

Mental health of LGBTIQ+ people in India during the COVID 19 pandemic: risks, access, lessons

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The COVID-19 pandemic and the associated containment measures have resulted in a mental health crisis globally. Marginalised populations have been disproportionately affected during the pandemic with an aggravation of existing inequalities, and this has increased the risks to their mental health. The LGBTIQ+ population is among those marginalised whose lives have been rendered even more precarious than before by the pandemic. This paper explores some of the main risks to the mental health of LGBTIQ+ people in India, the advice being given to them by mental health professionals and activists, and need for queer revisionings of uncertainty, the concept of a future and individualism.

Keywords: India; COVID-19; LGBTIQ+

Introduction

The COVID-19 pandemic and the associated containment measures, particularly the lockdown, have resulted in widespread psychosocial distress. Some of the causal factors for this distress are aptly summarised by Pfefferbaum and North (2020:1) as follows:

Uncertain prognoses, looming severe shortages of resources for testing and treatment and for protecting responders and health care providers from infection, imposition of unfamiliar public health measures that infringe on personal freedoms, large and growing financial losses, and conflicting messages from authorities are among the major stressors that undoubtedly will contribute to widespread emotional distress and increased risk for psychiatric illness associated with Covid-19.

The World Health Organization (WHO) (2020, 2,4) mentions other risks to mental health ‘...working from home, temporary unemployment, home-schooling of children, and lack of physical contact with other family members, friends and colleagues...’. These mental health risks are exacerbated for already marginalised populations who might live in poverty, depend on daily wages, have critical healthcare needs and/or be particularly vulnerable to violence. LGBTIQ+ people in India experience several of these risks. Confinement within hostile homes, isolation, loss of livelihood and income, threats of eviction, limited access to essential

medication, physical and emotional abuse, difficulties in accessing mechanisms of redress for violence, and the general absence of state support have contributed to unfavourable conditions for their mental health the world over, including in India. Activists have argued that the LGBTIQ+ community has been completely invisibilized in the pandemic (eg: Anand, 2020; Borah, 2020).

Moreover, the pathologization of queerness and the stigma associated with a lack of conformity to compulsory heterosexuality and cis-genderedness have already made LGBTIQ+ people vulnerable to psychosocial distress (see for example Kealy-Bateman, 2018; Nakamura and Logie, 2019; Wandrekar and Nigudkar 2020). This paper analyses some of the mental health risks confronting LGBTIQ+ people in India, the support offered to them by mental health professionals and activists, and the need for queer revisionings of mental health that are receptive of the lived realities of LGBTIQ+ people and that entail reconsiderations of the concepts of a future, uncertainty and the individualism of much of the mental health sciences.

The study is based on secondary sources comprising talks by and interviews with mental health professionals and LGBTIQ+ activists on the issue of queer mental health in India and news reports on the same that were collected through a general online search with the keywords 'LGBT lockdown India' and 'LGBT mental health India' as well as through links to various such resources shared on social media platforms including LGBTIQ+ support groups. To ensure the privacy of these groups, personal experiences of mental illness among LGBTIQ+ people and closed webinars restricted only to members were not taken into account; only resources publicly available were considered.

The paper is divided into three sections, each comprising an area of risk to LGBTIQ+ people's mental health, the coping strategies being recommended and the implications of these risks and recommendations for queer mental health. The first section outlines the challenges to livelihoods, housing and essential medication for LGBTIQ+ people, which foreground the need for a holistic approach to mental health that is premised on lived realities and that shifts away from the individualism of the mental health professions. The second section analyses the most frequently cited incursion into queer people's mental health, which is confinement in hostile home environments and the various entailments of this hostility. The suppression of selfhood as a mode of survival that this confinement entails and the uncertainty about the end of this suppression and about any fathomable visions of a future are explored. The final section explores the virtualisation of mental healthcare in COVID times and the challenges to accessing mental healthcare for LGBTIQ+ people, which further necessitates a shift beyond individualism.

Towards a mental health grounded in lived realities

The sudden imposition and indefinite extension of the nationwide lockdown in India beginning

on March 24th 2020 has resulted in severe economic hardships and challenges to accessing essential healthcare facilities. The transgender community is among the worst affected social group in India. Several transgender people who survive on daily wages earned through begging, sex work and festivals, weddings and other events have lost their livelihood as a result of social distancing rules (Chhetri, 2020; Dasgupta, 2020; Jadhav, 2020; Kotak 2020). Many live in rented accommodation and are often charged higher rents than non-trans people, which make them increasingly vulnerable to eviction as they run out of money (Chhetri, 2020). They tend to not have rent agreements resulting in exploitation by house owners (ibid, 2020). In the absence of formal documentation or discrepancies in name and/or gender on the available documentation, many trans people cannot avail of government schemes (Jadhav, 2020). Activist Urmi Jadhav says that she receives several calls from the transgender community asking her if they will be able to get on trains and stand at signals once the lockdown is called off, expressing worries about their future (ibid). Activists also reveal several distress calls from the transgender community about dwindling rations and food supplies (Chhetri, 2020; Jadhav, 2020). Trans men have a distinctive problem of tending to be very scattered, making it difficult for activists to reach out to support them in difficult circumstances (Borah, 2020). Trans and intersex communities in particular are also dealing with the stress of the Transgender Persons Act, 2019, which is highly discriminatory by homogenising their cultural diversities, limiting their opportunities to officially identify with their gender of choice, and which does not include any protocols for gender affirmative healthcare among other lacunae that are detrimental to gender minorities in the country (e.g. Singh and Shankar, 2020).

Accessing antiretroviral drugs (ARTs) used in the treatment of HIV and hormone therapy medication have become challenging for members of the LGBTIQ+ community owing to limited public transport and restrictions on using it, higher fares for taxis and autorickshaws, police patrols, and restricted hospital access (Chhetri, 2020; Jadhav, 2020; Kotak, 2020). Difficulties in accessing hormone therapy have resulted in some transgender people suffering serious health complications requiring emergency treatment (Jadhav, 2020). HIV clinics run by NGOs are also working on reduced hours, and when possible, employees with these NGOs are delivering ARTs to the homes of those who need them (Anand, 2020). Nevertheless, these efforts are still limited in comparison to the growing calls for assistance (ibid).

These threats to basic survival exemplify the general precarity of LGBTIQ+ lives and raise critical questions about the relevance of mental health support for those whose very existence is in jeopardy. Decolonial critiques of the psy disciplines of psychology, psychiatry, psychiatric social work and others related to mental health (e.g. Bhatia, 2018; Mills, 2014; Zapata, 2020) have emphasized the imperative for a grounded mental health that emerges from contextual realities including structural inequalities and people's lived realities. This becomes particularly necessary given the hegemony of the West in producing psy knowledge that is not reflective of global contexts. These critiques object to the individualism in the form of over-medicalization that characterise much of the psy disciplines whereby the illness is located in the person without

a concern for environmental specificities.

The challenges entailed in accessing essential survival needs of the LGBTIQ+ community illustrate the need for a holistic mental health that is receptive to the immediate urgencies of the community. This approach to mental health is reflected in the support being extended to LGBTIQ+ people wherein emotional reassurance is being provided in addition to advice on health and the practical supply of medication wherever possible. None of the literature analysed for this study made any mention of the vulnerability to mental illness that LGBTIQ+ people experience, which has been a major subject of concern. This is not to say that people with existing mental health problems ought not be given due attention in pandemic mental health studies but the contributory role of environmental stressors is being given due weightage, which seems appropriate. The psy disciplines alone have little to contribute to mitigating the stressors associated with the loss of daily wages, increasing poverty, threats of eviction and hunger being faced by LGBTIQ+ people and current discourses of LGBTIQ+ mental health during the pandemic illustrate the role of specialised mental health support *inter alia* other forms of interventions to help LGBTIQ+ people survive the pandemic.

Concerns persist about the over medicalization of mental health problems without due concern to context during the pandemic. For instance, Rochelle Burgess (2020) writes:

Once again, recommendations forget half of the equation: our need to address the social and economic conditions that contribute to poor mental health... Right now, the COVID-19 mental-health strategy is dominated by concerns about an increase in deaths by suicide, a rise in the incidence of depression and possible neurological damage caused by the virus, and rightly so. But labelling a condition doesn't make the social challenges around it disappear... We need a practice that recognizes the environments that can make people ill, and that supports efforts to do something about it.

Burgess goes on to cite examples of counselling helplines that connect people to food banks and emergency shelter facilities as illustrations of patient-centred mental healthcare because of their holistic nature. This discourse on LGBTIQ+ mental healthcare in India exemplifies a holistic approach to mental health that takes into account the material needs of people as well instead of attempting to tackle mental health alone.

Hostile home environments and the uncertainty about a future

Being trapped in hostile home environments with unsupportive natal families or abusive partners is the most commonly identified danger with which LGBTIQ+ people are faced during the lockdown (e.g. Anand, 2020; Borah, 2020; Chhetri, 2020; Dasgupta, 2020; Kotak, 2020; Mogli, 2020; Onir, 2020; Ragnekar, 2020; Vashista, 2020b). Many are forced 'back into the

closet' (Dasgupta, 2020) through restrictions on their sartorial expression in accordance with heterosexual and cisgender norms (e.g. Borah, 2020; Kotak, 2020; Vashista, 2020a; Vashista, 2020b) and through separation from support groups and/or families of choice (e.g. Dasgupta, 2020; Vashista, 2020b). There are fears of the lockdown sounding the 'death knell' for trans collectives (Dasgupta, 2020) and mental health risks resulting from isolation with the breakdown of 'kinship and friendship structures' for LGBTIQ+ people, particularly for those living in rural and semi-urban areas (ibid). Speaking on the subject of queer mental health, filmmaker Onir (2020) says that 'We have a family and we have a lover and suddenly that space is not there anymore. It's a vacuum...'

Physical abuse is a common occurrence (Borah, 2020; Chhetri, 2020; Dasgupta, 2020). Being forced to open accounts on matrimonial sites (Borah, 2020) and coerced into marriages (Mogli, 2020) are some of the violations of LGBTIQ+ people's rights that have been taking place during the lockdown. The pathologization of gender and sexual non-conformity has led to the emergence of a range of conversion therapies intended to 'cure' this non-conformity and restore cisgenderedness and/or heterosexuality (e.g. Narrain and Chandran, 2016). There have been cases of LGBTIQ+ people being subjected to forced medication during the lockdown in an attempt to convert them (Mogli, 2020). Moreover, physical assault, forced marriages, restrictions on sartorial expression and confinement within the home are also forms of conversion therapy (e.g. Mogli, 2020; Tenneti, 2020). A recent tragic case that occurred during the lockdown was the suicide of a young queer woman from Kerala who was subjected to forced sedation in a 'de-addiction' centre by her family who was unwilling to accept her (e.g. Chatterjee, 2020; Deol, 2020).

The limited scope for rescue, escape or seeking alternate accommodation and more supportive conditions have understandably compelled mental health professionals and activists to reiterate to LGBTIQ+ people the imperative to avoid confrontation with abusive families or partners (see for example Anand, 2020; Borah, 2020; Onir, 2020; Ragnekar, 2020; Vashista, 2020b). As Vashista (2020b) stresses, 'This is not the time to test the waters. This is not the time to come out to them because you do not know what the consequences can be.' Onir (2020) similarly says, 'It's the word 'compromise' [to] which we are always saying 'No, no, no'...But silence becomes your only way out.' Coping techniques such as dressing up as per one's choice in safe spaces such as the bathroom (Vashista, 2020b; Vashista, 2020c), looking at old photographs (Vashista, 2020c), avoiding looking in the mirror too often particularly if one is forced to not dress according to their gender of choice or is unable to maintain one's hair in accordance with their self-perceived gender identity (Vashista, 2020c), breathing techniques (Borah, 2020), and other grounding techniques to help in calming (Vashista, 2020b) are recommended to help LGBTIQ+ people get through the lockdown in hostile home environments. Advice about being prepared for emergencies that might entail leaving the house is also provided such as keeping important documents and cash ready (Borah, 2020; Vashista, 2020c).

The necessity for LGBT+ people to suppress their identity and tolerate queerphobic environments in the absence of external support as well as coping techniques that are likely to provide only temporary relief reveal the extreme precarity of LGBTIQ+ lives. Being forced to portray a dual selfhood, which entails the routine suppression of one's true self with only occasional opportunities for respite through self-affirming activities in specific safe spaces (if possible) and the constant threat of violence are sources of immense stress to LGBTIQ+ people living in hostile home environments. The worst part of this trauma is that it is unclear when it will end.

Vashista (2020c) writes in her post on LGBTIQ+ mental health 'THIS TOO SHALL PASS' to emphasize the temporariness of the current situation. But uncertainty is one of the key characteristics of the pandemic and the post-pandemic world with several speculations but no clear vision of the trajectory of current circumstances or of what 'normal' life is going to be. Lockdown restrictions are being tightened and then loosened. Hence, it is uncertain when LGBTIQ+ people trapped in hostile home environments are going to escape or what kind of employment those surviving on daily wages can hope for. For those covertly being subjected to conversion therapy or those who have already been married against their will, it is uncertain when redress will be possible, if at all, and whether and when these difficult times will pass.

The pandemic has also necessitated a rethinking of what constitutes 'queer futures'. Lee Edelman's rejection of 'futurity', which he associates with procreation and the subsequent devaluation of queer lives has been critiqued for being only one view of a future. Alison Kafer, for instance, emphasizes how queer people are often denied the promise of a future. The need for queer people to be able to conceive of and to have a liveable future is crucial to their survival (e.g. Goltz, 2011; Minadeo, 2019). The uncertainty facing the world today and the particular threat to the survival of LGBTIQ+ people requires that mental health interventions for rethink their therapeutic approaches excluding the assumption of an eventual restoration of normalcy. This does not invalidate grounding and visualization techniques or the suggestion to avoid confrontations – all of which could be crucial for their immediate survival – but whether and how these approaches will need to be reconsidered given the potentially new emerging world order will likely be necessary.

The virtualisation of mental healthcare

The containment measures adopted to curb the pandemic have resulted in the increased virtualisation of mental healthcare (e.g. Pang, 2020; Zhou et al., 2020) with several private practitioners shifting their practice online. An increase in calls on telephonic helpline services run by NGOs for the LGBTIQ+ community has also been observed (e.g. Anand, 2020; Borah, 2020). But accessing mental health services remains a challenge for the most vulnerable LGBTIQ+ people because of increased virtualisation. While various helpline numbers and lists of mental health practitioners offering free services are being uploaded online, they remain

inaccessible to those who do not have smartphones or internet access. Transgender activist, Urmi Jadhav, for instance mentions that many of the poorest transgender people who survive on daily wages do not possess a smartphone. Many support group meetings of LGBTIQ+ people have also moved online, which creates similar accessibility issues.

Moreover, privacy concerns preclude accessing both online and telephonic mental healthcare services, particularly for LGBTIQ+ people in hostile home environments. Some have found the bathroom or the terrace a safe space for a therapy session (Vashista, 2020a; Vashista, 2020c). This might not be possible for everyone, particularly in larger cities like Mumbai where houses tend to be small (Vashista, 2020c) and often with a large number of people living in a limited space. These issues in accessing virtual mental healthcare exist in addition to older problems such as the high cost of one-on-one counselling, finding a queer affirmative practitioner and the stigma and apprehension surrounding psychosocial distress and allied treatment regimes.

Requests for mental health support are being extended to people beyond mental health professionals, too. Festival organizer and author Sharif D. Ragnekar cites an important example about how non-professionals are receiving emergency calls from the LGBTIQ+ community. He recounts receiving 'random calls' from people in non-metropolitan cities like Jaipur and Indore asking him for help from hostile families and other problems created by the lockdown. This, he says, reveals their desperation. Jadhav (2020) also speaks of receiving several distress calls from the transgender community asking difficult questions about their future to which there are no clear answers. These examples suggest that the emergency of the pandemic has possibly decentred professional mental health, especially for minority communities, away from specific individuals trained in the psy disciplines to those who are trusted members of the community. It cannot be inferred that this was not the case prior to the pandemic but has been exacerbated now.

Another concern with virtual mental health, not mentioned specifically in the context of LGBTIQ+ mental healthcare in India but identified by Pang (2020) is the availability of safe spaces to conduct virtual counselling and to maintain confidentiality for mental health practitioners. Many LGBTIQ+ people who are providing mental health services for their communities might themselves be living in hostile environments perhaps with lower or no income and threats of eviction. The effects of this precarity on their practice deserve greater attention.

Therefore, a queer mental health approach will need to find new heuristics including new strategies to reach out to LGBTIQ+ people rather than the conventional individualist approach that involves making one's services known and available and waiting to be approached by potential patients. Currently, there does not seem to be an alternative to the online or the telephonic approach to queer mental healthcare or the heuristic of having individuals seek out

mental health services themselves. LGBTIQ+ activist Vivek Anand, mentions that since the decriminalisation of homosexuality in 2018, the government has made no efforts to create public discourses to spread awareness and legitimise the LGBTIQ+ community. These discourses would likely have positive implications for the mental health of the community and might become indispensable in a pandemic and post-pandemic world as personal counselling appears to be getting increasingly out of reach with increasing employment precarity and growing virtualisation. Furthermore, the apparent growing demand for mental health support from non-professionals as well as the mental health risks emerging at large owing to the uncertainty of the pandemic perhaps necessitate a new approach to mental health training that is more decentralised and available in languages besides English without compromising on technical rigour. There is also certainly a reciprocal need for the psy disciplines to ‘learn’ from the experiences of these non-professionals who are trusted by their communities.

Conclusion

The pandemic and the containment measures have had a severely detrimental effect on the mental health of the LGBTIQ+ population in India with loss of livelihoods and housing, limited access to crucial medication, being trapped in hostile home environments, and dwindling access to mental healthcare. Their predicament as well as the support being extended to them reveals the need for a holistic approach to mental health that is premised on their lived realities and social inequalities and that continues to shift away from the individualism of the psy disciplines the way it currently is. Queer mental health also needs to incorporate the uncertainty of the pandemic and the precarity of any promises of a future into its therapeutic practices and perhaps conceive of new ones. Finally, alternatives to the virtualisation of mental healthcare are necessary to make mental health accessible to the most vulnerable of the LGBT+ community and mental health education needs to be revised and decentralised in order to expand the discourse of queer affirmation.

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