BASICS OF SEX, GENDER, AND SEXUALITY

A Primer for Parents, Counsellors, and Allies

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Dr. Bhooshan Shukla
&
Bindumadhav Khire

BASICS OF
SEX, GENDER, AND SEXUALITY

An Introduction to LGBTIQA India
for
Parents, Counsellors, and Allies

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Dr Bhooshan Shukla

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Authors

Dr Bhooshan Shukla

Bindumadhav Khire

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Contact: bhooshan.shukla@gmail.com,
bindumadhav.khire@gmail.com

BASICS OF SEX, GENDER, AND SEXUALITY: An Introduction to Lesbian, Gay, Bisexual, Trans, Intersex, Queer, and Asexual (LGBTIQA) India for Parents, Counsellors and Allies is a compendium of facts and culturally appropriate experiences to help gain a better understanding of such issues in supporting a LGBTIQA family member, client, friend or colleague.

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- **Saurabh Bondre ~ Bisexual man**
- **Mx Sap ~ Agender and Asexual person**
- **Mr Anil ~ Father of a Gay son**
- **Mrs Reshma ~ Mother of a Lesbian daughter**

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Dr Bhooshan Shukla
Bindumadhav Khire
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INTRODUCTION

Why this book?

There are very few culturally appropriate books in India on LGBTIQA lives and issues written primarily for parents, Counsellors and allies, to help them understand the basics of sexual/gender minorities. We have attempted to write a short primer on these themes.

For whom is the book meant?

We authored this book primarily for parents, Counsellors and allies. It will also benefit the LGBTIQA community members, students of Sociology, Psychology and Political Science courses.

We have assumed that the readers may know very little about LGBTIQA issues, and hence, we have covered only the very basics in an easily understandable language.

We are aware that terms, knowledge and understanding in these fields are evolving rapidly. The knowledge herein may be outdated sooner or later. We will continue to be open-minded about the newer interpretations of sex, gender, and sexuality as it evolves.

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Scope of the book

The book primarily focuses on the three central dimensions of sex, gender, and sexuality, i.e., biological sex, gender identity, and sexual orientation. Other factors also impact a person's understanding and expression of sexuality, e.g., social norms, laws etc. But these dimensions have been left out intentionally, and we have kept our focus on sex, gender, and sexuality as nature has gifted us.

Since this book is a primer, we have intentionally avoided dealing with the complex topic of couple relationships within the dimensions of sex, gender, and sexuality.

The issue of Child Sexual Abuse (CSA) needs to be covered by every Counsellor and Psychiatrist when working on sex, gender, and sexuality. We have covered it perfunctorily here as the subject is complex and needs a separate book devoted to it.

Format of rest of the book

The book is a series of cases presented to a Psychiatrist or a Counsellor and an explanation of the issues involved. All the case studies presented in the book are fictitious but modelled on clients that the authors have handled in practice. The client names and locations described in the cases are also fictitious.

We have presented a series of cases in this book to explain the issues that arise when parents and their son or daughter first confront an issue related to sex, gender or sexuality. A Psychiatrist or a Counsellor facilitates each case, modelled on real life situations.

Statistics

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There are very few statistics on the Indian LGBTI population. In international spheres, various statistics on LGBTI have been quoted through surveys or Meta-analyses and at times, they differ a lot. To keep things simple, we have used one or two statistical indicators per category (LGBTI). That is not to say that the quoted statistics are the only reliable ones or the only statistics available. There may be readers who disagree with the statistics presented, and we respect their difference of opinion.

TERMS USED

TERMS ASSOCIATED WITH BIOLOGICAL SEX

Biological Sex	It is used to represent the anatomical/ gonadal/ chromosomal sex of a person.
Intersex	An intersex person is born with sexual / reproductive anatomy and/or chromosome patterns that do not fit the typical anatomy of a male or female. This may be apparent at birth or become so later in life.
Sex Reassignment Surgery	Surgical intervention to shape the sexual/ reproductive anatomy of the baby as per the gender chosen by the parents.

TERMS ASSOCIATED WITH GENDER IDENTITY

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Gender	Refers to being 'masculine' or 'feminine' and corresponding social roles and behavior.
Gender Identity	Refers to self-identification through self-experience as a male or female or both or neither.
Agender	A person who does not experience either male or female gender identity.
Cisgender	A person whose biological sex is in sync with the person's gender identity. e.g., the body of a male and gender identity of a male; the body of a female and gender identity of a female.
Transgender	A person whose gender identity is different from their biological sex.
Pangender	A person who experiences multiple gender identities (pan=multiple).

Gender Dysphoria	A medical term denoting a person who strongly and consistently indicates gender identity different from their biological sex. Gender Dysphoria includes a strong desire to be treated as per their gender identification and a desire to be rid of one's biological sex characteristics.
Gender - Affirmative - Treatment	Hormonal and/or surgical intervention to shape the anatomy as per the gender identification of the person.
Transphobia	Dislike and/or fear of transgender person/s.

TERMS ASSOCIATED WITH SEXUAL ORIENTATION

Sexual Orientation	The scientifically accurate term for an individual's enduring physical and emotional attraction to members of the same and/or opposite sex and includes Lesbian, Gay, Bisexual and Heterosexual (Straight) orientations.
Asexual	A person who does not feel sexual attraction to anyone for an extended period of time.
Bisexual	A person who has the capacity to form enduring physical and emotional attraction to men as well as women. Bisexual persons may experience this attraction in differing degrees over their lifetime.
Heterosexual/ Straight	A person whose enduring physical and emotional attraction is to people of the opposite sex only.
Homosexual/Gay	A person whose enduring physical and emotional attraction is to people of the same sex only.

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Lesbian	The word Lesbian is used to describe a Gay woman.
Homophobia	Dislike and/or fear of Gays and Lesbians.
Biphobia	Dislike and/or fear of Bisexuals.

OTHER COMMON TERMS

Closeted	A person who is not open about his/her/their sexual orientation or gender identity.
Coming out	Revealing your gender/sexuality to someone.
Queer	1. At times it is used as an umbrella term to include the entire LGBTIA spectrum. 2. At times it means a person who does not fit the traditional binary gender/sexuality framework. 3. At times it is used to imply someone questioning their gender/sexuality.
LGBTIQA	L-Lesbian, G-Gay, B-Bisexual, T-Transgender, I-Intersex, Q-Queer, A-Asexual.

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Note: Many of the definitions listed above have been drawn and adapted from: '*Sanchaar* Media Guide'- Recommended language manual for improved reporting on sexual minorities in India. (Copyright- The Humsafar Trust, 2015. Version 1.0. The '*Sanchaar* Media Guide' has drawn and adapted certain definitions from Gay and Lesbian Alliance Against Defamation (GLAAD) media reference guide.)

PART I: BABY TO ADOLESCENT

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AYAN

Smita: "Is my four-year-old son Ayan a homo?"

Background

Smita, the lady of the house, had gone shopping, leaving behind her four-year-old son Ayan with the *aaya*.

The *aaya* had sorted the laundry for washing, and now sat on the chair next to the humming washing machine. For the past hour, Ayan and his six-year-old neighbour, Nitesh, were busy playing in the other room.

After a while, all was quiet. Ayan and Nitesh's playful noises had ceased, and the *aaya* dosed to the gentle hum of the machine, nodding every so often, lost in a world of her own. She did not hear the latch turning as Smita opened the door and stepped into the house.

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Leaving the bags in the hall, Smita walked through the house and saw the *aaya* dosing. Smita's face set in disapproval; she would have to have a stern talk with the *aaya*. Walking past the *aaya,* she stepped into Ayan's room, where she had left him playing with Nitesh. Smita stopped abruptly, horrified at what she saw.

The boys were sleeping. Their half pants were pulled down, around their ankles. Upon a closer look, she saw that each had the other's penis in his mouth.

She was about to shout, but aware that the *aaya* was in the other room, she simply grabbed Ayan and, shaking him awake, pulled his pants up. Smita then shook Nilesh awake and almost dragged him out. Ringing the neighbouring flat's doorbell, Smita roughly shoved Nilesh onto his mother and, without a word, went back to her flat and banged the door shut as the neighbour stood at the door perplexed.

Smita shouted at the *aaya* for sleeping on the job. She told the

aaya to leave and threatened her with a pay cut for the day. She then spanked Ayan, who screamed in terror as she vented her fury on the small child. It was a while before she calmed down. Not knowing what to do and aware that she dare not talk to Ayan's father about this, Smita did nothing.

She spent the next few months keeping a close watch on Ayan, ensuring that he did not play with Nitesh. Her mind was in constant turmoil. Finally, after a lot of fretting, she decided to confide in Asha, one of her closest friends, who, in turn, referred her to a Psychiatrist.

Ayan's Case

The Psychiatrist sat quietly, looking at Smita. She was visibly agitated; her fingers, twisting her *sari pallu* again and again. She was overwhelmed while reciting what she saw. Understandably, coming from a very conservative family, she was on the verge of a nervous breakdown.

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The Psychiatrist gently asked her, “So what is your interpretation of the incident?” Smita was sure Nitesh had made Ayan do this. Ayan was the younger of the two and followed Nitesh wherever he went, emulating him all the time. Ayan used to like drinking milk. But since Nitesh did not like milk, Ayan had stopped drinking it. Smita erupted in anger.

Smita: *I don't care if Nitesh is like that, but not Ayan.*

Psychiatrist: *What do you mean by 'like that'?*

(Silence. Smita is visibly perturbed)

Smita: *No. No, Ayan is not like that.*

Psychiatrist: *Like what?*

(It takes a while for Smita to utter the word.)

Smita: *(whispers) Homo.*

Psychiatrist: *“Why do you think your son is a homosexual?”*

Smita: *(angrily responds) "Why else would the two boys do such things? I just don't want Nitesh to teach such things to my son. I will lodge a police complaint."*

The Psychiatrist told her that there was nothing to be troubled about regarding what she had seen. Smita looked at him as if he was crazy.

The Psychiatrist read her face, smiled and said, "Many parents have misconceptions as to what is age-appropriate behaviour, especially in the context of behaviour which seems/appears to be sexual or gender non-conforming. First of all, let me explain what behaviours are normal for a certain age. Secondly, I use the word *normal* because a child's **behaviour has to be interpreted from their point of view and not the adult."**

Smita's expressions indicated that she had not understood the Psychiatrist, who then explained that parents see different behaviours in their children at different age groups.

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The Science

Random Behaviour

From birth until the age of three, what we see in babies is 'Random Behaviour.' As a child starts developing motor control (muscle-related movement) and starts moving around, he/she will begin to suck his/her thumb or any other object the child can get its hands on. So, parents see little boys and girls sucking their thumbs, objects.

In addition to the mouth, they may end up sticking objects in nostrils, ears, vagina, anus on discovering these orifices of their bodies. The items could be anything small, accessible and something they can easily handle- a pencil, a bug, mud, sand, small stones, faeces, someone's thumb/toe, penis etc. All of these have no sexual context.

In the case of Ayan and Nitesh, the objects they were using were

each other's penises. They could as well have been sucking on each other's thumbs or pencils. For them, there is no difference between the three- pencil, thumb or penis. So, the mother's apprehension is entirely baseless, and her fear of Nitesh's' influence over Ayan is altogether unfounded.

The Psychiatrist hastened to add that, to prevent the child from coming to harm from a sharp object (e.g., a scissor or knife), parents should keep sharp items out of reach of children and always supervise their child.

Emulative Behaviour

The Psychiatrist further explained that parents start seeing 'Emulative Behaviour' in children from age three to eight. During these formative years, children observe and role-play the behaviours they see around them. They closely watch adults (parents, neighbours, older siblings, and friends) and people's behaviour on TV and cinema. The children then emulate some of these behaviours without understanding the context, sexual or otherwise.

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Example 1: A parent may see a boy attempting to kiss a girl (or vice versa) after witnessing a kiss on TV. This behaviour is an emulation of that act- there is no sexual context.

Example 2: A boy lies on top of a girl and makes thrusting movements after seeing simulated intercourse on TV or seeing intercourse of parents or neighbours or watching pornographic films. There is no sexual desire in the boy, nor is his expression sexual.

Example 3: At times, boys and girls play 'house-house', taking on the roles of husband and wife, looking after a baby-doll. At times the boy may play the mother's part by wearing female garments like saris, Punjabi dress. For children, this is simply play and fun. Nothing more should be read into it.

On a deeper level, children imitating people around them tell us

about the child's ability to observe, process these observations and communicate. Children do not understand the complexities of sex, gender or sexuality at this age. They simply copy behaviours they see in adults around them. Parents need not interpret any gender or sexual implications from such play.

IMPORTANT!

At times adults in the male child's family dress the child in frocks. They braid the child's hair and call him by feminine pet names. Such cross-dressing or feminine pet-naming does NOT change the boy's gender identity to female.

Gender identify and sexual orientation is probably fixed before the baby is born, so the way you bring up your child has nothing to do with them identifying as transgender or gay.

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Goal Directed Behaviour

From the age of four years on, parents slowly start seeing 'Goal-Directed Behaviour.' These behaviours may appear to be sexual; it is not so.

Example 1: A four-year-old boy repeatedly touching and caressing his testicles. He does this because it is pleasurable; there is no 'sexual' intent, as he is not aware of sexuality yet. There is no 'sexual desire', or 'sexual arousal' associated with this pleasure.

Example 2: A four-year-old boy may seek assistance in stimulation from another boy or a girl by asking them to touch or rub his genitals. Such behaviour is not sexual, nor it is for sexual gratification. This behaviour is for pleasure only. There is no sexual context. i.e., their request and behaviour is not for sexual pleasure.

Example 3: A five-year-old girl lying on her stomach tries to crawl and, while doing so, rubs her clitoris/vulva on the floor. She discovers the sensation of pleasure and rubs her clitoris/vulva repeatedly on the floor to seek that pleasure again and again. The

child is not seeking sexual pleasure, although the organ involved is a sexual organ.

Curiosity Directed Behaviour

From the age of five until ten years, parents see 'Curiosity Directed Behaviour.' As boys and girls realise that the opposite sex seems to have a different physical structure, they become curious to see it and compare it with their own.

Example 1: Boys and girls start playing 'Doctor.' They take each other's clothes off to examine each other's bodies. They may also touch each other's genitals, predominantly the area where they see a distinct difference. This play is nothing but curiosity; there is no sexual context to it. A boy may think, 'I want to see if she is like me,' or a girl might think, 'Why don't I have a that (penis) like him?'

Sometimes anxiety and fear may also become a reason for such exploration. A boy who sees a girl's body may worry about losing his penis and start to hold it or touch it repeatedly to reassure himself that it is there. Or a girl may fret when she will get a penis and repeatedly touch her vulva to check whether she has grown one.

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Note: The actions shown in the previous examples are either from curiosity or pleasure. It is important for the parent to gently redirect the child's attention without guilt, shame, anger or accusation. It is essential to know that children do not know or understand the concept of sex or sexual pleasure at this age.

Normal Physiological Responses

Finally, the Psychiatrist mentioned specific age-appropriate behaviours and bodily functions that adults frequently misunderstand as sexual.

Auto-Erection: From birth onwards, male babies have auto-erections of their penis; it has nothing to do with sexual arousal. The erection is due to an accumulation of urine in the urinary bladder. On voiding the urine, the erection subsides. This

phenomenon continues throughout boyhood and adulthood.

Vaginal Discharge: Girls from birth until six months may experience a slight vaginal discharge. It is considered a normal bodily function. (If the discharge has blood in it or has a bad smell, then the parent must get immediate medical attention.)

Fungal Infection: If a fungal infection develops around the genitals, the child (generally from age three onwards) will try to rub or scratch it to ease the irritation. The child will try to stick his/her hand in their underwear or hide under a blanket to rub his/her genitals. This behaviour is not sexual stimulation, although a sexual organ is involved.

SUMMARY

The Psychiatrist summarised the session, stating that the child's behaviour or act must be interpreted from the child's perspective and not an adult. Children do not understand sexual attraction/desire till they reach puberty. Misreading such actions as sexual and punishing the child for such behaviour is cruel and hurtful to the child.

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Gaining these insights, Smita relaxed. It has been a year now. During this time, she observed Ayan engage in a few age-appropriate behaviours. She had got anxious twice but did not panic nor react irrationally. With a new perspective on how children experienced their world, she was better informed to handle such scenarios.

KAVITA

Teacher "We don't want lesbians in our school. Kavita should be rusticated."

Background

The school recess was the usual chaos. Boys were buying *wada-pavs* and other snacks through the school fence as the hawkers stood on the other side peddling their wares. A few boys hurriedly finished off their lunch to play for the remainder of their lunch break. The girls sat in large and small circles eating, giggling and chattering away, lost in their worlds, disturbed only on rare occasions when an amateur but enthusiastic footballer missed his aim, and the football landed in their midst.

The teachers were in the teachers' room, having lunch, a few going through the stacks of homework notebooks, pushing themselves to complete the dreary chore, gossiping on the sidelines.

The day was unfolding like any other.

Halfway through the recess, the Physical Education (PT) teacher received a call related to the girl's *Kabaddi* inter-school competition. He ventured out to the school grounds looking for Kavita, the ninth standard monitor and the *Kabaddi* team captain. Not finding her amongst the girls' groups, he had asked a couple of students for her whereabouts. One of them mentioned that she thought Kavita had gone 'that way', pointing towards the old, dilapidated building which had served as a primary school till years ago when a storm had brought it down. Now the old building was strictly limited to providing shelter for boys smoking on the sly.

As he stepped through the remains of a rotting door frame, he paused, listening to the silence, wondering whether anyone was in there. He was just about to shout Kavita's name when he heard a rustle, and stepping in, he turned to the right, stopping abruptly. Kavita and one other girl were sitting in the corner, and… what

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were they doing? Were they lip-locked? As realisation dawned, furious, he roared, “What's going on here?” The two hurriedly broke off, Reema's cheeks burning as she embarrassedly struggled for a response, “n..no.. nothing..”

It was Kavita who tried to put up a defence. “She had got something in her eye; I was just trying to get it out..”

“What rubbish, both of you were kis…” the teacher couldn't get himself to complete the word.

They both hurriedly got up and went to him. Kavita tried to persuade the teacher, “No sir. There is some misunderstanding. I don't know what you are saying...” the remaining sentence remained unspoken as a tight slap landed on her cheek. Reema's face crumpled in fear and tears as the teacher ordered them to the Principal's office, immune to their pleading to let them go.

Later that afternoon, the Principal suspended Kavita for the rest of the term and was only allowed to attend the final exam. The Principal told her mother in no uncertain terms that she should enrol Kavita in some other school, as there was no place in this school for 'lesbians.'

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Kavita's Case

Kavita's mother was by nature assertive, but today as she sat in front of the Counsellor, she was just a shadow of her usual self. The Counsellor spoke first to the mother separately and then, sending out the mother, called in Kavita.

Kavita was understandably defensive. She kept insisting that this was all just a misunderstanding. She was trying to take out a dust particle from Reema's eye, and therefore she had to be physically close to her.

The Counsellor gently responded that, from what he understood, since there was little light in the room, they could have done that task more effectively in daylight. “No, there was enough light.” The Counsellor did not challenge Kavita but instead talked to her about

her friendship with Reema.

Counsellor*:* *How long have you known each other?*

Kavita: *Since the third standard. We have been in the same class since then.*

Counsellor: *Is she your best friend?*

Kavita: *(quickly) No. (pause.) Yes, but nothing like 'that.'*

Counsellor: *What do you mean by 'that'?*

Kavita: *Nothing like….. two girls together, I mean… I mean…*

Counsellor*:* *Yes?*

Kavita: *like that film… Fire*

Counsellor*:* *Reema has given a written statement to the Principal that you forced yourself on her; she didn't want to do it.*

Kavita: *That is not true. I don't need to force myself on her. I know a boy I like- Ajay; she is the one who does not have a single male friend.*

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The Counsellor then questioned Kavita about Ajay. Who was he? How had they met? How often did they meet? What did they do? Did anyone know about their friendship?

Kavita told the Counsellor that Reema and Vilas- a friend of Ajay's, knew about their friendship. Sometimes they all hung out together- eating '*bhelpuri'*, '*ice-cream*' etc.

The Counsellor then gently asked her whether Kavita and Ajay had ever kissed. Kavita was very embarrassed and looked down. The Counsellor added, "It's okay if you tell me." Kavita hesitantly nodded and then changed her answer. "No, no. I didn't hear your question correctly." She then changed tack, "Reema hates Ajay. She doesn't like me meeting him. She is very possessive that way."

The Science

The Counsellor invited Kavita's mother back into the room. He explained that as children reach adolescence, most start feeling sexual attraction. Until that point in life, children have no awareness and understanding of sexual attraction and desire.

The sexual awakening at the onset of adolescence is not an On/Off switch. As the adolescent body grows and matures physically, they experience a surge of emotions and begin to sense the desire for sexual intimacy. This change is a new development for them. In these days of social media and heightened peer pressure, it is a much-anticipated experience.

For boys, rapid changes at the physical level include increased height and musculature, deepening of the voice, hair on lips, armpits and pubic hair, enlargement of genitals, frequent erections, and nocturnal emissions.

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For girls, rapid changes happening at the physical level include increased height, fat deposition around hips, growth of breasts, hair in armpits, pubic hair, enlargement of genitals, and the start of the menstrual cycle.

Adolescents become obsessed with their looks, acne is perceived as a life-threatening issue, and body image becomes very important. We usually see adolescent boys repeatedly checking themselves in the mirror for acne and facial hair.

This phase is a constant emotional roller-coaster. Where they experience frequent high and low moods. Sexual exploration and experimentation is a part of this tumultuous phase in any adolescent's life.

Boys and girls seek privacy to take off their clothes. They stand in front of the mirror to see, admire themselves or scrutinise their body critically, worrying over their perceived inadequacies, especially in comparison with their friends.

Most adolescents start feeling sexually and emotionally attracted

to someone. And so, It is entirely natural for an adolescent- whether a girl or a boy to want to experience the new sensations of bodily pleasure. The following behaviours are expected in an adolescent and are not of concern or worry.

- In privacy, taking off one's clothes and touching different parts of one's body to experience the sensations felt.
- In privacy, taking off one's clothes and touching/fondling genitals or rubbing genitalia against an object to feel the sensation of pleasure. E.g., an adolescent boy rubbing his erect penis against a pillow or a girl touching her clitoris for sexual pleasure.
- Masturbating in privacy. The boy or girl pleasure themselves by touching/fondling or rubbing their sexual organs.

  Masturbation is not an illness. It helps address the sexual need to some extent and relieve tension and stress. E.g. exam stress.

  Masturbation has no adverse consequences. It will not affect sexual performance or 'marital duties.' It will not affect fertility. It does not cause acne. It does not reduce the size of sex organs. It does not make a person thin or fat. Most adolescents- boys and girls masturbate.

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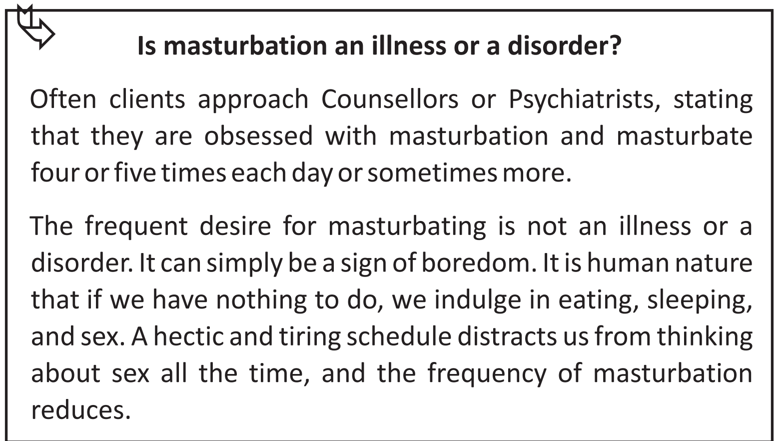

Is masturbation an illness or a disorder?

Often clients approach Counsellors or Psychiatrists, stating that they are obsessed with masturbation and masturbate four or five times each day or sometimes more.

The frequent desire for masturbating is not an illness or a disorder. It can simply be a sign of boredom. It is human nature that if we have nothing to do, we indulge in eating, sleeping, and sex. A hectic and tiring schedule distracts us from thinking about sex all the time, and the frequency of masturbation reduces.

The more adventurous adolescents may seek opportunities to experiment E.g., “How does it feel to have a person that I desire touch my breasts?” or “How does it feel to kiss?” Such curiosity is normal age-appropriate behaviour.

Some may try kissing a best friend of the opposite or the same sex. Some may try kissing a boy and a girl to determine whether there is a difference in experience between the two. The adolescents are simply trying to understand their new felt awareness.

By the time they reach adolescence, most boys and girls have absolute clarity about their sexual orientation. They know if their attraction and desire are for the same sex, the opposite sex or both or neither. But for some adolescents, for the first couple of years of their sexual awareness, there can be ambivalence.

Fleeting Sexual Attraction

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Adolescents' attraction to a person of the same sex could be fleeting and naturally subside over time. During this time, they may sexually experiment with the person. The experience is generally enjoyable. Over time their sexual attraction to same-sex persons ceases, and they will only experience sexual attraction with persons of the opposite sex.

You would be curious to know why some people experience a passing phase of same-sex sexual attraction? The answer is simple: science does not know yet.

A few will fleetingly experience sexual attraction for the opposite sex on similar lines. They will sexually experiment with a person of the opposite sex. After a couple of years, this opposite-sex attraction will cease, and they will experience attraction for persons of the same sex only for the rest of their lives.

This means that a person's first sexual experience does not dictate their sexual orientation.

In our experience, by the time a person is eighteen years of age, he/she/they know of their sexual orientation (which could be a

sexual attraction for men or women or both or neither); an orientation which will be reasonably stable in the long term (Refer Part III: Sexual Orientation.)

Experimention

The Counsellor explained to Kavita's mother that both Kavita and Reema were probably just experimenting. The Principal and Kavita's mother had mistakenly concluded from this episode that the two were lesbians.

Kavita's mother looked somewhat relieved, but a nagging suspicion remained. She asked the Counsellor whether Kavita's aggressive behaviour and interest in sports are signs that she would become a lesbian when she grew up.

The Counsellor explained that, in scenarios like these, laypersons quickly come to the wrong conclusions, that all people who do not follow stereotypical gender roles, i.e., masculine girls or feminine boys, are gay or transgender.

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“In Kavita's case, too, this single incident has ended up tainting your objectivity. You have ended up selectively picking up observable characteristics, which reinforce your misconceptions.” Such wrong causal linkages are misleading and, at times, have disastrous implications for everyone involved.

As the Counsellor indicated the end of the session, Kavita's mother had one last question, “Is Reema a lesbian? She is always with Kavita and so possessive of her. I am sure she pressurised Kavita into doing this.”

The Counsellor replied, “At this point, we do not know Reema's sexuality. Even if Reema is very possessive of Kavita, you are probably reading too much into this. Adolescents can be insecure about many things, including their friendships, and can be very possessive.”

The Counsellor concluded the session by saying, “The data available at present is not sufficient to come to any conclusion. It

will be a few more years before Kavita and Reema can be reasonably sure about their sexual orientation. The episode of experimentation will not, in any way, dictate the outcome of a person's sexuality."

The Principal should have dealt with the incident as an experiment between friends. His punishment of Kavita and Reema is disproportionate to an act that is natural in adolescents. It is a typical reaction of someone who has not received any training on sex, gender, and sexuality. He should have sent them off to the school Counsellor, assuming the school has one- someone who has a good understanding of sex, gender, and sexuality.

As Kavita's mother got up to leave, the Counsellor mentioned that he could meet the Principal to help him understand the situation but would need her permission first. Visibly relieved, she immediately gave permission and expressed hope that the Principal would re-evaluate his harsh punishment with this new knowledge.

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Summary

On reaching adolescence, boys and girls may experiment sexually with someone they know. Such sexual experimentation could be with a person of the opposite sex or the same sex.

Such experimental behaviour is not sufficient evidence of the adolescent's sexual orientation.

Hence, parents, neighbours, school authorities and other adults should not draw any hasty conclusions. People should remember that such sexual experimentation will not 'make' the adolescents 'gay' or 'straight.'

Ragging

There are instances where a meek, physically weak male junior college student is ragged by senior boy/boys. At times the ragging traumatises the victim for life and could even lead to the death of the victim. At times the ragging is sexual, where the bully forces the victim to perform sexual acts without his consent.

These acts are meant to humiliate the student, e.g., removing his clothes, making him perform oral sex on the bully, etc.

These sexual acts do not mean that the bully, or the student being ragged, or both are gay.

While either or both or none may be gay, the above act/s by themselves are not sufficient to come to any conclusion.

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PART II: GENDER

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RAVI

Ravi: "I like to dance like Sridevi."

Background

Leela comes from a middle-class background and is a schoolteacher. Her husband works in a private company and lives in a different city. She has one nine-year-old son, Ravi and one seven-year-old son, Siddharth (pet name Siddhi.)

Siddhi is a bit of a bully, and Leela has her hands full in keeping him out of trouble with the neighbourhood kids. He is poor in his studies, and she has to pay extra for the schoolteacher to teach him math and physics after school.

Ravi, on the other hand, is just the opposite: quiet, obedient. When he comes home from school, he freshens up, has snacks and studiously does his homework. She wished Siddhi was a bit like Ravi. It was very strenuous managing two kids, a job, and taking care of the household chores.

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Last Sunday, she and the other teachers were asked to attend a special two-hour meeting organised by the school principal to conduct a donation drive for the school. She had left for school early in the morning. Siddhi had quickly left to play cricket at a ground far off after leaving Ravi alone in the house.

As Leela reached the school, she received an SMS that the Principal had postponed the meeting as he was urgently required elsewhere. Cursing under her breath, she returned home.

The door was slightly ajar, and she could hear noises from inside the house. As she opened the door and stepped in, she saw five children, boys and girls all of Ravi's age, sitting on the floor in the living room. They were an appreciative audience to Ravi's act. He had put on lipstick, and adorned in a sari, was dancing to a Sridevi song.

Shocked, she asked the children to leave and closed the door.

Leela then hit Ravi repeatedly, asking, “Since when are you doing this?” Sobbing, Ravi had said nothing. In a fury, she had yelled at him, “Who taught you to do this? Tell me.” Ravi stood quaking in fear, crying loudly, wetting himself; she could not get a word out of him.

Leela then forcefully stripped the sari off him and told him to change and wash his face. In the meantime, she walked quickly to the neighbour's house and asked Anita, who had been part of the audience, “Anita come here. Since when he has been doing this?”

Anita warily replied, “A few months or so. He does it almost every time you and Siddhi are not around.” “What else does he do?” “Well, nothing much, songs and sometimes ramp-walks.” “Why didn't you tell me?” Anita, avoiding Leela's eyes, said nothing.

Leela returned home, went to her kitchen, and tried to busy herself. But, standing there, forcing herself to work, her mind was feverishly speculating, questioning: 'What is this?' 'Is he one of those you see on the streets, wearing saris and clapping?' But he has male reproductive organs. She knew as she had bathed him so many times. (Leela had heard that 'those' people did not have any organs 'down there.') Where had she gone wrong in his upbringing?

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She suppressed a sob. Whom should she consult? Neighbours? A definite no. Maybe Poonam, the school Counsellor. Yes, that would be a good idea.

And finally, at the recommendation of Poonam, she took an appointment with a Psychiatrist. She found it strange when he told her, “Let me talk to you alone, to understand the background. There is no need to bring Ravi at this stage.”

Ravi's Case

The Psychiatrist's office was a large one with an entire section designed as a play area. The play area was on a platform, raised by about six inches. It had washable walls with no rug and a

playhouse approximately four feet in height and width. The play area had a wide range of toys: a male and female doll, baby dolls, feeding bottles, bed, kitchen utensils, TV, truck, jeep, bike, lipstick, talcum powder, ornaments set- earrings, bangles, necklace, Superman and Superwoman toys, a toy train set, a Meccano set, crayons, and much more.

As Leela looked around the room, tears welled up in her eyes, and she suddenly started crying. The Psychiatrist sat patiently, as she continued to cry.

A while later, she took a tissue from the tissue box, dabbed her nose, and calmed down. Then in a dead tone, she told the story. The Psychiatrist quietly listened to her.

After she had finished, the Psychiatrist explored the background and issues. He asked Leela questions about her family members, economic condition etc.

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He then asked her many questions about the incident: 'When did you see this first?', 'How long has it been happening?', 'Where is this happening?' 'Are there any other activities that Ravi does about which you are worried?' Leela replied that he also seems to like doing 'ramp walk.'

The Psychiatrist asked her about Ravi's friends, school, studies, learning ability, sports abilities, health issues, etc. Then he again returned to the topic at hand and asked Leela whether Ravi cross-dressed in school or other places. e.g., neighbours place or a relatives' house.

He wanted to know which of his friends participated in these dance activities. Leela replied that, to the best of her knowledge, Ravi was the only one who cross-dressed. The rest of the children formed the audience.

The Psychiatrist then asked, “Does Ravi wear a sari on any other occasion? E.g., for school gatherings etc.?” Leela suddenly sat up alert, worry in her eyes, “Yes… school gathering… do you think

that's the reason he has become like ….?"

He immediately pacified her; "No... No… it's too early to jump to any conclusions. I am simply trying to get a complete picture here."

The Psychiatrist then focused on Ravi's mannerisms, clothes, makeup- powder, lipstick, nail paint. He asked for pictures of Ravi in a sari. Leela did not have any on her mobile, but she promised to check the old albums to see whether she could find a few from the school gathering.

Leela was understandably uncomfortable answering these questions and got very agitated when he asked her, "Does he remove his clothes when dancing?" She replied aggressively, "I don't know. I haven't asked."

"Are you aware of any incidences where anyone has tried to molest Ravi?" Leela moved to the edge of the seat, "Is that why he…" The Psychiatrist again reassured her that he was simply taking history and not probing causes.

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Psychiatrist: *What do you make of Ravi's actions?*

Leela: *Is he like those on the streets who…*
(She is unable to complete the sentence and shakes her head)
… No, no…"

Psychiatrist: *Those who…? Yes?*

(Leela clams up, and the Psychiatrist does not probe further.)

Seeing Leela's distress, the Psychiatrist changed his line of questioning slightly. "So, what did you do after you found out?" She looked down shamefacedly and admitted that she had hit and scolded Ravi and now was extremely worried about leaving him alone in the house. Other than Poonam, the school Counsellor, she had not spoken to anyone about this. She dreaded broaching this subject with anyone. She wanted to show Ravi's *Patrika* to the

astrologer, but he was out of town for a while.

Finally, the Psychiatrist said that he would now talk to Ravi. He explained to Leela that most young children have limited vocabulary and cannot understand or express a relationship or feelings as adults do. As such, he would explore Ravi's world through toys, games, and art.

The Psychiatrist further explained that a few play sessions would be necessary to establish rapport with Ravi. The purpose is to allow as much time as needed for Ravi to trust him to open up about his feelings and experiences.

The Psychiatrist was aware that parents complained about the fee he charged whilst 'nothing' happened in the rapport building sessions. He stressed that the sessions were essential for children to familiarise themselves with the play area, the office, and the Psychiatrist to build trust to express themselves openly.

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The Psychiatrist made a point of explaining the process and potential timeframe to Leela.

Rapport Building

A professional mental health practitioner first builds rapport with the child, to enable the child to trust the practitioner to openly discuss their issues and concerns. The practitioner does this by communicating at the child's level, providing a comfortable and safe environment, and allowing the child to adjust to the therapeutic process.

Two days later, Leela brought Ravi with her. Ravi was scared and kept looking wide-eyed at the Psychiatrist, who introduced himself to Ravi and explained that Ravi's mother had brought him for counselling as she was concerned about him. “I am going to try to understand your mom's concern. I can only understand that if we talk. Right?” Ravi nodded.

The Psychiatrist explained how Ravi could help him understand his mother's concerns. “Here is what you and I will do whilst your

mother sits in that corner. We will go to that play area and play with whatever is there. As you can see, there are a few toys- pencils, crayons, and paints for drawing and colouring. Come on; let's see what else is there."

The Psychiatrist suggested to Leela that she observe without intervening.

The Psychiatrist asked Ravi to accompany him to the play area on the raised platform. He sat cross-legged near the playhouse and invited Ravi to make himself comfortable.

Ravi, still wary, watched as the Psychiatrist pulled out several Ravi's age-appropriate toys– trucks, action heroes, makeup kit, sketchbook, stickers, sewing kit, etc.

The Psychiatrist pointed out various toys. "Do you like playing with toys? Or would you like to draw? How about you play with whatever you like?"

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Ravi sat quietly, just watching.

The Psychiatrist then took a paper and sketch-pens and started drawing, ignoring Ravi. He took care to draw a neutral picture, of nature, as he was aware that if he tried to draw a picture of a human being, it was likely that the child would copy the image and not bring his imagination into play.

Ravi kept still, watching. The Psychiatrist continued to draw.

Note: The mental health practitioner does not hurry this process. The client will only start communicating when they are comfortable and trust the environment and the process. Parents must understand that this process is essential for the child and not consider this time as 'wasted.'

The rapport-building went on until the end of the session. Ravi did not make a move to play. The Psychiatrist was extraordinarily patient and under no circumstances hurried the child to take up any activity, nor did he question him. He knew that he had to exercise patience and may need to utilise a couple of sessions

doing 'nothing', waiting for the child to feel comfortable, and trust him.

It was in the third session that Ravi doodled on a sketch paper for about 15 minutes.

The Psychiatrist was aware that he should not interrupt Ravi theoretically, but he initiated a conversation due to the time limitation. “What is the picture?” “What is that animal (*in the picture*) doing?” “Do you want to take this picture home?” The Psychiatrist then ended the session.

The Play

In the next session, the Psychiatrist asked Ravi whether he wanted to continue drawing. He wanted to take Ravi through the 'Draw-A-Person' (DAP) [1] exercise, but Ravi indicated that he wanted to play with dolls. The Psychiatrist went along with it, and Ravi started playing *Bhavla-Bhavli*(House-Play.)

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Ravi, engrossed in playing, talked to himself all the while. “Let's prepare lunch now.” He picked up pots, pans and cutlery and started to cook. Ravi then spoke to the male doll, “Here, eat your lunch. I will feed the baby.” He picked up the baby doll and pretended to bottle-feed the baby and put the baby to sleep.

Ravi continued with this play. A while later, the Psychiatrist gently initiated a conversation, asking about the characters and the meal.

The Psychiatrist knew NOT to ask- What is the **child's relationship with the characters.** e.g., “What is your relationship with the male doll?” or “Who are the parents of the baby?” He was aware that young children generally don't understand or express relationships the way adults do.

The Psychiatrist observed that Ravi was more interested in playing the caretaker role, cooking, putting the baby to sleep, etc. At the same time, he knew that children sometimes assumed roles they knew as routine at home or school. Therefore, a male child playing

a feminine role is not, on it's own, sufficient to assist in a diagnosis, even tentative diagnosis, of Gender Dysphoria.

The Drawing

At the next session, the Psychiatrist decided to explore what was going on in Ravi's mind. He chose the 'House-Tree-Person' (HTP) test to examine the child's worldview.[1]

He showed Ravi the picture he had drawn. The picture was a neutral picture of birds flying in the sky. He then suggested that Ravi draw a picture; it should have Ravi's house, a tree, and himself.

Ravi nodded and, taking the drawing tools that the Psychiatrist handed to him, started drawing. While Ravi was drawing, the Psychiatrist paid discrete attention to Ravi's facial expressions, body posture and drawing.

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Psychiatrist: *(pointing at the girl's image in the drawing that Ravi has drawn, next to the house and tree) Who is this?*

Ravi: *Babita.*

Psychiatrist: *Who is she?*

Ravi: *My best friend*

Psychiatrist: *What is that on her lips?*

Ravi: *Lipstick*

Psychiatrist: *In which standard is Babita studying?*

Ravi: *Third standard*

Psychiatrist: *Does she have friends in school?*

Ravi: *Yes. Sunita, Ranji.*

Psychiatrist: *Who are her male friends?*

Ravi: *a...Rajesh and Vijay*

Psychiatrist: *Does Babita play with them?*

Ravi: *No.*

Psychiatrist: *Do they know Babita wears lipstick?*

Ravi: *No. They will tease me if they come to know.*

Note : *Here, in addition to projecting his personality on Babita, Ravi has shifted to the first-person narrative) [2]*

Exploring Child Sexual Abuse (CSA)

When dealing with gender and sexuality issues with children, the highest priority is to understand their vulnerability to sexual abuse (Refer Chapter: Child Sexual Abuse).

Psychiatrists are trained on building rapport and trust to explore the extremely sensitive issue of child sexual abuse with their clients. Hence, the Psychiatrist did not broach this topic in any manner until he knew he had Ravi's trust.

In the subsequent session, while Ravi is engrossed in 'House-Play', the Psychiatrist mentioned that Ravi's mom was worried that Ravi could get in trouble for wearing a sari. He then gently explored the theme, asking Ravi- "When do you dress like a girl?", "What makeup do you use?", "Who helps you to dress or do makeup?", "Who all know that you like to dress up like Sridevi ?", "How do they react ?" etc.

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Psychiatrist: *Do you take part in school gatherings?*

Ravi: *Yes. I danced... teacher said I look beautiful in the nine-yard sari.*

Psychiatrist: *How did the boys in your class react to this?*

Ravi: *They tease me. They call me bialya (feminine.)*

Psychiatrist: *Do any neighbourhood boys meet you alone?*

Ravi: *a.. once, aa twice ... no. Only once.*

Psychiatrist: *So, what did they do when they met you alone?*

Ravi: *They called me 'darling.'*

Psychiatrist: *What else did they say?*

Ravi:	*They asked me whether I was a boy or a girl.*
Psychiatrist:	*Then what did they do?*
Ravi:	*They pulled my pant down.*
Psychiatrist:	*Then what happened?*
Ravi:	*(distressed) I started crying, and they ran away.*
Psychiatrist:	*Is there anyone else who has pulled down your pant?*
Ravi:	*(ashamed, looks down) No…*

Making sure that Ravi did not have anything further to add, the Psychiatrist spent some time talking to Ravi about BAD TOUCH (Refer Chapter: Child Sexual Abuse) and told Ravi to inform his mom immediately if something like that happened.

After getting that promise from Ravi, the Psychiatrist asked him if a fairy were to visit him and grant him two wishes, what would those be? Ravi replied, "I want to become Sridevi." The Psychiatrist pointed to the male and female dolls. "Which one of these you would like to become?" Ravi pointed to the female doll.

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For the second wish, Ravi replied, "Mom should never get angry with me." And on this note, the session ended.

Cross Verification

In the next session, the Psychiatrist spoke to Ravi's younger brother Siddhi to explore his childhood and perception of Ravi. After establishing the initial rapport, the session focused on cross-verifying Ravi and Leela's information to check for information and experience sharing consistency.

The Psychiatrist noted inconsistencies and explored those further. For example, in Ravi's case, Leela mentioned that she came to know that Ravi was cross-dressing in the house the first time she came home unexpectedly. But when the Psychiatrist spoke to Siddhi, Siddhi said that he had told mom months ago that Ravi was

cross-dressing, but she had ignored it.

It was possible, that since Leela managed a household singlehandedly, she had her hands full and so had not paid attention. Now, feeling guilty about not having taken Siddhi's information seriously, afraid that she would be considered a careless parent by her husband, she had hidden the fact from the Psychiatrist.

SUMMARY

For the closing session, the Psychiatrist invited Leela alone. She was now more relaxed while interacting with him.

He summarised the sessions "I have studied the history, Ravi's drawings, Ravi's thoughts, your's, Siddhi's and my observations. Right now, I feel it is improper to come to any conclusion. I cannot diagnose his gender as male or other than male this early. It will be a few years before we can be certain. We will know more once he reaches adolescence and can communicate better. We will then undertake a few psychological assessments to help in a diagnosis."

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Leela said, "Maybe we should put him in a boarding or military school. With macho boys around him, he will become more masculine."

The Psychiatrist strongly advised her against this approach. He stressed that Ravi is is vulnerable to abuse and will suffer a lot. In the current scenario, Ravi needed a safe space. And, if he insists on wearing a sari, it would be better to explain to him that he is to do it in his bedroom when no one is around so that he remains safe from harassment.

Leela was visibly upset that the Psychiatrist suggested Ravi be allowed to cross-dress in the privacy of his bedroom. He explained that Ravi's gender is not apparent at the moment. If it turns out that Ravi's gender is not male, he will find various means to express himself one way or the other. He could borrow earrings, bangles, nail paint from girl friends, steal these things if they were

not freely available.

If Ravi cross-dressed outside of the home, he could be the target of ridicule and abuse. The Psychiatrist recalled Ravi's experience, where two older boys had called him 'darling', and pulled down his pant once. So, it was clear that some older boys considered Ravi 'different.' “If he reports something of this kind to you, do not ignore it. Take it seriously, and if need be, contact me.”

“Remember that, right now, **our emphasis should be on two aspects only: 1) Ravi's safety and 2) No coercive measures to ensure that the child grows up 'correctly.'** “Do not make him the target of your anger. Beating him, punishing him for feminine behaviour will be cruel, and will only alienate him from you; you are his closest person, his safety zone.”

Leela, desolate, sat quietly. “I need some time to think about this.” The session ended with the Psychiatrist telling her, “If you have any more concerns or need to discuss this further, feel free to get in touch with me.”

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The Science

The experience of a person as male or female is that person's gender identity.

Society assumes that if a person has the anatomy of a male, he will identify with the male gender, i.e., his brain will interpret signals and respond as a 'male' person does; the person will experience the world and behave like a 'man.'

Society also assumes that if a person has the anatomy of a female, she will identify with the female gender i.e., her brain will interpret signals and respond as a 'female' does; the person will experience the world and behave like a 'female.'

For most people, this is true. It means that most people are cis-gendered. i.e., there is congruence between their anatomy and the gender they experience.

There are exceptions where the anatomy does not match the

gender of the person i.e., the way the brain perceives the world and experiences it is different from the gender assigned at birth by looking at the child's genitalia.

For example, a person having male anatomy may have a brain which processes, and responds like that of a female brain.[3] So there is incongruence between the gender assigned at birth (male) and the gender experienced by the person.

A person whose biological sex does not match his/her/their gender is diagnosed as Gender Dysphoric.

Diagnosing Gender Dysphoria in children

It is challenging to diagnose Gender Dysphoria in children. Children have limited vocabulary and experience to understand and express their feelings, desires, and identification.

Several studies have demonstrated that more than half of the children diagnosed with Gender Dysphoria, based on the DSM-IV, later identify with their birth-assigned gender once they reached adulthood.[4]

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It means that many persons who do not adhere to societal gender norms as children may not be diagnosed with Gender Dysphoria in their adulthood. Similarly, some adults who have complied with societal gender norms in childhood come out later as transgender with a diagnosis of Gender Dysphoria. So, a male child's feminine behaviour does not necessarily mean that the child is Gender Dysphoric.

Notes and References

[1] Drawing

One easy way of communicating with children between the ages of three to seven and understanding what is going on in their mind is to use drawing as a tool to have the child project their thoughts on the drawing. The three tests commonly used are:

a) Draw A Person Test (DAP Test)

b) Human Figure Drawing (HFD Test)
c) House-Tree- Person (HTP Test)

These tests can be used independently or together. Children above the age of seven may be reluctant to draw figures as they feel too old for such activity. In such cases, they are given the option- to draw figures or simply talk to the Psychiatrist.

a) Draw A Person Test (DAP Test)

Originally described by Florence Goodenough.

https://archive.org/details/in.ernet.dli.2015.268362

b) Human Figure Drawing (HFD) Test

A variation of the DAP Test, where the child is encouraged to draw three full figures. Not just a face or stick figures but man, woman and self. It is a tool used, in the early stages of counselling, to assess emotional disturbance in children.

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Cosden, M. "Review of the Draw A Person screening procedure for emotional disturbance." The Twelfth Mental Measurements Yearbook (1995): 320-322.

c) House-Tree-Person (HTP) Test

A projective test to assess the internal emotional environment of the child. It can also be used as a rapport building tool.

https://www.encyclopedia.com/medicine/encyclopedias-almanacs-transcripts-and-maps/house-tree-person-test#:~:text=Resources-,Definition,form%20of%20pictures%20or%20drawings).

[2] Interview Method

In Ravi's case, the Psychiatrist has asked questions using the lateral interviewing method: 'Step-ladder questioning technique' of Richard Gardner. He questions Ravi about the picture Ravi has drawn. After a while, when Ravi abandon the projection and openly identifies with Babita, the Psychiatrist abandons lateral

questioning.

[3] The use of the words '...brain will interpret signals and respond as a ...' etc. has been used in the general sense to help understand the concept easily.

[4] Diagnosis of Gender Dysphoria

(i) Kaplan and Sadock's Synopsis of Psychiatry. Eleventh Edition. Wolters. Kluwer. Chapter 18. Gender Dysphoria.

Course and Prognosis. Children diagnosed with Gender Dysphoria do not necessarily grow up to identify as transgender adults.

Note: The criteria for Gender Dysphoria diagnosis in children, adolescents and adults is provided in the book mentioned above.

(ii) Possibility of change is diagnosis of Gender Dysphoria.

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AISHWARYA

AISHWARYA "I was ashamed to face the fact that I identified myself as a woman. I just didn't know how to tell my parents."

Background

The email to Mr Makarand had been terse. 'Do you know that your son Ashish is a *Chakka*? Don't you believe me? Check out his photos on his Instagram account- '--------------'.'

Mr Makarand, at first, tried to ignore the email, but the thought kept gnawing at him. Finally he created an Instagram account under a fake name and sent a request to follow Ashish. Ashish responded immediately, and Mr Makarand got to see what he had been dreading.

Ashish's Instagram account was full of his photos in female attire. Many were in seductive poses. Despite being traumatized, Mr Makarand persisted and read the comments associated with various photos. Ashish seemed to have many followers. Many of whom appeared to be cross-dressers. They referred to him as 'Aishwarya.'

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Mr Makarand spent a few sleepless nights wondering who he should consult. He did not confide in his wife Anjali, who freaked out at the slightest out-of-the-box behaviour. Although Sandeep, his older son, stayed nearby, he did not consult him either. Sandeep had married recently, and Mr Makarand did not want to burden him.

He wondered whether he should talk to Ashish on his next visit home. Ashish was in Mumbai pursuing his degree in Journalism and Mass Communication.

In the meantime, Mr Makarand found an article on gender and sexuality by a Psychiatrist. He took an appointment to meet him.

The Psychiatrist listened to him and checked the Instagram photos. Mr Makarand had a lot of questions for the Psychiatrist- "What is this? How can this be? Could Ashish's behaviour be drug-

induced? He never seemed or behaved like that ever; I mean ever…" The Psychiatrist had calmed him down and stated that although all his questions were valid, he would need to speak to Ashish before he could answer any of them.

On Ashish' next visit home, Mr Makarand took him for a walk and told him about the email he had received. Ashish appeared shocked. He defensively and vociferously denied the imputation of the email. It was a prank, that was all, he claimed. That Instagram account was not his. Someone was playing a dirty joke on him.

It was then that Mr Makarand told him that he had seen some of his photos on Instagram. Ashish became livid. Trembling, he had screamed at his dad for violating his privacy, hot tears spilling from his eyes.

As Ashish cried in public, oblivious of passers-by, Mr Makarand, embarrassed at the spectacle, quietly stated that he had not told his mother. He told Ashish that he had met a Psychiatrist who was knowledgeable about the issue and it would help a lot if they visited him.

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Ashish obstinately refused. He was too angry at being outed in this manner to think rationally.

Finally, Mr Makarand remarked, "Look, I don't know what is going on here, but I am trying to understand and help you. I can't do that if you don't cooperate. If you want, you go alone, but do make at least one visit. I am at my wit's end. Here is the name and number of the doctor. Do give it a try."

Aishwarya's Case

Mr Makarand and Mrs Anjali sat quietly as the Psychiatrist spoke with them in his office. Ashish sat outside in the waiting room.

"I had invited Ashish to be present when I speak to you, but he is uncomfortable and prefers that I speak to you alone before we call him in."

The Psychiatrist continued, "As you know, Ashish came for a couple of sessions in the past month. I took a detailed history from him. In a nutshell, as a young adult, Ashish assumed he was gay. But after reading on various LGBTIQA topics, interactions with multiple people and groups on social media, Ashish realised that he was not gay. He self-identified as a female.

Aware of the transphobic attitude of society, Ashish had felt like a pariah and became intensely depressed. She didn't come out to you for fear of hurting you. She lost focus on her studies and spent the entire time contemplating her gender identity and suppressing her desire to express it. Finally, she sought and found support through transgender friends on social media platforms.

After suppressing her desire to dress and behave like a woman for years, she finally mustered the courage to cross-dress in private. Later on, gaining more confidence, she started to cross-dress at LGBT parties where someone gave her the name Aishwarya.

After taking a thorough history, I suggested a few psychological tests to her. The diagnosis is Gender Dysphoria. i.e. Ashish identifies as a woman. Although she has a male body, her brain processes signals and responds like a female. Her gender identity is female."

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Mrs Anjali: *"Stop saying 'she.' He is a man, for God's sake!"*

(Silence)

Mr Makarand: *(in a low voice) "Sorry doctor, my wife has been very disturbed since I told her about this."*

Psychiatrist: *"It is okay. All this must be a shock to you. It is understandable; anyone in your place would be."*

Mrs Anjali: *(wailing) "Where did we go wrong?"*

The Psychiatrist stated, "There is no evidence that upbringing has anything to do with gender identity. So, you as parents should not

blame yourselves for your son's Gender Dysphoria. You did nothing wrong. The fact that you are here worried about your daughter's future is a testament to the fact that you are caring parents.

She feels intense guilt for causing you this trauma and the unsavoury manner in which her gender was disclosed to you. She did not say anything to you for fear of hurting you and your rejection. She is not distressed about her gender identity. She is distressed for not confiding in you and hiding her true self from everyone."

There was silence for a while. Then Mr Makarand sighed, "So my son is a *Hijra.*"

The Psychiatrist replied, "We use the term 'transgender' or 't*ritiyapanthi*.' *Hijras* are a community of *Tritiyapanthis* having a cultural tradition in India."*[1]*

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Mrs Anjali responded angrily, "It's the same, right? A name doesn't change anything."

Mr Makarand quietly asked, "What can be done? Is there a cure?"

The Psychiatrist responded, "Being a transgender is not an illness or a disorder, so there is no question of a cure. No one can do anything to change her gender identity. It is how nature has created her. So don't hold it against her, don't be angry with her."

Mr Makarand said, "If you say he won't change, what should we do now? Will he join the *Hijras* we see begging on the street?"

The Psychiatrist replied, "I have spoken to Aishwarya; she wants to continue her studies and then pursue a career in Journalism and Mass Communication. She has not expressed any desire in joining a *Hijra gharana*. Many transgenders are flourishing in society who are not part of a *Hijra gharana*."

"But now that she is out to you, she will have to figure out her next course of action. These could be life-altering decisions- coming out at her job, legally changing her name/gender, transition,

staying with you or moving out etc. So, give her some time. Let her think it through. Allow her to discuss her issues with you if she and you feel comfortable. Don't force her to talk with you, but neither should you turn away if she wants to. If she desires, she can take an appointment and discuss her challenges with me. If she needs any referrals of LGBTIQA organisations, I can provide her with a few."

Mrs Anjali sobbed, "What do I tell our relatives? Our neighbours?"

The Psychiatrist replied, "Right now, you don't need to tell them anything. All of you should take some time- a few months at least to adjust to the new reality and think about the challenges and adjustments that lie ahead. First comes the security and happiness of your daughter. The rest will follow."

The Science

A person whose biological sex is male and gender identification is female is called a male-to-female Transgender or Transwoman.

A person whose biological sex is female and gender identity is male is called female-to-male Transgender or Transman.

In a few cases, persons may experience both genders. They identify as Pangender (Pan = multiple).

Lastly, in a few cases, persons do not experience any gender. They identify as Agender.

Being a Transgender, Pangender, or Agender person is neither an illness nor a disorder. So, there is no question of a 'cure.'

It is best to accept the person as they are. Do not attempt to 'correct' them. Such attempts will be futile, and worse, will end up harming them immensely.

Statistics

There is very little statistical data available on percentage of transgenders in the population. There is also variation in the available data.

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(a) Data from European hormonal/surgical clinics suggests that, one person in 11,000 whose anatomy is male has a female gender identity i.e., is a transwoman. Similary, one person in 30,000 whose anatomy is female has a male gender identity i.e., is a transman. [2]

(b) DSM-5 reports a prevalence rate ranging from 0.005 to 0.014 per cent for male-assigned and 0.002 to 0.003 per cent for female-assigned people.[2]

(c) Data from USA suggests that an estimated 0.3% of adults are transgender[3]

DAMINI

Transwoman, age 28

Preferred pronouns: she/her

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I spent 27 years of my life pretending to be a cisgendered heterosexual man, sexually interested in women. One fine day my family started the search for the perfect daughter-in-law.

Eventually, everybody agreed on a woman suitable to become the perfect *bahu* for the family. We got engaged, and our families started to plan a big wedding. After the engagement, my to-be wife and I would call each other every day. These calls made me realise that she had dreams of a blissful married life, and I was about to shatter her dreams.

I was very stressed and thought of dying by suicide. Finally, I took help from a Psychiatrist and got the courage to tell the world that I was sexually interested in men, not women. The marriage was called off. As I came out, I got mixed reactions- “take your time, it's just a phase”, “We wish you were never born”, “Maybe the girl is not a good match for you”, “One day you will feel very lonely and will need a partner”, “It's unnatural, and you have disgraced the family.” But, yes, some

also said, “It doesn't matter who you are; we are with you..”

Note that, till this point, I had not told anyone that my gender identity was female. Because frankly, then, I didn't know the difference between being gay and being a transwoman. I knew I was sexually attracted to men, but I did not know that I felt like a woman attracted to men and not like a man attracted to men.

My mental health deteriorated. I became an alcoholic, a spendthrift and a dipsomaniac. To be very frank, I wished I was dead.

One fine day, a kitten came into my lonely life, and I got attached to her. As I started caring for her, my mood got better. I felt like living again, to care for her, and move on.

It was around this time that I started craving to dress like a woman. I thought of it for a long time and finally, ashamed of myself, I bought a pink sari and makeup. I realised that what I felt was like a woman; I wanted to be a woman. I felt like a different person when I was in an Indian woman's attire. Finally, I had found myself. I clicked some selfies and put them on a dating app. I got a fantastic response, and this was the moment of my rebirth.

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In this painful journey, it was my sister who stood by me- “I will always stand by you, live your life as you desire.” These kind and inspirational words helped me gain confidence.

Currently, I am working in an IT company and have recently started the process of transitioning to a woman. I continue to be in touch with my family. Some are on my side. Some are not. So be it.

PAYAL

***Tritiyapanthi,* age 30**

Preferred pronouns: she/her

Though I was born a boy, I always liked dressing like a girl. I used to wear a sari when I was alone, at home. My schoolmates teased me because of my feminine behaviour. When I came home from school, I would freshen up and put on powder and *kajal* (eyeliner.) Boys from the neighbourhood would tease me and call me a *Hijra*. Because of my feminine behaviour, my family too started scolding and cursing me. I got depressed and thought of ending my life. I would pray to God- Please save me from this pain and anguish!

Later on, as the teasing and harassment increased, I started skipping school. When my parents got to know about it, they got furious and beat me a lot.

I left my studies after the 10th standard because of the hostile environment at school. I joined the *Jogta* community who devote their lives in service of a God and are predominantly from Maharashtra and Karnataka. My Shri Guru performed my initiation rituals (*Mal-Pardi*.)

Today, I can proudly say that I am out to everyone, and the boys in the neighbourhood do not harass me. My philosophy is that I live my life with dignity and respect and expect others to respect me. The neighbourhood has got the message.

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Notes and References

[1] *Tritiyapanthis* and *Hijras*

Third Gender (or Third Sex) describes individuals categorised as neither man nor woman. Quite often, the terms Third Gender, Third Sex, Transgender, *Tritiyapanthi* are used interchangeably.

The name *Hijra* has regional variations; for example, they are

called *Kinnar* in Delhi, *Aravanis* in Tamil Nadu.

Hijras of India are somewhat equivalent to male-to-female transgenders. The difference being that *Hijras* have a long tradition within cultural India. They have strong social ties within a *Hijra gharana*, *guru* and *chela*. A new member is inducted in the *Hijra gharana* after undergoing a formal ritual called *reet* and the new member comes under the patronage of a senior *Hijra* known as *guru*. The new inductee is then known as the *guru's chela*.

Hijras generally earn their living by begging (*mangti*), blessing newborn babies, dancing in ceremonies (*badhai*) or sex work. A few *Hijras* may be self-employed.

Some *Hijras* undergo a rudimentary form of Gender Affirmative Surgery through Castration and Penectomy; some may undergo a more elaborate surgery, hormone therapy. Note that, many *Hijaras* do not go in for Gender Affirmative Surgery for various reasons.

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Transgenders and Hijras

All *Hijras* are male-to-female transgender persons, but not all male-to-female transgender persons belong to the *Hijra* community. There are quite a few male-to-female transgenders who are not part of the *Hijra* community. They are better integrated with the mainstream and earn their living by working at a job or are self-employed.

[2] **Kaplan and Sadock's Synopsis of Psychiatry.**

Eleventh Edition. Wolters. Kluwer. Chapter 18. Gender Dysphoria.

[3] **Gary J. Gates (2011). The Williams Institute.**

How many people are lesbian, gay, bisexual, and transgender?

RIA

RIA "I hate having breasts… eeks!"

Background

As Neelam heard the loud crying from upstairs, multiple lines furrowed her brow. Not again! She had never thought that periods could be so painful. Yes, they were a bit of a pain, and it was a messy business, but the reaction she was seeing from Ria, her 14-year-old daughter, was out of this world.

It had been almost two years since Ria had her first period. Ria studied in a school well-known for being progressive. She had been taught all about periods and hygiene, so she was prepared for what was to come. The first time, her friend Kavita had taken her to the school Counsellor who had given her a pad. After coming home, she had cried and cried, and her distress had lasted for the duration of the period.

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Three weeks later, Ria started dreading that she would have another period soon. Crying, she confided in her mom that she did not want to have another period. Her mother consoled her, assuming Ria needed time to adjust to such a life-changing experience. But Ria continued to be distraught and cried a lot. Finally, Neelam took Ria to their family doctor.

The doctor explained that periods occur naturally because of hormonal changes in a girl's body. Having monthly periods is a sign of a healthy body as it readies the womb for a fertilised egg to attach and develop into a fetus.The menstrual cycle is typical in a female. The womb's lining disintegrates and bleeds out when there is no fertilised egg. It starts building again, and the process repeats at periodic intervals (approximately once a month) till the stage of Menopause.

The doctor prescribed Paracetamol and told Ria that everything would be alright. Ria came home and threw a tantrum. She did not want to have periods.

Over the next six months, the relationship between Ria and Neelam steadily worsened. Ria's fights with Neelam increased. Although Ria had been a topper in the class, her grades started to slip alarmingly. Ria was counselled by her school Counsellor many times. She also called Neelam to discuss Ria's poor performance, but there had been no improvement. At her wit's end, Neelam decided to talk to a Psychiatrist she knew.

Ria's Case

At the clinic, Neelam vented her frustration. “For the past six months, she has been such a nuisance around the time of her periods. And it is not as if she was not aware of this.”

“Was Ria in any pain?”

Neelam replied, “Everybody goes through some pain, but her reaction is so disproportionate to the discomfort.”

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The Psychiatrist then asked Neelam about Ria's lifestyle. Neelam replied that Ria has always been something of a tomboy; stubborn, roamed around with the boys, and played cricket. “I told her so many times, now that she is grown up, she needs to be more feminine. But Ria simply does not listen. She does not wear a sari or Punjabi dresses for formal events; she insists on jeans and a t-shirt. Oh! And one more thing. She had such lovely, silky hair. A month ago, she just got herself a crew cut without informing me. I was so furious. We had a big fight over this. She has reluctantly started to grow her hair, but now she always wears a cap to hide her hair.”

“Why do you think she is behaving like this?”

“I think she needs to be around girls so that she will stop emulating boys. Some time ago, I forbade her from talking to or playing with any boy. Whatever she wants to do- play, go for movies, lunch, dinner, picnics, she is free to do with her female friends. She refuses to listen. Yes, I know it's a bit of a challenge managing an adolescent. But frankly, this is way over my head. I tried to seek her

father's support; he is of no help."

Ria's Dad did not mind having a tomboy. "He just laughs it off; at times, he even encourages her. I made it clear to him that if we have difficulty finding a groom, I don't want to be held responsible.... Why do you think she is behaving this way?"

The Psychiatrist mentioned that she would have to talk to Ria. She did not mention the various possibilities and explanations for Ria's behaviour. She was well aware that many girls liked short hair because it was easy to take care of; girls wore jeans and t-shirts because it was comfortable and hip. She was also aware that many girls liked playing cricket, and given half a chance, they would play the whole day away. With Ria's social background, it was not surprising that she was confident in socialising with boys. So, none of the information she got from Neelam was relevant by itself.

The Psychiatrist introduced herself and built rapport with Ria before enquiring about the details of her life- about Ria's growing up years, her school experience, friends circle- male and female, and her interest in sports.

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"Somehow, I never enjoyed playing with girls. I always wanted to play cricket."

"Didn't the boys object to you playing with them?"

"Initially, they did, but now they all consider me as one of them."

After exploring details of Ria's love for cricket, the Psychiatrist moved on to her first period- "How did the first period affect your play?"

Ria replied, "Oh! it did affect my play. I complained to the family doctor, but he is stupid. He just gave me Paracetamol. It didn't help much. I kept on telling him I feel so uncomfortable, dirty. I don't like what is happening to my body. Boys don't experience this. And all he kept telling me was, I was just fine."

The Psychiatrist tried to probe further. "Why so? Don't you like your body?" Ria said, "It just doesn't feel right. Something is just

not okay. I mean, modesty aside, I know I have good looks; boys eye me in a certain way, you know. But I don't want this body, especially periods, breasts."

The Psychiatrist wanted to know from Ria if her discomfort was more than just physical. Did Ria have an innate aversion to this natural cycle?

Psychiatrist: *Can you elaborate 'uncomfortable'?*

Ria: *It feels alien to me. It shouldn't happen to me. Boys don't get periods.*

Psychiatrist: *What are your feelings when a period starts?*

Ria: *It's disgusting.*

Psychiatrist: *When you look at yourself in the mirror, how do you see your body?*

Ria: *I don't like some parts of my body.*

Psychiatrist: *So, you don't like some parts of your body?*

Ria: *(Empathically) No.*

Psychiatrist: *Can you identify the parts of your body that you don't like?*

Ria: *Number one- Breasts. Number two...*

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The Psychiatrist was aware that it was normal for girls to want to be beautiful, have a great well developed body, big breasts, and boys to have a six-pack and a long penis, but all of these desires were expressions that enhance/reinforce their gender. She was aware that Ria's replies were a contrast to the general expectations. A wish for a radical change in anatomy, which would alter gender expression, had to be explored.

The Psychiatrist probed further, asking her, "Given a choice would you prefer a chest like a man or like a woman?"

"A hairy chest like a man."

The Psychiatrist asked, "So have you taken any steps in that direction?" Ria replied that she did not understand the question.

The Psychiatrist rephrased the question, “What changes in your lifestyle have you tried to do to make yourself comfortable?”

Ria promptly answered, “Oh! Hmmm... there is one thing, but I will tell you only if you won't rat on me and tell mom. Okay?” The Psychiatrist assured her that, as long as whatever Ria disclosed was legal, she would keep it confidential.

So, Ria told the Psychiatrist that she used a scarf to tie up her breasts tightly and wore loose t-shirts so that no one, especially her mom, would notice what she has done.

Finally, the Psychiatrist asked Ria if she had researched this topic. Ria replied, “aa, yes. On the Internet. But I am confused. Who am I?[1] Momma says I am like this because I hang around with boys. But she is so wrong. I feel like them, which is why I hang around them.”

The Psychiatrist then probed her sexual orientation- sexual feelings, fantasies, masturbation, and experiences. Ria said, “I am confused there… I am attracted to women, but... there is a lesbian in my class. Or at least I think she is a lesbian. We once tried to make out. But then she started touching my breasts, and I slapped her hand away. Please don't tell mom. She will kill me. So am I a lesbian?”[2]

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After the session with Ria, the Psychiatrist spoke to Neelam and suggested a few psychological tests for Ria. The Psychiatrist said, “The test results will assist me in understanding Ria's gender identity.” Neelam responded, “I don't understand.” The Psychiatrist said, “I want to know more about Ria's gender. I want to verify whether Ria's gender is male, i.e. Ria's body is female and her brain receives signals and responds as a male. Such persons are called transmen.”

Neelam was shocked and responded, “How can that be? She is NOT male. Doesn't she understand that simple fact? Why is she under the illusion that she is not a woman?”

The Psychiatrist explained that this was not an illusion or delusion. “Everybody believes that a person's gender matches their anatomy. For many, it does, but in some cases, that is not so. I suggest you get some tests done. The results will give me a better idea.”[3]

Neelam was not convinced. She did not believe that there could be people whose gender was different from their anatomy. But she pressed on, “If the tests show that you are right, what is the cure for this?” The doctor replied that being a transman is not an illness, disorder or disease, so there is no cure.

For a moment, Neelam was at a loss for words and then suddenly flooded the Psychiatrist with questions. “What about her marriage? She can get married to a man and have a baby, right? She can have a family, right? That shouldn't be a problem as she has her periods.”

The Psychiatrist stated, “Well, we are getting ahead of ourselves. Let's take one step at a time. First, let's see what the tests tell us.”

Aware that very few Psychologists had experience conducting and interpreting tests in the context of gender identity, he recommended that Neelam take an appointment with one who had expertise in this field.

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As Neelam left, she was unsure whether she would go for the tests. She still felt that Ria was stupid in wanting to be a boy, and keeping her away from the boys was the answer. But at the same time, since the Psychiatrist had voiced her opinion, she knew she had to settle the issue one way or the other. Otherwise, it would keep on gnawing at her day and night. Reluctantly she did as the Psychiatrist suggested.

When the results were in, Ria's father accompanied Neelam for a session with the Psychiatrist. The Psychiatrist first gave an overall picture of the situation, starting with Ria's history, and explained her observations from Neelam and Ria's experience sharing. She then explained the test results and tentatively diagnosed Ria with

Gender dysphoria. Considering Ria's age, it would take a few more years to confirm the diagnosis.

The Psychiatrist added further, “At this stage, I cannot say that the family you have in mind is the family Ria will have. After a few years, we will have to assess her as an adult and get clarity on her gender identification. But right now she needs your support, acceptance and love. I know it is very challenging for you, but you are the best people in the world to provide that.”

The Science

There was very little understanding of gender issues until a few years ago. Health practitioners tried to suppress the gender identity of transgender persons by counselling, medications, and various inhuman therapies.

The professional associations of mental health practitioners now accept that gender identity cannot be changed by medicine or any therapy. (Refer Appendix A: IPS Position Statement and Appendix B: WPA Position Statement on Sexual Orientation and Gender Identity.) It is in everybody's best interest to accept a person's self-identified gender.

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Many transgender persons feel deeply distressed by the incongruence of their physical body and experience of their gender. This distress significantly affects all spheres of their lives-studies, sports, career, social functioning etc.

A few choose to undergo various psychological tests for gender identity assessment and are diagnosed with Gender Dysphoria. With this certificate, they try to bring a congruence, to a certain extent, between their anatomy and their gender identity- by Gender Affirmative Treatment and changing their gender/name in legal documents.

Gender Affirmative Treatment

Some transgender persons desire to undergo hormone therapy and surgical procedures. Others continue to live without medical

intervention. A transgender person who wants to undergo Gender Affirmative Treatment has first to approach a Psychiatrist.

The Psychiatrist will refer the client to a Psychologist for a set of psychological tests. If the tests indicate Gender Dysphoria, the person is given a certificate of Gender Dysphoria by the Psychiatrist.

Another Psychiatrist must issue another equivalent certificate. Based on two certificates of diagnosis of Gender Dysphoria, the client can undergo Gender Affirmative Treatment.

Note: Guidelines for standard practice in Gender Affirmative Treatment are evolving. Various associations, institutions could have different policies. A team of professional health and mental health practitioners who collaborate on Gender Affirmative Treatment will generally adopt one such guideline for consistency.

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Gender Affirmative Treatment is a combination of hormone therapy, surgical procedures and various other therapies used to mould the anatomy according to the gender identity of the person. Some may opt for hormone therapy only; some may opt for a specific surgical procedure only, some may opt for both.

Example 1: An Endocrinologist can guide a transwoman for female hormone therapy. The Transwoman could opt for a surgical procedure for breast enhancement. If she desires, she could opt for surgical procedure to remove Testes and Penis (Castration and Penectomy) and a Vaginoplasty (to create a Vagina.) (Note that while peno-vaginal intercourse is possible after a Vaginoplasty, the intercourse cannot result in a pregnancy as there is no Uterus.)

Example 2. A transman may, under the guidance of an Endocrinologist, take Androgen injections to reshape his body fat deposition, make his voice hoarse and grow a moustache. He may opt for surgical reduction of his breasts. He may opt to remove the Uterus, Fallopian Tubes and Ovaries (Bilateral Salpingo-Oophorectomy.)

Gender Affirmative Treatment is complex and needs a team of specialists- Psychologist for gender identity assessment, Psychiatrist for evaluation and certification, Endocrinologist for hormone therapy, cosmetic surgeon for surgery, and other specialists, e.g. voice therapist etc.

Mental Health Disorders in LGBTIQ

Statistically, more LGBTIQ community members suffer from mental health illnesses as compared to heterosexual, cisgendered persons. These mental health issues reduce in frequency and duration, when LGBTIQ community members live, study, work in an inclusive environment.

So, during assessment, if the Psychiatrist suspects any mental illness, the client may be recommended additional psychological tests and/or treatment.

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TRANSGENDERS AND THE LAW

In 2014, the Supreme Court of India, in the landmark judgment of NALSA v/s Union of India[4] gave a new legal identity to transgenders- 'Third Gender'.

In 2019, The Transgender Persons (Protection of Rights) Act, 2019 and the Rules framed therein gave every transgender and intersex person the right to identify as male or female or transgender.

A person may apply to the District Magistrate to seek a Certificate and Identity (ID) as a transgender person with their name given at birth or a new name. The Certificate issued can be used to apply for name and gender change on all documents like Aadhar card, PAN card, Voter ID, Ration card, school leaving certificate, property documents, passport etc.

Note that no medical examination, medical certificate of Gender Dysphoria, hormone therapy or surgery is required for

applying for a transgender Certificate and ID.

The website for the online application is:

http://transgender.dosje.gov.in/

But, if a person desires to change their gender from male to female or female to male, the person has to first apply for a certificate of transgender, as mentioned above. Once they get the certificate, they can, post hormone therapy/surgery, apply for a change of gender from transgender to female or male. For this, the transgender person has to upload a medical report from the concerned doctor/s.

Mx TRINAY

Transman, age 28 years
Preferred pronouns: he/him/his

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When I was young, I was confused about my gender identity. Was I a boy or a girl? Should I use a feminine pronoun or a masculine one? Most of the time, I used a male pronoun to describe myself. My teacher used to scold me and punish me. She would give me the exercise to write the sentences of everyday use on the blackboard, using feminine pronouns, so that I won't use male pronouns for myself.

In my childhood, I don't recall playing 'girl games.' I clearly remember playing *Vitti-Dandu*, cricket, marbles. I also remember that one time, one of my girl friends gifted me a cricket bat.

I always wanted to behave like a boy. I would even try to pee like a boy- standing up.

Eventually, such conflicts started to affect my studies adversely.

When I was in the sixth standard, I attained puberty. I felt very uncomfortable and told my parents that I don't want to have

periods as they reminded me that my body was female.

As my body started changing drastically, my frustration increased. My parents did not understand what I was going through. All of this was new to them. Finally, I mustered up the courage to tell my parents outright that I don't want this female body as I am a man.

My parent took me to a Psychiatrist to 'cure' me. Unfortunately, the Psychiatrist had no understanding of gender identity issues and gave wrong advice and treatment. I suffered a lot because of it.

Finally, after a couple of years, I approached gay activist Bindumadhav Khire, President of Samapathik Trust. He guided me to an LGBTIQ friendly Psychiatrist. From then on, my life improved. I got my gender assessment done, started hormone therapy and underwent breast reduction surgery.

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Mx SAMANYU

Transman, age 19 years

Preferred pronouns: he/him/his

In childhood most of the friends I had were boys and I remember hanging around with them. While watching movies, unlike other girls, I never fantasised having a husband. Like other boys I too wanted a wife. I would say this openly but because of my young age, no one took me seriously.

When I reached adolescence, I started behaving like a man. I started getting sexually attracted to women. My classmates started to tease me. Girls in my class started saying “She is a *chakka*.” Teachers in college refused to allow me to participate in various activities like NCC and I gave up participating in sports. An outgoing person by nature, I felt very hurt and became an introvert. I started staying away from classmates. I used to cry often. The discrimination and ridicule severely

affected my studies.

Alone and depressed, I had no one I could share my experiences with. I thought my parents would accept me and came out to my parents. But that did not happen. They started to force me to live like a woman. We would often quarrel.

My parents are superstitious and took me to various *babas* (holy men.) They performed various rituals to 'cure' me. E.g. adding *angara* (holy ashes) in my food etc. When I resisted, they would emotionally blackmail me.

In the tenth standard, I felt that my life was worthless. In frustration, I started inflicting pain on myself by starving and hitting my hands against the wall.

I tried my best to live the way my parents wanted, for example wearing women's clothing etc, but I felt very distressed. I told them I would try to fulfill all their expectations except two- I will not be a woman and I will never marry a man.

Finally, after one of our quarrels, my family asked me to leave. I left and called gay activist Bindumadhav Khire. He asked me to come to Pune. He promised to support me for a few months and his organization- Bindu Queer Rights Foundation started taking care of my food, shelter, and studies.

Currently, I am doing my second year BSc and want to specialise in Organic Chemistry.

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Notes and References

[1] In some cases, transmen will immediately voice that they are men and want to have a male body, as we saw with Mx Trinay and Mx Samanyu. But there are some persons, like Ria, where they don't have a concrete understanding of their gender identity. Quite a few are confused; they may first try to align their feelings with straight women and, when that fails, with lesbians. Ria's

confusion is related not to her object of sexual attraction but her attempt to relate as a woman, which she is not. She is unhappy when her breasts are part of sexual intimacy with her partner as she identifies breasts as a symbol of womanhood- someone she is not.

[2] Because of Ria's young age and without confirmation of her gender identity, confirming her sexual orientation would be premature.

[3] Various evaluation assessments and tests have been developed to aid Psychologists and Psychiatrists to diagnose depression, psycho-pathology, cognitive functioning, personality traits, etc. Depending on the history of the client, doctors prescribe different tests. Along with Gender Dysphoria, it is crucial to explore personality traits to understand the reliability of the information provided and the client's risk-taking behaviour. If the medical practitioner diagnoses mental health disorder during assessment, the client may be recommended additional psychological tests and/or treatment.

[4] **NALSA v/s Union of India**

Writ Petition (Civil) No. 400 of 2012 with Writ Petition (Civil) No. 604 of 2014.

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PART III: SEXUAL ORIENTATION

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YASH

Yash "On the one hand, I don't want to disappoint my parents, and on the other, I feel I have already done so."

Background

Yash is a brilliant student who has consistently exceeded his parents' expectations. When he effortlessly got admission to a Government college for MBBS course, his doctor parents were not surprised. It would have been a shock if he hadn't cracked the entrance exams.

His college professors quickly realised that he was the student to watch out for. Yash adjusted rapidly to the first year's perpetually chaotic routine and was ranked one of the top five students. He pushed himself mercilessly day and night as if trying to prove something to everyone.

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It was in his third year that something went wrong for Yash. Initially, the change was imperceptible. His parents and professors thought he had become too cocky and was taking his studies casually. But half a year later, everybody, including his friends, started giving up on him. The writing was on the wall, and he was sure to flunk.

A garrulous talker, Yash had lately withdrawn from his parents too. He spent most of his free time in his room sleeping. The Paediatrics professor, his father's classmate, called his father, and asked him to check up on Yash. His parents, now alert, spoke to him. Was it a girlfriend? Was it a money issue? Was it drugs? They had drawn a blank.

Yash's parents were at their wit's end; the tone of their voice had slowly and perceptibly changed from one of concern and anxiety to irritation, frustration. And now they no longer needed an excuse to start a shouting match with him.

Finally, his mother had spoken to a Psychiatrist colleague of hers, "Please find out what is going on in his mind. We have given up."

But Yash refused to meet the Psychiatrist.

He finally mustered the courage to call an organisation working with the gay community and sought an appointment. A day before the meeting, Yash sent an SMS stating that he was not keen on visiting the place as he did not want anyone to see him visiting an organisation that worked with the gay community. Could he instead get a referral for a Counsellor? On receiving the referral, Yash made an appointment with the Counsellor. The Counsellor had been sensitive and empathetic to his travails.

Yash's Case

When Yash reached adolescence he realised that he was sexually attracted to men. At first he tried to convince himself that it was just a passing phase. Although a part of him kept telling that this seemed to be for keeps, he went into denial.

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A couple of years later, seeing that there had been no change, he felt angry. Yash was angry at nature and the Gods for 'selecting him' to be gay. He was angry at being vulnerable, angry at his inability to communicate with anyone of the turmoil within, angry that many in the medical fraternity were homophobic, angry at his friends sharing homophobic jokes amongst themselves. It was in this hostile environment that he started hating himself.

The next step has been 'bargaining', where he had tried to change himself. He tried to do this by masturbating while fantasising about women hoping that, with practice, he will get his brain to respond to women as it responded to men. He soon realised that it was useless; it did not work at all.

He searched for therapies to see whether there were methods by which he could change his sexuality. It was here that he got confused. He came across articles stating that being gay was not an illness or a disorder. He also read that no one nor anything could change a person's sexual orientation. But he also came across material that talked of 'cures' by hypnosis, medications, counselling etc. Unbeknownst to his parents and friends, he tried

his hand at these 'cures' and realised that all these claims were bogus.

As a last resort, Yash started dating a female colleague to whom he was emotionally attached. He hoped that sexual intimacy with a female would change his sexual orientation.

Yash: *I am deeply attached to Savita.*

Counsellor: *Does Savita reciprocate your feelings?*

Yash: *Yes. She is in love with me.*

Counsellor: *Have you had physical relations with her?*

Yash: *Yes. Once.*

Counsellor: *Have you gone all the way?*

Yash: *Yes.*

Counsellor: *So, are you currently dating her?*

Yash: *No, (looking down) Breakup.*

Counsellor: *From whose side?*

Yash: *Mine… she is depressed because of the breakup*

(Yash is silent.)

Counsellor: *Did you give her any reason for breaking up?*

Yash: *(anguished) I want to like her sexually… She is a good person, she would be such an ideal partner… but I can't. I just can't. I..I.. I don't feel for her sexually.*

Counsellor: *Do you feel sexual about other women?*

(Yash is silent and on the verge of tears.)

Counsellor: *Are you sexually attracted to men?*

(Yash is silent for a long time)

Yash: *Yes. (Starts crying inconsolably.)*

It was after his breakup that depression set in. Yash realised that he would be gay all his life, and his whole life was going to be far different and more challenging than his heterosexual (straight)

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friends.

Aware that most of the society hated and despised people of his ilk, he became obsessed with his sexuality. Having a sexuality that was routinely made fun of and ridiculed was deeply disturbing, and he had been unable to deal with the stigma and self-hate.

He tried to reach out on social media and meet like-minded friends. Initially, he found support from gay men he had met online and had started feeling better about himself. But here, too, he began facing challenges.

He met a man, online, within his age group. Yash, for the first time, felt accepted and loved. They dated for a short while, and after they had sex, the man broke up with him. Yash soon afterwards found out that the man was married.

Yash realised that many of the people he met online had multiple identities, and the information they provided was more often than not false. Many pretended to be single but were married, living a double life, cheating on their wives, pretending to be straight. He had consoled himself thinking that at least he had not been robbed or blackmailed, like the many experiences he had read on social media.

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All these experiences and the absence of role models in the gay world made him withdraw even further into the closet. He was now living in a strange and alien world. He was unable to share his feelings and experiences with anyone, least of all his parents.

He was afraid of hurting his parents and letting them down. He knew his parents loved and cared for him. As their only child, and despite their busy schedule, his parents had made sure they gave him enough quality time.

Yet, Yash was sure that they would feel let down if they were to know the truth. He was sure that his father would be very angry with him. Yash had once heard him making homophobic remarks at the Supreme Court judgment on Section 377 IPC.

Yash was also sure, his friends and colleagues would ostracise him.

Despite being immensely talented, he has started wondering the point of it all.

Carrying the burden of living a dishonest life was too much for Yash. His confidence slowly crumbled. He became depressed, listless, ambitionless, careless, and insensitive. He experienced this unrelenting mental torture daily; life had become a living hell for him. He was at a dead-end, and lately, he had been having thoughts of ending it all.

Yet, Yash felt he must reach out to someone. He knew it was of paramount importance that he could trust this person. He wanted someone who would not judge him, someone who would be sensitive and accept him as he is.

The biggest barrier was not knowing who was the right person to approach. Could he trust the person? Would this person respect confidentiality? Would the person be knowledgeable about this issue?

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Being from a medical background, he was well aware that many doctors were very ignorant and insensitive about homosexuality. As such, he had not approached any of his professors or senior colleagues.

Finally, unable to bear the burden alone anymore, he had decided to approach an LGBTIQA organisation. But afraid of visiting the organisation, lest someone see him there, he had cancelled the appointment and sought a Counsellor's referral.

Yash had read about the Kubler-Ross Model of the five stages of grief and was aware that he had moved from the stages of denial, anger, bargaining, to depression. He wanted to reach the final stage of acceptance, but knew that he needed assistance to do so.

Yash was determined to reach the final stage, essentially because he did not want to be like the gay men he met online who refused to accept themselves. They remained stuck at the stage of denial or anger or bargaining or depression. Yash did not want to be stuck in these stages. He wanted to reach the stage where he could

unburden himself and be free.

Yash felt he could trust the Counsellor as she listened to him with empathy. He shared his fears and worries about his parents, career, and personal life. He felt thankful that he had found a Counsellor who un-conditionally accepted him as he was. At the end of the session, he felt relief; finally, he had taken the first step to be free.

But it was half a dozen sessions with the Counsellor before he mustered the courage to visit the organisation which worked for the gay community. A few months later, he came out to his mother.

The journey had been challenging. He lost a year of his studies as he struggled to accept his sexuality. But he felt it was all worth it. He was now very comfortable with his sexuality, content, and at peace with himself. He expressed his eagerness to volunteer for the organisation in assisting other gay youth.

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In the studies department, he cleared his backlog and started doing well again. No, he was not at the top of the class, but he was happy, which mattered a lot.

The Science

As a person grows into adulthood, he/she/they become aware of their sexual attraction to persons of a particular sex/s.

Sexual orientation is the long term, consistent presence or absence of sexual and emotional desire for adult persons of a particular sex or sexes.[1] It may be one of the following types :

Sexual and emotional attraction towards-

1. only persons of the opposite sex (Heterosexual); or
2. only persons of the same sex (Homosexual/Gay); or
3. persons of either sex (Bisexual); or
4. no one (Asexual)

Statistics

Approximately 3% of all men are exclusively gay, and 1% of all women are lesbians.[2]

Most persons become aware of their sexual orientation by the age of 12-14. For others, it takes longer to become sure.

Note that a person's first sexual experience does not dictate or decide his/her/their sexual orientation. A person does not need to have sexual intercourse with someone to become aware of his/her/their sexual orientation. Most people become aware of their sexual orientation by sensing the direction of their sexual attraction without having had physical intimacy with anyone. For others, it is the sexual intimacy that will unravel the puzzle- “Yes! This is what I desire” (Note the experience will only reveal what is hidden, it does not create or redirect the person's sexual orientation.)

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Being Gay

Being gay or bisexual is entirely natural. People cannot learn nor convert to being gay, lesbian, or bisexual. As of today, science does not know why some persons are gay or bisexual. All we know is that a person's sexual orientation is 'hard-wired', i.e. no one can change their sexual orientation.

In this conservative society, where being gay is a stigma, most gay men initially try to suppress their sexuality. This adversely affects their mental health. Many undergo bouts of depression. Eventually, when they start accepting themselves and develop a supportive network of family, friends, colleagues, their mental health significantly improves. Having gay friends who are comfortable with their sexuality, supportive parents, access to safe and healthy spaces, e.g. organisations working for the gay community, are essential in this journey of self-acceptance.

When the person comes out to his parents, the parents' first reaction is usually of shock and hurt. Those who do not have

scientific knowledge of the issue may believe that this is a fad or a passing phase. Some coerce the person to marry, stating, “Once you get married, everything will be all right.” Marriage does not make everything all right. It makes matters worse.

It takes time for the parents to come to terms with their child's sexuality. As the son or daughter comes out to their parents, the parents' painful journey of denial-anger-bargaining-depression and lastly acceptance- the final stage of accepting their son/daughter, starts. This is a very challenging time for them.

Parents worry about their child's future: Who will take care of their child in old age? They are upset that they won’t gave grandchildren. They are also concerned about how society will treat them, if the truth is out in the open.

Since parents are uncomfortable discussing this topic with relatives or neighbours, they have very few social support structures. They need support systems to assist them in dealing with the situation- assistance of a Psychiatrist or a Counsellor. It helps if they can read about the issue in vernacular language, speak to other parents who have accepted his/her gay child, interact with LGBTQIA organisations.

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MAYUR

Gay male, age 35

I was well aware that the decision of marrying a girl was mine and mine alone, and I would have to live with the consequences. I had to prepare myself mentally to deal with my marriage to a woman and all the complexities of living a dual life. On the other hand, if I decided not to marry a woman, I would have to deal with the challenges of living, if it comes to that, alone, all my life.

I was also afraid that if I were to come out to my parents, would they disown me? I was worried, scared. But as I looked at the photo of the girl they had proposed for a match, I felt it was unfair to cheat the girl for my selfish need for societal acceptance. The issue of my being gay was mine, and I would have to own it alone.

After a lot of thought, I decided to come out. Yes, it was challenging, and for days, I brooded over the strategy of coming out, who to, and waiting for the right moment.

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My mother instinctively realised that I was under immense stress. One day, in the afternoon, when only the two of us were in the house, she came to me. I was lying on the bed, staring at nothing. She asked anxiously, “Why are you so stressed? Are you tense because of the marriage proposal? There is no hurry to finalise a match. We will only proceed after we get a go-ahead from you.”

I was unable to utter a single word, and seeing my helplessness, she hugged me. I lost self-control and started crying like a baby. As I sobbed, I said, “I don't want to marry, not this girl or any other girl. I don't like girls. I am gay. Will you disown me for being gay? I won't be able to live without you, dad and sister.”

Mom assured me, “Don't you dare to think on these lines. No one is going to throw you out of this home; you will be with us. Period.”

Mr ANIL

Father of a gay son, age 54

My son was in the 4th year in IIT and had come home for vacation. It was then that he announced to his mother and me that he is not heterosexual. I was surprised, and I asked him, “Are you sure about what you are saying?” “Yes.”

His mother, too, asked him a few questions. I don't remember what they were, but my mind was in a tizzy. I had a little bit of knowledge about homosexuality, but I had never thought that this topic would suddenly crop up in my life in this manner. His mother assumed that it was a fad that would recede after a while. But I was not so sure.

After he went back to IIT, his mother and I tried to grapple with this unexpected information. I started reading all the relevant information on the topic from newspapers and magazines. Yet, I was unsure whether the information given was accurate and trustworthy. But the little information I got on this topic convinced me that being gay was completely natural. It was irrelevant to judge it as right or wrong.

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But the questions arising in my mind were not only related to it being natural or unnatural. The issue was, who should I approach for more information on this topic? When I approach a person, what should I tell the person? That I want this information just out of curiosity? And if he responded by asking- 'For whom do you want it?' or 'Why do you want it?' How do I answer?

On another front, relatives too had started inquiring- When is my son going to get married? What should I answer them?

As his parents, we were scouting alien terrain. I firmly support my son, but I know his mother is desolate. But to tell the truth, though I claim to be a strong supporter, as a father, a concern gnaws me all the time- Will my dear son, be happy?

Though I am worried, I am happy to note that my son is completely comfortable with his sexuality and has accepted it very well. And that is a significant relief for me.

Notes and References

[1] The layperson confuses homosexuality with paedophilia. These two are totally different terms. In homosexuality there is emotional and sexual attraction to adult persons of the same sex. Paedophilia is a sexual attraction to children, usually to pre-pubescent children.

[2] Shorter Oxford Textbook of Psychiatry.

Michael Gelder, Richard Mayou, Philip Cowen. Fourth Edition. Chapter 19.

… Subsequent estimates suggest that a more accurate figure may be nearer 3% of men and 1% of women are exclusively homosexual. (Gagnon and Simon, 1973; Laumann et al, 1994).

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NALINI

NALINI "My religion says I am a sinner."

Background

Nalini's parents were shocked when Nalini came out to them as a lesbian. She was 17 years old. Nalini's parents came from a very religious background and set about finding a doctor who could 'cure' Nalini. They found one who guaranteed a cure, and over two years, he proceeded to 'treat' Nalini. Nalini suffered a lot but was determined to go through this as she deeply desired to change; she did not want to be a sinner in the eyes of God.

But even after two years of 'treatment', there was no change. Now an adult, Nalini approached a Counsellor without the knowledge of her parents.

Nalini's Case

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While Nalini's negative perception of her sexuality was due to the religious environment, the previous doctor's attempts at a 'cure' had made matters worse. The doctor insisted that there was a cure, and Nalini was desperate for one.

After a couple of sessions where the Counsellor explored Nalini's beliefs, the Counsellor discussed the scientific understanding of homosexuality with Nalini. She then explained that homosexuality was not an illness or a disorder. Just as no one can convert a heterosexual person to a homosexual person, one cannot convert a homosexual person to a heterosexual. So, there was no question of a 'cure.' She provided Nalini with the Position Statements of IPS and WPA, on Sexual Orientation and Gender Identity. (Refer Appendix A and Appendix B.)

She then asked Nalini to read a few books on LGBT. But Nalini was afraid her parents would catch her reading books on LGBT issues. The Counsellor then referred her to a couple of lesbians who were willing to share their experiences with Nalini.

After one and half years of counselling, attending lesbian support group meetings, Nalini slowly started to accept that being a lesbian was a normal variant of sexuality. Nalini attended an LGBTIQA event- *Advait* Pune Queer International Film Festival, where she saw, for the first time in her life, *'Sancharram'* a feature film based on a lesbian love story. The film turned out to be cathartic and moved her to tears. She identifies that as a turning point in her life.

A couple of months later, Nalini invited her parents for a session with the Counsellor. Her parents were furious that Nalini had stopped meeting the previous doctor and had been meeting the new Counsellor on the sly.

Nalini's Dad: *But the last Psychiatrist stated that he would cure her.*

Counsellor: *Has that happened?*

Nalini's Dad: *No, but the Psychiatrist blamed Nalini for it. He said she is not serious and is not co-operating.*

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Counsellor: *From what she has told me, she has done everything to change herself.*

(Nalini's parents are quiet.)

Counsellor: *There is no cure—a few doctors and Counsellors promise a cure because of their homophobia, ignorance, or commercial reasons. But there is no cure because there is nothing to cure. It's not an illness.*

Nalini's Mom: *We will get her married. Once she has a kid, everything will be all right.*

Counsellor: *That would not be a good idea. A man having sexual relations with your daughter will be a 'corrective' rape. The marriage will*

be a disaster, and the husband will suffer too. If a child is born, the child will suffer too because of the marital discord.

The Counsellor added, “If we would not desire our straight daughter to marry a gay man, why would we want to marry our lesbian daughter to a straight man? Would it not be cheating the man? Even if you disclose her sexuality to the man and he agrees to marry your daughter, try to imagine the trauma your daughter would face. If you care for your daughter, let her be.”

Finally, the Counsellor suggested that Nalini's parents take counselling sessions to accept Nalini's sexuality. Furious at the suggestion, Nalini's parents left.

Last heard, Nalini had left her house and was staying in a hostel whilst working in an NGO. Her parents want her to come back home as relatives and neighbours have started questioning Nalini’s absence. But Nalini is not ready to go back; her parents want her back not because they have accepted Nalini but because of societal pressure.

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The Science

In 2020, a lesbian in her twenties from Kerala died by suicide while undergoing a forced unethical 'cure' at a 'rehabilitation centre' in Goa to convert her to heterosexuality.[1]

The Position Statements by Indian Psychiatrist Society (IPS) and World Psychiatrist Association (WPA) state that homosexuality is not a disorder or illness. They state that such purported cures are not only ineffective; they cause harm to the client. It is unethical to recommend or practice 'conversion therapy.'

Mrs RESHMA

Mother of a lesbian daughter. Age 55

When I told my daughter, on the phone, that a friend of your family is checking her horoscope for match-making, she started crying.

Anxiously I asked her, “What's wrong? Have you found a partner? Do you want us to wait a while before we start looking for a groom? Don't worry. We won't force anything on you.”

It was then that she told me about this (*that she was a lesbian*.) I was shocked.

But since she was staying alone, away from us, I tried to control myself. I knew that at this crucial moment, she needed her father and me the most. If I were to break down at such a time, who would support my daughter, all alone, so far away?

As always, God gave me strength, and I told her, 'You are not alone. We are with you. Remember, we will always stand by you.'

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Later on, I watched an interview of the gay activist Mr Bindumadhav Khire by the TV anchor Renuka Shahane on a TV channel- ‘*Yala Jeevan Aise Naav*' (This is life!.) I told my daughter about it. She, too, watched it on 'YouTube.'

A few months later, we met him. He spoke to us at length. I read his book- '*Indradhanu*' (Rainbow- Different colours of Homosexuality), written by him. After talking to him and reading his book, my perception started changing.

Today, I am happy to say that I have accepted my daughter's sexuality. Yes, it took me a while to get to this stage, but I have! And I am proud of that.

Notes and References

[1] Kerala student's suicide puts focus on dubious 'conversion therapy.'

Hindustan Times, New Delhi. By HT correspondent. May 18, 2020.

https://www.hindustantimes.com/india-news/kerala-student-s-suicide-puts-focus-on-dubious-conversion-therapy/story-fmgMhK8nFVUuddV97xvDXN.html

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PART IV: INTERSEX

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PRIYA AND MADHAV's BABY

GRANDMOTHER "Surgically alter my daughter's child to male."

Background

Priya and Madhav were looking forward to becoming parents. Priya had asked her mom to move in with them for a month to assist her. Madhav, too had taken two week's leave to be with Priya. There was a lot of tension and anxiety for the safety of the mother and the child.

It was noon when Priya felt the first cramp. Immediately, the family rushed her to the hospital, where Priya was registered for delivery. But it was a full eight hours of hand-holding by her mother as she timed Priya's contractions before Priya was ready to be taken to the delivery room.

Madhav couldn't stand to see Priya in pain and sat in the lobby, anxiously inquiring with the nurse or doctor every time they came to examine Priya.

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The baby was born at 9.11 pm the same day. Both Priya and baby were safe. The Gynaecologist asked for Madhav. Priya's mother immediately asked, "Is it a boy or a girl?" The doctor pretended not to have heard her and ushered them to a cabin and closed the door.

Madhav sensed something amiss in the doctor's mood. "Is Priya safe?" The doctor replied in the affirmative. "Is the baby safe?" "Yes.. but… right now, we are unable to tell you whether it is a boy or a girl."

Shocked, mouth ajar, Madhav looked at the doctor. "I… I don't understand…."

"See, the baby has some external organs of a baby boy and some organs of a baby girl."

"Huh? How is that possible?"

"Yes, in rare cases, it is possible. We will have to do some tests before I can tell you more."

"But... But..."

"You can speak with the hospital Counsellor a little more about this. She will give you more details. I will inform her that you will be seeking an appointment with her."

Case of Priya and Madhav's baby

The Counsellor heard them out with empathy. She told them that whatever they were feeling was normal. In times such as these, the family and especially the new parents felt very vulnerable.

The medical reports noted that the baby had no Uterus, an enlarged Clitoris, and Testes inside her partially fused Labia. i.e., the baby had ambiguous genitalia. The chromosome test (Karyotype test) showed sex chromosomes XY.

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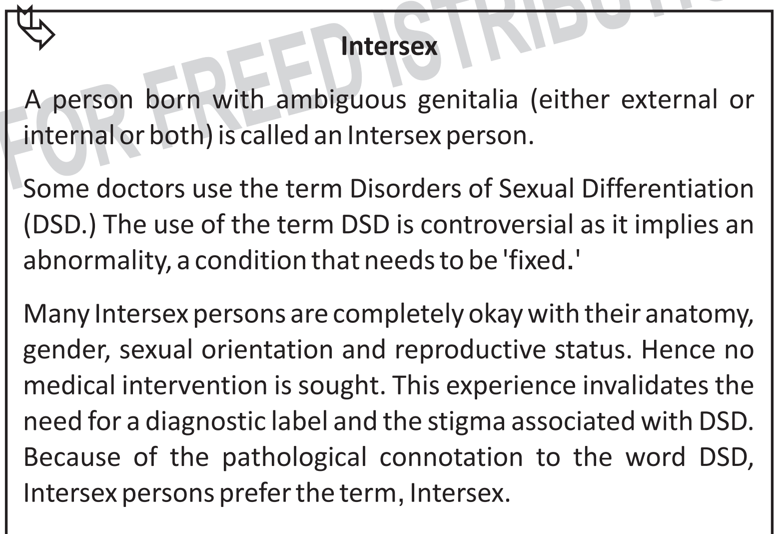

Intersex

A person born with ambiguous genitalia (either external or internal or both) is called an Intersex person.

Some doctors use the term Disorders of Sexual Differentiation (DSD.) The use of the term DSD is controversial as it implies an abnormality, a condition that needs to be 'fixed.'

Many Intersex persons are completely okay with their anatomy, gender, sexual orientation and reproductive status. Hence no medical intervention is sought. This experience invalidates the need for a diagnostic label and the stigma associated with DSD. Because of the pathological connotation to the word DSD, Intersex persons prefer the term, Intersex.

Priya's mom: *We had never imagined....*
(overwhelmed, Priya's mom starts crying)

Madhav: *We simply do not know how to deal with*

	the situation. I don't know what to tell our relatives. We have told them we have a baby boy.
Priya's Mom:	*(distraught) Why us? What did we do wrong?*
	(Avoiding Madhav's eyes) Her mother-in-law will blame her.
Madhav:	*(looking at her) No… No… I will talk to her. No one is blaming anyone. Ok!*
Priya's Mom:	*You always take Mom's side.*
Madhav:	*(angrily) Now listen…*
	(The Counsellor interrupted them.)
Counsellor:	*We will discuss this when we come to this step. Let's start from the beginning.*

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Generally, in such cases, the father is worried that people will question his manhood. The mother is concerned that the in-laws would blame her. She is also worried whether relatives will pressurize her to abandon the baby. All the parties involved need to understand that no one is 'responsible.'

These are some of the million other variations that occur in nature. So, no one is at fault, and no one should feel guilty.

Madhav asked, "I am worried about the baby's future." Priya's mother interrupted him. "Surgically alter my daughter's baby to male."

The Counsellor explained that the first thing that the parent needs to understand is that, unless the child has a life-threatening medical condition, it is not advisable to go for such surgery. For example, if the child does not have a urethral opening, it will need to be surgically created.

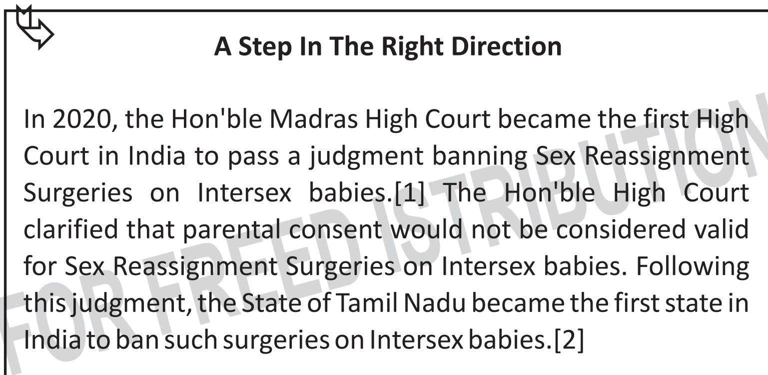
Some parents select the gender of the baby and ask doctors to surgically remove organs that are not in sync with the gender they have chosen. Some doctors do such Sex Reassignment Surgeries.

But it is not advisable to take this approach for two reasons:

(a) We do not know the gender of the baby. e.g. if we call it a girl and remove the male sexual/reproductive organs, and later on as the child grows and expresses male gender, we would realise too late that we made a mistake.

(b) There are times when such surgery has adverse side effects that manifest after the child reaches puberty because that is when the genitals rapidly grow and respond to sexual stimulus.

So, it is advisable for parents and their extended family not to go in for Sex Reassignment Surgery on their newborn baby.



A Step In The Right Direction

In 2020, the Hon'ble Madras High Court became the first High Court in India to pass a judgment banning Sex Reassignment Surgeries on Intersex babies.[1] The Hon'ble High Court clarified that parental consent would not be considered valid for Sex Reassignment Surgeries on Intersex babies. Following this judgment, the State of Tamil Nadu became the first state in India to ban such surgeries on Intersex babies.[2]

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Priya's mother insisted on the surgery, but Madhav being the rational one, responded, “Then, as parents, what do you suggest?”

Raising an Intersex Child

The Counsellor referred them to recommendations given by Dr Milton Diamond on raising an Intersex child.[3]

1. Since the parents do not know the gender of the baby, assign a tentative gender to the baby- boy or girl. Have that gender reflected in the legal documents.
2. Name the baby gender appropriately or, if possible, name the baby with a gender-neutral name.

3. Raise the baby in conformity to the gender assigned. e.g. clothing, toys etc.
4. Do not coerce/force/manipulate the baby into any gender-confirmative role.
5. Love and care for the baby as you would any other baby.

A Definite No!

The shock can lead to parents seeking remedies from quack, doctors, superstitious parents seeking remedies through *devrushipan*, and *jadutona*. This is completely useless! And best to be voided.

Till the age of 0 to 3 years, the child has little understanding of Intersex, and the child will grow like any other child. Gradually as the child sees genitals of same age boys and girls and starts to compare their genitals with one's own (e.g. while peeing or playing 'Doctor'), the child and the other children will start noticing the difference.

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The child will ask their parents, “Why am I different?” or “When will I become like them?” In such cases, the parent can reply, “Each one of us is different in different ways. You too are different, and that is nothing to worry about.”

Supervision and Support

If others know about the genital ambiguity, the child has a greater likelihood of being teased or ragged. So, the parent/guardian must ensure that the child is always supervised and periodically reassure the child that he/she is just fine.

As the child grows (Age 4 to 14), he/she/they will start expressing some gender traits. Some of these traits will evolve and grow stronger as days go by, while some other traits will regress. During

this time, the child may see himself/herself/themselves as an outsider. The questions will be more persistent, and the child may aggressively seek answers.

It is important not to avoid answering the questions. Answer the child honestly, factually, in a simple age-appropriate language they understand. While the parent should take care not to dramatise the situation, they should not trivialise it either. Since it is a difficult and challenging task, they can seek help from a LGBTIQA inclusive Counsellor who could work with the child to provide answers.

A typical answer could be, ''In some instances, babies are born with both organs, male and female. You are one of them, but certainly not alone. Over time you will get to meet others, and we will all try to find friends for you who are like you, but it will take time."

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In adolescence, the issue of legal identification and Gender Affirmative Treatment in concordance with the person's gender identity may arise.

You could say, "We feel that this is a decision you can take when you are an adult, and we will always support you. We are okay with whatever you decide and will help you. By then, you would have had time to understand yourself better, get information from various sources, and you will have more clarity on these issues. You can live your life the way you want, as a male, a female or as an Intersex person."

At adolescence, the person will start experiencing sexual desire. Some may be attracted to men, some to women, some to both, and some to neither. The urge to seek a relationship will remind them that they don't know anybody who will accept their intersex body. As the need for intimacy grows, the more alone, and unwanted they may feel. As they see their friends, colleagues pairing with each other, they will feel like an outsider and a misfit.

The person may withdraw in a shell, get depressed, lose focus in

studies, hobbies. Some may hate themselves and become anti-social, rebellious. At times the hurt will be directed towards their parents, and some may resort to self-harm. **It is crucial for parents to dialogue with the child and let them know that they are accepted and loved.**

It would help the person to find a way to vent these pent-up feelings by-

- Periodically talking to a LGBTIQA inclusive Counsellor or therapist.
- Helping them to find friends, organizations that work on Intersex issues. It is important to find friends with whom they can easily form a kinship. They will learn from each other, share their experiences, and it will help concretise their subsequent steps related to Gender Affirmative Treatment.

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It is important to note that not all adult Intersex persons desire to undertake Gender Affirmative Treatment. There are quite a few who accept their body as is.

Some may desire a part of the transition, but not all. e.g. An Intersex person with some male organs, no breasts, and whose gender identity is female may desire breast enhancement but may not want to remove male sexual/reproductive organs.

Finding a partner who accepts you, is not easy. Being Intersex carries a lot of social stigma, so most are unwilling to identify themselves, publicly, as Intersex. Nevertheless, with the increasing availability of social media platforms, it is becoming easier for Intersex people to communicate with others.

As far as reproductive ability is concerned, each Intersex person will have a different presentation of sexual/reproductive organs, maturity, and functioning. A few will have reproductive ability, a few may gain reproductive ability through hormones or surgery, and some will never get reproductive ability.

Intersex Persons and the Law

The Transgender Persons (Protection of Rights) Act, 2019 provides the framework for every Intersex person to legally identify as male or female or as a transgender person. (Refer Box 'Transgenders and the Law.' Chapter: Aishwarya.)

The Science

We are taught that our body can have only male or only female sexual/reproductive organs. If the newborn baby has male sexual/reproductive organs, the baby is called male; if the newborn baby has female sexual/reproductive organs, the baby is called female.

Since statistically, almost all the people are either anatomically only male or only female, most have never come across anyone whose anatomy challenges this prevailing notion.

But the scientific truth is that there are a few babies born with ambiguous sex chromosomes/Gonads/genitalia.

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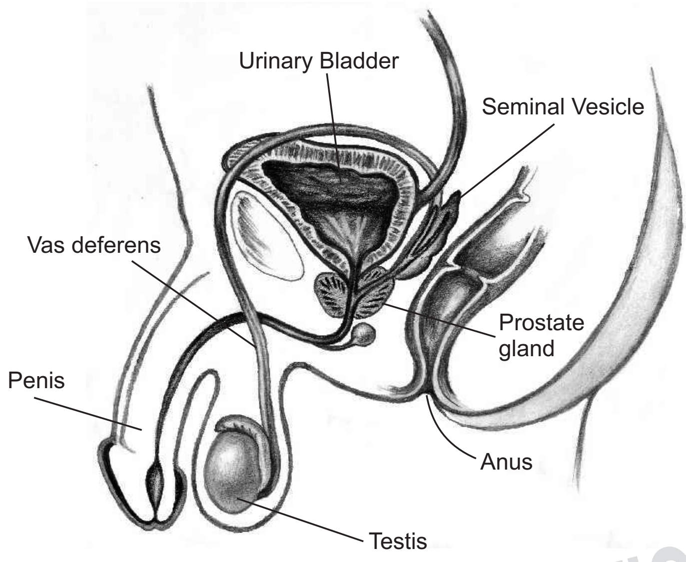
Anatomy

We have some sexual/reproductive organs which are outside of the body and hence visible. For males, these are the Testes and Penis. For females, these are Clitoris, Vulva, and vaginal opening.



Male sexual/reproductive organs

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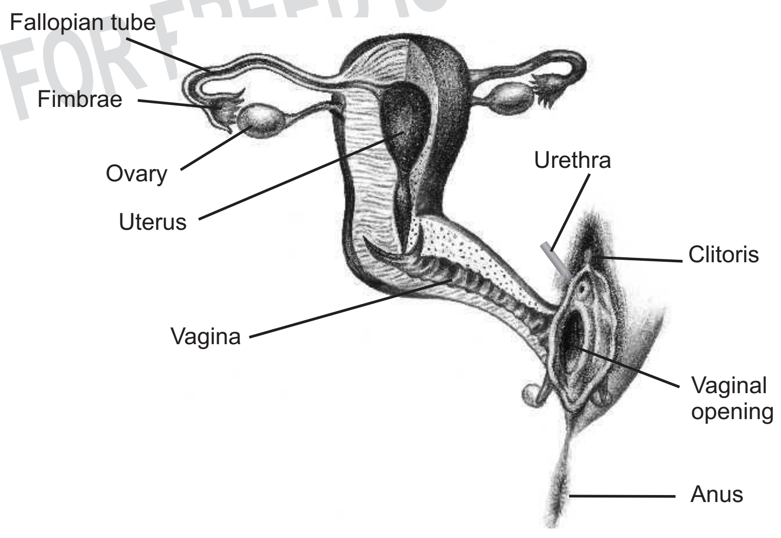

Female sexual/reproductive organs

Some sexual/reproductive organs are inside the body and not visible unless assisted by medical technology, e.g. sonography. For males, these organs are- Vas Deferens, Seminal Vesicles, and Prostate Gland. For females, these are- Vagina, Cervix, Uterus, Fallopian Tubes, and Ovaries.

For an Intersex person, the external reproductive organs or internal reproductive organs or both may be ambiguous. In rare cases, there may be presentations where the baby may look of one biological sex externally but could have a reproductive organ of the opposite sex internally. It means that in rare cases, the parents or the person himself/herself/themselves may not be aware of the internal ambiguous presentation.

Here we would like to emphasise that in many cases, Intersex variations are minor and do not affect sexual or reproductive function. In some cases, the Intersex variations may remain undetected throughout the lifespan. In some instances, Intersex variations are not detected in infancy or childhood but manifest in adolescence when there is a surge of hormones.

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How do genitals form?

To understand how a human being is created, let's use a simple analogy of building a house. When we decide to build a house, we first procure a blueprint of the house. Then we get the materials- cement, bricks, steel, etc. Then we get the transporter to take the materials to the site. At the site, the masons start building the house, using the raw material.

If we consider creating a baby as building the house, the genetic material (chromosomes) is the blueprint. Various hormones are the raw material, cells are the masons, and the cell receptors (doors for hormones to enter and leave the cell) are the transporters.

Chromosomes

Our body is made up of billions and billions of cells. Barring certain

exceptions, each cell has a nucleus. The nucleus has genetic material. The genetic material is the blueprint, i.e. a set of instruction manuals on how the baby will grow, develop, and mature.

Each of these instruction manuals is called a chromosome. Generally, 23 pairs of such instruction manuals (total 46 chromosomes) are present in the nucleus of each cell. We have used the word generally, intentionally; male Sperms and female Ova have a different count of chromosomes. Each male Sperm and each female Ovum have only half of these chromosomes or instruction manuals. i.e. 23.

The 23rd chromosome in each Ovum and Sperm are the sex chromosomes. They dictate the growth and development of male or female sexual/reproductive organs. In each female Ovum, the 23rd chromosome is always X. It is never Y. But, of the millions of male Sperms, about half have the 23rd chromosome as X, and the other half have the 23rd chromosome as Y.

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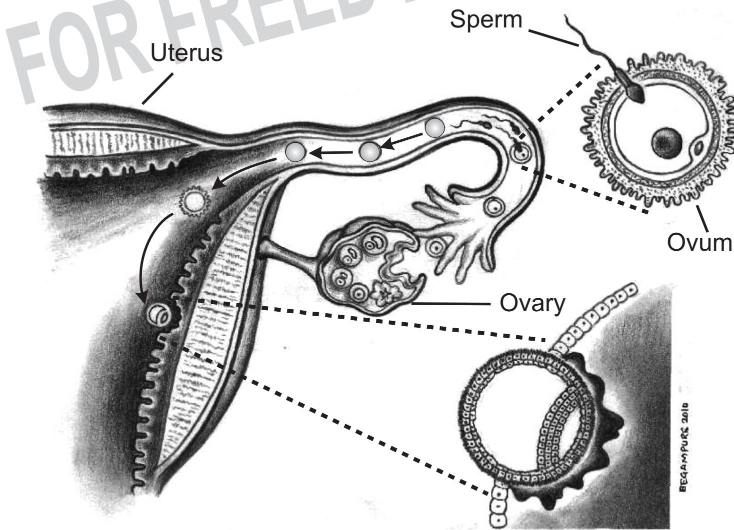

Fertilisation

Fertilisation

When one male Sperm and one female Ovum fuse during fertilisation, the result is a cell with 23 pairs of chromosomes (i.e. 46 instruction manuals)– 23 chromosomes from the Sperm and 23 chromosomes from the Ovum.

Since half the instructions of development of the baby come from the father and the other half from the mother, we see that the baby may present distinct characteristics of their parents– 'Oh! He has curly hair like his father and skin colour like his mother.'

So, it follows that, after fertilization, the 23rd pair of chromosome 45 and 46 will be either XX or XY. One X of the pair comes from the mother, and the other half of the pair, which can be either X or Y, comes from the father. These two sex chromosomes together provide instructions for the development of the genitals. The XX pair provides directions for developing female sexual/ reproductive anatomy, XY provide directions for developing male sexual/reproductive anatomy.

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Can a woman make a male baby without a Y chromosome from the male?

Women do not have a Y chromosome in their Ovum. The Y chromosome has to come from the Sperm, which comes from the male, to make a male baby. So women do not have the mechanism to make a male baby.

Development of Genitals

After fertilisation, the fertilised Ovum starts cell replication and moves towards the Uterus, settles in it, and the foetus starts to develop.

Eventually, two systems get created in the foetus: Wolffian ducts which can develop into male sexual/reproductive organs, and Mullerian ducts, which can develop into female sexual/ reproductive organs.

Suppose the fertilised Ovum has the 23rd pair of sex chromosomes as XX. In that case, the Wolffian ducts, which could develop into male sexual/reproductive organs, regress. The Mullerian ducts develop into female sexual/reproductive organs. The Gonads develop into Ovaries.

If the fertilised Ovum has the 23rd pair of sex chromosomes as XY, the Mullerian ducts, which could develop into female reproductive organs, regress. The Wolffian ducts develop into male sexual/reproductive organs, with the crucial contribution coming from the Y sex chromosome. The Gonads develop into Testes.

Hormones

Using the previous analogy, the materials used to build a house depend on the type of house we decide to build, e.g., wood, cement, etc. Similarly, specific hormones created in the foetus assist in developing the male or female sexual/reproductive organs. E.g., in the development of a male baby, various hormones of the Androgen class e.g. Testosterone play a significant role in developing the Penis. During the growth of the foetus, specific amounts of specific hormones are produced by the foetus at specific times for a specific duration.

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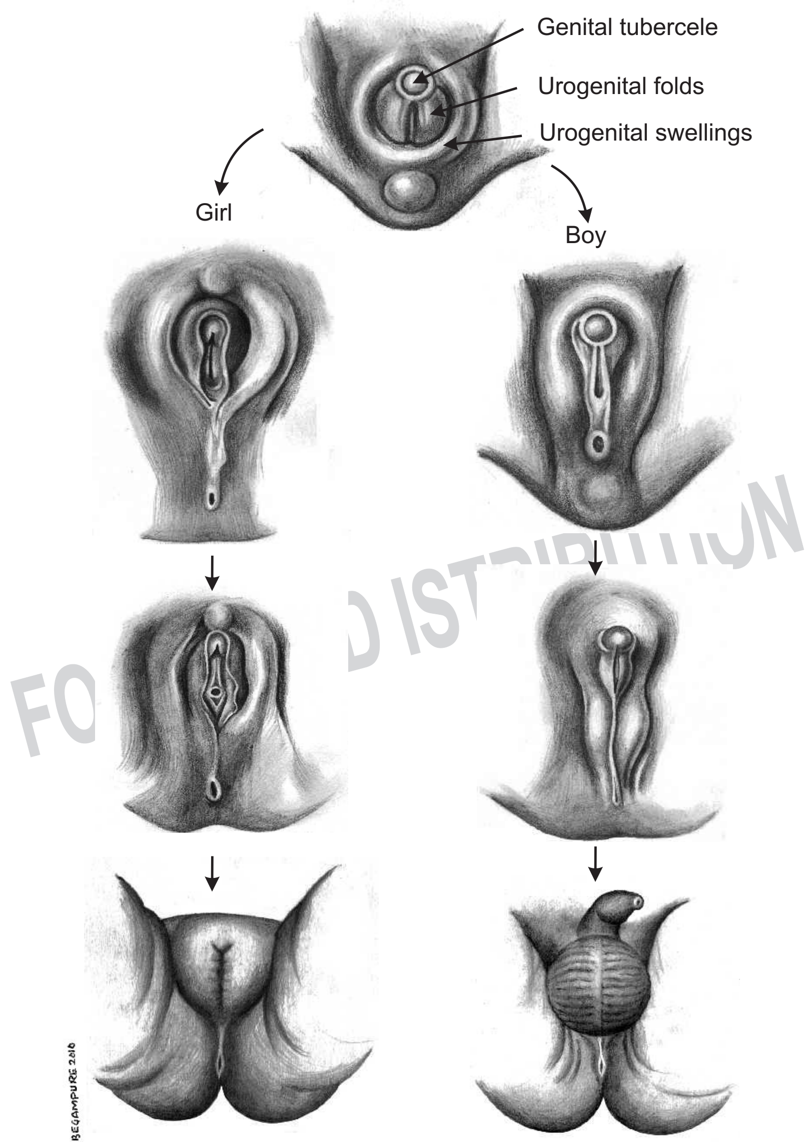
The various hormones are transported through the receptors into the cell, and then the cells use the hormones.

So, all of these components- sex chromosomes (the blueprint), hormones (material), cell receptors (transporters) and cells (masons) work together for the growth and development of the male and female genitalia.

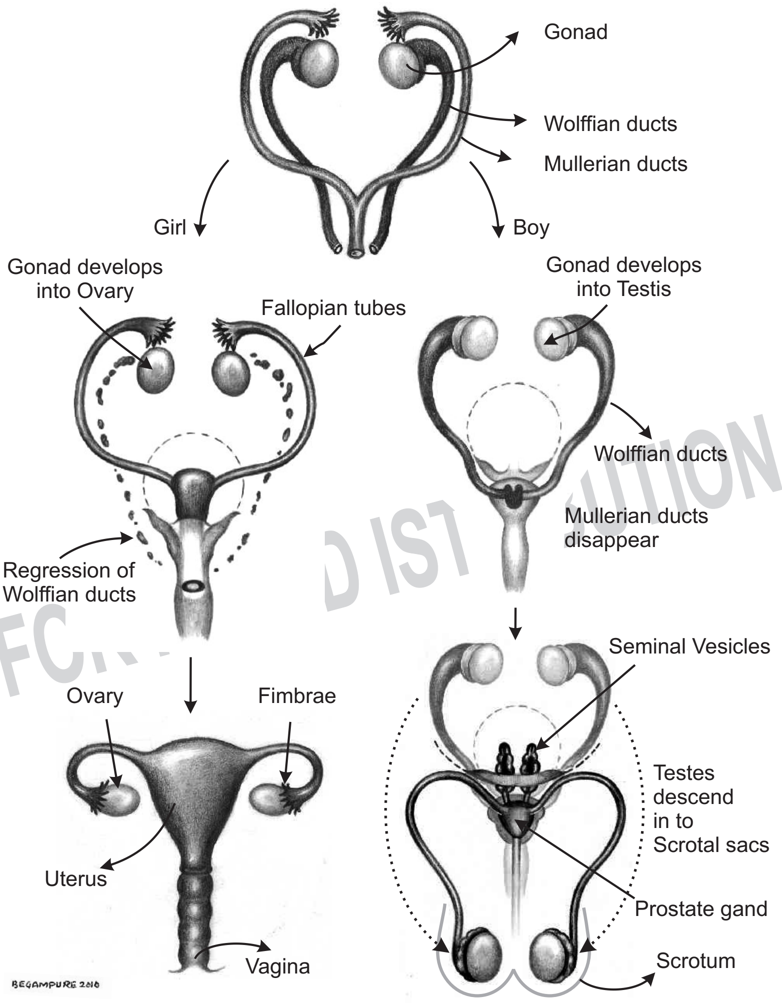
Intersex

On rare occasions, the above mechanism undergoes some variations, some examples of which are:

- A person may have three sex chromosomes instead of a pair of sex chromosomes (XX or XY). i.e. a total of 47 chromosomes in



Formation of external genitalia



Formation of internal genitalia

each cell instead of the usual 46 (Klinefelter Syndrome.)

- A person may have one sex chromosome instead of a pair of sex chromosomes (XX or XY) i.e., a total of 45 chromosomes in each cell instead of the usual 46.

- In some cases, the sex chromosomes are XY, but the Androgen receptors are insensitive to Androgens. (Refer Chapter: A Word On Hormones.)

- In some cases, more quantity of Androgen hormones are secreted than what is required. (Refer Chapter: A Word On Hormones.)

In the examples given above, the development and growth of the genitals will be affected, and at times, the presentation may noticeably vary from the typical male and female body.

Statistics

To get a general idea, the birth of an intersex child occurs in fewer than 2 out of every 10,000 births.[4]

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Note:

Very little survey and research has been done on Intersex issues in India, so very little is known about India specific statistics.

Difference between Under-developed Sexual/Reproductive organs, Absence of a Sexual/reproductive organ, and Intersex

(a) Under-developed Sexual/reproductive organs

This generally implies the development of all the reproductive organs of a male or female but, they do not grow and mature to the full extent. So, some of the sexual/reproductive organs may not be functional or are partly functional. As there is no ambiguity in the sexual/reproductive organs, such persons are not considered Intersex persons.

(b) Absence of a Sexual/Reproductive Organ

Absence of a sexual/reproductive organ does not necessarily mean that the person is Intersex.

Example: Absence of a Uterus in a woman does not mean she is Intersex. The question to ask is, does the person have sexual/reproductive organs or chromosomes or gonadal development, which is ambiguous? If not, then the person is not Intersex.

VAISHALI

Intersex, age 35
Preferred pronouns : she/her

I was born in a small village in Maharashtra. My father immediately noticed that my genitals were different (*Androgen Insensitivity Syndrome*) from the norm. He consulted a quack doctor in the village, who advised that the genitals will normalize with time.

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When I was in the 9th standard, my mother insisted that I see a doctor. I refused because I was terrified. I was afraid that people would start calling me a *Hijra*, if it got out that I was anatomically different. I knew there was no acceptance for people like me in society.

It was a while before I started to accept that I am not and will never be like other girls. I kept asking myself- Am I alone in this world? Are there other persons like me? Why can't I live the life of a normal girl?

All of this badly affected my life, and I lost my self-confidence. I got depressed. I knew no one who was like me, to share my feelings, express myself. I needed someone I could trust. I was going through this turmoil alone, all the while taking care to hide my feelings.

To deal with my depression, I started reading spiritual literature and autobiographies. They gave me some confidence. I began to realise that there must be some reason that I was created differently. If I was like others, then my life would have been of the usual dreary kind. Here I had a chance to do something different. I became ambitious and started studying.

I am now known as a well-educated and wise person. The villagers don't know that I am different, but they admire me for making a name for myself in my village.

A few of my relatives know that I am different, but they always treat me as one of them. They respect me, periodically take my advice as and when required, and admire me for taking charge of my life.

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Summary

Some children are born with body structure where genetic sex, external and/or internal sexual/reproductive organs do not conform to a single biological sex.

The most important decision at birth is usually– What will be the gender of the new-born?

The answer is based on several factors– external appearance, future chances of gonadal tumours that may have to be removed, and changes expected at puberty and fertility.

A detailed physical examination can give a general idea of the external presentation. Chromosomal studies, hormone studies, sonography, and CT/MRI tests are used to understand internal presentation. Rarely specialist examinations like laparoscopy or hysteroscopy are needed.

At the end of all this (usually a few weeks), doctors and parents can have a meeting to determine the gender for official purposes and how the parents would raise their new-born. The parents at this

stage must be counselled that none can predict gender identity of the baby. It helps to be open about this issue as the baby grows. Nurture the child to develop naturally.

Which child requires detailed evaluation?

A detailed evaluation is needed if the doctors observe any of the following in the new-born:

1. Bilateral non palpable Testes
2. Severe Hypospadias
3. Any degree of Hypospadias with Cryptorchidism (very small Testes)
4. Clitoromegaly (width more than 6mm and length more than 9mm)
5. Posterior Labial fusion
6. Single Urogenital Sinus
7. Palpable Gonads in Labio-scrotal fold
8. Any other appearance that creates doubt

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Notes and References

Authors Dr Bhooshan Shukla and Bindumadhav Khire are grateful to Dr Uday Phadke for reviewing the chapter and making significant suggestions.

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PART V: SPECIAL MENTION

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A WORD ON HORMONES

Authors: Dr Uday Phadke, Dr Bhooshan Shukla

PARENT "I cannot understand his aggression. Please check his hormone levels."

Case 1

16-year-old Manthan was in the counselling room with his father. He was unhappy to be there and did not try to hide it at all. His father was also visibly upset. Father complained bitterly about changes in Manthan's behaviour in the last two years.

Manthan had lost all interest in studies. He stopped attending tuition classes, so his academic performance was detiorating with each school exam. What was most troubling for the family was his behaviour.

Manthan was aggressive and abusive towards his mother and sister. Father was the only authority he listened to. In school, he befriended many girls one after another. Father suspected that Manthan was into physical intimacy with his girlfriends.

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"I know that boys can behave differently at this age, but Manthan's behaviour is beyond all reasonable limits. I suspect hormonal changes are making him crazy. Let us get his hormones checked." Father demanded.

The Counsellor patiently explained to him that hormonal tests would not prove anything useful. But Manthan's father was adamant, and he went ahead on his own to get a hormonal test done. As expected, all results were within the normal range.

Case 2

24-year-old Smita was brought to a Gynaecologist by her mother. Smita had a good job, and her family was now keen to get her married, but Smita refused marriage and declared that she wanted to live her own life and that she had no desire to get married. Immediately, the family consulted the trusted family

Gynaecologist to find out if anything was wrong with Smita's "hormones."

Case 3

20-year-old Arpan was brought to the family physician's clinic to discuss a delicate issue. He revealed to his family that he is sexually attracted to other men and has no sexual interest in women. His parents wanted the doctor to prescribe a hormonal evaluation to determine if "wrong hormones/hormonal changes" were causing Arpan to behave in such a manner.

Case 4

16-year-old Jyoti feels uncomfortable in her female body; she perceives herself as a man and wants to live life as a man. She is deeply uncomfortable with her monthly menstrual cycle. She wants to stop the menstrual cycle completely and explore hormonal therapy. Her parents want a hormonal assessment to determine why she feels this way and give hormonal treatment to change her perception.

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Case 5

19-year-old Ishaan was brought to a family doctor as he had not developed facial hair, his voice was still childlike, and he had a very thin frame. Physical examination revealed no body hair, less muscular frame, small Penis and Testes.

Case 6

18-year-old Bhavana was brought to a Gynaecologist as she had not started menstruating yet. She had almost no breast development.

Bhavana and her mother want to conduct hormonal assessments to determine what is happening with her body.

Case 7

22-year-old Sai consulted her Gynaecologist about her menses. Her menses lasted for just two days with little flow and happened

once in two or three months. She also reported a reduction in breast size over the last two years.

After detailed discussion, the doctor found out that Sai had started professional athletic training four years ago and chose long-distance running as her event. She already ran a half marathon, and she was training to run a full marathon over the next year. She had lost thirteen kilos over the last two years on her coach's advice and exercised for two hours every day with a 10KM run on Saturdays and Sundays.

And so on…

These are typical scenes in clinics of Endocrinologists, family doctors, Gynaecologists, Psychiatrists, and Counsellors. It is common to see parents, adolescents, and post-teen children consulting clinicians/Counsellors for various issues related to behaviour, sexual function, gender, and sexuality. Parents believe that "hormonal imbalance" is the cause, and appropriate investigations and hormonal treatments will solve the problem.

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By now, you know clearly, that the first four cases are not associated with the need for hormonal assessment. The next three require hormonal tests, sonography and other non-invasive investigations to learn more about the anatomy. Underdevelopment of sexual organs and absence of secondary sexual characteristics are clear indicators for further investigations.

Preferring friends over family, verbal aggression, loss of focus on academics, sleep and appetite variations, feeling intense sexual attraction for someone, exploration of sexuality are all common and typical manifestations of adolescence. It may extend into early adulthood as well. Most parents understand this well, but some are seriously upset by their child's behaviour and want to find the source of this trouble. "Hormonal changes and imbalance" is a favourite peg to hang parental difficulties with their youngsters.

How would a professionally qualified Psychiatrist respond to such demands?

If the sexuality and sexual identity of the person are in question, the Psychiatrist should always start with a confidential and non-judgmental discussion with the young person alone. If confidentiality is guaranteed, most young people are happy to discuss their sexuality-related issues with the Psychiatrist or Counsellor. If the issue is related to sexual orientation, no investigations are needed!

A thorough physical examination is needed when:

- physical development is inappropriate for age (ahead of age – precocious growth or behind age– Delayed Growth (previously known as Growth Retardation)
- mismatch of social role, physical appearance, and gender.
- doubts about genitalia, specific parts of the body (e.g., breast development, absence of one or both Testis)

These require a complete physical examination, including genital examination by a medical doctor. Gynaecologists, Paediatricians, Endocrinologists, Psychiatrists are trained for this task. Counsellors and Psychologists are not trained to do physical examination and interpret hormonal investigations.

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Things to look for in a physical examination :

- Height, weight, and blood pressure
- Muscularity
- Quality of voice
- Presence of secondary sexual characteristics
- Body hair distribution, presence of frontal balding in girls
- Presence and extent of acne (pimples)
- Genital examination for the development stage, size of organs, hygiene, and any ambiguity.
- Anosmia (inability to smell)
- Body proportion (trunk height as compared to limb height, upper segment to lower segment ratio)

Hormone Assays

Our body has dozens of hormones essential for normal function. Many hormones directly or indirectly affect sexual development. The most important thing to remember is– hormones do not influence sexual orientation, and gender identity.

A single hormone test or a panel of hormones to "find out what is wrong" is an unscientific way of going about it. After a detailed history and physical examination, a doctor will prescribe appropriate investigations (blood tests, electrolyte levels, hormone assays, challenge tests, sonography, MRI scan, biopsy, etc.) that prove specific results that will form a diagnosis conclusively. Trained specialist doctors are needed to interpret the test results and form a diagnosis.

Some conditions that require specialist investigations:

- **Congenital Adrenal Hyperplasia (CAH)**: This is one of the most common chromosomal variations seen in clinical practice. Multiple hormones, like glucocorticoids, mineralocorticoids, and androgens (male sex hormones) are secreted by Adrenal glands.

  Many enzymes are involved in the manufacture of these hormones. Any defect in these enzymes result in abnormalities in the production of these hormones.

  Abnormalities in the hormones result in women developing male patterns of hair growth and other masculine physical traits. It may present as virilization (masculinization) of a female and under virilization in some men and precocious puberty in both sexes. Some problems (primary development issues) may be evident at birth itself. Sometimes they can present later in life and can only be suspected in late adolescence or adulthood.

- **Androgen Insensitivity Syndrome (AIS)**: This is a rare condition in which a child with male sex chromosomes (46XY)

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may have an Intersex presentation. The cause is the insensitivity of the cell receptors to the androgenic hormones, which provide the masculinizing traits.

The extent of insensitivity (complete, mild or partial), affects the development of genitalia. This is evident at birth. The presentation of the condition can range from- an intersex baby at birth to only poor Sperm count detected in an otherwise typical looking male.

Complete insensitivity to Androgens in persons with male sex chromosomes (46XY) will result in an external presentation of typical looking woman with no ambiguity. They do not have a uterus and have no menses. Some may have abdominal Testes. They have normal male hormones in otherwise female appearing person. They usually do not have pubic and axillary hair. Other than these variations, these persons go through pubertal growth in a mostly normal manner.

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- **Disorders of testicular function**: Normal development of testes and their function from birth to end of life is complex. Any variation in the complex developmental sequence can lead to improper or inhibited growth affecting reproductive function. Testes are also susceptible to injuries, vascular accidents, and various tumors. All of these may not be noticed directly by the patient.

  Doctors often detect these when a patient presents with some other complaint like lack of progression of puberty, lack of adequate virilization, reduced libido/sexual function, and infertility. At times, during the histopathological examination, development of some ovarian component is seen along with theTestes. It is an example of an intersex presentation.

For Those Into Sports!

Many adolescents and young adults now engage in strict and regimented exercise and sports. Some coaches advise and even illegally administer a cocktail of hormonal pills and injections for accelerated growth of muscles and strength. It is a harmful and illegal practice. Serious complications lead to abnormal aggressive behaviour, liver failure, blood clots, genital problems, erectile dysfunction.

Doctors are reporting a rising number of cases in youths due to such ill-advised use of medications. If your adolescent child is in serious sports or bodybuilding, it is crucial to keep an eye on your child's exercise and diet plan.

Intensive training for high performance requires weight loss, exercise for two to three hours every day. In girls and women, this can reduce breast size, cause scanty or absent menses, etc. Final decisions about choice of sports and training are with the person, and they need to be informed about possible body changes.

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CHILD SEXUAL ABUSE

NILESH *"I wanted to tell my mom. But was afraid that this would be one more reason for her to be angry with me."*

Background

Tragically... No one told Nilesh that he was NOT BAD. No one told him it was NOT HIS but Uncle's fault. No one told him he was loved. No, that was wrong– there was someone who loved him.

Like his schoolmates, the boys in his neighbourhood were all bullies.

Nilesh had harangued his mom to buy the bat and ball simply to entice the boys to make him part of their team. But they demanded that he hand over his cricket bat and ball so that they could play. They then relegated him to the farthest corner of the playground to catch a wayward ball.

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For the next few months, he was relatively happy. Although he was placed at the far end of the playground, they at least didn't tease him. That was bliss. Before that, the only name they had for him was '*bailya nilya*' (effeminate Nilesh.)

For Nilesh' mom, his becoming part of the cricket team had been a bit of luck. She was tired of his whining at the tiniest slight, his inability to stand up to the usual bullying most boys face at some time or the other. She told him repeatedly not to behave like a girl; he was grown up, almost eight years old now. Her advice had fallen on deaf ears.

These days, it didn't take much for her to scream at him and hit him in anger. She had her hands full taking care of the two-year-old Neeta and could do with some help. The beatings had distanced him from her, and now he barely spoke to her, and when he did, it was in monosyllables.

It was in this background that Nilesh had sought solace in Uncle. He had seen Uncle pottering around in his garden adjacent to the

playground where he had stood, bored for hours, waiting for a ball to come his way. Uncle started small talk with him, and before long, Uncle became Nilesh's best friend.

It was while he was chatting with Uncle, that the ball came his way, and he dropped the catch. Despite being the owner of the bat and ball, the fury he had to face at the hands of the bowler, Makarand, was terrifying. He would have hit Nilesh with the bat had it not been for the timely intervention of his best friend, Uncle.

From then on, things changed. The security of being part of the cricket team ended. Soon Makarand got a gift of a bat, ball, and stumps for his birthday, and Nilesh was back to being '*Bilya Nilya*.' It was then that he started avoiding them. He would tell his mom that he was going out to play cricket, but instead he would head for Uncle's house.

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Uncle's wife was bedridden, and Nilesh saw her only once. He spent time working in the garden with Uncle or the kitchen or in the living room. Uncle was kind, generous, and well educated. When Uncle realized that Nilesh was not good at maths, he started helping him with his homework.

Their friendship soon grew, and Nilesh once took his Uncle to visit his house. Uncle brought a nice dress as a present for his little sister, Neeta and praised Nilesh a lot in front of his mother. Mom was thankful to see Nilesh happy and the fact that Uncle was helping him with his studies. With Nilesh's father working 12-hour shifts, he was more or less not around for any parenting.

It was after this visit that things gradually changed. With Nilesh's short height, he had to borrow a pillow to sit on the chair to properly read from the book placed on the table. But that pillow was missing one day. Uncle was seated on the chair and lovingly pulled Nilesh on his lap. Nilesh had been embarrassed but secretly delighted at Uncle's affection.

The following week, Uncle had accidentally spilt hot tea on Nilesh' clothes. He had started unbuttoning Nilesh's shirt ignoring his

protests. “I need to wash the clothes. We don't want permanent tea splotches on your clothes. Your mom will scold me *beta*, she may even beat me, you know her.”

As Nilesh tried to protest, Uncle had swiftly pulled down his shorts. Embarrassed, he was about to start crying, but then Uncle pulled him close and kissed him gently on his forehead and hugged him lovingly, mitigating his unease. “All my children have left me. Except you, there is no one who cares for me. You have no idea how much you mean to me. I wish you were my son.” These words made Nilesh feel proud that Uncle depended on him; it gave him a sense of belonging and made him forget that he was naked.

One day, Nilesh decided to stop going to Uncle's place after Uncle unzipped himself and made him do some disgusting things. As he resisted, Uncle had said, “It is ok if you don't help. After all, who am I to you? Nobody. But I am happy to have helped you when you were in need, when that bowler was going to hit you with the bat.” Wordlessly Nilesh had gone about doing what was asked of him. He felt nauseated and left determined not to come back again.

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Nilesh spent three days ruminating about the incident. The more he thought, the more disgusted he felt. He wanted to break his friendship with Uncle. But he also felt guilty. After all that Uncle had done for him, he was being so ungrateful. No wonder his classmates called him bad names. Nilesh thought to himself that he was bad, and ungrateful. Tears welled up in his eyes. He was bad, bad, bad.

On the fourth day, immediately after school, Nilesh went to Uncle's home. As he rang the door bell, he fretted; will Uncle be angry with him for not visiting him for three days? Will Uncle break off his friendship with him? He couldn't bear the thought. Uncle opened the door and looked at Nilesh. Nilesh looking down, said, “I am sorry, Uncle. You are not angry with me, na?.” Uncle lovingly patted his head. Nilesh went in, and Uncle closed the door.

The Science

A study on child abuse by the Ministry of Women and Child Development, Government of India, 2007 reported that almost 53% of children report experiencing some form of abuse at least once.[1] The numbers are considerable, and children between the ages of 12 and 15 years were most vulnerable. Boys and girls are equally affected.

Over the last few years, Indian media, the public, and even the government have noticed the need to address Child Sexual Abuse (CSA.) Though the existence of CSA in our society has been known for a long time, the social stigma attached to it combined with cultural issues about shame, sexual maturity, consent etc., prevented any meaningful change in the legal framework to address this issue.

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Finally, in 2012, the Protection of Children from Sexual Offences Act (PoCSO) was passed. This Act defined child sexual abuse as any sexual activity by an adult with a child. It is a criminal offence.

Asking the child to exhibit his/her sexual organs, touching private parts of the child, explicit sexual conversation, showing pornographic material to a child, making pornographic material of the child, the act of penetrative sex with the child, the adult exhibiting his/her/their sexual organs to the child, asking the child to touch the sexual organ of the adult, or asking the child to perform a sexual act with the adult or someone else, are all offences.

Details related to child sexual abuse, Protection of Children from Sexual Offences Act (2012), and treatment requirements of the affected child survivor are beyond the scope of this book. We have provided a short note below, focusing on children who may fall outside the normative spectrum of sexual orientation and gender identity.

Children who may seem to be within this spectrum are more

vulnerable. They are usually under much stress and very likely to keep their thoughts and feelings a secret.

The need for secrecy makes them susceptible to blackmail and exploitation. Child abusers are known to pick and groom vulnerable children. Befriending the child, providing a patient and friendly ear, and offering help are known techniques used by child abusers to gain the child's trust.

There is no reliable India-specific information about the exact extent of CSA in LGBTI children. Clinical experience and first-person accounts point to sexual exploitation by authorities, adults, older children, and even peers. Due to mental isolation from caregivers, children are less likely to report such abuse. Unfortunately, most never speak about these experiences, even in adult life.

Protecting Children from Sexual Abuse

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We strongly recommend educating children about protecting themselves from abuse. After many years of counselling sexual abuse survivors and their families and conducting many workshops, Dr. Bhooshan Shukla developed the “NO-GO-TELL” program.

The “NO-GO-TELL” program is designed as a simple and effective way to help protect children by:

1. developing a shared vocabulary between parent/ caregiver and the child;

2. teaching the child about privacy or “NO TOUCH” area of the body; and

3. educating the child about simple but effective steps of “Shout NO, GO to a trusted adult and TELL about the bad touch.”

This educative program does not involve any uncomfortable language or direct mention of sexual organs or act. It is an effective program adopted by hundreds of schools, child support agencies,

and NGOs across India.

We recommend the following steps when a child tells you about "Bad Touch":

1. Make sure the child knows that they are safe with you. If required, remove them from the abusive environment;
2. hear out the child without interrupting or counter questioning;
3. do not blame the child for what happened;
4. make sure that the abuser does not further exploit the child; and
5. seek assistance from a Psychiatrist / NGO that work on CSA or contact "Childline" on toll-free pan India phone number 1098, for immediate help and guidance at the local level.

   Details of this protection program are available on the website- **http://www.nobadtouch.com**
   The information on this website is for anyone to use freely.

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Notes and References

[1] https://resourcecentre.savethechildren.net/library/study-child-abuse-india-2007

PART VI: THE SUM OF IT ALL

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THE THREE-DIMENSIONAL SPECTRUM

The previous chapters looked at illustrative cases simplified to focus on the topics at hand. Many factors like socio-economics, religion, family, disability, education, etc. which influence the lives of clients and their families have been left out intentionally.

This chapter summarises the previous chapters' various threads with focus on sex, gender, and sexuality.

An individual's sex, gender, and sexuality are three parts of a person. To make this easy to understand, we will simplify, and hence scientifically, it may not be 100% accurate.

- Biological Sex, i.e., anatomy of the person
  - Gonads of boys and girls and their functioning. Whether the individual has Testes or Ovaries; termed the Gonad dimension.
  - Whether the individual has XX sex chromosomes or XY sex chromosomes, or some other pattern of sex chromosomes, this is the Genotype dimension.
  - Presentation of the external genitalia; termed as the Phenotype or physical dimension.
- Gender Identity of the person
  - After attaining puberty, whether the person identifies theirself as male or female or both or none; this is the gender identity dimension.
- Sexual Orientation
  - After puberty, whether the person is sexually attracted to men only, or women only, or both men and women, or neither; this is the sexual orientation dimension.

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These three dimensions of biological sex, gender identity, and sexual orientation are not related to one another. Generally, most people have unity in all these dimensions. It means the chromosomes of the individual, genitalia, gender identity, and sexual orientation are congruent. This uniformity or congruence is being male or female.

None of these dimensions is discrete; each of these dimensions is a continuum. Medical science is aware that there are many grey areas in these dimensions, so even specialists may not know much about these grey areas. In short, no one should claim that he/she/they know everything about these complexities.

A simplified graphical representation of the three dimensions of sex, gender, and sexuality is given on the next page (Figure A) followed by some examples of sex, gender, and sexual attraction spectrum.

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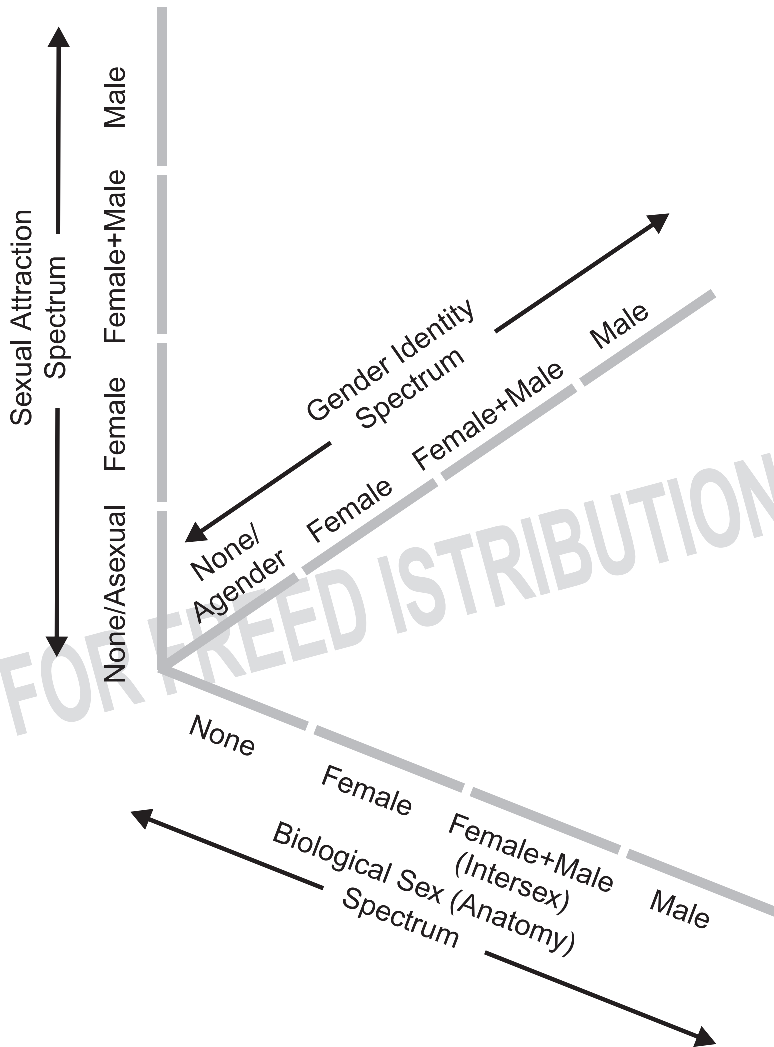

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Figure (A): The three-dimensions of biological sex, gender identity, and sexual attraction

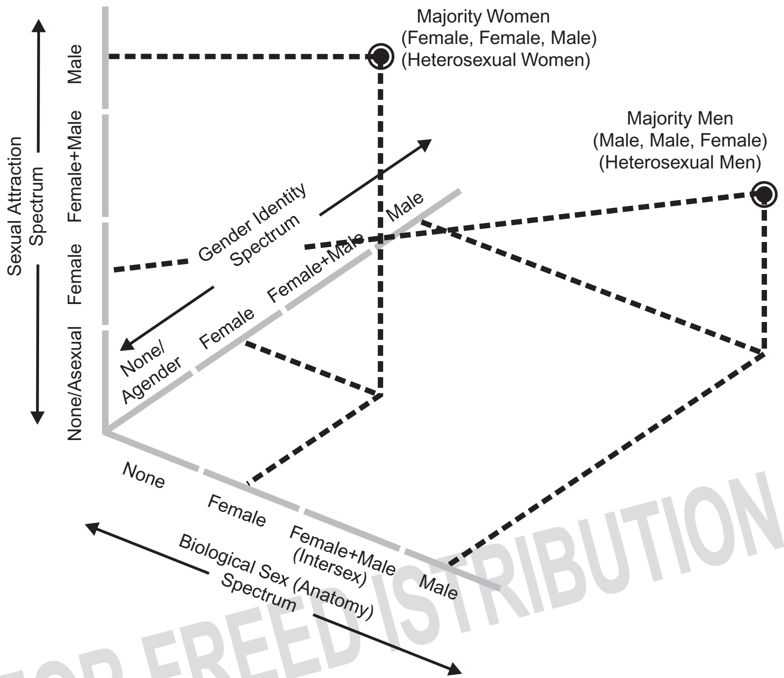

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Figure (B): Majority of men and women

Figure (B) Majority of men in the population, have biological sex male, experience the world as men (male gender identity), and experience sexual attraction for females only. Therefore, their coordinates are represented on the three-dimensional graph as- (Male, Male, Female.) These persons are cisgendered heterosexual men.

Majority of women in the population, have biological sex female, experience the world as females (female gender identity), and experience sexual attraction for men only. Therefore, on the three-dimensional graph, their coordinates are represented as (Female, Female, Male.) These persons are cisgendered heterosexual women.

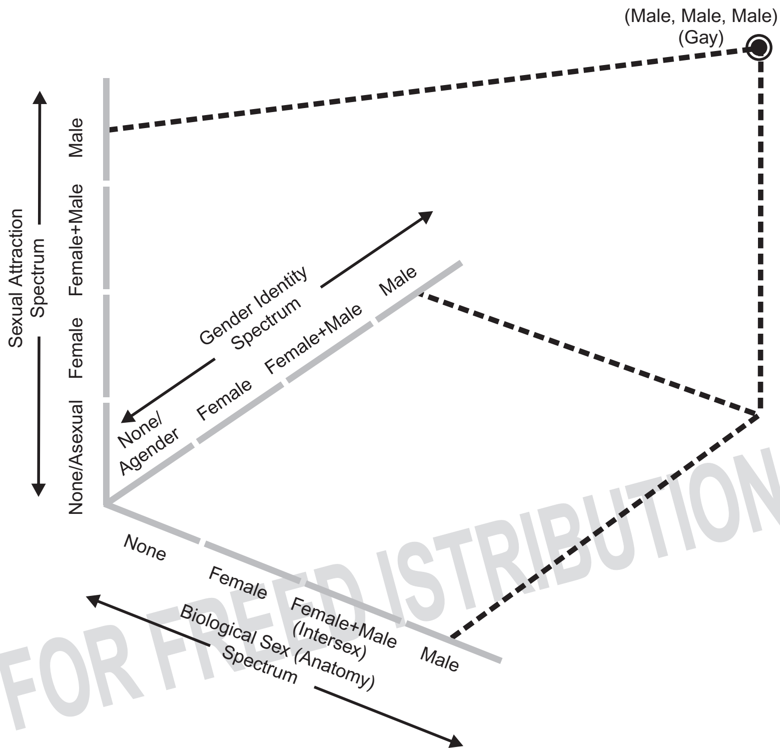

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Figure (C): Gay men

Figure (C) shows a person whose biological sex is male, experiences the world as a male (male gender identity), and experiences sexual attraction for men only. Therefore, his coordinates, on the three-dimensional graph are represented as (Male, Male, Male.) Such persons are gay men.

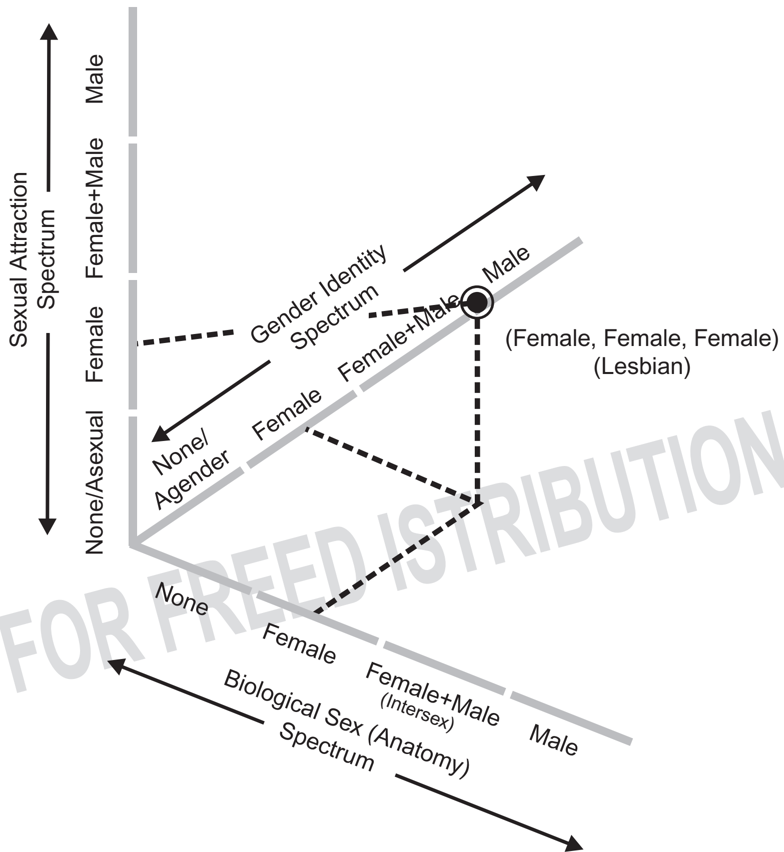

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Figure (D): Lesbians

Figure (D) shows a person whose biological sex is female, experiences the world as a female (female gender identity), and experiences sexual attraction for females only. Therefore, her coordinates, on the three-dimensional graph, are represented as (Female, Female, Female.) Such persons are lesbians.

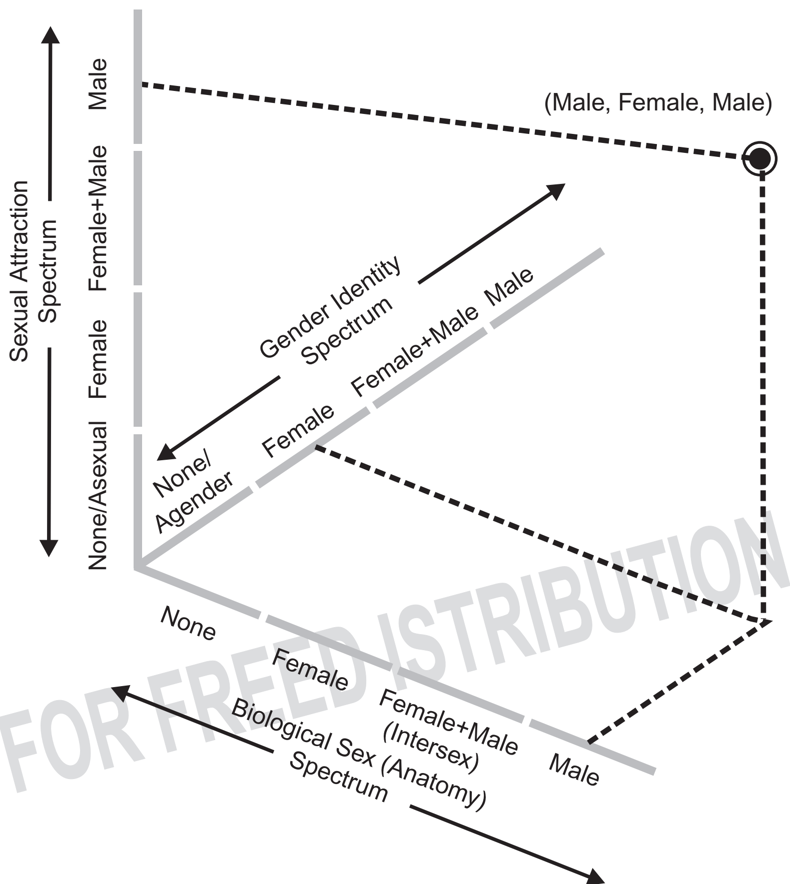

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Figure (E): A transwoman sexually attracted towards men

Figure (E) shows a person whose biological sex is male, experiences the world as a female (female gender identity), and experiences sexual attraction for men only. Therefore, her coordinates, on the three-dimensional graph, are represented as (Male, Female, Male.) The person shown in this example is a transwoman with sexual attraction towards men only.

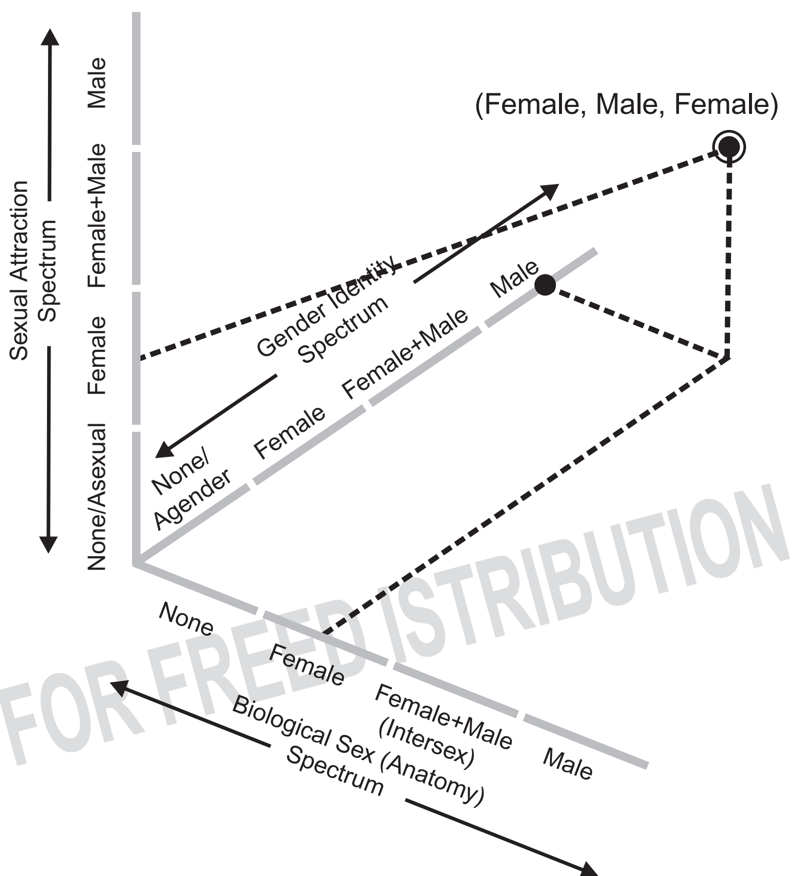

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Figure (F): Transman who is sexually attracted to women

Figure (F) shows a person whose biological sex is female, experiences the world as a male (male gender identity), and experiences sexual attraction for females only. Therefore, his coordinates, on the three-dimensional graph, are represented as (Female, Male, Female.) The person shown, in this example, is a transman with sexual attraction towards females only.

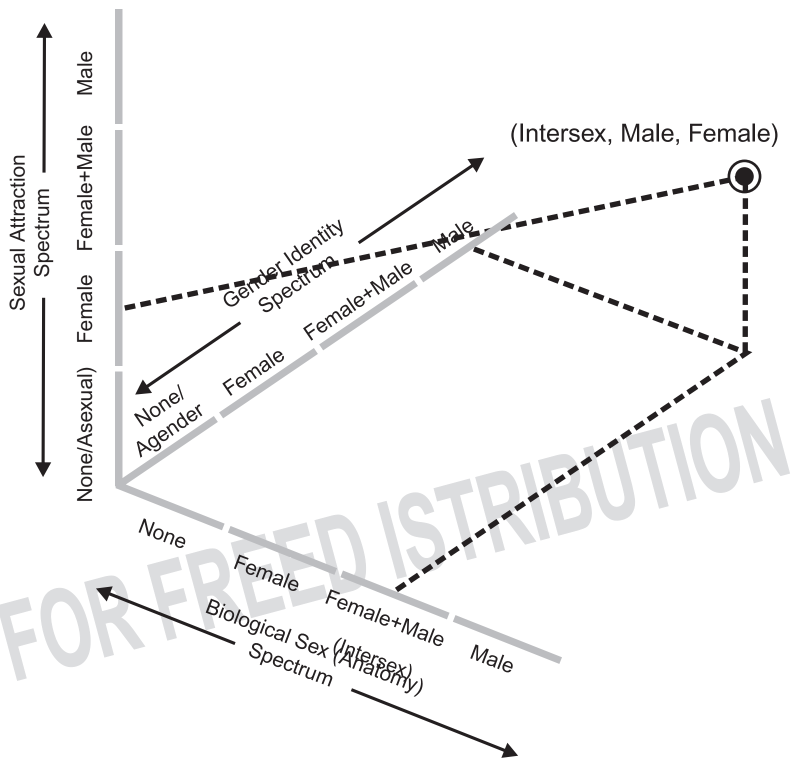

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Figure (G): Intersex person, gender identity male, sexual attraction to females

Figure (G) shows a person who is Intersex, experiences the world as a male (male gender identity), and experiences sexual attraction for females only. Therefore, his coordinates on the three-dimensional graph, are represented as (Intersex, Male, Female.)

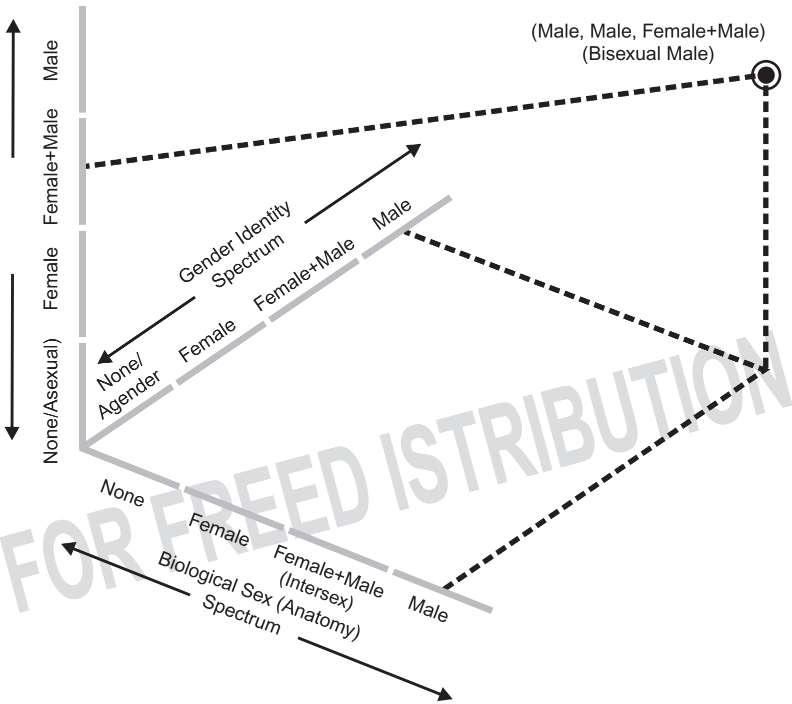

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Figure (H): Bisexual man

Figure (H) shows a person whose biological sex is male, experiences the world as a man (male gender identity), and experiences sexual attraction for females and males. Therefore, his coordinates, on the three-dimensional graph, are represented as (Male, Male, Female+Male.) The person shown, in the example, is a bisexual man.

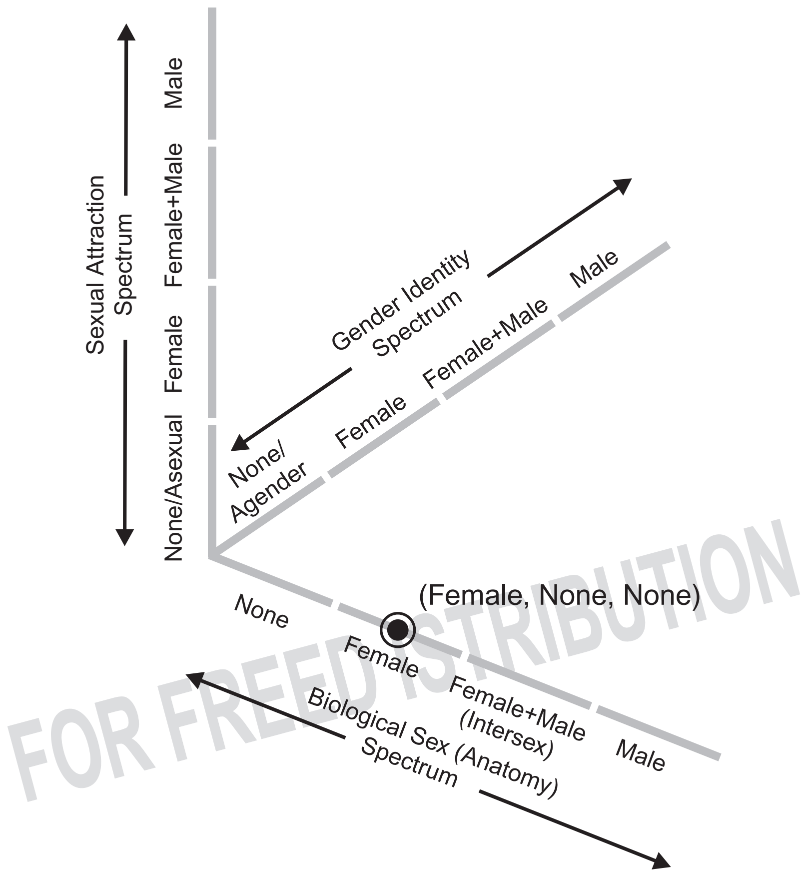

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Figure (I): Biological female, Agender, and Asexual

Figure (I) shows a person whose biological sex is female, experiences the world neither as a male nor as a female (agender gender identity), and experiences no sexual attraction to anyone (asexual.) Therefore, their coordinates, on the three-dimensional graph, are represented as (Female, None, None.) The person shown in the example is a biological female, agender and asexual.

SAURABH BONDRE

Bisexual male, age 41

As far as I remember my childhood, I was like other boys and slightly unlike them. I liked girls as well as boys. As I grew older, I learned about sexuality through discussions and vulgar jokes typical of teenagers. By the last year of school, I was aware of my physical attraction towards girls. Around the age of sixteen, I realized that I was sexually attracted to boys as well.

I realized two things quite clearly; First, I seldom felt guilty about my sexual orientation or exploration. Second, that society misconstrues my sexuality as a disorder, unnatural, and sinful. So, due to social pressure, I visited a couple of Counsellors to 'correct' my so-called disorder.

Most Psychologists those days were ignorant and ill-informed about these matters. Predictably, their efforts at 'correcting' me failed. Later, I met a Psychiatrist who provided affirmative counselling for Queer individuals. His counselling helped me gain a sense of dignity and self-confidence about many matters in my life, sexuality included.

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Around 2006-2007, I had started hanging around with the LGBTIQ communities in Mumbai, and I gained much more insight into various sexualities. A few sexual encounters with women and many more with men made it clear that I was technically bisexual with a more homosexual inclination. My attraction towards women was primarily physical. Had it been emotional, I would have indeed had some heterosexual 'affairs.' But with men, I got attracted physically as well as emotionally.

During this time, I met a youth I liked very much. He reciprocated my feelings but declined a relationship with me because I identified as bisexual. He felt that someday I might ditch him for a woman. I reasoned that if I was not faithful, I

could even ditch him for another man, but he said that that would hurt him less than if his boyfriend ditched him for a woman.

Besides, there are umpteen instances where bi-pretending men get married to unsuspecting girls upon reaching the age of marriage. I explained (and he understood what I was getting at) that many of these men are gay and use the 'bisexual' label to justify their relationship/marriage with the woman within the queer community. But I could not get him to shed off his insecurities about a bisexual boyfriend, and we broke up.

For a decade now, working in the queer movement, actively participating in organizing Mumbai Pride for six years, I experienced a lot of prejudice about bisexual men within and outside the queer community.

Many gay men refuse to date bisexual men because they think the person is cheating them. If the bisexual man wanted to cheat, he would not admit his bisexuality in the first place. He would rather pretend to be gay and enjoy the action as long as he can. So, I think it is very unwise to judge anyone based on their sexual orientation. The fact is, bisexual people genuinely feel sexual attraction towards both men and women. The relationship depends on the inter-personal relationship they share with that particular individual.

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Many bisexual people don't misguide others about their sexuality because that doesn't help gain anything. If people are only interested in physical pleasure, sexual orientation is entirely inconsequential. But if dating is to lead to a relationship, it makes sense to be honest from the very beginning. Ultimately, integrity counts in all sorts of social interactions, and is a precious virtue.

As far as intercourse is concerned, bisexual people find intercourse satisfying, with both women and men. Some bisexual people might naturally find intercourse with men

always more pleasurable than intercourse with women. Others might naturally find intercourse with women always more pleasurable than intercourse with men. Sexual satisfaction levels may depend upon their interaction with a sexual partner, or their mood or their partner's communication. There is no scope to generalise whether heterosexual or homosexual intercourse is more pleasurable for bisexual persons.

After I came out, my family like many other families having a gay child, was traumatised. But gradually, they came to terms with it. They can't talk about my sexuality as comfortably as I can. But they are convinced that I am normal, my sexual desire or expression is not a sin, nor am I a criminal, and that I have the right to lead a happy life in my way without harming others.

On a final note, I wish to thank my family for the support I have received from them. They accepted the fact that I do not want to marry a woman as I am far more into men than women.

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Mx SAP

Trans, Agender, Asexual, age 47

Preferred pronouns: they/them/their

It has been a long journey of self-identification and acceptance.

Though assigned female at birth, I never felt connected to it. I was the third girl child of my parents, born in a middle-class family. I was raised with complete freedom to express what I liked and what I didn't, what career I wanted to choose, what clothes I wanted to wear. From childhood, I was a person who never questioned much, but deep within, I felt different.

When my periods started at age 12, I thought it happened to everyone (not just girls.) It was a little later on that I found this

happens only for biological women.

I was pursuing my Arts degree when I fell in love with a girl in my class. It was the first, and the last time I fell in love. My partner identifies as a woman.

We have been in a committed romantic, asexual relationship for over 27 years. I love being with my partner, sharing my deepest fears, joys, sorrows, emotional support, and caring for her just like any other couple.

But, when we started our relationship, I did not know what to call this relationship. Those days' people saw me as a woman as they were not aware that I was a transperson. To be honest, neither was I aware of who I was.

When I was young, I looked like a 'tomboy.' I was underweight. My chest was almost flat. But later on, I started putting on weight. As my breasts began to grow, I felt very uncomfortable. I would love to have a flat chest like a man without any sexual organs (of either a man or a woman), but I didn't gender-identify myself as a man. So, here I was, not gender-identifying myself as a man or a woman. So, who was I?

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A couple of years later, I started coming across articles about different gender identities and labels. I joined gender non-binary groups on social media and met many people worldwide who were like me. That was when I found out that I was not alone. Gender, too, like sexuality, has a spectrum- for some of us, it's not an either-or thing, and society should respect our experiences, believe us, and accept us as we are. It is challenging for people with closed minds to understand the concept of a spectrum.

Being an artist by profession, I feel that seeing life in black or white is not enough. We should remember that when we mix these two colours, it gives us many shades of greys. Similarly, there are infinite possibilities of gender identification beyond

the male and female binary, known as ‘gender non-binary identities’.

And so finally I came to understand that my identity is– ‘Trans, Agender, Asexual’ person. So, instead of using binary pronouns like him/her, I prefer to use the pronouns they/them/their. I have chosen my name as Sap which is the first half of my legal name. Sap means life-generating fluid in plants. I love this name. I feel very much validated and euphoric when someone uses my chosen name and correct pronouns.

I have been very vocal about my gender and sexual identity. All my close friends and family are aware of my gender/sexuality. Yes, some senior family members have difficulty remembering my pronoun and gender identity, which I completely understand. But for others, I expect them to use my preferred name and correct pronoun. I consider that essential to my identity.

Today, I share all of this so that people become aware that there are people like me- people who may not be comfortable with the gender assigned at birth; people who may want to completely disregard gender and live as happy human beings and feel validated.

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Parents of LGBTIQA

When parents become aware of their son or daughter's gender/sexuality, they often blame themselves. Parents wonder whether their child's gender/sexuality is the outcome of the way they brought up their son or daughter. The answer to this question is a definite “No!.” There is no correlation between the upbringing of an individual and his or her gender identity and sexual orientation.

No one is responsible for a person's biological sex, gender identity, and sexual orientation. Neither parents nor anybody

else has any role influencing a person's sex, gender, or sexuality. A person's gender and sexuality may be inconvenient for him/her/them or their parents. But frankly, no one can do anything about it. We cannot change either gender identity or sexual orientation. Attempting a change has an adverse effect on that individual's self-worth (which is already poor, to begin with.) We do not gain anything from this approach.

Parents often seek Psychiatrists' advice and ask, “What can we do to change my son or daughter's gender/sexual orientation?” At times, some gay and transgender community members also approach Psychiatrists for a 'cure.'

Our blunt answer is that there is no 'cure.' None of the gender identities- cisgender, transgender, pangender, agender or sexual orientations- heterosexual, bisexual, homosexual, or asexual are illnesses or disorders.

The key is self-acceptance and acceptance by all others of the person with his/her/their sex, gender, and sexuality.

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Parents strongly believe that they have a significant influence in moulding their children. They need to note that this does not extend to moulding the child's sexual orientation or gender identity.

We would like to state that gender and sexualities are 'biologically driven' and cannot be influenced by a person's external world. This has been proven scientifically, time and again.

Yes, it is natural for parents to feel sad when they learn about their child's uncommon sex, gender, or sexuality; it is normal to feel the pain that their child is different from others. All of us can understand that and respect that. But if parents believe that, “I am responsible for my child's gender/sexuality and come what may, I will change it.” We clearly state that, it is impossible to do so.

At times we come across parents who accept their child's gender and sexuality but still want them to get married and have children

as a moral and social duty or obligation. Most parents expect this from their children. **The greatest injustice parents inflict on their children is forcing them to do things they are not programmed to do.** We have seen too many children miserable because their parents have forced them into vocations they are not interested in or do not have the aptitude. So you can well imagine their trauma of being forced into marriages, they do not want, in the name of religion or duty or social expectation. When it comes to gender/sexuality, parents should not expect fulfilment of their expectations based on what the majority expects.

Intending to make their son and daughter conform to the majority view, parents end up blackmailing their children. They force their prejudiced ideas on them and make their sons and daughters' lives miserable. In addition, after a forced marriage, his or her partner too suffers, as there is no bond of love and longing between the two. After marriage, if they have children, then these children suffer too. Will you marry your heterosexual daughter to a gay man? Or marry a heterosexual son to a lesbian? Then why do you apply one yardstick for your gay child and another for a heterosexual child? Why this hypocrisy? This is how we keep on bringing more and more people within this orbit of pain and misery.

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But here, we would like to emphasize that in our professions, we have seen and continue to see more and more parents, especially mothers, trying their best to understand and support their children whatever their sex, gender, or sexuality.

When parents come to know their child's sexual orientation or gender identity, their initial reaction is usually shock, anger, or anxiety. At times, parents believe that “this is not the appropriate time to focus on 'such' things; the child should focus on 'studies'.” So far, we have not come across any parent who can give a satisfactory age for 'such' things. Most prefer not to deal with this at any stage of their child's life.

Parents need to understand that media nowadays reports, and

discusses these issues much more openly than before. The child's access to the internet gives them multiple options to understand his/her/their sexual orientation and gender identity at an early age. It is not uncommon for adolescents, even in rural areas, to bring up this issue with parents. Clinicians are reporting a yearly rise in the number of children brought for counselling for similar issues.

What should parents do when a child or adolescent discloses that they belong to a minority sexual orientation or gender identity?

The first aim is to preserve a trusting and warm relationship between parents and children. This relationship is vital for the child's present and future. So, no steps should be taken that jeopardize this bedrock of a child's secure future.

It does not matter if parents come across this information about their child accidentally or if the adolescent decides to share it voluntarily with parents. Following general steps can help –

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1. Do not give your opinion or judgment immediately when you come across this information.
2. If your child voluntarily discloses this information to you, thank them for their trust in you. It takes a lot of courage to open to parents about complex issues.
3. Ask your child how did he/she/they find out and if they have come across any information that will help you as parents.
4. At times, the child will mention that he/she/they are 'non-binary' or that 'they know they are not hetero-normative, but cannot define who they are.' This could mean that they are still exploring, in the process of understanding what their sexual orientation or gender identity is, or it could mean that they belong to a gender/sexual minority population whose gender/sexuality is fluid, or it could mean that they prefer not to be tagged with any label- e.g. transperson, etc. It can be

doubly challenging for a parent to understand and support a child whose gender/sexuality is unclear. Nevertheless, do not push the child to declare themselves to be one or the other; do not assume that if they are unclear about their sexual orientation or gender identity, they can be somehow coerced, manoeuvred into hetero-normativity. Give them time; let them be.

5. If parents feel overwhelmed by this challenge or want to know healthy ways of responding, it is good to take help from a LGBTIQA aware and sensitive Counsellor or Psychiatrist.

6. Starting a discussion on 'focusing on studies' is not helpful in the long run as children are likely to look at it as a diversion technique by parents.

7. Some children will introduce this topic as, "I have a friend who is....", or "I read this story on the internet about a boy/girl who is......" this could be an attempt to test waters with the family, so it is always helpful to react non-judgmentally during these discussions.

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8. Most children are happy to hear warm and accepting words from their parents. Assurance that they are free to follow their own choices once they reach adulthood usually reduces friction significantly.

9. If the child is asking for Gender Affirmative Treatment we recommend that Gender Affirmative Treatment be dealt with after the child reaches adulthood; he/she/they can then make an informed decision.

10. Threats to abandon your child, throw them out of the house, force them into a marriage, blackmail them into conversion therapy are guaranteed to emotionally drive the child away from the safety of a family and become even more vulnerable. In need of support, such kids can befriend anti-social persons and expose themselves to more danger.

11. The parents' focus should be on the child's safety-
    (a) Safety from sexual abuse;
    (b) Protection from bullying, ragging and harassment;
    (c) Safety from blackmail; and
    (d) And lastly, safety from STIs and HIV/AIDS.

When you need support or guidance, talk to a LGBTIQA inclusive Counsellor or Psychiatrist. An immediate, angry reaction though understandable, is unhelpful and is most likely to scar the child for life.

LGBTIQA Youths

Just as parents should not force their prejudiced views on their children, LGBTIQA youths need to understand that they should not have unrealistic expectations from their parents. Parents have difficulty understanding sex, gender, and sexuality issues, as they are three generations behind their children.

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If we consider one generation to be 7-10 years, LGBTIQA youths are three generations ahead of their parents. It is unrealistic to expect parents, who are three generations behind their children, to understand uncommon sex, gender, and sexuality.

With maturity, you will realize that no individual can fully understand another individual. Acceptance by parents, giving you the freedom to live your life independently is one thing, but insisting that they should understand and support you completely may be expecting too much, especially if they come from a conservative background.

Some LGBTIQA clients state that now that their parents have accepted them, they should also 'support' them (e.g. Walk with them in a LGBTIQA Pride Walk etc.) If parents can do this, well and good. But some parents find it hard to do so. It is important to note that they struggle to understand and accept you with great difficulty and effort. This is a huge step forward for them. If they are trying hard to accept you, you as children should also respect

their efforts and give credit where due.

If you think your parents are not accepting you, you should consider the option of moving out of the house, staying independently, and living your life the way you want. And for that financial self-sufficiency is extremely important. We believe that every youth should look at financial self-sufficiency as an important component of their life-goals of freedom and respect. Sadly, we have come across LGBTIQA clients who, despite being adults, remain entirely financially dependent on their parents. They show no intention of letting go of the benefits of remaining part of the family but continue complaining that their parents are not providing sufficient 'support.'

The other side of the coin is, at times, parents, worried that their child would end up being a 'lost cause' if he/she steps out in the real world, become too protective. That kind of protection harms the child and keeps the child dependent on them forever. Once your child becomes an adult, he/she/they will have to start fending for themselves. At times, they will take decisions that could be devastating for them, but that is life. There are usually no perfect solutions to complex problems.

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Parents and LGBTIQA children need to understand that if both have to support each other, there will have to be compromises made by both sides. The situation is tough and challenging, and they should try to handle this pragmatically.

Summary

Both, parents and children, need to understand that constantly focusing on the child's gender/sexuality and excluding everything else can make the child obsessed with their gender/sexuality. That is the biggest tragedy of all. At no point in time is your entire being represented by your gender/sexuality. For sexual minorities, this always remains a big issue because they may not experience life beyond sex/gender/sexuality. This means that their entire universe, whether it be a career in any field, or a hobby, is

invariably tied to and limited to their sex/gender/sexuality. This can happen with most people at the beginning of adulthood and is understandable. But over a few years, they can move on. Sadly, some get fixated at this stage forever, and that is harmful. For them, gender/sexuality is the beginning and the end of everything.

Parents are obsessed with their child's sex/gender/sexuality; society is obsessed with sex/gender/sexuality, so it logically follows that LGBTIQA children remain obsessed with their sex/gender/sexuality. They don't get a chance to develop into whole, complete human beings. And struggling their entire lives to fit into one or other gender/sexual mould, they are unable to experience life like any other human being. But parents can help avoid this tragedy. We are aware that this is not easy in real life. It is easy to talk about it, but if parents do not do this for their child, who will?

Appendix A: The Indian Psychiatric Society's (IPS) Position Statement on Same-sex Attraction, Orientation, Behaviour and Life style. March 2016.

INDIAN PSYCHIATRIC SOCIETY

Headquarters : PLOT 43, SECTOR 55, GURGAON, HARYANA 122 003, INDIA
Secretariat : 19/C, Pioneer Park, Barasat, Kolkata - 700 124, West Bengal, India
Phone : +91 33 2284 5300, **Mobile :** +91 98300 55235, **Email :** ipssecretaryoffice@gmail.com
Website: www.indianpsychiatricsociety.org | www.indianjpsychiatry.org | www.e-ipsdir.org

Dr. G Prasad Rao	Dr. (Brig.) MSVK Raju	Dr. Gautam Saha	Dr. Mukesh Jagiwala	Dr. TSS Rao
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Hyderabad 500029	Pune - 411028	West Bengal	Surat - 395001	MG Road, Mysore 570 004
T : +91 40 66752222	T : +91 20 26802236	T : +91 33 25426836	T : +91 261 6592980	T : +91 33 24067325
M : +91 9985900005	M : +91 9890419481	M : +91 9830055235	M : +91 9879521795	M : +91 9845282399
E : prasad40@gmail.com	E : msvkraju@rediffmail.com	E : drgsaha@yahoo.co.in	E : mukeshjagiwala@yahoo.co.in	E : tssrao19@gmail.com

Executive Council (2016)

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Zonal Representatives:

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The Indian Psychiatric Society's Position Statement on same-sex attraction, orientation, behaviour and life style

Modern medicine and psychiatry, since the 1970's, have abandoned pathologizing same-sex orientation and behavior.[1] The World Health Organization accepts same-sex orientation as a normal variant of human sexuality.[2] The United Nations Human Rights Council values Les[illegible] [illegible]ay Bisexual and Transgender (LGBT) rights.[3]

India's Supreme Court recently issued [illegible] human righ[illegible] reinstating a law that bans gay [illegible] S[illegible] of th[illegible] Indian [illegible] Code.[4] The prevalent circu[illegible] and r[illegible] co[illegible] India suggests the need for [illegible] hen[illegible] posit[illegible] s[illegible]

[illegible] India[illegible] ecognises the universality of same-sex [illegible], across cul[illegible]res. It holds the position that homosexual orientation per [illegible] objective psychological dysfunction or impairments in ju[illegible] stability and vocational capabilities.[5] The Indian Psychiatric Society considers same-sex attraction, orientation and behaviour as normal variants of human sexuality.[5] It recognises the multi-factorial causation of human sexuality, orientation, behaviour 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.[5]

The Indian Psychiatric Society acknowledges social stigma and consequent discrimination of people with same-sex orientation.[5-6] It recognises that the difficulties they face are a significant cause for their distress and calls for the provision of adequate mental health support.[5-6]

The Indian Psychiatric Society supports the need to de-criminalise same–sex orientation and behaviour and to recognise LGBT rights to include human, civil and political rights.[6] It supports efforts at seeking the repeal of Section 377 IPC as the 19th century law has no place in a 21st century democracy. It supports the legal recognition of same-sex relationships, civil unions and marriage, adoption and parenting.[6] It also supports anti-bullying legislation, anti-discrimination student, employment and housing laws, immigration equality, equal age of consent law and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.[6] The Indian Psychiatric Society supports government efforts and encourages Parliament to leave a lasting legacy of progress by repealing Section 377 IPC.

1st Mar 2016

Dr. G. PRASAD RAO
M.D., D.P.M.
ASHA HOSPITAL
PRESIDENT
INDIAN PSYCHIATRIC SOCIETY

(PTO)

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Once you label me, you negate me ~ Soren Kierkegaard

Dr. G. PRASAD RAO
M.D., D.P.M.
ASHA HOSPITAL
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Appendix B: World Psychiatric Association's (WPA) Position Statement on Gender Identity, Same-Sex Orientation, Attraction, and Behaviours. March 2016.

WPA Francesca Sotgiu

From:	WPA Secretariat
Sent:	mercredi 23 mars 2016 14:23
To:	'samapathik@hotmail.com'
Cc:	Bhugra, Dinesh <dinesh.bhugra@kcl.ac.uk> (dinesh.bhugra@kcl.ac.uk)
Subject:	WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction and Behaviours
Attachments:	WPA Statement on Gender Identity and Same Sex Orientation March 2016.pdf

Dear Dr. Bindumadhav Khire,

As per your request, please find, attached, the WPA Statement on Gender Identity duly signed by Prof Dinesh Bhugra, President of the World Psychiatric Association.

A hard copy, signed by Prof Bhugra and with the WPA stamp, is also mailed today to your attention.

Yours sincerely,

Francesca SOTGIU
Administrator

WPA Secretariat
Geneva University Psychiatric Hospital,
2 chemin du Petit-Bel-Air
CH-1225 Chêne-Bourg/Geneva
Switzerland
Tel : + 41 22 305 57 37
Fax : +41 22 305 57 35
Email : wpasecretariat@wpanet.org
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ASOCIACIÓN MUNDIAL DE PSIQUIATRÍA

WPA President

Prof. Dinesh Bhugra
Professor of Mental Health and Cultural Diversity
Maudsley International
Health Service and Population Research Department
David Goldberg Centre
De Crespigny Park
London SE5 8AF
United Kingdom
Tel: +44 20 7848 0500
Fax: +44 20 7848 5056
E-mail: dinesh.bhugra@kcl.ac.uk

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WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours

Background

Recent controversies in many countries suggest a need for clarity on same-sex orientation, attraction, and behaviour (formerly referred to as homosexuality).

Along with other international organisations, World Psychiatric Association (WPA) considers sexual orientation to be innate and determined by biological, psychological, developmental, and social factors.

Over 50 years ago, Kinsey et al (1948) documented a diversity of sexual behaviours among people. Surprisingly for the time, he described that for over 10% of individuals this included same-sex sexual behaviours. Subsequent population research has demonstrated approximately 4% of people identify with a same-sex sexual orientation (e.g., gay, lesbian, and bisexual orientations). Another 0.5% identify with a gender identity other than the gender assigned at birth (e.g., transgender) (Gates 2011). Globally, this equates to over 250 million individuals.

Psychiatrists have a social responsibility to advocate for a reduction in social inequalities for all individuals, including inequalities related to gender identity and sexual orientation.

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Despite an unfortunate history of perpetuating stigma and discrimination, it has been decades since modern medicine abandoned pathologising same-sex orientation and behaviour (APA 1980) The World Health Organization (WHO) accepts same-sex orientation as a normal variant of human sexuality (WHO 1992). The United Nations Human Rights Council (2012) values Lesbian Gay Bisexual and Transgender (LGBT) rights. In two major diagnostic and classification systems (International Classification of Diseases (ICD-10) and DSM-5), same sex sexual orientation, attraction, and behaviour and gender identity are not seen as pathologies (WHO 1993, APA 2013).

There is considerable research evidence to suggest that sexual behaviours and sexual fluidity depend upon a number of factors (Ventriglio et al 2016). Furthermore, it has been shown conclusively that LGBT individuals show higher than expected rates of psychiatric disorders (Levounis et al 2012, Kalra et al 2015), and once their rights and equality are recognised these rates start to drop (Gonzales 2014, Hatzenbuehler et al 2009, 2012, Padula et al 2015).
People with diverse sexual orientations and gender identities may have grounds for exploring therapeutic options to help them live more comfortably, reduce distress, cope with structural discrimination and develop a greater degree of acceptance of their sexual orientation or gender identity. Such principles apply to any individual who experiences distress relating to an aspect of their identity, including heterosexual individuals.

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WPA believes strongly in evidence-based treatment. There is no sound scientific evidence that innate sexual orientation can be changed. Furthermore, so-called treatments of homosexuality can create a setting in which prejudice and discrimination flourish, and they can be potentially harmful (Rao and Jacob 2012). The provision of any intervention purporting to "treat" something that is not a disorder is wholly unethical.

Action

1. The World Psychiatric Association (WPA) holds the view that lesbian, gay, bisexual, and transgender individuals are and should be regarded as valued members of society, who have exactly the same rights and responsibilities as all

other citizens. This includes equal access to healthcare and the rights and responsibilities that go along with living in a civilised society.

2. WPA recognises the universality of same-sex expression, across cultures. It holds the position that a same-sex sexual orientation per se does not imply objective psychological dysfunction or impairment in judgement, stability, or vocational capabilities.

3. WPA considers same-sex attraction, orientation, and behaviour as normal variants of human sexuality. It recognises the multi-factorial causation of human sexuality, orientation, behaviour, and lifestyle. It acknowledges the lack of scientific efficacy of treatments that attempt to change sexual orientation and highlights the harm and adverse effects of such "therapies".

4. WPA acknowledges the social stigma and consequent discrimination of people with same-sex sexual orientation and transgender gender identity. It recognises that the difficulties they face are a significant cause of their distress and call for the provision of adequate mental health support.

5. WPA supports the need to decriminalise same–sex sexual orientation and behaviour and transgender gender identity, and to recognise LGBT rights to include human, civil, and political rights. It also supports anti-bullying legislation; anti-discrimination student, employment, and housing laws; immigration equality; equal age of consent laws; and hate crime laws providing enhanced criminal penalties for prejudice-motivated violence against LGBT people.

6. WPA emphasises the need for research on and the development of evidence-based medical and social interventions that support the mental health of lesbian, gay, bisexual, and transgender individuals

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The writing group was led by Professor Dinesh Bhugra and constituted Drs Kristen Eckstrand (USA), Petros Levounis (USA),Anindya Kar(India), Kenneth R Javate (Philippines)

Geneva, March 2016

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World Psychiatric Association Secretariat
Psychiatric Hospital
Bâtiment Les Voirons
2, Chemin du Petit-Bel-Air
1225 Chêne-Bourg
Switzerland
Tel: +41 22 305 57 30
Fax: +41 22 305 57 35

President

World Psychiatric Association (WPA)

Ref: **WPA Position Statement on Gender Identity and Same-Sex Orientation, Attraction, and Behaviours/ March 2016**

ABOUT THE AUTHORS

Dr Bhooshan Shukla (M.D., DNB, MRCPsych)

Dr Bhooshan Shukla is an M.D. (Psychiatry), D.N.B. (Psychiatry), MRCPsych (London) and holds a Medical Diploma in Hypnosis (London.) Dr Shukla has worked as a Consultant Psychiatrist and Psychotherapist since 1999. After completing further education in Psychiatry in the UK, he returned to India in Feb, 2008 and started full-time work as a Child & Adolescent Psychiatrist and a Parenting Coach.

Dr Shukla's passion and proficiency lies in his work at the clinic and with various schools, NGOs, and Government agencies to help children with academic, emotional, developmental, and behavioural difficulties.

Dr Shukla's training program of "NO – GO – TELL" in preventing abuse was featured on Amir Khan's *Satyamev Jayate* and has been adopted by various NGOs and government agencies. Dr Shukla has been a relentless advocate of mental health as an essential component of overall wellbeing. He works with multiple schools, colleges, Family Courts and the Juvenile Justice system. In addition to his private practice, Dr Shukla conducts parenting workshops too.

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Bindumadhav Khire

Contact: bindumadhav.khire@gmail.com
Whatsapp: 9763640480

Bindumadhav Khire, born on June 21, 1968, in Pune, is a gay activist working in Pune (India) since 2000 on LGBTIQA rights. He has done his B.E. in Computer Science and has a degree in Law (LLB.) Bindumadhav retired from his IT career at the age of 35 and founded Samapathik Trust (2002) in Pune. In 2019, he founded Bindu Queer Rights Foundation.

Books in English authored by Bindumadhav:

1. Manual: Basics of LGBTIQ Inclusion In Hospitals. Bindu Queer Rights Foundation. 2020.
2. No Man's Land. A memoir of a gay activist. Self-published. 2020.
3. Manual: Legal Tips For Social Workers Working on LGBTIQA Issues. Bindu Queer Rights Foundation. 2021.

Books in Marathi authored by Bindumadhav:

1. *Partner*. Self-published, Pune. 2004. (Fiction novella)
2. *Laingik Shikshan, Laingikata, HIV/AIDS Helpline Margadarshika (Running a Helpline on Sex Education, Sexuality and HIV/AIDS.) Samapathik Trust, Pune. 2007.*
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5. *Intersex- ek prathamik olakh (Introduction to Intersex.) Samapathik Trust, Pune. 2015.*

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Books in Marathi edited by Bindumadhav:

1. *Antaranga– Anthology of true stories of gays and lesbians*. *Samapathik Trust, Pune.* 2013.
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3. *Manachiye Gunti- Anthology of true stories of parents of gays and lesbians*. *Samapathik Trust, Pune.* 2013.

Translations:

Beautiful People; an English translation of *Manachiye Gunti*. *Samapathik Trust, Pune.* 2016

Other Works:

Editor: *Samapathik* Diwali Ank (Annual magazine in Marathi, on LGBTIQ issues) (2019 and 2020)

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BASICS OF SEX, GENDER, AND SEXUALITY

Dr. Bhooshan Shukla
(M.D., DNB, MRCPsych)

Bindumadhav Khire
(LGBTIQA Activist)

BASICS OF SEX, GENDER, AND SEXUALITY: An Introduction to Lesbian, Gay, Bisexual, Trans, Intersex, Queer, and Asexual (LGBTIQA) India for Parents, Counsellors, and Allies is a compendium of facts and culturally appropriate experiences to help gain a better understanding of such issues in supporting a LGBTIQA family member, client, friend or colleague.

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The book consists of a series of case-stories about common presentations, related to LGBTIQA, in clinical situation. Common issues arising with these cases are discussed.

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