The International Journal of Indian Psychology
ISSN 2348-5396 (Online) | ISSN: 2349-3429 (Print)
Volume 9, Issue 3, July- September, 2021
DIP: 18.01.013.20210903, DOI: 10.25215/0903.013
http://www.ijip.in

Research Paper

Understanding Depression and Anxiety in the LGBTQIA+ Community and Its Causes

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ABSTRACT

Through the means of secondary research this paper aims to understand the relationship between homosexuality, depression and anxiety and studies homosexuality through the perspective of minority stress model by Meyers, 2003 suggesting interventions accordingly. The objective of the same to promote and facilitate positive discussion about the mental health of the LGBTQIA+ community especially in the Indian sub-continent since such research is really lacking here. The paper also hypothesizes the reasons for depression and anxiety specifically in the LGBTQIA+ youth and interventions to help with the same.

Keywords: *LGBTQIA+, Queer, Discrimination, Violence, Bullying, Depression, Anxiety, Substance Abuse, Stress, Minority Stress Model and Homosexuality*

"*Being gay is like being left-handed. Some people are, some people aren't and nobody really knows why. It's not right or wrong. It's just the way things are*."

The following paper looks at the LGBTQIA+ community in terms of depression and anxiety. It aims to understand the relationship between homosexuality, depression and anxiety. It also aims to understand and hypothesize the reasons behind depression and anxiety faced by individuals who identify as a part of the LGBTQIA+ community. It studies homosexuality through the perspective of minority stress model by Meyers, 2003 and suggest interventions accordingly. Depression and anxiety specifically in the LGBTQIA+ community is not a well-researched topic. Research on the same is lacking especially in the Indian sub-continent. It is thus very important to understand the mental health challenges faced by the community and provide interventions which actually help. Inclusivity is rather important. Based on the method of secondary research this paper aims to promote and facilitate healthy discussion about the mental health of the LGBTQIA+ community and further research about the same. The paper functions on the hypothesis that those who identify as a part of the LGBTQIA+ community have a higher risk of having depression and/or anxiety. This paper also provides inclusive and important vocabulary related to the community.

LGBTQIA+ or LGBT is an abbreviation used to define people who are otherwise referred to as homosexuals or capped under the general term of "Gay" and/or "queer". Here are the

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Received: May 06, 2021; Revision Received: July 04, 2021; Accepted: July 31, 2021

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ABCs of the LGBTQIA+ community: (Please note that this list by no means is the inclusive list of vocabulary)

Asexual and Aromantic: Asexual or 'ace' is a term generally used to refer to people who experience no or little sexual attraction. Aromantic(s) on the other hand are individuals who experience no or little romantic attraction. It is important to understand that not all aromantic(s) are necessarily asexual and not all asexuals are necessarily aromantic(s).

Androgynous- Refers to people who identify as non-binary.

Bisexual- Bisexual is generally used to define people who are not only attracted to their gender but also to the opposite gender. For example: A bi woman is attracted to both men and women. Similarly, a bi man is attracted to both men and women. Bisexuals are often stereotyped or seen as confused but neither of the following are true. Bisexuality refers to attraction to both genders and not a stage of confusion.

Cisgender- It refers to those individuals whose gender identity matches with the one assigned at birth. For example: F.A.A.B or female assigned at birth identifying with pronouns she/her.

Demisexual- Individuals who don't experience sexual attraction until and unless they establish a strong emotional bond or connection with someone which is not necessarily romantic in nature.
F.A.A.B- It is the acronym for Female assigned at birth.

Gender Queer, Gender Fluid and Gender Non-Conforming- Gender queer is the term used to refer to individuals whose identity falls outside the female and male category. They exhibit both male and female characteristics. Gender fluid on the other hand is used to refer to individuals whose identity shifts or fluctuates. Gender fluid people can feel more masculine some day and more feminine the other days. Gender neutral people generally go with the singular pronoun of they or them and don't prefer being described as a particular gender.

Gay- Gay is used as an umbrella term to generally refer to the entire community as a whole. Gay stands for the men who are attracted to men.

Heterosexism- It refers to preferential treatment to people who identify as straight or heterosexuals. It functions on the assumption that heterosexuality is right.

Intersex- It is a term used for individuals born with biological characteristics that aren't traditionally associated with gender binary or male/ female bodies. Intersex doesn't refer to gender expression or sexuality/ sexual orientation.

Lesbian- Lesbian is generally used to refer to women who are attracted to women.

M.A.A.B- It is the acronym for assigned male at birth.

Non- Binary- It refers to people who fall outside the binary gender i.e.; male or female. Individuals who identify neither as male or female. It is also sometimes referred to as 'enby'.

Pansexual- Pansexuality refers to attraction to all despite gender boundaries. It refers to love or attraction beyond gender identity. It refers to being attracted to qualities of an individual

and not their gender identity or expression. It differs from bisexuality in terms where bisexuality is seen more as gender binary i.e.; confined by female or male whereas pansexuality is attraction beyond gender binary.

Preferred Gender Pronouns- Generally used when introducing an individual other than when being introduced by their names. It refers to the pronouns the individual prefers when being referred to: he/him, she/her, they/them, zir/ze/hir.

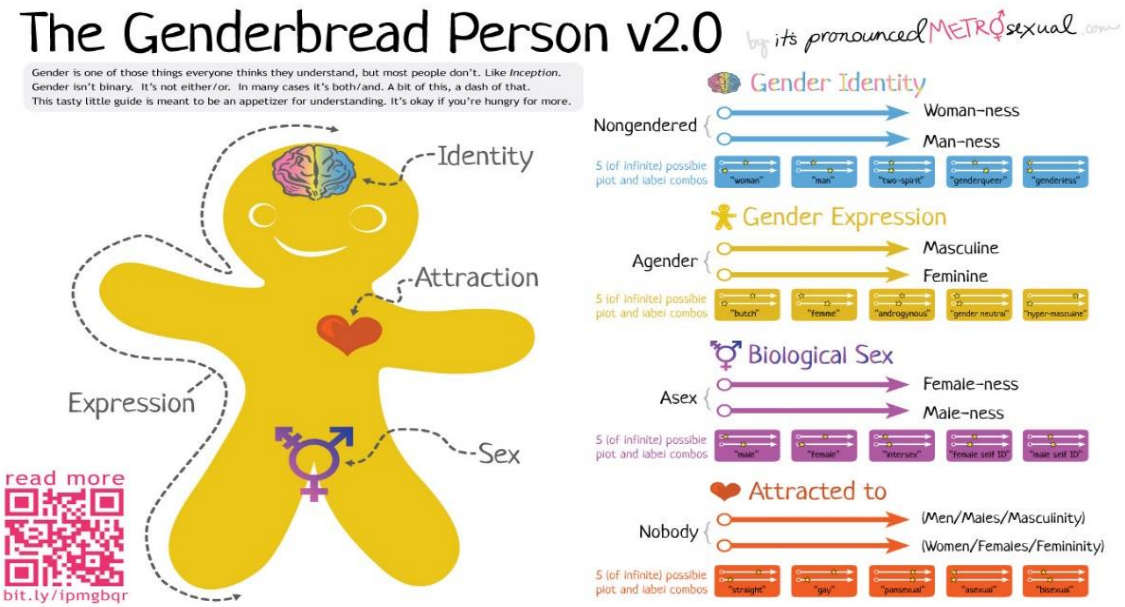
Queer- It is often used as an umbrella term for the LGBTQIA+ community. It has meanings which are personal to every individual. It can be used to refer to people who don't identify as CIS gendered or straight or heterosexuals.

Sexual Orientation- It refers to sexual or physical attraction that is felt by one towards others irrespective of self-identity in terms of gender or sexuality.

Trans/Transgender- It is generally used to refer to people whose gender identity or gender expression differs from the one assigned at birth or their biological gender.

U.A.A.B- It is the acronym for unassigned at birth.

Ze/ zir- It is a set of alternate pronouns and is generally gender neutral.



It is important to note that there are subgroups of sexual minorities such as lesbian, gay, bisexual, etc. and further dimensions of sexual orientation such as: behavior, attraction and identification.

[2]Depression is characterized by persistent sadness and a lack of interest or pleasure in activities which were previously pleasurable or enjoyable. According to the DSM-IVR depression is characterized by 5 or more of the following symptoms present for a period of

[2] QUILTBAG: Labels, acronyms and explanations – Rarely Wears Lipstick

more than 2 weeks. There should also be a representing change in function and one symptom must be either depressed mood or loss of interest. The symptoms listed are as follows:

1. Depressed mood for most time of the day for most days.
2. Reduced interest in activities found otherwise pleasurable.
3. Significant weight loss or gain characterized by significant decrease or increase in appetite.
4. Insomnia or hyper insomnia
5. Agitation or retardation.
6. Fatigue
7. Feelings of worthlessness and also inappropriate guilt.
8. Reduced ability for thinking and/or concentrating.
9. Recurrent thoughts of death or suicide [3]

Anxiety is generally a feeling of worry, nervousness or unease about an event which has uncertain outcomes. According to the DSM-IVR generalized anxiety disorder is characterized by:

a) An excessive anxiety or worry (apprehensive expectation), which occurs for more days than none for a period of at least 6 months which can be about a number of events or activities.
b) Difficulty in controlling the worry
c) The anxiety and worry are associated with three or more of the following six symptoms with at least some of the symptoms present for more days than not for the past 6 months.
    1. Restlessness or feeling on the edge/keyed up
    2. Fatigue
    3. Inability or difficultly in concentration and mind often going blank.
    4. Irritability
    5. Tensed muscle
    6. Disturbed sleep including difficulty falling or staying asleep and restless unsatisfying sleep
d) The focus of the anxiety and worry is not about having a panic attack, being embarrassed in public, being contaminated, being away from home or close relatives, gaining weight, having multiple physical complaints, or having a serious illness, and the anxiety and worry do not occur exclusively during PTSD.
e) The anxiety, worry or physical symptoms cause clinically significant distress or impairment in social, occupational or other important areas of functioning.
f) The disturbance is not caused by the direct physiological effects of a substance or a general medical condition and does not occur exclusively during a mood disorder, a psychotic disorder, or a pervasive developmental disorder. [4]

Meyers (2003) introduced the Minority Stress Model which focused on the damaging role of belonging to a minority group and the stress which was associated with the same. This stress can be viewed as discrimination and violence due to homophobia. The following model was initially used to study racial or ethnic minorities but was also applicable to the sexual minority groups. Minority stress model attempts to explain why minority groups have an increased susceptibility to develop all sorts of mental disorders in general. Hatzenbuehler (2009) further expanded the model by pointing out how this minority stress can alter general

[3] Appendix D—DSM-IV-TR Mood Disorders - Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery - NCBI Bookshelf (nih.gov)
[4] Diagnostic criteria for anxiety disorders set out in DSM-IV and ICD-10 classification systems - Clinical effectiveness of interventions for treatment-resistant anxiety in older people: a systematic review - NCBI Bookshelf (nih.gov)

cognitive and interpersonal processes which are associated with mental health problems. Meyers in this model suggested that in addition to general stressors that affect everybody there are stressors which are unique for sexual minorities that cause mental health problems including but not limited to suicidality. Such stressors can be characterized into distal minority stressors which are the actual or objective discrimination and violence faced by sexual minorities and proximal stressors like hiding one's sexuality, fear of coming out, internalized homophobia, etc. The buffer for the same is social support.

According to a research quoted by 'Adaa' 30% to 60% of those who identify as a part of the LGBTQIA+ community specifically lesbians, gay men, transgenders and bisexuals deal with depression and anxiety at some point of their life which is significantly (1.5 to 2.5) higher than those people who identify as heterosexuals i.e.; cishets.[5] It is thus very important to understand why do people of the community have significantly higher levels of depression and anxiety, the causes behind it and what interventions can help reduce these numbers. It is also very crucial to promote research about the same especially in the Indian sub-continent.

Aims and Objectives

The prevalence of homosexuality is an estimate which is difficult for reasons such as associated stigma and social repression. There is an unrepresentative sample that exists and gets surveyed. Medicine and science have continued to debate on the contributions of nature versus nurture as well as psychosocial factors to sexuality but nothing has been specifically determined. Anthropologists have documented significant variations in the meaning of same sex practices within societies. But these explanations are limited. Thus, further research is required. The objectives of this paper are:

1. To understand the relationship between homosexuality, depression and /or anxiety.
2. To understand and hypothesize the reasons behind depression and anxiety faced by individuals who identify as a part of the LGBTQIA+ community.
3. To study homosexuality through the perspective of minority stress model by Meyers, 2003 and suggest interventions accordingly.
4. To promote and facilitate positive discussion about the mental health of the LGBTQIA+ community which is oft forgotten

LITERATURE REVIEW

Ruth Vanita in paper titled "*Same Sex Weddings, Hindu traditions and Modern India*." explores the idea of same sex relationships, joint suicides and weddings mostly amongst women or lesbians and its relation with low income. The paper mostly focuses on low-income groups which are non-English speaking. It explores the same over the span of last 30 years from 2009 i.e.; from 1979 to 2009. This secondary research paper provides with crucial data to explain how families denying women to get married to each other leads to combined suicides stemming from the idea of "at least we would be together in death." Another key aspect of the following paper is its exploration of homophobia and how it's a very colonial idea. It talks about how homophobia was actually a part of a rather generalized attack on Indian sexual mores and practices which was undertaken by British missionaries as well as educators. It explores key themes of Hindu marriage and how Hindu marriages always functioned on the idea of the union of 2 souls irrespective of their gender (Gandharva Vivaha). An important implication of the following paper is understanding how despite what the Hindu scriptures say parents and society as a whole would rather accept their daughters committing suicide together (joint suicide) rather than getting married to the one, they love.

[5] Understanding Anxiety and Depression for LGBTQ People | Anxiety and Depression Association of America, ADAA

Another important aspect of this paper that needs to be discussed in accordance to the Hindu law, 2 women even though of the same gender would be considered married if they consent to it and get married with the help of a priest or a pandit. Even though same sex marriage hasn't been legalized in India, it isn't a crime anymore and can be done. It also points out how it is important to negotiate with family, religion and polity and the same has been done before with differential outcomes.

Nick J. Mulé and Kathleen Gamble in their paper "*Haven or precarity? The mental health of LGBT asylum seekers and refugees in Canada*" talk about how Canada is one of the 42 countries in the world to grant asylum or safe guard to people who identify as a part of the LGBTQIA+ community from persecution on the basis of their sexual perception and/or their gender perception. It goes on to explore whether or not this asylum provided by Canada has an impact on the mental health of the LGBTQIA+ refugees. It explores homo-bi-trans phobia engrained in Canadian social, political and legal structures and discrimination based on other identities such as gender, race and age. The paper also explores health care services provided to refugees of the LGBTQIA+ community and how the healthcare system isn't necessarily inclusive or non-discriminatory. The paper also discusses how the refugees face a constant fear of being outed by the health care workers after disclosing their gender identity or sexual orientation. It thus needs to be understood how not only the refugees face discrimination in terms of access to health care which happens to be a basic human right but also live in the constant fear of being outed in case they do end up getting medical attention. The paper then talks about how this discrimination can trigger memories or trauma faced in the native country compromising their mental health. Even though refugees who escape to Canada because of violence and pertinent discrimination in their native countries should view Canada as a safe haven but since they are often subjected to trauma while filing documents, providing proof of their sexual and gender orientation (triggering traumatic memories by reliving the moments), finding resettlement and getting discriminated, Canada proves to be far from a safe haven especially in terms of their mental health. The paper talks about how refugees often end up losing their jobs, not getting adequate medical care (both mental and physiological) face violence (not in Canada) and aren't provided with refugee protection. This paper provides key insights into some very important issues faced by refugee population in Canada but these insights aren't just limited to the refugees. It is important to understand the implications of the constant fear of being outed and thus also the anxiety that is caused by this very fear. It is also important to notice the issue of violence oft faced by the community. This paper published before decriminalization of 377 in India also points out how Indian refugees also ended up in Canada due to native land violence, discrimination, etc. Human rights are extended to all humans but these same human rights don't seem to be extended to the LGBTQIA+ community. It is important to understand the implications of the same.

Suzanne M. Marks in paper titled "*Global Recognition of Human Rights for Lesbian, Gay, Bisexual, and Transgender People"* published in 2006 talks about how there exists an interdependent relationship between health and human rights. The LGBTQIA+ community is not extended these basic human rights such as right equality and freedom from any discrimination, right to life, liberty, and personal security, right to freedom from torture and degrading treatment and recognition as a person before the law, and lastly the rights to marry and have a family. This discrimination extends to housing, jobs, healthcare, additional benefits, financial security, etc. and leads to harassment and discrimination. This affects their mental health as it leads to substance abuse- smoking, drinking and consumption of drugs, isolation (leading to depression), sexual risk taking (increases chances of contracting HIV), overeating, physical abuse, injuries and suicide ideation often leading to death. In several

countries such as Saudi and Iran the following isn't considered a human rights violation and laws are in place which call for execution of practicing homosexuals. This isn't considered a hate crime either. The paper also points out abuse by police in countries including India. It is important to understand from this very paper how despite of the laws slowly being implemented and human rights check being conducted by organizations such as amnesty international egregious human rights abuse against the people who identify as a part of LGBTQIA+ continue. It also important to note the implications of constant fear experienced by members of the community which can in turn lead to anxiety. It is crucial to understand from this paper how denying basic humans rights leads to both physical and mental health repercussions. The paper probes the question as to why aren't these rights extended to the LGBTQIA+ population even though most of these are extended to even the most gruesome criminals.

Lawrence S. Mayer and Paul R. McHugh in their paper titled "*Sexuality and Gender: Findings from the Biological, Psychological, and Social Sciences*" talks about sexual orientation and its biological, psychology and sociological implications. It discusses how some argue that sexual orientation is choice whereas some argue that one is born that way. Sexual autonomy is important and oft neglected in the LGBTQIA+ community. The paper talks about people who identify as a part of this community need to embrace this choice or their sexual autonomy. The paper presents an interesting analogy which states that being gay is like being left-handed, there is no particular cause, being left-handed isn't a phase and a left-handed individual wont suddenly one day magically turn into a right-handed individual. It is important to note from this very particular analogy that being left-handed isn't necessarily wrong. Different from most of the population i.e.; right-handed people but not wrong. Sexual identity and orientation generally have social and political implications thus it needs to be understood in not only individual terms but also scientific, personal, social, political and moral terms. It quotes the example of Oscar Wilde and how he died in jail after being persecuted for "gross indecency" where "gross indecency" refers to being GAY. The paper also introduces the Kinsley scale developed in the 1940s which was used to classify sexual orientations and desires in a measurable criterion. People are asked to choose on the following scale:
0 - Exclusively heterosexual, 1 - Predominantly heterosexual, only incidentally homosexual, 2 - Predominantly heterosexual, but more than incidentally homosexual, 3 - Equally heterosexual and homosexual, 4 - Predominantly homosexual, but more than incidentally heterosexual, 5 - Predominantly homosexual, only incidentally heterosexual, 6 - Exclusively homosexual.

The paper discusses how sexual abuse and violence in childhood could possibly contribute to sexual orientation. It points out how the LGBT subpopulations are at higher risk, compared to the general population, of numerous mental health issues- at a higher risk of suicidal behavior, mental disorder and substance misuse as well as dependence. It estimates that those who identify as homosexuals are 2.47 times higher life- time risk compared to heterosexuals in terms of suicide attempts, they are also about twice as likely to experience depression over twelve-month periods, and 1.5 times as likely to experience anxiety. There is an elevated risk for substance abuse problems which are 1.51 times as likely especially in homosexual women- 3.42 times higher than heterosexual women. Homosexual men are at a particularly high risk for suicide attempts and the community as a whole has a 2.47 times greater risk of suicide attempts over their lifetimes. It discusses the co-morbid mental health issues associated with gender dysphoria. It is crucial to understand from this very paper the disparities in the mental the health of those who identify as queer when compared to those

who identify as cishets. It is also important to discuss the potential reasons of the same-political, moral, social and psychological. There has to be an understanding in terms that there is no right or wrong here just like there is no right or wrong in being left-handed or right-handed. The Kinsley scale is also an important pointer of the following paper. Lastly, the paper explains how even though there isn't a biological cause or even a psycho-social cause which is specifically linked to homosexuality it doesn't make homosexuality wrong. Whether it is a choice or a thing which was bestowed through birth, sexual autonomy is a choice everyone gets to make.

Jessica P. Brown and J. Kathleen Tracy's paper "*Lesbians and Cancer: An Overlooked Health Disparity*" discusses how there are health disparities when it comes to cancer diagnosis in terms of their incidences, prevalence, mortality, and other adverse health conditions. It explains how women who identify as lesbians have an earlier sexual debut and are likelier to have multiple sexual partners and engage in riskier sexual behaviors. They also use fewer oral contraceptives which have been shown as protective barriers against cervical and breast cancer. They are less likely to participate in annual pap screens and cervical cancer screening and thus have an increased risk of contracting cervical cancer. The paper concludes how it is important to identify disparities in terms of cancer diagnosis and treatment which are largely social. It is important to understand the root cause of these disparities. This paper brings to light how illnesses as terminal as cancer can get ignored in the homosexual population due to a variety of disparities. It is important to understand where these disparities stem from and how can we intervene in a way to make sure that these disparities do not become the means for denial of basic healthcare rights to those who identify as members of the LGBTQIA+ community.

Devdutt Patnaik in this book titled '*Shikhandi, and other queer tales they don't tell you*.' Talks about how queerness isn't only modern, western or sexual. It dates back to mythology. The book takes a look at tales from Hinduism that have been overlooked. It explores stories such as the story of Shikhandi who was born a man but became a woman to take revenge from Bhism Pitamaha or the story of lord Mahadeva who became a woman so as to be able to devotee's child, Chudala, a woman who became a man to enlighten her husband and Samavan, a man who became the wife of his male friend, etc. The book is touching and aims to study how Indians now make sense of queerness viewing it as abnormal and criminal when mythology clearly begs to differ. This sheds light on the notion of how even though homosexuality is viewed through the angle of sodomy due to the laws of Hinduism, our mythology is rather rich with queer stories and thus, we need to see where our biases come from.

Harjant S. Gill, a queer anthropological filmmaker in his research paper titled, "*Censorship and Ethnographic Film: Confronting State Bureaucracies, Cultural Regulation, and Institutionalized Homophobia in India*" talks about his encounters with the Indian censor board and the bureaucratic set up behind such governmental institutions. He starts by giving the example of '*Mardistan*' (2014) an ethnographic documentary which explores the concept of masculinity in India. He recalls how he was told that some content in his film was found objectionable in his film and thus, cuts were required. Words such as 'gandu' which is the Hindi equivalent of faggot were to be removed for broadcast on doordarshan. He further explains that bureaucratic institutions such as the censor board are often used as a means of regulating culture, controlling speech and also stiffening descent. The censor board regulates the content based on notions of obscenity and vulgarity which are rather colonial. These same rather vague concepts are paternalistic, heteronormative and nationalistic. This paper also

explores how bureaucracies such as the censor board have been infiltrated with religious and political institutions and even YouTube has been censored. This furthers the nationalist agendas which are heteronormative and homophobic. The attempts to censor out this information is not only official but also unofficial such as anonymous threatening calls, blatant threats, etc. Since all films have to legally go through the censor board filmmakers can't avoid this grotesque. India has a long history of such bureaucratic institutions being dysfunctional especially corruption but Gill didn't have the resources to pay this bribe. Due to the high illiteracy rates media is seen as a tool for modernizing India and censor board acts as a regulatory service for mass media dissemination. It treats viewers as immature which can be swayed easily by what's on display in the mass media. Gill talks about how Milind Soman was arrested and persecuted for modelling nude and seeing this particular photoshoot made Gill realize about his queerness which was also seen as obscene and criminal by the same institutions which persecuted Soman. Any threats to the heteronormative and patriarchal familial institutions are censored. The fight by the LGBTQIA+ community for equal rights was hindered by this concept of sodomy which is a rather heterosexual agenda which protects the patriarchal set up. Vague interpretations of the term sodomy criminalize thoughts, desires, gender and sexual identities based on myopic reading of the laws. The paper concludes on the note that through the systems of bureaucracy such as the censor board infliction of structural violence are institutionalized. It is important to understand from this very paper that the idea of normalcy is rather patriarchal and propagated through bureaucracy which is heavily influenced by corruption, political and religious systems, etc. Criminalizing and stopping mass media from disseminating information which is against this notion of normalcy curbs desires and sexual and gender identity and orientations. This provides an insight into where our biases stem from and how can we act against them. Understanding bureaucracy is also important.

In the research article "*Psychological Wellbeing of Middle-Aged and Older Queer Men in India: A Mixed-Methods Approach*" by Anupam Joya Sharma and Malavika A. Subramanyam is an essential literature available when it comes to research about the queer population in India and is therefore very important for this research. It explores the psychological wellbeing of middle aged and older queer men mostly from the urban areas belonging to well off families. It uses both qualitative and quantitative methods. It is guided by the minority stress model by Meyers. It explores internalized homophobia, age related stressors and psychological well-being. It takes into account gay and bisexual men. A study carried out online, took into account experiences of over a million queer participants showed how that almost 40% of the participants were aged 45+ years and out of them 30% were married to women and 20% hid their identities from their spouses and families. Internalized homophobia is linked to decreased self-esteem and psychological distress. The paper also explores self-stigmatization. This is generally reduced through social support or third safe space through LGBTQIA+ groups and interactions. Internalized homophobia and closettedness affects psychological well-being. This study provides a rare insight into the lives of 207 queer participants. It discusses both sexual minority and age. Depression is seen as a result of helplessness. Optimism and resilience help negotiate with loneliness and depressive symptoms. Isolation from true self, internalized homophobia- it's a sin, pressed sexual desires, self-stigmatization and social isolation due to conflicting identity and maintaining their marriages and families as heterosexual individuals is tough. This paper provides key insights into why there is a likelihood for queer individuals to face more psychological distress and depression and how the same can be dealt with.

Nishant Upadhyay in his paper "*Hindu Nation and Its Queers: Caste, Islamophobia, and De/coloniality in India*" explores how decriminalizing 377 was seen as decolonialization. The intention of this could be decolonial but it also has other things at play such as colonialism, islamophobia and Brahminical supremacy. True understanding of queer and trans suppression in the postcolonial era would only be through understanding Brahminical supremacy along with colonialism. In India, endogamy and blood purity are important concepts. They have always been important in regulating gender and sexual orientations. Caste is also an important factorial. The ideas of Hindutva attack on desires, intimacies and love in India. These aren't just limited to queer love and desires but also inter religion and inter caste. The decrimilization of 377 isn't decolonialization completely it is also a challenge to these ideas of Hindutva which dismantle the very ideas of desire and love if not patriarchal and inter caste and inter religious. Islam has the same provisions and thus to understand and really dismantle what seems to be trans and queer phobia through suppression we need to understand these institutions and their implications.

Robert P. Cabaj in his research article "*Homosexuality and Neurosis*" explores the correlation between homosexuality and neurosis. The link between homosexuality and mental illness. In the guise of biomedical research there are also studies being conducted to understand the biological reasons behind homosexuality. This is to find out if homosexuality is treatable and how to cure the same. Psychiatric literature has subtle biases which assumes that homosexuals are sicker if not ill. There is a higher probability of someone who identifies as a homosexual to develop alcohol and substance abuse which is 30% when compared to 10% in heterosexuals. Community mental health programmes can provide insight into dealing with people of the community who identify as LGBTQIA+ if gay literature is taken into account with knowledge about homosexuality. Homophobia can affect transference and counter transference. This is because there is always a tinge of homophobia in both the client and therapist because of being bought up in a homophobic society. There aren't training programmes in place which help someone deal with homosexual clients. Gay people come to therapy for usual reasons such as depression, anxiety, phobias and loneliness. Seeking help for coming out is also common. Lifestyle changes are also a common issue. Coping with grief and loss especially of a partner is common. In case the person doesn't want to reveal homosexual identity, they refer to their partner with the opposite gender names which are often made up. This is because patients believe that to seek help which is psychotherapeutic in nature and even just to be listened to, they have to present themselves as willing and wishing to change. Self-hatred and low self-esteem need to be looked into as well. The paper talks about the concept of retroactive heterosexuality which is confused behaviour occurring due to loss or change or trying to supress desires which are sexual or gender based in nature. Even a patient comfortable with their sexuality would have issues with internalized homophobia and want to change one's sexual orientation. A non-biased therapist can help an individual deal with their identity. No matter how accepting the patient or the therapist are homophobia will always be present in the relationship. Mostly covert or internalized. Myths or stereotypes such as gays can't have successful relationships, older gays are sad and lonely, if choice is provided gays would want to be heterosexuals, gays don't have fulfilling lives when compared to heterosexuals and it is an illness can make things worse. It isn't an illness and accepted sexuality variations shouldn't be used to treat gay and lesbian patients. Social phobias are also very common. Anxiety disorders in such circumstances are tougher to treat due to situational anxiety faced because of the environment. Medication could be required if anxiety is linked to accepting homosexuality. Stereotypes further where men need to be seen as manly and women need to have children to feel fulfilled being homosexual gets tougher. Homophobia isn't just the fear of homosexuals but also hatred and loathing internalized

homophobia can thus involves self-doubt, a belief in their inferiority, self-fulfilling prophecy, etc. Even though there is no particular correlation between neurosis and homosexuality, neurotic issues are affected by patient and therapist's sexual orientation. Homophobia will inevitably play a role in the alliance but knowledge is a powerful countermeasure.

Richard C. Freidman in his commentary "*Homosexuality, Psychopathology and Suicidiality*." Talks about a previously done twin study which conlcuded that homosexual men aare much more likely to have a lifetime risk of sucicide due to psychaitric comorbidity. The paper talks about how the correlation between depression and suicide isnt neccesarily an explored one in this paper. The subjects in the researhc were also not asked about the onset of their suicide ideation and their discovery of their homosexual desires. It speculates that adolescents can feel depressed and suciidal as a result of alientation due to their non-scientific and different from others sexual and gender orientations. Although social factors such as homophobia, bullying, isolation can influence suicidiality it needs to be looked at through a biological and psychological perspective due to the empahisis on biopsychosocial model in psychiatry. Clinically and common sensically depression and sucide are linked amd thus the increased risk of suicide can also be linked to increase depression. This commentary probes more research on the topic which takes into account the newer biopsychosocial perspective of psychopathology. The examined research corelates with the additional investigations which show associations between depression, suicide, psychopathology and homosexuality but causes of the same still need to be researched about.

Jack Drescher in the research article titled "*Out of DSM: DE-pathologizing Homosexuality*" talks about how in the 1973 APA removed homosexuality as a diagnosis or disorder from DSM II due to comparing theories that viewed homosexuality as normal and ones who viewed it as a disorder. This marked the beginning of a paradigm shift where medical sciences started theorizing homosexuality. ICD-10 also removed homosexuality as a disorder in the 1990 which triggered the same ripple effect. Homosexuality shifted from psychaitry and medicine into politcal realms such as religion, governmental, educational, media, etc. Cultural attitudes also changed especially in the USA and homosexuality started being viewed as normal. It wasn't an illness but still against the bible. This triggered a lot of rather very important questions about rights of those who identified as homosexuals specifically in terms of the sodomy laws. Looking at the historical perspective of homosexuality and its journey from a disorder to somewhat normal is important to shift the medical perspective from "its an illness" to "how can we help the community better."

James Rudolph in his selective review of literature titled "*Counsellors' Attitudes Toward Homosexuality*" evaluates the atttitudes of professionals in the field of cosuelling towards those who identify as homosexuals. It explains how professionals view homosexuals as full functioning but with internal and societal issues. Understanding the sociopolitical and cultural stand point is important. Non-pathological view of homosexuality has counsellors torn, and homosexuality shouold be viewed as anoter expression of human sexuality. The survey research on atttiudes is essential but limited. Attitude surveys might not always show what the respondents believe due to social correctedness. Antigay atttiude and AIDS are big threat to the homosexual friendly therapy. Psychotherapeutic support is needed and failing the population isn't an option.

Götz Mundle, Lieselotte Mahler & Dinesh Bhugra in their article titled "*Homosexuality and Mental Health*" talks about how as a topic homosexuality has seen a lot of changes along the years from being a disorder in both DSM and ICD to having public policies seeing positive

chnages with the emerging LGBTQIA+ rights movements. Stigmatization and discrimination have trended with violence, police brutality, subtle discrimination, etc. Medical community also has sublte discriminatory patterns and access to healthcare is lacking because of this very discrinination. These factors influence the overall mental health. This calls for changes which address issues concerning both health and mental health of those who identify as LGBTQIA+. The paper, in conclusion calls for some serious changes in not only medical associations but also organizations and services. Ending on a positive note the paper discusses how World Psychiatric Association has set up a presidential task force on the subject of homosexuality and the changes that need to be formulated. Opening a dialouge is progress but there is still a long way to go.

Martin Ploderl, Maximilian Sellmeier, Clemens Fartacek, Eva-Maria Pichler, Reinhold Fartacek and Karl Kralovec in their paper titled "*Explaining the Suicide Risk of Sexual Minority Individuals by Contrasting the Minority Stress Model with Suicide Models*" talk about how many studies have found that there exist elevated levels of suicide ideation and attempts in those who identify as sexual minorities. The suicide risk is thus explained by the minority stress model, Interpersonal Psychological Theory and the clinical model. The paper discusses how one protective factor for the same is enhanced social support and reduced internalized homophobia. The paper points out how there is sparse available data suggesting that sexual minorities are at high suicide risk and more research is required in the field. Research for this paper was done through an electronic questionnaire where answers were taken from those who identified as a sexual minority and a recruited heterosexual comparison group. Suicide ideation was measured through Beck's scale for suicide ideation, hopelessness was assessed through Beck's 10 item version hopelessness scale, depressive mood through Allgemeine Depressions skala, impulsivity through Barratt's Impulsivity scale and aggression through Buss and Perry's aggression questionnaire. Further, social support was assessed with the Fragebogen zur sozialen Unterstutzung and sexual identity through questions such as "what describes your sexual orientation the best?" the results were as follows: amongst the sexual minority participants 14% attempted suicide at least once in their life compared to 5% in heterosexuals, this was strongly correlated to depression and hopelessness, burdensomeness and failed belongingness. Internalized homophobia and general violence along with coming out could also be seen as reasons. Overall, through the means of various scales the paper concluded how depression and suicide is an increased risk in sexual minorities due to the factors listed above. Depression and hopelessness were present 14% in homosexuals compared to 5% in heterosexuals. The following paper used reliable instruments but the disadvantage was the fact that the minority samples weren't necessarily correlated with the sexual majorities in terms of age, education, etc. So, these comparisons need to be made with extreme caution. Homosexuality was characterized under the branch of ills such as demonic possession, drunkenness and sodomy which were scientifically known as insanity, alcoholism and homosexuality. Lastly, the psychoanalytic theory was based on Freud's seeing expression of adult homosexual behaviour caused by immaturity and arrested psychosexual development. The theory explained how homosexuality is assuredly no advantage but it's not something to be ashamed of or classified as an illness. It is a variation of sexual function produced by stunted sexual development. The paper concludes by explaining how Depathologizing homosexuality was the beginning of the end of medicines participation in social stigmatization of homosexuality which then resulted in repeal of the sodomy laws, enactment of human rights protecting the sexual minority, ability of the sexual minority to join military, marriage equality, adoption rights, etc. The question shifted from what's wrong with homosexuals to how can we help the LGBT patient populations.

Jack Drescher in the paper titled "*Out of DSM: Depathologizing Homosexuality*" explains how in 1973, the American Psychiatric Association removed homosexuality as a diagnosis from DSM. This was due to the contracting theories with pathologized homosexuality versus those who viewed it as normal. The paper reviews the historical scientific theories and arguments which first placed homosexuality into DSM and then removed it. The paper also discusses the aftermath of this very decision. Theories of pathology saw adult homosexuality as a disease which is a condition deviating from normal heterosexual development. These theories view homosexuality as a sign of defect, as morally bad and socially evil. Theories of immaturity, psychoanalytic in nature regarded expressions of homosexual feelings or behaviours that were normal at a young age and a step towards adult heterosexuality. Homosexuality in adult years was viewed as stunted growth and thus didn't see homosexuality as necessarily bad. Theories of normal variation viewed homosexuality as a phenomenon that occurs naturally like left handedness and functions on the belief that people are born gay. These theories don't see any place for homosexuality in a diagnostic manual. Gender belief theories drew upon gender beliefs which regarded essential qualities of men and women and are based on gender binaries. Some of the earlier theories of homosexuality saw it has morally bad and sinful which led to scrutiny from law, medicine, psychiatry, sexology and human rights activism.

Bhattacharya, S.S. argues in her article published in the online journal *citizen matters* (2018, June) titled '*labelled, bullied, humiliated: What LGBT students in our schools go through*' that even though awareness about LGBT community has increased, with increase in number of pride or rainbow parades etc. students in schools all across India are subjected to bullying and harassment due to their sexual identities. The article aims to study the case of a teenage school student from a reputed school in Gopalpuram, Chennai who was teased, ridiculed and labelled after a screenshot of her answer to the question- first crush you ever had, was shared and circulated in the school. She was abused and called a prostitute and in an unfortunate turn of events she ended up suiciding. The article cites a research on how homophobia in schools is largely due to the incompliance of the authorities and is a large unaddressed yet important issue. It concludes that there is a dire need of sex education in schools which not only focuses on heterosexual relationships but also focuses on homosexual relationships, and how homophobia can be curbed by making strict rules against bullying and ragging of the LGBT students as well. This article is an important read in terms of understanding how homophobia and bullying can be linked to suicide. Social factors play an important role in psychopathology in the LGBTQIA+ community and this has been a trend in many of the papers examined above. We need to pay heed to these social factors and find solutions to the same.

DISCUSSION

"Why is it that, as a culture, we are more comfortable seeing two men holding guns than holding hands?" – Ernest Gaines

Delhi high court made a landmark judgement which declared that section 377 of the IPC was in violation of fundamental constitutional rights and international human rights and secular legal trends. This did not however change the anti-homosexual attitudes of religious and community leaders reflecting the existence of widespread prejudice in India. Not only this, heterosexism and anti-homosexual attitudes are still very prevalent in psychiatrists, healthcare workers, mental health professionals, etc.

Over the years, there has been a shift in understanding of homosexuality and it has gone from sin, crime and pathology to a normal variant of human sexuality. This new understanding is based on the higher prevalence of same sex feelings and behaviors in both men and women which spans across cultures as well as species because homosexuality has been seen to be prevalent in non-human primates as well. Research has demonstrated that people who have homosexual orientations do not have any objective psychological dysfunction or impairments in either judgements, stability or vocational capabilities.

Meyer (2003) in the "minority stress model." explained how those who identify as sexual minorities face hostile stressors for example homophobic victimization or slurs and bullying due to their sexual minority identity i.e.: being gay. These stressors have a negative impact on the health of this very minority group. The model posits how being a part of a sexual minority group results in health disparities which are generally induced by a homophobic culture. Homophobia often leads to a lifetime of maltreatment, harassment, discrimination, victimization, bullying etc. This can also impact one's access to care. This model provides significant insight into the impact of homophobia.

This model provides better understanding of the stigma, prejudice, discrimination faced by people of the community and also the repercussions of the same. This is important because it provides key insights into the reasoning behind the fact that people of the community face rejection and internalized homophobia both of which are linked to disorders such as substance abuse, depression, anxiety and can also fuel physical ailments such as HIV and AIDS due to riskier sexual behaviors, lack of sex education and proper healthcare services.
According to researches applying this model into the field of research has shown that people who identify as a part of the LGBTQIA+ community especially gay and bisexual men tend to have a higher chance of developing polysubstance use and also sleeping with multiple and sometimes rather anonymous partners (Kalichman & Cain, 2004; Kashubeck-West & Szymanski, 2008; Bimbi et al., 2006). Research sheds light on how multiple partners can lead to HIV and AIDS whereas, polysubstance use can be linked directly to mental health disorders. Therefore, we can conclude that being a part of the minority sexual orientations has repercussions which involve both mental as well as physical health.

The question remains… WHY? To shed light on the same we go back to the minority stress model. Risky behaviors such as substance use and unprotected sex can be a result of hostile stressors faced by the sexual minorities- internalized homophobia, discrimination, victimization, etc. can all serve as the root cause for the same. Inappropriate coping mechanisms as well as the lack of knowledge and information increases susceptibility to both physical and mental ailments.

The very concept of sexual minority stems from both the psychological and social associations and orientations that have been described in terms of the relationship between what is minority and what is majority which further results into serious conflicts. What this statement basically means is the fact that as a society we have been exposed to the idea that being heteronormative is accepted and normal. This can be seen as a result of the clear majority that heterosexuals hold. This very idea of normalcy and acceptance based on the existence of majority results in discrimination based on the fact that homosexuality isn't very normal and thus not accepted. The idea of heteronormative behaviors is engrained in patriarchy where the union of a male and female is to create a family or having off springs. Even though having kids is an evolutionary idea there is no proof what so ever that being gay is not biologically normal or sound. In fact, homosexuality is found in 450 species including

humans (homophobia? Not so much.) Stigma, stemming from this very idea has serious consequences which further lead to prejudice and related outcomes.

Based on this model of minority stress by Meyers the paper further dwells into understanding the mental health (specifically depression and anxiety) in the community and also establishing a causal relationship.

Being gay comes with a sense of constant fear against bullying, discrimination, victimization, etc. These are some serious stressors. Exposure to these stressors can lead to serious mental health issues. Some other causes that can be seen contributing to mental health struggles in the LGBTQIA+ community include:

1. Social isolation: Isolation isn't inherently bad because people crave solitude in certain situations but social isolation on the other hand is involuntary isolation and is linked to both mental as well as physical ailments. Research shows that social isolation is linked to coronary heart disease as well as dementia. Hawkley in his paper "effects of perceived social isolation across the life span" talks about how loneliness can wreak havoc on an individual's mental, cognitive and physical health including ailments depression, poor sleep cycle, insomnia, impaired cognitive and executive functions including accelerated cognitive decline, poor cardiovascular function and impaired immunity at every stage of life. The American cancer society after analysing data for more than 5,80,000 adults found that social isolation increases the premature death risk faced by individuals which can be a result of several causes. Research also shows that the risk which is presented by social isolation is very similar in terms of magnitude to the risk of obesity, smoking and lack of access to care and physical activities. It also showcased an increase 30% risk of strokes. This can be a result of lack of encouragement from social support systems such as family and friends which may lead to those riddled with loneliness to slide into some very unhealthy habits. Not only this loneliness has been found to raise levels of stress, impede sleep and then in turn harm the body. It can also thus, augment depression and anxiety. Marginalized groups such as the LGBTQIA+ community are more likely to face and deal with social isolation. Depression, anxiety and suicide ideation is linked to social isolation and loneliness. Furthermore, as stated previously according to the minority stress model social support acts as a buffer against the ill effects of minority stress the lack of the same can thus expose the minority groups to the same.

2. Discrimination*:* Discrimination is defined as an unjust or prejudicial treatment of different kinds of peoples based on the grounds of sex, age, gender, caste, race, etc. According to research posted by UCLA when people are chronically discriminated it can have effects such as mental ailments linked to stress like depression and anxiety. It can also lead to issues regarding self-esteem. It can also lead to feelings of shame, hopelessness and isolation. There is also reluctance to ask for help and get further treatment. Lack of social support and understanding, fewer employment opportunities, bullying, harassment and physical violence along with self-doubt. There are a number of physical and mental health effects such as high blood pressure, cardiovascular diseases, breast cancer and mortality along with stress, depression, anxiety, substance abuse, etc. Stigmatization and discrimination in terms of the LGBTQIA+ community can vary from subtle homophobia to public rejection, verbal and physical violence, criminal sanctions and death penalty. Countries like Afghanistan, Iran, Mauritania, Somalia, United Arab Emirates have capital punishment for those who indulge in same sex relationships but of course these killings aren't just prevalent in countries where it is legal to kill people based on their sexual orientations but also extend to countries where

extrajudicial killings are oft punished. This could be done in the name of social cleansing, honor killing and persecution of people who belong to the LGBTQIA+ community. Let's put this in perspective and imagine what it feels like to be killed for being yourself. It is argued that being gay isn't a choice but rather biological so then what does it feel like to be killed for being someone you can't change? The constant fear related to being outed and the constant fear for loving someone can't possibly be healthy for someone's mental health. To a heterosexual couple under most circumstance than none being killed for loving someone is not common on the other hand for homosexuals this fear is rather real. Now club this with social isolation and inability to find help what would this fear do to an individual. This constant fear then leads to stress, depression and anxiety. Unhealthy coping skills such as substance abuse or engaging in unsafe sex can lead to further health repercussions. What still does not make sense is being killed for falling in love or being true to yourself over something which isn't even a choice.

3. Access to basic human rights and security:_ People who belong to the LGBTQIA+ community oft face discrimination and are denied the most basic human rights. For the purpose of this paper lets focus on an example: Healthcare Services. According to Article 21 of the Indian constitution healthcare is a basic human right for all Indian citizens. The article considers health integral to the right to life and puts the government at a constitutional obligation to provide health facilities.[6] Criminals in jail have also been extended the right to healthcare despite how gruesome their crime is. You know who does the right to healthcare not extend to? The LGBTQIA+ community. It is often assumed that the LGBTQIA+ health involves only HIV/AIDS. But in fact, the full scope of the LGBTQIA+ health agenda includes breast and cervical cancer, hepatitis, mental health, substance abuse, tobacco use, depression, access to care for transgender persons and other concerns.[7] The LGBTQIA+ community is often denied access to basic healthcare. This is especially prevalent when it comes to the transgender community. A case reported in 2013 explained how a transgender victim of a train accident, died unattended, because for 3-4 hours, doctors could not decide whether to admit her to a male or female ward. A 2016 Lancet paper on transgender health in India and Pakistan says that while the transgender community may have received legal recognition, its access to quality healthcare remains alarmingly scarce. And, there are hardly any anti-discrimination laws in place to safeguard equality in healthcare access.

Case in point, an Indian lesbian couple trying to get pregnant; since adoption rights also don't extend to the LGBTQIA+ community would first be denied any IVF or sperm bank services and in case after a lot of struggles they do end up finding a way to get pregnant getting medical help throughout the pregnancy would be close to impossible. Not only the health of the mother would be compromised but the discrimination would also extend to an unborn child. Getting pregnant with IVF etc. is a privilege considering its higher costs and if despite all these struggles a middle class or upper middle-class couple does end up getting pregnant and cared for this service does not extend to those with less monetary resources.

A rather recent example would be that of covid. In light of the worldwide pandemic the entire world came together to support one and another. On the other hand, India joined forces to collectively ignore the trans community and their right to healthcare. According to Census

[6] https://ijme.in/articles/the-fundamental-right-to-health-care/?galley=html#:~:text=The%20Constitution%20of%20India%20on%20the%20right%20to%20health%20care&text=Article%2021%20of%20the%20Constitution%20guarantees%20protection%20of,personal%20liberty%20to%20every%20citizen.&text=Similarly%2C%20the%20Court%20has%20upheld,maintain%20health%20services%20(7).

[7] http://www.glma.org/index.cfm?fuseaction=Page.viewPage&pageId=532

2011, India has a transgender population of 4.88 lakh, though the actual numbers are said to be much higher.[8]

Transgender people in India are deprived of right to healthcare entitlements because of their gender non-conformity. The fear of being stigmatised and ridiculed by healthcare professionals discourages them from using healthcare services which is now leaving them at increased risk of not being tested or treated for COVID-19. Many transgender people in India lack education, and are excluded from society, which forces them into acute poverty and leaves them dependent on *dahnada* (sex work), *mangti* (begging), or *badhai*. As a result, they are now at increased risk of contracting COVID-19 because they are spending time in public places, cannot practice physical distancing and isolation, or recommended handwashing practices.[9] Not only the trans community is denied healthcare and put at risk in these testing times but when government extended relief services to the lower and less privileged socio-economic sections of the society, they completely ignored the trans community.

In terms of security, according to Maslow security and safety is a basic need. For the purpose of this paper, we will examine how jobs provide the same.

Imagine you are going to work. You stop at a red light and a transwoman shows up, knocks at the window of the car or cab you are in or stands beside the auto you took and asks you for monetary help. You give her money in exchange for blessings. In a different scenario someone in your family recently got married or had a baby and a bunch of transwomen show up at your doorstep asking for money in exchange for blessings. Has it ever made you question why this line of work for money? To answer this question, we need to look at the existing opportunities available in terms of jobs for people of the LGBTQIA+ community specifically those with visible-queer differences such as the trans community.

A study by the world bank estimated that India loses up to $32 billion in GDP due to homophobia and transphobia.[10] Stats like these should really get us thinking in terms of changes that are required to create a more inclusive workplace. When company policies aren't inclusive, they also lose out on a massive chunk of talent pool and opportunities which in turn means that they are also losing out on revenue. These losses can easily be covered up through inclusivity but the journey ahead is far and long. The question is- where do we start?
As discussed previously denial of basic human rights as well as security such as healthcare, speech, etc. can lead to serious mental health repercussions such as depression and anxiety. This is related to the stress that is caused by the inability and the no or low access to health care and other such basic human rights. Lack of security and constant fear of being outed or being discriminated against coupled with the fear of being assaulted both physical and sexually can also result in stress related disorders such as depression and anxiety. It can also lead to substance use and abuse.

4. Harassment and intimate partner violence: The term harassment refers to any form of unwanted verbal or physical behavior that is aimed at offending or humiliating a person and can be seen as a form of discrimination. It includes a wide range of rather offensive behaviors which demean, humiliate or embarrass an individual. This affects the physical and mental wellbeing of an individual. In terms of legality these behaviors are also seen as disturbing,

[8] https://www.dailyo.in/variety/covid-19-transgender-hijras-health-risk-social-stigma-aadhaar-coronavirus-in-india/story/1/32608.html
[9] https://www.hhrjournal.org/2020/03/living-on-the-edge-covid-19-adds-to-distress-and-discrimination-of-indian-transgender-communities/
[10] https://allthingstalent.org/2020/06/26/state-of-lgbtq-inclusion-indian-workplaces/

upsetting as well as threatening. Harassment can take many forms including mental, physical, discriminatory, sexual, prejudicial, emotional, psychological and cyber or online harassment. Certain rights are rather inalienable and guaranteed by birth to humans. As mentioned before, even the most gruesome criminals have rights. The protection of human rights act, 1993 defines these and guarantees them by birth enforceable in the courts in india. They evolve from discriminatory grounds and can nullify or impair a person from taking the benefit that their rights provide to them. Amongst one of these rights is the right to live with dignity. Any sort of harassment amounts to a breach of the right to live with dignity. Various sections and articles of the IPC protect citizens against the same such as ipc-1860, section 354, IT act, section 67-A, etc. Keeping aside the effectiveness and actual practicalities of the same the penal code offers quite the safeguard against harassment and yet people from the community face significant amounts of harassment through multiple means without any recluse. Gay men and lesbian women are raped, beaten and even killed. Why does the privilege of law not extend to the community? What does it do the mental health of those who identify outside the very privileged heteronormative? To answer this question, I have another question-imagine being constantly harassed and staying in constant fear for your safety, approaching the law and getting neglected or even worse harassed even more. How would that make you feel? Does this stress you out? Does this constant fear give you a sense of sadness or panic? Similarly, the law protects people against violence including domestic violence and intimate partner violence but this privilege also just extends to those who are in heteronormative relationships. Imagine being abused and then ending up with no recluse. Toxic relationships are not only linked to social isolation but also to serious amounts of stress. Constant harassment both sexual and physical in nature can also cue stress and can ultimately lead to depression and anxiety. A UNESCO report shed light on this matter. It explained how LGBTQ students face bullying and harassment in Indian schools in the name of sexual orientation and Gender identity. Nearly 70% of the bullied students in India face anxiety and depression and one third discontinue school due to gruesome physical bullying. Shocking as it is, it's rather true and spreads light on our majorly flawed systems. [11]

5. Sexual autonomy and education: Sexualities and genders are complicated. They extend beyond the idea of gender binary and heteronormativity. Not only is the education and understanding about the same lacking but also people who belong to the community rarely get to express their sexual autonomy as well as romantic preferences without being shot down or facing some sort of repercussions. This of course has its own sets of mental health challenges that follow. In India specifically, there are a lack of sex education and a lot of it comes from all the wrong resources including pornography. Sex education especially lacks for the LGBTQIA+ community. Instead of being supported people from the community are sexualized "how can 2 women have sex?" "aren't bisexuals really just wanting threesomes?", etc.[12] No sexual autonomy and sexualization as well has sexual harassment again have serious mental health repercussions. People from the community are openly denied sexual autonomy which was lifted a little after the decriminalization of section 377 but they still lack relevant sex education. This increases risky sexual behaviors and the likelihood of contracting HIV and AIDS or other STDS. This can be linked to increased amounts of stress, depression, anxiety, social isolation, etc. It creates a vicious cycle of distress, depression and anxiety.

[11] Sexual harassment at educational institutions a challenge for India's LGBTQ community, finds UNESCO report | Business Insider India
[12] How to Support (Not Sexualize) Your LGBTQ+ Friends | Talkspace

6. Police brutality and abuse: Harassment and discrimination by law enforcement including police officials is a serious issue for those who belong to the gay community. This is done both inside and outside holding cells. This is not only scary but actually holds up a mirror to the society, the same people who are meant to protect citizens of their country irrespective of their identity are actually involved in harassing and assaulting the same citizens because of their sexual orientation. This can cause distress and prolonged stress. Fear can lead to anxiety, isolation and depression.

CONCLUSION

No topic has undergone as many changes and controversies in multiple fields such as medicine, society and politics as much as homosexuality. DSM stopped pathologizing homosexuality in 1973 whereas the ICD continued to pathologize homosexuality till 1991.

Karl Heinrich Ulrich was one of the earliest gay rights advocates who hypothesized that some men are born with female spirits. Karoli Maria Kertbeny first coined the term homosexual and homosexuality and argued that homosexuality was inborn and unchangeable and rather normal. In the mid-20th century activist groups accepted the psychiatric illness model of homosexuality and shifted focused from societal condemnation and immorality to something that needed treatment which sought to cure and treat homosexuality. Even though this could be viewed as the start of conversion therapy it was also yet another significant milestone in the very history of homosexuality and the activism associated with it. From these humble beginnings we have come a long way but there is still a long way to go.

Human sexuality is complex and thus there needs to be an acceptance of the distinction between desires and behaviors. Identities also need to be acknowledged along with the multiple dimensions of sexuality but this is oft the case.

Growing up as a queer youth in India is a rollercoaster ride which spirals downwards 99.9% of the times and goes up rather rarely. Imagine being on a roller coaster which spiral downwards into oblivion now let's club that with some questionable statements from our democratic leaders. It's quite a struggle to choose a ludicrous statement to be honest but despite the rather challenging competition one that points out the exact problem with the system is by the BJP leader Dr. Subramaniam Swami- "The government should invest in medical research to see if homosexuality can be cured." "It is not a normal thing. We cannot celebrate it, it's a danger to our national security" "There is a lot of money behind it. The Americans want to open gay bars, and it'll be a cover for paedophiles and a huge rise in HIV cases." Let's break down this statement by Dr. Subramaniam swami. According to him instead of investing in equal healthcare services for the queer youth the government should rather invest in medical services against the queer youth which can be equated to conversion camps- "Reparative" or "conversion" therapy is a dangerous practice that targets LGBTQ youth and seeks to change their sexual or gender identities. It is a range of dangerous and discredited practice that falsely claims to change a person's sexual orientation or gender identity or expression. It has been highly discredited due to his mental health repercussions. In conclusion, according to our leaders we should not only strip the community of their very rights but also invest government money to torture them mentally to death. Kill the gays because Hindutva[13] is against the gays, not killing. In his statement the leader rightly points out the sexual health concerns of the community but then goes on to blame the queer youth for HIV.

A major logical flaw with the statement is the mention of Hindutva. Holy texts have widely been used to back the anti-gay agenda even though in reality according to our mythology the homosexual community was widely accepted for example: Shikhandi a trans-woman who helped pin down Bhism pitahma and changed the course of Mahabharat as we know it. Not only this, historically transwomen were keeps for the queen of the kingdoms when their husbands were away. This sheds light on the sort of advancements we have made. We pride ourselves about how far we have come and the progress we have made but clearly in terms of acceptance we have digressed even further. We have failed in recognizing how fragile the human ego has become that one single threat to patriarchy and we go out of our way to deny the most basic human rights to people who are as humane as the heterosexuals including the right to healthcare.

According to research LGBTQ+ individuals are at great risk for poor mental health across developmental stages. Various research evidence has shown elevated rates of major depression, anxiety disorders, Post Traumatic Stress Disorder (PTSD), substance use and abuse and suicide along with gender dysphoria- a psychological disorder in which an individual assigned at birth gender doesn't match with their gender orientation.
In this paper, we have largely discussed the problems faced by the gay community. The question still remains well what are the solutions?

As far as solutions the go the very first step is:

[13] https://www.deccanherald.com/opinion/panorama/mental-health-issues-among-the-lgbtq-810246.html

1. Acceptance through awareness: *There* is an absolute dearth of Indian Psychiatric Literature that investigates issues that are related to homosexuality. There is no data on prevalence, emotional problems, support groups, clinical services, etc. Research into the field is lacking and is crucial for increasing our understanding of homosexuality. Despite medicine and psychiatry now arguing that homosexuality is a normal variant of human sexuality there is yet a clear stand that needs to be taken on the issues that are prevalent. There is thus a need for research as the first step to spreading awareness. Awareness is the tool that creates sensitization and breaks the vicious cycle or bullying and harassment. It counters stereotypes and prejudices and provides support. Disseminating the correct information, creating informed youth circles and a generation which sees beyond the realms of gender and sexuality is important. Even though it is tough we have to start somewhere. We have to understand the problems of the community, give them a voice and amplify it. We need to research and represent in ways that don't make a joke out of sexualities as we see in the Indian cinema. There needs to be education about the human rights and possible human rights violations that can happen. The emphasis should not just be on education but also attitude change. The focus needs to be on humanity and not sexual orientations. Inclusivity always starts at awareness and sensitization thus the first step to creating environments which are safe and inclusive is making sure that every individual has been sensitized about the same. We need to get to the bottom of stereotypes and biases and find out ways to shake their very foundation. Of course, this isn't going to be easy or a onetime exercise that's why it's necessary that everyone is committed to the cause. It is important to educate people about their own biases, tell them where they come from and help them question it. We need to abolish the very idea of 'abnormal' when it comes to differential sexual and gender orientations. It is also important to educate and enable those who identify as a part of the LGBTQIA+ community about their rights and of course this can only be followed by creating, implementing and keeping a check on such policies (anti discriminatory and against harassment). There should be zero tolerance when it comes to both transphobia and homophobia. Inclusive policies need to go beyond just lip- service and make actual change. The implementation should be unbiased. We need to propagate and accept and only then can we move forward to the rest.

2. Providing social support: Degree of openness and social support is important as it helps people establish control over their environments and build coping abilities early on in life compared to later. Suicidality linked to early coming out resulting in violence which can also be reduced by providing the right social support. Not only this, spirituality and religiosity have shown to help due to lower violent experiences that is if the religion is accepting. Social support can also help tackle internalized homophobia and failed belongingness by providing a validating environment which lacks discrimination to help deal with it. Support groups can be of a huge help. Mobilizing communities through awareness is also a great stepping stone.

3. Conducive Mental Health Services: The percentage of gay people who seek counselling or psychotherapy ranges from 25-65% which is 2-4 times higher than the heterosexual groups. This is not surprising given that homosexuals experience higher rates of anxiety, depression, suicide ideation, and other such mental health concerns. But the satisfaction or therapeutic stress reduction is generally very low due to counsellor attitude such as prejudice and lack of understanding. This dissatisfaction reduces when they are treated by gay therapists. 50% of gay clients report discontent with their counseling experiences compared to heterosexual clients whose rates are very low. The problem is counselor inconsistency of opinions and acceptability of homosexuality conveyed to gay clients through their attitude. Counselors who wish to work with clients that belong to the community need to be cognizant,

tolerant and open minded. They need to be well versed with gay issues and needs. Workshops and courses on homosexuality and gay psychotherapy can be a good way of doing the same. Changing negative attitudes and anti-discriminatory policies can also help. There is a lack of well-grounded discussions which can be seen as contributing to the ongoing pathologizing and criminalization. Lack of knowledge, missing research, prejudices are also common. Necessary sensitivity is required along with knowledge of patient needs. Provision of mental health services and treatment opportunities and changes in medical system are also very much required. Medical education, research, institutionalized serviced and attitudes of medical professionals need to be kept in check. People with non-heterosexual orientations have a higher rate of mental health problems such as major depression, suicidality, anxiety disorders or addiction. The complexities in the identities of those who identify as homosexuals require tolerance, respect and understanding of the sexual matters. The clinical assessments need to be detailed and go beyond the labelling that exists. Issues such as lifestyle choices, identity, relationships and social support also need to be assessed. This is to provide help to people so as to understand their own sexuality in a society that is larger heterosexual. Hurdles such as conflicts accepting and acknowledging one's homosexual feelings, the meaning of coming out of the closet or disclosure and the problems that come with it need to be addressed as well. Gay-affirmative psychotherapies need to be worked towards. Sexual conversion therapies raise serious ethical questions and do more harm than good such as inducing depression and sexual dysfunction and thus clinicians need to keep their first do no harm in mind and provide medical service with compassion and respect for human dignity irrespective of their sexual identities and orientations. Clinical services need to be sensitive and provide holistic care. A positive and non-judgmental attitude can go a long way in relieving stress. There needs to be increased awareness of these issues and transfer the same knowledge and skill to increase competence of health care workers.

4. Sex education: Also, an important part of awareness it is important to educate the youth about the sexualities and their complexities to avoid biases.

5. Providing a legal crutch: A key issue pointed out in the paper was harassment, intimate partner violence, police brutality and discrimination. Inclusive law and providing a legal crutch against such issues can help stop it. Confronting these issues with law and support from police can go a long way. We need to address police brutality and create awareness. Laws should be strong enough to back the queer community. Inclusivity goes a long way.

In conclusion, this paper raises a lot of relevant questions such as- how accepted does the youth feel? How comfortable is a person to step up and accept their identity? And as far as human rights are concerned, do they even extend to the community when they have to constantly strive to prove themselves relevant, normal and worthy of equal rights and representation? Denying their identity as an act of self-preservation abetting them against bullying, homophobic remarks, discrimination, name calling etc leads to some serious mental health repercussions. As if the conversion camps weren't enough the youth also has to deal with serious mental and physical abuse. This is due to the very fact that the LGBTQ+ community spends a large part of their lives masking in a country that questions a person's choice to fall in love with someone they want to, in a country where leaders in power openly state that homosexuality needs to be 'cured', 'is unnatural' and is 'a threat of national security' and this seriously compromises their mental as well as physical health.

We need to understand that homosexuality isn't a new concept. Homosexuals are as much humans as heterosexuals are. And the fact that in reality they need to fight for equal rights,

walk in parades to not be deemed as criminals, needs to be changed. Why are people who identify as LGBTQ+ treated in a way that even criminals aren't treated?

The future isn't just male or female. Its nonbinary, gender fluid, queer and trans. Its gay, its bi, its pan and ace. It's time for change. Let's walk towards a more conducive society. Let's provide help and acceptance and not ignore the numerous cries for help. Let's become informed and start changing the system step by step even if it takes a lot of effort and time. Let's hold hands and work towards equality and human rights for all irrespective of their gender or their sexual preferences.

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Acknowledgement
The author(s) appreciates all those who participated in the study and helped to facilitate the research process.

Conflict of Interest
The author(s) declared no conflict of interest.

How to cite this article: Manaktala K. (2021). Understanding Depression and Anxiety in the LGBTQIA+ Community and Its Causes. *International Journal of Indian Psychology*, *9*(3), 96-119. DIP:18.01.013.20210903, DOI:10.25215/0903.013