CURATIVE VIOLENCE AGAINST LGBT+ PEOPLE IN INDIA: KEY ISSUES AND PERSPECTIVES

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ABSTRACT

Ending violence against LGBT+ people is a major aspect of queer rights and several efforts have been made to document these forms of violence for purposes of advocacy, support and affirmative therapy. One form of violence comprises efforts to eliminate queerness or to suppress its expression through a range of interventions including medication, electroconvulsive "therapy", hormone administration, physical assault, enforced dress codes, confinement within the home, corrective rape, and several others. This form of violence, referred to as curative violence in this paper, has received some attention as a specific category of LGBT+ violence in India. However, further and focused studies in this domain of violence are necessary. The present study is an effort in this direction. Based on a critical literature review of documentation on curative violence and of published narratives of LGBT+ people's experiences of curative violence as well as interviews with LGBT+ rights activists with a focus on India, this study is an attempt to develop a holistic understanding of curative violence as it exists in India today. The findings of the paper suggest that it is predominantly the family and immediate associates of LGBT+ people who commit acts of curative violence or seek out curative therapies, with the biomedical establishment being relatively less frequently cited as a site of curative violence[i].

Furthermore, the absence of an emphasis on children's rights and a lack of value for the autonomy of children have been identified as crucial factors in the perpetuation of curative violence in childhood, which was found to be the time in people's lives when curative violence was most pervasive.

INTRODUCTION: CONCEPTUALISING CURATIVE VIOLENCE

The proscription of queerness in its different manifestations has led to various kinds of violence against LGBT+ people the world over, which is further complicated through intersectional axes of oppression (e.g.: Patterson and Gossett 2016; Mogul, Ritchie and Whitlock 2012, Wells and Poulders 2006, Whitaker 2011). The term "curative violence" appears to be apt to capture the various manifestations and nuances of the proscription of queerness in its various forms. The term was first used by Eujung Kim in her book *Curative Violence: Rehabilitating Disability, Gender and Sexuality in Modern Korea* (2017) to describe the various rationales and modes through which disability is governed–and curtailed –in society using the logic and means of "cure". Kim analyses the ways in which sexuality and gender are mobilised in the project of governing disability through the principles of eugenic world-building. She explores the inextricability of compulsory able-bodiedness and compulsory heterosexuality–which she draws on from scholars in queer disability studies such as Alison Kafer and Robert McRuer–which helps to mobilise the logic of cure to explore overlaps between queer studies and disability studies. Her work does not particularly focus on various efforts to regulate queerness, but her conceptions of cure and curative violence offer valuable analytical frameworks for queer studies.

Kim conceptualises cure in two ways: "a crossing of times and categories through metamorphosis" (2017: 10) and "a transaction and negotiation that involves various effects, including the uncertainty of gains and the possibility of harms…as well as what are considered benefits" (ibid.). She terms the latter "curative violence". Kim's conception of cure shifts the concept away from the prerogative of the medical field into the social and cultural field. Thus, cure for Kim is not confined to the complete elimination of the "sick role" (Parsons 1951) but captures the complex and conflicted rationalities that compose cure.

In the present study, curative violence constitutes a specific form of violence against LGBT+

people that aims to enforce conformity to binary norms of gender and sexuality or to suppress the expression of transgression in matters of gender and sexuality. On the one hand, the scope of curative violence is extremely narrow in terms of its specific focus on the elimination or the suppression of queerness. In this sense, it could be used as a synonym for medical violence that pathologises queerness and attempts to regulate its prevalence (e.g.: Narrain and Chandran 2016, Dickinson 2015, Drescher, Shildo and Shroeder 2018, Nicolosi and Freeman 1997). On the other hand, curative violence is broad enough to include *all* forms of violence against LGBT+ people, since the very act of othering members of non-normative gender and sexual minorities instantiates the concomitance between violence and cure.

The forms of pathologisation and cure have varied across the LGBT+ spectrum. A large body of work on curative violence has focused on medical interventions such as electroconvulsive therapy, hormone therapy, counselling therapy and other forms of reparative therapy to cure homosexuality. The case of Robert Spitzer and the history of the declassification of homosexuality as a mental disorder in *the Diagnostic and Statistical Manual for Mental Disorders (DSM)* is of immense significance in the history of queer rights (Carey 2012). Spitzer was instrumental in advancing the rigorous classification of mental disorders in the *DSM* and advocated for the declassification of homosexuality as a mental disorder on the grounds that homosexuality did not necessarily entail any kind of distress unlike alcoholism or depression. This was how Spitzer played a key role in declassifying homosexuality as mental illness and replacing it with "sexual orientation disturbance" to include specifically those conditions where a person's sexual orientation was a source of distress. However, Spitzer published a controversial paper entitled 'Can Some Gay Men and Lesbians Change Their Sexual Orientation?' in 2001 in which he argued that reparative therapy might at times be successful among gay people who were very keen on "overcoming" homosexuality. Spitzer's method of interviewing ex-gay people was highly criticised for its flaws, but the study was still published. It was only in 2012 that Spitzer issued a public apology about his

flawed work, emphasising that there was no evidence of the success of reparative therapy. Spitzer's fraught contributions to the depathologising of queerness illustrate the value-ladenness and subjectivity of medicine in the history of queer rights. Despite the denunciation of conversion therapy, several attempts–both within biomedicine and alternate medicine–in an attempt to cure homosexuality, persist.

Similar debates have existed about the classification of gender dysphoria as a mental disorder. While the *DSM-IV* pathologised all forms of gender non-conformity under the term "gender identity disorder", the *DSM-V* has replaced the term with "gender dysphoria". The *DSM-V* defines gender dysphoria as follows:

> …the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. Although not all individuals will experience distress as a result of such incongruence, many are distressed if the desired physical interventions by means of hormones and/or surgery are not available ... [It] focuses on dysphoria as a clinical problem, not identity per se (2013: 451).

This conception of gender dysphoria suggests that it is only the distress arising out of gender non-conformity that could be classified as a mental disorder and not the non-conformity itself. However, the entry on gender dysphoria proceeds to include various descriptors of gender transgressive expression and feelings, thus re-pathologising gender transgression. The *ICD-11* has proposed a transfer of gender dysphoria from a mental disorder to a sexual disorder, thus merely altering the discourse around the pathologising of gender transgression. Another important reason for the enduring pathologising of gender transgression is the argument of co-morbidity wherein gender dysphoria is said to have a correlation with schizophrenia and other kinds of mental disorders (e.g.: Rajkumar 2014). These correlations make it increasingly difficult to entirely declassify gender dysphoria as a disease category altogether, following the logic of bio psychiatry. This argument has been disputed (e.g.: Byne

et al 2018), but it remains a mode of thinking in psychiatry in India. As with homosexuality, several attempts to treat gender dysphoria including counselling, hormone therapy and even physical violence have known to exist. These are based on the premise that this is a pathological condition that can and should be cured.

Intersex variations[ii] raise important ethical debates that are distinct from those of homosexuality and gender dysphoria. The discussions raised earlier reveal the prominent role played by the psy professions or the mental health professions of psychology, psychiatry and psychiatric social work among others in the pathologising of homosexuality and gender dysphoria. But in the case of intersex conditions, various branches of somatic medicine contribute to their pathologising[iii] (Karkazis 2008, Davis 2015). The fact that intersex variations are much more explicitly localisable within a biological substrate has, in several ways, hindered discourses about their depathologising in relation to homosexuality and gender dysphoria. This does not mean that no form of intersex activism exists; it certainly does. But in India, for instance, the biological essentialist view of intersex conditions has delayed the political mobilisation of intersex people. It is only in recent times that debates on intersex people's rights have gradually begun to gain attention in the context of queer rights. The arbitrary and, at times, enforced attribution of a binary gender to intersex babies both through surgeries and other means is an attempt to "fix" gender "ambiguity" and is an important form of curative violence of queerness.

The three examples cited earlier are some of the seminal illustrations of curative violence that affect LGBT+ people and that have characterised LGBT+ history and politics the world over. While the present study focuses on India, it is essential to contextualise the discussion in India within transnational discourses to allow for an exploration of the relevance of extant frames of reference of curative violence and to develop new ones. In India, a case of curative violence triggered one of the earliest demands for the decriminalisation of homosexuality. In

2001, a gay man approached the Naz Foundation claiming that he had been subjected to drugs and behaviour therapy by a psychiatrist to render him averse to homosexuality. But when an effort was made to register a complaint with the National Human Rights Commission (NHRC), the complaint was not registered on the grounds that homosexuality was illegal which does not make attempts to cure it illegal. Ever since, several attempts by doctors to cure or at least discourage homosexuality have been documented in India. The Campaign for Open Minds (Orinam 2009) mobilised healthcare providers to take a stand opposing conversation therapy and contributed to identifying queer-affirming mental health providers who filed a petition against the Supreme Court 2013 verdict recriminalising homosexuality. The Humsafar Trust conceptualised a *#QueersAgainstQuacks* campaign to call out health practitioners who propagated curative violence and brought out a manual directed at spreading awareness about the legitimacy of alternate gender and sexual identities. Forced gender assignment/reassignment surgeries on intersex babies is a subject that has not received mainstream attention in LGBT+ discourses in India but remains a seminal area of concern. However, a clear and holistic understanding of curative violence against LGBT+ people in India and the very notion of "cure" itself in this context is still absent, which constitutes the fundamental rationale of this study.

The aim of the present study is to map the terrain of curative violence in India in an effort to identify its forms, causes and means of coping that people who experience these forms of violence adopt. This is done through a critical literature review of documentation of LGBT+ violence and of personal narratives of LGBT+ people with respect to the curative violence they have experienced as well as through interviews of LGBT+ activists about the cases of curative violence that they handle. The study reveals the centrality of the family and the immediate associates of the person in perpetuating curative violence and the ways in which biomedicine is cited relatively less often[iv]. It is also revealed that the limited recognition of children's rights and the curtailed autonomy of the child contribute to the prevalence of

curative violence in childhood, which is a major time for curative violence for LGBT+ people.

Before proceeding with the paper, a quick note on terminology is warranted. The terms "queer" and "queerness" have been used as synonyms for non-conformity in matters of gender and sexuality. LGBT+ is a term sometimes used synonymously with non-conformity in terms of gender and sexuality but more often as a set of identities. As some of the people spoken to for this study did not wish to be referred to as "queer", the term queer is not used as an adjective for *people*; instead, LGBT+ is used in these contexts.

METHODOLOGY

The study adopts a qualitative research methodology; two approaches have been adopted. For the first section, the literature review of available literature on curative violence in India has been adopted. The texts chosen document attempts to eliminate gender and sexual transgression or to curb their expression through biomedical, religious, alternative healing and a range of social and cultural approaches with a specific focus on India. The literature includes legal and medical texts documenting curative violence as well as an analysis of personal narratives of LGBT+ people about their experiences of curative violence. These personal narratives offer insights into the role of the family and the immediate acquaintances in perpetuating curative violence as well as the role of law enforcement authorities, potential employers and society at large at perpetuating curative violence across the lifespan. These narratives offer perspectives that are often not considered in broader discourses of curative violence as mentioned in legal and medical literature. It was intentional not to interview LGBT+ people about their experiences of curative violence because of the ethical issue of expecting them to relive their trauma. Since an analysis of existing narratives has not yet been attempted with the aim of identifying forms of curative violence, it appeared to be most suitable to conduct such an analysis prior to interviewing LGBT+ people regarding their

experiences. However, given the breadth of themes that emerged, such a study was not found to be necessary.

The second method adopted in the study was interviews of LGBT+ activists. These narratives were found to be important as it was assumed that they would reveal ground realities of curative violence that might not have been captured in the literature. From an ethical standpoint, the activists were not expected to share personal narratives of their own, which did not risk putting them through the trauma of reliving painful experiences. These activists were recruited from well-known non-governmental organisations or NGOs in Mumbai, Chennai and Bangalore. An e-mail was sent to the organisation, which then recommended the names of members who could be contacted. In some cases, the activists were contacted directly. The names of the organisations to which the activists belong have been kept confidential.

The present study does not contain epidemiological data on the prevalence of specific forms of curative violence against LGBT+ people. The activists and staff members interviewed were located primarily in Mumbai, Chennai and Bangalore. Thus, the findings of the study cannot be generalised for the whole of India. No specific forms of curative violence against asexual or bisexual people could be identified, which does not make the study exhaustive. These are some of the limitations of the study.

MAPPING THE TERRAIN OF CURATIVE VIOLENCE AGAINST LGBT+ PEOPLE IN INDIA

Curative Violence by the Medical Establishment

The term “cure” embedded within curative violence aligns this form of violence most closely with medical interventions, particularly biomedicine. As Arvind Narrain and Vinay Chandran state in the introduction to their book *Nothing to Cure: The Medicalisation of Sexual*

Orientation and Gender Identity (2016):

> …medical discourse always pathologised most non-procreative, non-marital sexual desire. Alongside religion and law, medicine sought to control what it perceived as 'deviant' sexual behaviours. Medical classifications were created to control such deviance and while applying to a large majority of sexual behaviour they affected homosexuals the most (p. 4).

Narrain and Chandran's quote reveals the important role of medicine in the pathologising of homosexuality. It further illustrates the fact mentioned earlier that medicine alone does not have the prerogative in the pathologising of homosexuality; religion and law are among other domains responsible for the same. They emphasise the need to advocate for the depathologising of queerness among medical professionals and the formation of support groups for gay people to enable an affirmation of their identity. This section comprises four sub-sections that explore various aspects of medical violence against LGBT+ people. They include medical students' and medical practitioners' perspectives on homosexuality, the pathologising of transgenderedness by the medical establishment, attempts to cure intersex variations and the approaches of the psy complex to curative violence against LGBT+ people.

Medical Students' and Practitioners' Perspectives on Homosexuality

Doctors' and medical students' perspectives on queerness as a pathological condition are likely to increase the risk of them attempting to treat or cure queerness in the course of their career. Hence, an analysis of medical practitioners' perspectives on queerness as a legitimate way of being or as a pathological condition in need of treatment is an integral component of a study on curative violence.

Studies exploring the perspectives of medical students towards homosexuality provide important data for the quality of treatment that homosexual patients are likely to receive as

well as serve as an assessment of the risks of curative violence that medical students might commit in the future. These studies generally reveal positive attitudes of medical students towards homosexuality. For instance, in Bharath Reddy's study, 52.17% of medical students expressed acceptance of homosexual friends (2016: 71) 79.35% observed no differences in learning and working habits of homosexual and heterosexual people (ibid.) and 69.56% stated that homosexual patients deserved the same quality of care as heterosexual patients (ibid., 73). However, 55.43% considered homosexuality to be a psychological disorder that required treatment (ibid.), 45.65% believed that gay people were more likely to be sadistic (ibid.) and 41.30% believed that gay people were more likely to be promiscuous than heterosexual people (ibid.). Equally significant, only 29.34% considered homosexual attraction to be normal (ibid., 74) and only 28.26% did not consider homosexual behaviour to be natural (ibid.). The sample size of the study was small at 92 but the findings are nevertheless significant in that they reveal how complex and fraught with contradictions the category of "acceptance" is. The data makes it difficult to identify any possible correlation between doctors' acceptance of homosexuality and their likelihood of attempting to cure it. This is particularly conspicuous through the finding that an almost equal percentage of medical students accept their homosexual friends but consider homosexuality to be a "psychological disorder". When analysed in the context of the historical pathologising of homosexuality, the belief that homosexuality is a mental disorder that does not warrant the ostracizing of gay people likens homosexuality to disease or impairment, which warrants pathologising and treatment without necessarily attributing blame or culpability to the persons afflicted by it.

Kar et al's (2018) study on attitudes of medical students towards homosexuality conducted in Calcutta National Medical College with a sample size of 270 revealed largely positive attitudes towards homosexuality with 55.6% stating that homosexuality was not an illness, 70.8% claiming that homosexual people were capable of forming stable relationships and

81.8% stating that a liberal society would mitigate many problems faced by homosexual people. However, the authors express concern over the 28.1% of students who believe that homosexual people are promiscuous and those who believe that homosexuality is an illness or a neurotic disorder. Their cause for concern is warranted given the urgency to promote queer affirmative therapy as an ethical and scientifically valid healthcare provision.

A study by G. Banwari et al (2015) on medical students' knowledge about homosexuality revealed generally poor knowledge in various aspects of alternate sexualities. Out of a sample size of 244, 72.5% correctly responded that homosexual people generally come out first to their friends and then to their families, 70% responded that sexual orientation is generally well-established by adolescence and 54.1% responded that homosexual men and women are generally prone to more mental health problems than other populations. These were the questions that received the highest percentage of correct responses. Some of the test items on which respondents scored the lowest included the misconception that homosexual people have a stronger sex drive than heterosexual people on which only 20.1% respondents answered correctly, the belief that homosexuality has been increasing in the past twenty-five years which received only 9% correct responses, high promiscuity among homosexual people (20.1%), the erroneous belief that cultures have historically been intolerant towards homosexuality (9.4%), the absence of awareness that heterosexual people often report homosexual fantasies (20.4%) and about one-half of men and one-third of women report having homosexual fantasies (16.3%). An overview of the test items on which respondents scored the lowest suggests a lack of awareness of the pervasiveness and "everydayness" of homosexuality and the false belief that homosexuality is "exceptional". All the three studies on medical students emphasise the need for improved medical education to destigmatise homosexuality and promote greater awareness of alternate sexualities.

Ketki Ranade's study on conversion therapy being used on homosexual men in western India

comprises interviews with forty healthcare providers from Mumbai and Pune. Participants in the study comprise "psychiatrists, sexologists, gynaecologists, dermatologists, urologists and counsellors" (Ranade, 2016:95). Nineteen of the forty participants are psychiatrists, a fact which once again reflects the predominance of mental health in the area of health of homosexual people. All practitioners identified as treating "male homosexuals" and the therapies they offered are classified into conversion therapy as well as other forms of therapy although the focus of the study is on the former with a thrust on exploring the medical practitioners' rationale for conversion therapy. These rationales are identified as followed: ego-dystonic homosexuality or distress experienced by people who identify as homosexual on account of their sexual orientation; practitioners' beliefs that homosexuality is the result of environmental factors such as sexual abuse, experiences in same-sex environments, and other external factors beyond the biological; "superficial homosexuality" where the practitioner believed that the person was mistaken about their homosexual identity and the practitioners' discerning a motivation to change on the part of the homosexual person. In all these situations, according to the discretion of the practitioners, conversion therapy was warranted. The methods used to administer conversion therapy included counselling or advice regarding suppressing the expression of homosexuality and attempts to "improve" sexual performance through drugs, surgery and hormone therapy. Significantly, the practitioners aimed to mitigate "sexual dysfunction" and enhance heterosexual performance while not claiming to eliminate homosexuality altogether. Therefore, as Ranade observes,

> … [the practitioners] restricted the focus of their therapy to the clinical symptom of sexual dysfunction within the framework of a conventional marriage, while completely ignoring sexual identity and related issues. However, in helping both unmarried and married clients to improve their heterosexual expression, issues such as dealing with the pressure to marry or finding out whether or why a homosexual person wanted to get into a heterosexual marriage was not addressed (p. 12).

Ranade's observation reveals the failure to perceive homosexuality as a legitimate sexual identity as a major cause of conversion therapy. Heterosexual performance within the context of marriage is used as the reference framework for pathologising homosexuality, employing methods of conversion therapy and evaluating the success of this therapy. It could be argued that the absence of alternate frameworks for valorising the legitimacy of homosexuality is revealed in the previous studies on medical students mentioned wherein apprehensions about the "normalcy" of homosexuality testify to negative attitudes towards homosexual people and increase the risks of these students subscribing to a curative culture in the future.

The practitioners' attitudes towards conversion therapy reveal an important aspect of cure. Cure is not the elimination of the pathological condition–in this case, homosexuality–but is a complex set of strategies and negotiations with a network of gains and losses that include medical logics but not exclusively. The rationales to administer conversion therapy and measure its success are clearly contingent on social and cultural contexts and concomitant values and are determined in terms of what would be considered socially appropriate. This is reminiscent of the multi-dimensionality of curative violence as mentioned by Kim as well as Narrain and Chandran in their conception of medical violence.

The above studies illustrate the ambiguities surrounding queerness, particularly homosexuality, among medical students and practitioners and the absence of any kind of consensus around the pathological status of homosexuality. However, the studies further reveal a research bias in favour of male homosexuality without adequate attention being paid to other identities along the queer spectrum. The term "LGBT+" risks concealing the dynamics of exclusions and inclusions that are internal to the matrix. There are several reasons for this, particularly the dominance of gay men in India's queer rights movements owing to their cultural capital by way of cis-gender, male and other privileges and the political mobilisation and visibility that was feasible through HIV AIDS activism (e.g.: Dave

2012, Semmalar 2014). Nevertheless, documentation on other forms of curative violence against people on the LGBT+ spectrum, besides gay men, has been carried out as well.

The Pathologising of Transgenderedness

The challenges that transgender people face in accessing healthcare owing to medical practitioners' apathy, ignorance and biases are captured in a number of works (e.g.: Chakrapani 2010, Chakrapani and Narrain 2012, Palival 2017, Ramanathan 2017, Ming, Hadi and Khan 2016). These studies are indicative of the range of healthcare services that are often inaccessible to transgender people on account of hostility by medical practitioners, which include mental health, sexual and reproductive health, HIV/AIDS treatment, gender affirmative therapy, emergency medicine as well as general medical care. They also question the indispensable role accorded to the biomedical professionals–particularly psychiatry–in certifying a transgender person as eligible for gender affirmative surgery.

Ramanathan, S. (2017) and Ankur Palival's (2017) work is representative of an emergence of journalistic studies in the area of medical violence against LGBT+ people. Both studies point out doctors' ignorance about transgenderdness, which is caused by their apprehensions of transgender people and concomitant biases. The pathologising and stigmatisation of transgender people subsequently leads to several doctors denying treatment to transgender people altogether, including emergency healthcare. In addition, it manifests itself in the form of derogatory comments and ridicule of transgender patients, taking their health concerns less seriously, expressing shame or discomfort in treating transgender patients or violating doctor-patient privilege in revealing personal details about transgender patients to the patients' families without their consent. The result of this hostility from the medical establishment takes several forms to affect transgender people, particularly a breakdown of their trust in medical practitioners, turning to self-medication or alternative medicine, poor mental health, increased alcohol consumption and other adverse responses. Ramanathan narrates an incident

of curative violence wherein a trans woman was forcibly taken by her mother to a mental health practitioner who was uncomfortable with her "effeminate" behaviour. The interviewee narrates having explained her feelings about her gender of choice to the doctor who, to her surprise, revealed her entire story to her mother who had no prior knowledge about her transgender identity. The doctor warned her mother to control her child's behaviour lest it bring shame to the family. This betrayal of confidentiality estranged the interviewee from her family and severely compromised her mental health. This is the only instance of curative violence per se mentioned in these articles, but the various instances of doctors' negligence, apathy, ignorance and hostility are risk factors for curative violence against transgender people, as was discussed in medical students' attitudes towards homosexual people.

Chakrapani's as well as Ming, Hadi and Khan's studies illustrate many of the above challenges that transgender people experience in accessing healthcare and the prevalence of medical violence in various forms that pose serious health risks for transgender people. Their work–along with Ramanathan's and Palival's–raises the possibility of curative violence compromising a dimension of "cure through denial" wherein medical practitioners' failure to validate transgenderedness is a tacit attempt to negate it altogether. This perspective arguably broadens the scope of curative violence by including every instance of failure to validate a trans identity–or any queer identity–as an act of curative violence.

Venkatesan Chakrapani and Arvind Narrain's report to the UNDP entitled *Legal Recognition of Transgender People in India: Current Situation and Potential Options* explores the various legal processes entailed in gender affirmation of transgender people and the positive developments in transgender rights until now in India and advocates for progressive models for legal recognition of transgender people's gender of choice. The authors are critical of the WPATH Standards of Care Version 7[v] for transgender health, which are premised on a

medical approach or a "gender dysphoria/diagnostic approach" to transgender health, which specifies the guidelines for various surgeries that comprise gender affirmative surgery. These guidelines also include diagnosis and treatment for mental health issues, specify the need and duration of hormone therapy, require that the trans people live "in a gender role that is congruent with their gender identity" (2012: 25) prior to a phalloplasty or a vaginoplasty, and other such provisions. While appreciating the strengths of this approach on the grounds of its standardisation, acknowledgement of gender transition as a process and not a single event, based on consensus of medical practitioners globally, they maintain that a "self-identification" approach to gender affirmation is preferable since it acknowledges the uniqueness of every transgender person's experiences and their journey to affirmation. It also recognises that people of various alternative genders (and not just transgender people) might seek access to opportunities to validate their identity on their official identification documents and might choose a combination of surgeries or hormone therapies to affirm their identity of choice. They draw on the Yogyakarta Principles[vi] to advocate for this model of self-identification in the validation of a transgender identity.

Chakrapani's and Narrain's study does not directly mention doctors' violence towards transgender people or curative violence, but they express skepticism over doctors' prerogative to determine the eligibility of and determine the course of one's transition independent of the specific case of each individual. Curative violence is most likely to arise when patient autonomy is subordinate to practitioner autonomy. Narrating the struggles of transgender people seeking to secure certification from a psychiatrist in order to undergo gender affirmative surgery, Gee Imaan Semmalar writes:

> 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'" (2016: 197 – 198).

Semmalar's critique of the gatekeeping role of psychiatrists provides a clear explanation of the logic of certification and the bureaucracy involved that often entails inevitability of curative violence. In comparison to homosexuality, there appears to be greater consensus among healthcare practitioners, including those advocating for transgender rights, that transgenderedness is a pathological condition. There are apprehensions about entirely declassifying gender dysphoria as a mental disorder although the reasons for the same remain unclear. It is found that the denial of the legitimacy of a transgender identity is a form of curative violence besides any deliberate attempts made to curb or eliminate gender non-conformity.

Furthermore, the family as the primary site of pathologising transgenderednesss and seeking out medical interventions to curb the same is also revealed through the literature. This raises an important ethical question about patient rights wherein the person seeking treatment is often not the patient themselves. Thus, the imperative for doctors to be sufficiently aware about LGBT+ rights is even more strongly emphasised.

Attempts to Cure Intersex Conditions through Genital Surgery

Very little research has been done on the intersex population in India. It is only in the last few years that intersex people have begun to mobilise publicly. Intersex people cannot easily be assigned a binary gender at the time of their birth owing to various bodily characteristics that defy this kind of stereotypical bodily classification. Bindhumadhav Khire has attempted to document the lives of intersex people in India in his book *Intersex, Ek Prathmik Kodak* written in Marathi. In an interview, he explains how he managed to identify only three

intersex individuals who were willing to talk to him owing to the silence surrounding intersex conditions, their ability to pass as cis-heterosexual people owing to the relative invisibility of their variations which enables them to better integrate into their families and the extreme rarity of intersex variations (Barua 2017).

Intersex babies are at particular risk of being arbitrarily assigned a binary gender based on a highly subjective and often ambiguous diagnosis based on external genitalia and overall physical appearance, heterosexual reproductive functions and fertility and a variety of social norms (Karkazis 2008, Davis 2015). Epidemiological studies on intersex variations in India are few and are all premised on the imperative to "cure" by assigning–or attempting to assign–a binary gender to the person and facilitate heterosexual identification. The somatic descriptors of intersex variations have foreclosed debates around their status as pathological conditions within the medical fraternity as well as within LGBT+ circles.

Mayur Suresh, in his study on intersexuality in India, mentions a case of a person who was born with intersex variations and, as a result, could not be assigned a binary gender at birth. The doctor wished to wait until the child was older and suggested the possibility of surgery later in life to assign a binary gender. However, at the parents' behest, the doctors arbitrarily assigned a female gender to the child. However, the child began to identify as male. This is an illustration of the attempt to cure gender non-conformity by enforcing an arbitrary norm of a binary gender. This example reveals an important aspect of curative violence against intersex people, which is violence committed against minors.

Another instance of explicit pathologising of intersex variations in minors and the foregrounding of the imperative to cure is reflected in an article on a clinic set up in Navi Mumbai to treat intersex infants. The urologist interviewed in the article says, "it is possible to give these children a proper diagnosis, treat them and assign them a *meaningful gender*

[emphasis added],” (Kausar 2015). The “meaninglessness” of non-conformity to gender binaries and attempts to “make meaningful” these variations is a clear instance of curative violence wherein the lack of bodily conformity to binary norms of sex/gender is automatically assumed to be pathological and, hence, meaningless irrespective of whether the condition poses any health threats to the child or whether there are attempts to understand how the child relates to their body and expresses their gender and sexual identity.

Regarding violence committed through the assignment of a binary gender, Suresh observes:

> When confronted with such disorderly bodies, the medical establishment treats these bodies as pathologised, suffering or as a body that needs to be normalised to prevent future embarrassment and hence in need of immediate medical attention; very often this means surgery while the individual is still an infant. The surgery is performed in order to materialise notions of the perfect male or female body (2016:161).

Suresh observes how the process of assigning a binary gender to a child results is the use of various proxy indicators of the “true” gender such as “appearance of genitals, or the presence or absence of certain hormones, or based on the chromosomes of the individual” (ibid.) or physically constructing what the true gender of the individual is considered to be (ibid.). Suresh emphasises the failure to disclose their intersex status to people with these variations and the imperative to perform gender assignment surgeries without the consent of the intersex person as acts of violence that both doctors and the family impose on people with these variations. Suresh cites the Yogyakarta principles that foreground the protection of intersex children’s right to self-determination. As shall be discussed in subsequent sections of the paper, the precarious legal status of children as autonomous citizens poses a major barrier to the identification and prevention of curative violence. In a landmark decision in 2019, Tamil Nadu banned unnecessary genital surgery on intersex infants (Deccan Herald, 2019). This is

the result of efforts by activists who have argued that this surgery done at a very early age can cause psychological damage (ibid.).

Read in conjunction with previous discussions on homosexuality and transgender issues, it is revealed how the movement along the spectrum from transgressions in terms of sexual orientation to gender non-conformity including transgender variations where a person does not identify with the gender that was assigned to them at birth and intersex variations where a person's anatomy defies a clear classification within either of the binary genders results in greater exclusion from the mainstream on LGBT+ rights with most research interest on the same focusing on homosexuality and the least on intersex variations. It could perhaps be inferred that the closer the situatedness of queerness within the body, the greater its pathologisation and the greater the reluctance to depathologise these forms of queerness.

Approaches of the "Psy" Professions to Curative Violence against LGBT+ People

The psy professions of psychology, psychiatry and other mental health professions have played a very important role in the history of queer health. The legacy of the *DSM* in the history of the declassification of homosexuality and the complex classification history of gender dysphoria are testimony to the importance of the psy professions in the promotion or resistance to curative violence. There has also been a long history of LGBT+ people being forcibly taken to mental health professions in an attempt to suppress their gender and sexual transgression.

In 2016, the Indian Psychiatric Society (IPS) issued a statement depathologising homosexuality, which is considered a landmark stance in Indian medical history. This excerpt from the statement captures its essence:

> The Indian Psychiatric Society considers same-sex attraction, orientation and behaviour as normal variants of human sexuality. It recognises the multi-factorial causation of human sexuality, orientations, behaviours and lifestyles. It

> acknowledges the lack of scientific efficacy of treatments, which attempt to change sexual orientation and highlights the harm and adverse effects of such therapies (IPS 2016).

The Supreme Court judgment reading down Section 377 cited the statement of the Indian Psychiatric Society to argue for the depathologisation of homosexuality. While the stance of the IPS is significant, there is a long and complex history to the depathologising of homosexuality by the psy professions in India. As Ketki Ranade observes, even post the declassification of homosexuality from the *DSM,* Indian psychiatrists continued to recommend conversion therapy for homosexuality as is evidenced in articles published in the *Indian Journal of Psychiatry (IJP)* in the 1970s and 80s. They also mention that just two years prior to the abovementioned statement by the IPS, the *IJP* published an article entitled 'A fresh look at homosexuality' in which the author argued that while they sympathised with the gay rights movement, they expressed reservations over the complete dismissal of the possibility that there is a pathological component of homosexuality. They point out instances of articles pathologising homosexuality and exploring the effectiveness of treatment options for the same as recently as 2012. Ranade further observes the general absence of any discussions on homosexuality in the *IJP* and the *Indian Journal of Clinical Psychology*. Therefore, while the statement of the *IPS* is being regarded as seminal, the stance of the psy professions on the legitimacy of homosexuality remains ambivalent. There remains little discussion on the subject of homosexuality in some of the key psy journals in India and the stand taken on LGBT+ issues remains ambiguous.

Arvind Narrain and Vinay Chandran's work comprises several studies of mental health professionals' perspectives on queerness, particularly homosexuality. Their own study on mental health practitioners' perspectives towards homosexuality reveals that these practitioners draw a distinction ego-dystonic and ego-systonic homosexuality with the former

meaning the distress that people experience on account of their homosexual identity and the latter referring to their acceptance of this identity. Several mental health practitioners, the authors note, believe that only the first kind of homosexuality requires treatment while the latter does not. However, as the authors note, the causes behind ego-dystonic homosexuality are not considered by the practitioners interviewed. They also observe how the denial of the existence of anything like ego-dystonic homosexuality is not helpful because it precludes a clear identification of the complex factors including social pressures that pose mental health risks for gay people. Moreover, there are instances where doctors identify even ego-systonic homosexuality as ego-dystonic by disregarding the patients' own understanding of their sexual orientation. These findings suggest the wide range of perceptions–generally limited and/or regressive–that mental health practitioners have about homosexuality. The dearth of queer affirmation counselling knowledge and practices testifies to the high risk of curative violence to which queer people are subject. Furthermore, the findings of the study illustrate a recurring argument throughout this study about the concept of cure, which is the impossibility of defining cure purely in terms of the elimination of homosexuality. Instead, cure exists in the form of various "treatments" aimed at altering the behaviour and expression of sexual transgression. This fact raises important questions about the possible predominance of behaviourist modes of treatment in contemporary thinking in the psy professions in India and the challenges they pose to queer affirmative medicine.

CURATIVE VIOLENCE IN THE SPHERE OF RELIGION

Instances of religious figures and establishments promoting curative violence have been documented. Gay rights activist Harish Iyer, in an article in *The Quint*, provides a sample of a disturbing document entitled 'Pledge to Quit Homosexuality' that was recovered from the web page of the *Dera Sacha Sauda* cult, the leader of which, Gurmeet Ram Raheem Singh, has recently been arrested under charges of rape. The pledge states that homosexuality is "unnatural" as established by "religion, morality and spirituality" and by "scientific rationale"

and that people choose to give it up by their "free consent".[vii]

Yoga guru Baba Ramdev is well-known to have considered homosexuality to be a disease and considers yoga to be the cure (Nelson 2009). Describing homosexuality as a "sexual illness", he is quoted as having said, "Homosexuality can be cured through yoga…this will return a man towards natural sexual behaviour" (Pradhan 2018). The argument about the gay gene or the localisability of homosexuality within a genetic substrate is also widely prevalent among religious figures. For instance, tele-evangelist Zakir Naik is quoted as having said, "Generally, naturally, no human being loves the same sex… it is not genetic" (Singh 2018). The evoking of biomedical rationality (through genetics) by religious figures raises important questions about the assumed dichotomy between science and religion. The fact that both medical professionals and religious figures can evoke faulty notions about science to justify the pathologising of queerness foregrounds the baselessness of explanations of curative violence. These views illustrate an important aspect of curative violence–the advocacy of pathologising views on queerness and stating the need to cure queerness constitute curative violence even in the absence of implementation as they harm the integrity of LGBT+ people and promote risks of curative practices. Moreover, the use of genetic rationality to explain the aetiology of homosexuality is reminiscent of eugenic thinking that seeks to selectively eliminate a pathological condition–in this case, homosexuality–from the human population. As has been explained, both religion and science contribute to the eugenic core of curative violence.

The natal family has often been found to place the most pressure on LGBT+ people to undergo religious conversion therapy. In their book *No Outlaws in the Gender Galaxy*, Chayanika Shah, Raj Merchant, Shals Mahajan and Smriti Nevatia document fifty life

histories of queer people assigned gender female at birth. One of their respondents, Sam, recounts having been subjected to exorcism after he came out about his sexual preferences to his parents, which is an under-reported form of curative violence in India.

A. Revathi, in her autobiography *A Life in Trans Activism* (2016), narrates an instance of her mother insisting that she donate her hair to the Samayapuram temple to rid her of "mohini pisasu (seductive female demon)" (p. 17). This, too, is a case of curative violence through exorcism. Revathi recounts the severity of her distress at the loss of her hair:

> The next day when my hair was shorn off at the temple, I felt more pain and hurt at this than when my brother thrashed me. I wanted to pour out my sorrow in front of the goddess. But even that I had to do silently. Within myself, I felt like an ocean churning. But I had to keep my feelings bottled up (p. 17).

This section on religious forms of conversion therapy indicates a greater need for empirical studies in this area given the mere availability of anecdotal evidence of the same at the present time.

CURATIVE VIOLENCE BY THE FAMILY AND IMMEDIATE ASSOCIATES RECOUNTED THROUGH PERSONAL EXPERIENCES

While curative violence by the medical establishment and the religious sector are significant, the family and the immediate associates of the person remain the primary sites of this form of violence. Several factors are responsible for this. The collectivist culture of India warrants that the family remains the primary site of support as well as control for most people. The regulatory power of the family is revealed by the fact that it is usually the family that forces cures onto LGBT+ members. Given the close relationship between the individual and the family in matters of curative violence, it becomes almost impossible to talk about one without mentioning the other. Hence, this section explores personal experiences of curative

violence by LGBT+ people, including instances of curative violence by the family. Semmalar (2016) observes about curative violence against trans men, which could be extended to other LGBT+ people as well:

> I have heard of instances of electric shock therapies, house arrests, being chained to their bed posts, trans men being forcefully administered female hormones and marriage being prescribed as a 'cure' (p. 198).

As mentioned earlier, empirical studies exploring forms of curative violence particularly within the family are few. Moreover, the taboos surrounding gender and sexual transgression as well as rape preclude adequate documentation of the prevalence of these kinds of violence. However, personal narratives of LGBT+ people offer crucial anecdotal insights into the kinds of curative violence prevalent.

Curative Violence through Attire

Clothing and attire are important forms of self-expression; one of the common ways in which curative violence occurs with LGBT+ people is through restrictions on wearing clothing of their choice. These restrictions could be enforced, recommended or internalised by the person themselves and all these variations of sartorial curtailments could be explained within the framework of curative violence.

In her autobiography, A. Revathi recounts several instances from her childhood when she was prevented from wearing the clothing of her choice and the extreme violence she was subjected to when she refused to comply with gender stereotypical ways of dressing. She writes:

> My middle brother was home. The moment he saw me, he closed the door and began to hit me with a cricket bat. That will teach you to go with those ombodhus [A derogatory term for transgender people in Tamil]! Let's see you wear a sari again

> or dance, you mother-fucking pottai [A derogatory term for transgender people in Tamil]!' I thought I would die, that he would never stop. I tried to protect myself but he kept shouting and raining blows on me. I felt my hands swell up. He beat me on my legs, back, and finally, he brought the bad down heavily on my head. My skull cracked and there was blood all over, flowing, warm (p. 16).

The drastic form that curative violence can assume is revealed through this example. She recounts how her choice of clothing was accepted until she reached puberty after which her family began to pressurise her to dress up in more gender-conforming ways. She also narrates instances about her ways of negotiating with these pressures. For instance, she recounts an incident in her childhood when she dressed up as a "kurathi (female gypsy)" (p. 7) for a temple festival and her family was extremely unhappy with her decision to wear a sari and make-up. She managed to convince her parents that she had only dressed this way to appease the goddess Mariamman. Not only were they convinced by this explanation, but the village also praised her for her efforts and even suggested that she should have been born a woman–something to which she enjoyed listening. This illustration from Revathi's life indicates the significance of context and culture in the acceptance or rejection of non-conformity and indicates the ways in which she–and other gender non-conforming people–use available cultural resources to validate their choice of gender expression.

Shah et al's respondents speak of the damaging effects not being able to wear their clothing of choice had on them. The authors observe that people who identified as male were able to wear clothing that matched the gender of their choice. However, there were still negotiations around being able to wear the clothing of their choice as one of their respondents, Santosh, narrates. He recalls his family attempting to restrict his clothing at home; but he would still wear a shirt and a *mundu* [a garment worn around the waist by men] at home while he would wear a skirt to school. He narrates tensions with his brother who was ridiculed for Santosh's

gender transgressions. Santosh's narrative is a clear instance of the natal family as the site of curative violence through the enforcement of restrictions on the LGBT+ person's sartorial expression. A second respondent named Sam, who was referred to earlier about being subjected to exorcism as a form of curative violence, narrates how his choice of attire stopped being respected when he confessed to his parents about his attraction to women. This led to house arrest, breaking of his music system, forcing him to dress more effeminately, ostracism within the home, and the forceful use of exorcism to rid him of his gender transgression.

Another person interviewed in the study was forced to wear a sari as per the sartorial norms present in his village and was "seen in public unambiguously as a woman" (2015:29). Another instance is cited of a woman who "saw herself as 'woman from outside but not fully a woman'" (ibid.) because people around hir did not consider hir to be a woman owing to hir reproductive health issues. Anand, another respondent, recounts instances of curative violence through an enforcement of gender-conforming attire in his school:

> I continued with guys' clothes though my hair was long, until eighth standard, when the teacher said, "Now you have to wear the tunic." She was very patient, explained why and I agreed. I don't think I had much of a choice (2015:75).

The desire to obtain employment also curtails LGBT+ people's sartorial expression. Shah et al write about a person named Prem who wished to "wear trousers and shirts, and have hir hair short" (ibid.) but who felt compelled to restrict hir clothing choices because of demands of future employment. These instances are significant in that there is no clear identification of a specific external agent enforcing restrictions on the sartorial expression of the respondents. Instead, it was community norms that proscribed sartorial transgression and concomitantly the freedom of the people to "name" themselves. This internalisation of the proscriptions on sartorial expression should be seen as a form of curative violence, as they limit scope for self-determination. Prem's apprehension about the limitations on employment

opportunities that ze might face if ze transgressed gender norms of clothing is an example of how the workplace can function as a site of curative violence, too. It is not merely on those already employed that binary gender norms of clothing are enforced, but the *ethics* of workplaces in general that perform a regulatory role in society as a whole. Prem notes that ze would not face these limitations in an NGO but did not seem to want to restrict hir employment opportunities only to the NGO sector. Therefore, curative violence in its various forms hinders social mobility by restricting opportunities.

An interesting relationship between the workplace and corrective violence is reflected in Revathi's autobiography where her gender transgression is seen as compromising her ability to get "decent work" (2016:10), as her parents say. "We have high hopes that you will be educated and get a decent job. And you do this to us!" (ibid.). This hostile reaction by Revathi's family testifies to the argument that Prem makes that queerness and employability are not seen as compatible with each other. Revathi also narrates an instance of a trans man who applied for the job of a salesperson and the potential employer told him that he would get the job if he grew his hair and wore a sari (2016: 121). Therefore, even if queerness cannot be eliminated, efforts to suppress the *expression* of gender and sexual non-conformity are seen as crucial to employment, and regulating one's sartorial expression is often seen to be critical to this endeavour.

Schools become an important site for the enforcement of "morality" and "discipline" through the enforcement of binary gender conformity. One of the respondents in Shah et al's study named Vasu narrates his experiences at school:

> I specifically hated the uniform, then they would insist on plaiting my hair…And wearing a dupatta. All that would make me a girl and I didn't like it (2015:74).

Trans activist, dancer and videographer Christy Raj narrates his ways of negotiating his choice of gender non-conforming sartorial expression:

> We had to tuck in our shirt. I would tuck it in on one side and leave the other side loose and even lift my collar up like a rowdy! My science teacher would twist my ears and ask me to dress 'properly'. I wanted to dress like men. But this was the nearest I could get at satisfying those desires. Every day I got into trouble with the same teacher because she felt I was not dressing like a girl (2016: 184).

The experiences with clothing and sartorial expression of several LGBT+ people indicate the ways in which restrictions on attire operate as common forms of curative violence. Multiple sites of control enforce this form of regulation including the family, educational institutions, and employers. At the same time, it is also revealed how people leverage cultural norms to seek social sanction for their choice of attire, thus attempting to destigmatise gender non-conforming clothing choices.

The Relationship between Curative Violence and Puberty

The literature seems to suggest that the onset of puberty places greater demands on LGBT+ people to conform to binary gender norms, which leads to increased tension and likelihood to experience curative violence as LGBT+ children grow up.

A. Revathi narrates how her gender transgression was tolerated until the time she reached puberty, after which her family became enraged and subjected her to severe violence. She writes:

> …I loved to draw kolams, the beautiful floral and geometric rice flower designs women draw outside their homes in South India, to help my mother in the kitchen, I preferred to play with girls and to dress up as a girl. It seemed most 'natural' for me to do so.
>
> My family thought that this was just a passing phase. However, to their horror, when they realised that it was not, they began to punish me severely to make me behave like a 'normal' boy. At school, teachers and students used to make fun of me. I was

> called ‘ombodu’, ‘ali’ and ‘pottai’, all derogatory terms used to describe trans women and kothis (p. xi).
>
> As discussed in the previous section, Revathi’s experiences of curative violence are reminiscent of similar forms of violence faced by several LGBT+ children once they reach puberty even in situations where their transgression of gender and/or sexual norms was hitherto tolerated. About the imperative to conform to cis-heterosexual norms, which unfortunately increases with age, Revathi says:
>
> When I was five years old, like most children of that age, I played together with boys and girls. We even peed together! At that time, we had no rigid distinctions such as ‘You are a girl!’ and ‘I am a boy!’ Isn’t it sad and even strange that only as we grow older do we acquire the notion that the two sexes are very ‘different’ and therefore we should stay apart from one another? (pp. 2 – 3).

Santosh, one of the respondents in Shah et al’s study mentioned earlier, recounts his parents defending him against his brother’s attacks for his gender transgression when he was a child. However, they began to object to Santosh’s circle of male friends as he reached puberty because they were worried about his (and their) reputation. Another respondent Rahul similarly recounts how his identification as a tomboy became a major issue once he reached puberty. He says, “A time comes when you are made to realise that you are a girl. That time came. I felt bizarre” (2015:52). A third respondent named Arun recounted the violence hir father subjected them to for not conforming to norms of accepted womanhood. Hir staying out until late warranted house arrest, beating, tearing off hir shirts and forcing them to dress in more gender-conforming ways. Arun narrates how ze would adhere to some of these demands temporarily and then return to hir preferences eventually. These illustrations reveal the significance of the temporal nature of curative violence and how adolescence is a particularly crucial time when a surge in curative violence is most likely.

Forced Marriage and Corrective Rape

Closely related to puberty is the pressure for marriage. Kirti, a respondent in Shah et al's study, narrates being forced into marriage against his will by his father who attributed his apprehensions about marriage and his dislike of men to general anxieties about the same, without recognising Kirti's identity as a queer person. Marriage and later sex within marriage become rape for people whose sexual orientation and/or gender identity do not adhere to the cis-heterosexual norm. Moreover, as Rohini Chatterji documents, "corrective rape" or the rape of LGBT+ people in an attempt to change their sexual orientation and/or gender identity to make it more conforming is prevalent. Chatterji mentions fifteen cases of corrective rape as reported by an LGBT crisis intervention team in Telangana. She writes about how an exact estimate of the number of cases is difficult to identify because of the taboo surrounding queerness in general and sexual violence as well as the fact that many people who experience corrective rape distance themselves from their families. Nevertheless, irrespective of their numbers, the very existence of corrective rape as a form of curative violence is a major cause of concern.

The family is likely to think of curative violence as assertion of their duty to their children and to preserve their family honour. As Revathi says,

> …while I perceived their abuse of me as unfair, they believed that it was all for my own good; to make me mend my ways and live 'normally'. Hence, I decided to first publish my story in English because no one in my family reads English and I wanted to avoid getting into trouble with them as by then, I was reunited from my family (2016:83).

This section explores the family and the immediate acquaintances of LGBT+ people as perpetrators of curative violence. Visible expressions of gender transgression such as attire

are strongly regulated and these constitute some of the most common forms of curative violence that LGBT+ people face. The narratives of LGBT+ people also reveal how gender non-conformity is often tolerated until puberty but tends to be severely curtailed later. Corrective rape by the family and other acquaintances of the person is a sensitive and highly taboo subject that has not been adequately studied but remains a drastic form of curative violence.

ACTIVIST PERSPECTIVES ON CURATIVE VIOLENCE

A few activists associated with NGOs and community-based organisations working with LGBT+ people in Mumbai, Chennai and Bangalore were interviewed for their study in order to understand their perspectives on curative violence. This section comprises an analysis of some of the main themes that emerged from the interviews.

Medical Interventions Versus Family Interventions

All activists interviewed mentioned that medical interventions were not the primary forms of curative violence. For instance, Rumi observes that curative violence by the medical establishment is not as common as that by the family. He says, "Most of the time, it is either through beating up or violence through sexual violence or through gods and all those things."

Megha, a counsellor with an LGBT+ organisation, observed that she hadn't come across many cases of medical violence aimed at curing queerness but that she had "heard of" cases of electric shock therapy administered by mental health practitioners aimed at curing homosexuality. She recounted an incident where a person approached her stating that they had visited a counsellor who had recommended that they work towards curing their homosexual identification. Megha said that she alerted her organisation and that they exposed this counsellor for curative violence to caution future potential clients. Megha mentioned an important reason why she thought medical violence is not as well documented as family violence although both might be directed at suppressing one's gender/sexual

expression:

> There could be a bias in reporting medical violence. In India, family is so important that people feel that if my family doesn't accept me then what else can I expect? So, it's not that there is less medical violence but violence by families is likely to be given more attention.

The emotional burden and insecurity of not being supported by one's family tends to overpower the burden of having experienced biomedical forms of curative violence. But while the recognition of this emotional burden by LGBT+ people is imperative, a concern arises about whether the constant reiteration of curative violence by the family risks a comparative underestimation of the medical establishment as a site of curative violence. Delfina and Sajju, other activists working with different support groups for LGBT+ people, also observe that the incidence of medical violence is not as significant and they have not encountered curative violence in the context of medicine as much as they have in the context of family violence. Sajju mentioned that he had heard of incidents of gay people being subject to electric shock therapy, but he said that this was rare and he had never personally come across such a case. Both activists identified the family as playing an important role in regulating the expression of gender and sexual non-conformity. Delfina pointed to an important catch-22 in this context. They said:

> While the family can definitely be an oppressive place, there are some benefits that one can get only within the family. So, there was this person who was trans and they wanted to join a group of trans women. But if they did that it would not be possible for them to study further. But if they stayed in their family, they would have the chance to go to college but there were restrictions on their ability to be themselves. So, it is a difficult situation.

Delfina mentioned how this person being referred to eventually joined a group of trans women because “at that point, being able to freely express their gender identity was their priority”, as Delfina said. This instance reflects some of the difficulties entailed in leaving one’s natal family in pursuit of alternative kinship structures that would allow for the free exploration and expression of one’s gender and sexual identities. In many cases, people might choose to stay back in oppressive families and endure curative violence for other opportunities that might not be available in more gender affirmative arrangements. Delfina further explained that living in a *gharana* does not give one unbridled freedom to express their sexual and/or gender identity and there are restrictions on expression in these places, too.

Nadika mentioned an important area of medical violence against intersex people in which activists from her support network has intervened. She mentioned a spate of incidents where doctors in a prominent government hospital in Mumbai were performing gender assignment surgeries on intersex babies. Nadika mentioned that this practice was widely prevalent and that some LGBT+ groups were working to spread awareness among doctors against these practices that are irreversible and take place without the consent of the child. Rumi also spoke about efforts to spread awareness about intersex people’s rights of which he is a part. He said that he had contacts with a couple of doctors in NIMHANS to whom people with intersex variations facing any kind of difficulties are referred to.

Children and Curative Violence

The personal narratives discussed in the previous section suggest the high likelihood of children expressing curative violence once they attain puberty. This suggests the particular vulnerability that children face with respect to curative violence because of their limited autonomy. However, many more nuanced and complex discussions on children and curative violence emerged through the interviews. Megha and one of her former colleagues, who was

also a counsellor with the same organisation but had left, mentioned that their organisation's policy prevented them from working with anyone below the age of eighteen. Megha explained that even after the reading down of Section 377, this section of the IPC remains critical to child sexual abuse. This is because Section 377 is the only section under which sexual violence against boys can be persecuted as other rape laws only provide for the protection of girls. Hence, as a matter of caution, the organisation does not work with children. Megha and Richa have, however, worked with teachers and counsellors regarding queer affirmation.

When asked if children are more at risk from curative violence, Rumi replied,

> In India, as a child, you hardly have a say as to how you can be express yourself openly in a house. That's hardly done. As a child, you hardly get a chance to express either your sexual identity or your gender identity. You might be showing different kinds of gender identities for which you will be, in the name of parental correction, face violence. But as such it is not seen as children facing certain things. That sort of an expression has really not gained in India.

Rumi proceeded to observe about curative violence among children,

> They *do* experience it, but they are not able to articulate it, except in very few cases. Even if someone is behaving in a different manner, it is never acknowledged as a queer, trans or intersex issue. It is usually seen as a behaviour deviance except in very upper-class families where they are able to articulate otherwise.

The fact that there is limited scope for the expression of gender and sexual identity in general limits the possibility of a child's gender and/or sexual transgression even being *perceived* as transgressive. This makes curative violence even more elusive since the premises on which it is based, which is fundamentally queerness, itself is largely invisible by virtue of a general invisibility of self-expression in matters of gender and sexuality.

With respect to handling cases of children experiencing curative violence, Rumi mentioned that he would recommend the cases to the Child Welfare Commission (CWC) or consult with them, but that the organisations he worked with were not equipped to work with minors. "The specific structure of the law in India is such that it does not give the child any freedom," he said, citing this as one of the particular challenges entailed in working directly with children.

Like Rumi, Sajju also mentioned that the organisations with which he worked did not directly engage with children not as a matter of policy but because they lacked the expertise. Delfina mentioned the same and stated that they found it more effective to work with families and schools as opposed to children owing to the limited autonomy that children in India have. "Since it is parents and teachers who ultimately control the children's lives and take all important decisions for them, it is more important to work with these people than it is to work with the children directly," Delfina said.

Seeking Help from the Law and the Police

Activists were asked if they had ever had to seek legal help or police intervention for cases of curative violence that they handled. Rumi was firm in stating that the organisations they work with seek help from lawyers but completely stay away from the police because the latter "believes in the Manu Smriti ideology that even adult women do not have the right to live alone; they always need a caretaker." He emphasised that no matter how progressive Supreme Court decisions might be, the police never allow them to be implemented. Rumi cited an instance related to a case that he was handling where a police official directly stated that the Supreme Court did not matter to him and that family honour was everything.

Sajju stated that there are efforts being made by the group he works with to sensitise the police about LGBT+ issues. He, too, commented on the hindrances posed by the police to the realization of LGBT+ rights.

Self-inflicted Curative Violence

Richa reported instances where people approached her saying that they were gay and they wanted to change themselves. She said, “I tell them that being gay is normal so you can’t do anything about it. There is nothing wrong with you.” She also recounted instances where people came to her saying, “We are attracted to people of our own sex so we want to have a sex change.” She said she handled these cases by talking to these people to find out if they might be trans or if they did not consider homosexuality to be a legitimate sexual orientation. Delfina similarly recounted instances where people who identified as LGBT+ would sometimes come to them to ask for help in becoming heterosexual/cisgender. They said that they would counsel these people about the impossibility of this kind of change and work towards helping them to accept themselves.

Numbers Shouldn’t Matter

Taboos surrounding queerness as well as gender and sexuality in a broad sense preclude the reporting of curative violence. This has been a challenge to epidemiological studies on curative violence. But the question remains about whether this form of violence should not be given adequate attention because the extent of prevalence is not clear as yet. Megha expressed her concern about the absence of quantitative studies on violence against LGBT+ people as she believed that only through the numbers could legislations be implemented. But Rumi had a different opinion about the importance of numbers in initiating awareness and support programmes. While speaking about the difficulties entailed in supporting intersex people given the limited visibility of intersex people, Rumi observes:

> It has never been about numbers. We will not wait for people to come and then

take action. We just look at the issue and take action.

This is the rationale that is most suitable for curative violence as well, as it foregrounds the importance of the issues involved without an over-reliance on the exact prevalence of various forms of violence.

CURATIVE VIOLENCE: THE WAY FORWARD

The present study has explored some of the major forms of curative violence against LGBT+ people in India. While the term "cure" has clear medical connotations, society at large including the family and the immediate acquaintances, employers, educational institutions, religious institutions and others play a much more pervasive role in perpetuating curative violence. A holistic approach to understanding curative violence is warranted. An analysis of existing literature revealed the ambiguous attitudes towards homosexuality and transgender variations among medical professionals and students. The percentage of medical professionals who consider homosexuality to be a normal variation of human sexuality is only marginally higher than those who consider it to be pathological. Similar findings exist about mental health practitioners' perspectives on the same. The literature on medical practitioners reveals a certain bias towards understanding their perspectives on homosexuality as opposed to other forms of queerness. Hence, limited literature on medical practitioners' opinions on other kinds of queerness exists. Based on literature on doctors' approaches to transgender people, a clear anxiety about validating gender diversity exists. It is observed that as one moves from homosexuality to intersex variations, the willingness to depathologise reduces, suggesting that the more "embodied" queerness is, the greater the unwillingness to depathologise. This raises important questions about the ways in which curative violence varies across different identities across the LGBT spectrum and how the body and its expressions constitute the site for different kinds of curative violence.

The study also points out to the ways in which religion is often responsible for curative violence and in doing so, sometimes employs the vocabulary of biomedicine such as that of genetics. While anecdotal instances of people being subject to exorcism and other kinds of religious forms of conversion therapy exist, a strong dearth of research in this area has been identified. Moreover, research into forms of curative violence in the alternative healing sector is strongly needed.

The analysis of personal narratives of LGBT+ people as well as the interviews of activists strongly pointed out to the precarity of childhood and the curative violence that results from the failure to consider children as autonomous legal citizens, independent of their families. It has been found that curtailing children's attire to enforce its conformity to binary gender norms is one of the most common forms of curative violence. Furthermore, it was found that gender and sexual transgression was tolerated up to puberty but not beyond, and a range of violent acts including physical assault, confinement within the home and verbal humiliation are used in order to reinforce gender and sexual conformity. Activists also pointed to the limited autonomy of children as being the basis of curative violence and that this form of violence would be naturalised as a parental right and obligation. Also, the fact that Section 377 offers protection to boys from sexual abuse hinders the ability of rights-based organisations from directly reaching out to children. Activists also spoke about their distrust of law enforcement agencies in matters of curative violence owing to the lack of sensitisation of LGBT+ among these agencies and their moral preclusions to prevalent heterosexist binary norms. While some activists pointed to the need for more quantitative data on curative violence, others claimed that this was not a priority for them and that they were only concerned with specific cases.

Thus, the study has attempted to map the phenomenon of curative violence against LGBT+ violence, has revealed its multiple dimensions and has identified some of the crucial areas in

which further research is warranted. It has also explored some of the different methodological approaches that could be used to gain greater insights into this form of violence and to facilitate documentation in the future.

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[i] The fact that biomedical forms of curative violence emerge as less significant than other forms of curative violence cannot be generalized beyond this study for several reasons. The stigma associated with being LGBT+ and with curative violence result in underreporting. Moreover, there is the possibility that survivors of curative violence experience greater trauma when this form of violence is imposed by the family and hence tend to report it more than violence by the medical establishment. It could also be that violence by the biomedical establishment is often not questioned and is taken for granted.

[ii] The terms "intersex variations" and "intersex conditions" are used interchangeably in this paper. The former is a preferred term since it suggests that intersexuality is not pathological but is a part of sexual diversity. This view is also supported in this paper. However, it is argued that the dismissal of the term "conditions" on grounds that it has connotations of pathology and hence deprives intersexuality of its legitimacy is problematic since it suggests that pathology cannot be a basis for agency or epistemological legitimacy. Hence, both the terms are used interchangeably to contest the assumption that to have a pathological condition is necessarily inimical to agency.

[iii] Debates on the existence of the gay gene suggest the pathologizing of homosexuality by somatic medicine, as well, but it has largely been the psy professions comprising psychology, psychiatry and other branches of mental healthcare that have played a prominent role in the pathologising of homosexuality.

[iv] This is not to say that biomedicine is less responsible for curative violence than the family and other social institutions. It is only to say that biomedicine was not emphasised as much as other sources of oppression. A letter by a number of biomedical practitioners from India and of Indian origin petitioning for LGBT+ friendly biomedical healthcare is an instance of how practitioners are in need of greater sensitisation about gender and sexual diversity (Orinam 2009).

v The World Professional Association for Transgender Health (WPATH) provides guidance to healthcare practitioners across various branches of biomedicine including urology, gynecology, mental health and others with the aim of promoting quality healthcare to transgender, transsexual and other gender non- conforming individuals. This aim is achieved through the publication of list of Standards of Care (SOC) document with detailed guidance regarding the above. The first such document was published in 1979 and the seventh edition, which is the latest was brought out in 2012. https://www.wpath.org/media/cms/Documents/SOC%20v7/Standards%20of%20Care_V7%20Full%20Book_En glish.pdf Last accessed on January 31st, 2020.

vi The Yogyakarta principles refer to a set of international guidelines about LGBTI human rights. The principles were framed in 2006 at a meeting of LGBTI activists from across the world who met in Yogyakarta, Indonesia. There were 29 principles of begin with and 10 principles were later added. https://tgeu.org/yogyakarta- principles/ Last accessed on January 31st 2019.

vii Harish Iyer (2017), in his article on curative violence, suggests that the possibility of rape as a form of conversion therapy practiced by the cult cannot be ruled out. He proceeds to provide instances of women who either identified as or were thought to be lesbian being raped by their fathers and/or brothers in an effort to convert them to heterosexuality although this latter argument is not clearly a form of religiously-motivated curative violence.

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About the R. Rajaram GRIT Research Fellowship:

Endowed by his children in memory of R. Rajaram, citizen, civil servant and lifelong supporter of women's rights, the R. Rajaram GRIT Research Fellowship is an opportunity for young scholars to undertake a short original research project on sexual and gender-based violence for one year. The Rajaram Fellow also curates and authors the annual Gender Violence Report for the Fellowship year.

About the author:

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About this study:

Based on a critical literature review of documentation on curative violence and of published narratives of LGBT+ people's experiences of curative violence as well as interviews with LGBT+ rights activists with a focus on India, this study is an attempt to develop a holistic understanding of curative violence as it exists in India today.