigma, or feelings of shame, about what he thinks of as his mannerisms – does he consider them "effeminate"? Obviously gay? In what ways does he see himself, his self-expression, not fitting in with traditional notions of masculinity?
Coming out to others	Explore what getting caught means to him.
Discrimination and harassment	Help him build strategies to combat the discrimination he is likely to face if his sexuality becomes known.
Invisibility	

NEUTRAL PRACTICE	AFFIRMATIVE PRACTICE
Formulation of the problem: as social anxiety and lack of confidence at the workplace	**Formulation of the problem:** in terms of shame because of masculinity norms and the stereotype of the effeminate gay man.
Focus: on confidence building, social skills, skills to make presentations– Such a focus remains on the individual and concentrates solely on the individual equipping himself with skills to perform better at the workplace – in a manner that is decontextualised from the client's heteronormative and possibly hyper masculine environment, which is the main source of his difficulties.	**Focus:** on helping the client recognise the emotion of shame that comes from not meeting masculinity and sexuality norms– Place the shame squarely at its source, on the social norms rather than on the client's behaviour or mannerisms. Work through the shame to recognise internalised homonegativity and facilitate self-acceptance (refer, in particular, to **5.3 –** 'Tenet 5: Facilitating self-acceptance'). *Help the client understand that it is the homonegative and therefore hostile work environment* that is not welcoming, or open to, his gender and sexuality expressions. Collaboratively *strategise to develop coping mechanisms* to manage the distress that such an environment causes.

Explore with the client whether there is any scope for advocacy at the workplace to enhance diversity and inclusion. Does the workplace consist primarily of cis-heterosexual men of the sort who make the client feel as he does, or are there others who might be supportive?

CASE 4

Your client is 18 years old. Her name is Razia. She is very close friends with her roommate Rupa. They have been friends for two years and do everything together, share each other's things, tell each other everything. There are no secrets between them, and their lives revolve around one another. Razia is aware that she is in love with Rupa, and views their closeness as being in a relationship, although the two of them have neither discussed this, nor professed love for each other. One day, Rupa tells Razia that she is dating a boy from their class. Razia is very hurt by this news. She is now silencing herself and censoring her feelings for Rupa, for fear of losing the friendship they have shared so far.

PROBES

1. Would you consider this a romantic relationship?
2. In the session, how much emphasis or space will you give to the experience of love that Razia talks about?
3. What is the predominant emotion the client has brought into the session?

YOUR NOTES

THE QACP RESPONSE

UNIQUE LIFE STRESSORS	INTERVENTION PLAN
Invisibility, erasure	Validate Razia's love for Rupa and uphold her love experiences. Recognise the deep loss and heartbreak that Razia is going through, and hold her through this difficult time.

NEUTRAL PRACTICE	AFFIRMATIVE PRACTICE
Formulation of the problem: as a friendship between young girls, which one or both persons could easily confuse with romantic love; a part of growing up, a phase that people usually grow out of.	**Formulation of the problem:** as Razia's heartbreak and deep sense of loss at the relationship with Rupa ending.
Focus: on the friendship over the love relationship– Assure Razia that they can still be 'best friends' and that the loss that she is experiencing now is about having to share Rupa's love with her boyfriend.	**Focus:** on holding the experience of love and the pain of heartbreak for the client– Experience of rejection in love can be a difficult emotion and experience to navigate for a young, 18-year-old person. However, in this instance, the heartbreak and feeling of rejection are made far more complex by the added layer of Razia's feeling rejected because she is a woman (who will never be able to offer Rupa the social sanction, respect and validation that a relationship with a man would). This could well be one of Razia's reasons (apart from fear of losing the friendship) for not telling Rupa about her feelings. She does not experience these feelings as valid or "viable"; she has not felt "loving a woman" to be a real option.
Erasure of Razia's love for Rupa	
Focus on Razia's age and encourage her to pay attention to studies as that is more important at this age.	

Razia's sense of isolation in the midst of this experience of love and rejection, because it is probably not something she is able to talk of with anyone else, would add to her vulnerability.

In addition to this being a distressing time in Razia's life, it could also be a time when she might be dealing with questions about her sexuality, and perhaps moving towards coming out to herself.

The MHP would *help Razia work through her questions about her sexuality* and her possible coming out to herself, through *encouraging her to articulate her feelings, fears, and so on, while foregrounding self-acceptance* as a goal. *Validating Razia's love for Rupa is crucial.*

CASE 5

Your client is a 28-year-old cis man, Mario, who is married to a woman he is not able to satisfy sexually, as he has erectile dysfunction. He informs you that the psychiatrist has diagnosed him as a person with OCD (Obsessive Compulsive Disorder), 'obsessed with thoughts of having sex with men'. Mario says that while he is attracted to men, he wants to stop feeling this attraction. He pleads with you, 'You convince me that I can be straight. You tell me that I am not gay. Since sexuality is a choice, I should be able to choose my sexuality.'

PROBES

1. What are your thoughts on the diagnoses of erectile dysfunction and OCD?
2. What is the predominant emotion the client has brought into the session?
3. How will you use your expertise to opine on 'sexuality is a choice'?

YOUR NOTES

THE QACP RESPONSE

UNIQUE LIFE STRESSORS	INTERVENTION PLAN
Internalised homonegativity	Help the client make the connection between his desire for men, his own shame or stigma regarding this, and the diagnoses of erectile dysfunction and OCD.
Self-acceptance	Help normalise the attraction between men, and explore the barriers to self-acceptance that Mario experiences.
Coming out to self	Facilitate his self-acceptance of his sexuality.
	Gently challenge the diagnoses of erectile dysfunction and OCD.
	Help him recognise the negotiations he might need to make in the marriage in order to be more authentic about his sexuality.

NEUTRAL PRACTICE	AFFIRMATIVE PRACTICE
Formulation of the problem: client diagnosed with erectile dysfunction and OCD, needs help to adapt to his marital life better; his asking to be told he is straight is a clear request for conversion treatment.	**Formulation of the problem:** shame and internalised stigma arising from the client's desire for men.
Focus: on learning new sexual behaviours and managing OCD symptoms–	**Focus:** on addressing shame and internalised homonegativity, and facilitating self-acceptance–
This would mean that his desire for men gets erased within a heterosexual set-up, pathologised and subsumed under the broader diagnosis of sexual dysfunction.	The MHP would *help strengthen the client's ability to cope with all that non-normative experiences bring.* His sexuality-related desires and *experiences need to be validated and his desire for men upheld.*

Continuing to apply what we have learnt, let us look at the skill of affirmation with couples. The following case studies foreground the concerns of couples as clients.

CASE 6

SESSION 1

Mohit: I am Mohit and this is Sanjay. It was important that we see you. Things are getting difficult and really messy. Let me talk about myself first. Sanjay may want to add, but let me start. So, I am 32 and work as a project manager at a call centre in Andheri. He is 30. Well, actually, we are in a relationship. Like I mean we are serious about each other. In fact, we have been together for the past six years. We met at work. He also works there – another department, but same company. So well, we are now having problems. We have started having fights. Small-small things. I mean, they happen mainly out of expectations. We seem to have too many expectations from each other. Actually…

Sanjay: I think let me explain. Why are you mincing words? The issue is that our relationship is not known to many. You know why? Let me tell you. Because Mohit here is married. He was married when we met, but at that time he assured me that nothing is going to come between us. He also told me that he had no feelings for his wife and that he had got married due to pressure from his parents. I understand, these things happen. And honestly, whatever said and done I loved this man. But you know what? Within a year of our meeting, he tells me that his wife is expecting their baby. I mean, hello? What is this? Where did all that 'I don't care for her' story go? It was a shock! I just felt like leaving him right away. I actually stopped talking to him. But we did get back together. What's done is done, I thought. I did tell him that if he did not tell his wife about us and leave her, I would go away from his life. It's been six years now. He has still not told his wife. I am fed up. Seriously, I am tired of living like this. We are lucky that we work on the US time zone. We get to meet every day, at least. But I don't

want to live like this. I want to be open about my relationship with him. What's there to hide? We are so dead serious about each other. I want to be able to go out in public with him, live with him, share every moment with him. Every time he goes back home, I feel as if I don't exist. As if there is this solid wall between our world and his world. I hate it. I have now decided. He does not want to tell his wife, so I will tell her. I know her well. I get introduced as this great office colleague to all his family, you see.

Whenever I broach this topic, that he has to tell his wife, he is so evasive. He is so non-committal. Countless times I have asked him what is going to happen to us in coming years? Do we really have any future? Do we continue to be like this, our relationship hidden from all as if it's a big crime? I just feel so trapped. Now he has a son also. That's going to complicate things, too, isn't it? He is going to start asking questions soon. If he comes to know, then what? I don't want to live with the guilt of traumatising a young kid. I want him to know of our relationship as one which has dignity and not something which is under wraps. We don't know what is going to happen, actually… I don't know what our future is.

FORMULATION OF THE PROBLEM

Probe 1: What are some of the difficulties that the couple is facing, and which of these arise because of the Charmed Circle? (societal hierarchies; which relationships are considered valid and are more valued)

Probe 2: What "normativising impulses" could creep in? (attempts to save the heterosexual marriage; the ways in which parenting is understood)

INTERVENTION PLAN USING AN AFFIRMATIVE STANCE

Focus: on what the two persons are saying about their relationship and love for each other, and on what has held the couple together for six years, despite all the difficulties–

The MHP would–

Foreground who makes up the couple

Mohit and Sanjay, despite Mohit's being in a heterosexual marriage, are in a couple relationship with each other. The heterosexual marriage is not aligned with Mohit's sexuality. Mohit's and Sanjay's love for each other suggests they are the "real" couple; their relationship needs to be held by the MHP, especially given that one of the major sources of their distress is the erasure of their couplehood on a daily basis.

Help them acquire greater empathy for each other's situations

As a couple they are both challenged by the realities of the Charmed Circle and are both suffering, in different ways, yet together, because societal structures prevent their being with each other in open and authentic ways. The MHP should help the couple to recognise that theirs is a united struggle against forces that are outside of them; rather than see their situation as a fight with each other. For instance, Mohit's sense of responsibility and, possibly, guilt towards his family, particularly his child, may be framed within the context of the pulls of the Charmed Circle's dictates; helping Mohit to separate out those dictates from his own values, aspirations and dreams for his life would both ease his burden and help Sanjay empathise with him. Similarly, Sanjay should be enabled to see the ways in which his aspirations for a happy relationship are framed by the prescriptions of the same Charmed Circle, which possibly make him doubt the authenticity of his relationship with Mohit.

Reframe the structural power of heterosexual marriage

This would involve helping the clients to look at Mohit's marriage as a life circumstance which he and Sanjay have to take into account

– just like the circumstances any couple must face, such as debt or illness or parental disapproval, which can create stress in their relationship, and which they need to negotiate in order to be with each other. Heterosexual marriage is decidedly one such circumstance in the lives of many gay couples. Given social and familial pressures, many queer/trans people are pushed into cis-heterosexual marriage, which needs to be framed as a difficult circumstance that requires navigating.

Also, terms like "husband" and "wife" and "marriage", though socially determined, are heavily laden with emotion. Reframing these normative terms can help shift their inherent structural power and make them more reflective of interpersonal realities. For example, "wife" may evoke relational meanings that do not exist for Mohit. Could she be referred to as his legal partner, instead, to describe better what he shares with her? Or she could be referred to as a co-parent of Mohit's son. Even the marriage could be spoken of as a legal situation. These terms, when gently introduced and used, can help reflect the nature of the relationship they share with each other, which would, in turn, help both Sanjay and Mohit to navigate their interpersonal issues with less anxiety and conflict.

Marriage is a legal and social contract that can be renegotiated between legal spouses. Can the contract in question be revisited, in the light of Mohit's sexuality? Perhaps the MHP can help shift the focus from looking at Mohit and his legal spouse's marriage as a social contract to seeing it as an interpersonal equation? Mohit might then feel better equipped to renegotiate the equation so that it is not merely following what the social script dictates.

Explore Sanjay's relational power in the relationship as well

The very nature of power is such that it is disaggregated, whether in institutions and social structures or in interpersonal contexts. In this relationship, it would seem as though Mohit holds all the power, given his socially sanctioned family situation that includes marriage and parenting. Just as this normative social position of power

needs to be questioned in therapy, and Mohit's vulnerability needs to be brought forth for Sanjay to see and empathise with, Sanjay's power needs to be acknowledged as well. In an obvious sense, Sanjay feels invisibilised, and like the "other"/ outsider when it comes to Mohit's life. However as a "single" (without the trappings of a heterosexual marriage or children) gay man, he does have the power to make of his life what he will, while Mohit does not have the same choices available to him as easily. This realisation may help Sanjay shift from a position of victimhood to one of agency.

Address concerns using the power-vulnerabilities framework

At one point Sanjay says to the counsellor, 'He does not want to tell his wife, so I will tell her. I know her well.' It is important for the counsellor to be alert to the workings of power and vulnerability in the client couple's relationship. While Sanjay's statement can certainly be read in terms of his vulnerability due to feeling invisibilised as Mohit's partner, it can also be read as a threat to "out" Mohit – who, as a married man with a child, does have social privileges that he stands to lose if his unmarried, out gay boyfriend decides to tell Mohit's wife about his own relationship with Mohit. The therapist's awareness of the precarity of the power and vulnerabilities that arise from being outside the Charmed Circle is crucial. In the given scenario, whether the therapist reads Sanjay's statement as a threat or as a call for help is not as important a consideration as is the question of whether the therapist recognises the workings of power-vulnerability in the situation and makes space to explore if Mohit perceives it to be a threat

THE VERY NATURE OF POWER IS SUCH THAT IT IS DISAGGREGATED, WHETHER IN INSTITUTIONS AND SOCIAL STRUCTURES OR IN INTERPERSONAL CONTEXTS

and if Sanjay means it as a cry for help (see 4.1.3 – 'Intimate Partner Violence (IPV) and queer relationships').

These are some of the directions that affirmative work with the couple work could take. It is of utmost importance to note that none of this can be rushed. When the pressures of the Charmed Circle are so strong and the people on its margins and outside it so stigmatised, it takes a very long time to arrive at authentic meanings and relationships. MHPs need to be able to hold each person in their journeys and negotiations.

YOUR NOTES

CASE 7

SESSION 1

Aditya and Veena have come for their first therapy session. For the last three months, they have been facing issues related to coming out as a couple, being accepted by their families, and so on. It has taken time for Aditya to persuade Veena come for sessions, and she has finally agreed. The session unfolds.

Aditya: We have been in a relationship since four years, and we lived together for a year when we both worked in another city. Things were amazing then. Living with someone you love can be a magical experience – and yes, all issues related to the household, like who will do the dishes and who will pay the bills, were sorted out after long and involved discussions (laughs). However, now that we are back in our hometown, we both have to stay with our respective families. I feel we should start talking to our parents about ourselves. I identify as a trans man. I started with my transition just a year back, and a lot remains to be done. Nowadays, we end up having a lot of fights. The main issue is that she does not give me time anymore. Our outings have decreased to once a month. Post work I don't expect to meet, but at least on weekends? Recently, she also met a guy, as a marriage prospect. Her parents are putting a lot of pressure on her and have spread the word in their community that they are looking for an alliance for her. Whenever I go to her place, I am still seen as her friend, and they tell me to get her to agree to marriage. Her cousins, too, still treat me as a woman, even after being told about my gender identity. I acknowledge that she tries

her best to explain my identity to them, and she has been very supportive all this while. But just the other day, she told me to be "a real man" and work on my issues. We end up fighting almost daily. We hardly have happy moments, or any physical intimacy. I feel insecure and hurt, but I want to work on this with her and solve this. This relationship and Veena mean a lot to me. I want her to be happy too.

Veena: Yes, we have been together since four years. But it was different when we were there. I did not have parents there to whom I was answerable. Here, I have to tell them everything I do and don't. I try my best to meet him and be with him but feel torn between pressure from parents and constant lying and pretending to them, and his expectations from me. I do try to meet him at least once in 15 days if not every weekend. I had to meet that boy, if I refuse to do these things then my family will start questioning me and things will get all the more difficult for me. My cousins and mother have already started suspecting, and I am scared of their questions. I don't know what to say. Aditya has not even had his top surgery and he is not even sure of his parents' support. It is difficult for me to introduce him to my family as a man. I have tried to explain to my sister, and she thinks I am a lesbian. I understand he wants to take this relationship ahead, but I am not sure if I am ready. Can't we wait for some more time? I miss him too, but my family will not approve. I don't want to hurt him, or my family. I don't know what to do. I just can't leave the family and decide for myself. I can't be so selfish. I am scared, and he doesn't understand that it is very difficult for me. Nowadays we seem to be going round and round on this same topic.

FORMULATION OF THE PROBLEM

Probe 1: What must the therapist keep in mind, with reference to the Charmed Circle?

- Aditya's vulnerability as a trans man – he is completely invisible to the mainstream world, and continuously misgendered as a result.
- Veena's cisgender reality – which gives her a position of relative privilege in the Charmed Circle, but also her vulnerability as a woman facing marriage pressure from family.
- The negative impact on both of the current erasure of their four-year relationship, which affects Aditya more intensely – as the erasure is not just of his sexuality and of the nature of his relationship with Veena, but also of his gender identity.
- Veena's experience of vulnerability as a cis woman is very different from Aditya's as a trans man, although both emanate from the prescriptions of normative gender-sexuality. In fact, in one instance, Veena had made a fairly violent comment when she asked him to be "a real man" and to 'work on his issues.' Although she may have said this in the context of feeling overwhelmed and distressed, her choice of words – "real man" – is an example of gender-based violence that comes wholly from cis privilege (see 4.1.3 – 'Intimate Partner Violence (IPV) and queer relationships').

Probe 2: What "normativising impulses" could creep in?

- What might the therapist make of Veena's saying, 'I am not sure if I am ready'? Would they read it as her confusion about being in a relationship with a trans man – and based on this, explore with Veena the option of her marrying a cis man?

Probe 3: What are some of the difficulties the couple is facing? Which of these arise from the structure of normative gender-sexuality?

Probe 4: What is the couple saying about their relationship and love for each other? Is the therapist able to recognise, validate and value that? In what ways? What would be the therapist's take on the fact that the clients' relationship has lasted four years?

INTERVENTION PLAN USING AN AFFIRMATIVE STANCE

Focus: on the couplehood–

The MHP would–

Help the couple connect to some of their earlier experiences of couplehood

Currently the couple seems to be in an emotional crisis, with Aditya's insecurities and anxieties about their relationship being experienced as pressure by Veena, and her attempts to keep her parents happy and avoid precipitating a crisis being read by Aditya as emotional distancing – which adds to his insecurity. In the absence of social support, the couple may feel extremely alone in dealing with this crisis. Since both persons are presently overwhelmed, trying to cope with stressors in their individual lives, they seem to be adding to each other's distress instead of reaching out to support one another. It is important that the MHP recognises that four years of togetherness, in the absence of any social or legal support, is a significant length of time. What was it that kept the couple together?

Help them build empathy for each other's situation

As seen in earlier case examples, the MHP should help the couple to recognise that theirs is a united struggle against social forces that are outside of them, rather than seeing their situation as a fight with each other. Aditya's distress about Veena meeting other men with a view to marriage is not about him being controlling or possessive, but about feeling vulnerable that the pressures of the Charmed Circle may take her away from him. Also, when Veena appears to conform to certain Charmed Circle expectations, it is a form of self-protection against being "found out" – and could even be a strategy for biding her time, fulfilling normative family expectations till she can be with Aditya. To formulate a "circular hypothesis" (commonly used in systems-based couple therapy) the therapist may want to explore some of the following questions: How does Veena read Aditya's distress and requests or "demands" for meeting more often? How does she respond to these? How does Aditya read her responses? Similarly,

how does Aditya understand Veena's behaviour of "compliance" with her family? These discussions could help to build mutual empathy and allow the couple to move away from the stances of blame and hurt.

Work towards building resilience

Veena needs to recognise that in order to be in a couple relationship with Aditya, she must be prepared to lose certain Charmed Circle privileges. The couple may not be able to pass as a heterosexual couple until Aditya's medical transitioning has progressed considerably; even after that, the couple would need to decide whether they want to present as, or be read as, a straight couple, or as queer/trans, or whatever other label/nomenclature works for them.

Given the distress this couple is experiencing, it is possible that one or both persons will decide that they do not want to continue being together as a couple. The therapist would then have the task of figuring out how the work with the couple is to be terminated; the ways in which Aditya may need support; and how this would be different from the support that Veena might need, given their different locations vis-à-vis the Charmed Circle.

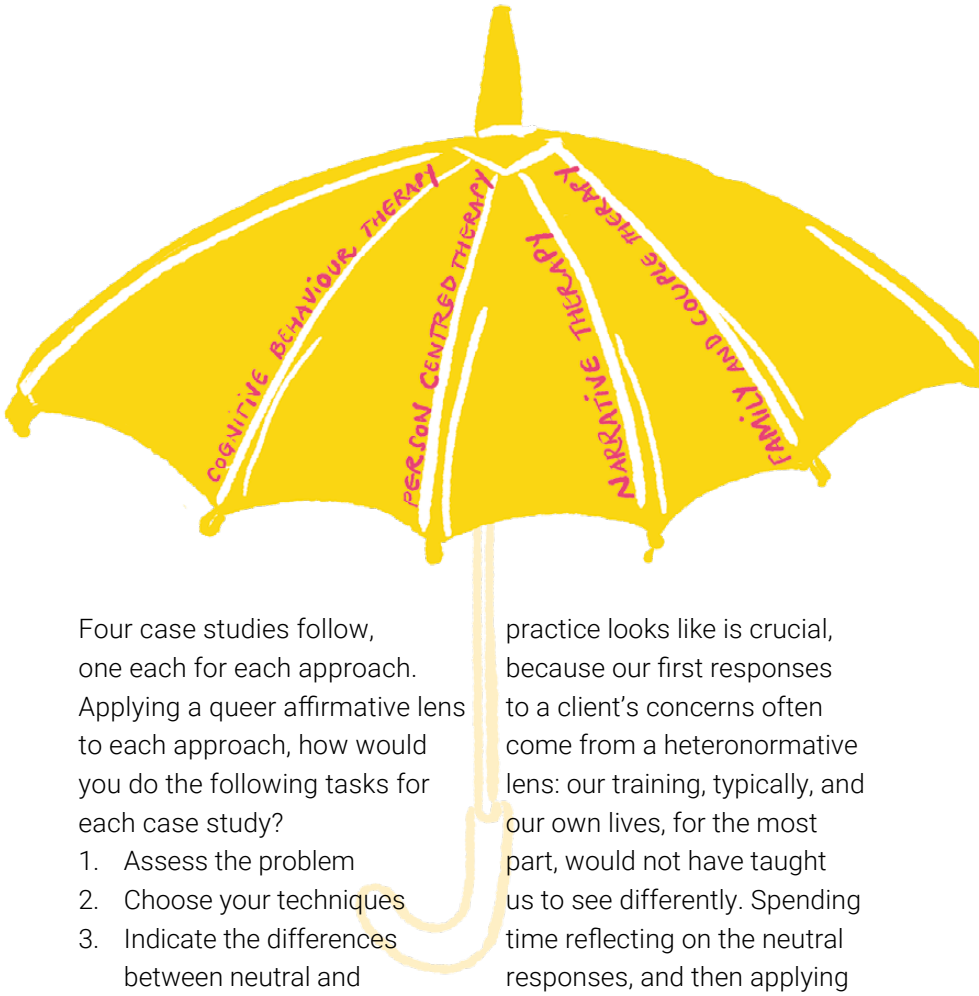
YOUR NOTES

6.2 Queering counselling approaches

We have chosen four commonly used approaches, in an attempt to show how counselling work within each would look different when informed by a queer affirmative lens. We start with ***cognitive behaviour therapy*** (CBT), one of the most popular models of psychotherapy, with a wide range of applications in both clinical and non-clinical settings. The second approach to which we apply the QACP lens is ***person-centred therapy*** (PCT), in many ways the opposite of CBT by virtue of it being non-directive, client-led self-exploration for emotional and psychological growth. ***Narrative therapy*** (NT), with its origins in social constructionist thought, is a "natural" choice for us to explore as QACP practitioners, and is the third approach we discuss here. Finally, we demonstrate the application of QACP to ***family therapy***, which is influenced by what is called family systems theory, and which we chose because the first three approaches mentioned are used mainly for working with individuals, while we wanted to demonstrate using the QACP lens while working with families as well – the families of queer/trans persons being, as we know, an important group that needs therapeutic attention. The choice of these particular approaches is based also on the competence of the authors and on experiences within their own practice.

All MHPs may not be well-versed in all four approaches; they may not be using all of these, or could be using different approaches in their individual practice. Please attempt responding to the questions that accompany the approaches with which you may be familiar, and apply the broad principles demonstrated here to any other approach not addressed here.

1. Cognitive Behaviour Therapy (CBT)
2. Person Centred Therapy (PCT)
3. Narrative Therapy (NT)
4. Family and Couple Therapy (FCT)



Four case studies follow, one each for each approach. Applying a queer affirmative lens to each approach, how would you do the following tasks for each case study?

1. Assess the problem
2. Choose your techniques
3. Indicate the differences between neutral and affirmative counselling
4. List any challenges faced while shifting from a neutral to an affirmative stance

In each section, we have attempted to lay out assessment and intervention plans in a stepwise manner, to help MHPs think through how to make these affirmative. The deliberate focus on recognising what neutral practice looks like is crucial, because our first responses to a client's concerns often come from a heteronormative lens: our training, typically, and our own lives, for the most part, would not have taught us to see differently. Spending time reflecting on the neutral responses, and then applying what we have learnt so far, might thus be a useful way to strengthen our queer affirmative lenses and our affirmation skills.

Possible questions to ask yourself, or steps to follow, as you engage with each case study:

1. What are the likely themes emerging from what the client is saying/experiencing?

Think about what mainly stands out for you, and what the client might be bringing to you if you were to apply your understanding of the Charmed Circle and of unique life stressors.

2. What would assessment of the problem be from a neutral lens?
3. What would a neutral lens miss or overlook in terms of choice of techniques, using that particular approach?
4. How can you now try to make the approach you are using more affirmative?

This chapter also attempts to demonstrate that the "queering" of approaches is not only possible, but also necessary. In the abstract of their article 'Decentering Heteronormativity: A Model for Family Studies', **(Oswald et al.,** 2005) write, 'queering processes refers to acts and ideas that resist heteronormativity by challenging the gender, sexuality, and/or family binaries described.' QACP includes the belief that any of the established counselling approaches used by MHPs can be made responsive to queer/trans therapeutic needs. We also believe that queering approaches benefits not just queer/trans clients, but may be applied to therapeutic practice overall. Queering is, then, a political position that enables us to think about social justice through our therapeutic practice **(Hodges,** 2011; **Nylund & Temple,** 2018).

Queering is, then, a political position that **enables us to think about social justice** through our therapeutic practice – Hodges, 2011; Nylund & Temple, 2018

6.2.1 Queering Cognitive Behaviour Therapy (CBT)

CASE STUDY

My name is Michael. I am 25 years of age, and I am gay. My doctor has referred me to you for CBT for social phobia. I graduated from college three years ago and now have a job working with computers. I have always wanted to be in a significant relationship with another man, but have never been in one. I have only had a few sexual experiences, none of which was in the context of an ongoing relationship. I have a few friends. I also have a few gay, male acquaintances who I believe, call me only when they need a favour. I live by myself in an apartment, but have difficulty finding enjoyable leisure activities to engage in – weekends are especially difficult because they are less structured and, unlike the weekdays when I am at work, I am not forced to socialise with people. During these times, I experience increased feelings of sadness and have a low mood for the day and sometimes wonder what is the purpose of living? I have been suffering from social anxiety for quite some time. I believe it began when I was in school and when I began to feel different from other boys my age. Although I did well in class throughout high school, I had a difficult time with my peers and had very few friends. During college, my social anxiety grew in intensity. I chose to attend college in a city close to my parents' hometown, and although I lived at the college hostel, I went home most weekends and avoided involvement in most college-related social activities. During this time, I began to realise that I am

contd.

contd.

attracted to men. The few friends I had, I did not like them, as they would ridicule people who were "out". It was not until last year that I started to be open about my sexuality and discovered places where I could meet other men, but mostly in anonymous situations. However, after such experiences, I would often feel shame and guilt and think, 'I am not normal' and 'I am disgusting for desiring men.' Often when I went to gay parties I would not be able to talk to anyone as I felt that they would not be attracted to me, and I would leave the party after a few minutes. So I feel socially quite isolated, and I need to address my social anxiety so I can get out more.

Applying a queer affirmative lens to CBT for Michael's case study, how would you do the following tasks?

1. Assessment of the problem
2. Choice of techniques
3. Indicate differences between neutral and affirmative stances
4. List any challenges faced while shifting from a neutral to an affirmative stance

Cognitive Behaviour Therapy (CBT) is a generic term referring to a number of cognitive-centric therapies, including Rational Emotive Behaviour Therapy (REBT) developed by Albert Ellis, and Cognitive Therapy by Aaron Beck. As an approach, CBT hinges on the premise that every behaviour is learnt, and can be modified by modifying the cognitive processes that led to it. The foundational idea is that how we feel and how we act is determined not by the situation *per se* but by what we believe about ourselves, about others, and the world at large. **Operationalising CBT is commonly done by using the A-B-C model popularised by Albert Ellis, wherein A is the Activating Event (situation), B represents the beliefs about A, and C represents the emotions and feelings that are a result of B. CBT asserts that A does not**

As an approach, Cognitive Behaviour Therapy (CBT) hinges on the premise that every behaviour is learnt, and can be modified by modifying the cognitive processes that led to it.

cause C, and that C is wholly a result of B. This is based on the understanding that most beliefs lie outside our conscious awareness; they are habitual or automatic, often consisting of our underlying personal "rules" about how the world and life should be.

Some core ideas of CBT

The A-B-C model

CBT involves looking at the involuntary negative thoughts towards and core beliefs about situations that lead individuals to feel and behave in ways that are harmful, because CBT sees an individual's responses to a situation as dependent upon the beliefs they hold about themselves, other people and the world. Such beliefs would be, in the case of persons belonging to the LGBTQ+ community, significantly shaped by the stressors they experience because of living in a cis-heteronormative world. Sexual minorities experience stressors unique to them because of their sexual orientation, in addition to the more general stressors that life presents **(Meyer,** 2003; **Meyer, Schwartz & Frost,** 2008). Together these stressors can have a considerable impact on their cognitive and affective responses to situations. What this means is that the "A" will also need to be examined closely, along with the "B", in the A-B-C model, using the lens of minority stress.

Studies have shown that CBT as an approach is quite valuable in addressing dysfunctional behaviour, as well as dysfunctional affective and interpersonal patterns, when it comes to non-normative sexualities **(Pachankis,** 2014).

The specific techniques of CBT can effectively be used to alter the cognitive and affective pathways through which minority stress operates, replacing them with others that promise a healthier mental health outcome. In Michael's case, too, a number of his experiences are a result of his belonging to a sexual minority. Many of his responses to situations are a consequence of the stressors emanating from that location.

Irrational thoughts/Cognitive distortions

Cognitive distortions are thinking patterns towards real events that are usually inaccurate and negative. It is believed that these negative thought patterns develop as coping strategies in response to adverse life events. Such a sustained negative response can turn into a rigid, automatic pattern of thought which then governs how one responds to certain situations. According to Beck's model (1976), cognitive distortions are likely to become activated in times of high stress. The dysfunctional thinking that results can make a person more vulnerable to developing emotional as well as behavioural psychopathology.

Michael's growing up years were marked by discrimination, rejection, isolation and an acute sense of being "different". Such early and chronic minority stress tends to communicate to queer/trans persons that they are deficient, inferior, or impaired in some way, which affects their mental health adversely **(Panourgia & Comoretto,** 2017).

Core Beliefs

A person usually goes about life adhering to certain beliefs about the self – assumptions about oneself, others, the world, and/or deep-rooted and prescriptive rules that dictate how things "should" be. People begin to develop these ideas right from childhood. These core beliefs, or enduring understandings, often rigid and considered absolute truths – just the way things "are" – determine the individual's responses to situations. Michael, too, would have developed such a set of ideas through his experiences at home, in school and college, at his workplace, in queer spaces. And considering the stressors to which he would

have been exposed due to his sexuality, his ideas would be bound to be quite different from those of a heterosexual person. For instance, he believes he is "disgusting" and undesirable.

Disputing

Disputing is the process of challenging irrational thoughts and core beliefs to replace them with helpful thoughts and beliefs. In Michael's case, his negative ideas about himself as being undesirable and about others rejecting him or being opportunists, may be challenged and corrected to more self-affirming and helpful ideas, which in turn could help him tackle his avoidance of social situations.

Assessment of the problem and choice of techniques/ interventions

The success of CBT lies, then, in identifying the individual's unhealthy and unhelpful core beliefs and disputing these, so as to replace them with healthy, helpful ones.

Michael's experiences seen in terms of the A-B-C model:

A (ACTIVATING EVENT/S)	B (BELIEFS)	C (FEELINGS & BEHAVIOURS)
• Going to queer events • Non-serious relationships • Socially demanding weekends • Discrimination • Rejection	• This is disgusting • I am abnormal • I am not good enough • I am unlovable • I have social anxiety • I am different (bad difference) • Having many friends is good, and I don't have any • I am always getting "used" (by gay friends)	• Putting oneself down • Sense of worthlessness • Inability to talk • Leaving events early • Anxiety • Guilt, shame • '…what is the purpose of living?'

Michael's core beliefs need to be assessed from a queer lens. Let us look at ideas which could inform the way we frame Michael's beliefs before disputing them–

Internalised Homonegativity

Michael experiencing himself as "disgusting", undesirable, and "not normal", must arise from being socialised in the heteronormative context where anything but the normative is frowned upon, ridiculed, stigmatised and abhorred. Persistent messages from the external world to this effect would certainly contribute towards a feeling of not belonging and thus not worthy of being included, which is what often runs through Michael's mind. This internalised homonegativity is affecting Michael at all levels – personal and interpersonal, as well as social. There is a wanting to be part of a social group which mirrors his sexuality and, at the same time, wanting to stay away, which could well be a further fallout of the homonegativity he experiences within – as queer spaces, too, would be felt as intensely unfamiliar owing to heteronormative socialisation, and could add to the undervaluing of the self.

Misinformation about the queer community

Michael's assertion that all his gay male friends are opportunists who call him only when they need something is a reflection of his limited experience (and also flawed information) with the queer community (see 4.3 – 'Community as resource', for more information on the role of community). His homonegativity precipitates a sense of mistrust and wariness that leads to active avoidance. It may be helpful to explore if Michael harbours any active prejudicial attitudes towards the queer community which he may have taken and internalised from the heteronormative world.

The clinical diagnosis of "Social Phobia"

Psychiatrist, psychologists, therapists are all figures of authority, and when a diagnosis is pronounced it is taken to be a true description of something that then needs to be "fixed". Michael does not even question the social phobia diagnosis.

All his present life issues are repeatedly articulated by him through the filter of social phobia.

Notions about friendship

The aspiration of having many friends is a normative idea; the ability to make friends is commonly seen as a desirable social trait. Society views those who have large groups of friends as popular, extroverted, desirable, and as people who know their way about. Michael appears to have internalised this idea, and more than once speaks of himself as lacking friends.

Livability of life

As a queer person, Michael is repeatedly subjected to discrimination, in various forms and in numerous social spaces. For queer individuals, relationships are all the more difficult to seek and to have, given that access to other queer folks is limited and fraught with uncertainty. The absence of meaningful relationships ('I have always wanted to be in a significant relationship with another man, but have never been in one.') can lead a person to question the whole purpose of living. It is not surprising, therefore, that Michael has come to the end of his tether and is questioning whether life is truly worth living. What we mean by "livability" concerns the feasibility, the possibility, of a queer life – one that involves intimate, meaningful relationships and friendships, and feeling loved and wanted. Since Michael has a high degree of internalised homonegativity as well as misinformation about the queer community (in the absence of affirming experiences in his interactions with the gay people he knows), he is unable to imagine what kind of life could be possible for him. His inability even to dream of thriving can be heard in the helpless statement, 'What is the purpose of living?'

CBT has a plethora of techniques for disputing beliefs to choose from, or for helping clients go past their irrational beliefs by means of deliberate actions. However, when it comes to queer/trans clients, the choice of techniques needs to go through the assessment filters of relevance and safety. Certain techniques, the very foundations of which lie in the normative, would hold no relevance for

queer/trans lives. For instance, as a CBT practitioner one might choose the over-generalisation or magnification technique to dispute beliefs – thus, Michael's belief about his inability to make friends could be disputed using these techniques to guide him towards an awareness of the irrationality of his thoughts by showing how he magnifies or exaggerates the problem. However, research suggests, for instance, that queer persons often lose friends after coming out to them **(Harrison,** 2003). Isolation, loneliness, social disapproval and rejection are unique life stressors (ULS) in such cases, the "A" in the person's life, the actual situation – and not just their evaluation of the situation, i.e., "B". The inability to have many friends could well be truly difficult for queer/trans persons, and disputing will not succeed in changing this belief. **Pachankis** (2014) has demonstrated the use of CBT to facilitate the restructuring of cognitions such as chronic expectations of rejection, internalised homophobia, and contingent lack of self-worth arising from unsupportive or hostile environments.

Safety evaluation also becomes extremely necessary when it comes to queer/trans clients. For example, if the CBT practitioner chooses to use a commonly used behavioural technique such as systematic desensitisation to treat Michael's social phobia, and tries to expose him to heteronormative spaces, it could be harmful for Michael as many of these spaces can be hostile to queer persons.

While disputing the client's beliefs, the therapist needs to ensure that the source of distress is located in systemic inequality. For example, it would need pointing out that shame stems from the stigma that is attached to desiring men, but it is not the client who is "bad" for desiring men – it is a failure of social norms to be inclusive.

Only after Michael has fully grasped that the problem is not intrinsic to him can the therapist focus on helping him build up self-belief, and equipping him with coping skills in the face of discrimination and oppression from society. This could be done by using techniques like role playing wherein the therapist

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simulates social situations (both queer and non-queer) for Michael to learn assertion, engagement and other social skills. Using the technique of "Devil's advocate" could also help, where the therapist plays the part of someone with social anxiety, and Michael attempts to use disputation to challenge the core beliefs underlying the social anxiety.

Disputing someone's beliefs about their own undesirability could be done by supplying information about queer realities, as well as by dispelling misinformation. Michael appears to have misconceptions about how the gay community operates (not having any 'significant relationship', people calling 'only when they need a favour'). These could be debunked by introducing him to examples of a reality that run contrary to his beliefs, possibly through documentaries or print material, or even queer people to whom the therapist might have real-like access. It would be absolutely necessary at all times to provide consistent validation and affirmation of his sexuality. It is important that the therapist recognises that the therapeutic space is perhaps the only one at present that can offer him such validation, which can be strengthening and empowering for Michael.

Neutral vs. affirmative stance

Neutral stance

1. The traditional CBT approach would be to identify and challenge irrational thoughts. In Michael's case, the irrational thoughts that get picked up for disputing could be: undesirability, self-disgust, feelings of inadequacy. The neutral therapist may not recognise that these are not irrational thoughts but responses to real life experiences arising from the unique life stressors Michael faces on account of being queer.
2. Additionally, since the presenting problem is social anxiety (corroborated by a psychiatrist), the choice of techniques could be exposure therapy, or scheduling behaviour activation, which would require Michael to expose himself to social situations in a gradual manner. The therapist may fail to recognise that the avoidance of social situations is probably Michael's way to avoid violence and stay safe. Choosing such techniques could expose Michael to situations that could be harmful or risky.
3. Common techniques to treat phobia, like systematic desensitisation and flooding, might be used, wherein Michael would be asked to go into social situations in non-queer spaces in a phased manner to overcome his social phobia. This could, however, prove potentially dangerous, as these spaces may be violent and discriminatory towards a gay man.
4. Role-playing is also commonly used in CBT to lessen anxiety, and a neutral practitioner might use it in order to reduce Michael's social anxiety. However, if the practitioner is not aware of the nature and dynamics of queer social spaces, the role play would not reflect likely actual situations. Using such techniques without adequate knowledge of queer realities would be pointless, and could even prove detrimental if the therapist uses a normative lens to frame situations.

Affirmative stance

1. **An affirmative therapist would recognise that the feelings of shame and of being undesirable associated with being gay, are not irrational thoughts, but a direct consequence of having been constantly exposed to a homonegative social belief system.** Framing them as irrational would thus be tantamount to invalidating Michael's lived reality. These internalised beliefs can, however, be put into perspective by locating their source in the external mainstream social system which deems non-normative sexuality abnormal and deviant, hence undesirable.
2. It could be pointed out to Michael by the therapist that his avoidance of peers and of social activities in college were in fact functional behaviours rooted in an accurate appraisal of a hostile environment – that they were not dysfunctional acts and need not be framed as symptoms of social phobia. Using terms like "dysfunctional" in effect focuses on some deficit in an individual, who is thereby considered "broken" in some ways and therefore in need of "fixing". **A queer affirmative therapist would recognise that there was nothing to "fix" in Michael; that all his behaviour derives from the ULS he experiences because he is gay.**
3. A technique like exposure therapy can prove harmful as it would make Michael vulnerable in cis-het spaces, which are also potentially abusive and violent. **An affirmative therapist would know this and would use the technique with caution.** It could be used for queer spaces that are known to be safe and are validated as safe by Michael himself.
4. **Role play could be used by the therapist to help Michael learn skills of assertion in spaces that are discriminatory.** This technique can effectively teach Michael social and behavioural skills that he could use in queer spaces as well. **However, the therapist would need to be adequately informed about the nuances and dynamics of queer**

spaces (parties, meetings, hangouts, activist gatherings, and so on) to train Michael in being able to tackle social situations at queer events.

5. The misinformation about the queer community can be disputed and resources provided to support the disputation – for instance, **the therapist could provide a list of queer films and reading material that have more accurate representations of queer people and spaces, so that erroneous notions held by Michael might be challenged and replaced.**
6. Validating his sexual experiences and the pleasurable, rewarding aspects of these would be important. Also, **actively discussing the ideas of "not normal" and "disgust" about these sexual experiences could prove insightful** for Michael. If these notions are linked to a belief about healthy sexuality being possible only in the context of a long-term relationship with a man, then breaking down this belief as something shaped by the dictates of normative, marital, reproductive heterosexuality would enable Michael to claim the pleasurable aspects of his sexual experiences during what he calls "anonymous situations".

List any challenges faced while shifting from a neutral to an affirmative stance

What neutral CBT could overlook–

1. Presenting problems may be taken at face value, and disputed without examining their sources.
2. The problem may be construed as catastrophisation (a common cognitive error in persons with social anxiety and phobias) or even personalisation, if seen through the mainstream lens.
3. Problems assessed through the mainstream lens would be addressed via techniques or interventions that are potentially harmful to the queer client – such as exposure, emotional reasoning, all or none thinking, applying the catastrophe or fear scale.

4. A neutral practitioner disputing the client's belief about his undesirability may point to other areas of the client's life and achievements to suggest "desirability". For instance, pointing out that he is well-educated and has a good job as evidence of why it is irrational to think of himself as undesirable. However, what would be missing in such a response is the therapist's recognition that the client's struggle with the idea of undesirability may not apply when it comes to those aspects of himself that are socially valued; that it has relevance for that part of him that has not received validation or nurturing from anywhere – neither from friends or family, nor from colleagues (he may not be out in the workplace), not even from lovers – and that cannot become acceptable or valuable just because he has a certain educational degree or job. Thus disputation or cognitive restructuring in CBT from a QACP lens would need to be mindful of the unique life stressors experienced by queer/trans persons, and the long-term impact of these on their sense of self and worth.

What MHPs can do in order to queer CBT–

1. Queering CBT would involve first recognising, acknowledging and naming the sources of the beliefs the client has about self, relationships, the queer community, and the world at large.
2. This is possible only when the practitioner is aware and empathetically connected to queer/trans lived realities.
3. Being able to see, clearly, the influence of a cis-heteronormative social order on queer/trans lives would be a key step towards empathy for the psychic realities of queer/trans persons and making interventions truly queer affirmative.
4. A sound understanding of the stressors in the lives of queer/trans individuals is necessary while choosing interventions. An absence of such knowledge could result in tools being employed that prove harmful to the client's physical and/or mental and/or emotional well-being.

5. Behavioural modification techniques such as assertiveness skills training, using a queer affirmative lens to deal with social situations of encountering homoprejudice or subtle homonegativity, can be useful. An initial lack of assertiveness could be a minority stress reaction.
6. Keeping queer/trans resources handy would be useful in order to educate queer/trans clients, challenge misinformation that they might carry, as well as bolster their self-belief.

6.2.2 Queering Person-Centred Therapy (PCT)



My name is Rohit and I am a 32-year-old chartered accountant. From the time I remember, I have always been like this, and yet the question "Why am I like this?" has remained with me. When people talk about childhood as this carefree time – the best years of their lives, with no worries and lots of play and laughter – I am filled with a deep sense of disconnect with this image. When I think of childhood, I think of it as a scary time… first there was my way of walking, talking, and the clothes I was comfortable in, that would draw all the wrong kinds of attention to me; I mean, teachers would scold me, I would get bullied in the sports period in school, and my father would constantly be on my case about what I was wearing, with whom and with what I was playing! For so many years, I have actually prayed to God over this question – Why am I like this? All

contd.

contd.

my friends and cousins are married, they have children, they celebrate festivals as a family, go on vacations. When in despair, I am just left with these thoughts about why I am cursed to be like this. Is this some kind of punishment for being attracted to boys all my life?

Taking up Rohit's case study under PCT, let us attempt to apply a queer affirmative lens to the PCT approach:

In contrast to the mechanistic approach of Cognitive Behaviour Therapy (CBT), Person- or Client-centred therapy is based on a more humanistic approach to psychology which, (as articulated by Abraham Maslow and Carl Rogers) lays emphasis on looking at individuals as unique beings capable of understanding themselves and reaching their full potential **(Rogers,** 1957). This approach rebelled against both, the psychoanalytic approach with its focus on unconscious motives as the basis of behaviour and feelings, and the behaviourist approach which emphasised the deterministic stimulus-response model of behaviour. PCT discarded the notion that people lack control over their motivations.

Contemporary humanistic psychology looks at individuals more broadly, taking on board three ontological methods: existential psychology, transpersonal psychology, and constructivist psychology **(Bland & DeRobertis,** 2017), which consider all aspects of the person in the context of subjective experiences, while highlighting maturity, meaning-making and values as contributors towards the person's becoming a "fully-experiencing individual".

This perspective informs Person Centred Therapy (PCT), which is a non-directive approach that focuses on facilitating greater understanding of the self by

providing conducive therapeutic conditions. The emphasis is on the attitudes and personal characteristics of the therapist, and the quality of the client-therapist relationship, as being the determinants of a successful therapeutic process.

> 'We think we listen, but very rarely do we listen with real understanding, true empathy. Yet [active] listening, of this very special kind, is one of the most potent forces for change that I know.'
> **(Rogers,** 1980, p. 116)

> 'It is the client who knows what hurts, what directions to go, what problems are crucial, what experiences have been deeply buried. It began to occur to me that unless I had a need to demonstrate my own cleverness and learning, I would do better to rely upon the client for the direction of movement in the process.'
> **(Rogers,** 1961, p. 11)

> 'When you are in psychological distress and someone really hears you without passing judgment on you, without trying to take responsibility for you, without trying to mold you, it feels damn good!'
> **(Rogers,** 1980, p. 12)

Some core ideas of PCT

Theory of Change

PCT talks extensively about facilitating and encouraging self-awareness in the client through a non-judgmental therapeutic climate by making use of signature therapeutic techniques of PCT like active listening, mirroring, reflecting emotions, using open-ended questions, and so on. This in turn opens the doors to greater self-acceptance and unhindered self-expression. Having a safe space enables the client to be less defensive and more open to self-examination. This further broadens self-awareness, and the cycle continues as the client develops more and more insights for and by themselves. In a queer individual's case, such a space is crucial to overcome the primary barriers to self-acceptance, which is one of the hardest unique life stressors to overcome.

Conditions of worth

These are circumstances when 'self-experience is avoided (or sought) solely because it is less (or more) worthy of self-regard' **(Rogers,** 1959, p. 224). What this means is that conditions of worth are what we develop when we take on board other people's values and ideas about how we should be. Conditions of worth refer to judgmental and critical messages from important people in one's life – messages which influence a person's self-concept and self-worth. When an individual has conditions of worth imposed on them, their self-image tends to be poor. Queer/trans individuals grow up with messages that reflect the Charmed Circle norms and values, their non-adherence to which means that they regularly experience discrimination and rejection. These conditions of worth impact queer/trans lives greatly, adversely affecting their self-image and consequently their mental health.

Incongruence

PCT speaks of bridging the gap between a person's real self (all of one's experiences, feelings, wishes, perceptions, self-evaluation, self-image) and ideal self (what one wants to be). The incongruence between the two selves prevents change and growth. Queer individuals often grow up with a notion of

the ideal self which reflects the normative – as that is usually the only template available or familiar to them. Because this ideal self is in conflict with their lived experience, it causes incongruence. Congruence is possible only when we accept who we are. Self-acceptance, then, is the key to bridging the gap so that one may live one's life in a manner that is authentic to oneself.

Fully functioning person

A person who meets their own need for positive regard rather than relying on others, would be considered a fully functioning individual. For growth to occur there needs to be a shift to an internal locus of evaluation. A healthy, non-judgemental therapeutic climate facilitates such a shift by encouraging self-awareness, and facilitating unconditional positive regard for the self. Constant experiences of social oppression often result in internalised homonegativity among sexual minorities, which becomes a barrier to this shift. PCT seeks to encourage the shift by providing the necessary conditions for it in the therapeutic space: therapist's congruence, unconditional positive regard, and empathetic understanding.

Self-actualisation

People have a tendency to work towards self-actualisation, which refers to developing in a complete way towards intrinsic goals, self-realisation and fulfilment, and involves both autonomy and self-regulation.

For growth to occur there needs to be a shift to an internal locus of evaluation. A healthy, non-judgemental therapeutic climate facilitates such a shift by encouraging self-awareness, and facilitating unconditional positive regard for the self.

Self-actualisation is considered one of the basic human needs (Rogers, 1957) and should be viewed in a subjective context. The gender-sexuality location of an individual will determine what they believe their self-actualisation needs are. For example, having a well-settled healthy family in a marital set-up may not be the self-actualisation goal of a queer individual as this is not an option they have. But coming out to one's parents or to significant people in their life may be a goal that some find worth pursuing.

Assessment of the problem and choice of techniques/ interventions

Some themes that may come up while working with Rohit's case are discussed here. As PCT does not have a prescribed set of techniques, the therapist's responses to each theme have also been explained.

Incongruence

We find Rohit repeatedly speaking of his own life in reference to the normative script. As when he says, 'All my friends and cousins are married, they have children, they celebrate festivals as a family, go on vacations.' It becomes apparent that his imagination of the ideal self is normatively constructed, while his "real" self might be that of a closeted queer person. This is a likely cause for incongruence within Rohit, causing distress as it translates into a big gap between real and ideal selves, so that he perceives himself as a man with no family and no chance at happiness.

In order to bridge this gap, the therapist may want to explore facilitating self-awareness through framing his feelings of frustration and loss as consequences of living in a heterosexist world that does not accept other sexualities and relationships as normal. **Active listening, paraphrasing, summarising and mirroring may be effectively used to make Rohit feel heard as well as validated.** Also, the therapist could explore with him some alternate ways of leading his life that might be more fulfilling – for instance, introducing the idea of chosen family, suggesting he could celebrate festivals in innovative ways that are in

alignment with his identity, having conversations about how he would like to dress, behave, act – and exploring safe ways of doing these. Once Rohit is able to recognise that the very social system in which he lives is discriminatory, he might be willing to explore how he would like to shape his own life. If the mainstream script did not exist, how does Rohit think about what he wants in life and how to achieve it? Being encouraged to think along these lines, in a safe therapeutic space, could help Rohit develop insights into his own life that would be more self-affirming and better aligned with reality.

Low self-image resulting from negative social evaluation

In Rohit's story we hear about certain externally imposed conditions of worth (criticism of his way of walking, talking, clothes; being scolded by teachers and bullied in the sports period; his father's pressure on him to conform; surveillance). Such normatively determined conditions of worth are commonly imposed on queer persons, leading to reduced self-worth – which Rohit articulates as, 'Why am I like this? . . . I am cursed to be like this. Is this some kind of punishment . . . ?' **A therapist, by providing a conducive therapeutic climate, can encourage Rohit to explore his uniqueness, celebrate his "different-ness", and come to a place of replacing external conditions of worth with internally generated self-value.**

Growth

Growth is possible in an environment of unconditional acceptance, positive regard, empathy, openness and genuineness – qualities sorely missing from the life currently lived by Rohit. From the way he speaks of his growing up years as a scary time, unlike the carefree and laughter-filled childhood others recall, it is evident that his being "different" had an immense impact on him, since he grew up in an environment that was neither nurturing nor enabling.

Tangible and intangible forms of oppression, and their impact on Rohit's life

Rohit experiences various forms of tangible and intangible oppression in terms of bullying,

abuse and discrimination, lack of access to a socially acceptable family, loss of privileges, and an inability to reach the milestones that mark the journeys of cis-het people. These oppressions cause him considerable distress, to the point of making him question the validity of his identity.

It becomes necessary, then, for the therapist to help Rohit firmly identify the heteronormative system as the source of these tangible and intangible oppressions. For instance, to explore why Rohit looks to certain milestones – where did they come from? and why can't he have them? Through recognising that these milestones are tied to what society considers valid and acceptable, Rohit might grow to realise that his aspirations are being defined and impeded by the social system, and not by his sexuality.

The therapeutic climate

Unconditional positive regard, congruence and empathy have the potential to counteract the experiences and effects of stigmatisation, gradually leading to an *emotionally corrective experience* in the course of therapy.

The nature of the therapeutic alliance obviously has an impact on the outcome of therapy, and a healthy alliance is possible when–

1. The relationship with the therapist is characterised by genuineness, openness and empathy – where there is no need for Rohit to hide, pretend, or fear rejection.
2. Rohit's efforts at survival and stigma management are acknowledged by therapist through:

    - ***Explicit validation***
      This could be necessary because such open validation may have been lacking in Rohit's life thus far, and would take into account the detrimental effects of experiencing the unique life stressors of growing up gay. Additionally, he may have experienced invisibility, erasure, invalidation, both from past therapists and in personal relationships outside the counselling

situation, and could well be afraid that his counsellor might be hostile and/or non-affirmative. Explicit validation would help reduce Rohit's anxiety and enable a meaningful therapeutic relationship.

- ***Role modelling***
  This would imply that the counsellor's attitude does not change upon Rohit's disclosure about his sexual orientation, but remains genuinely open because the counsellor is self-reflexive enough to recognise and address their own normative assumptions.

- ***Reflecting Rohit's emotions empathetically***
  This would enable Rohit to become aware of the intensity of the pain, loneliness and self-blame he has experienced, but never articulated. It would also facilitate self-awareness and, eventually, allow for healing and for a sense of increased self-worth – for the change in self-concept that is one of the goals of therapy.

- ***Mirroring, containment, and attunement with Rohit***
  We have spoken extensively about unique life stressors (see 3.2 & 3.3) – discussing isolation, alienation and invisibility. Explicit validation through mirroring works as the opposite of these stressors. Those aspects of the self that have been mirrored back to the client as their "bad self" by peers and adults (parents, teachers) while growing up, are mirrored back to the client by the queer affirmative PCT therapist in the light of the client's struggles with the heteronormative world – in Rohit's case, his efforts at survival, his resilience, and so on. Being attuned to the client, and thus being able to empathise with the client's loneliness and pain, and to contain these, are important processes in PCT. A knowledge of ULS only enhances the attunement and empathy.

While acknowledging that person-centred counselling –

with its emphasis on a genuine therapeutic relationship, validation, unconditional positive regard and empathy – enables sexual minority adolescents to experience healing and growth, **Lemoire & Chen** (2005) suggest three additional helping processes to compensate for the limitations of the PCT approach in responding to the special needs and contexts of LGBTQ+ clients. Besides explicit identity validation (as discussed already), these include guided risk assessment for the client in making disclosures about their sexuality, and positive exposure to sexual minority communities and socialisation. The counsellor thus plays several roles at once – person-centred therapist, supporter, information provider, and so on.

Neutral vs. affirmative stances

Neutral stance

1. A PCT practitioner might acknowledge and accept Rohit's childhood experiences and his pain and despair by focusing only on his being bullied or ridiculed, and not on the reasons for this.
2. The practitioner might merely reflect on Rohit's feelings, without seeing them in the context of the cis-heteronormative social structure in which he exists.
3. The practitioner, in acknowledging Rohit's inability to pursue normative life scripts, might inadvertently assert the validity of the Charmed Circle.

Affirmative stance

1. While reflecting back to Rohit his feelings of frustration, despondency and confusion, **the affirmative therapist would underline the role of unequal social structures vis-à-vis gender-sexuality in being responsible for these feelings.** This would put things into perspective for Rohit and help him to acknowledge that the problem does not lie in him but in an unjust society.
2. **The therapist, while facilitating self-awareness, could help Rohit realise that milestones in queer lives can be and often are different from normative milestones.** They could

demonstrate empathy by pointing to the extra work queer persons are required to do to recognise externally imposed conditions, their own internalisation of these, the impact on their self-worth – and then the labour of having to rebuild self-value in order to lead a fulfilling life.

3. **A queer affirmative therapist would empathise with and validate the experiences of trauma Rohit had while growing up; shed light on the role of society in causing that trauma, giving Rohit an anchor to make sense of all that he has gone through since childhood.** The therapy space would be a non-judgemental, safe space for him to talk openly about all that he has experienced, and to be seen and heard.

List any challenges faced while shifting from a neutral to an affirmative stance

What Neutral PCT could overlook–

1. The therapist, in a bid to be empathetic and convey unconditional positive regard, might come across to the client as tokenistic in offering validation, if the context of deprivation and of the ULS in queer/trans lives is not acknowledged as well.
2. Passive acknowledgment, or merely summarising and paraphrasing, will not help moving the therapy forward.
3. Real empathy will be difficult if the lived realities of queer people are not well understood and appreciated.
4. A PCT practitioner might fail to recognise that clients' notions of the ideal self are often based on normative scripts – which would make the therapeutic goal of congruence impossible, as the real self would always be incongruent with the normative for a queer client.

What MHPs can do in order to queer PCT–

PCT is, in itself, an approach that keeps the client at the centre, and therefore the direction of therapy is often client-led. **Its three pillars of congruence, unconditional positive regard and empathy are, by themselves, excellent tools to convey validation.**

However, these pillars cannot be very effective if the perspective and framework of unequal social structures vis-à-vis gender-sexuality is not recognised and brought up in the therapeutic process.

Each of the pillars can be queered in the ways described here:

Unconditional positive regard

1. Check your own prejudices/ biases regarding gender and sexuality.
2. Use your expert position to challenge erroneous notions about non-normative lives, if such references come up during the therapy.
3. Acknowledge, and respond with an awareness of, the Unique Life Stressors.
4. You may need to take on an influential/educative role, especially if you observe that the client's ideal self is a reflection of the normative.

Empathy

1. Familiarise yourself with queer/trans lived realities through active or passive knowledge acquisition – literature, films, articles, events.
2. Be open about your limitations: it always helps to state upfront your lack of knowledge and the limits of your experience.
3. Your willingness to listen and learn should be amply demonstrated.
4. Practice active listening at all times, as the therapy space is often the only space where queer clients can be themselves and talk about their lives without filters.
5. Go beyond simple encouraging open questions; reflect feelings and tie the client's experiences back to the systemic imbalance that favours the mainstream cis-heterosexual sections of society.
6. Validate the client's reality at every opportunity.

(All these represent ways of attempting to make invisible lives visible in a safe therapeutic space.)

Congruence

1. Do realise that genuineness cannot be faked; when you say it, mean it.
2. Familiarise yourself with queer affirmative language, and use it consciously.

3. Make the therapeutic space affirmative in terms of the décor; have books and pictures that affirm queer realities.
4. Do not hesitate to offer a bit of self-disclosure, if you sense it could be helpful.
5. Train your staff to be affirmative, sensitising them about queer realities and equipping them with queer affirmative language.
6. Make queer resources available, or guide the client toward resources which reflect non-normative lives.
7. Finally, while doing all of the above, be genuine, and in case of errors be quick to acknowledge these.

6.2.3 Queering Narrative Therapy (NT)

CASE STUDY

I think the idea of "Trishanku" (a king in Hindu mythology, who lived suspended mid-air between heaven and earth) best describes my early psychic life. It is this sense of belonging and un-belonging, togetherness and alienation, all at once, that I constantly experienced. I will narrate an incident, as example, from the time I was 12 or 13. There was this festival called Bhondla being celebrated in our chawl. This is a Hindu Maharashtrian celebration by young girls and women, usually during Navratri, in which the women go around a rangoli with an elephant motif at its centre, holding hands and singing traditional songs. These songs are mostly about the relationships of married

contd.

contd.

women with their in-laws and husbands, and also about the fertility of the soil and of women.

That evening, everyone had started gathering in the courtyard for the songs and prayers, and I was very uncomfortable about participating in this ritual. I guess, it was just this idea of celebrating marriage, and the banter between women about conjugal life, and young girls jokingly being given life lessons by their mothers and grandmothers about how they should look, groom, behave, sit, walk and talk in order to be blessed with a good husband – all this just made me sick. So I was sitting at home trying to do some homework and hoping that I could avoid the whole thing. That's when my father insisted that I join my mother and elder sister in the festivities. I tried going down and coming back up a couple of times, only to be yelled at by father for not going out and being with girls my age. After this, I remember spending that whole evening hiding below the staircase of the first floor, the floor between the courtyard and my parents' house. This is what I mean by "Trishanku" – being in limbo, not belonging, neither inside the home nor outside it! Over a decade later, I still have the same question, 'Will I ever belong?'

[Excerpt (edited) from the book 'Growing Up Gay in Urban India – A Critical Psychosocial Perspective' (Ranade, 2018) Prelude, Chapter 3 Exploring Early Years: Childhood and Adolescence of Young Gay and Lesbian Persons, p.61]

Taking up this case study under NT, let us attempt to apply a queer affirmative lens to the NT approach:

Possible themes for exploration

The theme of belonging is quite present in the narrative. Is its absence a desire for it, and is the client perhaps wondering which space or identity has the potential to offer it? It challenges the practitioner to think of belonging as far more complex than finding a box in which to fit. What does one do when the boxes that are available are not viable options? The gender binary as a box leaves out so many realities and lives – for instance, this client may be nonbinary, where their felt gender does not find any reflection in the man-woman gender categories.

This is also the practitioner's struggle – that the therapeutic journey may not have to do with finding out whether the client wants to find a home in the "man" or "woman" box, or to learn to fit into the world of either sister, mother, grandmothers, or of the disciplining father. This is the moment to foreground how the idea that there are only two genders, man and woman, is a constructed idea, not a scientific fact.

Queer theorists emphasise the need, when working with dominant understandings of gender and sexuality, to ask, 'Who do these categories serve? Who do these categories include and whom do they exclude? Who has the power to define the categories? How are the categories policed? How do these categories change over time and across cultures?' **(Doty,** 1993, as cited in **Nylund,** 2016, p. 97).

These questions offer much scope for exploration, healing and strengthening in the case under discussion, given how exclusion, policing, and the status quoist agenda are all present in the narrative.

Some core ideas of Narrative Therapy

(ideas that lend themselves to the queer affirmative lens)

1. Problems as separate from persons.
2. Clients as expert of their own lives.
3. The power of stories and

language to shape lives and experiences.
4. An awareness of how power differences and social hierarchies shape our experience and understanding of our lives.
5. Challenging dominant discourses that are social projects put in place to uphold the status quo.
6. The concept of "dominant stories" or "problem stories", and "preferred stories" – the former referring to that which society and the dominant structures produce; the latter referring to those stories that people want to tell about themselves, and which they experience as strengthening.
7. Working with preferred stories or alternative stories as a political task.

Assessment of the problem and choice of techniques/ interventions

What is the client distressed about?

The distress comes from being expected to fit into the gender assigned at birth from which the client, who is a teenager, feels disconnected – asked to participate in gendered rituals which, to quote the client, 'made me sick'. We first need to discuss the problem story of unbelonging and being alienated, and establish what type of dominant discourse is at work here, before going into a preferred or alternative story.

In the problem story, there is an articulation of difference, but also of this being a "bad" difference. The individual has been experiencing the consequences of not fulfilling "good girl" cultural expectations for over a decade. This is reflected in the question that is still being asked a decade after the incident narrated, 'Will I ever belong?' There is also the sense of 'being in limbo', and the "Trishanku" image of a person 'suspended mid-air', which should alert the practitioner to the psychic experience of this client – of being at odds with the dominant gender binary scripts of the Charmed Circle. All of which indicates the need to explore, in this case, the rigidities of the gender binary, which do not appear to reflect the client's gender, thereby causing a sense of unbelonging.

How is the act of hiding framed in therapy?

We want to highlight that "hiding" is usually associated with shame. The therapist may want to open this up for the client and, in the process, explore some of its other meanings – such as self-protection, survival, resistance – which can help to construct the alternative story. Hiding below the stairs becomes, then, not an act of shame or even simply of escape, but one of resistance. It is also an act of self-protection. To see it in these ways, it becomes necessary to interrogate dominant understandings of resistance. For instance, being in the closet could be understood as an act of self-protection as well as indicating the lack of safe spaces.

Naming the problem

Society has not created space for this client's lived realities, or for felt experiences of gender that do not conform to the binary. Therefore, in naming the problem, the gender binary system must be named. More specific formulation for this case could include feeling sick when in a traditionally feminine ritual space. The rigidity of the gender binary system would be the underlying reason.

Using the externalisation technique

The client has been experiencing the consequences of not fulfilling cultural gendered expectations for more than a decade. Is it something about their self that is responsible for the distress, or is the distress caused by social norms?

Deconstructing the problem, as used in NT

This would involve mapping the effects of the problem on self-esteem and identity. Externalising questions like the following may be asked, to help in deconstruction–

1. What are some of the other occasions that make you "feel sick" in similar ways?
2. How have these experiences of feeling sick made life difficult for you?
3. Were there times when you did not succumb to this sick feeling during activities involving girls and women? Describe these.
4. Were there times when you felt good or at ease

participating in some activity/ celebration that felt less gendered, or gender neutral?

The practitioner who recognises that the client's distress stems from the binary genders being the only available options for belonging could pick up the "not belonging" itself as the thread to develop the alternative story – the aware and queer affirmative practitioner could then speak of being nonbinary (NB) as a valid locus as well as a gender identity. The practitioner could also explore with the client the possibility of using pronouns for themselves that better reflect their gender reality – "they", for instance.

The practitioner who recognises that the client's distress stems from the binary genders being the only available options for belonging could pick up the "not belonging" itself as the thread to develop the alternative story – the aware and queer affirmative practitioner could then speak of being nonbinary (NB) as a valid locus as well as a gender identity.

Re-storying/re-authoring

Buttress the validity of "not belonging" by referring back to the "Trishanku" image and feeling, and providing the client with nonbinary/genderqueer resources. Since cultural metaphors and stories are significant in the practice of NT, and the client's narrative has multiple such references (Bhondla, Trishanku), the therapist may want to explore using metaphors that speak to ideas of belonging and un-belonging. A participant at our QACP course in Bengaluru had narrated an alternative story from Tamil Nadu, of Trishanku as king – not suspended mid-air, but having his own space and his own kingdom to rule. Re-authoring is thus an exercise in finding your own voice through the noise of problem story and, in this case, the dominant discourse of gender binarism.

Thicken the alternative story, too, by recognising and validating the client's acts of resistance such as hiding on the stairs. In the language of narrative techniques, what might a "unique outcome" look like, in this case? The hiding can be understood as self-protection, in place of rebuke by the father, and experiencing distress or feeling sick through having to be part of a traditionally feminine ritual space. Hiding also becomes an act of resistance by the client against forcibly imposed and enforced norms.

Neutral vs. affirmative stances

Neutral stance

The problem story appears to be one of not belonging. The neutral therapeutic exploration might be towards finding spaces to belong within the existing normative system. The therapy would then end up pushing the client to fit into either of the two gender categories, woman or man. Neutral practice might even support and validate the client's sense of being different from the expected social norms for femininity, yet erase the client's gender identity as being different from that assigned at birth.

Affirmative stance

1. **The client would not be pushed to fit into any binary gender box, as neither box fits.** Bringing the rigidity of the gender binary structure into the picture would alter the client's relationship with the problem story – through placing the onus for distress on the gender binary, and showing how there is no space in it for the client's gender experiences. This should help the client recognise that the problem does not lie within but outside them.
2. **The alternative story would not be about finding belonging in the normative, because the normative cannot and will not offer it.**
3. **Exploring belongingness with the client:** For what kind of world would you want to get out from under the stairs? In what kind of world do you feel you could be who you are? Imagining the answers to such questions may help with re-storying the person's ideas of family, community, relationships and future aspirations, hopes and

dreams. The therapist would play a role in linking the person with the resources they need to move in these new directions.

4. What would some of the core themes of the new narrative be, and how might these be thickened? **Explore discovering with the client the joys/freedoms possible in the Trishanku position.**
5. How to sustain the new narrative? **The therapist could encourage the client to explore journaling, to write letters to their old self and/or future self, besides connecting them to useful resources.** After assessing the readiness of the client, the therapist could help with introductions to community and activist spaces.

List any challenges faced while shifting from a neutral to an affirmative stance

What Neutral NT could overlook–

1. Stories that do not fit normative ideas of resistance may never get recognised as resistance or subversion; hiding, for instance, could be construed as an act of shame. When working with the marginalised, it is important to examine and question normative notions of resistance – in which values such as "honesty", "bravery" and "struggle" are often defined by the oppressors.
2. Resources in the form of stories of lives and experiences outside the Charmed Circle are not many, in comparison with the popular narratives produced within the Charmed Circle. Thus the risk exists that the client will be guided to stories that reinforce norms rather than to stories exemplifying resistances.
3. There may be an abject absence of outsider witnesses. There are clients who are able to bring their queer selves only to therapy perhaps, and are self-censoring as well as getting erased in every other space. This means that there is no one performing that witness role for the client, particularly within normative kinship systems.

What MHPs can do in order to queer NT–

1. **Use the queer lens to name the problem.** The therapist as the de-centred yet influential person in the therapeutic space deploys this influence to name the problem in ways which show an awareness of cis-heteronormative knowledge systems.
2. **Recognise that the sense of feeling stuck or being in a limbo is very much a part of the experience of living a queer life within a heteronormative structure.** This should not be minimised, since the life trajectories of queer/trans persons are often impeded unless their gender and/or sexuality are validated. This is crucial so as to avoid coming across as "focusing on other aspects" when the client is sharing distress related to gender-sexuality. Gender-sexuality locations are not an issue in therapy for cis-heterosexual people, because that fundamental aspect of the self is not under question or attack.
3. **Recognise and put together all the micro resistances, in order to thicken their presence in the alternative story.** Bring to light acts and situations of resistance that might go unnoticed by even the client themselves.
4. **Perform the role of "outsider witness" in the absence of others.** Also, look for witnesses outside the normative systems of family and kinship. Because families of origin may not accept and validate queer/trans realities, the MHP will have to look beyond these for such witnesses. Clients may themselves devalue those witnesses who do not belong to their normative kinship systems, but the MHP can support the client in recognising the value of witnesses from, say, the queer communities.
5. **Use the queer community as a resource for thickening alternative stories.** Stories of hope and of possibilities can be drawn from communities of people who have had similar struggles. Ways to cope, information, and solidarity can be sought from the wider queer community. (see 4.3 – 'Community as resource').

6. **Trace the links between dominant norms and certain scripts that are popular in queer/trans communities.** Queer/trans communities may also have norms that reflect the dominant scripts. For instance, a certain kind of masculinity may be valued in some gay circles. Or cis queer people may erase nonbinary gender. When a client faces discrimination within a queer/trans community, it would be the MHP's role to point out how those discriminatory ideas, too, are a reflection of larger societal norms.

6.2.4 Queering Family Therapy (FT)

CASE STUDY

My name is Daisy, and these are my parents David and Rosemary. To give you a bit of a background on why I sought an appointment with you, I am 32 years old and have been working in a software company in Bombay for eight years now. I have a place of my own and I'm doing pretty well for myself. My parents have been pushing marriage on me for a decade now, and I have managed to get away by using the excuse of studies, and then work and career. I did not tell them the real reason for me not wanting to get married, primarily because I know them and I knew how they would freak out. They do love me, but I don't think they get me. Even when I was buying this flat where I stay now, there was this constant bickering about why do you need a place of your own, it is so small, the locality is not great, why don't you just stay at home with us…?

contd.

David: But we have accepted that you have chosen not to live with us, and we have also accepted that you don't want to marry, haven't we?

Daisy: Accepted?! What do you mean accepted? You can't even yet say the word "lesbian" – not out loud, maybe not even to yourself… And about me moving out of the house, what else would I do? Would it be okay if I brought a girlfriend home? Would you be nice to her and offer her wine like you do with the wives of both my cousins?

David: I did not know that this was the real reason for your moving out. You have always told us that it makes financial sense to buy property in Bombay and for tax purposes and all that… Now I am hearing the truth for the first time here, in front of the counsellor.

Daisy: Papa, the reason why we are here is that there are many things we are not able to talk to each other about, and I don't enjoy hiding things from you.

Rosemary: We know that, beta. You have always been a very good daughter to us. We have been very proud of all your achievements always. We want to be supportive now too, but maybe we are old-fashioned. We worry about you. We are not sure how will you be treated if people find out – even in our own family, how will people look at this? What will your future be like? You don't even have a brother or sister to look after you when we are not there anymore. You will say all this is silly, but I worry about all this as a mother.

Taking up Daisy's case study under FT, let us attempt to apply a queer affirmative lens to the FT approach:

The very terms family, marital, or couple therapy have been critiqued as being heterosexist in nature, and thereby not inclusive of or responsive to families involving gay, lesbian, bisexual persons **(MacKinnon & Miller,** 1984). However, much is changing in the field of family and couple therapy, at least in some western parts of the world. A content analysis of 17 journals of marriage and family therapy between the years 1975-95 revealed that a total of 77 of 13,217 articles focused on gay, lesbian, bisexual issues **(Clark & Serovich,** 1997), while a follow-up study of articles focusing on LGB issues between 1996-2009 revealed the number to have increased to as many as 8,781 articles in the 17 journals considered **(Hartwell et al.,** 2012). In many of these articles the field of family and couple therapy is seen to be undergoing major shifts, with several researchers and therapists attempting to articulate ways in which family therapy principles may be adapted, through reflexive praxis, to be inclusive and affirming of same-gender sexuality. In this section, we attempt to do this through one case example.

Assessment of the problem and choice of techniques/ interventions:

Family Life Cycle Stages

One of the ways to assess problems within the family is by asking at what developmental stage the family is, i.e., its *Family Life Cycle Stage*. These stages derive from a system of categories that divides the family's life into segments, each characterised by certain transitions and by changes in family status. Traditionally, these stages have been defined in terms of the presence and ages of children in the household, for instance Duvall's (1977) eight stages that start with a married couple without children, going on till Stage 7 – the middle-aged couple with an "empty nest" (their last child having left home), and Stage 8 – the aging family (from retirement to the deaths of both spouses). The most obvious problem

with this categorisation is its lack of universal applicability, since it takes account only of heterosexual, nuclear family units, and is rooted in a specific cultural-historical context. Even so, these stages as well as the emotional responses of each family member to the transitions at each stage are seen as having significant value in guiding family therapy work.

If we were to assess the family of Daisy, David and Rosemary using the lens of family life cycle stages, this family would be at a stage called "Launching Family" **(Duvall,** 1977), or youth launching into adulthood, which begins when the oldest child leaves home for education or work, and eventually starts their own family. What are called "second order changes" in family status at this stage include certain tasks: accepting multiple entries and exits from the family; a re-alignment of relationships to include in-laws, grandchildren, and so on; maintaining a supportive home base for the child who is launching out; the development of an adult-adult relationship between parents and children; and the renegotiation of the marital structure as a dyad, i.e., the parents are a couple again, a dyad, with the children having launched out **(Carter & McGoldrick,** 2005). This is a textbook example of what happens at the Launching Family stage. However, what does this stage look like when it is a queer adult child being launched? When, as in Daisy's case, the act of leaving home is not for higher education or work (she has a job in the same city), nor to get married and move in with husband and in-laws? When the launching out is not for any of the reasons experienced as "valid" because they are socially sanctioned, what is the heteronormative family's emotional response? Are they in denial? Confused? Overwhelmed? Are they resisting the launching out? Are they perhaps in (passive) denial, refusing to acknowledge this as launching out at all? Daisy's words, '…there was this constant bickering about why do you need a place of your own, it is so small, the locality is not great, why don't you just stay at home with us…?' suggest resistance on the part of her parents to her launching out. The fact

that Daisy herself has used the excuse of "tax purposes" to buy a place of her own suggests her own participation in the family's resistance, and her difficulty in drawing boundaries or at individuation. If the family is unwilling to acknowledge its status as a launching family, then the second order changes required of the family system, for instance welcoming new members into the family, realigning family relationships, or developing an adult-adult relationship between parents and child, would become challenges.

While acknowledging that the theory of family life cycle stages, as originally conceived, may not fully speak to the queer/trans experience, it still acts as a useful tool to understand the heterosexual parental sub-system and some of its struggles in response to the coming out of their child, and the child's difficulty in asserting boundaries in response to parental resistance. Do Daisy's parents see the daughter's moving out, without marriage as a reason, as their failure to launch out their only child? Exploring parental feelings about this could be significant.

Some further themes that would need to be explored in the course of assessing the family's problems are–

Acceptance

The term "acceptance" has been used by the father in the context of the daughter choosing to move out of the natal home and choosing not to marry. There has been an expectation of heterosexual marriage for a decade, and now there is this claim about acceptance – what has the process of this change been like for David? Exploring what David means when he says "acceptance" could provide the therapist with some useful insights.

The mother uses another idea affectively related to acceptance, that of wanting to "be supportive" of her daughter's choices, adding, 'but . . . maybe we are old-fashioned.' Exploring what she means by "old-fashioned" could provide insights into the mother's (and parents') ideas of sexuality and morality. The mother says, 'You have always been a very good daughter to us. We have been very proud of all your achievements.' Yet she also

asks, '. . . how will people look at this?' which seems to imply, 'How will they treat you if they discover the truth?' – and the underlying emotion, then, might be worry, or shame, but it is certainly not pride. Is the mother, Rosemary, making a distinction between being proud in her daughter's achievements and being proud of her daughter? What does Daisy hear? If Rosemary were asked to repeat the statement to Daisy, in the session, and Daisy were asked to elaborate on what she just heard, it could help to open up a conversation on how the parents see Daisy as a person, and also on how they see Daisy as a queer person.

Communication

The family seems to be struggling with communication, as reflected in Daisy's statement, '…there are many things we are not able to talk to each other about…' If we consider the dialogue about acceptance between Daisy and her father David, it seems that Daisy wants more open communication about her being a lesbian. She wants to be able to talk to her family about her girlfriend, and wishes them to engage with each other. It appears that David is stonewalling any "real", affective communication by saying, 'But we have accepted that you have chosen not to live with us, and we have also accepted that you don't want to marry, haven't we?' – as if to say, 'What more do you want from us?' David may be expressing his underlying disappointment, disapproval, even homonegativity and denial of his daughter's queerness, while overtly and verbally speaking of acceptance.

Another paradoxical bit of communication between David and Daisy occurs when David says, in a near-accusatory tone, 'Now I am hearing the truth for the first time here, in front of the counsellor,' implying that he has been open to this particular point of communication (that his daughter is lesbian), whereas it seems he has resisted the communication. Daisy's frustration at this is reflected in her words, '…I don't enjoy hiding things from you.'

The overall sense gained from the conversation in the session is that Daisy is taking on an active

role in communication, and is seeking an open dialogue with her parents, while simultaneously attacking the parents, particularly the father, in response to his stonewalling (possibly to provoke a response). Rosemary seems to play the traditional role of pacifying both father and daughter, but also communicates her own ambivalence towards Daisy's sexuality.

Worry

This is a theme that Rosemary introduces into the family dialogue, when she connects worry for Daisy with her own role as a mother. She also evokes Daisy's status as single child, with no siblings to look after her when her parents are gone. Rosemary's words of worry refer to what she sees as an uncertain future for Daisy. Interestingly, Rosemary does not even mention, or take account of the fact that Daisy has a girlfriend. We do not hear of efforts made by Rosemary to assuage her worry for her daughter by engaging more with her queer life, her girlfriend, trying to find out if Daisy is happy, feels loved, cared for, and so on. Do Rosemary's words, 'What will your future be like? You don't even have a brother or sister to look after you when we are not there anymore.' communicate nothing more than a mother's worry for her child? Or is there some homonegativity, disapproval, judgement here?

Anger

Daisy expresses her anger at not being heard, seen, acknowledged by her parents. This anger is met with attempts at pacifying her (without any real change, or acknowledgement of Daisy's queerness) by Rosemary, and stonewalling by David, both leading to Daisy's increased sense of being let down, discriminated against and wronged by her parents. If this kind of conversation were to become an established pattern between the three of them, Daisy might well be pushed to *act out* even more, only to be further invalidated and possibly labelled as aggressive, domineering, disrespectful towards her father – she could then be seen to be performing the classic stereotype of "man-hating, angry lesbian". In order to break this cycle, it may be useful first to help Daisy give a name to her feelings, i.e., anger,

hurt, feeling invalidated, and so on, and then to frame these feelings in the twin contexts of homonegativity and prejudice within the family, and of their double bind communication – worry vs. erasure of her queerness; acceptance vs. stonewalling; pride vs. a refusal to acknowledge Daisy's sense of being treated unfairly. This would validate Daisy's feelings and help to change the current pattern. Perhaps, the next time around, it will not be Daisy making the follow-up appointment with the family therapist, but one of her parents! In any case, making space for Daisy to express how she has been feeling since she came out to her parents would be significant to break the current status quo in the family.

Having explored some of the emotional content (or even before that), the questions that must urgently be asked of this family are, 'Why are you in therapy? What has brought you here? Which of you came up with the idea of family therapy, and what were the responses of the others to the suggestion?' Answers to these questions would not only help to assess what the problem is, i.e., how it is perceived by each family member, but would also be of use in setting some intermediary and long-term goals.

It would be a good idea to explore the actual event of Daisy's coming out to her parents, in terms of when it happened, what the immediate reactions were, what their pre-disclosure relationships were like. Did they have a sense of cohesion as a family unit, what was the extent of interpersonal safety between them before the disclosure, what has changed with the daughter's coming out? And then ask if she has changed completely for them from who she was because she is queer? The responses to such questions would help to understand the current impasse and to assess the family's motivation to work through it. Taking up some of these questions in a joint session would enable each member to listen to each other and to understand the beliefs, limitations, challenges faced by each member – possibly enhancing mutual empathy. The cautionary note here is that when it comes to young queer persons,

listening to the deep-rooted homoprejudicial attitudes of their parents may be more harmful than helpful; in the case under discussion, the therapist may want to make informed decisions about which issues to explore in joint sessions and which to keep for discussing with the parents alone.

Family Psychoeducation

The therapist may consider a few sessions of family education that debunk common stereotypes related to being queer, address questions that the parents may have, provide queer affirmative resources (books, films, information on parent support groups, queer events), and so on. **Sanders et al.** (2000) suggest the use of an affiliative (relational, romantic) understanding of gay and lesbian persons while working with families and parents instead of a sexual (genital) conceptualisation that tends to reduce the whole person and their sexuality to the sexual act. While this could be read as downplaying the sexual, sanitising queer sexuality and replacing it with "respectable" ideas of love and romance, it can be a useful initial strategy to help parents engage more with their queer adult child.

Family education may include–

1. Helping family members to go beyond stereotypes about queer persons and to engage with the queer/trans adult child and their life so as to understand them better. Several worries that parents have may be related to stereotypes to do with promiscuous lifestyle-related illnesses, depressed and lonely old age, rampant substance abuse in the queer sub-culture, and so on. These notions can be debunked.
2. Helping parents move from a place of shock and grief, of treating the news of their child's queerness as a tragedy or an unfortunate accident, to treating difference as enriching rather than diminishing. In the case of Daisy and her parents, encouraging the parents to engage with their daughter's partner and get to know their relationship better can make queerness more real and relatable for the parents.

Locating the source of distress

Help the parents locate themselves within the Charmed Circle – help them to recognise, explicitly, the privileged position they have long occupied through the social structures that give them social respectability; and to acknowledge their difficulties in coming to terms with the fact that their queer adult child will not occupy the same position, and they too will face social disapproval by virtue of being her parents. Actively discussing, in family sessions, the consequences of being outside the Charmed Circle and the unique life stressors of queer persons, is useful to build empathy for the queer child as well as to help the queer person see why their parents are struggling. This mutual empathy can help in placing the problem outside the family and naming it for what it is – the wider system of heteronormativity and heterosexism!

Actively discussing, in family sessions, the consequences of being outside the Charmed Circle and the unique life stressors of queer persons, is useful to build empathy for the queer child as well as to help the queer person see why their parents are struggling.

It is important that mapping positions of power and marginality vis-à-vis the Charmed Circle is not done merely as a cognitive exercise. The emotional valence of positions within and outside it needs to be deeply explored. Taking specific examples from the parents' and adult child's lives, for instance, the MHP could explore the emotion behind Daisy's question to her father, 'Would you be nice to her and offer her wine…?' Or ask the parents to reflect on the specific occasions when they have participated in making fun of and telling jokes about queer sexuality – and to think about what it was that gave them the confidence to believe that their relationship could be celebrated through marriage and anniversaries, while other persons' could be looked down

upon, laughed at? It is important to keep emotions and their interpersonal effects at the centre of the therapy while exploring power.

Framing the parents' struggle with their daughter's queerness as a response emerging from a homoprejudiced society, as opposed to locating the problem within the daughter or her sexuality, is to use an important tool in QACP – helping the parents to see that their feelings of shame and disgust surrounding queer sexuality are socially constructed could even be quite liberating for them. Affirmative work with parents is also about reframing the cultural trope of parents as protectors to include parents as protectors of queer children against a heterosexist society. The ways in which parents can support and mitigate their child's struggles in a heterosexist society – extended family, workplaces, neighbourhoods – could be discussed.

Family rituals

Prescribing family rituals is a significant tool used in systemic family therapy, especially in the context of familiarising parents with queer lives and communities. Heteronormative rituals may be modified to include for instance, having weekly family meals that include the adult child's partner, attending LGBTQ+ family support meetings, going for an LGBTQ+ film festival together, planning a coming out celebration for close friends and family. In our research with families of queer persons **(Ranade et al.,** 2016), we encountered families where parents planned such parties for close friends, siblings, nieces and nephews, and so on, to come together as a family and talk about their adult queer child in an affirmative way.

Malley et al. (1999) tell us that rituals, both public and private, are important, as they mark the significance of relationships and of the responsibilities these entail. Public rituals may be key to recognition for a same-gender relationship among a wider circle of friends and family **(Slater,** 1995).

Family therapy intervention with Daisy's family could move from exploring initial responses,

Affirmative work with parents is also about **reframing the cultural trope** of parents as protectors **to include parents as protectors of queer children against a heterosexist society.**

and parental education about queer lives, to reducing anxiety within the family system, facilitating individuation and redefining family rules, roles and boundaries, with the parents acknowledging the couple sub-system of Daisy and her girlfriend.

Inducing Crisis

Some strategic family therapy interventions, such as inducing a crisis into the family system, may be tried with the family under discussion in case of an impasse. This would include getting Daisy's parents to articulate their worst fears related to their daughter's queerness, for themselves and for her as well. This may help with reducing any catastrophisation in which the parents may be engaged. It could also include discussing with the parents the possibility of what is referred to in research literature as parentectomy/siblingectomy, i.e., the queer person may completely cut themselves off from the family of origin and choose a family for themselves where the parents or siblings have no space. It is

important to note that such a strategic intervention, particularly inducing a crisis into the family system, is a well-thought-out intervention, meant to break an impasse, and is generally not done in the initial stages of therapy. With that caution in mind, a therapist employing the last-mentioned intervention may want to introduce into the family system the radical idea that parents have to earn the right to be part of their queer adult child's life **(Sanders et al.,** 2000). This would be a decisive shift from parents treating their child's queerness as a tragedy that they need to mourn.

Neutral vs. affirmative stances

Family in India is socially and legally defined as a group of persons related by blood, adoption, or marriage, and this is the perspective that dominates family studies in India. Thus a neutral approach in family therapy would not recognise queer relationships to begin with; harmful practice would prescribe a "cure" for the child's homosexuality, or attempt to establish causation for the homosexuality by delving into family pathology. If a family therapist were to acknowledge queer sexuality without pathologising it, the neutral stance would be to use the existing heteronormative lens to understand queer relationships and families. Moreover, the heteronormative family would be the gold standard against which all queer experience would be measured/understood.

In the case of Daisy and her parents, a neutral practitioner might empathise with the parents' shock or grief at hearing about Daisy's queerness, and choose to support them in moving forward in the grief cycle and reconcile with the reality through acceptance. However, such a practitioner is unlikely to explore the question of why queerness should be considered a tragedy at all, or a cause for mourning. Neutral practice is unlikely to move beyond acceptance to open the path for celebration and pride. The neutral practice stance would be that the practice does not change/differ based on the gender-sexuality of the client. In other words, there is no recognition of the stressors unique to queer/trans lives in

neutral practice, nor is there a need felt to educate oneself about and engage with affirmative resources about non-normative gender-sexualities. In the absence of knowledge about the unique stressors and challenges queer persons face, and due to a lack of engagement with queer lived realities, the neutral practitioner would be likely to overlook the sense of unfairness and of being discriminated against, that underlie Daisy's anger. Thus, Daisy's anger or hurt would be framed merely as resulting from parental disapproval, on par with other forms of parental disapproval related to an adult child's choices – the choice of, say, vocation, or of spending habits, and so on. However, the parents not being able to say the word "lesbian" goes beyond such simple parental disapproval.

A neutral approach that is not informed by a lens of queer lived experiences and by an analysis of heterosexism would miss the multiple meanings of Daisy's questions, 'Would it be okay if I brought a girlfriend home? Would you be nice to her and offer her wine like you do with the wives of both my cousins?'

A neutral family therapist is likely to hypothesise this family's problem as gendered coping responses to the daughter's coming out – the father engaging in problem-focused coping, and talking about acceptance and moving on; the mother engaging in emotion-focused coping, continuing to worry about society and relatives. This would be a partial and limited, and therefore unhelpful, understanding of what is going on with the family.

List any challenges faced while shifting from a neutral to an affirmative stance

1. The idea of "real" family as people related through blood, adoption, or marriage, and thus carrying a sense of fixed membership in the family unit that lasts forever and is unchanging, may be resistant to change. This is possibly one of the biggest challenges in bringing a queer affirmative lens to bear on family and couple therapy work.
2. Most FCT theory and practice that informs training and curriculum is based on work done with heterosexual families (mainly nuclear,

urban families), which makes it that much harder to learn about the unique stressors experienced by queer couples and families.

3. The gendered nature of the roles of family members in traditional family therapy theorisation is based on the binary understanding of gender, with women playing expressive roles and men playing instrumental roles within the family system. This has been critiqued – contemporary family therapy training invites trainees to engage, for instance, in an assessment of roles, leadership and decision-making patterns while being self-reflexive and not imposing traditional gender roles on families who come to the clinic. However, articulations of gender beyond the binary, and the possibilities of gender transition, are not discussed in-depth in family and couple work.
4. Finally, a critical analysis of power that goes beyond the interpersonal contexts in the family system – that includes an understanding of the normative construction of gender-sexuality as well as of the implications for the individual psyche of being non-normative, and of the individual's consequent position within the family system – is currently absent in FCT training. The absence of such a framework for how the "normal" is created and perpetuated by the family (along with other social institutions), and the implications of this socially constructed normal and abnormal for clinical practice, constitutes one of the major obstacles to a more general shift from the neutral lens to the affirmative.

Conclusion

The main purpose of this chapter was to demonstrate the skill(s) of queer affirmation, and how any therapeutic approach may be made responsive to queer/trans realities by applying a queer affirmative lens, or framework. Each case study was discussed using a step-wise methodology to help MHPs think through how to make their assessments and interventions more affirmative. We believe this step-wise reflection is necessary, because the ways in which we are taught to think is heteronormative. Thus, our first responses to a client's concerns may well come from a neutral/normative space. Awareness of this possibility, and a deliberate attempt to make our responses affirmative, are crucial. Any approach being used by the practitioner can follow steps similar to the ones discussed so as to arrive at a more affirmative assessment and intervention. MHPs are encouraged to practice this with the approaches they use. We would like to reiterate here that queer affirmative work does not advocate that we do away with existing therapeutic approaches and techniques. On the contrary, all approaches have the potential to be queer-responsive when situated within a queer affirmative framework, which includes building our perspective about, and knowledge of, queer/trans lives. The chapter also urges MHPs to reframe the therapeutic approaches they use by "queering" them.

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Illustration: Parth Pawar (@artwalahoe)

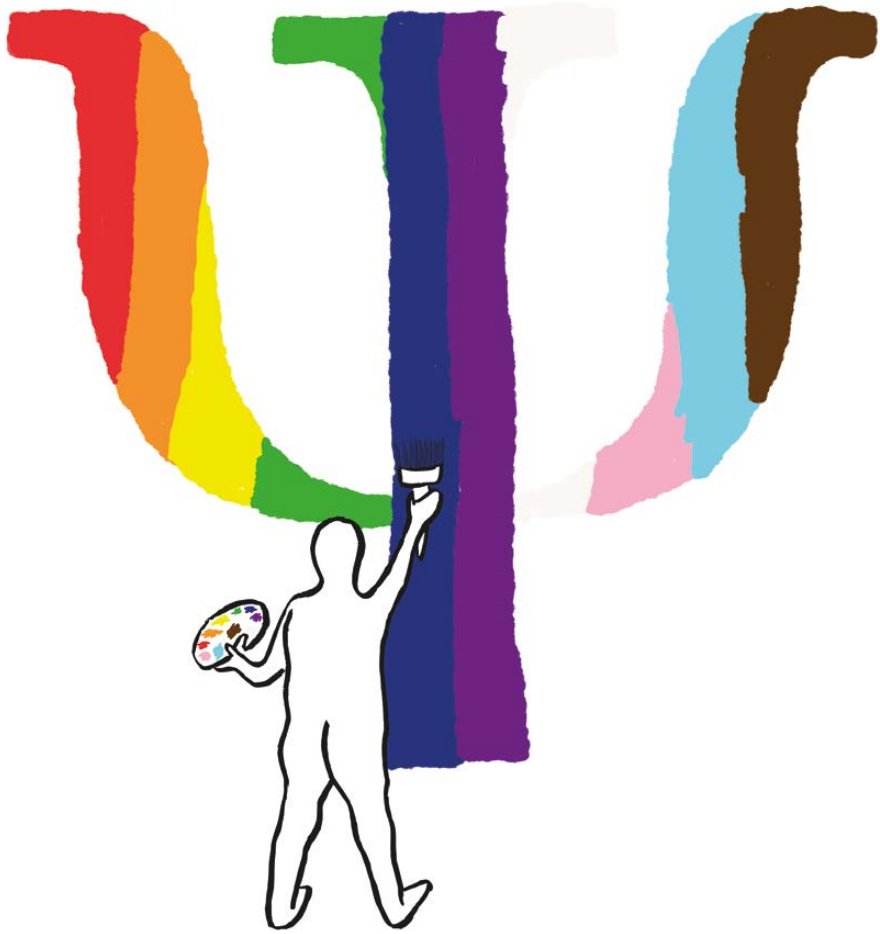
Queering Some Clinical Ideas

Queer affirmative counselling practice (QACP) is not only about working with those marginalised by gender-sexuality but also about intersectionality, social justice and questioning existing dominant narratives. QACP provides a blue-print to question and challenge, to start working from an anti-oppressive framework. This knowledge can be applied to challenge all systems that are discriminatory, thereby QUEERING MENTAL HEALTH.



CHAPTER 7

Queering Some Clinical Ideas



7.1 Revisiting mental health care emergencies from a queer lens – reframing suicide and self-harm

In the previous chapters of this resource book, we have used the terms queer as well as queer/trans as signifiers to refer to persons and identities that fall outside the normative grid of sex-gender-sexuality. In this chapter, we use queer as a verb, to queer or queering something, i.e., to trouble, make strange, disturb certain concepts and ideas considered to be givens in our knowledge systems. These concepts are not limited just to gender-sexuality; we suggest here that queering a range of ideas and practices within our disciplines can be productive. Hence the title 'Queering Some Clinical Ideas'. In this chapter, we try to queer three broad clinical ideas/domains: suicide and self-harm; sexual dysfunction and disorders of sexual preference; and, finally, ideas of recovery and healing as they exist within the psy disciplines. While we have chosen to discuss these three domains, we hope that this perspective – the queering that we do here – may be applied by readers to several other clinical realities they routinely encounter.

We begin by reframing suicide, self-harm, and non-suicidal self-injury. Readers well-versed in the canonical texts of psychology and psychiatry would be familiar with the idea of suicide risk, and whom this literature considers to be most at risk. Certain personal characteristics such as being male, single, having a diagnosis of major depressive disorder, or borderline personality, or eating disorder, being young and queer/trans, abusing substances, and so on, are closely associated with the risk of death by suicide. The first section of this chapter provides analytical insights into this suicide risk literature and looks at newer ways of understanding what constitutes self-harm.

7.1.1 Reframing suicide

This section looks at suicide using a queer lens. In the classroom space, a discussion on reframing the approach to suicides could begin with debating the statement–
'It is okay to take one's own life.'

The classroom is divided into two groups – one speaking for, and the other against, the given statement. The following are examples of points likely to come up (this is not an exhaustive list; participants could add many points the debate).

FOR	AGAINST
No one should have to endure suffering.	Dying is a permanent solution to a temporary challenge.
Each individual has the agency to decide to end their own life.	You leave loved ones behind to suffer and grieve for the rest of their lives.
What is the point of life and living? It is meaningless.	There is meaning and purpose to life. You just need to find yours.
I am unable to see any possible solutions.	This is not you, it is your depression talking.

The "for" column discusses points such as agency and a person's right over their own life; the arguments "against" are in favour of giving life a chance, for a number of reasons. It is fortuitous to be able to have this debate at a time when suicide is no longer a criminal offence under the Indian Penal Code. Reframing the approach to suicide using the QACP lens would involve revisiting several of the widely held understandings mentioned in the table above.

Livable Lives

If we limit ourselves to the framework of individual agency when it comes to understanding suicidality among queer/trans persons, it would be an incomplete reading of the situation. Lives on the margins often do not have the circumstances and resources that provide opportunities to thrive. The idea of livability, discussed by Judith Butler in some of their early writings, provides a conceptual basis for understanding the ways in which lives are rendered unlivable due to social and political forces.

For a queer/trans person, the exercise of agency (in taking one's own life) tends to be in the context of choosing not to live over living an inauthentic life. Inauthenticity, here, does not refer to dishonesty; rejecting inauthenticity is, rather, about the giving up of a self that erases the very core of one's being. For a queer/trans person, the inauthentic life may be akin to death because it means being forced to live a life that feels incongruent in the most fundamental of ways. It becomes important, then, to explore what we, as persons with agency, require 'in order to maintain and reproduce the conditions of (our) own livability' **(Butler,** 2004). To recognise better what factors make for livability, it is as important to engage with the precarity of lives on the margins as with lives that are less precarious. According to **Butler** (2009), precarity denotes a 'politically induced condition in which certain populations suffer from failing social and economic networks of support and become differentially exposed to injury, violence, and death' (p ii).

Some factors that are ever-present in queer/trans lives, and that play a role in making a life not livable, are 1) its precariousness; 2) its incompleteness; 3) its defencelessness before the law; 4) its dependence on others who could go missing at any point.

Legibility

Let us now confront another challenge in engaging with the idea of livability. How do we discuss the livability of lives that are not even legible? Are these

lives even recognisable in their everyday presence? When we consider how little we know about lives on the margins, we realise that the Charmed Circle's gaze trains us not to "see" certain lives. Which means that a lesbian couple might continue to be read as "close friends". A trans person might continue to be misgendered and deadnamed. Misgendering is a way of erasing that which the cis and heterosexual world does not want to see. This is the very challenge that, in the preceding chapters, the authors have attempted to address: to make visible those lives and experiences that are written out of social, cultural and political histories and practices.

We also know that these lives are not out of sight because they are necessarily lived quietly. It is because by their mere existence, to use Sara Ahmed's phrase, they 'pose a problem' **(Ahmed,** 2017, p.37). They are, in fact, systematically framed out of view **(Zaharajevic and Bojanic,** 2017). The ways in which queer/trans lives become visible (often through suicides) is evidence of the fact that the social and economic organisation of lives is unequal. As **Navaneetha Mokkil** (2011) explains, it is in the sensationalism of the suicide that the ordinary queer life lies exposed.

Enforced Unlivability

According to **Zaharajevic and Bojanic** (2017), conversation on what conditions could make lives legible and livable reveals–

- not only the historical conditions of their becoming illegible
- but also the power relations that lead to enforced unlivability

What we are saying, then, is that instances of queer/trans persons dying by suicide is an issue of preventable and premature deaths **(Butler,** 2004). These are lives that end because individuals are denied the conditions necessary for human beings to create livable lives. This is not about intrinsic human vulnerabilities; it is about vulnerabilities that are produced by social and political inequality. Such a reframing is crucial for the practitioner's understanding of suicidality among queer/trans persons.

The absence of social structures that could provide conditions of livability contributes to what **Lauren Berlant** (2007) calls "slow death". According to Berlant, certain populations are marked for being worn out by structural and governmental factors – and queer/trans lives fit this description. Suicide becomes, then, something that merely puts an end to the slow death, or provides an escape from it.

It is society's responsibility to provide conditions for livability. Social, political and legal infrastructure, and support systems, are essential conditions. In fact, **McNeilly** (2015) proposes a shift from right to life to right to livability – because, as Butler says, "being" cannot by itself constitute a life worth living.

Grievability

Grief is a crucial aspect in the struggle for livability, according to Butler. The grievability of lives is not equal. Some lives are not seen as worthy of being grieved. Some bodies do not matter. The way in which society conveys this is by not considering these lives grievable. This means that there were lives that were not deemed important enough to even be grieved in death let alone be provided with support to live.

Suicides of queer persons have often been sensationalised by media on the one hand, and completely hushed up and erased by families and communities (normative kinships of neighbourhood, caste, and so on), on the other. The hushing up also means that these deaths get recorded in a way that completely erases their queer identity as well as the fact that being at the receiving end of queer and trans negativity may have pushed the person to die by suicide. The community has known instances of trans persons who were buried or cremated dressed in the clothing of their assigned gender, and deadnamed during their last rites. In the case of Swapna and Sucheta, a lesbian couple from rural West Bengal, who died by suicide because their families objected to their relationship, even their last wish of being cremated together (mentioned in their suicide note) was not honoured.

Suicides of queer persons have often been sensationalised by media on the one hand, and completely hushed up and erased by families and communities (normative kinships of neighbourhood, caste, and so on), on the other.

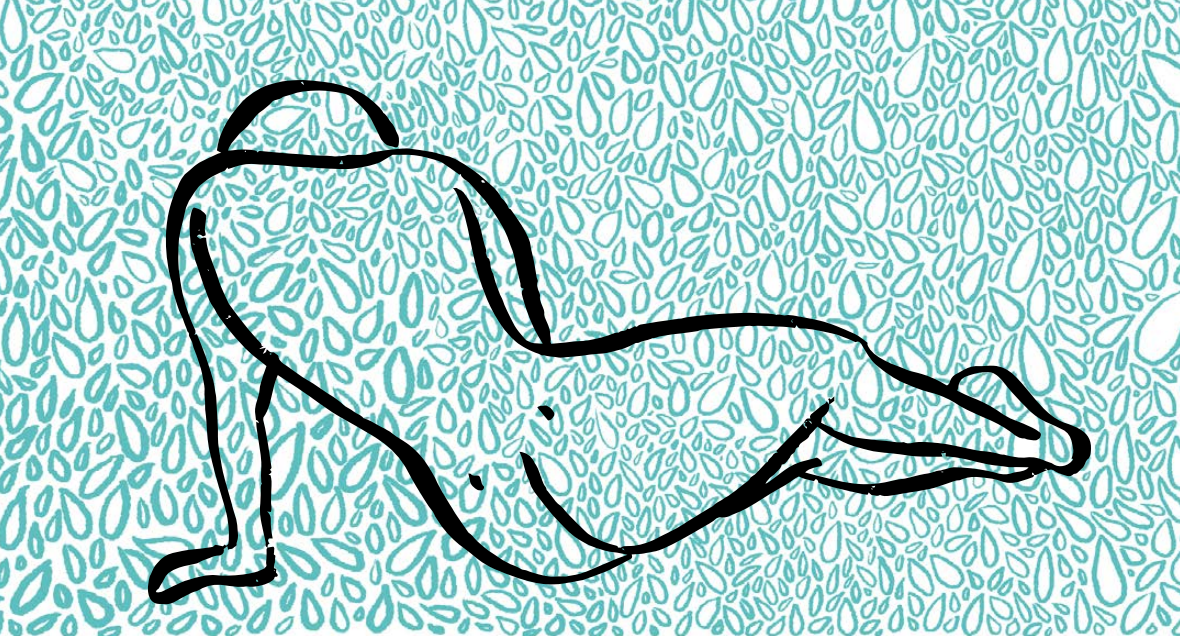
Who does the grieving?

The conditions for livability do seem beyond reach for queer/trans people, and the lives of many do end as a result. However, this does not automatically mean that there is nobody who grieves for them, or that no one is affected. Within stigmatised communities, there has been much documentation on how the suicide of a person affects the collective well-being of the community.

Queer feminist collectives, like Sappho for Equality in West Bengal and Sahayatrika in Kerala, have published fact-finding reports in the aftermath of suicides in the community. These reports serve both as a place of mourning, and as a way to mourn; they are also labours of love, and acts of resistance against the larger conspiracy of silence.

Queer/trans communities do lose people to suicide. Some of these make the news, and some do not. And we do grieve for them as communities. We may sometimes know the individuals who have died, or we may not – but grieve, we do.

If your queer/trans client is grieving a suicide in the community and they are asked how they were related to the person who has died by suicide, the question might not provide a legible response. They may not have been friends, or connected in any way. They may never even have met. The person who has died may not be a famous LGBTQ+ person either,



but possibly just an ordinary queer/trans person, living a queer/trans life that offered other queer/trans people possibilities for their own lives.

"How did you know them?", "Were you close?"– questions such as these in order to understand the intensity of a client's grief might, therefore, be irrelevant and meaningless, emerging as they do from the social and economic arrangements of the Charmed Circle. Collective grieving by the queer/trans community does not speak to a normative understanding of who grieves for whom, or when and why. We mourn as individuals and as a community in the face of no validation for such grief.

The collective grieving also happens because a suicide in the community makes queer and trans persons wonder about the possibilities for their own lives. We engage with questions of our own livability in the aftermath of loss in terms like, "If it happened to them, it could happen to us." The grieving is in part for the person who was lost, and in part for the self.

Reframing our approach to suicide using a queer lens thus rests on four pillars:

1. livability
2. precarity
3. legibility
4. grievability

7.1.2 Reframing self-harm

In the previous section we gained a perspective on how suicide in the case of queer/trans lives is a matter of preventable deaths. In this section, we shall closely examine another common mental health care emergency: self-harm.

Nonsuicidal Self-Injury (NSSI), or self-harm, refers to the intentional destruction of one's own body tissue without suicidal intent **(Favazza,** 2012). Traditionally, NSSI has been classified into pathological and non-pathological; tattooing or body piercing would be a typical culturally sanctioned form of self-mutilation, i.e., non-pathological self-harm. Pathological NSSI is usually a practice used to regulate emotions.

Self-harm may, then, be looked at from a broader perspective. Although the textbook definition of NSSI refers to damage to body tissue, self-could include damage done at the emotional and mental levels, in a bid to regulate intense harmful emotions. Queer and trans individuals experience the inherent stressors unique to their identity as well as the stressors arising from their minority status. It is reported that young people in sexual minorities are four times more likely to self-harm than those who identify as heterosexual **(Irish et al.,** 2019). In order to understand the various forms of self-harming behaviour that could present themselves in a queer/trans person's life, we suggest conducting the following exercise.

OBJECTIVE

To identify self-harming behaviours in the given narrative.

I am a 36-year-old woman. Homemaker. I wake up feeling lonely every day. The moment I open my eyes, I just lie in bed thinking about the long dreary day that lies before me. Yes, I look over to the other side of my bed and I see my husband stretched out next to me. But yet I feel lonely. The feeling of loneliness is just too much. It has been this way since my teenage years. I remember the pain of living a life where I used to just wonder whether my attraction toward women was correct. I used to feel so "different" in school when all my friends used to talk about having or wanting to have boyfriends, and I used to stand there grinning stupidly. The feeling of immense sadness and also shame used to overwhelm me. That was the time I discovered the pleasure of cutting myself. Paradoxical, isn't it? But yes it did feel like pleasure in comparison. I don't think I ever had the courage to state my truth. To anyone. I listened to my parents and got married to this man when I was 26. He treated me well but I used to struggle to satisfy him. I couldn't do even this thing correctly. I could feel myself slipping slowly and slowly into depression. Then I met one of my husband's female cousins and one thing led to other and we slept together multiple times. I felt liberated. I had found love. I had found myself. I dreamed about running away with her. I was in love! I must admit it was not rosy always. We had our share of fights. Every time we fought, I would have a drink too many. That helped. It still does. We had this little secret between us for four years. It was bliss. Then she left me. I am still wondering, am I so undesirable? Really? I tried to find out. I needed to know! I felt so worthless. I even tried online dating apps. To be honest, even Facebook. So many new friends I made. It felt good. This was so important to me... It was about my survival!

Participants could be asked to point out behaviours that qualify as self-harm. Responses may include–

- Cutting
- Excessive drinking
- Casual, possibly unsafe relationships, through an indiscriminate use of dating apps
- Staying in the heterosexual marriage
- Forcing herself to have sex with husband

Going by textbook definitions of self-harm, common forms would include cutting, branding, burning, scratching, and so on. However, there are ways of self-harming that may less commonly be described as such – for instance, picking at one's skin, substance use, binge eating, not allowing wounds to heal, picking up fights – all mechanisms for intentionally harming oneself. When it comes to sexual and gender minorities, other forms of self-harm are also observable. These may not appear to be self-harm, and yet they cause physical, mental, as well as emotional harm. Queer and trans individuals live, as we have seen throughout these chapters, in a world which is predominantly cis-heterosexual; their upbringing and social conditioning is, in most cases, deeply normative. As a result, in the absence of a socially acceptable alternate script, they are inclined (often pushed) to follow the *normative script* handed to them, despite its not aligning with their lived reality: the detrimental consequences for their physical and mental health, potentially causing deep distress, qualifies this, too, as self-harm.

Some relatively disguised forms of self-harm that may be observed in the lives of queer and trans individuals include–

Fitting in: In a bid to follow normative scripts, deliberately trying to "fit in" in mainstream social circles becomes likely. Such attempts are often traumatic, as cis-heterosexual ways of being are quite far from queer persons' lived experiences. Also, trying to fit in is not a one-time act, but a repeated exercise bringing daily experiences.

Marriage: In order to adhere to mainstream norms, and

possibly because of some degree of internalised homonegativity, many queer/trans individuals enter into cis-het marriages. This is in itself a self-erasure of identity, potentially causing deep pain and distress. For some, it is a form of self-punishment for being "different". Getting into a marriage is also a way of conforming to the Charmed Circle, when the consequences of flouting its norms grow – as they often do – inordinately painful and intensely violent.

Self-correction: This has a person trying to modify their appearance, behaviour, even mannerisms, because of the belief that their current presentation (style of dressing, hair, and so on), behaviour and/or mannerisms are "wrong" or "abnormal". This often results in severe distress, as such "correction" goes against how the queer/trans person experiences themselves. For instance, for a person assigned female at birth (AFAB) who is most comfortable wearing T-shirt and trousers, having to wear stereotypically feminine clothes can be extremely distressing, but the person might still go ahead and do so to "fit in", or to "set right" an impulse they believe is an aberration.

Multiple partners/Casual relationships/Unsafe sex: Despite being aware of the risks involved while getting into multiple relationships or having unsafe sex, queer/trans individuals do find themselves practicing this self-harming behaviour. The reasons could be many–

- The inability to imagine a full, thriving future, and hence a degree of callousness towards oneself in the present.
- The feeling of not being "deserving" of love, and looking at having unsafe sex as a way of punishing oneself.
- Attempting to experience a high by doing things that make one feel alive in a world bound by dogmatic edicts around sex and sexuality.
- In an affection-deficit life, any kind of attachment,

however unsafe, could appear desirable.
- A lifetime of erasure and silencing leading to seeking out spaces that can provide some outlet for self-expression and for the assertion of one's sexuality and/or gender identity.

Continuing in abusive relationships: Queer/trans individuals do find themselves in relationships that are abusive and toxic. In spite of being aware of this, many continue to be in these relationships. As discussed elsewhere in this book, deficit and deprivation are a core part of queer/trans lives and experiences; the uncertainties around finding a partner in an already impoverished world when it comes to individuals who are non-normative in terms of their gender and/or sexuality, often compel an individual to remain in the toxic relationship despite the abuse and risks.

Deliberate aggression: Getting involved in situations fraught with conflict and violence is yet another example of self-harming behaviour. This may derive from a need to assert one's identity – given how sexual and gender minorities are historically invisibilised, such assertion tends to be excessive in order to be "seen" and acknowledged.

Coming out in situations where violence is anticipated: Coming out is a process that is exhilarating and liberating, anxiety-inducing and fear-causing, all at the same time. The inability to state one's truth openly tends to be painful and suffocating, and may be further laced with internalised homonegativity. Given these factors, coming out in unsafe spaces may occur as an act of defiance, or as a means to punish oneself, or simply to relieve oneself of the burden of a secret carried around for a long time – years, perhaps.

While there are a number of disguised self-harming behaviours when it comes to queer and trans people, it is also essential to note that there are certain behaviours which may appear as self-harm, but

are not. An example would be: hiding one's true identity and leading a double life. Because discrimination and violence are very real eventualities for queer/trans persons, leading two lives – one for the unaccepting cis-heterosexual world, the other to affirm their queer/trans identity – is probably the only recourse left for self-preservation. The denial of the self in many spaces is intentional (for safety); it is not about emotional regulation, and cannot be construed as self-harm.

Similarly, binding is, for trans men, both an act of resistance and an assertion of their gender identity, even though binding can cause physical damage. Body dysphoria can also prompt a trans person to opt for medical interventions. This is a bid to live a life aligned with their inner experience and, therefore, a matter of authenticity. Many queer/trans individuals defy societal norms of marriage or monogamy – again, an act of resistance and an assertion of agency, of living the life they choose. While being nonbinary, or otherwise non-normative in terms of gender-sexuality, often attracts violent consequences, it is not a matter of choice but a matter of being for the queer/trans individual: while there is certainly the likelihood of harm to self, it is not an act of self-harm.

Hence it becomes crucial for a mental health practitioner to understand the nuances of queer/trans lives, so as to be able to draw a distinction between behaviours that may be categorised as self-harm and those that may not. These distinctions, in turn, can help to frame the client's experience and behaviour more accurately, either as coming from a space of coping with distress, or from a space of attempting to live their lives more authentically.

Why self-harm?

After learning about the self-harming behaviours of queer and trans individuals, it would be worthwhile to examine the motivations behind self-harm. People engaging in NSSI report that cutting or other pain-inducing acts give rise to a momentary phase of euphoria that improves mood, and are often done to regulate intense negative emotions. Extreme negative emotions can many

a time lead to dissociation or a sense of numbness, and NSSI helps in getting back in touch with themselves and feel "alive" again. Some also self-harm as a way to punish themselves, evident when there is a sense of shame and guilt associated with one's sexuality or gender. Studies have shown that NSSI is associated with high self-criticism and low levels of self-worth **(Fox et al.,** 2019). There is also evidence that NSSI serves as a means of influencing other people, or to manifest tangible emotional distress. It needs, however, to be recognised by MHPs as a mechanism often used to cope with the distress arising out of the stressors experienced due to structural inequities and systemic oppression.

Queering self-harm

Historically, especially in the late 1900s and early 2000s, self-harm or NSSI was recognised simply as a significant symptom of Borderline Personality Disorder (BPD). Moreover, it was also widely believed that NSSI was also an attention-seeking behaviour. It was viewed as undesirable behaviour that needed mitigation and correction. Abstinence from such behaviour was the desired outcome of therapy. Since then, a good deal of research has overturned those conceptions by showing that NSSI occurs regardless of BPD, and is not necessarily performed to seek attention **(Klonsky et al.,** 2014). For an extended time, it was also believed that self-harm would naturally progress to suicide; preventing self-harm at all costs was, therefore, the focus of therapy. This notion was also disproved in time, where it was demonstrated that self-harm, is on the contrary, most often performed in the absence of suicidal ideation **(Favazza,** 1998).

In the last decade, NSSI has increasingly been looked upon as a means to cope, and less as a symptom of a mental illness or as a precursor to suicide **(Midkiff et al.,** 2018). American psychiatrist and author of the book 'Bodies Under Siege: Self mutilation in Culture and Psychiatry', Armando Favazza, describes intentional self-injury as a morbid form of self-help, temporarily relieving distress and

gaining some form of personal order. This understanding of self-harm broadened its scope to allow for the inclusion of intangible forms (emotional and mental) of self-harm as well. Thus, the way clinicians sought to address self-harming behaviours also changed – from an abstinence-focused approach to one that recognised the agency of the person who self-harms, while checking their behaviour for lethality. Acknowledging self-harm as a form of coping, and thereby validating the individual's experience of distress, has a significant impact on therapy outcome: the client can access their distress and be open to exploring healthier ways of coping. Ensuring that the self-harming behaviour is done in a safe way also aids this process.

When it comes to queer and trans individuals, this approach needs to be further extrapolated to recognise self-harm as being, possibly, an act of coping in response to the unique life stressors experienced by the queer community. As practitioners, it becomes crucial also to be aware that many times the coping outlets available to a cis-heterosexual person, in terms of social access, validation from family and friends, or other spaces where their distress can be understood, validated and possibly redressed, are not available to a queer individual – which makes self-harm a ready outlet to cope with distress. The emotional repercussions of the unique life stressors are often so intense and the pain so debilitating that self-harm becomes a viable recourse to release and/or dull the pain. An affirmative stance, then, would be to recognise such self-harming behaviour as an act that may be inextricably

Acknowledging self-harm as a form of coping, and thereby validating the individual's experience of distress, has a significant impact on therapy outcome: the client can access their distress and be open to exploring healthier ways of coping.

linked to a queer/trans person's survival, and not as an act of helplessness or weakness. It needs to be validated as a response to distress that requires courage and resilience. After such validation is amply communicated, the lethality of the behaviour can be addressed, so that the self-harm does the least possible damage to the individual. Framing self-harm in this fashion would help relieve the queer/trans client of the sense of shame and guilt that may be associated with the act. This would itself be a step towards making them feel more "seen", valued, and appreciated.

Hence, a queer affirmative protocol for self-harm would involve–

- **Acknowledging the person's agency**
  It is important to recognise that the individual is the expert of their own life, and therefore it is critical to acknowledge their agency – in owning their body, as well as in choosing ways of coping that work best for them.

- **Validation**
  Validate the client's need to do self-harm, and frame it as their way of coping with the stressors that arise from systemic oppressions and structural inequalities external to the person. Acknowledge the fact that their self-harm is a form of release linked to the individual's need to self-preserve, and that it requires significant courage and resilience. Concurrently, it would be useful to help the client gain insights into disguised forms of self-harm and the impact these could have on their lives.

- **Harm reduction vs. abstinence**
  Recognising self-harm as an act of self-preservation would help to reframe the therapy outcome to reducing harm, rather than aiming for abstinence. This could, in turn, help reduce the instances of self-harm, possibly diminishing the need to self-harm, as the internal resources of the

individual progressively become sufficient enough to cope with distress in a less harmful manner.

- **Impulse wave management**
  Managing the impulse to self-harm, especially when the need to self-harm is very high, would be an important consideration towards harm reduction. Working with the client to arrive at ways in which the moment of an intense urge to self-harm can be delayed, or navigated so as not to cause excessive physical or emotional damage, could be useful.

- **Knowing that self-harm does not necessarily mean a suicide attempt or a progression towards suicide**
  Lastly, it would be important to recognise that self-harm is not necessarily a precursor to suicide. Along with the shame associated with self-harm, we often find fear of causing oneself such intense pain that the regulation of emotions is not possible, because that act has gone a step beyond the intended self-harm. A queer affirmative therapist would need to allay such fears by drawing out the distinction between self-harm and suicide, and the different motives underlying each. Demystifying self-harm to the client is a vital affirmative step the therapist can take towards helping the client navigate self-harming behaviour.

7.2 Revisiting clinical diagnoses related to gender-sexuality from a queer affirmative lens

In this section, we attempt to queer some areas of the psychiatric diagnostic systems that classify a range of behavioural and mental symptoms into different types of mental illness. We focus here only on those classes of diagnosis wherein gender-sexuality is directly implicated. Earlier feminist writings on women and mental health in India have extensively interrogated mental illness as a construct, as well as commented on the gendered dimensions of the diagnoses and treatments for these **(Davar,** 1999; **Addlakha,** 2008; **Vindhya,** 2007). Here we go beyond the analytical gender category of cis woman and use a broader gender-sexuality framework to highlight ways in which both normative and non-normative gender-sexuality are constructed and reinforced within the classification systems for mental disorders.[42] We will highlight classes of diagnosis from the ICD-10 and the DSM-V, which are the two classification systems widely used by MHPs in India.

We would like to remind the readers of learnings from an earlier section of this book (see 5.1 – 'Pathologisation and medicalisation of the queer and trans subject: A historical account') and urge them to read the present section alongside 5.1 to optimise their insights into the role of the psy disciplines in creating both, the normal and the pathological gendered-sexual being. In this section, we will be closely reading two categories of mental illness as classified in the ICD-10 and DSM-V:

1. Sexual Dysfunction not caused by organic disorder or disease (coded as F52 in ICD-10), and Sexual Dysfunctions (coded as 302.71-76 in DSM-V)
2. Disorders of Sexual Preference (coded as F65 in ICD-10), and Paraphilic Disorders (coded as 302.2-4, 302.81-84, and 302.89 in DSM-V)

7.2.1 Sexual dysfunction

Sexual dysfunction, as a category of mental illness within the ICD-10 or DSM-V, is not meant only to discuss heterosexual sexual encounters, i.e., nowhere in the description of this category or its sub-categories are we told that it applies only to heterosexual sexual activity; and yet descriptions of F52 and its various sub-codes/ categories focus explicitly on the cisgender binary of male and female, and carry the underlying subtext of peno-vaginal intercourse as the "normal" sexual act. F52 is further divided into several sub-sections such as: 'F52.0 Lack or loss of sexual desire'; 'F52.1 Sexual aversion and lack of sexual enjoyment'; and so on. F52 '*covers the various ways in which an individual is unable to participate in a sexual relationship as he or she would wish*' (ICD-10, p. 149). The introductory paragraph of F52 includes the following text–

> 'Some types of dysfunction (e.g. lack of sexual desire) occur in both men and women. Women, however, tend to present more commonly with complaints about the subjective quality of the sexual experience (e.g. lack of enjoyment or interest) rather than failure of a specific response. The complaint of orgasmic dysfunction is not unusual, but when one aspect of a women's sexual response is affected, others are also likely to be impaired. For example, if a woman is unable to experience orgasm, she will often find herself unable to enjoy other aspects of lovemaking and will thus lose much of her sexual appetite. Men, on the other hand, though complaining of failure of a specific response such as erection or ejaculation, often report a continuing sexual appetite.'
>
> (ICD-10, p. 150)

We may see how F52 is based on several assumptions about sexual dysfunction. These include beliefs about "normal" men and women and their normal sexual appetite; the belief that all sex is heterosexual, peno-vaginal, and penetrative in nature; that there is such a thing as the right amount of sex and the right amount of pleasure in sex for everyone. It is from such assumptions that the diagnostic criteria for sexual dysfunction are derived.

Let us take two sub-categories under F52 as an example:

F52.1 SEXUAL AVERSION AND LACK OF SEXUAL ENJOYMENT

> **F52.10 Sexual aversion**
> 'The prospect of sexual interaction with a partner is associated with strong negative feelings and produces sufficient fear or anxiety that sexual activity is avoided.'
>
> **F52.11 Lack of sexual enjoyment**
> 'Sexual responses occur normally and orgasm is experienced but there is a lack of appropriate pleasure. This complaint is much more common in women than in men.'

[all emphases added]

An aversion to sex, avoidance of sex, and not enjoying sex, are presented as clinically "abnormal" behaviours, with no mention of *asexuality* as a valid sexual identity. Moreover, these criteria do not guide the clinician towards assessing any background information such as the client's psychosocial context, or the quality of the relationship between the sexual partners, their relationship histories, issues related to body image, shame, guilt associated with sex in a sex-negative culture, access to an affirmative sexuality education, the role of fatigue and the dual burdens on women in domestic and familial spaces, any previous history of violence/sexual abuse, the sexual orientation of the partner/s, and so on. **One of the sub-categories discussed here names an attribute, in a highly subjective manner, as**

"lack of appropriate pleasure." It would be interesting to know whether this refers to pleasure as experienced by the woman, as reported by the man, or as judged by the clinician based on overall reporting by the couple? In a culture in which women's chastity, virginity, and innocence are celebrated, one wonders about the contexts in which the diagnosis of lack of sexual enjoyment is made, and what its role might be in the construction of ideas of "normal" sexuality.

The ICD-10 also has the diagnostic sub-category 'F 52.7 Excessive sexual drive', described as being more common during the late teenage years and early adulthood.

> **F52.7 Excessive sexual drive**
> 'Both men and women may occasionally complain of excessive sexual drive as a problem in its own right, usually during late teenage or early adulthood. When the excessive sexual drive is secondary to an affective disorder (F30-F39) or when it occurs during the early stages of dementia (F00-F03), the underlying disorder should be coded.' *(Note: This sub-category includes nymphomania, satyriasis)*

In a country that has sought legal intervention to ban sex education in schools, and where the mainstream culture is repressed, sex-negative, and equates virginity, especially of its young girls, with purity, innocence, and family honour, a question that comes to mind while reading the text of F52.7 is, 'What would "appropriate"/healthy sexuality in late teenage or early adulthood look like?'

Another example we would like to cite is 'F52.2 Failure of genital response'.

> **F52.2 Failure of genital response**
> 'In men, the principal problem is erectile dysfunction, i.e., difficulty in developing or maintaining an erection suitable for satisfactory intercourse. If erection occurs normally in certain situations, e.g. during masturbation or sleep or with a different partner,

the causation is likely to be psychogenic. Otherwise, the correct diagnosis of nonorganic erectile dysfunction may depend on special investigations (e.g. measurement of nocturnal penile tumescence) or the response to psychological treatment.
'In women, the principal problem is vaginal dryness or failure of lubrication. The cause can be psychogenic or pathological (e.g. infection) or estrogen deficiency (e.g. postmenopausal). It is unusual for women to complain primarily of vaginal dryness except as a symptom of postmenopausal estrogen deficiency.'
(Note: This sub-category includes female sexual arousal disorder, male erectile disorder, psychogenic impotence).

It is noteworthy that while establishing the psychological origin of erectile dysfunction in men (ruling out an organic cause), the criteria suggest that the clinician should explore if erection is normal during masturbation or during sex with another partner. While discussing the failure of genital response in women, the criteria refer to several possible organic/hormonal causes for vaginal dryness in women, they do not, however, guide the clinician to explore the women's sexual experiences during masturbation or sex with another partner. Moreover, the criteria suggest that it is unusual for women to complain primarily of vaginal dryness. What does "unusual" here mean? Simply that it is biologically/physically unlikely? Or are there sociocultural, gendered realities underlying this statement about women's sexual desires, pleasure, arousal, reinforcing the culturally sanctioned silences around, say, pain during sexual intercourse? The diagnostic sub-categories of 'Nonorganic Vaginismus' and 'Nonorganic Dyspareunia' in the ICD-10 also fail to address some of these gendered aspects of sexual dysfunction in women and, in doing so, fail to alert the MHP about factors to which they need to attend in their assessment of sexual dysfunction, including the sexual orientation of the patient or of

her partner – which may not be heterosexual.

F52.5 Nonorganic vaginismus
'Spasm of the muscles that surround the vagina, causing occlusion of the vaginal opening. Penile entry is either impossible or painful. Vaginismus may be a secondary reaction to some local cause of pain, in which case this category should not be used.'
(Note: This sub-category includes psychogenic vaginismus).

F52.6 Nonorganic dyspareunia
'Dyspareunia (pain during sexual intercourse) occurs in both women and men. It can often be attributed to a local pathological condition and should then be appropriately categorized. In some cases, however, no obvious cause is apparent and emotional factors may be important. This category is to be used only if there is no other more primary sexual dysfunction (e.g. vaginismus or vaginal dryness).'
(Note: This sub-category includes psychogenic dyspareunia).

Without explicitly stating so, F52 is about cisgender, heterosexual people – not needing to state this explicitly is a reflection of the cisgenderism and heteronormativity that underlies the classification systems of mental illness. Consequently, F52 fails to tell us much about sexual function or dysfunctions that may occur among non-cisgender or non-heterosexual persons. The sexual dysfunction section in the DSM-V is a far improved version that is attentive to psychosocial issues and guides the clinician to include contextual, relational and cultural realities while conducting assessments. The introductory section for sexual dysfunctions in the DSM-V asks the MHP to be attentive to the following–

'In addition to the subtypes "lifelong/acquired" and "generalized/situational," the following five factors must be considered during assessment and diagnosis of female sexual interest/arousal disorder given that they may be relevant to

> etiology and/or treatment:
> **1)** partner factors (e.g., partner's sexual problems, partner's health status);
> **2)** relationship factors (e.g., poor communication, discrepancies in desire for sexual activity);
> **3)** individual vulnerability factors (e.g., poor body image, history of sexual or emotional abuse), psychiatric comorbidity (e.g., depression, anxiety), or stressors (e.g., job loss, bereavement);
> **4)** cultural/religious factors (e.g., inhibitions related to prohibitions against sexual activity; attitudes toward sexuality); and
> **5)** medical factors relevant to prognosis, course, or treatment.' (DSM-V, p. 423)

There is some attention to the diversity of sexualities as well; for instance, for the diagnoses of 'Female Sexual Interest/ Arousal Disorder' (302.72) and 'Male Hypoactive Sexual Desire Disorder' (302.71), there is a mention of (self-identified) asexuality as an exclusion criterion for making these diagnoses.

> 'If a lifelong lack of sexual desire is better explained by one's self-identification as "asexual," [sic] then a diagnosis of female sexual interest/arousal disorder would not be made.' (DSM-V, p. 434)

> 'If the man's low desire is explained by self-identification as an asexual, then a diagnosis of male hypoactive sexual desire disorder is not made.' (DSM-V, p. 443)

While it is an encouraging sign that "self-identification" (which may here be read as self-determination) and asexual(ity) are briefly referenced in the DSM-V section on sexual dysfunctions, it would be important for MHPs to educate themselves further about both these terms, as well as about human sexual diversity including mixed orientation marriages, specifically in the context of diagnoses of sexual dysfunction.

7.2.2 Disorders of sexual preference, or paraphilic disorders

'Disorders of sexual preference' (F65 in the ICD-10) or 'Paraphilic disorders' (302.2-4, 302.81-84, 302.89 in DSM-V) are the next types of diagnosis to which we wish to draw the readers' attention.

F65.0 Fetishism

'Reliance on some non-living object as a stimulus for sexual arousal and sexual gratification. Many fetishes are extensions of the human body, such as articles of clothing or footwear. Other common examples are characterized by some particular texture such as rubber, plastic, or leather . . .

'Fetishism should be diagnosed only if the fetish is the most important source of sexual stimulation or essential for satisfactory sexual response.

'Fetishistic fantasies are common, but they do not amount to a disorder unless they lead to rituals that are so compelling and unacceptable as to ***interfere with sexual intercourse*** and cause the individual distress.

'Fetishism is limited almost exclusively to males.'

F65.2 Exhibitionism

'A recurrent or persistent tendency to expose the genitalia to strangers (usually of the opposite sex) or to people in public places. Exhibitionism is almost entirely limited to heterosexual males who expose to females, adult or adolescent, usually in some public place.'

F65.3 Voyeurism

'A recurrent or persistent tendency to look at people engaging in sexual or intimate behaviour such as undressing.'

F65.4 Paedophilia
'A sexual preference for children, usually of pre-pubertal or early pubertal age. Some paedophiles are attracted only to girls, others only to boys, and others again are interested in both sexes.

'Paedophilia is rarely identified in women.'

F65.5 Sadomasochism
'A preference for sexual activity that involves bondage or the infliction of pain or humiliation. If the individual prefers to be the recipient of such stimulation this is called masochism; if the provider, sadism. Often an individual obtains sexual excitement from both sadistic and masochistic activities.

'Mild degrees of sadomasochistic stimulation are commonly used to enhance otherwise normal sexual activity. This category should be used only if sadomasochistic activity is the most important source of stimulation or necessary for sexual gratification.'

[emphases added]

The various disorders listed under F65 are a good illustrative example of the role played by the psychiatric diagnostic system in reinforcing normative and socially acceptable ideas of sexuality, and thereby exerting social control on sexuality. These diagnostic categories have been produced in the context of hegemonic ideas of "respectable sexuality", i.e., virtuous, pure, within the paradigm of hetero-reproductive and monogamous marriage. Some deviation from the normative peno-vaginal sexual acts within this paradigm is acceptable, as indicated by statements such as, 'Fetishistic fantasies are common', or 'Mild degrees of sadomasochistic stimulation are commonly used to enhance ***otherwise normal*** sexual activity' **[emphasis added].** The diagnostic criteria indicate, in unambiguous terms, that "normal" sexual activity is the desired goal of human sexuality; some deviation is fine, as long as it occurs

within the paradigm of "normal sexuality". This is also implied in the diagnostic criteria for fetishism which state, 'Fetishistic fantasies. . . do not amount to a disorder unless they lead to rituals that are so compelling and unacceptable as to interfere with sexual intercourse.' Thus, disorders of sexual preference are clearly conceptualised within the grid of social morality and societal prescriptions of normative sexuality.

The idea of consent for sexual acts among adults is completely missing in the articulation of disorders of sexual preference in the ICD-10. Thus, acts involving sexual violence such as paedophilia, exhibitionism, voyeurism are discussed alongside sexual preferences such as the use of objects, bondage, domination/submission, which by themselves do not constitute abuse, and which are a source of excitement, arousal and pleasure when carried out in a context of consent, trust, communication and a mutual affirmation of sexuality. The diagnostic criteria thus fail to see the distinction between consensual, kinky, pleasurable sex, and non-consensual, coercive, boundary-violating, abusive sex.

Nearly all the sub-categories of F65 state that these disorders are predominantly or only found among heterosexual males: 'Fetishism is limited almost exclusively to males.'; 'Exhibitionism is almost entirely limited to heterosexual males who expose to females, adult or adolescent, usually in some public place.'; 'Paedophilia is rarely identified in women.' Statements such as these, unaccompanied by any social or contextual explanations, serve to further the stereotype of the unbridled, savage, male sexuality that needs to be reined in through institutions such as marriage, family, and psy interventions.

Finally, there is the bringing together of a range of social outcasts – the crossdresser, the sadomasochist, and the kinky – under an umbrella diagnosis of multiple disorders of sexual preference, as a list or even "combination" as suggested in F65.6, not too different from the list of

disorders that was listed in the 'Psychopathia Sexualis' in 1886.

The idea of consent for sexual acts among adults is completely missing in the articulation of disorders of sexual preference in the ICD-10. Thus, acts involving sexual violence such as paedophilia, exhibitionism, voyeurism are discussed alongside sexual preferences such as the use of objects, bondage, domination/ submission, which by themselves do not constitute abuse, and which are a source of excitement, arousal and pleasure when carried out in a context of consent, trust, communication and a mutual affirmation of sexuality.

F65.6 Multiple disorders of sexual preference
'Sometimes more than one disorder of sexual preference occurs in one person and none has clear precedence. The most common combination is fetishism, transvestism, and sadomasochism.'

After reading sections of F65 in ICD-10, readers may wonder whether anything has changed at all (medically or even socially or politically) in our understanding of sexuality in the last 140 years. We suggest the answer is both 'Yes', and 'No'. Yes, in the sense that LGBTQ+ folks around the world, and in India, have organised, collectivised, and raised their voices against the "expert", "scientific" opinions that pathologised them, leading to scientific authorities and texts such as the DSM and the ICD depathologising homosexuality and transgender identities; No, in the sense that deeply entrenched ideas of sexual

monogamy and of heterosexual penetrative and reproductive sex as the standard continue to pathologise and medicalise all sex and all desires and fantasies that lie outside of their ambit, irrespective of whether these are practised, or held, by cis-heterosexual men and women or by queer and trans folks. In this sense the medico-social project of rehabilitating non-heteronormative sex continues globally.

The DSM-V and its paraphilias

The DSM-V defines paraphilia as follows–

> 'The term ***paraphilia*** denotes any intense and persistent sexual interest other than sexual interest in genital stimulation or preparatory fondling with phenotypically normal, physically mature, consenting human partners.' (DSM-V, p. 685)

[emphasis added]

The very definition of paraphilia is in reference to what is considered to be "normal" sexuality and has been articulated as anything 'other than' genital stimulation, preparatory fondling (presumably as preparation for genital sexual intercourse), and so on, as stated. Consent among partners in a discussion of sexuality in the DSM is a welcome change. However, if we look at all the other aspects that qualify as "normal" sex, these suffer from the same normativising pressure whereby genital sex is considered to be above all other forms of sex; fondling is fine as long as it is preparatory, and so on. The strength of paraphilic sexual fantasies, behaviours, or urges, is evaluated in relation to normophilic sexual interests and behaviours, with the DSM-V guiding MHPs to ask examinees during the clinical interview whether their paraphilic fantasies, urges, or behaviours are less than, equal to, or stronger than normophilic sexual interest. **Zonana** (2011) suggests that paraphilia as a concept is 'vulnerable to societal pressures rather than advances in science' (p. 249), hence diagnosis may be more grounded in societal norms than in psychiatric health. Inherent to this definition of paraphilias is

the idea of sexual deviance and the "unnatural" – both ideas that we have critically interrogated in this book.

The most exclusionary aspect of the definition of paraphilias is the idea of the *'phenotypically normal'*. What this means is that bodies that are legible and fit squarely into the formula of two sexes equals two genders are the only bodies that may qualify as having "normal" sex. Bodies that have been medically altered/changed to enable persons to live in the gender that they are, and not the gender assigned to them at birth, or bodies with sex characteristics that do not fit the category of "normal male/female" are by definition excluded from the possibility of having "normal" sex. In other words, all sex that is had, or fantasised about, by trans bodies or intersex bodies, even if it were genital and consenting, would by definition be paraphilia. Any bodies that do not fit the medical definition of phenotypically normal male and female would thus be always pathologised within the DSM-V framework **(Serano,** 2016).

Paraphilic disorders in the DSM-V are further classified into two types–

> 'The first group of disorders is based on anomalous activity preferences. These disorders are subdivided into courtship disorders, which resemble distorted components of human courtship behavior (voyeuristic disorder, exhibitionistic disorder, and frotteuristic disorder), and algolagnie disorders, which involve pain and suffering (sexual masochism disorder and sexual sadism disorder). The second group of disorders is based on anomalous target preferences. These disorders include one directed at other humans (pedophilic disorder) and two directed elsewhere (fetishistic disorder and transvestic disorder).'
> (DSM-V, p. 685)

Here we focus specifically on transvestic disorder, categorised above under 'anomalous target preferences'. Transvestic

disorder in the DSM-V (302.3) refers to persons in whom cross dressing or thoughts of cross dressing are accompanied by sexual excitement. The DSM-V states–

> Transvestic disorder in men is often accompanied by autogynephilia[43] (i.e., a male's paraphilic tendency to be sexually aroused by the thought or image of himself as a woman). Autogynephilic fantasies and behaviors may focus on the idea of exhibiting female physiological functions (e.g., lactation, menstruation), engaging in stereotypically feminine behavior (e.g., knitting), or possessing female anatomy (e.g., breasts). . . . Some cases of transvestic disorder progress to gender dysphoria.

[emphasis added]

The above definition of transvestic disorder points us to an obvious question – is this supposed to be a description of a cis man with 'paraphilic tendencies'? Or does it describe a (pre-transition) transfeminine person, who is coping with her gender dysphoria through images and fantasies of a gender-congruent body that allows her the pleasures (including sexual pleasure) of the body-mind-self that she deeply desires but which may be severely policed and punished in a cisgender world that also devalues femininity?

In her paper titled 'Autogynephilia: A Scientific Review, Feminist Analysis, and Alternative Embodiment Fantasies Model', **Serano** (2020) uses the term embodiment fantasies as a 'non-pathologising umbrella term for those sexual fantasies and patterns of arousal wherein the focus is mostly (or in some cases, solely) placed on our own embodiment' (p. 7). She further argues that these embodiment fantasies among women (cis and trans women) can be read in the context of women navigating the male gaze in the everyday and therefore being more aware and cognisant of how they are being 'sexually evaluated, appreciated, or objectified' by other people.

This credibly describes the way women experience their sexuality, and may better explain female embodiment fantasies than the essentialist view of sex and gender provided by the autogynephilia theory. Serano further argues that by attributing erotic motives to trans women's experiences of gender and transitioning, the autogynephilia theory erases their experiences of transness, dysphoria/euphoria, and dehumanises them by sexualising their motive for transition.

In conclusion to this section on revisiting clinical diagnoses, we would like to re-emphasise that diagnostic frameworks that pathologise non-normative genders and sexualities do so not by citing reasons of morality, social control, or surveillance of gender and sexuality, but by evoking distress and the need to alleviate the same. It would not be uncommon for an MHP to justify the presence of a diagnostic category such as fetishism by asking, 'If a fetishist is miserable, should we not be able to diagnose and cure him of his fetishism?' We would like readers to remember that a similar question was asked and used as justification for surgical interventions to "cure" homosexual men of their homosexuality in the early 1900s. We urge queer affirmative practitioners to attend to the misery and the suffering but also to ask the more relevant question, 'What exactly does the homosexual/the transgender/ the fetishist suffer from?' 'The situation is analogous to African-Americans who are depressed as a result of living in a racist environment or to women who are miserable due to living in a misogynist society. Psychiatrists might want to help African-Americans and women with their depression, but they will not try to cure them of their race or womanhood.' **(Singy,** 2012, p. 10).

Revisiting clinical diagnoses using a queer affirmative lens has two primary motives–

a) to become alert to the continued pathologisation of gender-sexuality in our diagnostic systems; and not believe the myth that by declassifying homosexuality as a type of mental illness, or by changing the nomenclature

from "gender identity disorder" to "gender dysphoria", the psy disciplines have given up on their role of disciplining gender-sexuality

b) to recognise individual distress arising from being part of a non-normative sexuality-gender minority, so as to be able to respond with a non-shaming, minority-informed perspective, support and empathy

We urge queer affirmative practitioners to attend to the misery and the suffering but also to ask the more relevant question, 'What exactly does the homosexual/the transgender/the fetishist suffer from?'

7.3 Reframing recovery from a neurodivergent, queer affirmative perspective

Mental health discourse in India, certainly in terms of policy, law and – to some extent – the clinic, is showing signs of a perspectival shift from the clinical management of mental illness to a rights-based, participatory, inclusive, recovery-based one. This section will raise some critical questions about the expert-driven, bio-medical model of care and about the assumptions of normalcy, normativity and neurotypicality within these, finally queering the notion of "re-covery".

A narrative account by a neurodivergent queer feminist activist

'One of the things to keep in mind when trying to "see" with a queer lens is that gender and sexuality are not the only axes of marginalisation – they may not even be the central articulations of one's lived experience. I want to make a distinction here between 'queer', the identity, and 'queer', the lens. "Queerness" in a lens speaks to identity, yes, but also to power – namely, the recognition that power exerts itself in certain ways, prioritises certain people over others, values certain markers of body, caste, binary, and operationalises as privilege, exclusion and erasure. What does the queer lens do when engaging with a mind, then? What is a queer mind? I do not here mean the mind of a queer person – I mean the acknowledgement that power plays out here as well, prioritising certain kinds of minds, certain markers of mental health, functionality, productivity, conformity, wellness, and marginalising those whose "minds" do not fit the common conception of a "good" or "whole" mind. I mean the kinds of minds that are marginalised outside of, and within, mental health systems. How, in a field that was founded specifically to identify and separate people with good minds and people with bad, broken, malfunctioning minds, do we queer our approach to mental illness?

'There are two questions I have been asked many times in my life: When did you realise you were queer? And when were you diagnosed with mental illness? I find these questions quite funny, because they seem to suggest that there was a pre-queer potentially heterosexual person somewhere in my past, and a pre-discursive neurotypical person I lost at the point of diagnosis. That before I began to articulate myself as a queer neurodivergent person, there was somebody who existed who was not these things. The sense I get from interacting with a lot of mental health practitioners is that though you may mean well, you somehow end up citing this heteronormative neurotypical "normal" as the benchmark of lived experience. The framework set up by a lot of MHPs is oppositional – there is a cis-het queer trans dichotomy, and there is a neurotypical able neurodivergent disabled dichotomy. We are starting to push ourselves when it comes to the first one – few MHPs will now (openly) say that queer trans people need "fixing", but they still see queer and trans identities as sites of trauma, and cis-het methodologies as a site of healing. Neurotypical able-minded and neurodivergent disabled is a different matter. The goal of a mental health intervention for a person who has mental illness or a psychosocial disability is to fix them, to bring them back to the "prior" state – to reinforce that I was somebody else before mental illness happened to me, and the only way forward is to go back.

'People with psychosocial disabilities and neurodivergent folx constantly hear about X therapy or Y methodology aiding in their recovery, how Z intervention will make them a functional member of society; how they will be normal again. Other than the obvious issues associated with the "normalisation" of anything, there is one other glaring flaw – some of us never recover. Not to recover from mental illness is to be constantly in limbo – because if you are not recovered, then you have failed to recover, and your life is measured in terms of failure. We have started to see (especially in a post-COVID world) colourful posters of MHPs promising to do away with the darkness and isolation of mental illness, saying you can "cure" depression and anxiety (two popular words used to denote the entire spectrum of psychosocial disability and neurodivergence). A flippant off-handedness that reduces the very real lived experiences of people with mental illness to a cool graphic, and an unfulfillable promise. Similar to queer and trans negative things neatly tied up with a rainbow ribbon, a lack of understanding and self-reflexivity on the part of MHPs can be, quite literally, fatal [for the client].

'The promise of a "fixed" futurity, the constant reminder of failure, the sense that you could have been somebody else, is at the centre of violence done by MHPs and the institution(s) of mental health. And because there is already so much vulnerability and isolation in the experience of being different or divergent, and so little affirmation or community available to those of us who are, it is easy to measure yourself by the yardstick of neurotypicality, and to see your life only in relation to the lives of neurotypical people. I did it for many years – believed in the rhetoric of "it gets better", that if I could find the right therapeutic space and the right medication, I would emerge from this a different person. There was always the (misleading) promise of being rehabilitated, of things I could achieve if I could reliably function from 8am to 5pm, of the productive member of society I could be… When the reality of the situation is that I didn't suddenly become bipolar when I was 18 at the point of diagnosis – there wasn't something abruptly wrong with me, or a sudden trauma that broke me. I've always been this way – I was a queer child with mental illness, and now I'm a queer adult with mental illness. Or, if I don't want to identify myself [in terms of] pathology – I am, have always been, and will always be, neurodivergent. You cannot fix me, because there is nothing wrong with me – I exist on a spectrum of human experience, and though my mind may not be "normal", it is valid.

'What are the sites of trauma for a neurodivergent person? It is often reinforced when speaking of people with mental illness that the individual is the site for trauma – that suicidal ideations, destructive behaviours, substance abuse occur at the level of the person. This is made easier when you articulate neurodivergence and psychosocial disability as pathology. The biomedical model isolates the person from their circumstances – circumstances that are more often than not an assemblage of marginalisations. It is so much easier to say, "that person committed suicide because they were mentally disturbed", instead of identifying death as a symptom of marginalisation, isolation, erasure, and structural oppression, in which you yourself might be complicit. It is my opinion that trauma occurs at the point that the self interfaces with the world – the place where the two come together. For instance, it is not my internalised, purely organic experience of anxiety that makes it hard for me to negotiate the world, often to the extent of ideations of self-harm. It is the way my anxiety engages with a world that pathologises and dismisses anxiety as weakness, and forms social networks and systems meant specifically to exclude experiences of anxiety. It is because anxiety, in the world, is equated to failure, and the shame and loathing internalised because of that constant sense of failure manifests as self-harm. However, I do want to caution about locating trauma wholly outside the person as well – the all-or-nothing inside/outside framework often oversimplifies complex interactions of self and systems. Trauma is a lived experience of an individual, a legacy of marginalised communities, and can be reinforced and amplified by MHPs who cannot recognise that.

I see you and to



see you I must situate myself

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'If we acknowledge sites and systems of trauma, and are critical of recovery, then perhaps the way forward is to change the framework to focus on healing and affirmation. "Healing" is quite a popular word, and it often indicates a saccharine-laden, superficial attempt to sweep difficult processes under the rug. I am not talking of the healing referred to in florid posters, in "feel-good" advertisements, in therapeutic sweet nothings. I'm talking about the messy, painful, raw process of healing – of healing constantly, because trauma is a continuum. Healing that requires both parties – the client and the MHP – to reckon with structures and power, and how they manifest. For a mental health practitioner the challenge is creating an environment where healing is possible, by locating yourself in the systems that cause trauma, by recognising your own complicity in those systems, and understanding how power functions to disadvantage and isolate. You cannot conflate healing with recovery. The former opens doors, acknowledges personhood, allows for a relational dynamic between MHP and client. The latter is linear, pathologised, and sets up a singular power hierarchy. There is no neutrality in affirmation – to see someone and validate their lives you must reflect on yourself – your privilege, the power you have, the systems you reproduce.

'If healing comes through affirmation, then affirmation is the complex ongoing process of acknowledging somebody else's world through your critical engagement with your own. When a client walks into a therapeutic space and closes the door behind them, the room does not shrink to the here-and-now – the client comes in bringing their world. And you, the MHP, also do not leave your locus and biases behind – they are right there in the room with you. If you envision the therapeutic space to be some kind of vacuum, then to you it is just two chairs, facing each other a few feet apart in an empty room. There is no context, there is no depth, no scope for anything beyond the prescriptive. If instead, you see those two chairs as two worldviews – as dynamic, interlinked yet distinct entities – then you set the foundation for affirmative work. The kind of work that says, "I see you, and to see you I must situate myself." That second chair will have queer, neurodivergent, disabled, marginalised people. And if those margins are not in the centre of your therapeutic space, taking up space as you cede it, then you will replicate the systems that exist outside that room.'

Amalina Kohli Dave is a queer feminist mental health activist. She has spoken about her lived experiences as a user-survivor at the intersection of queerness and mental illness in colleges, conferences, and in activist and community-led spaces. She has been guest faculty at Mariwala Heath Initiative's (MHI) course on Queer Affirmative Counseling Practice. She is also on the Advisory Board of MHI. While her day job is working on the conservation of rare books and documents, she has studied gender and queer theory, and is inspired by a disability rights approach and crip theory.

Conclusion

All the sections in this chapter – queering suicide and self-harm, queering diagnostic categories of sexual dysfunction and paraphilias, and queering recovery and healing – attempt to shift the gaze from the pathologised gendered-sexual other to the surveillance and governance function of the normative with its use of disciplinary techniques and of apparatuses such as diagnoses and treatment modalities. We hope that QACP practitioners, in addition to developing empathy for the lived experiences of their queer/trans clients, would also develop a perspective that queers cis-het knowledges and ways of knowing.

In conclusion, we would like to summarise some of the core tasks that the QACP course and this resource book seek for trainees/readers to perform:

1. Attending to and learning from the lived experience of queer/trans persons in the clinic, as also in the social world. As we have attempted to underline on several occasions–
   Don't put the entire burden of educating you on your queer/trans client; make the effort to educate yourself, while frequently taking a learner position with your client. Ask yourself, "How many queer/trans persons inhabit my social world, among my family, friends, colleagues, neighbours?" and "How aware am I of gender-sexuality diversity?"
2. Bringing self-reflexivity to issues of gender-sexuality in one's life and practice; asking oneself–
   "In what ways do my upbringing, my relationship with my body and gender, experiences of sexuality shape my understanding of normative as well as diverse gender-sexuality? What does my social location of gender,

sexuality, ability, caste, class, religion have to do with this? What are taboo issues for me when it comes to gender-sexuality? Do I have spaces within my social circle, or in supervision, to reflect on these issues?"

3. Knowing about the histories of pathologisation and medicalisation of non-normative genders and sexualities, and being attentive to these pathologising impulses in contemporary research, curriculum and practice, through critical questions like–
   "Do I see how and why research that individualises queer/trans person's mental health concerns, or that labels queer/trans communities as high-risk populations for HIV or mental illness, is a continuation of historical ideas of pathologisation?"
4. Knowing that the present mainstream mental health knowledge systems are pathologising at worst and queer/trans-ignorant or erasing at best; making the effort, therefore, to visibilise queer/ trans mental health concerns through research and advocacy, and to queer existing knowledge systems and therapeutic models in order to make them responsive to and affirmative for queer/trans clients.
5. Being aware that the psychic and the social are interwoven, and hence that framing subjective experience without attention to the social, political, cultural contexts, or attempting to reduce all psychic meanings and experiences deterministically to the social/structural alone, would be fallacious. A critical psychosocial perspective, therefore, informs QACP.

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CHAPTER 1

Setting the Scene: An Introduction

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5. Ranade, K., Shah, C., Chatterji, S. (2016). "Making Sense: Familial Journeys towards Acceptance of Gay and Lesbian Family Members in India", Indian Journal of Social Work (IJSW), Special Issue on Family Transitions and Emerging Forms, Vol No. 77, Issue No. 4, pp. 437-458
6. Ranade, K. (2018). Growing Up Gay in Urban India: A Critical Psychosocial Perspective. Springer Nature: Singapore, ISBN 978-981-10-8365-5.
7. See this article for details on response of associations of mental health professionals to conversion treatments in India at – **www.medium.com/@chintan_connect/a-dangerous-inclination-for-conformity-5f96aa1612c6 last accessed on 20/11/20**

ENDNOTES

CHAPTER 2

Reflecting on Normative Gender-Sexuality

8. Suggested readings for this section: Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. Social perspectives in Lesbian and Gay Studies; A reader, 100-133.Menon, N. (2005). How natural is normal? Feminism and compulsory heterosexuality. Because I have a voice: Queer politics in India, 33-39.
9. Suggested readings for this section: Delphy, C. (1993). Rethinking sex and gender. Women's Studies International Forum, 16(1), 1-9. www.doi.org/10.1016/0277-5395(93)90076-I
   Scharrón-del Río, M. R., Dragowski, E. A., & Phillips, J. J. (2014). Therapeutic Work With Gender-Variant Children: What School Psychologists Need to Know. School Psychology Forum, 8(1).
   Coolhart, D., & Shipman, D. L. (2017). Working toward family attunement: Family therapy with transgender and gender-nonconforming children and adolescents. Psychiatric Clinics, 40(1), 113-125.
10. Technique for dividing a large group into smaller groups: If participants need to be divided into, say, four groups, go round the room with the first participant saying "1", followed by the next participant saying "2", then "3" and then "4". Continue round the room, with participants repeating 1,2,3,4 aloud, till each of them has a number. Then all those with the same numbers come together to form the smaller groups.

ENDNOTES

CHAPTER 3

What does it mean to live as a queer/trans person?

11. An earlier version of Unique Life Stressors is published in Ranade, K., Chakravarty, S. (2013). Gay Affirmative Counselling Practice Resource and Training Manual, Saksham-TISS. Available at – www.academia.edu/22507988/Gay_Affirmative_Counselling_Practice_Resource_and_Training_Manual *Last accessed on 13th June, 2021*
12. www.prajnyaforpeace.wordpress.com/2019/06/20/coming-out-in-india-questioning-western-psychological-models-of-gay-lesbian-and-bisexual-identity-development-with-dr-ketki-ranade/ www.prajnyaforpeace.wordpress.com/2019/07/19/there-is-no-one-way-of-being-queer-on-straight-passing-queer-labour-and-stigma-management-strategies-in-india/
13. Readers may recall the discussions about the "Charmed Circle" in Chapter 2, and will note that not all kinds of heterosexuality are rewarded equally in society: heterosexual couples who violate community, caste, religious norms of marriage may face dire consequences too. Yet in terms of sexual hierarchy, heterosexuality is placed above queer sexuality.
14. Narrative written by Aryan Somaiya, transman, practicing psychologist, and co-founder of Guftagu Counselling and Psychotherapy Services
15. Distress due to the non-congruence between one's gender identity and the sex-gender assigned to one at birth.
16. It is important to acknowledge that "passing" is a complicated word for most trans persons, particularly trans binary persons – trans people who recognise themselves in the binary of men and women (Moncel, 2020). Read more about this at www.beyounetwork.org/articles/the-politics-of-passing
17. For resources related to gender transitioning, please refer to the following: Standards of Care for the Health of Transsexual, Transgender and Gender Non-conforming people, 7th version, WPATH, available at www.wpath.org/publications/soc

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Indian Standards of Care for Persons with Gender Incongruence and People with Differences in Sexual Development/Orientation, available at **www.athionline.com/publications**

A Good Practice Guide to Gender Affirmative Care, available at **www.sapphokolkata.in/wp-content/uploads/2017/06/GAC-Guideline1.pdf**

18. Sex Reassignment Surgery, popularly known as SRS, is the term that continues to be used by medical and mental health professionals as well as within trans communities, though a more affirmative term that is suggested for use is Gender Affirmative Therapies (GAT).
19. For discussion on reproductive options for transgender persons, refer to the Standards of Care for the health of Transsexual, Transgender and Gender Non-conforming people, 7th version, WPATH, available at **www.wpath.org/publications/soc**
20. This refers to research from a developed country, and while we do not have studies such as these from the Indian context, we must remember that caregiving for elderly parents is a far more complex issue in India, where social security or state systems are nearly absent for the care of dependent citizens, including the elderly – care is seen, instead, as a naturalised function of the family, an institution that has at its centre the value of filial duty.

ENDNOTES

CHAPTER 4

Learning from and about Queer Relationships

21. For more information on these approaches please refer to the following links:
    - The Life Cycle approach – www.endvawnow.org/en/articles/298-the-life-cycle-and-violence.html
    - An overview of existing theories, and of Johnson's Typology – www.bwjp.org/2019-11-14-ppt-1-per-page.pdf
    - www.openaccess.city.ac.uk/id/eprint/20806/
    - The feminist and social work approach – www.excoradfeminisms.files.wordpress.com/2010/03/bell_hooks-feminism_is_for_everybody.pdf
    - The family conflict viewpoint – www.ukessays.com/essays/sociology/applied-theory-of-domestic-violence-sociology-essay.php
22. Shared by Aryan Somaiya, transman, practicing psychologist, and co-founder of Guftagu Counselling and Psychotherapy Services.

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CHAPTER 5

Some Core Ideas of QACP

23. See Silverstein, 1991, for discussion on hormonal treatments for homosexuality
24. Available at - **https://en.wikisource.org/wiki/A_Letter_from_Freud_(to_a_mother_of_a_homosexual)** *Last accessed on 18th July 2020*
25. See Zachar et al.'s (2012) paper titled, 'The removal of Pluto from the class of planets and homosexuality from the class of psychiatric disorders: a comparison' for a critical discussion on ways in which scientific classification and declassification can sometimes work.
26. Shaleen Rakesh v/s NHRC, 2001, Available at – **www.lawandotherthings.com/2009/07/naz-foundation-and-nhrc/** *Last accessed on 18th July 2020*
27. Find links to statements at **www.medium.com/@chintan_connect/a-dangerous-inclination-for-conformity-5f96aa1612c6**
28. Find the petition at - **www.orinam.net/377/wp-content/uploads/2013/12/SC_MentalHealthProfessionals_WrittenSubmissions.pdf**
29. Dr Tirthankar Guha Thakurta discusses the lacunae in medical curricula in this blogpost – **www.gaylaxymag.com/articles/health-sexuality/the-homophobic-doctor/#gs.b2r09j** *Last accessed on 18th July, 2020*
30. Kenneth J Zucker (known for his work on reparative therapy on gender-non-conforming children) and Ray Blanchard (who coined the controversial term autogynephilia) played leading roles in determining the language of the Sexual and Gender Identity Disorders section for DSM-V.
31. The text of the NALSA Judgement is available at – **https://translaw.clpr.org.in/wp-content/uploads/2018/09/Nalsa.pdf**
32. A copy of the Act is available at – **www.socialjustice.gov.in/writereaddata/UploadFile/Binder2.pdf**
33. **www.hindustantimes.com/india-news/the-making-of-a-standard-protocol-in-gender-care/story-bbncDzdQX3CIZD76doHS0L.html**

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CHAPTER 5

Some Core Ideas of QACP

34. We have borrowed the term 'queer labour' from Rinchin, writer and activist from Bhopal who used it in her talk titled, 'Asking Questions: Queer Peoples' Labours in a Straight World' during a conference - Women in the Worlds of Labour: Interdisciplinary and Intersectional Perspectives, 22nd February, 2014 at TISS, Mumbai. Rinchin used this term to refer to the labour of queer feminist activists in women's movements in the country that until then had primarily engaged with issues of cisgender, heterosexual women.
35. **www.alp.org/breaking-isolation-self-care-and-community-care-tools-our-people**
36. An earlier version of Tenets of QACP is published in Ranade, K., Chakravarty, S. (2013). Gay Affirmative Counselling Practice Resource and Training Manual, Saksham-TISS. Available at – **www.academia.edu/22507988/Gay_Affirmative_Counselling_Practice_Resource_and_Training_Manual** *Last accessed on 30th October, 2020*
37. APA's 'Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients' (2012); APA's 'Guidelines for Psychological Practice with Transgender and Gender Nonconforming People' (2015); BACP's 'Good Practice across the Counselling Professions 001 – Gender, Sexual, and Relationship Diversity (GSRD)' (2019).
38. **www.mhi.org.in/qacp** is a one-stop resource bank with a collection of 100+ videos, podcasts and articles on queer/trans lives and LGBTQ+ mental health. The same link also includes a list of queer affirmative MHPs, peer supporters and queer/trans collectives from all over the country.

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CHAPTER 5

Some Core Ideas of QACP

39. A guide to LGBTQ+ films can be accessed here **www.editorial.rottentomatoes.com/guide/best-lgbtq-movies-on-amazon-prime** and links to some more films- 1977 by Peque Varela **www.vimeo.com/26781224**, Blurring Lines by Ramsha Alam & others (MCRC, Jamia) **www.youtube.com/watch?v=gi3huO3QFtc**, Orchids - My Intersex Adventure by Phoebe Hart **www.dailymotion.com/video/x7x18oa**, That's My Boy by Akhil Sathyan **www.youtube.com/watch?v=McY2ccJa0oo**
40. List of queer/trans collectives from across India **https://docs.google.com/spreadsheets/d/1Ij2QD707rXjWO9so_CCaBjHMr4zs6u774BbyKnljoaw/edit#gid=1634002743** Last accessed on 15th June 2021.
41. For details on nominated representatives in the MHCA, please refer to Chakravarty, S. (2020). 'Nominated Representative' and Queer Lives. Research Journal of Humanities and Social Sciences, 11(4), 371–373.

ENDNOTES

CHAPTER 7

Queering Some Clinical Ideas

42. Parts of this section have been previously published in Ranade, K., Anjali – mental health rights organisation, (2017). Sexual Rights of Women with Psychosocial Disabilities: Insights from India. Kuala Lumpur: Asian-Pacific Resource & Research Center for Women (ARROW).
43. See 5.1.4 for discussion on Autogynephilia

DISCLAIMER

MHI urges individuals to do their own due diligence before approaching a mental health practitioner (MHP), whether QACP certified or not. Participating in the QACP Course does not guarantee that professionals will implement this training in their practice. MHI is not responsible for the actions of persons who have undergone the QACP training in their professional spheres. It is suggested that the best source of information for due diligence is the LGBTQI+ community itself.

The Queer Affirmative Counselling Practice (QACP) Resource Book is for mental health practitioners (MHPs), social workers, stakeholders within mental health and those working on gender and sexuality. This is a pathbreaking text for the Psy disciplines - which have historically colluded to pathologise queer-trans identities.

The authors are from the LGBTQ+ community. They are MHPs, academicians, researchers, trainers and activists with over twenty years of experience in India. They believe that it is possible for a cisgender heterosexual practitioner to be part of a queer-trans client's journey in a meaningful way. The book offers a balance of information, perspective, skill and an eclectic set of pedagogic tools to engage with the knowledge drawn from queer and trans realities. This can help MHPs respond affirmatively to challenges faced by those marginalised on account of their gender and sexuality. This book is informed by queer feminist theory, critical psychology, mad studies, and feminist therapy.

This Resource Book goes beyond working with queer-trans clients and foregrounds linkages between structural oppression and mental health. In doing so it highlights an anti-oppressive framework to challenge unequal systems, thereby 'queering' mental health and contributing to social justice.

ISBN 978-81-947894-0-6
9 788194 789406

PUBLISHED BY
mariwala health initiative

COVER DESIGN
/ Anuja Khokhani